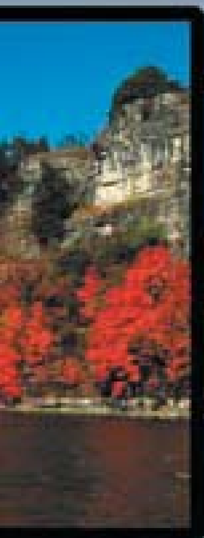
Substance Abuse Treatment Workforce Survey Report

2004



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Missouri Addiction Treatment Providers

Missouri Department of Mental Health, Division of Alcohol & Drug Abuse

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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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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 Missouri. The content of this report is organized around five guiding questions: (a) What are the characteristics of the Missouri 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 Missouri? The first portion of this report provides a summary of the major findings.

Summary of Characteristics of the Missouri Addiction Treatment Workforce

Gender: Females comprised a majority of workforce staff (55.0%) and directors (60.9%).

Race/Ethnicity: Both staff (85.3%) and directors (87.0%) were predominantly Caucasian.

Age: Staff ranged in age from 24 to 69 years, with an average age of 45.80 years and a median age of 47.24 years. Directors ranged in age from 33 to 63 years, with an average age of 49.92 years and a median age of 50.15 years.

Work Experience: More directors than staff have worked in the field of alcohol and drug treatment (78.3% vs. 42.4%) and at their current work setting (54.2% vs. 20.4%) for 10 or more years.

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

Education: Almost half (47.9%) of the workforce staff, and 70.8% of the directors had a graduate degree.

Salary Distribution: The modal salary range for staff was $25,000 to $34,999 in comparison to $50,000 to $74,999 for directors.

Certification status: Over half (58.6%) of the addiction treatment staff, and 41.7% of the directors were currently certified or licensed to provide addiction treatment services.

Summary of Services Provided by the Missouri 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 spent most of their time in direct service activities such as individual (29.9%) or group counseling (16.0%); however, paperwork and documentation activities (15.7%) also constituted a high percentage of weekly hours. Directors spent most of their time in administrative duties (77.5%).

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: Treatment providers were utilizing evidence-based practices—such as relapse prevention and cognitive-behavioral skills therapy as opposed to an exclusive focus on 12-Step models of treatment.

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

Skills and Training Needs of the Missouri Addiction Treatment Workforce

TAP 21 Addiction Counseling Competencies: The majority of treatment staff (60%) 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, psychopharmacology, and motivational interviewing were rated as three of the top five training needs by both staff members and agency directors.

Supports and Stressors for the Missouri Addiction Treatment Workforce

Job Retention: Staff members and agency directors agreed that improvements in salaries and employee benefits were two things that would improve job retention. These would be followed by individual recognition and more training opportunities.

Agency Support Systems: A majority of the staff and the 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 the staff, satisfaction with direct service work was higher than with the conditions of employment (i.e, salary and benefits).

Barriers: Low pay, stigma associated with addiction, and competition from other fields were the top three barriers to recruitment perceived by both directors and staff. Directors noted the difficulties of finding applicants with the appropriate experience and/or education.

Consultation Needed: Directors thought they most needed technical assistance in three areas: teaching staff about client assessment, learning to use assessments to document program effectiveness, and raising the overall quality of counseling.

Pressure for Change: Directors reported that the strongest pressures for changes in their agencies came from funding entities.

Adequacy of Work Resources: Directors reported that their greatest need was more qualified staff.

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.

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.

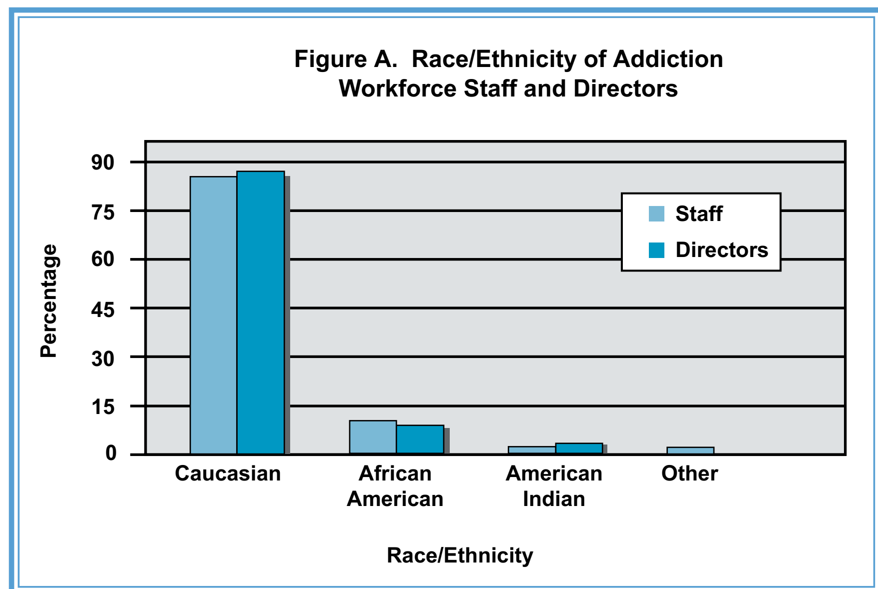
The survey instrument used in this study was a modified version of a workforce survey originally developed by RMC Research Corporation for the Northwest Frontier ATTC. The Mid-America ATTC adapted the survey based on feedback from addiction educators, training directors, certification and licensing authorities, 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[1]. Each of the three Single State Authorities endorsed the project, including Michael Couty, Director of the Missouri Department of Mental Health, Division of Alcohol and Drug Abuse. Endorsement letters were included as cover pages for the surveys.

Agencies were randomly 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, 40% of the Missouri agencies (n = 76) were randomly 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 443 surveys were sent to Missouri staff and directors. Follow-up efforts resulted in the receipt of 192 staff surveys (48% response rate) and 24 agency director surveys (55% response rate), representing 63 treatment agencies in Missouri.

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

In this section of the report, the demographic characteristics of Missouri 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 also provided.



Demographics

Females comprised more than half (55.0%) of the workforce staff and 60.9% of the directors. Staff members were primarily Caucasian (85.3%) with 10% as African American, 2.1% as American Indian, 0.5% as Asian, and 2.2% as multiethnic or other (refer to Figure A). Directors were identified as Caucasian (87.0%), African American (8.7%), and American Indian (4.3%). None of the staff or directors reported their ethnicity as Hispanic.

Age Range

Staff ranged in age from 24 to 69, with 71.2% being at least 40 years of age (see Table 1). Directors ranged in age from 33 to 63 years, with over 80% being at least 40 years of age.

Table 1. Age Distribution of Addiction Workforce Staff and Directors

Age	Staff		Directors	
	*Frequency	Percent	*Frequency	Percent
20-29	21	11.4%	--	--
30-39	32	17.4%	3	13.6%
40-49	58	31.5%	9	40.9%
50-59	57	31.0%	9	40.9%
60+	16	8.7%	1	4.5%
	* Missing data = 8		* Missing data = 2	

Work Experience

A higher percentage of directors (78.3%) than staff (42.4%) 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 (54.2%) than staff (20.4%) reported being at their current work setting 10 or more years. Notably, half (50.3%) of the treatment staff worked in their current agency for less than 4 years, and 25% 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.

