Michigan Treatment Workforce Development Report

2021

WAYNE STATE
School of Social Work

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The Michigan Treatment Workforce Development Report examines responses gathered from Michigan's substance use disorder (SUD) treatment workforce. Respondents replied to the internet-based survey on a volunteer basis. Findings are presented within the following areas: worker demographics; education, certification, and licensure; employment information including salary, benefits, job tasks; job satisfaction; training; and supervision.

Acknowledgments
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Executive Summary

The Substance Use research team from the School of Social Work at Wayne State University conducted the 2021 Treatment and Prevention Workforce Development Survey to gain insights on the experiences and training needs of substance use treatment and prevention providers in Michigan. This report presents the results from 443 respondents who completed the online survey. Below, we describe participants' background characteristics and key findings related to Employment and Benefits, retention and work obstacles, clinical supervision, and training needs. We encourage readers to view the full report to understand the depth and breadth of these findings and see comparisons to results from earlier years.

Demographics

- Most respondents were women (74%, n=264).
- Eighty-seven percent of respondents self-identified as White (87%, n=310), and smaller numbersidentified as Black (6%) or Other Races (7%).
- The largest age group represented was between 35 to 44 years old (25%, n=90).
- Over a third of respondents (35%, n=123) identified as in recovery (35%).

Education, Certification & Licensure

- Respondents' education levels varied: 61% reported they had a master's degree (n=268), 17% had a bachelor's degree, and 11% reported some college.
- Half of the respondents (52%) reported a current substance use certification, and an additional 26% were working under a development plan towards certification (n=115).
- Of those currently certified, the most common certifications include:
    - CAADC – Certified Advanced Alcohol and Drug Counselor (33%, n=147)
    - CCS – Certified Clinical Supervisor (12%, n=55)
    - PSS/RC- Certified Peer Support Specialist/Recovery Coach (13%, N=56)
    - CADC – Certified Alcohol and Drug Counselor (10%, n=44)
- Respondents who reported current state licensure most frequently indicated:
    - Social Work (Clinical) (38%, n=166)
    - Counseling (LPC) (18%, n=81)

Employment & Benefits

- Most respondents reported full-time employment (90%, n), and a smaller proportion reported working part-time (6%) or on a contractual basis (4%).
- Respondents worked in 52 counties across Michigan. The counties with the greatest number of respondents performing work there were:
    - Kalamazoo (13%, n=56)
    - Oakland (10%, n=43)
    - Macomb (9%, n=41)
- For full-time employees, the most frequently reported salary range was $40,000 to $49,999 annually (24% of full-time employees). The most commonly reported salary for part-time or contractual employees was between $20,000 and $29,000 annually (47% of part-time/contractual employees).
- Most respondents served the general adult population aged between 18 to 59 years old (79%, n=351).
- Respondents were asked how to promote the retention of clinical staff. The most common suggestions were:
    - More frequent salary increases/promotions (cited in the top three recommendations by 51.2% of the sample)
    - Lessen/assist with paperwork (cited in the top three by 29.6%)
    - Improved ongoing training (cited in top three by 22.9%)
    - Credentialing/licensure support (cited in top three by 18.2%)
    - The least cited factor for job retention was:
        - Improved physical work environment (n=149)
- Benefits from employers varied. Respondents receive the following benefits from their employer:
    - Health insurance (78%, N=275)
    - Sick leave (77%, N=271)
    - Disability insurance (62%, N=209)
    - Retirement contributions (52%, N=178)
    - Tuition reimbursement (9%, N=30)
- Respondents reported on the greatest obstacles that prevent them from performing work duties to satisfaction. Thirty-seven percent said changed or increased demands related to job duties, and37% indicated burnout prevented them from performing to satisfaction.

Training

- Half of the respondents reported they prefer training to occur in person (49%, n=177).
- The topics in which the largest number of respondents completed training include co-occurring disorders (73.6%), substance misuse and addiction (72.7%), trauma (70.2%), treatment planning (70.2%), and mindfulness (69.5%).
- Over two-thirds of participants received some training in medications for addiction treatment (68.6%) and naloxone (68.4%).
- The most frequently requested additional training include: trauma and abuse (72.6%), co- occurring disorders (71.3%), and coping and emotion regulation skills (68.2%).

Clinical Supervision

- Most staff (92.1%) typically receive clinical supervision, although the format varied (e.g., virtual, in-person group, in-person individual, case consultation, or coaching.

- Most respondents also reported their supervision continued during the COVID-19 pandemic, with 76% reporting either video or audio supervision.
- Concerning the frequency of clinical supervision, most respondents meet with their supervisor either weekly (38%, n=135), monthly (23.4%, n=83), or Bi-weekly (16.3%,n=58).
- Respondents felt the most important topic to cover during clinical supervision to be; counselor case presentation (28%) and discussing counselor problems/challenges (28%).

