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Representative Bureaucracy Through Staff With Lived Experience: Peer Coproduction in the Field of Substance Use Disorder Treatment

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Abstract

This study extends the representative bureaucracy literature by theorizing and empirically testing how staff sharing lived experience with service users can serve as user representatives in service provision processes (i.e., the peer coproduction mechanism). Using survey data from a representative sample of substance use disorder treatment clinics in the United States, we explore factors associated with descriptive representation (the presence of staff with firsthand experience of a substance use disorder in both frontline treatment and senior positions) and directors' perceptions of recovering staff's potential to serve as user representatives in individual care and organizational decision-making processes. Recovering staff accounted for a third of the field's workforce, but the majority of the clinics did not employ them in senior staff positions. Regression results suggest that organizational leaders' recognition of recovering staff's unique representation capacities may facilitate greater descriptive representation and grant meaningful organizational decision-making authority to recovering staff. Multiple research and practice implications are discussed.

Keywords

representative bureaucracy; staff with lived experience; peer coproduction; substance use disorder treatment; health and social services

The representative bureaucracy literature concerns bureaucrats' descriptive representation of marginalized identities and how their representativeness can be translated into more equitable policy and program administration processes (Meier, 1993). Despite having made important contributions to our understanding of how bureaucrats sharing constituents' minority identities can ameliorate inequities in public-service administration processes, the representative bureaucracy literature has multiple gaps. First, most studies have focused on racial, ethnic, and gender group representation with limited attention to other attributes (e.g., experience of immigration, violence, and poverty) that may shape bureaucrats' values

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and behaviors (Bishu & Kennedy, 2019; Meier & Nigro, 1976). Second, studies have been largely conducted in fields and settings where governments provide most services directly (e.g., education, law enforcement, and public aid). In the current era, when private actors assume most human service responsibilities as members of the "public-service network" (Dudau et al., 2019; Hodgkinson et al., 2017; Smith & Lipsky, 1995), representative bureaucracy theory can serve as a useful framework for understanding how privately owned organizations in diverse service fields hire and use staff who share similar characteristics and values with service users.

This exploratory study is an attempt to address these gaps. We use individuals' lived experience of marginalization and stigma as a core identity that may influence bureaucrats' perspectives and values and motivate them to serve as representatives of vulnerable service users—the peer coproduction mechanism (Park, 2020a). This study uses the field of substance use disorder (SUD) treatment in the United States as an example, where a significant proportion of the workforce has firsthand experience of SUD and the emphasis on patient-centered and responsive services is growing as private organizations offer most of the services (Bradley & Kivlahan, 2014; Carr, 2010; White, 2014). Using the National Drug Abuse Treatment System Survey (NDATSS)—a nationally representative survey of alcohol and drug use disorder treatment centers in the United States—this article asks three questions: (a) What factors are associated with descriptive representation at frontline and senior-level positions in SUD treatment clinics? (b) What factors are associated with directors' perceptions of the potential of staff with firsthand SUD experience to represent patients and influence organizational strategic decisions? and (c) How are the descriptive representation of staff with lived experience and directors' perceptions of their representation potential associated?

Asking these questions is important to scholars of public administration. Despite the call for more diversity and inclusion in the public-serving workforce, existing studies' lack of attention to organizational context and perspective on staff members sharing users' identity provides limited practical implications for practitioners and managers (DiTomaso et al., 2007; Pitts & Wise, 2010). A core argument for public workforce diversity and inclusion is its potential to create more equitable and responsive service provision (Bishu & Kennedy, 2019). However, changes in the individual care process and organizational practices may not come about by simply hiring more staff reflecting characteristics of service users. Recent studies show that various organizational, political, and institutional factors (e.g., hierarchy, stratification, socialization) can trigger or hinder active representation of bureaucrats sharing identities with service users (Carroll, 2017; Hong, 2017; Keiser et al., 2002; Wilkins & Williams, 2008). Adjustments in organizational structure, policy, incentives, and practice guidelines reflecting organizational norms and culture often require earning organizational leaders' support and recognition (Brodkin, 2011; Lipsky, 1980; Meier, 2019; Scott, 2001). Thus, in the context of diverse organizational and environmental settings, it is important to understand how organizational actors (particularly senior managers) perceive these staff members' potential to make differences in care and organizational processes before making substantive and practical suggestions (Favero & Molina, 2018).

We are aware that recent representative bureaucracy studies focus on the influences (or outcomes) of descriptive representation (Bishu & Kennedy, 2019; Bradbury & Kellough, 2011). However, examining how the descriptive representation of staff with lived experience influences the service outputs and patient outcomes of SUD treatment clinics might be premature, given that very few studies have explored the descriptive representation phenomena using people's lived experience as a focal identity or private actor–dominant service field as a case. Health and social science communities also discourage conducting such outcome-focused studies without sufficient evidence and thoughtful consideration of the potential impacts on users' care experiences, service user–provider engagement, organizational contexts, and future research (Krumholz, 2008; Mosley et al., 2019; Pinto & Park, 2019). However, better understanding of the conditions for descriptive representation and positive perceptions of the representation potential of staff with lived experience (from the perspective of senior managers) will provide important grounds for investigating how they can make substantive differences in service users' immediate care experience and long-term outcomes by serving as representatives of these vulnerable users.

This article proceeds by briefly reviewing the representative bureaucracy literature and its gaps and introducing the field of SUD treatment. Then, we propose the idea of staff with lived experience assuming a representative role and discuss factors potentially associated with their descriptive representation and directors' perceptions of the potential of recovering staff. An explanation of methods ensues, followed by a presentation of empirical test results on the questions above. We conclude by discussing the potential and limitations of hiring staff with lived experience as user representatives and various implications.

Representative Bureaucracy Theory

Representative bureaucracy concerns public-serving bureaucrats' representation of all segments of the population, including marginalized and disadvantaged groups (Meier, 1975). Two core assumptions behind the theory are that (a) people with similar characteristics and life experiences will share similar values through socialization, and (b) bureaucrats will attempt to use their discretion to push forward their value-congruent practices (e.g., female senior staff will support equal pay and workplace child care; Meier, 1993). Mosher's distinction between active representation (i.e., bureaucracies advancing interests of attribute-sharing groups) and passive representation (i.e., bureaucracies' descriptive representation of the population they serve) provided a basis for further development in theoretical and empirical studies (Mosher, 1968). Riccucci and colleagues theorized that the symbolic effects of descriptive representation make organizations and institutions more legitimate and trustworthy to those service users and citizens whom they claim to represent and yield greater cooperation and effectiveness (Riccucci et al., 2014; Riccucci & Saidel, 1997).

