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The Substance Abuse Treatment Workforce of South Africa

Ruthlyn Sodano · Donnie W. Watson · Solomon Rataemane · Lusanda Rataemane · Nomvuyo Ntlhe · Richard Rawson

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Abstract The purpose of this paper is to describe characteristics of substance abuse treatment counselors in the Republic of South Africa, including demographics, education, training, and job duties. Counselors recruited from 24 treatment centers completed a survey after signing informed consent. Counselors were primarily female (75%), racially diverse (36.4% White, 30.8% Black, 18.9% Coloured, 12.6% Indian or Asian, and 1.4% Cape Malay), and were 38 years old on average. The majority (62.3%) held at least an equivalent of a bachelor's degree, and just under half (49%) were registered social workers. Counselors had a mean of 5.3 years' experience in substance abuse treatment. The substance abuse treatment workforce of South Africa appears to be young and educated, yet only one third of the counselors had any formal training in Cognitive Behavioral Therapy. South African counselors could benefit from more training in evidence-based techniques.

Keywords Workforce · Substance abuse · Treatment · Counselors · Demographics

Understanding and developing the substance abuse treatment workforce is a major priority at the global level. The United Nation's Declaration on the Guiding Principles of Drug Demand Reduction (United Nations 1998) states, "[This initiative] responds to the need for an international instrument on the adoption of effective measures at the national, regional and international levels against the demand for illicit drugs" (p. 1). The Declaration also emphasizes that "states should place appropriate emphasis on training policy makers, programme planners and practitioners in all aspects of the design, execution and evaluation of demand reduction strategies and programmes" (United Nations 1998, p. 4). Therefore, it is clear that building an educated, well-trained substance abuse workforce is a high priority.

R. Sodano (✉) · D. W. Watson · R. Rawson
UCLA, Los Angeles, CA, USA
e-mail: rsodano@mednet.ucla.edu

S. Rataemane
University of Limpopo, Medunsa, Gauteng, South Africa

L. Rataemane · N. Ntlhe
Mental Health and Addiction Centre, Pretoria, South Africa

Before mounting efforts to address workforce needs, it is important to ascertain the demographic characteristics and skills of the existing workforce. Understanding the workforce is vital in determining the skills and knowledge that practitioners need and the best way of addressing those needs. Within the substance abuse treatment system in many parts of the world, a category of professionals or paraprofessionals referred to as "counselors" constitute a central component of the staffing for many treatment organizations. However, little has been documented about who these counselors are, how they are trained, and what their training needs are. Our review of the published reports on the international substance abuse treatment workforce (Home Office 2006; National Centre for Education and Training on Addiction 2003; Roche et al. 2004) revealed that relatively minimal information is available on the nature of the workforce in general and even less about counselors specifically.

In the United States, counselors play a key role in delivering substance abuse care, and since the late 1990 s, attempts have been made to describe this group. Fifty to seventy percent of substance abuse treatment counselors are female, middle-aged (40–55 years of age), and White (84.5%) (Harwood 2002; Knudsen et al. 2003; Mulvey et al. 2003; National Association of Alcoholism and Drug Abuse Counselors (NAADAC) 2003; RMC Research Corporation, 2003). Considerably diverse education levels have been found among counselors across various studies in the United States. Several studies reported that 80% of the direct care workforce had at least a bachelor's degree (Johnson et al. 2002). Harwood (2002) found that 53% of direct service treatment staff had a master's degree, and Mulvey et al. (2003) found that in publicly funded programs, 72% had at least a bachelor's degree, 47% a master's degree, and 7.4% a doctorate.

Considerable diversity is also found in the academic disciplines for counselors in the United States. According to a study by the National Institute on Drug Abuse (NIDA) Clinical Trials Network (CTN), the most common master's degrees among substance abuse counselors were in social work (29%), counseling (27%), and psychology (22%). In a study of the CTN direct care workers, the majority worked full-time (over 35 h a week), spending between 41% and 61% of their time seeing clients and 20% of their time doing administrative duties such as paperwork (McCarty et al. 2007). Direct service treatment staff spent just over one-fifth of their time on paperwork (NAADAC 2003) and about half their time counseling clients (RMC 2003). Half the treatment professionals had worked in their current organization for 5 years or less.

New counselors entering the substance abuse treatment field in the United States tend to do so later in their career (mean age 38). Almost half indicated that they entered the field as a second career, and that their entry into the field was due to personal or family experiences with substance abuse (61%) (NAADAC 2003; RMC 2003). Other reasons for joining the field included the challenging nature of the work (95%), the desire to work in a helping profession (91%), and the existence of substance abuse problems in their community (78%) (NAADAC 2003).

