Published in final edited form as:

J Subst Abuse Treat. 2008 July ; 35(1): 93–98. doi:10.1016/j.jsat.2007.08.007.

Comparing credentialing requirements of substance abuse treatment staff by funding source

Sheryl Pimlott Kubiak, Ph.D., M.S.W.^{a,*} and Cynthia L. Arfken, Ph.D.^b

^aMichigan State University, College of Social Science, East Lansing, MI 48824, USA

^bWayne State University, Detroit, MI, USA

Abstract

Studies have found that clinicians with higher education and/or attainment of national certification have a more favorable outlook regarding the adoption of evidence-based practices. However, staff hiring decisions may be based on a multitude of factors, including available resources and demands stemming from different funders. Using a mixed-methods case study approach with 34 agencies within one state, we assessed administrators' perspectives of the most important funding source, views on clinical hiring practices, and current staffing. We found that funding source predicted views and actual staff level of credentialing and education. Those agencies citing a criminal justice entity as the most important funder had the lowest requirements for credentialing and education. As the substance abuse treatment delivery system evolves and expands, we must ensure that vulnerable groups have access to more highly—rather than less—skilled workers to assess and facilitate recovery.

Keywords

Workforce; Financing; Criminal justice; Credentials

1. Introduction

Studies have found that clinicians with higher education and/or attainment of national certification have a more favorable outlook regarding the adoption of evidence-based practices (Arfken, Agius, Dickson, Anderson, & Hegedus, 2005; Fuller, Rieckmann, McCarty, & Ednundson, 2006; Knudsen, Johnson, & Roman, 2003; McCarty et al., 2007). Hiring decisions for substance abuse treatment staff, however, may be influenced by other concerns. Resource Dependency Theory (Pfeffer & Salancik, 1978) posits that organizations seek essential resources to secure their prolonged existence, often altering their behavior to acquire and maintain resources. Therefore, the way that an agency is funded is likely to have important implications for the delivery of care (Horgan, Reif, Ritter, & Lee, 2001).

Most resources for substance abuse treatment (80%) come from public sources, such as federal block grants, state funds, and Medicaid (Horgan & Merrick, 2001). Private sources of funding for substance abuse treatment, including health care insurance and self-pay, are decreasing in

© 2008 Elsevier Inc. All rights reserved.

*Corresponding author. Michigan State University, College of Social Science, 254 Baker Hall, East Lansing, MI 48824, USA. Tel.: +1 517 432 7110; fax: +1 517 353 3038., E-mail address: spk@msu.edu (S.P. Kubiak).

Earlier versions of this article were presented to the Michigan Department of Community Health Workforce Development Taskforce (2006) and at the Addiction Health Services Research Conference (2006), Little Rock.

percentage of total reimbursements (Mark et al., 2005). As private sources of revenue decline, other funding may emerge and gain in importance. The National Association of State Alcohol and Drug Abuse Directors, Inc. (2002) surveyed the Single State Authority (SSA), the entity designated in each state to administer federal block grant monies. Among the systems identified within each state, the largest provider of non-SSA treatment services was, by far, the states' criminal justice (CJ) system or Department of Corrections (DOC). Thirty-eight states identified DOC as operating substance abuse treatment services, and in at least 21 states, DOC purchased community-based services such as residential treatment for those on probation and/or parole status.

To address the issue of funders and hiring decisions, we examined the differences in staff credentialing and education levels by primary source of funding (i.e., public, private, or CJ) based on the perspective of treatment agency administrators. The study used a mixed-methods case study analysis of 34 different agencies within one state. Using organizational-level survey data and interviews with administrators within those agencies, we examined the perceptions of funder demands and regulations on staff educational and credentialing requirements by these three funding categories.

2. Materials and methods

2.1. Study site

Michigan's deliberate funding system of substance abuse treatment through a separate decentralized public regulator and DOC provides a case example for examining funder and workforce while holding constant state requirements. In this state, the SSA is decentralized into 16 coordinating agencies responsible for the distribution and regulation of treatment dollars within their geographic catchment area. Collectively, in fiscal year 2005, they delivered more than 57,000 treatment episodes (Treatment Episode Data Set URL: <http://webapp.icpsr.umich.edu/cocoon/SAMHDA-SERIES/00056.xml>; Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 2006). Overall, public funding levels for substance abuse treatment were generally lower than insurance reimbursement rates.

