Behavioral Health & Recovery

RESEARCH BRIEF from the Division of Behavioral Health and Recovery | Aging and Disability Services Administration

The Chemical Dependency Professional in Focus: Issues in Diversity and Workforce Planning

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The aim of this research brief is to inform policy makers, treatment providers, and other stakeholders about diversity issues related to workforce planning for chemical dependency professionals (CDPs)[1] in Washington State as gleaned from the 2009 Provider Survey. The Division of Behavioral Health and Recovery (DBHR) conducts a statewide survey of chemical dependency (CD) treatment facilities every three years to provide the Substance Abuse and Mental Health Services Administration (SAMHSA), under the U.S. Department of Health and Human Services, with information to assess staff diversity as part of the goal to advance cultural competency in health care organizations.[2] It is widely acknowledged that treatment agencies can more effectively meet the needs of patients when staff reflects the cultural diversity of the communities they serve.[3] The federal Office of Minority Health considers staff diversity as one of the fourteen national standards for meeting culturally and linguistically appropriate services (CLAS) in health care.[4] The Washington State Governor's Interagency Council on Health Disparities includes workforce diversity in a multi-pronged strategy to eliminate health care disparities.[5]

Understanding diversity issues is essential to CDP workforce planning especially at a time when Washington State faces a projected increase in the number of individuals in need of CD treatment because of expanded Medicaid coverage resulting from health care reform.[6] Recognizing diversity issues can help formulate strategies to bridge disparities that may prevent treatment agencies from fully meeting the needs of their patients. Since CDPs are directly involved in patient care, addressing diversity issues can support efforts to foster cultural competency and, in the long-run, improve the quality of CD treatment. Studies have shown that CD treatment generates savings in medical and other health care costs in Washington State, in addition to helping affected individuals reduce criminal justice involvement and increase their chances of employment.[7,8] CDP workforce planning that considers diversity issues can contribute meaningfully in sustaining publicly funded CD treatment as a viable option for cost-savings under a climate of severe budgetary constraints. The analysis of CDP data from the 2009 Provider Survey focuses on ethnic and gender diversity, and compensation. The findings indicate that:

- **An imbalance exists between the ethnicity of CDPs and the patient population they serve.**
- **CDPs working in publicly funded treatment agencies are undercompensated compared to their counterparts in private facilities.**
- **CDPs are mostly female serving a mostly male population.**
- **Over the last six years, the growth in the number of CDPs has not kept pace with the growing number of publicly funded CD patients.**

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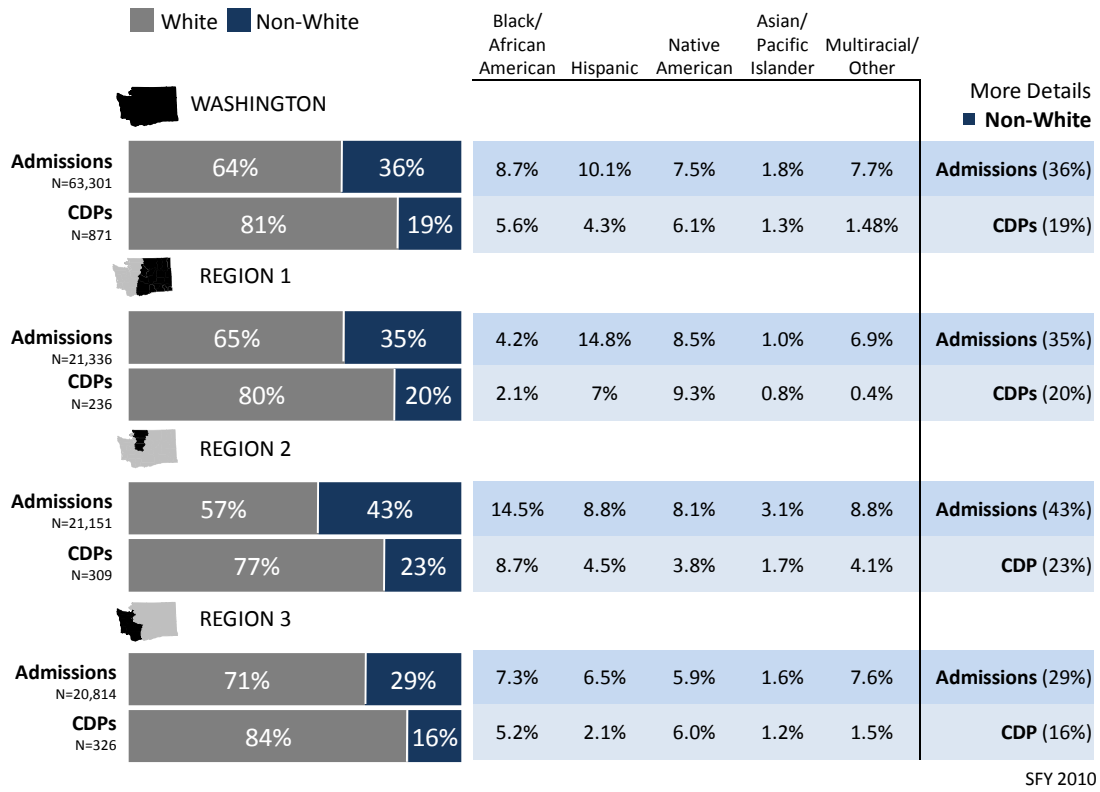
ETHNIC DIVERSITY | How does the ethnicity of currently served patients compare with CDPs in publicly funded treatment?

