

Testimony of Cynthia Moreno Tuohy, NCAC II, CCDC II  
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My name is Cynthia Moreno Tuohy, and I am the executive director of NAADAC, the Association of Addiction Professionals. NAADAC is an organization with a long history, going back more than 35 years. Today, there are over 11,000 members, and affiliates in 47 states. In addition to my current position, I have over 13 years of experience as a director of county-wide, state funded addiction treatment programs. As a result, I have experienced first-hand the challenges faced by the addiction recovery workforce. I have overseen the entire spectrum of addiction programs, from juvenile justice to school districts to treatment for the elderly. Workforce development is one of the greatest challenges staring down the field of addiction recovery today. To ensure the furtherance of this profession, we must take several steps to recruit, retain, and reward our current and future workforce. There is no silver bullet when it comes to workforce development. NAADAC has conducted Workforce Surveys through the Practitioner Services Network studies. We know what trends occur in the workforce, and have a good idea as to what the future holds. What we need now are plans to move forward the addiction profession, in order to keep up with the needs of each state and community. Statewide Workforce Development Plans need to be planned in conjunction with the Addiction Professional Groups, in order to examine what techniques would be successful in each state. We must find a way to reduce bureaucratic red tape, so that counselors can spend less time on paperwork and more time with patients.

Just as in basic education, there are "Three Rs" essential to the improvement of the addiction workforce. The first of the three Rs of workforce development is "recruitment." The field, and federal and state governments, must concentrate great amounts of energy on recruiting bright, young, energetic people to pursue a career in addiction counseling. The government, non-profit associations, and private industry must collaborate in order to create a "career arc" that will take new professionals from student to trainee to counselor to supervisor. There must be a future in the field and room for advancement for promising young counselors; otherwise, there will be great difficulty in recruitment. There are several ingredients in the recipe for successful recruitment, but we must begin by taking something away from the equation. I am referring to stigma. For years, substance abuse and addiction has carried with it a stigma. Too many in our society view addicts as people who are weak, who have no will power, and who choose to

destroy their lives. As a result, the recruitment of young professionals becomes difficult. Few and far between are the people who would opt to work in a field where the condition to be treated is viewed in such a negative light. Yet addiction is a disease, much the same as cancer or diabetes. In an attempt to have the government and public recognize addiction as a disease, NAADAC would like to move from using the terminology of "Substance Use" to the term "addiction". The terms "substance use" or "substance abuse" carry with them an aura of choice. In reality, addicts cannot choose whether to abuse drugs- their addictions override all other thoughts and actions. When an addict uses drugs, it is because they cannot control themselves, because a disease has taken over their mind and body. NAADAC urges state governments across the country to help end the stigma of drug addiction, by supporting stronger incentives to enter the addiction recovery workforce and promoting the education of the general public on the complexities of addiction. Professionals who become doctors or researchers in hopes of eradicating those diseases are praised and encouraged. They receive incentives from the federal government, such as loan repayment and forgiveness. Those who choose to fight addiction should be encouraged and rewarded in a similar manner. Another recruitment issue includes recruiting minorities into the profession. This issue goes beyond equal opportunity- studies have shown that patients are far more likely to follow a regimen of care prescribed by someone of their own ethnicity. More minority counselors will make treatment more effective, and more widespread. The role of state universities in training the addiction treatment workforce needs to be supported by the state- and not only to encourage a career in counseling. Even more so, states must put adequate funding in place to promote addiction prevention and treatment courses, degrees in counseling, and field practicum at all educational levels. Of course, parallel to this, adequate salary and benefits packages need to be in place in order to retain an infrastructure of competent addiction professionals.

Currently, addiction counselors who apply to the National Health Service Corps are classified under the auspices of mental and behavioral health professionals, which includes clinical psychologists, clinical social workers, marriage and family therapists, and licensed professional counselors. Though addiction counselors can apply to the Corps, they can only do so under the mental health banner. Yet Mental Health and Addictive Disorders are not always interchangeable. We need to acknowledge the specific competencies, education and training for addictive disorders. Addiction is not only a brain disease- it is biological, physiological, psychological, psycho physiological, and psychiatric- all at the same time. Mental health issues and addiction issues share many of the same roots- but it is important to remember that an oncologist and an allergist are both doctors, but require different training in order to excel in their chosen profession. Even more specifically, an oncologist who specializes in breast cancer must receive differed training from an oncologist who specializes in colon cancer. Mental health and addiction professionals often have the same needs, but just as often have different needs. And addiction counselors who work in tobacco have different needs than addiction counselors who work in methamphetamines. By ensuring that addiction counselors can compete on a level playing field for federal loan forgiveness and/or scholarship programs, additional counselors will be able to enter the profession and others likely will choose to continue to practice if they can secure some financial relief.