Based on these theoretical foundations, scholars across disciplines have empirically tested whether bureaucratic representation results in responsive and congruent services and outcomes and, if so, how and under what conditions (Meier & Morton, 2015; Riccucci & Ryzin, 2017; Schröter & Von Maravić, 2015). Due to complex and varying human needs and the indeterminate nature of service technologies, bureaucrats' possession and exercise of discretion is an inevitable necessity in any human service setting (Hasenfeld, 2010;

Lipsky, 1980). However, multiple studies suggest that active representation (or exercise of discretion) may be facilitated under certain conditions, such as when bureaucrats' active representation directly benefits service users and the shared identity of bureaucrats and service users changes the interaction between them (e.g., women police officers reporting sexual assault; Keiser et al., 2002; Meier & Nicholson-Crotty, 2006). The salience of the issue of an identity shared between bureaucrats and service users is another important condition (e.g., racial profiling for racial and ethnic minority police officers; Hong, 2017). Active representation of bureaucrats can also be hindered or facilitated by organizational socialization. Many organizations use socialization to shape bureaucrats' behavior and perspectives, adhering to the organizational mission and curbing deviation from enshrined scripts (e.g., racial minority officers internalizing police departments' racist values and practices rather than actively advocating for the concerns of minority groups; Wilkins & Williams, 2008). At the same time, representative bureaucrats can also socialize colleagues who do not share users' salient identities (e.g., female police officers sharing culturally sensitive practice examples with male officers and emphasizing the importance of sexual assault reporting; Carroll, 2017; Meier & Nicholson-Crotty, 2006) as active institutional entrepreneurs (Battilana et al., 2009).

Gaps in the Representative Bureaucracy Literature

Despite significant theoretical and empirical advances, the representative bureaucracy literature has two major gaps. First, apart from race, ethnicity, and gender, little attention has been paid to characteristics and identities that may influence individuals' values and perspectives in fundamental ways. Individuals become social actors by behaving in accordance with their identities and actions through internalizing social norms and values across the life course (Bicchieri et al., 2018; Parsons & Shils, 1951). Despite the call for expanding the literature beyond racial, ethnic, and gender identities (Meier, 2019; Meier & Nigro, 1976), very few studies have answered the call (Gade & Wilkins, 2013; Meier, 2019; Thielemann & Stewart, 1996). Lack of attention to the representation of diverse identities (e.g., sexual orientation, disability status, age, immigration status) and lived experience (e.g., of unstable housing, poverty, or SUD) in the literature is concerning. Depending on policies, programs, and services that bureaucrats administer, some identities and lived experiences may be more salient and have greater potential to affect bureaucrats' value formulation and behavior than race, ethnicity, and gender (e.g., disabled bureaucrats processing social security benefits and second-generation immigrant bureaucrats interviewing asylum seekers; Park, 2020a).

Second, the representative bureaucracy literature largely pertains to settings where the government provides the majority of the services directly (e.g., the federal government, welfare offices, police departments, and public schools; Grissom et al., 2015; Roch & Edwards, 2017; Schröter & Von Maravić, 2015; Watkins-Hayes, 2009). Considering the literature's emphasis on more equitable program outputs and policy outcomes, public actor–dominant fields could be good venues in which to build theory. However, we believe that the theory should be extended to the fields where private for-profit and nonprofit organizations administer the majority of public services on behalf of the government (through contracts and public subsidies; Allard, 2009; Marwell, 2007; Smith & Lipsky,

1995). In various health, social, and human service fields, private organizations share the responsibility and obligation of ensuring production of not just equitable but also responsive services as members of a public-service and value-producing ecosystem (Dudau et al., 2019; Hodgkinson et al., 2017). Compared with public organizations, private organizations are perceived to possess unique capacities to accommodate service users' concerns and local circumstances in innovative and efficient ways—a core assumption behind the privatization process (Donahue, 1989; Smith & Lipsky, 1995). However, these private organizations might be losing ties to the communities they serve and the capacity to represent the marginalized groups' interests under multiple macro trends, such as growing reliance on external funding, emphasis on economic value–promoting paradigms, and workforce professionalization (Eikenberry & Kluver, 2004; Guo & Musso, 2007; Park & Mosley, 2017; Specht & Courtney, 1994; Weisbrod, 1997). Besides, private organizations are under growing pressures to produce better performance and outcomes as a demonstration of the accountable use of public resources (Benjamin, 2008). Thus, there are growing needs for mechanisms to ensure *responsive services* that may produce better performance—such as diversifying the workforce and hiring representative staff members as active advocates (Institute of Medicine, 2001; Park, 2020b; Pitts & Wise, 2010; Stewart et al., 2000).

Beyond the benefits of the substantive representation of user attribute–sharing staff members (e.g., service responsiveness and better outcomes), private organizations might also be interested in gaining symbolic and economic benefits from descriptive representation. Securing and maintaining the legitimacy of their existence and operation are increasingly salient issues as many health and social service organizations become bureaucratized and hire more professionalized staff over lay individuals sharing identities and experiences of service user groups (Marwell, 2007; Spitzmueller, 2016). Thus, in addition to formal and participatory mechanisms incorporating local voices into organizational processes (e.g., advisory community boards), hiring staff members sharing service user group attributes and identities can be an important symbolic means of acquiring such legitimacy (Guo & Musso, 2007). Another important but less discussed motive for private organizations to hire more representative staff members can be labor cost saving. Organizations that are financially constrained (or seeking for competitive advantage by lowering operational costs) might be particularly incentivized to hire more staff members sharing marginalized identities who often have limited alternative employment options and are paid less compared with their peers (Graf et al., 2019; Olmstead et al., 2007).

In sum, in addition to public organizations, private nonprofit and for-profit organizations may have multiple motives for hiring staff members sharing characteristics and identities of service user groups, possibly looking for substantive (equitable and responsive service provision and improved outcomes), symbolic (legitimacy), and financial benefits (labor cost saving). Thus, investigating the prevalence and conditions for descriptive representation in fields where private actors are assuming growing public responsibilities is important not only for diversifying the cases for the representative bureaucracy literature but also for facilitating cross-sectoral comparison and learning (e.g., reconsideration of hiring practices and expectations for representative staff).

This article is an attempt to close these gaps and extend the representative bureaucracy literature using the SUD treatment field in the United States as an example where private organizations provide most services. We consider individuals' lived experience as a focal identity that may shape the values and behaviors of health and social service providers. Many health and social service fields that address issues of marginalized and traumatized groups often hire staff with similar lived experience. Representative staff are perceived to better understand and respond to service users' concerns and needs, grant symbolic benefits (e.g., users perceive such organizations and providers as more legitimate and trustworthy partners who can relate to their difficulties and provide responsive services), and sensitize other staff members without firsthand accounts of marginalization and stigma (Park, 2020a; Riccucci & Saidel, 1997; White, 2014).

Peer Coproduction in the SUD Treatment Field

Many SUD treatment clinics make use of the peer coproduction mechanism—hiring staff with firsthand experience of SUD as advocates for patients' interests and concerns (Park, 2020a). Since the inception of the field, staff with lived experience (or staff in recovery) have been essential service provision agents. With limited alternative treatment options, self-organized mutual support groups were the primary SUD treatment care in the United States until the middle of the 20th century, when the government increased spending on addiction treatment and medical service providers entered the field (White, 2014). Even under the professionalization trend over the past several decades, staff members with firsthand SUD histories have generally been thought to add unique value to the care process by complementing clinical services with essential peer recovery support (Reif, Braude, et al., 2014).

Recovering staff possess unique and tremendous potential to serve as legitimate and active representatives of patients by satisfying multiple conditions for active representations identified in the representative bureaucracy (Keiser et al., 2002; Meier & Nicholson-Crotty, 2006). Recovery from SUD is a salient lifelong process for recovering staff and they often express strong commitment (and sometimes obligation) to support others' recovery process (Bellamy et al., 2012; White, 2014). Besides, the interactions between patients and staff with lived experience can be strikingly different from patients' typical interactions with other staff. From the perspective of patients, who often distrust clinicians based on previous stigmatizing and coercive experiences, staff with lived experience may be perceived as relatively trustworthy partners and potential role models (Carr, 2010). Thus, leveraging their experiences and identities as both previous users of treatment services and current providers, staff with lived experience have the potential not only to better relate to patients' difficulties and challenges, but also to recognize services and practices that may better provide for patients' needs and concerns.

