SAMHSA-HRSA
Center for Integrated Health Solutions

# Workforce Issues Related to: Bi-Directional Physical and Behavioral Healthcare Integration

## Specifically Substance Use Disorders and Primary Care

## A Framework of Issue Briefs

## ISSUE BRIEF #4

## Substance Abuse Treatment Workforce: Implications for Integration

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## WORKFORCE AND THE INTEGRATION OF SUBSTANCE USE DISORDERS

A number of recent reports have been issued which focus on the behavioral health workforce. One addressed the development of a national action plan to remedy the insufficient behavioral health workforce, difficulties in recruiting and retaining staff, limited access to appropriate and effective training, the erosion of supervision and critical leadership and broken and inadequate reimbursement systems. A second report, *Strengthening Professional Identity: Challenges of the Addictions Treatment Workforce* limited its scope to only the substance abuse treatment workforce. Both reports contain somewhat similar recommendations in areas particularly germane to this report; among other areas, both identified the need to expand recruitment and retention to address worker shortages, as well as to improve access to and the quality of training available, especially in relation to implementation of evidence based practices.

The substance abuse treatment workforce includes physicians (including psychiatrists), social workers, nurses, psychologists, counselors, providers of recovery support services and others. Providers of substance abuse treatment are varied in terms of their formal training and degrees, as well as certification specific to substance abuse treatment. One key aspect of working collaboratively is to have understanding about the background and skills of those on your team.

One assessment of the size and professional characteristics of the workforce was published in a 1997 Institute of Medicine report and is presented in Table 1, which reflects the relative small number of "addiction specialists" across all disciplines.

Another national estimate of the workforce based on outpatient, residential and methadone treatment sites and data collected in 2000, found 67,400 workers directly involved in psychosocial treatment services, an additional 80-90,000 medical and administrative staff, and 17,000 other behavioral health professionals.

*Table 1. Number of Practitioners and Certified Addictions Specialists, by Healthcare Discipline*

| Discipline | Workforce size | Certified Addiction Specialist |
|---|---|---|
| Primary Care MD | 700,000 | 2,790 ASAM certified |
| Psychiatry | 30,000 | 1.067 addictions psychiatrists |
| Clinical Psychology | 69,800 | 950 APA certified |
| Social Work | 300,000 | 29,400 (self-described SA specialist) |
| Nursing | 2,200,000 | 4,100 (self -described SA specialist) |
| Physician assistant | 27,500 | 185 (self-described specialist) |
| Marriage/Family Counselors | 50,000 | 2500 ( self-described specialist) |

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

Others, also using data from 2000, have estimated that the national total of substance abuse treatment direct services staff is likely to be greater than 130,000 swelling to approximately 200,000 individuals if medical and administrative staff numbers are added.

Many individual states have compiled basic workforce statistics thru the regional Addiction technology transfer centers (ATTC's). Established in 1993 and funded by SAMHSA, the Addiction Technology Transfer Centers are a network of regional centers that focus on raising awareness of evidence based treatment practices and building skills in the workforce to improve practice in the addictions treatment and recovery services field. Using the New England States as a convenience sample, Maine, Vermont, New Hampshire, Connecticut and Massachusetts, reported that the largest proportion of direct substance abuse treatment service providers were addiction counselors, accounting for at least two thirds of the workforce. Most recently the Bureau of Labor Statistics estimated that in 2008, there were 86,100 individuals employed as counselors (employed in all types of settings- not just substance abuse treatment settings) in 2008. They also projected growth of 18% in the ten years between 2008 and 2018 and suggested that the number of jobs would exceed the number of graduates from counseling programs.

- *Substance Abuse Treatment Counselors*

  Because counselors are the backbone of the SA treatment workforce, their training and background is important. While combined into one occupational code by the Bureau of Labor Statistics, many have identified that mental health and substance abuse counselors often have quite different approaches to the problems they encounter. Training for mental health treatment has largely taken place within mainstream educational pathways while at least initially, persons recovering from addictions, often became the providers of addiction treatment and developed substantial clinical knowledge through their experience. However, one national study of the substance abuse treatment workforce found that almost 3 of 4 counselors in substance abuse treatment programs had a bachelor's degree and 72% were certified or licensed as substance abuse/mental health professionals. These researchers hypothesized that increased managed care and a focus on supporting evidence based practices has resulted in an increase in "formal education" for addiction counselors. Libretto and others also estimated that about 71% of counselors had at least a college education. However, at least for some states in the one region assessed, between 12% (Vermont) and 49% (Connecticut) of direct care staff reported less than a bachelor's degree; it appears that in some states, associate degree preparation is likely (for example 28% of Connecticut's workforce reported an associate degree as their highest degree).

