White Paper on California Substance Use Disorder Treatment Workforce Development

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WHITE PAPER ON CALIFORNIA SUBSTANCE USE DISORDER TREATMENT WORKFORCE DEVELOPMENT

EXECUTIVE SUMMARY

Traditionally, substance use disorder (SUD) services have been delivered in isolation from the rest of health care, with a paraprofessional treatment staff, different treatment philosophies, different sources of funding, and different expectations for treatment than the rest of the healthcare system. In the past two decades, this has begun to change, as increasing numbers of formally trained clinicians have entered the SUD workforce and begun providing more evidence-based treatments. With the enactment of legislation mandating parity in insurance coverage for SUD with the treatment of other medical conditions and the growth of the insured population under the Affordable Care Act, trends toward the professionalization of the SUD treatment field will accelerate in the next few years.

As SUD services are increasingly integrated into primary care settings in the coming years, providers will need to evolve from being SUD providers (who deliver services only to address SUD) into *behavioral health specialists*—providers who deliver services to address SUD, mental health, and the management of associated medical conditions. Thus, in the future, California's SUD workforce will be bifurcated into two distinct *workforces*—one that treats acute SUD in the specialty care system and another that provides integrated behavioral health services in general medical settings.

It is important to note that this White Paper is focused on the workforce development needs for the *treatment* of substance use disorder. It does not address the needs of the

primary prevention workforce, which will be equally as important as the implementation of ACA and its focus on primary prevention.

Key Issues in developing the workforce for the future.

- It is difficult to precisely measure the quantity or quality of California's current SUD workforce. Two challenges inhibit a thorough assessment of the California SUD workforce's capacity: (1) the lack of any comprehensive data concerning the California SUD workforce's size and composition, and (2) the lack of any comprehensive assessments measuring the California SUD workforce's professional capacity. Nonetheless, various data sources do give some insight into the size, composition, and professional capacities of the state's SUD workforce. Available data indicate that the SUD workforce in California is lacking in both quantity and quality; it is undersized and undereducated and lacks critical skills for implementing evidence-based SUD services in specialty care and for providing behavioral health services in primary care settings.

- The specialty SUD workforce of the future will need to have an adequate understanding of: (1) a basic minimum of professional knowledge, skills, and attitudes needed to provide SUD treatment; (2) recently developed evidence-based practices for SUD treatment; and (3) how to provide appropriate recovery support services. In order to achieve these ends, the California Department of Health Care Services (DHCS) needs to take steps to improve the recruitment and retention of qualified and skilled providers in the SUD workforce.

- To survive and thrive in the integrated behavioral health workforce of the future, SUD providers will need to adapt to working in new clinical roles and develop a new set of clinical and professional competencies. These individuals will need considerable knowledge and skills about working within medical settings and working as part of a comprehensive healthcare team, and they will need a solid foundation in addressing a wide range of mental health and other behavioral conditions.

- Negative attitudes and knowledge gaps concerning substance use conditions among medical and mental health providers working in primary care settings need to be addressed in order to ensure that patients receive appropriate services for substance use conditions.

Recommendations

1. DHCS should conduct a thorough and comprehensive assessment of the California SUD workforce's size, composition, and professional capacity in order to guide future workforce development planning and activities.

2. The State should expand existing training and technical assistance services to ensure that the SUD workforce develops capacity in areas that are critical to providing comprehensive and evidence-based SUD treatment. These activities should be designed to prepare two distinct workforces—one that will continue to work as SUD providers in specialty treatment settings and another that will evolve into integrated behavioral health (IBH) providers in medical settings. While

expanding the workforce, it is also critical that DHCS ensures that SUD and IBH providers are reimbursable.

3. The State should develop strategies to increase compensation for the SUD treatment workforce.
4. The Substance Abuse and Mental Health Service Administration (SAMHSA) career ladder for SUD counseling should be implemented in California.
5. DHCS should collaborate with institutions of higher education to increase recruitment and properly train the SUD workforce.
6. DHCS and providers of SUD services across California should make a concerted effort to recruit young individuals, males, and racial/ethnic minorities into the SUD workforce. Fewer members of these groups are involved, and generally it is preferable for clients to receive treatment from individuals who are of similar age, gender, and racial/ethnic background.
7. DHCS should train medical and mental health professionals working in integrated care settings on the basics of substance use and SUD, and their impact on health.

I. Background and Context: The Professionalization and Bifurcation of the SUD Treatment Workforce

Overview

Traditionally, substance use disorder (SUD) services have been delivered in isolation from the rest of health care, with different treatment staff, different treatment philosophies, different sources of funding, and different expectations for treatment. In the past two decades, this has begun to change, as increasing numbers of formally trained clinicians have entered the SUD workforce and begun providing more evidence-based services. With the enactment of legislation mandating parity in insurance coverage for SUD with the treatment of other medical conditions, as well as the growth of the insured population under the Affordable Care Act, trends may encourage a more professional workforce for SUD specialty services.

Furthermore, as SUD services are increasingly integrated into primary care settings in the coming years, providers will need to evolve from being SUD providers (who deliver services only to address SUD) into *behavioral health specialists*—providers who deliver services to address SUD, mental health, and the management of associated medical conditions. Thus in the future, California's SUD workforce will need to become two distinct *workforces*—one that treats acute SUD in the specialty care system and another that provides integrated behavioral health services in general medical settings.

The Ongoing Professionalization of California's Substance Use Disorder (SUD) Treatment Workforce

Historically, most SUD services in California have been delivered in standalone nonprofit or government-run treatment agencies that were isolated from the rest of the healthcare system.[1] Physicians and other health professionals received minimal to no addiction education or training and generally had not been involved in the care of SUD patients. SUD services operated outside of the medical field. Staff employed in SUD treatment settings were usually addiction counselors who made key decisions related to SUD treatment admission, planning, and discharge without input from physicians or other formally trained medical professionals.[2] Most addiction counselors organized their programs around self-help, mutual aid, and 12-step principles.[3] Often, counseling consisted of encouraging clients to engage with 12-step programs such as Alcoholics Anonymous and Narcotics Anonymous; little was done to treat SUD with psychological, psychiatric, or medical interventions.[4] SUD providers and the medical field generally did not accept that relapse is part of the natural course of chronic conditions such as substance dependence, or that disease management strategies are necessary to ensure sustainable SUD treatment outcomes.[5]

The SUD workforce has begun to evolve over the past 25 years, becoming increasingly formally trained in using evidence-based strategies and methods adapted from other health disciplines. In the 1990s, an increasing number of academically trained

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[1] Jeffrey A. Buck, "The Looming Expansion and Transformation of Public Substance Abuse Treatment Under the Affordable Care Act." *Health Affairs (Millwood)* 2011;30(8):1402-1410; David R. Pating, Michael M. Miller, Eric Gopelrud, Judith Martin, Douglas M. Ziedonis, "New Systems of Care for Substance Use Disorders: Treatment, Finance, and Technology Under Health Care Reform" *Psychiatric Clinics of North America* 2012;35:327-356.

[2] A. Kennison Roy III & Michael M. Miller, "The Medicalization of Addiction Treatment Professionals" *Journal of Psychoactive Drugs* 2012;44(2):107-118; National Center on Addiction and Substance Abuse, *Addiction Medicine: Closing the Gap Between Science and Practice.* New York: The Author, 2012: Buck, "The Looming Expansion"

[3] Buck, "The Looming Expansion"; Roy & Miller, "The Medicalization of Addiction Treatment Professionals"

[4] Ibid.

[5] Ibid.

master's-level addiction therapists began entering the SUD workforce. These providers, who had a strong background in developmental psychology and mental health treatment, began utilizing more sophisticated interventions that were tailored to individual client needs.[6] In particular, SUD clinicians with backgrounds in behavioral psychology created therapeutic modalities (e.g., motivational interviewing, cognitive behavioral therapy, contingency management) that utilized proven psychological and counseling techniques to achieve and maintain positive SUD treatment outcomes. The subsequent development of new SUD medications (e.g., naltrexone, buprenorphine) also helped facilitate an increased presence of physicians in the provision of SUD services in recent decades.[7]

These trends have been buttressed by concerted efforts at the federal and state levels to bring the quality of SUD services up to that expected in the rest of health care. Since 1993, the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (CSAT) has sponsored a network of Addiction Technology Transfer Centers (ATTCs) to enhance professional development among the SUD workforce.[8] In California, the California Department of Alcohol and Drug Programs has disseminated knowledge of best practices in SUD treatment and facilitated their implementation in clinical settings across the State.

Increased Demand for SUD Treatment as Part of Medical Care

Recent changes in healthcare policy will accelerate the integration of the SUD treatment field with the rest of the medical system in California, while expanding service

[6] Ibid.
[7] Joan DiLonardo, *Workforce Issues Related To: Physical and Behavioral Health care Integration, Specifically Substance Use Disorders: A Framework*. Paper developed for joint ONDCP/SAMHSA/HRSA meeting, Washington D.C. August, 2011.
[8] Center for Substance Abuse Treatment, *Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice.* Technical Assistance Publication (TAP) Series 21. HHS Publication No. (SMA) 08-4171. Rockville, MD: Substance Abuse and Mental Health Services Administration. 2006.

access and utilization. These trends will hopefully compel SUD service providers to enhance their professional competency in order to operate as members of the healthcare workforce.

