

Substance Abuse Treatment Workforce Environmental Scan

November 2003



PARTNERS
for recovery

Prepared by:
Linda Kaplan
Danya Institute, Inc.



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
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Introduction

Workforce development is such an important issue to the substance abuse field that the Substance Abuse and Mental Health Services Administration (SAMHSA) identified it as a cross cutting principle affecting all of its major programmatic areas. With SAMHSA's recognition of workforce development issues, CSAT commissioned a report under its new initiative – Partners For Recovery – to systematically document and highlight the demographics of the workforce, policy and economic issues, and to inform the next steps in the planning process.

This document addresses a number of workforce issues that were identified by a group of experts who served on a Center for Substance Abuse Treatment (CSAT) Workforce Consensus Panel. The panel met four times between 1999-2000. The Workforce Panel recommended the following goals: To provide a national platform to address workforce issues including establishing a National Workforce Development Office at CSAT; to develop and strengthen a comprehensive infrastructure that attracts, supports, and maintains a competent, diverse workforce, reflective of its client population; and, to improve the competency of a diverse addiction workforce by providing didactic, clinical, and experiential education and training based on a core body of the latest evidence-based knowledge.

After the Consensus Panel provided its input, this environmental was conducted to document the issues based on the literature. The following are the areas that were identified as most critical:

1. *The lack of quantitative data.* No national database exists nor is the infrastructure in place to systematically collect data on the workforce. Without such a database, the field's ability to track the composition, supply and demand, and basic trends in staffing patterns is limited.
2. *No universally recognized standards.* Multiple credentialing systems and standards exist across the nation.
3. *Raising the skill level.* The acceleration in the development of evidence-based practices requires a continued focus on new learning.
4. *Stigma related difficulties.* The substance abuse field experiences difficulties recruiting and retaining staff due to the negative consequences of stigma associated with this disease, which constrains salaries below competitive levels.
5. *Demographic and economic factors.* A significant demographic issue is the aging of the workforce. In addition, addiction treatment tends to be a second career for many which contributes to the aging phenomenon.

With this environmental scan now complete, SAMHSA/CSAT can turn towards developing a comprehensive strategy on workforce issues.

Methodology

Workforce development documents collected by CSAT for almost a decade and a half were analyzed for this report. They included Government-funded reports, such as the Practice Research Reports, studies and white papers from a variety of professional groups and coalitions, and survey results from some of the Addiction Technology Transfer Center (ATTC) regions. These materials have been catalogued by document type and will serve as the basis for a repository of workforce documents.

In addition, a literature review of recent articles on workforce development in the substance abuse treatment field was conducted. To make this environmental scan as relevant and useful as possible, it concentrated on EBSCO, MEDLINE, PubMed, and PsycInfo articles, papers and studies conducted in the past five years. Using recent data provides a more accurate description of the current workforce conditions facing the substance abuse treatment field. The urgency around workforce issues has intensified within the last few years, which is in turn increasing the prevalence of available surveys and studies.

Although some research has been conducted, the lack of a standardized survey instrument or a study of sufficient scope limits the conclusions and comparisons that can be drawn regarding the workforce. Inconsistent methodologies coupled with the fact that the studies examine different professional groupings, make it even more difficult to capture an accurate picture of the workforce.

Based on our review of the literature and feedback from committees, workgroups, and task forces that have been convened on workforce issues by CSAT's Workforce Issues Task Group, the ATTCs, and the Partners for Recovery initiative, this environmental scan is divided into the following key sections:

- Background Information;
- Demographics of the Workforce;
- Recruitment;
- Retention; and
- Training and Credentialing.

Background

Health care Professionals: Current Trends

Health care workforce issues have become a subject of increasing concern in the past few years, in part driven by a shortage of nurses, the under-representation of minorities in health care professions, and concerns about the distribution of the workforce. A look at the larger health care workforce provides a broader context for the review of the substance abuse treatment workforce. Matherlee (2003) reported that 15.1 million people were employed as health professionals or as working in health services, representing 10.4 percent of the nation's workforce.

In regard to mental and behavioral health care, as of 2000 there are 518,000 workers (inclusive of substance abuse counselors), or 5 percent of the health care workforce. By 2010, the number of mental and behavioral health workers is projected to reach 657,000, a 27 percent increase. Mental Health and Substance Abuse Social Workers were listed as the 26th fastest growing profession, expected to increase from 83,000 in 2000 to 116,000 in 2010. The impact of this projected growth on the substance abuse treatment field is hard to determine from the existing data. There is no specific projection for the growth in the number of substance abuse counselors.

The Substance Abuse Workforce: Current Trends

Concerns about the closure of many substance abuse-specific treatment agencies have been voiced during the past decade and these closures have had an obvious impact on the delivery of treatment services and on staff. McLellan, Carise, and Kleber (2002) reported on the results of their contacts with 125 out of 250 randomly selected programs taken from the National Survey of Substance Abuse Treatment Services (NSSATS). They found that 19 percent of these programs had stopped providing substance abuse treatment services and about 30 percent had been re-organized under a mental health or public health agency. Another study conducted by Johnson and Roman (2002) found that during the period between 1995-1999, 15 percent of the 450 private sector agencies in their study had closed.

The organizational and administrative infrastructures of many programs were found to be inadequate and unstable. McLellan (2002) found that most programs did not have a full-time physician or nurse, and very few programs had full-time social workers or psychologists. This study also found that most senior level people were responsible for administrative, rather than clinical services.

