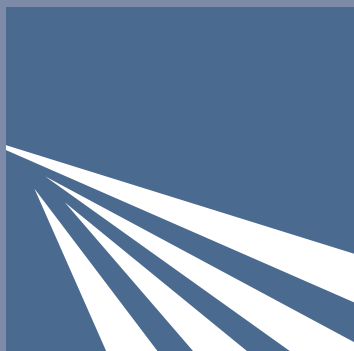


# STRENGTHENING PROFESSIONAL IDENTITY



## Challenges of the Addiction Treatment Workforce



**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
Substance Abuse and Mental Health Services Administration  
Center for Substance Abuse Treatment  
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*Strengthening Professional Identity*

**Challenges of the  
Addiction Treatment Workforce**

May 2005

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## **Acknowledgments**

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The report is based on a review of current research and detailed discussions from nine stakeholder meetings that were convened by CSAT from January through May 2004. The meetings included 120 participants representing the many organizations, institutions and agencies that support and provide addiction treatment and recovery services. SAMHSA/CSAT wishes to acknowledge the individuals whose guidance and expertise shaped this document.

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# Introduction

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*“Like other troubled industries, addiction treatment needs financial and technical investments as well as incentives to raise quality and to attract the best personnel. Indeed...without modernization and investment, the addiction treatment system will...fail to meet the public’s needs” (McLellan et al., 2003).*

## **A Workforce in Crisis: New Opportunities for Change**

Addiction treatment is facing a workforce crisis. High turnover rates, worker shortages, inadequate compensation, insufficient professional development, lack of defined career paths and stigma currently challenge the field. These deficiencies have a direct impact on workers and the patients/clients under their care. Further challenging the workforce are an increasingly complex patient/client population, the demand for greater accountability in patient care, limited access to information technology and the need to rapidly incorporate scientific advances into the treatment process. The addiction treatment field is composed of workers from many different professions (e.g., counselors, physicians, nurses, social workers, psychologists). This diversity gives the field a rich array of perspectives and skills, but also requires complex, coordinated responses to workforce issues.

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Even as the treatment system struggles with these challenges, the foundation is solidly in place to take action to strengthen the professional identity of the workforce. The progress in science and the emerging consensus about the need for academic accreditation and national core competencies provide opportunities for the workforce to move forward with new resolve. The field is at a pivotal point in the development of its workforce. By investing in the chief asset of the treatment system—the individuals who provide addiction treatment and recovery services—significant progress can be made to address critical workforce issues.

Workforce issues in health care have gained recent prominence on the national agenda. In 2001, for example, the Institute of Medicine (IOM) produced a landmark report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, which concluded that the U.S. health care system needs fundamental change. Report recommendations included a framework and strategies for achieving substantial improvements, including six approaches to improve health care and ten rules to guide the redesign of the health care system. While the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (SAMHSA/CSAT) has been addressing workforce issues for more than a decade, these issues have been further elevated due to concerns raised by the diverse professions that comprise the workforce regarding recruitment, diminished funding, adoption of best practices and staff

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retention. This report is intended to serve as a catalyst and guide for the development of national, State and local strategies that address addiction treatment workforce issues.

In 1999, prior to the IOM report, SAMHSA convened a Workforce Issues Panel as part of the National Treatment Plan Initiative to examine workforce issues related to addiction treatment. The Panel recommended (1) creating a national platform within SAMHSA/CSAT to address addiction workforce issues; (2) developing and strengthening an infrastructure to attract, support and maintain a competent and diverse workforce representative of the patient/client population; and (3) improving workforce competency by providing education and training rooted in evidence-based knowledge.

Recognizing the need for more comprehensive information about the workforce, SAMHSA/CSAT commissioned an environmental scan of the recent research related to the treatment workforce in 2003. The environmental scan identified five specific needs:

- Quantitative data on the workforce;
- Educational standards and workforce credentialing;
- Training to raise skill levels of the existing workforce;
- Strategies to reduce stigma; and
- Strategies to address an aging workforce (Kaplan, 2003).

Following the environmental scan, SAMHSA/CSAT convened 120 individuals representing diverse stakeholder groups in nine separate stakeholder meetings from January through May 2004. During these meetings, SAMHSA/CSAT solicited information and recommendations from representatives knowledgeable about the exceptional challenges faced by the addiction treatment workforce. Individuals from the following organizations and employment categories provided input: Addiction Technology Transfer Centers, certification boards, Federal agencies, professional trade associations, addiction counselors, clinical supervisors, college and university professors, faith-based providers, human resource managers, marriage and family therapists, nurses, physicians, psychiatrists, recovery support personnel, researchers, social workers, State Directors and treatment providers (see Section IV for a list of individuals who participated in these discussions). This report includes recommendations that emerged from these expert panels.

## **The Addiction Treatment Workforce**

The addiction treatment workforce is composed of highly dedicated practitioners who care for patients/clients with substance use disorders. It includes members of a number of different

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professions, including physicians, psychologists, nurses, outreach and intake workers, case managers, counselors, social workers, marriage and family therapists and clergy. Each of these groups contributes to a comprehensive treatment and recovery process. Recovering individuals have been a critically important component of the workforce from the inception of the field. They serve as trained professionals, as specialized recovery support workers and as volunteers.

The nature of the addiction treatment workforce has changed substantially over the past 40 years. Prior to the mid-1970s, recovering individuals provided counseling services with minimal formal training. In the late 1970s, States and national associations established professional standards and credentialing processes (Keller and Dermatis, 1999). Credentialing bodies now exist in every State and a college degree is the norm rather than the exception for professionals in the field. Eighty percent of direct care treatment staff, for example, hold a Bachelor's degree (Johnson et al., 2002; Knudsen et al., 2003; RMC, 2003) and 53 percent have a Master's degree or above (Harwood, 2002).

Remarkable advances in scientific knowledge, professional development and standards of care have enabled addiction treatment to emerge as a specialty health care discipline. However, problems related to infrastructure, recruitment, retention and education and training of the workforce create a context in which it is increasingly difficult to implement the most effective treatment. The challenges to maintaining a qualified workforce are numerous. Greater academic demands are being placed on treatment professionals. Many individuals who have traditionally entered the workforce may be discouraged from working in the field either because of the increasing academic requirements, because compensation is inadequate to justify the investment of time and monetary resources required to obtain additional educational training, or because workloads and schedules make it difficult or impossible to complete required academic training.

Concurrently, the Federal government has invested new resources to expand treatment. Appropriations for addiction treatment have increased from \$1.9 billion in FY 1996 to nearly \$2.8 billion in FY 2004, or by 43.9 percent over this eight year period (ONDCP, 2004). However, relatively few resources have been dedicated to strengthening the human infrastructure that provides treatment services.

As scientific knowledge in the field of addiction treatment has expanded and the level of credentialing has increased, one thing has remained constant: the exceptional level of passion and dedication that counselors, other professionals in the field and volunteers bring to their work. While the field currently faces a variety of challenges, the sense of mission which drives the treatment workforce gives it a unique resilience. Efforts to address workforce issues in the

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addiction treatment field need to build on this momentum and tap into the extraordinary assets that addiction professionals regularly evidence.

Rejuvenating the workforce will take a concerted effort over time. The extent of the workforce crisis is such that immediate action is required. While the issues are complex, the consequences of failing to act are enormous. By confronting the challenges head on and seizing opportunities to strengthen the workforce, we will lay the groundwork for improving quality of care.

## Organization of This Report

This report consists of four sections:

- Section I: Historical Context: Trends Impacting the Workforce
- Section II: Recommendations
  - A: Infrastructure Development Priorities
  - B: Workforce Development Priorities
  - C: Recruitment Priorities
  - D: Addiction Education and Accreditation Priorities
  - E: Retention Priorities
  - F: Study Priorities
  - G: SAMHSA/CSAT Implementation Priorities
- Section III: Next Steps
- Section IV: Participants

Section I provides a historical context, discussing funding, demographics, regulatory and practice trends relevant to understanding current workforce issues and the kinds of strategies that will be required to address them. This section provides a background for the recommendations that follow. Section II presents recommendations that emerged from the SAMHSA/CSAT-sponsored stakeholder meetings. Although these categories overlap, they provide a useful framework for a systematic analysis of the recommendations. Section III outlines the steps SAMHSA/CSAT will need to take to assure the implementation of the recommendations made in Section II. Finally, Section IV lists and acknowledges stakeholder meeting participants and other individuals who contributed to the development of the report.

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# I. Historical Context: Trends Impacting the Workforce

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The purpose of this section is to provide a context for understanding and addressing both long-standing and emergent workforce issues. The addiction treatment field and the social, economic and political contexts in which the workforce operates have evolved significantly over the past 30 years. While many of the challenges facing the addiction treatment workforce have remained relatively constant over time, others have emerged more recently.

Among the key issues facing the workforce are:

- Insufficient workforce/treatment capacity to meet demand;
- The changing profile of those needing services;
- A shift to increased public financing of treatment;
- Challenges related to the adoption of best practices;
- Increased utilization of medications in treatment;
- A movement toward a recovery management model of care;
- Provision of treatment and related services in non-traditional settings;
- Use of performance and patient outcome measures; and
- Discrimination associated with addiction.

## **Insufficient Workforce to Meet Treatment Demands**

Nationally, addiction treatment capacity is insufficient to accommodate all those seeking services and is grossly inadequate to serve the total population in need. Capacity issues vary by geographic area, population and the type of treatment required. Per capita funding for treatment services also differs by State. Some States are able to invest substantial State and local resources into treatment, whereas others rely primarily on Federal funding. Given limited resources, States and localities are faced with difficult decisions, such as limiting the types or number of services individuals can receive and/or limiting the number of individuals who can receive services. Moreover, in recent years many States have experienced severe revenue shortfalls that have reduced treatment capacity, despite Federal budget increases.

When treatment systems are required to provide additional services with less funding, providers and the workforce experience enormous pressures. Additionally, a large number of individuals are unable to access care due to limited workforce capacity. The *2003 National Survey on Drug Use and Health* (NSDUH, 2004b), which collected data on self-reported drug and alcohol use, found that:

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- Approximately 22.2 million individuals, age 12 and older, needed specialty treatment for alcohol or illicit drug problems;
- 1.9 million of these individuals received treatment at a specialty facility;
- Of the 20.3 million persons who were determined to need but did not receive treatment, only 1.0 million acknowledged a need for treatment; and
- Of the 1.0 million persons who felt that they needed treatment, 727,000 did not attempt to access it, and 273,000 reported that they were unable to access treatment.

The high costs of not treating alcohol and drug abuse are well documented. Economic costs associated with alcohol abuse are estimated to be \$184.6 billion and the costs of drug abuse are estimated to be \$143 billion (Mark et al., 2005). These include the medical costs associated with alcohol and drug abuse, lost earnings linked to premature death, lost productivity, motor vehicle crashes, crime and other social consequences. The data further reflect that treating substance use disorders can result in cost benefits for many other systems, such as primary health care, child welfare, welfare and criminal justice (NIDA, 1999).

The capacity constraints that the field faces go beyond limited treatment resources. Capacity is also limited by the lack of a sufficient number of skilled practitioners. Treatment capacity at any level cannot exist without a viable workforce and treatment organizations are currently struggling to recruit, hire, train and retain staff to respond to the demand for services. When available, increases in treatment dollars are primarily used to expand capacity to serve the greatest number of individuals, often neglecting the workforce infrastructure. Low salaries, minimal benefits, high turnover and staff dissatisfaction make recruiting staff to expand capacity a mounting challenge. Additionally, the emergent issues discussed in this section are creating further pressure on an inadequately sized workforce that is battling to keep pace with these new demands and will require a new way of doing business and intensive technology transfer efforts.

## Emergent Issues Facing the Workforce

### The Changing Profile of Those Needing Services

Over the past decade, drug use patterns and resultant treatment needs have substantively changed. For example:

- The preferred route of administration among youth changed from inhalation to injection from 1992 to 2000, with the rate of injection among heroin users increasing from 34 to

## I. Historical Context: Trends Impacting the Workforce

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51 percent among those under age 18 and from 48 to 63 percent among those ages 18 to 24 (SAMHSA, 2003).

- The non-medical use of prescription pain relievers, such as oxycontin, increased by 233 percent, from 600,000 persons using in 1990 to more than 2,000,000 persons using in 2001 (NSDUH, 2004a).
- The number of older adults with substance use disorders is expected to increase from 2.5 million persons in 1999 to 5 million persons by 2020, a 100 percent increase (Gfroerer et al., 2002).

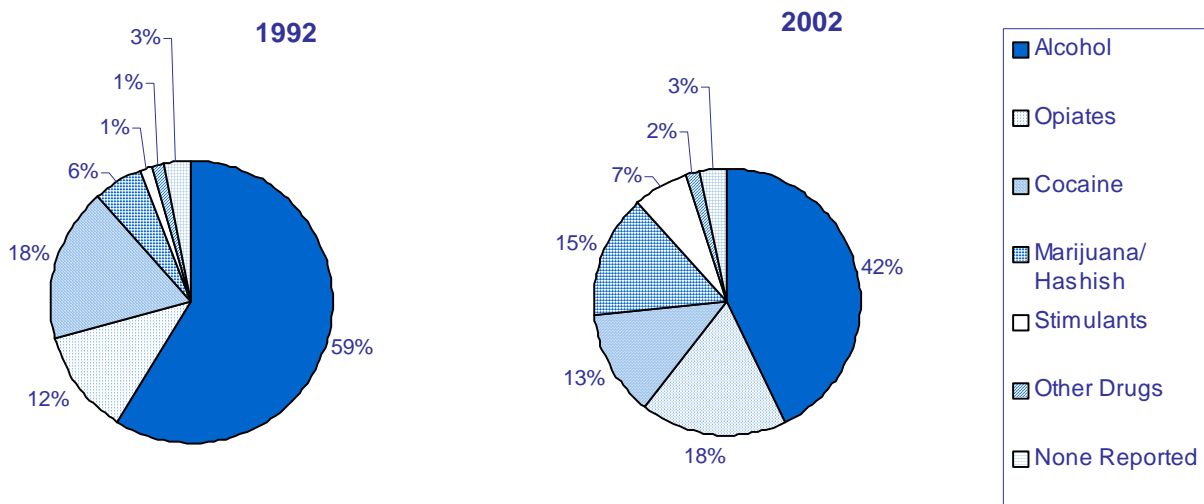
Admission patterns to treatment facilities also changed significantly from 1992 to 2002. For instance, admissions for alcohol dependence and abuse declined from 59 percent to 42 percent and admissions for cocaine declined from 18 percent to 13 percent. These decreases were offset, however, by increases in admissions for marijuana/hashish users from 6 percent to 15 percent, for primary opiate users from 12 percent to 18 percent and for stimulant users from 1 percent to 7 percent. Among youth 15 to 17 years of age, admissions for marijuana rose from 23 percent to 63 percent (SAMHSA, 2004b). These data point to the necessity of having a workforce prepared to respond to both changes in drug use and patient characteristics.

