

# **A Qualitative Exploration Of The Obstacles And Contributing Factors To The Effectiveness Of Addiction Treatment Programs: Perspectives From Social Workers**

**Bander Sloum Al Lahyani\*, Turki Ali Alasmari, Waleed Mohammed Al Qasim, Hatem Abdullah Alharbi, Sabriah Abdulelah Al Sadi, Fatima Sawed Al Bahri, Saeed Salih Gharmallah Al Ghamdi, and Essam Ghalib Sulaiman Alqurashi**

*Irada and Mental Health Complex - Irada Services, Jeddah, Makkah Region, Saudi Arabia.  
\*Corresponding Author e-mail [bndral.8181@gmail.com]*

## **Abstract**

Substance use disorders are an important health concern in the world as well as a major health challenge faced by a large number of individuals in the world today that are characterized by great challenges to access and complete evidence-based treatment. Social workers are the frontline professionals in addiction treatment centers, and they have a distinct understanding of the intertwining of systemic, organizational and individual factors that affect the outcomes of treatment. This qualitative literature review integrates the evidence on obstacles and facilitators to effective treatment of substance use disorder with specific focus on the social work perspective and role. The review mentions multi-level barriers such as systemic resource limitations, organizational disintegration, geographic inequality, individual socioeconomic issues, and widespread stigma. At the same time, it discusses such facilitators as integrated care coordination, the implementation of evidence-based practice, the sufficient staffing and financial resources, and the organizational commitment to continuous quality improvement. The paper has implications on social work practice at micro, mezzo, and macro levels by highlighting how social workers can promote person-centered, trauma-oriented, and culturally competent care and policy changes that increase equitable access to care. These results highlight the importance of considering treatment barriers as a multi-level issue that needs to be overcome through policy reform, organizational capacity building, clinical workforce development, and community-level support systems making social work a critical component of the change effort in substance use disorder treatment systems.

**Keywords:** Obstacles, Contributing, Addiction Treatment Programs, Social Workers.

## **Introduction**

Substance use disorders (SUDs) are a serious global health issue that poses a threat to people, families, and communities. Although there exist evidence-based treatment methods, several addicts have serious obstacles to their access and completion of treatment programs. The frontline professionals working in the addiction treatment settings are social workers, who can have a special insight into the intricate combination of barriers and enablers that can influence the results of treatment. The clinical intervention, case management, advocacy, and systemic coordination of these activities are not exhaustive roles of social

workers in prevention and treatment of alcohol and drug addiction, which is one of the biggest health and social problems (Daley and Feit, 2013).

There is an abundance of literature that reports systemic obstacles hindering access and retention to treatment. In a prospective qualitative study of substance use disorder treatment providers, Ashford, Brown, and Curtis (2018) found that systemic barriers impeded the effectiveness of treatment of the identified problem, and the organizational and structural constraints were viewed as the key barriers. In the same manner, McNeely and colleagues (2018) established that the barriers and facilitators to substance use screening in primary care clinics are a result of patient, provider, and institutional staff interaction, which means that treatment barriers are not solitary but deeply rooted in the structure of organizations and human relationships. In their study of retention in substance use disorder treatment within an adolescent population, Acevedo and colleagues (2020) illustrated that the effect of various barriers, facilitators, and disparities combine to determine retention in treatment, showing that demographic and systemic factors form different treatment experiences among populations.

In addition to the barriers on an individual level, geographic and economic factors also make it complicated to access treatment. Browne and colleagues (2016) underlined the idea that rural communities have unique barriers and facilitators to substance use treatment, implying that place-based influences on the context are considerable determinants of treatment access and usage. At the same time, Sarkar, Tom, and Mandal (2021) found the barriers and facilitators unique to low- and middle-income nations in the qualitative review synthesis and highlight the necessity of a localized perspective on treatment planning and the fact that treatment issues differ significantly depending on economic and geographic contexts. Full systematic literature review of patient-reported barriers and facilitators in multiple dimensions in the study by Cernasev et al. (2021) has shown that this problem is multifactorial, and patients with substance use disorders face barriers and facilitators across different dimensions during their treatment journeys. Also, a wider summary of systematic reviews by Farhoudian and colleagues (2022) considered barriers and facilitators to treat substance use disorders worldwide, and the trends and themes in them that do not depend on a particular population but show the universal problematic dimension of enhancing treatment utilization and outcomes.

However, with these enables there are some vital facilitators and strengths that need to be looked at. There has been a recent effort to study positive factors and recovery processes that have led to the improvement of the effectiveness of treatment. Vanderplasschen et al. (2025) discussed the topic of specialist substance use and addiction treatment as a component of recovery capital, which can be redesigned to promote the protective environment, community relations, and client strengths as recovery pathways. Moreover, systematic approaches to social work interventions have been proven to be good as research indicates social work intervention using systematic approach leads to better general health outcomes among individuals addicted to opioids in treatment centers, which justifies the idea that planned coordinated social work treatment can increase treatment outcomes (Raheb et al., 2016). Moreover, Russell and colleagues (2025) studied the discourse of substance use disorder recovery on social media platforms and found that personal recovery stories and social support make an addition to the larger discussion of treatment and healing, meaning that recovery is beginning to be treated as a social and relational process that is facilitated by a network of peers and experiences.

Moreover, primary care environments can be discussed as one of the areas where the barriers to and facilitators of treatment can be better comprehended. Ross and colleagues (2015) completed a qualitative study on the barriers and facilitators to primary care between individuals with mental health and substance use issues, proving that the barriers to treatment do not only exist solely within specialized addiction programs but also are also aspects of primary care providers as key points of interaction with people who require support. Recently, network analysis has been utilized by Serre and colleagues (2025) to analyze the ecological momentary assessment data to determine predictors of substance use during treatment to addiction, which offers complex empirical evidence regarding the dynamic nature of factors

that influence treatment processes and the multifaceted interplay of personal and environmental and treatment related factors that determine recovery processes.