  Sixty six organizations are involved in the licensing and credentialing of substance abuse treatment counselors across the United States. Findings from a study of requirements for counselor certification or licensure for substance abuse counselors in comparison to mental health counselors show that on almost every level, generally more was required of mental health counselors than counselors in substance abuse. For example, only about ½ of the states required

a specific credential for a substance abuse in comparison to 85% for a mental health counselor; almost all states (98%) required a master's degree to qualify as a mental health counselor; 45% of states did not require any college degree to qualify as a substance abuse counselor. Substantial differences in the same direction were also observed for minimum degree requirements, hours of coursework, practicum or training hours; the requirements for substance abuse counselors only exceeded that of mental health counselors in the amount of supervised work experience required prior to credentialing. While a consensus model for national core competencies for addictions counselors exists, these standards have not been universally adopted. Included in this consensus model are knowledge and attitudes needed by all disciplines working in the addiction field and specific competencies for addictions counselors in clinical evaluation, treatment planning, referral, service coordination, counseling, client, family and community education, documentation, and professional and ethical responsibilities.

With a specific view towards integration, it is important to note that only nine states had a minimum requirement for courses related to health and disease for substance abuse counselors and only two states for mental health counselors. No minimum requirements were observed that focused specifically on teamwork or communication with other professionals, but twenty-two states did include minimum course requirements in professional ethics, responsibilities and preparation. Some have called for more uniformity in state credentialing for both mental health and substance abuse counselors.

Licensing and credentialing is an important state function. It ensures a minimum level of quality, encourages consumer confidence, and provides safeguards against poor practices that could harm clients. Beyond the development and adoption of national accreditation standards for counselors, it is important to note that at least among the New England states, a significant proportion (ranging from a high of 55% to a low of 17%) of direct substance abuse care workforce (across all disciplines) did not report having current or pending licensure or certification.

Most states (90%) require continuing education for recertification for substance abuse counselors but the majority does not have very specific requirements about its content. Only one state required continuing education in health issues for mental health counselors; two states had this requirement for substance abuse counselors. In one study of regional training needs, the following were identified as high priority: 1) co-occurring mental health and substance use conditions; 2) treating special populations; 3) treatment models; 4) relationship between substance abuse and other medical problems; 5) treatment methods and 6) substance abuse and addiction models. Interestingly, respondents thought they were highly proficient and (therefore) had low interest in training included interpersonal communication skills, and referral skills. Across all disciplines, lack of time was seen as the most frequent barrier to continuing education, but both counselors and social workers also reported client needs, poor resources, policies and procedures and the need for more training as barriers.

- *Social Workers: Mental Health and Substance Abuse Practice*

  The Bureau of Labor Statistics estimated that in 2009, there were 137,300 mental health and substance abuse social workers and employment opportunities for this type of social worker were expected to grow twenty percent, from 2008 to 2018 (separate statistics for substance abuse were not available). The New England states reported some part of the direct service providers were social workers, but the range varied from eleven percent of the workforce in Vermont to a high of 25% in two states, Maine and Massachusetts. One national study of social workers found that only 2% of social workers responded that addiction was their primary practice area; an additional 14% said that it was their secondary or tertiary practice area. Nine of ten social workers indicated they had experience in providing mental health services; 55% reported current involvement with mental health; 39% reported mental health as their primary practice area. Yet almost three fourths (71%) reported taking one of more actions relating to substance abuse in the preceding year. Social workers who worked in mental health settings reported that they frequently worked as part of a team (results not reported separately for substance abuse treatment settings). A core skill among social workers is assisting clients to identify needed community services and so these competencies may place social workers in prime positions to be used as care mangers.

