

Introduction to the Third Issue of *The Bridge*

By Paul Roman

A workforce is the obvious “body and soul” of any specialty field of endeavor.

The substance abuse treatment workforce is large and diverse, and has a very colorful history, very well documented by Bill White (1998) in his matchless biblical-like history of this specialty arena.

The past decade has been distinctively marked by aggressive and vigorous promotion of technology transfer centered on new sets of evidence-based practices (EBPs). When counselors have been studied as key actors in EBP adoption, the poor quality of information that we have about the substance abuse treatment workforce has been highlighted. This workforce has been defined as being in crisis in terms of its ability to support adequately the professional demands and aspirations around which the future of substance abuse treatment is being defined. Both the [Substance Abuse and Mental Health Services Administration \(SAMHSA\)](#) and the [National Institute on Drug Abuse \(NIDA\)](#) have assigned priority to workplace development and workplace research, respectively, in their emerging goals for the coming decade.

As part of its current period of funding from SAMHSA, the Addiction Technology Transfer Center (ATTC) National Office is charged with completing a national study of the substance abuse treatment workforce. That project, being conducted, in part, by the National Development and Research Institutes (NDRI) of Raleigh, North Carolina, has several critical phases, the first of which has been to abstract and collate the state of current knowledge about the substance abuse treatment workforce in the US. The report from that work is presented to the substance abuse community for the first time in this issue of *The Bridge*, and follows this introduction.

The monograph on the state of current knowledge, co-authored by Deena Murphy and Robert Hubbard of NDRI, is intended to offer both substantive summary data as well as provide a platform for a soon-to-be-launched national survey of the substance abuse treatment workforce. Laurie Krom, the ATTC National Office Director, suggested inviting the Editorial Board of *The Bridge* to offer their comments on the monograph's contribution in preparation for the national survey.

Thus the third issue of *The Bridge* has four opportunities embedded for our readers.

First is the chance to read this excellent summary of what available data and published studies tell us about the substance abuse treatment workforce.

Second is the opportunity to read and reflect upon six diverse commentaries about the monograph's implications for the upcoming survey. Written by our [founding editorial board members](#) Mike Boyle, Heather Gotham, Hannah Knudsen, Dennis McCarty and myself, we are joined in this issue by our newest member, Dr. Steve Martino of the Department of Psychiatry at Yale University and the Connecticut VA Health Center. Steve is the chair of the Research Utilization Committee of the National Drug Treatment Clinical Trials Network and thus has broad exposure to issues surrounding technology transfer. We are also joined by a guest contributor co-authoring with Dennis McCarty, Dr. Traci Reickmann of Oregon Health and Science University.

The **third** opportunity is to share the reflections of the authors of the review monograph, Deena Murphy and Bob Hubbard, who have prepared a reactive response to the Editorial Board commentaries.

Fourth is the opportunity for you, our readership, to reflect and react to the many issues and concerns that are raised in the monograph, the discussion, and the reaction statement. We want to hear from you. Please send your comments about workforce-related issues or about the upcoming national survey to thebridge@ATTCnetwork.org, and they will be reviewed for publication in a future issue of *The Bridge*.

The Devil Will Be in the Details

By Steve Martino, Ph.D.

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The expert panel members for the ATTC National Office report, [*Understanding America's Substance Use Disorders Treatment Workforce*](#), should be commended for their initial efforts to develop a survey that will systematically evaluate the development needs of the addiction treatment and recovery services professional workforce. As noted in the report, the workforce is aging out and there is an insufficient number of adequately prepared professionals coming into the field and/or remaining there to meet the treatment needs of people who have substance use disorders. Reliable and valid information is needed in three areas that detail: 1) the workforce's demography; 2) anticipated workforce development needs for the next five years; and 3) strategies that might best prepare, retain, and maintain professionals in the field.

Needs identified by the survey likely will drive future Substance Abuse and Mental Health Services Administration (SAMHSA) workforce development initiatives. The report presents a review of the extant literature and summarizes what is known and needs to be known in each of the three areas as the first step in developing the survey. My commentary addresses additional issues absent in the report that need to be known and methodological suggestions to sharpen the capacity of the survey to answer the expert panel's key questions.

Basic demographics of the workforce

The report details standardized individual and organizational demographics and retention indicators that will be used in the survey. The evaluation of professional demographics (e.g., sex, ethnicity, educational level, certification status, etc.) is straightforward. The assessment of major structural organizational characteristics (e.g., treatment modality, urban/rural, size, private versus public, etc.) is logical. The inclusion of retention indicators (e.g., staff turnover) is critical to understanding what factors are associated with professionals' decisions to leave their jobs.

However, because the survey will be administered only to agency directors, it will not directly tap the experiences of other professionals (e.g., their perception of the program's motivation to change, institutional resources, staff attributes, and organizational climate) (Simpson & Flynn, 2007), which might influence treatment center staffs' work satisfaction and job turnover. For example Knudsen and colleagues (2003, 2006) found that counselors who perceived their managers as 1) empowering them to make decisions about how to perform their jobs, 2) being fair in their distribution of work and rewards, and 3) seeking staff input in decision-making had less job-related emotional exhaustion and intention to quit.