Over one-third (37.0%) of the Missouri staff indicated that addiction treatment was a second career. Previous employment areas were quite diverse, ranging from law enforcement and education, for example, to farming and construction work.

Table 2. Work Experience of Staff and Directors

Range of Time	Time at Current Work Setting		Years in A/D Treatment Field	
	Staff *Frequency/ (Percent)	Directors Frequency/ (Percent)	Staff *Frequency/ (Percent)	Directors Frequency/ (Percent)
Less than 4 years	96 / (50.3%)	7 / (29.2%)	48 / (25.1%)	1 / (4.3%)
4 to 9 years	56 / (29.3%)	4 / (16.7%)	62 / (32.5%)	4 / (17.4%)
10 or More years	39 / (20.4%)	13 / (54.2%)	81 / (42.4%)	18 / (78.3%)

* Missing Data: Time at Current agency: Staff (1); Years in Addiction Treatment Field: Staff (1) Directors (1)

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 members 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). Nearly two-thirds of the directors cited a personal interest in the field as a motivator to work in the area of addiction treatment, whereas one-third indicated that they had joined the workforce because of experience in a similar field.

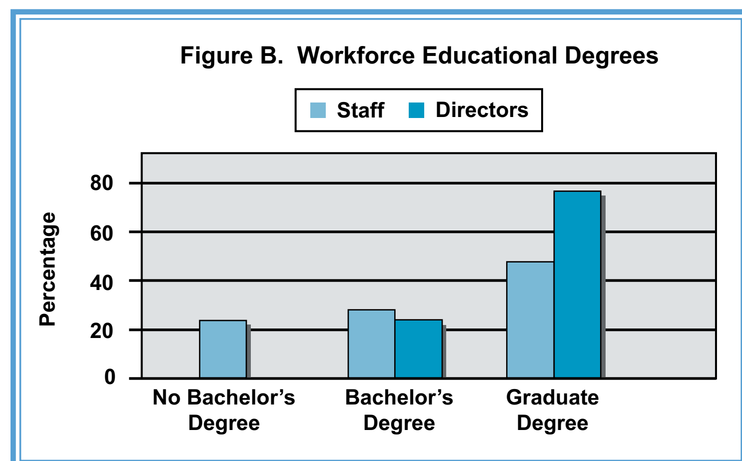
Table 3. Reasons for Entering Addiction Treatment Field

Potential Reasons	Staff		Director	
	Frequency	Percent	Frequency	Percent
Personal/family experience with addiction and/or recovery	109	57.1%	3	12.5%
Personal interest	106	55.5%	9	62.5%
Experience in similar field	56	29.3%	9	37.5%
Academic work/degree in a similar field	56	29.3%	4	16.7%
Unplanned decision	49	25.7%	4	16.7%

Education and Certification Status

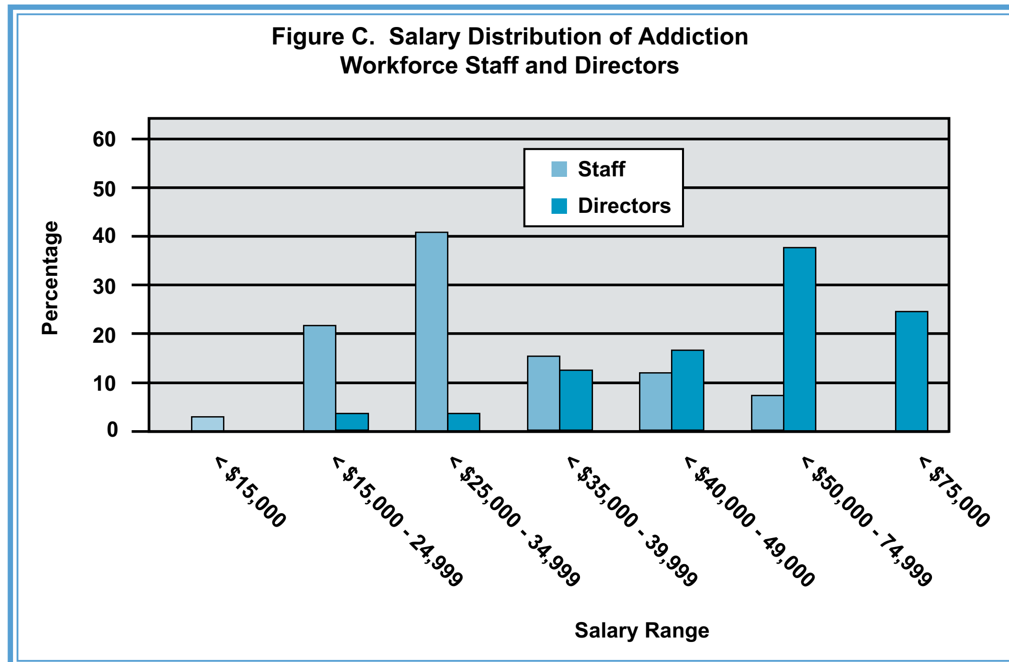
Almost half of the staff (47.9%) and a majority of the directors (70.8%) held a graduate (masters or doctoral) degree (refer to Figure B). These findings mirror those in other regions of the United States (e.g., Mulvey, Subbard, Hayashi, 2003), suggesting that the addiction treatment workforce is more educated than once believed. A little over half (58.6%) of the addiction treatment staff and 41.7% of the directors were certified or licensed in the addiction treatment field at the time of the survey.

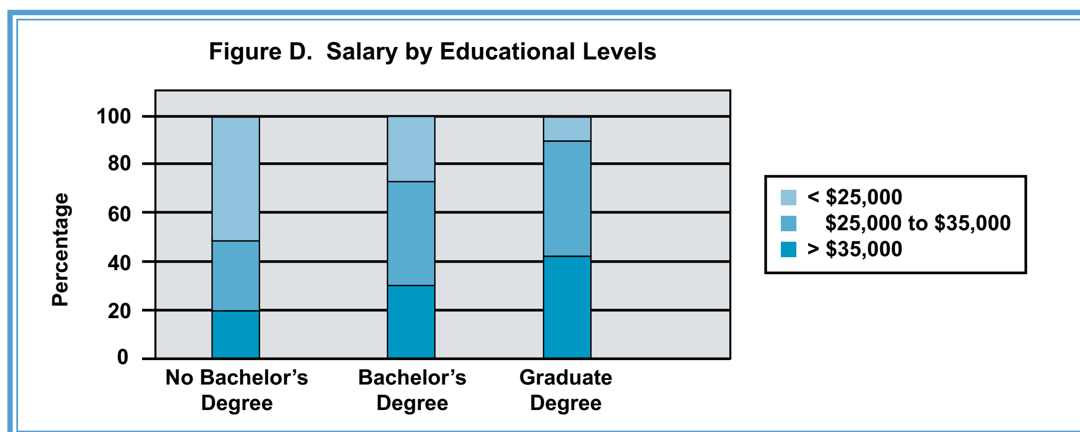
Figure B. Workforce Educational Degrees



Salary Distribution

The most frequent salary range for Missouri staff was between $25,000 and $34,999 (refer to Figure C), and the majority of those staff (60%) who earned more than $35,000 annually, made between $40,000 and $49,999. In comparison, the most frequent salary range for directors was between $50,000 and $74,999, double the modal salary of staff. Education levels were strongly associated with salary (see Figure D). For example, over half (52.2%) of the workers without bachelor's degrees were earning less than $25,000 per year, compared to 27.5% of those with bachelor's degrees and 10.3% of those with graduate degrees.





