

SUBSTANCE ABUSE TREATMENT WORKFORCE SURVEY REPORT

2004



PREPARED FOR:

OKLAHOMA ADDICTION TREATMENT PROVIDERS

OKLAHOMA DEPARTMENT OF MENTAL HEALTH & SUBSTANCE ABUSE SERVICES



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

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

***Gender:*** Females comprised almost two-thirds of the workforce staff (61.2%) and less than half (41.2%) of the directors.

***Race/Ethnicity:*** Both staff (70.5%) and directors (86.5%) were predominantly Caucasian followed by American Indian/Alaskan Natives representing 17.8% of the staff and 11.8% of the directors.

***Age:*** Staff ranged in age from 23 to 75 years, with an average age of 46.9 years. Directors ranged in age from 33 to 65 years, with an average age of 50.0 years.

***Work Experience:*** More directors than staff have worked in the field of alcohol and drug treatment (70.6% vs. 28.7%) and at their current work setting (38.2% vs. 11.6%) for 10 or more years.

***Employment Type:*** Approximately two-thirds (62.1%) of staff and three-fourths (76.5%) of directors worked in a private non-profit setting.

***Education:*** Almost half (45.0%) of the workforce staff, and 61.7% of the directors had a graduate degree.

***Salary Distribution:*** The modal salary range for staff was \$15,000 to \$24,999 in comparison to \$40,000 to \$49,999 for directors.

***Certification status:*** Slightly less than half (46.9%) of the addiction treatment staff, and half (50.0%) of the directors were currently certified or licensed to provide addiction treatment services.

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

***Professional Experience:*** Both directors and staff cited the most frequent reasons for entering the addiction treatment field; these included personal or familial experience with addiction and/or recovery or a personal interest in the field.

***Work Tasks:*** Staff spent most of their time in direct service activities such as individual (23.2%) or group counseling (19.2%); however, paperwork and documentation activities (16.7%) also constituted a high percentage of weekly hours. Directors reported spending most of their time in administrative duties (69.0%).

***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 primarily 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 Oklahoma agencies was a Caucasian male between the ages of 26 and 64. American Indian/Alaskan Natives were the second most frequently served group in terms of race/ethnicity.

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

***TAP 21 Addiction Counseling Competencies:*** Over two-thirds (69%) of treatment staff was NOT familiar with the Center for Substance Abuse Treatment's nationally defined competencies.

***Staff Self-Efficacy:*** Staff members were the 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 were most confident in their day-to-day operations skills, including staff and program development, and less confident in their external relationship skills (e.g., advocate to policymakers, develop effective relationships with potential funders).

***Training Needs:*** Co-occurring disorders, trauma and abuse, and grief and loss were rated as three of the top five training needs by staff members. For agency directors it was treatment planning, group counseling, and co-occurring disorders.

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## ***Supports and Stressors for the Oklahoma 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 frequent promotions.

***Agency Support Systems:*** Fewer staff members were in agreement with the directors about the amount of in-house mentoring, direct supervision, and ongoing training that occurred in their agencies.

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

***Barriers:*** Low pay, large case loads, and salary competition from other fields were the top three barriers to recruitment perceived by both directors and staff. Directors also noted the difficulties of finding applicants with the appropriate experience and/or education.

***Consultation Needed:*** Directors thought they most needed technical assistance in two areas: teaching staff about measuring client performance and using clients' assessments to guide clinical and program decision-making.

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

***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.

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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.

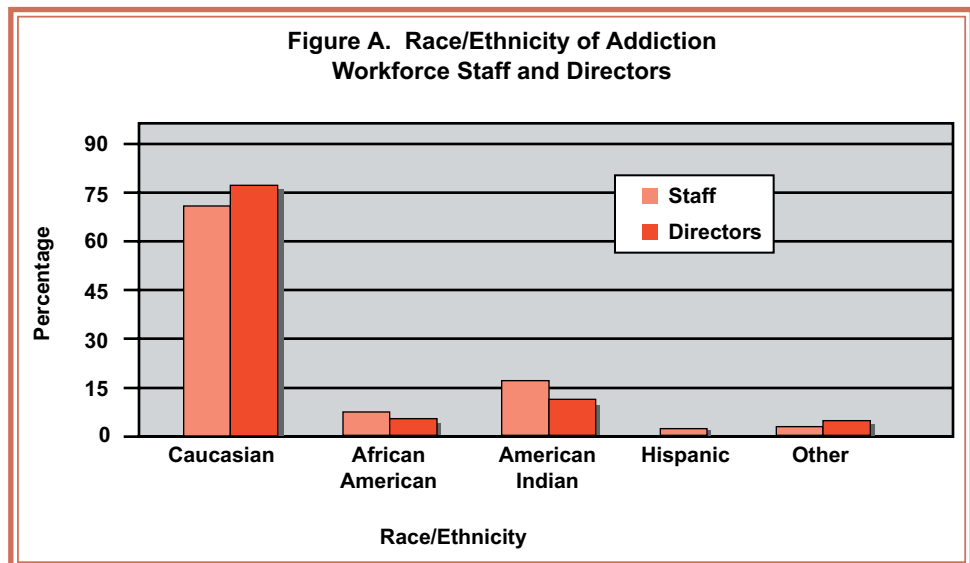
The survey instrument used in this study was a modified version of a workforce survey originally developed by RMC Research Corporation for the Northwest Frontier ATTC. The Mid-America ATTC adapted the survey based on feedback from addiction educators, training directors, certification and licensing authorities, 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 Ben Brown, Deputy Commissioner for Substance Abuse Services at the Department of Mental Health and Substance Abuse Services in Oklahoma. 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, 60% of the Oklahoma agencies ( $n = 75$ ) 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 383 surveys were sent to Oklahoma staff and directors. Follow-up efforts resulted in the receipt of 130 staff surveys (41% response rate) and 34 agency director surveys (51% response rate), representing 49 treatment agencies in Oklahoma.

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

In this section of the report, the demographic characteristics of Oklahoma 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.



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## *Demographics*

Females comprised more than half (61.2%) of the workforce staff but less than half (41.2%) of the directors. Staff members were primarily Caucasian (70.5%) with 17.8% as American Indian, 8.5% as African American, less than 1% as multiethnic or other, and no staff reported their race as Asian (refer to Figure A). Directors were identified primarily as Caucasian (86.5%), American Indian (11.8%), and African American (5.9%). No directors and less than 3% of the staff reported their ethnicity as Hispanic.

## *Age Range*

Staff ranged in age from 23 to 75 years, with 71.5% being at least 40 years of age (see Table 1). Directors ranged in age from 33 to 65 years, with over 84.8% being at least 40 years of age.