The Michigan DOC Substance Abuse Division grew from a few pilot programs inside facilities in 1988 to a large network of various modalities within the prison and the community with annual expenditures of US\$18 million in 2004. In 2004, DOC's centralized operation contracted with 19 residential and 56 outpatient treatment agencies in the community, purchasing more than 14,000 treatment episodes for probationers and parolees (Michigan DOC, 2005). Overall, DOC reimbursement levels were generally lower than those of Medicaid or block grant funds.

At the state level, Michigan regulations for staff education and credentialing have been subdued,¹ with the exception that clinicians are required to pass a "fundamentals examination." The Fundamentals of Alcohol and Other Disorders Professional examination is a paper-and-pencil test based on a manual on drugs of abuse and substance abuse treatment. Furthermore, there is no educational or experience requirement; anyone can take this examination. Individual coordinating agencies can implement additional requirements such as the Certified Addiction Counselor credential. Although this latter requirement was initially devised around national credentialing standards, it is considered a state rather than a national credential and requires the practitioner to meet educational requirements and a specified number of hours in supervised practice.

¹In late 2006, Michigan Department of Community Health amended these regulations requiring agencies that receive funding from the SSA to employ staff with national credentials. The new regulations will be implemented over time

2.2. Study sample

This study was part of a larger longitudinal study of organizational processes associated with adoption of effective treatment strategies. Selection of the initial agencies was based on administrators' agreement to be part of a clinical trials research network ($n = 5$) and nonresearch agencies matched on coordinating agency location, major funding source (public vs. private), owner-ship, modality, and specific population targeted ($n = 10$). As there were minimal differences in clinical staff characteristics or attitudes between these two groups, they are not analyzed separately here (Arfken et al., 2005). To address CJ funding, we supplemented this sample with all agencies funded by the state-level DOC not currently surveyed in one coordinating agency location ($n = 7$). Agencies not receiving DOC funds but matched on location, ownership, modality, and specific population targeted were also recruited ($n = 11$). Of the agencies approached for participation, both in the initial sample and the supplemental sample, only one declined to participate. One agency was dropped from the analysis because it relied on charity aid only, leaving 34 agencies for analysis.

2.3. Study methods

A mixed-methods case study approach was used with each of the 34 agencies, which included interviews and survey dissemination with three staff persons from each agency. Typically, the three individuals interviewed were the executive director, clinical supervisor, and another counselor or clinical staff. We used the responses from the executive directors who all said that they were highly involved in hiring decisions for this analysis.

The domains in the surveys included treatment modality, treatment focus, staffing, services, use and knowledge of evidence-based practices, leadership style, and organizational functioning. Specific questions analyzed here include the following: number of admissions, primary focus of service delivery, number of employees, types of treatment modalities, and staff characteristics. Two questions on hiring decisions were utilized: "How important are the following when considering hiring someone as a counselor: education and credentials?" using a 5-point scale (from 1 = *not important* to 5 = *very important*) and "How important are the following when considering hiring someone as a clinical supervisor: education and credentials?" Guided interviews included questions on organizational structure, sources of funding, and the impact of funding on the agency. One question asked them to identify which was the "most important source of funding" to their agency. The interviews were conducted in the presence of two people: one to ask the questions and attend to the interview and the other to transcribe. The interviews lasted approximately 1 hour. The transcripts were immediately reviewed independently by both of the researchers present at the interview for completeness, content, and clarity. The transcripts were then read by four research staff who had created a coding schematic based on a priori categories. After completion of these steps, the transcripts were then loaded into a qualitative software program (MAXQDA, 2004) and analyzed by content codes. Quantitative data were analyzed using analysis of variance (using Tukey's honestly significant difference for post hoc comparison of differences) and chi-square tests in SPSS (Chicago, IL).

2.4. Sample characteristics

Most of the agencies had substance abuse as their primary clinical focus (65%), with the remainder endorsing mental health or a combination of services (35%). The most common modality was outpatient (57.6%), with the remainder opting for residential or a combination of residential and outpatient. The size of the agencies varied greatly; the mean number of client admissions was 194.5 (range, 12–600), and the average number of full-time employees was 44.2 (range, 6–320), with the number of full-time clinicians (or equivalent) ranging from 3 to 175 ($M = 28.71$, $SD = 47.8$).

2.5. Funding source categorization

Funding sources for agencies included an array of public and private entities, which were then combined into three groups: private, public, and CJ. The first, private, included sources such as nonpublic insurance, foundations, and self-pay. Public funding included all federal, state, and local funding. Because of our interest in the differences within publicly funded treatment organizations, we categorized public funding into two groups: public and CJ. Public included Medicaid, Medicare, block grant, and other sources of state or local funds other than CJ, and CJ included the Federal Bureau of Prisons, state DOC, county funding from local CJ, and court programs.

