Ideology and Social Work Practice in Substance Abuse Settings

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The profession of social work has a unique role in preventing and treating alcohol and other drug problems. In human services settings shared beliefs or ideologies of care are expected to have substantial influence over the way in which problems are perceived and the types of service technologies used. Thus, it is important that social work professionals be cognizant of what beliefs they hold and how their beliefs about substance abuse treatment and prevention may affect practice. This article discusses current ideologies of care in the substance abuse arena, including the disease/abstinence, psychosocial, ecological, and harm-reduction approaches. In addition, this article examines managers' beliefs about substance abuse programs to determine if there are differences between those who have a social work background (that is, hold at least one social work degree) and those who do not. Suggestions for social work practice and future research also are provided.

Key words: *beliefs; human services organizations; ideologies of care; prevention; substance abuse*

The social work profession has a unique role in preventing and treating alcohol and other drug (AOD) problems (Magura, 1994). Many social workers are engaged in substance abuse practice and related activities. Review of the 1991 NASW membership reveals that about 4,000 members (4.6 percent) designated substance abuse as their primary area of practice (Gibelman & Schervish, 1993). Another 3,600 NASW members identified substance abuse as their secondary area of practice. Many more work in settings where AOD problems are likely to affect clients seeking treatment for services. In addition, numerous other social work researchers, policymakers, and academicians are involved in macro practice related to substance abuse.

Given the range and scope of involvement by social workers in substance abuse prevention and intervention, it is important that social work professionals be cognizant of their beliefs about service provision in this arena and how those beliefs affect their professional efforts. Studies of human services organizations (HSOs) have placed increasing importance on the role of shared beliefs or practice ideologies

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to the organization and delivery of human services (Hasenfeld, 1992a, 1992b). Little empirical research exists, however, to indicate what belief systems or "ideologies of care" prevail among social workers who provide substance abuse treatment or other human services.

As the brief review of current ideologies about prevention of and intervention for AOD-related problems indicates, no single ideology of care prevails in the AOD treatment field, although previous research suggested that the U.S. treatment community has widely embraced abstinence-based approaches that are closely related to a disease model of substance abuse problems (Blume & Roman, 1985; Weisner & Morgan, 1992; Weisner & Room, 1984). Despite the preeminence of abstinence as an approach to prevention and intervention with AOD problems, a range of other perspectives also exists in this arena (Diwan, 1990). Some of these other orientations may in fact be more consistent than the abstinence approach or disease model with traditional social work values and social work's emphasis on a more holistic, ecological, or systems approach to such problems (Freeman, 1992).

This article reports findings from the 1988 Drug Abuse Treatment System Survey (DATSS). The DATSS is based on a national, representative sample of outpatient substance abuse treatment (OSAT) units. These data are used to examine how managers in OSAT organizations differ in their support for beliefs about substance abuse practice depending on their educational background. More specifically, this article examines the following research questions: To what extent do managers in OSAT units support various beliefs about prevention and intervention with substance abuse and related problems? Do managers who have earned at least one social work degree differ significantly from those who have no social work degree in their support for various beliefs about practice? This article also discusses the implications of these findings for social work research and practice.

Ideology in HSOs

In human services settings, shared beliefs or ideologies of care have substantial influence on the types of service technologies used (Hasenfeld, 1992a, 1992b). Moreover, because uncertainty is associated with intervention technologies in HSOs, these organizations often rely on practice ideologies or ideologies of care to guide the provision of services (D'Aunno, Sutton, & Price, 1991; Hasenfeld, 1986). Such ideologies typically constitute "rational myths" (Meyer & Rowan, 1977) or "moral systems" (Hasenfeld, 1992b) rooted in the external or "institutional" environment in which HSOs operate.