The complex constellation of conditions with which individuals often present to treatment, including co-occurring mental health and substance use disorders, co-morbid medical conditions, homelessness and criminal justice or child welfare system involvement, places exceptional demands on the workforce and requires a sophisticated, multi-disciplinary approach bridging the mental health, medical and other systems.

Screening for hazardous substance use patterns and potential addictive disorders is beginning to be adopted in generalist settings, i.e., hospitals, emergency rooms, ambulatory clinics and other medical and non-medical settings. This practice will likely result in individuals presenting for specialty addiction services earlier in the progression of their addictive disorders. As protocols for Screening, Brief Intervention and Referral to Treatment (SBIRT) are adopted more broadly, the professionals in the addiction treatment field will increasingly be faced with two populations that, heretofore, have typically not been served: individuals described above, who are just beginning the progression to dependence, and individuals with a diagnosable dependence disorder, who are not yet ready to initiate traditional treatment but may be willing to engage in low-demand motivational interventions that could eventually lead to treatment. Staff will need to be trained to effectively engage patients/clients in a manner that is fully cognizant of and responsive to both their clinical presentation and their readiness for change.

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**Figure 1. Primary Substance at Admission: 1992 and 2002**



Source: AMHSA, 2004b.

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For many organizations, developing the capacity to more effectively treat those who are multiply impaired, those who are just beginning the progression toward dependence and those who, while dependent, are not yet ready to engage in treatment, represents a significant challenge. Growing evidence indicates that the addiction treatment field must be prepared to serve populations that present with increasing levels of impairment across multiple domains as well as populations that present earlier in the progression of a substance use disorder than in the past. Four trends related to increased severity cause concern:

- **Increased potency of illegal drugs such as marijuana and heroin.** The University of Mississippi's 2000 Marijuana Potency Monitoring Project showed that commercial grade marijuana tetrahydrocannabinol (THC) levels rose from under 2 percent in the late 1970s and early 1980s to 6.1 percent in 2000 (DEA, 2003). Also, data from the System to Retrieve Information from Drug Evidence (STRIDE) showed that the nationwide average purity for heroin from all sources in 2000 measured approximately 37 percent, in contrast to 26 percent in 1991 and 7 percent in 1980 (DEA, 2001).
- **Consumption of dangerous drugs among younger users and, in particular, increased heroin addiction within this population.** The availability of high-purity heroin, which can be snorted, has given rise to a new generation of younger users (DEA, 2001).

## I. Historical Context: Trends Impacting the Workforce

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- **Serious medical problems among the patient/client population.** Increasingly, addiction programs are treating patients/clients with serious medical problems. According to the Centers for Disease Control and Prevention (CDC), the number of individuals living with AIDS who were exposed by injection drug use increased from 55,735 in 1998 to 68,636 in 2002, an increase of 23.1 percent (CDC, 2002a). Viral hepatitis is also a significant problem among injection drug users (IDUs). According to the CDC, 17,000 (60 percent) of the 30,000 new cases of hepatitis C in 2000 occurred among IDUs. Hepatitis B and C infections are also acquired rapidly among IDUs. Within five years of beginning drug use, 50 to 70 percent of IDUs contract hepatitis B, while 50 to 80 percent contract hepatitis C (CDC, 2002b).

The rapid growth in methamphetamine use has led to a range of serious health problems among users. Cardiovascular problems associated with methamphetamine use include rapid heart rate, irregular heartbeat, increased blood pressure and stroke-producing damage to small blood vessels in the brain. Acute lead poisoning is also a growing problem among methamphetamine users, since a common method of illegal production uses lead acetate as a reagent (NIDA, 2002). Because lead poisoning in adults is associated with increased incidence of depression, aggressive behavior, antisocial behavior and brain damage, the treatment of patients/clients with lead exposure is challenging (NIDA, 2002).

- **Complex co-occurring disorders.** Complex co-occurring disorders are a significant issue among individuals in addiction treatment. According to the 2003 National Survey on Drug Use and Health, there were an estimated 19.6 million adults aged 18 or older with Serious Mental Illness (SMI) in 2003. This represents 9.2 percent of all adults compared to the rate of 8.3 percent found in 2002. Among adults with SMI in 2003, 21.3 percent were dependent on or abused alcohol or illicit drugs, while only 7.9 percent of non-SMI adults did so (SAMHSA, 2004a). An even larger concern is the number of individuals entering addiction treatment with a mild or moderate mental illness. The *2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions* (NESARC) found that 19.7 percent of the respondents with any substance use disorder had at least one independent mood disorder during the same 12-month period. Furthermore, 17.7 percent had at least one independent anxiety disorder. Of those who sought treatment for an alcohol use disorder, 40.7 percent, 33.4 percent and 33.0 percent had at least one independent mood disorder, independent anxiety disorder, or drug use disorder, respectively.

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Among respondents with any drug use disorder who sought treatment for that disorder, 60.0 percent had at least one independent mood disorder, 42.6 percent had at least one independent anxiety disorder and 55.7 percent had a co-morbid alcohol use disorder (Grant et al., 2004). Only 8.5 percent of individuals who need specialty addiction treatment access care, suggesting that those entering treatment are waiting until their conditions are more acute before seeking help (NSDUH, 2004b). The NESARC provides evidence that mood and anxiety disorders must be addressed in the generalist setting, before individuals require treatment within the specialty treatment setting. Left untreated, these disorders can lead to relapse of substance use disorders and other adverse outcomes.

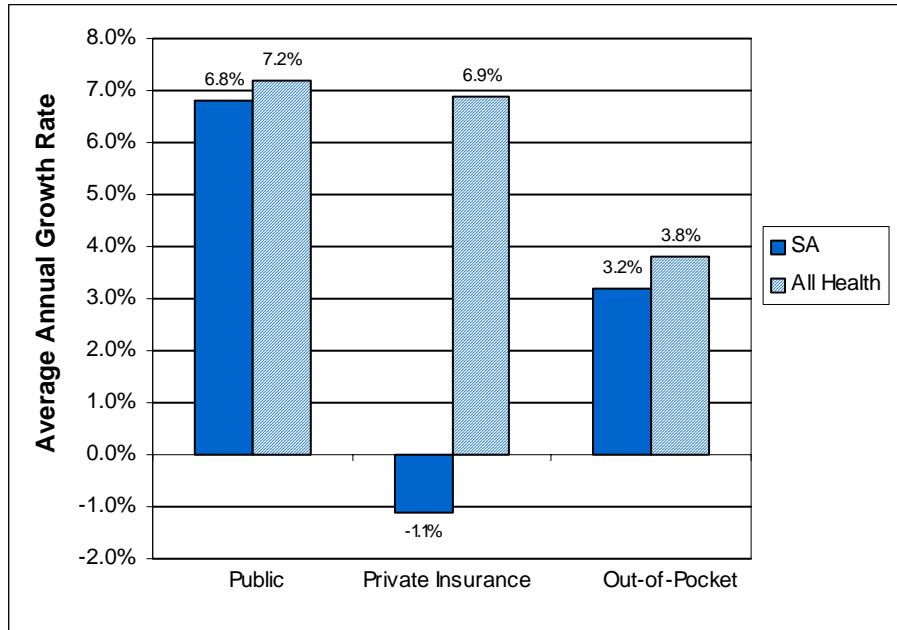
### **Shift to Increased Public Financing of Treatment**

Individuals with substance use disorders rely on public sources of funding to a much greater extent than people with other diseases. According to *National Expenditures for Mental Health Services and Substance Abuse Treatment 1991-2001*, 76 percent of total substance use spending was from public sources, while only 45 percent of all health care was publicly financed (Mark et al., 2005). During the 10-year period covered by the report, public expenditures for substance use grew by 6.8 percent annually whereas overall public health care expenditures grew by 7.2 percent annually. Strikingly, private payer expenditures in the form of insurance reimbursements for substance abuse services trended in the opposite direction, falling by 1.1 percent annually while overall insurance expenditures for health care increased by 6.9 percent annually during that period. Out-of-pocket spending for addiction-related services grew by 3.2 percent annually, compared to 3.8 percent for all health (Mark et al., 2005).

This study unequivocally points to the fact that the majority of substance use disorder treatment is financed by the public sector, that this trend is continuing and that care for substance use disorders is not financed in the same manner as other health care conditions. Though addiction impacts all segments of society, lack of health coverage for treatment places enormous demands on an already overburdened publicly funded system and its workforce. Given current pressures on public funding of treatment services, particularly at the State and local levels, this precipitous decline in coverage is especially onerous.

# I. Historical Context: Trends Impacting the Workforce

**Figure 2. Growth of Public, Private Insurance and Out-of-Pocket Payments for Substance Abuse (SA) versus All Health, 1991-2001**



Source: (Mark et al., 2005).

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## Use of Best Practices

The adoption of best practices requires a stable infrastructure, organizational commitment and staff development. Indeed, the gap between what we know and what we practice is sizeable.

Increasingly, the workforce is assimilating best practices into its work. Practitioners are replacing unproven approaches involving harsh confrontation with research-based approaches such as brief intervention, brief treatment, motivational interviewing and motivational enhancement techniques, social skills training, contingency management and community reinforcement. Many of these clinical approaches primarily focus on the use of objective feedback and empathic listening to increase a person's awareness of the potential problems caused, consequences experienced and the risks faced as a result of his or her substance use (Rollnick and Miller, 1995).

Although the field has progressed toward incorporating best practices into its work, a disconnect exists between research findings and traditional approaches. Hester and Miller (1995) studied the use of evidence-based practices by community-based providers and found that addiction treatment practitioners most frequently used approaches with the least scientific validity, such as insight psychotherapy, relaxation training, education and milieu therapy.

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In fact, practitioners relied least frequently on approaches with the strongest foundation of research. *The Handbook of Alcoholism Treatment Approaches: Effective Alternatives* states, “The negative correlation between scientific evidence and treatment-as-usual remains striking and could hardly be larger if one intentionally constructed treatment programs from those approaches with the least evidence of efficacy” (Hester and Miller, 1995). These results underscore the challenges of transferring new knowledge into practice.

## Increased Utilization of Medications in Treatment

Since the 1980s, medications for treating substance use disorders have become more available. Advances in this area have profound implications for improving treatment outcomes and the quality of life for patients/clients. Combining pharmacological and behavioral treatments often improves patient/client response better than either component alone. For example, just as high cholesterol can be dramatically reduced by combining diet and exercise with cholesterol-lowering medications, risk of relapse for an alcohol-dependent person can be reduced by administration of Naltrexone in combination with treatment and community-based supports. Addictive disorders mirror other chronic disorders in that they often respond better to treatment approaches that extend over time, addressing physiological and neurological components of the disorder in addition to providing strategies and supports to replace unhealthy patterns with healthy ones.

Medications are used for detoxification, co-morbid psychiatric conditions, opioid agonist/antagonist therapy, office-based opioid treatment, maintenance of abstinence and pain management. For example, approval of Buprenorphine by the Federal Drug Administration (FDA) provides a viable new option (in addition to Methadone) for addressing opiate addiction. By offering an office-based treatment option, Buprenorphine has the potential of expanding access to services by making them available in settings previously not possible, i.e., physician practices. In addition, Disulfiram (Antabuse) has long been used to assist individuals with alcohol dependence to abstain. Naltrexone has also been used to assist alcoholics and opiate addicts in maintaining abstinence. In July 2004, the FDA approved Campral (Acamprosate) for assisting individuals in maintaining abstinence after withdrawing from alcohol. Acamprosate is the first medication approved for the treatment of alcoholism in a decade.

The prevalence of co-occurring mental health disorders requires concurrent pharmacological and psychosocial interventions, making psychotropic medications an increasingly significant component of the addiction treatment process. Moreover, the high rates of co-morbid chronic medical disorders and contagious conditions with which individuals seeking publicly funded treatment present require that programs have the ability to administer and monitor a broad array

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of medications to treat conditions ranging from hypertension and high serum cholesterol to tuberculosis, hepatitis C and HIV disease.

Though attitudes are changing, some physicians remain reluctant to prescribe medications to treat addictive disorders or co-occurring mental health disorders. In addition, many treatment professionals still harbor negative perceptions about the use of pharmaceutical interventions. The increasing use of medications has significant workforce implications. Not only does it require increased availability of nurses, physicians and other health care practitioners to prescribe, administer and monitor medication, it also requires practitioners to learn to assess potential medication needs and to incorporate pharmacological interventions into treatment plans and treatment protocols. Finally, the increasing use of medications will require further rapprochement between the specialist treatment and generalist medical care systems and will likely require co-location of generalist and specialist staff in both systems.

