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On the Front Lines: Managerialism in Substance Abuse Agencies

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ON THE FRONT LINES: MANAGERIALISM IN SUBSTANCE ABUSE AGENCIES

by

JOCELYN LEWISKIN, LCSW

A dissertation submitted to the Graduate Faculty in Social Welfare in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

2018

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Jocelyn Lewiskin

This manuscript has been read and accepted for the Graduate Faculty in Social Welfare in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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ABSTRACT

On the Front Lines: Managerialism in Substance Abuse Agencies

by

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Neoliberal economic policies have led to changes within the field of human services in the United States since the mid-1970s. These policies, which seek to reduce the role of the federal government through tactics such as privatization, continue to be evident across human services organizations today. This policy approach is operationalized through New Public Management (NPM), which is also referred to as 'Managerialism', and is characterized by output-orientated, quantitative focused, performance based measures and evidence-based practice. These characteristics have impacted the workforce in human service organizations. Using qualitative semi-structured interviews of front line workers, this dissertation will examine the effects of Managerialism on workers in the sector of substance abuse treatment within the larger human services context. These front line workers offer a unique perspective since substance abuse treatment is an area within social service delivery that has seen many policy transitions towards a Managerialism model.

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CHAPTER 1: PROBLEM FORMULATION AND STUDY AIMS

Human services agencies have a long history in the U.S. of delivering services to vulnerable and marginalized individuals, families, and communities as they tackle a variety of social problems. Because human service agencies can be considered the vital lifeline in connecting clients to the needed services, interventions and resources, it is important that researchers, policy makers and practitioners work together to ensure that agencies uphold this legacy of service provision both effectively and efficiently. It is critical to the survival of agencies that they remain open and adaptable to the ever-changing world in which we live. This adaptability can include embracing new findings in research, science and technology and managing shifts in the political and economic climates. Notably, the recent shifts in policies under the Neoliberal paradigm have created new organizational arrangements referred to here as Managerialism but that the scholarly literature also refers to as New Public Management (NPM). The purpose of this study is to examine how changes introduced by Managerialism have affected the human services workforce, especially the front line workers in substance abuse agencies. Substance abuse remains a chronic social problem in New York City as well as the United States. However, little research exists that specifically examines if and how Managerialism policies and tactics affect the quality of their work.

The economic crisis in mid-1970s led to the restructuring of the US welfare state designed to undo the New Deal by redistributing income upwards and downsizing the state (Harvey, 2005; Mullaly, 2007). The tactics included tax cuts, budget cuts, privatization (shifting social welfare responsibility from the public to the private section) and devolution (shifting social welfare responsibility from the federal government to the state and weakening the influence of social movements) (Abramovitz, 2018). In this analysis, Managerialism represents a

manifestation of privatization. Most commonly privatization refers to the method used to reduce the role of the government in entitlement program such as Social Security and Medicare.

However according to Harvey (2005) and Abramovitz (2012), privatization also refers to bringing market principles or business goals, principles and methods into the operation of human service agencies. Hasenfeld and Garrow (2012) refer to this as applying the institutional logic of business management to the human services sector. Also referred to as the business model, Managerialism has led agencies to increase their focus on productivity, accountability and efficiency (Alexander, 2000; Connell, Fawcett & Meagher, 2009; Stark, 2010).

The literature from the US and internationally reports that the implementation of these goals associated with Managerialism has led to faster pace of work; increased use of measurable standards of performance outcomes; changes in federal, state and local government regulations; diminished resources for agencies due to budget cuts; increased reliance on private funders; greater use of evidence-based interventions, more time spent on reporting and documenting outcomes, increased pressure to meet targeted goals and growing demands to do more with less (Alexander, 2000; Banks, 2013 Carey, 2008; Connell, Fawcett, & Meagher, 2009).

Some in the field support the rise of Managerialism arguing that its methods introduce a more scientific, efficient, and measurable approach to social work, increase the effectiveness and the creditability of the human services, and otherwise benefit agencies workers and clients (Hood, 1991; Mullaly, 2007). Critiques, such as Baines (2006) and Carey (2008), worry that these new policies threaten the quality of service delivery.

These and other opponents fear that these changes risk stripping the fundamental “care” and “relational aspects” from the human services (Baines, 2006a; Abramovitz & Zelnick. 2010).

The controversy around the transformation occurring in the human services merits further

study. Yet few researchers have asked front line workers--who sit at the intersection of clients and agency policies--about their experience with Managerialism. Through the use of semi-structured qualitative interviews, this study brings the voices substance abuse programs workers into the discussion of Managerialism.

CHAPTER 2: LITERATURE REVIEW

Rise of Neoliberalism and the U-Turn in Public Policy

Neoliberalism as an Ideology

Neoliberalism has been on the rise in the United States throughout the last several decades. Connell, Fawcett & Meagher (2009) define Neoliberalism as “the project of economic and social transformation under the sign of the free market” (p. 331). Neoliberalism favors principles of individual liberty and responsibility, competition, and the work ethic (Hasenfeld & Garrow, 2012). Harvey (2005) states, “Neoliberalism is in the first instance a theory of political economic practices that proposes that human well-being can be best advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets and free trade” (p. 2).

The movement towards Neoliberalism counters the liberal notion dating back to the 1930s in the US in which the government, via the welfare state, is responsible for providing resources to people in need. Instead, Neoliberalism promotes the use of the free market to allocate resources, including privatization of formerly public services. When applied to the field of human services, privatization can alter both organizational structure and agency functioning.

The rise of the social welfare state: 1935-1945. The rise of the US welfare state can be seen as a result of the economic downturn that followed the 1929 stock market crash. Up until this time in US history, society left most social welfare provisions in the hands of religious and charitable organizations or local and state governments. However, the economic devastation of the Great Depression led the nation’s leaders to call for a greater response from the federal government. As a result, programs such as the New Deal brought in a restructuring of the political economy that included an expanded role of government in many areas, including the

role and function of the welfare state (Abramovitz, 2018). During this time, two historical events solidified the emergence of the welfare state: (a) the Supreme Court's declaration of the constitutionality of federal responsibility for the general welfare of people and (b) the movement towards a Keynesian economic approach in which greater government spending is needed to stimulate economic growth (Abramovitz, 2018; Harvey, 2005).

The golden era of capitalism: 1945- 1975. With the expansion of the welfare state after World War II, many individuals and families turned to the new social welfare system to access income and needed services (Abramovitz, 2012). Government support, especially cash assistance, also helped to boost spending and spur economic growth. This era, often called the “golden era of capitalism” because it created job security for many workers, rising wages, strong unions and a progressive income tax system (Abramovitz, 2004).

This “golden era” ended by the mid-1970s, when the US experienced the second major economic crisis of the 20th century that led to a slowdown in economic growth and falling profits. Over time, de-industrialization at home, expanding globalization along with tax cuts and deregulation of firms had restructured the political economy in ways that eroded the jobs, high wages and the prior high standard of living of US workers. These changes along with increased exportation of production abroad led corporate America less reliant on US workers, leading businesses to become less willing to support the welfare state programs that helped support the work force (Abramovitz, 2004).

The fall of the welfare state: 1975-present. The response to this economic crisis led to a “U-turn” in public policy, which sought to undo the New Deal by redistributing income upward and downsize the state (Abramovitz, 2018). Once viewed as the solution to US social and economic problems, Neoliberalism redefined big government as the cause.

To reduce the size of the federal government, Neoliberalism called for tax cuts, budget cuts shifting social welfare responsibility downward from the federal government to the states (e.g. devolution) from the public to the private sector (e.g. privatization), from the collective to the individual (e.g. individualism), increased use of punishment to enforce compliance with program rules (weakening the influence of social movements opposed to the Neoliberal approach) (Abramovitz, 2012; Mullaly, 2007; Taylor-Goody, 2004)

Neoliberal Tactics Enter the Human Services

Several of these Neoliberal strategies and tactics led to direct changes in the delivery of human services including retrenchment, devolution and privatization. Retrenchment refers to the tax and budget cuts that reduced government funding for social services. Devolution allowed decision regarding the funding, structure and operations of social service programs to be made by state and local governments whose budgets and agendas vary widely. Privatization introduced market solutions to social problems.

Abramovitz and Zelnick (2015) describe three stages of privatization that have had led to changes in social work practice and service provision: (a) Marketization; (b) Managerialism; and (c) Financialization. Marketization is the delivery of publically financed social welfare benefits through the market. Managerialism highlights the incorporation of business principles into the management of human services agencies. Financialization, often seen as the final stage of the operationalization of privatization, allows for the use of investment principles for the financing and growth of human service agencies. These strategies reflect the Neoliberal agenda since they seek to shrink the welfare state, expand the role of the market, advance pro-market policies, allow for new accountability measures and increase competition for reduced resources among human service agencies (Abramovitz & Zelnick, 2015; Carey, 2008).

Managerialism is reshaping service delivery and practice decisions across human service agencies. Yet, little research has been conducted to examine how this policy approach affects the human service workforce. Carey (2008) argues that Managerialism represents one of the most significant changes in the delivery of social services over the last few decades. He states,

There has also taken place a ‘cultural revolution’ in which new ideas have influenced, and, to an extent, colonized, the hearts and minds of state social workers. Particularly, a market hegemony has succeeded in establishing now largely accepted rituals such as resource and contract-led practice, as well as a sustained emphasis placed upon accountability, efficiency, performance, audit and the application of scientific laws and new technologies to vastly regulated and standardized practices (p. 919).

Managerialism/NPM. Managerialism can be defined as the operationalization of Neoliberal privatization within non-profit social service organizations. According to Reinders (2008) the stated goals of Managerialism, include improving the performance of the human services by introducing “managerial techniques taken from private enterprise” (p. 566). The advocates of Managerialism believe that the private sector market-based business practices are better suited to solving organizational issues and that competition and efficiency improve bureaucracy and organization functioning (Alexander, 2000; Hood, 1991). Managerialism is characterized by a focus on cost-effectiveness and efficiency, and the use of professional management practices based on business models (Alexander, 2000; Banks, 2011; Connell, Fawcett, & Meagher, 2009).

These broad and complex organizational practices known as Managerialism became popular in the early 1970s as a way to “modernize” the public sector especially in Western

industrial countries including the United Kingdom, the Netherlands, Australia, New Zealand, Canada. However, over the years often pressed by funders, the practices have also been adopted by the non-profit human service organizations in the US. The practices are sometimes termed New Public Management (NPM), reflecting their origins, especially internationally, to reform the public sector. To avoid confusion given this study's focus on the non-profit agencies, the term Managerialism will be used.

Greuning (2001) offers a list of the common characteristics of Managerialism which include: (a) budget cuts; (b) accountability for performance; (c) performance auditing; (d) privatization; (e) competition; (f) performance measurement; (g) changed management style; (h) improved accounting; (i) improved financial management; and (j) more use of information technology. Lonne (2003) describes Managerialism as “fundamentally alter[ing] the organizational contexts in which social workers and human service practitioners operate” (p. 279). Connell, Fawcett & Meagher (2009) describe “the shift from many-leveled, finely graded bureaucratic pyramids with strong professional specializations, to “flat” organizational structures and generic skills” (p. 334). According to Reinders (2008), Managerialism seeks to improve the public sector's performance since this sector “... is considered inefficient, too expensive and the goods it delivers are of insufficient quality that often fails to meet specific needs” (p. 567).

Debate About Managerialism in Human Services

Under the principles of Managerialism, workers are expected to follow a “profit-making logic” and are held accountable through “performance management” guidelines (Connell et al., 2009). Essentially, Managerialism, promises to improve quality and performance through the application of managerial techniques borrowed from the private business sector. These include the use of performance measurements, an emphasis on outcomes and results, cost effectiveness

and a disciplined use of resources. Alexander (2000) describes Managerialism in human service organizations as rooted in a few assumptions: (a) the efficiency of the market; (b) the value of competition as a strategy for improving organizational performance; and (c) the concept of management as a general practice that has been perfected by the private sector. Hood (1991) who uses the term NPM, posits that the main features include: (a) explicit standards and measures of performance; (b) emphasis on outcomes and results; (c) disaggregation of public bureaucracies into agencies on a user-pay basis; and (d) disciplined use of resources and emphasis on cost-effectiveness. Reinders (2008) notes that Managerialism was put into practice to help reduce the high cost of the public sector and to help improve performance.

The rise of Managerialism has generated considerable debate with the human services much of it critical. Boston (2000) one of the early writers about Managerialism, noted that despite the vast amount of literature on this reform, there was little research that addressed the epistemological, conceptual and methodological issues that accompany policy evaluation in this area. Consequently, this lack of clarity makes it difficult for researchers to clearly identify and understand Managerialism and some of its implications for human services agencies. Boston (2000) also argued that the literature was focused on particular managerial policies or tactics, and the claims made around the impact of these specific changes were of questionable validity. He also noted that the limitations on policy evaluation in the field of public management are largely wrapped up in ethical and political beliefs, which influences interpretations, assessments and conclusions drawn from research.

Proponents also argue that Managerialism offer a more scientific, efficient and measurable approach to human services and social work. They suggest that the integration of these methods into human services agencies increases the effectiveness and the creditability of

the field by focusing on outcome measurements, accountability reporting and other management techniques. Supporters of Managerialism argue that this paradigm provide organizations with tactics and strategies that benefit agencies' workers and clients (Hood, 1991; Mullaly, 2007).

Alford (1997) and Davis (1997) both view Managerialism as a set of beliefs and practices that assumes better management will resolve a wide range of economic and social problems. Similarly, Tropman (2002) argues that Managerialism, which he equates with good management practices, is a much needed approach for the field of human services in the US due to rising expectations from funders, shrinking budgets and increased competition.

In response to Tropman, Tsui, and Cheung (2004) question whether Managerialism offers the best solution to the challenges facing human services agencies. In their view, Managerialism detracts from the human services to the extent that (a) the client is viewed as a customer (not a service consumer); (b) the manager (not the front line staff) is the key to efficiency; (c) the staff are employees (not professionals); (d) the organization relies management knowledge (not common sense or professional knowledge); (e) the market (not society or the community) is the environment; (f) efficiency (not effectiveness) is the yardstick; (g) cash and contracts (not care and concern) are the foundation of relationships and (h) quality is equated with standardization and documentation.

Other opponents, Lonne (2003) and Hasenfeld and Garrow (2012) fear that Neoliberalism will ultimately undercut a focus on social justice, social rights and policy advocacy. They argue that privatization, performance-based contracts and other market principles, may alter the environment of human service agencies in ways that can limit their to advocate for social rights and may disempower already vulnerable populations by turning them into consumers rather than citizens. Lonne (2003) adds that Managerialism has negatively affected service delivery through

“expanded policy directives, decreased professional autonomy, increased accountability, altered ethical values, creeping proceduralism within proliferating case management systems, tighter eligibility requirements for service users, and greater emphasis on social compliance and social control” (p.279).

Impact on social service staff. Baines (2006a) argues that a focus on ‘quantitative projects’ can lead to an erosion of professional discretion as well as a decrease in the quality of service and care. Baines (2006a) worries that Managerialism will displace ‘social caring’ as the central ethic and operating principle within the sector. Duffy (2011) suggests that current economic restructuring and political retrenchment is changing the boundaries of paid care work and leading to the “erosion of [the] relational aspect of the job” (p. 75). She suggests that managerial strategies limit paid care workers’ professional autonomy and control as well as reduce the ability to “care” in ways that will negatively affect workers’ delivery of services.

Carey (2008), in turn, asks whether or not privatization within social care sectors has led to the deterioration of staff working conditions and client services. He posits that while the advocates of privatization argue that it produces more efficient and effective services, it can also lead to an overly bureaucratic care system, the exploitation of care workers and ultimately new barriers that interfere with workers’ abilities to care for vulnerable populations (Carey, 2008). These concerns about caring and relating are fundamental aspects of human services provision and social work practice.

Banks (2013) raises another concern related to the increased application of Managerialism policies in the human services and social welfare arenas. Her concern, which stems from the European transition to Managerialism, focuses on the impact of increased standardization of practice, the imposition of externally-defined target goals, the introduction of

market competition, contracts for services and the demand for measurable outcomes. She fears that the changes threaten workers' personal engagement and that important aspects of the work, such as caring, developing empathy and compassion for clients may be undermined due to the pressures to meet professional accountability measures.

Loss of a creative craft? Additional critiques of Managerialism focus on what is seen as the loss of the art and craft of social work practice, including the de-skilling of social workers by limiting decision-making of direct practitioners, reducing levels of discretion and autonomy and standardization of practice techniques (Abramovitz & Zelnick, 2015; Baines, 2006a; Carey; 2008; Fabricant, 1985). It is argued that the growing reliance on evidence-based practice mandates, and the use of standardized treatments have the potential to undermine professional autonomy, creativity and flexibility – the hallmarks of professionalism (Abramovitz & Zelnick, 2015; Baines, 2006a; Banks, 2013; McCracken, & Marsh, 2008). Baines (2006b) and Stark (2010) also fear that agencies might be pressed to 'cream' clients as funders press them to choose those clients more likely to succeed. Ultimately, this could lead to agencies withholding services to those clients most in need or those who present with more complex and difficult problems -- simply because they may not produce successful outcome measures.

As Managerialism moves agencies towards focusing on quantitative outcome measures, evidence based practices, privatization and other market-driven or Neoliberal activities, how will it affect the creativity and flexibility of the front line worker responsible for direct service delivery?

A Closer Look at Managerialism in Human Services – Empirical Research

Despite the debate about Neoliberalism in the literature, only a few empirical studies focused on the experience of human service workers exist. In the early 2000s, Abramovitz

(2005), surveyed workers in 107 nonprofit human services agency asking about the impact of welfare reforms on their clients, jobs and delivery of services. Workers reported less time for direct service due to increased time spent complying with new regulations, mandates and paperwork. Workers also reported feeling less effective, an increase in burn-out, more ethical conflicts, less control over their jobs and having overall less time to dedicate to service delivery. Similarly, a 2008 study sponsored by the National Association of Social Workers (NASW), concluded that front line workers were facing several workplace stressors that included heavy workloads, insufficient time to meet work demands and inadequate support, supervision and resources for doing their work well (Arrington, 2008). Although these studies do not specifically name Managerialism, they capture some of the themes and experiences associated with these policy reforms. Their findings offer valuable insight into the effects of policy changes on workers and their ability to carry out their jobs, which warrants more targeted research as Managerialism continues to be implemented throughout human services agencies.

Alexander (2000) conducted a multiphase study of non-profit human service agencies that examined strategies used by organizations to adapt to devolution as well as managerial policies that changed agency functioning. The study examined over 200 non-profit human services agencies that implemented “new managerialism that required entrepreneurial leaders who emphasize the values of efficiency, economy and effectiveness” (Alexander, 2000, p. 288). Using longitudinal focus groups, the study revealed devolution created financial pressures leading to cutting programs, cutting staff, rationing client services, relying more on volunteers and working to stretch current revenues to cover costs. The study also highlighted new issues emerging in the Managerialism era, which included increased competition amongst providers,

use of for-profit services, and pressures to demonstrate efficiency and effectiveness in order to maintain funding.

Baines (2006b) conducted a multi-year, three-province study of social service restructuring in Canada, where front line workers were asked about their everyday work experience in the context of ongoing transition to Neoliberal policies. The results of these interviews highlight the dilemmas faced by social service workers in Canada, Australia and most of the industrialized, English-speaking world. Participants highlighted worker's loss of relationships with clients that accompanied the standardization of work and the use of flexible staffing patterns. In follow-up interviews, two years later, participants noted ongoing issues related to these changes such as; “. . . loss of our vision of what social work is supposed to be and who it is supposed to serve’, ‘. . . we forget what social services should be about’ and ‘. . . we forget why we are here in the first place and get caught up in other directions’” (Baines, 2006b, p. 23).

Another Canadian study by Aronson and Smith (2011) examined the impact of Managerialism on managers in the social services. This longitudinal qualitative study of managers in social services in Ontario illuminates how managers can counter managerial constraints and adapt to progressive change. Participants reported to be “in spaces filled with tension and contradiction, positioned as they are at the intersections between communities, clients, front line staff and more senior managers, governments, funders and regulators” (Aronson & Smith, 2011, p. 433). The study highlights the workers personal experience of the multi-dimensional roles as managers, which include managing tensions, resistance and conflicting performances under the Managerialism paradigm.

A more recent study by Abramovitz and Zelnick (2015) describes the operationalization

and implementation of privatization on the front lines and explores the impact of privatization on service delivery and direct practice from the perspective of the practitioner. The authors describe the preliminary qualitative results from a survey of human service workers in the public and non-profits sectors in New York City. Results of this study highlight a variety of front line worker concerns including: being asked to do more with less, managing greater levels of accountability in practice as well as challenges to professional autonomy.

It is evident that Managerialism is changing human services and social work practice. Yet, more information is needed about how human service workers experience Managerialism and how it affects service provision and social work practice. This research examines this phenomenon from the perspective of the front line staff within substance abuse services. It is hoped that voices will shed more light on the pros and cons of Managerialism and provide suggestion for change where needed.

CHAPTER 3: SUBSTANCE ABUSE

Substance Abuse: Current Scope of the Problem

Substance abuse continues to be a serious and persistent social and medical problem in the US (Mark, Levit, Vandivort-Warren, Coffey, & Buck, 2007). According to a 2016 National Survey on Drug Use and Health (NSDUH) an estimated 28.6 million Americans aged 12 or older (10 % of this population) were current illicit drug users, meaning they had used an illicit drug during the month prior to the survey interview (SAMHSA, 2017). The report indicated that an estimated 21.0 million people aged 12 or older needed substance use treatment however only 3.8 million (1.4%) of persons aged 12 or older received treatment at a specialty facility in the past year (SAMHSA, 2017).

Over the past 30-40 years, Neoliberal policy shifts have shaped substance abuse policies and services in a variety of ways including budget cuts, managed care, and Managerialism. The latter includes performance-based contracts, increased use of quantitative outcome measurements, and evidence-based practice, among other tactics. But, little is known about the impact of these changes on service provision, working conditions, direct practice or the well being of the substance abuse workforce. The literature documents the presence of some managerial practice in substance abuse treatment programs. But there is no research to date that examines the overall experience of front-line workers in substance abuse programs under this new paradigm. This dissertation investigated how Managerialism affected the human service workforce and the quality of services provided in the realm of substance abuse services in New York City.

Substance Abuse Policy Overview: Reflections of a Neoliberal Agenda?

Simultaneous to the emergence of Neoliberal policy in the 1970s, which sought to shrink “big government,” illicit drug use within communities emerged widely as a prominent social problem. Prior to the rise of Neoliberalism, professionals and government officials defined substance abuse as a public health problem meriting government funded rehabilitation services (Mark et al., 2007). It was understood through the lens of the medical model with a focus on developing treatment and interventions.

The advent of Neoliberalism in the 1970s led to a more punitive approach to substance abuse. In 1971, President Nixon declared a “war on drugs” and identified the substance abuse problem to be a “national emergency” (Drug Policy Alliance, n.d). Subsequent legislation criminalized substance abuse and increased utilization of law enforcement while expanding the role of federal government in the passage of new drug laws. In his efforts to enhance federal control of drugs, Nixon pushed for the passage of comprehensive laws such as the Controlled Substances Act (CSA). The Controlled Substances Act (CSA) established federal drug policy under which the manufacturing, importation, possession, use, and distribution of certain substances became federally regulated. This legislation also created the five schedules (classifications) of substances, with the qualifications for a substance to be included in each schedule. In July 1973, he authorized the creation of the Drug Enforcement Administration (DEA), a single-mission federal agency to enforce the CSA (Sacco, 2014). This emphasis on federal regulations and law enforcement reduced the focus and funding for substance abuse treatment.

In 1981 first lady Nancy Reagan launched a highly publicized anti-drug campaign, coining the slogan "Just Say No" (Drug Policy Alliance, n.d). The campaign reflected national

concerns about the rising drug epidemic – particularly the rise of crack/cocaine use in low-income communities. The initiative also set the stage for ongoing punitive measures and criminalization of substance abusers. The Reagan administration intensified Nixon’s punitive approach, emphasizing “zero tolerance” for drug users as well as drug dealers. By 1986, the Anti-Drug Abuse policy placed full responsibility for addiction on the drug user, prosecuting individuals for possession of drugs and penalizing them through the criminal justice system. Some block grants provided funds for drug treatment at this time, but the rehabilitative efforts were insufficient to meet the overwhelming amount of drug abuse (Rosenberger, 1996). Reagan’s drug policy largely reflected a moralistic view of addiction, mirroring the Neoliberal call for individual responsibility. The "Just Say No" campaign, which reflected the Neoliberal call for individual responsibility, also shifted the burden of care from the state back to the individual (Drug Policy Alliance, n.d).

The rising demand for and utilization of substance abuse services during the 1980s marked the height of the drug epidemic. At the same time, private sector employers and others began to hold substance abuse treatment responsible, at least in part, for rising health care costs. Seeking to contain costs, employers turned to managed behavioral health care plans operated by private insurance companies. These managed behavioral health care plans were expected to reduce costs, monitor quality of care and regulate access to substance abuse treatment. They reflected the Neoliberal agenda, as in addition to offering a means for cost control and regulation of behavior they also focused on outcome measurements and monitoring of quality control (Rosenberger, 1996).

In 1995, President Clinton allocated an extra \$1 billion for governmental drug policies and programs, bringing the total budget for substance abuse to \$13.2 billion. This budget

consisted of \$5.4 billion for education, prevention, treatment and rehabilitation for substance abusers and \$7.8 billion for supply-side efforts that criminalized drug dealers (Rosenberger, 1996). Thus, while Clinton increased spending on substance abuse services by a small amount, more dollars and effort were focused on the supply side rather than on rehabilitative effort for the demand side. The Clinton administration did little to alter its approach to addressing substance abuse from the policies already in place by its predecessors.