Ideologies of care are not uniform or static in human services arenas. As Hasenfeld (1992b) pointed out, "The institutional environment in a culturally pluralistic society is both heterogeneous and turbulent. That is, it consists of diverse interest groups upholding conflicting values and norms" (p. 10). The pressures emanating from this dynamic institutional environment may become embedded in the formal and informal rules that dictate what are regarded as appropriate approaches to service delivery. Because the institutional environment is fragmented and turbulent, human services providers may often be forced to choose between rival moral systems, adapt to emergent moral systems (Hasenfeld, 1992b), or develop strategies for accommodating multiple belief systems (D'Aunno et al., 1991).

Ideologies of care are specialized sets of beliefs about the nature of client problems and the best practices or strategies for preventing or alleviating such problems. Because multiple and even competing ideologies of care coexist within human services sectors (Diwan, 1990; Hasenfeld, 1992a, 1992b), staff in HSOs will vary in the nature and strength of their adherence to particular ideologies of care. Variation in belief systems has been attributed in part to the education and job-related training of personnel in service sectors, as well as their membership or other associations with professional groups (Meyer & Rowan, 1977). To make matters more complicated, ideologies of care are not necessarily mutually exclusive. Hence, variation among staff may be more reflective of differences in emphasis on one ideology or another, rather than strict adherence to one ideology of care to the exclusion of all others (Heaney & Burke, 1995).

Ideologies of Care in Substance Abuse Settings

Historically, beliefs about substance abuse policy and practice have been diverse. Lender and Martin (1987) noted that since 1933 (that is, the end of Prohibition), alcohol treatment and prevention in the United States has supported several theoretical approaches to alcohol problems. Diwan (1990) argued that five distinct ideological approaches to alcohol-related treatment and prevention currently exist: (1) the medical model, (2) the Alcoholics Anonymous (AA) 12-step model, (3) the sociopsychological approach, (4) the social learning approach, and (5) the public health approach.

Except for the public health approach (which emphasizes the host, agent, and environment), each of the above perspectives focuses on the individual as the primary source of AOD problems. The medical model, for instance, views the etiology of AOD abuse as a biological disease (Hanson, 1991). Similarly, the 12-step approaches initiated by AA and Narcotics Anonymous groups also view substance abuse as a disease (D'Aunno, 1992) and place the responsibility for recovery on the individual. Each of these abstinence-based perspectives can be traced to the work of Benjamin Rush in the early 1800s, who viewed alcohol-related problems as having moral and physical causes (Katchner, 1993). In contrast, "symptom," psychosocial, or learning models view substance abuse as a product of psychological and social factors (Diwan, 1990; Hanson, 1991).

More recently, harm reduction has gained increasing support as an approach to substance abuse and related problems and can properly be regarded as an emergent ideology of care. As a prevention perspective, harm reduction has no standard fundamentals, although the emphasis on public health is a key aspect of this approach (Des Jarlais, 1995). Newcombe (1992) has further elaborated the harm-reduction perspective, asserting that this approach emphasizes minimization of the negative effects associated with drug use in the absence of complete abstinence and can be regarded as an alternative to abstinence-based drug policy. Harm-reduction efforts focus on identifying and meeting the needs of drug users as they relate to health concerns of the public. Therefore, the harm-reduction approach places secondary emphasis on abstinence as the basis for treatment, depending on the needs of the drug user. Methadone maintenance programs, for example, take a harm-reduction approach to intervention for intravenous (IV) drug users. The harm-reduction approach attempts to protect the public's health and the health of individuals with AOD problems by acknowledging that denial, dependency, and relapse may prevent or delay abstinence.

Social Work and Beliefs about Substance Abuse

As a profession social work has made a longstanding commitment to view problems like those associated with the use of AOD differently than workers in other helping traditions. Traditionally social work has placed high priority on concerns for equality, client strengths, the right to self-determination, social justice, and public welfare (Freeman, 1992; Specht & Courtney, 1994). Moreover, since the 1960s social work has placed increasing emphasis on the value of an ecological, person-in-environment, or systems perspective to social work education and practice (De Hoyos & Jensen, 1986; Germain, 1981).