Several recent pieces of legislation will facilitate the incorporation of SUD treatment services into the rest of the healthcare system. The 2008 Medicare Improvements for Patients and Providers Act (MIPPA), the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA), and the 2009 Children's Health Insurance Program Reauthorization Act (CHIPRA) have brought insurance coverage for substance use conditions in line with that offered for other chronic conditions by reducing co-payments and increasing benefits for SUD treatment. The 2010 Affordable Care Act (ACA) will expand Medicaid coverage to between 149,000 and 195,000 previously uninsured Californians who need access to health care (including SUD treatment),[9] and provide them with access to SUD services as mandated by the MIPPA, MHPAEA, and CHIPRA. It is hoped that a significant number of Californians will be gaining access to SUD services in the near future, and that the treatment they receive will be funded by health insurance rather than block grants or other siloed SUD treatment funds. Overall, it is anticipated that these shifts will require the SUD treatment workforce in California to grow by between 2,100 and 2,828 FTEs by 2019.[10]

The shift in funding for SUD treatment promises to revolutionize the way that SUD services in California are structured and delivered. Whereas in the past most SUD services have been provided by undertrained, uncertified individuals with little training in

[9] Technical Assistance Collaborative & Human Services Research Institute, *California Mental Health and Substance Use System Needs Assessment: Final Report.* Report prepared for California Department of Health Care Services. Boston: Authors, 2012.
[10] Dale Jarvis & John Freeman, *Briefing Paper 4: Workforce Issues Today and in the Future: Workforce Implications of Increased Demand for Mental Health and Substance Use Service.* Paper prepared for California Institute of Mental Health. Seattle, WA: Dale Jarvis and Associates, LLC: 2012.

evidence-based practices, insurers may exert pressure for providers to be properly educated, certified, and able to deliver evidence-based services.[11]

Integration and the Bifurcation of the SUD Treatment Workforce

The ACA will also facilitate the integration of SUD services with other physical and mental health care services in California. The ACA provides incentives for primary care providers to become Patient Centered Medical Homes for patients with chronic health conditions, including SUD. Though there will be some initiatives to co-locate medical providers in specialty SUD treatment settings, the main focus of integration under the ACA will be the integration of SUD service providers into general medical settings. Though individuals with acute and poorly controlled SUD will continue being treated in the specialty SUD treatment system, many believe that patients with mild to moderate substance use conditions or SUD that is well managed will receive services within integrated primary care and other general medical settings.[12]

The providers who deliver SUD services in integrated care settings will need to expand the scope of their work beyond the diagnosis, treatment, and management of substance use conditions. In almost all of California, the integration of SUD services into primary care settings is occurring as part of a broader effort to integrate *behavioral health* treatment—a broad array of services that includes mental health services, SUD services, and services for co-occurring mental health disorders and SUD—into primary care settings.[13] Thus providers who deliver SUD services in integrated primary care settings will need to operate as *integrated behavioral health* (IBH) providers,

[11] Pating et al., "New Systems of Care"
[12] Barbara J. Mauer, *Substance Use Disorders and the Person-Centered Healthcare Home.* Report prepared for the National Council for Behavioral Healthcare. Rockville, MD: National Council for Behavioral Healthcare, 2010.
[13] Howard Padwa, Darren Urada, Valerie P. Antonini, Allison Ober, Desiree A. Crevecoeur-MacPhail, & Richard Rawson. "Integrating Substance Use Disorder Services with Primary Care: The Experience in California" *Journal of Psychoactive Drugs* 2012;44(4):299-306.

professionals who have a different treatment focus and a broader skill set than is needed in specialty SUD treatment settings.

Consequently, California's SUD workforce will become bifurcated in the future, with one group of providers working in specialty SUD settings that serve clients with acute SUD, and an IBH workforce that serves clients in integrated primary care settings, serving clients with a broad array of needs related not only to substance use, but also to mental and physical health. The major differences between the work of specialty SUD treatment providers and IBH providers are illustrated in Table 1:

TABLE 1.
Comparison of Specialty SUD Services and Integrated Behavioral Health

Area	Specialty SUD Providers	IBH Providers
Environment and Pace of Work	Planned and scheduled over several months	Spontaneous and hectic, with interventions lasting 3-5 sessions
Treatment Population	Acute SUD	Behavioral health problems (both mental health and SUD) at varying levels of severity
Treatment Focus	SUD	Interrelated medical and behavioral health problems
Who Provides Services	Individual SUD Provider	Integrated Care Team (including IBH provider)
Billing/Administrative Responsibilities	Only SUD system	Complex interrelationship across diverse policies and billing structures

- *Treatment Environment/Pace of Work:* Traditional SUD treatment tends to occur in relatively small treatment settings with low staff-to-client ratios, and with intensive treatment services being delivered in the 50-minute hour. By contrast, primary care and integrated medical environments where IBH providers work are characterized by a fast pace of brief interactions with patients, a high patient

volume, constant interruptions, and a persistent need to balance immediate needs and priorities.[14]

- *Treatment Populations:* The specialty SUD treatment workforce focuses on serving only individuals with acute substance use conditions who meet moderate and severe diagnostic criteria. IBH providers serve clients with more varied levels of severity (moderate to mild).
- *Expanded Focus of Treatment:* Specialty SUD providers generally provide services that address just one type of disorder (SUD) and at one level of severity (acute). IBH providers, on the other hand, need to be able to work with clients with several types of disorders (SUD and mental health disorders) and varying levels of severity. Compared to SUD providers, IBH providers need to deliver care that is more person-centered and focused on an individual's overall health than it is disease-specific.
- *Team Approach*: In specialty SUD treatment, individual providers play a central role in the planning, organization, and delivery of care. In integrated care settings, by contrast, teams of providers from a variety of medical and behavioral health disciplines deliver services and closely collaborate on treatment planning and service delivery activities. IBH providers need to have the communication skills required to work on teams, as well as a willingness to collaborate with others on patient care that is often not necessary in specialty SUD treatment settings. In addition, they will often be working on teams led by primary care physicians or other medical staff. In particular, medical staff will likely take the lead in organizing and delivering care for patients who have high levels of physical health need or low-level behavioral health conditions. For IBH providers

[14] DiLonardo, *Workforce Issues*

with experience in the SUD system, where they made unilateral decisions about treatment and service delivery without input from collaborators, the adjustment to working as an ancillary team member may be particularly difficult.

- *Billing and Administrative Responsibilities:* With the exception of Drug Medi-Cal services, most SUD services in California have been funded through various block grant, State, and local funds. The majority of behavioral health services delivered in integrated care settings, however, will need to be billed through the same health insurance systems that are used to bill all other medical and behavioral health services. Consequently, IBH providers who shift from specialty SUD settings to integrated care settings will need to become proficient in medical billing and associated policies and administrative responsibilities.

As California plans its SUD workforce development activities in the future, it will need to take the aforementioned differences between specialty SUD care and integrated behavioral health services into account.

Summary

The professionalization and bifurcation of the SUD treatment landscape will have significant implications for the present and future of California's SUD workforce. The specialty workforce will need to rapidly enhance its training, certification, and capacity to provide high-quality, evidence-based services in the specialty SUD treatment sector. Simultaneously, a significant proportion of the SUD workforce may need to develop skills and competencies needed to work as IBH providers, in order to serve new treatment populations in new treatment settings. The needs of the future specialty SUD workforce and the needs of the future IBH workforce are significantly different; this will be discussed in detail Sections III and IV, respectively.

II. The California SUD Treatment Workforce Today

Overview

It is difficult to precisely measure the quantity or quality of California's current SUD workforce. Two challenges inhibit a thorough assessment of the California SUD workforce's capacity: (1) the absence of any comprehensive data concerning the California SUD workforce's size and composition, and (2) the absence of comprehensive assessments measuring the California SUD workforce's professional capacity. Nonetheless, various data sources do give some insight into the size, composition, and professional capacities of the State's SUD workforce. The available data indicate that despite progress, California's SUD workforce faces many challenges that are similar to those faced by the SUD workforce across the nation.

Size

It is challenging to precisely measure the size or composition of California's SUD treatment workforce today.[15] A heterogeneous mix of SUD counselors, social workers, nurses, psychologists, and psychiatrists currently provide services to address SUD in a variety of treatment settings, making it difficult to quantify their numbers or precisely define their scopes of practice. As the authors of a 2012 report prepared for the California Office of Statewide Health Planning and Development's Workforce Investment Board (OSHPD/WIB) concluded, the State's SUD treatment workforce remains "undefined, lacks clear parameters, and cuts across multiple licensed, certified and unclassified professions"[16] that have not been systematically tracked or analyzed. Though it is not currently possible to precisely measure the size or composition of the

[15] University of California, Berkeley, Department of Public Health, *Health Workforce Development Council Career Pathway Sub-Committee: Updated Report.* Report prepared for Office of Statewide Health Planning and Development, California Workforce Investment Board, 2012.
[16] Ibid.

State's SUD workforce, data from several disparate sources can be merged to create a rough estimate of how many individuals are providing SUD services in California, as well as some of their basic characteristics.

According to OSHPD/WIB, there were fewer than 20,000 persons registered as alcohol or drug abuse counselors with the California Department of Alcohol & Drug Programs as of late 2012.[17] Data from the U.S. Bureau of Labor Statistics shows that in 2008, there were approximately 13,400 mental health and substance use social workers in California and 9,500 substance use and behavioral disorder counselors.[18] However, since these categories include both SUD service providers and individuals who do not provide SUD services, it is difficult to use these data to gauge how many SUD social workers or counselors are working in California.

Nonetheless, it is clear that California's SUD workforce is not as large as it should be. According to the 2012 OSHPD/WIB report, California had just 2.01 SUD counselors per 100,000 total population, approximately 8.6% lower than the national average.[19] Furthermore, the State's 2012 Mental Health and Substance Use Needs Assessment reported that there are "very few" board certified addiction psychiatrists practicing in California, and there is a dearth of SUD providers of any sort serving the State's rural populations.[20] Consequently, California's SUD workforce needs to grow and develop greater disciplinary and geographic diversity in order to better meet the SUD service needs of the State's population.