In sum, dislocation caused by closures, a greater demand for services, and an increased focus on outcomes have had a tremendous impact on the workforce, which is already in crisis. Staff shortages, lack of qualified staff, and job-hopping all undermine the delivery of services and further impact the stability of the treatment system.

Demographics Of The Workforce

Composition of the Workforce

Current estimates of all staff including direct care and support staff, whether clinical or administrative, in the substance abuse treatment workforce, places the number between 130,000 to 134,000 full-time staff (SAMHSA 2003; Landis 2002). In addition, there were 44,956 part-time staff and 22,283 contract staff employed in the substance abuse treatment system in 1996-1997 (SAMHSA 2003). Medical staff and graduate-degreed counselors each made up 17 percent of full-time staff; bachelor's level and non-degreed counselors made up 29 percent of full time; staff members other than medical and counseling made up 37 percent.

The Alcohol and Drug Services Study report cited differences between the full-time and part-time or contract staff. Part-time staff were more likely to have medical or graduate degrees and less likely to have a bachelor's degree. Direct-care staff who were more highly trained, educated, and paid were more likely to be hired on contract. Seventy-seven percent of agencies had master's degreed staff. Bachelor's level counselors were found in 68 percent of the agencies in the ADSS report (SAMHSA 2003). Many of these graduate-trained staff were either part-time or worked as contract staff.

According to Harwood (2002) there were 67,000 direct-service staff delivering counseling/psychosocial services to 985,000 clients in 13,000 centers in 1998. In this study, 53 percent of the counseling staff were credentialed alcohol and drug counselors and about 25 percent were credentialed in other disciplines. The remaining 22 percent were not credentialed professionals, although a majority of them reported that they were in the process of becoming credentialed.

Gender

Most studies found that females comprised the majority of the clinical workforce, ranging from 50 percent to almost 70 percent (Mulvey, et al 2003; RMC 2003; RMC 2003a; Knudsen 2003; NAADAC 2003; Harwood 2003; NTIES 2001, Johnson, et al 2002, Maine 2003 unpublished). Several studies found gender differences between management and direct service staff, with directors more frequently being male and direct care staff more frequently being female (RMC 2003; RMC 2003a). However, these two studies were based on either a region of the country (the Northwest) or on one State (Kentucky), so more information is needed concerning the gender of management staff to obtain an accurate picture.

In regard to people coming into the field, the National Association of Alcoholism and Drug Abuse Counselors found that 70 percent of their members who were new to the field were female, as compared to 57 percent of their overall membership (NAADAC 2003). However, although at least half the substance abuse treatment professionals were female, the clients were predominately male

(Landis, et al 2002; Mulvey et al 2003; SAMHSA 2003). This gender difference between clinical staff and clients may have important implications for treatment services and the training of staff. Research studies should examine whether gender differences impact the engagement and retention of clients and what types of interventions or treatment practices may produce the best outcomes.

Age

In most studies, the average age of the substance abuse clinical staff was in the mid-forties to early fifties (NAADAC 2003, RMC 2003, RMC 2003a, NTIES 2001, Harwood 2003). In a survey of Maine substance abuse treatment agencies, 70 percent of staff were over 40 years of age (ATTC-NE). Knudsen (2003) found that 75 percent of the workforce was over 40 years old, and one-third of the workforce was over 50. However, in the two studies that examined management staff, the average age of program directors was approximately 50 years old (RMC 2003, RMC 2003a).

In one regional study of the Northwest, a significantly higher proportion of male agency directors (58 percent) fell into the 51-60 year old category compared to female agency directors (34 percent). In fact, 57 percent of female agency directors were under the age of 50, compared to only 31 percent of male agency directors.

Differences in age between the staff and clients were reported in several studies, as almost 50 percent of substance abuse clients seen by substance abuse counselors were between the ages of 25-44 (Lewin-VHI 2003; Landis 2003). However, as indicated above, most clinical staff were over 40 years old. This discrepancy in age between clinicians and clients may have some treatment implications and should be further studied.

Race and Ethnicity

Studies indicate that from 70 percent to 90 percent of substance abuse treatment staffs are white. (RMC 2003; RMC 2003a; Harwood 2003; Knudsen, et al. 2003; Landis 2002; Mulvey 2003, Illinois Alcohol and Other Drug Abuse Professional Certification Association). Recent studies that focused on private treatment agencies reported fewer minority staff than did those that focused on publicly funded programs. One study (Mulvey, et al 2003) found that 85 percent of treatment professionals were white, while 57 percent of the clients were white. Landis (2002) also found that clients are over-represented by minorities when compared to staff.

The difference between the race and ethnicity of clients and direct treatment staff has not been adequately studied. Research on the effect of client-staff matching has been sparse and has not provided any clear direction (Landis 2002). One study (Sterling, et al 1999) reported that race and gender did not impact early dropout rates; however this is also an area that needs more study.

Education Level

Reports on education level varied more than did information on gender, age, or race. Direct care staff in the substance abuse treatment field held either a bachelor's or master's degree (SAMHSA 2003). Several studies found that 80 percent of the workforce surveyed had at least a bachelor's degree (Johnson et al 2002; Knudsen, et al 2003; RMC 2003a). In a study of Maine treatment agencies, at least 61 percent of staff had a bachelor's degree or higher (ATTC-NE.). The regional study by the Northwest Frontier ATTC (RMC 2003; Gallon 2003) reported that over 60 percent of staff had a bachelor's degree, with 57 percent of directors and 34 percent of staff having graduate degrees. Harwood (2003) reported that 53 percent of the direct service treatment staff had a master's degree, and Mulvey (2003), in his study of publicly funded programs, found 72 percent, 47 percent and 7.4 percent of staff had either a bachelor's, master's or doctorate, respectively.