Staff with lived experience also have potential to socialize other staff members without firsthand SUD issues about better ways to collaborate and serve patients. When making care decisions, treatment service providers often seek the opinions and perspectives of staff with lived experience rather than engaging patients who are often characterized as untrustworthy and/or manipulative individuals (Corrigan et al., 2009; White, 2014). Their

firsthand experience and knowledge of the physiology, psychology, and culture of addiction are highly valued assets in the SUD treatment field, granting staff with lived experience the same authority as subject matter experts among their colleagues and managers without firsthand SUD experience (Blum & Roman, 1985; Humphreys et al., 1996). Leveraging this expertise and authority, staff with lived experience can better reflect patient concerns and share culturally sensitive (e.g., less stigmatizing and self-reflective) approaches to colleagues without firsthand experience of SUD. Previous studies using shared experience as bureaucrats' core identity have reported similar peer coproduction phenomena in fields addressing issues and concerns of veterans and people living with HIV (Gade & Wilkins, 2013; Thielemann & Stewart, 1996).

Despite the large presence of recovering staff and their representative potential, not all actors in the SUD treatment field may welcome the idea of hiring more staff with SUD history and/or consider recovering staff as appropriate advocates for patients. In the SUD treatment field, strongly held positions on recovery processes coexist; the life-process model of addiction emphasizes total abstinence from all substances (including effective medication), and the disease model of addiction promotes medication-assisted treatment approaches that can facilitate the recovery process by reducing cravings and withdrawal symptoms (Goodnough, 2018). Although staff with lived experience tend to take a context-sensitive eclectic approach to treatment (Humphreys et al., 1996), many recovering staff have (and are perceived to have) a strong commitment to the life-process model of addiction. Thus, in an environment emphasizing technocratic expertise and promoting the disease model of recovery, organizational leaders and providers may not recognize the representative potential of staff with firsthand experience of SUD and even consider such an approach harmful (Cooke et al., 2006). It is also possible that recovering staff may promote treatment approaches they believe in or benefited from themselves over effective and innovative approaches that could help patients' recovery process (Doukas & Cullen, 2011; Hecksher, 2007). In other words, the tension between these two recovery models suggests that divergent views may exist on the presence of recovering staff and their representation potential in the SUD treatment field—a tension rarely discussed in the representative bureaucracy studies that focus on racial, ethnic, and gender representation.

A large presence of staff with lived experience in the SUD treatment field can be understood as a significant degree of descriptive representation of persons with lived experience in the field. However, little is known about factors that facilitate such descriptive representation. Besides, factors associated with how managers and directors perceive recovering staff's potential to serve as advocates of patients in individual care and organizational decision-making processes are rarely explored. The next section addresses factors potentially associated with the use of the peer coproduction mechanism in SUD clinics.

Factors Potentially Associated With Peer Coproduction

Many environmental and organization-level factors are associated with SUD clinics' use of peer coproduction, such as hiring clinical and senior staff with lived experience and recognizing recovering staff's representation potential.

Environmental factors.—A recent health care reform in the United States, the Patient Protection and Affordable Care Act (ACA), expanded market opportunities and intensified competition in the SUD treatment field (D'Aunno et al., 2015). With an increased number of service providers in a given region, clinics might face a shortage of professional workers to serve the increased demand for clinical services. In particular, clinics located in states that expanded Medicaid might be more incentivized to fill clinical positions with staff with lived experience who are often considered to be cheap and readily available alternatives to clinicians with medical training or academic credentials (Olmstead et al., 2007; White, 2014).

A clinic's use of the peer coproduction mechanism may also differ based on the urbanity of its resident county. In addition to preexisting racial residential segregation in the United States, the suburbanization trend in the second half of the 20th century intensified the demographic composition differences between inner-city areas with low-income, racial/ethnic minority groups and suburban and rural areas with more affluent Whites (Massey & Tannen, 2018). Although SUD was considered to be a problem of primarily inner-city minority groups, growing numbers of suburban and rural area residents are experiencing SUD with the increase of prescription opioid use disorder in the past three decades (Cicero et al., 2014). With different SUD treatment infrastructure (e.g., availability of maintenance therapy clinics) and different resident characteristics and needs (e.g., access to mainstream medical care), clinics in various urbanization-level areas may face different needs and motives for practicing peer coproduction.

Organizational attributes.—Clinics' use of peer coproduction might be influenced by their organizational service modality (e.g., inpatient, residential, outpatient), revenue sources, affiliation, accreditation status, and ownership (i.e., public, nonprofit, for-profit). For instance, opioid treatment programs (OTPs)—specifically licensed outpatient clinics offering medication-assisted treatment—might be discouraged from implementing peer coproduction due to rigid regulatory requirements for staff credentials and an emphasis on service reliability imposed by a certifying agency (Substance Abuse and Mental Health Service Administration [SAMHSA], 2015). In contrast, residential clinics may hire more staff members with lived experience not just to provide 24-hr support for patients' resocialization but also to manage costs. Because many residential clinics are owned and operated by recovering individuals, staff with lived experience are expected to have more senior positions with meaningful organizational influence and greater influence on organization-level strategic decisions (Segal, 2017; White, 2014). Treatment clinics owned by hospitals or mental health centers may subscribe to a parent organization's medically and psychologically oriented service mode and perceive the peer coproduction mechanism as less valuable, possibly discrediting recovering staff's representation role (DiMaggio & Powell, 1983; Lee et al., 2001). In like manner, the accreditation process may deter clinics from hiring staff with lived experience unless they also have credentials to deliver various clinical and medical services (Abraham et al., 2013; Friedmann et al., 2003).

Reflecting the sector's bureaucratized and professionalized workforce expectations, publicly owned clinics might be discouraged from hiring staff with lived experience because many recovering staff often fail to satisfy educational credential requirements (Humphreys et al.,

1996; Olmstead et al., 2007). However, once individuals with addiction history meet the standards and are hired, they may have greater chances to hold senior positions and have equal or greater influence over strategic decision-making processes under public clinics' efforts to diversify their workforce and legitimatize organizational decisions (DiMaggio & Powell, 1983). Nonprofit organizations might hire staff members with minority identities and lived experience of vulnerability (e.g., mental health clinics and homelessness shelters hiring previous service users) following the normative expectation to preserve downward accountability, provide equitable treatment, and ensure workforce diversity (Dees & Anderson, 2003; DiTomaso et al., 2007; Scott, 2001). For-profit organizations, despite relatively little interest in providing equitable services compared with public or nonprofit organizations, might be interested in hiring more representative staff not only to gain symbolic benefits (e.g., legitimacy and trust) but also to lower labor costs (D'Aunno, 2006; DiTomaso et al., 2007; Lee et al., 2001). Staff with minority identity or firsthand experience of trauma and marginalization have been found to earn less (e.g., women earned 85% of what men earned in 2018) and for-profit organizations have exploited this uncomfortable reality intentionally or unintentionally (Graf et al., 2019; Olmstead et al., 2007).