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.

Table 4. Staff Benefits that are Fully or Partially Provided by Employer

Type of Benefit	Full Benefits	Partial Benefits
	*Frequency / (Percent)	*Frequency / (Percent)
Sick Leave	141 / (73.8%)	27 / (14.1%)
Other Paid Leave	123 / (64.4%)	31 / (16.2%)
Health Insurance	81 / (42.6%)	91 / (47.9%)
Retirement Options	55 / (28.8%)	69 / (36.1%)

*Missing data = 2

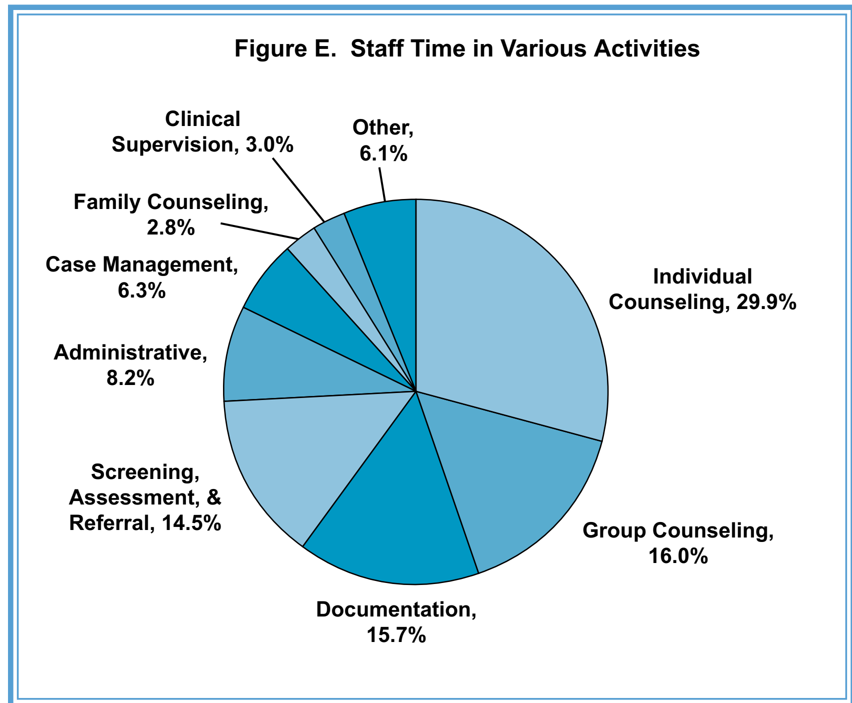
III. *What Services are Being Provided by the Workforce and to Whom?*

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

Missouri treatment staff reported spending the largest amount of time performing individual counseling (29.9% of work hours), followed by group counseling (16.0%), documentation (15.7%), and screening or assessments (14.5%) (see Figure E). For directors, a mean of 77.5% of work time was reserved for administrative activities with 20.9% of their time devoted to direct service.

Figure E. Staff Time in Various Activities



Further analysis of the reported work time indicated five distinct groups of *work profiles* including: (a) staff who primarily provided individual counseling (35.5% of participants), (b) staff who primarily provided group counseling (13.4%), (c) staff who performed a variety of job activities equally (31.7%), (d) staff who mostly carried out administrative duties (7%), and (e) staff who primarily conducted screening/assessment services (12.4%). For the most part, there were no differences between these five groups of workers in terms of demographic or professional background characteristics. One exception to this was those whose primary role was individual counseling; they tended to be more educated than those in the other four groups. This may well be a function of requirements by the insurance industry for a certain level of credentials for reimbursement of therapy services.

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

To gain more insight into the specific types of client issues in which staff members were involved, they 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.

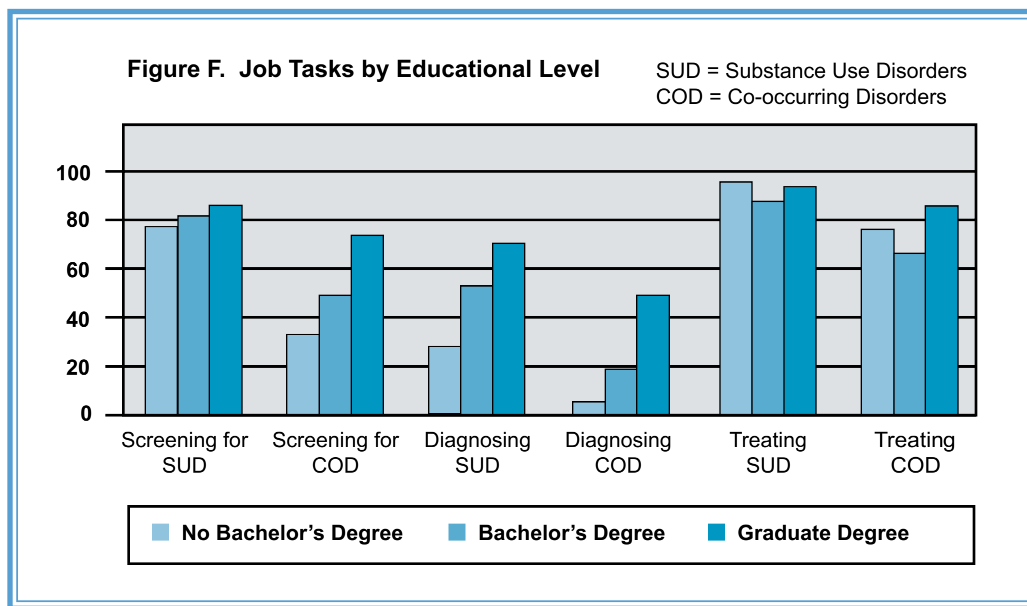
Note that these findings also underscore the significant amount of time that treatment staff spends working with clients who have co-occurring mental health problems. Directors' reports confirmed that an average of 54.2% of clients in their agencies were treated for alcohol and/or drug problems, and 41.7% of clients were treated for a co-occurring mental health disorder. Thus, workers in Missouri 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…	177	93.2%	149	78.4%
Screened clients for…	159	83.7%	109	57.4%
Diagnosed/formally assessed clients for…	106	55.8%	58	30.5%
Referred clients to services for…	133	70.0%	154	81.1%

*Missing data = 2

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 are equally likely to be involved with treating individuals with both substance use and co-occurring mental health disorders, and most workers are 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 a co-occurring mental health disorder. Finally, whereas most of the 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 be involved in screening for co-occurring mental health issues.



