U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Report to Congress
Addictions Treatment Workforce Development

Eric B. Broderick, D.D.S., M.P.H.
Acting Deputy Administrator
Assistant Surgeon General

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 (NSDUH, 2005). The human, social and economic costs of not treating substance use disorders are indisputable. Yet, substance use disorders treatment systems are constrained by an inadequate infrastructure to support current and future demands for treatment. The addictions treatment field is facing a workforce crisis. Worker shortages, inadequate compensation, insufficient professional development 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.

In its report on the Fiscal Year (FY) 2006 budget for the Department of Health and Human Services (DHHS), the House Committee on Appropriations stated the following:

> The Committee has concerns that people who are seeking substance abuse treatment are unable to access services due to the lack of an adequate clinical treatment workforce. People seeking treatment often have to wait for weeks or months before they are accepted into a treatment facility. The Committee requests that SAMHSA issue a report, after consultation with stakeholders and other Federal partners, on workforce development for substance abuse treatment professionals. The report should focus on both the recruitment and retention of counselors and on improving the skills of those already providing services as well as ways in which States can play a role. The Committee requests that this report be transmitted to the House and Senate Committees on Appropriations by March 1, 2006. (House report No. 109-143, page 117)

This report was prepared in response to the Committee request. It summarizes trends in addictions treatment and the challenges that confront the treatment workforce. Importantly, it also articulates the perspectives of stakeholders and Federal partners 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 priorities for further study. This report 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.

Background and Approach

Workforce development has been a principal area of concern for SAMHSA for many years. In recognition of the mounting workforce crisis, SAMHSA recently elevated workforce development to a program priority on its "SAMHSA Priorities: Programs and Principles Matrix." This designation will result in greater attention to this critical issue. This report was based, in part, on an environmental scan of recent research related to the treatment workforce.

SAMHSA subsequently convened 128 individuals representing diverse stakeholder groups in nine separate stakeholder meetings. During these meetings, SAMHSA solicited information and recommendations from representatives knowledgeable about the exceptional challenges faced by the addictions treatment workforce. The environmental scan provided a starting point for stakeholder discussions. 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, 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);
- 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 discussion, 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, 20 stakeholder recommendations are presented in this report.

A. Infrastructure Development Priorities

1. Create career paths for the treatment and recovery workforce and adopt national core competency standards;
2. Foster network development; and
3. 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.

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

Next Steps

This report, developed by SAMHSA with the guidance of expert stakeholders from the addictions treatment and recovery field and representatives of other Federal agencies, identifies and discusses current and emerging issues in the area of workforce development in the addictions treatment field. The future effectiveness of the addictions treatment workforce rests on its ability to develop 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.

Introduction

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 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, staff retention, and adoption of best practices raised by the diverse professions that comprise the workforce.

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.

Recognizing the need for more comprehensive information about the workforce, SAMHSA commissioned an environmental scan of 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).

Using the environmental scan as a starting point for discussions, SAMHSA convened 128 individuals representing diverse stakeholder groups in nine separate meetings. 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, 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, State Directors and treatment providers. This report includes recommendations that emerged from these expert panels.

Congress, concerned that individuals cannot access treatment because of a clinical workforce shortage, called on SAMHSA, as the lead substance abuse services agency, to develop a workforce development report for substance abuse treatment professionals. H. Rpt.109-143 required that the report be developed in consultation with stakeholders and Federal partners and focus on both the recruitment and retention of counselors and on improving the skills of those already providing services. It also required that the report identify ways in which States can address the workforce crisis.

The Evolution of the Addictions Treatment Workforce

The addictions treatment workforce is composed of highly committed practitioners, in a number of different professions, who care for patients/clients with substance use disorders. Each of these groups contributes to a comprehensive treatment and recovery process. Recovering individuals have been a critically important component of the workforce from the inception of the field. They serve as trained professionals, as specialized recovery support workers and as volunteers. The nature of the addictions treatment workforce has changed substantially over the past 40 years. Prior to the mid-1970s, recovering individuals provided counseling services with minimal formal training. In the late 1970s, States and national associations established professional standards and credentialing processes (Keller and Dermatis, 1999). Credentialing bodies now exist in every State, and a college degree is the norm rather than the exception for professionals in the field. Eighty percent of direct care treatment staff, for example, hold a bachelor's degree (Johnson et al., 2002; Knudsen et al., 2003; RMC 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.