<b>Age</b>	<b>Staff</b>		<b>Directors</b>	
	<b>*Frequency</b>	<b>Percent</b>	<b>*Frequency</b>	<b>Percent</b>
<b>20-29</b>	11	9.2%	--	--
<b>30-39</b>	23	19.3%	5	15.2%
<b>40-49</b>	31	26.1%	11	33.3%
<b>50-59</b>	36	30.3%	11	33.3%
<b>60+</b>	18	15.1%	6	18.2%
	*Missing data = 11		*Missing data = 1	

## Work Experience

A higher percentage of directors (70.6%) than staff (28.7%) 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 (38.2%) than staff (11.6%) reported being at their current work setting 10 or more years. Notably, almost two-thirds (62.0%) of the treatment staff worked in their current agency for less than 4 years, and 37% had been in the addiction field for less than 4 years. These results suggest that at any one time, agencies have many new and/or inexperienced workers in their organization.

Almost half (48.5%) of the Oklahoma staff indicated that addiction treatment was a second career. Previous employment areas were quite diverse, ranging from law enforcement and education, for example, to funeral directing 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	80 / (62.0%)	9 / (26.5%)	48 / (37.2%)	2 / (5.9%)
4 to 9 Years	34 / (26.4%)	12 / (35.3%)	44 / (34.1%)	8 / (23.5%)
10 or More Years	15 / (11.6%)	13 / (38.2%)	37 / (28.7%)	24 / (70.6%)

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

### *Professional Preference*

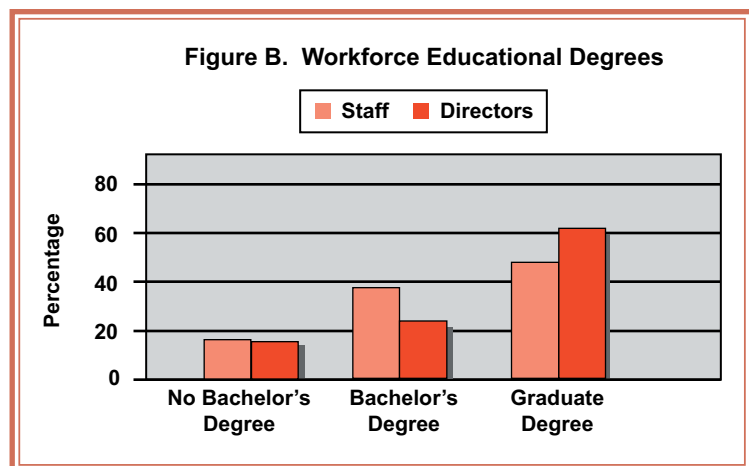
Staff and directors were asked to evaluate how each of the five potential reasons for entering the addiction treatment field was applicable to making their own career decisions. Total responses exceeded 100% because participants were told to mark all of the reasons that applied to them. Over half of 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). Similar to staff, slightly over half of the directors cited a personal/familial experience with addiction and/or recovery as a motivator to work in the area of addiction treatment, whereas 44.1% indicated that they had joined the workforce because of a personal interest.

**Table 3. Reasons for Entering Addiction Treatment Field**

Potential Reasons	Staff		Directors	
	Frequency	Percent	Frequency	Percent
Personal/family experience with addiction and/or recovery	73	56.6%	19	55.9%
Personal Interest	64	49.6%	15	44.1%
Academic work/degree in a similar field	36	27.9%	12	35.3%
Unplanned decision	35	27.1%	7	20.6%
Experience in Similar Field	33	25.6%	12	35.3%

### *Education and Certification Status*

Forty-five percent of the staff and almost two-thirds of the directors (61.7%) 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. Almost half (46.9%) of the addiction treatment staff and half (50.0%) of the directors surveyed were certified or licensed in the addiction treatment field at the time of the survey.



## Salary Distribution

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

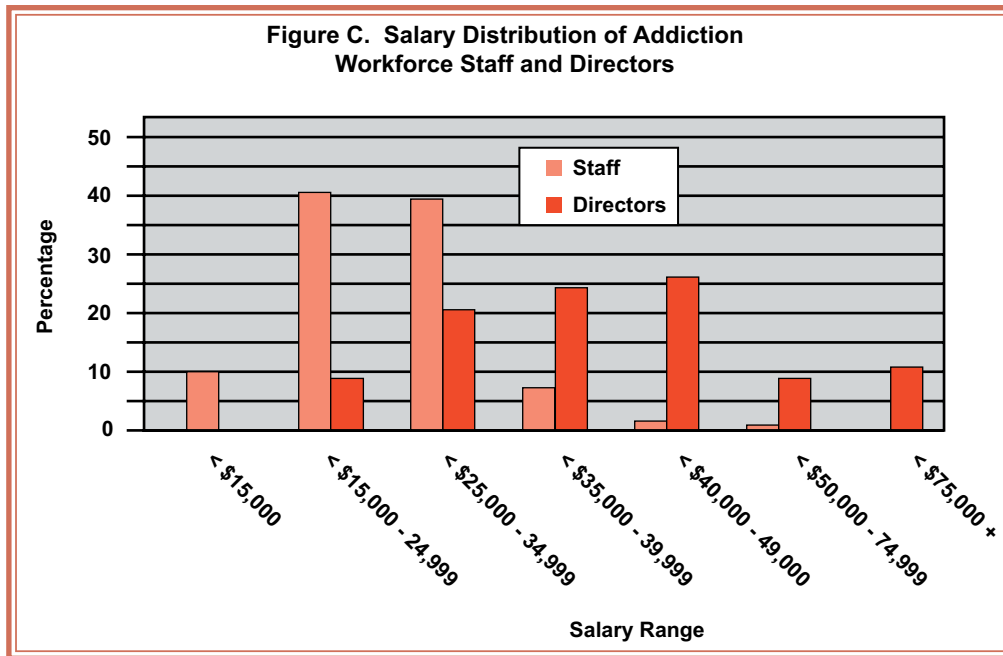
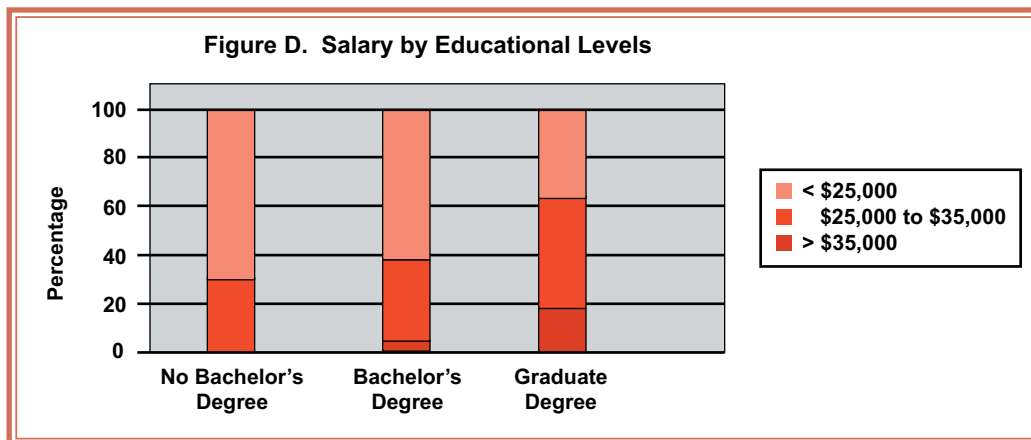