Models of Treatment

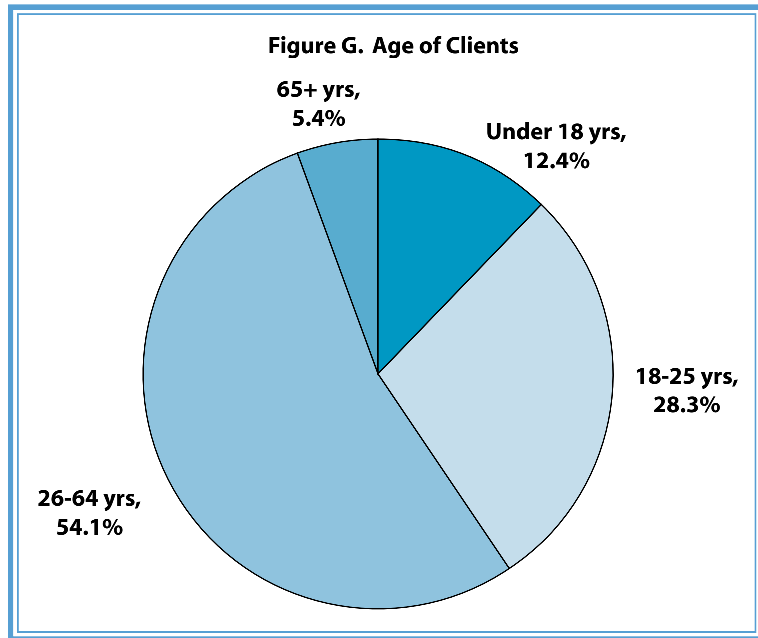
Staff members indicated which therapeutic models played a major role in their agency's treatment approach (refer to Table 6). The models most frequently reported in Missouri were *Relapse Prevention* (84.7%), *12-Step* (68.8%), *Solution Focused* (58.7%), and *Cognitive-Behavioral Skill Development* (50.8%) therapies. According to these results, Missouri 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

Models	% of staff endorsing the model as primary in their agency
Relapse Prevention	84.7
12-Step	68.8
Solution Focused	58.7
Cognitive-Behavioral Skill Development	50.8
Reality Therapy	40.7
Community Reinforcement	37.2
Therapeutic Community	33.0
Family Therapy	30.7
Behavioral Modification/Token Reinforcement	30.2
Harm Reduction	26.5
Rational Emotive Therapy	25.9
Motivational Enhancement Therapy	23.3
Gender Specific	19.1
Developmental Model	17.5
Pharmacotherapy	15.1
Culture Specific	11.6
Dialectical Behavior Therapy	11.6
Minnesota Model	9.0
Methadone Maintenance	7.7

Clientele Characteristics

Within agencies, each staff member worked with an average number of 34 clients per month with a range of 6 to 120 clients per staff member. More than half (54%) of the clients were between 26 and 64 years of age (see Figure G), and approximately two-thirds of clients were male. Client race/ethnicity was similiar to that of the treatment staff. Clients were primarily Caucasian (64.6%) with African Americans (27.9%) being the second most frequently served group. Hispanic (3.5%) and multiethnic (2.05%) clients were less frequently seen, and the number of American Indian and Asian clients was less than 1%.



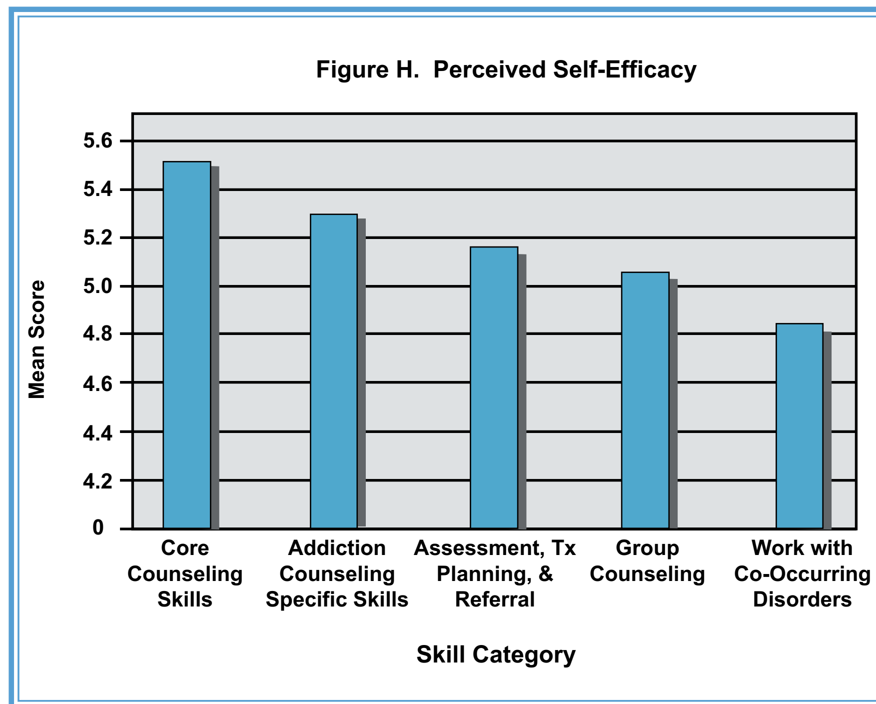
Primary service areas in Missouri were categorized as rural (58.3%), suburban (20.8%), or inner city (20.8%). Almost half of the addiction treatment programs surveyed were outpatient (45.8%). Many directors (66.7%) indicated that the number of clients served in their setting was steadily increasing rather 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 Missouri. 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 40% indicated *Yes* that they were familiar with the competency guidelines. Of those who were familiar with the guidelines, 76% *agreed or strongly agreed* that they utilized these competencies to guide their professional development. An almost equal number (52.7%) also indicated using the competencies for self-assessment and to improve treatment outcome (54.1%).



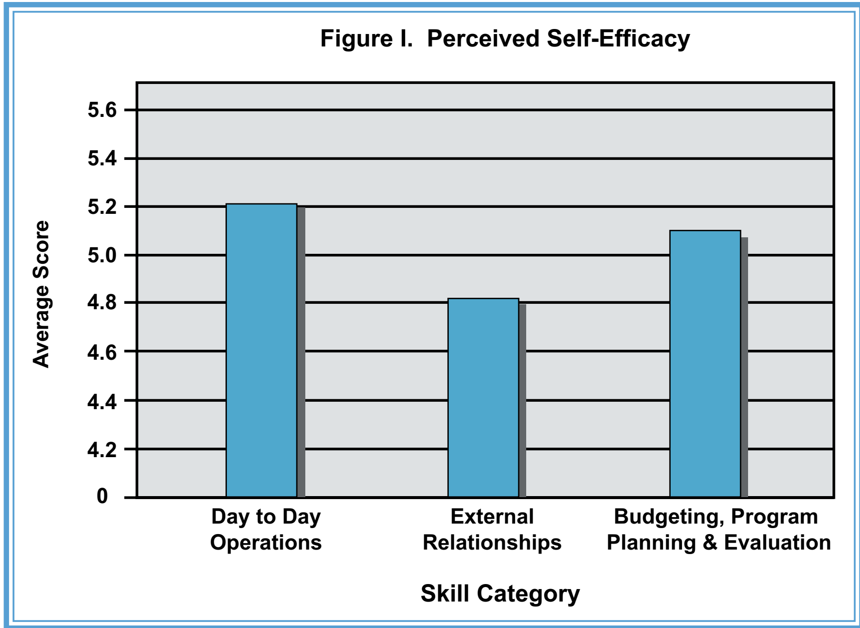
Workforce Skills and Perceived Self-Efficacy

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 (a*bsolute 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).