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 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 treatment professionals regularly evidence.

Organization of This Report

This report consists of four sections:

- Section I: Context: Trends Impacting the Workforce
- Section II: Stakeholder 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: Conclusion
- Section IV: References

Section I provides a historical context, 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 presents recommendations that emerged from the SAMHSA-sponsored stakeholder meetings. Although these categories overlap, they provide a useful framework for a systematic analysis of the recommendations. Section III concludes the report. Section IV contains the references included in the report.

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

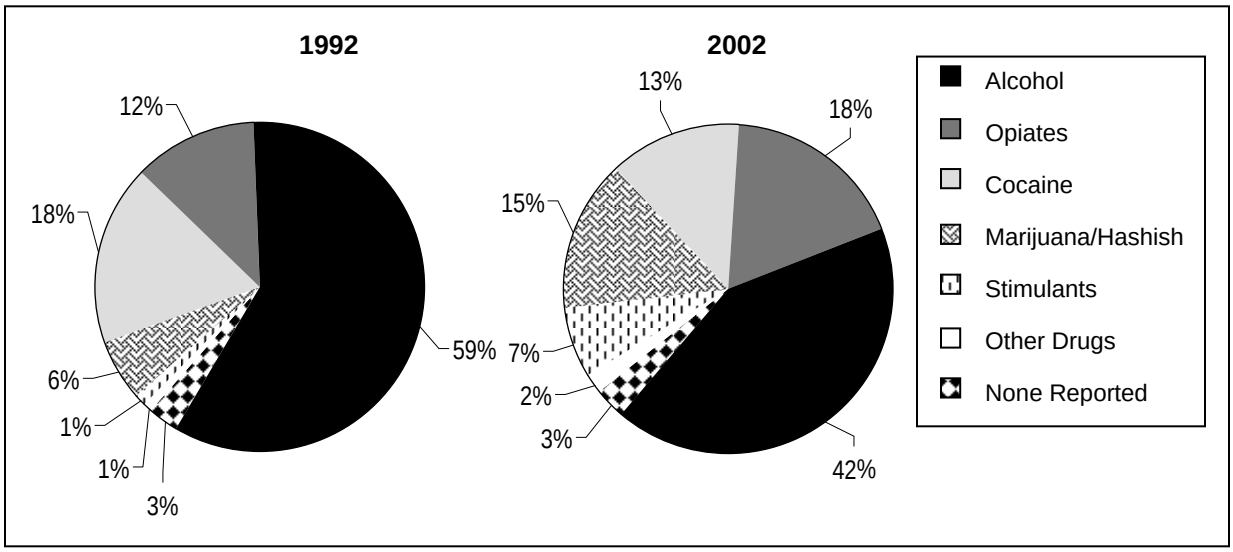
The Changing Profile of Those Needing Services

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

- 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 below). For instance, admissions for alcohol dependence and abuse declined from 59 percent to 42 percent, and admissions for cocaine declined from 18 percent to 13 percent. These decreases were offset, however, by increases in admissions for marijuana/hashish users from 6 percent to 15 percent, for primary opiate users from 12 percent to 18 percent and for stimulant users from 1 percent to 7 percent. Among youth 15 to 17 years of age, admissions for marijuana rose from 23 percent to 63 percent (SAMHSA, 2004b). These data point to the necessity of having a workforce prepared to respond to 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 that bridges 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 now occurs 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.

For many organizations, it will be a significant challenge to develop 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. 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 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.