The survey's apparent absence of assessing professionals' experiences at the individual level may significantly limit the degree to which it can identify workforce development needs and related future initiatives. If, for example, the experiences that professionals have where they work significantly contribute to their intention to stay in or leave their jobs (a likely proposition), then the survey, as currently designed, would be inadequate in its capacity to evaluate job turnover and how to effectively address it.

It would be prudent to add to the survey's methodology a procedure in which directors identify professionals that work within their agencies and to survey these individuals directly. While efforts will be made to include counselor and clinical supervisor input through focus groups for the purposes of developing the survey, their immediate experiences of their work lives at their employment settings do not appear to be part of what will be formally evaluated in the survey. The workforce survey may be excluding the perspective of the largest segment of the very workforce it aims to understand.

Anticipated workforce development needs

The report recommends that the survey collect current staffing needs (e.g., open positions) and the previous year's staff turnover rates as well as information about client demographics and treatment outcomes (program retention, treatment completion) to determine in which areas the workforce may need development. It is unclear to what extent the survey will evaluate access to computer- and internet-based technologies and the comfort professionals have in using them. Given the aging workforce, many addiction service professionals might not be familiar and facile with technologies that have become a routine part of younger adults' lives. The push for electronic medical records, multiple communication avenues (e-mail, texting, Facebook, Twitter), and growing distance learning opportunities for developing professional skills suggests that assessment of this area should be part of a survey that aims to anticipate potentially important workforce development needs.

Also unclear is the extent to which the perspective of clients who receive services within the agencies will be included in the survey's development. The primary aim of any addiction treatment setting is to serve its clients. Client observations of addiction service settings and professionals likely would be quite informative in identifying where the workforce needs to develop. As one example in a meta-analytic review of therapeutic alliance research, Martin, Garske, and Davis (2000) found that clients tend to view alliance as more stable than counselors. Thus, the first impressions of clients about their relationships with their counselors (and perhaps the agency) are likely to stick. This finding suggests that counselors need to have the skill to quickly establish positive alliances with their clients, especially because the clients' experience of the therapeutic alliance appears to be a consistent predictor of engagement and retention in addiction treatment (Meier, Barrowclough, & Donmail, 2005). At the very least methodologically, client focus groups could be conducted to get their opinions about what is included in the draft version of the survey and to determine if additional information might be needed.

Strategies to prepare, retain and maintain the workforce

The report is most comprehensive in its detailing of infrastructure needs (e.g., loan repayment programs, accreditation processes for addiction training programs), education and training needs (e.g., curricula development for supervisors and managers, identifying and disseminating best practices), factors impacting retention (e.g., salary, workload), and the importance of cataloging workforce development efforts within and across states. The report, however, does not explicitly mention if the survey will assess strategies professionals use to learn empirically supported substance abuse treatments. This area is of tremendous importance to the field given that these treatments typically are seen as the best interventions counselors have to offer clients, SAMHSA advocates for their implementation (e.g., National Registry of Evidence-based

Programs and Practices; <http://www.nrepp.samhsa.gov/>), and many Single State Authorities and managed care systems are beginning to mandate counselors to use them (e.g., <http://www.oregon.gov/DHS/mentalhealth/ebp/main.shtml>).

Traditional training strategies for empirically supported treatments include reading manuals, attending workshops, and receiving clinical supervision (Baer et al., 2007). Distance learning strategies include computer-assisted, Web-based, and simulation programs (Weingardt, 2004). In particular, distance learning strategies are likely to become more prevalent and popular in that they can make training more available to professionals from geographically diverse areas, easier to schedule, individualized and self-paced, standardized in quality, and lower in cost. Understanding how professionals view these different training strategies and what training options are available to them within agencies might better inform the field how to develop future training initiatives and could play a critical role in the preparation, retention, and maintenance of the workforce. Knudsen, Ducharme, and Roman (2008) learned this firsthand when they found that the perceived quality of clinical supervision was strongly associated with counselors' feeling they had more autonomy at work, were permitted input in decision-making, and were treated fairly, which in turn related to less emotional exhaustion and intention to leave their jobs. A survey about workforce development should evaluate these kinds of training issues.

Final thoughts

The ATTC National Office report on the initial effort to develop an addiction workforce survey through literature review and expert panel consensus provides a comprehensive account of the multiple factors that may influence the recruitment, preparation, and retention of professionals in the addiction treatment field. The planned stepwise procedure for developing the survey with targeted stakeholder input and conducting it across agencies in all 14 ATTC Regional Centers, with methods to ensure adequate sampling and high response rates, suggest the survey will produce data that will be very useful in understanding important workforce development needs and strategies for addressing them. In the meanwhile, the field awaits the final version of the survey to see if it will address all the major areas of workforce development that need to be known for the purposes of enhancing the workforce and improving addiction services. The devil will be in the details.