Nearly all (91.2%) of the treatment agencies received funding from at least two of our three categorical groups, that is, public, private, and CJ. More than half (55.9%) received funding from two sources and 35.3% received funding from all three. Although our sampling strategy included specifically selecting 10 (5 in the original sample and 5 in the supplemental sample) agencies that we knew received funding from state-level corrections, an additional 6 had other types of CJ funding (e.g., federal or municipal), resulting in 47% ($n = 16$) with some type of CJ funding.

No administrator hesitated answering the question pertaining to the most important source of funding. Half (50%, $n = 17$) identified public sources of funding (primarily block grant funds), 29.4% ($n = 10$) identified private sources, and 20.6% ($n = 7$) identified CJ as most important. We used this response to categorize the agencies in the analysis.

3. Results

3.1. Survey data

The administrators rated degrees and credentials as highly important for both counselors and clinical supervisors (Table 1). However, there were differences in the requirement and current staffing, which varied by most important funding source. Post hoc comparisons showed that agencies reporting CJ as the most important source rated credentials as less important than other agencies. In addition, post hoc comparisons found that those rating private sources of funding as most important were more likely to have a higher percentage of master's-prepared staff than those that stated that either public or CJ sources were the most important funder. There were no differences between the groups in size (number of admissions or staff measured continuously or in tertiles) or primary focus (mental health or substance abuse).

3.2. Interview data

Using the a priori topic areas on the importance of degree and certification in hiring, we found that the interviews validate the survey data presented above. Those administrators within the CJ group believed that there were fewer and lower expectations of degree and certification: "For substance abuse, [corrections] does not require a degree, but they do require that we do a criminal background check for offenses" and "[Corrections] doesn't require a license." Conversely, administrators within the private group were very clear that a master's degree and appropriate credentials were required by their funding source: "We have focused on getting more credentialed folks. That's due to the insurance wanting more credentialed folks" and "Insurance won't pay if they're not CSW's [Certified Social Workers]." For the administrators within the public group, there was more variation: "... require a Certified Addictions Counselor (CAC) plus degree," "The state doesn't require that [bachelor's degree]. They will eventually, but not now," and "Some CA's want master's degree." This later variation was particularly surprising given the fact that administrators were sometimes talking about the exact same funder.

There was unanimous agreement across sites and funding sources that although work expectations—particularly around documentation—have increased, pay has decreased: “I’d like to pay staff more money. Our greatest resource is human—they make the place go... But pay is greatest concern.” Many agencies felt that they could attract more skilled staff if they could pay more or provide greater benefits. However, there were a disproportionate number of those agencies that identified CJ as their most important funder. Many referenced the lower reimbursement rate from CJ sources: “Corrections requires a lot for the very little they give you and will even cut the budget in the middle of the year. Last year our budget was changed overnight three times.” More salient to our analysis of hiring practices were comments such as “... funding has limited our capability to hire competent, able persons.”

4. Discussion

Our study compared treatment administrators’ views on the importance of staff credentials and education based on the funding source identified as most important to the agency. Consistent with the Resource Dependency Theory, requirements for the workforce did vary by the most important funding source. Those administrators who considered CJ to be their most important funding source rated the importance of staff education or credentials for staff and supervisors lower than other directors. Conversely, those directors who considered private funding sources, primarily insurance, as most important rated educational levels and licensure highly. This distinction in ratings was translated into workforce composition.

The qualitative data provide two explanations: reimbursement requirements and administrators’ belief that they could not afford to pay more qualified staff. The discrepancy in reimbursement rates, for essentially the same service at the same location, appeared to drive hiring decisions and was a consistent thread throughout the interviews.

Perhaps most distressing is that those administrators stating that CJ was their most important funding source did not endorse the importance of credentials for either counselors or supervisory staff as highly as other administrators. CJ populations may represent one of the most challenging treatment populations for substance abuse clinicians from an individual and systems perspective (Taxman, Perdoni, & Harrison, 2007). Supporting this, our analyses of the National Survey on Drug Use and Health found that when comparing those in treatment for mental health or substance abuse disorders and those under some CJ sanction (e.g., parole or probation), those in the CJ group were more likely to have a myriad of issues demanding complex case management and system interface (Kubiak & Arfken, 2007; Kubiak, Arfken, Swartz, & Koch, 2006). In addition, a recent Bureau of Justice Statistics report (James & Glaze, 2006) found that more than 70% of those in prisons and jails have a mental health diagnosis. These complexities may demand a substance abuse treatment workforce that has a higher, rather than a lower, certification requirement.