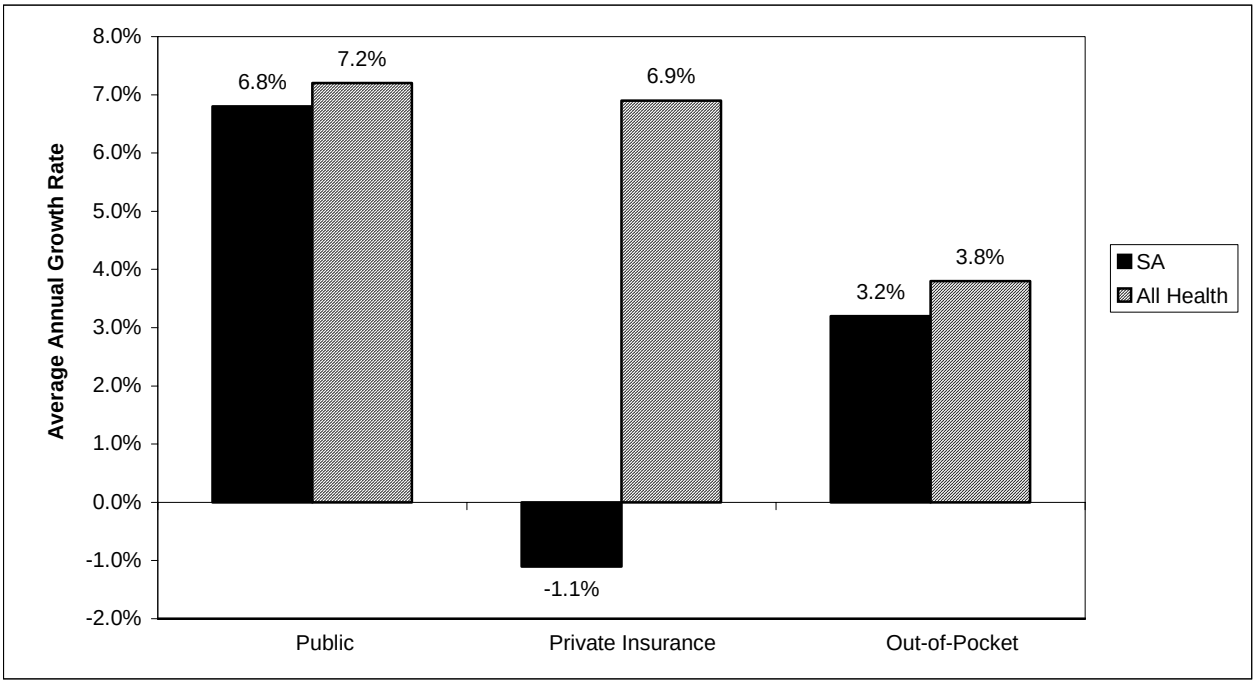
  With respect to these individuals, the *2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions* (NESARC) found that 19.7 percent of the respondents with any substance use disorder had at least one independent mood disorder during the same 12-month period. Furthermore, 17.7 percent 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 co-morbid substance use disorder, are immensely disabling" (Grant et al., 2004).

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 points to the fact that the majority of substance use disorder treatment is financed by the public sector, that this trend is continuing and that care for substance use disorders is not financed in the same manner as other health care conditions. Though addictions impact all segments of society, lack of health coverage for treatment places enormous demands on the 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.

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, co-morbid 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 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 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 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 provide 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.

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 now 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, including training related to serving those with co-occurring disorders.

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 substance use disorders and the opportunity to leverage resources dedicated to their 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 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 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

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).

Commitment is required at 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
- 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 felt that they needed it but did not receive treatment, 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. 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 increasing burdens on publicly funded treatment systems. 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 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.

II. Stakeholder Recommendations

The Stakeholder 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.

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.

Stakeholder 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.

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. 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.

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. 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.

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.

2. Foster network development.

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.

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, networks can provide career paths for addictions professionals and potential staffing pools for member organizations.

3. Provide technical assistance to enhance the capacity to use information technology.

Many treatment organizations lag behind their counterparts in the health care industry with regard to the ability to access and use information technology. 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.

Widely available technologies to support clinical and administrative services could alleviate many workforce challenges if they were broadly adopted by the addictions treatment field. 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).

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.

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.

Stakeholder Recommendations

To address leadership and management issues in the addictions treatment workforce, 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.**

Scientific advances and the emphasis on patient/client outcomes have heightened the need for well-trained, highly skilled and dedicated clinical supervisors. More than 80 percent of these early-career staff identified clinical supervision as having the greatest value in their professional development (NAADAC, 2003). However, as stakeholders pointed out, individuals are often promoted to supervisory positions without management training or specifically defined roles.