Manager attitude and perspectives.—Managers lead clinics, and their attitudes and perceptions can be influential in organizational practices and emphasis on peer coproduction. Across the medical service fields, patient-centered care is the normative practice mode: inviting patients into care-decision meetings, sharing relevant information, explaining different options, and deciding care plans collaboratively (Bradley & Kivlahan, 2014; Park et al., 2019). For managers who strongly emphasize patients' self-determination and autonomy, recovering staff's representation potential might not be a satisfactory mechanism to provide equitable and responsive services. In contrast, managers endorsing a 12-step approach that emphasizes mutual peer support might be more willing to promote the peer coproduction mechanism within their clinics.

Patient and staff characteristics.—Patient and staff compositions may be associated with clinics' use of peer coproduction. Placing significant value on peer support and lived experience, clinics serving alcohol use disorder patients may hire more staff with lived experience not only to facilitate therapy sessions but also to offer informal and nonclinical support and guidance for patients as advocates and role models (White, 2014). In such an environment, peer coproduction can be a natural mode of service provision. However, clinics with a greater proportion of staff with medical training may not necessarily value the representation potential of recovering staff.

Finally, descriptive representation and managers' perceptions of staff with lived experience can be associated with each other (Park, 2020a). Managers of clinics hiring more treatment staff members with lived experience may realize their potential to relate to and speak on behalf of patients. When managers perceive greater potential in staff with lived experience to represent the interests of patients and possibly provide more relevant and responsive services, they may show greater acceptance of the mechanism. Beyond hiring more recovering staff, managers may want to position them in key organizational roles with enough opportunities to influence organizational processes.

Method

Sample and Data

Since 1988, the NDATSS has been a comprehensive and representative data source examining how SUD treatment services are delivered and financed across the United States. National sampling frames are drawn with the list of SUD treatment programs across the United States, managed by the SAMHSA annually. Multiple previous studies provide strong evidence for the reliability and validity of the NDATSS (D'Aunno et al., 2014; Pollack & D'Aunno, 2010). This article uses the 2017 wave of data that include additional original survey questions about the presence and perception of staff with lived experience of SUD. A survey team reached out to both administrative directors and clinical supervisors of sampled agencies and collected a wide range of information about the administrative (e.g., modality, ownership), operational (e.g., revenue sources, owned by hospitals), and clinical aspects of clinics (e.g., emphasis on patient-centered care and patient compositions). Out of 730 sampled and eligible treatment clinics, 657 clinics responded with at least a partially completed survey by a director or supervisor (a 90% response rate; Chen et al., 2017). The sample for this study includes these 657 clinics.

Dependent Variables

Descriptive representation variables.—The first descriptive representation variable measured the proportion of treatment staff with firsthand experience of SUD in a clinic. Although this variable provided important information on descriptive representation among frontline clinical staff, changes in program composition and organizational policies that can improve organization-level service responsiveness may require individuals with lived experience in higher organizational positions (Meier, 1975). The second descriptive representation variable captured whether a treatment clinic had any staff with lived experience of addiction in senior positions (e.g., directors, human resource managers, and clinical supervisors; 1 = yes, 0 = no).

Directors' perception of staff with lived experience variables.—Beyond having a descriptive presence, possession of meaningful organizational authority and power can facilitate representative staff members' advocacy opportunities (Favero & Molina, 2018; Meier, 2019; Riccucci & Saidel, 1997). In other words, to better accommodate patient needs through organizational and individual care processes, staff with lived experience need to have a meaningful influence on strategic decision-making processes and be recognized as appropriate advocates. The first such variable measured directors' attitude toward recovering staff's potential to represent patient concerns in the individual patient care process compared with that of staff without lived experience. This composite measure was drawn from directors' degree of agreement with the following five statements, measured on a five-point scale (1 = *strongly disagree*, 5 = *strongly agree*): (1) Staff in recovery are better able to understand clients' needs; (2) staff in recovery are better able to develop therapeutic relationships with clients; (3) staff in recovery are better able to motivate clients; (4) staff in recovery are better able to inform staff about how best to approach clients; and (5) staff in recovery are more likely to be flexible in their approach to treatment. We performed

factor analysis and identified one factor that is internally reliable (Cronbach's α = .88) and captures most of the variance in the five variables (eigenvalue = 3.16).

The second variable captured directors' opinions about whether staff with lived experience possessed equal or greater levels of influence over organizational/strategic decision-making processes than those without lived experience. Many representative bureaucracy studies have investigated the impact of representative bureaucracy on individual user outcomes with limited attention to bureaucrats' potential to influence organizational processes. Individual bureaucrats' use of discretionary power can be a valuable way to amend unfair policy and program administration processes and mediate resource flow (Marvel & Resh, 2015). However, expecting bureaucrats to address the concerns of identity-sharing users every time such issues emerge may be unrealistic. Because frontline staff members juggle multiple competing demands (e.g., growing user demands, limited capacity and autonomy, and organizational incentives and rules shaping staff behavior), bureaucrats need to prioritize some issues over others, resulting in varying experiences among users sharing identities (Brodkin, 2011; Lipsky, 1980). Thus, when they have meaningful authority to make organizational and strategic decisions, staff with lived experience may have a better chance of bringing about structural and institutional adjustments that produce more relevant and equitable services for users. This variable was assessed via directors' response to the following statement: Although individual personalities matter, in general, compared with staff without a history of SUD, staff in recovery are more likely to influence strategic (organizational) decisions (i.e., target users, budget, and staff composition). Respondents chose the best answer on a five-point scale (1 = *strongly disagree*, 5 = *strongly agree*): 4% strongly disagreed, 41% disagreed, 44% neither agreed nor disagreed, 10% agreed, and 1% strongly agreed with the statement. Given the limited response variation, we recoded the five-category variable into a binary variable indicating whether staff with lived experience had equal or greater influence on strategic decisions affecting treatment clinics (1 = strongly agree/agree/neither agree nor disagree, 0 = strongly disagree/disagree).

Explanatory Variables

Multiple environmental and organization-level variables were included in regression analyses as explanatory variables.

Environmental factors.—Whether a clinic was located in a Medicaid expansion state at the time of interview (1 = located in a Medicaid expansion state, 0 = located in a nonexpansion state) and the urbanization level of its county of residence were drawn from the 2016 National Survey of Substance Abuse Treatment Services (SAMHSA, 2017). According to the National Center for Health Statistics' classification system, the urbanization-level variable classifies counties into six groups: (a) central counties in a metropolitan statistical area (MSA) of one million or more population (inner-city counties), (b) fringe counties in an MSA of one million or more population (suburban counties), (c) counties in an MSA of 250,000 to 999,999 population (medium metro counties), (d) counties in an MSA of 50,000 to 249,999 population (small metro counties), (e) counties in a micropolitan statistical area, and (f) counties not in a micropolitan statistical area (National Center for Health Statistics, 2012). Guided by the National Center for Health

Statistics' classification system, we generated a four-category urbanity variable (1 = inner-city counties, 2 = suburban counties, 3 = medium and small metro counties, 4 = rural counties).