Treatment staff have degrees in a variety of fields, with very few having specific academic courses or degrees in substance abuse treatment. Fifty-three percent of all NAADAC members have a master's degree and 7 percent report having a doctorate; however more than 50 percent of NAADAC members have another behavioral health credential, either social worker, licensed professional counselor, or licensed mental health counselor (NAADAC 2003). In the Northwest Frontier region, fewer than 50 percent of the staff and directors have either a degree or certificate specific to addiction treatment. Most professionals receive training in substance abuse, and almost 90 percent of directors and staff participated in relevant training during the past year (NAADAC 2003; RMC 2003; RMC 2003a).

Credentialing Status of Clinical Staff*

Most direct service staff have degrees and many are credentialed in their chosen discipline. However, the number of clinical staff who are credentialed as substance abuse counselors is lower than the number of staff providing therapeutic services. Therefore, as will be illustrated below, the issue of credentialing is complicated by the fact that professionals who are licensed or certified in other disciplines do not have to be credentialed as substance abuse counselors to practice in most States.

Studies indicated that numbers of credentialed substance abuse counselors ranged from a low of 45 percent (SAMHSA 2003) to a high of 72 percent. However, some states do require that 100 percent of direct care clinical staff be either credentialed as substance abuse counselors or have a license in another discipline. In the Northwest Frontier ATTC study (RMC 2003), 60 percent of staff were credentialed. Other studies included Kentucky (RMC 2003a), at 50 percent, and a Johnson et al (2002) study of private facilities at 55 percent. Mulvey et al (2003) reported that 72 percent of the treatment professionals who participated in their survey were credentialed addiction counselors. In Maine, 67 percent of staff were either credentialed or licensed.

Harwood (2003) found that about 53 percent of staff were certified/licensed as substance abuse counselors, and that 56 percent of certified substance abuse counselors had a master's degree. In fact, this study reported that uncertified/licensed counselors rarely had graduate degrees and that 56 percent of uncertified substance abuse counselors had less than four years of college. It is important to note that up to 25 percent of staff did not possess a credential and were not in the process of becoming certified (Harwood 2003; RMC 2003). In the Harwood study, 15,500 counselors were not yet licensed/certified and 16,700 other behavioral health workers who were not credentialed in substance abuse counseling.

The ADSS study reported that less than 50 percent of the direct service treatment staff were certified/licensed in substance abuse treatment (SAMHSA 2003). In the ADSS report, (SAMHSA 2003) statistics on substance abuse counselor certification varied by type of facility. Outpatient non-methadone facilities had the highest percentage of certified staff and methadone programs the fewest. This may be due to the fact that more staff at methadone facilities are required to have medical credentials to meet Federal standards and regulations. This study also found that private not-for-profit and for-profit agencies had higher percentages of credentialed substance abuse staff than publicly owned facilities. In addition, the study reported that community mental health centers had fewer certified substance abuse counselors than other agencies.

NAADAC (2003) reported that 79 percent of its members were certified/licensed as substance abuse counselors at the State level. However, 31 percent of NAADAC's members were Licensed Professional Counselors, 22 percent were Licensed Clinical Social Workers, and 16 percent were Licensed Mental Health counselors. There was no information on how many of these people held multiple licenses or certifications, but based on the data, many NAADAC members are dually credentialed as both a substance abuse counselor and in another discipline.

Quality care requires a competent workforce that is well trained, educated, and skilled in providing appropriate services to clients. In the substance abuse treatment field, credentialing and licensing standards have been competency-based. However, the fact that a significant portion of the direct service workforce in various settings are not certified as substance abuse counselors raises questions about the quality of addiction treatment being provided. This is an area that needs further study. For example, do certified counselors have better client outcomes? Are counselors who are credentialed or licensed more likely to engage clients in treatment and are they more likely to retain clients in treatment? These and related questions are potential areas of investigation.

Salaries

Salaries in the substance abuse treatment field have also been considered low compared to other fields. However, several studies indicated that degree status was related to compensation. For substance abuse counselors, holding a master's degree and being credentialed led to higher salaries (Landis 2002). The study in the Northwest States found that a person's degree status was

the strongest predictor of salary, regardless of position (RMC 2003). Having a higher degree, being in a management role, having more years in the field, and working in an urban area were also related to higher salaries (RMC 2003; RMC 2003a). The majority of agency directors (68 percent) reported earning between \$40,000-\$75,000, while the majority of treatment staff (61 percent) reported earning between \$15,000-\$34,999 (RMC 2003; RMC 2003a).

As reported in Landis (2002) the median income for Substance Abuse and Behavioral Disorder Counselors in 2000 was \$28,510 and the average salary was \$30,100. The median income for Mental Health and Substance Abuse Social Worker during the same time period was \$30,170 and averaged \$32,240. Johnson, Knudsen & Roman (2002) reported that the average counselor salaries were low and only increased from \$29,767 to \$34,125 in the decade from 1992-2002, or about 2 percent a year. And in the study by Knudsen et al (2003) of private treatment centers, 88 percent of substance abuse counselors made less than \$40,000 a year and most earned between \$25,000 and \$40,000.