Although this is accumulating evidence, there are still gaps in the research as to how social workers specifically perceive, negotiate and resolve these impediments and facilitators in their day-to-day practice. Social workers have a unique role in the world of clinical care, advocacy, and systemic change, which means that their views are vital to creating more effective and equitable addiction treatment interventions. This qualitative inquiry aims to introduce the field of social work to the discussion on the effectiveness of treatment by exploring the barriers and the factors that drive the results of addiction treatment as perceived by social work researchers and practitioners.

## **2- Barriers to Substance Use Disorder Treatment**

The treatment systems of substance use disorder (SUD) have deep structural and organizational issues that considerably hinder the effectiveness of treatment and client outcomes. These barriers exist on various levels- macro level policy and financing structures and micro-level client related factors- forming complex barriers that need a thorough understanding. This literature review summarizes the studies of the barriers to substance use disorder treatment, exploring the systemic, organizational, access-related, individual, and contextual barriers that influence the treatment engagement and outcomes. The insight of these complex barriers will be crucial in creating specific interventions and policies that would enhance the accessibility, engagement and effectiveness of treatments among different populations and geographic environments.

### **2-1 Systemic and Organizational Barriers.**

The systemic and organizational barriers mean structural restrictions, institution policies, inefficiencies in procedures and failures in inter-organizational coordination, which impedes the capability of individuals to access, participate, and obtain substance use disorder treatment. In contrast to individual-level barriers that can be found within personal situations, systemic barriers are found within the system of treatment and are manifestations of larger organizational cultures, resource distribution choices, and policies (Ashford et al., 2018). These obstacles usually work behind the scenes and are institutionalized in daily practice but they greatly influence treatment experiences and results of the client's seeking attention. The systemic barriers are pervasive in nature, which means that to enhance access to and quality of treatment, it is necessary both to implement measures on an individual level, as well as to restructure the treatment systems and policies to the core.

#### **2-1-1 Structural and Institutional Constraints.**

A case study on the attitudes of addiction treatment workers has shown that the organizational structure and institutional design pose serious barriers to quality delivery of treatment. A prospective qualitative study of Ashford, Brown and Curtis (2018), in the sphere of professionals in the field of treating substance use disorders, revealed that the potential barriers to the capacity and quality of the treatment's programs are systemic, and they can be seen through inadequate funding, insufficiency staffing, absence of integrated care coordination, and service fragmentation. The structural constraints drive the treatment providers to tough choices concerning the use of the resources, which leads to waitlists, fewer session opportunities, and lower levels of service intensity among clients requiring holistic care. The treatment capacity scarcity serves a gatekeeping role in which only those who are most severely affected receive treatment and many with large issues are left untreated.

The interagency fragmentation or distribution of treatment services among various agencies and providers is one of the most dramatic organizational barriers. There is a tendency to have treatment systems in isolation whereby various programs on substance use disorders, mental health, medical care and social services are independent of each other and lack sufficient coordination mechanisms. This fragmentation brings about gaps in care, duplication of assessment, inconsistent treatment planning, and confusion to the clients who are experiencing a variety of systems at the same time (McNeely et al., 2018). The absence of

a unified care delivery necessitates clients to become their own case managers, which most are ill-prepared to play at the time they are dealing with active addiction or early recovery. This discontinuity applies to the patient with co-occurring substance use and mental health conditions, who is a population that constitutes a big percentage of people seeking treatment (Daley and Feit, 2013).

Although organizational policies and administrative procedures are usually aimed at achieving accountability and quality, they can unintentionally act as a hindrance to access to treatment and engagement. Insurance demands, credentialing, licensing regulations and intake procedures often slow down the initiation of treatment or place onerous demands on the clients. As an illustration, the intake processes can be discouraging and lead to people not starting the treatment or to the withdrawal in the pre-treatment stage because of the lengthy intake tests, repeated information collection with numerous providers, and complicated proof of eligibility (McNeely et al., 2018). Also, financial limitations can create and promote policies on the length of treatment and the number of sessions per session, and discharge variables, which could restrict the extent and length of care required by individual clients to recover. The services are not available to all of the most vulnerable patients with complex treatment requirements due to restrictive policies about the kind of person that can get treatment, including those who have certain diagnoses, legal histories, or previous treatment failures (Cernasev et al., 2021).

### **2-1-2 Staffing Barrier and Workforce Challenges**

The barriers that are faced in the organization regarding the treatment workforce also play a major role in determining the capacity and quality of delivery service. Treatment programs of substance use disorders have a significant problem in the recruitment and retention of qualified workers that have a high turnover, little supervision, and low training opportunities. Staffing shortages compel current clinicians to have too many cases to attend to and leave them with less time and attention to focus on a single client and cause burnout and job dissatisfaction among the clinicians. Financial constraints in the development of staff, remuneration, and career progression opportunities in the workforce lead to workforce instability and could cause less competent or less experienced staff to offer treatment services. This instability in the workforce is especially concerning in the light of the fact that the quality of treatment is heavily reliant on the competence of the clinicians, therapeutic alliance, and the commitment of the clinicians to the difficult task of addiction treatment.

