Solutions to the New York State Addictions Workforce Crisis: IPDA's Response

This white paper was prepared by IPDA's Workforce Development Task Force

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Many thanks to all board members and staff for their contributions to this document

White Paper on the Addictions Workforce

Few people familiar with the Alcohol, Tobacco and Other Drug (ATOD) service delivery system in New York State would disagree with the notion that its workforce is rapidly approaching a crisis stage.[1]

The abuse of alcohol, tobacco and illicit drugs is the number one health problem in the nation, placing an enormous burden on the country.[2] It strains the resources of our health system and contributes to the death and ill health of millions of Americans every year. ATOD abuse costs taxpayers more than $294 billion annually in preventable health care costs, extra law enforcement, accidents resulting in injury or death, crime, and lost productivity.[3]

In 1998, substance abuse and addiction cost New York State 18% of its $48 billion budget, excluding costs related to the State workforce.[4] Yet, despite this enormous financial expenditure, recent data from the New York State Office of Alcoholism and Substance Abuse Services (OASAS) suggest that 1.8 million New Yorkers need treatment for chemical dependency and that less than 20% of them are known or able to access treatment on demand.

Addiction is the outcome of a number of interacting factors, which vary by individual, including genetics, the properties of the substance being abused, family and peer influences, an individual's personality, cultural and societal factors, and pre-existing psychiatric conditions.[5] It is a chronic, progressive, relapsing disorder, and for many people more than one attempt at treatment is needed – sometimes over a long period of time – before a sustained period of recovery is achieved. Research funded by the National Institutes of Health (NIH) has demonstrated that drug addiction is a complex brain disorder,[6] which has significant biopsychosocial causes and consequences. Therefore, while addiction is sometimes preventable, and effective treatment helps individuals both achieve sobriety and develop the resources to maintain recovery, the complicated nature of this illness requires that prevention and treatment use an integrated, multi-disciplinary approach.

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[1] NYS OASAS Workforce Report, 2002
[2] Schenider Institute for Health Policy, 2001
[3] US Department of Health and Human Services, 2001
[4] Shoveling up: The Impact of Substance Abuse and Addiction on State Budgets. The National Center on Addiction and Substance Abuse at Columbia University
[5] Substance Abuse: The Nation's Number One Health Problem
[6] NIDA's Brain Imaging Studies Server as Powerful Tools in Drug Abuse Treatment, 1996

Effective treatment and prevention require continuous access to a well-trained staff that is equipped to resolve the multidimensional problems leading to and caused by addiction. Research has revealed that the problems presented by clients have become more complex with the introduction of new drugs and the recognition of co-occurring disorders that have preceded or are the consequences of addiction. These disorders include physical and mental illness, as well as cognitive and sensory disabilities. Providing quality care to a population with multiple needs is further complicated by a lack of public commitment to addiction prevention and treatment, ignorance of the scope and consequences of addictions to society, scarce resources, complex government requirements for documentation, and the stigmatization of this population.

This Workforce White Paper has been prepared to inform and advise policy makers, educators, representatives of government, and foundations about the workforce crisis, which severely challenges the field of addictions prevention and treatment. The Institute for Professional Development in the Addictions (IPDA), a not-for-profit corporation, comprised of leaders from the addictions field, authored this workforce white paper. IPDA's mission is to strengthen the skills and knowledge of all disciplines in the addictions workforce, in order to promote quality in prevention, treatment, research, education, training, and policy development.

The focal point of this document is the crisis in workforce recruitment and retention across all treatment and prevention specialists – direct care counselors, nurses, social workers, rehabilitation counselors, educators, trainers, researchers, psychologists, psychiatrists and other physicians. The present shortage of a qualified addictions workforce, which shows no signs of improving, will severely impact access to addictions services and patient outcomes. Therefore, it is critical that significant resources be directed to the expansion and development of the current and future workforce.

In this document, IPDA offers strategies for alleviating many of the problems that currently exist and provides recommendations for: (1) developing a workforce that is integrated and interdisciplinary, and (2) ensuring that a career in addictions treatment and prevention is a viable option. A strengthened workforce will ensure that the clients served will have access to the quality of care necessary to achieve an effective and sustainable recovery.

I. Background

In response to the escalating societal and economic consequences of addictions, the ATOD field began in the early 1970's with public recognition of and government funding for treatment and prevention programming. Early efforts at alcoholism treatment and prevention were integrated into traditional mental health systems, while separate substance abuse treatment and prevention programming developed in specific modalities and environments. The early workforce consisted of people who were recruited from related social service agencies or people who achieved recovery through a particular program.