Overall spending on substance abuse services, both private and public, through the last few decades has not kept pace with other health spending. Although substance abuse spending grew from \$9.3 billion in 1986 to \$20.7 billion in 2003, the actual annual growth rate was only 4.8% for substance abuse compared to 8% for the total of US health care spending (Mark et al., 2007). More specifically, spending on substance abuse “fell from 2.1% of all health spending in 1986 to 1.2% in 2005” (Mark, Levit, Vandivort-Warren, Buck, & Coffey, 2011; p.285). Mark, Coffey, Vandivort-Warren, Harwood, and King’s 2005 study estimates the annual cost of substance abuse treatment services at \$18.3 billion, with approximately three quarters (76%) derived from public sources including Medicaid (19%), Medicare (5%), state and local government (38%), and the federal government (14%). The remaining 24% comes from private sources including health insurance (13%), out-of-pocket expenditures (8%), and other private sources (3%).

More current data (Mark, Levit, Yee, & Chow, 2014), indicates that spending on substance abuse treatment only accounted for 1% of all health spending in 2009 and is anticipated to remain at that level until the year 2020. Mark et al. (2014) posit that the spending on substance abuse treatment is expected to continue to lag behind growth in spending for all health care, in line with its past historical trend. Mark et al. (2014) and SAMSHA (2008) both

acknowledged the trend towards relying on increased public financing for substance abuse treatment as the private sector declines their private financing, however evidence of increased public spending is not being forecasted.

Managerialism Tactics in Substance Abuse Treatment Programs

New York State Office of Alcoholism and Substance Abuse Services (OASAS) funds, certifies, and regulates chemical dependence and gambling treatment, prevention, and recovery services across New York State. It is the single designated state agency responsible for the coordination of state-federal relations in the area of addiction services (OASAS, 2016). The agency currently certifies, inspects, and monitors more than 900 chemical dependence treatment programs across New York State. OASAS estimates that 12% (1.9 million) of New York State residents age 12 and older have a substance use disorder (substance dependence or abuse) annually. As an addiction treatment system, OASAS provides a full array of services including prevention, education, treatment and support for recovery to a large, culturally diverse population of approximately 254,000 individuals each year (OASAS, 2016).

OASAS' chemical dependence treatment services include inpatient, outpatient, and residential treatment settings statewide. Its chemical dependence treatment programs have an average daily enrollment of nearly 100,000 people (OASAS, 2016). Three defining principles guide the practice approaches of OASAS: (a) addiction is a chronic but treatable disease; (b) prevention and treatment programs must use evidence-based strategies that yield measurable results and successful outcomes; and (c) recovery is a life-long process that includes healthy lifestyle choices, housing, employment and support from a recovery movement (OASAS, 2016).

Managerialism concepts and tactics -- particularly those that focus on measureable outcomes -- are fundamental to OASAS's strategic planning. The 2013 Interim Plan, which

outlined OASAS's comprehensive strategic plan for the years 2012 to 2016, indicated that the agency would continue to develop and strengthen policies that enhance the quality and effectiveness of clinical services within the addictions system. The agency will also promote integration with the health system. Specifically, in relation to Managerialism, the plan states that "to ensure improved services, OASAS will continue to apply the principles of outcomes management as it moves toward implementing pay for performance for funding treatment providers." The organization committed to a redesign of its addictions system for improved cost efficiencies and measurable outcomes by 2014 (OASAS, 2013).

OASAS's recent shift towards an outcome-based system to measure progress is a clear example of the introduction of a key component of Managerialism into substance abuse programs. The redesign plan will base future budgeting decisions on the state's performance measures rather than the past practice of making across the board cuts (OASAS, 2013). To this end, New York State plans to strengthen monitoring, measuring outcomes, and regulations and compliance strategies. OASAS's upcoming priority is "improving all its monitoring systems" and "improving provider accountability."

OASAS also reports a commitment to using only evidence-based practices, defined as the gold standard of treatment interventions. To enforce its new approach the organization launched the Gold Standard Initiative in 2010 to reward programs that demonstrate high performance, positive outcomes, and excellent program management practices. OASAS also designed a new prevention scorecard that would be used to publicize performance successes and improve the quality of services at the program, county, and system levels (OASAS, 2016). These changes, which reflect the Managerial approach, will affect front line workers who are directly responsible for the delivery of services.

Performance Based Contracting (PBC)

As outlined in OASAS's strategic planning, several substance abuse programs across the country have increased their reliance on measurable performance outcomes. One popular measurement tool is the performance-based contract (PBC). The PBC specifies output and outcome performances and ties at least a portion of the contractor's compensation to their achievement (Kettner & Martin, 1993). Although PBCs seek to improve efficiency and accountability and to reduce costs (Martin, 2005), they are also heralded as ways to improve the quality of care based on the financial incentives included in the contracts that reward the attainment of pre-determined levels of performance and defined treatment criteria (Brucker & Stewart, 2011).

Kettner and Martin (1998) identify three historical periods that have shaped the emphasis towards performance based contracting in the field of human services that mirrors the shift towards the Managerialism era. During the first period, or the "formulative years" (1968-1979), contract accountability was defined in terms of *inputs*. Contracts focused on ensuring that agencies hired qualified staff, acquired appropriate facilities and resources and served the most eligible clients. During the second period, the "maturing years" (the 1980s), funders defined human services contract accountability in *process* terms. The process shifted towards standardizing service delivery and focusing on service outputs. State human service departments began holding contractors (agencies, providers) accountable for providing specific amounts of service, usually measured in terms of "units of service" (e.g., one counseling session, one meal). The standardization of output measures enabled state human service agencies to move from cost reimbursement contracts to unit cost contracts. Finally, the third period of accountability in human services contracting, the "performance years," (the 1990s) led to a definition of

accountability based on performance that measured output and outcome for both direct service delivery and contract service delivery (Martin, 2000).

As this movement unfolded across the United States, one human service department in at least 10 states (e.g., Arizona, Florida, Illinois, Kansas, Maine, Massachusetts, Minnesota, North Carolina, Oklahoma, Pennsylvania) took the lead to experiment with performance-based contracting (Martin, 2005). A study that examined the use of performance-based contracting across these states (Martin, 2005) found that the practice succeeded in its goal to encourage contractors (agencies) to increase their focus on accountability of agency performance. However, Aristigueta and Foote's (2009) research in Delaware did not find that performance contracts led to more effective and efficient service delivery by human service agencies.

PBC and substance abuse treatment programs. In 1992, the Maine Office of Substance Abuse (OSA) introduced its first version of performance-based contracting (PBC) in an attempt to shift the publically funded treatment system to a focus on outcomes (Brucker & Stewart, 2011). The initial results of PBC were mixed. Concerns about the validity of the reporting led to a restructuring of PBC, and by 2007 Maine had implemented a new PBC system.

Brucker and Stewart (2011) conducted several studies to determine the impact of PBCs in Maine's substance abuse treatment system. The studies compared service utilization rates for one year before and one year after the implementation of PBC (2007-2008). They also compared the timeliness of access to substance abuse assessments and treatment between PBC and non-PBC agencies, and discharge data from the year prior to implementation of PBC and the year after the implementation of PBC (N=6,740). The findings suggest that PBC had only minimal effects on agency payments and no effect on time to assessment, time to treatment, level of client participation, length of stay, or completion of treatment. Yet, substance abuse programs continue

to move forward with PBC. This research did not examine the impact of PBC on front line workers who are responsible for the delivery of service, and subsequent reporting of performance outcomes.

Martin (2005) found that contracts varied by type of agency, with more performance-based contracts found in substance abuse than mental health services. More specifically, substance abuse contracts tied payment to performance targets such as attendance and graduation rates and at times included a "graduation bonus" when a client successfully completed the program (Aristigueta & Foote, 2009). This research also uncovered multiple dilemmas presented through the implementation of performance measurements and performance-based contracts in substance abuse services. For example, one substance abuse program participant explained that using attendance as an outcome measure posed an unfair challenge because the client's decision to attend a program is beyond the control of the agency and may or may not be a proxy for the desired outcome (graduation) (Aristigueta & Foote, 2009).

Shen (2003) of the Maine Addiction Treatment System (MATS) found that PBC created financial incentives for providers to treat less severe clients in order to improve their performance outcomes and explored whether or not providers of substance abuse responded to this incentive. Based on standardized admission and discharge data, Shen found that following the implementation of PBC the percentage of clients classified as "most severe" dropped by 7% ($p \leq 0.001$). This finding strongly suggested that human service agencies did in fact "cream," thus reducing access to treatment for those arguably most in need. These results support Baines's (2006b) concern that agencies may engage in "creaming" clients in order to produce good outcomes for the needed quantitative measures. Creaming – the bias selection of clients to enroll in program who are more likely to be compliant and produce greatest outcome measures -- is a

special concern in substance abuse treatment, as those with the most severe addictions tend to be those who need treatment the most.

The nature of the disease of substance abuse may not always lend itself to immediate successful treatment intervention, particularly for individuals with extensive substance abuse histories or other confounding variables such as another chronic disease, severe psychosocial stressors, or mental illness. If substance abuse treatment agencies become biased in selecting their clients, those individuals with the greatest need for help may be overlooked. How are front line workers managing this issue? What pressures or expectations are front line workers experiencing?

Evidence-Based Practice (EBP)

Evidence-based practices (EBP) are used in many human services agencies as well as in OASAS. As the U-turn in social policy led to the increase of Neoliberal practices, some researchers and professionals focused their attention to the gap between research and social work practice. These researchers and professionals argued that social work interventions were not effective in large part because social workers failed to use current research to guide their practices (Gambrill, 2006; Yunong, & Fengzhi, 2009). Consequently, EBP for social work practice began to be seen as a solution (Gambrill, 2006; Tanenbaum, 2003). EBP grew out of evidence-based medicine (EBM), which argued for the importance of using the best evidence in making decisions about the care of the individual patient (Tanenbaum, 2003).

Although EBP is intended to help maximize opportunities to help clients and to avoid harm, it was also developed as a way to cut costs by reducing services that have no empirical validity. This approach ensures the effectiveness of social work interventions as well as to establish social work practice as an applied science (Gambrill, 2006; Thyer & Meyers, 2011).

Like many other managerial practices, EBP, which seeks to improve effectiveness and efficiency, has elicited controversy among substance abuse providers and practitioners. According to some viewpoints (Nevo & Slonim-Nevo, 2011; Rubin, 2007; Webb, 2001), EBP may reduce worker autonomy in decision-making, decrease creativity and discretion in intervention, and is too “standardized” to be practical given the complexities of social services work.

Evidence-based practice and substance abuse treatment. Prior to the implementation of EBP in substance abuse treatment, practice wisdom rather than scientific evidence was more likely to guide treatment practices (Steenrod, 2004). Walker, Howard, Walker, Lambert, and Suchinsky (1995) found that substance abuse treatment practices varied in their treatment approaches, were not supported by empirically sound evidence, and tended to be ineffective. EBP was introduced as a corrective measure, designed to foster cost-efficient and effective treatment decisions. This was based on the premise that implementation of EBP directly supports the integration of best research evidence, clinical expertise and patient values (Steenrod, 2009; Rieckmann, Kovas, Fussell, & Stettler, 2009).

To help encourage the implementation of EBP in substance abuse treatment programs, local and state funders have begun to link funding for programs to the use of standardized EBP techniques. Like performance-based contracts, the Substance Abuse and Mental Health Service Administration’s (SAMHSA) contracts require substance abuse programs funded by block grants to report their use of EBP as a part of the National Outcome Measurement Study (Steenrod, 2009).

Research indicates that staff concerns may exist in response to implementation of EBP. Steenrod (2004) found that many outpatient substance programs were not using EBP despite

funding requirements to do so. They asked if substance abuse programs utilized standardized EBP techniques (e.g., screening tools to assess for substance abuse disorders, assessment tools, and specific practice guidelines) and found that several programs were struggling to adjust to the new standardized procedures of EBP. Rieckmann, Bergmann, and Rasplica (2011) examined workers' responses to EBP during the planning implementation and adjustment to the mandate of EBP. Using longitudinal data from focus groups and interviews of substance abuse clinicians, the researchers investigated clinicians' experiences and attitudes towards this policy change. Clinicians reported concern about being able to retain individualized treatment and clinical autonomy. They reported feelings of distrust about government involvement in the decisions of clinical care, while also expressing a need for improved accountability and credibility for the field of substance abuse treatment (Rieckmann, Bergmann, & Rasplica, 2011).

The criticisms of EBP, especially as it pertains to the impact on front line workers in direct service delivery, represent a significant concern. Baines (2006a) offers an extensive critique of the use of standardized treatment protocols and the use of quantitative measurements in the realm of social work practice, arguing that the infiltration of such neoliberal ideology displaces "social caring" as the operating principle within the field of treatment. Concerns around workers experiencing a loss of creativity, autonomy and ability to build trusting relationships are central to this debate. Baines (2006a) also argues that having clinical staff focused on "quantitative projects," including the reporting of EBP, will lead to an erosion of professional discretion as well as a decrease in quality of service and care. This concern was also echoed in Rieckmann, Bergmann, and Rasplica's (2011) study, described earlier, which is one of the few studies that focused specifically in the realm of substance abuse treatment.

Privatization of Medicaid: Introduction of Managed Care Plans

Another way in which Neoliberal philosophy has affected substance abuse treatment is within the movement towards the privatization of Medicaid. As federal health care devolves authority from the federal level, states have adopted policies that force Medicaid recipients to choose among competing private sector managed care plans for their medical coverage.

The Neoliberal promise is that market forces will keep the costs of poor people's healthcare down (Maskovsky, 2000). Included in the proposed benefit of the privatization of Medicaid is that clients will be able to gain access to preventative health care through the use of a primary care provider (PCP) associated with health maintenance organizations (HMO), rather than through emergency rooms or hospitals. Managed care may also improve access to and quality of care by more efficiently addressing the added health risks and complications associated with addiction and substance abuse. While reducing healthcare costs and improving quality of care through Medicaid-managed care, the privatization of Medicaid has raised important issues especially around access to healthcare and staff workload.

In the early stages of introducing Medicaid coverage that included managed care plans, researchers (Callahan, Shepard, Beinecke, Larson, & Cavanaugh, 1995) assessed the impact of a statewide specialty mental health managed care plan for the Massachusetts Medicaid program. The study focused on program expenditures, access and quality within mental health and substance abuse treatment. It reported favorable outcomes including reduced costs with no reported reductions in access or relative quality (Callahan et al., 1995). However, the reductions in cost were associated with fewer inpatient admissions; lower prices paid for reimbursement, and reduced lengths of stay in treatment. Another study by Leslie and Rosenheck (1999) found that lower costs associated with lower inpatient admissions did not translate into more outpatient

care. Ultimately, these studies suggest that managed care plans might be limiting the overall care available to clients.

Managed care in substance abuse treatment. Other research on the impact of the privatization of Medicaid through managed care and its effect on substance abuse treatment and outcomes shows an increase of utilization of services. McFarland and colleagues (2005) conducted a study comparing Medicaid clients enrolled in the Oregon Healthcare (N=1,751) to those clients enrolled the following year in 1996, after managed care was implemented (N=14,813). The study noted an increased utilization of services but no statistically significant difference in outcomes (using measures such as treatment retention, completion of treatment, abstinence at discharge and readmission to treatment) between the two comparison groups despite the increase in utilization.

Another study (Olmstead, White, & Sindelar, 2004) looked at the role of managed care in substance abuse services, as well as the types of services offered in substance abuse treatment facilities. This study aimed to assess existing research reporting that the advent of managed care in substance abuse treatment programs led to an increase in treatment effectiveness and utilization. Olmstead and colleagues (2004) looked at services from 10,513 substance facilities, virtually all of the facilities in the United States. They found that facilities with managed care offered fewer treatment services overall. Managed care increased the likelihood of offering substance abuse assessments and relapse prevention treatment but decreased the likelihood of offering after-care services intended to support relapse prevention and re-admission into treatment.

Medicaid in New York State. In 2011, New York State, Governor Andrew Cuomo appointed the State Medicaid Redesign Team (MRT) to increase the effectiveness and efficiency

of treatment in order to reduce recidivism (OASAS, 2013). The strategic plans for the implementation of changes to Medicaid include the expansion of managed care programs that can support the reduction of unnecessary inpatient hospitalizations and improve access to outpatient substance abuse services. The plan also would establish Behavioral Health Organizations to cover addiction and mental health treatment. This would be a "carve-out" service, rather than fee-for-service as it was previously organized (OASAS, 2013). In 2014, Governor Andrew Cuomo announced that New York has finalized terms and conditions with the federal government for a waiver that will allow the state to reinvest \$8 billion in federal savings generated by Medicaid Redesign Team (MRT) reforms. The MRT waiver amendment was intended to transform the state's health care system, bend the Medicaid cost curve, and ensure access to quality care for all Medicaid members (OASAS, 2016). Reflecting the Neoliberal paradigm, Cuomo's plan seeks improve efficiency and reduce Medicaid cost.

Managerialism within Human Services: Here to Stay?

While the ideologies and principles driving Neoliberalism and the philosophy of Managerialism promise to offer certain benefits, little is known about how these policies change service provision and staff experiences (Baines, 2006a; Baines; 2006b; Stark, 2010). Although the literature to date principally reports on the research on the Managerialism in the public sector, similar trends are occurring in the non-profit sector as well affecting the entire realm of social services. According to Stark (2010), "The logic of social work is not the logic of profit," (p. 9). Stark (2010) posits that the profession of social work is meant to uphold certain values and ethics that may not be in line with private enterprise. He questions if the profession of social work continues to move in its current direction, will professional ethics be compromised? Stark (2010) notes, "The market should not have the power to decide whether or not someone receives

the necessary means for a life in human dignity” (p. 9). This statement highlights the importance of examining how Managerialism is being operationalized and experienced within the human services, especially in substance abuse programs. Without this understanding of the phenomenon, we will not know how to proceed in moving forward with planning, policy or practice.

CHAPTER 4: THEORETICAL PERSPECTIVES

Theoretical Framework -- Street-Level Bureaucracy

This dissertation examines how public policy has affected the practice of front line workers in substance abuse agencies. In *Street-Level Bureaucracy*, Lipsky provides a theoretical approach that can usefully guide this examination of how Managerialism, an expression of Privatization within human service agencies, has affected the work in substance abuse agencies.

Lipsky (2010) presents street-level bureaucrats as pivotal to service delivery and subsequently policy delivery. He argues that, “Public policy is not best understood as made in legislatures or top-floor suites of high-ranking administrators, because in important ways it is actually made in the crowded offices and daily encounters of street-level workers” (p. xii). Although Lipsky’s book was initially published in 1980, the publication of the 30th anniversary edition highlights the contemporary concerns that build on the fundamental theory of street-level bureaucracy outlined in the original edition. Lipsky’s theory of street-level bureaucracy will serve as a theoretical framework for this study, as it provides a lens by which to examine the impact of Managerialism policies on front line workers.

In the original 1980 edition of *Street-Level Bureaucracy*, Lipsky introduces the notion of “street-level bureaucracy” as a concept and makes two initial distinct claims: (a) the use of discretion is a critical dimension of the work of public workers (referred to as street-level bureaucrats) who regularly interact with citizens in the course of their job and (b) the work of street-level bureaucrats, although diverse (e.g., social workers, police officers, guidance counselors) is structurally similar.

In a later edition, Lipsky (2010) identifies an inherent paradox embedded in the work of street-level bureaucrats beginning with the use of the phrase “street-level bureaucracy.” The term

“bureaucracy” implies a set of rules and hierarchal structures, while “street-level” implies a certain distance from that authority, where direct practice may occur. Lipsky recognizes that street-level work is replete with conflict, giving way to the book’s subtitle, “dilemmas of the individual in the public services.” He points to this tension between bureaucracy and street-level work as critical to understanding the functioning of agencies and the delivery of services. In this 2010 edition of his book, Lipsky focuses on the human services sector as an area in which this tension is critical to agency functioning, further supporting a theoretical foundation for this study.

Street-Level Bureaucrats as Policy Makers

Lipsky (2010) pioneered the concept of street-level bureaucrats as policy makers. Using a bottom-up approach to policy implementation, he argues that discretion in street-level bureaucrats work with clients is a critical and undeniable aspect of the work. Furthermore, he recognizes that street-level bureaucrats face complex presenting problems coupled with the need to respond to the unique human dimension of each client. The role of the street-level bureaucrat is largely dependent on the degree of discretion available and the relative autonomy from organizational authority. Lipsky adds that the results of individual actions of discretion add up to agency behavior, which can ultimately be seen as the face of policy implementation.

Lipsky then unpacks the ways in which the complexities of worker discretion and their level of autonomy shape the worker’s experience, as well as the ways in which organizational policies come to life in practice. He observes that street-level bureaucrats actually make policy when they behave in ways that may be unsanctioned, or even in contradiction with official policy. He suggests that the complex nature of their jobs makes it difficult to achieve the expectations of their work and highlights the point of tension between bureaucratic standards and

actual street-level work. This tension is of particular importance when looking at human services work, where clients present with a multitude of complex presenting problems within an organizational system that is loaded with standardized policies.

Lipsky's theory suggests the formal policies of human service agencies are often vague, ambiguous or have conflicting objectives and that these characteristics create a space that allows for street-level bureaucrats to exercise discretion in their practice. It is under such conditions that the very actions of street-level bureaucrats arguably become policy. Lipsky's theory of street-level bureaucracy brings to light an innovative way to examine the role of the street-level worker in policy-making. When applied, this theory serves as a useful framework to examine the role of the front line workers in human service agencies.

In line with this, Lipsky (2010) states, "Street-level discretion promotes workers' self-regard and encourages clients to believe that workers hold the key to their well-being" (p.15). This is essential to building the foundation of a trusting relationship between worker and client and is subsequently an inherent component of street-level work.

Hupe and Hill (2007) describe the importance of trust and discretion as concepts within street-level work,

The combination of trust, rule application, and the principally undetermined character of what the professional will be confronted with, presupposes a degree in his or her competence to produce desired responses, and to deal with situation that may be exceptional in a sensible and creative way (p. 282).

As the transition to Managerialism unfolds within human services, particularly within substance abuse programs, how will the degrees of discretion and professional autonomy from

institutional structures change the experience of the front line worker? How will these policy changes affect the ability for workers to form trusting relationships with clients?

Beyond Lipsky's Street-Level Bureaucracy

Lipsky (2010) and Brodtkin (2011) recognize the importance of understanding street-level organizations as pivotal players in the making of public policy, as their informal construction and reconstruction of policy is a part of the everyday organizational life. Brodtkin (2012), who builds on Lipsky's theory, credits Lipsky for developing a foundation for a theory of street-level bureaucracy that offered a template for empirical investigation. Brodtkin argues that Lipsky's theory examines work "from the inside out" (p.3), or from the perspective of the worker. Acknowledging the unique street-level experience, including the role of discretion, helps to explain how changes in the work environment can ultimately "affect what they [street-level bureaucrats] produce as policy through their informal routines" (Brodtkin, 2012, p.3). She concludes that Lipsky's theory "created an analytic framework that contextualized and made more transparent their struggles to do good work" (Brodtkin, 2012, p. 2). Brodtkin also points out that Lipsky highlights the political significance of the role of street-level bureaucrats. She states,

[Street-level bureaucrats] operate as defacto interpreters of public policy, but also because they operate as the interface between government and the individual.

Although what they do matters most directly for policy delivery, it also has importance for the relationship between citizens and the state (2012, p.2).

Lipsky's theory of street-level bureaucracy clearly offers an innovative approach to examine the intersection of the worker experience and policy-making. Over time, there has been much discussion about how to apply Lipsky's theory. Such discussion has offered both support

and critique of his original claims.

The Intersection of Accountability and Discretion

As Managerialism strategies become more evident in human service organizations, there is an inherent focus on accountability measures. In the later chapters of the 30th anniversary edition of *Street-Level Bureaucracy*, Lipsky notes that as a result of the fiscal crisis new administrative measures are in place to secure accountability (a key issue in this research) among street-level bureaucrats, particularly in the arena of human services. This discussion addresses some of the emerging concerns under the Managerialism agenda in human service organizations. Lipsky (2010) writes,

Bureaucratic accountability is virtually impossible to achieve among lower-level workers who exercise high degrees of discretion, at least where qualitative aspects of the work are involved. Nonetheless, public managers are pressured to secure or improve workers' accountability through manipulation of incentives and other aspects of job structure immediately available to them...the results may not simply be ineffective but also may lead to an erosion of service quality (p.159).

According to Lipsky, discretion used by the worker may make it difficult to secure accountability. He also begins to unpack how the pressures of accountability could harm the quality of service delivery. Acknowledging the specific tensions that may be faced within the human services sector serves as a useful theoretical frame for this study.

Brodkin (2008) uses Lipsky's approach to street-level bureaucracy to explore issues of accountability and discretion in her own work within street-level organizations. In examining more contemporary issues of social welfare agencies, she questions how the Managerialism strategies that organizations use to promote accountability can actually establish accountability

without undermining worker's professional discretion and decision-making. Brodtkin questions whether the Managerialism techniques that offer performance measurements are an accurate means to secure accountability in organizations. Her doubt rests upon the underlying assumption with Managerialism strategy where higher-level officials create incentives and set goals, while lower-level workers have to figure out how to reach the goals. She also notes how the general accountability measures are not designed to capture the textured complexities of street-level work. Brodtkin (2008) writes,

Even advanced efforts to improve accountability by applying New Public Management (NPM) techniques of performance measurement and “pay for performance” contracting, at time, may do more to provide the appearance of accountability than accountability-in-fact (p. 318).