Learning the Most About the Substance Abuse Treatment Workforce, Including Technology Transfer Roles

By Heather J. Gotham, Ph.D.

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The Murphy-Hubbard interim report to the ATTC does a great job of reviewing what is known about the addiction workforce and outlining ways in which the proposed ATTC Network Workforce Survey can help gather needed information. In particular, having current national estimates of the demographics of addiction counselors by treatment modality, geographic location, and organizational characteristics will be a huge step toward understanding the field through having solid data about the workforce. From this basic information, we will be better able to forecast workforce shortages, design recruitment and retention strategies, and, as an ATTC Network, focus our efforts on what the field most needs.

In addition to those mentioned in the report, there are several other areas in which a better understanding of the current workforce and agency practices would benefit the field. These areas are described with the caveat that the proposed ATTC Network workforce survey will be conducted at the level of program directors, not program staff.

- **Workforce needs for direct care staff other than counselors.** In addition to describing addiction counselors, it would be helpful to understand other members of the addiction workforce, including peer recovery support staff, addiction techs, community support workers, case managers, co-occurring specialists, vocational rehabilitation staff, etc. As the field shifts from an acute care model into a recovery oriented system of care, the roles of these non-counselors within addiction treatment programs will increase. It is essential to understand the workforce development needs of these staff members.
- **Workforce needs for clinical supervisors.** Similar to the previous point, it would be helpful to have a better understanding of the roles of clinical supervisors. Much current attention is being focused on clinical supervision (e.g., CSAT's *Competencies for Substance Abuse Treatment Clinical Supervisors*, TAP 21-A, on-line courses in clinical supervision, the NIDA/SAMHSA Blending Product *Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency [MIA: STEP]*). What are agency requirements for clinical supervisors? What are their job duties? What types of supervision are provided and how often?
- **Reasons why agencies have difficulty filling open positions.** Including items that assess program directors' recent experiences in filling staff positions would highlight gaps in the workforce and/or workforce development needs. These can include items regarding the minimum qualifications for addiction counselors (e.g., training/education, experience, applied skills, certification, social/interpersonal skills) and how often these requirements are not being met by applicants. Other items could assess program directors' understanding of why qualified counselors are not interested in jobs at the agency (e.g., salary, hours, caseload), or other reasons why there might be a limited applicant pool (e.g., rural location).

How can the survey aid in our knowledge of the substance abuse treatment workforce as a conduit for technology transfer?

The ATTC Network Technology Transfer Workgroup recently defined technology transfer as “a multidimensional process that intentionally promotes the use of an innovation. Technology transfer begins during the development of an innovation, continues through its dissemination, and extends into its early implementation. This process requires multiple stakeholders and resources, and involves activities related to the translation and adoption of an innovation. Technology transfer is designed to accelerate the diffusion of an innovation.”

The addiction treatment workforce has numerous roles to play in the process of technology transfer (Gotham, 2006), including: as direct service providers who use evidence-based practices (EBPs) in their work with clients; as opinion leaders and as champions who help disseminate EBPs and influence the attitudes and behavior of staff toward adopting EBPs; as clinical supervisors who provide targeted supervision specific to the EBPs as well as assess and provide feedback regarding clinician’s fidelity to EBPs; as change agents who lead the clinical and administrative implementation of EBPs in their agency; and as program directors/administrators who serve as sponsor, mentor, critic, and institutional leader for all aspects of technology transfer (Van de Ven, Polley, Garud, & Venkataraman, 1999).

The upcoming survey could enhance our knowledge of technology transfer-related workforce issues directly by assessing factors such as whether agency staff play the various technology transfer roles in the agency, what EBPs are currently being used in agencies and whether new staff are required to have previous training/expertise in any EBPs, and what types of training/expertise program directors would like to have included in pre-service educational and training programs for addiction counselors. It would be very helpful to assess agency use of specific implementation strategies (e.g., Fixsen et al., 2005).

Without turning the focus of the survey too specifically on technology transfer, we may gain knowledge about technology transfer indirectly by having a better understanding of the level of education and expertise of addiction treatment staff, the make-up of treatment teams (e.g., other addiction workforce professionals and paraprofessionals), and the use of management and supervision strategies. This information, when combined with other data, may assist federal agencies, states, and other parties who mandate the use of EBPs in planning how best to roll-out technology transfer efforts.

Understanding Addiction Treatment Workforces: Capturing the Full Diversity is Crucial

By Dennis McCarty, Ph.D., and Tracie Reichmann, Ph.D.

Oregon Health and Science University

The National Drug Abuse Treatment Clinical Trials Network (CTN) completed one of the more comprehensive organizational and workforce assessments, focusing on the membership of the CTN (Fitzgerald & McCarty, 2009; Fuller et al., 2007a; Fuller et al., 2007b; McCarty et al., 2008; McCarty et al., 2007). A summary of the results reveals a diverse workforce that varies by job title and across levels of care.