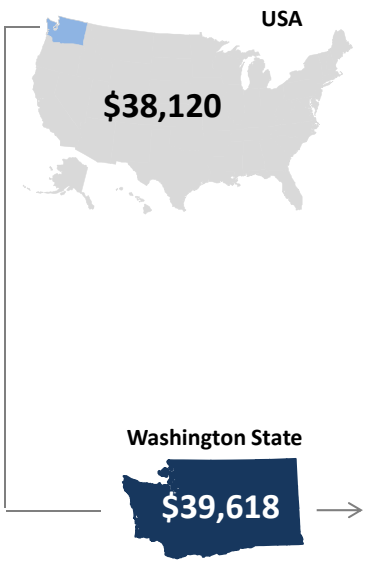


Sources of data: DBHR Treatment Analyzer with run date of June 23, 2011; 2009 Provider Survey.

- Improving outcomes and the quality of care in publicly funded CD treatment will involve addressing the imbalance in the proportion of CDPs and of the minority patients they serve. It starts with supporting programs to encourage more non-White professionals to enter the field, and to recruit and retain them in publicly funded treatment programs. In SFY 2010, non-Whites accounted for 36% of patients admitted to publicly funded treatment, but only 19% of CDPs were non-Whites. The imbalance is greatest among Hispanics, 10% of patients versus 4% of CDPs.

- Correcting the imbalance requires a local approach that recognizes the needs of minority communities. Overall, the imbalance appears to be worst in Region 2 where 43% of patients are non-White compared to only 23% of CDPs. Significant imbalances can be found in some counties for specific minority groups as shown in the Appendix. More African American CDPs are needed in King and Pierce County. Data would indicate a need for more Hispanic CDPs in Adams, Franklin, Kittitas, Walla Walla, and Yakima, and more Native American CDPs in Ferry, Okanogan, Snohomish, Whatcom, Clallam, Clark, Grays Harbor, and Pacific.

COMPENSATION | From a broader perspective, what are earnings for CDPs?