Similar to Lipsky, Brodtkin (2011) challenges the Managerialism belief that how policy work is done does not matter as long as performance standards are met. Brodtkin (2011) notes,

Street-level practitioners do not just respond to performance incentives; they use their discretion to adjust to them, producing informal practices that are substantively different from—and more diverse than—what policymakers or managers tend to recognize (p. 253).

She also suggests that the Managerialism focus on the “bottom line” is based upon a flawed understanding of how street-level organizations really work that may not take into account the ways in which professional discretion may be understood in service delivery. This belief, in turn contributes to overly optimistic expectations for performance measurements as a managerial technique. To understand how policy work takes shape under Managerialism it is necessary to pay attention to the value of street-level discretion, but this may yield tension with the effort to

calculate outcomes using quantifiable metrics. Street-level bureaucracy offers insight into what occurs at the intersection of formal rules and informal practice, a territory that is at the core of this research.

In line with Lipsky's theory, Brodtkin states that discretion gives street-level practitioners the ability to adapt to changes in policy and management in new ways, which may not correspond to quantifiable metrics and may offer greater challenges to measuring accountability. Brodtkin argues that the "decisions of street-level bureaucrats, the routines that they establish and the devices they invent to cope with the uncertainties and work pressures, effectively become the public policies they carry out" (Lipsky, 2010, p. xiii). Lipsky (2010) highlights the importance of recognizing those at the "bottom" as the real "policymakers," since discrepancy is required at the point of service delivery. It is the lower level bureaucrats who are making the decisions and interpreting the policy, and those routine activities of front-line workers can never fully be controlled or monitored from above. This understanding of front line work calls attention to both discretion and accountability and highlights the complex relationship between these two concepts.

Brodtkin (2008) argues the case for the use of Lipsky's street-level approach since "a street-level perspective as an applied theory offers a reverse view of accountability. That is, it approaches accountability in organizations not from the outside in but from the inside out" (p. 325). She also discusses the ongoing challenge of how to manage/maintain street-level discretion in light of the ongoing search for effective strategies of administrative oversight that promote accountability. She seeks to do so without undermining worker responsiveness and professional discretion, both of which are critical to the nature of the work. In acknowledging that accountability measures are often "too crude" to capture the complexities of street-level work,

Brodkin (2008) also discusses the problems with compliance measurements, noting that policies often “oversimplify problems...overpromise solutions...with the intentions of legislative success” (p. 326). Brodkin applies Lipsky’s original theory of street-level bureaucracy as a theoretical lens through which to understand the paradoxical reality of the transition in this Managerialism era.

Another view of accountability. Hupe and Hill (2007) examine how the concept of governance adds to the complexity of understanding how street-level bureaucrats are held accountable and suggest that the issue of accountability at the street-level be re-examined. They note that in “conventional discussions about street-level bureaucracy, the autonomy of staff working at the base of government has been seen either as posing a control problem at the ‘top’ or as a justification for more direct forms of accountability to the ‘street’” (Hupe & Hill, 2007, p. 279).

Amidst this discussion is the argument that accountability of street-level bureaucrats should be viewed as complex and multi-directional, in contrast with the historical perspective of a direct vertical relationship between “top” and “bottom” (Hupe & Hill, 2007). This perspective challenges Lipsky’s view on accountability because it describes the street-level bureaucrat being involved in a much more complex web of relationships that will shape both their use of discretion and issues of accountability.

Hupe and Hill (2007) argue that looking at all the ways in which accountability at the street-level is managed suggest considering the concept of governance. Since governance can include a variety of clusters of activities practiced by various actors that can take place at different administrative levels, it calls into question how to assess street-level accountability. It is

also argued that in this multi-dimensional micro-network of relations, street-level workers may practice ‘multiple accountability’. Hupe and Hill (2007) write,

In the context of governance, ‘the street-level’ needs to be conceived of as a layer – administratively formal or not – where governance may be multiple.

Governance of and by street-level bureaucrats is practiced in a variety of action situations, while street-level bureaucrats are held accountable in various relations: bottom-up as well as top-down, but also ‘sideways’ (p. 295).

They also support the notion that different kinds of accountability exist within different types of settings, something that Lipsky overlooks. The emphasis on “multiple accountability” does not dismiss the debate around the importance of accountability. Instead, it strengthens the argument for a more precise understanding of the issues at hand. Hupe and Hill (2007) summarize their view on street-level bureaucrats and accountability as follows,

Street-level bureaucrats are held accountable in different ways and to varying degrees, but certainly in more ways than strictly from the political center alone. Within the web of these multiple accountabilities, which produce possibly contradictory action imperatives, street-level bureaucrats constantly weigh how to act. The evaluation of these acts, particularly at an aggregated level, ultimately remains a matter of political judgment. However, analyzing these accountabilities as practiced at the street-level, is open to empirical-comparative research. This latter may add a new chapter to the development of the theme of street-level bureaucracy (p. 296).

In awareness of Managerialism moving human services organizations towards market approaches to policy delivery, issues of street-level accountability as well as discretion are even

more important to consider. Brodtkin (2012) notes that in this new era of Managerialism, accountability and discretion are subject to new influences that are being shaped by changing organizational forms and evolving managerial techniques and strategies. What exactly is happening on the front lines under the paradigm of Managerialism has yet to be fully researched and despite some noted limitations, Lipsky's street-level bureaucracy offers a grounded theoretical platform by which to examine this phenomenon.

The Debate on Discretion and Accountability Continues.

Lipsky (2010) argues that professional use of discretion as well as accountability measures are necessary and critical components of street-level work. However, under the Managerialism era, which tends to focus on increasing accountability measures, the use of discretion remains under continued scrutiny.

Do more rigid policies and rules reduce levels of street-level discretion or do they create more opportunity for interpretation and therefore widen the bounds of discretion? Brodtkin (2012) argues that street-level workers retain discretion in order to adapt to their environment and that the current challenge is in determining how policy affects the conditions under which discretion takes place. Hupe and Hill (2007) also support the premise that street-level bureaucrats must use discretion while noting how discretion and rules are interrelated. While rules specify duties and obligations, discretion provides workers with freedom of action. Thus discretion is always imbedded in a rule structure. Hupe and Hill (2007) write, "While nearly all rules embody matters of interpretation, this is particularly the case with complex rules guaranteeing benefits or services" (p. 281). Citing prominent sociologists such as Blau (1955), Merton (1957) and Simon (1955), Hupe and Hill (2007) note that rules are never self-executing and that actors involved are expected to make choices about how to deal with a specific rule. Despite the examination of the

possible changing levels of discretion in street-level work, discretion remains an important variable in understanding the worker experience in policy execution and service delivery.

Arguably, discretion in street-level work remains, but how so under new accountability measures and strategies?

Writing about the UK, Evans and Harris (2004) review the debate about whether or not the current policy climate supports or curtails social work discretion. This debate centers on differing views regarding the “manager’s desire for, and ability to secure, control workers’ ability to resist control and seek discretion” (p. 871). The authors introduce an alternative argument about discretion that is based on two concepts: (a) rules and regulations should not automatically be equated with greater control over professional discretion; paradoxically, more rules may create more discretion, and (b) discretion should not be assumed to be a “good” or “bad” thing, but should be considered in both lights. Eliminating the “all or nothing” approach to discretion reminds us that discretion can be a valuable component in professional decision making but also can be used as a professional abuse of power. Evans and Harris (2004) suggest that moving away from such a dichotomous view of discretion can help advance the understanding and examination of the role of discretion in social work practice. It is argued that it would be more valuable to regard discretion on a continuum including a series of gradations of freedom to make decisions that should be evaluated on a situation-by-situation basis.

Evans offers still another critique of Lipsky’s account of discretion. He posits that Lipsky’s analysis gives insufficient attention to the role of professionalism, especially the impact of professionalism on the relationship between front line managers and workers. In a qualitative case study based on interviews with social work managers and practitioners, Evans (2011) suggests that the professional status of social workers influences both the nature of their

discretion and the way in which it is managed. Evans acknowledges that Lipsky's theoretical approach valuably challenged the previously assumed rhetoric of management control. However he notes that Lipsky presents managers as disconnected from street-level bureaucrats and assumes managers and street-level workers are categorically different and possibly antagonistic (Evans, 2011, p. 369). In contrast, Evans calls for a more complex understanding of the manager-practitioner relationship, which could include having shared views, support and guidance rather than pure managerial and hierarchical control.

In his book, *Professional Discretion in Welfare Services: Beyond Street-Level Bureaucracy*, Evans (2011) builds on Lipsky's theory of the street-level worker's discretion and autonomy based on in-depth interviews with 12 social workers employed within a British government-run, social service organization. Evans explores the British social worker's practice experience within social service organizations with an emphasis on contextual factors such as "managerialism" that shape a worker's initiative, discretion and creativity in policy implementation at the street-level. Utilizing a case study to analyze the nature and scope of the use of discretion in social services, the Evans study examines the professional experiences of front line social work managers and practitioners with policy implementation at the community level. The analysis attempts to understand the practice of discretion in the case study examples through the lens of each worker's perspective.

Evans notes that Lipsky's perspective on discretion was widely appreciated by social work practitioners and organizations in the UK until the policy reforms in the health and social care increased debates about the role of management in curtailing discretion (Pardasani, 2011). In light of policy changes (such as the National Health Service [NHS] and Community Care Act of 1990), Evans calls into question issues of worker discretion and autonomy, pointing to a

limitation of Lipsky's theory. Evans (2011) suggests, "While Lipsky has been characterized as a bottom-up theorist, his theory actually straddles both perspectives" (p. 369). Evans notes how Lipsky recognizes the opportunity for bottom up policy implementation yet also adopts a top-down perspective where he views strategic policy intention as the measure of discretion.

Evans (2011) challenges Lipsky's argument that in this current era street-level workers can exercise significant discretion and autonomy in their decisions about service delivery. He suggests that there are several variables that can influence discretion techniques. While calling for a separation of the concepts of "management" and "managerialism," he suggests a more integrated approach to examining the issue of discretion.

In a review of *Professional Discretion in Welfare Services: Beyond Street-Level Bureaucracy*, Pardasani (2011) suggests that Evans makes a valuable contribution to the development of knowledge about social service organizations in the UK with regard to the role and nature of management and its impact on staff conduct and consumer services. Pardasani (2011) notes that the findings of Evans's study could have widespread implications for social service organizations around the world given that with "the current global economic downturn, reduced social services expenditures have led to stricter regulations for eligibility-testing, greater reliance on governments contracting with private agencies for direct service provision, and a rigid adherence to achieving stated program outcomes" (p. 439). Pardasani credits Evans for recognizing that within the context of austerity, social work practitioners have felt increasingly torn between meeting clients' unique needs while managing to operate within narrower policy guidelines. Included in this argument are that managers are also struggling to balance "professional social work values, empathy for the challenges faced by their front line workers, and the demands from senior management for greater adherence to procedures and budgetary

guidelines” (Pardasani, 2011, p. 440). Another critique of Evans’s book is the missing rationale of how the front line staff exercise discretion. Furthermore, it is noted that the Evans study was limited to government-operated social service organizations, limiting its relevance for private social service agencies and nongovernmental organizations.

Durose (2011) presents another critique of Lipsky’s street-level bureaucracy. Durose revisits Lipsky’s influential analysis to explore whether contemporary front line workers in the UK present differently from the originally conceptualized “street-level bureaucrat” that Lipsky introduced more than 30 years ago. Durose posits that under the current policy paradigm, “front-line workers need to be entrepreneurial to innovate and work the emergent spaces of local governance.”

Durose’s 2011 study used an interpretive analysis to explore how front line workers understand and relate their everyday work through “storytelling.” She collected data through informal meetings with front-line workers, neighborhood managers and senior officers, and conducted semi-structured interviews with more than 40 front line workers in neighborhood teams. The responses of these front line workers offered the “story” of how their day-to-day work was changing. One practitioner in the study reported a noted increase in flexibility, noting,

[There is] more flexibility within their roles to do what is the right thing within that setting ... That’s quite a big change because essentially we work in a bureaucracy where people are cogs in a wheel and they do their bit and what we [in neighbourhood management] are asking them to do is to step out of that mold and make it up as they go along a bit more (Durose, 2011, p, 985).

Another front line worker from the study told her story on the emerging flexibility in her role: “[I] was very excited by some of the ideas that were developing ... there weren’t any actual

constraints or boundaries” (Durose, 2011, p.985). Another further front line worker commented on the innovative practice emerging in local governance: “I think that there is stuff going on with individual officers that is pioneering that ... does push the boundaries” (Durose, 2011, p. 985).

The collected stories were interpreted as “civic entrepreneurship.” The study concluded that front line workers demonstrate a range of strategies, which they use to help them build relationships with the community. Strategies such as “reaching,” “enabling,” and “fixing” demonstrate how front line workers engage with the community to build relationships. Durose (2011) states, “Civic entrepreneurship is more expansive than Lipsky’s notion of street-level bureaucracy, which is characterized by ‘discretion’ as choice or judgment within bureaucratic constraints” (p. 991). Durose concludes with the argument that local governance requires front line work that is less like “street-level bureaucracy” and more like “civic entrepreneurship,” and suggests more attention be given to this area for further research and inquiry.

In the 30 years since Lipsky first introduced the concept of street-level bureaucracy, many political, economic and social changes have affected the way in which this theory can be applied to the analysis of human service organizations. Recent transitions offer an opportunity for an array of criticism as well as support for Lipsky’s street-level bureaucracy. One aspect of Lipsky’s theory that remains unanimously supported is the critical role of street-level bureaucrats and *how* their experience is an important component of understanding the ways in which policy impacts service delivery on the front line.

Despite the varying criticism in which certain aspects of Lipsky’s theory may need to be re-examined, the fundamental concept of the street-level bureaucracy serves as a very useful foundation for a theoretical approach to this study. Street-level bureaucracy reminds us to give voice to the front line worker, which is the intention of this study. This theoretical approach also

highlights the pivotal role of the front line worker-- referred to by Lipsky as the street-level bureaucrat-- and offers a lens by which to examine the experience of workers as they exist in the complex web of ongoing policy shifts, organizational demands, work ethics and their relationships with their clients.

CHAPTER 5: METHODOLOGY

Research Methods

This dissertation employed a qualitative methodology, using a focused, semi-structured interview guide. The data was coded and analyzed through the use of template analysis (TA). The purpose of this study was to understand the experience of human service workers in the field of substance abuse treatment during the current era of Managerialism. More specifically it examines the ways in which the implementation of these policies is shaping practice and worker experience. To date there has been limited research that looks at the overall and cumulative impact of Managerialism on workers and their capacity for quality service delivery. This study served as an opportunity for a closer examination of the phenomenon within the critical area of substance abuse treatment programs.

Ontological Frame and Epistemological Discussion

To gain a deeper understanding of the front line workers' experience with Managerialism on the job, it was important to create a space for discovery, flexibility and openness to new information. To this end, this study used inductive approaches of discovery in ways that provide an opportunity to obtain more comprehensive and insightful findings (Patton, 2002). Using open-ended questions and empathic neutrality, the development of a trusting relationship can uncover necessary but often hidden data that are often missed by quantitative studies that have different goals. Qualitative methods provide contextual information and provide rich detail into human behavior that can be overlooked through a positivist perspective (Guba & Lincoln, 1994). Using a qualitative approach allows for the investigator to excavate perspectives of the participants in relationship to the phenomenon under investigation (Janesick, 1994). As a result, this approach fits the rationale and aims of this study.

Template analysis offers a theoretical approach that allows for a thematic organization of data. This approach is often considered a technique rather than a distinct methodology and is most often used in organizational research such as the current research (King, Cassell, & Symon, 2004). Template analysis can assume a “contextual constructivist” position in which the researcher assumes that multiple interpretations can always be made of any phenomenon. This approach highlights issues such as the reflexivity of the researcher, the attempt to approach the topic from differing perspectives, and the richness of the description produced (King, Cassell, & Symon, 2004). A key characteristic of template analysis is its flexible coding system. This approach involves the development of conceptual themes, the clustering into broader groups, and ultimately the identification across cases of “master themes” with their subsidiary “constituent themes” (King, Cassell, & Symon, 2004).

Research Questions

This study explored and sought to understand how front line workers in substance abuse treatment programs experience Managerialism. The specific questions the study proposed to answer were:

1. What Managerialism policies, if any, are evident in substance abuse programs?
2. In what ways, if any, do workers believe these policy changes have effected their day-to-day functioning on the job?
3. How do these changes affect workers’ experience of practice and service provision?
4. Do these policy changes promote or hinder workers ability to deliver quality services?

Sampling

This study employed a non-probability purposive sampling strategy to recruit respondents that are the most representative or useful to the purpose of the study (Patton, 2002;

Rubin & Babbie, 2008). Typically, qualitative studies involve small samples sizes that allow for information-rich cases that can lead to deeper understanding of an experience (Patton, 2002). Purposive sampling was the best fit for my study because I was interested in a very specific sample that can offer the rich detailed information about Managerialism in substance abuse agencies.

Criteria for inclusion in study. To be selected as part of the sample, participants were required to meet all of the listed the criteria for the study:

1. Participant has been in current position for at least three years as a front line worker or comparable role that involves working directly with clients
2. Participant is employed at a program where the primary focus is substance abuse treatment and direct services are offered, within New York City
3. Participant holds a license for direct service delivery (CASAC, LMSW, LCSW)
4. Participant is able to communicate in English
5. Participant is able to sign informed consent to participate in study

I used *purposive sampling* as well as *snowball sampling*. Purposive sampling allowed me to examine a specific sub-group of workers in greater depth. This sample consisted of front line workers in substance abuse programs in New York City who deliver services directly. Padgett (2017) describes snowball sampling to be “used [when] members are not likely to be found and cooperate without referral from others in their network” (p. 69). I used snowball sampling as participants referred to me other professional colleagues who might be interested to participate in the study.

Recruitment. I began recruiting for this study by emailing the recruitment flyer to my professional contacts within the field of substance abuse treatment. From there, I used snowball

sampling, asking participants to recommend other colleagues and professional peers who might have been interested to participate. I also posted the recruitment flyer inviting participants on the professional network website LinkedIn. From there, I was able to exchange emails and phone calls with potential participants who responded to the posting. All interested participants went through a preliminary screening interview that inquired if they met the criteria for participation and if they were willing to meet with me for a face-to-face interview. Once participants passed the screening interview, an interview was scheduled.

In the very early efforts of recruitment, I found that supervisors and program directors expressed interest in being interviewed despite the recruitment flyer calling for front line workers. All parties who expressed interest to participate indicated previous experience as front line workers. Many described their promoted roles as being the “middle man [sic]” between the front line and higher-level program administrators. After considering the potential added value of the perspectives of these supervisors and directors, I included them in this study. All participants met the criteria for participation despite the expanded inclusion of supervisors and directors.

Data Collection

I collected data through focused, semi-structured interviews with front line workers and supervisors in substance abuse service programs. Interviews took place between December 2016 and September 2017, at mutually agreed upon settings in New York City. Most were conducted at the participant’s office at the substance abuse program, a few at this investigator’s private office and a few at a neutral meeting spot such as a café or coffee shop in New York City. Locations were mutually agreed up by both parties involved but were based on convenience, privacy and comfort for the participant. The content of the interviews focused on current work experience in substance abuse programs in New York City although a few participants had

previously worked at agencies on Long Island or Westchester, which they referenced. Interviews lasted 45 minutes to an hour and were conducted face-to-face following an interview guide.

Interviews were all audio-recorded and transcribed verbatim by this investigator.

Face-to-face individual interviewing using a semi-structured interview guide allowed for an in-depth discussion around the phenomenon of interest, and for the discovery of more detailed and potentially rich information. It met the needs of my study because it offered the foundation to establish a rapport while maintaining a certain flexibility and openness to addressing the phenomenon of inquiry. The attached semi-structured interview guide (Appendix A) was created to ensure that the set of questions pursued with each interviewee remained aligned with the purposes of the study.

Role of the investigator. My interest in this research topic is rooted in my own professional practice experience working in substance abuse. Having the experience of working as a direct service provider in substance abuse treatment from 2004-2011, I appreciate how policy can shape a workers' experience. However, after many years of being out of the field of substance abuse, I became increasingly curious as to how workers are experiencing the ongoing integration of Managerialism. In pursuit of this inquiry, it was clear that this study benefits from the development of a relationship between respondent and interviewee especially since I knew a few of the participants through my professional network. These past professional ties might hinder the possibility of open discussions or evoke tensions or challenges in the interview. To encourage respondents to fully and honestly express themselves, comfort or rapport was established. I believed it was important that my professional background was transparent to all my participants, especially since I was aware of how this variable may influence my role as an investigator.

Patton (2002) highlights the importance of achieving empathic neutrality, stating that the investigator should be perceived as both caring and interested in the participants, but also “neutral about the content they reveal” (p. 569). To ensure my stance of empathic neutrality, I disclosed to all the participants that I had professional work experience in substance abuse treatment several years prior to this study. This disclosure seems to have helped to foster a sense of understanding and rapport with participants. Furthermore, participants did not have to go into great detail explaining the nuances and professional language of substance abuse treatment since these details I was already familiar with. This common ground helped the interviews run smoothly.

It was also critical to disclose to the participants that I have been *out* of the field for the last six years. This absence created a comfortable space for participants to share their experience knowing that much has changed in the interim. In line with Taylor and Bogdan’s (1984) suggestion that self-disclosure in qualitative research should be “truthful but vague”, having some physical distance from the field made it particularly easy to leave my work experience as a blurry detail while keeping the focus on the participant’s experiences. Participants seemed to feel compelled and excited to “fill me in” on what I’ve missed.

Introducing my self-disclosure before the interview, helped to shape the interview experience for me as well. Padgett (2017) describes the importance of the qualitative researcher to always return to reflexivity and mindfulness throughout the interview and interpretation process. The self-disclosure reminded me of those techniques. I became aware of *what I do know* from my work experience, from the literature, and from the theoretical perspective provided by Lipsky’s *Street Level Bureaucracy* but also *what I do not know*. The self-disclosure became a

useful tool in orienting myself at the onset of the interview to challenge my preconceived notions and assumptions and allow for new discoveries to unfold.

Strategies for rigor. Padgett (2017) identifies several strategies to increase the rigor of qualitative research, among those, *triangulation of data*, *member checking* and *keeping an audit trail* were used in this study. Triangulation involves using two or more sources to verify observations or impressions (Padgett, 2017). In this study, I used data triangulation, which the use of more than one data source (interviews, agency materials, observational data) in order to corroborate my findings.

Lincoln & Guba (1985) describe member checking as an important strategy to guard against research bias. Throughout my interviews, I checked in with participants around clarification, elaboration and used reflective listening techniques. I also followed up via email and/or telephone with many participants after the interviews in order to ensure the accurate representation of the data (Patton, 2002).

Padgett (2017) describe the use of an audit trail which include, “samples of raw data (de-identified) as well as memos and iterative versions of a codebook or thematic analysis plan” (pg. 220). I maintained a small field notebook that included such raw data. I took notes during each interview about my impressions, reactions and other things that arose in the interview that could not be capture through an audio-recorded interview.

Issues of trustworthiness. Lincoln and Guba (1985) introduce concepts of *credibility*, *transferability*, *dependability*, and *confirmability* as alternatives to the quantitative researcher’s concepts of internal validity, external validity, reliability and objectivity. Padgett (2017) notes that the latter quantitative standards are not an appropriate match for the assessment of

trustworthiness of a qualitative research study. Lincoln and Guba's (1985) concepts guided this study to account for trustworthiness.

Credibility refers to the degree of fit between the participant's perspective and the researcher's description and interpretation (Padgett, 2017). To ensure this, I often used reflective listening techniques in which I would reflect back what was said to me in the form of a question to ensure its accurate understanding. This technique gave the participant a chance to clarify if any misunderstandings or misinterpretations. I also consulted with two professional colleagues to ensure that my interpretation and understanding of the data was also congruent with their understanding of the responses.

Transferability refers to the generalizability of the study's findings (Padgett, 2017). Transferability considers the ways in which the specific phenomenon in this particular context helps explain the experience of similar populations in the same type of context (Patton, 2002). Dependability refers to documenting the study's methodology and procedure to ensure consistency in the study's findings and results (Padgett, 2017). The final concept of confirmability refers to the demonstration that the study's findings are linked to the data that was collected. Patton (2002) suggests using an audit system to ensure the results are not an outcome of the researchers bias but instead are objective.

Data Analysis: Template Analysis

Template analysis was used to build upon *a priori* conceptual framework drawn from theory and empirical literature about Managerialism and its effect on human services work. The use of *a priori* template of codes can help guide and accelerate data analysis (King, 1999). For the purposes of this study, there are some pre-set concepts from the literature and previous research. The use of *a priori* template was a useful technique in organizing and understanding

the data from qualitative interviews. Despite the use of a template, this technique involves flexibility in its coding, interpretation and analysis across several interviews, which can help to develop broader themes and concepts across the data (King, 1999).

To begin using template analysis, King (1999) suggests identifying two or three “higher level” codes at the onset of the research, which are based off already available research and literature. It is also recommended that other sub-codes be identified as data collection progresses. Since template analysis can be considered a combination of Grounded Theory and Phenomenological Analysis, it is essential to consistently revisit the research questions, consider all the emerging themes from the data, and allow for modifications to be made to the template as needed (King, 1999). Template analysis considers the initial *a priori* codes as a starting point but describes the coding process to be iterative.