Looking at substance abuse counselors who were in the field three years or less, NAADAC (2003) found that only a quarter of these early career members earned more than \$35,000 per year. However, NAADAC reported that 47 percent of all NAADAC members working in agencies and 78 percent of all NAADAC members in private practice earned more than \$35,000. This lends support to the studies cited above, indicating that higher salaries are associated with a graduate degree, longer tenure in the field, and being credentialed, since the majority of NAADAC members meet those criteria.

Further studies should be done comparing salaries of substance abuse counselors with other disciplines that require that same level of training and education. In addition, it will be important to segment the analysis based on degree status and credentialing requirements to get a comprehensive picture of how salaries compare to other behavioral health care professions.

Work Conditions

An important component of practices in the workplace are related to both caseload and to client-staff ratios. In the ADSS study (SAMHSA 2003) client-staff ratios varied by treatment setting and ranged from 1-1 in inpatient hospital facilities, to non-hospital residential of 5-1, to outpatient non-methadone of 19-1, and to 24-1 in methadone facilities. This study found that the lower the ratio of clients to staff, the more treatment services were offered. The same held true for support services, with more offered in facilities that had lower client-staff ratios (SAMHSA 2003).

According to NAADAC (2003), counselors spent most of their time counseling clients either in group, individual, or family sessions. This varied from 41 percent of their time for those counselors working in agencies to 61 percent for those in private practice. Counselors working in both settings reported spending more time on individual counseling than group counseling. Direct service treatment staff reported spending just over one fifth of their time doing paperwork,

constituting approximately one day each week (McLellan et al 2002; OASAS 2002; RMC 2003; RMC 2003a). Other barriers cited were long hours and large caseloads (RMC 2003a).

Summary

Based on the limited data available the substance abuse workforce appears to be primarily female, middle-aged, and white. The discrepancies between the gender, age, and race of the workforce when compared to the clients may have implications for retaining and engaging clients in treatment. Certainly, some services research needs to examine whether these factors impact treatment outcomes, and there is a need to develop appropriate evidence-based practices to enhance practitioners' skills. The differences and impact of race and ethnicity of clients and their direct treatment staff has not been adequately studied. Research on the effect of client-staff matching has been sparse and has not provided clear direction.

Since only about 50 percent of clinical staff are credentialed as alcohol and drug counselors, clinicians from other disciplines who are providing direct services may not have knowledge and skills specific to addiction treatment. However, little research has been done to determine whether credentialed substance abuse counselors have better client outcomes.

As will be discussed later, salary is an issue for substance abuse clinicians and is a barrier to entering the field. Studies comparing salaries of credentialed substance abuse counselors with other comparably educated and trained professionals needs to be conducted to determine more appropriate wage structures.

Although there is a fair degree of concordance in much of the demographic data gathered from the studies cited above, there is still not a comprehensive study of the substance abuse workforce. An analysis of ATTC State and regional surveys is in process, which may provide more data and indicate common elements and gaps in information. However, a major limitation to this analysis is the variation in the design of the studies and the methodology that was utilized for the various studies. The paucity of data hampers our ability to obtain a clear picture of the substance abuse treatment workforce and calls for a national study that includes data on demographics and workplace conditions.

Recruitment

Future Staffing Needs

The Bureau of Labor Statistics estimates that in 2010 there will be 4,000 job openings for Mental Health Substance Abuse Social Workers and 3,000 openings for Substance Abuse And Behavioral Disorder Counselors due to net growth and net replacement of counselors (Landis 2002). Using a modeling simulation, Lewin-VHI (1994) predicted that 5,000 new counselors would be needed each year to replace those who were leaving the field.

Current Conditions

As demonstrated by the demographic profile, the current substance abuse treatment workforce is middle-aged and even new staff entering the field do so relatively late in their careers (RMC 2003; RMC 2003a; NAADAC 2003). In addition, it is clear from all the studies to date that the substance abuse treatment workforce does not mirror the race, age, or gender of the clients in the treatment system.

In the few studies that looked at differences between agency directors and treatment staff there appeared to be little difference between years in the field and years in their role, indicating that most enter the field in the role they currently hold (RMC 2003; RMC 2003a). In addition, both agency directors and treatment staff had a relatively high mean age of entry into the field, entering at 36 years of age and 38 years of age respectively. Although the average age of entry was high, there was a large age range, indicating that people in all stages of life are entering the field for the first time (RMC 2003; RMC 2003a; NAADAC 2003).

Nearly half of both agency directors (47 percent) and treatment staff (49 percent) indicated that their current work in substance abuse is a second career (RMC 2003). People entering the field often do so as a second career because of personal or family experiences (RMC 2003; RMC 2003a; NAADAC 2003). This data would indicate that there are few advancement opportunities, which is an area that needs to be studied in greater detail.

Recruitment of staff is reportedly problematic. In fact, in one study, 73 percent of agency directors and 48 percent of staff reported difficulty recruiting qualified staff (RMC 2003). In the Northwest region and in Kentucky, agencies have reported staff shortages of up to one or two full-time equivalents, with agency size ranging widely from two to more than twelve direct service staff. Therefore, the impact of such a shortage is difficult to gauge without a clear understanding of the percent of positions that remain unfilled. Low salaries were frequently cited as a large barrier to recruitment (RMC 2003; RMC 2003a; OASAS 2002). Management staff also reported that candidates often did not meet the minimum job requirements due to lack of training and education or experience in substance abuse treatment (RMC 2003).