Demographics

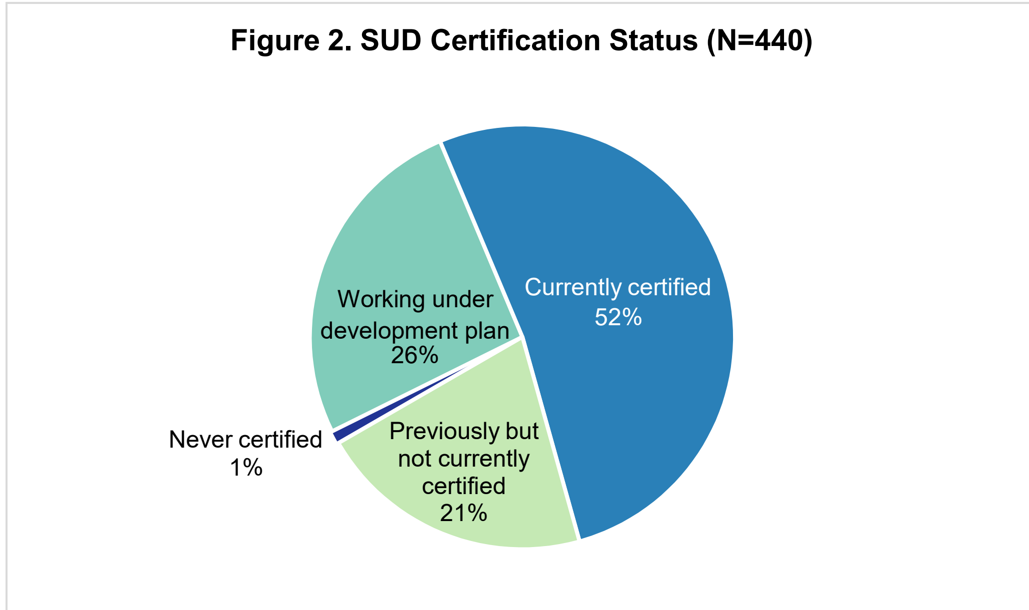
Of the 443 respondents to the 2021 Treatment Workforce Survey, a total of 264 identified as female (74%), 89 identified as male (25%), and four identified as non-binary genders (1%) (**Figure 1**). A range of ages was represented in the sample. The largest age category represented was ages 35 to 44 (25%), followed by 45 to 54 (23%), and ages 55 to 64 (23%). Most respondents self-identified as White 87% (n=310) and smaller proportions identified as Black 6% (n=23) or other races (7%, n=31). A total of 123 respondents described themselves as being in recovery (35%).

Figure 1. Gender (N=357)

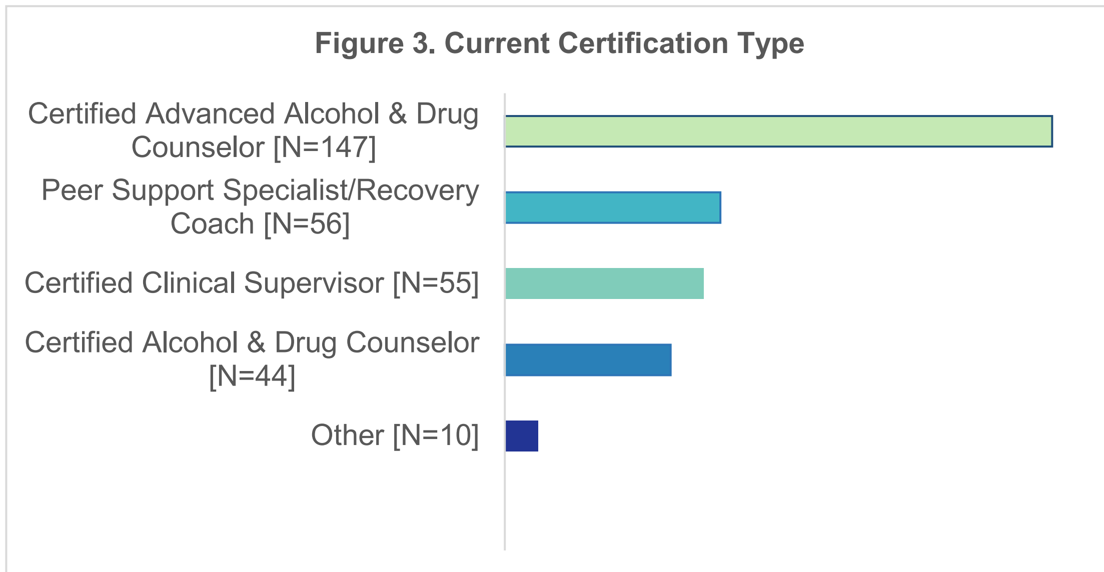
Education, Certification, & Licensure

Most respondents reported a master's degree as their highest level of education (61%). Notably, 73 respondents reported a bachelor's degree as their highest level of education (17%), and 11% of respondents reported some college but not achieving a completed degree.

Figure 2 illustrates the certification status of each respondent in SUD treatment; 52% reported current certification in SUD treatment, and 26% reported currently working under a development plan. Of the 21% of respondents that reported never being certified in SUD treatment, ten respondents identified themselves as a Peer Support Specialist/ Recovery Coach.



Of respondents that indicated current certification in substance use treatment, **Figure 3** provides a breakdown of the type of certification held by each respondent. Respondents were instructed to select all certifications that apply to them. The highest number of respondents reported the following certifications: 147 Certified Advanced Alcohol and Drug Counselors and 55 Certified Clinical Supervisors. A total of 357 respondents indicated an active license in the State of Michigan, 166 reported a license in Social Work (38%), 81 selected Counseling (18%), 16 respondents selected Psychology (4%), four respondents selected Marriage. Family Therapy (1%) and 90 respondents selected Other (20%). Again, respondents were instructed to select all applicable license titles. Therefore, the total percentage will not be equal to 100%.



