The Substance Use and Addictions
**Workforce and Organizational
Development Strategic Plan:**
Year 1 Results and Update

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COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF PUBLIC HEALTH

MA Department of Public Health
BSAS
BUREAU OF SUBSTANCE
ABUSE SERVICES
Prevent • Treat • Recover • For Life

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the following for their hard work in producing this Plan:

Members of the Statewide Stakeholders' Advisory Group

Participants in the SAG Working Groups

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Staff of the Bureau of Substance Abuse Services

Members of the Strategic Plan Steering Committee

DMA Health Strategies

The Substance Use and Addictions Workforce and Organizational Development Strategic Plan: Year 1 Results and Update

How to Use This Plan

This Plan is a "living plan," intended to be reviewed by individual and institutional stakeholders to prompt individual and joint action. As needs and circumstances change, its use can be adapted to take advantage of new resources for achieving the Vision of a strengthened workforce.

The audience for this document is wide. Depending on your familiarity with Substance Abuse and Addictions Workforce and Organizational Development, and time permitting, you may wish to read more or less deeply.

- ► **If you have limited time** read the Executive Summary and the Vision. More details on implementation can be found by reading the Recommendations and associated Implementation Steps.
- ► **If you would like more background** read the Purpose, Background, Current Reality and Vision.
- ► **If you would like more discussion, suggestions or resources** for a topic, see the relevant Appendix. In particular, many of the ideas generated by the Stakeholder Advisory Group are listed in Appendix C, as are many other national resources for strengthening the workforce.

Once you have reviewed the Recommendations, you may find the suggestions in Appendix B "Using this Plan to Take Action" helpful in implementing next steps.

This vision was developed by the statewide group of stakeholders participating in the collaborative Substance Use and Addictions Workforce and Organizational Development strategic planning process.

The Vision

We envision a workforce that:

- ► Is respectful, respected, competent, confident, enthusiastic, and reflects the population that it serves;
- ► Consists of people who believe their work in prevention, intervention, treatment and recovery makes a difference, and who advocate for the field;
- ► Understands that addiction is chronic and that recovery is an ongoing process which takes place in the context of a larger social environment, requiring a continuum of services;
- ► Understands that prevention addresses the critical role of the environment in shaping and maintaining healthy and drug free behavior;
- ► Strives to provide culturally and linguistically appropriate services based on each individual's and community's needs and readiness for change;
- ► Has the experience, knowledge, and skills to support consumer participation and empowerment, and community engagement;
- ► Responds effectively to new research and information by regularly examining and updating practices as part of ongoing quality improvement.

Principles for success

- ► **Communication** is fostered through collaborative, multidisciplinary teams that include providers, consumers, researchers, educators, payers, government, and others.
- ► **Continuous Learning** is incorporated into practice, is readily accessible and available, enhances skills, and supports the professional growth of all workers and organizations.
- ► **Education** programs provide current, relevant, and practical information through skills-based, experiential teaching methods.
- ► **Quality Supervision** and mentoring occur regularly, at every level of work within an agency.
- ► **Compensation** supports workers' costs of living, and comes in a range of diverse forms, such as salaries, comprehensive benefits packages and reimbursements.
- ► **Experience** (in life and work) is recognized as a valuable asset to the field.

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Executive Summary

This document provides a summary of recommendations for action by all who have a stake in the strength of the substance use and addictions workforce. Currently, many treatment providers work in under-resourced agencies, with clients whose needs vary according to socio-economic status, race, culture, age, gender, ability and natural supports, as well as the severity of their substance use disorder. The national crisis in recruitment and retention of such workers has been well documented for over a decade, and includes a shortage of thousands of workers and turnover rates as high as 50%[1]. There have been multiple efforts at the state and national level to address this crisis directly. Massachusetts is currently engaged in implementing its own plan to address this crisis.

Following the lead of the Commonwealth's 2005 Substance Abuse Strategic Plan, a Workforce Development Strategic Planning Stakeholder Advisory Group was formed in 2007-2008. Out of the several large and small working group meetings of consumers, providers, regulators, professors, and researchers came recommendations and strategies for addressing workforce development issues in the substance use and addictions field. Over the course of the next year, those recommendations and strategies were incorporated into a first draft of a Workforce and Organizational Development Strategic Plan.

Since that first draft was completed, there have been political and economic changes. These include ongoing implementation of Massachusetts' own health care reform, passage of Massachusetts' Mental Health Parity legislation and national parity legislation, implementation of the Children's Behavioral Health initiative, national health care reform proposals, filing of various legislation related to CORI reform and third party reimbursement for substance use and addictions services, and a downturn in the economy resulting in budget cuts to human services. Despite these changes, the challenges, opportunities, recommendations and strategies initially put forth during stakeholder meetings have remained at the core of this Strategic Plan, and have guided ongoing training and workforce development activities at the Bureau. Even more recently, a separate stakeholder process was initiated in the spring of 2009 to update the 2005 Substance Abuse Strategic Plan. The updated version contains specific language about Workforce Development, which further supports the content of this more detailed Workforce and Organizational Development Strategic Plan.

The Vision developed in this process is of a workforce that is capable, caring, connected to the community, energized by their job and compensated appropriately. This vision can be realized. The challenges are to make the direct connection between workplace needs and the education and training of workers; to change how training is delivered to agencies; and to support programs in creating a work culture that leads to retention and recruitment practices which result in the right staff being hired.

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[1] See the Annapolis Coalition report: "An Action Plan for Behavioral Health Workforce Development, prepared by The Annapolis Coalition on the Behavioral Health Workforce (Cincinnati, Ohio) under Contract Number 280-02-0302 with SAMHSA, U.S. Department of Health and Human Services. 2007. See also Appendix C, National Data and Resources for state-by-state Addiction Technology Transfer Center survey results.

The overall Recommendations in this Plan center around four key elements:
- collaborative effort;
- supporting continuous learning and quality improvement;
- increasing the value and reward of work in the field;
- direct technical assistance for programs in recruitment and retention practices.

These recommendations were developed based upon input from stakeholders during a series of working group and general meetings.

Recommendation 1:
Identify and Create Structures for
Communication and Collaboration among Stakeholders

Strategies:

1.1 Support Collaboration among stakeholders

    1.1.1 Initiate collaborative projects among stakeholders that address specific themes from this Plan

    1.1.2 Formalize an ongoing collaborative among stakeholders

1.2 Promote communication opportunities among stakeholders

    1.2.1 Increase availability of web-based information

    1.2.2 Promote provider-oriented communication and collaboration activities

    1.2.3 Promote interagency collaboration on substance abuse and addictions workforce development across the Commonwealth

1.3 Strengthen and formalize alliances between the substance use and addictions field and higher education

1.4 Unify and coordinate diverse marketing messages and effective social marketing approaches for workforce issues

Recommendation 2:
Support Effective and Continuous Learning Opportunities for Individual Workers and Organizations that include Critical Clinical and Administrative Topics

Strategies:

2.1 Replicate Work-Based Learning initiatives

2.2 Enhance organizational training and development

2.3 Improve the effectiveness of training and education

2.4 Support quality improvement at all levels

2.5 Increase technical and administrative program support

Recommendation 3:
Increase the Reward and Value of Work in the Field

Strategies:

3.1 Advocate for enhanced funding for education and training of workers

3.2 Advocate for improved salaries, career ladders, reimbursement and benefits

Recommendation 4:
Improve Recruitment and Retention Strategies at Provider Organizations

Strategies:

4.1 Improve providers' skills in recruiting and retaining staff

4.2 Learn more about current workers and organizations and their specific needs and successes

4.3 Identify and learn more about potential workers, particularly those who reflect the populations being served

Implementation

Because the necessary efforts reach across organizational and disciplinary boundaries, it will require collective action to reach the goal. The good news is, this work is being done in multiple states and across the nation; and this strategic planning process has set the stage for a substance use and addictions workforce and workplace renaissance in Massachusetts. Specific implementation steps are outlined for each Strategy. Near term, medium term and long term actions are proposed at the end of the report.

The Substance Use and Addictions
Workforce and Organizational Development
Strategic Plan: Year 1 Results and Update

Purpose

There is an ongoing national crisis in the hiring and development of substance use and addictions workers[2]. In 2007, the Bureau of Substance Abuse services initiated a strategic planning effort designed to create a statewide, coordinated response to the crisis as it affects Massachusetts.

The specific goal of the Substance Use and Addictions Workforce and Organizational Development Strategic Planning project was to develop a plan which aligns the efforts of all Massachusetts stakeholders to support the recruitment, retention and effectiveness of quality substance use and addictions workers.

This plan is intended to be used as a guide to action by stakeholders in professional associations, advocacy groups, individual agencies, and state government. The focus is on the Recommendations and their accompanying Strategies. Each Recommendation has a set of Implementation Steps.

The Appendices capture much of the detailed information generated by the Stakeholder Advisory Group members as well as research which provided the underpinnings for the process. After achieving a clear understanding of the Recommendations, refer to Appendix B, "Using this Plan to Take Action" and Appendix C, "Resources and Suggestions from Stakeholders" for ways to adapt its content to your individual setting. Circumstances vary by level of care, location and population served, but many suggestions put forth by one level of care be easily adaptable to others.

This Plan is a "living" plan – as needs and circumstances change, it must be adapted dynamically to use new tools in achieving the Vision of a strengthened workforce.

Lastly, after much discussion, this report uses the term "Substance Use and Addictions Workforce" to describe the field and workers. It is intended to cover the full spectrum of prevention, intervention, treatment and recovery services, as they relate to the use of substances and gambling. For further discussion, see Appendix D, "Choice of Wording."

Background

The Annapolis Coalition on the Behavioral Health Workforce published "An Action Plan on Behavioral Health Workforce Development" in 2007[3]. Based on five years of work across the nation, supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), and involving an estimated 5,000 participants, this report synthesized the growing body of literature describing a pervasive difficulty in recruiting and retaining effective substance use and addictions

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[2] See the Annapolis Coalition report: "An Action Plan for Behavioral Health Workforce Development, prepared by The Annapolis Coalition on the Behavioral Health Workforce (Cincinnati, Ohio) under Contract Number 280-02-0302 with SAMHSA, U.S. Department of Health and Human Services. 2007.

[3] ibid

workers, and the impact this difficulty has both on people who need services and on service provider organizations. The report also integrated the suggestions participants developed about how to address this issue at the local, state and national levels.

The Annapolis Coalition report describes a workforce that is aging and retiring, into which the flow of new workers is insufficient. Leadership, in particular, is being lost, along with valuable experience that needs to be shared. It is difficult to recruit qualified new workers, and turnover is high. Those who remain at work in addictions are overtaxed by their workloads; by compensation packages which are sometimes incomplete, requiring workers to hold two jobs to make ends meet; and by unclear paths for career advancement. Workers are not sufficiently prepared to provide culturally responsive services to the broad range of clients they serve. The composition of the workforce often does not reflect that of the clients served - most of the workers are white women over 40; the majority of clients are not. Workers are not supervised frequently enough or well enough and often lack appropriate evidence based supervision and training. They are often devoted to their work, but stressed by a lack of resources. They need more space to see clients and smaller caseloads, as well as information technology as basic as email (70% of frontline workers say they do not have access to email at work). As it is now, the Annapolis Coalition documents that services are insufficient to meet the huge need across the country. In some areas, there are simply not enough qualified practitioners, while in other areas a reconfiguration of existing resources is required. With a loss of experienced leadership and a shortage of mid and entry-level workers, the projections are bleak.

These trends in both the quantity and quality of resources available stand in contrast to recent progress in treatment options: current scientific and medical research provides new understanding of addiction as a manageable chronic condition and new, effective tools with which to treat it. Evidence-based practices (EBPs) ranging from ongoing medication-assisted therapy to brief cognitive and behavioral interventions are proven to be effective. The tools to spread new practices successfully and improve the quality of existing services are also being honed. A sophisticated understanding of the staffing configurations which can best implement and spread these effective new practices is important to making progress in combating addiction; and *filling* those staffing needs with qualified workers is crucial.

Massachusetts was well-prepared to begin the strategic planning process and address these problems. In 2005, the Commonwealth began implementation of its Substance Abuse Strategic Plan. Workforce was one of the many components of the plan that needed to be addressed. BSAS created the position of Workforce Development and Training Coordinator in 2006, and in late 2007, initiated this strategic planning project focused on Workforce Development. In fact, this effort was modeled after the process used to develop the Commonwealth's Substance Abuse Strategic Plan. BSAS contracted with DMA Health Strategies to support the project. BSAS invited a Stakeholder Advisory Group to participate in a guided set of interactions which

- ► Examined the **current reality** of the substance use and addictions workforce;
- ► Developed a **vision** for that workforce;
- ► **Identified gaps** between the current reality and vision and;
- ► Developed concrete suggestions for how to **close such gaps**.

A summary of the planning process is included in Appendix A, with a list of participants in Appendix E. The individuals represented consumers, their families, clinical and administrative staff from providers, provider organizations, government agencies, payers, educators and trainers.

Since a first draft was completed, there have been political and economic changes. These include ongoing implementation of Massachusetts' own health care reform, passage of Massachusetts' Mental Health Parity legislation and national parity legislation, implementation of the Children's Behavioral Health initiative, national health care reform proposals, and a downturn in the economy resulting in budget cuts to human services. Despite these changes, the challenges, opportunities, recommendations and strategies initially put forth during stakeholder meetings have remained at the core of this Strategic Plan, and have guided ongoing training and workforce development activities at the Bureau. Even more recently, a separate stakeholder process was initiated in the spring of 2009 to update the 2005 Substance Abuse Strategic Plan. The updated version contains specific language about Workforce Development, which further supports the content of this more detailed Workforce and Organizational Development Strategic Plan.

The Current Reality

The current environment for substance use and addictions treatment and prevention is explored in the following sections by looking at Unmet Need for services, the Workforce providing services, Challenges and Strengths.

Unmet Need

There is significant unmet need for substance use and addictions prevention, intervention, treatment and recovery services[4]:

- ► The number of Massachusetts residents aged 12 years or older[5] who needed treatment for drug or alcohol abuse but did not receive treatment in a specialty care setting in 2006-7, was
  - 477,000 people (8.79%) abusing or dependent on alcohol;
  - 140,000 people (2.57%) abusing or dependent on illicit drugs.
- ► A 2003 study by Brandeis University conservatively found that there were 39,450 Massachusetts residents with *severe* substance abuse disorders who needed treatment but were unable to access it.[6]

According to a recent CASA study, there seems to be a disproportionate distribution of substance abuse funding in Massachusetts, where 97% of substance abuse dollars are spent across all agencies on responding to the impact of undertreated substance abuse at "downstream" programs such as Corrections and Public Safety, while only 3% of those dollars is spent in the substance use and addictions field directly, 1% each in prevention, treatment, and regulatory compliance.

The Massachusetts Substance Use and Addictions Workforce

The Substance Use and Addictions Workforce include at least three distinct components:

- ► **Workers primarily dedicated to addictions** prevention, intervention, treatment, and recovery

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[4] The comparable national figure is almost 21 million people across the United States (8.34% of the population over 12 years old) needed treatment for drug or alcohol abuse but did not receive it in a specialty care setting in 2007

[5] 2007 National Survey on Drug Use and Health (NSDUH, 2007) State Estimates of Substance Abuse and Mental Health, Table 43 (2006-7 data) http://oas.samhsa.gov/2k7State/Massachusetts.htm, accessed 12-7-09

[6] Administration and Policy in Mental Health, Vol. 32, No. 4, March 2005 (_ 2005) DOI: 10.1007/s10488-004-1667-y

► **Workers who do some addictions work** in the many other fields addictions touch, e.g.: mental health, education, corrections, healthcare, child welfare, private practice, employee assistance programs

► **Consumers and their families/communities** touched by addictions

The Commonwealth's system for prevention, intervention, treatment and recovery consists of a service array delivered by multiple public and private providers. Job functions vary for each of the services in the array, from provider to provider, and entail different professional development and educational requirements. A comprehensive approach to strengthening the workforce must be flexible enough to address these many diverse components. The diagram below represents the various intervention, prevention and treatment services provided for substance use and addictions by state and local, public and private agencies.

The professionals in these various services do not work in isolation. Specialists and non-specialists both play significant roles in the identification of individuals with substance abuse and addiction concerns. Increasing interagency collaboration was a cornerstone of the Commonwealth's 2005 Strategic Plan and is at the center of its 2009 Update. Progress has been made in cross-agency training, interagency sharing of data, joint initiatives and coordination of care for individuals whose service needs span multiple services.

Health care reform and the initiation of Medical Homes in Massachusetts are also encouraging this cross-agency work. For example, in the Office-Based Opioid Treatment project spread throughout the Commonwealth, BSAS pays for a nurse care manager in the primary care practice. The nurse is the link to specialty care, and is becoming the de facto care manager. This type of co-location of behavioral health specialists in primary care settings will become more and more common as medical homes are implemented.

System Capacity: Treatment, Prevention and Early Intervention

Those working directly in services for substance use and addiction support the system's capacity for treatment and prevention.

Treatment Capacity

In the year prior to this planning process, there were approximately 100,000 admissions[7] to BSAS funded programs located across the state. Roughly 70% of admissions were to four levels of care: acute detox and outpatient (50% between the two), Opioid, and 1st Offender programs. About one hundred and thirty unique agencies provide treatment at over 500 sites[8]. Over 2000 licenses and certifications specializing in addictions were held by staff; tens of thousands of more general mental health-related licenses and certifications were active for professionals who encounter substance abuse in the course of their work, such as social workers, psychologists, marriage and family therapists, physicians, and others.[9] Any workforce development plan needs to address training, licensing and employment dimensions of this diverse set of workers.

Prevention and Early Intervention Capacity

Prevention programs can be categorized by their target population:

- *Universal* programs reach the general population, such as all students in a school or all parents in a community.
- *Selective* programs target subsets of those at risk, such as children of substance abusers or those exhibiting problems at school.
- *Indicated* programs are for those already experimenting with alcohol, tobacco and other drugs or showing signs of other risky behaviors.

