

SUBSTANCE ABUSE TREATMENT WORKFORCE SURVEY REPORT  
2004



PREPARED FOR:  
ARKANSAS ADDICTION TREATMENT PROVIDERS  
ARKANSAS DEPARTMENT OF HUMAN SERVICES, DIVISION OF BEHAVIORAL HEALTH  
SERVICES, OFFICE OF ALCOHOL AND DRUG ABUSE PREVENTION



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At the time of this report, Charles G. Curie, MA, ACSW, served as the SAMHSA administrator. H. Westley Clark, MD, JD, MPH, served as the director of CSAT, and Karl D. White, EdD, served as the CSAT Project Officer.

The opinions expressed herein are the views of the authors and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA, or CSAT. No official support or endorsement of DHHS, SAMHSA, or CSAT for the opinions described in this report is intended or should be inferred.

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## Table of Contents

|  |           |
|--|-----------|
| <b>Acknowledgements .....</b>  | <b>4</b>  |
| <b>Executive Summary .....</b>   | <b>5</b>  |
| <b>Summary of Characteristics of the Arkansas Addiction Treatment Workforce.....</b>   | <b>5</b>  |
| <b>Summary of Services Provided by the Arkansas Addiction Treatment Workforce.....</b> | <b>6</b>  |
| <b>Skills and Training Needs of the Arkansas Addiction Treatment Workforce .....</b>   | <b>6</b>  |
| <b>Supports and Stressors for the Arkansas Addiction Treatment Workforce .....</b>     | <b>7</b>  |
| <b>I. Introduction &amp; Methodology .....</b>   | <b>8</b>  |
| <b>II. What are the Characteristics of the Addiction Treatment Workforce?.....</b>     | <b>9</b>  |
| Demographics .....   | 10        |
| Age Range.....   | 10        |
| Work Experience.....   | 11        |
| Professional Preference.....   | 12        |
| Education and Certification Status.....  | 12        |
| Salary Distribution .....  | 13        |
| Workplace Benefits .....   | 14        |
| <b>III. What Services are Being Provided by the Workforce and to Whom? .....</b>       | <b>15</b> |
| Job Activities.....  | 15        |
| Provision of Services for Substance Use Disorders versus Co-Occurring Disorders.....   | 16        |
| Models of Treatment.....   | 18        |
| Clientele Characteristics .....  | 19        |
| <b>IV. How Does the Workforce Perceive their Skills and Training Needs? .....</b>      | <b>20</b> |
| Addiction Counseling Competencies Familiarity and Use.....                             | 20        |
| Workforce Skills and Perceived Self-Efficacy.....                                      | 20        |
| Leadership Skills.....   | 22        |
| Staff Training Needs .....   | 23        |

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## Table of Contents

|   |           |
|---|-----------|
| <b>V. Quality of Work Environment in Terms of Supports/Constraints and Job Satisfaction ...</b> | <b>24</b> |
| Retaining Qualified Staff .....   | 24        |
| Agency Support .....  | 25        |
| Staff Technology Use.....   | 26        |
| Job Satisfaction .....  | 27        |
| <b>VI. What are the Challenges to the Future Workforce? .....</b>                               | <b>28</b> |
| Barriers to Entering the Field.....   | 28        |
| Stigma and Perceived Status of the Field .....  | 29        |
| Recruitment Difficulties.....   | 30        |
| Agency Change.....  | 31        |
| <b>VII. Conclusions and Recommendations.....</b>  | <b>34</b> |
| Section II – Characteristics of the Workforce.....  | 34        |
| Section III – Services Provided.....  | 34        |
| Section IV – Workforce Skills and Training Needs .....  | 35        |
| Section V – Workplace Support and Job Satisfaction.....   | 37        |
| Section VI – Challenges for the Workforce .....   | 38        |
| <b>Footnote .....</b>   | <b>39</b> |
| <b>References .....</b>   | <b>40</b> |
| <b>Addendum – Regional Comparisons</b>  |           |

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## ***Executive Summary***

The Workforce Development Project is part of a national effort to gather data on the current addiction treatment workforce. As rapid changes have occurred since the formalization of addiction treatment services (White, 1998), gathering current workforce information on frontline workers, agency directors, and their agencies is necessary. This report summarizes data gathered by the Mid-America Addiction Technology Transfer Center (Mid-America ATTC) on the addiction treatment workforce in Arkansas. The content of this report is organized around five guiding questions: (a) What are the characteristics of the Arkansas workforce? (b) What types of services are being provided and to whom? (c) How does the workforce perceive their skills and training needs? (d) How is the work environment perceived in terms of supports/constraints and job satisfaction? and (e) What are the future challenges to the workforce in Arkansas? The first portion of this report provides a summary of the major findings.

### ***Summary of Characteristics of the Arkansas Addiction Treatment Workforce***

***Gender:*** Females comprised a majority of workforce staff (61.3%) and 43.8% of directors.

***Race/Ethnicity:*** Both staff (74.8%) and directors (81.3%) were predominantly Caucasian.

***Age:*** Staff ranged in age from 23 to 69 years, with an average age of 45.3 years and a median age of 46.0 years. Directors ranged in age from 46 to 64 years, with an average age of 52.7 years and a median age of 51.2 years.

***Work Experience:*** More directors than staff have worked in the field of alcohol and drug treatment (87.5% vs. 17.1%) and at their current work setting (43.8% vs. 5.7%) for 10 or more years.

***Employment Type:*** Approximately two-thirds of both staff and directors worked in a private non-profit setting.

***Education:*** Only 25.8% of the workforce staff had a graduate degree whereas 56.3% of the directors had a graduate degree.

***Salary Distribution:*** The modal salary range for staff was \$15,000 to \$24,999 in comparison to \$50,000 to \$74,999 for directors.

***Certification status:*** Only 29.5% of the addiction treatment staff were currently certified or licensed to provide addiction treatment services whereas 56.3% of the directors were.

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## ***Summary of Services Provided by the Arkansas Addiction Treatment Workforce***

***Professional Experience:*** For staff the most frequently cited reasons for entering the addiction treatment field was due to having had either personal or familial experience with addiction and/or recovery. For directors it was due to a personal interest in the field.

***Work Tasks:*** Staff members spent most of their time in direct service activities such as individual (25.2%) or group counseling (14.7%); however, paperwork and documentation activities (16.5%) also constituted a high percentage of weekly hours. Directors spent most of their time in administrative duties (74.7%).

***Addiction and Mental Health Services:*** Most staff reported some type of work (e.g., screening, treatment, referrals) with clients who have co-occurring mental health and substance use disorders.

***Treatment Models:*** 12-Step models were the most frequently endorsed model of treatment occurring in Arkansas agencies. Treatment providers also indicated several evidence-based practices were present, such as relapse prevention and cognitive-behavioral skills therapy.

***Clients:*** The typical client treated in Arkansas agencies was a Caucasian male between the ages of 26 and 64.

## ***Skills and Training Needs of the Arkansas Addiction Treatment Workforce***

***TAP 21 Addiction Counseling Competencies:*** The majority of treatment staff was NOT familiar with the Center for Substance Abuse Treatment's nationally defined competencies.

***Staff Self-Efficacy:*** Staff members were most confident about their micro-counseling skills and addiction intervention skills and least confident about their work with co-occurring mental health disorders.

***Leadership Efficacy:*** Agency directors felt confident about their day-to-day agency operation skills, but were less confident in their ability to negotiate external relationships with funding resources and oversight agencies.

***Training Needs:*** Co-occurring disorders, trauma and abuse issues, group counseling skills, working with grief and loss, and motivational interviewing were rated as the top five training needs by staff members. Of those areas, agency directors rated co-occurring and group counseling as priority training needs.

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## ***Supports and Stressors for the Arkansas Addiction Treatment Workforce***

***Job Retention:*** Staff members and agency directors agreed that more frequent salary increases would improve job retention. This would be followed by promoting career growth, more individual recognition and training opportunities, and increased opportunities for staff input.

***Agency Support Systems:*** A majority of staff and directors reported adequate in-house mentoring, direct supervision, and ongoing training occurring in their agencies.

***Job Satisfaction:*** Overall, agency staff and directors were satisfied with their current jobs. For staff members, satisfaction with direct service work and with their agency and co-workers were higher than with the conditions of employment (i.e, salary and benefits).

***Barriers:*** Low pay and salary competition from other fields were the top two barriers to recruitment perceived by both directors and staff. Directors noted the difficulties of finding applicants with the appropriate certification as well as education/training in addiction treatment. According to directors, the most difficult barrier was a lack of funding to fill vacant counselor positions in their agencies.

***Consultation Needed:*** Directors thought they most needed technical assistance in three areas: using client assessments to guide clinical and program decision-making, increasing program participation by clients, and matching client needs with services.

***Pressure for Change:*** Directors reported that the strongest pressures for changes in their agencies came from accreditation or licensing authorities.

***Adequacy of Work Resources:*** Directors reported that their greatest program need was for technological resources (computers, Internet access).

***Organizational Climate:*** The organizational climate was generally rated as strong by agency directors and found by most to be relatively free of stress.

***Workforce Characteristics:*** Agency directors reported that they were open to growth and change and perceived having adequate influence for change efforts in their agencies.

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## ***I. Introduction & Methodology***

A key priority of the Substance Abuse and Mental Health Services Administration (SAMHSA, 2000) includes developing a capable addiction treatment workforce to provide high quality services for the millions of individuals in this country who need treatment for alcohol and drug abuse or co-occurring mental health disorders. Workforce development includes the recruitment and retention of qualified counselors and the provision of training and supervision to improve counselors' skills (Gallon, Gabriel, & Knudsen, 2003). Although workforce development in the addiction treatment field is critical, up-to-date information about the characteristics of the current treatment workforce is lacking.

To address this need, members of the Addiction Technology Transfer Center (ATTC) Network have been collecting data from addiction counselors and agency directors in their respective regions. The aim of the data collection is to develop a more complete picture of the addiction workforce including their current level of skills, their satisfaction with their jobs, sources of stress and support in their work environment, and perceived challenges faced by agencies and the larger addiction treatment field.

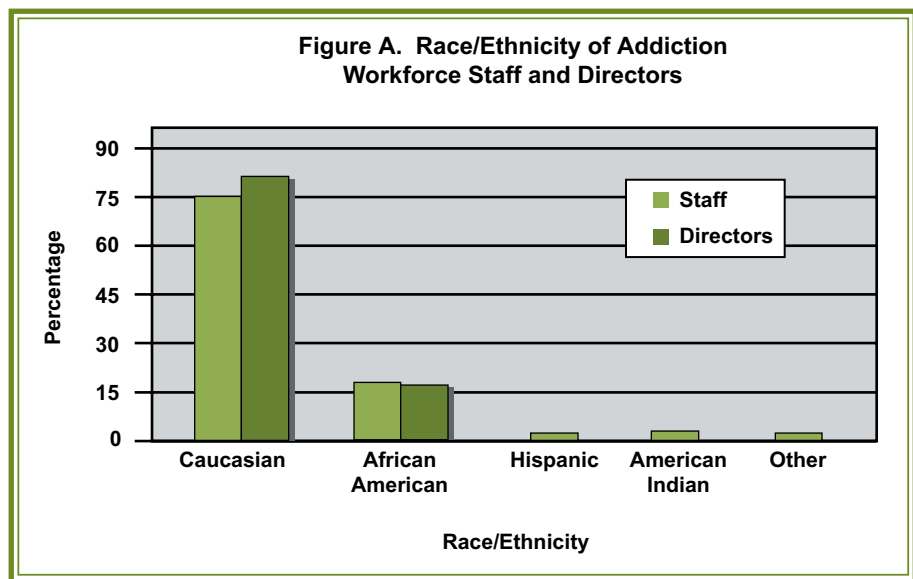
The survey instrument used in this study was a modified version of a workforce survey originally developed by RMC Research Corporation for the Northwest Frontier ATTC. The Mid-America ATTC adapted the survey based on feedback from addiction educators, training directors, certification and licensing authorities, and state personnel in the region. Separate versions were developed for staff and agency directors to use in the states of Arkansas, Missouri, and Oklahoma<sup>1</sup>. Each of the three Single State Authorities endorsed the project, including Garland Ferguson, Director of the Arkansas Alcohol and Drug Abuse Prevention Treatment Services. Endorsement letters were included as cover pages for the surveys.