A three stage survey obtained responses from 106 of 112 organizations (95% response rate) describing the corporate structures and identifying 384 treatment units (residential, outpatient, detoxification and methadone). Next the 348 treatment units (91% response rate) provided data on their services, clients served and generated lists of employees by job category. Finally, 3,786 individuals (71% of the 5,334 eligible employees) completed a survey assessing education and training, opinions toward specific behavioral therapies and medications, and organizational readiness to change. Respondents to the workforce survey included 1,757 counselors, 908 support staff, 522 medical staff, and 511 managers or supervisors (88 were missing data on job category). Most workforce surveys collect data only from counselors. Thus the resulting descriptions of the addiction treatment workforce have been incomplete and fail to offer a comprehensive perspective on the complexity of the workforce and its needs.

Within treatment units participating in the CTN, support staff (e.g. counselor aides, receptionists, intake administrators) represented 24% of the workforce and reported more hours of direct patient contact than counselors. Their attitudes and beliefs about addiction treatment, therefore, may have substantial influence on shaping program cultures and normative expectations. Over half (58%) of the support staff completed their education with a high school diploma or less, 71% were women, and 46% were minorities (African American = 31%, Latino/Hispanic = 11%, multi-racial = 3%; other = 1%). As a group, support staff tended to be less supportive of pharmacotherapy and behavioral therapies. They were more supportive of discharging noncompliant clients and using confrontation with clients. Efforts to introduce evidence-based practices, therefore, may need to direct attention toward support staff as well as counseling staff.

Counselors (48%) and manager/supervisors (14%) accounted for more than 6 of 10 respondents to the workforce survey. Graduate degrees were relatively common (counselors = 42%, manager/supervisors = 58%). Counselors in outpatient settings were much more likely to have graduate degrees (53%) than those working in residential settings (30%). The most common masters degrees reported were in social work (29%), counseling (27%) and psychology (22%). In contrast with the findings among support staff, managers tended to have the most positive attitudes toward evidence-based pharmacological and behavioral therapies and were least supportive of using confrontation and discharging patients for noncompliance.

Nurses (64%; n = 251) dominated the the total number of licensed medical practitioners working in the participating programs (n = 392). A relatively large number of potential prescribers (physicians = 77; nurse

practitioners and physician assistants = 8) completed the survey. Based on the 348 treatment units providing data for the workforce survey, there is, on average, about one prescriber per four treatment units ($85/348 = 0.24$). Medical staff had the most positive opinions about pharmacological treatments for addiction. Overall, support for the use of evidence-based pharmacological and behavioral therapies was variable but modest.

Finally, a more ambitious assessment would also include licensed practitioners in private practice and group practice settings. CSAT sponsored assessments of addiction treatment within practice research networks for psychiatrists (Svikis, Zarin, Tanielian, & Pincus, 2000), psychologists (Smith, 2001), and NAADAC (National Association of Alcohol and Drug Abuse Counselors) members (Kowalski, Harwood, & Ameen, 2001). Practitioners in private practice settings will have different workforce development needs than those employed in specialty addiction treatment centers.

The bottom line is that the addiction treatment workforce is actually many workforces across a range of treatment modalities and without a common educational core. Analyses of the workforce and assessments of their professional development needs, therefore, must examine levels of care and job categories in order to embrace the full diversity of women and men working in treatment centers that address alcohol and drug use disorders.



Are Counselor Salaries the Right Focus for Improving Workforce Retention? Re-Considering the Importance of Managerial Practices and Clinical Supervision

By Hannah K. Knudsen, Ph.D.

University of Kentucky

The growing interest in turnover among counselors is well-placed since turnover disrupts service delivery for clients and is costly for organizations which must recruit and train new staff. A key retention strategy identified in the new report, [*Understanding America's Substance Use Disorders Treatment Workforce: A Summary Report*](#), is to focus on the relatively low salaries that are paid to treatment staff. Our research on counselor salaries, conducted as part of the National Treatment Center Study, has highlighted the relatively low pay for counselors. In our study of counselors in privately funded treatment programs, we found that nearly 90% of counselors earned less than \$40,000 a year (Knudsen, Johnson, & Roman, 2003). Later surveys of counselors working in therapeutic communities and in programs affiliated with NIDA's Clinical Trials Network found that the average counselor earned between \$25,000 and \$30,000 per year (Knudsen, Ducharme, & Roman, 2006; Knudsen, Ducharme, & Roman, 2008).

How do these salaries compare to patterns of income across the US? The US Census Bureau collects data on personal income and reports this information for individuals who are aged 25 or older. Interestingly, Census data from 2006 show that 43% of individuals earn less than \$25,000 per year, and that nearly 70% of individuals have income of less than \$50,000 annually. Placed in this context, the seemingly low counselor salaries in substance abuse treatment organizations are perhaps not surprising.