The dearth of expertise in evidence-based practices, cultural competence, and trauma-informed care is an organizational hindrance that has an impact on the quality of the treatment. Unless the treatment organizations invest in staff development and training, the clinicians in the field might be using old models, and in the process unwittingly propagating stigma or not recognizing and treating the histories of trauma that often coexist with substance use disorder (Daley and Feit, 2013). Not only is the social work profession better placed to mitigate the workforce development barriers by means of supervision, consultation and organizational leadership due to its knowledge in the area of systemic change, advocacy and strengths-based practice. With proper support and training of social workers in treatment organizations, they can be changing agents to enhance quality and access to treatments. It has been shown that the systematic approach to social work intervention can increase the overall health outcomes in people with opioid addiction in the treatment center, and this fact allows stating that systematic, coordinated social work intervention can promote treatment efficacy (Raheb et al., 2016).

### **2-1-3 Resource Allocation and Funding Barriers**

Inadequate and discontinuous funding is one of the systemic barriers that reflect in treatment organizations. Treatment programs are run with chronic resource limit and have to make choices of priority thus influencing the scope, quality, and access of services. Low budgeting can lead to inadequate quantities of treatment spots, waitlists that do not prompt the creation of care, fewer than three weekly sessions, moderate-income access to medication-assisted treatment, and the failure to provide multifaceted, wraparound services that can fulfill the needs of clients (Ashford et al., 2018). The instability of funding,

especially relying on grant funding or unreliable insurance reimbursement, brings uncertainty to the organization and restricts the ability to plan in the long run. This uncertainty makes it impossible to invest in infrastructure development, employee development or technology enhancement that could enhance service quality in treatment organizations.

Another barrier to resources is the discrepancy between the requirements of the evidence-based treatment and funding mechanisms. The models of reimbursement based on fee-for-service can encourage short, intermittent care even though extensive treatment over longer periods has shown better results with a range of clients. On the other hand, the low rate of reimbursements on specific services can make programs unwilling to provide those services despite the requirements of the clients, which are clinically necessary. These monetary pressures and limits are characteristics of the structure of treatment systems that define the nature of services offered regardless of clinical evidence or client demands (Cernasev et al., 2021). Also, unequal financing of regions will result in unequal access to care with resource-rich urban centers getting more investment compared to rural and low-income urban centers. Table (1) illustrates the nested levels of systemic and organizational barriers by showing how treatment barriers affect different organizational levels and layers, and the interrelated effects of treatment barriers on client access and quality of treatment. References are given to publications that report obstacles at all levels.

**Table 1: Levels and Examples of Systemic and Organizational Barriers to Substance Use Disorder Treatment**

Level of Barrier	Specific Examples	Primary Impact on Treatment	Source
Institutional/Organizational Level	Fragmented services, inadequate staffing, limited funding, outdated policies, organizational silos, lack of integrated care	Reduced treatment capacity, poor care coordination, prolonged waitlists, reduced service quality, limited treatment intensity	Ashford et al., 2018; McNeely et al., 2018
Inter-organizational Level	Lack of referral pathways, poor communication infrastructure, competing organizational priorities, absent partnership agreements, siloed electronic health records	Gaps in care, treatment discontinuity, client confusion, duplication of services, missed opportunities for coordinated care	McNeely et al., 2018; Ross et al., 2015
Workforce Level	High turnover, insufficient training in evidence-based practices, excessive caseloads, low salaries, limited supervision, inadequate professional development	Lower service quality, clinician burnout, less experienced staff, inadequate clinical oversight, reduced therapeutic alliance	Daley & Feit, 2013; Ashford et al., 2018
Resource/Financial Level	Inadequate and unstable funding, reimbursement misalignment with evidence-based practices, insurance authorization delays, funding disparities by region	Limited services, inability to offer comprehensive treatment, waitlists, reduced treatment intensity, unequal access across regions	Cernasev et al., 2021; Ashford et al., 2018

Policy/Regulatory Level	Restrictive intake policies, exclusionary criteria, duration/frequency limits driven by finances, licensing barriers, insurance requirements	Restricted access for vulnerable populations, suboptimal treatment intensity, delayed care initiation, administrative burden on clients	McNeely et al., 2018; Cernasev et al., 2021
Policy/Systemic Level	Criminalization of addiction, fragmented national policies, competing health priorities, inadequate integration into primary care	Deterred help-seeking, systemic inefficiency, access obstacles, inadequate prevention and early intervention	Farhoudian et al., 2022; Sarkar et al., 2021

## 2-2 Access and Location Clusters

Substance use disorder treatment is an important issue, especially in rural, underserved, and low-resource communities. The geographic barriers, such as the shortage of treatment, transportation, and poor infrastructure create great obstacles to the initiation and engagement of treatment. The imbalanced geographic allocation of treatment facilities as a matter of fact establishes a de-facto system of treatment have and have-not, wherein residence location is primarily a determinant of care availability irrespective of clinical need or personal preparedness to be treated.

### 2-2-1 Barriers to Accessing Rural Treatment

Systemic barriers to accessing treatment opportunities include the geographic location of treatment resources, especially to those living in rural and underserved areas. The treatment programs are usually concentrated in the urban areas resulting to geographic distance between the rural population and care. Browne, Priester, Clone, Iachini, DeHart, and Hock (2016) qualitatively studied obstacles and facilitators to substance use treatment in rural south and found that geographic isolation, transportation infrastructure, lack of treatment providers, and lack of service varieties were important obstacles in rural settings. Where they are available, rural treatment programs usually have small capacity, reduced special services (including medication-assisted treatment), and staff that are less trained in evidence-based practices. All these circumstances imply that the rural population with substance use disorders has significantly limited opportunities to get it and have to travel long distances in order to use the specialized services.

Also, rural populations may have special cultural determinants, increased social stigma, and increased familiarity between providers and clients, posing confidentiality and privacy challenges that further reduce the willingness to seek help. Lack of specialized treatment in rural locations implies that in those locations individuals have to spend a significant distance of their life in search of treatment which can be prohibitive when people have low financial means, unreliable means of transportation, children, or work commitments (Browne et al., 2016). In rural adolescents especially, geographic remoteness inter-relates with developmental issues and lack of peer support to place especially high barriers on access and retention to treatment.

