The Current State of Addiction Treatment

Results from the 2005 NFATTC Substance Abuse Treatment Workforce Survey

State of Oregon

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Acknowledgements

The Northwest Frontier Addiction Technology Transfer Center along with RMC Research Corporation would like to thank the entire substance abuse treatment community in Oregon for making this survey possible. First and foremost we would like to express our deepest appreciation to all the agency directors and clinicians who took the time to complete our workforce survey. This project would have little value without the energetic response of substance abuse treatment professionals across the region.

We would also like to thank the Office of Mental Health and Addiction Services for engaging in the survey process. The value of this collaboration can be seen throughout the report, especially in the fantastic response rate obtained. Finally, we would like to thank the Commission for the Advancement of Addiction Professionals for their ongoing support and guidance. The work of the Commission has assured from day one that the purpose and content of the survey reflects the needs and best interests of substance abuse treatment providers, educators, and policy makers across the region.

The authors hope that this report adequately captures the information necessary for understanding the workforce issues affecting the field and can ultimately help advance the current state of addiction treatment.

Executive Summary

The National Treatment Plan, published in 2000 by the Center for Substance Abuse Treatment, identifies workforce development as one of five major issues to be addressed in order to improve the current state of treatment for substance use disorders. Since 1998, the Northwest Frontier Addiction Technology Transfer Center (NFATTC) has invested heavily in workforce development, with recurrent needs assessment at the forefront of this investment. The current report discusses results from the 2005–2006 administration of the NFATTC Workforce Survey.

In the fall of 2005, workforce surveys were sent to a full census of agency directors in Alaska, Hawaii, Idaho, Oregon, and Washington (674 agency directors representing 936 treatment facilities). Agency directors, in addition to completing a survey, were asked to distribute surveys to clinicians at each facility they manage. A 68% response rate was obtained across the region, with 459 agency director responses returned along with 1,564 clinician responses. In Oregon, 101 agency directors and 452 clinicians completed the survey, resulting in a 68% response rate. Results provide rich detail regarding the demographic, academic, and professional background of the substance abuse treatment workforce in Oregon, as well as critical information on important topics such as salary, staffing and turnover, training, and technology. Significant findings are highlighted for the following topics:

- Workforce Demographics
- Academic and Professional Background
- Work Detail
- Salary and Benefits
- Staffing and Turnover
- Recruitment and Retention
- Job Satisfaction and Stress
- Training
- Technology Access and Use

Workforce Demographics

- Overall, 55% of agency directors and 60% of clinicians are female, and the majority of both agency directors (86%) and clinicians (79%) are white.

- The average age for those surveyed is 53 years old for agency directors and 48 years old for clinicians. Results indicate that 73% of directors and 50% of clinicians are 50 years old or older. Further, 25% of directors are 60 years old or older.

- The percentage of clinicians in their 20s in 2005 is half of what it was in 2002, perhaps indicating that fewer young people are entering the field.

- The entire workforce also demonstrates a high average age of entry into the field. Results indicate that the average age of entry is 37 for directors and 39 for clinicians. In fact, 75% to 80% of the workforce indicate entering the field after the age of 30.

- Approximately 50% of directors and clinicians report that substance abuse treatment is a second career.

- Data indicate that 38% of directors and 43% of clinicians report being in recovery. Interestingly, a significantly larger proportion of male than female clinicians report being in recovery.

Academic and Professional Background

- The most frequently cited reasons for entering the field for both directors and clinicians are a personal or family experience with addiction or recovery (57% and 60%, respectively) and a personal interest in substance abuse treatment (49% and 54%, respectively).

- Directors average 16 years in the field and 7 years in their current position, while clinicians average 9 years in the field and 5 years in their current position.

- Despite an average of 9 years experience in the field, approximately one third of clinicians (32%) have only 0 to 4 years experience. Further, the average age of clinicians who have 0 to 4 years experience is also quite variable, again highlighting that clinicians are entering the field at all ages. It is important to note that more than half of these recent entries into the field (56%) are over 40 years old.

- Results indicate that 81% of directors and 65% of clinicians have a Bachelor's degree or above. Further, 59% of directors and 34% of clinicians have a Master's degree or above.

- A significantly smaller proportion of minority directors and clinicians have a Bachelor's degree or above. Also of interest, a significantly smaller proportion of recovering directors and clinicians have a Bachelor's degree or above.