Clinical supervisors are critical to 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.

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

Leadership and management practices impact all aspects of the organization: fiscal, clinical, administrative and human resources. 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.

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 prominent role as the basis for addictions 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.

Most organizations that provide addictions treatment services do not have a coordinated plan to manage existing and future gaps in leadership. Required leadership and business management 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), collaboration skills and mentoring.

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 (The Lewin Group, 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, and must accommodate the dynamic nature of the treatment field, including increased demand related to new types of funding for treatment services, the need to keep pace with scientific advances, staff turnover and required training time for staff. Recruitment efforts must also address the underlying conditions that make people reluctant to enter the 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

Stakeholder Recommendations

Stakeholders made the following recommendations:

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).

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.

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

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.

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. 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 postgraduate education.

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.

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 IOM report, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce* (2004), IOM member Brian Smedley stated, "Part of a comprehensive strategy to reduce health disparities is to increase diversity in the health care professions, which will lead to improved access to care, greater patient satisfaction and reduced cultural and linguistic barriers" (Levin, 2004).

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

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. 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.

Stakeholders pointed out that there are populations that recruitment efforts should target. 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. 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 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. 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. 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. The success of stigma reduction efforts has instilled the nursing profession with a more positive self-image and shown nurses to be a valuable and necessary national resource.
The nursing profession has approached the issue of stigma and its workforce crisis in a variety of ways (Nevidjon and Erickson, 2001). It has:

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

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

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 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 altogether.

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 evidence-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.

Stakeholder 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).**

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. 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).

Similar 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. 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).

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. Educational institutions use a number of standards when developing curricula. These standards include the IC&RC twelve core functions; the International Coalition for Addictions Studies Education (INCASE) standards; the NAADAC Certification Standards; and SAMHSA's *Technical Assistance Publication 21 (*TAP 21*) Addiction Counseling Competencies: The Knowledge, Skills and Attit*udes of Professional Practice (SAMHSA, 2002).

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.

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

Academic accreditation standards for addictions studies programs need to be developed, adopted and supported. 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 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.

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

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).

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 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).

6. **Develop college and university courses on 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. Systematic mechanisms are needed to disseminate research findings to academic institutions and 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 report *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.

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).

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 with 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 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).

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

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.

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.

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.

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.

Stakeholder 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.

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.

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.

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 make 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.

2. Address substance misuse and relapse within the workforce.

While all professions employ individuals in recovery, the addictions treatment field is unusual in the proportion of its workforce that is in recovery. The addictions treatment workforce is unique in that many of the recovering individuals among its ranks work in the same health care system through which they received treatment.

To date, little attention has been given to the issue of substance misuse and relapse in the workforce. The 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.

Stakeholders recommended that existing programs serving professionals working in the addictions treatment field be identified, and that national, State and local certification boards or professional societies for addictions treatment professionals 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

To date, studies on the addictions treatment workforce have been limited in number and scope. A number of ATTCs have conducted surveys of the treatment workforce (Knudsen and Gabriel, 2003; Gallon et al., 2003). The surveys, which differ in 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 sufficient data to guide the development of the addictions treatment workforce.

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

Stakeholder Recommendations

Stakeholders identified three topics as priorities:

1. **Conduct studies that examine the relationships among level of education, type of education, training and 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 questions such as:

- 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?

2. **Conduct studies that examine the relationships among clinician and patient/client cultural, demographic and other characteristics, therapeutic alliance 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 therapeutic alliance (the relationship

that develops between a patient/client and a clinician) and treatment outcomes. However, little substantive research is available on the effects of an addictions 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 therapeutic alliance and/or treatment outcomes? If so, which ones?
- Do learned cultural competency skills improve therapeutic alliance and/or treatment outcomes?
- Are treatment professionals in recovery more effective?
- Does gender matching affect treatment outcomes? If so, how?

3. Conduct studies that explore questions related to the characteristics of clinicians that enhance therapeutic alliance and outcomes.

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. Another factor that may significantly 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, client satisfaction and positive outcomes is not well known. As the field strives to improve patient/client outcomes and enhance the skills of its workforce, answers to questions such as the following 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?
- Is there a correlation between clinician recovery status and client outcomes?