Organizational attributes.—Administrative directors provided information on the operational and managerial aspects of clinics, including service modality (outpatient OTP [OTP/non-OTP], inpatient, residential), ownership (private nonprofit, private for-profit, public), and proportion of private and commercial insurance and Medicaid income (ranging from 0% to 100%). Directors also answered questions on whether a clinic was owned by a hospital or a mental health facility and the clinic's accreditation status (by two main bodies, either the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities).

Manager attitude and perspectives.—Directors reported whether the regional SUD treatment field was very competitive or not (1 = yes, 0 = no) and the extent to which they relied on professional information sources (e.g., professional publications, conferences, associational meetings, and seminars; 1 = *no extent*, 2 = *a little extent*, 3 = *some extent*, 4 = *a great extent*, 5 = *a very great extent*). Clinical supervisors indicated whether they perceived the 12-step model, emphasizing peer support and individuals' lived experience, as an effective treatment mode or not (1 = yes, 0 = no). The value and emphasis clinical supervisors placed on person-centered care were estimated with 10 original questions. To control for respondents' social desirability bias, wordings and structures of questions were adopted from two validated instruments: the Person-Centered Care Assessment Tool (P-CAT) and the Shared Decision Making Questionnaire (SDM-Q; see Supplemental Appendix for question wording and descriptive statistics; Edvardsson et al., 2010; Scholl et al., 2012). Factor analysis on 10 questions identified one factor with an eigenvalue of 3.15 and Cronbach's alpha of .79.

Patient and staff characteristics.—Clinical supervisors provided information on the total number of patients receiving SUD services and the composition of patient groups, including the proportion of Black patients, Hispanic patients, female patients, alcohol use disorder patients, opioid use disorder patients, prescription opioid use disorder patients, and patients without health insurance (all continuous variables). Directors provided information on the number of staff members (full and part time), the proportion of staff with medical training (i.e., medical doctors and registered nurses), and the proportion of staff with academic credentials (i.e., nonmedical master's degree holders). Directors also reported typical active caseload for treatment staff.

Analytic Approach

We estimated weighted means and standard deviations of variables using the survey weight developed by the NDATSS team (Chen et al., 2017). Multivariate linear regression was applied to the analysis using continuous dependent variables (i.e., the proportion of treatment staff with lived experience of SUD and the composite variable on recovering staff's perceived potential to represent patients' concerns in the care process). Multivariate logistic regression was used for the analyses using binary dependent variables (i.e., the

presence of at least one senior staff member with lived experience and recovering staff's perceived influence on strategic organizational decisions). In addition to explanatory variables, we used descriptive representation and perceived influence variables to predict other descriptive representation and perceived influence variables to understand relationships between them. Due to moderate correlations between the descriptive representation variables (corr. = .49) and the perceived influence variables (corr. = .31), we introduced one perceived influence variable at a time when predicting descriptive representation variables, and vice versa. To preserve sample size and minimize estimation bias from missing values of explanatory variables, we imputed datasets 40 times using the multiple imputation by chained equations method (van Buuren & Groothuis-Oudshoorn, 2010). For easier interpretation, multiple continuous variables were standardized when used as explanatory variables. Two highly skewed variables (i.e., number of patients that received SUD services, number of staff) are log transformed to satisfy statistical assumptions.

Results

Descriptive Statistics

In 2017, 33% of the SUD treatment field's frontline treatment workforce had firsthand experience with SUD (see Table 1). Despite their noteworthy presence in the field, staff with lived experience held senior positions at 44% of the clinics, implying that most recovering staff held lower rank positions. At 55% of the clinics, recovering staff had an equal or greater level of influence over organizational decisions than staff members without firsthand experience of SUD. In other words, at 45% of the clinics, staff with lived experience were perceived to have relatively less influence over organization-level decisions.

A majority of the clinics were located in Medicaid expansion states. Roughly two-thirds of the SUD treatment clinics were non-OTP outpatient clinics (66%), followed by residential (21%), OTP outpatient (8%), and inpatient clinics (4%). The majority of the clinics were private nonprofit clinics (57%), and private for-profit clinics accounted for 30%. The majority of the clinics (54%) were accredited by the two major accreditation bodies and 60% of the directors reported a high degree of competition, signaling a highly institutional and competitive environment. About 50% of the patients served had an alcohol use disorder, whereas 33% had an opioid use disorder and 28% had a prescription drug use disorder, in keeping with the recent opioid epidemic. Providers with a medical training (7%) or a graduate degree (32%) made up significant proportions of the clinics' workforce.

Correlates of Descriptive Representation

Clinics located in medium/small metro areas and rural areas hired smaller proportions of staff members with firsthand SUD experience, compared with clinics located in inner-city communities of large metropolitan areas (see Table 2). Compared with non-OTP outpatient clinics, the proportion of treatment staff with lived experience in residential clinics was 11% higher after controlling for various factors. The expected proportion of treatment staff with lived experience was 5% higher in for-profit clinics than in nonprofit clinics. Clinics hired more staff with lived experience when their clinical supervisors believe clinical effectiveness of the 12-step recovery model and hired fewer staff with firsthand SUD experience when

the clinical supervisors emphasized the importance of patient-centered care. A greater proportion of staff members with medical training and nonmedical graduate degrees were associated with a lower proportion of treatment staff with lived experience. Greater numbers of Black patients and a larger number of staff were negatively associated with the proportion of treatment staff with firsthand experience of SUD. The odds of having at least one senior staff member with an addiction history were lower in clinics located in inner-city counties of large metropolitan areas compared with clinics in medium or small metro counties. Clinics serving more Black patients and those with a bigger staff were more likely to have senior staff with lived experience of addiction.

Both descriptive representation variables were significant predictors of each other. Clinics had 19% to 21% more treatment staff with lived experience when they had at least one senior staff member with lived experience. An additional 30% of treatment staff with lived experience (equivalent to one standard deviation) was associated with more than 500% higher odds of having a senior staff member with lived experience. Although recovering staff's perceived influence on organization-level decisions was not associated with either descriptive representation variable, a director's positive perception of the potential of staff with lived experience to be patient representatives was positively associated with both descriptive representation variables after controlling for other environmental and organizational factors.

Correlates of Director's Perceptions of Staff With Lived Experience

Fewer associations were identified in the analyses of variables related to perceptions of recovering staff (see Table 3). At clinics emphasizing the patient-centered care approach, directors were less likely to perceive staff with lived experience as better representatives than staff without SUD history in the individual care process. Both descriptive representation variables were significant and positive predictors of recovering staff's perceived potential to serve as patient advocates. Finally, the perceived influence of staff with lived experience over strategic organizational decisions and the expectation that they could represent patients' concerns were positively associated with each other after controlling for various factors.

Discussion

With the unique development of the SUD field and high regard for individuals' lived experience of addiction, staff with lived experience comprise an important portion of the workforce with the potential to represent vulnerable patients' interests and concerns. Using nationally representative data from SUD treatment clinics in the United States, we examined factors associated with recovering staff's descriptive representation of patients and their perceived potential. Although the presence of staff with lived experience has decreased from a high of 70% to 80% in the 1980s (White, 2014), they still constitute a third of the SUD treatment workforce. Recovering staff were perceived to have lower levels of influence over organizational decisions at 45% of the clinics, and 44% of the clinics had at least one senior staff member with addiction history. These statistics seem to signal an underleveraged potential of staff with lived experience as mediators and translators between patients and staff members at the clinics.

