

STRENGTHENING PROFESSIONAL IDENTITY



**Challenges
of the
Addictions
Treatment
Workforce**

A Framework for Discussion

Strengthening Professional Identity

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December 2006

Acknowledgments

Abt Associates Incorporated prepared this report 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 128 participants representing the many organizations, institutions and agencies that support and provide addictions treatment and recovery services. This report reflects the views and priorities of the addictions treatment field in the area of workforce development. The report also benefited from the input of A. Thomas McLellan, Leslie J. Scallet, and Joan Zweben.

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Executive Summary

Strengthening Professional Identity: Challenges of the Addictions Treatment Workforce

Executive Summary

In 2004, over 23 million Americans age 12 and older needed specialty treatment for alcohol or illicit drug problems. Of those in need, only 10 percent received treatment at a specialty facility (NSDUH, 2005). There are a number of factors that contribute to low treatment participation rates. One of the most fundamental is the lack of an adequate human infrastructure to support current and future demands for treatment. The addictions treatment field is facing a workforce crisis. Worker shortages, inadequate compensation and stigma currently challenge the field. Increasingly, treatment and recovery support providers also struggle with issues related to recruitment, retention and professional development of staff. The ability to provide quality addictions treatment and recovery support services is severely hampered by these conditions. Without investment in human infrastructure, this critical public health function will not be equipped to respond effectively to the overwhelming need for services.

Strengthening Professional Identity: Challenges of the Addictions Treatment Workforce summarizes trends in addictions treatment and the challenges that confront the treatment workforce. Importantly, it 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 specific implementation strategies. The report discusses current trends in funding, staff recruitment and retention, patient characteristics and clinical practice and identifies recommendations in the following six areas: infrastructure, leadership and management, recruitment, education and accreditation, retention and studies priorities. *Strengthening Professional Identity* focuses on all professionals who provide addictions treatment and recovery support services, e.g., addictions counselors, physicians, psychologists, nurses, outreach and intake workers, case managers, social workers, marriage and family therapists, recovery support workers and clergy.

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Background and Approach

Workforce development has been an area of concern for the Substance Abuse and Mental Health Services Administration (SAMHSA) and for the addictions treatment field for many years. In recognition of the mounting workforce crisis, SAMHSA elevated workforce development to a program priority on its “SAMHSA Priorities: Programs and Principles Matrix.” This designation has increased focus on this critical issue. The development of this stakeholder report began with an environmental scan of the recent research related to the treatment workforce.

Following the environmental scan, SAMHSA convened 128 individuals representing diverse stakeholder groups in nine separate stakeholder meetings from January through May 2004. During these meetings, SAMHSA solicited information and recommendations from representatives knowledgeable about the exceptional challenges faced by the addictions treatment workforce. Individuals from the following organizations and employment categories provided input: addictions counselors, Addiction Technology Transfer Centers (ATTCs), certification boards, Federal agencies, professional trade associations, 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, and State Directors. The participating Federal government partners represented a wide range of agencies, including the Departments of Labor, Transportation, Defense (Marine Corps and Navy), Veterans Affairs, Justice and Education, as well as the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, the Health Resources and Services Administration, the Centers for Medicare and Medicaid Services, and each of the SAMHSA Centers.

Context: Trends Impacting the Workforce

This report begins with a discussion of both long-term and emergent issues impacting the addictions treatment workforce. The information included in this section provides a context for understanding the challenges facing the addictions treatment workforce and a background for the recommendations that follow.

Among the key issues facing the workforce are:

- Insufficient workforce/treatment capacity to meet demand;
- The changing profile of those needing services (e.g., an increasing number of injecting drug users, narcotic prescription and methamphetamine users);

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- 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 (i.e., a chronic care approach analogous to those adopted for the treatment of other chronic disorders, such as diabetes and heart disease);
- Provision of services in generalist and specialist settings (e.g., provision of services in primary care and other settings in addition to addictions treatment program settings);
- Use of performance and patient outcome measures; and
- Discrimination associated with addictions.

Stakeholder Priority Recommendations by Focus Area

Following the context, the report includes a listing of stakeholder priority recommendations for key focus areas and a detailed discussion for each focus area and recommendation. In total, 21 stakeholder recommendations are presented in this report. These recommendations represent the most critical subset among a larger group of recommendations that stakeholders made.

A. Infrastructure Development Priorities

1. Create career paths for the treatment and recovery workforce and adopt national core competency standards;
2. Establish a National Addictions Health Professional Services Corps Loan Forgiveness and Repayment Program;
3. Foster network development; and
4. Provide technical assistance to enhance the capacity to use information technology.

B. Leadership and Management Priorities

1. Develop, deliver and sustain training for treatment 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.

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C. Recruitment Priorities

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

D. Addictions Education and Accreditation Priorities

1. Include training on addictions 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. Call for the use of national addictions core competencies as the basis of curricula;
3. Support the development and adoption of national accreditation standards for addictions education programs;
4. Encourage national and State boards for the health professions to have at least 10 percent of licensing examination questions pertain to addictions;
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. Develop college and university courses in addictions-related health services research and its application; and systematically disseminate research findings to academic institutions.

E. Retention Priorities

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

F. Study Priorities

1. Conduct studies that examine the relationships among level of education, type of education, training and treatment outcomes;

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2. Conduct studies that examine the relationships among clinician and patient/client cultural, demographic and other characteristics and treatment outcomes; and
3. Conduct studies of clinician characteristics, training and skills that enhance therapeutic alliance.

Summary

The stakeholder priority recommendations presented in *Strengthening Professional Identity* are directed at a variety of organizations. Implementation of these recommendations will require the commitment of time and resources from each of these entities.

This report was developed with the guidance of expert stakeholders from the addictions treatment and recovery field and representatives of Federal agencies. It provides a template to guide concerted action in the area of workforce development in the addictions treatment field. The future effectiveness of the addictions treatment workforce rests on its ability to invest intelligently in its future, developing systems to address issues of recruitment, retention, and staff development. Other health care professions (e.g., nurses and physicians) have demonstrated that such efforts can prove effective. It is time that the addictions treatment field, in partnership with States and the Federal government follow that example, taking the steps necessary to address the challenges faced by the addictions treatment workforce. Only by doing this will the barriers to treatment access be addressed and the quality of care substantially improved.

Introduction

“Like other troubled industries, addictions 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 addictions treatment system will...fail to meet the public’s needs” (McLellan et al., 2003).

A Workforce in Crisis: New Opportunities for Change

Addictions treatment is facing a workforce crisis. High turnover rates, worker shortages, an aging workforce, 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 addictions treatment field is composed of workers from many different professions (e.g., counselors, physicians, nurses, social workers, psychologists, marriage and family therapists, outreach and intake workers, case managers and clergy). This diversity gives the field a rich array of perspectives and skills, but also requires complex, coordinated responses to workforce issues. While the majority of practitioners in the addictions treatment field are counselors, the roles of all professions involved in the provision of addictions treatment are critically important.