  ▶ Prevention programs employ Environmental Strategies (reach large populations) or serve small groups (10s)
  ▶ All programs are Evidence-based
  ▶ Programs are viewed through the Federal Strategic Prevention Framework
  ▶ Elements of prevention are found in the work of other points in the services spectrum
  ▶ UMASS School of Public Health partnered with the Regional Center for Healthy Communities for study on prevention competencies eight years ago, resulting in delineated competencies for certified health education specialists

Prevention[10]	
# of Programs	Description
28	Evidence-based prevention programs - 14 have Environmental Strategies components EBPs: All-Stars, CMCA, Friendly PEERsuasion, Project Northland, Life Skills
6	Regional Centers for Health Communities
3	Recovery High Schools
3	Intervention programs: individuals, families, communities
Multiple, Expanding	SBIRT
Multiple	Elderly and College initiatives
Multiple, Ongoing	Policy Development and Implementation; Coordinated Enforcement, Education, Media Campaigns

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[7] Admissions to BSAS funded programs from BSAS "Utilization by Modality", 2007
[8] BSAS, derived from Licensed Programs Report, 11/23/07; and spreadsheet from Licensing Unit, 6/25/09; Opioid information updated 10/13/09.
[9] See Appendix F, Massachusetts Treatment Capacity
[10] From José Morales, BSAS

The Massachusetts Board of Substance Abuse Counselor Certification recently approved a Massachusetts Prevention Specialist Certification, using the standards of the International Certification & Reciprocity Consortium of which the Board is a member (see Appendix C for details).

Strengths

Massachusetts has a strong infrastructure to draw upon, and a history of careful review and revision of services to address the complexities of substance abuse prevention, intervention, treatment and recovery.

Massachusetts has:

- ▶ Hundreds of well-organized providers
- ▶ Active provider associations
- ▶ Consumer groups ready to help
- ▶ An established educational infrastructure
- ▶ An active training infrastructure
- ▶ An Interagency Council on Substance Abuse which helps coordinate efforts of different MA agencies
- ▶ Legislators who are responsive to the role state contracting practices play in provider stability
- ▶ Participating payers
- ▶ A vibrant academic research base
- ▶ State Executive Office of Labor and Workforce Development
- ▶ Federally-supported Substance use and addictions efforts (e.g., SBIRT award to MA, Annapolis Coalition work)
- ▶ Collaborations between the Bureau of Substance Abuse Services and the Division of Children and Families, (DCF), Early Intervention, Division of Youth Services (DYS), and others on cross-systems training and communication
- ▶ Demonstration projects exist for many of the strategies recommended in this plan

BSAS has:

- ▶ A statewide presence for its entire continuum of service
- ▶ A well-articulated comprehensive continuum of service
- ▶ Counselor and Program Licensing Regulations designed to insure quality
- ▶ An active Strategic Plan which is being implemented with continuous quality improvement efforts
- ▶ Subsidized provider training

Additional support includes:

- ▶ National and other state efforts
- ▶ Private Foundations (for example, The Robert Wood Johnson Foundation)

Challenges

The challenges facing Massachusetts mirror those of the nation in sustaining a workforce and organizations which are able to deliver services tailored to the unique needs of individuals which vary across culture, ethnicity, age, severity of substance use disorder, gender, ability and natural supports, among other aspects. The challenges fall into the following broad areas: education and training, use of licensure and certification, recruitment and retention practices, and compensation.

Education

The preparation of new workers for entry-level jobs most often occurs in educational settings. In addition, many workers in higher level positions seek additional education in order to advance in their careers. How well prepared a worker is for the first day on the job has a strong correlation with the success of that worker and the effectiveness of the program he or she joins. Currently, educational opportunities do not fully match worker and workplace needs, resulting in underdeveloped competencies for those entering the field or advancing in the field. Much of this information was documented in the Annapolis Coalition report and subsequently confirmed for Massachusetts in Working Group meetings during this strategic planning process. The challenges in educating the substance use and addictions workforce include:

- ► **Lack of Accessible, Accurate Information about programs and courses**: It is not readily apparent which educational programs match the needs of a student, whether for licensure preparation or introduction to the field, depending on the professional area the student is focusing on. Some programs have stable or increasing enrollment over the last three years, and a diverse student population, including students in recovery; others shut down. There is no centralized resource providing information on courses, programs, licensure, certification and professional job requirements which would be helpful in guiding students.
- ► **Inconvenient Scheduling**: Traditional daytime course hours do not meet the needs of the many working individuals who would like to take substance use and addictions classes. Some sites have introduced evening classes to address this need. Others have introduced online learning for local students or "distance learning" in which courses may be taken online by individuals far from the instructor and often when convenient for the learner. However, there is more progress to be made, and not all distance learning programs meet licensing requirements.
- ► **Inconvenient Location**: Many workers find it difficult to travel to educational programs.
- ► **Legal and other considerations**: In a survey of stakeholders for this workforce development project, one educational program reported loss of up to 30% of students to various life problems including CORI issues which prevented field placement and relapse which sometimes resulted in arrest or inability to continue with their education at the time.[11]
- ► **Lack of Relevant, up-to-date Content:** Examples were cited of instructors using out of date material, or curricula which are not in line with the needs of the substance use and addictions workplace
  - • Content draws only on text books and not on articles in current professional journals
  - • Focus on co-occurring disorders (mental health conditions) is the exception, rather than the rule; understanding of co-morbidities (concurrent medical conditions and their interaction with substance abuse/addiction) is also the exception rather than the rule

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[11] September 19, 2007 email summarizing BSAS analysis of telephone survey of higher education stakeholders.

- Addiction as a chronic disease is not recognized as a primary and secondary disability
- Opportunities for medical personnel to acquire extensive substance use and addictions training are even slimmer than for other health professionals

► **Lack of Adapted Teaching Styles:** The students who are interested in working in the field are diverse in age, experience and background. Traditional "frontal" teaching methods are not as effective as interactive teaching methods which reflect current research on Adult Learning. In addition, today's younger student is more influenced by technology than many older learners, but technology is absent from most classrooms teaching substance use and addictions material.

► **Not enough field placements for internships**

► **Lack of feedback from the field on content**

► **Academic programs do not have consistent policies accepting experience and training for academic requirements.**

Training

In order for new understandings of substance use and addictions to be put into practice, people who are already in the field need to have accessible, comprehensive and up-to-date training. Currently, substance use and addictions training does not fully match either the workers' or workplaces' needs, resulting in underdeveloped competencies for those already in the field. This leads to services which do not adequately meet the needs of the people they serve[12] because:

► **Treatments proven effective by research can take *over a decade*** to be widely adopted by practitioners.

► **Most substance use and addictions professionals lack *specific expertise*** in treating many sub-populations who benefit from tailored care (youth, elderly, rural, cultural groups; those with co-occurring disorders, those needing medication-assisted therapy, or those needing help with gambling).

► **More substance use and addictions clients are identified with complex needs** than in the past (such as other physical health conditions, need for medication-assisted therapy, mental health conditions, social circumstances). Research shows that outcomes are better when such other conditions are addressed.

► **Workers do not have a comprehensive understanding of the services** available and how to access and coordinate them.

The deficits which need to be corrected include:

► **Lack of accessible, accurate information about training opportunities** (cost, content, location, commitment, CEU availability, etc).

► **Scheduling not oriented to the working person -** Training programs are not always available to workers due to cost, location or time. Workers and agencies lose money in order to send staff to trainings if in a fee-for-service structure. Staff often must pay on their own and take vacation time for training.

► **Inconvenient Location –**Training should be offered in multiple modes – at the worksite, in regional settings, online.

► **Lack of Relevant, up-to-date Content –** although much improved in recent years, content does not consistently reflect current evidence-based practices, and new practices based on

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[12] Annapolis Coalition Report

current literature, with relevant adaptations for culture, age, ability and other population-specific needs.

► **Lack of Adapted Teaching styles** -- trainings still do not consistently use the methods current research shows that adult learners need: more experiential and interactive components.

► **Training the individual and not the Organization** The traditional model of training has been for an agency to send individual workers to trainings outside the agency; the expectation is that this worker will bring new skills not only into their individual practice but help to spread them in the agency. However, this model does not result in successful spread of skills as thought; and in fact, experience shows that agency culture often prevents full implementation of newly acquired skills by individuals. In addition, when an individual leaves their job, their training leaves with them. Training must be focused not only on individuals but on organizations in order to have a practice adopted and self-sustaining.

► **Lack of training in supervisory practices and management skills which support fiscal health of agencies.**

Licensure
- Is a legal status conferred upon an organization or an individual
- Is granted by a state to those who are qualified for a profession
- Eligibility may involve prior experience and a test of knowledge, as well as verification of capabilities for an organization

Certification of individuals
- Is not a legal status, but recognizes the competency of a program or an individual
- May be conferred by a state; however "certification" may also be offered by a non-state organization as well – to prepare an individual to take a state licensing exam or a state certification exam, show a course of study was completed.

Accreditation
- Conferred by a national organization to an agency or institution

Licensure and Certification of Individuals, and Accreditation of Organizations

In a 2004 Survey by the New England Addiction Technology Transfer Center, 41% of Direct Service Providers in New England said they had never been certified or licensed to provide specialty Substance Use and Addictions care[13]. Workers and potential workers do not understand the difference between Licensure and Certification for individuals in MA[14] or the value of each for professions relevant to substance use and addictions. In addition, is it difficult to find courses which meet the requirements for either. Accreditation applies to agencies or institutions, and adds to the multiple requirements that these organizations must adhere to.

► There is no clear crosswalk between licensure requirements and the relevant courses available.
► Some licenses are linked to higher reimbursement (LICSW, LMHC); others are not (LADC).
► There is not close coordination between provider/practice needs and licensure/certification preparation courses.

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[13] Summary of Regional Findings – Direct Service Providers. http://www.attc-ne.org/initiatives/NE%20Direct%20Service%20Providers12.15.04.pdf
[14] About half the states use licensure to provide quality checks, and about half use certification. There is active debate in the substance abuse field (and other adjunct health professions such as radiography, physician's assistants and EMTs) about the best use of each. Some professions have clear value to licensure (nursing, physicians) or certification (PA, EMT); others do not.

In order to get the most out of the Licensures and Certifications available to workers,

- ▶ Workers must be able to find information to decide which credential to seek, and hiring organizations must be able to assess the value.
- ▶ A cross-walk should be easily available describing each licensure and certification, how to fulfill the requirements (and where courses/training to fulfill the requirements is offered) and the usefulness of each.
- ▶ CEUs and certification/licensure requirements should consistently reflect the best addictions practices of the relevant field

The MA program licensure regulations were revised in the fall of 2008, effective December 2008. The National Association of Alcoholism and Drug Abuse Counselors has developed a draft scope of work and career ladder document, submitted to SAMHSA, which would provide a nationally recognized framework. In addition, NAADAC has developed a Basic Level Certification through its independent National Certification Commission, which is customizable by each state (see Appendix C and www.naadac.org).

Recruitment and Retention

Working Group discussions during this process illustrated the wide variety of recruitment and retention activities, and the range of capabilities, which exist in provider agencies. Many agencies feel they have little chance of success in recruiting new, qualified staff, with little salary to offer and little budget for advertising, and no focused retention program. A few feel they have very strong overall programs which enhance the attractiveness of their site to potential workers, though they still work hard at recruitment. Recruitment and retention practices vary not only by size and experience of the provider organization, but also by the population-specific or specialty services offered.

There is little systematic data gathering on the success of recruitment and retention practices themselves, but much anecdotal discussion. There is no systematic categorization of job titles and job descriptions across the field of substance use and addictions. What we do know is that the overall MA Substance Use and Addictions workforce is not stable:

- ▶ 50% Annual Turnover Rate for Program/Agency Directors in New England[15]
- ▶ 67% Annual Turnover Rate for Direct Service workers in New England[16]
- ▶ 77% Annual Turnover Rate for Direct Service workers in MA
- ▶ Employment of substance abuse and behavioral disorder[17] counselors was expected to grow 34 percent from 2006-2016[18] which is much faster than the average for all occupations.
- ▶ In a 2004 survey by the Addictions Technology Transfer Center – New England, 38% of respondents reported that their agencies have difficulty recruiting staff[19].

Recruitment and retention practices miss opportunities to help stabilize the workforce. Below are a few examples, identified during stakeholder discussions, of barriers to workforce stability.

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[15] Addiction Technology Transfer Center- New England, 2004, http://www.attc-ne.org/initiatives/NE%20Managers12.15.pdf

[16] Addiction Technology Transfer Center- New England, 2004, http://www.attc-ne.org/initiatives/NE%20Direct%20Service%20Providers12.15.04.pdf

[17] Addiction Technology Transfer Center- New England, 2004, http://www.attcne.org/initiatives/NE%20Direct%20Service%20Providers12.15.04.pdf

[18] http://www.bls.gov/oco/ocos067.htm

[19] http://www.attc-ne.org/initiatives/NE%20Managers12.15.pdf

Recruitment:

> ► When job descriptions and duties are not clearly defined or implemented
> ► When job descriptions and duties are not aligned with fulfilling the mission of the organization
> ► When programs miss pools of potential candidates
> ► When advertising is not effectively used
> ► When interviewing techniques do not ensure the best fit or long term commitment
> ► When programs do not have competitive data on salaries, and do not implement consistent methods for determining salary

Retention:

> ► When new employees start work with minimal or no formal orientation, acculturation, and mentoring
> ► When new employees are not given feedback or individual training to ensure that they master the tasks of the job
> ► When programs do not attend to potential attractors or retainers – positive culture, mentoring, recognition, compensation, ongoing training, supervision, career path/ladder

Compensation

Mental health and substance abuse workers are paid less, on average, than comparably educated or skilled workers in other fields.[20] Even within the same discipline, such as social work, mental health and substance abuse workers earn about $8,000 per year less than others on average[21].

Stakeholders reported that payers distinguish between mental health and substance abuse conditions, reimbursing less for substance abuse diagnoses. Given the choice, clinicians generally report they will bill a mental health condition for a client who has both mental health and substance abuse conditions, because the mental health condition will be reimbursed at a higher rate.

It was common in the Stakeholder discussions during this process to hear of substance use and addictions workers holding two jobs in order to make ends meet.

Recruiters report that salary concerns are one of the top three difficulties in recruiting, and poor salary/benefits was the top source of job dissatisfaction for those who responded to a New England Addiction Technology Transfer Center survey in 2004.[22] Disparities in benefits between those employed as consultants and salaried workers are a concern to some stakeholders.

In addition, some providers, including many minority agencies, are not yet equipped to maximize third party billing with efficient administrative mechanisms to generate bills from clinical encounters, or to be included in insurers' panels. The change in environment – healthcare reform locally and nationally, and the Commonwealth's change to unit rates – may disproportionately impact minority agencies.

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[20] US Department of Labor. (2004). Occupational and employment statistics. Washington, DC: U.S. Bureau of Labor Statistics, Division of Occupational Employment Statistics as cited in Annapolis Coalition p. 278. Updated October 2007 at http://www.bls.gov/oes/current/oes_nat.htm#b29-0000.

[21] Updated October 2007 at http://www.bls.gov/oes/current/oes_nat.htm#b29-0000. Comparison of occupation codes 21-1021, 21-1022 and 21-1029.

[22] Sixty percent said salary/poor benefits were the top source of job dissatisfaction. http://www.attc-ne.org/initiatives/NE%20Direct%20Service%20Providers12.15.04.pdf

Recommendations

Recommendation 1:
Identify and Create Structures for Communication and Collaboration among Stakeholders

Rationale:

Across the nation, and throughout the strategic planning process in MA, the most commonly-expressed need for the field is increased communication among stakeholders as well as between stakeholders and the public.

Strategies:

1.1 Support collaboration among stakeholders

    1.1.1 Initiate collaborative projects among stakeholders that address specific themes from this Plan

    1.1.2 Formalize an ongoing collaborative among stakeholders

1.2 Promote communication opportunities among stakeholders

    1.2.1 Increase availability of web-based information

    1.2.2 Promote provider-oriented communication and collaboration activities

    1.2.3 Promote interagency collaboration on workforce development across the Commonwealth

1.3 Strengthen and formalize alliances between the substance abuse and addictions field and higher education

1.4 Unify and coordinate diverse marketing messages and effective social marketing approaches for workforce issues

Strategy 1.1
Support Collaboration Among Stakeholders

Strategy 1.1.1
Initiate collaborative projects among stakeholders that address specific themes from this Plan.

Rationale:

Many projects have been accomplished across the nation by groups of stakeholders focused on a single element of workforce development, such as recruiting more rural workers, or developing a new curriculum.

AK Model:

Collaborative Projects focused on Elements of Workforce Development

In Alaska, a project to address the need for more rural workers was funded in 2005 to create a new certified Behavioral Health Aide position, and curriculum to support the position. This focused project involved a partnership between the Alaska Mental Health Trust, the State of Alaska Department of Health and Social Services, and the University of Alaska.

NC Model:

Legislature-initiated, staffed by Institute of Medicine

The North Carolina General Assembly asked the North Carolina Institute of Medicine to convene a task force to study substance abuse services in the state. The Institute of Medicine in NC ran the initial project of assessing the current workforce and service delivery system and making recommendations. The IOM still hosts the website and continues to support stakeholder collaboration.

Implementation Steps:
A. BSAS initiates a joint project as a demonstration model for collaborative work.
B. BSAS encourages another stakeholder to initiate and lead a collaborative project.

Strategy 1.1.2
Formalize an Ongoing Collaborative of Stakeholders

Rationale:
The potential for duplication of effort by stakeholders in addressing workforce issues is huge, and the waste of precious stretched resources unacceptable. Many other states and other fields have formed successful collaboratives to support workforce development in a coordinated way. Collaboratives should be made up of diverse groups of stakeholders.

Collaboratives can provide opportunities for determining the right targets for resources by: collecting data about specific workforce deficits in specific services; creating differentiated strategies to address the identified target areas; developing resources for evaluating the success of strategies; spreading those strategies that are shown to work; and sustaining the efforts of the collaborative. In addition, a collaborative can connect providers, share techniques for retaining workers, and identify promising practices in a range of areas.