- Fewer than 20% of the workforce in Oregon report having a substance abuse-specific degree. Interestingly, more directors and clinicians report having mental health degrees than substance abuse degrees.

- Overall, 57% of directors and 69% of clinicians report current certification. In addition, 30% of directors and 21% of clinicians report current licensure.

- Estimates indicate that approximately 16% of directors and 24% of clinicians have both active/current certification and licensure. Conversely, estimates indicate that approximately 24% of directors and 9% of clinicians have neither active/current certification nor licensure.

- A significantly larger proportion of recovering directors and clinicians have current certification and current licensure.

Work Detail

- On average, directors report spending 83% of their time on administrative tasks, while clinicians report spending 64% of their time on client-related tasks. Not surprisingly, how directors spend their time varies significantly based on the size of their agency, with directors at smaller agencies spending significantly more time on client-related tasks.

- Clinicians report spending 18% of their time conducting individual counseling sessions, and 16% of their time leading group counseling sessions. Clinicians report spending only 3% of their time providing family counseling. It is also worth noting that clinicians report spending just 14% of their time (approximately 1 hour each day) on paperwork/documentation.

- Multivariate analysis of variance results indicate that clinicians' time spent on client-related and administrative tasks does not vary in a practically meaningful way based on academic and professional background characteristics.

- The majority of clinicians (81%) report carrying a caseload with an average caseload size of 35 clients. Only 14% of clinicians report that their caseload is not manageable.

- From directors' and clinicians' perspectives, relapse prevention, motivational interviewing, cognitive-behavioral therapy, and strengths-based treatment are the most frequently endorsed models playing a major role. While these data do not address fidelity of implementation, it is encouraging that all 4 of these models are considered to be evidence-based practices.

- Overall, 64% of directors and 54% of clinicians report that daily or weekly clinical supervision is occurring at their agency. Clinicians report spending an average of 3% (approximately 1½ hours) of their time each week receiving clinical supervision.

Salary and Benefits

- Director salaries are quite variable in Oregon, although 80% of directors report earning $45,000 or more per year. Clinician salaries are less variable, with 86% of clinicians earning less than $45,000 per year.

- A significantly larger proportion of directors at agencies with 12 or more staff report earning $65,000 or more each year. A significantly larger proportion of clinicians at agencies with 12 or more staff report earning $55,000 or more each year.

- Clinician salaries also vary significantly by agency type, with a significantly larger proportion of clinicians at government agencies (local, county, and community) reporting higher salaries. Both director and clinician salaries also appear to be lower at agencies who do not receive single state agency funding.

- Overall, 92% of directors and clinicians report receiving full or partial health insurance benefits, while 79% of directors and 77% of clinicians report receiving retirement benefits.

- It appears that since 2002 fewer directors are without health insurance benefits. In addition, it appears that a larger proportion of clinicians are now being fully provided with retirement benefits.

- Both sick leave and vacation/other paid leave are provided to the vast majority of the workforce, while a sizeable portion of the workforce is not provided with maternity leave or tuition assistance.

- Regression analysis results indicate that a few individual factors appear to be significant predictors of salary in Oregon. For directors, managing a larger agency (in terms of staff size) is strongly related to earning a higher salary. For clinicians, recovery status, degree status, years experience in the field, licensure, provision of health insurance, retirement benefits, and agency geography are all related to earning a higher salary.

Staffing and Turnover

- Oregon agencies employ 13 clinical staff on average. Agency size ranges from 1 to 90 direct clinical staff.

- On average, agencies employ 1 trainee for every 10 clinicians on staff.

- Based on agency director reports of staffing in the past year, agencies experience an average turnover rate of 23% of their staff. This rate is slightly elevated from the 20% turnover rate reported in 2002. Consistent with 2002 data is the fact that most turnover (over 60%) in agencies across the state is voluntary (quitting).

- Reported turnover rates are significantly larger at agencies employing 3 to 5 direct clinical staff, with a mean turnover rate of 39%. In addition, turnover rates also appear to be significantly elevated in small towns.

- Regression analysis results indicate that agency and agency director characteristics account for 25% of the variability associated with turnover in Oregon agencies. Five factors are identified as significant predictors of turnover: (a) gender; (b) minority status; (c) recovery status; (d) agency size; and (e) receipt of state alcohol and drug authority funds.