Magura (1994) argued that because of their education and training, social workers have much to contribute to substance abuse practice with clients who face "multiple emotional, family, interpersonal, and environmental problems" (p. 3). In his view social work education equips practitioners to take a broad approach to client needs and to engage in a diverse set of intervention-related tasks to manage and coordinate services for multiproblem clients. Furthermore, Magura suggested that social workers have diagnostic and assessment skills, familiarity and comfort with positive therapeutic approaches, and a commitment to practice evaluation that can improve the quality of care in substance abuse settings.

That social workers actually take a different approach to care in substance abuse settings or necessarily exhibit distinctive beliefs about practice is not clear. Social workers may be engaged in "overturning the medical model" (Weick, 1985) and reducing their reliance on

the disease concept after years of struggle to increase their status by embracing the medical model (Freeman, 1992). As more social workers are engaged in providing services to individuals with AOD problems, "there may be a tendency to move back toward the dominant [disease/abstinence] force in the field" (Freeman, 1992, p. 7). By moving back to the disease/abstinence perspective, social workers risk losing their focus on a client-centered viewpoint: beginning where the client is, encouraging mutuality between worker and client, and building on client strengths (Freeman, 1992).

Little empirical data exists, however, to reveal what social workers actually believe about practice in these settings or to determine how different their beliefs are from those held by other service providers in this arena. Although an ecological or systems approach has been widely adopted as a framework for guiding practice in social work, little agreement exists about what such an approach entails (De Hoyos & Jensen, 1986). The extent to which education and training in ecological or systems frameworks actually affect the way social work professionals approach care in this sector remains to be seen. In addition, a recent study indicated that social workers generally have little exposure to specialized course work or curriculum content about substance abuse issues, and when they do this content tends not to challenge the disease model (Alaszewski & Harrison, 1992).

This study examined a range of ideologies and beliefs about practice in OSAT programs. Social work and non–social work managers were asked to share their perceptions about approaches to AOD problems (that is, disease, psychosocial, ecological) and the extent to which they support a harm-reduction approach to preventing HIV/AIDS among their clients. In addition, managers were asked to respond to questions regarding their beliefs about desirable qualifications in staff, characteristics associated with staff effectiveness, conditions clients must meet for AOD treatment to be effective, and perceived importance of specific AOD treatment goals.

Although there is little previous empirical work to guide this research, it is anticipated that social work and non–social work managers will differ in their ideological orientations to care in this sector. Because of their education and training in an ecological or systems framework, managers who hold at least one social work degree are expected to be less likely to endorse the disease/abstinence approach than managers with no social work degree and more likely to endorse a psychosocial or ecological explanation for the etiology of AOD problems. For the same reason, social work managers are expected to be more supportive of a harm-reduction approach to HIV/AIDS prevention. Social work manager also are expected to believe more strongly in the importance of addressing a broad range of concerns when setting treatment goals, including issues involving employment, legal concerns, and relationships.

Because of their own commitment to professional education and the struggle to achieve recognition as professionals, managers with at least one social work degree also are expected to be more supportive of hiring practices and beliefs about staff effectiveness that emphasize professional education. It is anticipated that social work managers will be more supportive than non–social work managers of beliefs emphasizing the development of new insights and skills as conditions for effective treatment and less supportive of beliefs traditionally associated with abstinence-based approaches, such as the need for clients to "hit bottom."

Methods

Design and Data

This study used data from the 1988 DATSS, collected by a research team that included one of the authors. Although almost a decade old, these data are still one of the most comprehensive and representative sources of information about OSAT programs. The study collected information about a broad range of issues in HSOs, including an exploration of ideologies of care in this sector. These data were collected at a critical time when the harm-reduction approach was gaining prominence as an alternative or adjunct to disease or abstinence approaches. In particular, growing awareness of the relationship between HIV/AIDS prevention and AOD treatment in the 1980s raised the

stakes on failing to limit the damage caused by AOD use in the absence of complete sobriety.