Implementation Steps:
A. BSAS invites a core group of stakeholders (Steering Committee) to lead the startup phase
B. Steering Committee seeks donated resources from stakeholders to support Collaborative infrastructure, including staffing, meeting space and basic communication tools.
C. Steering Committee chooses model for structure drawing on the expertise of the Prevention professionals and other Collaboratives
D. Steering Committee convenes first general Collaborative meeting
E. Collaborative forms subgroups which can actively work on a range of topics such as recruitment, retention, training and other areas
F. Collaborative members research and apply for funding to sustain and expand Collaborative work
G. Collaborative members revise and update this Plan

OH Model:

Provider-initiated Collaborative focused on Virtual Presence and State programs

NAADAC, The Association for Addiction Professionals in conjunction with OAADAC, the Ohio Association of Alcohol and Drug Addiction Counselors and the Ohio Council of Behavioral Healthcare Providers have founded the Ohio Workforce Development Center. Rather than investing in bricks and mortar the Center initially has a virtual base at www.ebasedtreatment.org with anchors in Cleveland, Columbus and Cincinnati. Funded through a Federal Budgetary Earmark, the Center is focused on effectively identifying the critical issues surrounding the workforce crisis.

In addition, Ohio created an Office of Workforce Development and Cultural Competence.

Strategy 1.2
Promote Communication Opportunities among Stakeholders

Strategy 1.2.1
Increase availability of Web-based workforce related information

Rationale:

There are multiple, but incomplete, efforts begun by individual stakeholders to provide much of the information which is useful for workforce development, but little coordination. A person trying to track down information can easily miss a helpful site, or be directed to an out-of date site. Coordinating those existing efforts so that the resources are more readily available to the public and kept up to date is an important step. Filling in the gaps is another important goal. A "one-stop shopping" web portal may be necessary to support information sharing, community building, and marketing. Other states have successfully set up limited portals.

Implementation Steps:

A. Investigate whether important content for each stakeholder group has an appropriate web presence.

B. Continue to create links among other efforts and publicize them, including SAMHSA's Workforce Development website.

C. Explore establishing a single web-portal.

Strategy 1.2.2
Promote provider-oriented communication and collaboration activities

Rationale:

Informal sharing of information in real-time among colleagues is just as important as formal meetings, conferences and other technology transfer activities. Maintaining and enhancing existing venues, and creating new ones, will support this interaction. In addition, while emails containing information about current events, job openings and other news are often shared amongst small groups of individuals and their professional networks, many workers are left out of the loop. The present sharing needs to be encouraged and expanded.

Implementation Steps:

A. Promote existing state, regional and local venues
   • Foster communication among providers through
      − Regional provider meetings
      − Level of Care (previously called Modality Management) meetings
      − Professional organizations
      − Conferences
      − Working groups
      − Focused training of groups of agencies
      − Multiple government agencies in which substance use and addictions are addressed.
   • Report to Interagency Council
B. Create new venues
   • Excellence Conferences
   • Provide opportunities for different professions to better understand the field and each other
   • Ensure use of multi-media communication channels
C. Reach out to other government agencies in which substance use and addictions are addressed

BSAS Level of Care Meetings

The Bureau of Substance Abuse Services has supported ongoing **Level of Care Meetings** (formerly called Modality Management Meetings). Contracted providers across the state who work in the same level of care are invited to meet quarterly at a BSAS-facilitated Level of Care Meeting. The meetings focus on reviewing current statistics related to each level of care, discussing what performance measures are most appropriate to compare across the level of care, and sharing information about level of care-specific training and learning opportunities. They also provide an opportunity to voice shared concerns and to network.

Regional Provider Meetings

Contracted providers from all levels of care who work within the same BSAS region are required to attend **Regional Provider Meetings**. The meeting frequency varies from monthly to quarterly, depending on the region. Some are facilitated by the BSAS Regional Manager, and some are run by an independent provider group (and the BSAS Regional Manager is invited). The meetings focus on giving an update to providers about regional events or news, and give providers an opportunity to make announcements about new programs, job openings, and other organization news. There is often an invited speaker as well.

Strategy 1.2.3
Promote interagency collaboration on workforce development across the Commonwealth

Rationale:

The Commonwealth is in a strong position to support cross-agency work in substance abuse and addiction prevention, intervention, treatment and recovery. Specific projects related to agencies working with special populations, and in particular Education and Criminal Justice, can complement the Commonwealth's work with private and non-profit partners.

Implementation Steps:

A. BSAS Report to the Interagency Council
B. BSAS review the Commonwealth's Strategic Plan Update and support Council members in implementing it.

Strategy 1.3
Strengthen and Formalize Alliances between the Substance Use and Addictions Field and Higher Education

Rationale:

As discussed earlier, substance use and addictions issues arise in all kinds of human service settings. Clients at these settings are served by workers from a wide variety of professional backgrounds, including social work, marriage and family therapy, psychology, nursing, medicine and other allied health professions, as well as counseling degrees from schools of education. Although some workers come from educational programs specializing in substance abuse, few Associate's, Bachelor's and Master's Degree programs in these various fields require substantial coursework in substance use and addictions or offer internships which provide experience working with clients who struggle primarily with those issues. Students often emerge from these programs with solid skills in their profession but very little in the way of up-to-the-minute, practical skills and knowledge about the substance use and addictions components of the work they are about to begin. Those programs which do offer substantial focus on substance use and addictions must ensure that the skills and theory they teach are tied closely to evolving standards of care in the field.

National Example:

The Association for Medical Education and Research in Substance Abuse (AMERSA)

Founded in 1976, AMERSA is a national organization of health care professionals focusing on health professional faculty development in substance abuse. With a five-year cooperative agreement from the US Health Resources and Services Administration, AMERSA is developing a strategic planning document to guide the improvement of health professional education on substance abuse, and implementing a national faculty development program.
www.amersa.org

Local Example:

The Institute for Addiction Recovery at Rhode Island College

"The Institute for Addiction Recovery, launched at Rhode Island College was established to strengthen Rhode Island's capacity to assist individuals, families, and communities in their recovery from addiction through collaboration and integration of academic and community resources. The eleventh affiliate of the College's Center for Public Policy, it is a scholastic hub to explore and analyze critical issues related to addiction and recovery; to enhance practice in substance abuse prevention, treatment and recovery; and to support individuals and families in recovery."
Website:
www.ric.edu/addictionrecovery/

Implementation Steps:

A. Create and publicize a crosswalk between courses and the licensing/certification requirements they satisfy, and where to take them

B. Use BSAS statutory authority to shape accepted curriculum for counselor licensure focused on proven practices.

C. Identify populations for whom sub-specialty workforce certification is appropriate and develop curricula and standards.

D. Increase internship opportunities by identifying and addressing barriers (including implementation of CORI reform and linking agencies to area colleges/universities)

E. Invite Deans of relevant schools to discuss substance use and addictions education curricula within the field of substance abuse directly and in related courses of study such as allied health professions and management

F. Invite Certification and Licensing Boards for various fields to discuss course requirements and the value of experiential training

G. Provide opportunities for educators and practitioners to interact and make alliances through lectures, educational and community events.

Strategy 1.4
Unify and Coordinate Diverse Marketing Messages and Effective Social Marketing Approaches for Workforce Issues

Rationale:

Workers and potential workers in the Substance Use and Addictions field consistently cite stigma (of the field, clients and workers) as a strong factor in their dissatisfaction with their work or their disinterest in exploring a career in the field. A consistent campaign which reaches both potential workers and the general public can serve two purposes for the field, both of which affect recruitment and retention:

► Stigma can be addressed by a campaign that educates the general public about addiction as a chronic disease which can be prevented with outcomes similar to or better than other chronic

Local Example:

The Massachusetts Department of Developmental Services (formerly the MA Department of Mental Retardation)

faced a similar workforce challenge to the one faced by the substance use and addictions field. DMR initiated a vigorous marketing campaign involving all stakeholders, and the campaign was launched in 2001. An initial pilot program yielded 2000 new candidates, 200 hires, was expanded statewide, and spawned a new nonprofit: Rewarding Work Resources, Inc.; the nonprofit offers a website where workers and hirers can find each other, and the option of a partner organization to screen resumes and help with hiring. This project has expanded to include NJ, CT and RI.

For the first year, costs were $100,000 (including DMR and provider contributions; and this included startup costs not required in subsequent years).

National Example:

ATTC's Addiction Careers national substance use and addictions workforce website is http://www.addictioncareers.org/addictioncareers/

conditions, such as diabetes and heart disease.

► Stereotypes about the substance use and addictions field itself can be addressed by a campaign that also emphasizes the attractive elements of the field, including cutting edge scientific and social intervention tools, in addition to the positive societal impact.

As the field reaches outside traditional sources for workers, this kind of marketing will be even more important. Taking advantage of existing universal messages marketing the field will help.

Implementation Steps:

A. Identify existing national, state and local marketing campaigns for substance use and addictions and explore ways to work with them and expand them.

B. Maintain a consistent theme and message in all BSAS communications, similar to current practice.

C. Share and coordinate with other stakeholder marketing and PR initiatives.

D. Learn from other fields (see Appendix C Resources and Suggestions from Stakeholders)

E. Analyze costs and seek funding for multiple marketing efforts

Recommendation 2:
Support Effective and Continuous Learning Opportunities for Individual Workers and Organizations that include Critical Clinical and Administrative Topics

Rationale:

Effective practice depends on workers having current knowledge as well as the individual skills and institutional support for implementing that knowledge. There are a wide variety of jobs, clients and workers, all of which require learning to be tailored to their needs for both general, cross-cutting skills and specialty skills for specific populations, treatment levels of care or locations. These skills require continuously updated knowledge at both the individual and organizational level.   In addition, Quality Improvement efforts must be used not only with clinical and business practices related to clinical efforts, but also with recruitment and retention efforts. Although BSAS requires monthly, onsite training for licensed programs, the need of workers across this wide variety of content and modes of training are still not being met.

> "All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics."
>
> Source: p. 118 of Annapolis Coalition Report

Participants requested that Technical Assistance be available to help implement and spread these practices. This section addresses how training should be made more effective, and it should be understood that content areas which are important for clinical and administrative workers include: Motivational Interviewing, Office-Based Opioid Treatment, Evidence-based and other proven practices and integration in general health settings using tools such as Screening, Brief Intervention and Referral to Treatment.

Strategies:

2.1 Replicate Work-Based Learning initiatives

2.2 Enhance organizational training and development

2.3 Improve the effectiveness of training and education

2.4 Support quality improvement at all levels

2.5 Increase technical and administrative program support

Strategy 2.1
Replicate Work-Based Learning Initiatives

Rationale:

Work-based learning optimizes the location, timing and relevancy of education and development of employment-related skills and knowledge. The approach provides the opportunity for a unique collaboration between treatment providers and local institutions of higher education (such as community colleges, 4-year colleges, or universities). It also allows agency workers who already have certification to receive college credit for it, and in addition to receive credit through on-site courses that are tailored for their specific job category. Workers are able to earn GED or college credits for work and certifications, and these academic achievements in turn make them eligible to move forward in the field. The participating organization's investment in individuals is intended to increase retention – workers believe in and feel supported by the organization, which helps them advance, and stay.

Implementation Steps:

A. Promote work-based learning to providers, educational institutions and licensing/credentialing groups by

- Publicizing existing demonstration projects.
- Publicizing effectiveness research
- Connecting interested parties.

Strategy 2.2
Enhance Organizational Training and Development

Rationale:

The traditional model of sending staff to be trained one-by-one as money becomes available does not support the adoption of new practices into agency-wide practice. In fact, without changing agency culture or practice, it is likely that individuals will not incorporate the new skills into their practice successfully. A technical assistance component must be added to certain trainings to be sure that individuals are able to implement new skills in their work setting. "Train the agency, not just the individual" is the aim.

While some major strides have been taken over the past several years to provide more opportunities for this model of individualized, coaching-based training that works directly with agencies on a longer-term basis, this type of training is expensive and often difficult to coordinate with staff schedules.

Finding a way to make sure that training is not only educationally effective and relevant, but also accessible in terms of geography and time, will require serious effort on every level.

The workplace culture must encourage and actively support workers in seeking individual training. Many agencies, however, face the reality that to send a worker for training requires replacing that worker or losing the income they generate, both of which are costs incurred on top of the cost of the training itself. Addressing this issue will require advocacy and planning.

The RWJF and Hitachi Foundation supported the Jobs to Careers program linking SSTAR in Fall River with Bristol County Community College brought education to staff at the worksite, and gave them academic credit for some of their certifications as well as some of their work activities.

Council on Linkages between Academia and Public Health Practice

A coalition of representatives from 17 national organizations that has worked for over 16 years to further academic/practice collaboration to assure a well-trained, competent workforce and a strong, evidence-based public health infrastructure. Supported by the CDC and staffed by the Public Health Foundation.

The Council's most recent projects include:
- map the pipeline of governmental public health agency workers
- refine and update the Core Competencies for Public Health Professionals.

In 2008, the Pipeline and Core Competencies Workgroups issued related policy statements regarding their work.

The Public Health Foundation also hosts TRAIN - TrainingFinder Real-time Affiliate Integrated Network, a web-based clearinghouse of on-site training and distance learning opportunities available in local, state, and national jurisdictions. It houses information on over 9,500 public health courses offered by more than 2,200 providers.

http://www.phf.org/link/index.htm

Implementation Steps:

    A. Continue and enhance existing projects that are models for this kind of work, including Motivational Interviewing adoption projects with adult and adolescent treatment programs, Brief Treatment with SBIRT programs, and NIATx.

    B. Investigate and replicate successful projects being implemented in other fields.

    C. Ensure that online and other referral sources for training and educational programs are up to date and easy to use.

    D. Supervisors should be competent to support the skills gained in training by individual supervisees.

Strategy 2.3
Improve the Effectiveness of Training and Education

Rationale:

Both training and educational instruction should be focused on up-to-date content which is relevant for the workplace, and delivered with experiential methods which reflect the current understanding of adult learning. Learning should be evaluated based upon observed competencies, not just hours spent or written tests completed. This kind of evaluation fits into both Work-based Learning and Organizational Training approaches to training described above, but should be used even in traditional didactic, one-time learning experiences.

Although there are some goals in common between Education and Training, implementing changes in each area requires different stakeholder efforts. For example, BSAS contracts for trainings and can influence the content for its providers, but changes in education require colleges and universities to go through lengthy processes of curriculum development.

> **Adult/experiential learning techniques**
>
> **Massachusetts Adult Residential Motivational Interviewing (MARMI)**
>
> In addition to training individuals, the programs were provided in-house follow-up coaching to the majority of staff (from Executive Directors to Receptionists). The coaching was interactive, and included role plays, multimedia demonstrations, and opportunities for staff to practice in their jobs between coaching sessions.

Implementation Steps:

    A. Consistent with Recommendation 1, communication between higher education and the field to ensure information in substance use and addictions courses are current, and that substance use and addictions information is suffused into relevant professions. This includes not only health practitioners but also administrators as well as educators, criminal justice professionals and others whose primary work is not substance use and addiction.

    B. Explore ways to help agencies focus on consistently implementing appropriate proven clinical and administrative practices related to substance use and addictions.

    C. Stakeholder Advisory Group members generated suggestions for courses and trainings which are necessary to keep practitioners current (see Appendix C).

    D. Assess training in a more effective way (see Appendix C).

    E. Provider Organizations request training aimed at a particular level of achievement and position (see Appendix C).

F. Provider Organizations request, and training organizations provide, trainings that take into account the needs of workers and clients based on culture, age, health status and other factors.

- Offer trainings in multiple languages.
- All trainings must *be* culturally responsive and *train* providers to be culturally responsive.

Strategy 2.4
Support Quality Improvement at all Levels

Rationale:

Agencies should adopt quality improvement strategies for their business and clinical practices, along the lines of NIATx and Institute for Healthcare Improvement techniques. These techniques can also be applied to workforce and organizational development issues, particularly related to recruitment and retention of staff board members.

Several BSAS projects have incorporated quality improvement methodology derived from the Network for the Improvement of Addiction Treatment, including "NIATx 200" and the annual Independent Peer Review required by the Federal Block Grant each year.

There are specific tools available to help agencies follow CSAT's TAP 21 and 21A best practices resources which are related to clinical work and clinical supervision[23]. In addition, the regional and national Addiction Technology Transfer Centers (ATTC) provide trainings and materials on their websites, and Boston Public Heath Commission/Institute on Urban Health Research at Northeastern University work with agencies to adapt evidence-based practices to specific elements of their primary populations.

Substance use and addictions service providers can also examine and refine their administrative practices with these methods, in the areas of reimbursement, HR, risk management, financial objectives, and of course, recruitment and retention.

Implementation Steps:

A. Learn more about existing Quality Improvement efforts in substance use and addictions and other fields

B. Spread access to resources, particularly free ones such as the Institute for Healthcare Improvement's on-demand video streaming series about their Model for Improvement, creating change teams and using data[24]

C. Encourage internal and external input on Workforce Development strategies.

D. Apply Quality Improvement techniques in working to create a positive work environment, improve the client and worker experience, improve supervision, streamline paperwork, gather data on recruitment and retention, and improve recruitment and retention practices.

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[23] http://kap.samhsa.gov/products/manuals/pdfs/tap21_a_08r.pdf
[24] (see http://www.ihi.org/IHI/Programs/AudioAndWebPrograms/OnDemandPresentationMFI.htm

Strategy 2.5
Increase Technical and Administrative Program Support

Rationale:

Under Massachusetts' health care reform, agencies will be able to bill third party payers for many more services. However, it will be necessary to provide technical assistance to providers to ensure that third party payments are maximized. Technical assistance may include helping establish effective billing practices, and ensuring that agencies are included in insurers' networks. In addition, it has been anticipated that the move to unit rates, together with the downturn in the economy and healthcare reform, may negatively affect minority agencies disproportionately. Infrastructure is necessary to generate authorizations, and technical expertise required to translate clinical practice into managed care vocabulary in order to generate a bill.