Over the next decade, the ability to utilize medications to treat both mental health and addictive disorders will become increasingly important. The demands on the workforce will be significant and cross-systems collaboration will be essential to make available the kind of multi-disciplinary teams necessary to effectively provide care in this environment. While there is wide variation in the level of medical staffing across programs, States and localities, a recent study found that, nationally, only 54 percent of “programs had even a part-time physician on staff. Outside of methadone programs, less than 15 percent of programs employed a nurse” (McLellan et al., 2003). Mechanisms for recruiting and training additional physicians, nurses and other primary health care practitioners will need to be found.

## **Movement Toward a Recovery Management Model of Care**

Although substance use disorders are often chronic, conventional treatment approaches have typically used acute models of care. As Dennis, Scott and Funk (2003) note:

Longitudinal studies have repeatedly demonstrated that addiction treatment (particularly for 90 or more days) is associated with major reductions in substance use, problems and costs to society ... However, post-discharge relapse and eventual re-admission are also the norm ... The risk of relapse does not appear to abate until 4 to 5 years of abstinence ... Retrospective and prospective treatment studies report that most clients undergo 3 to 4 episodes of care before reaching a stable state of abstinence ... In spite of this evidence of chronicity and multiple episodes of care, most ... treatment continues to be characterized as relatively

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self-encapsulated, serial episodes of acute treatment with post discharge aftercare typically limited to passive referrals to self help groups.

In the past 15 years, the primary health care field has developed a new approach to the treatment and management of chronic health care disorders such as diabetes mellitus, hypertension and asthma. This approach is called “disease management.” Managed care organizations have built disease management protocols into requirements for the treatment of chronic conditions, such as diabetes. Segments of the addiction treatment field are beginning to evaluate how they can apply similar models. Such models are critically important as the use of medication-assisted therapies for substance use disorders becomes more prevalent and as the profile of the publicly-funded addiction patient/client becomes more complex, involving an increasing variety of co-morbid medical and psychiatric conditions that must be managed in concert with the substance use disorder.

The disease/recovery management concept applied to addiction treatment focuses on interventions that strengthen and extend the length of remission periods, reduce the number of relapse events, quickly re-engage individuals in services at the time of relapse and reduce the intensity and duration of relapse episodes. Recovery management models:

- Apply new advances in scientific research and practice;
- Build upon peer-to-peer support, a practice used traditionally in the field;
- Involve individuals in the management of their own illness;
- Implement best practices with a professionally trained workforce, supported by trained recovery specialists;
- Utilize case management to ensure continuity of care;
- Place greater emphasis on the long-term recovery process as opposed to a specific treatment episode; and
- Incorporate monitoring support (e.g., check-ups) throughout treatment, using the results to guide the course of subsequent care.

States are including disease/recovery management in their substance use disorder treatment services. For example, the State of Connecticut has designated the concept of “recovery” as the overarching goal of its delivery system for mental health and addiction services. Through identified model programs, it has created Centers for Excellence in key recovery-oriented areas: outreach and engagement, cultural competency, person-centered planning, peer-run programs, core skills and supported community living. The State of Arizona has revised its Medicaid plan

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for addiction services to include peer-delivered recovery support through the full continuum of care.

Findings to date on the application of recovery management principles are encouraging. For example, a recent NIDA-funded study of individuals (n = 448) randomly assigned to recovery management checkups (RMCs), assessments, motivational interviewing and linkage to treatment re-entry, found that participants assigned to RMCs were significantly more likely than those in the control group to return to treatment, to return to treatment sooner and to spend more subsequent days in treatment. They were also significantly less likely to be in need of additional treatment at 24 months (Dennis et al., 2003).

Preliminary research indicates that recovery management approaches hold great promise. To the extent that States and treatment provider organizations adopt such approaches, the workforce will not only need training and support to integrate these protocols, but will also need to establish networks with a variety of traditional and non-traditional partners.

## **Provision of Treatment and Related Services in Non-Specialty Settings**

A diverse group of individuals within the addiction treatment workforce provides services in two sectors: the generalist and specialist treatment sectors. The generalist setting consists of primary health care centers and other community settings (e.g., trauma centers/emergency rooms, ob-gyn clinics, occupational medicine programs, schools with student assistance programs and student health services, welfare offices and work sites with employee assistance programs). Staff ranging from medical personnel to social workers and health education workers deliver services in generalist settings and perform three primary functions:

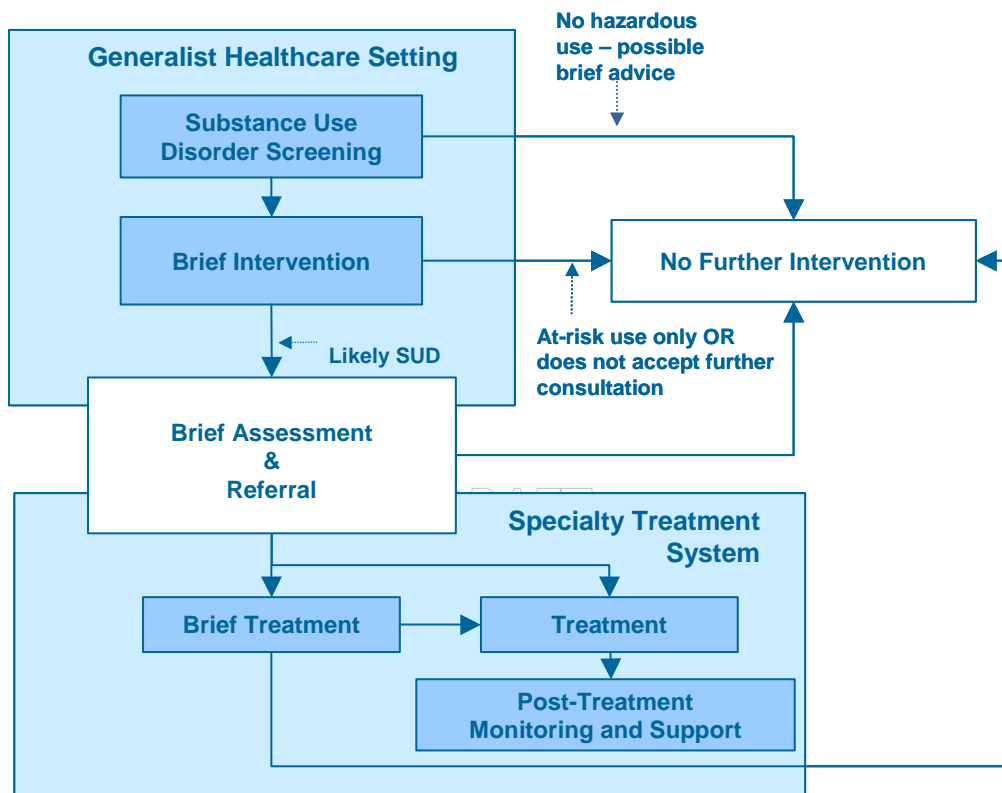
- Screening for alcohol and drug problems;
- Brief intervention and brief treatment for non-dependent users; and
- Referral and follow-up to the specialist treatment system for dependent users.

Historically, staff within the generalist setting has not screened and provided services related to substance use problems to non-dependent users in a concerted way, but changes are occurring due to a recognized need to intervene with individuals before high-risk behaviors progress to a diagnosable substance use disorder. Generalist setting staff has not been trained in substance use disorders and they lack the knowledge to detect such problems. To help overcome these barriers, SAMHSA/CSAT developed the SBIRT Initiative, which is now being implemented in seven

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States. An evaluation of this \$22 million effort is underway, so that the field may benefit from the knowledge gained from it. Figure 3 illustrates a basic SBIRT model.

**Figure 3. Illustrative SBIRT Flow Chart**



The specialist setting is designed to treat individual users with substance use dependence. In the for-profit sector, specialty addiction treatment may be provided through managed care organizations, private independent programs or private practitioners. However, the vast majority of specialty addiction treatment is provided through community-based, non-profit agencies with public funds.

The diversity of the population with substance use disorders requires the workforce to be equipped to address the disease in both the generalist and specialist settings. A large segment of the population would benefit greatly from screening and brief intervention in the generalist setting, potentially reducing the number of individuals who would eventually require specialty treatment. However, the workforce within the generalist setting is not prepared to address this issue in a significant manner without substantially more education and training, including

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training related to serving those with co-occurring disorders. Further, the workforce within the specialist setting has ongoing training needs due to changing treatment technology and staff turnover. Cross-training of generalists and specialists is critically important. The magnitude of this disease and the scarcity of resources dedicated to its treatment require that the two settings work together to meet the challenges that drug and alcohol use present.

## Use of Performance and Patient Outcome Measures

The addiction field is experiencing increasing demands for accountability in treatment performance. Funding entities and service providers want quantitative feedback on the benefits experienced by service recipients and on measures necessary for enhanced treatment efficiency and effectiveness. The Washington Circle Group, “a multi-disciplinary group of providers, researchers, managed care representatives and public policy makers” convened by SAMHSA/CSAT in 1998 to develop a core set of performance measures for addiction treatment, has noted that “monitoring the quality and availability of alcohol and other drug services must be a central tenet of any health-related performance measurement system.” The Washington Circle Group has further noted that “performance measures for alcohol and other drugs need to become an integral part of a comprehensive set of behavioral and physical health performance measures for managed care plans” (Washington Circle Group, 2005).

Nationally, across both private and public sector managed care plans, the Health Plan Employer Data and Information Set (HEDIS) is the most widely adopted package of performance measures (Washington Circle Group, 2004). Developed by the National Committee for Quality Assurance (NCQA), HEDIS is a set of standardized performance measures designed to permit reliable comparison of the performance of managed health care plans (NCQA, 2005). Until 2003, it included no performance measures related to the treatment of addictive disorders.

In February of that year, NCQA added two measures specific to substance use disorders that had been developed by the Washington Circle Group: 1) *Identification of Alcohol and Other Drug Services*, which tracks the percentage of plan members who initiate addiction treatment services and the type of service provided; and 2) *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*, which measures the percentage of plan members who receive two or more additional substance use disorder services within 30 days of initiation (NCQA, 2003).

In a report entitled *Rewarding Results: Improving the Quality of Treatment for People with Alcohol and Drug Problems*, a national policy panel headed by Jerome Jaffe, M.D., affirmed the Washington Circle Group’s performance measures. However, the panel recognized that “weak

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infrastructure dramatically limits the effectiveness of many basic quality improvement strategies.” The panel acknowledged that “many programs are well run and provide high quality care,” but pointed out that “too many are fiscally weak and unstable.” The panel argued that “only in a more stable treatment system can we hope to use training to achieve significant increments in quality” (Join Together, 2003).

To begin developing a stable infrastructure upon which to build training, technology transfer and quality improvement systems, the panel recommended that public and private funders financially reward programs with good results. Acknowledging the difficult truth that doing so would mean “taking patients and funds from programs with consistently poor results,” the panel recognized that weaker programs would likely need to close or consolidate with other programs. However, the panel expected that under such financial incentives, “new partnerships should evolve among providers that help them preserve their viability without total merger – for example, arrangements that allow them to share specialized personnel and administrative or technology costs” (Join Together, 2003).

Systems that provide financial incentives for the provision of quality care offer hope for the field, but also represent a significant challenge for provider organizations and clinicians and may be perceived by many organizations and professionals as more of a threat than an opportunity. However, it will require committed efforts of this kind on the national, State and local levels to significantly improve the quality of addiction treatment nationally. Such efforts would go a long way toward securing for the field the recognition and central role in health care systems that it merits. The field must play such a role to effectively address the addiction treatment needs faced within the United States.

## **Discrimination Associated with Addiction and the Addiction Treatment Workforce**

Negative perceptions of addiction have far-reaching results that go beyond their impact on the treatment workforce. A Join Together issue paper says rampant discrimination restricts access to education, housing, employment, financial assistance and health care for people with an addiction (2001). Some examples are:

- Insurance policies that deny or restrict coverage for addiction treatment;
- The Drug Free Student Aid provision of the U.S. Higher Education Act, which denies financial aid to students with a drug conviction; and
- The 1996 welfare reform provision that imposes a lifetime ban on welfare benefits for people convicted of possessing or selling drugs.

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According to *The Christian Science Monitor*, experts in treatment and recovery estimate that when recovering individuals are honest about their drug histories, they will get turned down for a job 75 percent of the time (Marks, 2002). A Join Together feature article cites a California survey in which 59 percent of employers said they would never hire anyone with a felony conviction (Curley, 2002).

As noted above, discrimination also results in avoidance of treatment, often delaying care until the substance use disorder has progressed substantially and/or complex co-occurring disorders emerge or worsen. Among the one million people who felt they needed but did not receive treatment, 19.6 percent reported that they did not try to access it due to the stigma associated with addiction (NSDUH, 2004b). The net result of such treatment avoidance is that individuals present to treatment later with more complicated needs. They are subsequently more costly to treat than they would have been had an intervention occurred earlier. Effectively addressing stigma around addiction could result in more timely intervention, improved outcomes and reduced health care costs.

Discrimination also affects the addiction treatment professional. Many believe that the stigma attached to addiction results in decreased funding to address workforce issues and has a detrimental effect on attracting and retaining professionals in the workforce. Addiction treatment struggles to be recognized as a field that provides vital health care for a life threatening chronic disorder.

## Implications of Current Trends

Over the past decade, trends have reflected the increasing pressures experienced by the addiction treatment workforce. Individuals entering treatment are presenting with more complex and severe disorders while resources have remained relatively scarce. Private health plan coverage of addiction treatment has declined in fixed dollars and as a percentage of overall health plan coverage over the past decade, placing even greater demands on a system that was already inadequately funded to meet demand. In 1991, private insurance accounted for 24 percent of substance abuse treatment expenditures whereas, in 2001, it accounted for only 13 percent (Mark et al., 2005). At the same time, the profile of the publicly funded addiction treatment patient/client has changed. Clinicians and programs must be prepared to address the needs of both a more severely impaired population with problems that are more numerous and more intractable and a less impaired population that is being referred earlier in the progression of the addictive disorder. To maintain skills that will keep pace with the rapidly changing environment,

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the workforce must be resilient, clinically competent and adaptable. Addressing these challenges will require continuing skill development at the executive, management and practitioner levels.