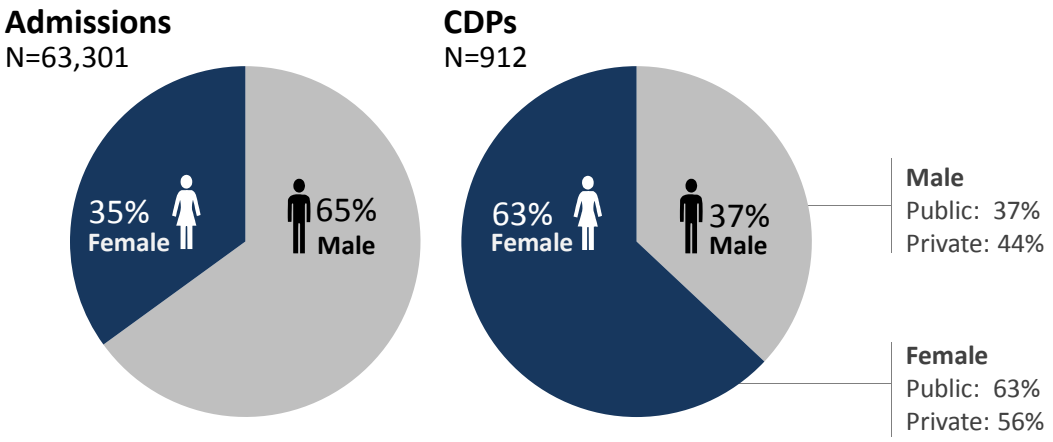
	Public	Private	Total
Gender	*N=777*	*N=170*	*N=947*
Male	$39,510	**$42,000**	$40,000
Female	**$39,225**	$39,000	$39,225
Race	*N=743*	*N=167*	*N=909*
White	$39,000	**$40,000**	$39,373
Non-White	$39,500	**$45,000**	$40,000
Education	*N=777*	*N=172*	*N=949*
High school/Some college	$39,000	**$40,000**	$39,000
Associate's	$37,397	**$38,000**	$37,500
Bachelor's	$39,640	**$42,000**	$40,000
Master's/Doctorate	$43,000	**$45,993**	$43,700
Geography	*N=800*	*N=173*	*N=973*
Region 1 (Eastern Washington)	$37,397	**$40,051**	$38,001
Region 2 (North Puget Sound)	$40,000	**$42,000**	$40,000
Region 3 (Western Washington)	$39,000	**$40,000**	$39,000
Agency Size	*N=800*	*N=173*	*N=973*
3 or less FTEs	$38,000	$38,000	**$38,000**
4-10 FTEs	$40,000	$40,000	**$40,000**
11 or more FTEs	$39,443	**$42,000**	$40,722

Sources of data: U.S. Department of Labor, Bureau of Labor Statistics; 2009 Provider Survey.

- Chemical dependency treatment has been documented to reduce medical and other health care costs especially among Medicaid recipients.[9] Encouraging more CDPs to serve in publicly funded treatment agencies would require that the state take the necessary steps to adjust CDP compensation as they perform a critical role in achieving cost-savings through CD treatment. Even if CDP median earnings in Washington State is higher than the national median earnings for substance abuse and behavioral disorder counselors,[10] the state has to consider market forces that increase the competition for CDPs, thus exerting upward pressure on CDP compensation as a whole. On the supply side, the number of CDPs is not growing fast enough as older CDPs retire. On the demand side, higher skill levels would be needed to implement evidence-based practices, better case management, and the integration of CD treatment with primary care. Aside from market forces, the need for equity would dictate that the state not only offer just compensation but also reduce the gap in CDP earnings between publicly funded and private treatment agencies.

- Overall (both public and private), male CDPs earn approximately $1,000 more than females. However, the gap is less in publicly funded than in private treatment agencies. A number of factors may be responsible for the earnings gap between male and female CDPs in private agencies, such as experience, administrative duties, and share in ownership. Any gender disparity in wages should be a cause for concern.

GENDER | How does the gender distribution of patients compare with CDPs in Washington State publicly funded treatment agencies?

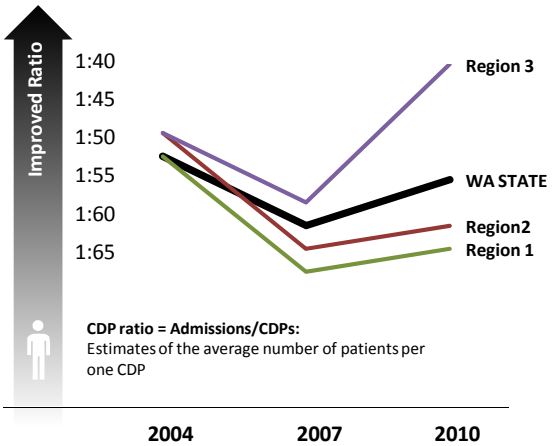


Sources of data: DBHR Treatment Analyzer with run date of July 13, 2011; 2009 Provider Survey