Staff and directors surveyed felt that the stigma of addiction extends to those who provide services. Most staff in the Northwest Frontier ATTC survey reported that they had lower professional status than other health professionals (RMC 2003). A series of focus groups throughout New York State indicated that the stigma of alcoholism and drug abuse prevents other professions from recognizing and accepting addiction professionals as peers (OASAS 2002).

Reasons for Entering the Field

According to NAADAC (2003) early career members indicated the following reasons for entering the substance abuse treatment field:

- 95% said the work is challenging or interesting;
- 91% had a desire to work in a helping profession;
- 78% were motivated by substance abuse problems in community; and
- 61% indicated that either they, a family member, or friends had substance abuse problems.

In contrast, 16 percent indicated that salary or benefits were of great influence and only 19 percent were influenced by job availability in the field. Early career counselors also saw Internet materials as having little utility (NAADAC 2003). This would suggest that ongoing, regular clinical supervision is an important early retention factor. The amount of mentoring and supervision that members new to the field receive was related to greater job satisfaction. Members who received more hours of supervision reported higher levels of satisfaction.

Summary

Based on the demographics and the need for net replacement of staff, attracting younger people into the field as a career choice is a challenge for the current leadership. The age of entry into the substance abuse field also presents some challenges to the field in the areas of training, skills development, and career ladders. Recruitment at academic institutions should be increased to encourage students to look at substance abuse counseling as a career choice. If student interest increased, it would drive the demand for more course offerings in the field of addiction and perhaps leads to specific addiction counseling degree programs in colleges and universities. In addition, a career ladder should be developed for the substance abuse counseling field that would encourage younger adults to consider a career in the field early in their professional lives.

Salaries are mentioned as the biggest barrier to recruitment, but stigma also surfaced as an issue. Both issues may be helped by the suggestions listed above, as the evolution of career pathways will further efforts toward professionalism. Thus, people who enter either through the traditional route of their own recovery, or through an academic program, would have direction about their professional career. In regard to salaries, the field needs to look at the implications of low salaries as it affects recruitment. An economic analysis should be done to determine the cost of

staff shortages and staff turnover to agencies and the system at large. The recruitment of new staff is expensive and time-consuming.

Stigma reaches far beyond recruitment problems, but does demonstrate that everyone working in the field should be involved in educating the public and working to change attitudes about substance abuse treatment. Providing supervision was cited as an important factor for early career counselors in the NAADAC study and could be used as a recruitment tool.

Retention

Recruitment of staff has been cited as difficult. In addition, staff turnover creates gaps in service, greater demands on the already overworked remaining staff, and ultimately, adversely affects treatment services. Retaining qualified staff is a priority issue for the substance abuse treatment field.

Turnover Rates

Staff retention has surfaced as a major workforce development issue. Reports of staff turnover rates range from 33 percent (McLellan, et al 2002) to 18.5 percent (Johnson et al 2002). Some survey results indicated a staff turnover of 25 percent per year across agencies sampled, a rate that is more than double that of all occupations (11 percent) across the Nation (Gallon, et al 2003). Most turnover was voluntary (resignation). This rate was quite consistent across States, urban or rural location, agency size, and public or private status (RMC 2003). In a survey of Kentucky programs, the turnover rate was 17 percent, and almost all of it was voluntary (RMC 2003a). In a study of counselors in Virginia, 76 percent of staff indicated they planned to leave their position in the next five years, and 18 percent stated they planned to leave the field (Evans and Hohensil 1997).

In the context of other professions, this turnover rate is high. Nurses report 11 percent turnover, teachers have turnover rate of 13 percent, and the national average across all occupations is reported at 11 percent (Knudsen, Johnson & Roman 2003). Even more dramatic, and perhaps more destabilizing to the treatment programs, was the finding in one study that about 50 percent of the program management staff had been in their positions for less than a year (McLellan 2002).

According to one study, turnover was lower in agencies that receive the majority of their funding from public sources and have directors with many years of experience in the field, though not necessarily in longevity in their current position. No significance was attributed to gender, ethnicity, size, location, or degree status of the director (Gallon, et al 2003).

Turnover Rates

Years As Director in the Field	Turnover Rates
Less than five years	50%
Five to ten years	30%
Eleven to twenty years	22%
Twenty-one to thirty years	12%

Source: Gallon, Gabriel, Knudsen, 2003

There are discrepancies in the reporting of turnover rates, which is likely impacted by the type of survey, the area of the country, and whether or not the agencies were publicly or privately funded. This indicates a need to further study the turnover rate across the country using a consistent methodology and survey instrumentation.

Staff Tenure

In one study (Harwood 2003), the median number of years credentialed counselors had been in the field was 10. However, in regard to longevity on the job, 68 percent of clinicians had been in their current positions for five years or less. Therefore, as shown on the chart below, though 63 percent of the credentialed counselors have been working in the field for at least six years, almost seven in ten have been in their current positions for less than five years. This illustrates that people are staying in the field but changing jobs.

Staff Tenure in the Field

Years in the Field	Percent of Staff
One - Five Years	36%
Six – Ten Years	28%
Ten Years or More	35 %

Source: Harwood, H.J., Survey on Behavioral Health Workplace, Frontlines, November 2002

In a retrospective study of treatment professionals in public sector programs, tenure in the field was higher, with 86 percent of the staff having worked in the field for five years or more, and 62 percent in the field for more than 11 years (Mulvey et al 2003). Though this study reports a higher tenure rate than the one above, professionals tended to move from facility to facility, as half had been in their current positions less than five years. Knudsen reported that the average tenure at the current position was low, with 56 percent of clinical staff in their current job less than four years.