To our knowledge, only two other countries have collected information on their substance abuse treatment workforce: Australia and the United Kingdom. The data available from these countries is collected on staff and counselors alike, with no breakdown of the data by group beyond profession. Thus, specific comparisons of the counselors with other groups of counselors are limited.

In Australia, one study by the National Centre for Education and Training on Addiction (2003) surveyed 234 managers of alcohol and other drug (AOD) treatment agencies regarding the characteristics of the agencies, the workforce, and workforce development issues (Roche et al. 2004). Managers reported that approximately 70% of the workforce consisted of frontline therapeutic staff, with the remainder being ancillary and administra-

tive staff as well as managers with no caseload. When asked to describe their staff by occupational group, managers indicated 26% were nurses, 19% were general AOD workers, 8% psychologists, 6% counselors, and 5% social workers. Other reported occupations included teachers, pharmacists, and health promotion officers. In the United Kingdom, the workforce that has direct contact with the substance abuse population includes nurses (17%), criminal justice workers (16%), service managers (12%), counselors (11%), outreach workers (5%), social workers (5%), doctors (3%), psychologists (1%), and other professionals such as pharmacists and teachers (Home Office 2006). The workforce also includes practitioners who have become qualified through other pathways such as National Vocational Qualifications and, in large numbers, through volunteerism.

Besides data from the United States, Australia, and the United Kingdom, information on the substance abuse treatment workforce is minimal to non-existent. The purpose of the present report is to add to the body of knowledge about the nature of this workforce on the international level. We report on a sample of substance abuse counselors in the treatment system in the Republic of South Africa.

Method

The workforce data are drawn from a larger study based in the Republic of South Africa that compared three different methods of training substance abuse counselors in the skills and techniques of Cognitive Behavioral Therapy (CBT). Counselors were recruited from 24 treatment centers in five provinces of the Republic of South Africa: Gauteng Province, North West Province, Free State, Western Cape, and Kwa-Zulu Natal. Clinics were selected for inclusion based on voluntary participation by the clinic director and staff, the availability of stimulant using clients, adequate number of counselors, and geographic distance relative to the Medical University of South Africa (MEDUNSA) from which one of the training conditions (distance learning) was broadcast. An urn randomization procedure was used to randomly assign sites to conditions, balancing assignment in terms of clinic distance from MEDUNSA, size of the facility (large vs. small), and ethnic make-up of the counselor population (White vs. Non-White ratio). Randomization was done by clinic, so that all counselors in a given clinic were assigned to the same condition and received the same training. As inclusion criteria, counselors were willing to be randomly assigned to either the in-vivo, distance learning, or manual training conditions, participate in training sessions and weekly group supervision sessions, and have their sessions audiotaped for review for the duration of the protocol.

At study initiation, after written informed consent was provided and before randomization occurred, the counselors were asked to fill out a 10-page clinician survey form that requested information on demographics, training, and experience (e.g., "How many years have you practiced as a substance abuse counselor?"); profession and job responsibilities (e.g., "How much of your time is spent on administrative tasks?"); treatment approaches used (e.g., "How well does a Rogerian approach describe your approach to treatment?" using a 5-point Likert scale with 0=*Not at All* to 5=*Very Much*); and beliefs about counseling substance abusers (e.g., "How well does this statement describe your beliefs: Resistant clients are very difficult to work with and unlikely to change" using a 5-point Likert scale with 0=*Not at All* and 5=*Very Much*). This paper will describe the background of these counselors. All study data were collected under the approval and supervision of the Institutional Review Committee of Friends Research Institute.

Results

Although the South African substance abuse treatment system includes a diverse set of health care professionals, including physicians and nurses, the present study focused on the personnel defined by program administrators as "counseling staff." A total of 148 individuals from 24 clinics initially consented to participate in the study, but 5 failed to provide baseline data and participate in the training protocol, and thus were not included in the final study sample of 143 counselors.

Demographic Characteristics

Seventy-five percent of the South African counselors were female, and their average age was 38.1 (*SD*=11.78). The counselors were ethnically and racially diverse, with 36.4% identifying themselves as White, 30.8% as Black, 18.9% as Coloured (mixed race), 12.6% as Indian or Asian, and 1.4% as Cape Malay. The majority of counselors were either married/cohabiting (53.1%) or single (35%). The remainder reported being divorced (9.8%) or widowed (2.1%). The majority identified either Afrikaans (36.6%) or English (33.8%) as their primary language, with the remainder identifying other African languages such as Northern Sotho, Southern Sotho, Xhosa, Zulu, or Tswana as their primary language.