As the ATOD field consolidated and matured, government regulations, funding sources, and third party payers mandated credentialing programs for counselors and the creation of addictions specialties in professions such as nursing, social work, psychology, psychiatry, medicine, and rehabilitation counseling. Subsequently, these professions developed their own standards and certifications related to the addictions field, and professional associations arose to provide vehicles for advocacy, standardization, and advanced education. In spite of these efforts, fewer people have chosen to work in the ATOD field, and there has been an increase in people leaving it.

The current focus on research-to-practice models, the integration of evidence-based findings into service delivery, and the challenge of maintaining existing staffing levels are critical issues facing the addictions field. Success in addressing these issues is dependent upon organizations that can readily adapt to change and a workforce that is able to accept and implement new protocols.

The growing crisis in the addictions workforce has been recognized at local, state and national levels. In recent months, in response to this crisis, descriptive information about the nature and make up of the addictions workforce has been collected and disseminated via the Addiction Technology Transfer Centers (ATTC) and its prime funding source, the Center for Substance Abuse Treatment (CSAT), and other behavior health care groups[7]. This information supports observations that the field is "in transition, primarily [from] one that has relied on experientially trained counselors to one that emphasizes graduate training."[8]

This crisis, which exists in the entire workforce – among direct care counselors, professionals with specialized credentials, and those who provide education and training – underlines the need for several key initiatives. Substantial change requires new attitudinal perspectives toward clients, an interdisciplinary approach to the nature and delivery of services, increased education and training opportunities (including an enhanced curriculum), innovative methods of recruitment and retention, and more effective ways to advocate for and secure funding.

[7] NIAAA's Frontline, Nov 2002 p. 3
[8] NIAAA's Frontline, Nov 2002 p. 2

I. Challenges

A. Attitudinal Perspectives

The stigma and negative attitudes toward individuals with substance use disorders (SUD) have had a detrimental impact on attracting qualified professionals to the workforce. Historically, health and human services professionals believed that addictions were a moral deficiency. While research and practical experience have led to the viewpoint that addiction is a complex biopsychosocial disorder, many professionals still may consider clients with substance use disorders as difficult to treat. They do not want to place themselves at risk for burnout or they see themselves as not competent to intervene.[9] Negative stereotypical views of addicts are communicated to the prospective workforce, clients, and their families. Thus, while progress has been made in changing attitudes, negative expectations for recovery from substance use persist among a significant number of health care professionals.

B. Interdisciplinary Approaches

The addictions field has emerged from two distinctly different directions. Addictions treatment and prevention theory are grounded in the research and academic environments in the fields of social work, nursing, psychology, medicine, human development, and rehabilitation counseling. Experienced-based and self-help practice models are rooted in the personal successes of men and women in recovery who, in their role as substance abuse counselors, share their narratives with others. The professionals often do not fully understand the approaches that fall outside of their own disciplines' experience and research, while non-academically prepared staff often do not recognize or appreciate the potential impact of the professionally trained staff. These dual perspectives impede the full integration of all disciplines working in the addictions field.

Ultimately, however, there is no single "right" way to treat and prevent addictions. What is needed is an integrated biopsychosocial, spiritual, holistic approach that respects input from a variety of sources and recognizes that prevention and treatment methods must be individualized according to the needs of the person served, their family, and their community.

[9] Alaszewski & Harrison, 1992; Amodeo & Fassler, 2001

C. Education and Training

Education and training of the addictions workforce follows two paths. One is the training of direct-care counselors and prevention educators, where the emphasis is on preparing individuals for counseling and prevention work in the addictions field; the other is the training of the discipline-specific workforce that contributes to the overall course of treatment.

Many individuals become direct-care counselors as a result of their own experiences with addiction and treatment. Others enter from related fields including counseling, child-welfare, criminal justice, religious service, and the Peace Corps. Regardless of their backgrounds, it is essential, at a minimum, that staff have the benefit of a variety of educational experiences, including course work that leads to becoming a Credentialed Alcoholism and Substance Abuse Counselor (CASAC), a Certified Prevention Professional (CPP), or a Certified Prevention Specialist (CPS). Subsequent training to pursue an Associate's and/or Bachelor's degree also could be encouraged. The lack of academic opportunities to train counselors and prevention professionals is due to the failure of colleges and universities to provide faculty and programs designed specifically to prepare this workforce. The programs as they exist now would benefit from standardization, increased professional recognition, and links with academic institutions. It is imperative that treatment and prevention programs support educational efforts with financial resources, flexible schedules and, upon completion, recognition through salary increases and the assignment of greater responsibility.