The new ATTC workforce report suggests that increasing counselor salaries are an important method for improving workforce retention. But how important is salary in understanding counselor turnover? Our studies of counselors who work in a diverse range of treatment organizations suggest that it is perhaps of limited importance. For counselors in privately funded treatment organizations, we found that counselors with higher salaries reported lower turnover intention (meaning that they are not actively searching for a new job or intend to leave their current position) (Knudsen et al., 2003).

It is important to place that relationship into the context of the other results. When the size of the relationship for salary is compared to job autonomy (i.e. empowering counselors to make decisions and have control over their work), the relationship of salary to turnover intention is just half the size of that of job autonomy. We found a similar relationship in a later study of counselors in privately funded and publicly funded treatment organizations (Ducharme, Knudsen, & Roman, 2008). In our other studies of turnover intention among counselors in therapeutic communities and CTN programs, salary has not been associated with turnover intention (Knudsen et al., 2006; Knudsen et al., 2009).

Across these studies, counselor salaries have only a limited and inconsistent impact on turnover intention. What we have repeatedly found is that it is far more important to focus on the relationships among counselors, their clinical supervisors, and program management. Supervisors and managers have a great influence on the context in which counselors work. They determine whether the workload is spread equally across counselors, whether counselors are given the chance to have input about organizational changes,

whether counselors are supported when they try to be creative in their work, and whether counselors are allowed to have control over how they perform work.

In the research literature on workplaces, these facets of organizational life are called distributive justice, procedural justice, support for creativity, and job autonomy. Not only are lessened presence of these factors associated with turnover intention—they tend to also be associated with emotional exhaustion which is a central feature of burnout. Overall, the relationships between these factors and turnover intention tend to be 2-3 times greater than the relationship between salary and turnover intention.

While attractive in its simplicity, increasing counselor salaries is simply unrealistic. Substance abuse treatment programs face an increasingly turbulent funding environment and lack the flexibility to increase counselor salaries without comprising some other treatment deliverable.

The advantage of focusing on managerial practices and the relationships between counselors, clinical supervisors, and program managers is that behavioral changes, rather than financial changes, are required. It may require managers and supervisors to re-think how they interact with counseling staff, but long-term fixed costs in the form of higher salaries would not be required. To the extent that programs are able to better manage their counseling workforce, our data clearly suggest that management will actually see financial benefits in the form of reduced turnover.

We Need Much Less of the Same: Transforming the Substance Abuse Workforce

By Mike Boyle, President/CEO

The Fayette Companies

The estimates of addiction treatment staff shortages in the near future all appear to assume the current treatment system will continue as it has for the past 40 years. An alternative approach is to envision what the treatment system may or perhaps should be in the future and identify staffing resources needed to implement different and hopefully more effective approaches.

The current system is an acute care model consisting of admission to structured programs, treatment and discharge. There is usually no continuing support following active treatment. Most services are delivered through groups provided in residential or outpatient settings. Everyone attends the same groups whether or not they have an identified need for the content. Usually few individual or family sessions are provided. When people return to use of alcohol and other drugs following discharge and again seek assistance, they are put into the same services previously provided. The majority of persons entering treatment have been in treatment before, many for multiple episodes.

Albert Einstein defined insanity as doing the same thing over and over and expecting different results. I will explore how we may do some different "things" in the treatment of substance use disorders and how these approaches may impact the need for future staffing of these services.

The National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-based Treatment Practices endorsed by the National Quality Forum (NQF) in 2006 may serve as starting model. These standards were developed by a committee of national experts.

The first five of these standards are directed towards primary care practices regarding screening, assessment, brief interventions and engaging those in need into treatment. Thus, primary care is envisioned as a crucial resource in addressing substance use problems. Under this scenario, the treatment "field" is expanded and integration of the current substance abuse treatment system and primary care will be necessary for successful implementation of these standards.

The involvement of medical specialists is also essential to implement standards 6, 8, 9 and 10. These state that pharmacotherapy be provided to manage withdrawal and offered to all persons who are dependent on opiates, alcohol or nicotine. Further, literally dozens of research studies are underway within the pharmaceutical industry to develop new medications that target other drugs of abuse. Some of these show considerable promise to be more effective than current medications with treating alcohol, opiate or nicotine dependence. Implementation of medication use requires that all providers employ medical personnel. The 2004-2006 National Treatment Center Study conducted by the Institute for Behavioral Research at the University of Georgia found that only 60% of addiction treatment programs had a physician employed or on contract and 36.5% employed nurses.

In a time of shortage of both primary care and nursing staff, more of this medical expertise will needed within

the substance abuse treatment field. An opportunity that should be explored is collaboration with Federally Qualified Health Centers that receive greatly enhanced reimbursement rates from Medicaid and Medicare. A question yet to be answered is whether these enhanced reimbursement rates will also apply under some form of national health insurance.