Agencies were selected to participate from SAMHSA's Substance Abuse Treatment Facility Locator, an electronic listing of all private and public facilities that are licensed, certified, or otherwise approved for inclusion by each state. The locator also includes treatment facilities administered by the Department of Veterans Affairs, the Indian Health Service, and the Department of Defense. To ensure a representative sample of participants, all of the Arkansas agencies ( $n = 34$ ) were selected from that list.

Several steps were taken to increase participation rates. First, all of the identified agencies were notified beforehand, and agency directors were asked if they would be willing to have their agency participate. If so, the number of eligible staff was ascertained so that the appropriate number of surveys could be sent. Each agency was then mailed a survey packet for the director and staff members, along with individual postage-paid return envelopes so that staff and directors could return their surveys separately. After two weeks, follow-up phone calls were made to all agencies as a reminder to return the surveys. As an incentive to participate, each participant received a resource library CD-ROM that included 67 reports, brochures, PowerPoint presentations, Treatment Improvement Protocols (TIP) Series, Technical Assistance Protocols (TAP) Series, and links for additional treatment information. Furthermore, one agency from each state was randomly selected from a list of those agencies who returned all their surveys to receive a television and VCR/DVD package and various Mid-America ATTC curricula. A total of 254 surveys were sent to Arkansas staff and directors. Follow-up efforts resulted in the receipt of 125 staff surveys (56% response rate) and 16 agency director surveys (69% response rate), representing 24 treatment agencies in Arkansas.

## II. *What are the Characteristics of the Addiction Treatment Workforce?*

In this section of the report, the demographic characteristics of Arkansas participants are described including their age, gender, ethnicity, salary, and current work setting. Participants' levels of preparation for their jobs are summarized, including their level of education, certification status, and years of experience in the field. The reasons participants gave for entering the addiction treatment field are provided.



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## *Demographics*

Females comprised more than half (61.3%) of the workforce staff and 43.8% of the directors. Staff members were primarily Caucasian (74.8%) with 19.5% as African American, 3.3% as American Indian, 2.4% as Hispanic/Latino(a), and 2.4% as multiethnic or other (refer to Figure A). Directors were identified as Caucasian (81.3%) or African American (8.7%).

## *Age Range*

Staff ranged in age from 23 to 69, with 70.3% being at least 40 years of age (see Table 1). Directors ranged in age from 46 to 64 years, with the majority being at least 50 years of age.

| Age   | Staff              |         | Directors |         |
|-------|--------------------|---------|-----------|---------|
|       | *Frequency         | Percent | Frequency | Percent |
| 20-29 | 9                  | 7.4%    | --        | --      |
| 30-39 | 27                 | 22.3%   | --        | --      |
| 40-49 | 46                 | 38.0%   | 6         | 37.5%   |
| 50-59 | 36                 | 29.8%   | 8         | 50.0%   |
| 60+   | 3                  | 2.5%    | 2         | 12.5%   |
|       | * Missing data = 4 |         |           |         |

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## *Work Experience*

A much higher percentage of directors (87.5%) than staff (17.1%) had been employed in the field of alcohol and drug treatment for 10 or more years (refer to Table 2). Similarly, when asked about time at their current work setting, a higher percentage of directors (43.8%) than staff (5.7%) reported being at their current work setting 10 or more years. Notably, over half (65.9%) of the treatment staff worked in their current agency for less than 4 years, and 45.5% had been in the addiction field for less than 4 years, suggesting that at any one time, agencies have many new and/or inexperienced workers in their organization.

Nearly half (46.8%) of the Arkansas staff indicated that addiction treatment was a second career. Previous employment areas were quite diverse, ranging from teaching and administrative work, for example, to cosmetology and marketing.

**Table 2. Work Experience of Staff and Directors**

| Range of Time     | Time at Current Work Setting   |                                   | Years in A/D Treatment Field   |                                   |
|-------------------|--------------------------------|-----------------------------------|--------------------------------|-----------------------------------|
|                   | Staff *Frequency/<br>(Percent) | Directors Frequency/<br>(Percent) | Staff *Frequency/<br>(Percent) | Directors Frequency/<br>(Percent) |
| Less than 4 years | 81 / (65.9%)                   | 5 / (31.3%)                       | 56 / (45.5%)                   | 1 / (6.3%)                        |
| 4 to 9 years      | 35 / (28.5%)                   | 4 / (25.0%)                       | 46 / (37.5%)                   | 1 / (6.3%)                        |
| 10 or More years  | 7 / (5.7%)                     | 7 / (43.8%)                       | 21 / (17.1%)                   | 14 / (87.5%)                      |

\* Missing Data: Time at Current agency: Staff (2); Years in Addiction Treatment Field: Staff (2)

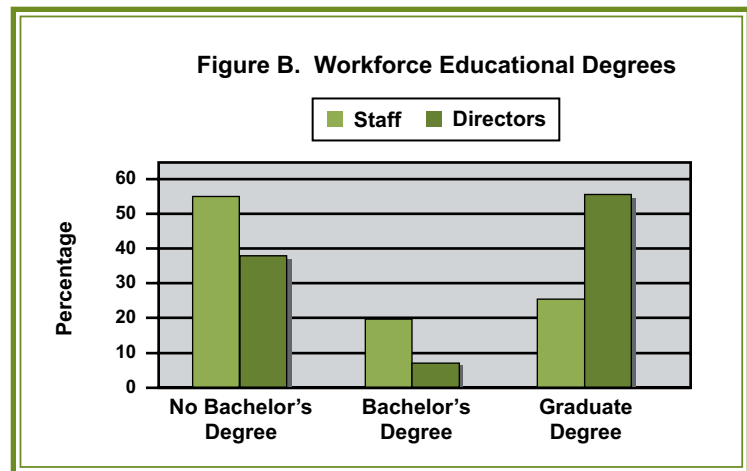
### *Professional Preference*

Staff and directors were asked to evaluate how each of five potential reasons for entering the addiction treatment field was applicable to making their own career decisions. Total responses exceeded 100% because participants were told to mark all of the reasons that applied to them. Over half of the staff cited personal/familial experience with addiction and recovery and/or their personal interest as influencing their decision to enter the field (refer to Table 3). Half of the directors cited a personal interest in the field as a motivator to work in the area of addiction treatment, whereas 25% indicated that they had joined the workforce because of personal/familial experience with addiction.

| Potential Reasons   | Staff     |         | Directors |         |
|---|-----------|---------|-----------|---------|
|   | Frequency | Percent | Frequency | Percent |
| Personal/family experience with addiction and/or recovery | 75        | 60.0%   | 4         | 25.0%   |
| Personal interest   | 71        | 56.8%   | 8         | 50.0%   |
| Academic work/degree in a similar field                   | 31        | 24.8%   | 1         | 6.3%    |
| Unplanned decision  | 29        | 23.2%   | 5         | 31.3%   |
| Experience in similar field                               | 23        | 18.4%   | 3         | 18.8%   |

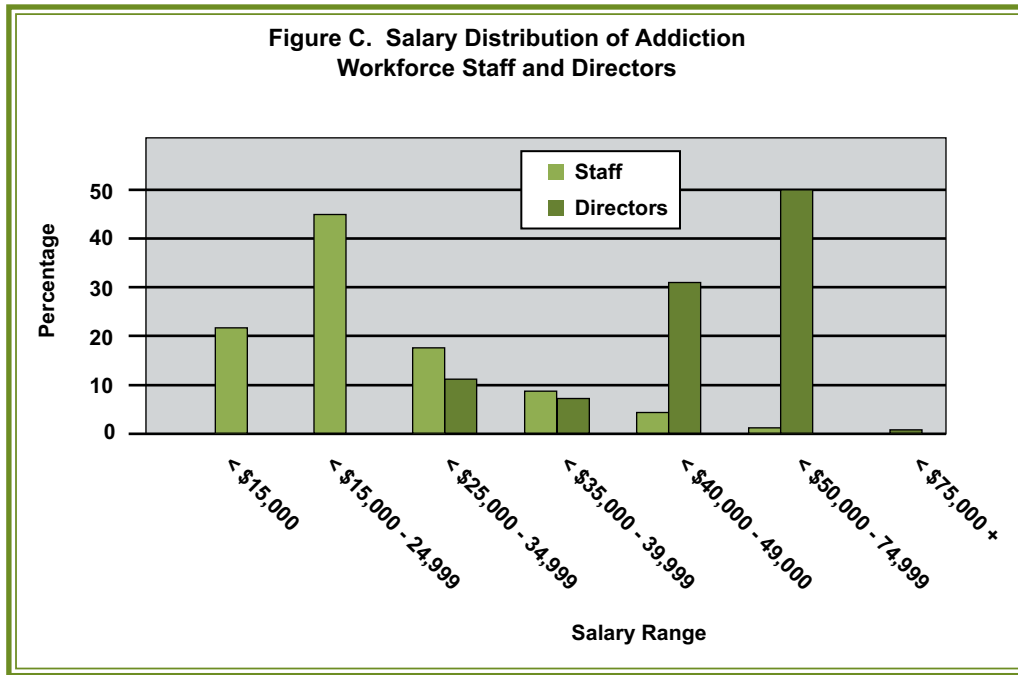
### *Education and Certification Status*

A little over half of the Arkansas directors (56.3%) held a graduate (masters or doctoral) degree, however, only 25.8% of staff did (refer to Figure B). Similarly, 56.3% of the directors were certified or licensed in the addiction treatment field. Again, a smaller percentage of the addiction treatment staff (29.5%) was certified or licensed at the time of the survey.



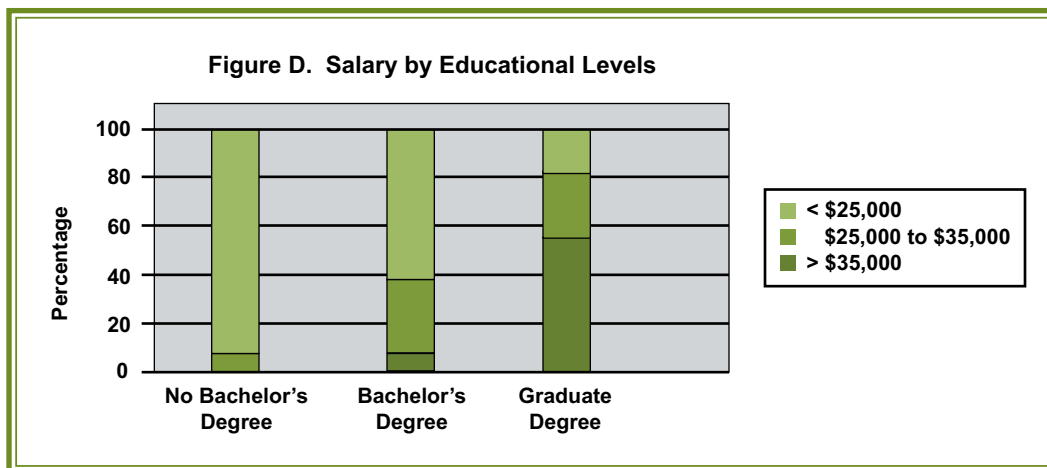
## Salary Distribution

The most frequent salary range for Arkansas staff was between \$15,000 and \$24,999 (refer



to Figure C), and almost all the staff surveyed (93.3%) earned less than \$39,999 annually. In comparison, the most frequent salary range for directors was between \$50,000 and \$74,999, triple the modal salary of staff. Education levels were strongly associated with

salary (see Figure D). For example, most (91.0%) of the workers without bachelor's degrees were earning less than \$25,000 per year, compared to 62.5% of those with bachelor's degrees and 17.9% of those with graduate degrees.