Retention Issues

In a number of studies that looked at retention, a major factor contributing to retention problems was low salary (RMC 2003; RMC 2003; Gallon et al 2003; Lewin-VHI 1994; NAADAC 2003; Knudsen, Johnson & Roman 2003). In focus groups conducted throughout New York State, salary was identified by the eleven workforce development focus groups as the single most important issue for staff recruitment and retention (OASAS 2002).

In addition to salaries, staff reported that documentation and paperwork took them away from working with clients (McLellan et al 2002; OASAS 2002; RMC 2003; RMC 2003a). Other barriers cited were long hours and large caseloads (RMC 2003a.).

Management Practices

Average counselor salaries have remained low, having increased from \$29,767 to \$34,125 for an annual increase of less than 2 percent from 1992 –2002, which has been the single most cited factor impacting retention (Johnson, Knudsen & Roman 2002). However, the same study found that other management practices that might reduce turnover were the following: allowing staff more autonomy in their day-to-day work improving communication between management and counselors and improving aspects of the job that lead to emotional exhaustion (Johnson, Knudsen, & Roman 2002).

Another study (Knudsen, Johnson & Roman 2003) examined the relationships between management practices, organizational commitment, and turnover intention among substance abuse treatment counselors in privately funded agencies. The survey sampled 1,074 counselors from 345 randomly selected privately funded treatment centers. They found that older counselors and those with longer tenure had significantly higher commitment than younger and less tenured staff. Increased education was negatively associated with commitment, meaning that counselors with greater human capital resources (educated and certified) reported greater turnover intention. Salary was negatively associated with intention to quit; that is, higher salary resulted in less intention to quit. Low salaries have been cited as the major cause of staff turnover and the biggest issue in staff recruitment and retention.

Clinical supervision also impacts retention. Culbreth (1999) found that counselors want to be supervised by a clinical supervisor who is certified as an alcohol and drug counselor, has at least a master's degree or has a national counselor certification, and considers him/herself a substance abuse counselor. Counselors preferred proactive supervision that included goal-setting and specific interventions.

Agency directors and treatment staff showed agreement on the top four things that an agency could do to promote retention: more frequent salary increases, more individual recognition and appreciation, reduction of or assistance with the amount of paperwork, and more and improved ongoing training (RMC 2003). Other studies pointed to enhancing career growth opportunities, providing better benefits, automatic COLA increases, tiered compensation levels and bonuses for staff when they become credentialed (RMC 2003a; OASAS 2002).

Job Satisfaction

Agency directors and treatment staff indicated more factors that contribute to satisfaction than factors that contribute to dissatisfaction. Role as a change agent, commitment to treatment, one-on-one interactions with clients and agency coworkers were among the most frequently cited sources of satisfaction for both agency directors and treatment staff. Interestingly, personal growth opportunities were cited as a source of satisfaction, but career growth opportunities were not. Low salaries also contributed as an important source of dissatisfaction (RMC 2003, RMC 2003a).

Early career members indicated the greatest dissatisfaction with salary, workload and the amount of time they have for their clients (NAADAC 2003). Regardless of dissatisfaction with salary or workload and the finding that only about half of early career members see opportunities for career advancement in the substance abuse field, more than 86 percent overall indicated that it is likely or very likely that they will pursue a long-term career in the field. This finding is consistent across all age categories. However, 21 percent of those with less than two years experience indicated that it was unlikely or very unlikely that they will continue in this career choice, indicating that there is a need to enhance job satisfaction and retention for very new addiction counselors (NAADAC 2003).

Summary

Though staff turnover in the substance abuse field is higher than the national average, for the most part, people are staying in the field, but changing jobs every four or five years. This churning of the workforce has an adverse impact on agencies, creates instability, and is costly. The single most important factor in staff retention is salary. However, other issues, such as increasing job autonomy, providing individual recognition, improving and increasing training, lessening paperwork, and more frequent salary increases were cited as actions that could positively impact turnover. In order to improve retention, Gallon et al (2003) recommended that “Managers might do well to balance their effort between enhancing salary and benefits and meeting more personal needs of staff in areas of recognition for work performed, professional growth opportunities, and organizational development.”

In a study of human services workers, which found similar recruitment and retention problems, the following approaches were suggested: rewards for superior performance and effectiveness, reasonable workloads, career paths, clear performance expectations that relate to a coherent organizational mission training and development opportunities on the job ability to change bad management and supervision, and adequate base compensation (Annie E. Casey Foundation 2003). Based on the evidence from the current literature, these recommendations are well suited for the substance abuse treatment field.

A cost benefit analysis on the economics of increasing salaries to stem the turnover in the field could offer important information for policymakers and providers. The monetary consequences of recruiting new staff may well be offset by increasing salaries and benefits. In addition, there are many non-monetary management and leadership practices that are effective in improving retention. A management “best practices” curriculum should be developed that covers all aspects of substance abuse treatment program management. This curriculum should be delivered throughout the country to all program managers.

Training and Credentialing Issues

Training

Pre-service and in-service education and training are part of the continuum of ongoing preparation that substance abuse clinicians need to be competent and knowledgeable. Both academic education and pre-service and continuing training are part of workforce development strategies.