  With regard to training in substance use disorders, 81% of social workers reported that they had received some kind of education/training at some point in their lifetime; 68% indicated that they received that training as continuing education. Slightly more than 1/3 said they received substance abuse training as part of their academic program and the majority of those through clinical supervision. In one an assessment of substance abuse training needs in social workers employed in substance abuse treatment agencies in New England, Hall and others found that respondents reported considerable need for additional training, especially in assessment, advanced clinical techniques and dual diagnoses. Only 1% reported completing a specific substance abuse certification program.

- *Psychologists*

  According to the Bureau of Labor Statistics, in 2008, 170,200 psychologists were employed across the nation. Of these 21% worked in health care settings, including substance abuse treatment settings and 34% were self-employed. Psychology as a professional discipline was reported in the convenience sample of all the New England States but Connecticut, and ranged from fourteen to twenty percent of the state's SA workforce. BLS estimated average growth in demand for psychologists, noting that doctoral preparation with an applied specialty, such as healthcare will be in most demand and opportunities for persons with bachelor's or master's degrees in psychology will have less opportunity. While some have suggested that psychologists play a major role in integration of behavioral health into primary care, we need to better understand their role related to substance use conditions.

- *Registered Nurses and Advanced Practice Nurses*

  It is difficult to estimate both the number and types registered nurses specifically prepared for practice in the addictions treatment field. Registered nurses are most often prepared at the associate and bachelor's degree. The Bureau of Labor Statistics recently estimated that about 2.6 million registered nurses were employed and that the majority of these are employed in hospitals. However, employment in outpatient settings, such as physician offices, is expected to be one of the fastest growing settings for opportunities for nurses over the ten year period, 2008 to 2018. In the New England regional study of the SA workforce, nursing was reported as a professional discipline in direct service within a substance abuse treatment agency in only two (Maine and Massachusetts) of the five states and in each of these States was about 12% of the direct service workforce. Compilation of all the Addiction Technology Transfer Center (ATTC) workforce statistics are beyond the scope of this report, but these data from one region suggest that beyond counselors, there may be significant state to state variation in the types and proportions of different practitioners in the existing SA treatment workforce.

  Advanced practice nurses (APRN's), who are prepared at the master's level, may be certified as psychiatric mental health nurses and may practice either as clinical nurse specialists, or psychiatric mental health nurse practitioners. While the number of either registered nurses or advanced practice nurses working specifically in substance abuse treatment are not known, 79,638 advance practice nurses with a psychiatric/mental health clinical specialty were reported as working in hospitals, and 53,130 in non-hospital settings in 2008.

  Advanced practice nurses are highly qualified clinicians who provide cost-effective, accessible , patient centered care and have the education to provide the range of services at the heart of the health reform movement, including care coordination, chronic care management, and wellness and preventive care.

  APRN's integrate substance abuse and medical conditions into their critical activities; one recent study found that performance of a risk assessment including substance use behaviors and life threatening physical conditions was endorsed as the second most critical work activity for such advanced practice nurses. Some have suggested that the most appropriate model for advanced practice is the psychiatric-primary care nurse practitioner, who is prepared to provide comprehensive health services in either psychiatric or primary care settings. Nurses at both the basic and advanced practice level may also apply for certification specific to addictions nursing, sponsored by the Addictions Nursing Certification Board. In addition, a consensus model for APRN regulations, licensure, accreditation, certification and education has recently been endorsed by multiple specialty nursing organizations and a blueprint for the development of the psychiatric mental health advanced practice nurse workforce to support the development of an integrated model of behavioral health care has been created.

- *Physicians*

  In 2008, the Bureau of Labor Statistics estimated that physicians and surgeons held about 661,400 jobs, while the Health Resources Services Administration (HRSA) estimated about 817,000 active physicians under the age of 75. In 2007, the American Medical Association estimated that 32% of physicians were in primary care and another 10% in pediatrics. Over the period, 2008 to 2018, the Bureau of Labor Statistics estimated that physician employment would grow 22 percent, much faster than for most other occupations. HRSA noted a modest shortfall in the supply of physicians which could accentuate the existing geographic variations in supply. Physicians have been found to be poorly trained and oriented towards the detection and treatment of substance abuse conditions. Only about twenty percent of physicians reported that they were very prepared to discuss drug and alcohol issues with their patients.

