

Regular article

A national study of the substance abuse treatment workforce[☆]

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Abstract

This study's purpose is to gain a current perspective on the substance abuse treatment field's workforce. The data are from the Retrospective Study of treatment professionals designed to document how the Treatment Improvement Protocols published by the Center for Substance Abuse Treatment have influenced the implementation of best practices. The Retrospective Study consisted of a two-wave cross-sectional survey with telephone follow-up. Data for this study were from demographic information on Wave 1 study participants, which had a response rate of 80.1% ($N = 3,267$). The results of the study showed that most treatment professionals are White (84.5%) and middle-aged (i.e., between 40 and 55 years old) and slightly more are female (50.5.0%) than male (49.5%). Treatment professionals tend to enter the field and stay in it, and almost 80.0% of respondents possess a bachelor's degree or higher. In addition, most treatment professionals are licensed or certified and treat clients from different racial and ethnic backgrounds than themselves. Implications for the provision of treatment services are discussed. © 2003 Elsevier Science Inc. All rights reserved.

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1. Introduction

Individuals with drug and alcohol dependency problems rely heavily on treatment staff (i.e., program counselors and clinical supervisors) to provide them with high quality, effective services. Because of this reliance, clients need to know that the staff who will treat them are qualified and responsible. Very few studies have been conducted regarding the background and qualifications of treatment staff. Because limited data exist regarding the qualifications of the substance abuse treatment workforce, it is difficult to provide accurate information regarding the qualifications of treatment staff to clients seeking treatment. The potential for publicly accessible data to contribute to clients' knowledge and understanding of the treatment workforce's qualifications is substantial. Knowledge of a practitioner's

educational background and experience in the substance abuse treatment field can contribute to a client's decision making regarding which treatment services will best meet his or her needs. Furthermore, knowledge of a practitioner's qualifications helps the client to trust the practitioner. For these reasons it is important to make access to this type of data readily available to both the private and public sectors.

To determine what is already known about professionals who provide substance abuse treatment services, the authors examined literature that presented staff characteristics (e.g., demographics, required education, years of experience, place of employment) for eight core disciplines that make up the substance abuse treatment field (i.e., counseling, psychiatry (including psychology), psychiatric nursing, social work, guidance counseling, school psychology, marriage and family therapy, and psychosocial rehabilitation) (Brown, 1996; Lewin Group, 1999; Peterson, et al., 1995, 1998).

Most relevant to the current study is previous research conducted on the staff characteristics for the first core discipline of the substance abuse treatment field, that of addictions counseling. Brown (1996) noted that the majority of addictions counselors are para-professionals. The term "para-professional" counselor usually (but not always) mean an ex-addict counselor. Brown also found that because

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the treatment community relied heavily on the skills and efforts of para-professional, para-professional staff members, values were dependent on their personal experiences as ex-addicts rather than their educational achievements. Consistent with Brown's claims, individuals who hold a bachelor's degree, or less, but who have extensive work experience in human relations, make up the majority of treatment staff. Price and D'Aunno (1992) provided educational data on 44% of a national sample of the workforce, of which 23% possessed college degrees and 21% had something less than a college education (e.g., a high school diploma). Similarly, a report by Mulligan, McCarty, Potter, and Krakow (1989) found that of the 55% of alcohol and drug abuse counselors in Massachusetts who were surveyed, 34% had college degrees and 21% had less than a college education.

Previous research also provides information on the job titles of individuals working in substance abuse treatment programs. The Substance Abuse and Mental Health Services Administration (SAMHSA, 1993) conducted a national survey of all known treatment programs and found that 36% of full-time staff other than nurses (9%), social workers (6%), or psychologists (4%) were counselors. Administrative staff made up 26% of the full-time category and 18% practiced in "other" direct care. Brown (1996) found that these figures have remained relatively the same as figures from surveys done almost 20 years earlier.