Standards for Education and Training Programs

The demand for academic education is increasing among substance abuse counselors. Of NAADAC members, 65 percent received formal in-service training this past year, with 22 percent taking university/college courses. Edmundson (2002) studied NAADAC's listing of 260 programs that offer academic preparation for substance abuse practice. Fifty-five percent were at the community college or two-year level, 32 percent at the graduate level, and 13 percent at the bachelor's level. There was great variability in the two and four-year programs in program titles. Seventy-three percent were B.S. degree programs and 27 percent were B.A degree programs. The number of credits for undergraduate programs differed widely, as did the two-year programs. This variability underscores the need for some type of accreditation standards for academic programs. There is no accreditation body for undergraduate or continuing education programs to oversee these programs and ensure consistency.

Science to Service

One of the greatest challenges facing providers is the transfer and integration of evidence-based interventions into service settings. In a study by Roman et al (2003), innovation adoption was found to be partially dependent on education and skill of the workforce. Higher 12-step orientation was associated with lower ratings of innovation acceptability; having a master's degree was positively associated with innovation acceptability; and greater provision of innovation-specific training was also associated with greater innovation acceptability. Being certified/licensed and personal recovery status were not significant predictors of acceptability. In the Roman et al (2003) work to-date, preliminary findings suggest that adoption of new practices requires ongoing dissemination of information about treatment innovations. Training about innovations can enhance acceptability, but data in this study indicated that these training experiences are not widespread (Roman 2003).

Training of clinical staff needs to be buttressed by ongoing supervision and mentoring (Keller & Dermatis 1999; Culbreth 1999). The adoption of skill-based learning takes time and mentoring, requiring ongoing clinical supervision. However, supervisors receive little instruction in mentoring, teaching, and evaluating their roles. Clinical supervisors don't have enough time to

observe, provide feedback, and build relationships. There is a need to research the current state of clinical supervision and assess its impact on the quality of care and treatment outcomes. Strong supervision is the key to maintaining fidelity to science-based practices, and improving clinical services (Gallon 2002).

Concerns about the transfer of evidence-based practices extend to academic, graduate and professional pre-service education, as well as in-service continuing education in primary and behavioral health care (IOM 2001; Hoge & Morris 2003). Training in graduate programs and residency programs do not prepare students to practice in the current health care environment, and practicing professionals do not receive effective continuing education or skills to use evidence-based practices (IOM 2001).

In-service and Continuing Education

Continuing education requirements are part of the recertification process in every State in the country. These requirements vary from State to State and may range from 20 to 40 continuing education hours per year. State-specific information can be obtained at the National Addiction Technology Transfer Center website: www.nattc.org.

In the Northwest Frontier and the Kentucky studies (RMC 2003; RMC 2003a), nearly 90 percent of both agency directors and treatment staff have participated in substance abuse related training or workshops over the past year. On a yearly basis, behavioral health care practitioners, who are not substance abuse professionals, took fewer than 9 hours of course work in substance abuse issues, even though they reported that about 20 to 25 percent of their clients had substance abuse issues (PRN 2001). Sixty-five percent of NAADAC's members reported having in-service training and 22 percent were taking university or college courses (NAADAC 2003).

Clinical supervision, co-occurring disorders, staff recruitment, and staff retention were identified as the highest priority training areas for agency directors. Co-occurring disorders, drug pharmacology/pharmacotherapy, and cultural competency were identified as the highest training priority areas for treatment staff (RMC 2003).

One-quarter of NAADAC's early career members said that co-occurring substance abuse and mental health disorders was an area in which they would like further training and education. Women's issues and pharmacology were other frequently identified topics. Adolescent treatment was the next most requested. NAADAC surveyed members concerning availability of resources and professional development needs in organizational settings. More than 20 percent of early career members had little or no access to instructional materials or currently published literature (NAADAC 2003).

Credentialing Issues

Credentialing of counselors has been an issue in the substance abuse treatment field since the 1970s. Credentialing has been the primary method of determining minimum competencies for substance abuse counselors for the past three decades. However, the lack of uniform standards, reciprocity between State certification boards, concerns about introducing academic requirements and the movement toward licensure have embroiled substance abuse counselors in some contentious debates over the past decade. State credentialing boards are primarily affiliated with either the International Certification and Reciprocity Consortium (IC&RC) or with the NAADAC National Certification Commission.

Currently, credentialing and scope of practice standards are set by States. But these State standards are being reassessed in light of an increasing reliance on the Internet and the formation of multi-state provider groups (IOM 2001). The need for uniform standards for the substance abuse counseling field is becoming even more pressing.

Certified Staff

In the ADSS study (SAMHSA 2003), only 45 percent of direct-care staff across all facilities were certified, with outpatient non-methadone facilities having the highest percentage of certified staff. Methadone facilities had the lowest percentage of certified direct-care staff, except for inpatient hospital. However, methadone clinics have more staff certified in other areas such as medicine or nursing. It is important to note that there is variation on the staffing requirements for methadone and non-methadone outpatient clinics by State, and in some States the qualifications for staff may be the same in either type of modality.