Even as the treatment system struggles with these challenges, the foundation is solidly in place 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 addictions 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. In 2005, the IOM report *Improving the Quality of Health Care for Mental and Substance Use Conditions* included a

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dedicated chapter discussing the need to increase substance use and mental health workforce capacity for quality improvement. While SAMHSA has been addressing workforce issues for more than a decade, these issues have been further elevated due to concerns regarding recruitment, diminished funding, adoption of best practices and staff retention raised by the diverse professions that comprise the workforce. This report, which was developed on behalf of the addictions treatment field, is intended to serve as a catalyst and guide for the development of national, State and local strategies that address addictions 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 addictions treatment. The Panel recommended (1) creating a national platform within SAMHSA to address addictions 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.

In 2003, recognizing the need for more comprehensive information about the workforce, SAMHSA commissioned an environmental scan of the recent research related to the treatment workforce. 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's Center for Substance Abuse Treatment (CSAT) convened 128 individuals representing diverse stakeholder groups in nine separate stakeholder meetings from January through May 2004. During these meetings, CSAT solicited information and recommendations from representatives knowledgeable about the exceptional challenges faced by the addictions treatment workforce. Individuals from the following organizations and employment categories provided input: Addiction Technology Transfer Centers, certification boards, Federal agencies, professional trade associations, addictions 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

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individuals who participated in these discussions.) This report includes recommendations that emerged from these expert panels.

The Addictions Treatment Workforce

The nature of the addictions treatment workforce has changed substantially over the past 30 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 Research Corporation, 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 addictions treatment to emerge as a specialty health care discipline. However, problems related to infrastructure, recruitment, retention and education and training of the workforce create an environment 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 the required academic training.

Concurrently, the Federal government has invested new resources to expand treatment. Appropriations for addictions 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 addictions treatment has expanded and the levels of credentialing have 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 that drives the

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treatment workforce gives it both a unique history and a unique resilience. Efforts to address workforce issues in the addictions treatment field need to build on this foundation and tap into the extraordinary assets that addictions 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: Context: Trends Impacting the Workforce
- Section II: Recommendations
 - A. Infrastructure Development Priorities
 - B. Leadership and Management Priorities
 - C. Recruitment Priorities
 - D. Addictions Education and Accreditation Priorities
 - E. Retention Priorities
 - F. Study Priorities
- Section III: Summary
- Section IV: Participants

Section I provides a historical context, discussing finance practices, demographics, and 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 lists and categorizes recommendations that emerged from the stakeholder meetings. Although these categories overlap, they provide a useful framework for a systematic analysis of the recommendations. Section III provides a summary of the report. 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. Context: Trends Impacting the Workforce

The purpose of this section is to provide a context for understanding and addressing both long-standing and emergent workforce issues. The addictions 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 addictions 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 services in generalist and specialist settings;
- Use of performance and patient outcome measures; and
- Discrimination associated with addictions.

Each of these issues is discussed below.

Insufficient Workforce to Meet Treatment Demands

Nationally, addictions treatment capacity is insufficient to accommodate all those seeking services and is substantially 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 *2004 National Survey on Drug Use and Health* (NSDUH, 2005), which collected data on self-reported drug and alcohol use, found that:

Approximately 23.48 million individuals age 12 and older needed specialty treatment for alcohol or illicit drug problems;

2.33 million of these individuals received treatment at a specialty facility;

Of the 21.15 million persons who were determined to need but did not receive treatment, only 1.2 million acknowledged a need for treatment; and

Of the 1.2 million persons who felt that they needed treatment, 792,000 did not attempt to access it, and 441,000 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. (A table showing the median salary of addictions counselors and of similar professions in 2000, the most recent year for which data is available, can be found in Section II, under *Retention Issues*, below.) 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. To meet these demands, the workforce will need to adopt a new

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way of doing business. Intensive technology transfer efforts will be required to make this possible.

The addiction treatment system has been under-funded for many years. As a result, providers often do not have the infrastructure to prioritize training, provide regular salary increases and make technology improvements, much less expand service provision and implement evidence-based practices. Because of the chronic nature of the funding crisis experienced by publicly funded treatment providers, there is a tendency to view the status quo as the norm or as an acceptable standard. The service system requires additional resources to effectively support the provision of services at current levels. Expansion of capacity will require an even more significant investment in infrastructure. Broad adoption of evidence-based practices and implementation of effective quality improvement and performance monitoring systems will require a greater investment. Investment that does not attend to infrastructure deficits is not likely to generate the quality of outcomes desired.

The Changing Profile of Those Needing Services

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

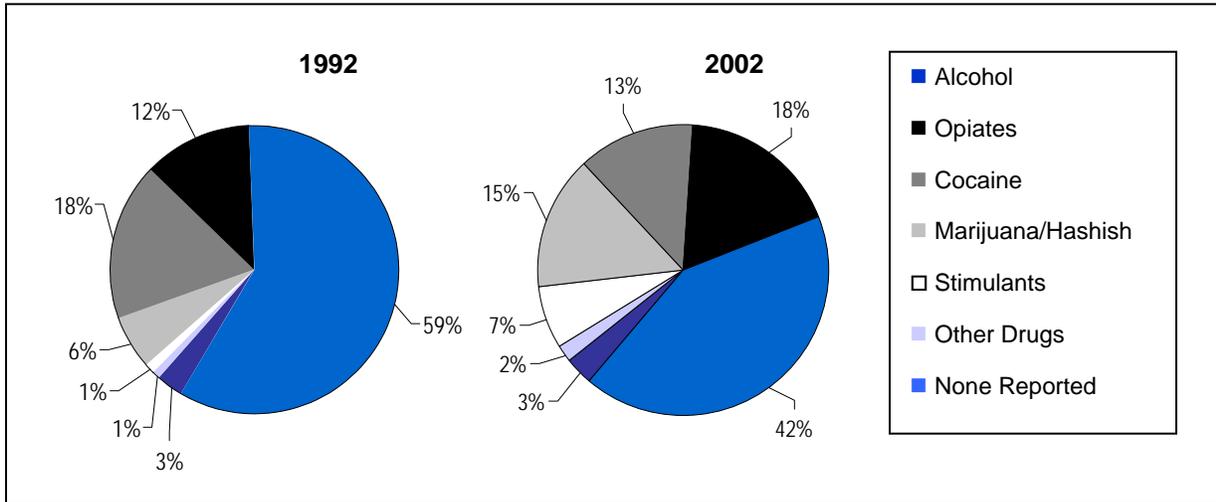
- The preferred route of drug administration among youth changed from inhalation to injection from 1992 to 2000, with the rate of injection among heroin users increasing from 34 to 51 percent among those under age 18 and from 48 to 63 percent among those ages 18 to 24 (SAMHSA, 2003).
- The numbers of persons using prescription pain relievers non-medically for the first time increased from 600,000 in 1990 to more than 2 million 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 (see Figure 1.). 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

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rose from 23 percent to 63 percent (SAMHSA, 2004b). These data point to the necessity of having a workforce prepared to respond to changes in both drug use and patient characteristics.