Employment Information

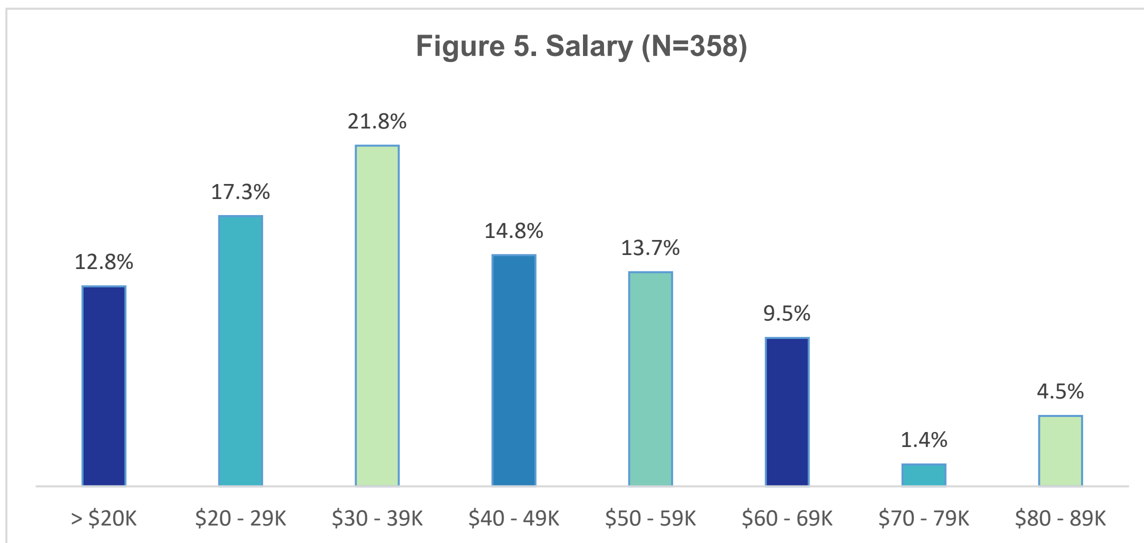
Most respondents reported their employment status to be full-time (90%), while 6% reported part-time employment, and 4% of respondents reported contractual work. **Figure 4** highlights

several descriptors regarding the length of time in the field and current agency. Responses are reported as an average of all respondents. The average length of time reported in the SUD treatment field was 9.3 years, and the average time spent with the respondent's current employer was 5.9 years. Interestingly, the largest group of respondents reported having worked in SUD treatment between 1-5 years, N=181. Many of the indications provided by respondents supported the assumption that many SUD treatment and prevention employees are relatively new to the field, with most respondents indicating experience to be less than five years in each category of **Figure 4**.

Figure 4. Employment Descriptors

Length of time working…	2019 Average (in Years)	2021 Average (in Years)	2021 Highest Frequency
In SUD Treatment	10.8 (N=315)	9.3 (N=368)	1 year (N=50)
In SUD Prevention	5.3 (N=228)	4.8 (N=234)	1 year (N=38)
In Social Services (excluding SUD)	9.5 (N=260)	9.6 (N=243)	5 years (N=23)
At current agency/employer	7 (N=318)	5.9 (N=360)	1 year (N=87)
In current position	4.6 (N=318)	4.1 (N=375)	1 year (N=108)

Figure 5 outlines the salaries of 358 respondents. Most respondents earn between $40,000 and $49,999 annually (N=78). For full-time employees, the most frequently reported salary range was $40,000 to $49,999 annually (24% of full- time employees). The most frequently reported salary for part-time or contractual employees was between $20,000 and $29,000 annually (47% of part- time/contractual employees).

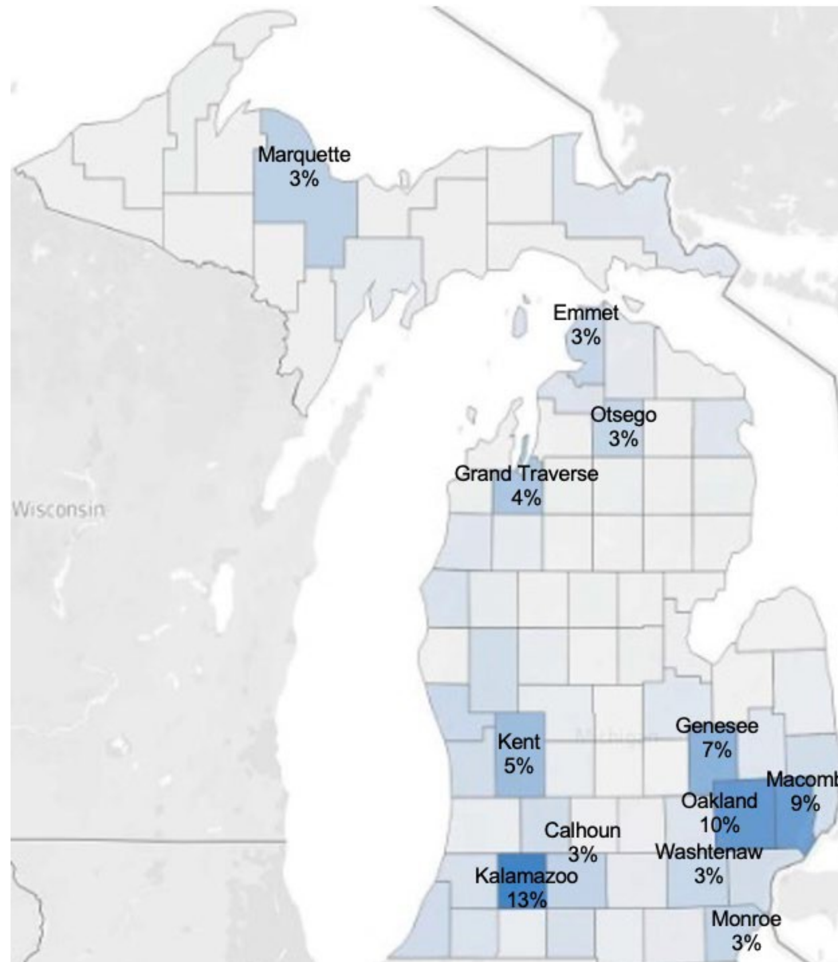


Concerning employer-provided benefits, respondents reported most often receiving full health insurance benefits (78%, n=275). Sick leave (77%, n=271) and other paid leave (75%, n=254).