Figure C); only 10% earned more than \$35,000 annually. In comparison, the most frequent salary range for directors was between \$40,000 and \$49,999 with 20% making more than \$50,000 annually. Education levels were associated with salary (see Figure D). For example, 70.0% of the workers

without bachelor's degrees were earning less than \$25,000 per year, compared to 61.4% of those with bachelor's degrees and 35.7% 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)
Sick Leave	95 / (74.8%)	9 / (7.1%)
Other Paid Leave	88 / (69.3%)	15 / (11.8%)
Health Insurance	55 / (43.0%)	34 / (26.6%)
Retirement Options	37 / (28.9%)	29 / (22.7%)

\*Missing data = 3

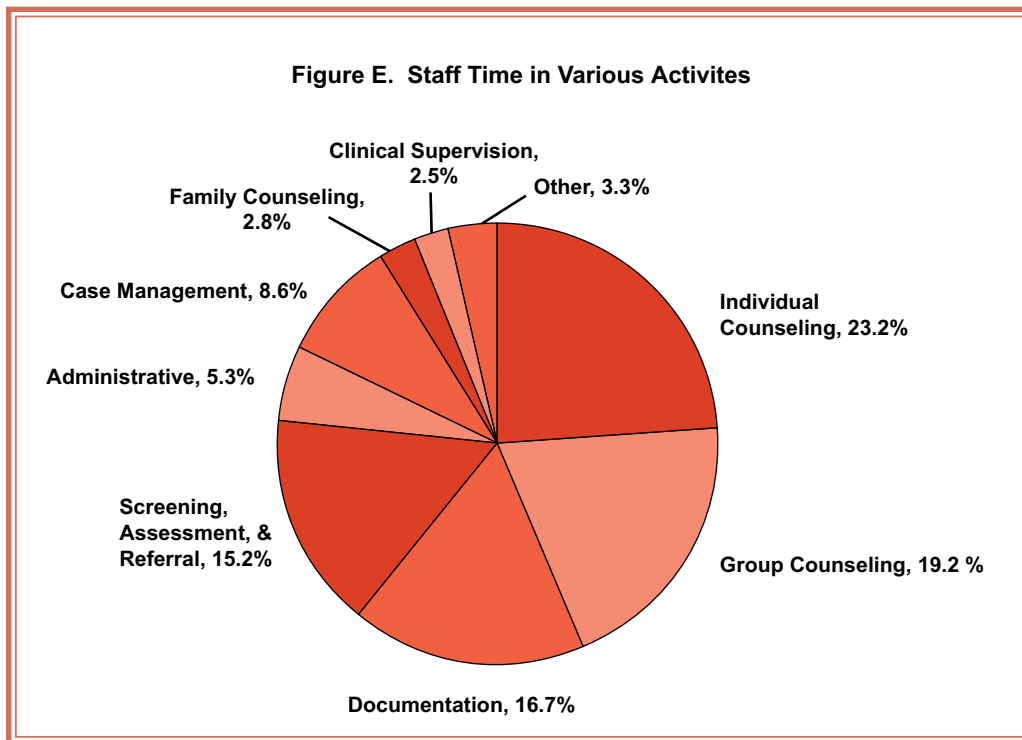
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### ***III. What Services are Being Provided by the Workforce and to Whom?***

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***

Oklahoma treatment staff reported spending the largest amount of time performing individual counseling (23.2% of work hours), followed by group counseling (19.2%), documentation (16.7%), and screening or assessments (15.2%) (see Figure E). For directors, a mean of 69.0% of work time was reserved for administrative activities with 22.7% 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 (22.1% of participants), (b) staff who primarily provided group counseling (21.3%), (c) staff who performed a variety of job activities equally (41.0%), (d) staff who mostly carried out administrative duties (3.3%), and (e) staff who primarily conducted screening/assessment services (12.3%). For the most part, there were no major differences between these five groups of workers in terms of demographic or professional background characteristics. One exception to this included 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, although more staff was involved in screening, assessment, and treating clients with substance use versus co-occurring disorders, a large proportion of staff screened, made referrals, and treated clients with co-occurring disorders.

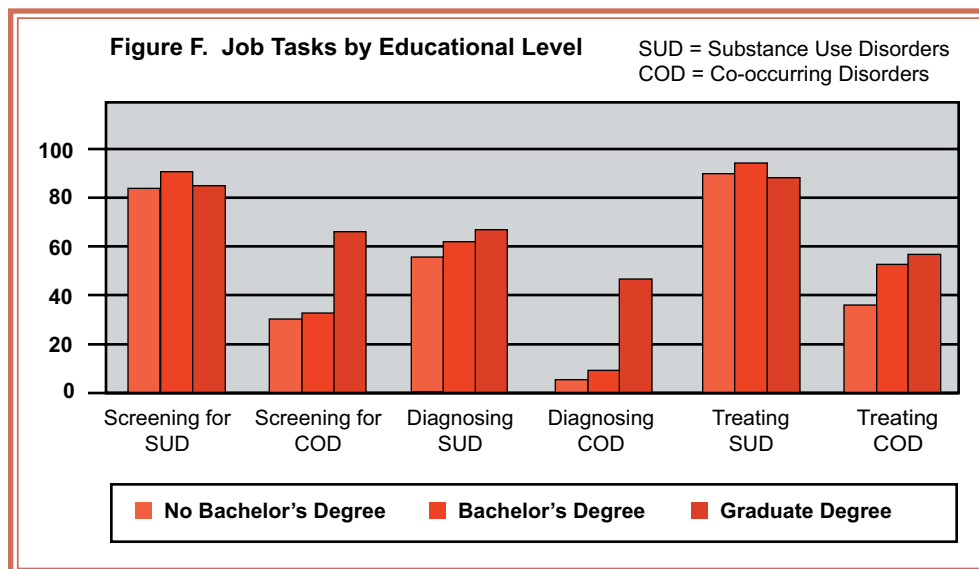
These findings underscore the amount of time that treatment staff spends working with clients who have co-occurring mental health problems. Interestingly, a discrepancy is noted between the workforce staff and the directors. While directors' reports confirmed that 75.0% of clients in their agencies were treated for alcohol and/or drug problems, they also reported that only 25.0% of clients in their agency were treated for a co-occurring mental health disorder. Thus, workers in Oklahoma 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**

Services	Substance Use Disorder		Co-occurring Mental Health Disorder	
	*Frequency	Percent	*Frequency	Percent
Treated clients for...	117	90.7%	67	51.9%
Screened clients for...	112	86.8%	61	47.3%
Diagnosed/formally assessed clients for...	82	63.6%	32	24.8%
Referred clients to services for...	97	75.2%	96	74.4%

\*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 with or without a bachelor's degree are likely to be involved with treating individuals with substance use disorders. On the other hand, staff members with a bachelor's or graduate degree were more likely to treat clients with co-occurring mental health disorders. Formal assessment and diagnosis of clients with substance use disorders are equally likely to be handled by staff across all levels of education. However, clients being assessed for a co-occurring disorders are often left to those with higher levels of education. Finally, whereas all 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 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 Oklahoma were *Relapse Prevention* (79.7%), *Cognitive-Behavioral Skill Development* (66.4%), *12-Step* (57.8%), and *Solution Focused* (57.0%) models. According to these results, Oklahoma 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).