### 2-2-2 Infrastructure and Transportation barriers

The infrastructure barriers involve poor telehealth infrastructure, inappropriate technology system, poor electronic health record capacity, and poor communication technology to facilitate organization coordination. Such infrastructure constraints impact rural and low-resource environments especially, with treatment organizations potentially not having simple technological infrastructure to coordinate care, monitor client progress, and exchange information safely between providers (Sarkar et al., 2021). Additionally, there are practical barriers to regular treatment due to poor infrastructure in the form of inadequate public transportation, high prices of own registered transportation and distance between treatment units and the homes of treatment clients. Transportation-related challenges can also overburden the unemployed, poor, or those without quality vehicles—groups of people that tend to have high prevalence

of substance use disorders (McNeely et al., 2018). The cost of getting to the location of the more frequent treatments can be too hard to bear by the already disadvantaged person, which will lead to missed appointments and disengagement in treatment.

## **2-3 Personal and Patient-Individual Barriers**

Although systemic barriers establish the structural environments in which people can access treatment services, individual and patient-related factors influence whether and how people access the existing treatment services. These obstacles are personal factors, attitudes, conditions, and experiences that affect the conduct of seeking treatment and participation. It is necessary to understand the individual level barriers in order to design the person-centered interventions that would tackle the barriers and build on the individual strengths and resources.

### **2-3-1 Demographic and Socioeconomic Barriers**

The socioeconomic status of substance use disorders is often poorly defined, poorly educated, unemployed, and unstable in their housing status and poor, which alone presents obstacles to treatment access and participation. The direct treatment costs, transportation costs, costs of childcare during treatment, and lost income during participation in treatment are among the financial barriers. Acevedo, (2020) studied barriers, facilitators, and disparities in adolescent treatment retention and revealed that demographic disparities (according to race, ethnicity, socioeconomic status, and gender) had a strong impact on retention in treatment and adolescents of low-income families had higher treatment dropouts than minority adolescents. This observation underscores the interplay between the unique demographic features of individuals and the systematic injustices in order to pile disadvantages on the most vulnerable groups.

Social disadvantage overlaps with other personal barriers to compound the impediments of treatment. Homeless people or those who have housing instability encounter specific difficulties in participating in outpatient care that must be attended on a regular basis and have balanced contact information. The parties who are part of the criminal justice system might encounter conflicting requirements between the legal mandate and treatment attendance, whereas those with childcare duties might have a hard time attending treatments and managing family needs. Numerous people experience many of the disadvantages in a way that intersects to form intersectional barriers such that race/ethnicity, poverty, gender and other marginalized aspects converge to produce particularly significant barriers to accessing and retaining treatment (Ross et al., 2015).

### **2-3-2 Knowledge and Health Literacy Barriers**

The lack of awareness regarding substance use disorders such as health conditions, lack of knowledge regarding existing treatment sources, and limited health literacy develops information-related obstacles to treatment. Even many individuals and families are not aware that there are evidence-based, effective treatment options or they have a misconception of treatment options, expectations of recovering and treatment time. This knowledge gap can lead to the delay in help being sought, the poor choice of treatment, or a premature end of the treatment process because expectations are unmet. Also, low health literacy can be a barrier to the health literacy of individuals navigating through complex insurance systems, comprehending treatment documents and agreements, and communicating efficiently with healthcare providers regarding their needs and concerns (Cernasev et al., 2021).

### **2-3-3 Co-morbidity of Health and Mental Health**

A huge number of patients with substance use disorders have a comorbid mental disorder, a chronic medical condition, or both, presenting further treatment needs. In a scenario where the treatment programs lack sufficient resources to manage the co-occurring conditions, they might fail to get treatment or obtain treatment in bits, only focusing on substance use and overlooking the vital mental health or medical needs. Depression, anxiety, trauma or chronic pain, without any treatment, may weaken the motivational factor towards substance use treatment and lead to higher rates of treatment dropout. The fact that numerous

conditions are managed together makes the management process complicated and necessitates coordinated treatment of the conditions that cuts across a variety of service sectors an arrangement that is hardly realized in systematically disjointed treatment systems (Daley and Feit, 2013).

## 2-4 Stigma and Social Barriers

Stigma The negative attitudes, beliefs and stereotypes of people with substance use disorders is a potent inhibitor of seeking and engaging in treatment. Both the public stigma (stigmatizing attitudes of society) and self-stigma (negative beliefs of addicts themselves) prevent help-seeking and create barriers to recovery. Stigma functions as a social process that marginalizes the sub-population of people with substance use disorders, limits their access, reduces social support, and forces them to bear a psychological burden making it difficult to treat. Figure 1 displays a detailed flowchart of the mechanisms of operation of barriers to substance use disorder treatment achieved through multiple systems levels namely, macro-level, organizational-level, inter-organizational-level, geographic/infrastructure-level, individual-level and stigma-related level and how these barriers interact to decrease access to treatment, delay treatment initiation, decrease retention and ultimately worsen treatment outcomes.