Retirement contributions (52.2%, N=178) and tuition reimbursement (9.4%, n=30) were less frequently provided employment benefit.

Respondents performed their work in 52 counties throughout Michigan. **Figure 6** highlights the counties with the largest number of respondents. The top three counties of service include Kalamazoo (13%, n=56), Oakland (10%, n=43), and Macomb (9%, n=41). A total of 72% of respondents reported performing job duties in a metropolitan county.

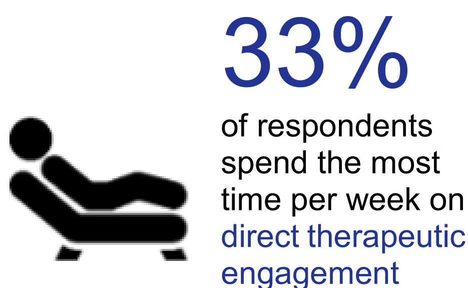
Figure 6. Workforce Distribution by County



The primary age group served by respondents was 18 to 59-year-olds or general adults (79%, N=351). When asked to indicate populations served, respondents frequently indicated working with individuals involved with the criminal/legal system (81.7%, N=362) and pregnant women/women with children (56.7%, N=251).

Figure 7 highlights work tasks the respondents reported spending the most time on per week. Respondents reported that direct client therapeutic engagement consumed most of their time each week (33%). Administrative activities were the second most time intensive activity for respondents weekly (27%). Respondents reported the least amount of their time spent per week on case management (6.6%).

Figure 7. Task Spent the Most Time on per Week (N=115)



Employment Retention

388 (92.8%) respondents reported they are currently performing the job they were hired to do, while 30 respondents (7.2%) reported performing different work tasks than initially defined. The most common explanation for variation in job duties included: promotion, additional unexpected job tasks, and reassignment to a new service area.

Factors that could influence employment changes are illustrated below in **Figure 8**. Most respondents reported they expected to stay at their job or their agency. Small numbers of respondents indicated they plan to leave the substance use treatment field.

Figure 8. Within the Next 12 Months, Possibility of…

	Not at all Likely	Not Very Likely	Neutral	Somewhat Likely	Extremely Likely
Change job but stay at your current agency (N=406)	**45.6%**	22.7%	18.2%	9.1%	4.4%
Change employer but stay in the field (N=406)	**50.2%**	22.9%	16%	6.4%	4.4%
Leave substance use disorder treatment field (N=401)	**56.9%**	23.9%	13.5%	4.7%	1%
Continue working for current employer (N=418)	4.3%	4.3%	9.6%	17.9%	**63.9%**

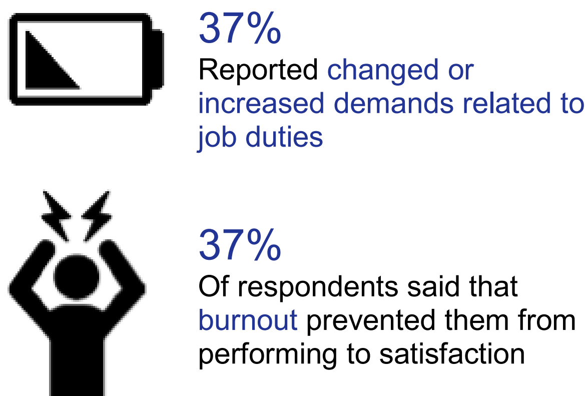
Figure 9 highlights the most and least important factors that respondents reported contribute to staff retention. Respondents cited that more frequent salary increases and promotions would contribute to retention efforts (n=261). Respondents also reported less paperwork or assisting with paperwork and improved ongoing training would improve staff retention.

Figure 9. Most and Least Important Factors to Staff Retention (N=443)

The least important factors to retention efforts were improved physical work environment, more varied work opportunities, and decreased management or oversight.

Figure 10 highlights obstacles that prevent respondents from performing work duties to their satisfaction. A total of 127 respondents (37%) reported that changed or increased job duties directly prevented them from performing work duties to satisfaction. Additionally, 127 other respondents (37%) reported burnout as a significant obstacle to job satisfaction.