It is particularly critical to increase the size of California's SUD treatment workforce because demand for SUD services will grow dramatically in the coming years. According

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[17] Ibid.

[18] Technical Assistance Collaborative & Human Services Research Institute, *California Mental Health and Substance Use System Needs Assessment*

[19] University of California, Berkeley, School of Public Health, *Career Pathway Sub-Committee Updated Report*

[20] Technical Assistance Collaborative & Human Services Research Institute, *California Mental Health and Substance Use System Needs Assessment*

to estimates from the California Employment Development Department, demand for all categories of mental health and SUD service providers will have increased at least as fast as average compared to other occupations between 2008 and 2018. Demand for many behavioral health professionals—particularly those who work in fields related to the delivery of SUD services—will have accelerated at a significantly more rapid rate than demand for other occupations; demand for mental health and substance use counselors will have increased by 15.7%, demand for substance use and behavioral disorder counselors will have increased by 14.7%, demand for mental health counselors will have increased by 16%, and demand for rehabilitation counselors will have increased by 9.1%.[21]

In all likelihood, these projections underestimate the actual growth in demand for SUD services, as they were made before recent developments that will likely lead to significant spikes in SUD treatment demand. California's 2011 Public Safety Realignment Act (Assembly Bill 109) will increase the number of criminal justice offenders under community supervision, and between 60% and 90% of the offenders being sent back to local communities have SUD treatment needs.[22] Furthermore, the Affordable Care Act will give between 149,000 and 195,000 previously uninsured Californians who need SUD services access to health care (including SUD treatment), thus further driving demand for a larger SUD workforce.[23]

[21] Ibid.
[22] California Mental Health Planning Council, *AB 109 Implementation, The First Year: How Four California Counties Met the Challenges of the 2011 Public Safety Realignment in Their Communities*. Sacramento, CA: The Author, 2011.
[23] Technical Assistance Collaborative & Human Services Research Institute, *California Mental Health and Substance Use System Needs Assessment*

Composition

Though it is difficult to develop a detailed picture of the California SUD workforce, two statewide surveys—one conducted by the County Alcohol and Drug Programs Administrators' Association of California (CADPAAC) in 2007[24], the other conducted by the Pacific Southwest Addiction Technology Transfer Center (PSATTC) in 2011–2012[25]—provide some insight into the California SUD workforce's demographics, makeup, training, and job roles. Both of these surveys have limitations: the CADPAAC survey is over five years old and had a very low response rate; the PSATTC survey did not include detailed information concerning the workforce's job duties or capacities and includes data from Arizona as well as from California. Nonetheless, the data from the two surveys can be triangulated to get a rough picture of the State's SUD workforce (Table 2).

California's SUD workforce is predominantly female, White, and in their 40s and 50s. A significant proportion of the workforce—between 39% and 57%—is personally in recovery from SUD. The workforce is not highly educated, with approximately 40% of SUD workers reporting that they did not earn a college degree, and approximately 10%–20% reporting that they only finished high school or less. Slightly more than one-fifth of California's SUD workforce has graduate degrees, and only 2%–3% of the workforce has a doctoral or medical degree. Approximately half of the workforce has current certification or licensure, and around one-quarter of them have certification or licensure pending. Though the PSATTC data do not provide detailed information on job roles, the CADPAAC survey indicates that the bulk of SUD providers in California are addiction counselors (72.7% of the workforce). Social workers account for 14% of

[24] Pacific Southwest Addiction Technology Transfer Center, *CADPAAC Alcohol and Other Drug Abuse Treatment Workforce Survey.* Survey Analysis and Summary Report prepared for County Alcohol and Drug Programs Administrators' Association of California. Sacramento, CA: Authors, 2009.
[25] Margaret Camarena, *Pacific Southwest ATTC 2012 Regional Workforce Report.* Report prepared for Pacific Southwest Addiction Technology Transfer Center, 2012.

California's SUD providers, psychologists account for approximately 12%, and nurses and medical staff make up just 3%. Thus, in spite of the aforementioned trends that have facilitated an increased role for formally trained mental health and medical professionals in SUD treatment settings, a significant portion of the SUD workforce remains poorly educated, has no advanced training, and lacks appropriate certification.

TABLE 2.
CHARACTERISTICS OF THE CALIFORNIA SUD WORKFORCE

	CADPAAC Survey (2007)	**PSATTC Survey (2012)**
Gender	61.6% Female	67% Female
Race	50.4% White 20.8% Hispanic/Latino 14.7% Black/African American 3.1% Asian/Pacific Islander	77% White 4% Hispanic/Latino 6% Black/African American 4% Asian/Pacific Islander
Age	54.1% in Age Range 41–59	53% in Age Range 35–55
In Recovery from SUD	56.5%	39%
Education	High School or Less: 9.4% Some College: 29% Associates Degree: 14.9% Bachelor's Degree: 17.5% Master's Degree: 18.9% Doctoral Degree: 3.2%	High School or Less: 21% Some College: 19.5% Associates Degree: 13% Bachelor's Degree: 17% Master's Degree: 22% Doctoral Degree/MD: 2%
Certification/Licensing	Never/Not Current: 20.8% Pending: 28.1% Current: 49.4%	Never/Not Current: 9% Pursuing: 23% Pending: 5% Current: 54%
Job Role	Addictions Counseling: 72.7% Social Work/Human Service: 14.0% Psychology: 11.9% Nursing: 2.5% Medicine: 0.5%	N/A

Judging by these indicators, together with findings from other major reports such as the State's 1115 Waiver Mental Health and Substance Use Needs Assessment,[26] OSHPD/WIB's Health Workforce Development Council Career Pathway Sub-Committee,[27] and the 2008 Little Hoover Commission on California's SUD treatment

[26] Technical Assistance Collaborative & Human Services Research Institute, *California Mental Health and Substance Use System Needs Assessment*
[27] University of California, Berkeley, School of Public Health, *Career Pathway Sub-Committee Updated Report*

system,[28] it is clear that California's SUD workforce is understaffed, undereducated, and underqualified.

Training and Technical Assistance Needs

Data concerning the California SUD workforce's professional capacity to deliver evidence-based care across the continuum of SUD services are sparse. However, the little information available supports the finding that the State's SUD workforce is underqualified and undertrained in several key areas. The closest available proxies for determining professional capacities are the sections of the 2007 CADPAAC survey where respondents self-reported on their training and technical assistance needs (Table 3).[29]

[28] Little Hoover Commission, *Addressing Addiction: Improving & Integrating California's Substance Abuse Treatment System.* Sacramento, CA: Authors, 2008.
[29] Pacific Southwest Addiction Technology Transfer Center, *CADPAAC Alcohol and Other Drug Abuse Treatment Workforce Survey*

TABLE 3. CALIFORNIA SUD STAFF TRAINING AND TECHNICAL ASSISTANCE NEEDS	
TRAINING/TECHNICAL ASSISTANCE NEED	**PERCENT REPORTING NEED**
Providing trauma informed/trauma sensitive services	47.6%
Treating co-occurring SUD and mental health disorders	46.8%
Providing clients with integrated treatment services for co-occurring SUD and mental health disorders	43.0%
Improving client problem solving skills	39.5%
Improving behavioral management of clients	39.2%
Improving client thinking skills	38.6%
Improving cognitive focus of clients during group counseling	38.3%
Using pharmacological interventions with clients	36.7%
Using computerized client assessments	35.2%
Providing culturally competent services	34.2%
Working with staff on other units/agencies	29.1%
Monitoring client progress	21.7%
Assessing client problems and needs	21.1%
Improving rapport with clients	17.6%

Respondents to the CADPAAC survey revealed a high level of need in areas that are essential to the delivery of comprehensive SUD care. In domains related to the assessment of clients entering treatment, over one-fifth of respondents reported needing assistance on assessing client problems and needs, and over 35% reported needing assistance using computerized assessment tools. Significant numbers of providers reported needing assistance improving clients' problem-solving skills (39.5%) and thinking skills (38.6%), and 39.2% reported needing assistance with the behavioral management of clients. Most important, over 35% of respondents reported needing training and technical assistance with the delivery of critical evidence-based services: 36.7% reported needing training and technical assistance on how to utilize pharmacological interventions, and 45%–50% reported needing training and technical

assistance on how to provide services for co-occurring SUD and mental health disorders and trauma-informed care.

Notably, 96.5% of staff report knowledge of the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment's Treatment Improvement Protocols (TIPs) and Technical Assistance Publications (TAPs).[30] These manuals are free, easy-to-use guides designed to advise and train clinicians on evidence-based practices and treatments, and can help develop the workforce's professional competence and service delivery capacity. However, even though staff report being aware of the existence of these publications, none report ever actually using them.[31] Thus, effective training and technical assistance services are needed to help translate the knowledge in the TIPs and TAPs into practice. Yet, according to the CADPAAC survey, SUD agency administrators have difficulty providing these services; over half of them report challenges in accessing effective training programs and resources for their staff.[32] Furthermore, over 46% report that they do not even know which treatment interventions or strategies should be the foci of staff training and technical assistance activities.[33]

It is clear that California's SUD workforce needs further training and technical assistance to improve its professional capacity, but the breadth and depth of need is so great that it is difficult to pinpoint the exact areas where further training and technical assistance efforts should be targeted.

[30] Ibid.
[31] Ibid.
[32] Ibid.
[33] Ibid.