More recent research provides evidence of the amount of time substance abuse treatment counselors have worked in their current positions, that is, counselor turnover rates (Carise, McLellan, Gifford, & Kleber, 1999; Carise, McLellan, & Gifford, 2000; Carise, Gurel, Kendig, & McLellan, in press; Finney, Ouimette, Humphreys, & Moos, 2001; Lamb, Greenlick, & McCarty, 1998). Having staff remain in their jobs over an extended period of time is important for consistency in service and has been found to lead to better treatment outcomes (Lamb et al., 1998). Much of the data available on staff turnover rates was gathered as part of other research programs and therefore does not appear in the available literature (e.g., Carise et al., 1999, 2000, in press; Finney et al., 2001). In addition, many findings regarding staff turnover rates are inconsistent. For example, the State of Wisconsin recently completed a review of that State's workforce and found that the average time counselors have worked in their current positions is 4 years (A.T. McLellan, personal communication, July 2002). Conversely, Finney et al. (2001) found that counselors working in programs sampled for their research for the Veterans Administration (VA) had been working for their current programs an average of 12 years. Finally, work conducted for the Drug Evaluation Network System (DENS) discovered that counselor turnover was as high as 49% in 6 months (Carise et al., 1999, 2000). Although different samples and sample sizes were used in these studies, the clear inconsistency in results indicates that the issue of staff turnover in the substance abuse treatment field requires further investigation.

In summary, previous research provides a snapshot of who, in the past, treated clients seeking substance abuse treatment services. Although this research sheds light on the background and qualifications of the substance abuse treatment workforce, much of it is out of date (i.e., most previous research was conducted in 1996 or earlier), and more recent studies provide inconsistent findings. As a result, the purpose of this study is to provide current data on the demographics, education levels, and employment histories of the professionals working in State recognized treatment programs operating in the United States. The current study also provides a comparison between the demographics of the substance abuse treatment providers and the demographics of the clients they serve.

2. Materials and methods

2.1. Overview of study design and research procedure

The workforce study data are drawn from the Retrospective Study of treatment professionals, that is, Single State Agency (SSA) directors, facility directors, clinical supervisors, and program counselors). This study was designed to document the extent to which the Treatment Improvement Protocols (TIP) series, which are best practice guidelines developed through a field consensus process and published by the Center for Substance Abuse Treatment (CSAT), has influenced the substance abuse treatment field (CSAT, 2000). The Retrospective Study employed a two-wave cross sectional survey with telephone follow-up to determine treatment professionals' awareness of, attitudes toward, and practices (i.e., uses) regarding the TIP series.

The workforce data were obtained from information provided on the Wave 1 survey. Wave 1 surveys were mailed to a random sample of 4,200 facility directors, clinical supervisors, and program counselors working in State-recognized substance abuse treatment programs listed in the National Master Facility Inventory (NMFI). Surveys were also mailed to all 57 SSAs. Each State has its own SSA director. The other seven SSA directors are from Washington, D.C., the U.S. territories that have Single State Agencies (Puerto Rico, Virgin Islands, American Samoa, Guam, and Northern Mariana Islands), and the independent State of the Republic of Palau. Two independent States with which the United States has agreements (Micronesia and the Marshall Islands) were not included because their agreements were set to expire during the course of this study.

In addition to the mailed survey, respondents were offered the opportunity to respond to the surveys electronically. In the instructions for the mailed survey, respondents were alerted to the option of responding on-line. Anyone who selected this option was instructed in how to access the survey through a Web site and was given a user name and password. Respondents were also instructed to enter the six-digit number printed on the top of each survey that was used

as each respondent's unique identifier. The response fields for the on-line survey were linked directly to the response database so that responses of individuals who answered on-line were immediately written into the database.

2.2. Data collection instruments

The survey instrument was designed to address treatment professionals' awareness of, attitudes toward, and uses of the TIP series. Separate versions of the questionnaire were created for each target audience, so that the wording of some questions and response categories could be modified slightly to be the most appropriate for each audience—SSA directors, facility directors, clinical supervisors, and program counselors. In the questionnaires, response sets were organized to make it easy to answer each question. For example, screening questions were used to move respondents through the questionnaires quickly by allowing them to skip categories of questions they did not need to answer. An effort was made to make maximum use of skip patterns to help shorten the instrument, and each question (and skip pattern) was accompanied by a clear set of instructions for completion or implementation.

In addition to asking respondents about their knowledge of, attitudes toward, and practices regarding the TIP series, the Wave 1 survey collected respondents' personal characteristics data. These data included traditional demographic information (e.g., age, race, and gender), experience data (e.g., certifications and years in the job), personal assessment data (e.g., how likely they were to adopt an innovation before colleagues did), and organizational data (e.g., type of organization and number of staff). To minimize the response burden on participants, questions addressing basic organizational characteristics, such as the treatment modality and primary treatment population, were omitted from the survey, and these data were obtained from the 1997 Uniform Facility Data Set (UFDS). Facility data were kept in a separate file and merged with the questionnaire responses for analyses.