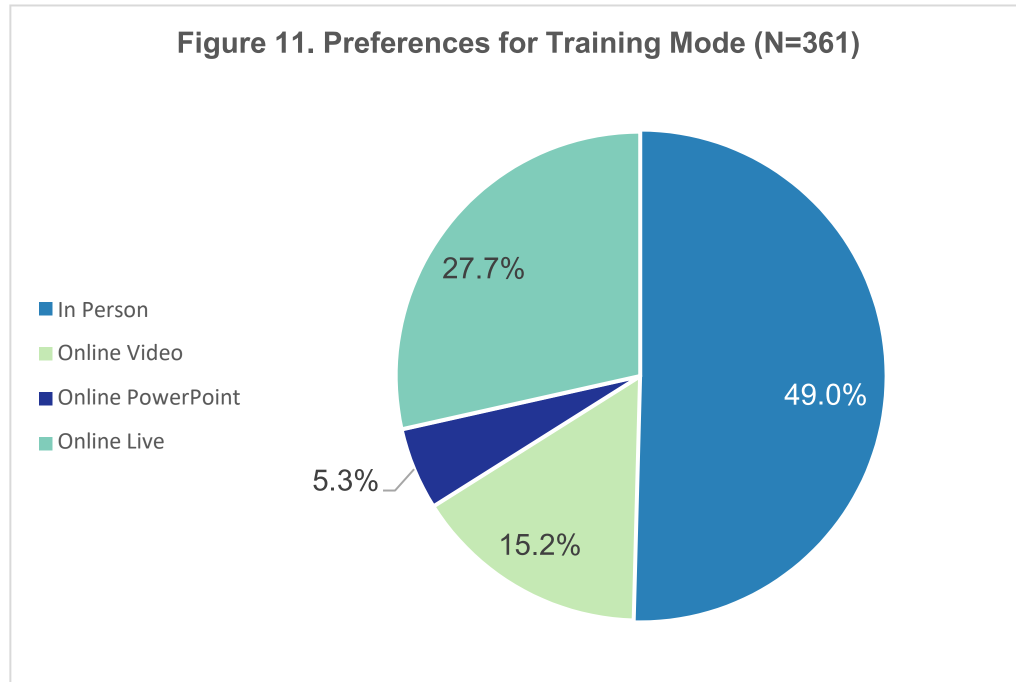
Figure 10. Greatest Obstacles that Prevent Performing Work Duties to Satisfaction (N=343)



Training

Respondents indicated the mode in which they prefer to receive training, as shown in **Figure 11**. Nearly half (49%, n=177) of respondents prefer in-person training. However, data was collected during the COVID-19 pandemic and may have had some impact on preferences. In addition to the training mode, respondents also indicated areas where they had completed training and areas where additional or new training is needed. **Figure 12** highlights the

knowledge areas where respondents reported some training. Areas, where more respondents had completed training include co-occurring disorders (73.6%), substance misuse and addiction (72.7%), treatment planning (70.2%), trauma (70.2%), and mindfulness (69.5%). The fewest participants reported training were adolescents (49%), pregnant women, and dialectical behavioral therapy (DBT). Over two-thirds of participants received some training in medications for addiction treatment (68.6%) and naloxone (68.4%)



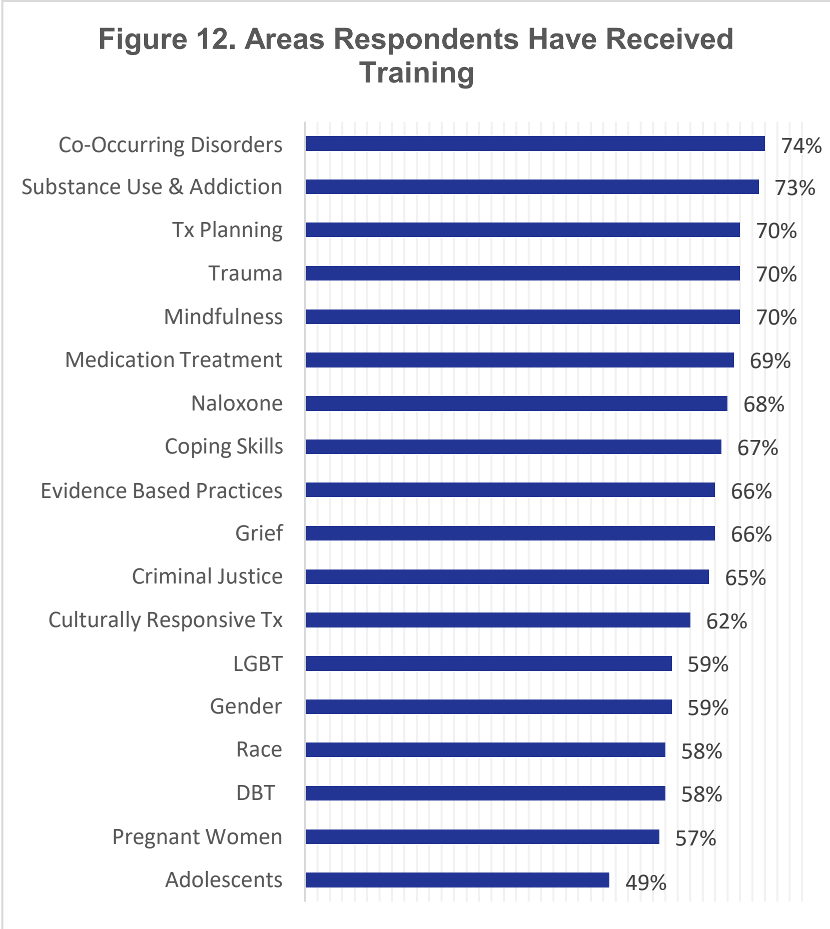
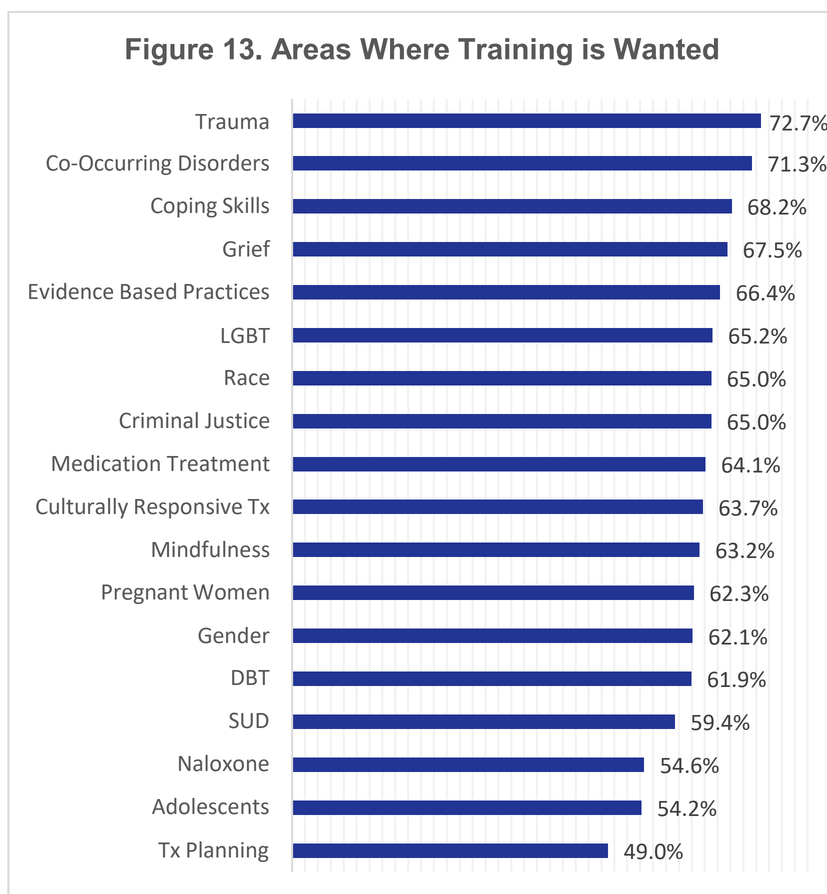