Figure 1. Primary Substance at Admission: 1992 and 2002



Source: SAMHSA, 2004b

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.

Practitioners in generalist settings are beginning to screen for hazardous substance use patterns and potential addictive disorders. Such screening is being adopted in hospitals, emergency rooms, ambulatory clinics and other medical and non-medical settings. This practice will likely result in individuals presenting for specialty addictions 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 addictions treatment field will increasingly be faced with two populations that, heretofore, have typically not been served. These are (1) individuals who are just beginning the progression to dependence; and (2) individuals with diagnosable dependence disorders, who are not yet ready to initiate traditional treatment but who 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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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 addictions 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 measured approximately 37 percent in 2000, in contrast to 26 percent in 1991 and 7 percent in 1980 (DEA, 2001).
- **Consumption of dangerous and illegal drugs among younger users and, in particular, increased heroin addictions 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).
- **Serious medical problems among the patient/client population.** Increasingly, addictions 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 damage to small blood vessels in the brain that can lead to stroke. 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

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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 addictions treatment. According to the National Survey on Drug Use and Health (NSDUH), there were an estimated 21.4 million adults aged 18 or older with Serious Psychological Distress (SPD) in 2004. This represents 9.9 percent of all adults compared to the rate of 8.3 percent found in 2002. Among adults with SPD in 2004, 21.3 percent were dependent on or abused alcohol or illicit drugs compared to 7.9 percent of adults not experiencing SPD (SAMHSA, 2005). An even larger concern is the number of individuals entering addictions treatment with a mild or moderate mental illness.

With respect to these individuals, 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 had at least one independent mood disorder, 33.4 percent had an independent anxiety disorder, and 33.0 percent had a drug use disorder. Moreover, 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 9.9 percent of individuals who needed specialty addictions treatment in 2004 accessed care (NSDUH, 2005).

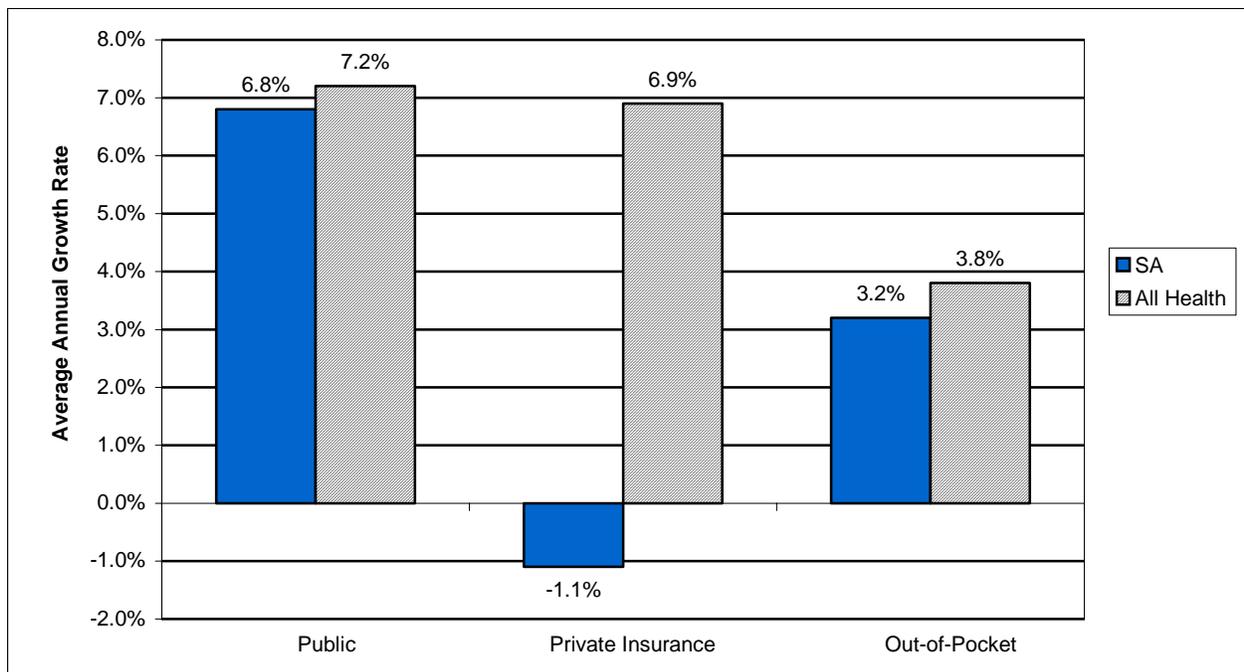
The NESARC provides evidence that mood and anxiety disorders must be addressed in the specialty addictions setting and that alcohol and drug use disorders must be dealt with in the generalist and specialty mental health settings. The study authors emphasize the seriousness of both substance-induced and independent mood and anxiety disorders. “Substance induced disorders,” the authors point out, “have been shown to increase the risk for poor outcome of substance dependence and lifetime number of suicide attempts.” Untreated, independent mood and anxiety disorders among individuals receiving addictions treatment can lead not only to relapse, but also to suicide. “Short of this ultimately adverse outcome, independent mood and anxiety disorders, particularly among individuals who have a comorbid substance use disorder, are immensely disabling” (Grant et al., 2004).

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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. Notably, 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 addictions-related services grew by 3.2 percent annually, compared to 3.8 percent for all health (Mark et al., 2005). (See Figure 2. below.)

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

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

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disorders is not financed in the same manner as other health care conditions. Though addictions impact 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 decline in private insurance coverage is especially onerous.

Challenges Related to the Adoption 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 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 substance use (Rollnick and Miller, 1995).

Although the field has progressed toward incorporating best practices into its work, significant disparity remains between approaches indicated by research findings and those typically implemented by programs. Hennessy reports that the average time lag between development of an innovative practice and its adoption in practice is 17 years (Hennessy, 2004). Barriers that impede the use of evidence-based health services include resistance to change by entrenched and threatened organizational structures, outdated reimbursement rules, lack of effective provider training and lack of resources (Corrigan et al., 2001). Given these challenges related to transferring new knowledge into practice, individuals who access addictions treatment will often not receive the interventions that current research indicates are the most likely to assist them in achieving positive outcomes.