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## *Workplace Benefits*

Staff members were also asked whether they received additional employee benefits (see Table 4). Most were fully or partially provided with health insurance, sick leave, and other types of paid leave. Fewer workers reported receiving retirement options as part of their employment package.

| Type of Benefit           | Full Benefits          | Partial Benefits       |
|---------------------------|------------------------|------------------------|
|                           | *Frequency / (Percent) | *Frequency / (Percent) |
| <b>Sick Leave</b>         | 87 / (71.9%)           | 21 / (17.4%)           |
| <b>Other Paid Leave</b>   | 77 / (63.1%)           | 19 / (15.6%)           |
| <b>Health Insurance</b>   | 56 / (45.9%)           | 54 / (44.3%)           |
| <b>Retirement Options</b> | 46 / (37.7%)           | 32 / (26.2%)           |

\*Missing data = 4

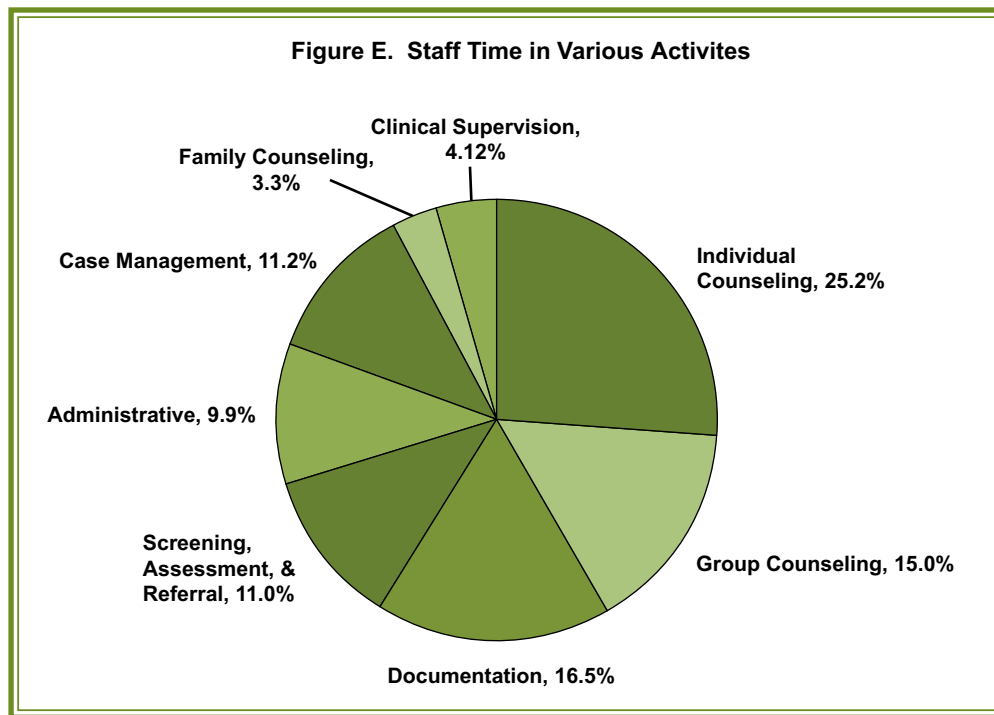
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### ***III. What Services are Being Provided by the Workforce and to Whom?***

Data reported in this section summarize the types of work-related activities performed by the staff and directors, including the different treatment models underlying their therapeutic work and characteristics of clients served.

#### ***Job Activities***

Arkansas treatment staff reported spending the largest amount of time performing individual counseling (25.2% of work hours), followed by documentation (16.5%), group counseling (15.0%), and case management (11.2%) (see Figure E). For directors, a mean of 74.7% of work time was reserved for administrative activities with 18.6% of their time devoted to direct service.



Further analysis of the reported work time indicated five distinct groups of *work profiles* including: (a) staff who primarily provided individual counseling (23.5% of participants), (b) staff who primarily provided group counseling (9.2%), (c) staff who performed a variety of job activities equally (50.4%), (d) staff who mostly carried out administrative duties (10.1%), and (e) staff who primarily conducted screening/assessment services (6.7%). There were differences between these five groups of workers in terms of educational background. Those staff who reported performing a variety of job tasks equally, tended to be less educated than those in the other four groups.

***Provision of Services for Substance Use Disorders Versus Co-Occurring Disorders***

To gain more insight into the specific types of client issues being presented, staff members were asked whether they had provided each of four different services (treatment, screening, diagnosis/formal assessment, and referral) during the last 12 months to clients with substance use disorders and/or co-occurring substance use and mental health disorders. As seen in Table 5, more staff was involved in screening, assessment, and treating clients with substance use versus co-occurring disorders whereas more service referrals were provided for those with co-occurring disorders versus substance use problems only.

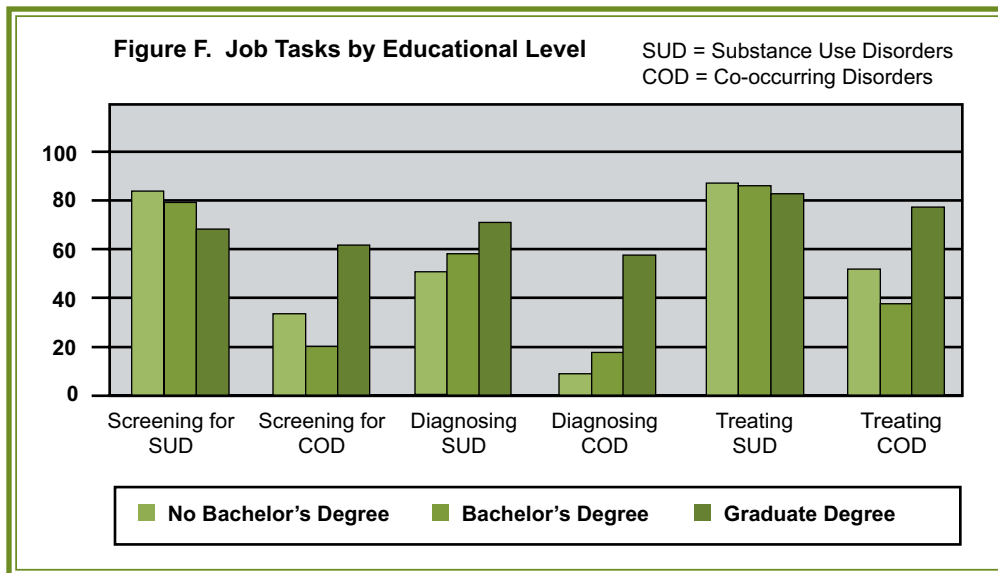
Note, however, that these findings also underscore the significant amount of time that treatment staff spends working with clients who have co-occurring mental health problems. Directors’ reports confirmed that an average of 62.5% of clients in their agencies were treated for alcohol and/or drug problems, and 37.5% of clients were treated for a co-occurring mental health disorder. Thus, workers in Arkansas are facing the same kinds of challenges documented in the literature (e.g., Drake et al., 2001; SAMHSA, 2003), including how to best provide comprehensive treatment that addresses both substance use and co-occurring mental health disorders.

**Table 5. Percentage of Staff Providing Services for...**

| Services                                   | Substance Use Disorder |         | Co-occurring Mental Health Disorder |         |
|--|------------------------|---------|-------------------------------------|---------|
|  | Frequency              | Percent | Frequency                           | Percent |
| Treated clients for...                     | 108                    | 87.1%   | 69                                  | 55.6%   |
| Screened clients for...                    | 98                     | 79.0%   | 47                                  | 37.9%   |
| Diagnosed/formally assessed clients for... | 72                     | 58.1%   | 29                                  | 23.4%   |
| Referred clients to services for...        | 77                     | 62.1%   | 88                                  | 71.0%   |

\*Missing data = 1

Figure F shows the breakdown of services provided based on the educational level of the worker. Several trends are immediately apparent. Staff members across all education levels were equally likely to be involved with treating individuals with both substance use and co-occurring mental health disorders, and most workers were performing these tasks. However, formal assessment and diagnosis of clients is most often left to those with higher levels of education, particularly if the client is being assessed for co-occurring disorders. Finally, whereas most staff members were involved in screening for substance use disorders, those with graduate degrees were more than twice as likely as those without bachelor's degrees to screen for co-occurring disorders.



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## ***Models of Treatment***

Staff members indicated which therapeutic models played a major role in their agency's treatment approach (refer to Table 6). The models most frequently reported in Arkansas were *12-Step* (86.8%), *Relapse Prevention* (75.2%), *Solution Focused* (65.3%), and *Cognitive-Behavioral Skill Development* (48.8%) therapies. According to these results, Arkansas treatment is following many of the recommended best practices in the field (National Institute on Drug Abuse [NIDA], 1999) including use of relapse prevention and cognitive-behavioral strategies. Fewer staff members, however, reported use of behavioral therapies (e.g., behavioral modification, community reinforcement) and motivational enhancement therapy as prominent in their agency. Both of these models are also considered scientifically-based approaches to addiction treatment (NIDA, 1999).

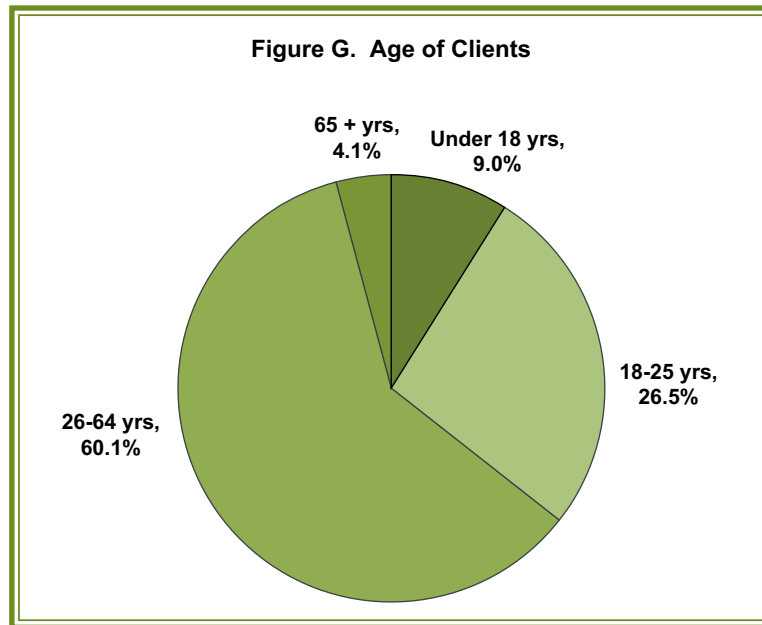
**Table 6. Primary Treatment Models Used**

| <b>Models</b>                               | <b>% of staff endorsing the model as primary in their agency</b> |
|---|--|
| 12-Step                                     | 86.8   |
| Relapse Prevention                          | 75.2   |
| Solution Focused                            | 65.3   |
| Cognitive-Behavioral Skill Development      | 48.8   |
| Therapeutic Community                       | 43.0   |
| Reality Therapy                             | 39.7   |
| Harm Reduction                              | 37.2   |
| Behavioral Modification/Token Reinforcement | 35.8   |
| Community Reinforcement                     | 33.9   |
| Family Therapy                              | 34.7   |
| Rational Emotive Therapy                    | 26.4   |
| Motivational Enhancement Therapy            | 21.7   |
| Gender Specific                             | 30.6   |
| Developmental Model                         | 16.7   |
| Pharmacotherapy                             | 17.5   |
| Culture Specific                            | 7.4  |
| Dialectical Behavior Therapy                | 8.3  |
| Minnesota Model                             | 3.3  |
| Methadone Maintenance                       | 8.4  |

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### *Clientele Characteristics*

Within agencies, each staff member worked with an average number of 17 clients per month with a range of 5 to 45 clients per staff member. More than half (60.1%) of the clients were between 26 and 64 years of age (see Figure G), and 60% of clients were male. Client race/ethnicity was similar to that of the treatment staff. Clients were primarily Caucasian (74.1%) with African Americans (15.9%) being the second most frequently served group. Native Hawaiian and Pacific Islander (4.5%) and Hispanic (2.9%) clients were less frequently seen, and the number of American



Indian, Asian, or multi-ethnic clients was less than one-percent.