Workforce data for this study are drawn from the Retrospective Study Wave 1 survey instrument. Specifically, treatment professionals' demographic, experience, personal assessment, and organizational data were obtained. This information is used to understand the background and qualifications of the population of treatment professionals.

2.3. Sampling procedure

The chosen sampling universe included CSAT's four major target audiences—that is, the populations of (a) SSA directors, (b) facility directors working at State-recognized treatment facilities listed in the National Master Facility Inventory (NMFI), (c) clinical supervisors working in State-recognized treatment facilities listed in the NMFI, and (d) substance abuse treatment program counselors working in State-recognized treatment facilities listed in the NMFI.

The decision regarding the appropriate sampling procedure was based on an understanding of the composition and characteristics of the four target populations. The entire population of SSA directors was contacted because there was no efficiency to be gained in sampling SSA directors (total population of 57). In contrast, a sample needed to be drawn for facility directors and clinical supervisors, with an estimated population of 10,700 (one per facility), and for program counselors (an estimated five per facility). Additionally, a power analysis determined that samples of approximately 1,300 facility directors, 1,300 clinical supervisors, and 1,600 program counselors were needed to achieve the desired precision in the survey. As a result, sampling was accomplished by surveying the entire population of SSA directors and by drawing three successive samples without replacement from the list of State-recognized treatment facilities in the 1997 National Facility Register (NFR) and then targeting the facility director, the clinical supervisor, or a program counselor working at these facilities. The total sample for Wave 1 of the Retrospective Study was thus 4,257 potential respondents.

2.4. Data collection procedure

The data collection procedure was organized on a sequence of contacts with the four target audiences of SSA directors, facility directors, clinical supervisors, and program counselors. Each step included plans for the initial contact and for tracking the results of that contact. These steps were designed to monitor the response and determine what follow-up was required to obtain the desired response rate. The following subsections specify how the mailings and follow-ups were conducted.

2.4.1. Conduct initial and follow-up mailings

Once appropriate samples were drawn, the Retrospective Study was implemented in September 1998. An introductory letter was mailed 2 days before the questionnaire packages were mailed to the potential respondents in the three facility-based target audiences. The introductory letter was signed by the SSA director of the State in which the respondent's facility was located. The letter explained that the questionnaire would arrive in a few days, discussed the significance and importance of the study, and encouraged the subject to respond to the survey. This letter, which was printed on the stationery of the endorser (i.e., CSAT), was prepared and mailed by the contractor responsible for conducting the study. The contractor's toll-free ("800") number was included for respondents' questions.

The questionnaire package consisted of the questionnaire and a cover letter from CSAT's Acting Director referring to the introductory letter, explaining the purpose of the survey, encouraging a response as soon as possible, ensuring confidentiality, and offering the toll-free number in case any questions arose. All letters were addressed to the facility director by name or to "current director." In one-third of the

letters, the director was asked to complete and return the survey. In another third, the facility director was asked to forward the survey to the facility's supervisor of clinical services (or an equivalent person) and to encourage that person to complete and return the survey. In the final third of the letters, the facility director was asked to determine which program counselor's surname was listed first alphabetically among the staff, and to forward the survey to that counselor to complete and return. The facility director was also asked to complete and mail an enclosed addressed, stamped postcard identifying the supervisor or counselor by name, in order to contact with the supervisor or counselor if follow-up was required. Each package contained a pre-paid, pre-addressed return envelope for the respondent to use. Each questionnaire was assigned a unique six-digit code that was entered into a tracking database. As responses were received, the information was entered into the system.

Two weeks after the initial mailing, all respondents were sent a reminder postcard. The card thanked those who had already responded and asked those who did not respond to complete the questionnaire and return it as soon as possible. It also asked those who had lost or misplaced their questionnaire to call the "800" number for a replacement. Requests for replacements were sent within 48 hr.

Four weeks after the initial mailing, a replacement questionnaire was sent to those who had not responded. These potential respondents were identified through the tracking system. This package contained the same items as the first package with the exception of a new cover letter. The new letter explained that the questionnaire had not been returned, and that a replacement was being provided for the convenience of the participant in case the original was lost or misplaced. Participants were also reminded that the questionnaires could be completed on-line via the Internet.