Barriers to Growth and Improving Professional Capacity

The low size and professional capacity of California's SUD workforce reflects serious challenges in the recruitment and maintenance of qualified direct care staff. SUD providers in California report significant difficulty recruiting and maintaining qualified direct care staff. Over 45% of respondents to the 2007 CADPAAC survey and nearly one-third of respondents to the 2012 PSATTC survey reported difficulties filling staff vacancies.[34] As in other parts of the country, the major challenges facing SUD programs trying to recruit staff is the lack of qualified applicants; most do not have the education, experience in SUD treatment, and/or certification needed to work in most SUD service settings.[35]

The low salaries offered to SUD treatment staff amplify these recruitment challenges.[36] SUD workers receive particularly low salaries because SUD services are grossly undervalued by third-party payers, and SUD treatment agencies often fail to factor necessary administrative and benefit costs into their fees. Since SUD treatment agencies' revenues are artificially low, so are the salaries they pay their staff.[37] In California, nearly half of SUD treatment staff earn less than $35,000 per year, and over one-fifth earn less than $25,000 per year.[38] These salaries are not commensurate with the high levels of stress associated with SUD services or the skills required to deliver them well (a direct care worker in a 24-hour residential treatment facility earns less than an assistant manager at a Burger King).[39] Compared to their counterparts elsewhere in

[34] Ibid; Camarena, *Pacific Southwest ATTC 2012 Regional Workforce Report*
[35] Ibid; Steven L. Gallon, Roy M. Gabriel, & Jeffrey R.W. Knudsen, "The Toughest Job You'll Ever Love: A Pacific Northwest Treatment Workforce Survey" *Journal of Substance Abuse Treatment* 2003;24:183-196.
[36] Ibid.
[37] Debra Langer, *Taking Action to Build a Stronger Addictions Workforce: An Update of Accomplishments.* Report prepared for the Northeast Addiction Technology Transfer Center. Pittsburgh, PA: Northeast Addiction Technology Transfer Center, 2006.
[38] Pacific Southwest Addiction Technology Transfer Center, *CADPAAC Alcohol and Other Drug Abuse Treatment Workforce Survey*
[39] Office of National Drug Control Policy and U.S. Department of Health and Human Services (Substance Abuse and Mental Health Services Administration and Health Resources and Services Administration),

the health care system, SUD service providers are particularly poorly paid; a social worker with a master's degree working in a SUD treatment agency earns less money each year than a peer provider working in a general health care agency.[40] Furthermore, nearly half of individuals in California's SUD treatment workforce do not receive employer-sponsored insurance.[41] Because of the combination of poor pay and inadequate benefits, many members of the SUD workforce live in near poverty, and some even qualify for food stamps.[42]

Compensation issues are further exacerbated by the lack of professional respect accorded to SUD treatment professionals. The stigma against SUD often extends to the profession of SUD treatment as well, and widely held skepticism about the efficacy of SUD treatment further undermines attempts to make SUD treatment seem like a desirable career choice for qualified applicants.[43] Furthermore, once individuals enter the field, there are numerous obstacles to keeping them in the SUD workforce: the certification and licensing process is cumbersome, confusing, and expensive; the cost of classes needed to professionally advance can be prohibitively high; many workplace environments are unsafe; and the actual job of SUD service provision is difficult and often frustrating.[44]

Given these conditions, it is hardly surprising that the relatively small pool of qualified potential SUD workers often opts for a career other than SUD treatment.[45] Recently, an online employment site ranked SUD counselor the third most "high stress/low pay" job in

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Workforce Issues: Integrating Substance Use Services into Primary Care. Summit Proceedings, August 2011.
[40] Ibid.
[41] Pacific Southwest Addiction Technology Transfer Center, *CADPAAC Alcohol and Other Drug Abuse Treatment Workforce Survey*
[42] Substance Abuse and Mental Health Services Administration [SAMHSA], *Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues*, January 2013.
[43] Ibid.
[44] University of California, Berkeley, School of Public Health, *Career Pathway Sub-Committee Updated Report.*
[45] Little Hoover Commission, *Addressing Addiction*.

the United States.[46] In fact, a significant portion of the SUD workforce actually did not originally plan to enter the field of SUD treatment at the outset of their careers; in California, 34% of SUD workers report that SUD treatment is a second career for them, not their original career plan.[47] Furthermore, once individuals enter the SUD treatment workforce, rates of turnover are exceedingly high, between 20% and 50% annually.[48]

Summary

In 2008, the Little Hoover Commission studying California's treatment system observed that there is an inherent tension between the need for quantity (having an adequately sized workforce) and quality (having an adequately trained/competent workforce) in the SUD system. According to the commission, "Absent a focus on results, government agencies that fund treatment and the providers who administer treatment, largely have opted to treat as many people as possible, regardless of outcomes. This approach is built on a cost structure that results in low pay for the treatment workforce, high staff turnover, and inexperienced and undereducated counselors." [49] Though data on the State's SUD treatment workforce are limited, it is apparent that five years after the Little Hoover findings, the SUD workforce in California is lacking in *both* quantity and quality; it is insufficiently large enough, educated, or trained to meet the State population's SUD treatment needs.

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[46] SAMHSA, *Report to Congress*

[47] Pacific Southwest Addiction Technology Transfer Center, *CADPAAC Alcohol and Other Drug Abuse Treatment Workforce Survey*

[48] Lillian T. Eby, Hannah Burk, Charleen P. Maher. "How serious of a problem is staff turnover in substance abuse treatment? A longitudinal study of actual turnover." *Journal of Substance Abuse Treatment* 2010;39:264-271.

[49] Little Hoover Commission, *Addressing Addiction*.

III. Developing the Specialty SUD Treatment Workforce

Overview

As discussed in Section I above, the California SUD workforce of the future will be divided into two distinct workforces—one that operates in the specialty SUD treatment sector as it does today, and another that evolves into part of a broader, more interdisciplinary integrated behavioral health workforce. This section delineates areas where the Department of Health Care Services can focus efforts to improve the capacity of the specialty SUD treatment workforce of the future. The specialty SUD workforce of the future will need to have an adequate understanding of: (1) a basic minimum of professional knowledge, skills, and attitudes needed to provide SUD treatment; (2) recent advances in the field of SUD treatment; and (3) how to provide appropriate recovery support services. In order to achieve these ends, DHCS needs to take steps to improve the recruitment and retention of highly qualified and skilled providers in the SUD workforce.

Baseline Knowledge, Skills, and Attitudes

The basic knowledge, skills, and attitudes the specialty SUD treatment workforce should have are laid out in the Center for Substance Abuse Treatment's Technical Assistance Publication (TAP) 21, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice (The Competencies)*.[50]

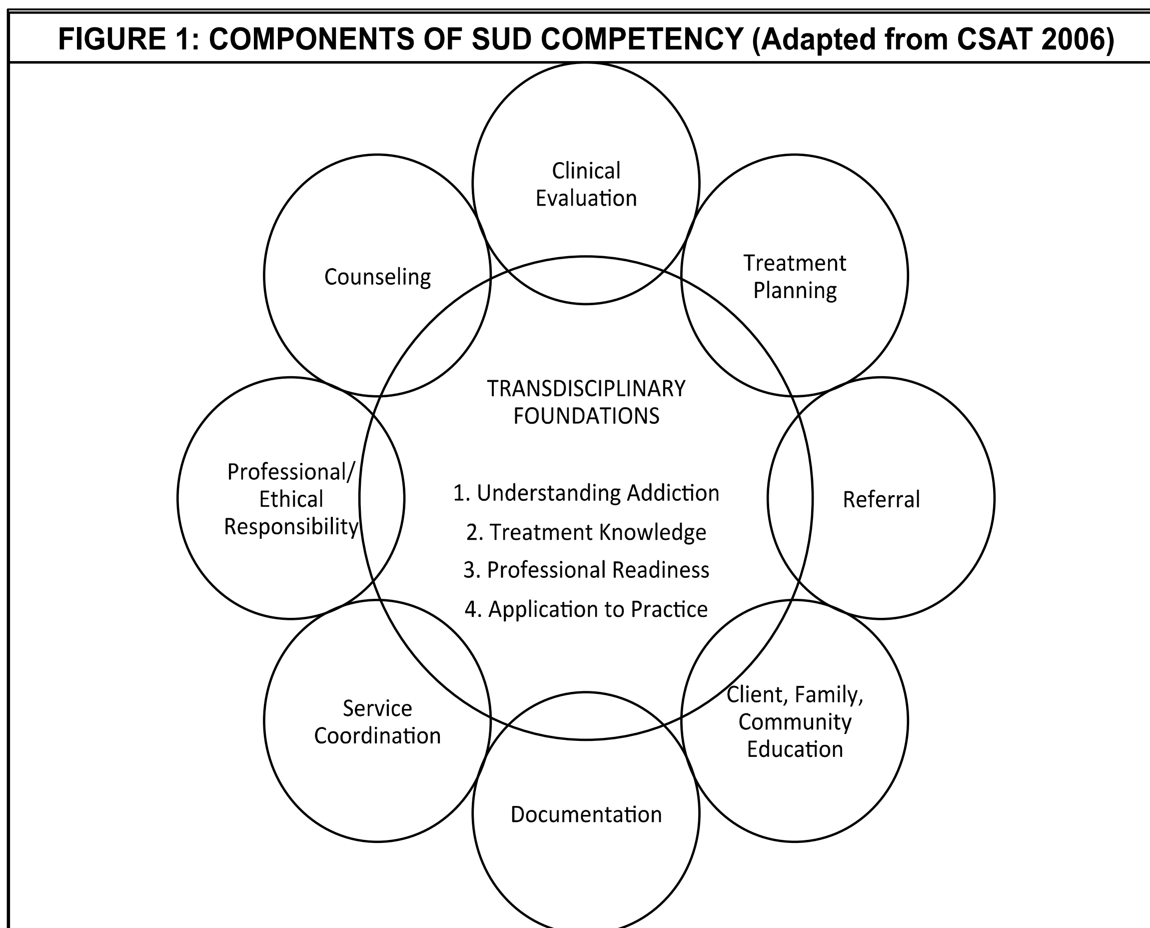
TAP 21 delineates two sets of core competencies for SUD counseling—four transdisciplinary foundations of SUD treatment and eight practice dimensions. The transdisciplinary foundations—understanding addiction, treatment knowledge, application to practice, and professional readiness—are knowledge, skills, and attitudes

[50] Center for Substance Abuse Treatment, *Addiction Counseling Competencies.*

that are needed to provide high quality SUD services regardless of discipline, scope of practice, treatment setting, or service orientation. Medical providers, social workers, counselors, case workers, peer recovery support staff, and others who work with individuals in treatment should have mastery of these four fundamental competencies in order to deliver effective SUD services.