- Overall, 45% of agency directors report that their agency is understaffed, with an average staff vacancy of 1.89 FTE after all budgeted positions are filled. Based on this data, the total staff shortage across the state is estimated to be approximately 150 full-time clinicians.

- Data indicate that 71% of directors reporting a staff shortage would still be under-staffed if all budgeted positions were filled.

- Across the workforce, 44% of directors indicate that they expect to hire staff, reporting an average of 1.95 FTE in planned hires. Within these agencies, the number of planned hires range from 1 to 7 FTE.

- Results indicate that 71% of directors and 61% of clinicians have worked for more than one agency, with 68% of directors and 56% of clinicians voluntarily changing agencies at least one time. Overall, data indicate that 67% of director movement and 62% of clinician movement within the field is voluntary in nature.

- Overall, 89% of directors and 71% of clinicians rate their likelihood of changing agencies within the next two years as remote or not at all. In addition, 85% of directors and 77% of clinicians rated their likelihood of leaving the field within the next two years as remote or not at all. It is worth noting that a number of clinicians indicate not being sure about their future with their agency (13%) or in the field (9%).

- A significantly larger proportion of directors (69%) than clinicians (46%) report that their likelihood of changing agencies is not at all. Also, a statistically significant larger proportion of clinicians in recovery report their likelihood of leaving the field as not at all.

- Both directors and clinicians cite better salary, better work opportunities (within the field), and burnout as significant factors in clinicians voluntarily leaving (i.e., quitting). The burnout experienced by clinicians appears to be largely underestimated by directors as only 16% of directors compared to 39% of clinicians indicate that burnout is a factor in clinicians' decisions to quit.

- Logistic regression results indicate that certain factors are predictive of directors and clinicians planning on changing agencies (and those not), and between those planning on leaving the field (and those not). Overall, individual turnover seems to be strongly

related to financial considerations (being the primary wage earner for your family), mobility considerations (degree status, previous experience in another field), past turnover behavior, and job satisfaction and stress. Interestingly, simply earning a higher salary does not appear to be a significant predictor of staying at an agency or staying in the field.

Recruitment and Retention

- In terms of staff recruitment, 57% of directors and 43% of clinicians indicate that their agency has difficulty filling open positions.
- The most frequently cited reasons for applicants failing to meet minimum qualifications are applicants having little or no experience, insufficient or inadequate training/ education, a lack of appropriate certification/licensure, and a lack of practical applied skills.
- Salary is identified as the number one barrier to entering the substance abuse treatment field by both directors and clinicians. Other frequently cited barriers include evening and weekend work hours, large caseloads, and negative preconceptions about the nature of addicted clients.
- Overall, 69% of directors and 68% of clinicians report that from the perspective of other helping professionals, addiction professionals are thought to have lower status. Reasons for the perception of lower status are numerous, but lower salary was the most frequently cited by both directors and clinicians.
- In addition to more frequent salary increases, both directors and clinicians frequently cite more individual recognition and appreciation, assistance with paperwork (or lessening the amount of paperwork), and better health coverage and benefits as retention strategies.
- Interestingly, only 25% of directors compared to 42% of clinicians endorse taking formal steps to reduce emotional burnout as a strategy to retain staff.

Job Satisfaction and Stress

- 83% of directors and 71% of clinicians report their job satisfaction as above average. Only 3% to 4% of the workforce report below average job satisfaction.
- Overall, directors and clinicians cite qualities in their work as more frequently contributing to their satisfaction than their dissatisfaction. Some expected differences exist between factors that contribute to directors' and clinicians' satisfaction, as directors more frequently cite qualities such as decision making and leadership, while clinicians more frequently cite work with clients and colleagues.
- Both directors and clinicians report job stress as relatively high. In fact, 54% of directors and 52% of clinicians report above average job stress.

Training

- Results indicate that 89% of directors and 92% of clinicians have participated in substance abuse workshops or training in the past two years. On average, directors report having attended 6 workshops/trainings in the past two years, while clinicians report having attended 7 workshops/ trainings in the past two years.

- Directors and clinicians self-rated both their proficiency and training interest in 28 Addiction Counseling Competency areas. Based on comparisons of 2002 and 2005 data, clinicians report a significant increase in proficiency in client, family, and community education and co-occurring disorders since 2002. Proficiency in other competency areas such as adolescent treatment, marriage and family therapy, and patient placement criteria also show upward trends for clinicians since 2002.