Regression results highlight the relationships of various environmental and organizational factors with recovering staff's descriptive representation and perceived potential. First, directors' positive attitudes toward recovering staff's potential to better represent patients in the care process was the only variable significantly and consistently associated with all the other dependent variables (i.e., proportion of frontline staff with lived experience of SUD, presence of at least one senior staff member with lived experience, and perceived potential to influence organizational decision-making processes). A particularly noteworthy pattern is that directors' recognition of recovering staff's potential to represent patients' concerns in the care process was the only factor associated with director's recognition of the potential of staff with lived experience to influence organizational strategic decisions. In other words, regardless of the magnitude of descriptive representation and other environmental and organizational conditions, clinic leaders' recognition of the unique representation capacities of recovering staff in the care process appears to be linked with their potential to meaningfully influence strategic organizational decision-making processes—potentially important and necessary conditions for their active representation. This finding confirms the importance of leaders' perspectives in facilitating (and hindering) active representation opportunities of staff members sharing minority identities (Favero & Molina, 2018; Meier, 2019; Riccucci & Saidel, 1997). It is worth mentioning that a supervisor's endorsement of the 12-step recovery model was associated only with the proportion of treatment staff with lived experience. Despite valuing individuals' firsthand experience of addiction, the peer support–based recovery model may not necessarily allow meaningful representation opportunities for recovering staff to influence organizational processes or enable them to be effective advocates for patients (Brigham, 2003). Also, directors may not recognize how the peer support model can help individual-level care processes that might be a core function of clinics. These remaining questions might be better answered with future qualitative studies.

Second, many SUD treatment clinics seem to bow to institutional pressures when it comes to hiring staff with lived experience. Clinics that employed more staff with specialized training were less likely to hire staff with lived experience. When clinical supervisors emphasized a normative practice in the medical service fields (i.e., patient-centered care), clinics were expected to hire fewer recovering individuals as frontline staff and directors were less likely to believe in the recovering staff's potential to represent patients' concerns in the care process. Thus, in an environment emphasizing technocratic expertise, clinics may not just be discouraged from hiring recovering staff or leveraging their experiential expertise but also ask patients to share their concerns directly (i.e., patient-centered care) rather than indirectly through staff with lived experience (Cooke et al., 2006; DiMaggio & Powell, 1983). These results suggest that there are differing views on the legitimacy of staff with lived experience of SUD as patients' representatives. This dynamic—recovering staff's representation opportunities are bounded by the link between their identity and contested beliefs about their effects on recovery—is rarely discussed in the representative bureaucracy literature. It would be helpful for future qualitative research to investigate this pattern more closely not just in the SUD treatment field but also in other service fields in which multiple care approaches and beliefs coexist and collide (e.g., child welfare, mental health).

Third, our results suggest very little sectoral differences in the use and perception of staff with lived experience as patient representatives. One difference was that for-profit clinics

hired more staff with SUD history as frontline clinicians than nonprofit clinics. However, the motivation behind for-profit clinics' hiring patterns is less clear. For-profit clinics may hire staff with lived experience for economic reasons (e.g., as readily available and less expensive workers; Olmstead et al., 2007). It is also possible that these clinics are responding to patients' need for nonclinical support services by hiring more recovering staff. Nevertheless, for-profit clinics' nonsignificant associations with other dependent variables signal that for-profit clinics may seek only symbolic benefits from peer coproduction efforts. Other than the proportion of frontline staff with SUD history, our regression analyses predicted no sectoral differences in senior recovering staff's presence or the perceived potential of staff with lived experience. This important finding of no sectoral differences suggests that the practice and perception of peer coproduction might be very similar across the three sectors —supporting the utility of representative bureaucracy in fields where private organizations play an important role in the public value and public-service producing ecosystem (Dudau et al., 2019; Hodgkinson et al., 2017).

Other relationships are also worth discussing. The total number of regional SUD patient admissions was positively associated with the proportion of staff with lived experience. The proportion of Black patients was negatively associated with the proportion of frontline staff with lived experience of SUD and positively associated with the presence of senior staff with lived experience. Previous studies have shown that minority patients tend to receive substandard services and find fewer treatment options (D'Aunno et al., 2014; Friedmann et al., 2003). Thus, the current findings may highlight an additional racial disparity in SUD treatment services: Black patients' inadequate level of access to emotional, informational, and instrumental support from peers and opportunities to be represented (Reif, George, et al., 2014). Our findings also imply that clinics serving more Black patients may seek symbolic benefits by assigning staff with lived experience to a senior position while not recognizing their potential to improve care processes or influence organizational strategic decisions. Unfortunately, due to the lack of specific data, we cannot identify what proportion of recovering staff were Black or racial/ethnic minorities.

Clinics' descriptive representation was significantly correlated with the urbanity of their residence counties. The most plausible explanation for the relationship between the proportion of treatment staff with lived experience of SUD and urbanity would be that clinics located in major metropolitan areas tend to hire more staff with lived experience because they are located in the areas where recovering staff are often clustered. It is not clear why clinics located in medium/small metro counties are more likely to have at least one senior staff in recovery compared with clinics located in the centers of large metropolitan areas. Inner-city clinics might hire staff with firsthand experience exclusively for direct service provision. Clinics in medium or small metro counties may seek symbolic benefits from hiring a recovering person to fill a senior position. Future studies investigating different motives behind the use of descriptive representation seem like promising next steps.

Our findings need to be interpreted carefully, due to several limitations. Data from organization-level surveys administered by directors and clinical supervisors are vulnerable to measurement gaps and biases. Despite being a nationally representative study of the SUD treatment field, the NDATSS dataset did not capture the responses of frontline clinicians and

patients. Managers may not be the best people to reflect the daily practices of staff with lived experience, and the lack of reports from frontline clinicians and patients is a critical limitation of this study. The effects of response bias also loom large. Despite the effort to control for social desirability bias by adopting the wordings and structures of validated measures, supervisors may have provided normative answers to the questions asked. Our study may not capture important environmental conditions (e.g., racial/ethnic composition, income level, labor market conditions) that can affect clinics' use of peer coproduction. Also, the relationships observed in the SUD treatment field may not be relevant to other service fields. Finally, only associational relationships can be discussed with cross-sectional data.

Implications and Conclusion

Despite the limitations, this study has several implications for research and practice. Departing from the commonly used race, ethnicity, and gender identities in the representative bureaucracy literature, we used a person's lived experience as a core identity. Notably, previous conceptual and empirical studies have suggested that shared identity may shape a bureaucrat's values and behavior (Gade & Wilkins, 2013; Meier & Nigro, 1976; Park, 2020a; Thielemann & Stewart, 1996). As a step toward empirically examining this idea, this study investigated how a service field used staff sharing lived experience with users and how managers perceived staff's potential to influence processes of individual care and organizational behavior. We also used representative survey data from the field of SUD treatment, where public providers do not possess major responsibility for service delivery and there is a dearth of studies on representative bureaucracy.