A review of the programs that prepare professionals involved in the addictions fields (nurses, social workers, psychologists, physicians, and rehabilitation counselors), has determined that courses in substance abuse and dependence are typically electives, a segmented course, or altogether absent from the curriculum. Across the entire spectrum of professionals, too few faculty members have sound knowledge and skills to teach current students and practitioners core competencies because often educators are not involved in direct treatment, prevention, or research into addictions. Interdisciplinary training is rare in educational institutions due to competition for resources, 'turf' issues, and budgetary allocations. In addition, few academic institutions have linkages with treatment and prevention programs for field education. Yet, the education and training of professionals in health and human services is key to ensuring that high quality addictions prevention and treatment services are provided.

Deficiencies in training and the need to meet state certification requirements have created obstacles to recruiting and retaining a qualified workforce. Training and education in addictions practice are insufficient and vary in quality. This is further hampered by general shortages in critical disciplines, such as nursing and social work. Organizations and institutions that provide education and training need support to build the capacity, interest, knowledge, and skills required to expand the addictions workforce.

D. Recruitment and Retention

The absence of comprehensive educational opportunities and clearly defined entry points into the addictions profession have direct implications for recruitment and retention. While applied learning experiences and specialized graduate training do provide opportunities to recruit students into the addictions workforce, skilled mentors within the student's discipline and in field placement settings are needed. Supervision is crucial for the development of a student's professional identity and skills. Due to the current workforce crisis in all disciplines, there is a deficit of mentors and field placement opportunities.

For the entry-level counselor, the challenges of recruitment and retention are directly related to low salary levels and highly demanding work, coupled all too often with inadequate supervision. Also, there are limited entry-level addictions positions and few career ladders for counselors who enter the field as individuals in recovery, obtain CASAC certification, but pursue no further formal education.

Staff at all professional levels leave the ATOD field because of non-competitive salaries, limited opportunities for advancement, and their perceptions that their work is undervalued. In many addictions treatment and prevention programs, staff spends disproportionate amounts of time on paperwork and regulatory requirements, taking time away from providing direct services. This constitutes a disincentive to seek or continue employment in the addictions field. Professionals who do have the opportunity to play important roles in direct patient care have limited time to take advantage of training and career advancement opportunities.

E. Funding and Advocacy

Additional funding is required for education and training in collegiate settings and for other training and credentialing programs, as well as to provide appropriate compensation across the entire spectrum of health care professionals in the field of addictions services. Insufficient and unstable funding contributes to the inability of the service delivery system to effectively address these issues. Advocacy efforts that focus on building a continuum of academic preparation and staff development are critical to successfully addressing the workforce crisis in New York State.

II. Recommendations

Recognizing that attitudinal changes are needed, enhancement of an interdisciplinary practice perspective is desired, comprehensive recruitment efforts are imperative, enhanced educational and training opportunities are required, and advocacy and funding are necessary to meet the challenges in the ATOD workforce crisis, the following recommendations are proposed.

A. Attitudinal Perspectives

1. Promote evidence-based perspectives supporting the principle that recovery from addictions is possible.

2. Acknowledge that different approaches work better with different patients, in order to provide a wider range of options and a greater possibility of success.

3. Support the differences that exist in the background and training of staff in order to maximize the benefits of a diverse workforce.

B. Interdisciplinary Identity

1. Establish ongoing dialogue and foster cooperation among the diverse professional disciplines that serve people affected by alcohol, tobacco and other drug problems.

2. Develop supportive responses and approaches to care delivery, and integrate the traditional and modern methods of treating addictions.

3. Achieve a policy of mutual respect and cooperation within all treatment settings and disciplines servicing clients.[10]

4. Improve relationships and increase dialogue and collaboration among the research, education, and practice communities.

[10] Humphries, 1993

C. Education and Training

1. Forge partnerships among academic institutions, professional schools, and training providers to develop professional training programs in addictions services. A comprehensive approach would include integrated content as well as specialized courses.[11] Course work should address not only the skills necessary for assessment, treatment, and prevention, but also federal, state and local policy as it impacts the provision of these services.