In addition, the Annapolis Coalition report stated that in a 2003 survey, "20% of substance use disorder provider agencies had no information systems, including email or voicemail systems. In an additional 50% of those organizations, information systems existed but were not available to the direct care counseling staff."[25] This leaves 70% of direct line staff without access to such technology. At the most basic level, these technologies are important for enabling workers to document their work, connect with other workers, and obtain information on current best practices. They contribute to the satisfaction or dissatisfaction of workers with their job, and influence recruitment and retention. In addition, the modern substance use and addictions program must utilize data rapidly and flexibly for internal quality improvement processes as well as external reviews. Information about the effectiveness of staff and their deployment are key elements in designing workforce development strategies.

Separately from the need for technical infrastructure, stakeholders strongly argued that differing reporting requirements from funders, payers and regulatory bodies have placed an unmanageable burden on existing administrative resources. They report that additional staff specifically for such administrative compliance is required, even after processes are streamlined as much as possible. The Network for the Improvement of Addiction Treatment reports many cases of organizations that have successfully streamlined their paperwork. Individual organizations must take responsibility for that work. Similarly, within the same funding environment, some organizations have successfully integrated technology and some have not; the work of the former can provide some direction on how to achieve that goal. At the same time, there is a systemic issue which funders, payers and regulatory bodies should address together: the need to rationalize the varying reporting requirements as much as possible. Provider groups and BSAS may be able to provide technical assistance to those organizations that have little experience with technology.

Implementation Steps:
   A. BSAS and the Association for Behavioral Health should provide technical assistance in the development of business practices which maximize third party billing, and concentrate efforts on minority agencies.
   B. Assure that all available funding for training and support is being used and leveraged.
   C. Providers without enough program and technology must invest in these tools to share best practices with and learn from other providers. They can replicate appropriate strategies used by those who have already made the investment.

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[25] Annapolis Coalition report, p. 152, citing McLellan, A.T., Caries, D. & Kleber, H.D. (2003). Can the national addiction treatment infrastructure support the public's demand for quality care? *Journal of Substance Abuse Treatment*, 25, 117-121.

D. Providers should streamline paperwork and systems to be as simple as possible, given the differing requirements.

E. BSAS and provider organizations can provide technical assistance in finding successful programs to adopt changes from, and in streamlining systems.

F. BSAS, funders, payers and providers can work together to rationalize and simplify the requirements they make of providers, in order to maximize resources spent on direct service.

Recommendation 3:
Increase the Reward and Value of Work in the Field

Rationale:

Stakeholders report that substance use and addictions work is reimbursed at a lower rate than other comparable mental health work, whether in a fee-for-service scale or in a salaried position. There is a broad perception that raising salaries alone would solve the recruitment and retention problems for the field. However, labor studies show that multiple negative elements (sometimes referred to as "dissatisfiers") contribute to a worker leaving a job. If salary is one dissatisfier, it still takes other conditions to make someone leave, and providers can influence those conditions, whether they are related to the physical work environment, employee recognition, career path, schedule or other factors (see Recommendation 4, Improve Recruitment and Retention Practices at Provider Organizations). Compensation must be conceived of as more than salary. Benefits (such as health, retirement, vision, dental, and life insurance; paying for training or education), which have a direct financial impact for a worker, and other items which have an indirect financial impact (onsite childcare, direct paycheck deposit), can be combined to add value to salary. Adjusting salary levels has a longer horizon for success than some of these other factors, and while this Plan includes strong efforts to advocate for fair and equitable wages for substance use and addictions workers, it also includes suggestions for other compensation-improvement steps agencies can take. Non-compensation funding, such as federal programs to forgive loans made by higher education, can also create an environment where workers' needs are met by more than just the compensation they receive directly from their employer.

In the first year of implementation of Chapter 257, rate increases are proposed for a number of services. However, there are no stipulations that such monies be used for such workforce and organizational development strategies as have been discussed in this plan.

Strategies:

     3.1 Advocate for increased funding for education and training of workers

     3.2 Advocate for increased salaries, career ladders, reimbursement and benefits

Strategy 3.1:
Advocate for Enhanced Funding for Education and Training of Workers

Rationale:

The premise of continuous learning is that education and training are encouraged for and available to workers. Actions that make the timing and location more accessible, and create a culture of support for education and training, were discussed in the Continuous Learning section of this report. Education and training costs (including the direct and indirect costs associated with revenues lost when workers spend time away from the office) can be a significant barrier for workers and for their employers. Some agencies have found ways to

Local Examples:

- A Tuition Waiver program entitled "Tuition Remission Program for human service providers" was developed and implemented by the Board of Higher Education and the Massachusetts Council of Human Service Providers. It helps educate workers in certain positions in state funded agencies. Its criteria could be broadened to allow more workers to take advantage.

- Tufts University has a $500,000 endowment to help defray the cost of repaying loans for students who take public service jobs and stay at them.

provide these opportunities, and outside funding can also support workers or provide additional funding to the agencies. The recommended Strategies all relate to expanding on current programs and developing new ones. For example, NAADAC is working to support funding for the National Health Service Corps, and to include a behavioral health banner in the new funding so that more behavioral health practitioners might benefit from loan repayments and other fiscal incentives.

Implementation Steps:

A. Work with legislators and education professionals to support the kind of programs more widely available to other professions (see sidebar), particularly for individuals who already work in state-supported public services or who commit to such service in return for tuition support, such as:

- Loan forgiveness
- Tuition reimbursement
- Tuition waivers

B. Work with payers to support:

- Reimbursement to employers for training time and supervision of employees
- Courses for employees

C. Work with education professionals to expand existing programs such as "credit-for-experience" and free courses at state colleges for employees of state agencies.

D. Continue to learn about efforts in other states and other fields.

E. Publicize existing sources of funding for education

Strategy 3.2:
Advocate for Improved Salaries, Career Ladders, Reimbursement, and Benefits

Rationale:

The field of substance use and addictions involves professionals at extreme ends of the pay scale: physicians and nurses near the top and residential overnight staff near the bottom. Yet no matter what end of the scale they are on, if a professional is working within substance use and addictions, they will often earn less than if they

National Examples:

- National Health Services Corps loan forgiveness and repayment program provides assistance in repayment of student loans for graduates agreeing to serve for a set period of years in communities with a critical workforce shortage. Twenty-two thousand clinicians have participated over the 30 years of the program.
- **Scholarship -** In exchange for 2 to 4 years of service in an NHSC-approved site in a Health Professional Shortage Area of greatest need, students in training to become primary care physicians, dentists, nurse practitioners, certified nurse-midwives or physician assistants receive: *Tuition, fees, other reasonable educational costs and living stipend*
- **Loan Repayment -** In exchange for 2 years of service in an NHSC-approved site in a Health Professional Shortage Area physicians, nurse practitioners, certified nurse-midwives, physician assistants, dentists, dental hygienists, and mental health providers receive: *Up to $50,000 toward repayment of student loans. Potential for additional years of support*

NY Health Care Reform Act funds are used to support a Health Workforce Retraining initiative which gave 3 million dollars to 7 agencies paying for testing/assessment, tuition/instruction, staff replacement costs and other educational costs for 2 years or more

Source: WFD: Taking Action NEATTC

are working within mental health, and if they are in mental health they will earn less than if they are working in a physical health setting.[26] Career ladders leading to increased compensation are not well established in some of the organizations which address substance use and addictions the most, although there is a national effort to standardize substance use and addiction-related career paths.[27]

In many Stakeholders' experience, reimbursement by most insurers is higher for a mental health condition than for a substance use condition. Although most human service workers do not say salary is a factor in their career choice, low salary is discouraging to many, and it is a significant factor in decisions to leave an individual job or the field. Increasing reimbursement to be on par not only with jobs in mental health but with jobs in physical health, now that mental health parity legislation has passed at the federal level, is a key step.

Implementation Steps:

A. Work with legislators on increasing their understanding of the consequences of current reimbursement
- Support EOHHS's POS reform (affects some but not all BSAS providers)
- Support other legislative efforts as they arise.

B. Work with all public and commercial payers to expand the clinical, administrative and wrap-around services for which they provide reimbursement, at sustainable levels.

C. Inform and provide technical assistance to agencies regarding compensation strategies (see Appendix C, Resources and Suggestions from Stakeholders).

D. Publicize existing sources of funding for salary support to those many providers who do not know of them.

E. Utilize regulatory authority to encourage the use of new monies by providers to support workforce retention and development.

F. Encourage substance abuse providers to sustain and publicize clear career ladders.

New York State Provider Advocacy

"In anticipation of the 2005 fiscal year, IPDA and ASAP [*Institute for Professional Development in the Addictions,* and *Alcoholism and Substance Abuse Providers of New York*] provided the governor's office and OASAS [Office of Alcohol and Substance Abuse Service] with hard data which included documenting the actual cost increases for agencies and pass-throughs for staff with a focus on rising health care costs instead of salary needs. Their efforts succeeded largely because all relevant agencies worked together to make this happen. As a result, New York received an additional 8.5 million in the Governor's budget for investment in the residential treatment system. Most importantly, the money was not a one-time award but [was] added to the base budget for the future."

Source: p. 21 of Taking Action to build a stronger addictions workforce: an update of accomplishments.

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[26] Objective studies support this report from the Stakeholders. "Direct service workers in human services [including substance abuse counselor professionals and paraprofessionals] earn nearly $15,000 less than the same workers in health care, and nearly $5,000 less than their counterparts in other industries." Source: Recruiting and Retaining the Next Generation of Human Services Workers in Massachusetts, p.3, Mass Council of Human Service Providers, April 2007; In a study done by the Washington Business Group in 2000, "In general the large employers continue to place lifetime or episode-of-care limits on substance abuse treatment, even where they have eliminated them for mental health." Source: http://www.businessgrouphealth.org/pdfs/final_report.pdf, accessed August 2009.

[27] The National Association of Alcoholism and Drug Abuse Counselors has developed a draft scope of work and career ladder document, submitted to SAMHSA, which would provide a nationally recognized career ladder framework. See www.naadac.org

Recommendation 4:
Improve Recruitment and Retention Strategies at Provider Organizations

Recruitment and Retention are key measures of whether workforce development efforts are working. There are specific tactical steps that providers can take to make their recruitment and retention activities more likely to succeed, even in a difficult environment. It is important to note, however, that the participants in this process and the conclusions of other similar efforts establish that addressing broader systemic issues in education/training, compensation/funding and marketing are in fact <u>crucial</u> to improving recruitment and retention. The other Recommendations in this Plan link together to support recruitment and retention, for as BSAS Director Michael Botticelli said during the Marketing and PR Working Group meeting, "The better your product is, the easier it is to promote – we have to make sure that we are providing high quality, cutting edge services consistently and providing a high quality work experience."

Providers may need particular assistance in responding to the needs of their community through recruiting and retaining workers who reflect the members of the community.

BSAS and other stakeholders can implement recognition programs which highlight achievement publicly. This kind of activity will improve perception of the value of the field's work, for workers, consumers and the general public.

Strategies:

4.1 Improve providers' skills in Recruiting and Retaining Staff (see Appendix C Resources and Suggestions from Stakeholders).

4.2 Learn more about current workers and organizations and their specific needs and successes.

4.3 Identify and learn more about potential workers, particularly those who reflect the populations being served

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"Members of the workforce, no matter how well prepared, competent, and compassionate, must function within systems of care. A competent individual placed in a toxic environment cannot function efficiently and effectively and is far less likely to be retained. Strengthening the behavioral health workforce requires creating environments that support the health and well-being, not only of persons…with substance use conditions, but of the workforce as well."

Source: p.58 of the Annapolis Coalition Report

The Ben Gordon Center in Illinois doubled the number of service events with slightly fewer staff by making several types of changes, which are highlighted in the National Council for Behavioral Health publication <u>How to Get and Keep the Best Employees: A Guide to Workforce Innovation</u>. In addition, staff turnover went from 38% to between 2% and 5% in the same period.

Ben Gordon:
- **Centralized access** for all services,
- **Trained staff** to triage client calls into three categories: 1. same day, 2. within 24-hrs, and 3. within 3 business days.
- **Reduced paperwork**

The result was a 60% increase in persons served and a 40% increase in services delivered, and 4 new staff hired. They eliminated what had been a chronic 200 person waiting list within 30 days.

Salary increases were successfully tied to:
- Staying current with documentation
- Meeting performance indicators
- Using clinical best practice standards

Supervisors whose supervisees met the incentive goals also received salary increases.

Supervision involved coaching and data/ performance reviews, along with clinical issue reviews.

Meeting rules were modified for more efficiency. For example, if no agenda was provided 48 hours before the meeting, or if there was nothing new to report, a meeting would be cancelled.

Strategy 4.1
Improve Providers' Skills in Recruiting and Retaining Staff

Rationale:

Providers vary widely in their techniques for recruiting and retaining workers. Some are in dire need of assistance in the most basic of recruitment skills, such as developing a job description, where to market a position, how to adapt to the new technologies for communicating with potential workers, and how to recruit in specific cultural groups.
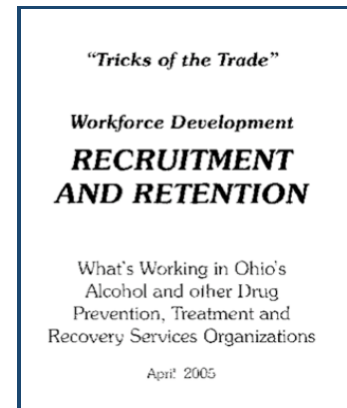
Providers also vary widely in their ability to create a positive workplace culture, which is key to retaining workers. A negative workplace culture is one of the most cited reasons for leaving a position or the field, and in working group discussions, a positive culture was one of the most-often cited reasons for staying with an agency.

See Appendix C, subsection "Recruitment and Retention."

Implementation Steps:

A. BSAS and other stakeholders should provide technical assistance broadly targeted by level of care, and in some cases, tailored to the needs of individual programs.

B. BSAS should institute an annual recognition event for the field. Possible individual counselor recognition at bi-annual Innovations conference, and program recognition at bi-annual Recovery conference.

C. Support providers in using quality improvement techniques to improve recruitment and retention practices.

D. Individual provider agencies make changes and share results with each other through the communication channels described in Recommendation 1.

E. If a Collaborative is formed, it would be the ideal source for much of this work.

The Ohio Workforce Development project developed a pamphlet which details many recruitment and retention tips.

"Tricks of the Trade"

Workforce Development
RECRUITMENT AND RETENTION

What's Working in Ohio's Alcohol and other Drug Prevention, Treatment and Recovery Services Organizations

April 2005

"Better data…are sorely needed. While that information is being generated, there is simply no time to delay action."

Source: P. 104 of Annapolis Coalition Report

Strategy 4.2
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Current Workers and Organizations and their Specific Needs and Successes

Rationale:

Anecdotal information and broad surveys are enough to indicate the problem, but not enough to target resources. The Annapolis Coalition Report stated, "There is a striking lack of data, not only about the workforce, but about workforce development practices."[28] Blue Cross Blue Shield has conducted a survey of the Behavioral Health workforce in Massachusetts which may yield

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[28] Annapolis Coalition report, p. 13

helpful findings. A national survey is also being initiated by the National Addiction Technology Transfer Centers.

Implementation Steps:
   A. BSAS and provider associations share existing information about where shortages are greatest
   B. BSAS should review licensure applications to collect information about staffing, education levels, licensure and certification
   C. Stakeholders independent of the licensing process, such as ATTC, survey providers to collect data on where the shortages are by region, level of care, position and profession; and provide de-identified information to BSAS so that resources can be targeted.

Strategy 4.3
Identify and Learn More about Potential Workers, Particularly Those who Better Reflect the Populations Being Served

Rationale:

Addiction crosses all lines, and people in all helping professions need to be knowledgeable about how to negotiate the treatment system, refer people into the system and support recovery. Increasing the competence of those in helping professions such as human services, education, healthcare and law enforcement, in addition to those traditionally associated with direct substance use and addictions work, will provide supports in the community and an adjunct workforce.

New workers whose primary field of work is substance use and addictions are also needed. A pipeline of new workers will be needed to replace the wave of retiring workers, as well as efforts to address unmet need. A survey of Massachusetts addiction professionals in 2004 found that 41% were over 50[29]. The search for new workers must extend to other fields and multiple community sources. Examples of potential new workers include: people in recovery and their family members, students, nurses and other healthcare professionals, retirees and people from diverse backgrounds who are invested in their communities.

Implementation Steps:
   A. Stakeholder associations and BSAS conduct focus groups, and share information, particularly developing strategies to hire diverse workers. Groups to reach out to include:
       • Schools for helping professions (social work, nursing, psychology, MFT, etc.)
       • Retirees – SCORE, AARP, etc.
       • Ethnic, linguistic and cultural minorities – partner with the prevention workers who know the communities; look to CADAC and other training programs for bilingual and bicultural counselors.
   B. Individual providers should:
       • Reach out to their communities through community colleges and universities, cultural organizations, high schools, religious organizations, charitable organizations, career centers and their Regional Centers for Healthy Communities.
       • Conduct a self-evaluation to determine which areas should be focused on to improve Recruitment and Retention (such as walk-throughs and exit interviews). See Appendix C.

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[29] Massachusetts Direct Service Providers – Summary of Findings. New England Addiction Technology Transfer Center, 2004. http://www.attcnetwork.org/explore/priorityareas/wfd/overview/documents/New%20England/WFrpt%20MA.pdf. Accessed 9/9/09.

Implementation of Plan: A Phased, Collaborative Approach

The success of this Plan depends on a) stakeholders working together in appropriate groupings for each area of action, and b) individual stakeholders making change where they are able. The communication necessary to take coordinated action would be greatly facilitated by a Workforce Development Collaborative, but many projects can be accomplished by small, focused groups. This plan will only be successful if all stakeholders contribute and there are ways to share their successes and learn from failures.

For specific ideas about steps you can take, see Appendix B, "Using this Plan to Take Action," and Appendix C, "Resources and Suggestions from Stakeholders."