Figure 13 provides a breakdown of additional training that respondents would like. Respondents indicated they wanted this training regardless of whether they had received any in the past. Top results include: trauma and abuse (72.7%), co-occurring substance use and mental health disorders (71.3%), coping skills (68.2%), and grief (67.5%). Just under two-thirds reported an interest in training in medication treatment (64.1%) and 54.6% reported an interest in naloxone training.



Due to the evidence around the use of medication treatment in SUD, **Figure 14** highlights questions asked to understand how Michigan providers view medication treatment. The following information can be used when planning for medication treatment training.

Figure 14. Medicated Assisted Treatment Attitudes

	Disagree	Neutral	Agree
Methadone is an effective treatment for opioid use disorders (N=377)	19.3%	27.3%	**53.3%**
Easy access to naloxone encourages risky behavior (N=375)	**71.7%**	16%	12.2%
Buprenorphine is an effective treatment for opioid use disorders (N=373)	7%	27.1%	**66%**
Naltrexone is an effective treatment for opioid use disorders (N=373)	6.9%	21.2%	**71.8%**
I am comfortable working with clients who are receiving medication treatments (N=373)	1.6%	6.4%	**92%**
Medications for opioid treatment are substituting one drug for another (N=374)	**65.8%**	19.8%	14.4%
Long-term use of medications to treat opioid use disorder is associated with improved outcomes (N=375)	13.3%	28.3%	**58.4%**

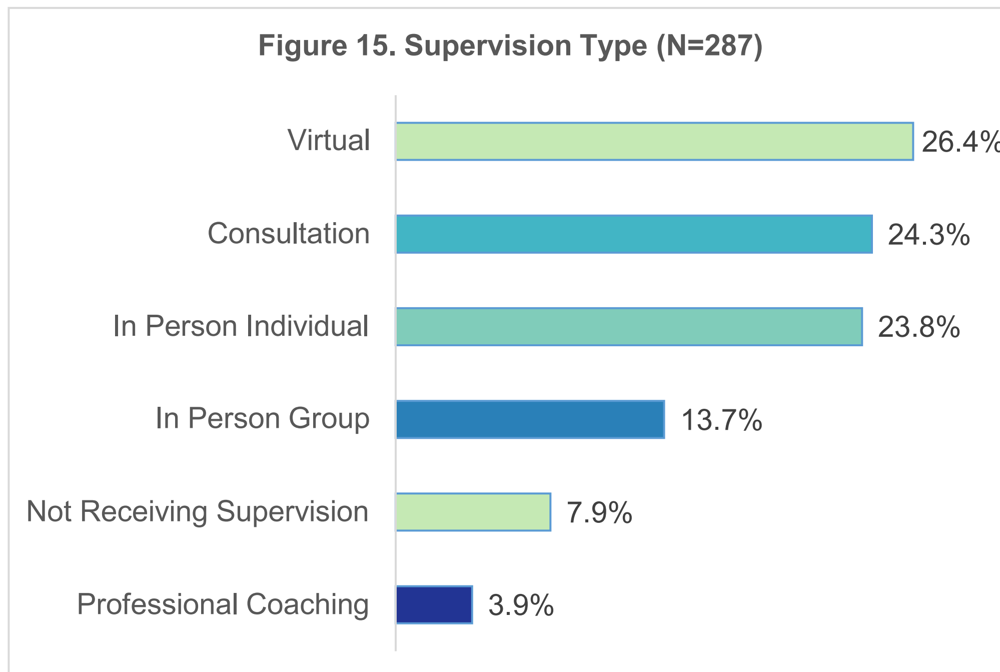
Respondents described any further training needs that were not addressed in this survey via open-ended responses categorized into five themes. Exemplary quotes for each theme were

provided in **Table 1**. Respondent themes centered around: requests for evidence-based training topics, affordable or agency-provided training, training to address coordination among service providers from various backgrounds, convenient training times and locations, and a return to in-person training as soon as possible.