Coding. Once all the interviews were transcribed verbatim, they were uploaded into the coding computer software, Dedoose (Version 8.0.35, 2018). Using King’s (1999) guidelines for developing analytic templates, four broad themes were established as *a priori* codes: 1) the presence of Managerialism policy; 2) the worker’s experience of Managerialism; 3) impact on professional experience; and 4) responses to Managerialism. Each code had several secondary codes that were examined and explored more deeply throughout the interviews, which allowed for the discovery of new themes and concepts to emerge. These *a priori* codes emerged from the conceptual and empirical literature on Managerialism and human services. In addition, an ongoing circling back to the research questions and examination of consistent emerging themes from the data allowed for the continued creation of new subcodes throughout this process. During the iterative process of coding, many new themes that had not been previously considered emerged and some of the themes prevalent in the literature did not present themselves

in the interviews and we therefore dropped. King (1999) encourages the investigator to use the initial template as tool to help guide the exploration of new themes and subcodes as the transcripts are reviewed. In this coding process, subcodes represented the emerging themes from the initial broader higher-level themes. Subcodes such as “Accountability” or “Quality of Care Concerns” were then categorized and from those identified subcodes, many more lower-level themes emerged in each category.

IRB and Human Subject Issues

The study was approved by the Institutional Review Board of the CUNY Graduate Center. All participants reviewed and signed the informed consent (Appendix B). Participation in this study was voluntary. Interviews took place either at the agency in which the participant works or in this researcher’s private office setting if the participant prefers a more confidential environment. The data gathered including all digital recordings and transcriptions are kept on this researcher’s computer in a password-protected file. To protect the confidentiality of the participants, neither their first or last names were recorded. All participants were assigned identifying numbers and later on a pseudonym, which was used in managing, analyzing and describing the data.

CHAPTER 6: THE PRESENCE OF MANAGERIALISM IN SUBSTANCE ABUSE PROGRAMS

Worker's Account of Managerialism

This study offers a qualitative description of worker's experiences with Managerialism policies in substance abuse programs in New York City. The literature describes a variety of Managerialism policies that can affect social work practice in a variety of ways. However, these discussions are broad and often situated in a theoretical context. This study examines the real life experience of Managerialism on the front lines and in real-world organizations. This chapter introduces the sample of participants and details the presence and operationalization of Managerialism in substance abuse agencies. Chapter Seven will detail the actual experience reported by workers.

Participants

Participants in this study represented a variety of inpatient and outpatient substance abuse treatment programs in New York City including: Outpatient Programs (OP), Methadone Maintenance Treatment Programs (MMTP), Intensive Outpatient Programs (IOP) and Residential Treatment (RT). All but one participant held a Master's degree in Social Work or related field, or a PhD. All participants held a license to practice that was relevant to their graduate education (i.e LMSW, LCSW, LMHC). The one participant without a graduate degree was a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) and was enrolled in a graduate program for his MSW. In total, twenty-two interviews were conducted with thirteen front line workers and nine supervisors (including one Chief Operating Officer (COO) and five Program Directors). This sample included four male and eighteen female participants. Sixteen participants identified as White/Caucasian, two identified as Asian, two identified as

Latino/Hispanic and two identified as Black/African American. The range of ages of the participants was from twenty-five years old to sixty-seven years old. (See Table 1. *Participants Demographics*). The figure below demonstrates the initial template for this study.

1. Presence of Managerialism Practices	<ul style="list-style-type: none"> a. Accountability b. Productivity c. Use of Technology d. Standardized Practices e. Increased Documentation
2. Integration of Managerialism	<ul style="list-style-type: none"> a. Transition to Business Model b. Issues with Work Environment
3. Impact on Professional Experience and Service Delivery	<ul style="list-style-type: none"> a. Quality of Care Concerns b. Professional Autonomy
4. Responses to Managerialism	<ul style="list-style-type: none"> a. Organizational Response b. Individual Response

Figure 1. Initial template for study.

The interviews uncovered managerial policies in all the substance abuse treatment programs under study. The types of policies reported by respondents were similar across the various programs, and highlight consistent themes. The most prevalent Managerialism practices substance abuse treatment programs in New York City included: (a) a rise in the use of accountability measures; (b) the introduction of new technology; (c) the increased demand for documentation (c) pressure for increased productivity; (d) a strong emphasis on the use of standardized practices; and (e) increased involvement with managed care.

Evidence of Managerialism

Accountability Measures

The Managerialism paradigm includes a focus on accountability, which refers to the obligation of an individual or organization to account for and accept responsibility for their actions. This often includes providing the funding source or regulatory agency transparent disclosure of completed activities. In substance abuse programs, this typically involves internal and external audits.

Participants discussed the increasing intensity and frequency of internal audits as a way the agency prepares for routine external audits from regulatory agencies such as OASAS. Concerns about failure to maintain good accountability reports are tied to fears about loss of funding and/or sanctions. Sherry, a program director at an outpatient program, discussed how accountability is measured through an audit procedure.

From what I've seen, [what] the auditors are often looking for is that the notes are done, the treatment plans are done, that everything's documented, that if a person's not coming, it's indicated why are they still enrolled [in the program], why isn't their treatment plan being adjusted, so that's something where we have to focus on more. . . I mean we've had we've had citations for not meeting numbers, like, I know OASAS has not given as much money at the fiscal year because we haven't met enough numbers.

Bob, a front line worker for eleven years in an intensive outpatient program, explained how his agency remains vigilantly prepared for external audits by routinizing internal audits. He said, "The audit process is pretty much ongoing here amongst ourselves and then every once in a while [the big boss] will just go and pick charts out to look at and start auditing them, and put a

note in about what is missing from the chart.” He said that audits in his organizations are taken seriously and the threat behind them remains powerful,

The impetus has been that we’re getting audited soon so that means that we have this review board, or that agency coming like OASAS, and they can shut us down, or you know, threaten our ability to do the work, and so we have to meet their standards. It can get pretty intense.

Later in the interview, Bob went on to discuss the variety of ways in which he prepares for audits. He described keeping “charts up to date” with progress notes and a variety of accountability forms. He explained how most forms require quantified reports on client’s treatment and progress that are used as measures of accountability, “Certainly I do a lot of reporting for accountability purposes but I’m not sure it really reflects that. OASAS is pretty concrete in their state forms -- the admission, and the discharge forms -- about what they’re looking for, but very often we have to guess [how to complete the form].”

Bob discussed the increase of accountability reports introduced over the last decade and discussed his difficulty reporting on this. He finds it a challenge to quantify client progress to a “checked box” because things do not always fit exactly as asked on the form. He also noted that the importance of completing the form has superseded the value of it being an accurate reflection of what occurred in treatment.

In line with Managerialism’s focus on accountability, use of such measures and reporting seemed to be an increasingly important aspect of substance abuse workers’ roles. Although participants discussed some variations in the frequency of internal audits, the majority spoke about the increasing pressure to meet the standards of accountability measures in order to produce accountability reports that satisfy OASAS requirements. Some participants discussed

the complexity of having several funding sources that demanded slightly different accountability reports.

Across all the interviews, it was clear that accountability measures are emphasized in substance abuse programs. While most workers identified the focus on accountability measures to be a stressful aspect of their professional role, others felt more comfortable with the accountability concept. Lillian, a program director, explained her rationale for the justification of accountability reports,

You gotta give them reports every month about what's happening, and how many services we offered and were utilized, you know, it's the usual stuff and you're still beholden to them [OASAS], you still have to tell what you are doing, you have to do what you have to do, anyone who gives you money, is gonna want that. I mean, that's the bottom line.

Introduction of New Technology

Managerialism policies embrace new technology in order to provide the best and most effective services. The most frequently discussed use of technology in substance abuse programs focus on the introduction of electronic medical records (EMR). Prior to the introduction of EMR, all substance abuse programs documented this work using paper charts that were stored in locked drawers, typically in an on-site administrative office. Workers were responsible for update each of their client's charts including progress notes, treatment plans, consent forms, and all other required paperwork. All this data was entered by hand and manually filed in the client's chart.

The transition to EMRs eliminated paper charts and removed the tedious chore of hand writing notes. Lillian, a program director, felt hopeful about the transition away from paper charts to EMRs. She explained, "One good thing that's changing. . . we just got electronic health

records. . . my staff were blown away when they got that training yesterday about how easy this is.”

Jessica, a 67-year-old clinical supervisor in an outpatient program, reflected on her positive experience with the transition to EMRs,

It took time but I got very good at that-, at electronic health records. I was very afraid that I wouldn't, but I did. There was a training, but really the best training, of course, is doing. So after the training, you get thrown right into the fire, 'cause you're doing it right away, and there's no going back! So it was trial and error, and we all had our learning curve but I did it, and in some ways, it made [work] easier and some ways it didn't. But this is, this is the future so I became very adept.

Other participants such as Karen, a 47-year-old front line worker, did not adjust as well.

We moved from paper to EMR and that was a huge nightmare. They gave us one, like, two- or three-hour training on a [software] program they bought, and expected everybody to be good to go, and nobody was, of course. We had to jump right in and of course things became more time sensitive. It was all just impossible to do.

Amelia, age 51, has had twenty-one years of experience in the same substance abuse treatment program. She has worked her way from front line worker to intake coordinator to clinical supervisor to program director, and now is the agency's chief operating officer (COO). Her perspective on the transition to EMR is as follows,

So we have an EMR, I've have some mixed feelings about it, but... in our case, we were really, a 'mom and pops' organization, and the old administration was

very resistant to any technology and so that really hurt us, you know, because it didn't move us forward, we were behind the times [not having any technology]. So now we're trying to get caught up with the times and in some ways it's wonderful, you know, it cuts down on the time. It's also great to have easy access to reports, to know who you're serving and what you're doing, and where you're lacking, and I mean, it's really helpful for quality assurance stuff like that but I have some mixed feelings about sharing data even if people sign consent forms, it's a little scary, uh... the amount of information that's out there now...

Only one participant reported the continued use of paper charts however she said she heard "ongoing whispers" that EMRs were coming but the transition had not occurred yet at this particular program. All of the other substance abuse programs had already abandoned paper charts for EMRs. Many participants reported the transition had occurred a few years previously, while others were still in the midst of the transition.

Many interviewees discussed having to transition to different software platforms since beginning to use EMRs to find a good fit. Sherry, a program supervisor, said her office was in the midst of preparing for a software transition. "We're switching to a new [software] next month, which is supposed to be better than what we have now . . . which has been giving us a lot of trouble." Some participants indicated that the introduction of EMRs was also the first time they had a computer in their office, reflecting a symbol of the changing times.

Increased Documentation

Proper documentation is critical to the vitality of social service agencies for a variety of reasons. Documentation is included in the professional responsibility of any service provider and is essential in substance abuse treatment for the purposes of liability as well as good practice. In

substance abuse treatment, required documentation can include all notes related to the referral, consent forms, intake assessment, psychosocial report, treatment plans, clinical progress notes, outreach notes, collateral notes, and termination forms. Essentially, workers must document anything that happens in the treatment of clients.

The importance of record keeping is not a new concept in this field. However, such documentation increased as part of the new accountability and productivity measures that accompanied Managerialism along with new insurance company requirements and new protocols. Ruby, a front line worker in an outpatient program, explains how documentation has changed during the thirty-three years she has been in the field,

Yeah, when I started I loved the field because the paperwork was basic. It started to change when I started working for places that have regulations like OASAS-run programs. . . Any call that comes in you have to document it, and any session you have with a client you have to document it. If a client misses an appointment you have to document it. If, um, a client decides to see you twice a week you gotta document it. If clients go to five groups you've gotta document for every single group, and then not only do you have to try to document it but do it on time. For the first fifteen years, it was manageable, and then things started getting stricter. The forms started to get more ridiculous, the demands of paperwork started to get a little too much.

Emma, a front line worker in an intensive outpatient program, describes the extent of her note taking and documentation,

There are required group notes, every single day. Individual notes every single day. . . collateral, third party calls, outreach calls. If they relapse [there is a note].

Concern resolution notes, treatment plans, updated treatment plans, the integrative progress summaries, which by the organization standards we need to do two a month per client. They each take, like an hour and a half but all of us are just like ‘screw that, um... we’re just going to do it when insurance needs it’, because otherwise I have like no time, there’s not enough time to get it all done.

While participants recognized it is reasonable to demand documentation of all services provided, participants expressed that the demands around documentation have been increasing over time. Rebecca, a program director of a methadone maintenance program, described her frustrations with the increase in documentation,

There’s a lot of documentation, I think that especially in the last eight years, I’ve felt that there’s more documentation... I’d like for SAMHSA, CARF, OASAS, to be a little more clear cut and transparent about what the requirements really are, because I feel like... I still spend a lot of time sort of translating typical jargon, like, what’s really being asked for from us. I don’t want to add more work for my already overworked staff.

Bob, age 66, is a front line worker in an intensive outpatient program. He described his experience with the increase of documentation over time,

So in the time that I’ve been here, which has actually been eleven years, the paperwork has increased a great deal. Our time gets sucked up with more and more forms. You know, we’re always getting new forms. I can think of once when they took away a form, but the other eight hundred times, there has been a form change it’s always been more forms! All that stuff sort of adds on another layer of stuff that [the program] suggests we have to do that and so we have to do

it, even if no one's ever gonna look at it. So... all the paperwork we do no one will ever look at except once every three or four years JCAHO or OASAS will show up, and look at the paperwork and if it's not there, [the program is] not gonna be happy.

Focus on Productivity

The focus on productivity and outcome measurements was another consistent theme. Productivity, largely connected to funding and other regulatory standards, was often referred to as “the numbers.” Front line workers and supervisors alike felt a pressure to meet the productivity standard set by higher-up administrators or regulatory agencies.

“The numbers” can reflect an array of productivity measures. Depending on the program type and level of care of treatment, productivity demands vary by settings (e.g., for outpatient programs, how many clients came to group today? For residential treatment programs, how many beds are filled?). The varying ways agencies require workers to report on productivity included counting client contact/encounters, program census, client activity, time spent on administrative tasks and any other billable hours – all considered “productive” use of time. Some workers were asked to report productivity at the end of each workday, while others with more lenient productivity pressures reported productivity weekly or monthly.

Sophie, a front line worker in an intensive outpatient program, described a recently introduced “points system” that is intended to measure worker productivity. As she spoke, she referred to a small piece of paper she kept on her desk that outlined this point system. She called this her “cheat sheet” and used it to keep track of her productivity throughout the day.

I think what they're saying now is that everyone has to have ten billable points a day. . . or wait, now its twelve billable points a day, it just went up. A point is,

like, this... if you're doing an assessment, that's three points. If you are seeing someone one on one for forty-five minutes, that's two points. . . If you're seeing someone one-on-one for twenty-five minutes, that's one point. If you have ten people in a group, one person is considered point five. . . a half point. So in an hour and fifteen minutes, for ten people, that's five points. This started because [the program] is looking at our productivity. It's been going on maybe two months already. And I'm pretty sure that they're doing this because they are also trying to see where do we do put the money and where are we going to take away the money? Who knows, it might be a point for assessment, it might be a point of redesigning the program, it might be a point where. . . who knows?

Sophie recognized this new system as an attempt to accurately measure worker productivity but also said it infused the message of the importance of this to her agency since they have put so much time and attention to this measure.

Emily, a front line worker in an outpatient program, also indicated recent changes in how her agency was looking at productivity,

There have been recent changes in terms of how we look at numbers and productivity, but I feel like it's because this is ultimately a business. I remember a few years ago, when they initiated this productivity spreadsheet that we had to enter in our monthly attendance, and that is something that has evolved. Most recently, it's changed even more. Now, they're looking at not just what's billable, it used to be what's billable but now they are also tracking how we're spending our time. This excludes phone calls, to insurance, but includes face-to-face time with clients. For example, in the morning intensive program if you meet with

someone individually after the group session that is not billable separately, but it's such important work. So we're now tracking that now and that gets included in our time spent.

Other participants discussed how their programs measured productivity by focusing on the overall program census, including emphasis around the numbers of admissions and discharges. The majority of participants explained that productivity measures were being implemented to measure client utilization and engagement in treatment. Despite the variations in implementation of this managerial approach, the emphasis on productivity existed at all the agencies.

Use of Standardized Practices

Managerialism calls for standardized practices. Consequently, the demand to use evidence-based practices (EBPs) was present in all substance abuse programs. Some participants described this demand as a more of a "mandate," while others resorted that the agency only "strongly encouraged the use of EBPs, However, it was clear that EBPs "must be reflected in the note." It was also clear that not all workers were using only EBP techniques. Despite the consistent demand of EBPs, there was a noted discrepancy between what workers were doing and what they were being asked to do.

Most participants concluded that only handful of EBP approaches worked well for substance abuse clients. The preferred approaches included Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), Solution Focused Therapy, Mindfulness techniques and other relapse prevention interventions. However, opinions varied as to how much flexibility workers could include in their practice before it constituted a deviation from these identified standardized approaches. Some participants discussed the use of a treatment curriculum and

other standardized approaches from workbooks intended for substance abuse treatment particularly related to group therapy. Sophie, a front line worker in intensive outpatient program said,

We use some manualized things, especially with cognitive behavioral therapy (CBT), we have a lot of manualized treatment here. . . you put me there [in group] to do it, and then later I will put it in [the note] in a way where it's clear what evidence based intervention was used.

When I asked Alice, a clinical supervisor at an outpatient program, about the emphasis of EBP in her treatment program she said that her program encourages EBP, however admits to a lack of related training for her staff,

It's emphasized, but's not taught. It's emphasized in that we know we're supposed to using evidence-based practices in our notes, or with our clients, but we aren't necessarily trained on this. You know, most of the staff is hired out of grad school. So they come with the training that they got in school and then whatever they learn on the side is. . . whatever they learn, so like, I'm sure we all say that we do CBT, is anyone formally trained in CBT? I mean, no. I would say we're probably using motivational interviewing the most, if that's evidence-based. . . or CBT. . . but that's pretty much the extent of the techniques encouraged.

Paul, a front line worker in an outpatient program, offered a similar experience,

Well, we're supposed to use evidence based practices and honestly the day I started working there, I just, developed language for myself whenever I do an intervention. MI/CBT, motivational interviewing and cognitive behavioral

therapy, these are the two interventions we're supposed to use. I've received no training on CBT training and with motivational interviewing; I went to a weekend workshop. I can tell you right now that a weekend workshop does not a motivational interviewer make.

Rebecca, a program director of a methadone maintenance program expressed that despite strong intentions and efforts to streamline treatment interventions to EBPs in her program, she believed this was difficult to achieve,

It's something that was not happening across the board with some of our staff members. I'm trying to get in as much training as we can but it's also hard because I feel like there's so much going on that like, to find the time to do that. . . doesn't always feel easy. I think the staff needs some concrete [training], like CBT, and we are gonna do a mindfulness training just about self care, and ethics, and just really getting down to the basics again or at least what I feel to be the basics.

Sherry, also a program director, but for an outpatient program, said that her staff was doing the best they could to transition to EBP and a more standardized practice approach but that this was a deviation from the way the way workers historically worked with their clients. She explained the expectation from the "higher up" administrators was that her staff utilizes EBP. She also reiterated the significance of that intervention being documented in the note,

We do some EBP. . . sure . . . um, I think we sometimes don't necessarily do it always, we don't do strictly evidence based practice. There's no way to do strictly motivational interviewing or CBT. I think we're more psychodynamically oriented, and that's, I think a lot of what, supervision is focused around. . . you

always put evidence based interventions in the note. You always document it and if you are using some interventions that's not strictly evidence-based, that's OK too as long as the evidence based practice is noted somewhere.

Emily, age 42, a front line worker for nine years in an outpatient program, proudly showed me her new workbook that included many new relapse prevention exercises that she looked forward to bringing to her clients. She described feeling safe working within the clinical guidelines of an EBP curriculum. Although participants had different experiences around EBP, including varied access to trainings and supervisions around EBP techniques, as well as commitments to alternative practice approaches outside of EBP; all reported they were expected to implement EBP techniques in service delivery.

Increased Involvement with Managed Care

The privatization of health insurance has led to firsthand involvement with managed care for substance abuse workers, focused on accountability, effectiveness, and outcome measures that are intended to improve effectiveness and reduce the cost of substance abuse treatment. Most participants discussed the transition to managed care, and how this has affected on their Medicaid clients. Amelia, a COO of an outpatient program discussed this transition,

So years ago, came the managed care, and in the beginning of the transition there were all these, um, criteria that could leave you on straight Medicaid like if you had HIV, if you were homeless, disabled, and that was a good portion of our patient population here. Now, almost nobody has straight Medicaid, so it's all HMOs, attached to the Medicaid, and what that meant was that we had to negotiate our fees with the HMOs. Also, treatment used to be carved out, so even if someone had a Medicaid HMO, substance use treatment was a carved out

service, meaning if someone has Medicaid HMO and they bill a service, it goes to the HMO first normally, but because substance use was carved out, it went directly to Medicaid and paid the Medicaid rate, the APG rate, which was a good rate. I mean. . . decent rate. Um . . . and then that changed not that long ago, maybe six years ago? Something like that where it's not a carved out service anymore, so meaning that the insurance company -- the HMO -- determines the rate of reimbursement.

According to participants, the introduction of HMOs to Medicaid clients changed reimbursement rates and fees, as well as access to treatment. In fact, several participants reported that a clients managed care plan is always taken into consideration when establishing their treatment plan.

Several participants talked about having to integrate phone calls to managed care companies into their daily routine. Agencies expect workers to call managed care companies on behalf of their clients for either initial treatment authorization or for continued authorization for ongoing care. Many of these participants reported that these phone calls took up a lot of time and were not seamless. Sophie, a front line worker routinely makes calls to the insurance companies on behalf of her clients. She has become accustomed to being told by managed care companies that her client cannot have access to the treatment she believes they need,

We cannot argue with the insurance. If the insurance says, 'For this person, OK, we will authorize their IOP but they'll have only five days'. We have to work with that decision, even if I disagree with the determination. So the challenge is really on the clinician to be clear about the treatment goal and presenting issues.

Later in the interview, Sophie explained how managed care company negotiation represent a relatively new part of her job. She stated, “The implementation of change around insurance. . . that’s what really caused the changes for us here. I remember when insurance was very kind and gentle. . . it was straight Medicaid and it was just so generous.” Sophie believed that the implementation of managed care completely changed the way in which her program functioned. Now, workers had to answer to their program administrators but also to the managed care companies.

Emma, front line in an intensive outpatient program, expressed similar frustrations with managed care and how it impacts her clinical practice.

Sometimes our entire individual experience [counseling session] is just around dealing with managed care, their anxiety about being cut off, how to deal with it, just gathering the info, working with them to make it work, you know, whatever is needed... but sometimes, nothing, sometimes it doesn’t even matter what we do, so...

Similarly, Julie, a front line worker in an outpatient program, complained that managed care often dictates the path of treatment for her clients. While she may determine a higher level of care is in the best interest for her client, that decision is not entirely up to her. She will need to call the client’s insurance company and negotiate with the managed care plan.

I think one of the most frustrating things is when you get a patient -- and this has to do with availability or access to services, as well as the barriers to services that managed care puts up—and I find it so frustrating when I finally get [that client] to agree to go into inpatient or rehab, and the managed care company sends them home after a week, or fourteen freaking days. . . that’s never enough! Or even

worse, the other thing is when [the client is] ready to go [to a higher level of care], and they say “I’m ready to go!” and we can’t get them a bed!

Most participants identified the increasing role of managed care clinical care. Although a few indicated that their agencies designated administrative workers to handle the managed care company negotiations, the majority noted that in most cases the agency delegated this responsibility to the clinical worker.

Summary

This chapter documented various Managerialism practices that present in all the substance abuse treatment programs under study. These changing practices created a fertile opportunity to examine in depth how Managerialism affected the daily experience of workers and the agencies organizational capacity for service delivery.

Table 1
Participants' Demographics

Pseudonym	Position	Years of Experience	Age	Edu	Race	Gender	Program
Paul	FL	3	39	MSW	W	M	OP
Alice	S	5	29	MSW	W	F	OP
Barbara	S	8	32	MSW	W	F	OP
Bob	FL	11	66	MSW	W	M	IOP
Rebecca	PD	9	32	MSW	W	F	MMTP
Vanessa	FL	3	25	MSW	W	F	OP
Debbie	FL	3	26	MSW	L	F	IOP
Timothy	FL	4	45	CASAC	B	M	RT
Jessica	S	12	67	MSW	W	F	OP
Sherry	PD	6	30	MSW	W	F	OP
Liz	FL	7	33	MSW	A	F	MMTP
Dorothy	PD	24	64	PhD	W	F	MMTP
Keith	FL	10	35	MSW	W	M	OP
Karen	FL	5	47	MSW	W	F	OP
Sophie	FL	43	67	MHC	A	F	IOP
Emily	FL	9	42	MSW	W	F	OP
Lillian	PD	21	54	MSW	W	F	RT
Emma	FL	5	29	MHC	W	F	IOP
Julie	FL	5	58	MSW	W	F	OP
Ruby	FL	33	57	PhD	L	F	OP
Renata	S	10	41	MSW	B	F	MMTP
Amelia	COO	21	51	MSW	W	F	OP

Note .FL= Front Line Worker; S= Supervisor; PD=Program Director; COO= Chief Operating Office, MSW= Masters Social Worker; MHC= Mental Health Counselor; CASAC= Credentialed Alcohol and Substance Abuse Counselor; W=White; A= Asian; B= Black/African American; L= Latino; OP= Outpatient Program; IOP= Intensive Outpatient Program; RT= Residential Treatment Program; MMTP= Methadone Maintenance Treatment Program.