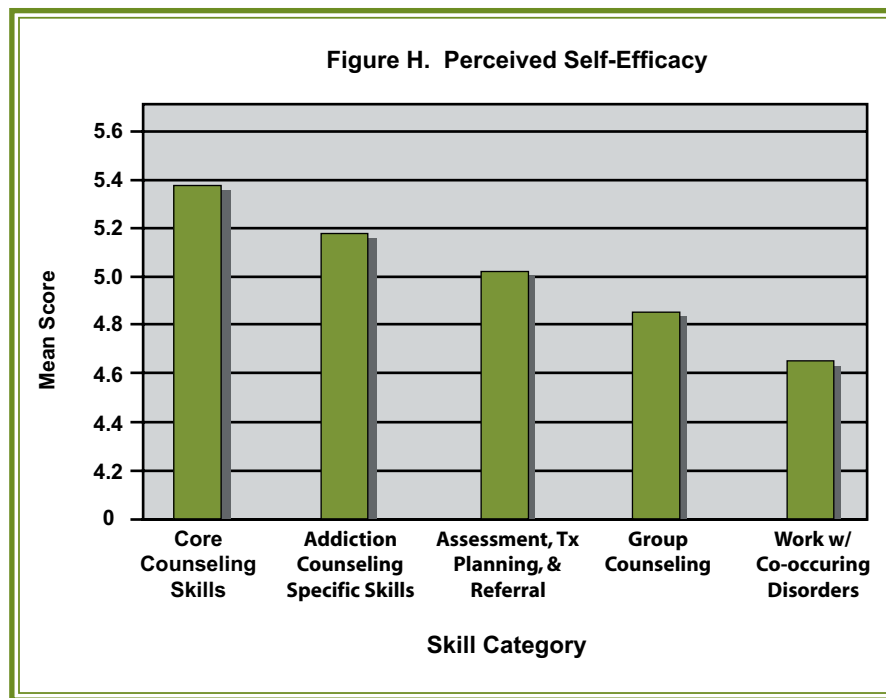
Primary service areas in Arkansas were categorized as rural (56.3%), suburban (25%), or inner city (18.8%). Most of the addiction treatment programs surveyed were residential (62.5%) or outpatient (31.3%) programs. Many directors (62.6%) indicated that the number of clients served in their setting was steadily increasing rather than decreasing or staying the same.

#### IV. How Does the Workforce Perceive their Skills and Training Needs?

In this section, we report on data collected to update the current knowledge, skills, and perceived training needs of the addiction workforce in Arkansas. To this end, staff and directors' self-efficacy for the various kinds of skills that are required on their job was assessed. Staff members and directors were also asked what they perceived to be the greatest training needs for the workforce.

##### *Addiction Counseling Competencies Familiarity and Use*

Treatment staff members were asked whether they were familiar with the *Addiction Counseling Competencies* published by the U.S. Department of Health and Human Services and the Center for Substance Abuse Treatment (CSAT). Only 27% indicated *Yes* that they were familiar with the competency guidelines. Of those who were familiar with the guidelines, 83.3% *agreed* or *strongly agreed* that they utilized these competencies to guide their professional development, for self-assessment (75%), and to improve treatment outcome (86.1%).



##### *Workforce Skills and Perceived Self-Efficacy*

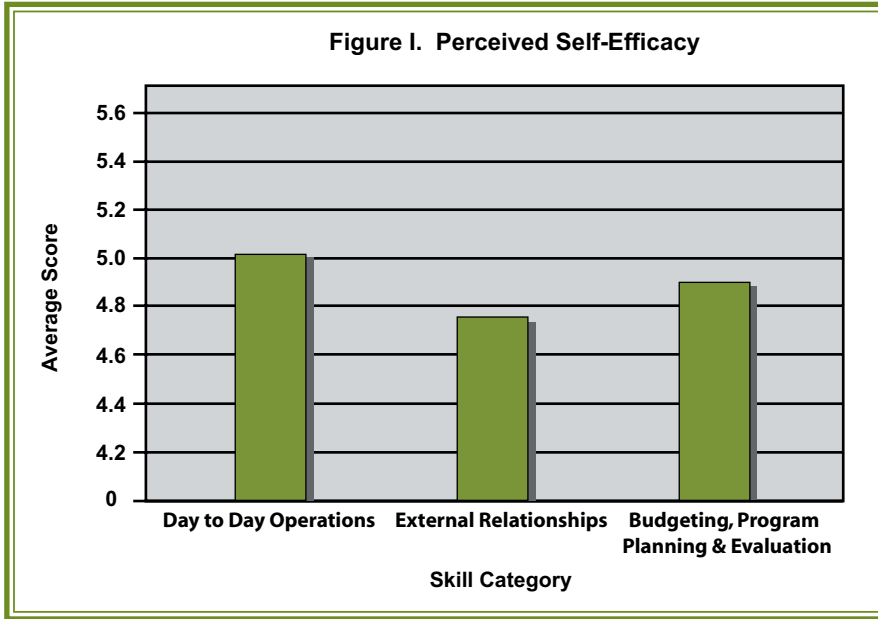
Staff was then asked about 67 different job skills. Items for this section of the survey were derived from the nationally defined *Addiction Counseling Competencies* noted above. Staff members indicated how confident they were in those 67 skills on a scale of 1 (*no confidence in performing this skill*) to 6 (*absolute confidence in performing this skill*).

Responses to these items were grouped into five main categories: (a) core counseling skills, (b) addiction counseling skills, (c) group counseling skills, (d) assessment, treatment planning, and referral skills, and (e) skills for working with clients who have co-occurring disorders. Staff responses to the items within each category were averaged to form total scores ranging from 1 to 6 (see Figure H).

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Overall, staff members felt most confident about their basic counseling microskills, including empathy, warmth, and facilitating a positive counseling atmosphere for clients. The average score in this category was 5.37 ( $SD = .69$ ). Staff members also reported high efficacy for their counseling skills specific to the treatment of addiction, for example, assessing a client's readiness to change substance use behaviors and helping clients determine triggers for relapse. Average scores in this area were 5.16 ( $SD = .71$ ). Staff felt least confident about treatment work involving co-occurring substance use and mental health disorders. This category included, for example, working with someone who has an addiction and a mood disorder. Scores in this category averaged 4.66 ( $SD = .88$ ).

Significant differences emerged in terms of group comparisons by educational level or whether staff members were certified or not. Specifically, those with graduate degrees reported significantly higher efficacy levels for working with clients with co-occurring disorders than those without graduate degrees. Recall that this same group is more likely to spend their time screening, diagnosing, and treating individuals for clients with co-occurring disorders. Significant group differences were also found in assessment, treatment planning, and referral skills. Specifically, those staff members who were certified or licensed in the field reported higher efficacy in this category than those who were not.



### ***Leadership Skills***

Directors were also asked about their confidence to execute 26 different leadership skills such as budgeting and managing program finances, forming positive relationships with treatment staff, and cultivating relationships in the larger community. Responses to these items were grouped into three main categories:

(a) day-to-day operations, including staff management, (b) external relationships, and (c) budgeting, program planning, and evaluation.

Directors’ responses to the items within each category were averaged to form total scores ranging from 2 to 6. As seen in Figure I, directors were fairly confident in all areas. They were most confident in their day-to-day operations skills (e.g., provide feedback to staff about job performance, build a team of staff who work together, manage around employees’ weaknesses) and less confident in their external relationship skills (e.g., advocate to policymakers, develop effective relationships with potential funders), and their program planning and evaluation skills (e.g., budget and manage treatment program finances, document program effectiveness).

An analysis of the individual items suggests one specific skill in which directors felt much less efficacious: negotiating with insurance industries, ( $X = 3.75, SD = .86$ ). In contrast, none of the other 25 skills had a mean rating below 4.62 on a scale from 1 to 6. Eleven of the 26 skills had a mean score of 5.00 or above, indicating a high level of self-efficacy in these areas.

### Staff Training Needs

In addition to perceived self-efficacy in work skills, staff and agency directors indicated in which competency areas additional training was needed. As can be seen in Table 7, in most (but not all) of the competency areas, a higher percentage of the directors perceived a need for staff training compared to the ratings of the staff members themselves. Staff and directors both had co-occurring substance disorders and group counseling as top training priorities. Recall that staff members also rated their skills for working with clients with co-occurring disorders and group skills lower than many of the other areas (refer to Figure H). Interestingly, staff and directors differed from one another on what additional areas were most important. For staff, working with trauma and abuse issues, grief and loss, and motivational enhancement were also rated highly, whereas directors wanted their staff to be trained in documentation, treatment planning, clinical supervision, and

**Table 7. Training Needs According to Staff and Directors**

| Competency areas                               | % Endorsement as a Training Need |           |
|--|----------------------------------|-----------|
|  | Staff                            | Directors |
| Co-occurring substance use and mental health   | 60.8                             | 87.5 (1)  |
| Trauma and abuse                               | 58.4                             | 31.3      |
| Group counseling skills                        | 52.8                             | 75.0 (2)  |
| Grief and loss                                 | 52.8                             | 31.3      |
| Motivational enhancement                       | 48.8                             | 43.8      |
| Drug pharmacotherapy                           | 46.4                             | 37.5      |
| Marriage and family therapy                    | 42.4                             | 43.8      |
| Treatment planning                             | 41.6                             | 62.5 (4)  |
| Spirituality and recovery                      | 39.2                             | 43.8      |
| Intervention                                   | 39.2                             | 31.3      |
| Documentation skills                           | 38.4                             | 68.8 (3)  |
| Clinical supervision                           | 37.6                             | 50.0 (5)  |
| Adolescent treatment skills                    | 36.0                             | 37.5      |
| Prevention strategies                          | 33.6                             | 25.0      |
| Administrative management skills               | 32.0                             | 37.5      |
| Offender treatment                             | 30.4                             | 31.3      |
| Gender specific treatment                      | 28.8                             | 31.3      |
| Referral skills                                | 28.0                             | 25.0      |
| Racial/ethnic specific treatment               | 28.0                             | 31.3      |
| Screening and assessment                       | 27.2                             | 50.0 (5)  |
| Professional and ethical responsibilities      | 25.6                             | 43.8      |
| Personnel management skills                    | 25.6                             | 25.0      |
| Detoxification                                 | 24.8                             | 25.0      |
| Lesbian/gay/bisexual specific treatment skills | 22.4                             | 18.8      |
| Elder/senior specific treatment                | 22.4                             | 12.5      |
| Patient placement criteria                     | 14.4                             | 31.3      |

screening/assessment. These differences are noteworthy, as staff members reported higher confidence levels for their treatment planning and documentation skills, for example, and did not view treatment planning nor documentation as priorities for future training.

Finally, almost all of the staff (92.3%) had completed a continuing education training or workshop during the past year including 87.7% of those who were not certified and all staff with current certifications. The average number of continuing education hours reported during the past year was 34.65 (*SD* = 25.90). Those not certified attended an average of 33.85 hours (*SD* = 30.66) versus 35.24 hours (*SD* = 14.73) for certified counselors.

## V. *Quality of Work Environment in Terms of Supports/Constraints and Job Satisfaction.*

Given the high rates of employee turnover reported in the field (Gallon, Gabriel, & Knudsen, 2003; Knudsen, Johnson, & Roman, 2003; McLellan, Carise, & Kleber, 2003) as well as annual addiction treatment agency closures (Johnson & Roman, 2002; McLellan et al., 2003), current efforts toward recruitment and retention of qualified personnel are imperative. This section reports on agency job retention and recruitment efforts, existing workplace support systems, and workers' job satisfaction.