The NQF's 6th standard is that empirically validated psychosocial treatments be utilized in substance abuse treatment. These practices would replace the didactic lectures, educational videos and open-ended "process" groups that dominate the approaches commonly utilized today. Achieving this standard will require more persons with advanced degrees in the addiction treatment settings to provide training, supervision and direct provision of evidence based practices. While some of these practices are manualized and persons without advanced education can be taught to effectively implement the techniques, many require a high level of clinical sophistication.

The last standard is provision of continuing care following active treatment. This implies that we move into actual practice our rhetoric regarding alcoholism and drug addiction as chronic disorders. A new National Quality Forum committee has been created to define what constitutes an episode of continuing care. The work of this committee may guide what workforce talents will be required for models of continuing care.

There are a couple of very important terms that need to be addressed in the fore-mentioned "voluntary standards" of the NQF. First, a standard is very different from a guideline. A guideline is a recommendation that may or may not be followed based on clinical judgment. A standard establishes a process that must be implemented to meet a defined quality measurement. While the word "voluntary" is utilized, the goal of many involved in this process is that the adoption and utilization of these standards will become the basis for funding and purchasing by governmental organizations and by insurance providers. The addiction treatment field would be wise to plan to implement these standards. Those who do not comply may be voluntarily giving up their funding sources in the future.

Beyond the NQF standards, I believe we need to explore whether our treatment focus is far too narrow. Most people entering the public funded addiction treatment system have multiple problems in addition to the most severe alcohol or drug dependency problems. They commonly lack employment, education, housing and positive family or social support. Yet, the focus of treatment is often only on the addiction with the assumption that other problems will eventually be resolved if abstinence is achieved. Further, the answer when someone relapses is often more of the same treatment with a longer length of stay – literally more of the same. And following longer treatment, they are once again discharged without a job and perhaps homeless. And we expect different results?

These people often have nothing left to lose and nothing on the near horizon to gain from abstinence except avoiding punishment such as imprisonment or loss of children to the child welfare system. We should attend to assisting people to obtain employment and/or begin GED or community college classes while in treatment. Building the positive side of their personal ledger may give an incentive for continued abstinence that provides reasons to use the skills acquired in treatment.

As an example, my organization has established computer labs in our residential programs that assist people

to gain skills that can be applied in the "real world". Utilization of the labs ranges from basic computer use, developing resumes, learning knowledge to obtain a GED to beginning on-line college courses. An hour spent gaining skills on a computer may be more beneficial than hearing the same lecture on the impact of drugs on the brain for the third time. Employment specialists have begun using supportive employment techniques (developed for working with persons with psychiatric problems) with persons with addictions who have difficulty obtaining employment. Assisting people to develop recovery capital as a component of treatment requires different skill sets that may not be present in the existing workforce.

To end on a provocative note, perhaps we will need less rather than more counselors to provide treatment in the future. On the average, staff salaries and benefits constitute 76% of addiction treatment costs. In comparison, the staffing component of building a Toyota is less than 10% of the costs of the automobile. A major reason for the difference is the use of technology.

When the term technology is used in behavioral health care, it usually limited to the idea of an electronic medical record. How about treatment and recovery supports delivered through telephonic and computerized systems? Existing research has demonstrated the effectiveness of virtual counselors delivered through computerized systems. Will nanotechnology someday allow the just-in-time release of a blocking agent to be released when the presence of a specific drug is detected? And, will that "someday" be far sooner than we expect?

Dave Gustafson, Director of NIATx, believes the addiction treatment field, characterized by low salaries and high turnover, is unsustainable. He believes the answer is in the development and use of technologies that can lead to less staffing demands and thus higher pay. Dr. Gustafson has secured National Institute on Alcohol Abuse and Alcoholism research funding to conduct a randomized clinical trial using smart phones to provide recovery support for persons following residential treatment. An overview of some of the technologies that will be provided in this research can be accessed at www.innovationsforrecovery.com. If new technologies are to be developed and utilized, researchers in these domains must be solicited to become partners, and persons with skills to implement these technologies must become part of, the treatment team. Can the substance abuse treatment field of today embrace these changes?

Making Use of Classical Approaches to Workforce Analysis

By Paul M. Roman, Ph.D.

University of Georgia

The ATTC Network review monograph is an excellent platform on which to construct a nationwide study of the substance abuse treatment workforce. The monograph effectively captures the research that is already completed, and fully outlines its many shortcomings. These translate into unknowns about the workforce, and hopefully will translate further into opportunities to learn as much as possible in this well-planned step-wise data collection project.

As this specialty looks toward its future, there are two very dramatic events that are bound to happen, but about which we seem to have little, if any, control.

First is the implementation of parity for the treatment of substance abuse, scheduled to be implemented in less than 3 months. Second is national health care reform. One can envision explosive growth for this specialty over the next decade if several "stellar alignments" occur. These include the possibility of true parity opportunities for the general population, supported by health care reform. A surge of interest in substance abuse treatment within the primary care sector is possible if attractive remuneration emerges. An accompaniment could be a dramatic reduction in drug interdiction and punishment as the solutions for drug problems, and the emergence of greater support for treatment. All sorts of combinations of scenarios can be imagined, but no vision can point to what really will happen.