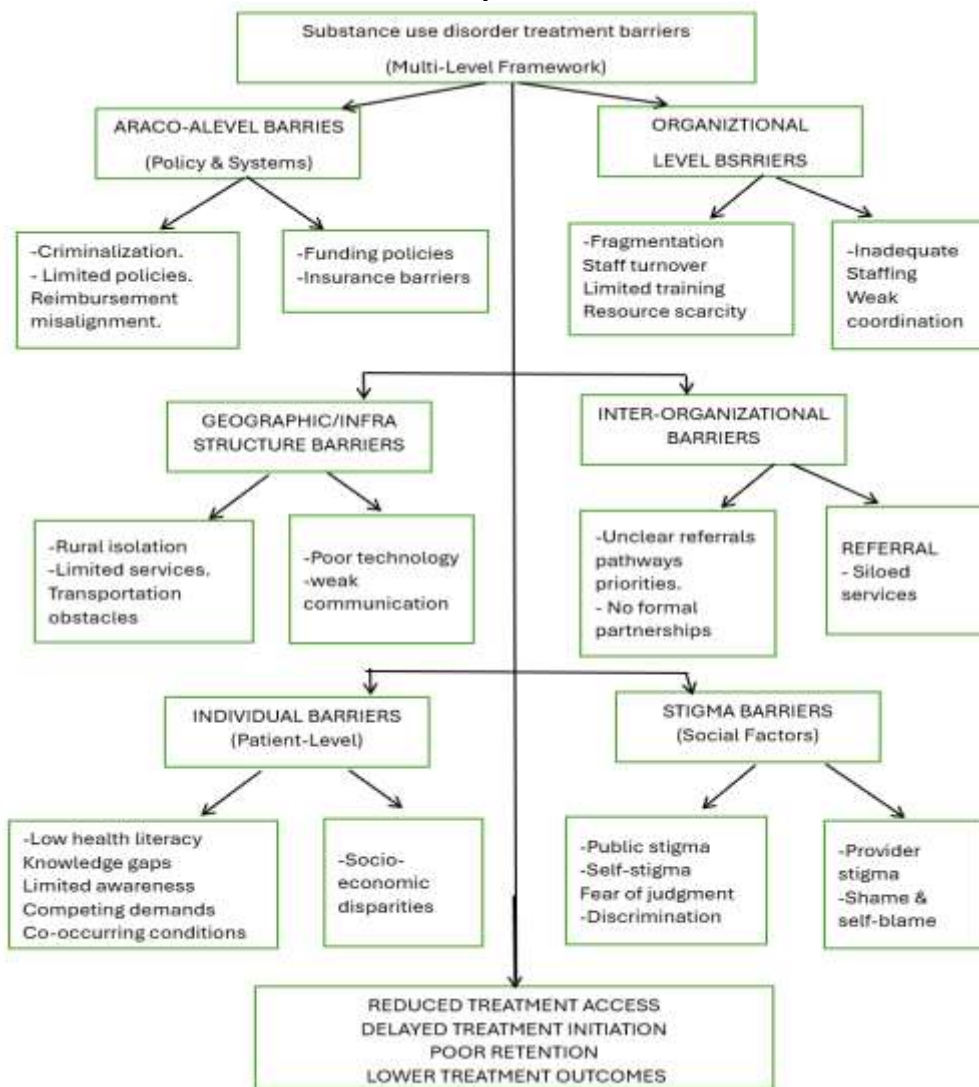


Figure 1: Flowchart of Barriers to Substance Use Disorder Treatment Across System Levels

### 2-4-1 The barriers are interconnected in nature

A notable conceptualization that has been derived as a result of the research is that obstacles to substance use disorder treatment are not self-contained but rather closely interdependent challenges existing within a multi-tiered system. In a rounded review of systematic reviews by Farhoudian, Razaghi, Hooshyari, Noroozi, Pilevari, Mokri, and Malekinejad (2022), barriers and facilitators to treatment of substance use disorder were examined in a number of studies; it was observed that barriers at the various levels of the treatment system interact and compound each other. As an illustration, insufficient funding (systemic barrier) can lead to a lack of sufficient staffing (organizational barrier), sufficient treatment slots, which will add to the waitlists (access barrier), which will cause people to lose motivation and fail to start receiving treatment, which will make them feel more ashamed and stigmatized when their condition gets worse (individual and stigma barriers). This successive chain reaction of correlated barriers produces cumulative disadvantage in which primary barriers of the system produce secondary and tertiary barriers which compound access to treatment more and more difficult.

The nature of barriers being interconnected implies that a barrier when addressed in isolation may have little effect when other barriers are still not addressed. As an example, creating new treatment slots (reducing access barriers) will change little when people are unable to pay transportation to access treatment (geographic/infrastructure barrier), are afraid of legal penalties when they disclose substance use (policy barrier), or perceive excessive stigma that intervenes to take help-seeking (stigma barrier). This structural approach implies that there is a need to use multi-level interventions in order to help significantly improve treatment access and effectiveness. The single-level response options, including enhancing the skills of individual clinicians without mitigating the resource limitations in the system or trying to reduce stigma without enhancing access to treatment, are not likely to help deliver sustainable improvements to treatment access and quality (Cernasev et al., 2021).

### **3- Facilitators and Strengths in Addiction Treatment Programs**

Despite all barriers to treatment systems, the substance use disorder systems have their own facilitators and strengths which allow support the treatment engagement, retention, and recovery outcomes. Although it is paramount to realize the obstacles and thus identify the factors that pose challenges, it is also important to realize the facilitators, the resources, the protective factors that help individuals to receive treatment, continue on the difficult path, and sustain a lasting recovery. Facilitators work at the same levels of the multiple system of barriers, macro-levels of policy support and organizational strengths to individual resilience and peer support, which creates the opportunity of positive treatment, engagement and results. The literature review focuses on facilitators and strengths of addiction care in the synthesis of literature on systemic support, organizational capacity, factors in treatment-related relationships, individual strengths and motivation, community resources, and creative ways of facilitating treatment access, effectiveness, and client outcomes. The awareness of these facilitators can give crucial information regarding the creation of strength-based interventions and policies that can utilize all available resources and develop new abilities to enhance the outcomes of substance use disorder treatment among diverse populations and environments.