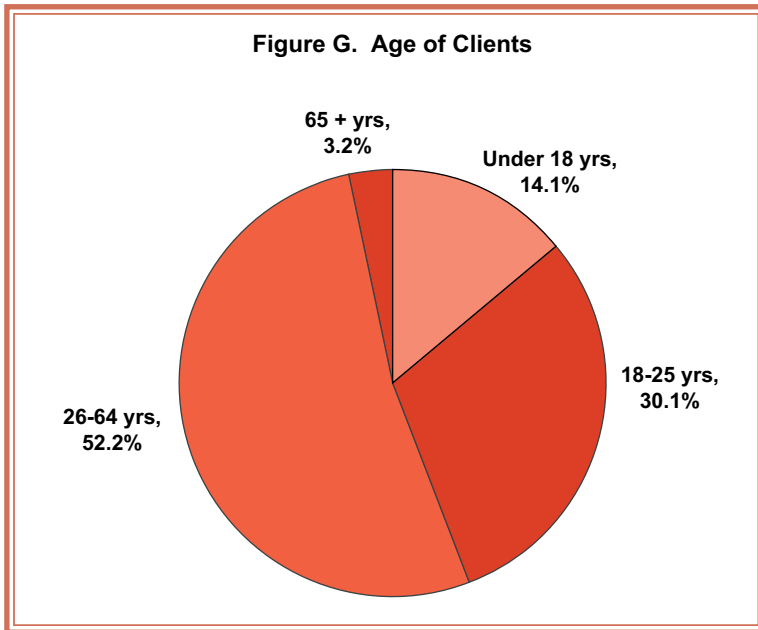
**Table 6. Primary Treatment Models Used**

<b>Models</b>	<b>% of staff endorsing the model as primary in their agency</b>
Relapse Prevention	79.7
Cognitive-Behavioral Skill Development	66.4
Twelve Step	57.8
Solution Focused	57.0
Reality Therapy	37.5
Rational Emotive Therapy	33.6
Therapeutic Community	32.0
Gender Specific	29.9
Behavioral Modification/Token Reinforcement	28.1
Family Therapy	27.3
Community Reinforcement	25.8
Harm Reduction	23.6
Motivational Enhancement Therapy	21.9
Culture Specific	21.1
Developmental Model	15.6
Dialectical Behavior Therapy	11.7
Minnesota Model	10.9
Pharmacotherapy	9.5
Methadone Maintenance	1.6

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### *Clientele Characteristics*

Within agencies each staff member worked with an average number of 20 clients per month with a range of 1 to 40 clients per staff member. More than half (52%) of the clients were between 26 and 64 years of age (see Figure G), and approximately two-thirds of clients were male. Clients were mostly Caucasian (53.8%) with American Indians (21.8%) being the second most frequently served group followed by African Americans (15.1%). Hispanic (5.5%) and multi-ethnic (3.6%) clients were less frequently seen. The number of American Indian and Asian clients was less than 1%.



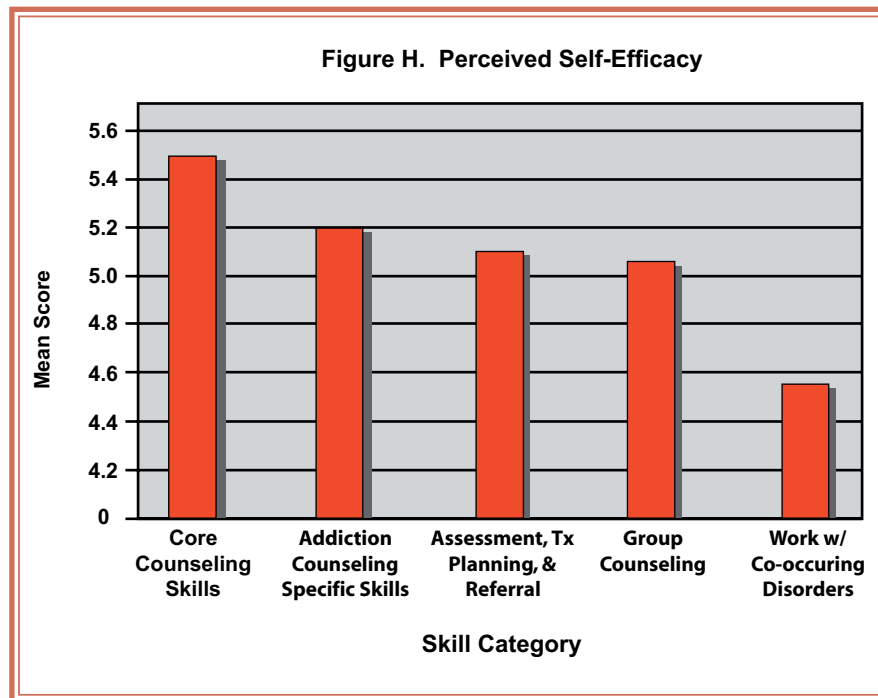
Primary service areas in Oklahoma were categorized as rural (60.6%), suburban (8.8%), or inner city (29.4%). Almost two-thirds of the addiction treatment programs surveyed were outpatient (61.8%). Over half of the directors (54.5%) indicated that the number of clients served in their setting was steadily 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 Oklahoma. 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, 1998). Only 31.0% indicated *Yes* that they were familiar with the competency guidelines. Of those who were familiar with the guidelines, 24.7% *agreed* or *strongly agreed* that they utilized these competencies to guide their professional development. An almost equal number (23.1%) also indicated using the competencies for self-assessment and to improve treatment outcome (23.9%).