2.4.2. Conduct telephone follow-up

Two weeks after sending the replacement questionnaire, telephone contact with those who had not responded to the replacement questionnaire began. A maximum of six attempts to contact non-respondents were made. Follow-up callers were trained in a protocol designed to aid respondents by enabling callers to answer any questions regarding the questionnaire and to encourage the completion of the survey. Follow-up callers also collected data on the reasons for not responding and barriers to completing the survey. Once callers made personal contact with an individual, follow-up calls to that individual ceased. To ensure the quality of the calls and that the proper protocol was followed, supervisory staff monitored calls on a random basis.

2.5. Response rates

The data collection procedure discussed above resulted in an overall response rate of 80.1% for the Wave 1 survey. By target population, 81.5% of the facility directors, 79.9% of the clinical supervisors, 79.1% of the program counselors, and

80.4% of the SSA directors returned completed the Wave 1 survey. The response rate is directly attributed to several factors, including using the Total Design Method (TDM), using the mixed mode survey, providing the contractor's "800" number, and the effectiveness of follow-up calls.

The tendency in survey research is to hire temporary employees or graduate students to make follow-up calls. Many researchers believe that all follow-up callers are equally effective provided they are trained in using a script; this assumption proved not to be true. A trained actor was hired to make the majority of the follow-up calls. His communication skills as an actor, his ability to listen critically, and his sensitivity to the nuances of human interactions led him to be far more successful in persuading people to respond than any of the other callers. Instead of badgering potential respondents, he talked with them and gained their trust. He answered their questions about the survey and addressed their concerns. His willingness to spend time with potential respondents was a big factor in his success.

Before follow-up calls began, the response rate was 49.4%; after follow-up calls were completed the response rate was 80.1%. Clearly, follow-up calls made a difference. Together, the data collection strategies provided a way for the target audience to have its questions answered and facilitated completion of the survey by enabling respondents to complete the survey in the medium, and at the time, that was most convenient to them.

The rigor in the developmental and implementation phase of the study, as well as an overall response rate of 80.1%, provides CSAT with the confidence to generalize the results of the workforce study to the administrators and treatment providers working in Federal and State recognized treatment facilities.

3. Results

3.1. Overall sample characteristics

The sample consisted of 3,267 respondents from a random sample of treatment professionals. Of the respondents, 36.9% were program counselors, 31.4% were facility directors, 30.3% were clinical supervisors, and 1.4% were SSA directors. Females made up 50.5% of the respondents. Of the treatment professionals, 5.6% were Hispanic. Of those who were not Hispanic, 84.5% were White, 10.8% were African American, and 3.5% were Native American/Alaska Native. More than half the respondents (60.4%) were between the ages of 40 and 55.

3.2. Experience data

As indicated in Fig. 1, 86.1% of the treatment professionals who answered the Wave 1 survey had worked in the substance abuse treatment field for 5 years or more. In

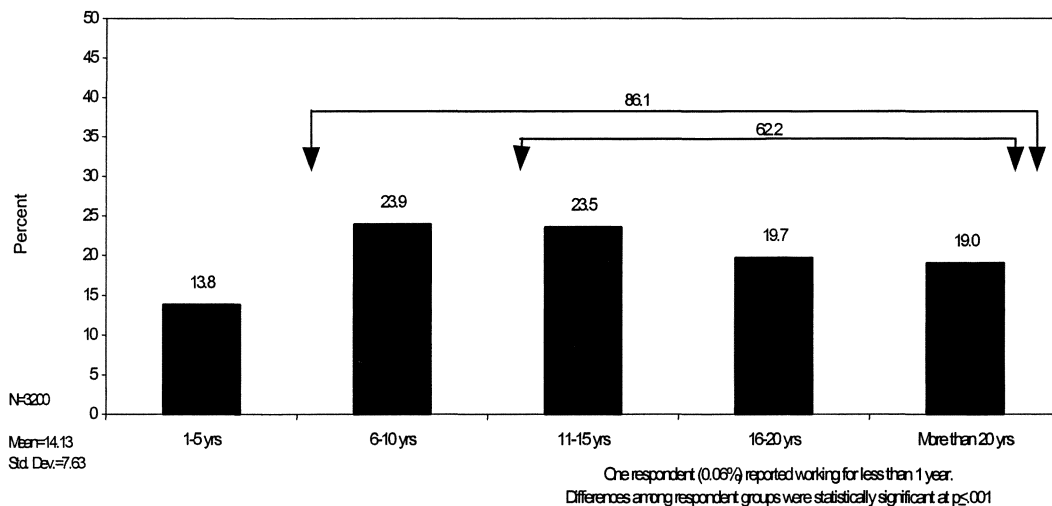


Fig. 1. “For how many years have you worked in the field?”

addition, 62.2% of respondents had worked in the substance abuse treatment field for more than 10 years, a trend indicating that substance abuse treatment professionals enter the field and remain in it.