CHAPTER 7: INTEGRATION OF MANAGERIALISM IN SUBSTANCE ABUSE AGENCIES

Transition to Business Model Approach

The previous chapter discussed the evidence of Managerialism practices in substance abuse programs. Although all participants indicated that they were aware that what I have identified as Managerialism had been integrated into the agency, none of them used the language of Managerialism or New Public Management (NPM). Instead, many spoke about the use of a “business model” and its effects on organizational policy and practices. This chapter discusses participants’ awareness of the integration of the business model including the emphasis on the bottom line and the overall impact of this integration on the working environment.

Emphasis on Bottom Line

Participants referenced a business model approach that among other things, emphasized on the “bottom line.” Jessica, a 67-year-old clinical supervisor with more than a decade of experience in substance abuse treatment, stated,

It’s become more of a business, from where I’m sitting. It’s become more of a business, and the bottom line is critical . . . census, units of service, funds from Albany -- that’s it. So, on an agency level, we try and do our best clinical work, and we go to trainings, and we read, and we brainstorm, and we discuss cases, and we learn the new DSM 5. . . But as it gets past me, to the director, and then to the administration, they don’t care, they don’t care. They just care about the bottom line. It is a business and it is about money, and if they can’t make money they can’t survive. And so the only way they make money is to make sure we see as many people as we can, so quality of care has definitely diminished.

Lillian, who has 21 years of experience in the field, discussed how her awareness of the bottom line was the critical motivation for how she ran her residential program,

I kept the focus on things like performance, improvement of clients, effectiveness -- because without demonstrating that we are productive we run the risk of losing funding. That's the bottom line. When I ran a program, you were judged not only on your retention, but your vocational number . . . You see, in a residential program your utilization is a very big deal. . . your beds have to be full. If you're operating under 90%, the statement you're making is that there's not a need in that particular area. So they can cut back your beds at any time, and that's money.

Karen, a front line worker, stated that while she can understand the integration of a business approach, she did not see this as an appropriate fit with the human services sector.

That's what I'm saying, of course it's a business model, I get that. I come from a different career, I was in the movie business, I was an executive. . . I was vice president level, so I know business but in a different type of way. So, I understand that this is business with survival needs but I just don't get it. . . I mean when you mix business with human services you know, it's very obvious that human services and business are not really the same. Putting it together is actually an oxymoron.

Karen was able to acknowledge some of the benefits of Managerialism but questioned if there can be a better way to integrate this approach with clinical values and the mission statement of the program.

Amelia, a program COO, acknowledged that the recent movement towards a business model with a greater focus on the bottom line has been a difficult change for her. She describes

her staff as being more clinically motivated with a limited understanding of the financial demands on the agency.

I mean, there's certainly areas where we need to improve, but that's more on the management functioning side and not on the clinical side. I think that we have a lot of dedicated staff who truly, truly care about the patients and so that makes it, you know, motivating to be here, and to want us to do well, and to want us to succeed and move forward.

Changes in Agency Leadership

Many interviewees discussed transitions in administration leadership, often indicating that new leadership had a clearer implementation strategy for Managerialism than did leaders whose tenures preceded this changing model. Amelia described the shift her agency is going through as they introduce more of a business model with a new administration. She noted that the founding administrators established what she called, a "mom and pop shop" in the 1970s. The transition to new leadership made way for an open embrace of a Managerialism approach.

One big difference that happened was that after the administration that was here for so long left, the first new person that came in was definitely much more business oriented. The new guy was still a social worker, just was also going for his MBA.

Amelia believed the transition to new leadership made way for an open embrace of a Managerialism approach. She described the new administration's approach as being more in line with a business model,

We didn't really have a CFO before either. We had [an] account manager, or something like that. I think having things like these kinds of professional titles

mean[s] something. Although right now we have a temporary comptroller, but I think either this person or someone else will be CFO moving forward. I think having a clearly identified senior staff, including a C suite, you know, is a change towards [a] business model... and the staff understands that language. It sets a tone.

While Amelia was able to focus on the positive aspects of this transition, other workers such as Dorothy, a program supervisor, offered another perspective.

So I think there are lawyers somewhere lurking in the distance who are not social workers, do you ever feel that that? Like behind the scenes are people who are not of our field, who are manipulating and making those demands, and it's infiltrating, so that's a top-down approach is the only way. And, unfortunately we're emulating the corporate culture, and you know, the irony of that is that corporate culture is trying to get softer. They are trying to become more humanitarian, so we're actually emulating the old IBM or Merrill Lynch, or whatever you want to call that, that's no direction in which to go. They should be using the previous administration as a model since everyone loved us then. It's our history here, which is why people stayed here much longer than they anticipated. I certainly stayed longer . . . weathering this storm.

Julie, a front line worker in an outpatient program, considered how "who is in charge" impacts the delivery of service.

I think there's probably some policy people that are involved in developing treatment planning, guidelines, and the regulations, that I am sure are research based, and client centered, and they want to help us. But, then there are the other

guys that are in charge of the money. . . and they want you to have more clients. . . more of a client load, per clinician, and put all of that together and suddenly, you have to cut your treatment time from forty-five minutes down to thirty-five instead. You do that, quality care will diminish of course.

Increased disciplinary actions. Jessica, a clinical supervisor for an outpatient program, expressed her difficulty adjusting to the approach of the new director of her program. While she could recognize he was under significant pressure to meet newly established standards set by OASAS and other funding sources, she believed he was too focused on the use of punitive measures.

Our new director was very harsh, and I thought he was very inappropriate, and he was very punitive, and could be very mean. He would write people up all the time and the threat of punishment was always looming. “I’m gonna write you up, you’re gonna be written up,” and then he would call me in and say, “You have to write a memo, ’cause you have to write up this one or that one [worker].” And I don’t ascribe to that kind of atmosphere. I believe that the nicer you are the more you get and that’s how I treated my staff. So a lot of the times I didn’t listen to the director. It made working there really hard.

Similarly, Dorothy, a program director with 24 years of experience at her agency, discussed her challenges adjusting to the new leadership style taken on by the higher-level administration.

I noticed, the last few times there was some disciplinary action taken, that it was the same thing. I disagreed with one of them [in upper management]. I thought it could have been handled in supervision as a clinical issue [and not with the upper

management], but that's not even considered anymore, it's an automatic punishment. . . But at least in this one case, the supervisor and the site administrator met in the supervisor's office with the counselor for a friendlier atmosphere, less of a tense, and artificial setup with somebody who's not even [clinically] trained.

More authoritarian leadership. Dorothy went on to discuss a colleague who worked with her at the agency from 1998 to 2005, and now 12 years later has returned. Dorothy said the colleague returned to the agency because of its legacy of providing quality of care and offering a warm and friendly work environment.

Of course, she noticed the changes that happened here between 2005 and now.

She actually used the term 'authoritarian, and later, fascistic,' to describe then new leadership here. I might not have even gone that far, but she did. 'Fascistic'?

She asked me, 'What has happened here?'

This noticeable change in management style was also discussed in the context of how the entire working culture is shifting to a more business model approach. Dorothy offered her own perspective about how things have changed over the two decades she's been at her agency.

I think it really boils down to a management style and a communication style. It used to be more collaborative and egalitarian in a way, because everyone had equal access to the top, and you never felt that there were a circle of people, that you could not penetrate... So if I were to draw that it would be like, we were spokes on that wheel, but we were equally distant from that center. That is no longer the case. It's oligarchic and top-down and that has impacted the atmosphere and the morale.

Karen, a front line worker also described how her boss had changed as the agency changed.

I watched [my boss] go from being really a friendly guy that could handle someone like me. . . to someone who is under so much pressure, that he started behaving like a dictator. It was terrible to see and over time, as outside pressures continued it became very difficult to work for him.

Productivity as a Priority

A critical aspect of the business model includes the emphasis on productivity. Sherry, a program director, spoke about the impact of these new demands on her staff,

I think what happens is, when you're so swamped [the work] becomes monotonous that you're sometimes, like, not even present. You're just like, going along with the routine of it and you're not necessarily really thinking. I've seen counselors not take the time when writing the treatment plan to really think, like, "Are they getting the right care, do they need different care?" Because instead it is just counselors complaining, "Ugh, I have to do another thing, one more thing that's on my plate."

Liz, a front line worker in a methadone maintenance program for seven years, expressed her concern that she was not offering the best quality of care to her clients because of the increased demand to prioritize her administrative workload.

I feel like the high caseloads that we have, we don't have the time to spend with them [the clients] and that's kind of like, a barrier but we try our best. Then at the end of the day we also have all this paperwork that has to be done. That's one thing I always hear, 'Don't fall behind.' I've been told, 'You know, if you need

time you should tell the supervisor that you can't meet with clients, you stay in your office and do your work. You can miss out on meetings, whatever you need to do to get the paperwork done.'

Amelia, a COO of a substance abuse agency, described the ways in which her programs are working to improve their productivity.

Well so, yes, so we are right now working on improving the revenue through groups, and so are currently talking a lot about that with the supervisors, knowing what the revenue is now, knowing where we're at in our budget, but also talking about the clinical significance and how groups are really the most evidence-based way to do substance use treatment. . . And then, the individual treatment is sort of supplementing it. . . we fall short in that area. And so we're coming at it from both the clinical side and the financial side. . . making sure that the clinicians understand the billing, that if someone goes to three groups in a day, we only can get paid for one group. . . but we want them to come anyway, because we want them to get the appropriate treatment, and it counts for our productivity.

Ruby, a front line worker, said that demonstrating productivity was explicitly the agency's priority, and that would cloud client care.

I've learned over the years to write almost every single event that took place. I would document it, so that was never a problem for me, but for the most part a lot of people struggled with note-taking, so it became very stressful. . . A lot of times your job was on the line if you didn't do your notes. Meantime the clients were either not getting better or being ignored because a lot of times counselors were [too] stressed out over the paperwork to even notice.

Technology and New Time Pressures

Participants all agreed that the new time pressure of administrative demands was driven by the introduction of new technology. Prior to the transition to electronic medical records (EMRs), workers found some flexibility with their handwritten paper charts, in which they were able to “back date” notes and reports. The introduction of such technology eliminated that option and meant that submissions to EMRs became more time sensitive. This phenomenon added new dimensions to workers’ documentation experiences. Paul, age 39, a front line worker with three years of experience, described,

Since I’ve been here, we’ve switched from paper records to electronic medical records and since we don’t have a lot of funds, we went with a provider for the EMRs that. . . well let’s just say the software that they provided is reasonably unwieldy. It’s slow so that’s one problem. You know, when you’re doing a paper chart, there’s a certain kind of latitude you have and you can build your own workflow. But now, I’m locked into whatever the software engineer decided, you know, how things should look.

Barbara, a program supervisor for an outpatient program, discussed her concerns about supervising staff around the time-sensitive nature of EMRs,

It [comes up in supervision meetings] yes, it is a challenge, just because everything is time-stamped now. But it’s not like, a note closes out if you don’t write it in a certain amount of time. However we’re switching to a new electronic medical records in the next few months ’cause the one we have is really not that great. And that one, there’s rumors that there might be more of a time-sensitive,

like if you don't write the note within a certain amount of time you lose the ability to write that note.

While some workers recognize the benefits of using technology, it appears that the transition to using EMRs poses challenges, whether these be inadequate training, a learning curve, a resistance to technology, software trouble, the stress of new time sensitivities, or difficulty adapting this new tool into a practice style. For some, the very presence of the computer in the office was a noted distraction.

Vanessa, a 25 year old front line worker said, "We spend a lot of time at our computers, I mean it's sorta funny 'cause I'm with clients a lot, but also I feel like a lot of the time, I'm like, logging things away on the computer so, it's just it's very fast paced." She emphasized that she is still figuring out how to manage the temptation of working on the computer while her clients are in her office.

Issues with Work Environment

A common theme across interviews was the ways in which Managerialism changed the work environment. All participants had a minimum of three years in the field, with the majority (82%) having more than five. Therefore, they were well-positioned to discuss how their work environment changed over time. Surprisingly, even participants with fewer years in the field acknowledged that the working environment was shifting as a result of the pressures and stresses related to managerial demands. This indicates that these trends are ongoing.

Budget Concerns

Most participants acknowledged that the financial health of an agency is vital to its survival. As stated by Ruby, a front line worker, "At the end of the day, your funding affects

which treatment facilities remain in business and what services they can provide.” Paul, a front line worker, reported,

I mean we are all worried about budget and we’re always talking about higher compliance, getting people in the door, pushing them into doing groups because we get more money. It’s not egregious, I don’t feel as though it’s manipulative, not like a Medicaid mill, but um, it is a constant pressure and I can see it stresses management out.

Ruby discussed how her agency’s tight budget has led to decisions that impact the worker,

So the [administration] buys these computer systems [the workers] have to use, but since they are trying to cut costs wherever possible, they don’t hire the right computer people to really give us good long-term training. Instead, we got one or two basic trainings, they try to cut costs so what happens is the staff is ill-prepared. So you have a bunch of [workers] expected to maintain updated work, on a system they barely understand because the agency could not spend the extra money to make that happen.

Jessica, a program supervisor, explained how budget cuts impacted her program.

They cut our funding recently, because our numbers were down. We were supposed to, according to the state, have a census of twelve hundred clients. . . twelve hundred, in service a year, and we didn’t make it so we knew our funding would get cut a little. Even though we expected it, it doesn’t make it any easier to deal with.

Sherry, a program director, acknowledged that budget concerns strongly impacted the day-to-day work on her staff.

In an ideal world, what I really do wish for is that we could have enough money for the agency. In an ideal world I wish counselors could have a caseload of about twenty-eight to thirty clients so they could have more time to take a breath. They could have more time to do notes and not feel like they're just going through the motions, or not having to schedule clients so back to back, 'cause that's how it has to be done right now, and they could have more time with certain clients.

Yeah, I do, I really, I do wish that but sadly this is not the reality of our financial situation.

Insufficient Training

Many front line workers reported that they felt they needed more training in order to keep up with the ongoing demands of the job. The program directors described the challenges in accessing trainings for staff mostly due to the high costs of trainings that exceeded program budgets. Rebecca, a program director, reported,

We just don't have the funding we need for training. I'm constantly looking and so are other staff members for free trainings and it's getting harder and harder to find those. We don't have the money for the trainings we would like. . . or even really need.

Sherry, also a program director, described how she struggles to get her staff properly trained to have the clinical skills they need for their jobs.

We wanted to send three staff to this [intervention] training. You know, to learn this stuff takes a lot of training, um. . . but it was a lot of money, money we don't

have. So what we did was apply for a grant to cover the cost of that training, but we didn't get the grant, so yeah, a lot of the curriculum-based stuff, at least from what I've found [is] just a bit too expensive.

Dorothy, another program director, explained how the lack of trainings had a great impact on her staff and their ability to perform.

There is pressure on some of the counselors who are so frustrated that they're falling behind because they do not quite know if they're even doing the note correctly. The training [for the note] was not adequate, the communication was tried, they were yanked out of a system that they had mastered and were doing well with, and now they're struggling with the threats of being punished. I know it's not just this agency, it's the outer other pressures, that make the paperwork so important, and so demanding at certain levels that the counselor feels torn. They gotta do something about this soon, you know the client is gonna sense that divided attention and that's something that the powers that be need to hear more about.

Staffing Issues

Participants spoke about the composition of staff in their organizations. Many explained that staffing decisions were often not determined by the agency's needs but rather by the budget. Debbie, a front line worker in an intensive outpatient program, discussed how the budget concerns in her program led to her agency hiring a part time consultant supervisor rather than having someone employed as full time staff.

As a result we don't really get a lot of support. We have an outsider that supervises social workers and the interns. This person only comes three times a

week, but sometimes only twice a week depending on her availability. She will have individual supervision with some of the some of the workers, and then we'll do group supervision but its definitely not adequate supervision.

Alice, a clinical supervisor, provided another example of this,

With the tight budget we have a limited number of psychiatrists. The budget is tight so that the doctors moonlight, so there's not a lot of coordination between the psychiatrists and the staff, which is a big problem. . . and I think when you have a high caseload, people fall through the cracks. Also, the staff of counselors is, forty percent CASAC in recovery, sixty percent mental [health] or MSW master's degree non-recovery because it's cheaper to pay a CASAC.

Alice also noted that recently management has made allowances for part-time staff, which was not something that was permitted in the past due to concerns about consistency of care.

I think that now they are happy to have part-time staff 'cause obviously again, they can pay them less, they always are inclined to hire fresh out of grad school and under-credentialed because they can pay them less.

Ruby, a front line worker, also believed that a tight budget has impacted staffing choices.

A lot of programs are not getting the kind of money that they need in order to hire professionals. So a lot of times we rely on interns and rely on counselors who are not that professional because they cannot pay professionals well.

Low Pay

Many participants acknowledged that the low pay of their jobs was a source of frustration, especially as their jobs became increasingly demanding. Ruby, a front line worker at an outpatient program, expressed,

People [are] working like dogs and not getting paid, and really, when you don't get paid to work in a stressful environment, it's really hard to stay motivated because at the end of the day, the motivation not only comes from the pay, but also having your clients do well. And how are your clients supposed to be getting better when there's a time clock ticking so intensely?

Debbie recently left her position as a front line worker at an intensive outpatient program because the "toxic" work environment combined with low compensation was not worth her continued suffering.

Well, specifically where I used to work was very stressful. I could not deal with the amount of required reporting and documentation. [The] majority of the people who work there are not happy. . . I think it's because of the low pay and because there is no incentive. The majority of the time, the clinical coordinator will tell you all of the things you're not doing, as opposed to, like, encouraging you and like, showing things that you're doing well. So that happened with other coworkers as well, who have expressed their concerns. But other than that it's just, like, you know, complain to your office mate and then just keep it moving, because nothing's gonna happen if you want to keep your job.

Paul, a front line worker, also addressed the difficulty his agency had with staff compensation.

So now, we're getting squeezed from both ends, we can't work overtime cause they can't afford to pay us but they can't afford to reduce our workload either! So we have to get everything done between the hours of nine to five, which is impossible, or if we stay late, potentially we just have to pretend like we didn't.

Feeling Devalued

Workers noted that the value of skillful and talented clinical staff became diminished over time. Karen, a current front line worker in an outpatient substance abuse program, talked about a previous professional experience in another outpatient substance abuse program in NYC. She stated that program's business model was so pervasive in the work culture that she felt unappreciated as a skilled clinician and subsequently left the job.

I understand business. If it had just been a place where they had respect for the people who worked there I would have stayed but I don't know, I really don't know what their thinking is and I don't know how driven they are. I think the feeling was that we're replaceable. There's no sense for how dedicated or how talented, or whatever, that team was, and we were. It was just about the bottom line. Always.

Ruby, a front line worker, also expressed frustration with her agency's emphasis on documentation over clinical skills.

Programs don't really hire people for being smart, you know. . . They hire people to do the paperwork, get the job done on paper, because if it's not on paper it didn't happen. You know, a clinician will be written up for missing paperwork more than they would for not being a good clinician, do you understand what I mean? If you can show paperwork that your client is stable, it doesn't matter that

your client hates you, but your paperwork is great, which means that you make the clinic look good.

Stressful Work Environment

Paul, a front line worker at an outpatient program, with just over three years of experience, articulated concerns that the cumulative stress over the years may lead him to burn out and offer lower quality of care. He said he sees this happening all around him with the more seasoned staff at his agency.

I look at older practitioners in my agency and they are all totally burnt out, or they've just moved out of clinical work because they don't want to deal with the workload anymore. Or if they stay [doing clinical work] they sort of rush through things with patients and I see how they give short shrift to the patients

Emma, a front line worker in an intensive outpatient program, expressed her concern that the managerial approach contributed to a pressured and stressful working environment.

I think that when they try and fill chairs, just to make sure there are people so that we have our high census, quality of care goes down. 'Cause there's already so much stress in having the process group, seeing people back to back, who knows what's gonna happen in terms of a crisis. There's no time to really, like, decompress and make sure I'm present in the room to provide quality care for the clients.

Renata, who serves both as a clinical supervisor and program director at a methadone maintenance treatment program, described her experience of supporting staff in her supervisory role. She discussed how workers' stress levels might impact quality of care and services delivered.

Oh yeah, the staff was stressed out because it's like, not human -- some of the things don't feel like they're actually humanly possible. There were numerous changes, and the expectations just added the amount of paperwork that had to get done. And it's like, if you have that much paperwork, you actually can't spend as much time with your client. You also want to be calm, and present. . . . You don't want to be worried 'bout all the things that have to get done. . . and by when, and the deadlines, and you're already running around trying to catch all your clients, 'cause the methadone population is not one where it's very easy to schedule anything. It's like if it was a computer that was supposed to meet these regulations, that's one thing, but as a human being, who's, you know, treating other human beings, it doesn't really work.

Renata admitted that in her ten years of experience working in substance abuse, she herself has felt flustered and stressed about how to understand new policy changes, so she remains sensitive to this with her staff.

I remember, years ago, there weren't as many regulations and everything happened very easily, and fluidly, it was not so stressful, and then regulations changed. The change was so bad, like me and my boss too. . . we feel like our brains have almost crumbled, because it's been so hard to wrap our brains around the constantly changing regulations. They came out with this really hard to interpret set of regulations, and I'm talking about OASAS in particular. Their language was so bad that it was hard to interpret what they were talking about. . . . And then they had to fix that mess, so they updated it with some clarification, and I think a year and a half or two years later, redid them again, and then did it again.

So there were three different regulations I was looking at over a short time period.

At a certain point, I couldn't remember what the current regulations were. So when we'd have issues with clients, I'd have to check the current physical regulations, 'cause I could no longer have any kind of clinical understanding of what makes sense, because it kept changing...

Alice, a clinical supervisor of an outpatient program, described the impact of the stress on the working environment,

I would say sometimes there's a lot of bitching about bureaucracy, and stuff like that, which is very unproductive. . .and it's a crazy high pressure high stress atmosphere, and even though I'm personally not affected by it anymore [now that I am off the front line]. You live in it, and you take it in, and you listen to people yelling, and it just is not the healthiest of environments.

Julie, a front line worker, described how the high-pressured environment related to administrative demands leads to a culture of stress,

[The workload pressure] affects your morale, and that is what's more likely to burn me out. Seeing a lot of patients in one day, that's OK but you know, but the frustration of not being able to get them help, the frustration of OASAS down on my head, like, you're not doing a good enough job because we're not seeing numbers on the bottom line, even though I have patients that, for the first time in their life, they're clean and sober, and happy. . . That's what can be the killer.

Ruby, a front line worker, reiterated that it is not the work with clients that is causing so much stress on the environment, but rather the pressure and demands of Managerialism that have lead the work environment to feel so unhealthy for her and her team.

[The work has] always been interesting, actually, it's always been incredibly interesting, and it will always be interesting, 'cause working with people is interesting, that's not the problem. The problem is the low pay, the paperwork, the high expectations, the pressure, what they want from us. . . it's the number of things they expect you to do for the salary. That's unethical in my book.

Summary

Study participants described a variety of ways in which integration of the business model has infiltrated into the workers' professional experience. In addition to new demands, many participants spoke about new administrative leadership in their agencies that are more open to incorporating these managerial demands into new practices. As a result of this integration, there are clear changes in the working environment.

CHAPTER 8: IMPACT OF MANAGERIALISM ON PROFESSIONAL EXPERIENCE AND SERVICE DELIVERY

The integration of Managerialism as discussed in the previous chapter led to changes in organizational functioning, which impacts the day-to-day life of the worker. Also, changes to the work environment in substance abuse agencies were addressed. This chapter describes participants' perceptions of how those changes influence the workers' experience of offering high quality care to clients, and being able to maintain professional autonomy in their work.

Quality of Care Concerns

Barriers to Quality of Care

Many participants relayed similar experiences of how increased demands concerning administrative tasks impacted their capacity to deliver quality services to their clients. Others remarked on the agency's shift away from a client-centered approach towards a business model, which also lead to concerns regarding quality of care.

Emma, a front line worker, discussed how disheartened she felt knowing that emphasis on client attendance and participation in treatment has shifted away from the clinical value of care. Instead, the implicit message from the agency is to fill chairs. She believes this approach undermines the value of care. Similarly, Jessica, a clinical supervisor in an outpatient program, stated,

I believe it has become less client centered, even though they say they're more into being client centered, I don't believe that. I think they're more concerned with Medicaid 'cause Medicaid pays. The only way they make money is to make sure we see as many people as we can, so quality of care has definitely diminished.

Rebecca, a program director, recalled her days as a front line worker just a few years ago. She discussed her past difficulties in managing the demands of productivity while also providing quality client care,

I honestly was someone that was always behind on their notes but also would always think to myself, “Just turn out a good product.” It doesn’t mean that every client did amazingly, but my numbers were high and I also worked my ass off and at the end of the day, my stuff got done. . . Yes, I was behind sometimes with case reviews. Yes, I was behind sometimes with notes, so I’m sorry to OASAS and SAMHSA and CARF about that. . . But I also know that I was putting patient care first and I was doing what I always felt was right for the client. And even if something was going on with myself personally, that wasn’t in the room with me. . . but I struggled with it. Having to keep the stress of being behind on paperwork out of the room was hard.