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Increased Utilization of Medications in Treatment

Since the 1980s, medications for treating substance use disorders have become more available. Advances in this area have 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, comorbid psychiatric conditions, opioid agonist/antagonist therapy, office-based opioid treatment, maintenance of abstinence and pain management. For example, the approval of buprenorphine by the Food and Drug Administration (FDA) provides a viable option (in addition to methadone) for addressing opiate addictions. Because it has been approved as an office-based opioid addiction treatment, buprenorphine has the potential to expand 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 generally requires concurrent pharmacological and psychosocial interventions, making psychotropic medications an increasingly significant component of the addictions 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 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

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professionals still harbor negative perceptions about the use of pharmaceutical interventions. The increasing use of medications has the following significant workforce implications:

- Creates increased demand for nurses, physicians and other health care practitioners to prescribe, administer and monitor medication;
- Requires practitioners to learn to assess potential medication needs and to incorporate pharmacological interventions into treatment plans and treatment protocols; and
- Results in further rapprochement between the specialist treatment and generalist medical care systems to bridge workforce gaps when they cannot be filled through hiring. This could well manifest itself as co-location of generalist and specialist staff in both systems.

Over the next decade, the ability to use 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 kinds of multi-disciplinary teams necessary to effectively provide care in this environment. States and localities have varying requirements with respect to medical staffing in addictions treatment programs. Some require programs to have medical and nursing staff, while others have no such requirements. Moreover, there is wide variation in the level of medical staffing across programs even within jurisdictions. A recent national study found that 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 addictions 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

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episodes of care, most ... treatment continues to be characterized as relatively 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 addictions 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 addictions 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 addictions treatment focuses on interventions that strengthen and extend the length of remission periods, reduce the number, intensity and duration of relapse events and quickly re-engage individuals in services at the time of relapse. 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 illnesses;
- Implement best practices with a professionally trained workforce, supported by trained recovery specialists;
- Use 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 addictions services. Through

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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 for addictions 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 Services in Generalist and Specialist Settings

A diverse group of individuals within the addictions 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). The specialist setting is designed to treat individuals with substance use disorders. It consists of specialized services provided by not-for-profit, and for-profit organizations and by private practitioners. The vast majority of specialty addictions treatment is provided through community-based, not-for-profit agencies with public funds.

At present, the following activities are beginning to be implemented in selected generalist settings:

- 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.

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Historically, generalist staff have usually not screened and provided services related to substance use problems, and addictions treatment specialist staff have rarely been stationed in generalist settings to provide such services. However, changes are occurring due to a recognized need to intervene with individuals before high-risk behaviors progress to a diagnosable substance use disorder. Very few generalist setting staff have been trained in substance use disorders. They lack the knowledge to detect such problems. To help overcome these barriers, SAMHSA developed the SBIRT initiative. In FY 2006, this effort is being implemented in nine States. An evaluation of this \$30 million effort is underway, so that the field may benefit from the knowledge gained from it.

The diversity of the population with substance use problems requires the workforce to be equipped to address issues as they arise in both the generalist and specialist settings. A large segment of the population would benefit greatly from earlier detection of this illness, 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.

The complexity of the specialist setting raises unique challenges for workforce development across both the public and private sectors. Not only do funding mechanisms and minimum staffing and care requirements vary greatly from State to State, but publicly and privately funded organizations have differing priorities, incentives, organizational cultures, philosophies, service mixes and target populations. Additionally, the workforce within the specialist setting has ongoing training needs due to changing treatment technology, staff turnover and recent initiatives to begin engaging individuals in the early stages of substance use problems through co-location or linkage with generalist settings. 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 addictions 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 in 1998 to develop a core set of performance measures for addictions treatment, has noted that “monitoring the quality and

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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).

SAMHSA has required the collection of National Outcome Measures (NOMs) to track outcomes and performance related to treatment services funded under the Substance Abuse Prevention and Treatment Block Grant. All States are required to report by September 2007. Discretionary grantees are already reporting NOMs. NOMs will track outcomes and performance across 10 domains: 1) abstinence; 2) employment/education; 3) crime and criminal justice; 4) housing stability; 5) access/capacity; 6) retention; 7) social connectedness; 8) perception of care; 9) cost-effectiveness; and 10) use of evidence-based practices. To support States in their data collection and reporting, SAMHSA will provide infrastructure and technical assistance through a new State Outcomes Measurement and Management System (SOMMS). Because the majority of addictions treatment services nationally are publicly funded, NOMs will become one of the most broadly adopted sets of outcomes/performance measures.

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 2003, 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 addictions 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 a “weak infrastructure dramatically limits the effectiveness of many basic quality improvement strategies.” The panel acknowledged that “many programs are well run and provide high quality

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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 report recommended that public and private funders financially reward programs with good results, such as reduced drug and alcohol use, reduced medical services utilization, reduced criminal justice system involvement and increased employment. 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 addictions treatment. 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 addictions treatment needs faced within the United States.

Discrimination Associated with Addictions and the Addictions Treatment Workforce

Negative perceptions of addictions 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 addictions (2001). Some examples are:

- Insurance policies that deny or restrict coverage for addictions 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

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- The 1996 welfare reform provision that imposes a lifetime ban on welfare benefits for people convicted of possessing or selling drugs.

According to *The Christian Science Monitor*, experts in treatment and recovery estimate that when recovering individuals are honest about their drug histories, they will be 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 one million people who were identified as needing treatment and who felt that they needed it, but did not receive it, 19.6 percent reported that they did not try to access it due to the stigma associated with addictions (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 addictions could result in more timely intervention, improved outcomes and reduced health care costs.

Discrimination also affects the addictions treatment professional. Many believe that the stigma attached to addictions results in decreased funding to address workforce issues and has a detrimental effect on attracting and retaining professionals in the workforce. Addictions 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 addictions treatment workforce. Individuals entering treatment are presenting with more complex and severe disorders while resources have remained relatively scarce. Private health plan coverage of addictions 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 addictions treatment patient/client has changed. Clinicians and programs must be prepared to address the

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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 an addictive disorder. To maintain skills that will keep pace with the rapidly changing environment, the workforce must be resilient, clinically competent and adaptable. Addressing these challenges will require ongoing knowledge and skill development at the executive, management and practitioner levels, and will also require diversification of the workforce through specialization among counselors and through the addition of a larger number of allied professionals. Specialized expertise is needed in areas such as brief treatment, medication-assisted therapies and co-occurring disorders.

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II. Recommendations

The Recommendations section summarizes the input from the diverse stakeholders, cites relevant literature and makes recommendations across major topic areas including the identity of the addictions 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 facing the addictions treatment field.

A. Infrastructure Development Priorities

Infrastructure Issues in Brief

A sound addictions 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 addictions treatment and related services (Harwood, 2002). By 2010, the need for addictions 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 this issue 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 (The Lewin Group, 2004). The treatment system's capacity to close the gap in alcohol and drug treatment is threatened by a lack of national occupational standards, inadequate incentives to enter the addictions treatment workforce and an absence of defined career paths.

II. Recommendations

Recommendations

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

1. Create career paths for the treatment and recovery workforce and adopt national core competency standards;
2. Establish a National Addictions Health Professional Services Corps Loan Forgiveness and Repayment Program;
3. Foster network development; and
4. Provide technical assistance to enhance the capacity to use information technology.