Regardless of what may happen tomorrow, we often lose sight of the potent opportunities that exist today. Specialty practitioners within substance abuse treatment often imply that this area of endeavor is underfunded, underappreciated, and trivial. For both practitioners and researchers, a culture of negativity, with an atmosphere of friendliness and informality, seem to suggest that this is a small, isolated, but highly dedicated specialty. Our well-honed talents at self-flagellation in the specialty help confirm a perception of marginality.

Yet in fact this is a very big business. Tom McLellan has estimated that a minimum of \$15 billion changes hands each year within the substance abuse treatment industry. This includes not only significant proprietary activities but many, many "non-profits" that are incredibly entrepreneurial and aggressive in their organizational behavior. Thus substance abuse treatment is not minor league. But its workforce is its backbone, and the Murphy/Hubbard report makes it very clear that "there is trouble in River City." A sound understanding of how to dramatically alter many features of our workforce is critically important.

Beyond these "big unknowns," there are some questions that would seem to be traditionally asked in a workforce analysis that seem to be missing in the planned ATTC project. My principal concern about what might be missing is based on definitions.

First and foremost, it is critical that the project begin with a careful and consensually developed definition of what constitutes the workforce. Since most workforce projects have clearly devolved to equating the

substance abuse treatment workforce with counselors, this error should not happen again. But I believe that more “spadework” may be necessary before the parameters around this workforce can be delimited. There is the need to enumerate all of the occupations and jobs that are involved in treatment delivery. McCarty and his colleagues, through their study of the CTN workforce, have made a good start in this direction. And McCarty and Reickmann point out that the “treatment center” is not the only place where substance abuse treatment happens, or where the substance abuse treatment workforce is employed. Thus, I would urge that before finalizing any survey design, the parameters of this workforce need to be very carefully defined, and to extend well beyond counselors.

Second is the need to define the counseling roles that comprise the treatment enterprise. While prior research recognizes diversity in training, background, and credentials among counselors, little has been done to construct either a catalog of counselor roles or a typology of the ways into which these roles are “bundled” into different counselor statuses. The clinical supervisor is well-recognized as a distinction among counseling roles, but counseling assistants and other roles that affect the engagement and retention in treatment need to be addressed. Overall, this might be seen as linking to a “job analysis” in the specialty of industrial psychology.

A third definition is complementary, namely defining the skills essential to each of the roles that are delineated in the job analysis. This in turn directs us toward the sources of skill learning, another black box in our understanding of the substance abuse treatment workforce. Rather than limit our understanding of acquired skills to recording years of education, degrees, in-house training, and continuing education, it could be of great importance to extract from individuals evidence of where they believe they acquired specific skills needed to perform counseling roles. This could aid immeasurably in specifying the kinds of formal and informal educational experiences that need to be made available for the workforces of the future.

Currently we have very few institutions that stand out as settings for specialized skill development for substance abuse counseling roles. We even lack the most basic tool of an emerging profession, namely consensually accepted textbooks that define the field of practice. While laudable in both their quality and availability, it’s a little cumbersome to imagine the 45-plus volumes of SAMSHA’s “TIPS” to cumulatively constitute the substance abuse treatment “textbook.” Yet when someone asks where they can learn “how to do it,” one or another “TIP” is a common recommendation. Thus the ATTC survey could help point to how these opportunities to effectively consolidate and diffuse professional knowledge could be effectively structured.

Considering roles and skills together could produce another badly needed product, namely the specification of dimensions of the **core technology of substance abuse treatment**. Such a definitional exercise establishes what is unique about substance abuse treatment in terms of techniques specific to this specialty that cannot be acquired through training or experience in the practice of a different specialty, no matter how “parallel” it might seem. This definitional exercise can also specify what is transferable from other bundles of techniques included in educational programs already in place for other specialties. Specification of core technologies and associated bundles of strategies leads to textbooks. I have no doubt that the ability to specify these techniques in a cogent way is readily available---it just seems that it has not been done.

I am not suggesting that these definitions be set as facts before the survey begins, but that the survey include enough detailed information about perceived current practice that it is able to have a skeleton upon which to place the empirical findings, and derive the differences between perceived reality and actual reality. Only if we know this can we move toward a “projected reality” that appears as central in the tasks of the ATTC-sponsored survey. In other words, I see the current approach as including too many “taken-for-granted’s” about the nature of the workforce and what kinds of roles different personnel perform.

The survey needs particular sensitivity to managerial roles within substance abuse treatment. As our own research has shown (Knudsen, Ducharme & Roman, 2009), retention of top managers is on one hand problematic in substance abuse treatment, but on the other hand is apparently avoidable. Our data clearly indicate qualities of managerial environments that affect turnover in substance abuse treatment, and monetary compensation is not singularly prominent. It is evident from other parts of our field research experience that management is probably the most neglected component of substance abuse treatment, yet also the issue most subject to denial by field leadership. Viewing managers, their roles, their development, and the retention of the best of them as vital to the workforce are important considerations for the survey.