The following section summarizes the input from the diverse stakeholders convened by SAMHSA, cites relevant literature and makes recommendations across major topic areas central to the discourse on the identity of the addiction treatment field and the challenges and opportunities it faces. It is intended to guide the development of organizational, local, State and national strategies for addressing the many workforce challenges faced by the addiction treatment field. In addition, it identifies SAMHSA/CSAT implementation priorities relevant to these workforce development strategies.

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### A. Infrastructure Development Priorities

#### Infrastructure Issues in Brief

A sound addiction treatment infrastructure ensures the availability of a qualified workforce capable of meeting the treatment and recovery needs of diverse populations. This infrastructure must include mechanisms to attract, educate, train and retain staff and to support the dynamic capacity of the treatment delivery system. The infrastructure also must include information systems that support and enhance workers' abilities to manage treatment services and ensure accountability and quality of care.

Current data indicate that more than 67,000 practitioners provide addiction treatment and related services (Harwood, 2002). By 2010, the need for addiction professionals and licensed treatment staff with graduate-level degrees is expected to increase by 35 percent (NASADAD, 2003). With anecdotal evidence already indicating a shortage of staff, more severe staffing shortages are anticipated in the near future. Exacerbating these issues is the current unmet need for treatment services. Staff workloads are high, salaries are low and employee benefits are minimal. The effects on the workforce are dramatic: staff turnover rates of nearly 20 percent and high levels of worker dissatisfaction (Knudsen et al., 2003; Gallon et al., 2003).

With treatment organizations struggling to recruit and retain staff, attracting individuals to the field to expand capacity is a challenge. A modest 10 percent increase in treatment capacity would require an additional 6,800 clinicians above the annual number currently required to replace staff leaving clinical practice (Lewin Group, 2004). The treatment system's capacity to close the gap in alcohol and drug treatment is severely threatened by a lack of national occupational standards, inadequate incentives to enter the addiction treatment workforce and an absence of defined career paths.

#### Recommendations

To strengthen the addiction treatment infrastructure, stakeholders made the following recommendations:

1. Revise existing core competency standards and create career paths for the addiction treatment and recovery workforce, including a strategy for adoption of national core competency standards by States;

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2. Establish a health services corps loan forgiveness and repayment program for addiction treatment professionals;
  3. Foster network development; and
  4. Provide technical assistance to enhance the capacity to use information technology.
- 1. Revise existing core competency standards and create career paths for the addiction treatment and recovery workforce, including a strategy for adoption of national core competency standards by States.**

Competency standards articulate expectations of professional practice and ensure that individuals holding a specific type of position have the same basic core knowledge, skill and/or ability. SAMHSA/CSAT, through a consensus process, developed *Technical Assistance Publication 21 (TAP 21) Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice*, which defines competencies and serves as a basis for the field to move forward on national competency standards. By developing and implementing national core competency standards, variation in clinical practice will be lessened and quality of care will be improved. The Institute of Medicine's (IOM's) recent report, *Health Professions Education: A Bridge to Quality*, calls for the adoption of core competencies across all health professions (2003). Further, creating career paths that incorporate core competencies provides credibility to the field and professional development and advancement opportunities for those wishing to enter the workforce.

### **Discussion**

*“A competency is a measurable human capability that is required for effective performance. A competency may be comprised of knowledge, a single skill or ability, a personal characteristic, or a cluster of two or more of these. Competencies are the building blocks of work performance. The performance of most tasks requires the simultaneous or sequenced demonstration of multiple competencies” (Marrelli et al., 2004).*

Although the addiction treatment field is relatively young, it has distinguished itself as a specialty. As in other health care fields, specialization creates the need to define standards of care and the core competencies required to provide care. While every State has a credentialing process and most States have an entry-level counselor credential (NASADAD, 2003), credentialing standards differ among States and, within a few States, there is more than one

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credentialing organization. National core competency standards for addiction treatment professionals have not been adopted.

To garner greater legitimacy and recognition as part of mainstream health care, it is critically important that the field move forward as a discipline and adopt national competencies. A collaborative process must be established with the States to implement and periodically update national core competency standards. By adopting national core competencies, States can develop career paths incorporating practice standards recognized by the field.

Career paths provide structure for organizations and individuals in the workforce and identify potential opportunities for career advancement. Additionally, career paths help individuals understand that they are part of a profession, validating not only training and academic credentials, but also time in the field and prior experience. For example, personal experience in recovery provides many clinicians with a unique and valuable experiential base and perspective. Moreover, many patients/clients prefer to be counseled by someone who has gone through treatment and the recovery process (McCarty, 2002). Career paths provide a mechanism for recognizing the value of this experience in addition to academic training through the range of positions that are offered on “the path.”

Career paths also support the retention of competent professionals, help to identify the range of managerial, supervisory and other professional options available to those entering the field, enable workers to plan their own professional development and set career goals and give recognition and status to individuals progressing along a track to higher-level positions. By developing career paths with associated core competencies, the addiction treatment field will demonstrate its commitment to maintaining professional standards for all individuals in the treatment and recovery workforce.

The process of developing and adopting both career paths and competency standards must include evaluating current State competency and credentialing requirements and reviewing the literature related to competency modeling. In addition, the process must include coordination with certification, licensing and accreditation boards to ensure linkages and internal consistencies among all oversight bodies and inclusion of competencies in credentialing and licensing examinations of all professionals working in the addiction treatment field (IOM, 2003). Recognizing the urgent need to act in these areas, the leadership of the National Association for Addiction Professionals (NAADAC), the National Certification Commission (NCC), the International Certification and Reciprocity Consortium (ICRC) and the Society of Credentialed Addiction Professionals (S.CAP) met in February 2005 and agreed to collaborate to advance the

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addiction treatment field. In April 2005, a proposal to consolidate existing credentials into a unified set was submitted to the ICRC board. This proposal will be submitted to the NAADAC board in July of 2005.

### **2. Establish a health services corps loan forgiveness and repayment program for addiction treatment professionals.**

A national health services corps loan forgiveness and repayment program would attract young and second-career professionals to the field and retain committed addiction treatment staff who seek training for professional development and recertification. Loan forgiveness and repayment programs would provide needed financial support to potential addiction professionals when low salaries make it difficult to pay for academic training. Since the 1980s and as recently as 2002, Congress has authorized loan repayment programs for teachers and some health care providers (e.g., primary care physicians, nurses). These programs have been successful in attracting and retaining individuals in professions experiencing critical staff shortages.

#### ***Discussion***

A national addiction health services corps could be modeled after the National Health Services Corps (NHSC) for primary care providers. Such a program for addiction professionals would provide assistance in repayment of student loans for graduates agreeing to serve for a set period of years in communities with a critical workforce shortage. Student loan forgiveness and repayment programs are designed to encourage students to pursue academic training that will lead to employment in specific occupations. These programs forgive all or part of students' debts in exchange for working in underserved or economically disadvantaged communities.

Because of the workforce shortage in most communities nationwide, a loan forgiveness and loan repayment program for addiction professionals should be made available to individuals who make a commitment to work in any community, with special consideration to those choosing to work in economically disadvantaged areas. A loan forgiveness program for addiction treatment supports the belief that individuals in the treatment workforce are a national resource and acknowledges the workforce shortage as a national crisis. A corps would provide meaningful financial incentives to physicians, nurses, social workers, psychologists and counselors who consider careers within the addiction treatment field.

The NHSC has been funded by the U.S. Department of Health and Human Services (DHHS) for 30 years and is housed in the Health Resources and Services Administration's (HRSA's) Bureau

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of Health Professions. It is a competitive program that makes contract awards to clinicians who agree to serve full-time at approved sites in designated health professional shortage areas for a minimum of two years. In return, NHSC participants receive funds to repay government and commercial loans for education expenses incurred during their undergraduate and health professions graduate education (DHHS/HRSA, 2004).

Since its inception, over 22,000 clinicians have participated in the NHSC nationwide. Highlights of the program's success include:

- Approximately 97 percent of clinicians fulfill their commitment;
- Approximately 60 percent of NHSC participants continue to serve their target population four years after completion of their service obligation and 52 percent continue to serve 15 years after completion of their service obligation;
- Approximately 53 percent of NHSC clinicians are from underserved populations, which is 35 percent higher than the national workforce; and
- NHSC clinicians are in every State, the District of Columbia, Puerto Rico and the Pacific Basin (Fox, 2001).

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Loan forgiveness and repayment programs have demonstrated a measurable impact on recruiting and retaining clinical professionals in many communities. A 1997 GAO study of a Federal loan repayment program for physicians found that the program had a “greater impact than scholarship programs in achieving . . . the objective of providing underserved communities with clinicians...and recruiting individuals motivated by a more altruistic desire to practice in underserved communities, a factor that can improve long-term retention” (DHHS/HRSA, 2004).

A national addiction health services corps loan repayment program to recruit and retain addiction professionals is a promising idea that would not only increase the long-term supply of professionals in a wide range of geographic locations, but would also assist with the recruitment of underrepresented groups, increasing racial, ethnic and gender diversity. Like the NHSC, the national addiction health services corps should establish partnerships with State loan repayment programs to strengthen the incentive. Further, it is recommended that components of the addiction services corps include continuing education, training and job placement assistance for individuals who complete their service obligation.

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### 3. Foster network development.

As the field faces agency closures, particularly among smaller treatment providers, networks represent an important mechanism for ensuring agency viability and service availability. In addition, in some cases, networks can provide career paths for addiction professionals and potential staffing pools for member organizations.

#### *Discussion*

A study of the national addiction treatment infrastructure found that the organizational and administrative infrastructures of many addiction programs were inadequate and unstable (McLellan et al., 2003). In fact, of the 175 drug and alcohol treatment programs included in the study, 15 percent had either closed or stopped providing addiction treatment services. Additionally, 29 percent had been taken over or “reorganized” under a different administrative structure. In an effort to help strengthen management efficiency and ensure long-term sustainability, small addiction treatment providers may benefit from collaborative engagement in a network or use of a shared management organization to assist with human resource needs and clinical and administrative functions.

Networks can enhance the infrastructures of member agencies by making available specialized staff. For example, nursing, vocational, psychiatric, psychological, clinical social work and other services can be shared through co-location, joint funding, referral, or rotation. This results in an economy of scale for participating agencies and also makes available critically needed supports, many of which would not be affordable otherwise to member agencies. As systems move toward evidence-based practices and expand the use of medications in treatment, affordable access to an array of specialized and relatively expensive staff resources becomes increasingly important.

In addition, networks can reduce pressure on the workforce by making available more appropriate program options and a greater pool of medical and clinical expertise than would otherwise be available. As noted above, network membership has the potential to be of particular value to smaller agencies because the resources that can be accessed (e.g., nursing and psychiatric services, shared information technology, billing, payroll and other administrative functions) enable them to function in a more cost-effective manner. Furthermore, the cost structures of small agencies often make operations difficult in times of economic constraint.

To the extent that networks are formalized (e.g., via contract with each other or with a shared management organization), they can also offer viable career paths for staff working at member

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agencies. Participating in such a program across agencies requires a workforce development plan that is shared across network agencies and that is designed to let all network members accrue the long-term benefits of a readily accessible pool of potential employees and a more stable workforce.

When organizations join together in networks, they benefit from the ability to manage care efficiently across agencies and those they serve benefit from access to a more complete array of services. This has the potential to simultaneously improve efficiency of patient/client flow and cost-effectiveness. Participation in a network may also make it easier for organizations to reach their target populations and to maximize positive outcomes through an improved match between programs and patients/clients. A study has shown that when programs offer a full continuum of services, they will have the ability to better match patients/clients to services, and clinicians will have a greater sense of job satisfaction (Kauffman and Woody, 1995).

#### **4. Provide technical assistance to enhance the capacity to use information technology.**

Widely available technologies to support clinical and administrative services could alleviate many workforce challenges if they were broadly adopted by the addiction treatment field. However, these technologies are cost-prohibitive for many addiction treatment agencies. The current health care environment demands that technology in the addiction treatment field be greatly improved. Technology permits clinicians, supervisors and administrators to benefit from real-time feedback and reporting to support care management, quality improvement, clinical supervision and outcomes monitoring. Greater access to information technology also provides professional development opportunities for managers and staff who want to obtain certifications and continuing education credits through the use of online training programs or Web-based university and college courses.

#### ***Discussion***

Treatment organizations lag behind their counterparts in the health care industry with regard to the ability to access and use information technology. Many small programs do not even have a computer, much less a network, automated billing, or clinical records/clinical management systems. In testimony before the National Committee on Vital Health Statistics, Thomas McLellan, Ph.D., stated, that “the clinical monitoring approaches used in the treatment of other chronic illnesses are also appropriate in the treatment of addiction. These approaches stress patient responsibility for disease and lifestyle management and the early detection of relapse ... [and]... require modern information management techniques and systems that provide standardized, relevant monitoring information to the clinician and to the payers.” He further

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noted that “less than 40% of addiction treatment programs have information systems available for clinical decision support and clinical record keeping. This infrastructure problem is due in some part to chronically poor funding levels but even more to the fact that so many of these programs are not connected professionally, financially or clinically with the rest of mainstream health care” (McLellan, 2005). Recognition as a part of mainstream health care and better integration with it could go a long way in reducing the digital divide that currently separates addiction treatment from the rest of health care.