2. Expedite the entry of professionals into this field by providing opportunities for students to work simultaneously toward Associate's, Bachelor's or Master's degrees, and certification.

3. Provide support to educational institutions that set a major goal of having on staff at least one full-time faculty member who specializes in addictions treatment and prevention and/or research.

4. Provide links between institutions of higher learning and training providers in order to share expertise.

5. Develop standardized guidelines across all licensed facilities for student experiences, appropriately supervised by members of each student's discipline.

6. Promote the acceptance of interdisciplinary education as preparation for knowledge and skills in addictions care.

7. Educate health care professionals about the range of treatment modalities, including 12 Step and self-help programs, the comprehensive therapeutic community technique, family therapy, counseling, cognitive-behavioral therapies, relapse prevention, psycho-education, and medication for addictions treatment.

8. Examine existing methods of financing education and training, so that agencies, universities, and other institutions share more equitably the costs, allocation of personnel, and institutional overhead needed to support the professional advancement of the workforce.

[11] Gassman, Demone & Albilal, 2001

9. Appoint to the IPDA board a liaison from the New York State agency, who is involved in graduate level curriculum development for all of the disciplines that work in the field of addictions. This person would work with the board to articulate the content, concepts, and issues that should be integrated into the curriculum, for which IPDA and OASAS would advocate.

D. Recruitment and Retention

1. Conduct a study to identify the factors that influence people to choose the ATOD field, the reasons staff migrate from one agency to another, and the factors that cause staff to leave the field entirely.

2. Implement a multi-disciplinary recruiting and retention initiative that begins at the earliest stages of career decision-making and provides applied learning opportunities, training, and career advancement.

3. Design marketing plans to enable key staff representing cross disciplines to conduct presentations at high schools, colleges, graduate schools, credentialing training sites, and career/job fairs.

4. Provide opportunities for staff to enhance their skills in the area of clinical supervision to ensure that adequate oversight is provided to maintain performance levels and retain staff.

5. Encourage experienced clinicians in the field of addictions treatment and prevention to provide the supervisory services required for training and certification.

E. Funding and Advocacy

1. Form an advocacy coalition that includes IPDA, the Alcohol and Substance Abuse Providers (ASAP) of New York State, and the Office of Alcoholism and Substance Abuse Services (OASAS), as well as related organizations – such as the National Association of Social Workers (NASW), the Association of Nurses in Substance Abuse (ANSA), the Association of Vocational Rehabilitation in Alcoholism and Substance Abuse (AVRASA), the Committee of Methadone Program Administrators (COMPA), the International Nurses Society (IntSA), and the American Society of Addiction Medicine (ASAM) – to educate the Governor, State Legislature, and behavioral health care associations about the need to increase funding and reimbursement for substance abuse programs and the services provided. Funding could be used to provide salary increases for current and future employees. This funding also should include institutional costs (administration, faculty, and training provider salaries), as well as student and intern scholarships and living stipends. These funding streams should be

made permanent to ensure the continuation of substance abuse training.

2. Formulate advocacy efforts directed to health care professional associations and New York State agencies to provide on-site consultation and technical support to schools, departments, and training providers. Their efforts will be directed toward improving, developing, and integrating substance abuse course content, and designing specialized programs and credentialing tracks for students and interns.

3. Dialogue with educational agencies to develop and implement standards for addictions content, which would be integrated into Associate's, Bachelor's, Master's, Doctoral, and credentialing training programs. They also should be urged to increase funding and implementation of training grants for educational programs affiliated with both academic institutions and service providers.

4. Create coalitions to establish standards for education and practice, and/or identify groups that have done so, and improve recruitment and educational agendas.

III. Conclusion

Labor projections forecast worsening shortages in many of the health care professions, which will have a direct negative impact on the delivery of substance abuse services.[12] The range of initiatives proposed here by IPDA is designed to promote the development of a well-trained, effective professional workforce. Improvements in attitudinal perspectives, the use of interdisciplinary approaches, enhanced recruitment and retention strategies, expanded educational and training opportunities, promotion and funding of addictions-specific research, and ongoing advocacy – together with the requisite funding – will facilitate the growth and effectiveness of the workforce, as well as the retention of established professionals in the addictions field. By strengthening and supporting the New York State ATOD field across disciplines, treatment and prevention agencies will be able to provide more effective services to all individuals and families affected by substance use disorders.

[12] Strategic Plan for Interdisciplinary Faculty Development, Hack and Hoover

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