Finally, a vital concept to workforce analysis is the career. There are essentially no data on the construction of careers in substance abuse treatment. The projected survey could definitely shed light on these careers, for they are the converse of the alleged pervasive problem of turnover. Research studies of turnover are in their relative infancy in this specialty, but a great deal of specification is needed in future studies. Different types of turnover need to be delineated, recognizing that turnover may be very positive for individuals and not always negative for organizations.

But the construction of a typology of careers within our specialty is a vital challenge. Given the sheer number of people who remain at this work for many decades, we know by inference that there must be stages of personal development, growing maturity, and changes in rewards. Understanding such careers, how they are fostered, and how they are blocked is very important for future recruitment, and perhaps for the more effective construction of a positive public image of the inner workings of substance abuse treatment.

Response to Issues Raised

By Robert Hubbard, Ph.D., and Deena Murphy, Ph.D.

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The development of the ATTC national workforce survey appears to have generated renewed and important interest in the issues surrounding the capacity to deliver effective and efficient treatment. The issues raised in the comments of the reviewers are all important and critical to the field. As Paul Roman states one of the critical issues is to develop a framework in which to systematically consider these issues and to direct a research and practice agenda to obtain and apply the knowledge gained. Two approaches could facilitate this process. In 1999, the National Institute on Drug Abuse published the Principles of Drug Addiction Treatment with an organizing framework of the core and comprehensive components of treatment outlined in a paper by Etheridge and Hubbard (2000). This paper presented a heuristic model of treatment structure and process within the multiple levels of service, program, system and environment. The model helps organize the complex and interrelated components of treatment, each of which needs to be staffed by the workforce.

Second, two main data systems now exist that provide useful information on treatment at the program level, the Treatment Episode Data System (TEDS) describing patient/clients/consumers and the National Survey of Substance Abuse Treatment Services (NSSATS) describing the program structure and services. A key missing element is the description of the workforce. We view the ATTC national workforce survey as a necessary basic step in filling this void.

Clearly, the responses to the report in this issue as well as our ongoing meetings with stakeholders in the field raise critical and fundamental issues to the comprehensive understanding of the workforce. While it is critical to consider and address the many issues raised, our fundamental goal for the ATTC national workforce survey is to establish a sound useful base of information to begin to address the three key questions identified by the planning panel and discussed in the report.

To achieve this rather modest but fundamental first step, we view a comprehensive coverage of basic information as the essential element in informing future steps. The design of the survey is constrained in many ways by the diverse concepts in the field, the lack of comprehensive information on the workforce and the resources available to support the proposed survey. We have taken a pragmatic approach that focuses on achieving as complete information as possible on the key basic questions.

The recommendation of the NSSATS as the listing of programs is based on the need to provide a common definition of program and modality as well as maximize the potential of using the TEDS and NSSATS databases. The recommendation of the program director/administrator as the respondent is based on the need for high response rates to confidently describe the workforce at the national level given the resources available to implement the data collection by ATTC Regional Centers. Most workforce surveys have achieved high response rates at the program level, but McCarty reports even the NIDA CTN workforce survey was only able to obtain a 70 percent response rate for the workforce sample. The recommended medium will be a web based system with a time burden of approximately 30 minutes.

The first and fundamental area of inquiry will be the descriptive information on the workforce with the

programs in the NSSATS listings. We would recommend assessing basic information on age, gender, ethnicity, education, certification, tenure and salary level. This can be accomplished following the rostering procedure used in the CTN workforce survey.

The second major area is the question of important issues for the field in the next five years. The issues being considered are (1) billing and payment systems, (2) assessment and electronic records, (3) incorporation of evidence based practice, (4) movement toward a recovery management model of care, (5) integration of medications for both addiction and co-occurring disorders, and (6) coordination of community based supports.

The third area will consider the approaches used at the program level to recruit, train and maintain the workforce. We will assess the extent to which program directors report using as many approaches as possible within each of these topics. At a minimum, we will ask about salary, job characteristics, work environment, supervision, career paths and linguistic and cultural competence. We would also consider the training and certification practices available to staff and supported by the programs including web-based, telemedicine and other distance learning approaches as well as traditional training approaches. The previous surveys conducted by the ATTC Regional Centers have developed very useful questions to assess the broad array of available options.

Once the meetings with key stakeholders are completed, the basic content of the survey will be recommended. We trust we will have the opportunity for the field to respond to the extent to which the survey covers the major questions. Based on these responses the final survey will be drafted, pre-tested and entered into the approval process. We believe with the great interest in workforce issues and informed input of the field, the ATTC National Workforce Survey will provide an important, albeit limited, base of information to answer some key questions as well as to inform the development of future research and practice that will expand and improve our understanding of the workforce.

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