Our findings also underscore the emerging importance of corrections or CJ funding on community-based treatment. The importance of this funding to community agencies needs to be weighed in the context of the Resource Dependency Theory against the demands of increased professionalization of the workforce and movement toward evidence-based practices (Friedman, Taxman, & Henderson, 2007). Although many administrators were not happy with the lower reimbursement rate that DOC provided, they complimented the ease of managing the contract and regulations, particularly in comparison with private funding that necessitated a great deal of oversight and staff time with cumbersome verifications. Many administrators commented that without DOC funding, their agencies would have been closed.

The addition of qualitative data clarified and illuminated variations observed across funding categories. A concrete example of how funders’ requirements effect hiring decisions was found

within the private funding group. Those directors stated that they would not be reimbursed for claims by an unlicensed professional and, thus, needed to hire only licensed professionals. It was also clear that the publicly funded agencies were most likely to interpret qualifications as credentials or certification related to substance abuse treatment competencies rather than licensure. As rare as it was for an administrator from an agency dependent upon private insurance to mention specialty certification, it was just as rare for someone from the public or CJ groups to discuss professional licensure. In addition, some agencies with public funding based their qualifications on passing a simple examination, a minimal requirement for professional treatment staff. More surprising was the variation in administrators' impressions of requirements within the same local geographic region for publicly funded agencies. This might be due to the changing landscape of substance abuse treatment regulations.

4.1. Limitations

The small number ($n = 34$) of organizations participating in the study within one state and their nonrandom selection limit the generalizability of the findings. Furthermore, the self-report data do not allow us to review objective evidence of grants and contract amounts to verify the relative importance of the funding sources. As such, this study should be understood as exploratory and should be followed with other studies across states to determine the relative impact of CJ funding and if there are variations in staff educational and certification levels based on funding source.

4.2. Conclusions

This study assessed multiple treatment agencies within one state to examine the possible influence of funding sources on the recruitment and hiring of clinical staff. This examination is the first to assess the potential impact of CJ funding on the delivery of substance abuse services by separating it from other sources of public funding. As substance abuse treatment agencies struggle to respond to increasing demands for economic efficiency and evidence of treatment effectiveness (McLellan, Carise, & Kleber, 2003), they must be responsive to both internal and external demands for change (Fuller et al., 2007). One strategy may be to diversify funding streams, but this means balancing often competing demands of funding sources. We found that the administrators' perception of the agency's most important funding source does have implications for the type of staff hired, which may have implications for the adoption of evidence-based practices. As the substance abuse treatment delivery system evolves and expands, we must ensure that vulnerable groups have access to more highly—rather than less—skilled workers to assess and facilitate recovery. Less qualified staff may jeopardize the Institute of Medicine (1998) principle of treatment equity.

Acknowledgments

This study was supported in part by a grant from the National Institute on Drug Abuse (RO1 DA014483). The authors would like to acknowledge and thank all the administrators and staff who participated in the survey.

References

- Arfken CL, Agius E, Dickson MW, Anderson HL, Hegedus AM. Clinicians' beliefs and awareness of substance abuse treatments in research and non-research affiliated programs. *Journal of Drug Issues* 2005;35:547–558.
- Friedman PD, Taxman FS, Henderson CE. Evidence-based treatment practices for drug involved adults in the criminal justice system. *Journal of Substance Abuse Treatment* 2007;32:267–277. [PubMed: 17383551]
- Fuller, B.; Rieckmann, T.; McCarty, D.; Ednundson, E. Counselor characteristics predict attitudes toward treatment practices. Presentation at the Addiction Health Services Research Conference; Little Rock, AK. 2006 Oct 25.