### *Retaining Qualified Staff*

Staff and directors were asked how their agencies could keep qualified counselors from leaving the field (see Table 8). Responses to 17 job retention strategies were clustered into three different categories: (a) better staff compensation, (b) better agency leadership and "climate," and (c) better working conditions. Of these three categories, improved compensation was most commonly endorsed. Staff and directors agreed that salary increases and improved employee benefits were most helpful in retaining qualified staff. Although such efforts may be

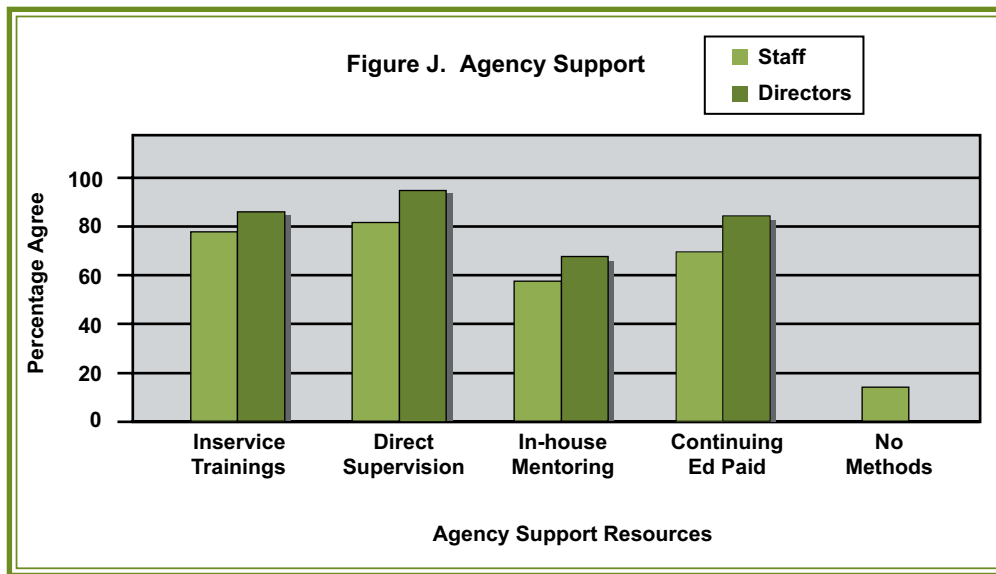
constrained by decreasing agency budgets, several of the other suggestions are not necessarily limited by monetary issues. For example, the provision of more individual recognition and appreciation as well as opportunities for staff input were highly rated by staff in this study.

| <b>My agency can do the following to better retain qualified staff...</b> | <b>% Strongly Agree or Agree</b> |                  |
|---|----------------------------------|------------------|
|   | <b>Staff</b>                     | <b>Directors</b> |
| More frequent salary increases  | 92.0                             | 93.8 (1)         |
| Promote career growth   | 72.6                             | 62.5 (4)         |
| More individual recognition/appreciation                                  | 72.0                             | 62.6 (3)         |
| More ongoing training   | 72.0                             | 50.0             |
| Increase staff opportunities for input                                    | 67.2                             | 50.0             |
| Better health coverage and benefits                                       | 63.2                             | 56.3 (5)         |
| More frequent promotions  | 62.4                             | 75.0 (2)         |
| Provide assistance with paperwork   | 52.8                             | 31.3             |
| Provide more varied work opportunities                                    | 48.0                             | 43.8             |
| Smaller client caseloads  | 45.6                             | 37.5             |
| Better management   | 40.8                             | 25.0             |
| Improved physical work environment  | 39.1                             | 37.6             |
| More supportive agency culture  | 37.6                             | 25.0             |
| Shorter work hours, flex time, job sharing                                | 33.6                             | 18.8             |
| Better supervision  | 32.8                             | 12.6             |
| Less management and supervision   | 11.2                             | 00.0             |

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## Agency Support

Staff and directors were asked about agency methods to promote skill development of the staff (see Figure J) as well as what additional support resources were available (see Table 9). Several differences emerged between staff members and directors' views of skill development within their agencies. The largest discrepancies were found in whether the cost for staff to attend continuing education training was paid for by the agency and the amount of direct supervision currently available.



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### *Staff Technology Use*

Access to technology resources can also be conceptualized as assessing the quality of support provided in the work environment. As such, treatment staff members were questioned about the frequency and methods of communication technology they utilized. Most reported daily use of computers, however, use of e-mail or the Internet was limited (see Table 9).

**Table 9. Utilization of Communication Technology by Workforce Staff**

| Communication Method | Very Rarely or Never   | Monthly                | Weekly                 | Daily                  |
|----------------------|------------------------|------------------------|------------------------|------------------------|
|                      | *Frequency / (Percent) | *Frequency / (Percent) | *Frequency / (Percent) | *Frequency / (Percent) |
| Computer             | 8 (6.5%)               | 4 (3.2%)               | 9 (7.3%)               | 103 (83.1%)            |
| Voice Mail           | 56 (45.2%)             | 8 (6.5%)               | 15 (12.1%)             | 45 (36.3%)             |
| E-mail               | 67 (54.5%)             | 7 (5.7%)               | 9 (7.3%)               | 40 (32.5%)             |
| Audio Conferencing   | 111 (89.5%)            | 4 (3.2%)               | 3 (2.4%)               | 6 (4.8%)               |
| Internet             | 59 (47.6%)             | 17 (13.7%)             | 13 (10.5%)             | 35 (28.2%)             |
| Missing data = 2     |                        |                        |                        |                        |

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## Job Satisfaction

When asked how satisfied staff members and directors were with their current job, both groups responded favorably, with almost all participants stating they were *mostly satisfied* or *satisfied*.

Staff and directors also

responded to a list of seven items considered sources of job satisfaction or dissatisfaction (see Table 10). An analysis of participants' responses suggested two distinct sources of job satisfaction, including: (a) aspects of treatment (e.g., interaction with clients, commitment to treatment), and (b) aspects of the work environment (e.g., career growth and learning opportunities, ability to influence agency decisions, compensation).

The average scores for the two groups of items indicated staff members had higher satisfaction ratings with treatment and their work with clients. For agency directors, those aspects of their work that involved learning, influence, and growth were most appealing whereas interactions with clients were not rated as highly. This finding is to be expected because most of the directors' time is spent in administrative activities and not in direct service.

**Table 10. Job Satisfaction**

| How satisfied are you with...                  | % Strongly Agree or Agree |           |
|--|---------------------------|-----------|
|  | Staff                     | Directors |
| One-to-one interaction with clients            | 95.9                      | 50.1      |
| Agency/co-workers                              | 80.3                      | 100       |
| Role as a change agent                         | 55.2                      | 75.1      |
| Opportunities for personal learning and growth | 72.7                      | 87.5      |
| Career growth opportunities                    | 48.4                      | 68.8      |
| Ability to influence agency decisions          | 42.9                      | 68.8      |
| Salary/benefits                                | 24.6                      | 62.5      |
| Overall satisfaction with job                  | 80.3                      | 87.5      |

## VI. What are the Challenges to the Future Workforce?

This final section reports on various workforce challenges in Arkansas. Staff and directors were asked about the most prominent barriers to qualified workers entering the field and the recruitment difficulties directors were encountering. The issue of stigma was also examined for how it affects treatment staff. This section concludes with a look at organizational characteristics of Arkansas agencies; specifically, how do directors perceive external pressures to make changes in their agencies and do they view their staff and agencies as having attributes cohesive to change.

**Table 11. Barriers to Entering the Field**

| People decide not to enter the A/D treatment field because of...   | % Strongly Agree or Agree |           |
|--|---------------------------|-----------|
|  | Staff                     | Directors |
| Low salary/poor benefits   | 89.4                      | 93.8 (1)  |
| Competition from other fields (in terms of compensation)   | 68.8                      | 81.3 (2)  |
| Negative preconceptions regarding clients and chemical dependency (e.g., difficult to work with; don't want to change) | 66.1                      | 50.0      |
| Large caseloads  | 59.9                      | 50.1      |
| Stigma/lack of respect for the field   | 59.9                      | 50.1      |
| Perception that A/D treatment is not a "real" profession   | 54.9                      | 50.0      |
| Evening and weekend hours  | 52.9                      | 62.5 (5)  |
| Perception that A/D treatment is not effective   | 51.7                      | 56.3      |
| Paperwork  | 48.4                      | 68.8 (3)  |
| A lack of encouragement (e.g., from educators, family, or friends)   | 47.5                      | 50.0      |
| Cost of training/education   | 43.0                      | 62.6 (4)  |
| Quality of work environment in terms of professionalism  | 39.3                      | 18.8      |
| Amount of training/education   | 34.7                      | 56.3      |
| Geographic constraints   | 13.9                      | 18.8      |
| Treatment models are not tailored to needs of racial/ethnic groups   | 12.3                      | 12.5      |
| Discrimination (e.g., disability, ethnicity, or gender)  | 4.9                       | 6.3       |

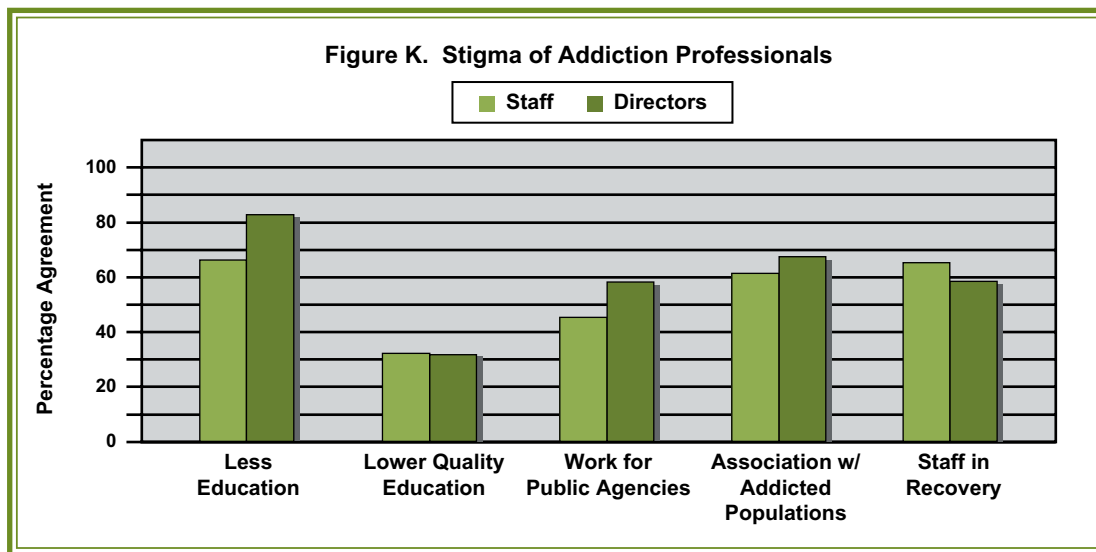
### **Barriers to Entering the Field**

Staff and directors' responses on barriers to entering the addiction treatment field reflected several of the findings in this report. As seen in Table 11, poor compensation was perceived as the most prominent barrier, paralleling findings from job retention strategies and sources of job dissatisfaction. These results underscore salary as a salient issue in the addiction treatment field. Interestingly, even though salary levels are strongly related to educational level (see Figure D), there was no association between workers' level of education and the tendency to most likely see salary as a barrier. Between 87% to 92% of the staff viewed salary as a barrier to entering the field across all three educational levels. Additional barriers selected by the staff and directors centered on negative preconceptions about the field and clients served, a work environment characterized by heavy client caseloads, and poor working hours.

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### *Stigma and Perceived Status of the Field*

Stigma and a lack of respect for those in the field were also highly ranked barriers. To further explore the perceived status of the field, staff and directors indicated how addiction treatment providers compared to other helping professionals. Specifically, are addiction treatment professionals thought to have a higher status, a lower status, or about the same status as other helping professionals? A majority of directors (75.0%) and staff (67.2%) felt that addiction treatment providers had a lower standing compared to other health professional groups. Reasons for the lower perceived status of addiction treatment professionals can be seen in Figure K, including lower staff educational levels, stigma due to an association with addicted populations, and the greater likelihood that treatment staff members have a history of addiction themselves.