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 5.52 (*SD* = .52). 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 5.30 (*SD* = .58). 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 4.85 (*SD* = .82).

The only significant difference that emerged in terms of group comparisons by educational level or whether staff members were certified or not was found in the co-occurring disorders category. Specifically, staff members with graduate degrees reported significantly higher efficacy levels for work in this area than those without graduate degrees. Recall that this same group is more likely to spend their time in individual counseling as well as providing assessments for clients with co-occurring disorders. Surprisingly, no significant differences were found in any of the five skill categories between those staff members who were certified or licensed in the field and 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. Reponses 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 budgeting, program planning, and evaluation skills (e.g., budget and manage treatment program finances, document program effectiveness).

An analysis of the individual items suggests two specific skills in which directors felt much less efficacious: negotiating with insurance industries, ($X = 3.67$, $SD = .60$) and advocating to policy makers ($X = 4.13$, $SD = .58$). In contrast, none of the other 24 skills had a mean rating below 4.50, and 17 of the 26 skills had a mean score of 5.00 or above. These results suggest a high level of perceived self-efficacy in most of the leadership skills.

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 motivational enhancement, drug pharmacotherapy, and co-occurring substance use and mental health disorders as top training priorities. Recall that staff members also rated their skills for working with clients with co-occurring disorders as 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, spirituality and recovery, and grief and loss were also rated highly, whereas directors wanted their staff to be trained in documentation, treatment planning, and gender-specific treatment. These differences are noteworthy, as staff members reported higher confidence levels for their treatment planning and documentaion skills, for example, and did not view treatment planning nor documentation as priorities for future training.

Table 7. Training Needs According to Staff and Directors

Competency areas	% Endorsement as a Training Need	
	Staff	**Directors**
Grief and loss	54.5	45.8
Co-occurring substance use and mental health	51.8	87.5 **(1)**
Trauma and abuse	46.1	37.5
Motivational enhancement	45.5	79.2 **(2)**
Drug pharmacotherapy	42.9	58.3 **(3)**
Spirituality and recovery	40.8	45.8
Group counseling skills	35.6	58.3 **(4)**
Marriage and family therapy	35.1	45.8
Racial/ethnic treatment	34.0	37.5
Offender treatment	30.9	41.7
Lesbian/gay/bisexual specific treatment skills	28.8	41.7
Intervention	28.8	45.8
Treatment planning	28.3	58.3 **(5)**
Documentation skills	28.3	87.5 **(1)**
Detoxification	26.7	41.7
Prevention strategies	26.2	25.0
Adolescent treatment skills	26.2	16.7
Gender specific treatment	23.0	54.2 **(6)**
Clinical supervision	23.0	20.8
Administrative management skills	21.5	29.2
Screening and assessment	20.9	33.3
Elder/senior specific treatment	17.8	29.2
Professional and ethical responsibilities	14.1	45.8
Personnel management skills	13.6	16.7
Patient placement criteria	11.0	25.0
Referral skills	9.9	29.2

Finally, almost all of the staff (93%) had completed a continuing education training or workshop during the past year including 91.2% of those who were not certified and 94% of those with current certifications. The average reported number of continuing education hours overall was 22.27 (*SD* = 17.77). Those not certified attended an average of 16.57 hours (*SD* = 15.45) during the prior year versus 25.46 hours (*SD* = 18.25) 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

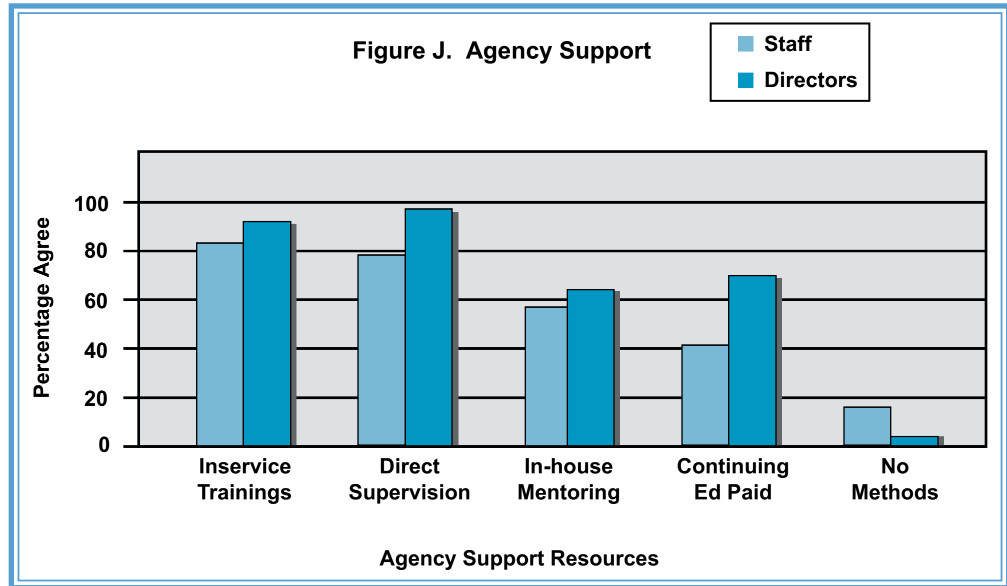
Staff and directors were asked how their agencies could keep qualified counselors from leaving the field (see Table 8). Reponses to 17 job retention strategies were clustered into three different categories: (a) better staff compensation, (b) better agency leadership and "climate," and (c) better working 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 to retain qualified staff. Although such efforts may be difficult given current financial constraints and 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 was highly rated by staff in this study.

Table 8. Job Retention Strategies

My agency can do the following to better retain qualified staff...	**% Strongly Agree or Agree**	
	Staff	**Directors**
More frequent salary increases	87.9	75.0 **(1)**
Better health coverage and benefits	73.7	62.5 **(2)**
More individual recognition/appreciation	71.2	58.3 **(3)**
More ongoing training	70.6	58.3 **(3)**
Increase staff opportunities for input	68.1	41.7
Promote career growth	66.7	50.0
More frequent promotions	62.1	62.5 **(2)**
Provide assistance with paperwork	60.0	62.5 **(2)**
Smaller client caseloads	51.6	50.0
Provide more varied work opportunities	48.2	41.7
More supportive agency culture	46.9	29.1
Better management	46.1	16.7
Improved physical work environment	44.0	25.0
Shorter work hours (flex time, job sharing)	41.9	45.9
Better supervision	35.8	16.7
Less management and supervision	11.6	00.0

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 activities available. Less than half (41.5%) of staff members agreed that their agency paid for continuing education, whereas 70.8% of their directors agreed this was the case. Also, fewer staff members than directors agreed that direct supervision was provided in their agency.