1. Create career paths for the treatment and recovery workforce and adopt national core competency standards.

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, 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. Unfortunately, these standards have not been universally adopted. SAMHSA recently revised TAP 21 to reflect the latest science. The revised version of TAP 21 should be adopted nationally. 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) 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.

II. Recommendations

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 addictions 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 credentialing organization. In addition, there are no uniformly adopted credentialing standards for social workers, psychologists, nurses, physicians and other professionals who practice in the addictions treatment and recovery field. National core competency standards for addictions 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. It is recommended that SAMHSA/CSAT establish a collaborative process with the States and national credentialing boards to implement and periodically update national core competency standards for counselors. By adopting national core competencies, States can develop career paths incorporating practice standards recognized by the field. It is also recommended that SAMHSA/CSAT initiate dialogue with stakeholders to adopt and periodically update core competencies for other practitioners providing addictions treatment and recovery support services.

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.”

II. Recommendations

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. As an example, a career path for an addictions counselor might begin with an entry-level position that does not require certification, licensure, degrees or extensive training and prior experience; then move to a position that requires completing a requisite number of hours of supervised clinical experience and passing a certification and/or licensure examination; and then move to an advanced level of certification or licensure that may require an advanced degree and/or additional supervised experience, and/or passing an advanced test. Such a career path could also include certification or registration in specific sub-specialties, such as treatment of adolescents or of individuals with co-occurring disorders. This career path, of course, need not end with clinical practice. It could also include program or agency management. Additional career paths will become available as the field relies more on recovery support services. By developing career paths with associated core competencies, the addictions treatment field will demonstrate its commitment to maintaining professional standards for all individuals in the treatment and recovery workforce. It is recommended that SAMHSA/CSAT convene expert stakeholders and facilitate a process leading to the development of model career paths that can serve as guidelines for State and local efforts.

The process of developing and adopting both competency standards and career paths 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 addictions treatment field (IOM, 2003). Recognizing the urgent need to act in these areas, the leadership of The Association for Addiction Professionals (NAADAC), the National Certification Commission (NCC), the International Certification and Reciprocity Consortium (IC&RC) and the Society of Credentialed Addictions Professionals (S.CAP) met in February 2005 and agreed to collaborate to advance the addictions treatment field. A proposal to consolidate existing credentials and to merge the IC&RC and NAADAC credentialing boards into a single board was submitted to the directors of the IC&RC in April 2005 and to the NAADAC leadership in July 2005.

II. Recommendations

2. Establish a National Addictions Health Professional Services Corps Loan Forgiveness and Repayment Program.

A National Addictions Health Professional Services Corps Loan Forgiveness and Repayment Program, hereafter referred to as “the loan forgiveness and repayment program,” would attract young and second-career professionals to the field and retain committed addictions treatment staff who seek training for professional development and recertification. Loan forgiveness and repayment programs would provide needed financial support to potential addictions 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 loan forgiveness and repayment program could be modeled after the National Health Services Corps (NHSC) for primary care providers. Such a program for addictions 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, it is recommended that a loan forgiveness and repayment program for addictions professionals 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 and repayment program for addictions 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, counselors and recovery support specialists who consider careers within the addictions 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 of Health Professions. It is a competitive program that makes contract awards to clinicians who

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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).

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 addictions loan forgiveness and repayment program is a promising idea that can increase the long-term supply of professionals in a wide range of geographic locations, and also assist with the recruitment of underrepresented groups, increasing racial, ethnic and gender diversity. Like the NHSC, a loan forgiveness and repayment program should establish partnerships with State loan repayment programs to strengthen the incentive. Further, it is recommended that components of the addictions services corps include continuing education, training and job placement assistance for individuals who complete their service obligation.

HRSA, in consultation with SAMHSA/CSAT, should develop and administer the loan forgiveness and repayment program.

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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 addictions professionals and potential staffing pools for member organizations.

Discussion

A study of the national addictions treatment infrastructure found that the organizational and administrative infrastructures of many addictions 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 addictions 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 addictions treatment providers may benefit from engagement in a network or use of a shared management organization to support human resource, 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 sharing of resources results in economies 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. The cost structures of small agencies often make operations difficult in times of economic constraint, and networking may enable them to successfully navigate periods of economic retrenchment.

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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 agencies. The operation of 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 networking 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). It is recommended that provider organizations explore the potential benefits and feasibility of establishing formal networks.

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 addictions treatment field. However, these technologies are cost-prohibitive for many addictions treatment agencies. The current health care environment demands that technology in the addictions treatment field be greatly improved. Technology permits clinicians, supervisors and administrators to benefit from immediate 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

Many treatment organizations lag behind their counterparts in the health care industry with regard to the ability to access and use information technology. Some small agencies do not have basic computer capabilities, much less a network, automated billing, or clinical records/clinical management systems.

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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). Many people entering the field find inadequate technology 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.

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 addictions. 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 noted that “less than 40% of addictions 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.” 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 addictions treatment from the rest of health care (McLellan, 2005).

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. “Creating, handling, filing and copying paper documents, forms and messages invariably involves more steps and time than performing the same functions electronically” (Adler, 2005). 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., the Health Insurance Portability and Accountability Act [HIPAA]) may require increased use of information technology in treatment settings. Technical assistance can help

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treatment organizations learn about these new rules and make the best use of information technology for communication, case management, staff development and delivery of quality, patient-centered care. Funding to cover the initial cost of automating processes remains a challenge for many organizations.

Recruitment, retention and development of the addictions 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. For those less adept with information technology, basic computer training, software and Internet access provide tools to improve clinical processes, resulting in more efficient patient/client care and information.

To assist States with technology and to support the collection, analysis and reporting of National Outcome Measures, SAMHSA has established the State Outcomes Measurement and Management System (SOMMS). Through this new system, SAMHSA, in partnership with the States, will: (1) standardize operational definitions and outcome measures; (2) link records to permit comparison of admission and discharge or post-discharge data; (3) develop benchmarking strategies to determine acceptable outcomes thresholds; and (4) produce routine management reports to direct technical assistance and the SAMHSA science-to-services program in a manner that will result in improved outcomes.

With the aid of other Operating Divisions of DHHS, it is recommended that SAMHSA develop a comprehensive information technology strategy to support States and provider organizations.

B. Leadership and Management Priorities

Leadership and Management Issues in Brief

The addictions 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 extent of the leadership and management issues in the addictions 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.

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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.

Recommendations

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

1. Develop, deliver and sustain training for treatment 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 treatment 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. Training specifically targeting recovery support services supervisors is also necessary.

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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 practices emerge. Competency-based training must acknowledge supervisors' varying skill levels. The Treatment Improvement Protocols (TIPs) developed by SAMHSA have long served as a tool to support the development of competencies and the adoption of specific practices. To further address these diverse training needs, a work group supported by SAMHSA 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. ATTCs should continue to enhance such efforts, providing ongoing training on clinical supervision based on the core competencies.

In addition to their other functions, clinical supervisors are instrumental in the retention of staff. A recent study of addictions 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).