Table 1. Workforce Training Needs (N=47)		
Theme of Response	**% of Responses**	**Sample Quotes**
Specific Training Topics	**19%**	*With high turnover rates, evidence-based techniques such as CBT, DBT, and MI would be at the top of my list for staff.*
Affordable training	**15%**	*We need more FREE training that count for MCBAP and State Renewals; we do not earn enough income in this field to afford the rising costs of needed trainings.*
Improved training	**19%**	*Techniques to bridge gaps between SUD providers in communities to coordinate care with clients. Ultimately,we are all employed to serve our CLIENTS.*
Convenient times/location forclinicians	**17%**	*Difficult to find time for trainings with caseload needs.*
Other	**30%**	*I do not do well with reading training on my own. I do not retain it when I read it. I prefer in-person, webinars, or podcast-style training.*

Supervision

Figure 15 presents the type of clinical supervision respondents are currently receiving. Most respondents (92.1%) are presently receiving clinical supervision, although the format varies (virtual, in-person individual, in-person group, consultation, or professional coaching. To understand the changes to clinical supervision caused by the Covid-19 pandemic, we asked participants about recent changes (See **Figure 16**). Respondents most often reported supervision has transitioned to video conference (55.1%), and a sizable number switched to audio-based supervision (20.9%). The frequency in which respondents most often received clinical supervision occurred weekly (38%, N=135), followed by monthly supervision (23.4%, N=83). Notably, 6.5% or 21 respondents reported only receiving clinical supervision when a problem arose.



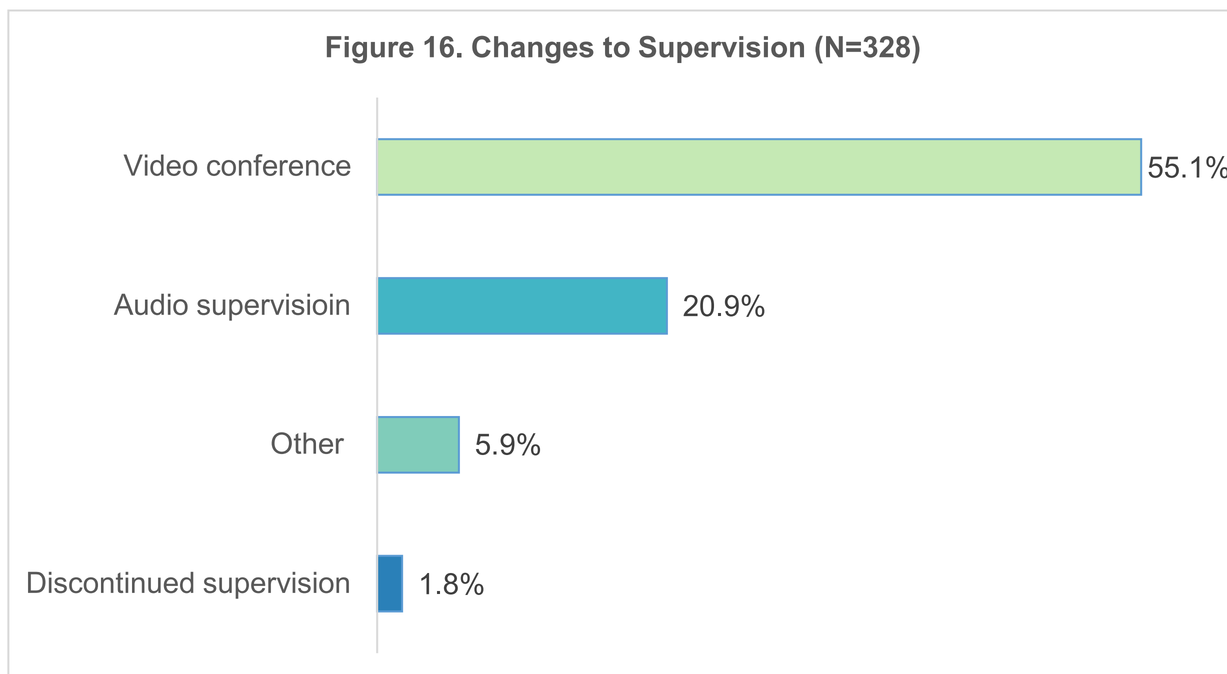


Figure 17: When asked to rank the most important topics covered during clinical supervision, respondents most often indicated counselor case presentation (28%, N=79) and discussing counselor problems/challenges to be equally important (28%, N=79).

Figure 17. Topics Most Important to Cover During Clinical Supervision (N=279)

To gather final thoughts regarding supervision needs, respondents were provided an open-ended question. Responses were grouped into six themes, and quotes from each theme were provided in **Table 2**. Respondents expressed a need for opportunities to review cases during supervision. This would ideally be a place to improve skills and receive feedback. Respondents also indicated a desire for professional development encouragement from supervisors, more individualized supervision where clinicians are encouraged and supported, consistent and focused supervision with specific goals and a concrete timeline, and agency standards for supervision, including supervisory training standards.