Liz, a front line worker in a methadone maintenance program, spoke about how paperwork serves as a barrier to quality care,

I mean the biggest thing was the notes. . . notes, yeah, because that hinders how we’re meeting with clients, the time that we have to spend with them. Well, we don’t get to spend much time with them, it’s almost like, I gotta run, you know, I gotta rush ’em out. . . because it’s a walk-in clinic, and the clients don’t have appointment times to meet with us, so usually when we open the doors it’s like a big rush of clients that will come in, so a lot of times I’ll miss some of them or I can’t see you today, I’m gonna have to see you tomorrow. So, I do wonder about my priorities. . .

Similarly, Bob, a front line worker, argued that his administrative duties interrupt his clinical focus.

Well, I will say that's an annoyance if not a bit of an outrage that I very often will feel like I need to cut this client off, or I really can't get to this phone call today, I've gotta get this done, I really hate that. Whether it's a report or numbers. . . I've gotta indicate, how much service I've provided to individual clients either in group or otherwise. All that nonsense gets in the way of doing good clinical work because the pressure is too much.

In discussing the role of regulatory agencies such as OASAS in the delivery of quality treatment, Barbara said,

I don't think it's also so fair of me to say that they're totally standing in the way 'cause their goal is addiction treatment -- to get a client clean, and back into the real world, whatever that means and. . . that's why they're there. We know that. . . But it's bigger than that, it's about treating everything about this patient that's gonna get them to stay clean. I feel like everything about OASAS would need to change, it would have to be more connected to mental health than it really is. Um, oddly, OASAS is really big right now about pushing trauma-informed care and it's like, OK let's push it, that's good, but like, what does that mean? Trauma-informed care means that... you're looking at everything through the lens of trauma, but we also are not able to process trauma in the way that OASAS wants us to treat people. So, now what?

Barbara also discussed her sense that the people who determine policy and regulation may not fully understand the implications on practice or may not have a full appreciation of practice.

[The new policies of standardized treatment] show me that they may not fully understand that recovery is lifelong and if you've been using [drugs] for forty years of your life, it's not just that you're just gonna walk into an outpatient program one day and you're cured! That's not reality, that's not how addiction works, you're not cured of it so quickly. Each person is a unique individual and so it is, like, a lifelong process. I think it just like, strengthens my feeling of anger towards some OASAS policies. I feel like in a lot of ways, it's not creating a way for an agency like ours to be sustaining and to give the best services to clients. We try our best to do it, but. . .

Client Feedback

Dorothy, a program director, reported getting client feedback about the decline of quality of care at her program.

Clients have noticed this and they've told us this. They'll say something like, 'I walk in to see my counselor, he or she looks so stressed. . .distracted. . .They're looking at the computer screen and they're trying to deal with me, but I know they have something else that they have to do.'

Dorothy described the new leadership style in her agency as "authoritarian" which she believes the clients have also picked up on. She described the atmosphere in the program to be one of stress and tension amongst staff, which ultimately trickles down to the work with the clients. This became an increasing concern for her when the clients began to complain about it.

When patients say to me, for example, that they will recognize the change, they will put it in a very pithy way and say, “You know, I feel like I’m walking into a bank.” When I heard a patient say that, it hurt me. That was just the other day. . . Or clients will say, “Staff seem very tense.” So I wanted to address [this] at the next supervisors’ meeting because it’s hurtful to everyone if staff are not looking up and smiling, or if there’s a lack of love. So clients also, they notice things, they’re very perceptive, some clients are talking about it. One client just said to me, “Well I just noticed that, it’s just more. . . I don’t know whether it’s more formal, or I don’t know.” Sometimes they’re not able to pin it down exactly, but they know something changed because some of them have been coming here for years. I know some of that authoritarian approach comes from the different management style and the administrations and their approach to things is important because it can filter down.

Sherry, a program director, expressed concern that the clients are not developing genuine connections with their workers because the workers rely too heavily on standardized curriculums for treatment.

I think [workers] can focus too much on what the interventions are, and focus on the curriculum, then they become robotic, and it could take you away from meeting what the clients’ needs are at the moment. It could lead to a sense of detachment. I think it probably takes a pretty advanced clinician to be able to really follow the curriculum and also be able to monitor and assess what the needs are, and like, and adjust accordingly.

Client Selection Bias

“Creaming” is a term that signifies the preferential selection of clients who are more likely to be compliant and produce greatest outcome measures for enrollment in a program. The concept of creaming came up in interviews without any direct prompting and was discussed in an indirect way. None of the participants used the actual term, but some described how this process implicitly occurs at their agencies.

Alice, a clinical supervisor, offered, “You know, we engage the people that engage back with us but that leaves behind a small percentage of people that need more support that we just can’t give.” She went on to describe “those who can engage” as those who end up as “compliant clients.” She admits that those compliant clients are given a little more attention in the program since they participate in more groups and bolster program activity.

Barbara, a supervisor from an outpatient program, also described a greater focus on compliant clients, with less flexibility for those clients struggling to engage or comply with treatment. She said, “We’ll have to tell this client that they have to go to a different program [if they can’t comply]. . . Sometimes I don’t want to do those things but we kind of have to.”

Both supervisors described these decisions as based on the emphasis on treatment outcomes within a certain time frame, rather than on offering quality of care or what’s in the best interest of the client. Similarly, Paul, a front line worker in an outpatient program, discussed a process of screening clients at his agency that indicated creaming.

Anyway, so we’re focusing much more on getting high quality patients who will be compliant, which means that they’re gonna come in to do a certain number of groups each day to maximize the financial benefit. What they seem to be aiming for right now are clients that can do one to two groups a day. Um, so clients really

need to be stable enough to be able to come in to group, but sick enough such that they qualify for the program. They should not be so well adjusted that they have other things going on. . . like a job or something. I think it also excludes certain personality disorders, where the dysfunction is gonna show up, or is gonna translate into noncompliance. If they don't come in, you know, they no-show you, you call them, uh, you get them to come back in and you talk about it. We don't have much time to do that. We don't have time to play that game, and we don't get enough money as an agency. So, it's essentially, like, we need to treat it as a for-profit agency, like we need to get clients in the door and maximize the value of each client, in order to get by as an agency and of course produce good treatment outcomes.

Paul went on to further discuss this process,

There's like a whole class of patients who technically could be treated by us, like, they're at our level of care, they're at an outpatient level but because they're not gonna be compliant enough, we can no longer afford to take them and this is actually a recent change.

Ruby, a front line worker, stated that her three decades of working in the field of substance abuse have given her a front row view of how the implementation of many regulations have impacted care. "I've seen the regulations go from almost no regulations, to a point that [regulation] is so restrictive, that some people who need care, can't get care." While she acknowledged that having almost no regulations was not the best way to function, she thought the new regulations were too restrictive and limiting for difficult and challenging clients. She

suggested that these new regulations served as a potential barrier for access to treatment for those who may need it most.

Challenges to Professional Autonomy

One of the criticisms of Managerialism as it applies to clinical practice is the potential for loss of professional autonomy. The demands of accountability, productivity, time-sensitive electronic notes and reporting, as well as the demand for standardized practices could lead to workers experiencing less flexibility in their clinical work and decreased ability to exercise professional discretion. Also, the restrictions of managed care plans often dictate duration and length of treatment, limiting the worker's role in determining an appropriate treatment plan.

Professional Discretion

Participants voiced the importance of maintaining discretion in their clinical work and how Managerialism put this to the test. Despite growing agency regulations and requirements, many workers still expressed their ongoing but more limited ability to hold on to their sense of clinical autonomy, mostly when alone with the client. Participants discussed how they negotiated professional autonomy within the ever-changing bounds of new agency regulations. According to Paul, a front line worker,

So I feel as though I have autonomy in the sense that when I close the door I can do what I want but I'm aware that I am always beholden to this reporting structure. I mean, I can only exercise my autonomy within the frame that OASAS has set up.

For Alice, this notion of clinical freedom helped her maintain a sense of fulfillment in her previous role as a front line worker. Now, as a clinical supervisor overseeing front line workers, she recognizes the protection of professional discretion as a priority. Alice explained, "I guess

I've chosen to look at [discretion] like a liberty, in that I've been able to have a lot of freedom and flexibility in how I run my sessions."

Alice added that in her role as supervisor she always supports her staff in exercising the same professional autonomy, as long as it remains in the bounds of "what's clinically appropriate." When asked to elaborate on that point, she smiled and said, "You just know the right thing to do for the clients." She said that she works hard to do what is in the client's best interest but also keeps the agency regulations in the forefront of her mind.

Barbara, also a clinical supervisor, echoed a similar experience with her own professional discretion,

I mean, yeah, with my patients, I have autonomy to do whatever I want as long as it's ethical [and within the guidelines]. So... I guess in *that* way there's not autonomy, but for the most part I feel like I have freedom as long as my beliefs about what the work is falls somewhat in line with what the agency is asking me to do. I'm free to be autonomous within those guidelines, if that makes sense.

Few participants felt that workers maintained too much professional autonomy. However, Sherry, a program director, was one of the few who expressed some concerns that her staff exercises too much clinical autonomy, and expressed support for stricter guidelines on practice.

As a program, we really encourage a lot of flexibility and a lot of ongoing assessment, and since we don't do as much curriculum-based work it's pretty open. We rarely say, unless it's a safety risk, this is what needs to be done by this session, and this is what I think you should do. . . I think a little more that of that could be good. And it's moving in that direction so that will be better I think.

The general consensus was that although workers felt the impact of Managerialism on their experience of professional autonomy, they valued protecting their sense of discretion.

Tensions Between Policy and Practice

Paul, a front line worker at an outpatient agency, spoke about the tension between what he does with his clients and what is expected of him from the agency. Notably, he mentioned that the ways in which he and his colleagues exercise clinical autonomy is not openly discussed.

OASAS has certain guidelines and expectations as to how a treatment is going to evolve with a patient, but implicitly that's not what we're doing at the agency. We have a different vision as to what treatment should look like. We have to report one way. . . but then we do another. That creates an inherent tension and that's never really dealt with explicitly at the agency.

Paul spoke openly about this conflict and was tearful during this part of the interview, It seems like there's this ethos on the part of the agency, this explicit-implicit split, where explicitly they're measured on the basis of these measurable outcomes, but implicitly, behind closed doors, clinicians talk about these more subjective existential themes. The problem is if anyone ever opens those doors. . . everyone's gonna pretend as if it's been the explicit outcomes-based thing all along and it really pisses me off, 'cause I just find it to be totally hypocritical and dishonest. . . And I've even been told, you know, once the door closes, my treatment is my treatment but as far as OASAS is concerned, it's what's on the treatment plan.

Similarly, Barbara, a clinical supervisor at an outpatient program, spoke about the tensions she experiences between practice and policy implementation,

Sometimes there's like, a disconnect between what front line workers want for their patients, what would be good for their patients, and what has to happen to [meet] the OASAS regulations or insurance regulations. I think OASAS wants patients to move through the program at a much quicker rate than we want them to. They kind of want it to be, like, quick drug treatment, and then they get out, but we kind of look at it more, um, deeper clinically than that. We try to keep patients for a lot longer to help support a deeper recovery process. My sense is that OASAS wants us to be less clinical than we are.

Barbara stated that her role as a supervisor includes working in conjunction with the administrators at her agency. She noted that as much as she recognizes her own tension with OASAS policies, she does not hold her agency administrators responsible for the policies OASAS decides to implement. She recognizes that the administrators at her agency struggle with this tension as well, however they are further from the front line and don't always see the consequences of the policy changes.

I think administrators feel like they have to push the policy regulations even if their clinical judgment is different than that. The higher people up in our agency are social workers so they think like social workers, so they're having a difficult time too. Even as a supervisor it's difficult for me to have to kind of push some of these regulations, when, like that's not really what I feel may be in the best interest. Sadly, I'm having an easier time, just like, dealing with the fact that policy is not always gonna match up with what is in the best interest of the patient.

Timothy, a front line worker at a residential program, said he often feels at odds with the policies his agency is implementing into practice. Despite his distress concerning these policies, he is somewhat prepared for this tension as it was discussed in his professional training to earn his certification as a Credentialed Alcoholism and Substance Abuse Counselor (CASAC). He said that he consistently thinks back to his training related to ethics and clinical practice, and recalls some wisdom from a professional mentor,

I remember [the mentor saying to us students], ‘Whether you do what you’re supposed to do, that’s up to you, but you’ll know what to do because I have taught you well.’ And there have been a few times that I’ve had to reach out to my mentor, like when something happens [at work] that I don’t really feel comfortable with and I don’t really know what to do and I don’t feel that my supervisors are taking it seriously. And [the mentor] said, ‘OK, well, this is what you’re supposed to do, this is what OASAS says you’re supposed to do, this is what, as a CASAC you have signed on to do. . . So, forget what that agency said because you’re not always going to work for the same agency.’

Timothy described several situations at his place of work where new policies have been implemented that were not in line with his ethics and values. Although he recalls the words of his mentor as source of support, he ultimately feels a sense of discouragement about how his agency functions, since he thinks the administrators just do “what they need to do to support the bottom line.” When asked if he was considering looking for a new place of employment, he said “I’m sad to say, I think all the agencies might behave the same way, so I am not sure what to do.”

Dorothy, a program director, summed up her 24 years of experience working in substance abuse, up to the present as her agency adapts to Managerialism,

It's been just an extraordinary ride, and I'm very privileged to have that experience, so I want to say overall that certainly that [the agency] mission remains intact, and it's partly because I feel the team is so committed to that mission. However, some of the policy changes, I think are a bit at odds with [the mission]. They are hurtful, you know, just personally. . . it hurts me to see things moving in this direction.

Decline in Morale

Many participants spoke about the deterioration of worker morale in recent years as a result of a stressful work environment. Julie, a front line worker in an outpatient program, said that due to the small size of her program, they would pride themselves on being community orientated with strong staff morale. She described initially feeling inspired by the friendly, warm and inviting nature of the program but that over time this sense of welcoming has deteriorated. She said, "You know, we've had a drop in morale, because of the way OASAS has been coming down on our heads about stupid stuff."

Ruby, a front line worker at an outpatient program, expressed similar perceptions that the shift to Managerialism is compromising workers' morale. She said, "The policies are destroying treatment, it's destroying treatment facilities. They're destroying the morale of staff."

Alice, a clinical supervisor, said,

The staff is loyal, but morale is pretty low. Does that make sense? Amongst the staff there's a strong sense of support-- I'll help you out, I'll cover for you, let's talk about a client, let's be there for each other -- but there's a huge disconnect between the staff and then the bosses. Staff do get yelled at [by the bosses], and

they are always fearing that they're gonna be fired or get into trouble for being behind on paperwork or something.

Karen, a front line worker, spoke about how she got so burnt out from working in this environment after just five years,

I got to the point where [the stress] was just deteriorating my motivation. My stress level was very high, and I dreaded going to work because of the low morale. . . it became contagious. You know, it was always about the numbers, but when it really got down to where [the job was] headed, it was clear there was no flexibility whatsoever. It wasn't just that the clients stopped mattering, it's the people who worked there stop mattering too. None of us mattered. . . all they wanted to see was good numbers.

Paul, a front line worker, felt so upset with changes in the work environment and the lack of organizational response that he decided to try to "take matters into [his] own hands." He described his efforts to raise upper management's awareness of the impact of cumulative stress on his team members through the lens of vicarious trauma. He said that he spent time reading, researching and gathering information to present to management about a potential intervention for staff to help them adjust to the new stressors and pressures they were experiencing. He recalled,

So in the spirit of evidence-based treatment for example, I remember I printed out a whole bunch of articles about vicarious trauma. I presented it to my supervisors, to try and show them that we needed to do something for the staff, like we needed to take the emotional impact on the staff into account in formulating the program structure as a whole. . .And I got a lot of pushback. . . There didn't seem to be

room for evidence-based findings that didn't correspond to the bottom line concerns, which I get. . . But why doesn't my well-being matter? So that's a big, that's a big one for me. 'Cause I just think about how much of my life. . . like, my basic life, am I giving away to this job?

Paul stated that he felt very alone at work when his effort to openly address the impact of Managerialism on workers was outright rejected. His experience was one of having to cope on his own with the discouragement, and thus ultimately his motivation to remain employed at this agency deteriorated.

Issues of Retention

One of the most notable themes that emerged from the interviews was that the workers' continued passion for their clinical work did not necessarily placate their growing tensions and dissatisfactions with their overall work experience. Although there may be some selection bias here, the overall tone was one of fatigue, stress and decline in morale.

More than half of the participants discussed imminent plans to leave their jobs. Of the 22 participants, 12 (55%) reported that they recently gave notice of resignation or had imminent plans to do so. An additional two participants reported they planned to stay on the job until their fast-approaching retirement (less than a year away for both).

Debbie, who had worked as a front line worker in an intensive outpatient program for three years, had recently given notice of her resignation. This interview took place during her final two weeks at this job. She was able to get another job in the field of substance abuse treatment, and expressed hope that the new agency is better managed and could offer a healthier work environment.

Liz, a front line worker for seven years, said she is aware that the ways she is currently working are not sustainable, and she is actively searching for another position elsewhere. She would like to continue working in substance abuse treatment but feels doubtful that she can find an organization that would be run better. Her current job is so stressful she feels as if she cannot take a vacation.

So I know that I have to plan my day out, and because of how busy things are I don't like taking days off, you know? That's another big thing, I haven't taken any days off, I haven't taken a vacation in over a year. I can't go on like for this for much longer.

Similarly, Timothy, a front line worker in a residential program, expressed overall discouragement about how his agency functions. He reported an active search for new employment but was worried that all substance abuse programs will be operating under the new Managerialism pressures.

Dorothy, with 24 years at her agency, gave her notice to leave a few weeks prior to the interview. Even though she was only a few years away from retirement, she said she could not bear to stay any longer and watch the agency she felt so proud to be a part of turn into what it was becoming. With her last few years of work before retirement, she decided to switch gears and accepted a job outside of substance abuse while remaining in the field of human services.

Renata, a program director with ten years in the field, recognized the difficulty she faced as a leader of the program to help nurture and support her staff. She is worried about staff turnover. Many of her staff have been there a long time, but she has recently sensed growing dissatisfaction that she fears will lead to staff loss.

I'm finding people who've been there a really long time, and the vibe that I'm getting from a lot of those people is that they're very burnt out. They were like, really struggling with the changes in regulation, recent changes in staff, the way that they, sort of have to make up for whatever is going on. . . So like, if with all the transitions they just get more and more people on their caseload temporarily. . . it's like there's no limit to it, there actually seems to be no wall for that. And I'm hearing some serious frustration, which I could really understand. . . But even if I can understand that, I can still see how the organization is in a difficult position to even provide some more structure. In some ways, you know, I can understand it from both sides, what's going on, why it's happening. . . But it's just really hard because in the end, there is a set of workers that will get things piled onto them with no end, there will be no end to that, that's rough. I worry they won't stay for much longer.

Summary

As workers discussed their concerns about the impact of Managerialism on service delivery, the issues of professional autonomy and discretion also were addressed. While workers seem committed to protecting their autonomy and discretion, worries about deteriorating quality of care were a consistent theme. The decline in worker morale and subsequent issues of retention in substance abuse programs seemed to be a consequence of the changing experience of working in substance abuse programs during this time.

CHAPTER 9: RESPONSES TO MANAGERIALISM

The previous chapters discussed the integration of Managerialism in the agency and its effect on the organizational practices. While, Chapter 8 discussed the impact of Managerialism on the workers professional experience and on service provision, this chapter focuses on how workers responded to or managed the major changes that Managerialism introduced. Faced with the lack of an organizational response to the problems that accompanied Managerialism, workers developed a wide range of survival strategies that included self-care, cutting corners, bending the rules, and demonstrating acts of resistance. Also, worker resiliency and ongoing pride about their work is addressed.

Organizational Response Patterns

The Lack of an Organizational Response

Workers reported that there were few if any organizational responses to Managerialism. Each organization handled the transition to Managerialism in slightly different ways, reflecting the organization's current leadership and/or past history. In many instances, the organization's response to Managerialism was still underway as new policy changes continue to be implemented.

Most direct conversations about coping strategies and adaptations to Managerialism took place in individualized supervision meetings. While workers appreciated this opportunity, most felt that it was an insufficient venue to address all the issues and challenges they were facing with the onset of Managerialism. Paul, a front line worker, explained, "There's very little room to process [the changes] for the front line staff. . . . Behind closed doors we talk about this stuff but in case review meetings [or team meetings] we never talk about this."

Agency Level Response

Only one organization presented a structured organizational response. Sherry, a program director at an outpatient program, noted her agency was working on an overall or transitional response to the use of the new regulations. Her boss has set up an on-site regulatory committee that includes a variety of staff to help discuss how to implement new policies and address practice conflicts as they arise. The impetus for this committee was the need to address new OASAS regulations that workers found difficult to navigate, and had led to many staff complaints. This committee was to meet monthly but has yet to be routinized. Sherry stated,

The new regulations are very vague . . . but what's confusing is that in the guidelines, they go into more details and offer specific clinical recommendations. . . . So, we set up this committee, which has been put a bit on hold right now. But about maybe like five months ago, [the boss] set up a regulatory committee. We have people from the different programs -- counselors, and supervisors get together and go through [the regulations and guidelines], to see if we are fulfilling the regulations. It was working really well, and then we'd have to look at the policies, we look to see if we're documenting certain things, we have to look if we're changing certain things. . . . But it's one of those things that we talk about and then we're like, "OK well let's put it on hold for now," and then, "Well let's find out more about that." You know, we are not sure we really should be making that change, sometimes it can be really confusing to know what's really expected from OASAS.

Although seemingly stalled in deliberation about regulations and practice, Sherry's agency made an attempt at a more structured organizational response through the creation of a

regulatory committee. Barbara, a clinical supervisor who works at the same agency but in a different program, also mentioned the committee but seemed less interested and more dismissive of the process.

There's now a review board at work that is comprised of supervisors and front line counselors to review the guidelines and see what we need to shift or adjust or . . . what we can do, so I think the people in that committee are more connected to that. I'm not on the committee. Yeah, it started several months ago when they came out with new policy and it's like in an effort to be more inclusive. I know it shouldn't all be top down decision-making . . . but I don't see the need to get involved with that committee. . . It seems like just more stress that I don't need.

Barbara didn't feel hopeful that the committee would help mitigate any stress related to policy changes. Ultimately, she stated that she understood that the agency must do as OASAS says, and that she chose to not exert her energy in what she perceived to be a losing battle.

Dorothy, a program director, identified her agency's lack of organizational response as troubling. She noted that the higher administration overtly discouraged any attempt at a larger group conversation related to policy change, such as a team meeting. She appeared deeply concerned that the administration seemed to be actively disempowering staff by interfering with any efforts at a collective complaint. At this point, she became tearful and said,

I believe, it's become a much more authoritarian top-down organization [in recent years] . . . it's a perception that is shared by many. I will give you an example. We haven't had a staff meeting, like a town hall style . . . staff meeting with the entire staff in quite some time. I used to have them monthly but there hasn't been one since last July, and that was done under duress, because workers demanded it, and

it was done after something [a policy] had started that counselors were very concerned about. Once it was recognized that this was why the counselors wanted this meeting, it was cut short when people started raising some difficult issues. My feeling is that dissent is not welcomed [by the administration], it's almost feared. . . . And staff has sensed that, so basically we can only have these conversations in individual supervision meetings. I was told to speak to each of [the counselors] individually in supervision. . . . Immediately one of the counselors said, 'Why aren't we having a staff meeting about this? You're splitting us, you don't want to hear us echo each other! We have problems with this!'

Dorothy agreed with the counselors. With no staff meetings allowed on the calendar, Dorothy believed the administration was actively avoiding dealing with the workers and their collective complaints and questions. Instead, the administration was leaving the clinical supervisors responsible to manage the workers. Dorothy disagreed with this approach and said that this was a change from how things were handled in the past.

A simple communication of policy, which is always held up at the top, is so critical to be communicated . . . to inform [staff] continually and to give context for the change, even to give us a reason those changes are being made. . . . It's something that absolutely would have been discussed in a [staff] meeting in the past. As a director myself for the last nine years, I would lead meetings every month, and that's the kind of thing I would have addressed in a meeting. Not anymore.

Dorothy went on to discuss how improved communication could serve as a way to help prepare staff for changes, which could lead to smoother implementation.

I think in many cases information, communication, and an effort to collaborate and . . . receive input and to inform staff . . . uh, particularly with regard to changes that may be made that are fairly significant is important. I have found over the last few years, and particularly recently, that initiatives have been rolled out with insufficient preparation, and I've been very outspoken about it.

Dorothy, who proudly talked about her 24 years of service at this agency, expressed disappointment and distress at the current direction of policy and regulations. She was concerned that eliminating the monthly staff meetings was both contributing to a breakdown in communication within the agency, and akin to oppressing workers who were organizing any resistance or advocacy.

Individual Supervision

Participants perceived a lack of response to Managerialism on the organizational level, but noted that the problems were addressed in individual supervision. The supervisors described how they dealt with workers' concerns and grievances related to Managerial policy changes in individual supervision sessions. All the supervisors agreed that issues related to Managerialism have become a new and complex dynamic for their professional role. While most felt equipped to provide supervision on clinical issues related to patient care, managing workers' responses to Managerialism-related policy shifts offered a new and separate challenge. Rebecca, a clinical supervisor, said being a supervisor posed very specific challenges that "were beyond [her] clinical expertise" and made her work difficult.

Renata, a program director and clinical supervisor at a methadone maintenance program, manages this challenge by gearing the supervision conversation towards the clinical context of the changing OASAS demands. She believes this approach helps workers to think more critically about whatever change is happening.