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### ***Recruitment Difficulties***

Another challenge to the field is recruiting qualified addiction counselors. Over half (56.3%) of the Arkansas directors surveyed said they had difficulty filling open job positions at their agency. The primary reasons for these difficulties, according to directors, included an insufficient amount of funding for open positions (100%) and/or staff disinterest due to the salary offered (88.8%). Additional reasons indicated by directors included that applicants did not meet the minimum qualifications necessary for the position (88.9%) and there was a small applicant pool due to the surrounding geographical location (55.5%) of their agency. Table 12 suggests reasons why directors felt applicants were not meeting minimum qualifications.

| <b>Table 12. Recruitment Difficulties</b>                            |                                  |
|--|----------------------------------|
| <b>Applicants do not meet minimum qualifications because they...</b> | <b>% Strongly Agree or Agree</b> |
| Lack appropriate certification/licensure                             | 75.1                             |
| Have insufficient or inadequate education or training                | 68.8                             |
| Have little or no experience in A/D treatment                        | 62.6                             |
| Lack practical or applied skills                                     | 56.3                             |
| Lack social or interpersonal skills                                  | 18.8                             |

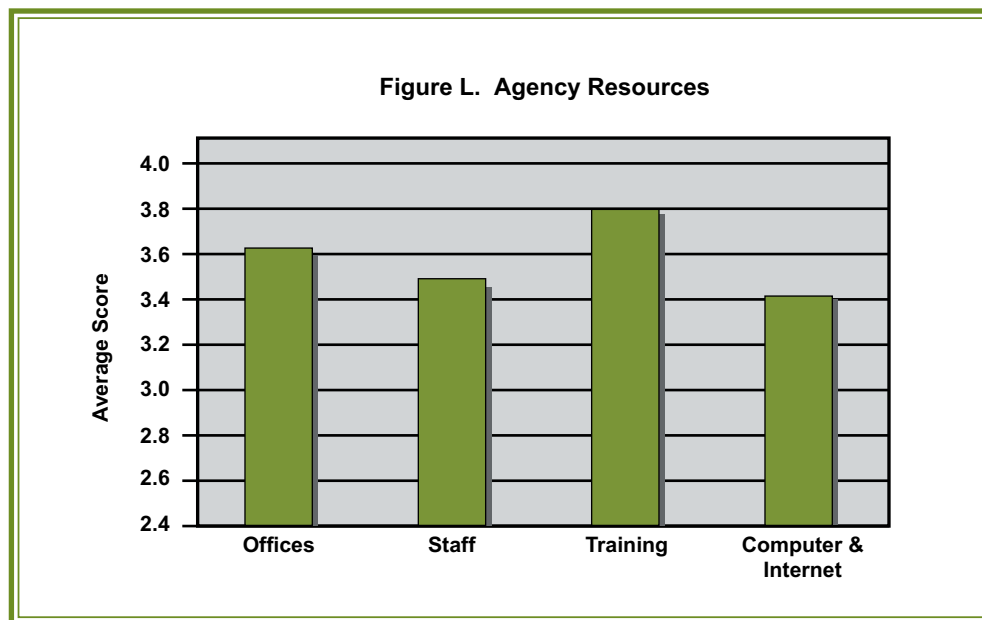
## Agency Change

Simpson (2002) provided a conceptual model of factors involved in organizational change within the addiction treatment field. Included in the model are different motivations for change (e.g., program and training needs) and various internal/external pressures for change (e.g., funding sources, clients in a program). The model also highlights various resources as well as agency and staff characteristics which are conducive to the change process.

| <b>Technical Assistance/Training Needed for...</b>                     | <b>% Strongly Agree or Agree</b> |
|--|----------------------------------|
| Using client assessments to guide clinical and program decision-making | 87.6                             |
| Increasing program participation by clients                            | 87.5                             |
| Matching client needs with services                                    | 87.5                             |
| Measuring client performance   | 81.3                             |
| Raising the overall quality of counseling                              | 75.1                             |
| Assessing client needs   | 75.1                             |
| Using client assessments to document program effectiveness             | 75.0                             |
| <b>Pressures for Change Come from...</b>                               | <b>% Strongly Agree or Agree</b> |
| Accreditation or licensing authorities                                 | 75.0                             |
| Program supervisors or managers  | 68.8                             |
| Program staff members  | 62.6                             |
| Funding and oversight agencies   | 62.5                             |
| Clients in the program   | 31.3                             |
| Program board members  | 18.8                             |
| Community action groups  | 6.3                              |

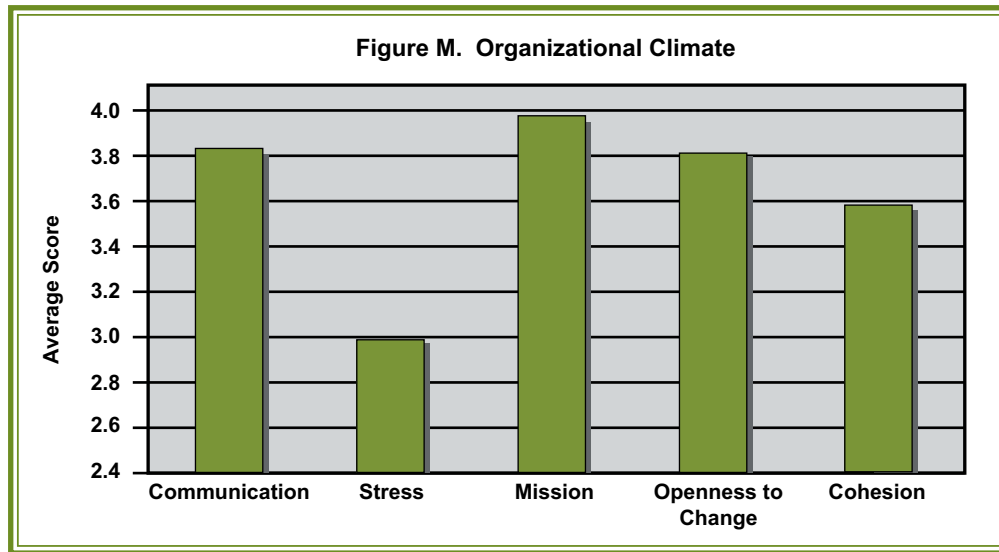
According to Arkansas directors, the highest priority areas for program changes included: (a) using client assessment to guide agency decisions, (b) increasing program participation by clients, and (c) matching client needs with services. As noted in Table 13, however, average scores in these three areas were similar to the other options directors had to choose from. Directors perceived the strongest pressures for change coming from: (a) accreditation/licensing authorities, and (b) program supervisors or managers.

Next, Arkansas directors were asked whether their agencies had various resources that were needed to implement change, including adequate facilities (e.g., office space), sufficient numbers and types of different staff (e.g., psychiatric services, support staff), and access to quality training and technology resources (e.g., computers, Internet). Directors' responses to each of the resource categories were averaged to form a total score in which higher scores indicated more resources. According to Figure L, Arkansas directors saw the biggest deficiency in technology resources ( $X = 3.42$ ,  $SD = .63$ ). Technology resources include, for example, access to computers, the Internet, and e-mail systems as well as computerized client assessment protocols.

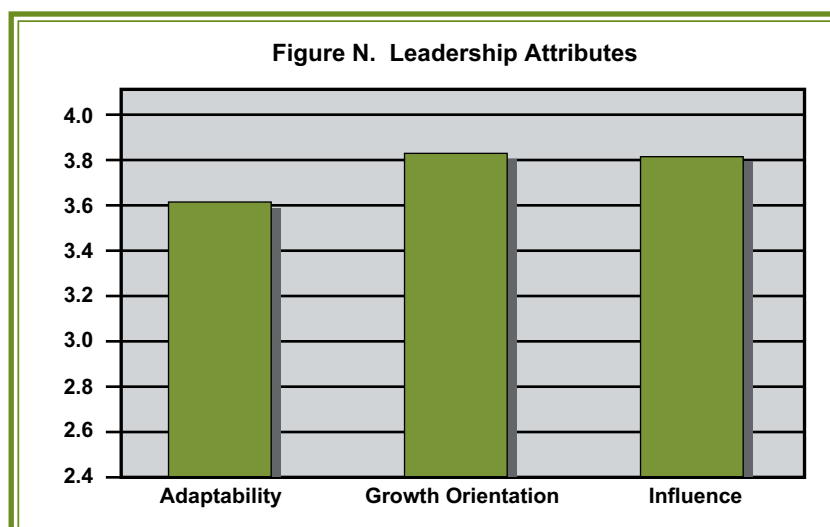


Each director was also asked to rate aspects of the agency climate. According to Simpson's model (2002), certain organizational and workforce attributes are conducive to program changes. These climate variables include having a clear agency mission and goals, adequate communication between staff and leadership, and an attitude of openness to change. Agencies would also have a lower amount of perceived organizational stress, including staff frustrations and friction, overwhelming pressures and job strain, and heavy workloads. Arkansas directors' scores on these items were again averaged and higher scores on all scales indicated more of the organizational attributes.

As can be seen in Figure M below, directors thought their agencies were generally strong in terms of their communication, clarity of mission and goals, openness to change, and worker cohesiveness. Ratings of organizational stress averaged only 2.99 ( $SD = 1.09$ ) on a scale of 1 to 5.



Finally, whether organizational change is successful involves various leadership attributes. These characteristics include leaders who are adaptable or flexible to change, initiate new ideas, and are growth-oriented in terms of both their own skills and growth of their agencies. Additional attributes to consider are whether or not leaders perceived themselves as having an influence in their agency and if their opinions and guidance are respected. Arkansas directors perceived themselves and their agency as strongly growth-oriented and high in their amount of perceived influence (see Figure N). Relatively speaking, ratings of their adaptability were lower, but average scores were still above 3.50 on a 5-point scale.



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## ***VII. Conclusions and Recommendations***

### **Section II – Characteristics of the Workforce**

Three striking demographic findings in this report include: (a) the limited treatment experience of Arkansas staff, (b) relatively few staff with graduate degrees, and (c) fewer staff with a current certification/licensure to practice addiction treatment. Despite the “newness” of staff members to the field, in terms of both the amount of time they have been employed in their current agencies and in the addiction field as a whole, over 70% were at least 40 years old. Agency directors were also at least in their mid-forties. These findings have implications for current recruitment efforts, in particular, seeking out prospective counselors early in the beginning stages of their education. Furthermore, given that nearly 70% of staff were employed at their current work setting for less than four years, a good portion of resources is being spent on training new employees.

Most Arkansas staff did not have a four-year degree. Staff salary levels, however, are strongly related to having an educational degree, and most staff without a bachelor’s degree earned between \$15,000 to \$25,000 annually. According to the US Department of Health and Human Services guidelines, a family the size of three is at poverty level when their annual salary is \$15,670. This raises a fundamental question at the heart of the workforce development project: how do we recruit a well-trained workforce when often there are low starting salary levels and poor benefits? In addition, it seems important to determine what level of education is actually required to yield competent addiction treatment workers.

### **Section III – Services Provided**

Those who work in addiction treatment may not be allocated enough time to provide valuable services. For example, case management, family counseling, and group counseling are all part of “best practices,” yet comparatively little counselor time was spent in these activities. Group counseling is empirically supported and traditionally has been a widely implemented therapy in the field. It is also less expensive than individual counseling, so why doesn’t more treatment staff conduct this type of treatment? Similarly, there was little reported time spent in family counseling activities. Including clients’ family members and significant others in the treatment process helps strengthen clients’ treatment plans and is important for both treatment retention and relapse prevention. Further exploration is needed to understand why family therapy is only minimally used. Perhaps counselors are not well-trained in this area, or they find that it is difficult to coordinate the schedules of entire families to attend treatment sessions.