SUD counselors should be able to build upon their knowledge of the four transdisciplinary foundations with competency in some or all of the eight practice dimensions—clinical evaluation, treatment planning, referral, service coordination, counseling, client/family/community education, documentation, and professional/ethical responsibility (See Figure 1). The eight practice domains span the full continuum of SUD care, ranging from screening and assessment to referral, service delivery, and recovery supports and services. A strong grounding in each of the four transdisciplinary foundations can equip the entire SUD workforce to deliver high quality, client-centered, and evidence-based services as they carry out daily functions, as delineated in the eight practice dimensions.

FIGURE 1: COMPONENTS OF SUD COMPETENCY (Adapted from CSAT 2006)



Recent advances in the field of SUD treatment

Specialty SUD service providers should also have more specific knowledge of the recent advances in evidence-based practices in the areas of SUD management and treatment. These areas include:

- Treating Individuals with Co-Occurring Mental Health Disorders: Over half of clients who present for services in specialty SUD treatment settings have co-occurring mental health disorders. In order to improve treatment retention and outcomes, it is critical for SUD service providers to be well-versed in methods of identifying clients with mental health disorders, how to adjust treatment modalities and interventions to meet their treatment needs, and approaches that should be taken to the treatment and management of co-occurring

disorders that are distinct from those generally used in specialty SUD treatment.[51]

- Medication-Assisted Treatment: Researchers have developed safe, effective, and evidence-based medications such as acamprosate (for the management of alcohol dependence),[52] naltrexone (for the management of opioid and alcohol dependence),[53] and buprenorphine (for the management of opioid dependence).[54] Many providers in specialty SUD treatment settings, however, remain reluctant to utilize these medications in treatment, particularly because they believe their use may compromise 12-step oriented recovery. In order to provide state-of-the art SUD treatment, it is critical for all providers to be educated about the use of SUD medications and the role that such pharmacotherapies can play in facilitating and sustaining recovery.
- Motivational Interviewing: Motivational Interviewing is a tool that SUD providers can use to understand the motives clients have in order to address their substance use problems, gather clinical and administrative information needed to plan care, and build and strengthen client readiness to change. It is essential for all providers of SUD services to understand and be prepared to utilize motivational interviewing techniques throughout the SUD assessment, treatment, and recovery processes.[55]

[51] Center for Substance Abuse Treatment, *Substance Abuse Treatment for Persons with Co-Occurring Disorders.* Treatment Improvement Protocol (TIP) Series, No. 42. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

[52] Center for Substance Abuse Treatment, *Incorporating Alcohol Pharmacotherapies Into Practice.* Treatment Improvement Protocol (TIP) Series, No. 49. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009.

[53] Ibid; Center for Substance Abuse Treatment, *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs* . Treatment Improvement Protocol (TIP) Series, No. 43. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2008.

[54] Ibid.

[55] Steve Martino, et al. *Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency.* Salem, OR: Northwest Addiction Technology Transfer Center and Oregon Health and Science University, 2006.

- Cognitive Behavioral Therapy: Cognitive Behavioral Therapy (CBT) is a treatment approach that focuses on the connections between thoughts, cognitive schema, beliefs, attitudes, and behavior. CBT has been proven effective in the behavioral treatment and management of SUD involving various substances and at varying levels of severity. All providers of SUD services should be well-versed in CBT techniques, have a strong understanding of situations where it can be effectively used, and be prepared to deliver services that incorporate CBT.[56]
- SUD Treatment for Women: Recent research has highlighted that gender differences can have a significant impact both on the development of SUD and on SUD treatment. By taking a biopsychosocial approach to treatment that addresses women's specific needs, providers can improve treatment engagement, and outcomes. Providers delivering specialty SUD treatment services should be aware of these factors and familiar with specific strategies and approaches that are effective in helping women achieve and sustain recovery.[57]
- Treating Stimulant Use Disorders: In the past few decades, a flurry of research has led to tremendous advances in knowledge of stimulant use disorders and their treatment with behavioral interventions. Providers of specialty SUD treatment should be well-versed in evidence-based

[56] Center for Substance Abuse Treatment, *Brief Interventions and Brief Therapies for Substance Abuse.* Treatment Improvement Protocol (TIP) Series, No. 49. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999.

[57] Center for Substance Abuse Treatment, *Substance Abuse Treatment: Addressing the Specific Needs of Women.* Treatment Improvement Protocol (TIP) Series, No. 51. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009.

engagement and treatment strategies and techniques for treating individuals with stimulant use disorders.[58]

- Chronic Pain: Chronic pain is common among individuals with SUD, is often interrelated with many of the physical and psychological challenges associated with SUD, and often underlies substance use conditions. Pain management is often essential for the successful treatment of SUD, and clinicians need to be well-versed in the causes of chronic pain, pharmacological and behavioral strategies to manage it, and the best ways to achieve and sustain recovery from SUD for clients experiencing chronic pain. Providers of SUD services should be able to assess clients for chronic pain conditions; develop treatment plans that address pain along with associated functional impairments and psychological symptoms; and monitor clients for pain-related issues that can lead to relapse. Even optimal pain treatment is unlikely to completely eliminate it, so providers need to be able to collaborate with clients to devise effective strategies to manage it. The most effective treatment of chronic pain often involves collaboration with other health professionals (e.g., medical doctors, psychologists), as well as clients themselves playing an active role in pain monitoring and management. SUD providers need to be able to balance the variety of tasks associated with the management of chronic pain among SUD patients in order to increase clients' chances of achieving and sustaining recovery.[59]

[58] Center for Substance Abuse Treatment, *Treatment for Stimulant Use Disorders.* Treatment Improvement Protocol (TIP) Series, No. 33. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999.
[59] Center for Substance Abuse Treatment, *Managing Chronic Pain in Adults with or in Recovery from Substance Use Disorders.* Treatment Improvement Protocol (TIP) Series, No. 54. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.

- HIV: Individuals who use psychoactive substances are at increased risk for contracting HIV, particularly if they are injection drug users. It is critical, therefore, for providers to be cognizant of HIV screening and assessment techniques, the treatment of behavioral health problems for SUD clients with HIV, case management for clients with HIV, the treatment and management of HIV, ethical and legal issues associated with the condition, and prevention strategies to help clients avoid spreading it.[60]
- Hepatitis: Individuals who use psychoactive substances are at increased risk of contracting viral hepatitis, particularly if they are injection drug users. However, many SUD treatment providers are poorly informed about how to identify, manage, or treat hepatitis. In order to safeguard clients' health and reduce the risk that hepatitis poses to their well-being, SUD providers should be able to educate clients about hepatitis, teach them the importance of managing the condition, and advise them on ways to avoid spreading it.[61]

Recovery Support Services (RSS)

Given that SUD is a chronic condition, clients who achieve recovery in specialty SUD service settings often need continuing support in order to sustain the gains they made in treatment. Recovery Support Services (RSS) are psychosocial and community-based services delivered in sober living homes, recovery centers, and faith-based recovery ministries to assist clients with self-management of SUD, facilitate their connection with community-based resources, and help them address the myriad physical health, mental

[60] Center for Substance Abuse Treatment, *Substance Abuse Treatment for Persons with HIV/AIDS.* Treatment Improvement Protocol (TIP) Series, No. 37. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2008.
[61] Center for Substance Abuse Treatment: *Addressing Viral Hepatitis in People With Substance Use Disorders.* Treatment Improvement Protocol (TIP) Series, No. 53: Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011.

health, social, economic, and housing challenges they may face once they have completed treatment.[62] Formally trained professionals generally deliver RSS for clients immediately after specialty treatment, utilizing telephone-based continuing care models and recovery management checkups to monitor client status, minimize risk for relapse, and provide linkages to services in the event of relapse.[63] Peers who have experienced SUD also play a key role in the delivery of RSS by providing nonclinical assistance to aid clients in initiating and maintaining recovery in the community and helping them enhance their quality of life.[64] For the specialty SUD treatment system to offer comprehensive and effective RSS services, it needs to have a RSS workforce that has strong skills in client engagement, motivational enhancement, communication, conflict resolution, crisis intervention, recovery enhancement, community liaison, and advocacy.

Professional Development for the Specialty SUD Treatment Workforce

SUD service providers need to be competent in a large number of complex areas—and do a job that can be physically and emotionally taxing. To develop a workforce that is up to the challenge of providing evidence-based SUD care, California needs to have a SUD treatment workforce that is highly qualified and motivated. Yet today, the vast majority of the State's SUD workforce is inadequately trained, faced with limited opportunities for career advancement, and subject to extraordinarily high rates of turnover.

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[62] Sarah J. Cousins, Valerie P. Antonini & Richard A. Rawson, "Utilization, Measurement, and Funding of Recovery Supports and Services," *Journal of Psychoactive Drugs* 2012;44(4):325-333. Office of National Drug Control Policy, et al. *Workforce Issues*: Alexandre B. Laudet & Keith Humphreys. "Promoting Recovery in an Evolving Policy Context: What Do We Know and What Do We Need to Know about Recovery Support Services?" *Journal of Substance Abuse Treatment* 2013;45:126-133.
[63] Ibid.
[64] Ibid.