I just try to introduce it more like, “Well, we want to have a little bit more structured time with the clients.” For everything that OASAS would try to put out to change regulations, we’d always try to find the clinical value in it. . . . We just kept trying to put the focus back on the client, and client care, even if it seemed like they [OASAS] were trying to load us down with work. We just tried to think of how we can work this into what we already have going . . . and also just how to make the time that they [staff] spend with the clients more meaningful.

Renata indicated that her agency’s administration has recommended discussing these policy changes in supervision since it offers the opportunity to process individual reactions and responses. She added that there were no other plans in place to address the multitude of changes happening at her agency but that the expectation was to “roll with it” and “deal with it on a one-on-one basis.”

Individualized Responses

With no structured organizational response in place, most participants devised their own survival strategies to navigate the evolving and stressful work environment.

Self-Care

Self-care refers to activities, behaviors, and practices that workers can regularly engage in to help maintain and enhance stable health and emotional well-being. Self-care practices are also

intended to reduce stress. Not surprisingly, all participants revealed they engaged in self-care activities.

Most workers turned to some kind of self-care both inside and outside of the workplace. Their self-care practices targeted managing the mounting stress associated with administrative and other demands linked to Managerialism. The workers pointedly noted that the need for self-care was not related to the regular challenges stemming from their clinical work with clients.

Time for self. Alice, a clinical supervisor, said that a part of her self-care practice includes making time after work to decompress before engaging in her personal life. She said, “I try to put at least an hour window in between work and doing anything in my personal life. Could be an hour of exercise but I try to have some time in between where I can relax.” For Liz, a front line worker, self-care practices include spending down time with her children.

I have two kids, I spend a lot of time with them, so that’s kind of like, my outlet. I guess watching TV, bingeing on Netflix, that’s something I do to help with coping, that’s like, my little reward on the weekend. To be able to check out a little bit.

Debbie, a front line worker with three years of experience in her role, discussed her self-care practices which include family time but also co-worker support.

Well, mainly family time is for self-care, but also in my facility we do share an office with another worker, so just talking to our coworkers helps. We talk about how stressed we are at work, basically about what’s going on here . . . it really helps . . . yeah, mostly . . . that’s what I would do, I would talk to my coworker, and, just try to enjoy recreational activities outside of work to get my mind off the stress here.

Setting boundaries on overtime work. Emma, a front line worker in an intensive outpatient program, has had to adjust her work efforts and expectations to support her self-care practice.

I probably spent a year and a half doing overtime, and I got too burnt out, it was too much. . . . So I've decided for myself that I will no longer do that. Now, I have a good supervisor and I've said, I'm leaving [work] when I need to leave, and I come in when I need to come in, and if something doesn't get done, the world will not end, there's always going to be more to do. . . . Right now, like in the mornings, I try and exercise, but I'm always injured, so I'm in physical therapy, twice a week, [psycho] therapy once a week, but um . . . but really useful is the open door policy in our office. Just knowing that you can go into your peer's office and maybe vent if you need to, or whatever it may be. I mean, self-care is key and I wasn't taking care of myself for the first year and a half I was working here.

Vanessa, a front line worker in an outpatient program, described how she also tries to establish boundaries that are in line with self-care.

I mean, I have in the past [worked overtime]. . . . There are nights when I have to, or I will write my notes at home, or I'll stay a little bit later but I really try not to do Saturdays unless I really have to, like before a vacation . . . when I have documents that I have to get out. Yes, I will admit, I have gone in and logged, like, an hour or two on Saturday. . . . But yeah, I really try not to do that to myself and try to do [paperwork] at home, and, or just leave it at work.

Ruby, a front line worker with 33 years in the field, found that she needed to increase her self-care practices over the year as stress at work intensified.

So I found myself, uh . . . you know, sometimes not taking lunch just to do paperwork, staying after work just to do paperwork, even though I was fairly organized and I would write things right away and not wait until they piled up. You have to develop a system, otherwise you would get buried. For the first 15 years, it was manageable, and then things started getting stricter, the papers started to get more ridiculous, the demands of paperwork started to get a little too much.

Taking care of mental health. Emily, a front line worker in an outpatient program, reports that work stress may be compromising her mental health. She disclosed that she has returned to therapy as a means of self-care.

My regular self-care was no longer enough. I think that returning to weekly individual therapy has been helpful for myself. I also . . . a little over a month ago, joined group therapy which has been really helpful. I moved to a new apartment, so that has been an exciting change for me. Um . . . I also like wine, and I like going out to dinner, and . . . I don't know, I mean, I just try to feel alright . . . but like I'm very much a person that needs to get the job done and do it well.

She spoke further about the balance of work pressures and self-care practices, So taking Lexapro helps too, by the way. Lexapro really helps, I think I was really too obsessive, when I started working here. There were too many moving pieces, too many things to do. So, I went on Lexapro about a year and a half ago. I

wouldn't just say it was because of work, but that was a pretty big part of my decision. And, yeah, it helps. . . . I love it.

Sherry, a program director with six years of experience in the field, also reported that her own mental health treatment was a critical aspect of her self-care practices.

I go to therapy now. . . . I also try to work out regularly, but therapy really helps. I definitely think talking about it . . . and talking about it with all my coworkers is an important thing too. . . . I think that's so valuable, and I think that's good that we have that community here amongst the staff. . . . Also, I definitely try to sometimes, take a second . . . close my door and take a few deep breaths, and mediate a bit. That can be very, very valuable to me 'cause sometimes if I feel, like, I'm just too stressed or too overwhelmed by something, I might just . . . I know I need to take a step back.

Some participants indicated it was difficult to find the time for self-care practices, despite their acknowledged importance. Paul, a front line worker at an outpatient program, believes the stressful work environment has led to the deterioration of his self-care practices.

My overall experience is when you take into account seeing the patients, doing the paperwork, doing the required meetings, running the groups and making sure everything is in on time . . . and when you take into consideration that in my four years of being here the workload and the deadlines involved and the closeness of the monitoring all seem to have increased. . . . What increasingly stands out for me is there's less and less space, if any, to deal with the emotional impact of the work in my life. I have noticed that I have no time to take care of myself.

Paul went on to discuss how he improved his self-care practices by caring less about the agenda set by the agency and subsequently accepting the impossibility of completing everything expected of him.

When I first started there I felt like I had to do everything, and I felt ashamed of myself if I couldn't. I no longer feel ashamed if I can't get everything done. I just can't get everything done. And I don't even care at this point, to blame them or to blame myself it's just . . . it is not happening . . . and it's just that simple. So that, for me, is a lot of self-care because I'm not torturing myself, I'm not beating myself up.

Supervisor Response: A Different Balancing Act

Supervisors and program directors faced different pressure given their administrative roles. Some supervisors tried to find the right balance of support for workers' self-care practices and their need to uphold work standards and expectations for front line staff. For example, Barbara, a clinical supervisor, described the complicated tension involved when trying to make space for self-care while also letting staff know that the work must get done.

Yes, of course, we talk about self-care, and self-care is important, but also we are on a timeline. . . You can't have your need for self-care to be overflowing. . . . So finding whatever adjustments you need to be able to do all that, 'cause the expectation is you get the work done and I was able to get it all done [when I was on the front line], and so sometimes it's hard for me to see, like, why can't people get it done?

Barbara is trying to instill her motto, "Work harder, work smarter," to help her staff consider improved ways to cope with their work demands. For Dorothy, a program supervisor,

open dialogue and communication with her staff and the administration are a critical aspect of her self-care practice.

I think there's a recognition that we need to speak to each other at the end of the day, and we use each other for that, and I believe women are conditioned to do that, and [as a team of women], we have been able to just that. . . . I have wonderful colleagues; I have ex-colleagues I'm very much in touch with as well. Also, I can say that despite all of these developments over the last four years, because I think I've been able to speak somewhat freely, perhaps it's not always been well received but I need to say it anyway . . . I need to speak freely. In doing that I think it's been protective, because it's allowed me to vent in a way that's healthy for my emotional well-being . . . If I suppressed it that would be worse for me.

Amelia, program COO, cited her past professional experiences as a front line worker in order to remain sensitive to her front line workers' experiences around new Managerial demands.

Well, I remember what it used to be that when there would be changes coming down from the state . . . In the beginning, you know, we would be told . . . 'OK, we have to do more groups, you have to bump up our group visits.' And you know, it would come down as sort of this directive that was never really discussed with us. . . . And as a result it felt like you're never doing enough, also failing somehow . . . and with no explanation about it . . . no idea what the actual standard was. That can feel tough and the need for self-care becomes more real. I get that.

Adjustment to new change. Supervisors and program directors also had a slightly different perspective from the front line workers on how to adapt to Managerial changes. Sherry, a program director, stated,

I think sometimes there can be a lot of resistance to the change, like it's just . . . there's this idea of, 'Well we've always done it this way. . . .' It's a lot [to] work towards changing it and you know, the counselors have so much on their plates. So when we . . . there's like these new . . . things to be implemented, or if it involves doing more work . . . even if it involves . . . doing more reflection on where their clients are at, what their needs are. . . it can be a lot to ask.

Lillian, a program director with 21 years of experience in the field, indicated that while she has empathy for workers' stress and their need for self-care, getting the job done was equally as critical.

You gotta give [OASAS] reports every month about what's happening, and how many services we offered . . . and you're still beholden to them, you still you have to do what you have to do . . . Anyone who gives you money, is gonna want that I mean, that's the bottom line. . . . I know a lot of people complain about . . . there's the people that won't last, the people that continue to complain about the way the current landscape is . . . or the people who want to be flexible and move with it . . . but if you can't do that, then you might as well do something else in this field. There's lots of need, so if you're a social worker and you're frustrated with where you're at because of the system, and there's too much paperwork and there's too much this, then . . . just don't do it.

Lillian later explained that in her supervisory role she's come to appreciate the need to be adaptable in this new environment.

The only way I've lasted in this field is to move with the changes, and the day that I can't move with the changes is the day I shouldn't be working in this field anymore. So I'm not gonna sit here and come to work, if I'm coming to work complaining about everything . . . how am I being a leader to my team . . . ? I may feel like it inwardly, like I wish things were different, but wishing is for kids!

Rebecca, a methadone maintenance treatment program director, stated that the biggest change her agency had experienced was the transition from paper records to electronic medical records (EMR). Speaking of implementing this technology, she explained,

I think that because of some of the staff [their age] that I'm working with there's continued reluctance to using computers. We moved towards electronic medical records in the middle of 2014. There's some staff that remain resistant to that, but not that it's an option, there's just still vocalization of how much, quote unquote, harder it is, or more cumbersome. As someone myself who feels pretty computer savvy, I think that it's actually faster . . . less cumbersome. . . . We're actually moving to a new EMR, in the next month or so, which I'm very excited about, that appears to be much more user-friendly. I'm looking forward to that, I think?

Rebecca admits that being a supervisor is a challenge for her.

I'm struggling a lot currently . . . in this new position with the staff that I'm working with. I'm having a difficult time encouraging them to let go of old habits that have not been so productive or fruitful, and really trying to get them to move more towards modern times for lack of a better word. . . . I believe we can offer

better treatment for clients to give them the best care, and ultimately, I don't want our doors to stay open if I think that we're doing things that aren't good practice.

Amelia, COO, was able to discuss the importance of moving the agency forward with the latest and best practices. Yet she still expressed some concerns particularly around the trouble her staff had adjusting to the transition.

Well, and that's the other thing, that's been really difficult for some staff. For the younger people coming in, it's quick and easy, and they love it. For the people who've been here many years who have no computer literacy, it's been a big challenge, and there was a lot of resistance. I mean, we still have a couple people who really won't read their email.

The resistance from older staff was echoed throughout the interviews. For example, Sophie, age 67, with 27 years in her role as a front line worker in an intensive outpatient program, described her outright resistance to using the computer to generate clinical notes. She lightheartedly described a barter system she established with her interns in which they do her paperwork on the computer.

They can do the paperwork, as a matter of fact, the interns, they're very computer savvy, because I'm still using my pen and hand . . . pens do this [clicking noise], I know how to use the pen well! . . . And then when [the interns] can see individuals, I support them through that and maybe give them some more clinical work than they expected.

Sophie expressed no intention of adjusting to the new technology, in the hope that before any of the higher-ups catch on to her strategy she will already be that much closer to retirement and no one will have the energy to "teach an old dog new tricks."

Survival Strategies: All Staff

All participants, regardless of their position, discussed how they respond to the specific demands of Managerialism. Some participants were open about the ways in which they manipulate the system to make it work better for them. In addition to self-care, the survival strategies discussed by the workers included cutting corners in patient care, bending the rules, and demonstrating resistance.

Cutting Corners in Patient Care

Alice, a program supervisor, admitted that one way she copes with work stress is by cutting corners in patient care to make time for her paperwork. She explained that in supervision workers often admit that to make more time in the day; they may give short shrift to some patient care responsibilities. Alice reluctantly described her own strategy,

If I have someone who is scheduled for 45 minutes, and after 10 minutes, because they're mandated to treatment they want to leave, I let them leave. Because if they don't want to stay for the extra 35 minutes, then I'm not gonna force them to. I'm gonna go do my notes, I'm gonna do the million and one other things that I have to do instead of trying to use that time to get the client to talk. And that's probably not good practice, but when someone's coming in with three-word answers, and saying they're ready to leave, you know, it's like, alright, not gonna make you stay.

Alice has learned from her supervisees that, "Other people cut corners by not doing paperwork, or being really stressed and so burnt out that they end up calling in sick." She talked about her ethical discomfort with these survival techniques. But she also indicated that she understood that the current situation is "leaving us with not many choices to deal."

Paul, a front line worker, was outspoken about the ways he manipulates the demands placed upon him. He also admitted to sacrificing patient care, if needed: “Sometimes I allow myself to check out in sessions, particularly if the client isn’t showing up, I’m just like, I’m not gonna try, I have other things to do be doing.” Paul also added,

Sometimes I cut corners in terms of seeing patients. When people don’t show up, uh, rather than taking time to outreach them and to try to get them into treatment, I have actually found that I rely on them not showing up, ’cause it’s one of the ways I have time to get my work done.

Bob is a front line worker in an intensive outpatient program who has access to the use of interns. He often uses the interns to his advantage, so that he does not have to do “all the boring work” that bogs him down. He noted,

There’s a belief here that clinicians with an average sized caseload cannot possibly get all their paperwork done by themselves, that you must have one or two interns to help you with the paperwork. OK, so right now, it so happens that I have only one intern and I usually have two. So, I’ll be honest, the intern is doing a lot of my paperwork right now, where I’m focusing on the more complicated stuff, like writing discharge notes or some sorts of evaluations, or treatment plans.

In reference to cutting corners, Bob said, “We all know that if it weren’t for the strategic lenience, people would get burnt out from this pretty quickly.”

Bending the Rules

Karen, a front line worker, discussed how it has become common practice at her agency to “fudge” some numbers and paperwork, but that generally she did not participate in this practice. One of her colleagues manipulated her productivity report so that it looked as if she

were meeting standards, but in actuality had merely found a loophole in the policy. Karen explained,

[My colleague] didn't want to do those reports in the first place, and so she just wrote down who came [leaving off those clients that did not show up]. So magically it appeared as if she had a hundred percent compliance every single time! Our program director was like, 'Bravo, yet again she does a perfect job,' and I know she's just writing down who was coming. . . . I'm looking at this program director, and I'm thinking, 'What, are you crazy? You think that she has perfect attendance for every group and every thing and that not one person, ever, over the course of months and months and months is never not coming?' Like . . . 'OK, you can go ahead and believe that!'

Paul, a front line worker, adjusts his work style to fit in his clinical values and self-care practices, rather than subscribe to the agency pressures. He stated, "I would rather get written up for being behind on paperwork than constantly pushing myself to . . . meet deadlines and if they don't like it they can fire me." He added, "If I feel like I need to do a session that's an hour long, I'm gonna do a session that's an hour long and if they don't like it they can deal with it. I do what I want regardless of whether or not I'm supposed to!" He also described how he pushes limits with his paperwork.

I do the bare minimum in terms of monitoring and evaluation paperwork. I look very closely at what the requirements of OASAS [are] and I put as little effort as possible with this kind of paperwork. I believe that any kind of subjective content they don't care about, and it just takes my time. I don't need to put clinical details in these reports, so I look at the majority of the paperwork as meaningless

busywork. This is not something management supports, but I just think that they're hypocritical and deluding themselves and being dishonest with me, so I just do it my way. . . . Everyone pretends like [the policies are] interesting and valuable, but . . . I personally am not buying it, and yet, when I am doing the paperwork, I'm saying that I'm using these interventions 'cause that's what I'm supposed to be doing . . . but I'm not necessarily doing [what I write]. I particularly don't like pretending that I'm doing one thing and then actually doing another.

Timothy, a front line worker in a residential program, provided another example of workers taking matters into their own hands, to "get the job done." He recently learned that a colleague was asking a client to take other clients' toxicologies, a task designated only for a staff member.

I could not believe it, there is a client supervising a toxicology . . . and I was like, that can't be . . . maybe they thought I was sleeping or something like that . . . one of the other staff came to me and she said, 'How is it that one client is supervising another client's tox?' I said, 'That's impossible.'

When asked about this the colleague shrugged it off, stating he regularly delegated this task to a client to create time to get paperwork and other administrative reports done.

Jessica, a supervisor at an outpatient program with 12 years of experience in the field, described her commitment to clinical values and exercising discretion during times of service delivery, which meant she would bend the rules slightly. She conceded that she is always aware of agency expectations and regulations, particularly around the use of evidence-based practices

(EBP) and standardized treatments. She holds these expectations in her mind, but prefers to be guided by her clinical expertise.

I would wander away from the curriculum a lot because I do believe that whether it's in a group environment or an individual environment, you need to be where the clients are. In group this week I wanted to speak about what was going on and I am not one to say, 'Well today we need to think about automatic thought response,' because that's what the [cognitive behavioral therapy] manual guidebook says we need to talk about today. You know, so I didn't do that, I chose to just let it go, and I think it worked well for everybody.

Jessica later discussed how she uses her clinical discretion in ways that keep her in compliance with her agency's regulations and requirements.

I am creative and I can write a very good note, and I know what to put in, to make sure I note an EBP intervention. I know what to leave out, what's salient, what isn't. . . . And to me . . . the most important part of my work is my patient. . . . So, if the notes don't totally reflect what happened in the session . . . as long as the client left with something they could hold onto, or process, or, and think about, that's all I care about. So I guess I am not that interested in what the administration is asking of me. Like I said, nobody ever called me out and said your note isn't correct . . . this, that, or the other thing. I don't know how it is at other agencies, but for me, that's never happened. I'm in the trenches but I know that they would come to us and they would talk to us about outcomes and target numbers, and I would just pay no attention.

Acts of Resistance

Bob, a front line worker in an intensive outpatient program, indicated that during 11 years of working at this program he has developed quite a reputation for being adversarial. As he inches closer to retirement, he feels a great sense of power in his resistance efforts and feels less concerned with any consequences or punitive measures that may come out of his actions.

I think a lot of people see me as, you know, a cranky old guy and I am. . . . You know, people say, 'You're a curmudgeon,' and I am, and I think that all the bullshit, the um, the procedures and policies and paperwork, they can really knock the stuffing out of you. And so, I tend to just generally ignore it and I've been here long enough that I get away with it, and if I were brand new I would probably be very reluctant to behave this way. But to some degree I know this program depends on some of my skills and that I would be hard to replace. . . . I realize I'm not irreplaceable, I know that, but it would take them a while to replace me. But I also know I am retiring in less than a year anyway.

Bob went on to say that a few years ago he was written up so many times for failure to comply with administrative demands that the agency suspended him from work. He reported that he did not regret the choices that led to lapses in his paperwork, because he always prioritized clinical care. Now, just less than a year away from retirement at age 66, he reported feeling immune to the punitive measures and noted his boss's awareness of this. Paul was another participant who described his small acts of resistance.

When management asks me to do things, like, 'Can you take on this patient,' and I'll say, 'No . . .' You know, I'm starting to take a stand . . . I mean it's baby steps here, but I'm starting to do it. I've decided to close [cases] even though I don't

technically have to according to the regulations, but to just make the decision clinically 'cause I don't want to deal with them anymore. I'll close them because all of the extra work. Also, like, 'Oh, volunteer at this . . . there's a fair over the weekend, do that.' I'm like, 'No, no, no, no.'

Similarly, Jessica, a front line worker, explained how the relative freedom of age made it easier to resist: "I think being of a certain age helps a lot. I am not afraid. I'm 67 years old now, and when I started I was 55. . . . What are they gonna do to me now?"

Dorothy, a program supervisor, discussed how she resisted, including standing up to upper management, in light of all the changes happening in her agency. "By remaining true to myself, it got me in trouble last year." In one instance Dorothy refused to co-sign a disciplinary action concerning one of her front line staff. "I refused to sign it, said, "I'm sorry," provided written explanation as to why and eventually resigned in frustration after 24 years of loyal employment."

Supervisor Management of Staff Resistance to Managerialism

Barbara, a clinical supervisor with eight years in the field, but just three years as a supervisor, explained that she has a lot of empathy for her staff as they adjust to new changes in the agency.

I am more accepting of [staff resistance] 'cause that's just how it is and I do get it.

I try to refocus staff on trying to give the best care to patients within the guidelines that are already set before us even if we don't like it and can't change it. Of course, it angers me at times too, but I don't allow it to consume me cause then I think that definitely is gonna affect the patients. There are some staff that I supervise who'll get more upset and heated about this so . . . and some act out

which is hard to manage. [The anger] affects their work with patients. I would say a good portion of supervision meeting is spent on managing that staff's emotions and resistance to new changes.

She described her struggle to provide effective supervision despite the agency's stressful environment.

I feel like in a lot of ways, [OASAS] is not creating a way for an agency like ours to be sustainable and to give the best services to clients. We try our best to do it but it's really hard and even harder in this supervisory role. I've been thinking lately that I do want to do more clinical work . . . see more clients and do less supervision. Supervision is much harder than I thought it was gonna be. Believe it or not, I feel better equipped to help the clients than the staff at this point.

Rebecca, a program director, was surprised and distressed that staff members pushed back in response to new demands to just get the work done. She admits to not having a full handle on how to manage this yet.

One counselor completed a termination for another counselor! This counselor completed the paperwork for a client that wasn't his own, and had also copied and pasted information that was no longer true about the client from his admission forms, um . . . and then also signed it without showing it to a supervisor . . . this stuff is happening as we speak.

She also discussed her experience with staff resistance to new policy changes.

That is my daily life -- staff resistance. It is unbelievable. I don't even know where to begin with that . . . staff resistance is everywhere. A perfect example is a spreadsheet that all of our counselors have been asked to do recently. They have

to sort through each of their cases, about specific data . . . to see if we're meeting or not meeting certain targets, like should this person still have take-home [methadone] bottles, do they receive site care, do they need site care, are they attending groups, are they assigned to groups, etc. The supervisors are reporting back to me that staff are resisting these assignments. The staff feel as though, like, these things are being done to them and . . . I just feel like there's some burnout there and I respect that but I also need them to do their jobs.

Rebecca went on to talk about the ways in which she comes to expect resistance from her staff since she only recently rose in ranks by being promoted to program director.

In that regard, I don't think that staff members trust me, because there's a lot of ideas about me being younger than some of them. . . . And even though I have more schooling than many of them, I think there's an idea that I'm coming to ransack the place and implement all sorts of new changes. There are some people that have been at this agency for decades, never had the appropriate schooling or training and have been doing things their way for all these years. There have been many not ideal practices that were allowed to happen here for literally 40 years. . . . So I get what I represent to staff. I represent change.

Later she added, "And it's hard to teach an old dog new tricks, I mean, we tell that to our clients all the time. . . . It's actually very hard to do that."

Worker Resiliency

Despite the stressors and challenges associated with Managerialism, participants expressed strong commitment and pride in their work. Workers demonstrated their resiliency as they negotiated at times difficult responses efforts while maintaining their continued passion for

the clinical work. Many workers understood that the substance abuse problem was getting worse and their commitment to this social issue was stronger than ever. They also reported a sense of accomplishment in being able to help those who are suffering with this problem despite the many new stressors experienced working in the field. Many revealed concern about the direction of treatment in this new era. At the same time, many workers spoke passionately about the need for improvements in quality of care and service delivery for this population. Despite working with so many challenges and stresses, the workers' resilience and love for their work shone through.

Teamwork. Many participants spoke of their colleagues as a source of support in management of work stress. The positive experience of working in a team became a common theme. Most participants spoke highly of the teamwork structure built into substance abuse treatment. Alice, a clinical supervisor of an outpatient program, reported that the stressful work environment is mitigated by her staff and their teamwork.

Part of what helps [alleviate stress] is the staff and the strong sense of camaraderie here, and so it's not isolating. My staff are very friendly, I mean people go out together on weekends, people . . . get close working as a team, so in that sense, there's something special here.

Liz, a front line worker in a methadone maintenance program, found support for the stressful nature of her job in teamwork with her colleagues.

We are really supportive, we actually have a really good team right now. We support one another, we check in with one another all the time, like, if they're having trouble catching up, we're always in each other's offices, like, "This is what you need to do," and . . . you know just try to stay on top of it. We share our files with one another, you know, like spreadsheets and stuff . . . we also share our

calendars with one another so that's how we try to support one another to really stay on top of covering each other too. We also do get along really well, so if anyone's having a bad day, we kind of like, all get together, and . . . we have like a little powwow, and all that.

Emma, a front line worker in an intensive outpatient program, offered a similar experience. She too found her team of colleagues to be a source of support in the stressful work environment.

My team . . . the evening team is so incredible and so supportive and . . . I think we work very very well together, we have a very good understanding of what we're trying to do . . . and we're all on the same page about, like, a lot of stuff . . . especially what stresses us.