#### **3-1 Humbert and Systems Facilitators**

Policies, institutional practices, funding mechanisms, and structures are systemic and organizational facilitators that promote access, quality, and effectiveness of treatment. These facilitators work at macro and organization levels to establish enabling conditions in which treatment may thrive, and people can enter into recovery processes successfully.

##### **3-1-1 Combined Care and Service Co-ordination**

The use of integrated care models to synchronize substance use disorder treatment with mental health care, primary care, and social services are important facilitators to enhanced treatment outcomes. Once the treatment organizations form formal collaborations, create joint electronic health records, implement single-intake mechanisms, and develop effective communication standards, the people receive integrated, holistic care to fulfill multiple needs at the same time. McNeely, Kumar, Rieckmann, Sedlander, Farkas, Chollak,

and others (2018) analyzed the barriers and enabling factors in the implementation of substance use screening in primary care clinics and found that organizational facilitators are integrated electronic health records, defined communication procedures with the addiction specialists, specific personnel on the care coordination, and developed referral channels. With these coordination mechanisms, primary care providers can detect substance use at an early stage and refer people to relevant treatments without any losses or delays in care. Integrated care also leads to a decrease in assessment and treatment planning duplication, client confusion in competing treatments, and providers of various fields to collaborate in reaching common goals of recovery. Successful integration also causes clients to feel that they are treated as a coherent system instead of fragmented services, enhancing the interactions and the results (McNeely et al., 2018; Ross et al., 2015).

The integration of mental health and substance use services, also known as integrated behavioral health, is an especially useful approach to people with co-occurring disorders. A closer collaboration between addiction specialists, mental health providers, and primary care physicians is beneficial because it enhances communication, is more effective in the treatment planning process, and provides the clients with comprehensive care that will meet all their needs. The studies indicate that the integrated models of care lead to lower hospitalization and emergency department visits, and treatment expenses and increased client satisfaction and treatment outcomes. Having care coordinators or case managers who assist clients in navigating the integrated system and continuity across the providers is a significant organizational facilitator which decreases the burden on clients and enhances engagement in treatment (Ross et al., 2015; McNeely et al., 2018).

### **3-1-2 Evidence-Based Program Implementation.**

Adoption of evidence-based treatment practices is one of the important organizational facilitators that enhance the quality and efficacy of treatments. Evidence-based practices which include cognitive-behavioral therapy, motivational interviewing, contingency management, and medication-assisted treatment are some of the practices that treatment organizations adopt and maintain in order to offer their clients the interventions that have been proven to be effective through rigorous research. The authors (Ashford, Brown, and Curtis, 2018) used a prospective qualitative study involving professionals working with substance use disorder and concluded that organizational facilitators are commitment to the evidence-based practice, training of the staff in those practices, the use of clinical supervision that ensures adherence to the evidence-based practices, and the processes of continuous quality improvement. When the organizations focus on training personnel on evidence-based practices and offer sufficient supervision, clinicians will produce a better quality of treatment, clients will engage in more positive therapeutic relationships, and outcomes will become better. Moreover, the application of measurement-based care, which is the regular assessment and monitoring of client progress by the provider with the help of validated instruments, allows treatment providers to track the results and modify treatment in case of inadequate progress, preventing premature discharge and promoting sustained engagement (Ashford et al., 2018; McNeely et al., 2018).

Companies with a culture of continuous improvement and learning provide spaces in which staff are encouraged to refine their practice and keep up with new evidence and adjust their methods according to feedback and outcomes data provided by clients. With organizational leadership incorporating values of evidence-based practice and investing in staff training and development, clinicians will experience their support in professional growth and will feel more competent to meet the needs of complex clients. It is an organizational commitment to quality improvement as one of the key facilitators since the effectiveness of the treatment is ultimately determined by the competence of the clinicians and competence is improved through training, supervision, and lifelong learning facilitated by the organizational infrastructure (Ashford et al., 2018; Cernasev et al., 2021).

### **3-1-3 Proper Financing and Staffing.**

Adequate and stable funding is a pillar organizational facilitator that helps the treatment organizations to be able to run smoothly and provide services to their communities in a comprehensive manner. Organizations that have consistent financial support in terms of funding can afford to have consistent staffing, invest in staff development and supervision, have adequate treatment slots, limit waitlists, and provide multifaceted services to meet the needs of multiple clients. Sufficient resources allow organizations to invest in technology infrastructure, clinical supervision, outcome monitoring systems, and quality improvement initiatives all of which increase the quality and effectiveness of treatment. Organizations that are adequately financed are in a position to offer the best salaries that attract and retain qualified employees, minimizing the rate of turnover and relationship with the clients. Long-term planning and investment in organizational infrastructure development to improve the treatment capacity and quality are also possible with stable funding (Ashford et al., 2018; Cernasev et al., 2021).

New funding models that match financial incentives with the evidence-based outcomes are valuable enablers of a better quality and effectiveness in the treatment. Treatment organizations can be motivated to pay attention to the outcomes of their clients and not on the number of services by value-based payment models, outcome-based contracting, and performance-based reimbursement. Organizations can afford to give proper intensity and duration of treatment when the reimbursement rates are based on the real costs of evidence-based treatment and can allocate sufficient time to thoroughly assess and design the treatment. On the other hand, in situations where funding is poor and reimbursement is low, the treatment organizations have to focus on financial survival and therefore neglect quality and end up making hasty assessments, poor treatment planning, and care that is not optimum. Sufficient funding is therefore a requirement to deploy other organizational facilitators and keep the organizational health to give effective treatment delivery (Ashford et al., 2018; McNeely et al., 2018).