The second R is retention. On this front, we have two responsibilities. The first is to ensure that counselors are rewarded as their careers progress, with promotions and recognition. The

second is to ensure that all counselors remain up-to-date on the latest advances in the field, through continuing education. This is a multi-issued, multidynamic disease that requires multi-disciplinary teams that are able to review the whole picture and texture of the patient, and not only recommend the treatment plan that may lead to success for that patient, and also for the patient's family. Resources need to cross traditional funding lines; addiction counseling and treatment, family treatment, dental and medical care, housing, food, and career training, education and placement. Currently, workforce development surveys indicate that few addiction counselors receive on-going clinical supervision. Administrative supervision is common, but this hardly amounts to the support that an addiction counselor needs in order to feel empowered and encouraged to remain in the profession. Multidiscipline clinical supervision is necessary due to the high percentage of addiction patients with co-morbid disorders. Teams with psychologists, clinical psychologists, and doctors are helpful in the consideration of these patients, who comprise a large proportion of the population currently undergoing treatment. Retention would also be increased with on-going training for the addiction counselor. Not just one stop workshops, but ongoing training that is transferred by technology. It must be skill based, and have the ability to report back the outcomes, concerns, barriers, and progress made in the techniques and methods used.

We are in need of policy that would lay a foundation for a higher cost unit rate of reimbursement, especially to publicly funded substance abuse treatment and prevention agencies. A percentage of this should be designated for staff salaries and benefits, in order to attract and retain qualified Addiction Professionals. Each state needs to have a clear standard of treatment methods that are either promising practices, best practices, or a combination thereof. The state should help consumers understand and choose among the various kinds of providers who offer treatment for addiction. Treatment centers with good outcomes, as evidenced through their state outcome studies, are the best treatment centers to attend. It is important for states to have contracts with treatment centers in order to fund them at an adequate level, to that they may hire competent staff, and retain that competent staff. This is necessary if we are to reinforce the type of outcomes we would like to see. We know that early in treatment, patients will typically choose the path of least resistance and change. This is not in the patient's best interest. Consumers need to know that this is a field with competent and trained professionals who are able to evaluate and coordinate systems of care. We are all aware of the Institute of Medicine's soon-to-be-released report entitled "Improving the Quality of Health Care for Mental Health and Substance-Use Conditions." Chapter seven of the report focuses on workforce development. One statement in the IOM report reads "There are no mechanisms in place to assure that any given clinician has been adequately educated and trained to offer any specific therapy, a process essential to the provision of safe, effective, and efficient care." While there are

no such government standards in place, there are mechanisms that do exist. NAADAC offers certifications on a national level that require very specific credentials. Also, there are NAADAC state affiliates in 47 states, each one requiring strong credentials for certification. There are specific core competencies, training, and educational curricula. Just as the American Medical Association recognizes competencies through their licensing body, so does NAADAC, through its certification process. NAADAC recommends we work together to bring the certification to a National level of acceptance through the managed care groups. IOM report Recommendation

7.4 reads "To facilitate the development and implementation of core competencies...institutions of higher education should place much greater emphasis on interdisciplinary didactic and experimental learning..." NAADAC is in full support of this recommendation. The addiction profession, and the health of the public, can only benefit from all health professionals being educated in the basics of addiction, especially when it comes to identifying the warning signs, and making sure patients are placed properly within the health care system. This would be facilitated in part by Senator Biden's bill, S. 538, designed "To educate health professionals concerning substance use disorders and addiction..." NAADAC endorses this legislation, and is hopeful it will pass this year. The third R is reward. Recruitment, and retention, would benefit if the rewards were worthy of a career dedicated to serving others. Successful counselors need training to one day become successful treatment program directors. Many of our Addiction

Professionals across the USA can currently qualify for food stamps - this is not acceptable - especially if we want quality, competent and long-term professionals. Salaries and benefits should be based in large part on credentials and levels of training. Each state should conduct a review of the salary schedules for counselors, including those at private treatment centers. A retirement package is essential if addiction professionals are to remain in this field. At the same time that individual counselors are rewarded based on performance, so must successful treatment programs be rewarded. We want to foster an even closer relationship with state alcohol and drug abuse directors, so that we may design incentives that reward productive programs. I thank you for the opportunity to speak here today. Clearly, we have much work to do as we strive towards our goal. It is my sincerest hope that all parties involved in this process can work together to improve the addiction workforce, and work towards a future when addiction is no more than another disease that has been wiped off the face of the Earth.

Thank you.

*Updated June 27, 2013.*