By extending the representative bureaucracy literature in many dimensions, this article suggests several topics for future studies. First, examining the impact of recovering staff's passive and active representation in patients' care experiences and clinics' service-output patterns would be a promising next step, demonstrating the clinical implications of peer coproduction. Second, the article also encourages scholars to explore how underexplored identities (e.g., sexual orientation, disability, and immigration status) may influence bureaucrats' values, behavior, and organizational effectiveness. Despite limited existing studies, the intersectionality between multiple identities (e.g., Black and female staff with lived experience of SUD) is an important subject to study in the effort to better understand the conditions for active representation and ways to promote diversity and inclusion in workforce and public-service provision processes. Third, qualitative studies with staff members and patients could generate a more nuanced understanding of how lived experience can serve as a representation base at SUD clinics (e.g., to what extent patients perceive staff with lived experience as their advocates, how internal policies and rules facilitate and hinder peer coproduction processes, how training backgrounds and organizational positions make differences in recovering staff's patient representation opportunities and their interactions with patients). Fourth, critical historical analysis of the evolution of the SUD treatment field in the United States with a particular focus on the role of representative staff members sharing marginalized characteristics of SUD patients (e.g., being poor, being Black, having multiple chronic conditions) could shed light on how descriptive representation is shaped by larger environmental contexts (e.g., the war on drugs, suburbanization) and whether

representative staff members made a difference. Fifth, another important future direction is investigating how service providers sharing lived experiences with service user groups could make a difference in diverse service fields, resulting in greater access to and utilization of need-satisfying services. Service fields attending to concerns and issues of marginalized groups and hiring many staff members sharing experiences of service users could be promising research venues: mental health disorder service organizations, domestic violence shelters, community-based organizations serving individuals with criminal justice system involvement, HIV prevention clinics, houseless service organizations, and organizations serving refugees and undocumented people.

This study provides useful information for managers and administrators of SUD treatment clinics as well. By highlighting nonclinical roles of staff with lived experience, the study encourages managers to take a second look at the current and potential roles staff with lived experience play and could play in providing more responsive and equitable services. Some clinics may simply prefer to get the symbolic benefit of descriptive representation though hiring staff with lived experience to fill frontline positions. But, to facilitate recovering staff's active representation of vulnerable patients, organizational leaders may need to believe in the positive impact of the peer coproduction mechanism, intentionally use staff with lived experience as patient advocates, and grant them meaningful authority in organizational processes. This article also suggests the need for a more democratic process between staff members with various types of expertise. Even if the concerns of patients are captured by staff with lived experience, clinics may lose opportunities to provide quality and responsive services if recovering staff do not have meaningful authority and opportunities to advocate within clinics or are not integral players in the organizational process.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Biography

Sunggeun (Ethan) Park is an assistant professor at the University of Michigan, School of Social Work. With an overarching research question, "how can health and social service organizations provide more responsive and effective services?", Park investigates how user's engagement in service decision-making processes (i.e., co-production) and intra/inter-organizational collaboration influence organizational behaviors and shape the experience of vulnerable service users.

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Table 1.

Weighted Descriptive Statistics of Variables.

Variables	Percentage	*M*	*SD*
Dependent variables			
Descriptive representation			
Proportion of treatment staff with SwLE		33.3	29.5
Presence of at least one senior SwLE	44.1		
Director's perception of staff with lived experience			
Potential to represent patients' concerns in the care process		0.1	1.0
Potential to influence over organizational strategic decisions	54.8		
Explanatory variables			
Environmental factors			
Located in Medicaid expansion state	69.6		
Urbanity			
Large metro counties (inner-city area)	35.2		
Large metro counties (suburban area)	16.9		
Medium/small metro counties	25.6		
Rural counties	22.3		
Organizational attributes			
Service modality			
OTP outpatient	8.4		
Non-OTP outpatient	66.0		
Inpatient	4.4		
Residential	21.2		
Ownership			
Private for-profit	29.8		
Private nonprofit	57.1		
Public	13.1		
Proportion of revenue from Medicaid		33.1	33.3
Proportion of revenue from private insurance		15.5	23.6
Owned by hospital or mental health facility	25.1		

Variables	Percentage	*M*	*SD*
Accredited	53.5		
Manager attitude and perspectives			
Perceives high competition	59.6		
Relies on professional information sources		3.4	0.7
Endorses the 12-step treatment model	55.6		
Emphasis on patient-centered care		−0.1	0.9
Patient characteristics			
Number of patients that received SUD treatment service		557.4	1,185.6
Proportion of Black patients		20.7	24.2
Proportion of Hispanic patients		14.2	18.7
Proportion of female patients		41.3	24.0
Proportion of alcohol use disorder patients		49.7	26.8
Proportion of opioid use disorder patients		32.7	32.4
Proportion of prescription opioid use disorder patients		27.6	25.4
Proportion of uninsured patients		25.2	28.5
Staff characteristics			
Number of staff (full and part time)		21.7	36.9
Proportion of staff with medical training (i.e., MD, RN)		6.9	12.5
Proportion of staff with nonmedical graduate degree		32.1	27.1
Average caseload for clinical staff		30.4	32.9

Note. SwLE = staff with lived experience; OTP = opioid treatment program; SUD = substance use disorder.

Table 2.

Correlates of Descriptive Representation in the Substance Use Disorder Treatment Field.

	Proportion of treatment staff with SwLE				Presence of at least one senior SwLE			
	(1)		(2)		(3)		(4)	
Variables	**Coefficient**	***SE***	**Coefficient**	***SE***	**OR**	***SE***	**OR**	***SE***
Environmental factors								
Located in Medicaid expansion state	−0.09	2.55	0.11	2.61	1.33	0.43	1.40	0.44
Urbanity (ref. Large metro [inner-city area])								
Large metro counties (suburban area)	−3.31	2.70	−3.72	2.80	1.61	0.58	1.63	0.59
Medium/small metro counties	−4.91*	2.53	−5.32*	2.57	2.30*	0.77	2.41**	0.80
Rural counties	−10.31**	3.07	−9.84**	3.15	1.69	0.68	1.83	0.73
Organizational attributes								
Service modality (ref. non-OTP outpatient)								
OTP outpatient	−4.48	2.36	−5.33*	2.42	1.34	0.46	1.35	0.46
Inpatient	3.34	4.88	3.66	4.96	1.31	0.78	1.36	0.79
Residential	10.85**	3.41	11.35**	3.58	0.82	0.36	0.84	0.37
Ownership (ref. private for-profit)								
Private nonprofit	−4.59	2.37	−4.86*	2.43	0.70	0.22	0.67	0.21
Public	−4.06	3.00	−3.71	3.02	0.58	0.25	0.57	0.24
Proportion of revenue from Medicaid[a]	1.08	1.24	0.54	1.27	0.85	0.14	0.84	0.13
Proportion of revenue from private insurance[a]	0.72	1.26	0.96	1.32	0.96	0.17	0.98	0.18
Owned by hospital or mental health facility	−1.76	2.28	−1.39	2.22	0.63	0.20	0.65	0.21
Accredited	−0.87	2.16	−0.48	2.20	0.69	0.18	0.71	0.19
Manager attitude and perspectives								
Perceives high competition	−3.55*	1.80	−3.65	1.87	1.03	0.26	1.03	0.25
Relies on professional information sources	0.55	1.30	0.40	1.34	1.36	0.23	1.32	0.23
Endorses the 12-step treatment model	4.51*	1.91	4.65*	1.94	1.41	0.35	1.39	0.35
Emphasis on patient-centered care	−3.02**	1.07	−3.64**	1.09	1.28	0.17	1.25	0.17
Patient characteristics								