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Additionally, recovery support supervisors should receive ongoing training. Although the training needs of supervisory staff in recovery support settings are different from those 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. The development of such training will require a careful study of recovery support services, the delineation of key categories of services and approaches, and the development of curricula that meet the needs of supervisors guiding the provision of such services. Over time, it would be beneficial to develop core competencies for certain categories of recovery support providers.

SAMHSA/CSAT and the ATTCs, in partnership with recovery support providers, should develop and disseminate core competencies for recovery support supervisors.

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

Many agency directors are approaching retirement age within the next decade and considerable turnover is 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 implemented and monitored by highly skilled managers. This progressively complicated treatment environment necessitates strong management practices. Therefore, it is recommended that leadership and management development initiatives be delivered and sustained for the addictions 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 addictions

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practices and there is a greater focus on outcomes and accountability. As the addictions 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. One example of such an initiative is the series of Leadership Institutes funded by SAMHSA through the Partners for Recovery (PFR) initiative and the Addiction Technology Transfer Centers (ATTCs). Incorporating the immersion training developed by the Graduate School of the U.S. Department of Agriculture, these six-month institutes provide a viable model for broad-scale leadership development.

As in any industry, active staff development and succession planning to prepare a new generation of leaders are critical to organizational survival. Most organizations that provide addictions treatment services do not have a coordinated plan to manage existing and future gaps 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;
- Rewarding staff for performance; and
- Providing supportive supervision and manageable caseloads (Annie E. Casey Foundation, 2003; Hager and Brudney, 2004).

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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 the dilemma posed by a lack of business and leadership skills among staff responsible for managing treatment programs, it is recommended that SAMHSA/CSAT continue to support and expand initiatives, such as the Leadership Institutes funded through the PFR initiative and the ATTCs. In addition, States and providers should establish initiatives to foster the development of business skills among staff and to assist providers in developing effective business processes. *The Network for the Improvement of Addiction Treatment (NIATx)*, a partnership between the SAMHSA/CSAT *Strengthening Treatment Access and Retention (STAR)* program, the Robert Wood Johnson Foundation's *Paths to Recovery* program, and a number of independent addictions treatment organizations, provides a good example of an initiative that addresses business processes. SAMHSA/CSAT should continue to support such activities.

C. Recruitment Priorities

Recruitment Issues in Brief

The ability to maintain an adequate addictions 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 addictions counselors by the year 2010 (Landis et al., 2002). Concurrently, as noted above, NASADAD projects that the need for treatment staff with graduate degrees will increase by 35% by 2010 (NASADAD, 2003). 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 are needed, such as a loan forgiveness and repayment program, described previously in Section 2, Part A. These strategies must accommodate the dynamic nature of the treatment field, including increased demand for treatment services, the need to keep pace with scientific advances, staff turnover and required

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training time for staff. Recruitment efforts must also address the underlying conditions that make people reluctant to enter the addictions 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).

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 addictions 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 addictions treatment workforce so that it more closely reflects the patient/client population. As Figure 3. (below) shows, there are discrepancies between the demographics of the addictions treatment staff and the addictions 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 addictions treatment workforce must become more diverse and culturally competent at all levels to better serve the patient/client population (Kaplan, 2003).

Figure 3. 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 addictions medicine;
2. Improve student recruitment with educational institutions, focusing on under-represented groups;
3. Employ marketing strategies to attract workers to the addictions treatment field; and
4. Continue efforts to reduce the stigma associated with working in addictions treatment.

1. Expand recruitment of health care professionals in addictions 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).

Discussion

Some of the boundaries that have traditionally separated specialty addictions 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 addictions medicine and to encourage larger numbers of nurses and medical social workers to obtain addictions certification. As Figure 4. shows, a relatively small percentage of physicians, nurses and other health professionals obtain addictions credentials or self-identify as an addictions specialist.

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Figure 4. Number of Practitioners and Certified Addictions Specialists, by Health Care Discipline

Discipline	Workforce Size	Certified Addictions Specialists
Primary care	700,000	2,790 ASAM certified
Psychiatry	30,000	1,067 addictions 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 addictions specialist

Source: IOM, 1997

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.

Figure 4. contains data from a 1997 IOM report that compares the number of practitioners by professional discipline to the subset of those same practitioners who have received specialized addictions certification. These data indicate that only a small number of individuals within the total health care workforce are certified as addictions practitioners. The numbers clearly illustrate the need to develop incentives and opportunities that will increase the number of practicing certified addictions 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 loan forgiveness and repayment program, such as the one proposed in *Infrastructure Development Priorities*, should make loan payment available to medical practitioners who specialize in addictive disorders and agree to work for a specified period of time in publicly funded programs targeting under-served communities. Such a program would encourage specialization of medical practitioners in addictions within both the generalist and specialist settings. The target audience for this special

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incentive would include physicians, advanced practice nurses, registered nurses and physician assistants who have large student loan obligations, and who desire additional formal training and certification to develop expertise and clinical practice in addictions treatment. It is recommended that marketing strategies and materials target experienced professionals who work in areas such as general internal medicine, family practice, pediatrics, cardiology, geriatrics and other medical specialties.

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

Student recruitment, at various age levels, is needed to expand the addictions treatment workforce. It is recommended that SAMHSA provide Federal leadership and partner with elementary schools, 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 (see Figure 3.), data show that minorities are under-represented and females are over-represented in the addictions treatment workforce relative to the patient/client population.

Discussion

For marked expansion of the addictions workforce to occur, a much younger cohort must be inspired to choose the addictions 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

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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, it is recommended that SAMHSA partner with educational institutions to collaboratively devise comprehensive recruitment strategies. These strategies must include the development of informational materials about the field for teachers, guidance counselors and librarians. Additionally, support should be made available for mentoring programs, internships, apprenticeships, educational scholarships, loan forgiveness and repayment programs and post-graduate job placement opportunities.

3. Employ marketing strategies to attract workers to the addictions treatment field.

Federal agencies could significantly enhance recruiting efforts by developing model social marketing and health communication strategies aimed at a more diverse group of professionals. Key groups that could be targeted include students, who might be encouraged to adopt addictions treatment as a career path, second-career professionals, individuals in recovery and their family members and other groups that have a natural interest in the field. The recruitment of students and young adults is critical to the development and long-term sustainability of the field.

Discussion

Nursing and other professions have made effective use of the media to recruit workers. 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.

The addictions treatment field should adopt similar strategies with the anticipation of seeing comparable results. 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. To support this, SAMHSA/CSAT should develop model social marketing and health communications strategies that States and providers can use as models. 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. As noted above, it will be critically important to recruit younger individuals who are interested in finding a long-term career path in addictions treatment. Over the long term it is through young persons who elect to make addictions treatment a career that the field will develop most fully as a unique profession.