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

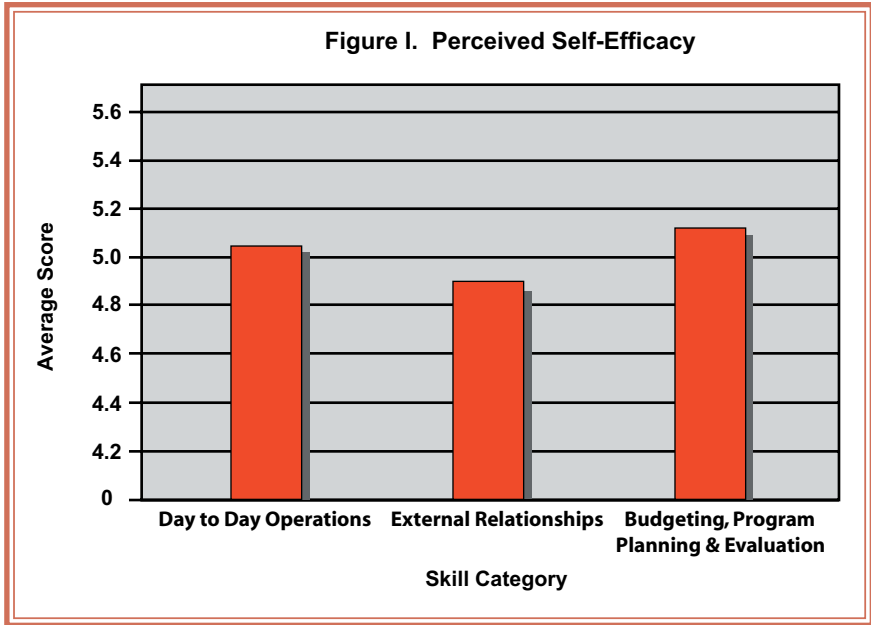
Staff was then surveyed about 67 different job skills. Items for this section of the survey were derived from the nationally defined *Addiction Counseling Competencies* noted above. Staff members indicated how confident they were in those 67 skills on a scale of 1 (*no confidence in performing this skill*) 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 5.49 ( $SD = .53$ ). 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 5.19 ( $SD = .62$ ). 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 4.54 ( $SD = .90$ ).

Surprisingly, no significant differences in self-efficacy ratings were found when comparing staff members by their educational levels. Those staff members without a bachelor's degree rated their skills similarly to those with a graduate degree. Significant differences were found, however, in terms of how long staff members had been in the field and whether they were certified/licensed or not. Specifically, those workers with more time in the field and credentials reported significantly higher efficacy levels in all skill categories than those staff members with less time in the field or without credentials.



**Leadership Skills**

Directors were also asked about their confidence to execute 26 different leadership skills. Examples included 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 within each category were averaged to form total scores ranging from 2 to 6. As seen in Figure I, directors 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 three specific skills in which directors felt much less efficacious: negotiating with insurance industries, ( $X = 3.88, SD = 1.43$ ), advocating to policy makers ( $X = 4.61, SD = 1.0$ ), and documenting the effectiveness of their treatment program ( $X = 4.61, SD = .90$ ). In contrast, none of the other skills listed had a mean rating below 4.61, and 17 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 staff needed additional training. 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, treatment planning, 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, drug pharmacotherapy, spirituality and recovery, and grief and loss were also rated highly. Directors wanted their staff to be trained in documentation, group counseling, and gender-specific and racial/ethnic-specific treatment. These differences are noteworthy, as staff members reported higher confidence levels for their documentation skills, for example, and did not view this competency area as a priority for future training.

Finally, almost all of the staff members (90%) had completed a continuing education training or workshop during the past year including 88% of those who were not certified and 94% of those with current certifications. The average reported number of continuing education hours overall was 30.93 ( $SD = 19.46$ ). Those not certified attended an average of 29.63 hours ( $SD = 21.69$ ) during the prior year versus 32.01 hours ( $SD = 17.52$ ) for certified counselors.

**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	59.2	64.7 (3)
Trauma and abuse	49.2	41.2
Grief and loss	46.9	35.3
Drug pharmacotherapy	46.9	41.2
Motivational enhancement	46.2	52.9 (5)
Spirituality and recovery	44.6	50.0
Treatment planning	44.6	76.5 (1)
Marriage and family therapy	42.3	41.2
Group counseling skills	40.0	67.6 (2)
Prevention strategies	41.5	35.3
Adolescent treatment skills	35.4	47.1
Gender specific treatment	35.4	55.9 (4)
Offender treatment	33.8	44.1
Lesbian/gay/bisexual specific treatment skills	32.3	26.5
Intervention skills	30.8	44.1
Documentation skills	30.8	67.6 (2)
Detoxification	31.5	20.6
Racial/ethnic treatment	29.2	55.9 (4)
Professional and ethical responsibilities	26.2	47.1
Screening and assessment	24.6	38.2
Clinical supervision	22.3	35.3
Elder/senior specific treatment	20.8	14.7
Administrative management skills	20.0	26.5
Personnel management skills	16.9	17.6
Patient placement criteria	16.2	44.1
Referral skills	15.4	26.5

## 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 to retain qualified staff. Although such efforts may be difficult given current financial constraints and decreasing agency budgets, several other suggestions were not necessarily limited by monetary issues. For example, staff highly rated the provision of more individual recognition and appreciation as well as opportunities for staff input.

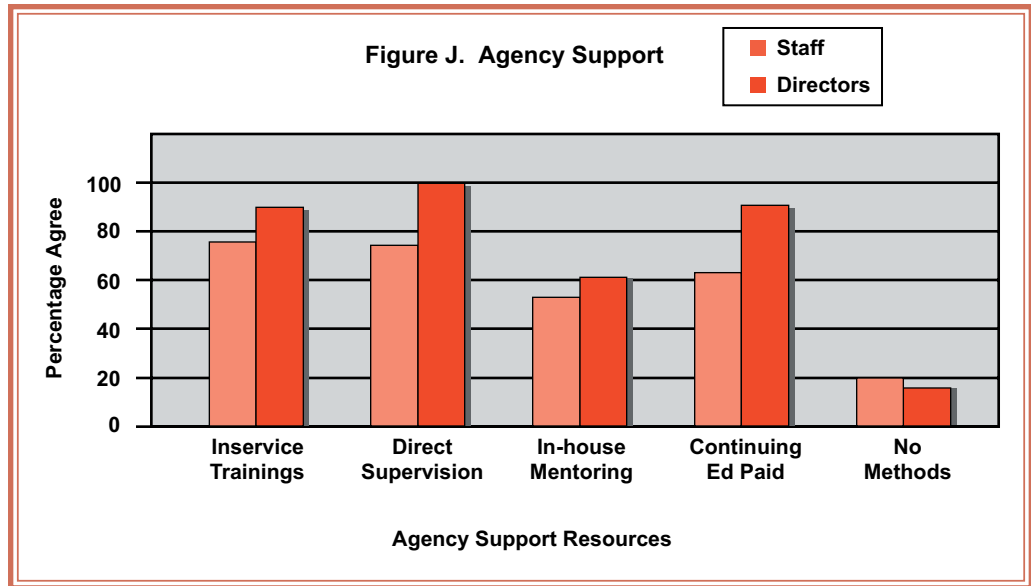
<b>My agency can do the following to better retain qualified staff</b>	<b>% Strongly Agree or Agree</b>	
	<b>Staff</b>	<b>Directors</b>
More frequent salary increases	83.6	85.3 <b>(1)</b>
Promote career growth	72.7	55.8
More ongoing training	70.3	58.8
More frequent promotions	64.1	61.8 <b>(5)</b>
More individual recognition/appreciation	64.1	76.5 <b>(2)</b>
Better health coverage and benefits	63.3	70.6 <b>(3)</b>
Increase staff opportunities for input	60.9	38.2
Provide assistance with paperwork	57.1	70.5 <b>(4)</b>
Provide more varied work opportunities	52.3	47.1
More supportive agency culture	47.6	35.2
Better management	45.3	26.5
Improved physical work environment	40.6	23.5
Smaller client caseloads	39.1	47.1
Shorter work hours (flex-time, job sharing)	38.6	44.1
Better supervision	37.5	38.2
Less management and supervision	11.0	5.8

## 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 inservice training available. Approximately two-thirds (63.5%) of staff agreed that

their agency paid for continuing education, whereas 91.2% of their directors agreed this was the case. Also, fewer staff members than directors agreed that direct supervision was provided in their agency.