SFY 2010

- The field of chemical dependency counseling has become a predominantly female profession serving a predominantly male patient population. In SFY 2010, males accounted for 65% of patient admissions in publicly funded treatment, while only 37% of CDPs were male.
- Publicly funded treatment agencies have done a worse job of recruiting male CDPs than private agencies. Males made up 37% of CDPs in publicly funded compared to 44% in private agencies.
- The state, together with treatment providers and other stakeholders, should examine the policy implications of gender imbalance between patients and CDPs in publicly funded treatment agencies. For example, should more male CDPs be encouraged to enter and stay in the field? What can be done to encourage males to pursue a CD counseling career? What are the consequences of the shortage of male CDPs on treatment outcomes for male patients?

CDP ratio by state and region



Health Care Reform 2014

Expanded Medicaid Coverage : Additional 41,000 CD patients projected and an estimated 774 CDPs needed to serve them.

WA State	SFY 2004	SFY 2007	SFY 2010
Admissions	38,763	48,530	50,679
CDPs	796	806	948
RATIO	**1:49**	**1:60**	**1:53**

Region 2	SFY 2004	SFY 2007	SFY 2010
Admissions	13,101	16,378	19,739
CDPs	275	270	337
RATIO	**1:48**	**1:61**	**1:59**

Region 1	SFY 2004	SFY 2007	SFY 2010
Admissions	11,954	15,546	15,898
CDPs	233	235	253
RATIO	**1:51**	**1:66**	**1:63**

Region 3	SFY 2004	SFY 2007	SFY 2010
Admissions	13,708	16,606	15,042
CDPs	288	301	358
RATIO	**1:48**	**1:55**	**1:42**

Sources of data: DBHR Treatment Analyzer with run date of October 11, 2011; 2003, 2006, 2009 Provider Survey.

- More CDPs will be needed to serve a growing CD patient population. Between SFY 2004 and SFY 2010, the number of admissions in publicly funded treatment agencies increased by 31%, whereas the number of CDPs rose only by 19%.[11] During the same time period, the ratio of CDP to patient admissions in Washington State changed from 1 CDP per 49 admissions to 1 per 53. In SFY 2010, the worst ratio can be found in Region 1 with 1 CDP per 63 admissions. Only Region 3 appears to show some degree of improvement in the ratio of CDP to patient admissions, changing from 1:48 in SFY 2004 to 1:42 in SFY 2010.
- Health care reform makes training of new CDPs a top priority for the state. With an expanded Medicaid coverage in 2014, it has been estimated that 102,000 individuals will be needing substance abuse treatment services.[12] Maintaining even the current minimal 40% penetration rate and using the state current ratio of 1 CDP per 53 admissions, it would require over 750 CDPs to serve an estimated 41,000 additional patients who will be seeking publicly funded alcohol and drug treatment in a given fiscal year as a result of extending Medicaid coverage to low-income adults.

CONCLUSION AND RECOMMENDATIONS

It is widely recognized that staff diversity is valuable to health care organizations. Understanding diversity issues is essential to making CDP workforce planning an effective process in fostering cultural competency and quality of care in CD treatment. Given the projected additional demand for CD treatment in Washington State as a result of health care reform, recognizing diversity issues in CDP workforce planning becomes even more important as treatment agencies formulate strategies to be more responsive to the needs of the communities they serve.

This research brief has identified diversity issues that can help inform decisions and policies related to CDP workforce planning. The issues revolve around ethnic and gender imbalances between CDPs and the population they serve, and undercompensation of CDPs in publicly funded treatment. Addressing these issues would require that the state initiate collaboration among county and other state agencies, treatment providers, and other stakeholders to develop a comprehensive plan that would incorporate these goals:

- Increase the representation of African American, Hispanic, and Native American CDPs in underserved areas.
- Increase the representation of male CDPs.
- Reduce the gap in CDP earnings between publicly funded and private treatment agencies.
- Increase the pool of qualified CDPs for employment in publicly funded treatment agencies in response to Medicaid coverage expansion.