Education, Experience, and Training

Participants' average number of years of education was 16.49 (*SD*=3.06), and their average number of years' experience as a counselor was 7.31 (*SD*=7.75). Average number of years' experience as a substance abuse counselor was slightly lower (*M*=5.30, *SD*=6.55). Counselors held their highest degree for an average of 8.5 years, and held the credential most relevant to their current work for an average of 9.0 years. Tables 1 and 2 present the data on highest degree held and credentials, respectively. The majority (62.3%) held at least an equivalent of a bachelor's degree, and just under half (49%) were registered social workers.

South African counselors stated they had an average of 9.29 h of clinical training in the past year. They received an average of 2.36 h of training in a 12-step approach, 3.63 h of training in psychodynamic or interpersonal therapy, and 3.93 h of formal training in CBT or

Table 1 Highest Level of Education

Level of Education	US Equivalent	*n*	%
Less than Matric	No High School Diploma	3	2.1
Less than Matric and Certified	No High School Diploma but Certification	5	3.5
Matric Only	High School Diploma	8	5.6
Matric and Certificate	HS Diploma+Certification	9	6.3
Matric and Diploma	HS Diploma+AA Degree	29	20.3
Matric and Degree	HS Diploma+BA Degree 3 year	28	19.6
Matric and Honors	HS Diploma+BA Degree 4 year	43	30.1
Matric and Masters	HS Diploma+MA Degree	16	11.2
Matric and Doctors	HS Diploma+PhD	2	1.4
Total		143	100

Table 2 Counselor Certification

Professional Certification	*n*	%
Registered Counselor	21	14.7
Professional Certificate of Proficiency	6	4.2
Certified Teacher	12	8.4
Registered Marriage and Family Therapist	3	2.1
Registered Social Worker	70	49.0
Registered Nurse	9	6.3
Registered Advanced Nursing Education	2	1.4
Registered Occupational Therapist	3	2.1
Registered Psychologist	4	2.8
Registered Physician	1	.7

relapse prevention treatment. Sixty-eight percent of counselors stated they had not received any formal training in CBT before the current research project. However, nearly two thirds of the counselors (65.2%) had been exposed to CBT readings at some point in their training, and said that CBT was their major counseling approach with an average of 20% of their clients. In other words, two thirds of the counselors learned CBT techniques on their own, and used these techniques as a major approach with one in five of their clients.

Current Role

Fifty-five percent of the counselors reported that they worked in an inpatient setting, followed by outpatient (28.2%), residential (11.6%), alcohol or drug education classes (2.2%), and other settings, including court ordered treatment, employee assistance programs, and pastoral services (2.9%). Counselors who worked in an inpatient setting were more likely to hold a graduate degree (25%) compared to those who worked in an outpatient setting (15%). Slightly more than half of the counselors (52.5%) stated they worked 40 h a week and three quarters worked 35 h or more per week at their current organization. The mean number of years they have been employed at their current organization was 4.49. However, two thirds (67.6%) of the counselors had worked at their current organization for 4 years or less, with the remaining third working anywhere from 5 to 26 years. Thus, the counselor workforce is relatively new.

Counselors stated they spent half of their time providing clinical service, including documentation related to service provision, a quarter of their time involved with clinical supervision or teaching, and the remaining quarter of their time serving in a clinical administration role. Counselors received an hour of supervision 3 times per month. Many counselors (42.5%) had no experience providing supervision to others. Counselors with no supervisory experience also had fewer mean years' experience (4.26) as a counselor compared to mean years' experience (6.92) for counselors with supervisory experience [F (1,132)=17.01, p<.001], and worked 6 h less per week than those counselors who did have experience providing supervision [F (1,130)=4.73, p=.03]. Age, years of education, and highest degree held did not differ between those with or without supervisory experience.

The mean number of clients seen by South African counselors over the past year was just over 100, at 102.68. Counselors believed approximately 46% of their clients had a primary substance abuse problem only, 21% a primary psychiatric or behavioral disorder only, and 32% co-occurring substance abuse and psychiatric conditions.