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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, 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).

<b>Communication Method</b>	<b>Very Rarely or Never</b>	<b>Monthly</b>	<b>Weekly</b>	<b>Daily</b>
	<b>*Frequency / (Percent)</b>	<b>*Frequency / (Percent)</b>	<b>*Frequency / (Percent)</b>	<b>*Frequency / (Percent)</b>
<b>Computer</b>	5 (3.9%)	2 (1.6%)	11 (8.6%)	110 (85.9%)
<b>Voice Mail</b>	53 (41.4%)	7 (5.5%)	15 (11.7%)	53 (41.4%)
<b>E-mail</b>	35 (27.6%)	8 (6.3%)	12 (9.4%)	72 (56.7%)
<b>Audio teleconferencing</b>	112 (87.5%)	11 (8.6%)	3 (2.3%)	2 (1.6%)
<b>Internet</b>	31 (24.2%)	9 (7.0%)	20 (15.6%)	68 (53.2%)

\*Missing data = 3

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## Job Satisfaction

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

How satisfied are you with...	% Mostly Satisfied or Satisfied	
	Staff	Directors
One-to-one interaction with clients	92.2	76.5
Agency/co-workers	80.5	85.3
Role as a change agent	67.7	84.9
Opportunities for personal learning & growth	64.1	79.4
Ability to influence agency decisions	49.6	79.4
Career growth opportunities	47.6	76.5
Salary/benefits	35.2	58.8
Overall satisfaction with job	84.4	91.2

*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 favorably. 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 Oklahoma. 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 Oklahoma 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 do not enter the A/D treatment field because of...	% Strongly Agree or Agree	
	Staff	Directors
Low salary/poor benefits	88.2	82.3 (1)
Competition from other fields (in terms of compensation)	74.2	76.4 (2)
Large caseloads	64.9	76.4 (2)
Negative preconceptions regarding clients and chemical dependency (e.g., difficult to work with, don't want to change)	64.5	44.1
Paperwork	63.0	73.5 (3)
Stigma/lack of respect for the field	60.9	53.0
Evening and weekend hours	60.2	58.8
Perception that A/D treatment is not effective	57.5	32.3
Cost of training/education	55.2	64.7 (5)
Perception that A/D treatment is not a "real" profession	50.4	35.3
A lack of encouragement (e.g., from educators, family, or friends)	50.0	64.7 (5)
Quality of work environment in terms of professionalism	43.3	23.5
Amount of training/education	42.5	70.6 (4)
Treatment models are not tailored to needs of racial/ethnic groups	18.1	26.5
Geographic constraints	15.8	35.3
Discrimination (e.g., disability, ethnicity, or gender)	10.9	11.8

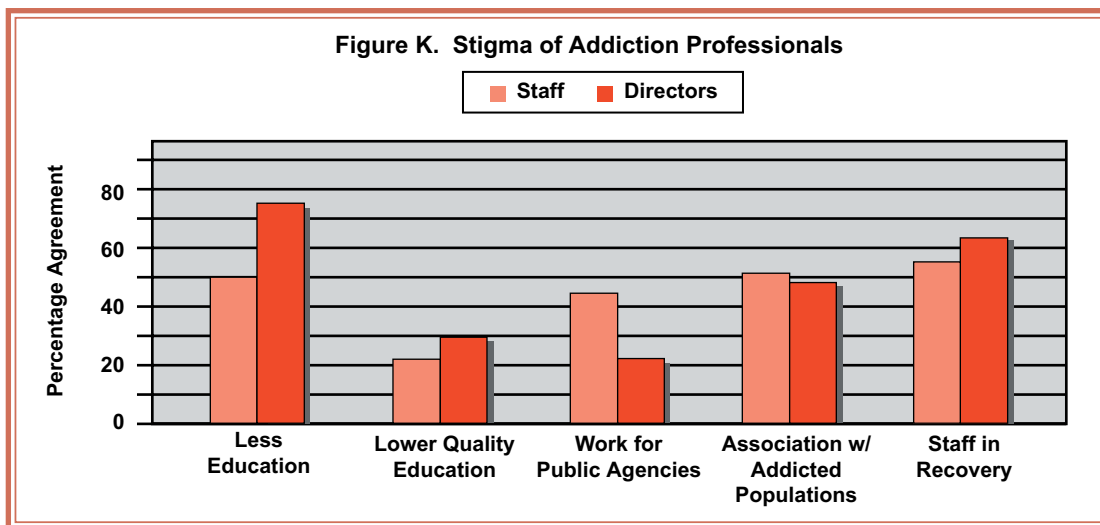
### **Barriers to Entering the Field**

Staff and directors' ratings on barriers to entering the addiction treatment field (see Table 11) reflected several of the findings in this report. For example, 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. Furthermore, there was a tendency for those with mid-level educations to most likely see salary as a barrier. For example, 91.4% of those with bachelor's degrees and 89.5% of those with less than a bachelor's, *agreed* or *strongly agreed* that it was a barrier versus 85.0% of those with a graduate degree. For both directors and staff, additional barriers centered on competition from other fields

in terms of compensation, a work environment characterized by heavy client caseloads, and the paperwork that comes with the heavy caseloads. Directors also considered the amount of education/training needed to maintain certification a barrier, and staff thought the evening/weekend hours required for their work was a barrier.

***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, do addiction treatment providers hold a lower professional standing compared to other helping professionals? Over half of the directors (53.1% ) and almost two-thirds of the staff (63.6%) felt that addiction treatment providers had a lower standing compared to other health professional groups. Reasons for the lower perceived status of addiction providers 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.



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### ***Recruitment Difficulties***

Another challenge to the field is recruiting qualified addiction counselors. Half of the Oklahoma directors surveyed said they had difficulty filling open job positions at their agency. Reasons for these difficulties included the following: (a) applicants not meeting the minimum qualifications necessary for the position (88.2%), (b) staff disinterest due to the salary offered (70.6%), and (c) a small applicant pool because of the rural location of the agency (70.6%). The primary reason indicated by directors, however, was an insufficient amount of funding for open positions (94.2%). Table 12 expands on the reasons why directors felt applicants were not meeting minimum qualifications. Lack of appropriate certification/licensure received the highest response.