Harwood (2002) reported that more than half (35,100) of the 67,000 direct service staff were credentialed substance abuse counselors. Of those who were not credentialed, 70 percent indicated they were in the process of becoming credentialed and another 10 percent indicated they had just completed the process. In addition, about 30 percent of the behavioral health staff from other disciplines who were working in addiction treatment centers indicated that they had a specialty credential and 32 percent said they were working toward a specialty credential. In many of the studies, direct service clinical staff have degrees and /or credentials in other behavioral health care professions. In the Northwest Frontier, less than 50 percent of both agency directors and treatment staff have an alcohol and drug specific degree or certificate, and nearly one third of both groups have had no alcohol and drug specific coursework. In Kentucky, where less than half the counselors are certified, there was support for the development of a tiered credentialing system (RMC 2003). According to the focus groups in New York, multiple hurdles and the high cost of credentialing impedes the number of people who pursue it (OASAS 2002).

Facilities that did not receive public funds had a higher percentage of certified counselors compared with those that were mostly publicly funded. Private for-profit and not-for profit

agencies had a higher percentage of certified direct-care staff than publicly owned facilities. Community mental health centers had fewer certified staff than facilities not in community mental health centers. Community mental health centers stress other credentials over substance abuse certification.

Credentialing processes provide a means to assess the skills and competencies of practitioners. The data from the studies of treatment agencies demonstrate that credentialing in substance abuse counseling is not universal. Though credentialing boards exist in every State, in some States certification is a voluntary process. A wide range of requirements exists ranging from none to mandatory requirements to practice, and no consistent credentialing practices exist. This is especially critical given that most other behavioral health professionals receives on the average, fewer than 9 hours of substance abuse training a year (PRN 2001). Again, more studies need to be conducted on whether there is a difference in treatment outcomes between staff who are credentialed substance abuse counselors and credentialed staff from other fields who are working in the field, but who are not specialists.

Summary

Training, education and credentialing standards help define a profession and are developed to ensure ongoing competency in a field of endeavor. For the substance abuse field, the lack of uniformity extends from the absence of an accreditation body for academic programs to the need for national credentialing and competency standards. The paucity of academic programs in substance abuse counseling often requires, that people who are interested in the working in the field take academic coursework in other disciplines. The fact that there are few course offerings in many behavioral health care academic programs has significant implications for the education of the workforce. Many graduate students do not have the basic competencies or education in substance abuse, though they may have other clinical skills. Therefore, an important strategy should be developed to require specific coursework on substance abuse and addiction in academic curricula and professional preparation programs for social workers, professional counselors, mental health counselors, and psychologists.

The adoption of new evidence-based practices is another area that requires a change in ongoing in-service education. Transferring new technology requires that clinical supervisors first be trained in the innovation so they can then reinforce the continual adoption of the new practice by staff. Staff should be trained and provided with ongoing supervision. Since only about two thirds of staff report receiving regular supervision, which is often brief in nature, increasing the number of clinical supervisors and upgrading their training should be a priority for the field. More intensive training for clinical supervisors, including building skills in clinical and management supervision, as well as technology transfer, should be a priority.

Of equal importance is the need to develop national standards for credentialing that are based on the competencies outlined in CSAT's *TAP 21, Addiction Counseling Competencies*. This

document has been endorsed by NASADAD, NAADAC, and IC&RC and should be used as the basis for the credentialing process. In addition, the credentialing process should be modeled after other disciplines, which often have one organization for State-level credentialing boards and a national level certification body for advanced and specialized credentials. The most critical issues are the lack of uniform standards, the ongoing division in the field, and perhaps most importantly, a seeming lack of vision to adapt to the changing environment and the community.

“Traditional methods of continuing education for health professionals, such as formal conferences and dissemination of educational materials, have been shown to have little effect by themselves on changing clinician behaviors or health outcomes” (IOM 2001).

The entire health care field is faced with an increased demand for competencies that meet modern medical and health care practices. Reacting to concerns about the quality of medicine today, the Institute of Medicine issued a report entitled “Crossing the Quality Chasm.” Among the recommendations made by the IOM (2001) are:

- Clinicians need to develop skills in knowledge management and incorporating evidence-based practices;
- Clinicians need to learn to work in multidisciplinary teams to address the increasing population with chronic diseases; and
- Clinicians need more skills in communications and supporting patient self-management to be able to train patients in self-care.

Competencies need to include cultural competency, leadership development, program management, and data analysis, among others. Continuous life-long learning is the new standard and public health workers should become “knowledge workers” (Public Health Workforce undated).

These recommendations certainly have relevance for the substance abuse treatment field and can help inform how we conceptualize our training and education programs.

Conclusion

There has been a growing recognition that the substance abuse treatment field is facing a workforce crisis. Recruitment and retention of staff have surfaced as critical problems for many agencies as finding and keeping qualified professionals has become difficult for many administrators. Education and credentialing standards are not uniform across all the States, which further erodes the growth of the substance abuse counseling profession. Couple these obstacles with the other pressures on the field, such as managed care, increased accountability, as well as the pressure to adopt new evidence-based treatments into practice, and the need to address workforce issues becomes apparent and urgent.

Workforce issues are complex and woven into many of the issues facing the substance abuse field in general. Stigma, under funding, lack of resources, lack of public support, and misconceptions about substance abuse treatment affect the entire system, and of course those who are employed in the field. However, the workforce is the underpinning of the entire infrastructure. Dealing with the issues and problems confronting the workforce is the foundation on which these principles and priorities can be achieved.

It is the workforce that will implement the priorities and uphold the principles for substance abuse treatment. Expanding substance abuse capacity, eliminating disparities, developing cost-effective strategies, and providing the many services needed for diverse populations depend on a well-trained, effective, competent workforce. Given the complexities of the changes facing the substance abuse treatment field, investing in human capital takes on an urgency that has not been experienced previously.

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