III. Conclusion

This report summarizes current and emerging issues confronting the treatment workforce. The report also provides recommendations developed by stakeholders and Federal partners. They are directed at a variety of organizations, including Federal and State entities, national trade associations, credentialing and licensing bodies and academic institutions.

Recognizing the complex nature of the challenges facing the addictions treatment field, stakeholders offered a multi-faceted approach to workforce development that addressed both short-term needs and the long-term viability of the field.

IV. References

Addiction Technology Transfer Center Network (ATTC), *The Change Book: A Blueprint for Technology Transfer (Second Edition)*, (Kansas City, MO: ATTC, 2004).

Annie E. Casey Foundation, *The Unsolved Challenge of System Reform: The Condition of the Frontline Human Services Workforce*, (Baltimore, MD: Annie E. Casey Foundation, 2003).

Bacon, K., K.E. MacKenzie and J.H. McKendrick, "Tomorrow's Nurses?" *Nursing Standard* 14(32), 2000, p. 31.

Center on Addictions and Substance Abuse (CASA), *Missed Opportunity: National Survey of Primary Care Physicians and Patients on Substance Abuse*, (New York: CASA, Columbia University, 2000).

Centers for Disease Control and Prevention (CDC), *HIV/AIDS Surveillance Report: Cases of HIV and AIDS in the United States, 2002*, (Atlanta, GA: CDC, 2002a).

Centers for Disease Control and Prevention (CDC), *Viral Hepatitis and Injection Drug Users*, (Atlanta, GA: CDC, 2002b).

Corrigan, P.W., L. Steiner, S.G. McCracken, B. Blaser and M. Barr, "Strategies for Disseminating Evidence-based Practices to Staff Who Treat People With Serious Mental Illness," *Psychiatric Services* 52(12), 2001, pp. 1598-1606.

Curley, B., "Discrimination Against People in Recovery Rampant, Advocates Say," *Join Together Online*, 2002, *Online*, <http://www.jointogether.org/sa/news/features/reader/0,1854,553416,00.html>, Oct. 2004.

Dennis, M., C.K. Scott and R. Funk, "An Experimental Evaluation of Recovery Management Checkups (RMC) for People with Chronic Substance Use Disorders," *Evaluation and Program Planning* 26(3), 2003, pp. 339-352.

Department of Health and Human Services (DHHS), "Access to Quality Health Care Services," *Healthy People 2010: Understanding and Improving Health*, 2nd ed., (Washington, DC: U.S. Government Printing Office, 2000), *Online*, <http://www.healthypeople.gov/Document/HTML/Volume1/01Access.htm>, March 2005, p. 20.

Department of Health and Human Services/Health Resources and Services Administration (DHHS/HRSA), "Optimizing the Impact of the National Health Service Corps," (Rockville, MD: DHHS, 2004).

Dochterman, J.M. and H.K. Grace, "Overview: Diversity in Nursing," *Nursing*, 2001, pp. 480-482.

Donley, R., M.J. Flaherty, E. Sarsfield, L. Taylor, H. Maloni and E. Flanagan, "What Does the Nurse Reinvestment Act Mean to You?" *Online Journal of Issues in Nursing*, 2002, *Online*, <http://www.nursingworld.org/ojin/topic14/tpc14_5.htm>, January 2005.

Drug Enforcement Administration (DEA), *Illegal Drug Price and Purity Report*, (Washington, DC: DEA, 2003).

Drug Enforcement Administration (DEA), "Drug Trafficking in the United States," (Washington, DC: DEA, 2001), *Online*, <www.dea.gov/concern/drug_trafficking.html>, Oct. 2004.

Galfano, S., "2004 Addictions Treatment Professional Career and Salary Survey," *Counselor: The Magazine for Addictions Professionals*, Vol. 5, 2004, pp. 24-29.

Gallon, S., R. Gabriel and J. Knudsen, "The Toughest Job You'll Ever Love: A Pacific Northwest Treatment Workforce Survey," *Journal of Substance Abuse Treatment* 24(3), 2003, pp. 183-196.