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 many technologies except audio teleconferencing (see Table 9).

Table 9. Utilization of Communication Technology by Workforce Staff

Communication Method	Very Rarely or Never *Frequency / (Percent)	Monthly *Frequency / (Percent)	Weekly *Frequency / (Percent)	Daily *Frequency / (Percent)
Computer	19 (10.1%)	5 (2.6%)	22 (11.6%)	143 (75.7%)
Voice Mail	64 (33.9%)	10 (5.3%)	18 (9.5%)	97 (51.3%)
E-mail	51 (27.0%)	12 (6.3%)	19 (10.1%)	107 (56.7%)
Audio Teleconferencing	159 (84.1%)	14 (7.4%)	7 (3.7%)	9 (4.8%)
Internet	49 (34.4%)	16 (8.5%)	32 (16.9%)	92 (48.7%)

*Missing data = 4

Job Satisfaction

Table 10. Job Satisfaction		
How satisfied are you with...	% Mostly Satisfied or Satisfied	
	Staff	Directors
One-to-one interaction with clients	93.1	65.2
Agency/co-workers	75.4	75.0
Role as a change agent	71.4	79.1
Opportunities for personal learning and growth	59.9	87.5
Career growth opportunities	48.2	79.2
Ability to influence agency decisions	35.1	75.0
Salary/benefits	35.1	66.7
Overall satisfaction with job	78.3	95.8

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.

VI. What are the Challenges to the Future Workforce?

This final section reports on various workforce challenges in Missouri. 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 Missouri 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

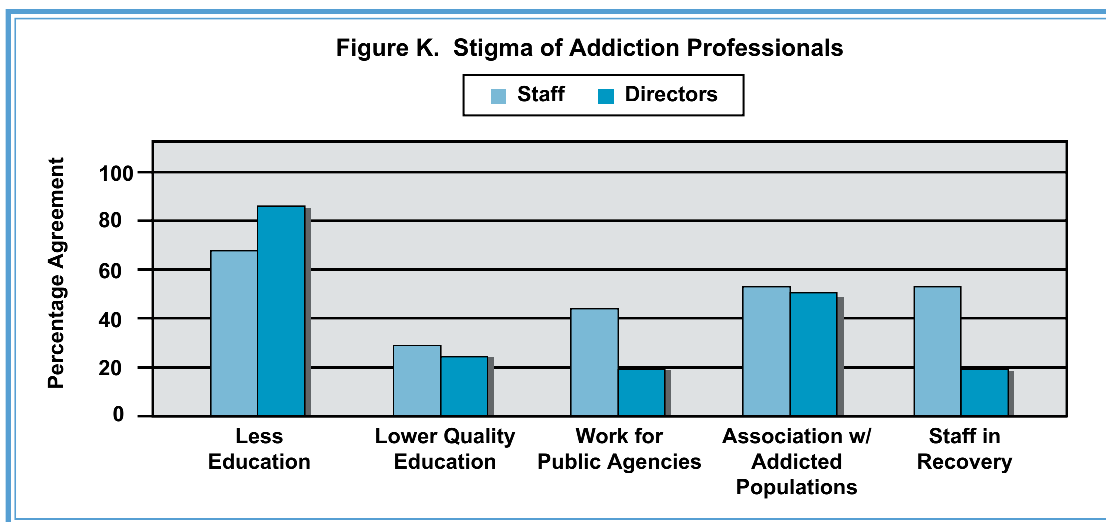
People decide not to enter the A/D treatment field because of...	% Strongly Agree or Agree	
	Staff	Director
Low salary/poor benefits	86.8	75.0 **(3)**
Negative preconceptions regarding clients and chemical dependency (e.g., difficult to work with; don't want to change)	78.2	83.3 **(1)**
Competition from other fields (in terms of compensation)	74.2	79.2 **(2)**
Large caseloads	63.7	62.5 **(5)**
Evening and weekend hours	60.3	75.0 **(3)**
Stigma/lack of respect for the field	59.5	50.0
Perception that A/D treatment is not effective	58.2	50.0
Paperwork	52.9	50.0
Perception that A/D treatment is not a "real" profession	49.8	54.2
A lack of encouragement (e.g., from educators, family, or friends)	49.5	70.9 **(4)**
Quality of work environment in terms of professionalism	44.0	29.1
Cost of training/education	41.3	29.1
Amount of training/education	36.3	37.5
Treatment models are not tailored to needs of racial/ethnic groups	16.4	25.0
Geographic constraints	12.1	33.4
Discrimination (e.g., disability, ethnicity, or gender)	5.8	4.2

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 (see 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, and there was a tendency for those with the highest levels of education to most likely see salary as a barrier. For example, 89.3% of those with graduate degrees and 86% of those with bachelor's degrees *agreed* or *strongly agreed* that it was a barrier versus 76.1% of those without a bachelor's degree. Additional barriers centered on negative preconceptions about the field, clients served, a work environment characterized by heavy client caseloads, and poor working hours.

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 (62.5%) and staff (67.4%) 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 education levels, stigma due to an association with addicted populations, and the greater likelihood that treatment staff members have a history of addiction themselves.



Recruitment Difficulties

Another challenge to the field is recruiting qualified addiction counselors. Half of the Missouri directors surveyed said they had difficulty filling open job positions at their agency. Reasons for these difficulties included an insufficient amount of funding for open positions (75.0%) and/or staff disinterest due to the salary offered (66.7%). Further reasons included a small applicant pool because of the rural location of the agency (58.3%) or lack of interest due to the nature of the work (41.6%). The primary reason indicated by directors, however, was that applicants did not meet the minimum qualifications necessary for the position (91.7%). Table 12 suggests reasons why directors felt applicants were not meeting minimum qualifications.