Near Term

BSAS (on its own and with other stakeholders) will:

- ► Distribute this Plan
- ► Report to the Governor's Interagency Council on Substance Abuse and Prevention
- ► Continue to research available websites and online resources
- ► Explore systematic workforce data collection
- ► Follow up with Department of Developmental Services on marketing
- ► Initiate discussion with Deans and provider organizations about curriculum development
- ► Initiate technical assistance on Recruitment and Retention, in collaboration with professional and trade organizations
- ► Continue to update list of workforce development resources
- ► Continue existing Workforce Development efforts
- ► Seek opportunities in existing or new marketing efforts to spread a positive message about the Field

Provider Organizations and Educational Institutions will:

- ► Distribute and study the Plan
- ► Discuss and begin their own priority actions
- ► Seek joint projects with other stakeholders

Medium Term

Stakeholders will individually and jointly:

- ► Expand Training opportunities
- ► Showcase successful demonstration projects of Work-Based Learning
- ► Education/Field collaboration begin to implement and evaluate curricular changes
- ► Clearinghouse established for available websites and online resources
- ► Reporting on workforce development targets
- ► Reporting on workforce development achievements
- ► Creating forum for recognizing and rewarding individuals and organizations who exemplify excellence in clinical and managerial practice

- ► Marketing efforts by all stakeholders (e.g. agency, education, state) presents a more unified message
- ► Initiate Collaborative

Ongoing

Stakeholders (and ultimately, a Collaborative) are actively involved in supporting all areas of workforce development – curriculum development related to field practice, recruitment and retention support, providing opportunities for connection among stakeholders, solidifying web resources and creating a repository of workforce development data.

Conclusion

The Vision outlined here is of a workforce that is capable, caring, connected to the community, energized by their job and compensated appropriately. This vision can be realized. The challenges are to make the direct connection between workplace needs and the education and training of workers; to change how training is delivered to agencies; and to support programs in creating a work culture that leads to retention and recruitment practices which result in the right staff being hired.

Appendices

Appendix A: Strategic Planning Process

A Stakeholder Collaboration

The Stakeholder Advisory Group was comprised of approximately 50 individuals, invited by the Bureau of Substance Abuse Services. A Steering Committee provided ongoing review of the process. The list of participants is provided in Appendix E.

Stakeholder groups working together in this process included:

- ▶ Treatment and Prevention Providers
- ▶ Professional Trade Organizations
- ▶ Bureau of Substance Abuse Services Staff
- ▶ Consumer/Family/Community Advocates
- ▶ Academics
- ▶ Researchers
- ▶ Healthcare professionals
- ▶ Training/Technology Transfer experts
- ▶ Licensing/Certification entities
- ▶ State Agency Representatives
- ▶ Payers

Two internal discussions with BSAS staff were held in September and November, 2007. Research into substance use and addictions workforce development across the nation, and an examination of data available on Massachusetts in particular, were used in these meetings to establish an initial set of information on the Current Reality, and draft Vision statement, which were revised by the Stakeholder Advisory Group.

Fifty people attended the initial Stakeholder Advisory Group meeting in Boston in January. The Current Reality material was presented for critique, and established a common reference for discussion. Breakout sessions were held on the following topics: revising the Vision, Identifying Gaps between the Vision and Current Reality, and Strategies to Close the Gaps. Suggestions for Working Group topics were gathered, and the topic interests of participants noted. A summary of the meeting was distributed to stakeholders.

Based on the first meeting, Working Groups were established in the areas of Recruitment/ Retention, Education/Training and Marketing/Public Relations. Web-based questionnaires allowed participants to provide input prior to and following these Working Group meetings. Between February and May, the Education/Training Working Group met twice, as did the Recruitment and Retention group; the Marketing/Public Relations Working Group met once. Each group reviewed information related to current concerns and efforts in their topic are, contributed their own expertise and experience, and made suggestions for further actions to be taken in Massachusetts. These suggestions formed the basis of the four overall recommendations and the detailed strategies outlined in this plan.

The Final Stakeholders Group meeting was held in Worcester in May, 2008, with 30 attendees. A summary of the process was presented to senior BSAS staff in June. This report was developed to document the resulting Stakeholder Advisory Group recommendations and support their implementation.

Appendix B: Using this Plan to Take Action

Once you have reviewed the Recommendations, stakeholders may find the following suggestions helpful in using the Plan to take action.

Consumers

Bring the Plan to the attention of any support or advocacy groups you are part of. Ask your members what they consider the primary workforce development needs, and bring that information to provider associations, the Commonwealth, and Educational institutions. Seek joint projects with other stakeholder groups.

Consumer/Family
Support or Advocacy Groups

Review the Recommendations with your board. Join other stakeholders to work on advocacy, and assist in strengthening the education/field partnership required to make formal education more relevant to the client experience. Seek joint projects with provider associations, training associations and/or educational associations.

Educational Institutions

Review the section on connecting education and practice. Meet with BSAS. Connect with a local agency for internships for your students, or to have staff take your courses. Do a self-study of how well substance use and addictions material is suffused into relevant fields from nursing to administration. Partner with AMERSA for help. Ask a local trade association to help review how current your materials are and consider updating your instructional methods.

Individuals who provide services

Look for opportunities to connect with other providers, and review the educational and training resources listed in Appendix C. Check out what your professional associations are doing and ask them to connect with other associations.

Individual Educators

Review the suggested subjects and teaching methods in Appendix C for your own practice. Reach out to colleagues in other professions and offer to help them include addictions instruction in their work. Reach out to local providers to encourage them to ask for placements from your institution.

Individual Trainers

Review your own practices in light of the suggested training topics and methods. Check out what your professional associations are saying about workforce needs.

Legislators

Review the Plan in light of current legislation and fiscal environment. Contribute legislative perspective to any joint projects.

Payers

Review the Plan. Review the cost effectiveness of substance use and addictions treatment, wrap around services, and your own costs and reimbursement schedules. Engage with the Commonwealth, professional associations and researchers about best practices.

Policy Specialists

Review the Plan. Help define the policy issues and inform the advocacy. Offer your advice to advocates, professional associations and the Commonwealth.

Provider Agencies

Review the plan with your staff and your board, discuss what your organization can do right away and in the long term, who you would like to work with, what other resources you might seek, and what you can contribute. See Appendix C to review many of the ideas generated during the Strategic Planning process. Check out what your provider association is doing and seek projects with other agencies.

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Appendix C: Resources and Suggestions from Stakeholders

The tables and lists of resources in this Appendix reflect the shared knowledge of the Stakeholder Advisory Group and others involved in this process. They are meant to be a "hand-off" to those who want to take up the work and move forward, as part of a joint project or as individual Stakeholders – literally, the answer to "where do I start?" on some of the relevant topics.

List of Topics in this Appendix

- ► Education
- ► Training
- ► Communication and Collaboration
- ► Recruitment and Retention
- ► Other Resources and Suggestions from Stakeholders
  - • Provider-Oriented Activities
  - • Curriculum Development; Aligning the Field and Higher Education
  - • Marketing
  - • Web-based Learning
  - • Organizational Training and Development
  - • Training/Educational Content and Delivery
  - • Funding for Education and Training
- ► National Data and Resources
- ► Other State Studies of the Substance Use and Addictions Workforce
- ► Other Studies
- ► Federal Resources
- ► Addictions Certifications and Requirements and DPH Licensing Requirements for Counselors

Education

MA Educational Resources identified in this process

Clinical Formal Education Programs

3 Associate's Program

- ► North Shore Community College – Drug and Alcohol Rehabilitation
- ► Northern Essex Community College - Alcohol and Drug Abuse
- ► Northern Essex Community College - AS Human Services

1 Bachelor's Program

- ► Springfield College - BS Rehabilitation and Human Services

6 Master's Programs

- ► Cambridge College - Education addictions counseling
- ► Cambridge College - Education (Mental Health, Addictions, School adjustment)

- ► Cambridge College - Education (Mental Health, Addictions Counseling)
- ► Springfield College - M.Ed. in Alcohol and SA Counseling
- ► Springfield College - M.S. in Alcohol and Substance Abuse Counseling
- ► Springfield College Human Service Administration

1 Ph.D. Program

- ► Brandeis NIAA fellowship

2 Post-doctoral programs

- ► Boston University - Chief Resident Immersion Training program
- ► Boston University - General Internal Medicine Fellowship - research on substance abuse for faculty and community practitioners

8 certificate programs

- ► Cambridge College - Addiction Rehabilitation Studies Certificate
- ► Cambridge College - Certificate in Alcohol & Drug Counseling
- ► Holyoke Community College - Addictions Studies Certificate
- ► Middlesex Community College - Alcoholism/Substance Abuse Counseling Certificate
- ► North Shore Community College - Substance Abuse Counseling Certificate
- ► Northern Essex Community College - Alcohol and Drug Abuse Counseling Certificate
- ► UMASS Boston - Alcoholism/Chemical Dependency Treatment Services Certificate
- ► Westfield State - Addiction Counselor Education Certificate

Individual courses in substance abuse are required in some programs for marriage and family therapy or social and rehabilitative sciences. For the purpose of licensure as an Alcohol and Drug Counselor, BSAS requires that applicants complete 270 hours of approved education related to alcohol and drug counseling. Evidence of approved education would include an official transcript from an accredited college or university (such as those listed above) or like documentation from a recognized DPH provider, funded, contracted or licensed by the Department.

Prevention

Prevention Formal Education Programs
Prevention can be a focus within the Massachusetts schools of public health, but there is no standing, formal educational program on Substance Abuse Prevention.

Specific Suggestions for course topics:

- ► Co-occurring disorders
- ► Evidence-Based practices
- ► Medication Assisted Therapy
- ► Cultural competency/age/health status etc
- ► Business skills for managers
- ► Management skills
- ► Addiction 101(see Westfield State)
- ► Clinical Supervision (follow up with David Powell, Pat DeChello -through AdCare)
- ► Group Skills

- ► GED
- ► Medications 101
- ► Ethics
- ► Compulsive behavior (gambling, shopping, smoking)
- ► Communication skills
- ► Special populations
- ► Criminal justice issues
- ► Cross-teach addiction and marriage and family therapy
- ► Substance Abuse prevention
- ► Health disparities in substance abuse

Specific Suggestions for teaching methodology:

- ► Infuse SA prevention and treatment throughout curricula broadly, in multiple specialties
- ► Blend students from different fields for substance abuse and addiction courses
- ► Experiential/hands on opportunities
- ► Increase availability of internship opportunities for students, particularly paid (perhaps by schools of social work)
- ► Onsite courses at Treatment Agencies
- ► Online courses
- ► Regional courses
- ► Mentoring and preceptorship

Curriculum Enhancement suggestions

- ► People to approach regarding AMERSA (the Association for Medical Education and Research in Substance Abuse) strategic plan implementation activities (Jeff Baxter and Thomas Adelis at University of Massachusetts; Maryann Amodeo, Boston University)
- ► Create a Master Curriculum colleges can adopt (such as Masters in SA Counseling at Keene, Antioch, Westfield State; or the PhD program at the University of Colorado; build on Rhode Island College Institute for Addiction and Recovery's work).

Training

Training Resources identified in this process

On-site/Regional/Statewide opportunities

- ► AdCare Educational Institute of MA and ME
- ► Aging with Dignity Conference
- ► ATTC trainings
- ► Boston University School of Social Work Institute for Geriatric Social Work
- ► Community Anti-Drug Coalitions of America (CADCA)
- ► CSAP Technical Assistance
- ► DARC program in CT
- ► Division on Addictions – Harvard Medical School
- ► HOPE (Hispanic Office of Planning and Education)
- ► Laban's Addiction Specific Trainings

- ► MA Council on Compulsive Gambling
- ► Mass Council of Human Service Providers' Cert. in Supervision & other Inhalants Conference
- ► Mass Forum through The Medical Foundation
- ► NEIAS – Summer School, Prevention School, Best Practices School (includes Annual Addiction Medicine Conference for General Healthcare Providers and Addictions Professionals)
- ► New England Research Institutes (NERI)
- ► Northeast Center for the Application of Prevention Technologies
- ► Regional Centers for Healthy Communities
- ► SPHERE
- ► The Cape Cod Symposium
- ► Regional Centers for Health Communities courses
- ► Prevention courses in social work and public health programs
- ► Community Prevention Trainings
- ► Northeastern University Institute on Urban Health Research - training modules on how to address the needs of specific populations
- ► Federal tools including not only TAP 21, but also culturally responsive practice and high quality supervision in TAP 21A and TIP 52

Sample On-line Training Opportunities

- ► CE-Credit.com and AddictionCounselorCE.com
- ► ATTC online courses
- ► Federal Prevention Pathway
- ► Boston University School of Social Work Institute for Geriatric Social Work

Training Topics suggested in this process

- ► Supervision skills (CSAT – TAP 21 clinical supervision, TAP 21A AND TIP 52 ATTC network training curricula; Need good computer capabilities for online downloads; Supervisors' understanding supervisions and supervisors providing professional supervision)
- ► Evidence-Based/Best Practices (NIDA & ATTC – disseminating "blended" products)
- ► Motivational Interviewing, Buprenorphine, Treatment Planning/ASI, Supervision of Motivational Interviewing, Working on Effective Practice/Adoption of successful practices -> Science to Services model ATTC)
- ► Core competencies (TAP 21, 21A; Boundaries; Ethics)
- ► Orientation for new hires (Work with Groups of Agencies, and not just new hires)
- ► Leadership development (Leadership Development School – ATTC/NE School run each year; joint program)
- ► "Special" populations including cultural variations, deaf/HOH, elderly, 18-24 yr olds, medication-assisted, etc (elders; important training issues – can have specialized referrals; ATTC focusing on these issues for the next 2 years)
- ► Quality Assurance/Continuous Quality Improvement (NIATx/NIDA/Federal funding/RWJ/State)
- ► Agency culture (Can look at bottom line/train CEOs and still improve quality)
- ► Evaluation, outcomes of trainings
- ► Coaching (helping people learn, relearn)

- ▶ How to support those in recovery
- ▶ Self care for those in recovery/counseling
- ▶ Moving from personal knowledge to best practices
- ▶ Professional responsibility
- ▶ Tools for self-sustaining and self-care
- ▶ Customer service
- ▶ Addiction 101 - Knowledge – what is addiction, how does it affect people, Chalk Talk
- ▶ Medication-Assisted Treatment

Suggested resources for keeping current

- ▶ Project Cork http://www.projectcork.org/newsletters/ has summaries of the latest news in the field from journals.
- ▶ Journal of Substance Abuse and Addiction Treatment
- ▶ http://www.basisonline.org/addiction_resources.html from the Cambridge Health Alliance
- ▶ Center for Substance Abuse Treatment (CSAT)
- ▶ Center for Substance Abuse Prevention (CSAP)

Communication and Collaboration

Web Based Information

The new ATTC Workforce Development website, mentioned in the body of this plan, provides an example of an existing central website; though it is not specialized to Massachusetts, much of the content is relevant to all locations. Explore it at http://nattc.org/explore/priorityareas/wfd/overview/.

Below are lists of suggested *Content* and *Functionality* to pursue, either by publicizing existing links or creating new vehicles via a single, central website.

Suggested Content

- ▶ Licensing/certification
- ▶ Educational/training opportunities online and in-person
- ▶ Funding
- ▶ Curricula
- ▶ Career tracks
- ▶ Job postings and resumes
- ▶ TA tips on best Recruitment & Retention practices for individual agencies
- ▶ Marketing
- ▶ Professional organizations
- ▶ Best practices
- ▶ Other efforts related to workforce and organization development/the field in general, including legislation
- ▶ Data showing effectiveness

Suggested Functionality

- ► Job/Resume posting area
- ► Chat rooms – general and by category (job level, modality, stakeholder)
- ► Listservs
- ► Links to up-to-date information about online and in-person education, training, licensing, certifications
  - • Where to get, how to fund, what courses count for which license/certification etc.

- ► Information about the Workforce and WFD efforts
- ► Collaborative Workgroups Virtual home
- ► Information for advocates – consumers, families, organizations
- ► Links to BSAS directory, RCHCs, BSAS prevention programs, Recovery communities, Best Practice resources

Examples of web resources which bring links together:

- ► OHIO - http://www.ebasedtreatment.org/ provides links for providers, and there is a comparable prevention oriented website.
- ► SAMHSA's Workforce Information Network to be launched in the near future (previewed at NIATx June 2008).
- ► ATTC-New England

Recruitment and Retention

The main text of this Plan emphasizes the importance of having clear career paths involving progressive responsibility and income commensurate with experience, education and training; quality supervision; training in new, relevant skills for those who are promoted. In addition, there are aspects of the work environment which can be used to influence retention and recruitment. Not all are applicable or possible in every setting, but we have presented them here in order to do justice to the extensive conversations of the Working Groups.

- ► Massachusetts' Executive Office of Labor and Workforce Development has funding and technical assistance resources for workforce development
- ► The National Addiction Technology Center website has a new section on workforce development with more options and additional information on some of the suggestions this process generation for improving recruitment and retention. See http://nattc.org/explore/priorityareas/wfd/overview
- ► The Providers' Council's "Addressing the Human Services Workforce Shortage: A Guide to Recruitment and Retention" is a useful resource. It can be accessed at : http://www.providers.org/ILEX/ResearchReports/helpwanted2.pdf
- ► Agencies can influence Recruitment and Retention through interventions which provide
  - • A direct financial benefit to the employee at a varying cost for the agency;
  - • Indirect financial benefit to the employee;
  - • Non-financial benefits which relate more to work environment
  One, a few or many interventions may be useful, depending on the agency, clients, positions being sought.