The DATSS was conducted by the Survey Research Center of the Institute for Social Research at the University of Michigan and funded by the National Institute on Drug Abuse. Interviewers obtained data from respondents in 575 of the 670 units asked to participate in the 1988 DATSS for a response rate of 86 percent. Selection of units was based on a stratified, random sample of OSAT units drawn from a list of the population of approximately 8,500 treatment units in the United States. The population was stratified according to treatment services offered (methadone or nonmethadone), ownership (private or public), and treatment context (hospital-affiliated, mental health–affiliated, and unaffiliated or "freestanding"). In each unit interviewers asked the two top managers (that is, unit director and director of clinical services) to complete telephone surveys. Interviewers asked directors to provide information about the unit's ownership, financing, strategies, and accreditation. Clinical supervisors were queried for information about personnel, clients, services, and beliefs about approaches to prevention and intervention. In 52 percent of the cases, a single administrator functioned as both the clinical supervisor and director. Table 1 provides a brief description of the organizations and managers included in the sample.

Measures

Social Work Manager. This is a dichotomous variable (1 = at least one social work degree, 0 = no social work degree) indicating whether the manager has a degree in social work.

Beliefs about Prevention and Intervention. Four ideological approaches to prevention and intervention with AOD problems were examined. Disease approach and psychosocial approach are dichotomous variables derived from OSAT managers' initial response to the following question: "In your view, what are the major reasons for substance abuse?" Any response indicating "it's a disease," "biological predisposition," "heredity," "genetic factors," and so forth was coded 1, and all other responses were coded 0. Similarly, any mention of problems with psychosocial or social skills such as "lack of problem-solving skills," "emotional distress," "low self-image," "feelings of inadequacy," and so forth was coded 1, indicating support for a psychosocial approach, and all other responses were coded 0. Support for an ecological approach is an index created by summing responses to four Likert-scaled items indicating agreement (1 = strongly agree) or disagreement

Table 1

Characteristics of OSAT Programs and Managers (N = 575)

Characteristic	M	%
Program		
Ownership		
Public		26.9
Nonprofit		60.7
For profit		9.7
Auspice/affiliation		
Hospital		17.3
Mental health		25.6
Other		31.6
Unaffiliated		26.4
Age of program (years)	11.7	
Total revenues ($1,000s)	314.0	
Total clients	574.2	
Staffing		
Total paid staff	13.5	
Professional (master's) staff		51.9
Ex-addict/recovering staff		31.1
Manager		
Age (years)	41.6	
Gender		
Male		56.2
Female		43.8
Ethnicity		
White		83.7
Black		12.6
Hispanic		5.0
Other		1.8
Education		
12 years		7.6
13–15 years		7.0
16 years		13.1
17+ years		72.4
Social work degree		28.0
Employment experience (years)		
Current position	3.5	
Current agency	12.2	
Primarily direct service	8.1	
Primarily supervision	5.4	
Substance abuse field	12.7	

NOTE: OSAT = outpatient substance abuse treatment.

(5 = strongly disagree) that steady employment, stable social relationships, physical health, and emotional well-being are important treatment goals. Items included in this index were rescaled before they were added together so that a higher score represents greater agreement with an ecological approach to AOD treatment.

Items in this index were selected based on principle component analyses (PCAs) of eight goal-related beliefs (Kim & Mueller, 1978). PCA detects "the minimum number of factors needed to account for the maximum proportion of variance represented in the original set of variables" (Hair, Anderson, Tatham, & Black, 1992, p. 231). Orthogonal rotation was used to derive independent factors (Hair et al., 1992). Only factors with eigenvalues of 1.0 were retained (Kaiser, 1958). In addition, factor loadings of .5 and above were considered meaningful and used in "naming" the factors. The Cronbach's alpha of .75 indicates good internal consistency for this index.