- Director data does not show any significant changes from 2002, although multiple proficiencies are trending upward since 2002. These areas include adolescent treatment, client, family, and community education, gender-specific treatment, and intervention skills. Training interests appear to be quite stable for both directors and clinicians since 2002.

- For directors, 4 areas are identified as training priorities: drug pharmacology, gender-specific treatment, racial/ethnic-specific treatment, and the relationship between substance abuse and medical problems.

- For clinicians, 4 areas are identified as training priorities: co-occurring disorders, drug pharmacology, marriage and family therapy, and racial/ethnic-specific treatment.

Technology Access and Use

- Overall, 100% of directors and 97% of clinicians report having computer access in the workplace. In addition, 96% of directors and 81% of clinicians reported having internet access in the workplace.

- The vast majority of both directors (88%) and clinicians (89%) report feeling proficient using technology to obtain information about substance abuse.

- A significantly larger proportion of directors than clinicians report using technology for alcohol and other drug research and for web-based professional development. Also of interest, a larger proportion of directors than clinicians report that their agency encourages the use of computers and web-based technology.

Introduction

The National Treatment Plan (NTP), published in 2000 by the Center for Substance Abuse Treatment (CSAT), identifies workforce development as one of five major issues to be addressed in order to improve the current state of treatment for substance use disorders. The NTP clearly identifies addressing the needs of the substance abuse treatment workforce as a crucial underlying strategy to improving client care, but cites a dearth of quantitative data examining those needs. More recently, the Substance Abuse and Mental Health Services Administration has added workforce development to its matrix of cross-cutting principles and strategies for improving the accessibility and quality of the nation's prevention, intervention, and treatment services.

Since 2000, multiple studies have been published describing characteristics and needs of the substance abuse treatment workforce (Gabriel & Knudsen, 2003; Gallon, Gabriel, & Knudsen, 2003; Knudsen, Johnson, & Roman, 2003; Kowalski, Ameen, & Harwood, 2003; Lewin Group, 2004; McGovern, Fox, Xie, & Drake, 2004; McLellan, Carise, & Kleber, 2003; Mulvey, Hubbarb, & Hayashi, 2003; Ogborne, Braun, & Schmidt, 2001). In addition, Addiction Technology Transfer Center (ATTC)-sponsored workforce needs assessment surveys have been conducted in 30 states, providing a wealth of data for treatment providers, addiction educators, and policymakers. As a result, the substance abuse treatment field has begun to move away from the anecdotal identification of workforce issues to more data-driven needs assessment and decision making. Data are now being

used to address long-held concerns and beliefs associated with the workforce (such as the apparent "graying" of the field, and staff turnover, recruitment, and retention practices).

NFATTC Workforce Development Strategy

Since 1998, the Northwest Frontier Addiction Technology Transfer Center (NFATTC) has invested heavily in workforce development, with recurrent needs assessment at the forefront of this investment. Consistent with the NTP, the primary reason for the NFATTC's investment is to assess the characteristics and practices of the substance abuse treatment workforce in the Pacific Northwest in order to further three objectives: (a) to improve the preparation and recruitment of new treatment professionals, (b) to increase the retention of existing, qualified staff in treatment settings, and (c) to identify agency and workforce development needs. Needs assessment data are used to develop state-specific workforce development plans and region-wide projects to address identified needs. Needs assessment is then repeated every 2 to 3 years to examine the impact of workforce development plans and initiatives, to track the changing needs and characteristics of the workforce, and to continue to build upon current knowledge concerning the workforce.

The primary needs assessment mechanism used by the NFATTC is the Substance Abuse Treatment Workforce Survey (NFATTC Workforce Survey), developed collaboratively by RMC Research Corporation and the NFATTC. Development and revision of the instrument has included key input from the Commission for the Advancement of Addiction Professionals which is composed of individuals from the five participating states (Alaska, Hawai'i, Idaho, Oregon, and Washington), representing treatment agencies, educational institutions, state agencies, and credentialing organizations. Two versions of the survey were developed—one for agency directors and one for clinical staff.

Administration of the NFATTC Workforce Survey

The initial administration of the NFATTC Workforce Survey occurred in 2000, providing the first empirical identification of workforce issues in the Pacific Northwest. In 2002 revisions were made to the original survey instrument and it was re-administered to treatment agencies in the region, including Hawai'i which joined the NFATTC region in 2001.