Computer systems and the capacity to access and use modern information technology are important not only for improving administrative functions and business operations, but also for enhancing treatment services and improving the work environment. A major concern frequently expressed by clinicians is the burden of redundant paperwork (OASAS, 2002). Technology can provide effective tools to reduce the administrative workload on staff and allow more time for clinician care.

Recruitment, retention and development of the addiction treatment workforce are facilitated by the availability of information technology, most especially among young adults who typically rely on computers and other technologies for accomplishing basic tasks. Many people entering the field find no computers in the work setting. A recent study, for example, found that 20 percent of 175 counseling centers surveyed had no information systems, e-mail or even voice-mail (McLellan et al., 2003). Further, although 50 percent of the treatment programs studied had a computerized information system available to administrative staff, these systems did not support the provision or monitoring of care. The systems were, instead, dedicated exclusively to billing or administrative record keeping.

Technology offers at least three important service opportunities for patients/clients and staff: (1) management of clinical practices and administrative paperwork; (2) staff participation in on-line learning; and (3) provider on-line patient counseling, i.e., e-therapy. The ability of providers to access and use computer technology effectively can mean the difference between whether some people—especially patients in rural areas, the physically disabled and other underserved populations—receive treatment or not (New Freedom Commission, 2003).

Basic computer training, software and Internet access also provide staff with the tools to improve clinical processes, resulting in more efficient patient/client care and information. Greater efficiencies in patient/client care decrease staff workloads and improve the work environment. At the same time, recent privacy rules and guidelines on use of patient records (e.g., Health Insurance Portability and Accountability Act [HIPAA]) may require increased use of information technology in treatment settings. Technical assistance can help treatment organizations learn about these new

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rules and make the best use of information technology for communication, case management, staff development and delivery of quality, patient-centered care.

### B. Workforce Development Priorities

#### Workforce Development Issues in Brief

The addiction treatment field has undergone significant changes in recent years, including a greater emphasis on accountability, patient-centered care and best practices. These changes place significant demands on the workforce, particularly leaders and managers in the field who have primary responsibility for ensuring that organizations have systems in place to support and manage the achievement of positive treatment outcomes.

The depth of the leadership and management issues in the addiction treatment field is evidenced by a 53 percent turnover rate in 2002 for program managers and directors (McLellan et al., 2003). The aging of program managers further compounds the need to develop a new generation of leaders.

Greater use of best practices has also placed new demands on staff supervisors and managers who need the knowledge and skills to reinforce new practices. Management must also provide detailed expectations of supervisors' roles and responsibilities as technology transfer agents to make the adoption of evidence-based practices successful (Heathfield, 2004).

Training alone is not adequate to ensure full and effective application of practices and their sustainability over time. In cases where practice differs from past methods, intensive supervision is essential to ensure that technology transfer occurs. As noted in *The Change Book*, "too often brief flurries of training alone are thought to be sufficient in bringing about lasting change. The results are usually short-lived alterations in practice followed by discouragement and a return to familiar but less effective ways of doing things" (ATTC, 2004). A technology transfer strategy is required to ensure effective adoption of evidence-based best practices. Technology transfer "involves creating a mechanism by which a desired change is accepted, incorporated and reinforced at all levels of an organization or system" (ATTC, 2004). For best practices to be adopted, leadership and management must develop a technology transfer strategy to ensure long-lasting organizational change.

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### Recommendations

To address these workforce development issues, stakeholders made the following recommendations:

1. Develop, deliver and sustain training for clinical and recovery support supervisors, who serve as the technology transfer agents for the latest research and best practices; and
2. Develop, deliver and sustain leadership and management development initiatives.

#### **1. Develop, deliver and sustain training for clinical and recovery support supervisors, who serve as the technology transfer agents for the latest research and best practices.**

Clinical supervisors are critical in sustaining and developing staff competencies and must become a key focus of professional development efforts. Further, training for clinical supervisors must be based on a set of core competencies. Given the increased attention being placed on patient/client outcomes, the role of clinical supervisors as technology transfer agents is vital.

### ***Discussion***

Clinical supervisors serve a number of functions in treatment organizations. They function as clinical skill developers, technology transfer agents and role models who influence retention of new and experienced staff (Culbreth, 1999; NAADAC, 2003). Because clinical supervision is not a reimbursable activity in most States, many supervisors carry caseloads in addition to their administrative and managerial responsibilities. Clinical supervision provides support for practitioners struggling with the day-to-day pressures of the job and enhances clinical skills and professional growth. Effective supervision, by monitoring the delivery of treatment services, serves as part of the quality improvement process. Simply stated, clinical supervision is sound management practice.

Scientific advances and the emphasis on patient/client outcomes have heightened the need for well-trained, highly skilled and dedicated clinical supervisors. However, as stakeholders pointed out, individuals are often promoted to supervisory positions without management training or specifically defined roles.

Lifelong learning that builds the competencies of clinical supervisors is essential. Supervisors need training to develop their management skills and to update their competencies as new

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practices emerge. Competency-based training must acknowledge supervisors' varying skill levels. To address these diverse training needs, a work group supported by SAMHSA/CSAT is developing core competency guidelines for clinical supervision. Realizing this tremendous need, several Addiction Technology Transfer Centers (ATTCs) have begun enhancing the skills of clinical supervisors through technology transfer efforts. It is critically important that future training reflects the core competencies currently under development and that systemic training is provided through the ATTC network.

In addition to their other functions, clinical supervisors are instrumental in the retention of staff. A recent study of addiction treatment professionals with three or fewer years of experience (NAADAC, 2003) underscores the importance of clinical supervision in promoting job satisfaction and in retaining new frontline workers. This study identified the professional development resources and materials staff found most helpful and found that staff preferred resources involving interpersonal interaction (e.g., internships, on-the-job training, supervision and mentoring) to more formal written or didactic resources. More than 80 percent of these early career staff identified clinical supervision as having the greatest value in their professional development (NAADAC, 2003).

Additionally, recovery support supervisors should receive ongoing training. Although the training needs of supervisory staff in recovery support settings are different from the training needs of treatment personnel, they both share a common goal, supporting an individual's recovery. Training should be specifically designed and based on the functions and roles of staff in recovery support positions.

### **2. Develop, deliver and sustain leadership and management development initiatives.**

The field is undergoing a leadership and management crisis with many agency directors approaching retirement age within the next decade and considerable turnover occurring at high levels of treatment organizations. New leaders and managers are needed to effectively guide increasingly complex delivery systems. Leadership and management practices impact all aspects of the organization: fiscal, clinical, administrative and human resources. Good management practices positively impact retention by maintaining staff, supporting organizational change and fostering increased productivity. They are also critical to maintaining pace in a challenging treatment environment.

For example, organizations frequently diversify funding to offer comprehensive care to patients/clients. Multiple funding streams generate numerous regulatory requirements that must be

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implemented and monitored by highly skilled managers. This progressively complicated treatment environment necessitates strong management practices. Therefore, leadership and management development initiatives should be delivered and sustained for the addiction treatment field.

### ***Discussion***

Many changes have occurred since the current generation of leaders entered the field. As co-morbid medical and mental health disorders are identified with increasing frequency among those served, the provision of treatment has become more complex, requiring the participation of multiple disciplines. Science has taken on a more prominent role as the basis for addiction practices and there is a greater focus on outcomes and accountability. As the addiction treatment field grows, the need for effective leadership has never been greater.

Leadership development initiatives must be established and sustained to build the human capacity necessary to manage the organizational and system demands on the workforce. As in any industry, active staff development and succession planning to prepare a new generation of leaders are critical to organizational survival.

In addition, most organizations do not have a coordinated plan to manage the existing and future gap in leadership. Required leadership skills have become more complex and include strategic planning; fiscal planning; an understanding of Federal, State and local policies; and contracting, communications (e.g., public speaking) and collaboration skills and mentoring.

As in all business enterprises, managers must have skills in financing, contracting, team building, marketing and human resource development to operate an organization effectively. Health care organizations' survival is heavily dependent on proven business practices. Many treatment agencies struggle to meet system demands when their managers lack strong business skills. A body of knowledge has begun to develop around best practices that will assist treatment agencies.

Introducing and fostering the use of leadership and management best practices can result in better-run facilities. Management best practices include:

- Providing staff development/training;
- Allowing for flexible work schedules;
- Rotating staff assignments;
- Providing staff mentors;

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- Rewarding staff for performance; and
- Providing supportive supervision and manageable caseloads (Annie E. Casey Foundation, 2003; Hager and Brudney, 2004).

A study (Knudsen et al., 2003) suggests good management practices that can improve staff retention and reduce turnover. These include:

- Increased job autonomy;
- Recognition and reward for strong job performance; and
- Establishing a work environment that supports creativity and innovation.

To address this workforce dilemma, a comprehensive initiative, focusing on leadership and management competencies, should be undertaken for State staff and community-based providers.

### C. Recruitment Priorities

#### Recruitment Issues in Brief

The ability to maintain an adequate addiction treatment workforce is threatened by the difficulty in recruiting staff. The Bureau of Labor Statistics estimates that there will be 3,000 unfilled positions for addiction counselors by the year 2010 (Landis et al., 2002). Another study reports that 5,000 new counselors will be needed each year to replace those leaving the workforce (Lewin-VHI, 1994). In addition, stakeholders offer anecdotal information indicating that staffing shortages exist at every level of the workforce. Demographic changes, particularly the aging of the current workforce, are expected to worsen these shortages over the next decade.

Innovative and comprehensive recruitment strategies, such as a national addiction professional health services corps, described previously in Section A, are needed. These strategies must accommodate the dynamic nature of the treatment field, including increased demand related to new types of funding for treatment services, the need to keep pace with scientific advances, staff turnover and required training time for staff. Recruitment efforts must also address the underlying conditions that make people reluctant to enter the addiction treatment workforce: low salaries, minimal benefits, negative public perceptions of the field, high caseloads, patients' increasingly complex health care needs, low professional status and stressful working conditions (Knudsen and Gabriel, 2003).

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Treatment agencies compete with other sectors of the economy that often pay higher wages and place fewer demands on workers' time. The need for staff with higher levels of education and training is greater now than it was even a few years ago due to the (1) increasing complexity of the patient/client population entering treatment and (2) scientific advances in treatment. The pool of trained workers is failing to keep up with demand. Compounding these issues is the limited supply of new workers. Between 2000 and 2030, for example, the total population of working age individuals (18 to 64 years) is projected to grow by only 16 percent (Scanlon, 2001).

Staff recruitment is therefore taking on greater urgency in the addiction treatment field. Unquestionably, the issues exacerbating staff recruitment problems are complex and difficult to resolve. The field is challenged with developing creative strategies that address these recruitment issues and must work in partnership with educational institutions, Federal and State agencies, the public health care system, the media and others to develop and implement effective strategies.

Key strategies should be developed for increasing the diversity of the addiction treatment workforce so that it more closely reflects the patient/client population. As Figure 4 (below) shows, there are discrepancies between the demographics of the addiction treatment staff and the addiction treatment patients/clients. Clinicians tend to be White females over the age of 45, while most patients/clients are younger males with more diverse racial and ethnic backgrounds. The addiction treatment workforce must become more diverse and culturally competent at all levels to better serve the patient/client population (Kaplan, 2003).

**Figure 4. Demographics of the Workforce**

	Clinicians	Patients
Age	Average age: 45-50	50% between ages 25-44
Race	70-90% Non-Hispanic Whites	60% Non-Hispanic Whites
Gender	50-70% Female	70% Male Admissions

*Source: Kaplan, 2003; SAMHSA, 2002.*

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### Recommendations

Stakeholders made the following recommendations:

1. Expand recruitment of health care professionals in addiction medicine;
2. Improve student recruitment with educational institutions, focusing on under-represented groups;
3. Employ new marketing strategies to attract younger workers to the addiction treatment field; and
4. Continue efforts to reduce the stigma associated with working in addiction treatment.

#### **1. Expand recruitment of health care professionals in addiction medicine.**

The tremendous growth over the past two decades in the availability of medications in substance use disorder treatment and the increasingly complicated medical conditions that the patient/client population brings to treatment reaffirm the need for more nurses, physicians and psychiatrists in specialty treatment. Few programs, other than those that offer methadone as an adjunct to treatment, have nurses on staff and just over half employ physicians (McLellan et al., 2003).

Some of the boundaries that have traditionally separated specialty addiction and generalist medicine need to become substantially more porous in order to permit the development of strong workforces and truly responsive care systems. Generally, strategies need to be developed to attract larger numbers of physicians to addiction medicine and to encourage larger numbers of nurses and medical social workers to obtain addiction certification. As Figure 5 shows, a relatively small percentage of physicians, nurses and other health professionals obtain addiction credentials or self-identify as an addiction specialist.

In the short term, recruitment strategies need to begin with professional associations, credentialing bodies and the institutions of higher learning and teaching hospitals where physicians, nurses, social workers, psychologists and other allied professionals are trained. Physicians, psychiatrists, nurses and other medical providers must be recruited within the generalist setting to provide a variety of care, including SBIRT, primary health care and mental health services. There is a critical need for cross-fertilization and cross-training. Specialists and generalists in substance use disorders need to establish care networks and otherwise collaborate to build systems of care that can effectively address the full spectrum of substance use problems, ranging from hazardous use to dependence with co-occurring medical and mental health disorders.

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### ***Discussion***

Data from a 1997 IOM report compare the number of practitioners by professional discipline to those who have received specialized addiction certification (see Figure 5). These data indicate that only a small number of individuals within the total health care workforce are certified as addiction practitioners. The numbers clearly illustrate the need to develop incentives and opportunities that will increase the number of practicing certified addiction treatment professionals. Increased use of medications alone requires additional physicians and nurses to prescribe, administer, monitor and manage patient care.