Chemical dependency treatment has proven to be a service that generates savings for Washington State. CDPs provide CD treatment and, thus, are essential in helping the state offset medical, health, criminal justice, and other costs related to alcohol and drug dependence. Addressing these issues in CDP workforce planning will have a positive impact not only on the profession and CD treatment, but also on the state's ability to generate savings in the long-term.

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[1] CDPs are recognized as a discrete category of health professionals in Washington State. See Revised Code of Washington (RCW) 18.205 at http://apps.leg.wa.gov/RCW/default.aspx and Washington Administrative Code (WAC) 388-805-310, 388-805-315 at http://apps.leg.wa.gov/wac. Accessed June 15, 2011.

[2] See the SAMHSA's Guidelines for assessing cultural competence, http://www.samhsa.gov/grants_culture.aspx. Accessed October 10, 2011.

[3] Anderson LM, Scrimshaw SC, Fullilove MT, Fielding JE, Normand J, and the Task Force on Community Preventive Services. Culturally competent healthcare systems: A systematic review. Am J Prev Med 2003:24 (suppl 3):68-79.

[4] U.S. Department of Health and Human Services, Office of Minority Health. National standards for culturally and linguistically appropriate services in health care: Final report. 2001. Available at: http://www.omhrc.gov/clas/. Accessed October 3, 2011.

[5] Governor's Interagency Council on Health Disparities. State policy action plan to eliminate health disparities. Olympia, Washington, 2010. Available at: http://healthequity.wa.gov/About/actionplan.htm. Accessed December 28, 2010.

[6] Mancuso D and Felver EM. Health care reform, Medicaid expansion, and access to alcohol/drug treatment: Opportunities for disability prevention. Research and Data Analysis Report 4.84. Olympia, Washington, 2010.

[7] Ford Shah M, Mancuso D, Yakup S, and Felver B. The persistent benefits of providing chemical dependency treatment to low-income adults. Research and Data Analysis Report 4.79. Olympia, Washington, 2009.

[8] See also: Luchansky B, He L, and Longhi D. Substance abuse treatment and hospital admissions: Analyses from Washington State. Research and Data Analysis Report 4.46. Olympia, Washington, 2002.

[9] See Ford Shah, *et al*., *op. cit*. and Luchansky, *et al*. *op. cit*.

[10] Source of data on national median earnings for substance abuse and behavior disorder counselors is the U.S. Department of Labor, Bureau of Labor Statistics, available at http://www.bls.gov/oes/current/oes211011.htm. Accessed June 18, 2011.

[11] Data on the number of CDPs for SFY 2006 and SFY 2007 were taken from Rodriguez F. Staffing patterns in Washington State chemical dependency treatment facilities: Trends over a 15-year period. Olympia, Washington, 2008.

[12] Mancuso D and Felver EM, *op. cit*.

Appendix:
County distribution of CDPs compared with treatment admissions among Black/African Americans, Hispanics, Native Americans, and Asian/Pacific Islanders, in percentages*