Although treatment professionals tend to enter the substance abuse treatment field and stay in it, they tend to move from facility to facility. Half (50.8%) the treatment professionals who responded to the Wave 1 survey worked in their current position (i.e., at their current facility) for 5 years or less (see Fig. 2).

Overall, the sample of treatment professionals was well educated. Most respondents possessed at least a bachelor’s degree (79.9%); 48.6% of those individuals possessed master’s degrees, and 7.4% held doctorate degrees. Looking at education by respondent group, SSA directors, facility directors, and clinical supervisors tend to have higher levels of education than do program counselors. Over half the SSA directors (81.8%), facility directors (64.0%), and clinical supervisors (60.6%) have graduate degrees, whereas only

41.8% of program counselors have a master’s degree and none of the program counselors have doctoral degrees. Program counselors are well educated—74.0% have at least a bachelor’s degree. In addition to their formal education, 72.0% of the treatment professionals who answered the survey were certified as drug and alcohol counselors. The majority of facility directors (68.9%), clinical supervisors (77.5%), and program counselors (72.0%) were certified or licensed as substance abuse/mental health professionals, whereas only 20.9% of SSA directors were certified or licensed. This should not be surprising, because most of the SSA positions involve political appointments by the governor of the state.

3.3. Comparison of staff demographics and client characteristics

When the demographics of substance abuse treatment professionals are compared with those of the general popu-

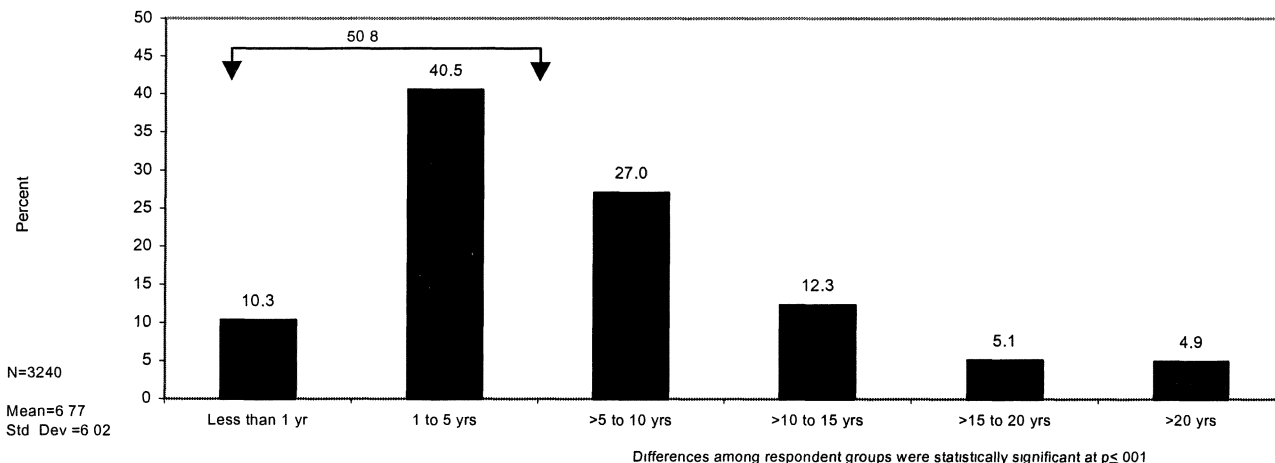


Fig. 2. “How long have you worked at this facility?”