- Fuller BE, Rieckman T, Nunes EV, Miller M, Arfken C, Ednundson E, et al. Organizational readiness for change and opinions toward treatment innovations. *Journal of Substance Abuse Treatment* 2007;33:183–192. [PubMed: 17434708]
- Horgan, CM.; Merrick, EL. Financing of substance abuse treatment services. In: Galanter, M., editor. *Recent Developments in Alcoholism*. Vol. vol. 15. New York: Kluwer Academic/Plenum Publishers; 2001. p. 229-252.
- Horgan, CM.; Reif, S.; Ritter, GA.; Lee, MT. Organizational and financial issues in the delivery of substance abuse treatment services. In: Galanter, M., editor. *Recent Developments in Alcoholism*. Vol. vol. 15. New York: Kluwer Academic/Plenum Publishers; 2001. p. 9-26.
- Institute of Medicine. *Bridging the gap between research and practice: Forging partnerships with community-based drug and alcohol treatment*. Washington, DC: National Academy Press; 1998.
- James, DJ.; Glaze, LE. Bureau of Justice Statistics # NCJ 213600. U.S. Department of Justice; 2006. *Mental health problems of prison and jail inmates*.
- Knudsen HK, Johnson JA, Roman PM. Retaining counseling staff at substance abuse treatment centers: Effects of management practices. *Journal of Substance Abuse Treatment* 2003;24:129–135. [PubMed: 12745030]
- Kubiak SP, Arfken CL. Beyond gender responsivity: Considering differences between community dwelling women involved in the criminal justice system and those involved in treatment. *Women and Criminal Justice* 2007;17:157–171.
- Kubiak SP, Arfken CL, Swartz J, Koch A. Association between entering substance abuse treatment and having been arrested: Substance abuse treatment at the front end of the criminal justice continuum. *Substance Abuse, Treatment, Prevention & Policy*. 2006
- Mark, TL.; Doffey, RM.; Vandivort-Warren, R.; Harwood, HJ.; King, EC., et al. *Health Affairs*. 2005. U.S. spending on for mental health and substance abuse treatment, 1991–2001; p. W5-133-W5-142. Web exclusive
- MAXQDA2. VERBI software. Berlin, Germany: 2004.
- McCarty D, Fuller BE, Arfken C, Miller M, Nunes EV, et al. Direct care workers in the national drug abuse treatment Clinical Trials Network: Characteristics, opinions and beliefs. *Psychiatric Services* 2007;58:1–10.
- McLellan AT, Carise D, Kleber HD. The national addiction treatment infrastructure: Can it support the public's demand for quality care? *Journal of Substance Abuse Treatment* 2003;78:125–129.
- Michigan Department of Corrections. Office of Substance Abuse Services annual report fiscal year 2004/2005. Lansing, MI: Issued by Michigan Department of Corrections Office of Substance Abuse Services; 2005.
- Identification and description of multiple alcohol and other drug treatment systems. Final report. Washington, D.C: National Association of State Alcohol and Drug Abuse Directors; 2002. National Association of State Alcohol and Drug Abuse Directors, Inc.
- Pfeffer, J.; Salancik, G. *The external control of organizations: A resource dependence perspective*. New York: Harper & Row; 1978.
- Substance Abuse and Mental Health Services Administration. *Treatment Episode Data Set (TEDS). Highlights— 2004*. Rockville, MD: National Admissions to Substance Abuse Treatment Services, DASIS Series: S-31, DHHS Publication No. (SMA) 06-4140; 2006. Office of Applied Studies.
- Taxman FS, Perdoni ML, Harrison LD. Drug treatment services for adult offenders: The state of the state. *Journal of Substance Abuse Treatment* 2007;32:255–266. [PubMed: 17383550]

Table 1
Comparison of the ratings of the importance of staff degree and credentialing by most important funding source

Organizational characteristic	Most important funding source				F (df = 2)
	Total (N = 34), M (SD)	Public (n = 17), M (SD)	CJ (n = 7), M (SD)	Private (n = 10), M (SD)	
Importance of counselor degree ^a	4.47 (0.8)	4.59 (0.9)	4.00 (0.8)	4.60 (0.7)	1.48 p = .24
Importance of supervisor degree ^a	4.58 (0.6)	4.63 (0.6)	4.17 (0.8)	4.81 (0.4)	2.11 p = .14
Importance of counselor certification ^a	4.53 (0.7)	4.71 (0.6)	3.71 (0.8)	4.80 (0.6)	7.30 p = .003
Importance of supervisor certification ^a	4.69 (0.6)	4.82 (0.4)	3.83 (0.8)	5.00 (0.0)	15.23 p = .000
Percentage of staff with master's degree	0.71 (0.3)	0.65 (0.4)	0.58 (0.4)	0.92 (0.2)	3.25 p = .05

Note. Post hoc testing was used (see Section 3).

^aMeasured on a 5-point scale (from 1 = not important to 5 = very important).