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Second-career professionals, while potentially having a shorter career span, bring maturity, broad life and work experience to the field that is extremely valuable. Those in recovery and their family members, of course, have long brought unique, first-hand experience, passion and perspective to the field. They represent an immense pool of potential workers whose talents would provide an immeasurable benefit to the field. Stakeholders have pointed out that, while such individuals already represent a significant segment of the addictions treatment workforce, the field has barely begun to tap this rich resource.

4. Continue efforts to reduce the stigma associated with working in addictions treatment.

Stigma devalues addictions 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, SAMHSA/CSAT leadership should be provided to develop strategies, including a public education campaign, to promote addictions treatment as a worthwhile career choice.

Discussion

Workforce recruitment efforts must overcome the stigmatization of the addictions 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

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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 addictions treatment field. However, additional approaches, such as the development of a national campaign to educate the public about the scientific basis and effectiveness of addictions 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 addictions treatment field and addictions studies as exciting, viable and respectable career choices and seek to build the public's confidence in the importance and effectiveness of treatment services. It is recommended that SAMHSA/CSAT partner with States, academic institutions, provider trade associations and other stakeholders to explore the feasibility of developing public information campaigns to market careers in addictions treatment.

D. Addictions 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 addictions 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 Addictions 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

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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 addictions treatment field. Historically, training for addictions 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-based 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 national competencies. Although efforts have been made to establish national academic accreditation standards for addictions 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 addictions 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 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 addictions studies programs, or the progress that has been made to increase minority enrollment.

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Recommendations

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

1. Include training on addictions 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. Call for the use of national addictions core competencies as the basis of curricula;
3. Support the development and adoption of national accreditation standards for addictions education programs;
4. Encourage national and State boards for the health professions to have at least 10 percent of licensing examination questions pertain to addictions;
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. Develop college and university courses in addictions-related health services research and its application; and systematically disseminate research findings to academic institutions.

1. Include training on addictions 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 addictions 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

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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 addictions into existing residency structures, increasing faculty knowledge and including more questions related to treatment on board examinations (Isaacson et al., 2000).

The U.S. DHHS should support expansion of SAMHSA/HRSA joint education initiatives. An example of such an initiative is Project MAINSTREAM (Multi-Agency Initiative on Substance Abuse Training and Education for America), which was 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 Abuse. This and similar programs were designed to enhance substance use disorders training and education among health professionals.

Such programs would benefit social workers. Many clinical social workers are eligible to practice in the addictions 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). Academic institutions, in partnership with professional organizations, should develop enhanced multi- and cross-disciplinary education and training programs to provide core curricula for social workers and health professionals on substance use disorders.

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2. Call for the use of national addictions core competencies as the basis of curricula.

Educational curricula must be based on solid research and on a unified national 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. SAMHSA Technical Assistance Protocol (TAP) 21, *Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice*, 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 number of standards when developing curricula. These standards include the International Certification and Reciprocity Consortium (IC&RC) twelve core functions; the International Coalition for Addictions Studies Education (INCASE) standards; the Association for Addiction Professionals (NAADAC) Certification Standards; and SAMHSA TAP 21.

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

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

- The **knowledge and attitudes** underlying competent practice for both addictions treatment counselors and practitioners in other disciplines: understanding addictions, 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 ensure 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

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knowledge and skills to provide appropriate and effective treatment services. Institutions of higher education should use national core competencies as the basis of curricula.

3. Support the development and adoption of national accreditation standards for addictions education programs.

There is no uniform national programmatic structure nor are there associated standards for addictions studies despite the existence of 442 addictions studies programs across the United States. Little is known about the quality of these programs and how they prepare future practitioners. Academic accreditation standards for addictions 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 addictions education programs. Educators in addictions studies expressed the feeling that their 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 addictions education programs. Several related issues will need to be considered as the process moves forward. First, addictions 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 members do not have terminal degrees and would therefore need access to doctoral programs. A third issue is that most programs in addictions 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 addictions studies programs and will enhance the reputation of existing programs that compete for students and institutional support.

It is recommended that SAMHSA/CSAT partner with institutions of higher education to foster adoption of national accreditation standards for addictions studies.

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

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 addictions, 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 addictions were included in the licensing and certification examinations, the topic of addictions 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 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 addictions. The addition of these questions to licensing and certification examinations will aid in ensuring that candidates are competent to recognize and treat addictions.

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. 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 addictions, as well as create criteria for evaluating programs that prepare these professionals to take licensure and certification examinations.

State addictions treatment authorities should work with licensing bodies to ensure that 10% of licensing questions pertain to addictions. To accomplish this, they will also need to work with

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institutions of higher education, to encourage development of curricula that prepare future professionals to address addictions.

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

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 workforce. A significant disparity already exists between clinicians and patients/clients in the addictions treatment field. Providing support for educational programs targeting racial and ethnic minorities will ultimately result in more graduates who will become part of the treatment workforce.

Academic programs that support racial and ethnic minority students offer great promise for addressing unmet health care needs. Initiatives supporting curriculum development, internships, apprenticeships, loan forgiveness and scholarships at academic institutions that serve minority populations would provide a mechanism to increase the diversity of the workforce and provide care in underserved areas (DHHS/HRSA, 2004).

Discussion

HBCUs and other minority-serving institutions should develop additional coursework and curricula in addictions studies. Greater variation in coursework makes programs more attractive to students, encouraging them to consider addictions studies. Internships and apprenticeship programs are also critical components in the development of clinicians. States and provider organizations should support paid internships and apprenticeships 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. The loan forgiveness and repayment program proposed in *Infrastructure Development Priorities* would be instrumental in supporting recruitment from HBCUs and other minority-serving institutions. 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.

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The steady growth in the number of racial and ethnic minorities requires an investment of resources to provide greater access and quality of care to these populations. A report by HRSA 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 (HRSA, 2003). Thus, support for addictions studies programs at HBCUs, Hispanic Serving Institutions, Tribal Colleges and Universities and other minority-serving institutions is needed to ensure workforce diversity and respond to the treatment needs of these diverse populations.

6. Develop college and university courses in addictions-related health services research and its application; and systematically disseminate research findings to academic institutions.

One of the greatest challenges for the addictions 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 ensure 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, addictions studies programs at colleges and universities must include courses that teach students about research and how to apply it in practice.

Discussion

The addictions 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 addictions 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. Unfortunately, many

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research findings have not reached the educator or practitioner and therefore have not influenced addictions 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. Therefore, it is recommended that NIDA and NIAAA disseminate research findings to colleges and universities, particularly to those offering addictions studies programs.

E. Retention Priorities

Retention Issues in Brief

Nearly 70 percent (67.8%) of addictions 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 annual turnover rate of 18.5 percent among addictions 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 addictions 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 pertain to the addictions 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.

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Retention efforts must be creative, innovative and address underlying reasons that cause individuals to quit their jobs or leave 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 substance misuse and 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 addictions 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” (The 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 addictions treatment field are not competitive compared to those of other health professionals in equivalent job categories. Figure 5. provides information on the median annual earnings for addictions treatment counselors and other health and social service providers by occupation in 2000.