The establishment of a career ladder that defines SUD job roles and lays out a career trajectory for individuals in the SUD workforce can help address all of these issues. The clear delineation of a career trajectory can encourage qualified individuals to enter the SUD treatment field and motivate those already in the SUD workforce to pursue further training and education so they can advance. Furthermore, the promise of merit- and skill-based advancement can incentivize performance and encourage providers to seek out opportunities for ongoing career development.

In 2011, SAMHSA published "Scopes of Practice & Career Ladder for Substance Use Disorder Counseling," which provides a model that states and other providers of SUD services can follow.[65] The SAMHSA ladder defines five levels of SUD counseling, as illustrated in Table 3. Each step on the ladder requires increasing levels of education and work experience, and increasing professional responsibility. By laying out a clear career path, with increases in pay and responsibility commensurate with each step, a career ladder can help establish professional standards for the field of specialty SUD treatment. As a result, it can also ensure that an adequately skilled, trained, and educated pool of providers enters and remains in the field, and that the SUD services it delivers are provided by staff that have appropriate levels of education and experience.

In California, approximately 40 community colleges offer accredited programs in addiction studies. Many four-year institutions also provide continuing education courses through their Extension programs, including Sacramento State, San Diego State, UCLA, Loyola Marymount, and Dominguez Hills. However, Extension programs are generally not accredited and course credits are not transferable to colleges or universities (Dominguez Hills is one exception where Extension class credits can be applied toward a bachelor's degree at the same university). California State University,

[65] Substance Abuse and Mental Health Services Administration, *Scopes of Practice & Career Ladder for Substance Use Disorder Counselors*. Rockville, MD: Author, 2011.

Fullerton, is currently the only school with a full bachelor's program—a BS in Human Services with emphasis in Substance Abuse Treatment and Prevention.

TABLE 4.
MODEL CAREER LADDER FOR SUD COUNSELING

TITLE	EDUCATION/TRAINING	SUPERVISED WORK EXPERIENCE	PROFESSIONAL RESPONSIBILITIES
Independent Clinical SUD Counselor/Supervisor (Level 4)	Master's Degree in SUD counseling or allied mental health profession with at least 300 hours SUD-related training	4,000 hours post-master's supervised work experience, 2,000 direct client hours	Clinical evaluation, treatment planning, referral, education, documentation, service coordination and case management, therapy, psychoeducation, services for co-occurring mental health disorders and SUD
Clinical SUD Counselor (Level 3)	Master's Degree in SUD counseling or allied mental health profession with at least 300 hours SUD-related training	3,000 hours post-master's supervised work experience, 2,000 direct client hours	Clinical evaluation, treatment planning, referral, education, documentation, service coordination and case management, therapy, psychoeducation, services for co-occurring mental health disorders and SUD
SUD Counselor (Level 2)	Bachelor's Degree in SUD counseling or allied mental health profession with at least 200 hours SUD-related training	2,000 hours supervised work experience, 600 hours direct client work	Screening, brief intervention, referrals, treatment planning, education, documentation, service coordination, case management, psychoeducation, therapy
Associate SUD Counselor (Level 1)	Associate's Degree, with at least 100 hours SUD-related training	2,000 hours supervised work experience, 600 hours direct client work	Screening, brief intervention, referrals, treatment plan monitoring, education, service coordination, case management, psycho-education
SUD Technician (Entry Level)	High School/GED 150 hours SUD training	1,500 hours supervised work experience	Screening, psychoeducation, participate in documentation and treatment planning

Summary

In spite of the California SUD workforce's current shortcomings, there are concrete steps the Department of Health Care Services can take to improve both the quality and quantity of the State's SUD workforce. By ensuring that the workforce is competent in the basic knowledge, skills, and attitudes needed to provide SUD treatment, capable of delivering evidence-based services, and prepared to provide recovery support services, DHCS can ensure that the workforce is prepared to meet the needs of the California population that needs specialty SUD services. By adopting the Scopes of Practice & Career Ladder model, it can create a workforce infrastructure that will help recruit individuals with the education, skills, and experience needed to provide high-quality SUD treatment into the workforce, and keep them there by providing ample opportunities for advancement. By taking these steps, the Department can ensure that California's future specialty SUD treatment workforce will be of sufficient quality and quantity to provide high quality, evidence-based SUD services for all Californians.

IV. Needs of the Integrated Behavioral Health Workforce of the Future

Overview

As discussed in Section I above, the California SUD workforce of the future will be divided into two distinct workforces—one that operates in the specialty SUD treatment sector as it does today and another that evolves into part of a broader, more interdisciplinary integrated behavioral health (IBH) workforce. This section delineates areas where the Department of Health Care Services can focus efforts to improve the capacity of the IBH workforce of the future. To survive and thrive in the IBH workforce of the future, SUD providers will need to adapt to working in new clinical roles and develop

a new set of clinical and professional competencies. Furthermore, as SUD services become integrated into primary care settings, it will be critical to ensure that clinicians from all disciplines—not just IBH providers—have at least a basic understanding of SUD and how services to address substance use conditions need to be integrated into medical care.

IBH Roles

To date, when IBH staff have worked in integrated health care settings, they have generally filled one of three roles—health educator, primary care behavioral health specialist, and expanded care manager. In order to facilitate the integration of current SUD workers into the integrated care workforce, efforts should be made to prepare them to fill the following roles:

- *Health Educator:* Health educators are members of healthcare teams who teach patients about behaviors that promote wellness, and they develop programs that encourage patients to make healthy decisions.[66] In integrated care settings, health educators who specialize in behavioral health screen patients for risk in a number of behavioral health domains—including depression, alcohol use, nicotine use, and the use of psychoactive substances—using standardized instruments.[67] If indicated, based on screening results, they then provide feedback or brief intervention services. In addition, health educators can be trained to provide motivational interviewing or case management services for

[66] Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2012-13 Edition*, Health Educators http://www.bls.gov/ooh/community-and-social-service/health-educators.htm
[67] DiLonardo, *Workforce Issues*

clients with and without SUD, and provide monitoring and support for patients receiving MAT for SUD within primary care settings.[68]

Health educators need to have strong knowledge of physical and behavioral health treatment, the social skills needed to engage clients, and the communication skills needed to identify patient needs and impart relevant information both to patients and their colleagues. In addition, health educators need to be able to manage time efficiently and to work effectively in collaboration with other health professionals.[69]

Generally, health educators have a bachelor's degree at the entry level, and some employers require that entrants to the field have a Certified Health Education Specialist (CHES) credential from the National Commission for Health Education Credentialing.[70] Individuals who lack these credentials can qualify if they have provided similar services as a Community Health Worker.[71] In California, Health Educators earn approximately $47,600 per year, which is significantly more than most in the SUD workforce currently earns. It is anticipated that demand for Health Educators will grow rapidly in the near future, particularly as more primary care clinics begin providing integrated services. In California, demand for Health Educators is expected to have risen 30% between 2010 and 2020, with the State workforce adding approximately 400 new Health Educators per year.[72]

[68] Ibid.
[69] O*Net Online (2012). Summary Report for Health Educators. http://www.onetonline.org/link/summary/21-1091.00
[70] Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2012-13 Edition*, Health Educators http://www.bls.gov/ooh/community-and-social-service/health-educators.htm
[71] http://www.onetonline.org/link/summary/21-1091.00
[72] United States Department of Labor, Employment, and Training Administration. (2013). *Occupation Profile: Health Educator, California*

- *Behavioral Health Specialist (BHS)*: Behavioral Health Specialists (also referred to as "Primary Care Behavioral Health Specialists") work as members of primary care teams and focus on identifying, triaging, and managing patients with behavioral health problems and other medical conditions.[73] BHS staff assist primary health care staff in recognizing and treating mental health disorders, SUD, and other psychosocial problems, and also assess the behavioral/psychosocial status of patients referred by other members of the primary care team for behavioral health evaluations. In addition, they assist in the detection of patients who are at risk for more serious behavioral or physical health problems, and help develop plans to develop action plans to manage these patients' chronic health conditions. For patients with chronic conditions that are prone to relapse (such as SUD), BHS providers also provide monitoring and relapse prevention services.[74]

  BHS providers need to have a strong understanding of chronic disease and self-care, be competent in assessment, and be able to provide treatment with brief cognitive behavioral, psychoeducational, and motivational interviewing techniques. The focus of BHS treatment services needs to be more oriented toward behavior modification than deep psychological probing or analysis, and their services will need to be more action-oriented and focused on identifying solutions to client problems rather than concentrated on going through thorough

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http://www.careerinfonet.org/occ_rep.asp?optstatus=011000000&soccode=211091&id=1&nodeid=2&stfips=06&search=Go
[73] DiLonardo, *Workforce Issues*; Society for Human Resource Management (2013). *Job Descriptions: Behavioral Health Specialist*
http://www.shrm.org/TemplatesTools/Samples/JobDescriptions/Pages/CMS_010205.aspx
[74] Ibid.

therapeutic processes. However, it is likely that in many primary care settings, administrators would want to hire BHS workers who could also be used to provide more in-depth, individualized care for patients who need more intense one-on-one counseling services. Given this reality, BHS workers should have a flexible enough skill set that they could also provide more in-depth treatment, using psychotherapeutic techniques, when necessary.[75]

BHS providers generally have a master's degree or higher and licensure or certification as a clinical social worker, professional counselor, or clinical psychologist. There are no data on typical compensation or projected job growth for BHP professionals, though it is anticipated that they will play a key role in providing integrated services in many treatment settings in the near future.