Gratitude and pride. As candid as participants were about their struggles in the workplace, they also appreciated their work and the opportunity to help people. Workers were able to express a sense of gratitude for their work and the opportunity to be a part of such meaningful change in individual lives. Alice, a clinical supervisor, stated,

It's nice when you start with a client and let's say they're coming every day, they're coming to four groups a week, and then you step them down, then they're only coming three times a week, or twice a week, and then eight months or a year later, they've been sober the whole time, they're happier, they've maintained work, that's nice to see.

Sophie, who has worked in the field 43 years, still loves her job as a front line worker in an intensive outpatient program.

I'm surprised with myself that my passion for service has not changed, if anything else, it's very alive. It's very alive, it's just like, I like process work, I also love when a group is working. It's like, to me, it's my metaphor is like, a Broadway show that has been running for years . . . but every night . . . it's a new experience.

Julie, a front line worker for an outpatient program, recognized the importance of maintaining a warm friendly work environment despite the challenges that might threaten it.

I can only speak for myself -- one of the things I like about working here is that every staff member pretty much knows every patient by name, so when they walk in here, it's not going to be like they walk into other places and don't even get a hello at all, but they're gonna be, you know, "Hello John, Hello Mary." I think that's important and it's something I am proud to be a part of.

Even workers who resigned or quit their substance abuse agency job still spoke about their continued passion for working with this population. Karen, a front line worker who worked in an outpatient program for five years but recently left due to the stressful working environment, stated,

Like I said, when I shut the door there was a lot of laughter and a lot of fun and . . . I have so many thank-you cards of gratitude, that say the same thing, which is I saved their lives. It's almost like, I became immune to hearing that, which I never ever thought that I would become immune to the words, "You saved my life." It is incredibly rewarding work.

Amelia, COO of a substance abuse program, expressed her pride about her work and her commitment to this work with this population.

Well, I think honestly, the most important thing that we do for patients here is treat people with dignity, because this is a population that gets doors slammed in their face and gets treated like crap everywhere they go. And I kind of feel like that's true with the staff as well, you know, and if the patients come first, and the staff knows that, then sort of everything stems from that. I've just learned so much working here and I felt like as a clinician I learned as much [from the clients] as I hope they've learned from me. It's like, a privilege, it's a privilege . . . it's hard . . . but you know, when people say how can you work in substance use, it's so depressing, do people ever succeed? . . . And you know, it depends on how you define success. . . People succeed a lot. And that's why we do it, to see that.

Summary

The lack of an organizational response to Managerialism meant that workers were left to manage this experience on their own seeking support in individual supervision or through the use of their own internal resources. As a result, the integration of managerial policies and practices led many workers to initiate new behaviors at work. These actions included navigating ways to bend the rules, cutting corners in patient care or putting forth effort at acts of resistance. Despite all of this, workers remained committed to the larger mission of offering quality care to those suffering with substance abuse disorders.

CHAPTER 10: DISCUSSION AND IMPLICATIONS

This chapter discusses the results of this study and implications for future social work practice, policy and research. The purpose of this study was to examine how the policies and practices as a result of Managerialism are impacting the human services workforce through the lens of the worker in substance abuse treatment programs. Semi-structured interviews were conducted, transcribed, and analyzed using template analysis (TA). TA allowed for the creation of *a priori* themes to help structure and guide the research and analysis (King, 1999). The existing literature offers a broad discussion on the scope and potential impact of Managerialism, which helped to shape the template for the study. However, there has been limited research that takes a closer look at the workers experiences through the transition of Managerialism as it continues to impact the entire human services sector. The findings of this study further deepens the understanding of how Managerialism policies are being implemented into practice and how those practices are impacting the worker in substance abuse treatment programs.

Extent of Managerialism in Substance Abuse Programs

As suggested by the literature (Geuring, 2001; Harvey, 2005; Hood, 1991; Lonne, 2003), Managerialism has been on the rise in the realm of human services. This study offered evidence of how Managerialism is currently being operationalized in substance abuse programs in New York City. All the participants in this study spoke of the presence of Managerialism policies and practices in their agencies. While most used varying language and terminology associated with Managerialism such as “a business model,” it was clear that the private market philosophies of Managerialism are being integrated into policy and reshaping practice. As a result, all participants discussed the ways in which this has impacted their work, overall professional experience and service provisions. Workers confirmed that their substance abuse agencies were

operating in line with what the literature refers to as “profit-making logic” that are being held accountable through “performance management” guidelines (Connell et al., 2009). As Managerialism introduces the business model to substance abuse programs, workers identified the specific implementation of new accountability measures, new technology, increased documentation, emphasis on productivity, demand to use standardized practices, and increased involvement with managed care. These findings offer more tangible examples of how Managerialism is being applied in substance abuse agencies.

Workers Experience of Managerialism

As the integration of Managerialism continues, the overall impact on the worker became clear. Workers spoke about the changing work environment as Managerialism was operationalized through new business model practices and policies. With an increased emphasis on the bottom line, workers spoke about higher demands of work productivity, along with tighter budgets, insufficient trainings, staffing issues, low pay, and a general sense of feeling devalued as clinical staff. The overall consensus was that the current working condition within substance abuse programs was stressful.

The findings of this study further support Abramovitz and Zelnick (2015) study on the impact of privatization. Abramovitz and Zelnick’s study, which draws on preliminary findings from a survey of human services workers across varying settings in New York City, concludes that front line workers are experiencing the impact of Managerialism and Financialization through a variety of ways including: greater accountability measures, tighter budgets and increasing demands to do more with less. Similar research suggests demands to demonstrate efficiency and productivity takes a toll on the workforce (Alexander, 2000). This study supports

the suggestion that the business model, in which the focus is on the bottom-line, does re-shape the working culture and has an impact on the worker.

With all the changes occurring at agencies, the impact on workers and their professional experiences was quite profound. In support of the literature (Baines, 2006; Lonne, 2003), participants expressed concerns that Managerialism was leading to an erosion of quality of care. Workers cited concerns that their clinical practice was becoming less client centered, as the transition to more standardized practices are implemented. Workers also emphasized how increased administrative demands are being placed on workers that led to concerns about able to be “genuinely present” with the client. With high demands for outcome measurements and expectations of productivity, many discussed the creaming techniques that occurred at their agencies. Participants also expressed concerns that clients were recognizing these changes and sensing the stress and new pressures both the workers and agencies were experiencing.

One of the major criticisms of Managerialism, as its applied to the human services sector, was the potential for threats to professional autonomy and discretion (Baines, 2006a; Carey, 2008; Fabricant, 1985; McCracken & Marsh, 2008). This concern was echoed throughout this study and workers discussed the ways in which they protected their professional autonomy and discretion in light of stricter guidelines and regulations associated with Managerialism. The noted tensions between policy and practice choices were illuminated in the stories from both the front line workers and supervisors. As a result of these new tensions experienced in this work environment, there was a prominent decline in staff morale and subsequently several issues of retention with staff.

Lonne (2003) argues that the embrace of business principles associated with Managerialism into the human services sector would undermine social justice missions since there would inherently be a greater focus on compliance and control. Participants, particularly, Paul, a front line worker, and Dorothy, a program director, expressed efforts at advocacy that were met with organizational resistance. Both participants were very vocal in expressing the ways in which these managerial changes made it difficult for them to deliver quality services. These findings support Abramovitz and Zelnick's (2010) concern that such policies create a "double jeopardy" in which workers and clients are being adversely impacted. Further more, this supports the question raised by Baines (2006a) about who really benefits from these policies?

As previously stated, the research on Managerialism and its impact on the workforce is limited, however, also of significance is that the response to Managerialism has also been unexamined. Given the clear and evident changes facing human services agencies today, it was surprising that only one organization in this study had begun to formulate an organizational response to address changes associated with Managerialism. Workers acknowledge that the managerial approach has made an impact in a variety of ways including worker's ability to offer quality care and service provisions. The organizational leaders who participated in this study, such as program directors, supervisors and the COO, all suggested improved communication around implementation of such policies as a way to help front line staff be more open to adaptation and change and yet there was little of evidence of this effort being implemented in an organized and systematic way. The lack of organizational response to this collective experience is a critical area that warrants further research.

Workers explained the ways in which they managed their individual responses to Managerialism. This was done through various efforts of self-care along with methods of

professional survival strategies, which included cutting corners in patient care, bending the rules and acts of resistance. The absence of a larger wider scale organizational response to Managerialism has left workers and supervisors to address these changes on a one-on-one basis. Workers and supervisors, alike, spoke of how these issues have infiltrated individual supervision meetings, which historically were intended for clinical process of client care. This altered use of individual supervision was distressful for both front line workers and supervisors.

Amidst all the changes brought on by Managerialism, the results of this study highlight the unrelenting passion and commitment of workers to their effort to offer high quality care to clients. Many discussed their continued desire to be a part of the solution to the ongoing and growing problem of substance abuse. Workers expressed appreciation for their colleagues who offered them support and gratitude for their work with clients. This persistent “love for the work” was refreshing and encouraging despite many workers feeling overly stressed and dissatisfied at their current place of employment.

Supervisors vs. Front Line Workers: Differing Perspectives

Despite all participants experiencing the integration of Managerialism, there were some differences in the responses between the front line workers and those with higher-level positions (such as chief operating officer [COO], program directors, or clinical supervisors). Of the 22 interviews, 13 participants identified themselves as front line workers and 9 identified themselves as supervisors (or higher). All of the supervisors disclosed having started their careers at the front line. Although some were promoted more recently than others, having had this professional experience gave them firsthand exposure to the role. For some supervisors, this afforded them the ability to have great empathy and patience for front line workers as they adjust to managerial demands. For other supervisors, they felt more aligned with the higher

administration and could more readily embrace the value of the standards set by outside regulatory agencies.

One such supervisor, Lillian, who has 21 years of experience in the field serving as a clinical supervisor and program director at various substance abuse programs, offered a more “tough love” approach, saying, “If you can’t handle the heat, get out of the kitchen.” Lillian, having many years of experience running programs, was one of the more outspoken participants with regards to her lack of empathy for front line workers who are struggling to keep up with the changes of Managerialism. She went as far to suggest that workers who are too frustrated should in fact leave their jobs because their complaining is the ultimate disservice to clients.

One study, Aronson and Smith (2011), highlights the specific position of supervisors and managers in social service agencies as being in a unique position to either resist or adapt to the changes of Managerialism. This unique positioning of this role was discussed in all of the 9 interviews with supervisors. It was evident that the role of supervisor is shifting away from direct clinical support and that workers are using individual supervision as an outlet to express themselves regarding managerial demands and new policy implementations. A consistent theme amongst supervisors was a general feeling of inadequacy around strategies to help front line staff cope with new demands of Managerialism. Alice, a supervisor who was promoted 2 years ago from the front line, pointed out that when her staff comes to her for supervisory support around administrative demands she feels, “[I never offer] any effective solutions”.

Other supervisors supported these frustrations and expressed difficulties feeling effective in their role as clinical supervisors. One clinical supervisor, Barbara reported, “This interview [is] also further confirming for me that I do want to go back to more clinical work; to see more

clients [and] do less supervision. Supervision is much harder than I thought it was gonna be with all these policies”.

Revisiting Street Level Bureaucracy

In his original 1980 edition of *Street-Level Bureaucracy*, Lipsky introduces the notion of “street-level bureaucracy” as a concept. One of the main themes addressed in the book is the use of discretion as a critical dimension of the work of public workers (referred to as street-level bureaucrats) who regularly interact with citizens in the course of their job. Lipsky (2010) identifies the ways in which the worker negotiates discretion and professional autonomy amidst organizational policy implementation acknowledging the obvious tension between bureaucratic standards and actual street-level work. The results of this study support that this negotiation continues today as Managerialism enters the human services sector and promotes the significance of the understanding the individual experience to policy.

Lipsky (2010) posits that street-level bureaucrats actually make policy when they act in ways that may be unsanctioned or in contradiction with official policy. This is especially critical to consider since this study offers evidence of workers acting in similar ways by demonstrating acts of resistance and bending the rules as means to manage Managerialism. Brodtkin (2011) recognized the importance of understanding street-level bureaucrats as pivotal players in the making of public policy since their informal construction and reconstruction of policy becomes part of everyday organizational life. Similarly, Lipsky’s (2010) notion that the cumulative results of individual actions of discretion add up to agency behavior and that this can ultimately be seen as the face of policy implementation which reinforces the importance of continuing to examine the individual worker’s experience of Managerialism. The findings of this study call into question how workers may have reconstructed policy through their individual actions.

Brodkin's (2012) suggestion that workers will try to retain discretion as they adapt to the policies set before them was seen in the findings of this study. As expressed by Paul, a front line worker, he is able to protect his discretion and autonomy within the given framework of the agency. Other participants also recognized their ability to maintain professional autonomy and discretion but this was often described as "behind closed doors" or "within the boundaries of agency policy". However, Lipsky (2010) and Hupe and Hill (2007) remind us that all the behaviors of the street-level bureaucrats make it a challenge to get an accurate portrayal of accountability which further questions the accuracy and effectiveness of such measures. This qualitative inquiry supports Lipsky's theory of street-level bureaucracy, as it remains clear that workers will continue to adjust and adapt in ways they see fit and not necessarily just comply with the policy set before them.

Limitations of Study

There were several limitations in this study to consider including my own bias, assumptions and beliefs based on my own professional experience working in the field of substance abuse. This potential for bias was something I considered and accounted for when conducting, coding and analyzing interviews and was addressed through the use of triangulation of data, member checking and keeping an audit trail. Another critique of this research might be around the challenges in generalizing these results to another agency, setting or population. I interviewed a non-random, purposive sample with a small N, which also limits generalizability. However, generalizability is not the goal of qualitative inquiry, which seeks to explore a deeper, more nuanced understanding of a phenomenon affecting a specific population. .

Another limitation in this study was the exclusion of any participants who worked in a 28-day inpatient rehabilitation setting. The vast majority of my sample was employed at varying

levels of outpatient settings, with only 2 participants who reported their employment at inpatient treatment settings. The inpatient settings included in this study were both residential treatment settings. Residential treatment offers long-term inpatient treatment to those who are addicted for anywhere from a few months up to 2 years. I was unable to recruit participants employed at a shorter-term inpatient program. Another source of error might be selection bias, as participants self-responded to the study recruitment flyer. It could be possible that those workers who were more dissatisfied with the integration of Managerialism were more likely to respond to my inquiry since they may have felt some motivation to advocate and have their voices heard.

Implications for Future Social Work Practice, Policy and Research

Today's political and economic climate places greater demands and higher expectations on substance abuse programs in New York City to provide effective treatment, achieve better outcomes, and to use evidence-based treatment protocols (OASAS, 2016). The literature to date suggests that in order to survive, adapt and be effective, human service agencies will need to respond to the new administrative strategies introduced by Managerialism (Alexander, 2000; Abramovitz & Zelnick, 2015). Despite the ongoing controversy around whether or not the application of business model techniques is a good fit for the human services sector, it is evident that Managerialism policies and practices will continue to be implemented.

This qualitative inquiry offers grounds for ongoing research in this area particularly around possible improvements for implementation of new such policies and practices. This study is consistent with Lipsky's theory of street-level bureaucracy, which encourages a possible point of intervention to be at the worker level. These results suggest that front line workers need more support around adjustment to new changes and supervisors need to be better equipped with how to manage workers as they adapt. Most front line workers in this study did not have the context

as to why new policies and changes were occurring at their agencies and for those that did; their efforts at advocacy around improvements were quelled. Several participants indicated a desire for improved communication between management and front line and this can be something to consider in helping to bridge the widening gap between the front line and management and improve workforce solidarity. Furthermore, workers need to be entering the workforce armed with an understanding of Managerialism. An improved understanding of the rationale behind Managerialism might help to bridge the gap between policy standards and clinical practice. As suggested by several participants of this study, there needs to be improved communication around Managerialism, which many agree could alleviate tensions.

An important area to consider further research would be into social work education and other clinical education. To date, there is a disconnection between such education and real-life practice. Introducing Managerialism into educational training curriculums can help new workers entering the workforce understand the fundamental intent of these policies and practices and continuing education trainings could help those who are seasoned and have been in the field bearing witness to these changes.

Conclusion

This study highlighted worker resiliency in light of major changes impacting workers day-to-day functioning as a result of Managerialism. Workers demonstrated ways in which they adjust, adapt, or resist; all without the guidance of an organizational or systematic response to help workers address these issues. It is important not to take for granted front line workers loyalty to the mission of their work, because the growing tensions between Managerialism and practice are also very troubling. Workers introduced several complaints of how Managerialism is reshaping organizational policies and therefore changing the ways in which they experience their

work. Workers discussed a variety of concerns including challenges to professional autonomy and concerns of quality of care but complaints about the new challenges, stressors, and demands associated with Managerialism were a dominant theme across all interviews. As Managerialism continues to assert itself across human service agencies, there is no better time than the present to continue to conduct further qualitative inquiries, possibly across other human service sectors, to gain a better understanding of how this can be better managed. Front line workers are not situated to change policy; however, they are at the unique intersection of practice and policy implementation. This could serve as an opportunity to further engage workers in an open dialogue around policy advocacy, which could offer opportunity for improved organizational responses and working alliances between management and front line workers. Without improved implementation of this model, the traditions of the social work and human service professions may be threatened.

Appendix A

INTERVIEW GUIDE**Introductory Comments:**

Thank you for taking the time out to talk with me about your experiences working in a substance abuse program. As indicated in the consent form, I will be asking you questions about your work experience. I would like to remind you that all answers will remain confidential and identifying information will also be kept confidential. As you know I will be taping your responses and this is really intended to ensure the accuracy of your responses. Please feel free to elaborate in any way that you feel relevant to any question. Please remember that you can stop the interview at any time and that you are free to not answer any of the questions that I ask and we can move on to the next question. Do you have any questions for me before we start?

1. Tell me about the agency you work at?

- a) Clients
- b) Level of care- type of setting
- c) Problems addressed

2. Tell me about your role?

- a) How long have you been at this job/role?
- b) Tasks, responsibilities, etc.
- c) How much direct service delivery with clients?

3. Tell me how you came to work here.

- a) Why this job?
- b) Now that you're here, what keeps you here?

4. How would you describe your agency's mission?

- a) How well does the agency meet its mission?
- b) Is the mission aligned with practice?
- c) What are the barriers/success in meeting mission?

5. How well do you feel your clients needs are being served?

a) What are the successes/barriers to serving clients?

6. Can you tell me about how reporting and documentation works here?

- a) Notes, charts, electronic medical records
- b) Other reporting measures
- c) How do these activities affect your practice?
 - a. Time with clients?
 - b. Supervision

7. Social Work agencies are also being asked to pay attention to, that is to measure, the impact of the services on client well-being (outcomes, performance based measurements) Is this something emphasized at your agency?

- a) Performance measures
- b) Grants
- c) Contracts
- d) Funding
- e) Do you understand how these work?
- f) How do you feel about these measures?

8. Another new trend is the growing use of Evidence Based Practice and other practice models. Is this something emphasized at your agency?

- a) If so, how is this enforced, monitored, implemented into practice?
- b) Do you know the reasons this was introduced?
 - a. Funding, contracting, compliance
 - b. Additional training? Supervision?
- c) How do you feel about this practice model?

9. Can you tell me how these and other trends that we have been discussing have affected your role?

- a) Discretion
- b) Professional autonomy
- c) Independent decision-making
- c) Creativity
- d) Client-trust
- e) Relationship building

10. There is a lot of discussion today about workers, agencies and clients having to do “more with less.” Can you tell me if your agencies have introduced cost saving measures and what they look like and how they affect your work, your agency, your clients?

- a) Budget cuts
- b) Staff cuts
- c) Greater use of part-time staff
- d) Greater use of less credentialed staff
- e) Program closures

11. Are there other issues that affect your work at this agency would like to tell me about?

12. We have been talking about various challenges that affect you, your agency and your clients. Can you tell me how you manage these daily challenges?

- a) Coping techniques
 - a. Bending rules?
 - b. Working overtime
 - c. Incentives /Seek additional support
- b) Impact on you?
 - a. Stress
 - b. Health Problem
 - c. Work/life balance
 - d. Job dissatisfaction /Loss of morale

Post-Interview Questions and Closing:

This wraps up our interview for today. Thank you so much for your responses. I am going to ask you just a few more questions about your experience today in speaking with me if that's ok with you?

- What was it like talking to me about your professional experiences?
- Have you ever talked about this before?
- Do you have any follow up questions for me?

Please keep in mind that after an interview like this, new feelings or thoughts can emerge about what we discussed. If this should occur, please feel free to contact me.

I really appreciate your time and thank you so much for your participation today!

Appendix B

INFORMED CONSENT**THE CITY UNIVERSITY OF NEW YORK
Hunter College Silberman School of Social Work****CONSENT TO PARTICIPATE IN A RESEARCH STUDY**

Title of Research Study: Examining the Impact of Managerialism/ New Public Management on Front Line Workers in Substance Abuse Programs

Principal Investigator: Jocelyn Lewiskin, LCSW
Doctoral Candidate
Silberman School of Social Work at Hunter College

Faculty Advisor: Mimi Abramovitz, DSW
Bertha Capen Reynolds Professor of Social Policy
Silberman School of Social Work at Hunter College, CUNY and
The CUNY Graduate Center

You are being asked to participate in this research study because you are a front line worker working in a substance abuse program.

STUDY PURPOSE

The purpose of this study is gain a better understanding of the experiences of front line workers in substance abuse programs under the paradigm of Managerialism / New Public Management policies.

STUDY PROCEDURES

If you volunteer to participate in this research study, you will be asked to do the following:

- Sign the consent form that indicates your consent.
- Participate in an interview that will last approximately 45-60 minutes. Depending on how you answer the questions posed to you, the interview may take a bit longer.
- Interviews will take place in the principal investigator's private office or another mutually agreed upon confidential space.
- With your permission, the interview will be audio-recorded so that the interview can be transcribed for data analysis.

Questions will be in regards to your professional experience as a front line worker in a substance abuse program. For example:

1. In recent years many social workers have been asked to spend more time on reports and documentation. Can you tell me about how reporting and documentation work at your job?
2. Another new trend is the growing use of Evidence Based Practice and other practice models. Is this something emphasized at your agency?

To protect your confidentiality, your real name and name of the agency you work for will not appear in the interview transcript. An assigned number and a general description of the agency type will identify you. There will be 25-30 social workers participating in this study. The data will be analyzed the data by the principal investigator. The information gathered in this study will be used to help other researchers, educators, practitioners, and policy makers provide more relevant and useful education and information. The results of this study will be written up for publication in academic journals and professional conferences. There will be no direct identifying information about you or your agency included.

STUDY RISKS

This risks involved with participation in this study may include the fact that questions are of a personal nature regarding your professional experience. If you feel uncomfortable with this, you can skip any questions or request to end this interview. Participants also are permitted to review, edit and/or erase the recording of the interview. Also, despite all effort to protect and maintain confidentiality there is always a possibility for a breach in confidentiality. Remember you are free to discontinue your participation in this study.

STUDY BENEFITS

There are no direct benefits to you for your participation in this study. However, the benefits to society may include in improvements in social work service delivery.

COSTS AND COMPENSATION

There will be no compensation for participation in this study.

NEW INFORMATION

You will be notified about any new information regarding this study that may affect your willingness to participate in a timely manner.

CONFIDENTIALITY

The principal investigator will do her best to maintain confidentiality of any information that is collected during this research study, and that can identify you. Disclosure of such information would only occur with your permission or as required by law.

All information obtained during this study will remain confidential. You be identified by an assigned number, and only the principal investigator will have access to your actual identifying information. All materials pertaining to your participation in the interview will be kept in a locked file cabinet in a locked office at CUNY and the audio-recorded interview will be uploaded to a password-protected file on the principal investigator's computer. The data will be kept for three years and destroyed thereafter.

The research team, authorized CUNY staff, and government agencies that oversee this type of research may have access to research data and records in order to monitor the research. Research records provided to authorized, non-CUNY individuals will not contain identifiable information about you. Publications and/or presentations that result from this study will not identify you by name.

PARTICIPANT RIGHTS

Please remember that your participation in this study is entirely **voluntary** and that you can withdraw from the study at any time. If you decide not to participate, there will be no penalty to you, and you will not lose any benefits to which you are otherwise entitled. Also, your participation or non-participation will not affect your employment at your agency.

QUESTIONS, COMMENTS OR CONCERNS

If you have any questions about this study, please contact the principal investigator at jlewiskin@gradcenter.cuny.edu

If you have questions about your rights as a research participant, or you have comments or concerns that you would like to discuss with someone other than the researcher, please call the CUNY Research Compliance Administrator at 646-664-8918. Alternately, you can write to:

CUNY Office of the Vice Chancellor for Research
Attn: Research Compliance Administrator
205 East 42nd Street
New York, NY 10017

SIGNATURE OF PARTICIPANT

If you agree to participate in this research study, please sign and date below. You will be given a copy of this consent form to keep.

Printed Name of Participant

Date

Participant Signature

Date

Printed Name of Investigator

Date

Investigator Signature

Date

CONSENT FOR AUDIO RECORDING

You agree to be audio-recorded for this interview. Please circle one:

YES NO

If circled yes:

With your permission, the interviews will be digitally recorded. All information gathered will be kept strictly confidential, and will be uploaded to a password-protected file and transcriptions of your interview stored in a locked file cabinet, to which only the principal investigator will have access.

Please sign below if you consent to the audio recording of the interview.

Participant Signature

Date

Investigator Signature

Date

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