In 2004, the National ATTC Workforce Development Committee recommended that all existing regional workforce surveys be reviewed and then synthesized into a single ATTC Workforce Survey instrument. This task was completed by RMC Research Corporation in conjunction with the ATTC National Office in the fall of 2004, resulting in a comprehensive instrument available for all regional ATTC Centers to use in future needs assessment surveys. This new instrument was adopted by the NFATTC and was used in its third and most recent regional workforce survey beginning in the fall of 2005.

The current study reports on results from the 2005 NFATTC Workforce Survey. Where possible, results are compared to those from the 2002 survey, offering for the first time a look at movement and change in the substance abuse treatment field in the Pacific Northwest. The authors believe that needs assessment data can lead to a better, more complete understanding of issues affecting the field, and can advance the current state of addiction treatment by:

a) Representing a major move from anecdotal reports to empirical evidence (this is important because empirical evidence not only confirms accurate perceptions, but it also disconfirms inaccurate ones),

b) Making issues and concerns more compelling to stakeholders and policymakers (issues backed by evidence are more likely to be given attention than those seen as anecdotal),

c) Providing a guideline for action (by identifying workforce characteristics and variables that consistently relate to important issues, a more effective plan of action can be constructed).

Methods
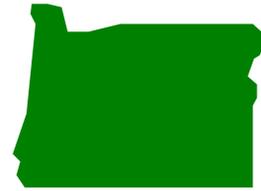
The administration of the 2005 NFATTC Workforce Survey is a direct continuation of the workforce survey work done in 2000 and 2002. As a planned replication of the 2002 survey, steps were taken to learn from the previous experience and to follow up on its findings.

Instrumentation

In 2004, all regional ATTC workforce surveys were reviewed and synthesized into a single ATTC Workforce Survey instrument available for all regional ATTC Centers to use in future needs assessment endeavors. The survey was piloted nationally by the ATTC National Office and performed well. This new instrument was adopted by the NFATTC in the summer of 2005 and was sent to single state agency (SSA) directors in all five states for review. Based on comments from SSA directors, 3 additional items concerning staffing and turnover were added and the instrument was finalized.

The 2005 instrument is very similar to the 2002 NFATTC Workforce Survey, as much of the content synthesized from other regional surveys was adopted from the NFATTC survey. The survey has two versions: one for agency directors and one for clinical staff. The two versions of the survey are identical except for items addressing agency setting and administrative issues which are included only on the agency director version. The content of the two survey versions is summarized in Exhibit 1.

Exhibit 1
2005 NFATTC Workforce Survey: Content by Version

Key Content Areas	Survey Version	
	Agency Director	**Clinical Staff**
Agency setting/characteristics	✓	
Demographics	✓	✓
Academic and professional background	✓	✓
Work detail	✓	✓
Salary and benefits	✓	✓
Staff size and turnover	✓	
Recruitment and retention issues	✓	✓
Job satisfaction and job stress	✓	✓
Proficiency and training interests	✓	✓
Technology access and use	✓	✓

Sampling

Agency directors were selected as the sampling unit for the current study, with a full census (100%) from Alaska, Hawai'i, Idaho, Oregon, and Washington included in the sample. Lists of treatment agencies were compiled from each state and organized by agency director name. Two important considerations guided the formulation of these lists: (a) agencies where substance abuse treatment was not the primary service provided were excluded, and (b) agency directors in charge of multiple facilities were asked to base their administrative responses across all facilities and to distribute staff surveys across all facilities. The lists of directors and facilities for each state was adjusted to reflect closures and, after adjustments, a total of 674 agency directors representing 936 treatment facilities were included in the final sample. Exhibit 2 details final sampling numbers.

Exhibit 2
Final Sampling Numbers

State	Number of Agency Directors	Number of Facilities	Number of Staff Surveys in Field (Facilities x 5)
Alaska	63	64	320
Hawai'i	30	31	155
Idaho	56	88	440
Oregon	148	250	1,250
Washington	377	503	2,515
TOTAL	674	936	4,680

Survey Administration and Follow Up

A packet containing 1 agency director survey along with 5 staff surveys for each facility was sent to each of the 674 agency directors in the sample. All agency directors were asked to have up to 5 clinical staff complete the survey at each facility they manage. Agency directors at larger agencies were advised that if they felt 5 staff responses would not sufficiently represent the size of their clinical staff, they could request more. These decisions were made in light of agency staff size data being unavailable, preventing a more scientific sampling strategy at the clinical staff level.