- *Expanded Care Manager*: Care managers are members of integrated primary care teams who assist patients and their support systems in managing medical conditions and related psychological problems more effectively. Many patients do not need care management services, but care managers' services are highly valued in the treatment of patients with multiple chronic conditions and patients with conditions that require a significant amount of high intensity or high cost care. Given the chronicity of SUD and the potentially high costs of SUD treatment, patients with substance use conditions are among those who could benefit from expanded care management services. For example, care managers can provide monitoring and support for physicians who are treating opioid-dependent patients with buprenorphine but do not have the time or resources to

[75] Di Lonardo, *Workforce Issues*

personally provide the appropriate medication monitoring or support services. Care managers may have a range of functions for a specific population of patients, including patient management care coordination, increasing self-efficacy in patients, tracking patients on registries, linking patients with needed resources, and consultation with other health professionals or specialists as needed.

Though there are no available data concerning salary or projected job growth for expanded care managers, it is anticipated that they will play a key role in the provision of integrated services, particularly for individuals with SUD.[76]

Skills and Competencies of the IBH Workforce

As models of behavioral health / primary care integration continue to develop, it is likely that current SUD providers will fill niches other than the three mentioned above (health educator, behavioral health specialist, expanded care manager) as members of the IBH workforce. Regardless of their precise role, however, it is anticipated that IBH service providers will need a number of core attributes, competencies, and skills in order to contribute as members of the integrated care service teams:

- *Efficiency:* Compared to specialty SUD treatment settings, primary care clinics are busy and hectic work environments: patients with a variety of medical and behavioral conditions with varying levels of severity and chronicity present for services; assessments, consultations, and interventions are often done quickly and spontaneously; and sessions are often interrupted or cut short. Consequently, providers working in integrated primary care settings need to be

[76] Ibid.

flexible and efficient. IBH providers need to be able to make clinical assessments quickly and accurately, and deliver services in a targeted, time-efficient manner.

- *Interpersonal communication skills*: Regardless of their precise role or title, strong interpersonal communication skills will be essential for all IBH providers. In their work with patients, behavioral health providers will need to be able to efficiently and thoroughly identify patient service needs. This will require them to make patients feel at ease and communicate sensitive, personal issues concerning mental health and substance use in a brief amount of time. It will also require strong listening, comprehension, and analytic skills to identify and clearly synthesize information gleaned from patients during brief screenings/interactions and then document it in patient charts. In addition, IBH providers will need strong interpersonal communication skills to effectively work with other members of their treatment teams, including being able to communicate information gathered during interactions with patients back to colleagues. Conversely, they will need to be able to understand information concerning clients' physical health that other treatment team members tell them, so they can incorporate it into service provision and treatment planning.
- *Collaboration and teamwork*: In traditional SUD treatment, individual providers play a central role in the planning, organization, and delivery of care. In integrated care settings, by contrast, teams of providers from a variety of medical and behavioral health disciplines deliver services and closely collaborate on treatment planning and service delivery activities. IBH providers will need to be willing to collaborate with others on patient care, a collaboration that is often not necessary in specialty SUD treatment settings.

- *Consultation and liaison skills:* One of the major roles behavioral health specialists will play in integrated primary care practices will be as consultants for medical providers who are serving patients with behavioral health conditions. To serve as an effective consultant in integrated care environments, behavioral health providers will need a strong understanding of the impact that mental health and substance use conditions have on physical health, and how they may present in medical patients. They should also have a strong understanding of treatment modalities appropriate for medically ill patients who present with common conditions or co-morbidities. As liaisons, behavioral health service providers should have the capacity to coordinate communication between medical providers and other staff who are involved in the management of patients' psychosocial needs.
- *Screening and assessment:* One of the major responsibilities of IBH providers will be the identification of patients who need behavioral health services. Whereas all clients in specialty SUD treatment settings clearly need services, a major task in primary care is the determination of which patients need mental health or SUD services, what the duration of these services should be, and how intense they need to be. Doctors and other medical professionals often lack the time and training to identify patients' behavioral health needs, so it will be incumbent upon IBH providers to identify patients who need either brief interventions or more intensive treatment services. Consequently, they will need to be well-versed in validated screening and assessment tools (e.g., PHQ-9, AUDIT-C) that are used to identify patients who are at risk for mental health disorders and SUD in primary care settings.

- *Brief Interventions for mental health and substance use:* The majority of patients with behavioral health service needs do not have conditions that are as chronic or acute as those usually found in specialty treatment settings. When working with clients who have mild to moderate behavioral health conditions, IBH providers will not have nearly as much time to establish rapport or deliver therapeutic services as they usually do in specialty treatment settings. Primary-care based interventions for individuals with mild to moderate behavioral health conditions tend to be brief and time-limited, generally three to five sessions that are 15 minutes or less. The provision of these services will require IBH to adapt a new clinical approach and a new clinical tool set geared toward achieving rapid behavior change and problem solving rather than personality-centered or insight-oriented therapy.
- *Harm reduction*: Many SUD providers have traditionally provided care that is abstinence-oriented and focused on making sobriety the ultimate goal of services. In integrated care settings, services need to be more holistic and tailored to making clients' overall health the top priority. When IBH providers work in primary care environments, they will need to adjust their approach to treatment in order to ensure that it is more oriented to harm reduction than to abstinence.
- *Care planning and care coordination:* IBH providers will need to be proficient in planning and coordinating various aspects of patient care. They will need to be able to collaborate with other providers to determine the role that behavioral health services will play in patients' overall treatment plan. Furthermore, as providers who will likely provide support services to assist patients with complex and multifaceted treatment needs, behavioral health providers will need to be well-versed in how to interpret and adjust care plans, how to coordinate the

organization and delivery of services, and how to make outside linkages and referrals when necessary.

- *Cultural competence and adaptation:* IBH providers will serve a diverse population with many specific cultural and linguistic characteristics that need to be taken into consideration when providing care. Though it will be difficult for IBH providers to have a deep knowledge of the culture/language of all clients, they will need to have a solid understanding of the way that culture and language impact the way that clients from diverse backgrounds interpret and use information related to physical and mental health. They should also be familiar with strategies that can be used to adapt communication styles and interventions to be culturally and linguistically appropriate for the patients they serve.

  The existence of disparities is well documented and understood in relation to physical health but not as clearly understood as related to substance use. While there are certain health conditions (hypertension, certain cancers, etc.) that are more prevalent in persons from certain racial/ethnic groups, the same is not true for substance use when controlling for environmental factors. Although substance use is an equal opportunity condition, we do know that certain racial/ethnic groups are disproportionately impacted. This view is critical in assembling the necessary local planning partners to comprehensively address the many factors involved in the occurrence of alcohol and other drug disparities.
- *Understanding of medical disorders and their treatment:* To provide truly patient-centered and holistic care, IBH providers will need to understand how mental health and substance use behaviors impact, and are impacted by, physical health conditions. In addition, they will also need to have a strong grasp on how treatment for physical conditions may affect patients' mental health or substance

use behaviors, and vice versa. A strong grasp of medical conditions and treatment will be needed to inform treatment planning and care coordination activities, and also to determine health behaviors (e.g., diet, exercise) that should be targeted in behavioral interventions and disease management activities. Furthermore, a solid understanding of basic physiology, psychopharmacology, and medical terminology will facilitate improved communication with team members who are in charge of providing physical health services and enhance the overall coordination and integration of care.

- *Understanding of stepped-care models:* Services in integrated primary care settings are often organized on principles of stepped care. Stepped care is structured to ensure that services cause the least disruption necessary in patients' lives, and that they are the least extensive, intensive, and expensive needed to achieve positive results.[77] In practice, this means that if a patient's functioning does not improve with the usual course of practice, they receive progressively more intense and specialized services, until ultimately being referred to specialty care, if conditions prove too intense or acute. Once patients are stabilized and their functioning improves, stepped care models call for their care to be "stepped down" to the least disruptive, extensive, intensive, and expensive level that is needed. IBH providers need to be familiar and comfortable with stepped care models, so that they can tailor service provision and treatment planning according to stepped-care principles.

It is currently unknown if individuals in the current SUD workforce possess the training or skills needed to serve as health educators, behavioral health specialists, expanded care managers, or other roles as members of the IBH workforce. Given

[77] Chris Collins, Denise Levis Hewson, Richard Munger & Torlen Wade. *Evolving Models of Behavioral Health Integration in Primary Care*. New York: Milbank Memorial Fund, 2010.

the glaring needs of the current SUD workforce in areas simply related to the provision of specialty SUD services, it is likely that they lack the expanded set of knowledge, skills, and attitudes they will need to work in integrated care settings. However, the SUD workforce's experience in working with individuals with SUD should be a valuable asset for primary care providers, many of whom are unfamiliar with or uncomfortable with managing and treating substance use conditions. Furthermore, adequately trained and competent specialty SUD providers should have many of the skills needed to evolve into IBH providers—screening, assessment, monitoring, care management, referral, motivational interviewing, cognitive behavioral therapy techniques, and other skills that are essential competencies for specialty SUD treatment providers will also be highly valued in integrated care environments. Unfortunately, many in the SUD workforce currently lack these competencies. However, if DHCS invests in rapidly and thoroughly improving the quality of the current SUD workforce (see Recommendations below), it can help adequately prepare current SUD providers for their roles as IBH providers in the future.