Retention

Direct financial benefit to employee

- ► Competitive Base Pay – research local salaries to be sure the agency's is competitive; if not, either raise it or emphasize another benefit
- ► Retirement plan – offer a retirement plan, or work with another agency to offer one jointly to share cost
- ► Increase salary for license – give a boost in salary to any employee who becomes licensed; their licensure may result in an increase in reimbursement from payers
- ► One-time bonus for license – this is a less expensive alternative to increasing salary for licensure, but provides some reward
- ► Agency pays for licensure/certification exams – one time fees provide some reward to workers
- ► Agency pay for continuing education, training, in-service trainings
- ► Agency offers free CEUs in-house
- ► Agency creates and Employee Assistance Program
- ► Agency offers tuition reimbursement for courses toward professional development – if it is part of an arrangement with college which provides credit for work experience, the courses could be free or of reduced charge to both the agency and the worker
- ► All employees on salary (versus fee for service) – this allows employees to have a more stable continuous income
- ► Pay raises at a fixed percent per year or in fixed increments – this allows some predictability for employees
- ► Additional fee for service opportunities to raise income – for those employees who can work extra hours, this can raise their pay and increase the income for the agency
- ► Productivity incentives (pay and/or vacation time) – for completing paperwork correctly, for seeing more clients, for billable hours – allowing the employee to share in the financial benefit to the agency can help the worker financially and give them an incentive to help the agency
- ► Merit and/or longevity bonuses (pay and/or vacation time)
- ► Competitive benefits (health, life insurance, dental, vision) – offering benefits can contribute to worker retention, as many workers need benefits; offering some benefits other agencies do not can also differentiate an agency
- ► All employees get benefits
- ► Conduct survey of local agencies to know whether benefits are competitive or not
- ► Uniform salary ranges for job grade – if salary ranges are not fairly used for the same pay grade, this can be a dissatisfier for employees
- ► Pay for training and/or pay salary for time at training (no loss of vacation time or pay) - see Phoenix House as a Massachusetts example.
- ► Flexible implementation of benefits (tailor to individual needs)
- ► Insurance plan where employees pay deductible only
- ► Join with another organization or trade association to negotiate benefits options
- ► Have a policy of paying a small percentage more than local competitors (such as 3%) – the amount may not be large, depending on the position and environment, but the policy can be attractive.

Indirect Financial benefit
- ► Free lunch
- ► Free parking
- ► Flu shots available at work, free if possible
- ► Workout time
- ► Generous leave time
- ► Use of organization's laptop, cell phone
- ► Auto deposit payroll
- ► Borrow against future income if employee in dire straits

Work Environment

- ► Structural/administrative
  - • Allow employees flexible scheduling
  - • Use a distributed decision-making structure
  - • Attractive workplace (includes appropriate space to do work)
  - • Employee input (satisfaction surveys, suggestion boxes, review formal job descriptions in light of actual duties; formal job descriptions; furniture)
  - • Team building staff events for team building (cook out, ropes courses, day shift make dinner for night shift); events with clients (chili bake off with clients judging)
  - • Value and support diversity - in hiring and in education/training programs, and in practice
  - • Diversify duties
  - • Reduce paperwork
  - • Support involvement in community
  - • Staff recognition - for quality, for birthday or other event, for productivity; employee of the month, gift cards, regular thank yous - in person; a card, a call-out, dinner/lunch with CEO; excellence conferences; give staff feedback on their impact or let them tell about their own impact
  - • Use and open support of best practices
  - • Supervision - regular/quick daily check for all; use TAP 21A and TIP 52; make extra supervision available
  - • Strong performance appraisal tool used regularly
  - • Promote from within
  - • Training offered onsite
  - • Front load vacation earlier in job tenure
  - • Assistance with housing
  - • Employees get their birthday off (with pay)
  - • Employees get a day with pay to reflect/regenerate
  - • Training for those who are promoted (supervision, management, leadership)
  - • Preceptor program
  - • Review job descriptions to be sure they are accurate and current, and create a potentially successful workflow. Where they do not create the potential for successful workflow, those job descriptions should be revised. Dissatisfaction with work can come from structural problems like this in the way the jobs are designed.
  - • Review jobs as performed and look for ways in which they do not match the job descriptions. Dissatisfaction can come from a disconnect between expectations (of the worker, supervisor or client) and reality.

- ▶ Increasing availability and quality of supervision
  - Use retirees as part-time supervisors,
  - Recruit from local SCORE for part-time supervisors
  - Provide Supervision onsite
  - Provide Supervision training (for example, SSTAR and Bristol County provide supervision training onsite)
  - Link training to supervisor's competencies
- ▶ Management Qualities
  - Managers are perceived as being accessible, listening, having an open door policy
  - Visibility of manager and "lead from front", "do whatever it takes" style
  - Avoid chastising for mistakes
  - Emphasizing the importance of mission
  - Foster individual growth

Recruitment

- ▶ Ways to expand the candidate pool
  - Former and current interns
  - People with personal experience (clients, family members, and professionals participating in programs such as the Substance Abuse Rehabilitative Program - a five-year program that exists to help nurses who have problems with alcohol and/or other drugs to return to practice while protecting the public's health, safety and welfare.
  - Current and former employees
  - Former youth members
  - Other local providers
  - Staff from fields with similar basic competencies
  - Community, particularly with needed skill sets and expertise
  - Peer support programs
  - Ask retired people to be consultant counselors
  - Ask retired people to provide supervision part time
  - Use local and out of state recruitment services
  - Use mailing list of certified professionals for targeted mass mailings
  - Do nationwide searches for leadership positions
- ▶ Interviewing Technique
  - Use a team interview
  - Include clients on an interviewing panel
  - Use multiple interviews
  - Be clear about mission/values
  - Be clear about advantages and disadvantages of the job ("realistic interviewing")
  - Use a behavioral questionnaire
  - Provide a copy of the job description
  - Use role plays
- ▶ Learn about CORI (and other legal barriers to internship or employment)
  - Those responsible for using CORI reports should be trained to distinguish items which should prevent someone from being hired in the specific setting from those items which should not prevent hiring

- Those involved in hiring should learn how to obtain waivers for appropriate candidates – often applicants themselves will not know that waivers are available or how to apply.

Other Resources Suggested by Stakeholders

Provider-Oriented Activities

▶ Continue BSAS regional provider meetings, and projects such as Massachusetts Adoption of Residential Motivational Interviewing

▶ Provide opportunities for people to bring resumes and get interviews at conferences (nominal fee for agencies to participate)

▶ Add on to existing meetings like Cape Cod Symposium/New England Schools of Addiction, Prevention and Best Practices

▶ Try OpenSpace conferencing techniques which allow conference participants to dictate the topics for discussion

▶ Increase/Improve Internal Communication and Collaboration
- Encourage more communication and knowledge within the field about the entire spectrum of Prevention, Intervention, Treatment and Recovery activities
- Encourage Regions to emulate the Central region's practice of sharing information by email

▶ Increase communication with outside efforts Collaborative
- Formalize relationship with Statewide WFD efforts, e.g.: Workforce Central, MA Human Service Workers
- Connect with other state and national efforts, e.g.:
  - Recruitment/Retention: OH, NJ-NY-PA; ATTC video
  - Education/Training: AMERSA, recent NAADAC magazine
- The Excellence Conference: bring together those across the state who are contributing to high quality service and excellence in the field, and also bring in rewarding speakers/activities/trainings which will enable them to continue championing excellence
- Cross-field activities, such as:
  - Training for Police Officers on addictions/prevention
  - Social workers 'ride-along' with police

Curriculum Development; Aligning the Field and Higher Education

Coordinate with other curriculum efforts, such as AMERSA and efforts in individual fields, as well as state efforts such as in Alaska and Kentucky

▶ AMERSA, the Association for Medical Education and Research in Substance Abuse, http://www.amersa.org/, which is a national effort aimed at suffusing substance abuse materials into education for multiple professions including, but not limited to, medicine, nursing, social work, psychology, dentistry, pharmacology, public health, and allied health

- Individual states have also created new curricula to match new positions in addressing career path issues as well

The topics for conversation with Deans and other Education professionals could include:

- Suffuse substance use and addictions information in all relevant fields, including nursing, Emergency Medical Technician, school counselor, business administration, criminal justice etc. (see note on AMERSA above, as a resource)
- Ensure teaching of proven practices from current sources
- Consider statewide/national curriculum to adopt for work in the field – see Rhode Island College Institute of Addiction Studies; UMASS Peer Recovery Support Services
- Ensure that the content of courses and training reflect the needs of field – see the list of suggested courses in these appendices.
- Review Cambridge College's model of curriculum revision
- Survey of local educational institutions to see if and how substance use and addictions information is taught
- Review models from Boston University School of Social Work, Bristol Community College, Cambridge College, Rhode Island Institute for Addiction and Recovery, Springfield College, and Westfield State College
- Create a Master Curriculum that colleges can adopt (such as Masters in SA Counseling at Keene, Antioch, Westfield State; or the PhD program at the University of Colorado).
- Clarify the value of license and certification, and the need to publicize that information as well as the connection to courses which meet the requirements or prepare for examinations
- Seek funding for professorships and courses in substance use and addictions – e.g. Kroc Foundation
- Engage the Trundy Institute on Mentoring and Preceptorships, Hispanic Office of Planning and Education (HOPE), and AdCare Educational Institute, which help individuals to prepare for certifications
- Create a Collaborative subgroup
- Involve credentialing groups (license and certification) to create the crosswalk between courses and requirements, and clarify the relevance of requirements.

Marketing

- Two of the national efforts identified during the process are
  - The Addictions Technology Transfer Centers, particularly the Northeast ATTC,
  - An effort supported by the Soros Foundation.
- Some of the suggestions for making best use of existing efforts included:
  - Survey existing efforts, coordinate with BSAS, professional organizations, consumer/family organizations
    - BSAS and AdCare develop and distribute canned presentation about BSAS and the field
    - Continue PSAs (such as NAADAC's)
    - Ensure workforce content is included in general PSAs as appropriate
- One of the sources identified, and with whom discussions have already been initiated, is the Department of Developmental Services, which conducted a successful marketing campaign which has led to increased recruitment

- ► A major campaign to students, the public, and existing staff campaign should identify target audiences, creating messages for potential workers as well as a general message to the public (e.g. Positive message, normalize addiction like diabetes, asthma, high blood pressure). The effort should create campaigns which can be tailored to specific target audiences (whether by profession, ethnicity/race, age, or recovery stage)
- ► Create new vehicles for projects
    - • Create an initial list of speakers for speakers' bureau
    - • Seek stories and books – the equivalent of <u>Mountains beyond Mountains</u>; <u>Slaying the Dragon</u>
- ► Materials which can be used by individual agencies are useful also, such as the ATTC recruiting video which can be adapted to display an individual agency's information.
- ► Learn from other fields

Work-based Learning

- ► An existing demonstration project is the SSTAR (Fall River) - Bristol Community College relationship which had Joint Hitachi Foundation and Robert Wood Johnson Foundation funding, which supports RWJF Jobs to Careers initiative.
- ► Suggestions for how to promote Work-based learning include:
    - • BSAS host a conference for providers and educational institutions at which the model is described.
    - • Set a goal of at least one replication.

Organizational Training and Development

- ► Recent BSAS projects include Massachusetts Adoption of Residential Motivational Interviewing (MARMI), Motivational Interviewing Skillbuilding in MA (MISMA), NIATx200, and NIATx Sustainability Efforts all of which bring together groups of agencies to learn new skills and learn from each other.
- ► The MA Council on Compulsive Gambling's TACT model was given as an example of following up with agencies after individuals have been trained.

Training/Educational Content and Delivery

- ► Publicize the various tools which are available and how to get them.
- ► Assess training in a more effective way
    - • Assessments based on demonstrated competency, not number of hours in training
    - • Supervision should focus specifically on certain skills/competencies;
    - • Periodically tape/observe client/group sessions;
    - • Use pre- and post-tests, portfolios for assessment (for example, SSTAR had AdCare observe pre and post)
    - • Training should be aimed at a particular level of competency, such "awareness, knowledge and proficiency" (used by the Council on Linkages Between Academia and Public Health Practice standards)
    - • Tailor training to the type of position: direct service or administrative or managerial.

- ▶ Northeastern University's Center for Experiential Learning may be a valuable contact on this topic.

Suggested Training implementation goals:

- ▶ Incorporate adult learning theories – Experiential, Interactive
- ▶ In-house, small groups from same program/agency
- ▶ Ongoing over a period of time
- ▶ Online
- ▶ Make it affordable and available (i.e. fees covered by agency; paid time to attend; flexible scheduling)
- ▶ Attaching a Technical Assistance component for ongoing implementation
- ▶ Develop and deliver training in multiple languages
- ▶ Customization of training to specific job
- ▶ Train staff to be trainers (they can train at work and can earn money outside of work doing trainings as well)
- ▶ States give CEU credit for in-house trainers as well as external trainings

Funding for education and training

- ▶ Credit-for-experience programs exist at Springfield College and Bristol Community College.
- ▶ A Tuition Waiver program entitled "Tuition Remission Program for human service providers" was developed and implemented by the Board of Higher Education and the Massachusetts Council of Human Service Providers. It helps educate workers in certain positions in state funded agencies. Its criteria could be broadened to allow more workers to take advantage.
- ▶ Tufts University has a $500,000 endowment to help defray the cost of repaying loans for students who take public service jobs and stay at them.
- ▶ A college which places interns will often offer one free course to the agency for each intern the agency takes (Worcester Consortium does this). If a college doesn't place interns at the CADAC-interested person's agency, this might be a way to get an intern and a course for the person.
- ▶ Westfield State does offer one Continuing Education Credit for agency staff who supervise student practicums.
- ▶ Educational Rewards Grant Program - The Educational Rewards Grant Program provides financial assistance to dislocated or incumbent workers to enable them to attend community or state college to receive the education they need to transition into jobs in targeted high-demand occupations.
    - • Grants are awarded to support part-time study relevant to a high demand occupation (for example: dental hygienist, radiological technician, registered nurse) at a state or community college in Massachusetts.
    - • The program awards grants between $200 and $3000 to be used for tuition, fees, and books; AND 30% of the grant can be used toward living expenses like childcare and transportation.
    - • Applications are accepted on a rolling basis. To apply visit www.osfa.mass.edu or contact: (617) 727-9420 x 1308   osfa@ofsa.mass.edu.

This program is being jointly managed by the MA Board of Higher Education and Department of Workforce Development.

- ► State employees can take free courses at state schools.
- ► The R.W. Johnson Foundation has introduced Ladder to Leadership: Developing the Next Generation of Community Health Leaders in 9 already selected communities across the US which does not include Massachusetts. However, their materials and goals may prove useful resources for leadership development in MA, and if professionals who graduated from the program move to MA, they would be likely candidates for leadership positions here.

Compensation

- ► How to share a single job (counselor, administration) between two agencies in order to share benefits costs and salary costs/to create a full-time position where each only had a part-time before, which may be easier to fill.
- ► Access available Federal and State and Foundation sources
  - • Federal sources – in NY, Health Care Reform Act funds are used to support a Health Workforce Retraining initiative which gave 3M to 7 agencies paying for testing/assessment, tuition/instruction, staff replacement costs and other educational costs for 2 years or more (source: WFD: Taking Action NEATTC)
  - • Clarifying use of the Salary Reserve (net result: some positions in the field are eligible, but many providers are not)
  - • Clarifying use of the MA Workforce Training Fund.
  - • Grants (need TA for providers on grant seeking and grant writing)
- ► Available reimbursement sources;
  - • Blended funding for Dual Dx from MH
  - • Integration, like CT
  - • ARISE intervention for family and "pre" treatment
- ► Increase number of licensed personnel which results in greater reimbursement
- ► Have substance use and addictions declared a Federal "distressed industry."
- ► Make sure that providers in Health Professional Shortage areas are aware of Medicare bonuses for physicians working there.
- ► Support legislation which has been filed to include licensed alcohol and drug counselors within the definition of mental health professionals for the purpose of determining coverage.