Table 12. Recruitment Difficulties

Applicants do not meet minimum qualifications because they...	% Strongly Agree or Agree
Have little or no experience in A/D treatment	77.2
Have insufficient or inadequate education or training	77.2
Lack practical or applied skills	68.2
Lack appropriate certification/licensure	63.6
Lack social or interpersonal skills	50.0

Agency Change

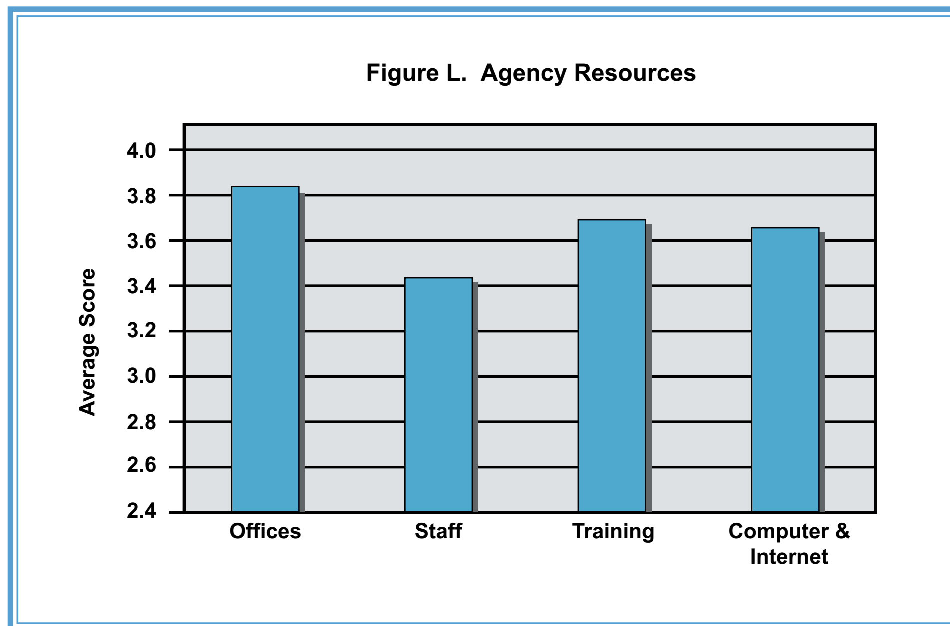
Simpson (2002) provided a conceptual model of factors involved in organizational change within the addiction treatment field. Included in the model are different motivations for change (e.g., program and training needs) and various internal/external pressures for change (e.g., funding sources, clients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

Table 13. Agency Change

Technical Assistance/Training Needed for...	% Strongly Agree or Agree
Measuring client performance	70.9
Raising the overall quality of counseling	70.8
Using client assessments to document program effectiveness	70.8
Using client assessments to guide clinical and program decision-making	66.7
Increasing program participation by clients	58.4
Matching client needs with services	50.0
Assessing client needs	45.8
Pressures for Change Come from...	**% Strongly Agree or Agree**
Funding and oversight agencies	82.6
Accreditation or licensing authorities	73.9
Program supervisors or managers	69.6
Program staff members	60.9
Clients in the program	56.5
Program board members	8.7
Community action groups	4.3

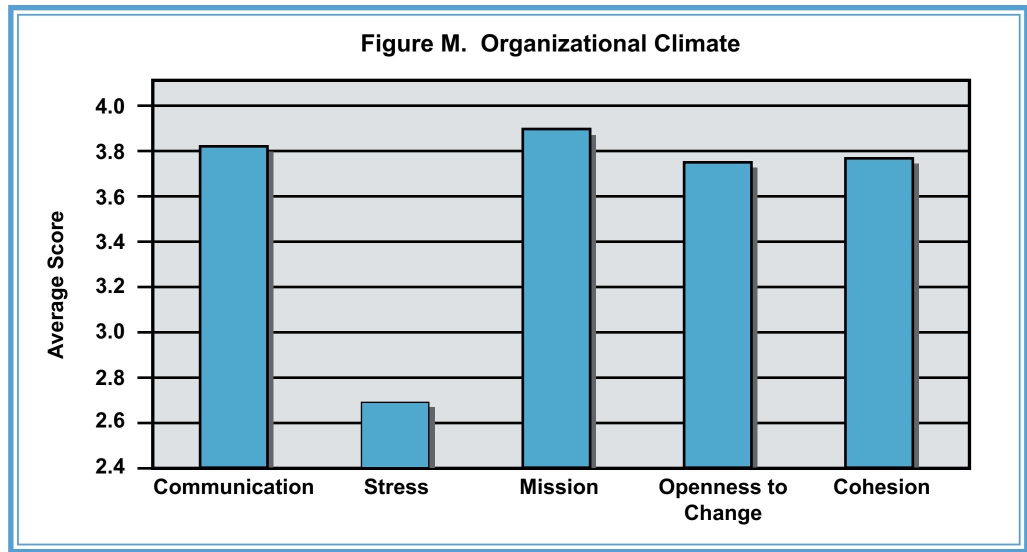
According to Missouri directors, the highest priority areas for program change included: (a) measuring client performance, (b) raising the overall quality of counseling, and (c) using client assessment to document program effectiveness (see Table 13). Directors perceived the strongest pressures for change coming from: (a) funding or oversight agencies, (b) licensing/accreditation authorities, and (c) program supervisors or managers.

Next, Missouri 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 resources categories were averaged to form a total score in which higher scores indicated more resources. According to Figure L, Missouri directors saw the biggest deficiency in resources as staff availability (X = 3.44, SD = 1.08). Staff availability includes, for example, having enough counselors to meet client needs and having an adequate support staff for program needs.



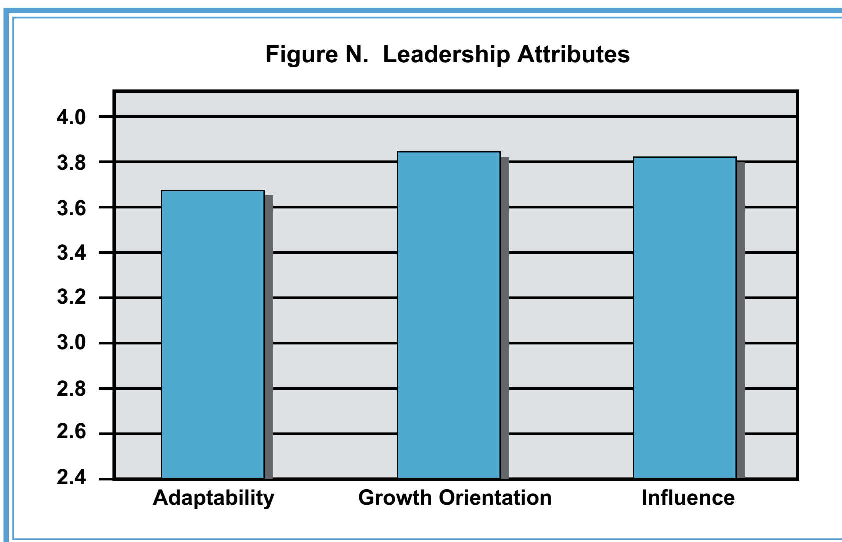
Each director was also asked to rate aspects of the agency climate. According to Simpson's model (2002), certain organizational and workforce attributes are conducive to program change. These climate variables include having a clear agency mission and goals, adequate communication between staff and leadership, 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. Missouri 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, 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 2.69 (*SD* = .99) on a scale of 1 to 5.

Finally, whether organizational change is successful involves various leadership attributes (Simpson, 2002). These characteristics include leaders who are adaptable or flexible to change and initiate new ideas and leaders who 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. Missouri 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.



VII. Conclusions and Recommendations

Section II – Characteristics of the Workforce

Two striking demographic findings include the age of the workforce and the mismatch between demographic characteristics of treatment staff members and clients they work with. For example, the typical addiction treatment staff member is 40 or more years old, Caucasian, and female. In contrast, the typical client is a Caucasian male, and 41% of clients are under 25 years old. In Missouri, there is also a lack of minority staff; in fact, no surveyed member of the Missouri workforce was identified as Hispanic or Latino(a).