To support the recruitment and training of medical personnel, a Federal loan forgiveness and repayment program for medical practitioners specializing in addictive disorders should be supported. Such a program would encourage specialization of medical practitioners in addiction within both the generalist and specialist settings. The target audience for this special incentive would include physicians, advanced practice nurses, registered nurses and physician assistants who have large student loan obligations and desire additional formal training and certification to develop expertise and clinical practice in addiction treatment. Marketing strategies and materials should target experienced professionals who work in areas such as general internal medicine, family practice, pediatrics, cardiology, geriatrics and other medical specialties.

**Figure 5. Number of Practitioners and Certified Addiction Specialists, by Health Care Discipline**

Discipline	Workforce Size	Certified Addiction Specialists
Primary care	700,000	2,790 ASAM certified
Psychiatry	30,000	1,067 addiction psychiatrists
Clinical Psychology	69,800	950 APA substance abuse certified
Social Work	300,000	29,400*
Nursing	2,200,000	4,100*
Physician assistant	27,500	185*
Marriage/family therapy	50,000	2,500*

\*Self-described addiction specialist

Source: IOM, 1997.

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### 2. Improve student recruitment with educational institutions, focusing on under-represented groups.

Student recruitment, at various age levels, is needed to expand the addiction treatment workforce. SAMHSA/CSAT should provide Federal leadership and partner with middle schools, high schools and institutions of higher learning to generate early student interest and to promote opportunities within the field. In particular, recruitment should focus on students with diverse racial and ethnic backgrounds and males to achieve a greater balance between the treatment clinicians and patients/clients. As noted above, data show that minorities are under-represented and females are over-represented in the addiction treatment workforce relative to the patient/client population (see Figure 4). Recruitment activities should begin with high schools, particularly targeting those in the public school system and continue through the undergraduate and post-graduate levels.

#### **Discussion**

For marked expansion of the addiction workforce to occur, a much younger cohort must be inspired to choose the addiction treatment field as a career. Educators report that students form opinions as early as fifth grade about careers that they deem desirable (Bell and Ginsburg, 2004). Young people must be exposed to information about the field so that they are aware that it is a viable career option later in life. It is also important to give students early, positive and clear images of the field to counter negative stereotypes and misperceptions they may have developed or encountered. Educational efforts should begin as early as elementary school, continuing through middle school and high school. Recruitment activities should begin in high school and continue through post-graduate education.

Any student recruitment effort must seek to create a more diverse workforce to ensure culturally competent care and to reduce health disparities. *Healthy People 2010* maintains that “increasing the number of minority health professionals is . . . a partial solution to improving access to care” (DHHS, 2000). Paraphrasing one of the key conclusions of the Institute of Medicine’s report, *In the Nation’s Compelling Interest: Ensuring Diversity in the Health Care Workforce* (2004), IOM member Brian Smedley stated: “Part of a comprehensive strategy to reduce health disparities is to increase diversity in the health care professions, which will lead to improved access to care, greater patient satisfaction and reduced cultural and linguistic barriers” (Levin, 2004).

Specifically, SAMHSA/CSAT and educational institutions should collaboratively devise comprehensive recruitment strategies. These strategies must include the development of

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informational materials about the field for teachers, guidance counselors and librarians. Additionally, support should be made available for mentoring programs, internships, educational scholarships, loan forgiveness and repayment programs and post-graduate job placement opportunities.

### **3. Employ new marketing strategies to attract younger workers to the addiction treatment field.**

Federal leadership should be provided to treatment agencies through technical assistance on social marketing and health communication strategies aimed at recruiting a younger, more diverse group of professionals.

#### ***Discussion***

Nursing and other professions have made effective use of the media to recruit workers. The addiction treatment field should adopt similar strategies with the anticipation of seeing comparable results. For example, an intensive multi-year campaign to attract individuals to nursing was implemented in 2002 (Johnson & Johnson, 2003). One year later, after years of declining enrollment, nursing schools began to experience an increase in the number of applicants and in enrollment.

Using basic principles of health communication and social marketing, the field should develop targeted, consumer-centered messages through deliberate placement of advertising designed to reach specific audience segments, including young people and minorities, to create diverse applicant pools. All media options and recruitment channels (e.g., employee referrals, job fairs, classified advertising, links with educational institutions and online job sites) should be explored.

### **4. Continue efforts to reduce the stigma associated with working in addiction treatment.**

Stigma devalues addiction treatment as a meaningful career and reduces the size of the prospective labor pool, making staff recruitment difficult. Drawing from best practices in other fields such as nursing, Federal leadership should be provided to develop strategies, including a public education campaign, to promote addiction treatment as a worthwhile career choice.

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### *Discussion*

Workforce recruitment efforts must overcome the stigmatization of the addiction treatment field. Other health professions, like nursing, have implemented successful initiatives to address stigmatization and its negative impacts, with support from Federal and State agencies. The success of stigma reduction efforts has instilled the nursing profession with a more positive self-image and shown nurses to be a valuable and necessary national resource.

The nursing profession has approached the issue of stigma and its workforce crisis in a variety of ways (Nevidjon and Erickson, 2001). It has:

- Worked to define and distinguish the profession through research, education and clinical service;
- Engaged professional nursing associations as advocates to gain support and recognition;
- Obtained support from professional colleagues (e.g., doctors); and
- Challenged the media to present positive and true images of the nursing profession (Donley et al., 2002).

Although negative images and stigma associated with nursing have not disappeared entirely and a nursing shortage still exists, progress has been made. A study by Bacon, MacKenzie and McKendrick (2000), for example, found that nurses are now viewed as well-educated, independent thinkers who play a key role within a high-tech medical world. This improved image has enabled the field to recruit more young people and career-minded professionals.

These strategies provide examples of what could be accomplished in the addiction treatment field. However, additional approaches, such as the development of a national campaign to educate the public about the scientific basis and effectiveness of addiction treatment, are also necessary. This campaign should:

- Demonstrate the effectiveness of treatment services;
- Bring distinction to the field; and
- Place a human face on recovery.

The written and electronic media, public education system and the health professions should be targets of the campaign. In particular, the campaign should present the addiction treatment field and addiction studies as exciting, viable and respectable career choices and seek to build the public's confidence in the importance and effectiveness of treatment services.

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### D. Addiction Education and Accreditation Priorities

#### Education and Accreditation Issues in Brief

Academic training is fundamental to developing a quality workforce and to providing quality care. Although progress has been made in raising academic standards in addiction studies programs to the level of programs in other health care disciplines, several serious gaps remain.

A significant problem is the lack of education and training on substance use disorders for primary health care and other health and human services professionals. The National Center on Addiction and Substance Abuse (CASA) at Columbia University reported that 94 percent of primary care physicians and 40 percent of pediatricians, when presented with a person with a substance use disorder, failed to diagnose the problem properly (CASA, 2000). If similar studies were available for other health professionals (e.g., nurses, psychologists, pharmacists, social workers, dentists), the results would likely be similar. The primary reason for health professionals' failure to diagnose substance use disorders is a lack of knowledge about the disease. Curricula in most health education programs and professional schools either inadequately address substance use disorders or exclude discussion of them all together.

New demands are being placed on the higher education system as the need for academic training grows within the addiction treatment field. Historically, training for addiction treatment tended to resemble an apprentice model. This model emphasizes experience over formal education. An apprentice model can best be described as training in which the majority of knowledge, skills and ability to practice are imparted through supervision. With the need to treat and manage complex patients/clients and implement evidenced practices in the workplace, the call for more formal education to complement supervision is changing the workforce culture. Increasingly, States are finding the need to require formal education through credentialing and licensure standards (SAMHSA, 2005).

Colleges and universities rely on a variety of standards to develop curricula, rather than one set of competencies. Although efforts have been made to establish academic accreditation standards for addiction studies, they have not been adopted. Program accreditation would provide recognition and demonstrate an ongoing commitment to quality education.

Presently, 442 colleges and universities across the country offer addiction studies programs. Eighteen percent are at the graduate level, 13 percent are at the undergraduate level and 69 percent are at the associate level (Taleff, 2003). Anecdotally, information from stakeholders

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suggests that tremendous variation exists among these academic programs with regard to level of course difficulty, use of evidence-based materials, quality of faculty and ability to prepare students for clinical practice. Additionally, the relevance of coursework and its relationship to research depends greatly on faculty members' abilities to stay current on recently completed and ongoing research.

The changing demographics of the Nation demand a multi-cultural and multi-lingual workforce. Although enrollment remains at record high levels for traditional college-age students, those under 25 years old (Jamieson et al., 2001), data are not available about the number of racial and ethnic minorities enrolled in addiction studies programs, or the progress that has been made to increase minority enrollment.

### Recommendations

To improve the academic caliber of education programs for the addiction treatment field, stakeholders made the following recommendations:

1. Include training on addiction as part of education programs for primary health care and for other health and human service professions (e.g., physicians, nurses, psychologists and social workers);
2. Encourage use of addiction core competencies as the basis of curricula;
3. Support the development and adoption of accreditation standards for addiction education programs;
4. Encourage national and State boards for the health professions to have at least 10 percent of licensing examination questions pertain to addiction;
5. Support academic programs in Historically Black Colleges and Universities (HBCUs), Hispanic Serving Institutions, Tribal colleges and universities and other minority-serving institutions; and
6. Encourage the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and National Institute on Drug Abuse (NIDA) to: (a) support development of college and university courses on health services research and its application; and (b) systematically disseminate research findings to academic institutions.

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- 1. Include training on addiction as part of education programs for primary health care and for other health and human service professions (e.g., physicians, nurses, psychologists and social workers).**

Primary care physicians and other health professionals frequently are the first point of contact in the health care system, yet they often do not recognize substance use disorders. Education related to substance use disorders must be incorporated in all education programs for medical and health professions in order to raise the skill level of health professionals and to expose individuals to the opportunity to specialize in addiction treatment.

### *Discussion*

Physicians and other health and human service professionals do not receive adequate education on substance use disorders. The absence of education on this issue has many implications for patients/clients. Physicians are failing to detect and diagnose problems, despite evidence supporting the efficacy of early intervention. They are failing to provide brief interventions and to refer patients/clients to specialty programs for care when necessary. These oversights have long-lasting consequences. Action needs to be taken in the early stages of substance use disorders when the potential for treatment success is high and the medical and social costs are low (CASA, 2000; Haack and Alemi, 2002; Saitz et al., 1997).

Failure to diagnose and refer patients with substance use disorders occurs, in large part, because of the lack of academic or other training related to substance use disorders. A national survey of residency program directors in seven medical specialties revealed that only 56 percent of the residency programs surveyed had a required curriculum in preventing and treating alcohol and substance use disorders. The most common barriers to providing training were a lack of time (58%), a lack of faculty expertise (37%) and a lack of institutional support (32%). According to the authors, education programs can be improved by integrating training on addiction into existing residency structures, increasing faculty knowledge and including more questions related to treatment on board examinations (Isaacson et al., 2000).

Existing SAMHSA/Health Resources and Services Administration (HRSA) joint education initiatives need to be expanded. Current initiatives include Project MAINSTREAM (Multi-Agency Initiative on Substance Abuse Training and Education for America), which is part of the HRSA-Association for Medical Education and Research in Substance Abuse (AMERSA)-SAMHSA/CSAT Interdisciplinary Project to Improve Health Professional Education on Substance

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Abuse. This and similar programs are designed to enhance substance use disorders training and education among health professionals.

Similar programs would benefit social workers. Many clinical social workers are eligible to practice in the addiction treatment field as a result of their social work license, but may lack the specialty education and training that would permit them to provide the most effective care. The curricula of undergraduate schools of social work, for example, vary in the extent to which the treatment of substance use disorders is covered. Some graduate schools of social work offer a concentration in substance use disorders; others offer only elective courses.

A 2000 survey of the members of the National Association of Social Workers by the Practice Research Network (PRN) Project found that only 38 percent of members had completed formal coursework in substance use disorder treatment during their academic programs, and 87 percent indicated that they held no certification in the treatment of substance use disorders (NASW PRN, 2001). Multi- and cross-disciplinary education and training should be enhanced to provide core curricula for social workers and all health professionals on substance use disorders.

### **2. Encourage use of addiction core competencies as the basis of curricula.**

Educational curricula must be based on solid research and on a set of core competencies to prepare a workforce that is both knowledgeable and skilled. A unified standard must be created within the higher education system based on core competencies identified by experts in the substance use disorder field. TAP 21 includes some of the best thinking in the country on this topic and is recommended as the basis for curricula development.

#### ***Discussion***

Educational institutions use a myriad of standards and information when developing curricula. These standards include the International Certification and Reciprocity Consortium (ICRC) twelve core functions; the International Coalition for Addiction Studies Education (INCASE) standards; the National Association for Addiction Professionals (NAADAC) Certification Standards; and SAMHSA/CSAT's TAP 21, (*Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice*).

The lack of consistency in academic curricula works to the detriment of the field. Many treatment professionals and organizations agree that TAP 21 should be the basis for curriculum

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development. TAP 21 is designed to impart the knowledge, skills and attitudes for achieving and practicing addiction counseling competencies.

Key entities that have endorsed the publication include the National Association of State Alcohol and Drug Abuse Directors (NASADAD), NAADAC, ICRC and several States. TAP 21 focuses on two broad themes:

- The **knowledge and attitudes** underlying competent practice for both addiction treatment counselors and practitioners in other disciplines: understanding addiction, treatment knowledge, application of knowledge to practice and professional readiness; and
- **Clinical skills and competencies**, including: evaluation, treatment planning, referral, service coordination, counseling, patient/client interactions, family and community education, documentation and professional and ethical responsibilities.

Focusing curricula on competencies is essential to assure that students leaving the academic community possess not only the knowledge they need, but also the skills and behaviors necessary to prepare them for clinical practice. Developing curricula based on core competencies ensures that students leaving the academic setting have a common set of knowledge and skills to provide appropriate and effective treatment services.