The same strategy was used to develop a measure indicating support for a harm-reduction approach to HIV/AIDS prevention with AOD clients. Three items are included in a summative index representing the extent of support (1 = no extent, 5 = a very great extent) for assertions that (1) clean needles should be distributed to IV drug users to prevent AIDS, (2) bleach solutions should be distributed to IV drug users to clean their needles, and (3) condoms should be distributed to IV drug users to encourage "safe" sexual practices (Cronbach's alpha = .74). Higher values on this index indicate greater support for a harm-reduction approach.

Beliefs about Hiring Practices. Six individual items were used to explore beliefs about hiring. These items also relied on a five-point Likert-type scale (1 = strongly agree, 5 = strongly disagree). All items were rescaled so that higher values represented greater agreement with each belief. Managers were asked to agree or disagree with statements that, when hiring treatment staff, applicants should have (1) a professional degree, (2) previous experience working in a substance abuse agency, (3) specialized training in the substance abuse field, (4) a personal history of substance abuse, (5) certification as a substance abuse counselor, and (6) supervised clinical experience.

Beliefs about Staff Effectiveness. Managers were asked to respond to four questions regarding beliefs about staff effectiveness using the same five-point, agree–disagree format. These items asked managers to indicate agreement/disagreement with the following four statements: (1) Ex-addicts or recovering staff have a special kind of experience that enables them to work more effectively with clients than nonrecovering staff. (2) Staff with professional degrees have more knowledge than those without professional degrees about the underlying causes of substance abuse that enables them to be more effective in treatment. (3) A recovering substance abuse staff person is better able to deal with client denial and resistance than a nonrecovering staff person. (4) Staff with professional degrees are better able to maintain an objective view of clients' substance abuse problems than staff without professional degrees. Items were reverse-scored so that higher scores on each represent stronger agreement with the statement.

Beliefs about Conditions for Effective Treatment. Managers were asked to respond to seven items rating how important (1 = not at all important, 5 = extremely important) each of the following is for effective treatment: (1) clients maintain sobriety while in treatment, (2) clients recognize and acknowledge their substance abuse, (3) clients accept personal responsibility for their recovery, (4) clients learn new skills for dealing with personal problems and sources of stress, (5) clients gain insight and understanding of the role that substance abuse plays in their lives, (6) clients recognize that they will never be able to use particular substances again, and (7) clients "hit bottom" or experience a major personal crisis related to their substance abuse problem.

Beliefs about Important Treatment Goals. Managers were asked how much they agreed (1 = strongly agree) or disagreed (5 = strongly disagree) that certain goals are important for AOD treatment. These items included complete abstinence from alcohol and drugs, learning how to use alcohol or drugs in a socially responsible way, steady employment, stable social

relationships, good physical health, emotional well-being, improved spiritual strength, and meeting legally mandated requirements. These items were recoded so that higher numbers indicate stronger support for each statement.

Findings

Table 2 summarizes beliefs about practice for all managers and compares social work and non–social work managers' beliefs using results from chi-square and independent sample *t* tests. These findings indicate that about one-fourth of managers, overall and in each group, support a disease approach to AOD problems, a surprising finding given the notion that a disease approach is such a dominant force in the substance abuse field. Managers, as a group, are actually more supportive of a psychosocial approach than a disease approach. Although a slightly larger percent of social work managers than non–social work managers endorse this perspective, the difference is not a statistically significant one ($\chi^2 = .33$, $df = 1$). Together the disease and psychosocial approach account for nearly two-thirds of respondents (65.2 percent). The remaining third cite as causes of substance abuse a wide range of factors not clearly related to either perspective, such as "availability in schools and peer groups" or "poor future outlook."

The means reported in Table 2 also indicate substantial support among managers for the ecological approach. Moreover, no significant difference was evident when comparing means for the two groups of managers. Overall, managers were less strong in their support for a harm-reduction approach. As anticipated, however, social work managers were, on average, more supportive of this approach than were non–social work managers.