### **3-1-4 People Management and Employee Care**

Investments in staff training, workforce development, clinical supervision, and professional development are also significant organizational facilitators that contribute to better treatment quality and clinician satisfaction. By focusing on staff development, the organization will train clinicians on competence on evidence-based practices, how to manage co-occurring conditions and acquire cultural competence that would allow them to work effectively with various populations. Clinical supervision, in which less experienced staff members are supervised by experienced clinicians, their work is assessed, and the clinicians trained to address the emotional burdens of addiction treatment, is a vital facilitator that enhances the quality of treatment and helps clinicians to survive in their work. Companies with sufficient supervision offer safer and more efficient treatment conditions and decrease burnout and the turnover of clinicians (Daley and Feit, 2013; Ashford et al., 2018).

Employee assistance programs, peer consultation groups, organizational acknowledgment of staff contributions are staff support programs that help to decrease burnout and raise staff dedication to the difficult job of treating addictions. When employees feel appreciated, encouraged, and esteemed by the leaders of the organization, they can be more motivated to deliver quality care and will not tend to quit their jobs. The social work profession is a profession that has the experience in the development of an organization, systems thinking, and advocacy, which makes it significant in facilitating the development of staff and health in organization. Social workers in supervisory and leadership roles can lead staff development efforts, provide conducive work environments and promote proper resources to support effective delivery of treatment. Social workers and other clinical leaders should promote their staff members to make them feel confident in delivering their best, which leads to better outcomes with clients (Raheb et al., 2016; Ashford et al., 2018).

## **4- Implications for Social Work Practice**

The treatment systems related to substance use disorders offer a lot of opportunities to social work practice at various levels of the system, which is based on the main values of the profession, which is the person-in-

environment point of view, social justice, and devotion to vulnerable populations. Awareness of barriers and facilitators to treatment can help social workers to promote evidence-based, fair, holistic practices to enhance access rates and outcomes of treatment.

#### **4-1 Micro-Level Practice: One-On-One Level of client interaction**

Direct practice social workers have the opportunity to adopt the strengths-based, recovery-oriented strategies and utilize the resources, resilience, and abilities that clients already have. Through thorough biopsychosocial evaluation, which can reveal not only the issues but also the strengths, relationships, and the achievements made in the past, social workers can make clients realize that they have a chance to change and imagine the way of recovery. Social workers are able to utilize motivational interviewing and person-centered practice that does not coerce but assists movement towards change, resulting in therapeutic relationships marked by empathy, respect and true collaboration. Social workers can promote in the clinical practice evidence-based treatment programs, specialized in trauma, cultural competence, and client-centered care that acknowledges the impact of systemic oppression, discrimination, and inequity on the life of individuals and mistrust in institutions. By doing this, social workers will also be able to make sure that the treatment is not only dealing with the substance use, but also with the employment, housing, family relationships, education, and other aspects of life that are critical towards the quality of life and long-lasting recovery. Social workers can assist clients in developing the full range of support networks they need to maintain engagement and achieve recovery through linking clients to wraparound services, peer support resources, and community-based recovery supports (Ashford et al., 2018; Russell et al., 2025).

#### **4-2 Mezzo Level Practice: Organizational and Program Development**

The social workers in the supervisory as well as leadership capacities can be the drivers to the evidence-based practice implementation, clinical supervision and staff support, and organizational cultures that put a premium on quality improvement and client outcomes. Social workers promote the competence of clinics and help to minimize burnout, which undermines the quality of care by promoting sufficient resources, training, and supervision. Social workers can be in the vanguard to incorporate substance use treatment with mental health services, primary care, and social services, eliminating silos that disintegrate care and overburden the clients. Social workers could develop and execute family involvement programs, integration of peer specialists, recovery community integration and other facilitators in the development of programs, which can lead to better treatment quality and outcome. Social workers may also be at the forefront to organize to hire and promote employees of racial and ethnic minority status, offer cultural competence training, and actively engage in efforts to establish antiracist and equal treatment practices. Social workers can use their ability to promote the culture of continuous quality improvement to make sure that organizations utilize outcome data in a systematic way to identify improvement areas and introduce evidence-based changes (McNeely et al., 2018; Ashford et al., 2018).

#### **4-3 Macro-Level Practice: Policy Advocacy and Systems Change**

Social workers are in a good position to champion policy amendments to increase access to treatment, eliminate obstacles and provide equitable services to people. Social workers can promote governmental investments in substance use treatment, insurance that covers treatment and comorbid mental health treatment, policies in favor of medication-assisted treatment and integration of treatment into primary care, decriminalization and diversion policies leading to less involvement of criminal justice and easing access to treatment, and policies in support of peer recovery support and community-based support. With policymakers, social workers can facilitate the development of policies and language that are recovery-oriented that can not just help with abstinence but also quality of life and community integration. Social workers can also increase the voices of individuals who have experienced addiction and recovery in advocacy work, making sure that the policy-making process involves and centers the voices of those who were most adversely impacted by substance use and the prevalence of treatment systems. Social workers may also act in order to overcome social determinants of health such as poverty, housing instability, employment barriers, discrimination, and absence of educational opportunity, which create vulnerability to

substance use and remaining barriers to treatment. Providing an opportunity to link substance use treatment expansion to the increased social justice and health equity initiatives, social workers can gain momentum towards a comprehensive and structural change (Farhoudian et al., 2022; Sarkar et al., 2021).

#### **4-4 Social Work Education and Professional Development Implications**

Social work education needs to equip students with skills of competence in substance use disorders, evidence-based practices of treatment, recovery-based practices, and skills in system change. The curriculum is to be developed based on the biopsychosocial character of addiction, evidence-based treatments and recovery support models, trauma and comorbid mental health issues, and cultural competence when dealing with populations at risk due to substance use. Social work students should also be trained in advocacy and policy change, which will allow graduates to pursue system-level changes that will broaden access to treatment and promote equity. Evidence-based practice, cultural competence, trauma-informed care, and emerging treatment innovations should be offered as professional development to practicing social workers. The area of practice excellence should be treated as a top priority by social work organizations and professional associations because social workers can do much to facilitate the development of the treatment system and promote recovery (Raheb et al., 2016; Ashford et al., 2018).