		Black/African American		Hispanic		Native American		Asian/Pacific Islander	
Region	County	Tx Admission	CDP	Tx Admission	CDP	Tx Admission	CDP	Tx Admission	CDP
Region 1	Adams	0.0%	0.0%	69.1%	50.0%	0.0%	0.0%	0.0%	0.0%
	Asotin	0.4%	0.0%	5.1%	25.0%	2.4%	0.0%	0.0%	0.0%
	Benton	3.3%	14.9%	14.1%	8.5%	3.8%	0.0%	0.7%	0.0%
	Chelan-Douglas	1.2%	0.0%	16.3%	19.5%	3.4%	0.2%	0.6%	0.0%
	Columbia	0.0%	0.0%	12.5%	0.0%	0.0%	0.0%	0.0%	0.0%
	Ferry	1.2%	0.0%	2.5%	0.0%	63.0%	0.0%	0.0%	0.0%
	Franklin	4.4%	0.0%	39.6%	15.8%	0.8%	0.0%	0.6%	0.0%
	Garfield	0.0%	0.0%	7.1%	25.0%	0.0%	0.0%	0.0%	0.0%
	Grant	1.7%	0.0%	37.6%	40.0%	1.5%	0.0%	0.5%	0.0%
	Kittitas	1.4%	0.0%	13.1%	0.0%	3.3%	0.0%	0.5%	0.0%
	Klickitat	0.0%	0.0%	3.5%	0.0%	8.1%	0.0%	0.6%	0.0%
	Lincoln	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Okanogan	0.5%	0.0%	6.5%	0.0%	63.9%	25.0%	0.2%	0.0%
	Pend Oreille	1.5%	0.0%	2.9%	0.0%	2.9%	0.0%	0.0%	0.0%
	Spokane	6.1%	2.8%	5.7%	0.9%	5.8%	11.5%	0.9%	1.7%
	Stevens	0.0%	0.0%	3.5%	0.0%	3.5%	0.0%	0.6%	0.0%
	Walla Walla	3.8%	0.0%	17.8%	0.0%	1.5%	0.0%	0.8%	0.0%
	Whitman	3.7%	0.0%	6.2%	0.0%	1.2%	0.0%	2.5%	0.0%
	Yakima	2.7%	0.0%	26.9%	14.7%	15.9%	23.6%	0.6%	0.0%
Region 2	Island	3.1%	0.0%	2.5%	0.0%	0.6%	0.0%	1.1%	0.0%
	King	21.5%	13.3%	9.3%	3.6%	5.9%	4.0%	4.3%	2.7%
	San Juan	1.8%		7.1%		0.0%		0.9%	
	Skagit	3.3%	0.0%	12.3%	8.1%	6.3%	0.0%	0.9%	0.0%
	Snohomish	5.4%	0.0%	5.9%	6.5%	10.1%	2.2%	1.6%	0.0%
	Whatcom	2.4%	2.5%	8.1%	5.1%	22.4%	7.6%	0.7%	0.0%
Region 3	Clallam	3.0%	3.3%	3.7%	0.0%	19.0%	12.5%	0.6%	0.0%
	Clark	4.4%	4.2%	6.3%	0.0%	2.1%	7.4%	1.8%	0.0%
	Cowlitz	1.3%	0.0%	5.0%	0.0%	3.7%	13.3%	0.2%	0.0%
	Grays Harbor	1.7%	5.9%	3.5%	0.0%	21.7%	0.0%	0.9%	0.0%
	Jefferson	0.6%	33.3%	2.4%	0.0%	7.2%	0.0%	0.0%	0.0%
	Kitsap	5.1%	2.8%	4.2%	5.6%	5.0%	11.3%	2.0%	2.8%
	Lewis	9.7%	4.9%	6.5%	4.9%	3.1%	4.9%	1.6%	0.0%
	Mason	5.7%	0.0%	3.2%	0.0%	10.4%	8.0%	1.1%	0.0%
	Pacific	0.0%	0.0%	6.8%	0.0%	6.8%	0.0%	2.3%	0.0%
	Pierce	14.4%	11.3%	9.9%	3.6%	4.7%	2.4%	2.1%	3.6%
	Skamania	0.0%	0.0%	2.9%	0.0%	7.8%	50.0%	1.0%	0.0%
	Thurston	4.1%	0.0%	6.2%	2.7%	4.4%	0.0%	2.0%	0.0%
	Wahkiakum	0.0%	0.0%	10.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Total	**8.7%**	**5.6%**	**10.1%**	**4.3%**	**7.5%**	**6.1%**	**1.8%**	**1.3%**

*Source of data for percentages of CDPs by county is the 2009 Provider Survey. Cases where race/ethnicity was not reported were excluded from the analysis. Percentages of treatment admissions were taken from the DBHR Treatment Analyzer with run date of July 15, 2011. Figures represent adult and youth treatment admissions to publicly funded treatment in SFY 2010, including programs administered by the Department of Corrections. Admission was used as the unit of analysis because an individual may be admitted to treatment multiple times.