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Results from this survey demonstrate that the addiction treatment workforce is not one homogenous group of people, but is comprised of smaller subgroups that spend their time in different ways. For example, slightly less than one-third of the staff (23.5%) surveyed primarily provide individual counseling services, whereas an additional one-half of those surveyed (50.4%) divided their time equally among several work activities (e.g., individual and group counseling, screening and assessments, documentation activities).

A further look into what services were being provided by staff highlights differences between interactions with clients who presumably have only a substance use disorder versus those with both substance use and a mental health disorder (co-occurring disorders). It is interesting that only 37.9% of staff reported screening for co-occurring disorders, yet 79% screened for substance use. Screening is not a high level skill and can be done by most staff members. The recommendation is to screen all clients for co-occurring disorders (e.g., Lehman, 1996; Drake et al., 1996); however, if a particular treatment center does not specialize in identifying co-occurring disorders, clients may not be screened correctly or receive appropriate treatment. A “no wrong door” approach is necessary, in which screening and assessment practices for co-occurring disorders are uniformly implemented across treatment agencies.

#### **Section IV – Workforce Skills and Training Needs**

Although a substantial portion of counselor time is not spent on the direct treatment of co-occurring disorders, most Arkansas workers reported having some interaction with clients who have co-occurring disorders. Staff members’ reported self-efficacy for various skill areas indicated that counselors felt least competent when working with clients with co-occurring disorders. Furthermore, there was a large variance in self-assessments across educational levels, with more highly educated workers reporting more competence in this area. These workers might be utilized within their agencies to provide training on these issues to those counselors with less education in this area. Such a training process might also give staff more confidence to screen for co-occurring disorders thus promoting this practice agency-wide. Workers who are more confident about their skills (i.e., report more self-efficacy) are more likely to engage in tasks, persist at difficult tasks, and in general perform better (Bandura, 1977). Similarly, more educated addiction counselors can disseminate their knowledge about co-occurring disorders to the mental health workforce, in exchange for the expertise that mental health workers could provide for the addiction treatment staff.

Finally, results from staff members’ self-efficacy ratings suggested a need to look further into what certification is affording counselors. Staff who were certified/licensed reported more self-efficacy than those without certification in only one skill category: assessment, treatment planning, and referral skills. These results, however, do not necessarily mean there are no actual skill differences among groups of counselors.

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An important task for the future is finding ways to assess actual counselor competence and determine if it is linked to certification. Counselors spend a great deal of time and money attaining and retaining certification/licensure; therefore, it would be interesting for the field to demonstrate that these credentials actually lead to improved skills and favorable client outcomes.

Directors also varied in their self-reported confidence for different skill areas. Their self-efficacy ratings were lowest among skills in advocating and negotiating with external constituencies such as insurance agencies and funders. Additional training in this area is necessary as these issues will most likely become more complex over time. In general, promoting leadership skills is important in developing external relationships as well as in establishing within-agency relationships. Many of the agencies surveyed had new and/or inexperienced staff at any given time. Professional development of these staff members is important and can be fostered through collaborative relationships with their agency directors. A strong, bidirectional communication system between the two groups of workers may also help to promote retention of new staff in the field.

Finally, there was a difference between the directors' perceptions of the counselors' training needs and the counselors' views of their own training needs. Directors felt their staff needed training in documentation activities, treatment planning, and screening/assessment. Less than half of the staff thought these were priority training needs. As the treatment system continues the trend toward more service accountability, documentation and treatment planning activities are important methods for demonstrating accountability. This may help explain the perceived need for additional skills in this area by directors, who are concerned about demonstrating agency accountability.

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## Section V – Workplace Support and Job Satisfaction

A study by Knudsen et al. (2003) found that both salary increases as well as non-tangible work rewards such as praise and recognition were significant indicators of treatment staff members' commitment to their agency. In general, many treatment agencies do not have the money to provide large financial rewards to their staff or pay for additional continuing education; therefore, it is important to note that Arkansas staff indicated a strong desire for more non-tangible work rewards. Such methods included praise and individual recognition for their work, creating a supportive work environment, and staff having a voice in decision-making. Examples of non-monetary suggestions given by staff members included:

- Agencies could offer incentives and perks that other professional fields don't have.
- Provide counseling for the counselors, or "mental health days," which might reduce burnout.
- Work on the counselors' own personal concerns; sometimes the counselors need counselors.
- Encourage more staff self-care.
- Provide more training and retreats for staff.
- Show more appreciation for staff, stand up for your employees, and show appreciation for their good work.
- Lower staff case loads.
- Encourage individual thought.
- Respond to problems workers pose.
- Show empathy, concern, and gratitude toward staff.
- Provide for more growth opportunities.
- Increase effective anti-burnout strategies.

Many of the staff members reported receiving ongoing supervision of their clinical work and agency in-service training. Fewer staff reported in-house mentoring activities, however. These findings are important, given that previous research has found a strong association between agency supervision and mentoring activities and staff job satisfaction (e.g., Evans & Hohenshil, 1997). Training directors or experienced staff could provide an in-house source of continuing education and growth at a low cost for both supervisors and supervisees.

Staff reported high job satisfaction ratings, and attributed their job satisfaction to their daily work with clients. These results are consistent with data in other aspects of this report. Persons in the addiction workforce primarily entered the field because they wanted to make a difference in the lives of others; they felt adequately prepared for the work with clients, and engaged in a range of client service activities. All of these tended to help promote satisfaction with the treatment component of their job. Issues that were identified as barriers to staying in the field included salary, benefits, and career advancement opportunities. These issues also influenced one's satisfaction with the work environment.

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## Section VI – Challenges for the Workforce

In terms of what changes are needed within their agencies, Arkansas directors reported a desire for technical assistance in most of the categories provided (see Table 13), making it difficult to ascertain what priority areas will be beneficial to first address. Pressure to make program changes, however, originated from two clear sources: (a) outside entities including accreditation or licensing authorities, funding and oversight agencies; and (b) internal members including staff and program managers. A limitation of this survey is that the types of changes needed with sources of pressure cannot be linked.

According to Arkansas directors, several aspects of the organizational structure within their agencies were conducive to change. They reported having mostly adequate resources in terms of building facilities and offices as well as access to quality training resources. Directors reported that deficiencies in terms of resources were primarily related to their computer equipment and other technology resources. Staff responses on the use of computer technologies confirm this deficiency; for example, less than half of the staff surveyed reported daily use of e-mail, Internet, or voice mail systems.

Overall, directors perceived their agency environment favorably, characterized by a clear agency mission, openness, and good communication. Directors viewed themselves as growth-oriented and influential among their staff. Such an environment seems ideal to incorporate several of the findings from this report. For example, the professional development of the many new and/or inexperienced workers currently in the field is especially needed to retain those workers. Non-monetary sources of support have been suggested by Arkansas workforce staff. Given that directors perceived difficulties in recruiting qualified staff, mostly due to a lack of funding, mentoring activities could occur within agencies to facilitate skill development of inexperienced staff and again, promote retention of qualified workers. Promoting a supportive and creative work environment, in which counselors feel they have a voice in the daily organizational functioning, may also help to offset sources of job dissatisfaction and barriers to entering the field (e.g., low salary levels, stigma associated with the work).

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## **Footnote**

<sup>1</sup>The state of Kansas is also in the Mid-America ATTC region. Under the leadership of Donna Doolin, Director for the State's Addiction and Prevention Services, the Kansas Addictions Workforce Study was conducted in 2002. Dave Kingsley, PhD, with GRI Research and Training, LLC, was responsible for the design and implementation of the survey project for Kansas. Dr. Kingsley modified the original Northwest Frontier ATTC Workforce Survey in terms of the measurement of items and scale construction. Mid-America ATTC utilized changes incorporated by Dr. Kingsley to survey the Arkansas, Missouri, and Oklahoma addiction treatment workforce. To view Mid-America ATTC's Workforce Survey as well as an electronic version of this report go to [www.mattc.org](http://www.mattc.org).

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## Addendum Regional Comparisons

In an effort to capture the “current status” of the addiction treatment workforce development needs in the Mid-America ATTC region, three of the four states in the region were surveyed: Arkansas, Missouri, and Oklahoma. Seventy-four agency directors and 447 treatment staff responded to the survey. An abbreviated review of the results is provided below with particular attention given to both the similarities and the differences that emerged among the three states.

### Workforce and Clientele Profiles

Regionally, females comprised more than half the workforce staff and approximately 40% of the directors. Staff members and directors were primarily Caucasian. The ethnicity/race ratio of treatment staff to client was compared among the three states. In Oklahoma, for example, 17.7% of their staff and 11.8% of their directors were American Indian/Alaskan Native, which was similar to the percentage of clients served in this state that were American Indian/Alaskan Native (21.8%). The opposite trend was found for Missouri. Although 27.9% of the clients were African American, only 10% of staff members were African American.

| <b>Table 1. Percentage of Workforce Time at Current Setting</b> |          |           |          |           |          |           |
|---|----------|-----------|----------|-----------|----------|-----------|
| Range of Time   | Arkansas |           | Missouri |           | Oklahoma |           |
|   | Staff    | Directors | Staff    | Directors | Staff    | Directors |
| Less than 4 years   | 65.9%    | 31.3%     | 50.3%    | 29.2%     | 62.0%    | 26.5%     |
| 10 or more years  | 5.7%     | 43.8%     | 20.4%    | 54.2%     | 11.6%    | 38.2%     |

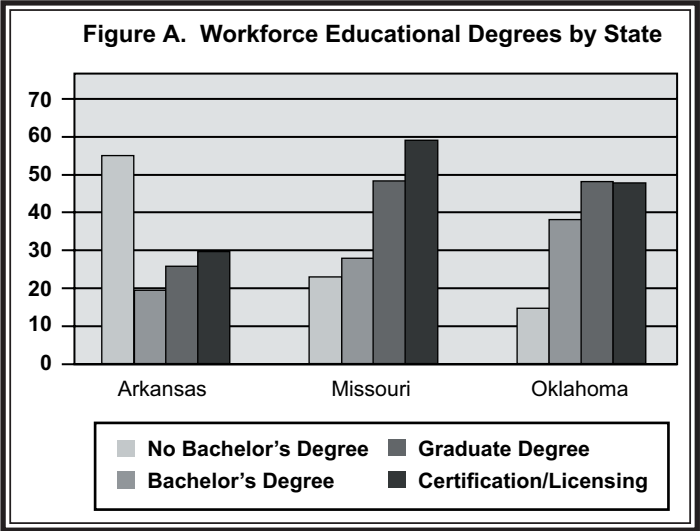
Overall, a higher percentage of directors than staff had been employed in the addiction treatment field for 10 or more years and/or employed at their current work setting 10 or more years (refer to Tables 1 and 2.) Of the three states participating in the workforce evaluation, Missouri’s workforce had been in the field the longest with fewer staff indicating that addiction treatment was a second career. The Arkansas workforce, in contrast, is newer and more inexperienced to the field. The proportion of Arkansas staff members with less than 4 years experience in the addiction treatment field was 45.5%, versus 25.1% for Missouri and 37.2% for Oklahoma.

| Range of Time     | Arkansas |           | Missouri |           | Oklahoma |           |
|-------------------|----------|-----------|----------|-----------|----------|-----------|
|                   | Staff    | Directors | Staff    | Directors | Staff    | Directors |
| Less than 4 years | 45.5%    | 6.3%      | 25.1%    | 4.3%      | 37.2%    | 5.9%      |
| 10 or more years  | 17.1%    | 87.5%     | 42.4%    | 78.3%     | 28.7%    | 70.6%     |

The average age of treatment staff and directors was fairly consistent throughout the region. Both Arkansas and Missouri have staff with similar age ranges, with the average age being 45 years. The staff age range in Oklahoma was slightly older (between the ages of 23 and 75) with 47 being the average age. As expected, age ranges for the directors were slightly higher. Arkansas directors had the highest age range (between the ages of 46 and 64), with 53 as the average age. These results suggest the importance of leadership building and support of the established staff members as well as mentorship for the newer, inexperienced workforce.