When asked to rate which therapy approaches best described their approach to counseling on a 5-point Likert scale, 63.3% of counselors reported that Motivational Interviewing described their approach "much" or "very much," and 54% of counselors reported that a Cognitive Behavioral or Relapse Prevention approach described their approach "much" or "very much." Rogerian, Solution Focused, and Family Systems approaches were the next most frequently endorsed at 41.2%, 40.9%, and 40.4%, respectively. Reality Therapy (31.1%), Psychodynamic Therapy (30%), 12-Step or Disease Concept (25.2%), and Gestalt Therapy (13.6%) were the theoretical approaches least used by counselors.

Discussion

South African substance abuse treatment counselors were racially, ethnically, and linguistically diverse, as is the case with the general population in South Africa. It should be noted that the clinics included in the sample were established centers offering highly regarded treatment programs. Few of the clinics were from rural areas or from areas of severe poverty. Therefore, this sample reflects the staffing of the better-resourced communities of South Africa and may not be entirely representative of the newer clinics established in the traditionally underserved communities of the country.

Similar to the United States, the counseling workforce was primarily female. However, the average age was somewhat younger (38 years) compared to the age of counselors in the United States, which is typically in the mid-forties to early fifties. As noted above, U.S. counselors tend to enter the substance abuse treatment workforce around the age of 38, often as a second career. South Africa appears to be more successful at drawing young professionals into the field.

Educational achievement and training for counselors in South Africa was similar to what has been found in the United States, including knowledge of and use of some evidence-based techniques such as Motivational Interviewing. Over two thirds of the counselors had not had any formal training in Cognitive Behavioral techniques, but it appeared that some of these counselors had taken it upon themselves to seek out material on CBT.

South African counselors were from a wide range of disciplines. However, it was notable that they were much more likely to report social work as their profession. Compared to the United Kingdom and Australia, South African counselors were 10 times more likely to be social workers, and almost twice as likely to be social workers compared to counselors in the United States. It might be of interest to explore the dynamics of why those in social work training programs in South Africa ultimately choose careers in the field of substance dependence treatment.

Three quarters (75%) of South African counselors worked full time, which was a somewhat lower percentage than the 86% of U.S. counselors that work full-time. In terms of how time was spent, about half of counselors' time was spent seeing clients and a quarter of their time was spent on paperwork and other administrative activities. This is comparable to what has been found in the United States. Thus, compared to the United States, fewer South African counselors work full-time, but they spend their work time in a similar fashion.

Graduate degrees were more common among counselors who worked in an inpatient setting versus an outpatient setting in South Africa. This is in direct contrast to the United States, where the opposite pattern is found. This may be because inpatient settings in the United States are more likely to employ counselors who are in recovery themselves (Mulligan et al. 1989). In contrast, U.S. counselors who choose to work in outpatient settings may do so because they have been exposed to newer forms of research-based

treatment (e.g., CBT) and find that such treatments are more practicable in an outpatient setting. In South Africa, it may be that inpatient settings are newer and not necessarily entrenched in a substance abuse treatment model similar to the traditional American one.

South African counselors reported that nearly half of their clients had a substance use disorder only, and about one third had co-occurring substance use and psychiatric disorders. United States counselors reported a higher incidence of primary substance use disorders among their clients (68%), but this number may include individuals with secondary psychiatric disorders as well. A direct comparison between the clients of South African counselors and those of U.S. counselors is therefore difficult.

Limitations

The sample of substance abuse counselors in this study was not a representative sample of South African counselors in this field, but rather a select group of counselors willing to engage in a study in which they would be trained in CBT techniques. Further, these counselors predominantly worked in clinics that were affiliated with the South African National Council on Alcoholism and Drug Dependence (SANCA) network of clinics, and were located in one of three specific regions in South Africa. These clinics may not be typical of South African substance abuse clinics in terms of counselor education, in-house training, and other factors.

Conclusions

This study was a first attempt at characterizing the direct services workforce of the substance abuse treatment field in South Africa. It will be important to continue monitoring the composition of the workforce as well as expand the scope of knowledge about it. For example, future surveys should collect information on counselor attitudes and opinions regarding their jobs and the field in general. Having a strong sense of who makes up the workforce allows overseeing organizations to implement initiatives in training and recruitment as needed. Another area to explore is the migration of South African counselors from non-governmental organizations (NGOs), which depend on government subsidies and their own strategies to raise funds, to more financially stable settings after receiving specialized training or certification. In this regard, it would be informative to track if counselors who obtain specialty training and additional experience in therapies such as CBT then seek jobs with government agencies or private organizations that have the financial resources to establish employee assistance programs. The substance abuse treatment workforce of South Africa appears to be young and educated, but could benefit from more training in evidence-based techniques.

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