Table 2. Workforce Supervision Needs (N=81)

Theme of Response	% of Responses	Sample Quotes
Case review/ treatment planning	**30%**	*Case review and short-term planning along with skill development on how to approach various co-occurring issues at different stages of motivation and different levels of severity.*
Challenge clinician to seek professional development	**14%**	*Not just telling me I am doing a good job. Challenging me to think outside of the box and help me improve my clinical skills.*
More individualized and constructive supervision	**25%**	*I would like to feel like supervision is a supportive thing, not punitive. I feel like I only see my supervisor when I am in trouble, or if I seek then out on my own, I am met with a disapproving attitude. When I ask for support, I am given allthe things that I do wrong, rather than ideas for doing things differently. This is the #1 reason I am leaving my agency to pursue employment elsewhere.*
Directed supervision	**11%**	*I find it most effective when supervision is organized and directed, this keeps meetings on task and does not allow time to be wasted "chit chatting." I also appreciate having a written agenda for specific items that will be discussed and then some free time to discuss issues that could not be planned for.*
Supervisory standards across the agency	**16%**	*Supervisors should be thoroughly trained in Supervision techniques that are empirically supported; evidence-based best practice. Current supervisors are not trained for Supervisory roles they are in at this time.*
Other	**.5%**	*I thrive in face-to-face interactions. Phone and Zoom meetings have been difficult for me to transition to.*

Overall Feedback

Final thoughts and comments were gathered from respondents through open-ended questions and responses categorized into five themes. **Table 3** highlights each theme and a supporting quotation from a single respondent. Overall, respondents reported: new clinicians are not adequately trained to begin working in the SUD field, salary and benefits offered do not meet the demands of the field, impacts of Covid-19 have negatively affected clients and clinicians alike, an apparent lack of support from administrative staff, and barriers created through state/government regulations on the SUD field.

Table 3. Workforce Environment or Treatment Workforce Needs (N=58)

Theme of Response	% of Responses	Sample Quotes
Unprepared workforce	**26%**	*As a person who is responsible for hiring it has been difficult to find qualified applicants for various positions within our agency. We find that we cannot compete with salaries provided by educational institutions or mental health providers. There is not parity in the reimbursement of services provided between substance use disorder services vs. mental health services. As such, SUD providers are not able to compete with salaries offered by mental health,medical or educational institutions.*
Inadequate salary/benefits to meethigh demands of workload	**22%**	*Direct care workers are a vital part of the workforce, yet they are paid poverty-level wages making it difficult or impossible to engage in adequate self-care. The low wages further cause high turnover and staffing shortages. This leads to people working excessive hours and the inability to take vacations. This causes burnout. If we don't care for our fellow staff members, especially the staff members who have the most contact with our clients, how can we really claim that we care for our clients? In addition to being an ethical issue, this is a customer service issue. If we treat our staff poorly, they will treat the customers poorly.*
Effects of Covid-19	**12%**	*COVID-19 impacts have made all levels of my job much more difficult (telehealth is not as engaging for many clients, it is harder to track progress in 2D, lack of time in between sessions, running case management errands with clients is not possible). As well, having many of my personal self-care and de-stressing outlets cut off due to the pandemic, my mental health and threshold for resilience has suffered as well. More consideration in the government for mental healthneeds to be taken in to account when eliminating outlets and physical environments for clients and service providers to remain whole and healthy.*

Table 3. Workforce Environment or Treatment Workforce Needs (N=58)		
Theme of Response	**% of Responses**	**Sample Quotes**
Agency support to improve clinicians work	**16%**	*I believe that agencies/clinics that are serving populations like SUD and low-income clients need to rework their whole model of care and begin taking care of employees as they would want their clients taken care of. The reward of workingwith SUD clients is immense but the stress of satisfying administrative nitpicking and over management is immense.*
State/Government/PIHP regulations create barriers to the field	**24%**	*My biggest concern in the workforce that has been largely under discussed has been the recent changes that LARA has implemented with MCBAP, enforcing that a degree be required prior to being eligible for a development plan, prohibiting their ability to perform services to clients even with supervision. In a rural setting, this has destroyed the applicant pool and made it even more difficult to hire professionals to be able to meet treatment needs.*

Comparison of Data

The Treatment Workforce Survey has been conducted on three separate occasions, and in each round of surveying, improvements were made to the questions asked. To better understand the changing characteristics of SUD treatment, several indicators will be compared from the 2019 version of the survey to the 2021 survey.

Figure 18 provides a comparison of topics that respondents reported needing additional training in despite having been previously trained. In 2019 respondents most often reported needing additional training in co-occurring SUD and mental health topics. In 2021 respondents most often reported needing additional training in trauma and abuse and co-occurring substance use and mental health disorders. Notably, training needs, as reported by clinicians, have changed little over surveying rounds.

Figure 18. Comparison of Training Needs

2019	2021
Co-occurring SUD & Mental Health	Trauma & Abuse
Trauma & Abuse	Co-Occurring SUD & Mental Health
Coping Skills	Coping Skills
Evidence Based Practices	

To understand factors that contribute to job satisfaction, **Figure 19** explores topics of focus employers can prioritize to increase retention efforts. Improvements to how respondents were asked about retention efforts were made in 2021, leading to a more robust understanding of the factors to clinicians' level of job satisfaction. In 2019 respondents prioritized their commitment to the field and interactions with others. However, in 2021 respondents reported salary increases, ongoing training, and agency support with paperwork and credentialing efforts to be most important.

Figure 19. Comparison of Job Satisfaction/Retention

2019	2021
My commitment to the field	More frequent salary increase/promotion
One-to-one interactions with people	Lessen/provide assistance with paperwork
Sense that I make a difference	Improved on-going training
My coworkers	Credentialing and licensure support

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