Findings from this survey also help to discredit a general myth about the alcohol and drug treatment field. Treatment staff in this study was highly educated, with nearly half the sample having attained a graduate degree. A limitation of this survey, however, is that we are unclear in what educational areas those degrees were obtained.

Education is strongly related to salary. This raises a fundamental question at the heart of the workforce development project: how do we continue to recruit a well-trained workforce when there often 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 (NIDA, 1999). 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.

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, approximately one-third (35.5%) of the staff surveyed primarily provide individual counseling services, whereas an additional one-third (31.7%) of those surveyed 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 57% of staff reported screening for co-occurring disorders, yet 84% 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 (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 Missouri 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 were no more efficacious than those without certification. These results do not necessarily mean that there are no actual skill differences among groups of counselors. 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. It would be interesting for the field to demonstrate that these credentials actually lead to improved skills and 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 also important to develop not only external relationships, but also 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 agencies' 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. The number one competency area in which directors felt their staff needed training was in documentation activities. Less than a third of the staff, however, thought this was a priority training need. 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.

Section V – Workplace Support and Challenges

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 any more continuing education; therefore, it is important to note that Missouri staff also 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:

- Validate treatment staff members and the importance of their work with clients.
- Provide positive feedback, constructive criticism, and reinforcement.
- Remind counselors about their motives for entering the field.
- Maintain a positive attitude.
- Promote a supportive work environment.
- Encourage healthy management and staff relations.
- Emphasize the importance of professionalism.
- Improve team mentality of older staff when newer staff members come on board.
- Be sensitive to counselor "burnout."
- Upper management is respectful of staff.
- Ask for staff feedback and allow for creativity.
- Allow counselors to be more hands on with staffing and other program decisions.

Many of the staff members did not report receiving ongoing supervision of their clinical work. Supervision is important, given that previous research has found a strong association between agency supervision and mentoring activities, and staff job satisfaction (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. By and large, persons in the addiction workforce entered the field primarily because they wanted to make a difference in the lives of others; they feel adequately prepared for the work with clients, and engage in a range of client service activities. All of these tended to help promote satisfaction with the treatment component of their job. In contrast, many issues that were identified as barriers to staying in the field, including salary, benefits, and career advancement opportunities are also issues that would influence one's satisfaction with the work environment.

Section VI – Changes for the Workforce

In terms of needed changes within their agencies, Missouri directors reported a desire to better document clinical outcomes in their programs. These findings converge with several results found in this report. For example, directors emphasized a need for staff to improve their documentation skills through additional training. In addition, directors' self-efficacy ratings for documenting treatment program effectiveness were comparatively lower than other leadership skill areas. Finally, directors reported that pressure to make program changes came from outside entities including funding or oversight agencies and licensing/accreditation authorities, which again suggests that program accountability is a concern for the field.

According to Missouri directors, several aspects of the organizational structure within their agencies were conducive to change. They reported having mostly adequate resources in many areas, including building facilities and computers as well as access to quality training and technological resources (e.g., computers, Internet). However, directors perceived staff shortages as more problematic. Specifically, there was not enough staff to meet the demands of clients, nor support staff to maintain the daily functioning of their agency. Directors also indicated they had difficulties recruiting qualified staff to fill open positions. Most of these difficulties were due to applicants not having the minimum qualifications necessary for the positions.

Directors perceived their agency environment favorably, characterized by cohesiveness, openness, and communication. They also 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 in the field. Non-monetary sources of support have been suggested by Missouri workforce staff. Due to a lack of experience in addiction treatment, directors perceived difficulties in recruiting qualified staff; however, mentoring within agencies could facilitate skill development of inexperienced staff. 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).

Footnote

[1]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.

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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.

Table 1. Percentage of Workforce Time at Current Setting

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%

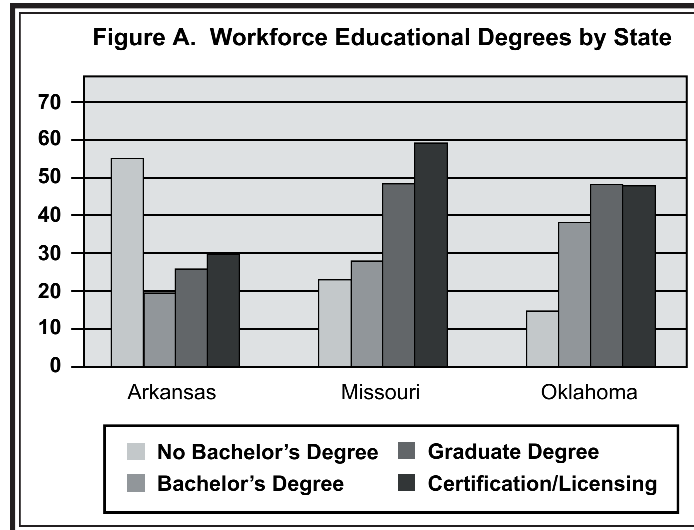
Overall, a higher percentage of directors than staff had been employed in the addiction treatment field for 10 or more years and/or employed at their current work setting 10 or more years (refer to Tables 1 and 2.) Of the three states participating in the workforce evaluation, Missouri's workforce had 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.

Table 2. Percentage of Workforce Overall Time in the Addiction Treatment Field						
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 and required amounts of education and work experience 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.

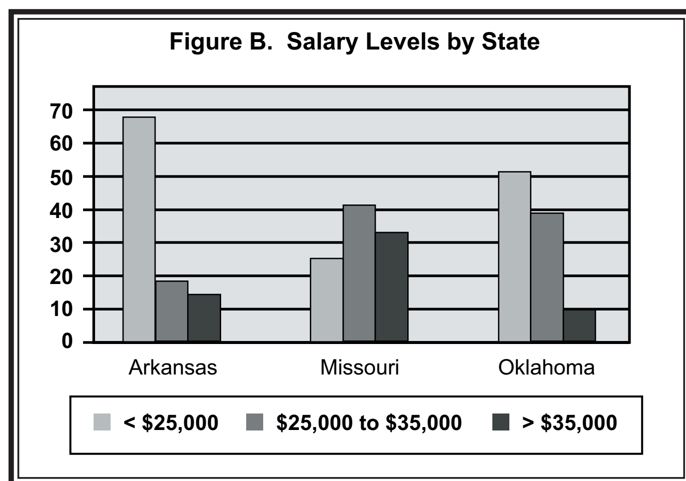


Figure B. Salary Levels by State

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.

Table 3. Percentage of Staff Time in Various 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

Table 4. Percentage of Staff Providing Services for Co-occurring Mental Health Disorders

	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.

Table 5. Top Five Training Needs According to Staff and Directors

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 Pharmaco-therapy	Grief and Loss	Co-occurring Mental Health
4	Motivational Enhancment	Treatment Planning	Motivational Enhancement	Group Counseling	Drug Pharmaco-therapy	Gender Specific Treatment
5	Drug Pharmaco-therapy	Clinical Supervision/ Screening and Assessment	Drug Pharmaco-therapy	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.