Table 1
Comparison of demographic data for three populations^a

	General population (<i>N</i> = 270,933)	Treatment providers (<i>N</i> = 3,267)	Treatment clients (<i>N</i> = 929,086)
Male	49.0%	49.5%	68.0%
Female	51.0%	50.5%	32.0%
Hispanic	11.4%	5.6%	14.3%
Non-Hispanic	88.6%	94.4%	85.7%
White	72.1%	84.5%	56.5%
African American	12.1%	10.8%	24.9%
Asian / Pacific Islander	3.7%	1.5%	0.8%
American Indian / Alaska Native	0.7%	3.5%	2.6%

^a The general population data were obtained from the 1998 U.S. Census Bureau Estimates (U.S. Census Bureau, 2000), the treatment provider data were obtained while conducting the described study; and the treatment client data were obtained from the 1997 UFDS (Office of Applied Studies, 1997) data. All data presented in this table were obtained by Federal Government efforts and, consequently, are in the public domain.

lation and with the clients they serve, some interesting trends emerge. As indicated in Table 1, the staff of the programs generally reflect the gender, race, and ethnic diversity of the general population; however, they do not reflect the characteristics of the population they serve. Half the substance abuse treatment professionals are female (51.0%), whereas 68.0% of the clients they serve are male. Similarly, the majority (84.5%) of treatment professionals are White, whereas only 56.6% of the clients are White.

4. Discussion

During the 1980s and 1990s many people in the field believed treatment staff were para-professionals who did not possess a formal education. Instead, treatment professionals had the requisite experience of “having hit bottom” and finding recovery. Because they were in recovery themselves, it was believed they could meet the needs of their clients. Today, substance abuse treatment professionals are more educated than was thought (i.e., 79.9% of treatment professionals have at least a bachelor’s degree, and 48.6% have master’s degrees). The study results also indicate that licensure and certification of treatment staff have made their way into the substance abuse treatment field. The impetus for these significant changes may be the advent of managed health care. To bill third parties, programs are required to have credentialed staff. This trend is likely to continue with the development and implementation of accreditation bodies. Also, despite that 72% of staff are currently certified and/or licensed as substance abuse professionals, only 20% of those responsible for directing the state network of providers (i.e., SSA directors) are currently certified or licensed. This situation poses a challenge that must be addressed from a national perspective. One possibility that could help to rectify this is to provide “in-

service orientations” via a variety of mechanisms to meet the needs of new SSAs.

In addition to the change in education, there has been, as with other areas of employment, a “graying” of the substance abuse treatment workforce. As these data indicate, the majority of treatment professionals are between the ages of 40 and 55. There is a need to infuse the system with younger adults. As the number of individuals seeking treatment services increases, the need for qualified treatment staff increases as well. Unless the field encourages young people to become substance abuse treatment counselors and mitigates the stigma that carries over to the staff working with the substance abusing population, the substance abuse treatment field will face a critical staff shortage.

Finally, treatment professionals are generally not from the same ethnic and racial backgrounds as the clients they serve. This situation presents a tremendous challenge to the field. In an age in which providers are striving to provide culturally competent services, it would be ideal to have treatment staff who are representative of the populations they serve. Currently, this is not the case. Clearly, there is a need for a system of care that is culturally competent in its treatment approach. Thus, programs must make it a priority to train staff to ensure the delivery of culturally competent approaches to recovery. To be truly effective, these trainings need to be supported at all levels of government as well as within the public and private substance abuse treatment industry.

In conclusion, a number of findings from this study are particularly helpful to the substance abuse treatment field and have implications for how the workforce might develop in the future. Specifically, this study identified changes in the substance abuse treatment field regarding the educational attainment and certification of treatment professionals. Treatment staff now have higher levels of education and are licensed and/or certified as alcohol and drug abuse counselors at higher rates than previously known. According to this study, individuals who choose to work in the substance abuse treatment profession stay in this field for quite a long time; however, staff turnover at agencies seems to be the norm. A key finding of this study was that the racial and ethnic make-up of the treatment staff does not resemble that of the treatment community they serve—a finding that may directly impact the client needs being met. Finally, the study found that the graying of substance abuse treatment staff will cause a critical shortage of substance abuse treatment professionals in the next 10 years. It is in the best interest of this field to encourage young people seeking a service profession to consider careers in substance abuse treatment.

Thus, the substance abuse treatment field must focus on continuing treatment professionals’ exposure to new treatment techniques through courses offering continuing education units. Agencies and programs should incorporate ongoing in-service trainings to ensure high quality care during staff turnover periods. Programs must also provide

practitioner trainings to ensure culturally competent services are delivered.

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