SUD Competency beyond the Current SUD Workforce

In integrated care environments, a broad array of providers—IBH providers with little background in SUD, physicians, nurse practitioners, and other health professionals—will become directly involved in the delivery of services for clients with substance use conditions.[78] They will need to be able to assess the effect that substance use has on clients' health and well-being; detect clients who have health problems related to substance use; provide services that help engage clients in appropriate treatment for

[78] Buck, "The Looming Expansion"; Roy & Miller, "The Medicalization of Addiction Treatment Professionals"

substance use conditions; and monitor the course of treatment for and recovery from SUD in collaboration with other members of their health care teams.

Unfortunately, available data indicate that the current medical and mental health workforces are poorly prepared to work with clients who have substance use conditions. Some health professionals may have negative attitudes about patients with SUD, harboring beliefs that they are violent, manipulative, and not motivated to make positive change. Consequently, compared to the care that they provide other patients, healthcare providers tend to be less personally engaged, less empathic, and less likely to provide full effort when treating individuals with SUD.[79] Furthermore, general healthcare providers receive relatively little training about SUD when compared to the training they receive about other chronic health conditions: only 56% of residency programs require training in SUD, and when required, the median number of hours of training is just 3–12.[80] Evidence suggests that mental health clinicians also have negative attitudes toward individuals with substance use conditions and are poorly trained on how to treat and manage SUD.

These attitudes and knowledge gaps must be addressed as the healthcare system prepares to serve increasing numbers of individuals with SUD in primary care settings.

Summary

SUD providers who transition into the IBH workforce will need to develop a new approach to service delivery and a new skill set, and they need to become capable of working with patients who traditionally have not been treated in the specialty SUD treatment system. Furthermore, the boundaries of what the “SUD treatment workforce” is

[79] Leonieke C. van Boekel, Evelien P.M. Brouwers, Jap van Weeghel & Henk F.L. Garretsen, “Stigma Among Health Professionals Towards Patients with Substance Use Disorders and its Consequences for Helathcare Delivery: Systematic Review” *Drug and Alcohol Dependence* 2013:131:23-35.
[80] Di Lonardo, *Workforce Needs*

will become increasingly blurred; providers who previously specialized in the treatment of SUD will need to develop the capacity to also address mental health disorders and physical health conditions related to substance use, and medical and mental health staff will become increasingly involved in the treatment and management of patients with SUD. Consequently, significant work will need to be done to prepare the SUD treatment workforce to deliver new services in their future roles as IBH providers. At the same time, the SUD treatment workforce will need to expand to include a broader range of providers from various health disciplines.

V. Recommendations

1. The California Department of Health Care Services should conduct a thorough and comprehensive assessment of the California SUD workforce's size, composition, and professional capacity in order to guide future workforce development planning and activities.

A number of published reports and peer-reviewed research articles from across the nation assert that the current SUD workforce is too small, underpaid, underqualified, and unstable to meet the population's needs. Though available data give the impression that California's SUD treatment workforce faces similar challenges, the scope and scale of the workforce's shortcomings remain unclear. Employment surveys and labor statistics that are used to draw broad conclusions about the workforce's size and makeup often do not distinguish SUD workers from other behavioral health workers; State data only capture counselors who are certified; and data from recent workforce surveys are of limited utility because they either ask only superficial questions or have very low response rates.

Consequently, we suggest that the Department of Health Care Services (DHCS) undertake a thorough and comprehensive SUD workforce-needs assessment that is more thorough and specific than existing data sources. The workforce-needs assessment should differentiate between the needs of the specialty SUD workforce and the SUD workforce that will be integrated into medical settings as behavioral health staff. This undertaking would provide DHCS with a more comprehensive and nuanced picture of the current SUD workforce than is currently available, and would enable the Department to prioritize workforce development activities based on current needs.

2. **The State should expand existing training and technical assistance services to ensure that the SUD workforce develops capacity in areas that are critical to providing comprehensive and evidence-based SUD treatment. These activities should be designed to prepare two distinct workforces—one that will continue to work as SUD providers in specialty treatment settings and another that will evolve into Integrated Behavioral Health (IBH) providers in medical settings.**

Though it is difficult to identify the California SUD workforce's most pressing needs, it is nonetheless clear that it needs significant training and technical assistance in areas critical to the provision of comprehensive and evidence-based SUD services. Agencies and individual providers report that they prefer to receive training and technical assistance at offsite meetings in which one or two staff members are trained and then disseminate the knowledge they've gained through trainings they provide at their clinics.[81]

[81] Pacific Southwest Addiction Technology Transfer Center, *Workforce Survey*

The California Department of Alcohol and Drug Programs has supported many training and technical assistance opportunities for SUD providers throughout the State in the past. It is strongly recommended that DHCS continue to do so, and expand them if possible, in order to ensure that as many members of the SUD workforce as possible develop the knowledge and skill set needed to provide state-of-the-art SUD treatment on a regular and consistent basis.

Training and technical assistance activities should be designed to reflect the future bifurcation of the SUD treatment workforce. One training and technical assistance track should emphasize the skills and competencies needed to deliver specialty SUD services, as described in Section III. A second training and technical assistance track should be designed to prepare the current SUD workers to become IBH providers, as described in Section IV. While expanding the workforce it is also critical that DHCS ensures that IBH providers are reimbursable.

3. The State should develop strategies to increase compensation for the SUD treatment workforce.

The SUD treatment field will not be able to attract significant numbers of adequately trained and qualified candidates if it does not begin paying its employees decently. DHCS needs to collaborate with California Workforce Investment Bureau (WIB), Health Workforce Development Council, Office of Statewide Planning and Development (OSHPD), and provider organizations to devise strategies to increase employee compensation and benefits, in order to make them competitive with those offered in other health care sectors. A variety of strategies should be considered: tuition assistance, loan forgiveness, performance-based or merit-based salary increases, and restructuring fee and payment schemes for agencies so that they can pay their

workforce competitive wages.[82] Though not all of these strategies may be feasible, it is urgent for DHCS to devise strategies to increase salaries, so it can attract and maintain an adequately trained and skilled SUD workforce.

4. The SAMHSA career ladder for SUD counselors should be implemented in California.

Many states have already adopted career ladders for SUD counselors, similar to that recommended by SAMHSA, but California has not. The adoption of a career ladder would require the input of and collaboration with the nine agencies that certify SUD counselors in California. The certifying organizations would need to agree on definitions of each step on the ladder, as well as the professional responsibilities, salaries, and benefits that should be linked to each title. Though this would be a significant undertaking, the adoption of a career ladder or similar scheme would help address the significant challenges to workforce recruitment and retention that currently affect California's SUD workforce. We concur with the recommendations of the 2008 Little Hoover Commission on Addictions and stakeholders interviewed for the Statewide Mental Health and Substance Use Treatment Needs Assessment in 2012, by strongly suggesting that DHCS create and implement a scheme—such as a career ladder—to create clear standards and career trajectories for individuals in California's SUD workforce.

[82] Michael A. Hoge, John A. Morris, Allen S. Daniels, Gail W. Stuart, Leighton Y. Huey & Neil Adams. *An Action Plan for Behavioral Health Workforce Development: A Framework for Discussion.* Report prepared for the Substance Use and Mental Health Services Administration. Cincinnati, OH: Annapolis Coalition on the Behavioral Health Workforce, 2007.

5. DHCS should collaborate with institutions of higher education to increase recruitment and properly train the SUD workforce.

Many community colleges, 4-year institutions, and graduate schools have programs that provide SUD education and training for prospective members of the SUD workforce. Though these institutions offer appropriate preparation for a career in SUD treatment, they are not producing enough graduates to satisfy the treatment system's workforce demands.[83] Thus, we suggest that DHCS initiate collaboration with institutions of higher education across the state to teach students about the SUD treatment field and the professional opportunities it offers. There is also a need for more SUD-specific degree programs at the bachelor's and master's levels. It is worth noting that this process will be much more effective once a career ladder (Recommendation 4) is established, and students can see that there is potential for decent compensation, growth, and career advancement within the SUD treatment field.[84] Once a career ladder is established, it can also be used to help institutions of higher learning design their curricula and training programs, so that graduates will complete their education prepared to enter the SUD treatment workforce.

6. DHCS and providers of SUD services across California should make a concerted effort to recruit young individuals, males, and racial/ethnic minorities into the SUD workforce.

The majority of the SUD treatment workforce is White, female, and in their 40s or 50s, making them highly mismatched for the clients they serve. According to ADP data, 63% of Californians receiving SUD treatment are male, and 57% of them are non-White

[83] Ibid.
[84] Ibid.

(34% are Hispanic, 16% are Black).[85] Furthermore, almost 60% of individuals who need SUD services are under the age of 35.[86] Though efforts to inculcate cultural competency and encourage the delivery of culturally appropriate services can help improve the quality of treatment delivered to these populations, it is still preferable for clients to receive treatment from individuals who are of a similar age, gender, and racial/ethnic background.[87] Thus, DHCS should focus workforce recruitment and expansion efforts on adding more men, racial/ethnic minorities (particularly Hispanics and Blacks), and young individuals to California's SUD workforce.

7. DHCS should train medical and mental health professionals working in integrated care settings on the basics of substance use and SUD and their impact on health.

Many of the physicians, mental health professionals, and allied medical providers who will serve individuals with SUD in integrated primary care settings continue to harbor negative attitudes about individuals with substance use conditions, and have received minimal training on how they should be treated. To address this issue, DHCS should make a concerted effort to provide training for doctors, nurses, and other physical health staff working in primary care settings on the nature of SUD, its etiology, and its treatment.

[85] Technical Assistance Collaborative & Human Services Research Institute, *California Mental Health and Substance Use System Needs Assessment*
[86] Ibid.
[87] Susan G. Pfefferle & Tyronda S. Gibson, *Minority Recruitment for the 21st Century: An Environmental Scan.* Report prepared for the Substance Abuse and Mental Health Services Administration. Cambridge, MA: Abt Associates, 2010.