The U.S. Department of Labor reports that in 2000 the median income for addictions treatment and behavioral disorder counselors was \$28,510. As of 2000, the mean annual salary for all addictions 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

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mean annual salaries for addictions 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 addictions 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 addictions treatment workforce found that the most prevalent recommendation for retaining staff was increasing salaries (Knudsen and Gabriel, 2003). In 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, it is recommended that SAMHSA 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.

Figure 5. 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

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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 addictions 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.

Anecdotal evidence indicates that recruitment and retention problems associated with faculty for addictions studies programs are just as severe 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 addictions 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 addictions 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 addictions treatment faculty at institutions of higher learning. With support from SAMHSA, Federal and State government agencies and colleges and universities should develop a pilot project to recruit addictions studies faculty. A successful pilot would establish a "promising practice" for workforce retention.

2. Address substance misuse and relapse within the workforce.

To date, little attention has been given to the issue of substance misuse and relapse in the workforce. Leadership is required in this area. The Addiction Technology Transfer Centers (ATTCs), in partnership with clinicians, treatment providers, States and other stakeholders, can lead the development of training that recognizes and addresses substance misuse and relapse within the workforce. Training areas should include, but not be limited to, strengthening Employee Assistance Programs (EAPs), wellness programs and health insurance and disability policies. Such training would target supervisors, human resource managers, the general provider workforce and State/Territory agency staff.

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Discussion

While all professions employ individuals in recovery, the addictions 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 potential for relapse is always present, even among addictions 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. In addition, substance misuse among clinicians and other treatment staff who may not have a diagnosable substance use disorder must also be addressed. EAPs are one mechanism for addressing this.

Small agencies often do not have adequate resources to offer EAP services to their employees and often are only able to provide very limited health and disability benefits. Wellness programs may offer an effective strategy for such agencies. They “have the potential to decrease absenteeism, reduce medical claims costs, and improve employee productivity, recruitment, and retention” and can be implemented inexpensively by smaller organizations (Sullivan, 2000). While not necessarily representing a direct response to relapse or substance use, a wellness program could serve as both a preventive measure and a support to interventions more specifically targeted to substance misuse and relapse in the workforce.

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 and resources that assist supervisors in taking appropriate action when impairment is detected. 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. The ATTCs, in partnership with States, provider organizations and other stakeholders, should develop and conduct training for human resource departments, supervisory and management staff and clinicians related to substance misuse and relapse prevention strategies.

Additionally, it is recommended that SAMHSA fund the piloting of an impaired professionals’ program for addictions clinicians to determine whether, when and under what circumstances a

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clinician who has relapsed can re-enter direct clinical practice. 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. A pilot could yield preliminary standards for the field. Such a program would interface with the EAP and the treatment agency human resources department. Lastly, provider organizations should train staff on how and when to refer colleagues for assistance when they suspect misuse of substances.

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 addictions treatment field should be identified, and the national, State and local certification boards or professional societies for addictions treatment professionals should be encouraged to explore development of peer education and support programs for impaired professionals in the addictions treatment field. Relapse within the addictions 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

Data on the addictions treatment workforce have been limited. A number of ATTCs have conducted surveys of the treatment workforce (Knudsen and Gabriel, 2003; Gallon et al., 2003). The surveys, which differ in content and methodology, focus on issues such as academic training and professional experience, recruitment and retention, compensation, treatment models, training interests and employee satisfaction. While informative, such studies do not yield data to guide the development of the addictions treatment workforce.

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Addictions 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 would enable the field to make informed decisions about professional development and improved practices.

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 by the stakeholders as priorities:

1. Conduct studies that examine the relationships among level of education, type of education, training and treatment outcomes;
2. Conduct studies that examine the relationships among clinician and patient/client cultural, demographic and other characteristics and treatment outcomes; and
3. Conduct studies of clinician characteristics, training and skills that enhance therapeutic alliance.

1. Conduct studies that examine the relationships among level of education, type of education, training and treatment outcomes.

It is recommended that NIDA and NIAAA 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?

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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, limited research has been conducted on how education and training are linked to treatment outcomes. 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.

2. Conduct studies that examine the relationships among 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, little research has been conducted to date on the impact of these differences on treatment outcomes. Survey data collected by the ATTCs provide general information about workforce demographics

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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. It is recommended that NIDA and NIAAA fund research examining the relationship between clinician and client cultural, demographic and other characteristics and outcomes.

3. Conduct studies of clinician characteristics, training and skills that enhance therapeutic alliance.

In the past two decades, a number of studies investigating the role of 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. An example of another factor that may impact therapeutic alliance is the recovery status of the clinician. Little research has been performed on the relationship between clinician recovery status, therapeutic alliance and outcomes. Therefore, the extent to which the recovery status of clinicians is associated with an effective therapeutic alliance is not well known. As the field strives to improve patient/client outcomes and enhance the skills of its workforce, answers to several research questions 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?
- Is the recovery status of the clinician correlated with the quality of therapeutic alliance?
- Do the philosophy and nature of interventions employed by recovering and non-recovering clinicians vary?

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

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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 addictions 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.

Stoffelmayr and colleagues found that, while a clinician's level of education influenced neither treatment goals nor techniques, recovery status of clinicians was correlated with the range of treatment techniques and treatment goals employed. Clinicians who were in recovery tended to adopt more varied treatment techniques and a broader range of treatment goals (Stoffelmayr, 1999). There is some evidence, therefore, that the recovery status of counselors affects how they approach the provision of treatment services.

Further research is required to better understand the relationship between recovery status of the clinician and therapeutic alliance. A better understanding of these relationships will allow recruitment and training efforts to better target individuals who are likely to be effective clinicians. Research will provide information on what clinical skills and clinician attributes support a quality relationship with the patient/client. It is recommended that NIDA and NIAAA fund research examining the characteristics of clinicians that enhance therapeutic alliance.

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III. Summary

This report summarizes trends in addictions 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 specific implementation strategies. The recommendations also set the stage for concerted action by DHHS Operating Divisions, the ATTCs, States, national trade associations, credentialing and licensing bodies, and academic institutions. They offer an agenda for the addictions treatment field now and into the future.

Fundamental improvements in the conditions of the workforce will require the collective action of institutional and organizational partnerships in the public and private sectors. The effectiveness of the addictions treatment workforce rests on its ability to invest intelligently in its future, by developing systems to address issues of recruitment, retention and staff development. Other health care professions (e.g., nurses and physicians) have demonstrated that such efforts can prove effective. It is time that the addictions treatment field, in partnership with States and the Federal government follow that example, taking the steps necessary to address the challenges faced by the addictions treatment workforce. Only by doing this will the barriers to treatment access be addressed and the quality of care substantially improved.

IV. Participants

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. Careful efforts have been made to ensure that all stakeholders who contributed to the development of this report are recognized and listed. Any omissions or exclusions are unintentional.

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