National Data and Resources

State and Regional Addiction Technology Transfer Center Studies

State	Year	ATTC study link
Alaska	2004	http--www.nfattc.org-uploads-AK_Final.pdf
Alaska	2005	http://www.nfattc.org/uploads/AKExecSummary.pdf
Arizona	2007	http://www.psattc.org/assets/documents/WFS_Arizona_Apr%202007.pdf
Arkansas	2004	http://nattc.org/explore/priorityareas/wfd/overview/documents/Mid-America/Workforce_AK.pdf
California	2007	http://www.psattc.org/assets/documents/WFS_California_Apr%202007.pdf
Colorado	2001 & 2003	http://casat.unr.edu/mwattc/docs/mwattc_workforce_study_g.ppt
Connecticut	2004	http://www.attc-ne.org/initiatives/WFrpt%20CT12%2015%2004.pdf
Delaware	2005	http://www.ceattc.org/workforce/DE_WorkforceReport_2003.pdf
Florida	2004	http://www.scattc.org/pdf_upload/2004AgencyDirectorFinalReport.pdf
Hawaii	2005	http://www.nfattc.org/uploads/HIExecSummary.pdf
Idaho	2005	http://www.nfattc.org/uploads/IDExecSummary.pdf
Kentucky	2002	http://www.ceattc.org/workforce/NeedsAssessment.pdf
Louisiana	2004	http://nattc.org/explore/priorityareas/wfd/overview/documents/Gulf%20Coast/Louisiana%20Workforce.pdf
Maryland	2005	http://nattc.org/explore/priorityareas/wfd/overview/documents/Central%20East/MD_WorkforceReport_2005.pdf
Maine	2004	http://www.attc-ne.org/initiatives/WFrpt%20ME12%2015%2004.pdf
Massachusetts	2004	http://www.attc-ne.org/initiatives/WFrpt%20MA12%2015%2004.pdf
Missouri	2005	http://www.mattc.org/_media/publications/pdf/Workforce_MO.pdf
New Hampshire	2004	http://www.attc-ne.org/initiatives/WFrpt%20NH12%2015%2004.pdf
New Jersey	2004	http://www.neattc.org/NeATTC-NJ-Workforce-Survey.pdf and http://www.annapoliscoalition.org/pages/images/NY_monograph.pdf
New Mexico	2007	http://www.psattc.org/assets/documents/WFS_New%20Mexico_Apr%202007.pdf
New York	2004	http://www.annapoliscoalition.org/pages/images/NY_monograph.pdf
Oklahoma	2004	http://nattc.org/explore/priorityareas/wfd/overview/documents/Mid-America/Workforce_OK.pdf
Oregon	2005	http://www.nfattc.org/uploads/ORExecSummary.pdf
Pennsylvania	2004	http://www.annapoliscoalition.org/pages/images/NY_monograph.pdf
Puerto Rico	2002	http://nattc.org/explore/priorityareas/wfd/overview/documents/Carribbean%20Basin/PuertoRicoSurvey.pdf
Rhode Island	2004	http://www.attc-ne.org/initiatives/WFrpt%20RI12%2015%2004.pdf
Tennessee	2004	http://www.ceattc.org/workforce/NeedsAssessment.pdf
Texas	2007	http://www.utexas.edu/research/cswr/gcattc/documents/Texas_Addictions_Workforce_Report_2007.pdf
U.S. Virgin Islands	2003	http://nattc.org/explore/priorityareas/wfd/overview/documents/Carribbean%20Basin/USVIResults.pdf
Vermont	2004	http://www.attc-ne.org/initiatives/WFrpt%20VT12%2015%2004.pdf
Washington	2005	http://www.nfattc.org/uploads/WAExecSummary.pdf
New England Regional Summary	2004	http://www.attc-ne.org/initiatives/workforce.html
New England - Managers	2004	http://www.attc-ne.org/initiatives/NE%20Managers12.15.pdf
New England - Direct Staff	2004	http://www.attc-ne.org/initiatives/NE%20Direct%20Service%20Providers12.15.04.pdf

Other State Studies of the Substance Use and Addictions Workforce

State	State Effort or Report	Report or Collaborative Title	Report Link	Description and Key Info
AK	2004	The Behavioral Health Workforce in Alaska: A Status Report	http://www.alaska.edu/health/down loads/Alaska%20Report.pdf	BH Workforce Status; Rural Issues. Project on developing a rural Behavioral Health aide at http://www.alaska.edu/health/downloads/BHP%20Init%20Final.pdf
AZ	2005	http://www.cabhp.asu.edu/pro-development/ Collaboration of Arizona State, University of Arizona, provides trainings, does projects (such as monitor peer support programs etc)		
CA	2004	California Addiction Training and Education Series (CATES) AND Western Conference on Addiction (WCA)		
DE	2003	Using Needs Assessment Data at the State Level to Improve the Current State of Addiction Treatment	http://www.ceattc.org/workforce/N eedsAssessment.pdf	Office of Training within the Division of Substance Abuse and Mental Health formed a Workforce Development Group; promotional video; holistic approach to training: standard work and management, wellness training; system wide job fair; standard orientation for all new hires at behavioral health agencies, sponsored by the state / ATTC study based on same RMC survey as Northwest Frontier; focus on Agency directors
ID	2006	The Current State of Addiction Treatment: Results from the 2005 NFATTC Substance Abuse Treatment Workforce Survey	http://www.nfattc.org/uploads/ID_Final.pdf	
KS	2008		http://www.dhs.state.ia.us/MHDD/ docs/APPENDIXH_VisionforHealt hcareWorkforce.pdf	
KY		leadership took actions; repealed law requiring master's degree for certification, work on tiered certification; dialogue with university system, established two degrees and master's degree		
MD	2005	Using Needs Assessment to Advance the Current State of Addiction Treatment: Preliminary Results from The Maryland Workforce Survey	http://www.ceattc.org/ppt/MD_A DAA.ppt#256,1,Using Needs Assessment Data to Advance the Current State of Addiction Treatment	ATTC report in link has really good summary of recruiting issues and statistics/ Office of Education and Training for Addiction Services; Central East ATTC; RMC Research Inc.
MD	2006	Results of a Statewide Needs Assessment of Behavioral Health Professionals	http://www.ceattc.org/workforce/ MD_WorkforceReport_2005.pdf	

State	State Effort or Report	Report or Collaborative Title	Report Link	Description and Key Info
NV			http://casat.unr.edu/mwattc/docs/workforcesurveyposter2004.pdf	nice workforce survey poster re: education
NH				Office of alcohol and Drug Policy, NH Alcohol and Drug Abuse Counselors Association, NH Board of Alcohol and Other Drug Abuse Professional Practice (licensing board), representatives from institutions of Higher Education (NH Technical Institute, Keene State College, Springfield College); connection to regional efforts of NEIAS, ATTC-NE and NAADAC.
NJ	2004	NEATTC Results of the New Jersey Workforce Survey: Final Report	http://www.neattc.org/NeATTC-NJ-Workforce-Survey.pdf; http://www.ireta.org/products/nw1991-DLD1.pdf	Training network; scholarships for training and education; residential college; new curriculum for Child Protection Specialists on SU. 13 Conference days. All supported by the Governor's Council on Alcoholism and Drug Abuse and the Division of Addiction Services.; For each Finding, gives an ACTION /ATTC Study based on the same RMC study as Northwest Frontier
NY	2004	Workforce Development Summit: Taking Action to Build A Stronger Addiction Workforce	http://www.ireta.org/wfmono.pdf	Comprehensive plan; 5 workgroups: Compensation/Benefits; Marketing; Administrative Relief; Credentialing/Licensure; Organizational Culture/Best Practices. Focused on regulatory streamlining (combine 2 regs into one). Changes in the renewal and requirements for certification; Northeast ATTC, IRETA, IPDA, NY association of substance abuse providers (ASAP), NY office of alcoholism and substance abuse (OASAS); NY OASAS created a Bureau of Workforce Development in 2001 State Dept link: http://www.oasas.state.ny.us/index.cfm; recent press release 1/08 http://www.oasas.state.ny.us/pio/press/pr-01-16-08.cfm
NY	2006	Update to Workforce Development Summit: Taking Action to Build A Stronger Addiction Workforce	http://www.ireta.org/products/mng996-DLD1.pdf	NE ATTC download for free
NY	2002-3	Solutions to the New York State Addictions Workforce Crisis: IPDA's response	http://www.ipdany.org/pdfs/WhitePaperontheAddictionsWorkforceRevised.pdf	
NY	2007	5 year comprehensive plan for a premier system of addiction Services for prevention, treatment, recovery	http://www.oasas.state.ny.us/pio/documents/2007AnnualUpdate.pdf	NY OASAS
NC	2007	North Carolina Institute of Medicine Task for on Substance Abuse Services	http://www.nciom.org/projects/substance_abuse/Clark-11-16-07.pdf	
OH	2007	Enhancing the Prevention Workforce in Ohio: Strategic and Comprehensive Recommendations	http://ocdp.ohio.gov/pubs/Recommendations%20Prev%20WFD%20TF.pdf	Ohio Alcohol and Other Drug Addiction Workforce Development Project
OH	2007	Enhancing the Alcohol and Other Drug Addiction Treatment Workforce in Ohio: Long-Term & Strategic Recommendations	http://cle.osu.edu/wp-contnet/uploads/enhancingthetreatmentworkforceinohio.pdf	

State	State Effort or Report	Report or Collaborative Title	Report Link	Description and Key Info
OH		Short summary article of Ohio Workforce Development Project (OAODAWD)	http://www.pfr.samhsa.gov/docs/OH_approved_web_article_5_1_06.pdf	
OH		slide show explaining the effort	http://www.ebasedtreatment.org/uploadedFiles/WorkforceDevelopment.pdf	
OH	2005	The Ohio Alcohol and Drug Abuse Prevention and Treatment Workforce Resource Project - Assessment of Addictions Workforce July 2005		NAADAC; Ohio Assn. of Alcoholism and Drug Abuse Counselors - rep direct service professionals; Ohio Council of Behavioral Healthcare Providers - rep Provider Agencies; University of Cincinnati - rep Higher ed; Ohio Dept. of Alcohol and drug Addiction Services - the Ohio Single State Authority; Ohio Chemical Dependency Professionals Board - Addictions Treatment and Prevention Licensing Board; Alcohol and drug Abuse Prevention Association of Ohio - Prevention professionals; Ohio Assn. of County Behavioral Healthcare Authorities - rep County Boards; Ohio Citizens Advocates and Faces and Voices for Recovery - rep Consumers; Urban Minority Alcoholism and Drug Abuse Outreach program and Hispanic Urban Minority Alcoholism and drug Abuse Outreach Program - expertise and focus on need for diverse culturally competent workforce; Ohio Resource network - website development; Great Lakes Addiction Technology Transfer Center - EBPs expertise.
OR				has a program with Dept of Corrections: http://www.oregon.gov/DOC/TRANS/PROGMS/wfd_ad_osp.shtml
PA	2004	NE ATTC newsletter	http://www.ireta.org/products/nwl991-DLD1.pdf	Workforce Development Taskforce (with stakeholders). 2004 plan included statewide taskforce - same working groups as NY. Comprehensive Training program - onsite; mini; regional.
TN	2004	http://www.ceattc.org/workforce/NeedsAssessment.pdf		Statewide prevention conference; leadership theme at advanced school on addictions; working on Leadership; prevention /ATTC Study used same RMC survey at Northwest Frontier
VT		The Status of the Vermont Substance Abuse Workforce Report & and Overview of the Core Functions	only hardcopy from BSAS	Substance Abuse Workforce Development Committee (in Dept of Public Health) http://healthvermont.gov/adap/workforce_committee.aspx (reps from higher ed, treatment, prevention, recovery organizations and state government)

Other Studies

Year	Area	Link	Author notes
2007	CANADA	http://www.ccsa.ca/CCSA/EN/Training/	
2007	Exploration of the Substance Abuse Workforce: Education, Preparation and Certification	http://ctndisseminationlibrary.org/PPT/212.ppt#256,1,Slide%201	Rieckman, Fuller, McCarty, Farentinos
2006	National Association of Addiction Treatment Providers	NAATP Addiction Treatment Salary Survey	
2005	CANADA	http://www.camh.net/Publications/Cross_Currents/Summer_2005/addictionsurvey_crcusummer05.html	
2005	Workforce Development Number 5, Vol. 1	http://www.cabhp.asu.edu/about/newsletter/winter_05/	Center for Applied Behavioral Health Policy - Arizona State University
2003	NAADAC survey of early career substance abuse specialists	http://naadac.org/pressroom/files/Year2SurveyReport.pdf	NAADAC

Federal Resources

Org	Date		Description	Link
National Addiction Technology Transfer Center	2008	Workforce Development Website	Active website providing suggestions and resources related to substance abuse Workforce Development	http://www.attcnetwork.org/explore/priorityareas/wfd/overview/
SAMHSA	2009	Workforce Development Resource Center	Active website for Mental Health and Substance Use Workforce Development information for job seekers, employers, recruiters, trainers and students	http://207.145.202.173/WDRCMain.aspx?s=abnhaj55tjcmqe553ackdp45&mis=1
CSAP	Current	Prevention Pathways	Online Education in Prevention; lists which states and national organizations accept the courses for certification credit	http://www.pathwayscourses.samhsa.gov/; http://www.pathwayscourses.samhsa.gov/courses-compare.htm
SAMHSA		TAP 21	Addiction Counseling Competencies	http://kap.samhsa.gov/products/manuals/pdfs/tap21_08r.pdf
SAMHSA		TAP 21A AND TIP 52	SA Treatment Supervision Competencies	http://kap.samhsa.gov/products/manuals/pdfs/tap21_a_08r.pdf http://kap.samhsa.gov/products/manuals/tips/pdf/TIP52.pdf
SAMHSA	2003	ADSS Alcohol and Drug Services Study	Chapter 3 on Staffing treatment	http://www.drugabusestatistics.samhsa.gov/ADSS/ADSSorg.pdf
SAMHSA	2003	Substance Abuse Treatment Workforce Environmental Scan	precursor to Annapolis Coalition	http://www.pfr.samhsa.gov/docs/Environmental_Scan.pdf
CSAT	2000	National Treatment Plan	General assessment of needs of the workforce	http://www.atforum.com/SiteRoot/pages/addiction_resources/CSAT%20Natl%20Tx%20Plan.pdf
SAMHSA		Knowledge Application Program	general resources for SA WFD, training, certification	http://kap.samhsa.gov/workforce/counselors.htm

Org	Date	Description	Link
SAMHSA		Partners for Recovery Workforce Development website	Recovery, Stigma Reduction, Workforce Development, Leadership Development	http://pfr.samhsa.gov/workforce_development.html
SAMHSA		Workforce Action Plan	2006-7 plan part of the MATRIX, updated with Terry Cline's signature	http://www.samhsa.gov/matrix2/SAP_workforce.aspx
SAMHSA		Workforce Information Network for Stakeholders	still seeking participants	Not available yet
SAMHSA	2006	Workforce Development Strategy		http://www.pfr.samhsa.gov/docs/Workforce%20Article_Final.pdf

Addictions Certifications and Requirements and DPH Licensing Requirements for Counselors

▲ Individual professions also have separate requirements for licensure such as Licensed Independent Clinical Social Worker (LICSW); Licensed Mental Health Clinician (LMHC); Marriage and Family Therapist (MFT); Psychologist; Nurse, Physician

▲ Contact the relevant organizations directly for updated requirements and costs

Massachusetts Alcohol and Drug Counselor Licensure

Full eligibility and reciprocity details are in the Massachusetts Licensure of Alcohol and Drug Counselors Regulations Section 168.006

Certification	Required Degree	Minimum hours of training (addressing the full range of education related to substance abuse counseling)	Hrs of supervised practical training	Complete a written examination	Other Requirements
Licensed Alcohol and Drug Counselor I (LADC I)	Master's or Doctoral degree in behavioral sciences	270	300	Y	6000 hours of supervised alcohol and drug counseling work experience
Licensed Alcohol and Drug Counselor II (LADC II)	Proof of high school diploma or equivalent	270	300	Y	6000 hours of supervised alcohol and drug counseling work experience (4000 if holds a Bachelor's degree)
Licensed Alcohol and Drug Counselor Asssistant	Proof of high school diploma or equivalent	50		Y	2000 hours of work experience in the alcohol or drug abuse field

American Academy of Healthcare Providers in the Addictive Disorders

Certification	Required Degree	Minimum hours of training (addressing the full range of education related to substance abuse counseling)	Hrs of supervised practical training	Complete a written examination	Other Requirements	Recertification
Certified Addiction Specialist (CAS)	Professionals with Masters or Doctorate from an accredited health care training program	Minimum of 120 hours (basic counseling) + minimum of 60 hours (clinical training in area of specialization)	3 yrs of post-graduate, supervised experience (Internships at an approved site may be applied accounting for one year)	Y	3 professional recommendations; A completed application with the $80 application fee	Annual 20hr CE (addiction related) Code of ethics signed annual
	Professionals with other degrees or without a degree: A high school diploma	Minimum of 120 hours (basic counseling) + minimum of 60 hours (clinical training in area of specialization)	5 yrs of supervised experience (providing direct health care services to those identified with an addictive disorder)	Y	3 professional recommendations; A completed application with the $80 application fee	Annual 20hr CE (addiction related) Code of ethics signed annual

National Association of Alcohol and Drug Abuse Counselors (NAADAC)

See NAADAC website – a Basic Level is also being introduced

Certification	Required Degree	Minimum hours of training (addressing the full range of education related to substance abuse counseling)	Hrs of supervised practical training	Complete a written examination	Cost	Other Requirements	Re-certification
Master Addiction Counselor (MAC)	Masters degree or another professional degree & current state certificate or license in your profession	500 hrs of education & training	3 yrs of supervised experience (two-thirds of which must be post-master's degree award)				
National Certified Addiction Counselor Level II (NCAC II)	A Bachelor's degree from an accredited college or university & current state certificate or license in your profession	450 contact hours of substance abuse education & training, (including 6 hrs of ethics training & 6 hours of HIV/AIDS training)	3 years full-time work experience or 6,000 hours of supervised experience as a substance abuse counselor	N			
National Certified Addiction Counselor Level I (NCAC I)	A current state certificate or license as a substance abuse counselor	270 contact hours of substance abuse counseling training, (including 6 hrs of ethics training & 6 hours of HIV/AIDS training)	5 years full-time experience or 10,000 hours of supervised experience as a substance abuse counselor	N			
Tobacco Addiction Specialist	A license or certification in the helping profession or teaching certificate or alcohol & other drug certification	500 hrs of education/training in a healing art	3 yrs of employment in the health care profession (Documentation of supervised work experience)	Y	1500	85 hr training course (on line), 150 question test, oral exam, cost includes NAADC membership	
Certificate in Spiritual Caregiving		6 hrs of training provided by a pastoral counselor or other professional based on the curriculum in Spiritual Caregiving to help Addicted Persons & Families	Evidence of contacts & visits with 3 treatment/recovery organizations in your community; Attend an open Alcoholics Anonymous meeting & an open Al-Anon meeting & write a reflection about both of your experiences	Y	50		

International Certification & Reciprocity Consortium (ICRC)

Massachusetts is a member of the IC&RC. The Massachusetts Certification Board added a MA Prevention Specialist Certification based upon the IC&RC certification requirements in late 2009.