### **3. Support the development and adoption of accreditation standards for addiction education programs.**

There is no uniform national programmatic structure nor are there associated standards for addiction studies despite the existence of 442 addiction studies programs across the United States. Not enough is known about the quality of these programs and how they prepare future practitioners. Academic accreditation standards for addiction studies programs need to be developed, adopted and supported.

#### ***Discussion***

*“Accreditation standards would give programs a greater degree of professionalism, would provide consistency and would standardize substance abuse education curricula”*  
(PFR Meeting of College and University Faculty, 2004).

Academic accreditation standards should be adopted to improve the quality and standing of addiction education programs. Educators in addiction studies expressed the feeling that their

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programs were given “second class” status by their institutions. Accreditation has advantages for educators as well as students. Educators gain access to a network of other accredited programs for sharing best practices and professional knowledge. Faculty members participate in peer review processes. Students benefit from an enriched environment for learning and greater ease in transitioning credits from one accredited school to another.

INCASE is developing accreditation standards for college and university addiction education programs. Several related issues will need to be considered as the process moves forward. First, addiction studies educators state that there is a shortage of qualified faculty, although data are needed to further substantiate this. A second issue is that many faculty do not have terminal degrees and would therefore need access to doctoral programs. A third issue is that most programs in addiction counseling are at the associate degree level and no accreditation bodies currently recognize associate degree level programs. When implemented, accreditation standards will assist schools in developing new addiction studies programs and will enhance the reputation of existing programs that compete for students and institutional support.

#### **4. Encourage national and State boards for the health professions to have at least 10 percent of licensing examination questions pertain to addiction.**

Representatives of licensure, certification and accreditation bodies in the health professions should enhance the content of their testing requirements to reflect key knowledge and concepts related to the treatment of addiction, by ensuring that at least 10 percent of questions pertain to substance use disorders.

### ***Discussion***

The core curriculum in the health professions is strongly influenced by licensing examinations and certification requirements. If items on the treatment of addiction were included in the licensing and certification examinations, the topic of addiction would receive more emphasis in the core curriculum of each discipline in the field (Haack and Adger, 2002).

Licensing and certification examinations could include questions relevant to methods of screening; brief intervention; motivational interviewing; pharmacotherapy and psychosocial interventions for relapse prevention; treating and referring for co-morbid medical and psychiatric conditions; recognizing and referring professional colleagues impaired by substance use; legal and ethical issues related to serving individuals with hazardous or dependent substance use patterns and a variety of other topics deemed appropriate by governing licensure and

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accreditation boards (Haack and Adger, 2002). For certain specialists whose licensing requirements include oral examinations, State licensing boards should also include competency content in the area of addiction. The addition of these questions to licensing and certification examinations will aid in ensuring that candidates are competent to recognize and treat addiction.

Federal agencies in partnership with private and public organizations, should take the lead in bringing this issue to the attention of key organizations with which they interact (Haack and Adger, 2002). Groups that should collaborate in this effort include national, State and discipline-specific organizations related to licensure, certification and accreditation of medical and nursing professionals and the licensing and accrediting bodies of other disciplines in the health professions (Haack and Adger, 2002). Implementation of this recommendation will help create a standard of care for health care professionals serving individuals with addiction, as well as create criteria for evaluating programs that prepare these professionals to take licensure and certification examinations.

### **5. Support academic programs in Historically Black Colleges and Universities (HBCUs), Hispanic Serving Institutions, Tribal colleges and universities and other minority-serving institutions.**

Racism and the stigma associated with substance use disorders make minority students especially reluctant to pursue education, training and a career in the addiction treatment field. Support for addiction studies programs at HBCUs, Hispanic Serving Institutions, Tribal colleges and universities and other minority-serving institutions is needed to ensure workforce diversity.

Racial and ethnic minority populations often suffer from limited access to quality health care (IOM, 2003). A report by HRSA (2003) indicates that minority physicians are more likely to practice in urban areas that experience a shortage of services, thereby increasing access to services for minority and medically underserved communities. Academic programs that support minority students offer great promise for addressing unmet health care needs. Initiatives supporting curriculum development, internships and loan forgiveness at academic institutions that serve minority populations would provide a mechanism to increase the diversity of the workforce and provide care in underserved areas.

### ***Discussion***

Nationally, racial and ethnic minorities are projected to grow from 28 percent of the population in 2000 to nearly 40 percent by 2030 (Dochterman and Grace, 2001). The multicultural composition of the population requires that greater attention be given to diversifying the

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workforce. A significant disparity already exists between clinicians and patients/clients in the addiction treatment field. For this reason, there is a call to address this issue now. Providing support for educational programs targeting minorities will ultimately result in more graduates who will become part of the treatment workforce.

Support must also be provided for curriculum development in educational institutions. Greater variation in coursework makes programs more attractive to students, encouraging them to consider addiction studies. Internships are also critical components in the development of clinicians. Paid internships need to be supported as a means of providing students with practical experience that can lead to future employment.

One of the most effective incentives for recruiting young people into the field is a loan forgiveness and repayment program. Such a program could be an effective mechanism for recruiting young, culturally diverse staff. Loan forgiveness alleviates the significant financial burden associated with obtaining professional staff credentials. Typically, a service requirement is met in lieu of payment. This benefits both the student and the workforce.

**6. Encourage the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and National Institute on Drug Abuse (NIDA) to: (a) support development of college and university courses on health services research and its application; and (b) systematically disseminate research findings to academic institutions.**

One of the greatest challenges for the addiction treatment field is the dissemination and institutionalization of evidence-based practices. NIDA and NIAAA have conducted considerable research in substance use disorders. However, systematic mechanisms do not currently exist to disseminate research findings to academic institutions. No mechanisms exist to assure that the most current research informs educational practices.

Implementing evidence-based practices requires a workforce trained to understand how to find and use new knowledge. As clearly noted in the IOM's report on *Crossing the Quality Chasm* (2001), clinical education needs to include courses on evidence-based practices and on learning how to access, understand and use research. Therefore, curricula in addiction studies programs at colleges and universities must include courses that teach students about research and how to apply it in practice.

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### ***Discussion***

The addiction treatment field's focus on evidence-based practice and patient/client outcomes requires a workforce equipped to be lifelong learners and accustomed to incorporating research findings in practice. Pre-service education should include required courses on understanding and applying these principles. As accreditation standards for addiction studies programs are developed, basic courses on research design, terminology, statistics and program fidelity should be a part of the required curriculum.

Over the past three decades, NIDA and NIAAA have supported rigorous research that has informed our understanding of substance use disorders and treatment. The unfortunate reality is that many research findings have not reached the educator or practitioner and therefore have not influenced addiction education or treatment practice. It is essential that faculty remain current on research findings, so that students receive information on the latest treatment technology and science.

### **E. Retention Priorities**

#### **Retention Issues in Brief**

Nearly 70 percent (67.8%) of addiction treatment staff have worked with their current employer for five years or less (Harwood, 2002). Data from the University of Georgia National Treatment Center Study indicate an average turnover rate of 18.5 percent among addiction treatment counselors. This rate far exceeds the national average of 11 percent across all occupations and is significantly higher than the average annual turnover rates for teachers (13%) and nurses (12%), occupations traditionally known to have high staff turnover (Knudsen et al., 2003).

Maintaining a stable workforce is the goal of every profession. Such stability helps ensure continuity, quality of care and a positive work environment. Turnover is minimized when individuals experience a high level of job satisfaction and are committed to staying in the profession. Low salaries, lack of career paths, insufficient mentorship programs, inadequate staff supervision, personnel shortages and large caseloads contribute to staff turnover and job discontent in the addiction treatment field.

The negative impact and costs of employee turnover are well documented. In testimony before the Senate Committee on Health, Education, Labor and Pensions, William J. Scanlon, Director of Health Care Issues at the Government Accountability Office (GAO), discussed the problem of turnover in the nursing profession (Scanlon, 2001). Many of the issues Scanlon raised also

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pertain to the addiction treatment workforce. Specifically, Scanlon identified the following costs related to staff turnover:

- Time and expense of recruitment, selection and training of new staff;
- Inefficiencies related to entry of new staff;
- Decreased group morale and productivity; and
- Disrupted continuity of patient care.

Retention efforts must be creative, innovative and address underlying reasons that cause individuals to quit their job or abandon the field. Career path development, training on clinical supervision, leadership and management development and marketing of the field have been discussed earlier in this report and are potential retention strategies.

### Recommendations

Stakeholders made the following additional recommendations to develop a multi-faceted retention strategy to improve workforce retention:

1. Identify and disseminate best practices in staff retention; and
2. Address relapse within the workforce.

#### **1. Identify and disseminate best practices in staff retention.**

National leadership should be provided regarding the identification and dissemination of best practices related to salary structure and benefits, financial incentives, continuing education, alternative work schedules, mentoring, employee wellness practices and professional advancement. Dissemination of practices to State Directors, providers, ATTCs and professional and trade associations within the addiction treatment field should be a major priority.

### ***Discussion***

*“Turnover takes away the most valuable resource that the field has: the knowledge and experience needed to help clients achieve recovery” (Lewin Group, 2004).*

When retention rates are low and turnover is high, facility operations and patient/client care are compromised. Low salaries contribute to high turnover. Salaries of individuals working in the addiction treatment field are not competitive compared to other health professionals in equivalent

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job categories. The table below provides information on the median annual earnings for addiction treatment counselors and other health and social service providers by occupation in 2000.

**Figure 6. Median Annual Earnings of Community and Social Service Counselors and Selected Behavioral Health Professionals in 2000**

Occupation	Median Annual Earnings (\$)	Occupation	Median Annual Earnings (\$)
Rehabilitation counselors	24,450	Medical and public health social workers	34,790
Mental health counselors	27,570	Educational, vocational and school counselors	42,110
Substance abuse and behavioral disorder counselors	28,510	Registered nurses	44,480
Licensed practical and vocational nurses	29,440	Psychologists (clinical, counseling and school)	48,320
Mental health and substance abuse social workers	30,170	Physician assistants	61,910
Child, family and school social workers	31,470	Family and general practitioners	130,000*
Marriage and family therapists	34,660	Psychiatrists	130,000*

*Source: U.S. Department of Labor, 2003 and, when indicated by an asterisk (\*), the American Medical Association*

The U.S. Department of Labor reports that in 2000 the median income for addiction treatment and behavioral disorder counselors was \$28,510. As of 2000, the mean annual salary for all addiction treatment counselors in the United States was \$30,100. The region with the most counselors (mid-Atlantic) had the highest mean annual salary at \$34,433 per year. While the mean annual salaries for addiction treatment counselors are comparatively low across the regions, the cost of living varies greatly by region. In many regions, salaries place many workers at bare subsistence. Additionally, a survey of addiction treatment counselors found that 30 percent had no medical coverage, 40 percent had no dental coverage and 55 percent were not covered for substance use or mental health services (Galfano, 2004).

A 2003 study of individuals in the addiction treatment workforce found that the most prevalent recommendation for retaining staff was increasing salaries (Knudsen and Gabriel, 2003). In

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addition, other financial incentives such as bonuses and performance awards aid in retention. Employees who perceive that their organizations provide them with more rewarding and supportive environments are more likely to be committed to the organization. Therefore, as the field develops a multi-faceted strategy for workforce retention, SAMHSA/CSAT should identify and disseminate to the States best practices related to workforce compensation and financial incentives and support strategic planning needed to implement a national workforce retention effort.

Private sector research also suggests that management practices and organizational commitments that (1) increase job autonomy and accountability for workers, (2) support creativity and new ideas and (3) provide non-tangible rewards linked to performance may improve addiction workforce retention (Knudsen et al., 2003). According to research in the public sector, good management practices that offer employee training, reduce paperwork, increase individual recognition, promote career growth and improve the physical work environment enhance retention (Knudsen and Gabriel, 2003). Creating a work environment that values and empowers all employees is vital.

Finally, anecdotal evidence indicates that recruitment and retention problems associated with faculty for addiction studies programs are just as grave as those seen in the rest of the workforce. At the present time, adequate data are not available on the academic workforce. The challenges involved in recruiting faculty for addiction studies programs in turn makes it increasingly difficult to recruit, develop and certify degreed treatment professionals. As part of a multi-faceted strategy to recruit addiction program faculty, experienced treatment professionals who are at risk of leaving the field should be offered the opportunity to participate in specially designed accelerated degree programs (i.e., Master's or Doctorate) or other training enabling them to become addiction treatment faculty at institutions of higher learning. Developing and supporting this type of initiative, as well as other creative measures, would require the collaboration of Federal and State governments and colleges and universities. A successful pilot would establish a "promising practice" for workforce retention.

### **2. Address relapse within the workforce.**

While all professions employ individuals in recovery, the addiction treatment field is unusual in the proportion of its workforce that is in recovery. It is unique in that many of the recovering individuals among its ranks work in the same health care system through which they received treatment. Anecdotally, the numbers of recovering individuals entering the treatment workforce may be decreasing, but the percentages are still significant by treatment agency estimates. The

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potential for relapse is always present, even among addiction specialists. While relapse is most likely during the first four to five years of abstinence, it can occur at any stage of the recovery process. Individuals in recovery are an invaluable resource to the field because they bring insight from personal experience, passion and commitment to their work.

To date, little attention has been given to the issue of relapse in the workforce. It is time that the addiction treatment field takes leadership in this area. The Addiction Technology Transfer Centers (ATTCs) should lead the development of training that recognizes and addresses relapse within the workforce. The training should target supervisors, human resource managers, the general provider workforce and State/Territory agency staff. Federal leadership is needed to support the provision of technical assistance related to policies and procedures on employee relapse and strengthen Employee Assistance Programs (EAPs), insurance and disability policies. Small agencies generally do not administer EAP programs and often are only able to provide very limited health and disability benefits to their employees requiring partnerships with other treatment agencies.