Gfroerer, J.C., M.A. Penne, M.R. Pemberton and R.E. Folsom, "The Aging Baby Boom Cohort and Future Prevalence of Substance Abuse," *Substance Use by Older Adults: Estimates of Future Impact on the Treatment System*, (Rockville, MD: DHHS, SAMHSA, 2002).

Grant, B.F., F.S. Stinson, D.A. Dawson, S.P. Chou, M.C. Dufour, W. Compton, R.P. Pickering and K. Kaplan, "Prevalence and Co-occurrence of Substance Use Disorders and Independent Mood and Anxiety Disorders: Results From the National Epidemiologic Survey on Alcohol and Related Conditions," *Archives of General Psychiatry* 61(8), 2004, pp. 807-816.

Haack, M.R. and H. Adger, "Strategic Plan for Interdisciplinary Faculty Development: Arming the Nation's Workforce for a New Approach to Substance Use Disorders," *Journal of the Association for Medical Education and Research in Substance Abuse* 23(3), Supplement, (Providence, RI: AMERSA, 2002), pp. 1-21.

Hager, M.A. and J.L. Brudney, *Volunteer Management Practices and Retention of Volunteers*, (Washington, DC: The Urban Institute, 2004).

Harwood, H.J., "Survey on Behavioral Health Workplace," *Frontlines: Linking Alcohol Services Research and Practice*, (Bethesda, MD: NIAAA, 2002).

Heathfield, S.M., "Ten Tips to Make Training Work," 2004, *Online*, <http://humanresources.about.com/library/weekly/aa081400a.htm>, Oct. 2004.

Hennessy, K.D., *SAMHSA's Science to Services Initiative and Expansion of the National Registry of Effective Practices and Programs (NREPP)*, Presentation to 14th Anniversary Conference on SMHA Services Research, Program Evaluation and Policy, 2004, *Online*, <http://www.nri-inc.org/Conference/Conf04/Presentations/Hennessy.pdf>, Jan. 2005.

Institute of Medicine (IOM), *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series,* (Washington, DC: National Academies Press, 2006).

Institute of Medicine (IOM), *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*, (Washington, DC: National Academies Press, 2004).

Institute of Medicine (IOM), *Crossing the Quality Chasm: A New Health System for the 21st Century*, (Washington, DC: National Academies Press, 2001).

Institute of Medicine (IOM), *Managing Managed Care: Quality Improvements in Behavioral Health*, (Washington, DC: National Academies Press, 1997).

Isaacson, J.H., M. Fleming, M. Kraus, R. Kahn and M. Mundt, "A National Survey of Training in Substance Use Disorders in Residency Programs," *Journal of Studies on Alcohol* 61(6), 2000, pp. 912-915.

Jamieson, A., A. Curry and G. Martinez, "School Enrollment-Social and Economic Characteristics of Students," *Current Population Reports*, (Washington, DC: U.S. Census Bureau, 2001).

Johnson & Johnson, "Johnson & Johnson Helping to Reduce Nursing Shortage Enrollment: Rates Up at Nursing Schools Nationwide/More Funding for Nursing Scholarships and Grants," *Johnson & Johnson News*, 2003, *Online*, <http://www.jnj.com/news/jnj_news/20030429_093808.htm>, Oct. 2004.

Johnson, J.A., H.K. Knudsen and P.M. Roman, "Counselor Turnover in Private Facilities," *Frontlines: Linking Alcohol Services Research and Practice*, (Bethesda, MD: NIAAA, 2002).

Join Together Online, "Rewarding Results: Improving the Quality of Treatment for People with Alcohol and Drug Problems: Recommendations from a National Policy Panel," 2003, *Online*, <http://www.jointogether.org/sa/files/pdf/quality.pdf>, March 2005.

Join Together Online, "Hot Issues: Discrimination," 2001, *Online*, <http://www.jointogether.org/sa/issues/hot_issues/discrimination/more/>, Oct. 2004.

Kaplan, L., *Substance Abuse Treatment Workforce Environmental Scan*, (Washington, DC: Abt Associates Inc., 2003).

Keller, D.S. and H. Dermatis, "Current Status of Professional Training in the Addictions," *Substance Abuse* 20(3), 1999, pp. 123-140.