TECHNICAL NOTES

Purpose

The Division of Behavioral Health and Recovery (DBHR) recognizes that staff diversity is an important component of patient care. CD treatment agencies are better able to respond to the needs of patients when staff reflects the cultural diversity of the communities they serve. As a matter of policy, the DBHR conducts a survey every three years to assess the representation of racial or ethnic minorities, women, persons with disabilities, and persons with multilingual ability in the staff of DBHR-certified CD treatment agencies in Washington State, with the goal of identifying disparities and developing policies to address them.

Methodology

The 2009 Provider Survey was mailed in early November to 547 treatment agencies. To be eligible, agencies should be certified by the DBHR to offer outpatient, intensive inpatient, recovery house, long-term residential, opiate treatment, and detoxification services. The mailing list was generated from the division's directory of certified treatment agencies which is updated regularly. The first section of the survey asks questions about provider characteristics, co-occurring disorder treatment services, and the use of evidence-based practices. The second section asks administrators to list all the positions in their agency and, for each, provide information such as the average number of hours worked per week, salary and education (only for treatment staff), chemical dependency professional (CDP) certification and other credentials, gender, race/ethnicity, disability status, and multilingual ability. Agencies were given three weeks to return the survey, but surveys were accepted until April 2010.

Sample

The DBHR received responses from 445 agencies. The original number of agencies in the mailing list was reduced to 514 after deducting eight that have closed and 25 that consolidated multiple sites into one agency. Effectively the survey response rate was 86.6%, with 92.8% of the publicly funded and 76.3% of private agencies participating. Publicly funded agencies receive state, county, tribal, and in some cases, federal dollars to support treatment services, while private agencies do not. There were no significant differences between responding and non-responding agencies with respect to geographical location and treatment services offered. However, non-responders were more likely to be private agencies (Chi square=28.37; $p<.001$). All of the responding agencies completed both sections of the survey except for two that refused to complete the second section despite repeated follow-ups.

Data Analysis

Double data entry was employed as in previous survey administrations to increase data accuracy. Staff data were weighted on one full-time equivalent position, or FTE, in order to adjust for full- or part-time employment. The survey identified 1,210 CDPs (948 public and 262 private) involved in direct patient contact. This number changed as a result of missing data for other variables. For example, missing data for gender reduced the total number of CDPs to 1,170 (912 public, 258 private); missing values for race/ethnicity reduced the yield to 1,124 (871 public, 253 private). The comparison of ethnicity and gender between treatment population and CDPs as a whole applies only to publicly funded treatment since only information on publicly funded treatment is reported to TARGET, DBHR's CD treatment management information system. Data on treatment admissions for state fiscal year 2010 (July 2009 – June 2010) were generated from the DBHR Treatment Analyzer which is based on TARGET data. Treatment admission counts were used since an individual may be admitted multiple times, and to avoid underestimating the volume of patients that are served during a fiscal year. In ethnicity categories, "multiracial" was combined with the group "other" because the percentages for these two categories were relatively miniscule for CDPs. The sum of individual percentages for non-White ethnicity categories may not equal 100% because of rounding. The median gross annual salary was used to compare earnings between subgroups. Only the salaries of full-time CDPs, defined as those working 32 hours or more, which is the generally accepted human resources benefits eligibility criteria, were included in the analysis. Missing values for salary reduced the number of full-time CDPs to varying levels in both publicly funded and private treatment agencies. The CDP to admissions ratio applies only to publicly funded treatment and was constructed as a measure of service capacity on a state and regional but not at the provider level. It was calculated by dividing the total number of admissions in intensive inpatient, recovery house, long-term residential, outpatient, and opiate treatment programs by the number of CDPs identified in the survey for each of the three state fiscal years. The limitation of this crude rate is that the number of CDPs may not include publicly funded agencies that did not participate in the survey. The total number of patient admissions could have been limited to those participating in the survey, but it would underestimate the number of admissions in a given year. Moreover, the number of CDPs employed in a given year may vary within and among agencies, so that limiting patient admissions to only those participating in the survey will not make the ratio anymore precise. However, since over 90% of publicly funded agencies have consistently participated in the survey since 2003, the ratio can be fairly generalized to the publicly funded treatment system on a state and regional level. Regions follow the new DSHS definition of three administrative divisions.

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