#### **Conclusion**

The social work practice related to treatment of substance use disorders consists of possibilities to assist people in recovery, build a holistic treatment program and organization, and promote policy reforms that would enhance access to treatment and perpetuate equity. Evidence-based practice, defining the voices of lived experience, focusing on systemic barriers and leveraging current strengths, and adhering to social justice can all play a vital role in helping social workers develop new treatment systems that promote equitable access to effective care and enduring recovery by all individuals suffering substance use disorders (Russell et al., 2025; Farhoudian et al., 2022).

#### **References**

1. Acevedo, A., Harvey, N., Kamanu, M., Tendulkar, S., & Fleary, S. (2020). Barriers, facilitators, and disparities in retention for adolescents in treatment for substance use disorders: a qualitative study with treatment providers. *Substance Abuse Treatment, Prevention, and Policy*, 15(1), 42.
2. Ashford, R. D., Brown, A. M., & Curtis, B. (2018). Systemic barriers in substance use disorder treatment: A prospective qualitative study of professionals in the field. *Drug and alcohol dependence*, 189, 62-69.
3. Ashford, R. D., Brown, A. M., & Curtis, B. (2018). Systemic barriers in substance use disorder treatment: A prospective qualitative study of professionals in the field. *Drug and alcohol dependence*, 189, 62-69.
4. Browne, T., Priester, M. A., Clone, S., Iachini, A., DeHart, D., & Hock, R. (2016). Barriers and facilitators to substance use treatment in the rural south: a qualitative study. *The Journal of Rural Health*, 32(1), 92-101.
5. Cernasev, A., Hohmeier, K. C., Frederick, K., Jasmin, H., & Gatwood, J. (2021). A systematic literature review of patient perspectives of barriers and facilitators to access, adherence, stigma, and persistence to treatment for substance use disorder. *Exploratory research in clinical and social pharmacy*, 2, 100029.
6. Daley, D. C., & Feit, M. D. (2013). The many roles of social workers in the prevention and treatment of alcohol and drug addiction: A major health and social problem affecting individuals, families, and society. *Social Work in Public Health*, 28(3-4), 159-164.
7. Farhoudian, A., Razaghi, E., Hooshyari, Z., Noroozi, A., Pilevari, A., Mokri, A., ... & Malekinejad, M. (2022). Barriers and facilitators to substance use disorder treatment: An overview of systematic reviews. *Substance abuse: research and treatment*, 16, 11782218221118462.
8. McNeely, J., Kumar, P. C., Rieckmann, T., Sedlander, E., Farkas, S., Chollak, C., ... & Rotrosen, J. (2018). Barriers and facilitators affecting the implementation of substance use screening in primary

- care clinics: a qualitative study of patients, providers, and staff. *Addiction science & clinical practice*, 13(1), 8.
9. McNeely, J., Kumar, P. C., Rieckmann, T., Sedlander, E., Farkas, S., Chollak, C., ... & Rotrosen, J. (2018). Barriers and facilitators affecting the implementation of substance use screening in primary care clinics: a qualitative study of patients, providers, and staff. *Addiction science & clinical practice*, 13(1), 8.
  10. Raheb, G., Khaleghi, E., Moghanibashi-Mansourieh, A., Farhoudian, A., & Teymouri, R. (2016). Effectiveness of social work intervention with a systematic approach to improve general health in opioid addicts in addiction treatment centers. *Psychology research and behavior management*, 309-315.
  11. Ross, L. E., Vigod, S., Wishart, J., Waese, M., Spence, J. D., Oliver, J., ... & Shields, R. (2015). Barriers and facilitators to primary care for people with mental health and/or substance use issues: a qualitative study. *BMC family practice*, 16(1), 135.
  12. Russell, A. M., Valdez, D., Wang, M., Allem, J. P., Bergman, B. G., Kelly, J. F., ... & Massey, P. M. (2025). Content analysis of substance use disorder recovery discourse on Twitter: From personal recovery narratives to marketing of addiction treatment. *Alcohol: Clinical and Experimental Research*, 49(3), 629-640.
  13. Sarkar, S., Tom, A., & Mandal, P. (2021). Barriers and facilitators to substance use disorder treatment in low-and middle-income countries: a qualitative review synthesis. *Substance Use & Misuse*, 56(7), 1062-1073.
  14. Sarkar, S., Tom, A., & Mandal, P. (2021). Barriers and facilitators to substance use disorder treatment in low-and middle-income countries: a qualitative review synthesis. *Substance Use & Misuse*, 56(7), 1062-1073.
  15. Serre, F., Gauld, C., Lambert, L., Baillet, E., Beltran, V., Daulouede, J. P., ... & Auriacombe, M. (2025). Predictors of substance use during treatment for addiction: A network analysis of ecological momentary assessment data. *Addiction*, 120(1), 48-58.
  16. Serre, F., Gauld, C., Lambert, L., Baillet, E., Beltran, V., Daulouede, J. P., ... & Auriacombe, M. (2025). Predictors of substance use during treatment for addiction: A network analysis of ecological momentary assessment data. *Addiction*, 120(1), 48-58.
  17. Vanderplasschen, W., De Meyer, F., De Ruyscher, C., Pouille, A., & Sinclair, D. L. (2025). The Role of Specialist Substance Use and Addiction Treatment in Building Recovery Capital. *The Handbook of Recovery Capital*, 169-192.