Variables	Proportion of treatment staff with SwLE (1) Coefficient	*SE*	(2) Coefficient	*SE*	Presence of at least one senior SwLE (3) OR	*SE*	(4) OR	*SE*
Number of patients that received SUD service[b]	1.50	0.92	1.38	0.93	0.93	0.11	0.92	0.11
Proportion of Black patients[a]	−3.94**	0.96	−3.51**	1.00	1.61**	0.22	1.68***	0.23
Proportion of Hispanic patientsa	0.29	1.16	0.68	1.18	0.80	0.11	0.82	0.12
Proportion of female patients[a]	−0.51	1.03	−0.29	1.08	0.82	0.11	0.83	0.11
Proportion of alcohol use disorder patients[a]	0.32	1.08	0.19	1.09	0.93	0.13	0.94	0.13
Proportion of opioid use disorder patients[a]	0.53	1.13	0.57	1.15	0.98	0.15	0.96	0.14
Proportion of prescription opioid use disorder patients[a]	−1.62	0.97	−1.73	1.00	1.02	0.14	1.04	0.14
Proportion of uninsured patients[a]	0.42	1.19	0.26	1.24	1.05	0.15	1.04	0.15
Staff characteristics								
Number of staff (full and part time)[b]	−8.97***	1.37	−9.49***	1.41	2.42***	0.47	2.44***	0.48
Proportion with medical training[a]	−3.32***	0.89	−3.25***	0.92	0.92	0.13	0.95	0.13
Proportion with nonmedical graduate degree[a]	−4.26***	1.15	−5.00***	1.15	0.78	0.11	0.76	0.11
Average caseload for clinical staff (tens)	−0.68*	0.32	−0.56	0.31	1.03	0.05	1.03	0.05
Descriptive representation								
Proportion of treatment staff with SwLE[a]					5.42***	1.39	5.72***	1.43
Presence of at least one senior SwLE	19.13***	2.04	21.19***	2.09				
Director's perception of SwLE								
Potential to represent patients' concerns in the care process	4.46***	0.99			1.34*	0.18		
Potential to influence over organizational strategic decisions			−1.68	1.82			1.454	0.35
F test	16.85***		14.81***		3.17***		3.34***	

Note. OR = odds ratio; OTP = opioid treatment program; SUD = substance use disorder; SwLE = staff with lived experience.

[a]Standardized.

[b]Log transformed.

*$p < .05$.

**$p < .01$.

***$p < .001$.

Table 3.

Correlates of Perceived Potentials of Staff With Lived Experience.

	SwLE's potential to represent patients' concerns in the care process				SwLE's potential to influence over organizational strategic decisions			
	(5)		(6)		(7)		(8)	
Variables	**Coefficient**	***SE***	**Coefficient**	***SE***	**OR**	***SE***	**OR**	***SE***
Environmental factors								
Located in Medicaid expansion state	0.12	0.10	0.11	0.10	0.93	0.25	0.93	0.25
Urbanity (ref. large metro [inner-city area])								
Large metro counties (suburban area)	−0.04	0.12	−0.08	0.12	0.82	0.23	0.82	0.23
Medium/small metro counties	0.06	0.10	−0.01	0.10	0.70	0.18	0.70	0.18
Rural counties	0.19	0.12	0.08	0.13	0.81	0.26	0.86	0.27
Organizational attributes								
Service modality (ref. non-OTP outpatient)								
OTP outpatient	−0.08	0.11	−0.14	0.11	0.78	0.21	0.82	0.21
Inpatient	−0.02	0.24	0.00	0.25	0.73	0.37	0.71	0.36
Residential	0.03	0.13	0.15	0.13	1.04	0.35	0.93	0.31
Ownership (ref. private for-profit)								
Private nonprofit	−0.09	0.10	−0.12	0.10	1.20	0.29	1.27	0.31
Public	0.00	0.14	−0.03	0.14	1.14	0.38	1.23	0.41
Proportion of revenue from Medicaid[a]	−0.07	0.05	−0.07	0.06	0.97	0.13	0.97	0.13
Proportion of revenue from private insurance[a]	0.04	0.05	0.05	0.05	1.04	0.12	1.04	0.12
Owned by hospital or mental health facility	0.04	0.10	0.04	0.10	0.90	0.22	0.93	0.23
Accredited	0.07	0.09	0.07	0.09	1.12	0.24	1.16	0.25
Manager attitude and perspectives								
Perceives high competition	0.01	0.07	−0.03	0.07	1.26	0.24	1.28	0.24
Relies on professional information sources	−0.05	0.06	−0.05	0.06	1.30 *	0.17	1.27	0.17
Endorses the 12-step treatment model	−0.00	0.08	0.03	0.08	1.14	0.23	1.07	0.22
Emphasis on patient-centered care	−0.11 **	0.04	−0.15 ***	0.04	1.04	0.11	1.06	0.11
Patient characteristics								

	SwLE's potential to represent patients' concerns in the care process				SwLE's potential to influence over organizational strategic decisions			
	(5)		(6)		(7)		(8)	
Variables	**Coefficient**	***SE***	**Coefficient**	***SE***	**OR**	***SE***	**OR**	***SE***
Number of patients that received SUD service[b]	−0.03	0.04	−0.01	0.04	1.09	0.11	1.07	0.11
Proportion of Black patients[a]	0.13*	0.05	0.08	0.05	0.83	0.10	0.84	0.10
Proportion of Hispanic patients[a]	0.06	0.04	0.07	0.04	1.03	0.10	1.03	0.10
Proportion of female patients[a]	0.01	0.04	0.01	0.04	0.99	0.10	1.00	0.10
Proportion of alcohol use disorder patients[a]	−0.02	0.05	−0.02	0.05	1.09	0.13	1.08	0.12
Proportion of opioid use disorder patients[a]	−0.02	0.05	−0.02	0.05	1.01	0.12	0.99	0.12
Proportion of prescription opioid use disorder patients[a]	0.03	0.04	0.02	0.04	0.89	0.10	0.91	0.10
Proportion of uninsured patients[a]	−0.03	0.05	−0.03	0.05	1.13	0.14	1.12	0.14
Staff characteristics								
Number of staff (full and part time)[b]	0.03	0.05	−0.07	0.05	0.89	0.11	0.93	0.11
Proportion with medical training[a]	0.06	0.05	0.03	0.05	0.99	0.11	1.02	0.12
Proportion with nonmedical graduate degree[a]	−0.07	0.04	−0.11*	0.04	0.95	0.11	1.01	0.11
Average caseload for clinical staff (tens)	0.02	0.01	0.01	0.01	1.05	0.04	1.06	0.05
Descriptive representation								
Proportion of treatment staff with SwLE[a]	0.30***	0.05			0.82	0.10		
Presence of at least one senior SwLE			0.35***	0.09			1.18	0.25
Director's perception of SwLE								
Potential to represent patients' concerns in the care process					2.25***	0.28	2.11***	0.26
Potential to influence over organizational strategic decisions	0.54***	0.07	0.52***	0.07				
F test	5.95***		5.19***		1.96**		1.94**	

Note. OR = odds ratio; OTP = opioid treatment program; SUD = substance use disorder; SwLE = staff with lived experience.

[a]Standardized.

[b]Log transformed.

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* $p < .05$.

** $p < .01$.

*** $p < .001$.