Additionally, an impaired professional program for addiction clinicians should be piloted to determine whether, when and under what circumstances a clinician who has relapsed can re-enter direct clinical practice. Lastly, organizations should be appropriately trained to refer any member of their workforce for assistance when they suspect misuse of substances.

### ***Discussion***

Clinicians face the reality of relapse every day in managing patients/clients, but many treatment agencies are not well prepared to address relapse within their own staff. Moreover, detection of a substance use disorder and relapse is often delayed by the ability of individuals to protect their job performance at the expense of every other aspect of their lives (Brown et al., 2002). Many organizations lack policies or resources that enable supervisors who detect impairment from intervening or taking appropriate action. Organizations shy away from human resource policies covering these situations due to liability, financial concerns and fears of disclosure. A relapse prevention strategy for managers and staff is needed for treatment organizations, as well as general training for referring employees for assistance related to a substance use problem.

While it may not be possible for a clinician to resume the provision of direct services immediately after a relapse, it may be possible to establish systems and supports that will enable the clinician to return to the provision of services within a reasonable period of time with special support and monitoring. SAMHSA should support the design and piloting of an impaired professional program

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serving addiction treatment clinicians who have relapsed. The pilot effort will yield initial standards that could be developed for the field. Such a program would interface with the Employee Assistance Program and the treatment agency human resources department.

Data from the medical profession indicate that such programs can be quite effective. One study compared 73 physicians who received ongoing monitoring after treatment in an inpatient setting to 185 middle managers who were treated but not monitored. It found that 83 percent of the physicians had favorable outcomes compared to 62 percent of the managers. The researchers hypothesized that the close monitoring received by the physicians accounted for the better outcomes. In addition, a study of 63 impaired or addicted physicians put on probation by the Oregon Health Board found that, of the subset that was monitored, 96 percent remained abstinent whereas only 64 percent of the subset that was not monitored had remained abstinent (Brown et al., 2002).

Any existing programs serving professionals working in the addiction treatment field should be identified and the national, State and local certification boards or professional societies for addiction treatment professionals should be encouraged to explore development of peer education and support programs for impaired professionals in the addiction treatment field

Relapse within the addiction treatment workforce presents the field with significant challenges. However, the development of relapse prevention strategies, relevant policies and procedures and impaired professional and peer education programs would provide tools to respond systematically and effectively to this challenge.

### F. Study Priorities

#### Study Issues in Brief

Addiction treatment would benefit from research data that show the relationship, between the education, training and demographic characteristics of treatment professionals and patient/client outcomes. These research findings will enable the field to make informed decisions about professional development and improved practices.

The ATTCs have conducted surveys of the treatment workforce (Knudsen and Gabriel, 2003; Gallon et al., 2003). The surveys, which differ somewhat by region, focus on issues such as academic training and professional experience, recruitment and retention, compensation, treatment models, training interests and employee satisfaction.

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### Recommendations

The list of study topics related to workforce development is potentially long. Many questions specific to workforce competencies, workforce performance and recruitment and retention practice have yet to be answered. However, three topics have been identified as priorities:

1. Encourage NIDA- and NIAAA-funded studies that examine the relationship between level and type of education and training and treatment outcomes; and
2. Encourage NIDA- and NIAAA-funded studies that examine the relationship between clinician and patient/client cultural, demographic and other characteristics and treatment outcomes.
3. Encourage NIDA- and NIAAA- funded studies that explore questions related to the characteristics of clinicians that enhance therapeutic alliance.

**1. Encourage NIDA- and NIAAA-funded studies that examine the relationship between level and type of education and training and treatment outcomes.**

NIDA and NIAAA should fund studies to determine the relationship between a practitioner's level and type of training and specific treatment outcomes. Minimal research currently exists on the impact of education and training on treatment outcomes. Health services research on this topic could provide valuable information to the field by focusing on the following questions:

- Do some types of training produce better treatment outcomes than others?
- What is the relationship between a clinician's education and treatment outcomes?
- Is experiential or academic training of greater value to treatment outcomes?

### ***Discussion***

Health services research has provided information on the basic competencies needed to perform certain treatment practices and the types of education and training necessary to support skill development. However, research on how education and training are linked to treatment outcomes is not available. Such research could help to guide the design of academic and continuing education, faculty development, supervision and technology transfer strategies. Research on the relationship of training and education to treatment outcomes would also provide the field with necessary information for recruitment.

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### **2. Encourage NIDA- and NIAAA-funded studies that examine the relationship between clinician and patient/client cultural, demographic and other characteristics and treatment outcomes.**

The disparity in age, gender, race and ethnicity between clinicians and patients/clients has led to increased concerns about the impact of these differences on treatment outcomes. However, little substantive research is available on the effects of an addiction treatment professional's demographic, cultural background and other characteristics on patient/client treatment outcomes.

Health services research is needed to address questions such as:

- Are cultural, demographic and other characteristics of clinicians relevant to improving treatment outcomes? If so, which ones?
- Do learned cultural competency skills improve treatment outcomes?
- Are treatment professionals in recovery more effective?
- Does gender matching affect treatment outcomes? If so, how?

### ***Discussion***

Available data show that clinicians are predominantly White women in their mid-forties to early fifties while patients/clients are somewhat younger males from racially and ethnically diverse backgrounds (SAMHSA, 2002; Kaplan, 2003). Although much has been said about the disparities between the demographic characteristics of clinicians and patients/clients, there has been little research conducted to date on the impact of these differences on treatment outcomes. Survey data collected by the ATTCs provide general information about workforce demographics and challenges, but shed little light on whether professionals with different educational backgrounds and demographic characteristics contribute differentially to treatment outcomes.

Research on these topics would help human resource personnel to focus recruitment and retention efforts appropriately. This research would also guide student and faculty recruitment, as well as culturally competent and gender-specific curriculum development at educational and training institutions.

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### 3. Encourage NIDA- and NIAAA funded studies that explore questions related to the characteristics of clinicians that enhance therapeutic alliance.

In the past two decades, a number of studies investigating the role of the therapeutic alliance in drug treatment have been published (Meier et al., 2005). This body of literature supports the fact that the relationship skills of the clinician are important in improving patient/client outcomes. However, as the field strives to improve patient/client outcomes and enhance the skills of its workforce, there are several research questions that would provide valuable information.

- What skills are needed to build a therapeutic alliance?
- Can training improve a practitioner's ability to build a therapeutic alliance?
- What training methods are most effective?

#### *Discussion*

A therapeutic alliance refers to the relationship that develops between a patient/client and a clinician. The relationship is often characterized by the emotional bond and trust that occurs between the clinician and patient/client. Among the common elements of psychotherapy, the collaborative relationship between the patient/client and therapist is one of the most important. This alliance is just as important for drug therapy as for psychotherapy (Roy-Byrne, 1996).

For addiction treatment, early therapeutic alliance appears to be a consistent predictor of engagement and retention in care (Meier et al., 2005). Yet, little is known about the characteristics of the clinician that enhance therapeutic alliance and therefore improve patient/client outcomes. Research will provide information on what clinical skills and attributes support a quality relationship with the patient/client. Through this understanding, issues related to how to transfer this technology to the broader clinical workforce should be explored.

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### G. SAMHSA/CSAT Implementation Priorities

Implementing the recommendations in this report will require SAMHSA/CSAT to secure the commitment of leadership at the highest levels of government and to establish partnerships with a number of institutional and organizational stakeholders in the public and private sectors. To achieve its workforce goals, SAMHSA/CSAT has identified the following implementation priorities:

1. Establishing a SAMHSA/CSAT Workforce Development Office;
2. Collaborating with the ATTCs to collect information about States' workforce development plans and activities;
3. Supporting the development of national core competency standards;
4. Partnering with institutions of higher education to foster adoption of national accreditation standards for addiction education programs and to encourage student interest in opportunities within the field;
5. Facilitating the establishment of a national health services corps loan forgiveness and repayment program for professionals receiving specialized training in addiction treatment;
6. Strengthening ATTCs to enable them to:
  - a. Foster the inclusion of addiction sciences in academic curricula;
  - b. Identify and disseminate evidence-based practices related to workforce compensation and financial incentives and support strategic planning needed to implement a national workforce retention effort;
  - c. Develop and provide training and technical assistance regarding relapse in the workforce, how to prevent it, and how to address it when it occurs. The training sessions should target supervisors, human resource managers, and the workforce as a whole; and
  - d. Provide training to clinical and recovery support supervisors in a variety of areas, including evidence-based practices, program and agency management and use of information systems.

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### *Discussion*

#### **1. Establishing a SAMHSA/CSAT Workforce Development Office.**

A SAMHSA/CSAT Office for Workforce Development would ensure that the resolution of the national workforce crisis remains a priority and would also be emblematic of SAMHSA/CSAT's ongoing commitment to support efforts to resolve it. The National Office for Addiction Treatment Workforce Development would spearhead SAMHSA efforts in the area of workforce development. Specifically, it would provide leadership in the collection, use, and the application of comparative national workforce data; partner with the Addiction Technology Transfer Centers to foster the development of cross-disciplinary competency guidelines; and support the adoption and evolution of national clinical competencies and national addiction studies program accreditation standards.

#### **2. Collaborating with the ATTCs to collect information about States' workforce development plans and activities.**

The SAMHSA/CSAT Workforce Development Office should perform this activity. It is crucial that workforce development efforts be coordinated and that duplication of efforts be avoided. The SAMHSA/CSAT Workforce Development Office should not only confer with States and other governmental entities on workforce plans and activities, but should also hold meetings or conferences at which States and other governmental entities can share with each other and jointly benefit from resources that the ATTCs will make available to them. The Office should also collect and disseminate information on leadership and workforce strategies that have been effectively applied in other sectors and might benefit the addiction treatment field. The Office should foster dialogue between private sector leaders and human resource executives and the addiction treatment field.

#### **3. Supporting the development of national addiction treatment core competency standards.**

Building on the work that has already been accomplished in this area, the SAMHSA Workforce Development Office should partner with States, certification boards and provider associations to support the development and adoption of national core competency standards. TAP 21 should be a significant element of the discussion. SAMHSA/CSAT should also continue to support collaborative efforts involving the National Certification Commission (NCC) of the National Association of Addiction Professionals (NAADAC), the International Certification and Reciprocity Consortium (ICRC) and the Society of Credentialed Addiction Professionals

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(S.CAP). In March 2005 these bodies announced a proposal to unify their independent credentials for addiction counselors into a series of credentials that will be available at the local, national and international levels. This proposal was presented to the ICRC Board of Directors in April 2005 and will be submitted to the NAADAC Board of Directors in July 2005.

#### **4. Partnering with institutions of higher education to foster adoption of national accreditation standards for addiction education programs and to encourage student interest in opportunities within the field.**

The Workforce Development Office should lead efforts toward the adoption of national accreditation standards building on the work already accomplished by INCASE and institutions of higher education. In addition, SAMHSA/CSAT should work with high schools, universities and colleges to promote interest in addiction studies.

#### **5. Facilitating the establishment of a national health services corps loan forgiveness and repayment program for professionals receiving specialized training in addiction treatment.**

The SAMHSA/CSAT Workforce Development Office should also spearhead this activity. It will be critically important that this effort receive broad and vocal support from the field and from Congress. Collaboration with HRSA would also be beneficial as such programs have historically been within its purview.

#### **6. Strengthening ATTCs.**

As noted above, the ATTCs should play a central role in SAMHSA workforce development strategies. The ATTCs should serve as a key point of intersection between SAMHSA/CSAT, States, local governments, provider associations, provider organizations and institutions of higher learning.

Coordinated efforts across a wide variety of governmental and organizational stakeholders are needed to fully achieve the workforce goals outlined in this report. Ultimately, the leadership and unflagging commitment of a SAMHSA/CSAT Workforce Development Office will be required to make these recommendations a reality. With the focused leadership that could emerge from an office dedicated to the development of the addiction treatment workforce, there is potential for enormous benefit not only to the addiction treatment field, but also to those it serves, and to citizens nationally whose tax dollars support the addiction treatment infrastructure. A stronger workforce infrastructure will lead to more effective treatment and recovery support services, benefiting all.

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## II. Recommendations

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### III. Next Steps

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This report summarizes trends in addiction treatment and the challenges that confront the treatment workforce. Importantly, the report also articulates a vision for the treatment and recovery support workforce by presenting a series of recommendations aimed at strengthening the field's professional identity. The recommendations in this report reflect some of the best thinking in the field and are intended to provide momentum for ongoing discussions among stakeholders about a specific implementation strategy. The recommendations also set the stage for concerted action by SAMHSA/CSAT and the larger community of stakeholders. They offer an agenda for the addiction treatment field now and into the future.

Fundamental improvements in the conditions of the workforce will require the engagement and collective action of a wide range of agencies, organizations and individuals. SAMHSA/CSAT will play a vital role by:

- Identifying and forming partnerships with Federal agencies, States, professional associations, academic institutions and other leaders to implement actions that enhance current and future workforce conditions; and
- Convening key leaders in the diverse sectors linked to the treatment workforce (academia, research, policy, treatment, recovery support) to develop specific strategies for moving the recommendations forward.

The effectiveness of the treatment workforce rests on its ability to meet the challenges ahead. However, the challenges also provide unprecedented opportunities for change and reform. The recommendations outlined in this report are presented with this in mind. It is now time for dialogue on these recommendations and for collective action. By initiating the dialogue and assuming a leadership role, SAMHSA/CSAT will help to shape the future of the addiction treatment field.

## IV. Participants

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This section acknowledges the participants who gave their time and input at a series of stakeholder meetings and contributed many of the ideas and recommendations included in this report. The listing of participants and their organizations on this roster does not imply organizational endorsement of this report.

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