<b>Applicants do not meet minimum qualifications because they..</b>	<b>% Strongly Agree or Agree</b>
Lack appropriate certification/licensure	85.2
Have insufficient or inadequate education or training	82.1
Have little or no experience in A/D treatment	77.8
Lack practical or applied skills	59.2
Lack social or interpersonal skills	37.0

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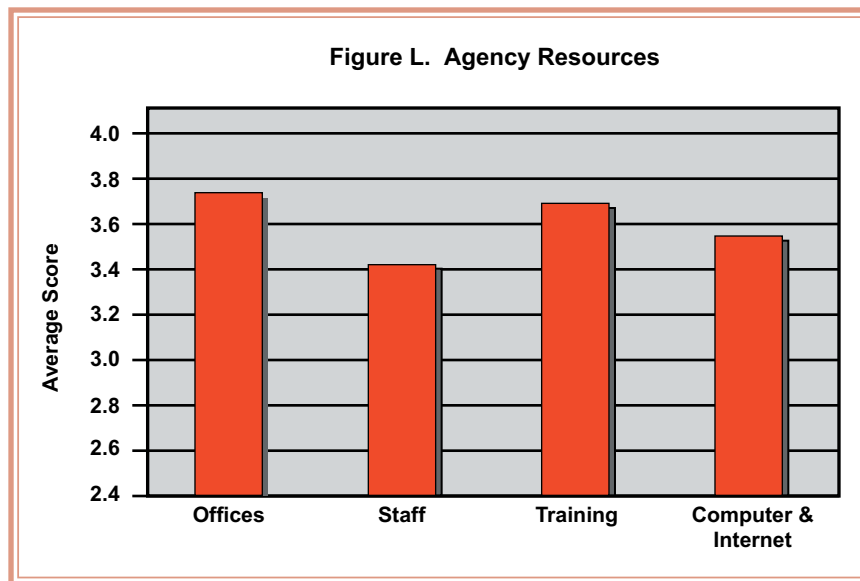
## *Agency Change*

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>
Measuring client performance	82.4
Using client assessments to document program effectiveness	76.5
Using client assessments to guide clinical and program decision-making	76.5
Raising the overall quality of counseling	70.6
Increasing program participation by clients	70.6
Matching client needs with services	70.6
Assessing client needs	67.6
<b>Pressures for Change Come from...</b>	<b>% Strongly Agree or Agree</b>
Funding and oversight agencies	79.4
Accreditation or licensing authorities	73.5
Program supervisors or managers	61.8
Program staff members	58.8
Clients in the program	44.1
Program board members	32.3
Community action groups	23.5

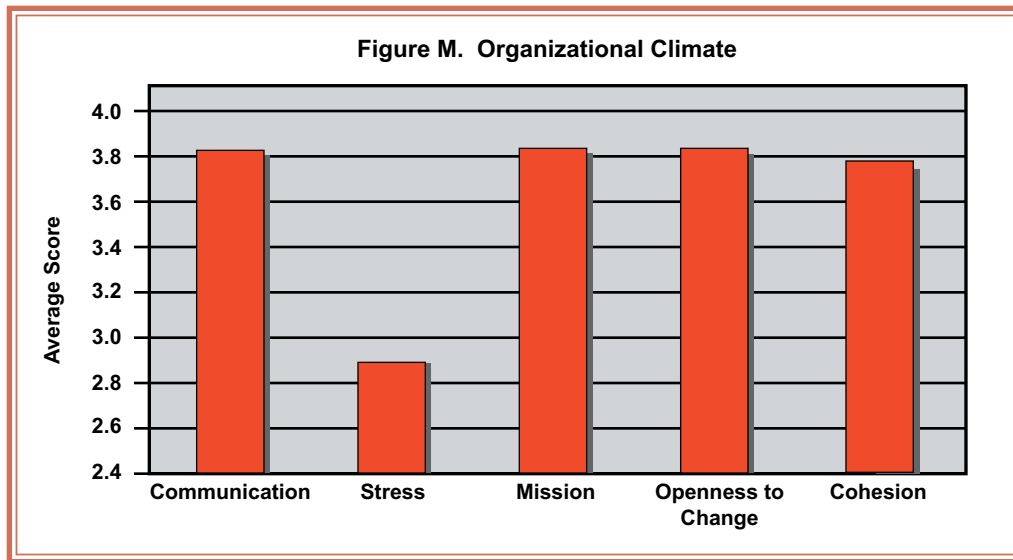
According to Oklahoma directors, the highest priority areas for program change included measuring client performance, and using client assessment to document program effectiveness as well as to guide clinical/program decision-making. Directors perceived the strongest pressures for change coming from external sources including funding or oversight agencies, and licensing/accreditation authorities (see Table 13).

Next, Oklahoma 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. As seen in Figure L, Oklahoma directors saw the biggest deficiency in resources as staff availability ( $X = 3.41, SD = .57$ ). Staff availability includes, for example, having adequate support staff to maintain daily program needs.

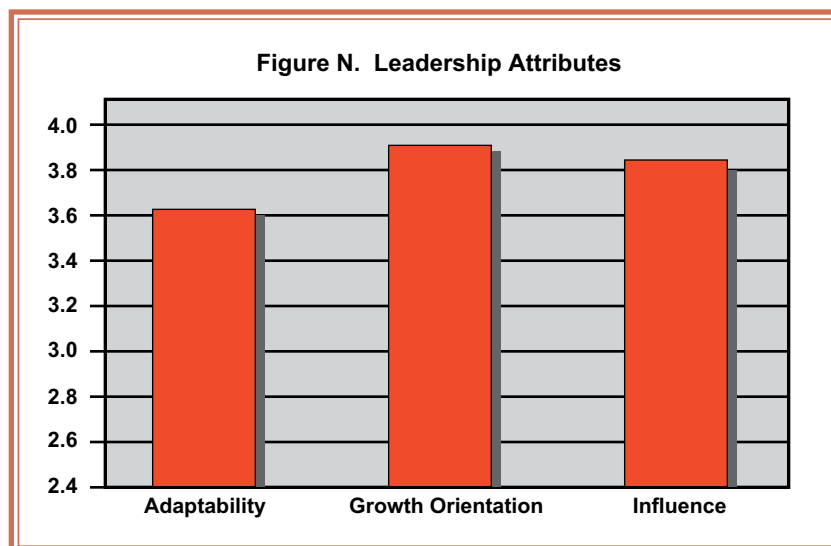


Each director was also asked to rate aspects of the agency's climate. According to Simpson's model (2002), certain organizational and workforce attributes are conducive to change. These climate variables include having a clear agency mission and goals, adequate communication between staff and leadership, 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. Oklahoma 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 clarity of mission and goals, communication, worker cohesiveness, and openness to change. Ratings of organizational stress averaged only 2.90 ( $SD = 1.05$ ).