Beliefs about hiring practices and staff effectiveness were most revealing of differences between social work and non–social work managers. As Table 2 shows, social work managers more strongly endorsed a belief in the importance of a professional degree than did non–social work managers. Social work managers were also stronger in their belief that professional staff were more effective and more objective in their dealings with clients than their counterparts without professional education. All managers believed that it was important for applicants to have specialized training in substance abuse, work experience in substance abuse settings, and supervised clinical experience.

Examination of managers' beliefs about conditions for effective treatment and treatment goals revealed that both groups were generally quite similar in their views about these aspects of practice. Social work managers ($M = 4.49$, $SD = .72$) were, however, less staunch than non–social work managers ($M = 4.61$, $SD = .61$) in the belief that clients must maintain sobriety while in treatment ($t = -2.03$, $p < .05$). These groups did not differ in the strength of their belief that, for treatment to be effective, clients must acknowledge they have a substance abuse problem ($M = 4.49$, $SD = .70$), accept personal responsibility for their recovery ($M = 4.66$, $SD = .54$), learn new ways of dealing with personal problems and stress ($M = 4.60$, $SD = .58$), gain insight about the role substance abuse plays in their lives ($M = 4.45$, $SD = .69$), and realize they will never use particular substances again ($M = 4.44$, $SD = .89$). Managers were generally less strong in their support of the belief that clients must "hit bottom" or experience a personal crisis of some kind for treatment to be effective ($M = 3.21$, $SD = .89$).

Managers in both groups strongly supported the belief that abstinence is an important treatment goal ($M = 4.80$, $SD = .54$). Managers also generally endorsed as important treatment goals emphasizing emotional well-being ($M = 4.86$, $SD = .39$), stable relationships ($M = 4.78$, $SD = .50$), good physical health ($M = 4.75$, $SD = .49$), meeting legal mandates ($M = 4.65$, $SD = .63$), steady employment ($M = 4.58$, $SD = .66$), and improved spiritual strength ($M = 4.53$, $SD = .68$). Managers strongly disavowed a belief in controlled drinking as a treatment goal ($M = 1.88$, $SD = 1.39$).

Discussion

These data reveal a number of interesting and important findings about managers and their beliefs about substance abuse practice. First, these data indicate that, by the late 1980s, a substantial proportion of managers (28.0 percent) in this sector had some background in social

Table 2

Comparison of Social Work and Non–Social Work OSAT Managers' Beliefs about Substance Abuse

Approaches and Beliefs	Social Work Managers			Non–Social Work Managers			All Managers			Statistic	N
	%	*M*	*SD*	%	*M*	*SD*	%	*M*	*SD*		
Ideological approaches to substance abuse treatment											
Disease	28.6			25.1			26.1			$\chi^2 = .72$	575
Psychological	41.0			38.4			39.1			$\chi^2 = .33$	575
Ecological		19.10	1.18		18.94	1.65		18.98	1.53	$t = -1.10$	553
Harm-reduction		9.75	3.00		9.21	3.19		9.37	3.14	$t = -1.80$*	542
Beliefs about hiring practices											
Professional degree		4.29	.86		4.10	1.01		4.15	.97	$t = -2.06$**	553
Substance abuse work experience		4.30	.81		4.31	.87		4.31	.85	$t = .12$	554
Specialized training in substance abuse		4.36	.77		4.41	.86		4.40	.85	$t = .67$	553
Personal history of substance abuse		2.52	1.11		2.50	1.15		2.51	1.14	$t = -.15$	554
Certification in substance abuse counseling		3.56	1.06		3.65	1.21		3.62	1.17	$t = .82$	553
Supervised clinical experience		4.53	.77		4.63	.64		4.60	.68	$t = 1.56$	554
Beliefs about staff effectiveness											
Ex-addicts more effective		2.98	1.15		3.11	1.18		3.07	1.17	$t = 1.15$	554
Professional staff more effective		3.55	1.10		3.22	1.23		3.31	1.20	$t = -2.90$**	552
Ex-addict staff more effective with client denial		2.83	1.15		2.89	1.27		2.87	1.24	$t = .56$	553
Professional staff more objective		3.53	1.14		3.17	1.18		3.27	1.18	$t = -3.26$***	554