Knudsen, H.K., J.A. Johnson and P.M. Roman, "Retaining Counseling Staff at Substance Abuse Treatment Centers: Effects of Management Practices," *Journal of Substance Abuse Treatment* 24(2), 2003, pp. 129-135.

Knudsen, J. and R. Gabriel, *Advancing the Current State of Addictions Treatment: A Regional Needs Assessment of Substance Abuse Treatment Professionals in the Pacific Northwest*, (Portland, OR: RMC Research Corporation, 2003).

Landis, R., B. Earp and S. Libretto, *Report on the State of the Substance Abuse Treatment Workforce in 2002: Priorities and Possibilities*, (Silver Spring, MD: Danya International, Inc., 2002 Draft).

Levin, A., "IOM Report: Building a More Diverse Health Care Workforce," *Health Behavior Information Transfer (HABIT)* 7(2), 2004, *Online*, <http://www.cfah.org/habit/vol7no2/IOM_report.cfm>, March 2005.

The Lewin Group, Inc., *The Clinical Workforce in the Substance Abuse Treatment System*, (Rockville, MD: DHHS, SAMHSA, 2004).

The Lewin Group, Inc., *Substance Abuse Training Needs Analysis, Final Report*, (Alexandria, VA: The Lewin Group, Inc., 1994).

Mark, T., R.M. Coffey, D. McKusick, H. Harwood, E. King, E. Bouchery, J. Genuardi, R. Vandivort, J.A. Buck and J. Dilonardo, *National Expenditures for Mental Health Services and Substance Abuse Treatment, 1991-2000*, (Rockville, MD: DHHS, SAMHSA, 2005).

Marks, A., "Jobs Elude Former Drug Addicts," *The Christian Science Monitor*, 2002, *Online*, <http://www.csmonitor.com/2002/0604/p02s02-ussc.html>, Oct. 2004.

McCarty, D., "The Alcohol and Drug Abuse Treatment Workforce," *Frontlines: Linking Alcohol Services Research and Practice*, (Bethesda, MD: NIAAA, 2002).

McLellan, A.T., D. Carise and H. Kleber, "Can the National Addictions Treatment Infrastructure Support the Public's Demand for Quality Care?" *Journal of Substance Abuse Treatment* 25(2), 2003, pp. 117-121.

Meier, P.S., C. Barrowclough, and M.C. Donmall, "The Role of the Therapeutic Alliance in the Treatment of Substance Misuse: A Critical Review of the Literature," *Addictions* 100(3), 2005, pp. 304-316.

National Association for Addiction Professionals (NAADAC), *The Association for Addiction Professionals' Year Two Final Report: A Survey of Early Career Substance Abuse Counselors*, (Alexandria, VA: NAADAC, 2003).

National Association of Social Workers Practice Research Network (NASW PRN), "Informing Research and Policy Through Social Work Practice," *NASW PRN Survey Final Report*, (Rockville, MD: CSAT, 2001).

National Association of State Alcohol and Drug Abuse Directors (NASADAD), *Recommendations Related to Closing the Treatment Gap*, NASADAD Policy Position Paper, 2003.

National Committee for Quality Assurance (NCQA), "What is HEDIS?" 2005, *Online*, <http://www.ncqa.org/Programs/HEDIS/>, March 2005.

National Committee for Quality Assurance (NCQA), "NCQA Releases HEDIS 2004, 10 New Measures Address Public Health, Service Issues," 2003, *Online*, <http://www.ncqa.org/communications/news/hedis2004.htm>, March 2005.

National Institute on Drug Abuse (NIDA), *NIDA Research Report – Methamphetamine Abuse and Addictions*, (Rockville, MD: NIH, 2002).

National Institute on Drug Abuse (NIDA), *Principles of Drug Addictions Treatment: A Research Based Guide*, (Rockville, MD: NIH, 1999), *Online*, <http://www.drugabuse.gov/PDF/PODAT/PODAT.pdf>, Oct. 2004.

National Survey on Drug Use and Health (NSDUH), *Results from the 2004 National Survey on Drug Use and Health: National Findings*, (Rockville, MD: SAMHSA, 2005).