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. Successful leadership also involves a growth-orientation in terms of both skill development and agency growth. Furthermore, it is important that leaders perceive themselves as having an influence in their agency, for example, that their opinions and guidance are respected. Oklahoma 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**

One interesting characteristic of the Oklahoma workforce report was the inclusion of minority workforce staff members, in particular, American Indian/Alaskan Native and African American staff members. Even though the typical client is a Caucasian male, between the ages of 26 and 64, American Indian (22%) and African American (15%) clients are the second and third most prominent racial groups requesting client services. Thus, the demographic characteristics of staff are similar to those of clientele in terms of ethnicity/race.

Findings from this survey 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 with staff members who held a graduate degree *earning substantially more money per year*. 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**

Most staff members are providing individual and group counseling as well as screening, assessment, and referral services. Very little counselor time was spent on family counseling, however. Family therapies are considered a “best practice” in the field, especially when treating an adolescent population (NIDA, 1999). Including clients’ family members and significant others in the treatment process helps strengthen treatment plans and is important for both treatment retention and relapse prevention. According to these survey results, Oklahoma staff spent less than 3% of their work time in family counseling activities. Further exploration is needed to understand why family therapy was 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, approximately a quarter (22.1%) of the staff surveyed primarily provided individual counseling services, whereas an additional 41.0% 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 47.3% of staff reported screening for co-occurring disorders, yet 86.8% 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 (Drake et al., 1996; Lehman, 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 Oklahoma workers reported having some interaction with clients who have co-occurring disorders. Regarding self-efficacy for various skill areas, counselors felt least efficacious when working with clients with co-occurring disorders. 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).

Furthermore, there was a large variance in self-assessments between staff certified/licensed in addiction treatment and those who were not. Specifically, staff who were certified/licensed were more efficacious than those without certification. These results do not necessarily mean that there are 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 credentials actually lead to improved skills and client outcomes.

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Certified/licensed workers might be utilized within their agencies to provide support and/or training on new or updated practices to those counselors without credentials. Such a training process might also give staff more confidence to screen for co-occurring disorders thus promoting this practice agency-wide. Similarly, staff members 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.

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 staff and the directors 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 top three competency areas in which directors felt their staff needed training were treatment planning, group counseling skills, and documentation. Only 44.6% of the staff, however, thought treatment planning was a priority training need. Group counseling skills (40.0%) and documentation (30.8%) were also lower rated training priorities by staff. 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 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's 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 Oklahoma 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. Specific examples of non-monetary suggestions given by staff members included:

- Combat the negative stereotypes with factual information on what “we” really do.
- Promote team problem solving.
- Place the principles of the agency before counselors'/staff members' personalities.
- Provide adequate supervision, positive role models, and mentors to support motivation.
- Show appreciation and facilitate advancement opportunities.
- Provide more respect, recognition, and educational opportunities.
- Encourage employees.
- Create a more family-friendly atmosphere (i.e., flex-time).
- Create a reward system to counter balance a stressful job environment.
- Minimize the roadblocks and quickly fix small problems in an enthusiastic and positive way.

Previous research has also found a strong association between agency supervision and mentoring activities, and staff job satisfaction (Evans & Hohenshil, 1997). Fewer Oklahoma staff members than directors perceived that ongoing supervision of clinical work or in-house mentoring were occurring within agencies. 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.

Overall, staff and directors reported high job satisfaction ratings. Staff members 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 treatment workforce primarily entered the field because they wanted to make a difference in the lives of others. In general, 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. In contrast, staff were least satisfied with aspects of their work environment. Issues that were identified as barriers to staying in the field included salary, benefits, and career advancement opportunities. These issues also influenced the staff members' satisfaction with their work environment.

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## Section VI – Changes for the Workforce

In terms of needed changes within their agencies, Oklahoma directors reported a desire to better measure client performance and document client outcomes in their programs. These findings converge with several results found in this report. For example, directors emphasized a need for staff members to improve their treatment planning skills. 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 originated from outside entities including funding or oversight agencies and licensing/accreditation authorities, which again suggests that program accountability is a concern for the surveyed agencies.

Oklahoma directors described their agencies as having adequate resources, including building facilities as well as access to quality training and technology resources (e.g., computers, Internet). Directors did note staff shortages as more problematic. Specifically, there were not enough staff members 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 Oklahoma workforce staff to promote staff retention. Due to a lack of experience in addiction treatment, directors foresaw future difficulties in recruiting qualified staff; however, encouraging mentoring within agencies would facilitate skill development of inexperienced staff. Finally, 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%

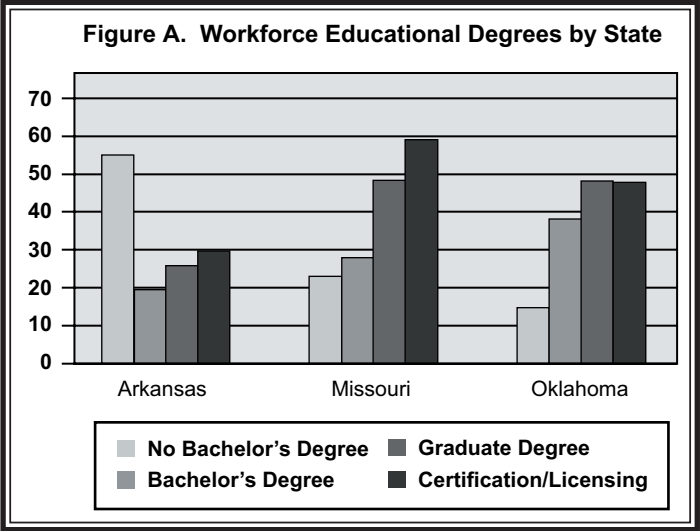
Overall, a higher percentage of directors than staff had been employed in the addiction treatment field for 10 or more years and/or employed at their current work setting 10 or more years (refer to Tables 1 and 2.) Of the three states participating in the workforce evaluation, Missouri’s workforce had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

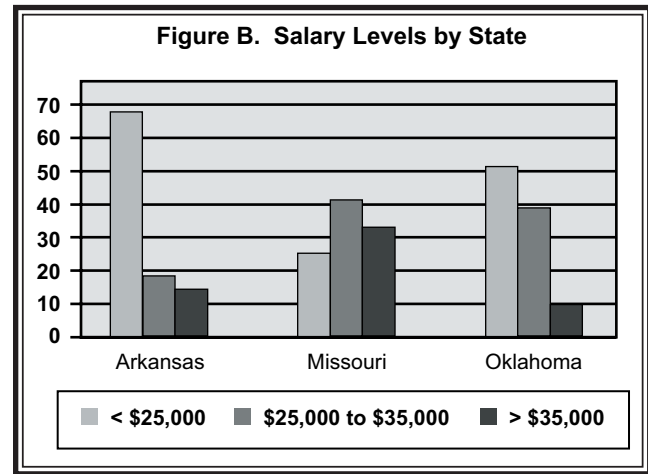
**Professional Background Characteristics**

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 spend 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.

**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 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.