  One national study estimated that only about 56 percent of residency programs require training in substance use disorder, and that when required, the median hours of training ranged from 3 to 12 hours. Despite the expanding awareness of the importance of substance abuse as a chronic health condition, education about substance abuse remains disproportionately low, when compared to other chronic conditions.

  In 2010, the Bureau of Labor Statistics estimated that there were 22,600 jobs held by psychiatrists. (Data are not reported separately for addiction specialists). Psychiatry has been reported to be the fifth largest medical specialty; the supply of child psychiatrists has grown more than general psychiatrists over the years. Although the IOM reported slightly less than 3000, physicians certified in addiction medicine in 1997, this number is currently estimated to be about 5000 addiction specialist physicians. Soyka and Gorelik however, observed that 1/3 of those with specialized certification in addiction medicine are not practicing in the field and that there have been fewer applicants for training and certification in addiction psychiatry. Psychiatrists can also benefit from specialized training in addiction. General psychiatry residents who attended a one day seminar had d improved attitudes about being able to help a patient with substance abuse, though the extent to which these positive results translate into different practices was unknown.

- *Physician Assistants*

  The extent to which physician's assistants are specifically involved in the provision of substance abuse treatment services is unknown; none of the respondents in the New England region identified themselves as a physician's assistant. The BLS estimated that in 2008, physician assistants held about 74,800 jobs in 2008 and projected that by 2018 employment would grow by 39%. In 2000, about 42% of the accredited physician assistant programs were at the master's degree level; in 2007 another study reported that this trend has accelerated, with 79% of the accredited programs offering a master's degree curriculum.

Other professional disciplines that specialty treatment workers across the New England area identified as their primary discipline include marriage and family therapists, adolescent treatment, criminal justice and other counseling disciplines.

- *Recovery Support Specialists*

Recoery support is also an important service for persons with substance use disorders. Recovery peer support workers are involved in advocating for the needs of the patient, assisting the patient to navigate the treatment system, and serving as a mentor for the patient in achieving sobriety. Specific estimates for the number of recovery support specialists working in the substance abuse field could not be located. However, these workers could be considered as included in broader job classification in the Bureau of Labor Statistics of Social and Human Service Assistants; BLS estimated that in 2008 there were 352,000 workers employed as social and human service assistants. BLS forecasted the need for an additional 23% of workers in this occupation by 2018.

The Health Services Resource Administration has also defined a similar but non-equivalent group, community health workers, who provide a wide range of supportive services including interpretation and translation services, provision of health information and education, informal culturally appropriate counseling on health, assistance with access to care, and advocacy related to health. A 2000 survey of these workers, estimated that there were about 86,000 community health workers with a variable supply state to state. Five predominant models of care involving community health workers were identified: 1) member of health care team performing tasks delegated by a lead provider; 2) navigator of the health care system; 3) screening and health education provider; 4) outreach-enrolling-informing agent and 5) organizer. Employers of these workers had a variety of different educational requirements: 21% had a minimum of a high school education or GED while 32% expected a bachelor's degree. Most employers provided post-hire training. The majority of these workers, however, were not specifically focused on substance abuse issues; however, more than 1/3 worked with patients with HIV/AIDS.

Recovery peer support workers in substance abuse can apply for certification in some states; Florida is one example. Certification requirements in Florida require a minimum of a high school diploma or general equivalency degree (GED), 1000 hours of volunteer or paid work in the addiction field, 75 hours of training, with detailed specification of what that training needs to include, passing a written examination, and submitting references.

Beyond the challenge of inadequate size, uneven preparation, and varying requirements for licensure or certification, especially for counselors and peer support specialists, the demographics of the workforce also suggest some challenges. A number of studies have found that a substantial portion of the workforce is Caucasian middle aged women, while the patients are predominantly younger and minority males. In comparison to other behavioral health professionals, and licensed substance abuse counselors, unlicensed substance abuse counselors

were more likely to be African-American; unlicensed substance abuse counselors were also more likely to work in a residential rather than an outpatient setting. The disconnect between the racial and ethnic identity of providers and clients in substance abuse treatment is not news; it was reported as a workforce challenge in a 2006 report about challenges facing the addiction treatment workforce. Some report the same difficulties in primary care, suggesting that cultural competence competencies will be key for both substance abuse and primary care staff.

***Please Note that references supporting this brief may be found in the complete paper.***