*Educational substitutes: An associate's degree in behavioral science may substitute for 1000 hours; a bachelor's degree in behavioral science may substitute for 2000 hours; a master's degree in behavioral science may substitute for 4000 hours

**140 hours of COD specific training that includes a focus on both substance use and mental disorders and considers the interactive relationship between the disorders. 6 hours must be counselor specific ethics training. One hour of education is equal to 50 minutes of continuous instruction

Certification	Experience	Education	Supervision	Written Examination	Re-certification
Internationally Certified Alcohol & Other Drug Abuse Counselor (ICADC)	*6000 hrs of supervised work experience specific to the AODA domains.	Total of 270 hrs. (6 hrs must be specific to counselor ethics)	300 hrs specific to the IC&RC 12 core function areas with a minimum of 10 hrs in each core function area	Y	40hrs CE every 2 yrs
Internationally Certified Advanced Alcohol & Other Drug Abuse Counselor (ICAADC)	2000 hrs of supervised AODA-specific work experience	Master's Degree in behavioral science with a clinical application + 180 hrs of AODA-specific education.	300 hrs specific to the IC&RC 12 core function areas with a minimum of 10 hrs in each core function area	Y	40hrs CE every 2 yrs
Internationally Certified Clinical Supervisor (ICCS)	Applicant must hold and maintain a certification as an AODA, AAODA, CCJP, CCDP or CCDP-D credential at the IC&RC reciprocal level or hold a specialty substance abuse credential in other professional discipline in the human services field at the master's level or higher.	*10,000 hrs of AODA counseling specific work experience plus 4000 hrs of AODA supervisor work experience (4000 hours may be included in the 10,000 hours and must include 200 hours of face-to-face clinical supervision)	30 hrs of education specific to the IC&RC clinical supervision domains with a minimum of 6 hrs in each domain. 1 hr of education is equal to 50 minutes of continuous instruction.	Y	6 hours of CE every 2 yrs. 6 hrs may be a part of the 40 hrs obtained for the AODA, AAODA, CCJP, CCDP, or CCDP-D recertification
Internationally Certified Prevention Specialist (ICPS)	2000 hrs of Alcohol, Tobacco & Other Drug (ATOD) prevention work experience	100 hrs of prevention specific education (50 hrs must be ATOD specific; 6 hrs must be specific to prevention ethics; 1 hr of education is equal to 50 min of continuous instruction)	120 hrs specific to the IC&RC prevention domains with a minimum of 10 hrs in each domain	Y	40hrs CE every 2 yrs

Employee Assistance Professionals Association

(Satisfactory certifying body, as defined in counselor regulations)

- ▲ If you have a graduate degree in an area that is directly related to EAP work (such as psychology, social work, or counseling), you qualify for Track II.
- ▲ PDHs must be earned within the three years immediately preceding your exam application date. If you have not been able to locate PDHs and would like to have CEUs post approved
- ▲ Your advisement papers (Documentation Form and Advisor Attestation Form) must be submitted for approval before you begin the advisement process.

Certification	Work Experience	Continuing education	Advisement/mentoring	CEAP Exam	Re-certification	Cost
Certified Employment Assistance Specialist (Track I)	A minimum of 3,000 documented hours of paid employment earned over a minimum of 2 years in an EAP setting of some type. This experience must have been completed within the 7 years immediately preceding the date of your EACC exam application.	A minimum of 60 Professional Development Hours (PDH, EACC approved continuing education hours) in specified domains: 10, 20, and 30 PDHs in Domains I, II, III, respectively.	A minimum of 24 hours advisement over a minimum 6-month period with a currently certified CEAP advisor; advisements must be acknowledged and approved in advance.	Y	60 PDH every 3 yrs OR Pass exam	PDH: $225.00 members 325.00 non-members Exam: 645.00 members 870.00 non-members AND $35 certificate fee
Certified Employment Assistance Specialist (Track II)	A minimum of 2,000 documented hours of paid employment earned over a minimum of 2 years in an EAP setting of some type. This experience must have been completed within the 7 years immediately preceding the date of your EACC exam application.	A minimum of 15 Professional Development Hours (PDH, EACC approved continuing education hours) in specified domains: 2, 5, and 8 PDHs in Domains I, II, III, respectively.	A minimum of 24 hours advisement over a minimum 6-month period with a currently certified CEAP advisor; advisements must be acknowledged and approved in advance.	Y	60 PDH every 3 yrs OR Pass exam	PDH: $225.00 members 325.00 non-members Exam: 645.00 members 870.00 non-members AND $35 certificate fee

Massachusetts Board of Substance Abuse Counselor Certification

Certification	Hours supervised counseling	Hours of education	Exam
Certified Alcoholism Counselor (C.A.C.)	• 4,000 documented hours (2 years full time) of supervised counseling of clients with substance abuse problems • 220 hours of supervised practical training in twelve counselor core function areas	180 clock hours of education alcohol and drug specific education	Y
Certified Alcohol and Drug Abuse Counselor (C.A.D.A.C.)	• 6,000 hours (3 years full time) of documented hours of supervised counseling of clients with substance abuse problems • 300 hours of supervised practical training	270 hours of education in the four categories	Y

University of Massachusetts Medical School, Division of Preventive and Behavioral Medicine

Certification	Education	Field Experience	Exam
Tobacco Treatment Specialists	• 2 day basic skills course and an intensive 6 day core competencies training course	Following training 2,000 hours of field experience (one full time year) in tobacco treatment	Y

National Council on Problem Gambling

▲ Applicants must have completed a supervised counseling internship at an approved site. College credit internships can be used either as educational contact hours or supervised experience but not both

▲ All applicants will be expected to abide by the Certified Gambling Counselors code of ethics

Certification	Required Ed.	Direct Service Experience	Supervision	Education	Re-certification	Cost
National Certified Gambling Counselor -I	High School Diploma	Minimum of 100 hours as a gambling counselor delivering direct treatment to problem/pathological gamblers and significant others	at least 4 one hour sessions.	• A minimum of 30 hours of approved gambling specific training or education • additional 300 hours of related training or education, (e.g., psychology, sociology, chemical dependency, counseling, social work, etc.) are required.	60 CE every 3 yrs (30 of these hours must be gambling specific approved hours)	$175
National Certified Gambling Counselor –II	High School Diploma	Minimum of 2000 hours (or one year full time equivalent) as a gambling counselor delivering direct treatment to problem/pathological gamblers and significant others	24 hr's: at least two one hour sessions per month for a minimum of 12 months.	• minimum of 60 hours of approved gambling specific training or education • additional 300 hours of related training or education, (e.g., psychology, sociology, chemical dependency, counseling, social work, etc.) are required.	60 CE every 3 yrs (30 of these hours must be gambling specific approved hours)	$175

American Academy of Health Care Providers in the Addictive Disorders

Certification	Required Ed.	Direct Service Experience	Supervision	Education	Cost
Certified Gambling Addiction Specialist	Master's or Ph.D in health care field	Three years (6,000 hours) of post-graduate, full-time supervised experience	a minimum of 120 hours of clinical training in core counseling skills including assessment, interviewing and diagnosis	a minimum of 60 hours of clinical training in gambling addiction treatment	$95
	Advanced Degree in another field or High School Diploma	Five years (10,000 hours) of full-time supervised experience	A portfolio of clinical training with a minimum of 120 hours of training in core counseling skills including assessment, interviewing and diagnosis	a minimum of 60 hours of clinical training in gambling addiction	$95

Appendix D: Choice of Wording

Substance Use and Addictions

The Annapolis Coalition report includes a discussion of the importance of recognizing the connotations of words used to describe work related to medical and social problems caused by some substance use. A draft SAMHSA recommendation on the use of wording from 2004 gives many perspectives on this topic[30]. The Annapolis Coalition participants had to agree to disagree, and while conscious of the potential unintended implications of certain words, move forward with phrasings used consistently by participants. **The pros and cons of certain words were well-debated in this Massachusetts process as well. In the end, in line with recent Federal guidance, the phrasing *substance use and addictions workforce* was chosen for this report.**

The word "*substance*" is included, because much of addiction relates to a physical object, like a drug or alcohol; "*addiction*" is included because one can be addicted to behaviors without a concomitant physical addiction to a specific object, such as in the case of gambling (one may be addicted to substances released in the body due to a behavior, which is still a physical addiction, but has manifestations due to behavior related to objects which themselves are not physically addictive). "*Use*" describes both risky and non-risky behaviors associated with substances, and encompasses work in both prevention and treatment. The group considered "*substance use disorder*," which more clearly emphasizes the medical condition all participants believe or "*risky substance use*" which emphasizes that it is worth intervening before physical and social consequences and certainly prior to addiction itself; and also considered "*addictive behaviors*," but felt that this wording did not convey the chronic condition and lack of choice as strongly as the participants wanted. "*Substance Use and Addictions*" is intended to cover the full spectrum of services: prevention, intervention, treatment and recovery.

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[30] SAMHSA's Center for Substance Abuse Treatment's <u>Substance Use Disorders: A Guide to the Use of Language</u>
<u>http://www.regionsix.com/Resource%20Library/Education/Education-Substance%20Use%20Language.pdf</u> (Accessed 10-15-08)

Appendix E: List of Participants

Stakeholder Advisory Group

Name	Working Group	Organization
Dan Alford		MA Screening, Brief Intervention and Referral to Treatment (MASBIRT)
Hortensia Amaro		Bouve College of Health Sciences, Northeastern University
Laura Ames	Recruitment/Retention	Spectrum Health Systems
Maryann Amodeo	Education/Training	Boston University
Anthony Andreottola		Justice Resource Institute (JRI)
Fred Blake	Recruitment/Retention	Hurley House
Michael Botticelli	Marketing	Department of Public Health (DPH) Bureau of Substance Abuse Services (BSAS)
Paul Bowman		Department of Transitional Assistance (DTA)
Leah Bradley		Community Health Link
Christine Breen		MA Organization for Addiction Recovery (MOAR)
Eileen Brigandi	Education/Training	Boston Public Health Commission (BPHC)
Douglas Brooks		JRI
Jim Callahan	Education/Training	Hawthorn Services
John Canty		Human Resources Development Institute, Inc. (HRDI)
Matilde Castiel		UMass Medical School
Carolyn Castro-Donlan	Marketing	DPH BSAS Office of Youth and Young Adults
Peter Crumb	Recruitment/Retention	MA Association of Alcohol and Drug Abuse Counselors (MAADAC)
Tom Delaney	Education/Training	Boston Alcohol and Substance Abuse Programs, Inc
Tracy Desovich		SE Regional Center for Health Communities (RCHC)
Sandra Smith Dickens		HRDI
Mindy Domb		SPHERE
Pat Emsellem		Stanley Street Treatment and Resources (SSTAR)
Mary Faraday		National Association of Social Workers (Mental Health)
Marcus Fowler		Department of Mental Health (DMH)
Maryanne Frangules		MOAR
Deborah Garnick		Brandeis University, Heller School
Ray Gordon	Education/Training	SSTAR
Frances Gordon	Recruitment/Retention	HRDI
Jim Gorske	Marketing	AdCare Educational Institute
Ruth Grabel	Education/Training	DPH Office of Healthy Aging,
Jessica Grasmere		Recover Project
Steve Gumbley	Education/Training	Addiction Technology Transfer Center of New England (ATTC-NE)
Jeff Harness	Recruitment/Retention	Western MA RCHC

Name	Working Group	Organization
Margie Henderson		Greater Boston RCHC
Haner Hernande	Education/Training	Hispanic Office of Planning and Evaluation (HOPE)
Kathleen Herr-Zaya	Marketing	DPH BSAS Prevention
Jim Hiatt	Marketing	DPH BSAS Planning and Development
Elaine Hill		DMH
Matt Hoffman	Education/Training	Answer House
Jim Hogan		SPHERE
Frank Holt	Marketing	DPH BSAS Adult Treatment
Constance Horgan		Brandeis University, Heller School
A.Jay Horowitz		Massachusetts Behavioral Health Partnership (MBHP)
Sue Hubert	Recruitment/Retention	Department of Children and Families (DCF)
Greg Hughes		Governor's Inter Agency Council
Hilary Jacobs		DPH BSAS Licensing
Steve Keel		DPH BSAS Prevention
Michelle Keenan		Boston/Metro West RCHC
Leroy Kelly		Cambridge College
Cheryl Kennedy-Perez		DPH BSAS Housing and Homelessness Services
Peter Kosciusko	Education/Training	Department of Youth Services (DYS) Director of SA
Kathy Kuhn	Education/Training	BU Institute for Geriatric SW
Bill Lowenstein		New England Institute of Addiction Studies (NEIAS)
Lisa Marshall		Institute for Health and Recovery (IHR)/DYS
Erin Mawn		MA Board of Higher Education
Linda Mazak		SPAN, Inc.
James McKenna	Recruitment/Retention	AdCare Hospital
Peggie Milisci		Mass Council on Compulsive Gambling (MCCG)
Bob Mills	Education/Training	Hope House
Linda Mullis	Education/Training	Addiction Counselor Education Program, Westfield State College
Marie Palumbo-Hayes		Community Care Services
Nancy Paull	Education/Training	SSTAR
Connie Peters		Mental Health and Substance Abuse Corporation of MA (MHSACM)
Joanne Peterson		Learn to Cope
Jerome Posey		HRDI
Karen Pressman		DPH BSAS Planning and Development
Thelma Price-Ware	Education/Training	DPH BSAS Consumer Advisory Board
Leah Randolph	Recruitment/Retention	HRDI - Griffin House
Barbara Reid	Education/Training	Cambridge College
Terry Rodriguez	Recruitment/Retention	DPH BSAS Consumer Advisory Board
Sarah Ruiz		DPH BSAS Planning and Development
Jim Ryan		NE RCHC

Name	Working Group	Organization
E. Vicente Sanabria		Central MA RCHC
Tom Scott		MOAR
Dominique Simon		Allies in Recovery
Betty Singletary		ATTC-NE (former employee)
Walter Spencer	Recruitment/Retention	Jeremiah's Inn
Scott Taberner		MBHP
Bob Turillo	Marketing	DYS
Karen Wakefield		STEP, Inc.
Patrick Walsh		MA Housing and Shelter Alliance (MHASA)
Marlene Warner		MCCG
Enid Watson	Education/Training	IHR
Roger Weiss		McLean Hospital
Glenna Wilson	Education/Training	
Melissa Young	Recruitment/Retention	Phoenix House

Working Groups

Recruitment and Retention
Education and Training
Marketing

Steering Committee

Michael Botticelli, Director, BSAS
Karen Pressman, BSAS
Jim Gorske, AdCare
Jennifer Parks, BSAS Coordinator of Training and Development
Rebecca Bishop, BSAS intern
Dick Dougherty, DMA Health
Deborah Strod, DMA Health

Appendix F: Massachusetts Treatment Capacity

The following tables provide data on treatment capacity, sites, licensees and certification statistics for the Commonwealth and its workforce. All but Clinical Stabilization Services (CSS) were from the most recent count in 2007; the CSS numbers are more recent.

Treatment Capacity by Level of Care		
Level of Care	Agencies	Sites
Ambulatory	100	395
Opioid Treatment	13	34
Acute Treatment	16	22
Family Shelter	9	10
Residential	49	73
Transitional	8	8
Clinical Stabilization	8	14

Number of Sites by Region						
Region	AMB	Acute	Family	Resid.	Trans.	CSS
1 Western	68	3	1	9	1	1
2 Central	38	1	2	8	0	2
3 Northeast	66	3	2	9	1	1
4 Metrowest	66	2	2	12	1	0
5 Southeast	81	7	1	10	2	9
6 Boston	76	6	2	25	3	1
Total	**395**	**22**	**10**	**73**	**8**	**14**

Number of Active Individual Licenses in Related Fields 2007					
LADC I*	1,368	LICSW**	11,420	LMHC***	5,378
LADC II	186	LCSW**	5,328		
LADC A	6	LSW	3,129		
		LSWA	1,348		

*Licensed Alcohol and Drug Counselor. Source: BSAS Licensing (11-07). There were at the time 396 licensees who had not yet renewed.

**Licensed (independent, clinical) Social Worker Source: State licensing board for social workers, email 12-3-07

***Licensed Mental Health Clinician Source: State licensing board for allied mental health professions Includes non-renewals, phone call 11-30-07

Certification Statistics (Mass. Board of Substance Abuse Counselor Certification 2007)	
CAC (Certified Alcohol Counselor)	109
Certified Alcohol and Drug Counselor (CADAC)	343
CADACII (Advanced Level)	227
Certified Criminal Justice Professional	21
Certified Clinical Supervisor	42
Registered Candidates for Certification*	112

*Have passed written exam and are in various stages of the Certification process)

Appendix G: Glossary

AMERSA	Association for Medical Education and Research in Substance Abuse
ASAM	American Society of Addiction Medicine
ATCC	Addiction Technology Transfer Center, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) to upgrade the skills of existing practitioners and other health professionals and to disseminate the latest science to the treatment community. Serving the United States and territories, it operates as 14 individual Regional Centers and a National Office.
BSAS	Massachusetts Bureau of Substance Abuse Services, within the Department of Public Health. The agency charged with funding and monitoring services related to substance use and addictions.
CASA	National Center for Addiction and Substance Abuse at Columbia University
Client/Consumer	Someone who uses services
Compensation	Salary, Health Benefits, Payer reimbursement, non-financial benefits given to individual workers
CSAP	Center for Substance Abuse Prevention, part of the federal Substance Abuse and Mental Health Services Administration (see SAMHSA below)
CSAT	Center for Substance Abuse Treatment, part of the federal Substance Abuse and Mental Health Services Administration (see SAMHSA below)
DPH	Massachusetts Department of Public Health
Individual Provider	A person who provides substance use and addictions services
MHSACM	Mental Health and Substance Abuse Corporations of Massachusetts, the statewide provider association
MOAR	Massachusetts Organization for Addiction Recovery, an advocacy organization for those in recovery from alcohol and other drug addictions.
Payer	An insurance or other entity which pays for substance use and addictions services.
Prevention	An active process involving education and other activities which help reduce risks for becoming addicted and help promote healthy lifestyles and environments.
Provider Agency	An agency which provides substance use and addictions services.
Provider Association	An organization or provider agencies
Recovery	A process of stabilization and healing.

SAMHSA	Substance Abuse and Mental Health Services Administration, the Federal agency charged with focusing attention, programs, and funding on improving the lives of people with or at risk for mental and substance abuse disorders. SAMHSA includes three Centers that engage in program activities focusing on Substance Abuse Treatment (CSAT), substance abuse prevention (CSAP) and mental health services (CMHS). The Office of Applied Studies collects, analyzes and disseminates national data on practices and issues related to substance abuse and mental disorders.
Stakeholder	Any individual or organization with a stake in how well substance use and addictions services are staffed.
Substance Use and Addictions	A phrase which encompasses prevention, intervention treatment and recovery services provided to individuals, families or communities seeking to address the use and misuse of substances or the affect of addiction (whether to a substance or not). See Choice of Wording above.
TIP	Treatment Improvement Protocol, developed and made available by CSAT. Guidelines for providing care.
Treatment	A process and set of services designed to help an individual or family with problems they may be having with alcohol, tobacco, drugs, gambling, and/or other behaviors.
Worker	An individual who provides substance use and addictions services.

For further information, contact:
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