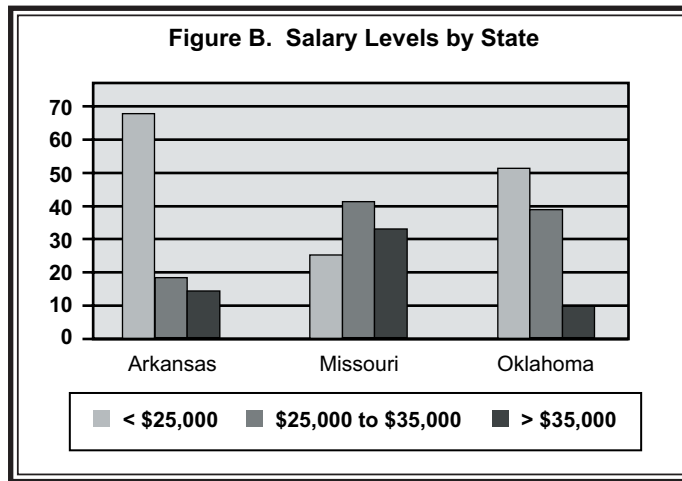
**Professional Background Characteristics**

Arkansas had a significantly lower proportion of treatment staff with graduate degrees and certificates/licensures compared to Missouri and Oklahoma (see Figure A). It is important to note that types of certification, education, and work experience that are required to practice are different across states. However, if educational degrees and credentials can be viewed as indicators of expertise in the addiction treatment field, Arkansas staff ranked behind Missouri and Oklahoma.



## Workplace Salary and Benefits

Salary ranges differed significantly across the three states even though the states are considered one region in terms of proximity (e.g., geographically close). In both Arkansas and



Oklahoma, a higher percentage of staff earned less than \$25,000 annually than did Missouri staff (see Figure B). Data from this report indicated that salary and education are strongly related. As Arkansas staff reported lower educational attainments, more of these same counselors fell into the lower salary range levels than those in Missouri and Oklahoma. In addition, agency directors made significantly more money than their staff across the three states, and in some cases the differences in

annual salaries were striking. For example, Arkansas directors' modal salary range was three times that of their staff.

Several workplace support systems were in place for staff across the region. These activities included direct supervision, in-service training, and in-house mentoring. Interestingly, discrepancies between staff and directors' endorsement of whether these activities occurred were found. Specifically, staff members endorsed fewer occurrences of these support activities than did their directors. The biggest disagreement between staff and directors was found in whether agencies paid for continuing education for staff; a higher percentage of directors indicated this was the case than staff, particularly in the states of Missouri and Oklahoma.

## Service Provision

In terms of overall staff time spent in various work duties, findings from this report suggest that workforce staff members were not a uniform group of counselors, but were comprised of smaller subgroups of counselors that spent their time in different ways. A subgroup of counselors exist who primarily perform individual counseling services whereas another subgroup is more likely to divide their time equally among several work activities. Table 3 shows a breakdown of the percentage of staff time afforded to different work activities during a typical week. Overall, minimal staff time was spent in family counseling activities, clinical supervision, case management, and administrative activities.

|                           | Arkansas | Missouri | Oklahoma |
|---------------------------|----------|----------|----------|
| Family counseling         | 3.3%     | 2.9%     | 3.2%     |
| Clinical supervision      | 4.1%     | 4.1%     | 2.9%     |
| Administrative activities | 9.9%     | 9.9%     | 5.7%     |
| Screening and assessments | 11.0%    | 14.5%    | 15.5%    |
| Case management           | 11.2%    | 6.3%     | 9.0%     |
| Group counseling          | 15.0%    | 16.0%    | 19.6%    |
| Documentation             | 16.5%    | 15.7%    | 17.1%    |
| Individual counseling     | 25.2%    | 29.9%    | 23.5%    |

Many of the recommended “best practices” in the field were endorsed as primary treatment models in agencies across the region. The top four treatment models that were reported included relapse prevention, 12-Step, solution focused, and cognitive-behavioral therapies.

## Workforce Skills and Training Needs

A majority of the staff across all regions indicated being unfamiliar with the nationally defined Addiction Counseling Competencies (CSAT, 1998); with 72.6% of Arkansas staff, 60% of Missouri staff, and 69% of Oklahoma staff indicating a lack of familiarity.

Staff rated their workforce skills favorably. In particular, they felt confident in their counseling microskills and addiction-specific intervention skills. The lowest confidence levels concerned skills for working with clients with co-occurring mental health disorders. This is an important finding as most staff reported some work with

|   | Arkansas | Missouri | Oklahoma |
|---|----------|----------|----------|
| Treated clients for COD                     | 55.6%    | 78.4%    | 51.9%    |
| Screen clients for COD                      | 37.9%    | 57.4%    | 47.3%    |
| Diagnosed/formally assessed clients for COD | 23.4%    | 30.5%    | 24.8%    |
| Referred clients to services for COD        | 71.0%    | 81.8%    | 74.4%    |

Note: COD = co-occurring disorders

clients with co-occurring disorders. Missouri staff, in particular, endorsed higher rates of interacting and treating clients with co-occurring disorders compared to Arkansas and Oklahoma (see Table 4). Counselors' lower sense of efficacy when working with clients with co-occurring disorders suggests that support, supervision, and/or mentoring activities may be especially beneficial to promote counselor skill development in this area.

Staff and agency directors indicated in which competency areas staff needed additional training. The top five training requests across the three states are listed in Table 5. The results suggest similar training concerns across the region.

| Rank | Arkansas                         |  | Missouri                   |                            | Oklahoma                   |                                 |
|------|----------------------------------|--|----------------------------|----------------------------|----------------------------|---------------------------------|
|      | Staff                            | Directors                                      | Staff                      | Directors                  | Staff                      | Directors                       |
| 1    | Co-occurring Mental Health       | Co-occurring Mental Health                     | Grief and Loss             | Co-occurring Mental Health | Co-occurring Mental Health | Treatment Planning              |
| 2    | Trauma and Abuse                 | Group Counseling                               | Co-occurring Mental Health | Motivational enhancement   | Trauma and Abuse           | Group Counseling/ Documentation |
| 3    | Group Counseling/ Grief and loss | Documentation Skills                           | Trauma and Abuse           | Drug Pharmacotherapy       | Grief and Loss             | Co-occurring Mental Health      |
| 4    | Motivational Enhancement         | Treatment Planning                             | Motivational Enhancement   | Group Counseling           | Drug Pharmacotherapy       | Gender Specific Treatment       |
| 5    | Drug Pharmacotherapy             | Clinical Supervision/ Screening and Assessment | Drug Pharmacotherapy       | Treatment Planning         | Motivational Enhancement   | Motivational Enhancement        |

Differences were observed between how directors perceived training needs for staff and the type of training staff thought they needed. Across the region, staff requested training for co-occurring disorders, trauma and abuse, grief and loss, and motivational enhancement, whereas the directors' training priorities for their staff included documentation skills, treatment planning, and gender-specific treatment.

## Challenges in the Work Environment

Perceived challenges for the future of the addiction treatment workforce were mostly similar across the region. One particular challenge concerned the stigma or lack of respect for the addiction treatment field in general. The majority of staff rated the field of addiction counseling as lower in professional status than other helping fields. This lower standing was attributed to counselors being stigmatized by their association with substance abusers and/or the assumption that addiction counselors have a history of substance use problems themselves.

Problems with access to current technology were also noted. For example, when questioned about the frequency and methods of communication technology, Arkansas staff reported using voice mail, e-mail or the Internet technologies less often than Missouri and Oklahoma staff.

Finally, the major limitations to recruitment and retention of qualified staff in the field are related to low salaries, perceived status of the field, and a lack of appreciation and validation for work well done. Even though salary issues were considered a primary barrier, staff had several suggestions on how to recruit not only new workforce members, but also to retain established workers in the addiction treatment field. These suggestions were organized in five main categories, including: (a) show staff appreciation and validation, (b) address professional burnout, (c) increase mentorship/ leadership, (d) create a supportive work environment, and (e) increase opportunities for personal and educational growth. In general, suggestions across the three states were more similar than different. Comments from the workforce staff for each of these categories are summarized below:

- ***Show staff appreciation and validation:*** The need for appreciation and validation for staff members' work was often repeated. Arkansas staff members provided these comments: *"Show empathy, concern, and gratitude toward staff"; "Give honor where honor is due"; "Stand up for your employees and show appreciation for their good work";* and, *"Offer incentives and perks that other professional fields don't have."*
  - Comments from Missouri staff around appreciation and validation included the importance of improving or maintaining the *"team mentality of older staff when newer staff members come on board."* Many felt there should be more opportunities for counselors to be *"hands on with staffing and other program decisions."* Simply, staff members would like to be asked for their feedback on agency decisions, especially decisions that will affect their work in the field.

- Methods for showing appreciation and validation according to Oklahoma staff included: “*Facilitate advancement opportunities*”; “*Provide more respect, recognition, and educational opportunities*”; and “*Create a reward system to counter-balance a stressful job environment.*” For one workforce staff member, promoting appreciation and validation may need to come through community education by “*Combating the negative stereotypes with factual information on what ‘we’ really do.*”
- ***Addressing professional burnout:*** The regional workforce voiced a need for “*mental health days,*” to reduce job burnout and/or to promote more anti-burnout strategies within their agencies. This was especially salient for staff in Arkansas who indicated there was a need to work on their own personal concerns: “*Sometimes the counselors need counselors.*”
- ***Increased mentorship/leadership:*** Staff indicated that “*responding to problems workers pose*” and “*encouraging individual thought*” would provide some of the incentives needed to retain staff. Also, providing “*adequate supervision, positive role models, and mentors to support motivation*” were important. Equally important was receiving “*positive feedback, constructive criticism, and reinforcement.*”
- ***Supportive work environment:*** A supportive work environment for some of the staff included reducing client caseloads so they could work more effectively. Other suggestions were: “*Encourage healthy management and staff relations*”; “*Create a more family-friendly atmosphere (i.e. flex-time)*”; and “*Promote team problem solving [to] minimize the roadblocks [and] quickly fix small problems in an enthusiastic and positive way.*” For some workforce staff, professional ethics needed to be addressed. For example, agency principles and norms could be used to manage staff conflict and promote a supportive work environment.
- ***Increased opportunities for personal/professional growth:*** Staff indicated they wanted to have “*professional encouragement*” to support their growth. To do so they suggested “*more training and retreats*” be available. Counselors also suggested that maintaining a positive attitude was important, and they should be reminded about “*their motives for entering the field.*”

## **Job Satisfaction**

Despite barriers to entering the addiction treatment field and recruitment/retention difficulties, staff members and directors across the region reported being satisfied with several aspects of their work. Sources of job satisfaction for staff were centered on their daily work with clients. One-to-one interaction with clients was very highly rated, with almost all staff members satisfied with this aspect of their work. For agency directors, aspects of their work that involved learning, influence, and growth were considered most appealing.

Staff members consistently reported low satisfaction with their employee benefits. Very few staff members received retirement benefits, and less than one-half of staff received full health insurance benefits. This was not the case with directors; however, the majority indicated they were satisfied with their employee benefits.

## **Recommendations**

Several regional recommendations can be derived from data found in this report. Staff and directors provided insightful suggestions for future workforce development needs including:

- Incorporate mentoring activities to promote staff members' skill development, in particular, for the areas they felt less efficacious.
- Center training needs around co-occurring mental health disorders for staff members and build relationships with external funding resources for directors.
- Address discrepancies between staff and directors about perceived training needs and agency support systems by fostering a bi-directional communication system.
- Emphasize non-tangible work rewards.
- Increase recruitment efforts for younger and minority candidates to enter the workforce.
- Reinforce leadership and support of the established staff as well as mentorship for the newer, inexperienced workforce.