NOTE: OSAT = outpatient substance abuse treatment.
*$p < .05$. **$p < .01$. ***$p < .001$.

work. These numbers were substantially larger than those reported about the representation of social workers among practitioners in this sector (Magura, 1994). As managers, these social work professionals were in a position to influence program policies and practices. A second important finding from this study is the general lack of support demonstrated by managers for a characterization of substance abuse as a disease caused by heredity or other biological factors. Regardless of their educational background, more OSAT managers endorsed a view of substance abuse problems as stemming from psychosocial factors, such as a lack of social skills, poor coping strategies, symptoms of an underlying psychological disorder rather than heredity, a biological predisposition, or disease.

Managers repeatedly endorsed beliefs supporting an abstinence-based approach to substance abuse treatment. These findings suggest that service providers do not necessarily link the disease and abstinence approaches. More specifically, providers may take a variety of positions about the etiology of substance abuse problems and still conclude that abstinence is vital to intervention. Furthermore, although social work managers tend to endorse abstinence as an approach to care, they are less likely than non–social work managers to believe that abstinence must be maintained for treatment to be effective. This finding is important because it suggests that social work managers may hold a different view of the relationship between relapse and recovery. Social work managers were more inclined than non–social work managers to accept relapse as a part of the recovery process and to establish policies that allow clients to continue in treatment even if they relapse. Social work managers were also more supportive than non–social work managers of a harm-reduction approach to HIV/AIDS prevention with AOD clients, perhaps also reflecting a willingness to be more flexible about the role of abstinence to practice in substance abuse settings.

This study indicates that a range of views about substance abuse are represented in the field. Whereas there is a good deal of support for abstinence-oriented approaches to practice among social work and non–social work managers, there also is widespread support for psychosocial and ecological approaches as well. In fact, few differences existed between social work and non–social work managers in their perspectives on etiology and intervention with substance abuse problems. In part this may be because of the way information was gathered from managers. Survey items allowed managers to indicate their level of support for various beliefs rather than choose one perspective over another, as in a "forced-choice" format. Future research using a different question format might more clearly differentiate among managers in their adherence to particular ideologies of care.

That beliefs about care not based on disease or abstinence are widespread among non–social work managers may reflect the influence that social work and other professional practitioners have on the field. This survey did not inquire into the nature and extent of exposure to social work courses non–social work managers accumulated without acquiring a degree. Non–social work managers may be exposed to psychosocial or ecological approaches to care through continuing education or professional development activities aimed at maintaining licensure or accreditation status. Also, given the strong ties among disease, abstinence ideologies, and the recovery movement in particular 12-step programs, variation in beliefs about practice may be more related to differences in recovering and nonrecovering status than to educational status. Exploring differences in beliefs among managers based on their status as recovering–nonrecovering persons is not possible with these data but would also be an important part of future research efforts.

Finally, it is important to consider the difference in emphasis placed by these two groups of managers on the value of professional education to substance abuse practice. Social work managers were stronger than non–social work managers in their belief about the importance of a professional degree to hiring practices and staff effectiveness. Further research is needed to understand the meaning and significance of these findings. More specifically, are social work managers' beliefs reflective of a commitment to the role of social work professionals in substance abuse practice, or do their beliefs encompass support for involvement by other types of

professionals as well? What specific values, beliefs, or skills do managers believe professionals bring with them into the service setting that result in their being more objective and more effective, and how are these values, beliefs, or skills related to ideologies of care? ■

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