National Survey on Drug Use and Health (NSDUH), "Nonmedical Use of Prescription Pain Relievers," *The NSDUH Report*, (Rockville, MD: SAMHSA, 2004a), *Online*, <http://oas.samhsa.gov/2k4/pain/pain.htm>, Oct. 2004.

National Survey on Drug Use and Health (NSDUH), *Results from the 2003 National Survey on Drug Use and Health: National Findings*, (Rockville, MD: SAMHSA, 2004b), *Online*, <http://www.oas.samhsa.gov/nhsda/2k3nsduh/2k3Results.htm>, March 2005.

Nevidjon, B. and J. Erickson, "The Nursing Shortage: Solutions for the Short and Long Term," *Online Journal of Issues in Nursing*, 2001, *Online*, <http://www.nursingworld.org/ojin/topic14/tpc_4.htm>, June 2004.

New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America, Final Report*, (Rockville, MD: DHHS, SAMHSA, 2003).

RMC Research Corporation, "Results of a Statewide Needs Assessment of Substance Abuse Treatment Professionals," *Kentucky Workforce Survey 2002*, (Portland, OR: RMC, 2003).

Rollnick, S. and W.R. Miller, "What is Motivational Interviewing?" *Behavioral and Cognitive Psychotherapy*, Vol. 23, 1995, pp. 325-334, *Online*, <http://www.motivationalinterview.org/clinical/whatismi.html>, Oct. 2004.

Saitz, R., K. Mulvey and A. Plough, "Physician Unawareness of Serious Substance Abuse," *American Journal of Drug and Alcohol Abuse* 23(3), 1997, pp. 343-354.

Scanlon, W.J., "Nursing Workforce: Recruitment and Retention of Nurses and Nurse Aides Is a Growing Concern," *GAO testimony*, (Washington, DC: GAO, 2001), *Online*, <http://www.gao.gov/new.items/d01750t.pdf>, Oct. 2004.

Substance Abuse and Mental Health Services Administration (SAMHSA), *A National Review of State Alcohol and Drug Treatment Programs and Certification Standards for Counselors and Prevention Professionals*, (Rockville, MD: DHHS, 2005).

Substance Abuse and Mental Health Services Administration (SAMHSA), *Overview of Findings from the 2003 National Survey on Drug Use and Health*, (Rockville, MD: DHHS, 2004a).

Substance Abuse and Mental Health Services Administration (SAMHSA), *Treatment Episode Data Set (TEDS) Highlights—2002. National Admissions to Substance Abuse Treatment Services*, (Rockville, MD: DHHS, 2004b), *Online*, < http://wwwdasis.samhsa.gov/teds02/2002_teds_highlights.pdf >, March 2005.

Substance Abuse and Mental Health Services Administration (SAMHSA), *The DASIS Report: New Heroin Users Admitted to Substance Abuse Treatment: 1992-2000*, (Rockville, MD: OAS, 2003), *Online*, <http://oas.samhsa.gov/2k3/newHeroinTX/newHeroinTX.cfm>, Oct. 2004.

Substance Abuse and Mental Health Services Administration (SAMHSA), *Trends in Substance Abuse Treatment Admissions: 1992-2000 Treatment Episodes Data Set (TEDS)*, (Rockville, MD: DHHS, 2002), *Online*, <http://wwwdasis.samhsa.gov/teds00/TEDS_2K_Chp2.htm>, Oct. 2004.

Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment (SAMHSA/CSAT), "Addictions Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice," *Technical Assistance Publication (TAP) Series 21*, (Rockville, MD: DHHS, 2002).

Taleff, M.J., "The State of Addictions Education Programs: Results of a National Cross-Sectional Survey," *Journal of Teaching in the Addictions* 2(1), 2003, pp. 59-70.

U.S. Department of Labor, Bureau of Labor Statistics (BLS), *2002-2003 Occupational Outlook Handbook*, (Washington, DC: BLS, 2003).

The Washington Circle Group, "Background of the WC," 2005, *Online*, <http://www.washingtoncircle.org>, March 2005.

The Washington Circle Group, "Specification of Performance Measures for the Identification, Initiation and Engagement of Alcohol and Other Drug Services," (Washington, DC: The Washington Circle, 2004), Online, <http://www.washingtoncircle.org/Final%20Specs%202004_03-30.pdf>, March 2005.