Surveys were mailed to agency directors along with an explanatory cover letter signed by Dr. Steve Gallon, Director of the NFATTC. Also included were instructions for completion and mail back. Prepaid return envelopes were included for surveys, as well as privacy envelopes. Surveys were returned directly to RMC Research Corporation. Prior to surveys being sent, a sponsor letter from each state's SSA director was sent to agency directors explaining the purpose of the study. In addition, a postcard was sent one week before the surveys were mailed to remind directors that the surveys were on the way.

In order to assure an adequate response rate, an extensive follow-up strategy was implemented. Key steps in the follow-up process included 10-day and 30-day reminder

postcards, follow-up phone calls with extensive SSA staff collaboration, and survey resends to nonresponders when requested. SSA staff follow-up activities included address corrections, reminder e-mails, phone calls, and assistance in coordinating resends. To accommodate return of resent surveys, the original survey due date of February 1, 2006, was extended to March 1, 2006. Key survey administration and follow-up activity dates are provided in Exhibit 3.

Exhibit 3
Key Survey Administration and Follow-up Dates

Survey Administration/ Follow-up Task	Date
Single state agency (SSA) endorsement letter	October 5, 2005
Reminder postcard	October 12, 2005
Survey mail out	October 17, 2005, through October 19, 2005
Follow-up postcards	October 24, 2005; November 14, 2005
Follow-up phone calls	December 1,2005, through December 16, 2005
SSA follow-up	December 1, 2005, through February 1, 2006
Survey return deadline	March 1, 2006

Response Rate

Final response rate was calculated using agency director response. As displayed in Exhibit 4, a 68% response rate was obtained across the region, with each state's response rate over or approaching 60%. In total, 459 agency director responses were returned along with 1,564 clinical staff responses. Efforts to hear from each facility across the region also appear to have been successful, as a director and/or a staff response was returned from 58% of the facilities in the region.

Exhibit 4
2005 NFATTC Workforce Survey Response Rate

State	Number and Percentage of Directors Returning their Survey	Number of Clinical Staff Returning a Survey	Number and Percentage of Facilities Returning a Director and/or a Staff Survey
Alaska	41/63 (65%)	137	41/64 (64%)
Hawai'i	21/30 (70%)	92	22/31 (71%)
Idaho	33/56 (59%)	92	34/88 (39%)
Oregon	101/148 (68%)	452	143/250 (57%)
Washington	263/377 (70%)	791	302/503 (60%)
TOTAL	**459/674[a] (68%)**	**1,564**	**542/936[a] (58%)**

[a]Total number of directors and facilities has been adjusted to reflect closures.

Analysis Strategy

Data were analyzed using an array of methods available in the Statistical Package for the Social Sciences (SPSS), Version 13.0 (SPSS, Inc., 2005). Because of the categorical nature of much of the data collected, data were examined using primarily cross-tabulations. Chi-square analyses were conducted on all cross-tabulations to identify statistically significant differences. Differences were examined across role (director vs. clinical staff), as well as across theoretically meaningful respondent characteristics (including gender, ethnicity, and recovery status) and agency characteristics (agency size), and are reported if significant. Multiple linear regression analyses were used to examine potential predictors of salary for agency directors and for clinical staff, and to examine predictors of staff turnover at the agency level. Individual turnover was examined using logistic regression analyses, resulting in odds ratios for characteristics predicting directors' and clinicians' likelihood of changing agencies or leaving the field.

Equivalence of 2002 and 2005 Samples

While some additional content is included on the 2005 NFATTC Workforce Survey, the vast majority of the instrument is parallel to that used in 2002. This consistency affords the opportunity for comparative analyses to address questions of change in the substance abuse treatment workforce of interest to policymakers across the region. For example:

- Is the cultural diversity of the workforce expanding to better match the characteristics of the service population?

- Are younger, new graduates moving into the workforce at a greater rate than in the past?

- Are evidence-based treatment practices more prevalent across the region?

While the instrument has changed little, considerable effort was directed toward increasing and strengthening the sample in 2005. A census sampling process was conducted in all states for the first time. As already reported, with significant investment and participation from the SSAs across the region, results were excellent. Among agency directors, the sample size available for analyses of the 2005 NFATTC Workforce Survey is more than 5 times that of 2002. More important than sheer numbers, the proportion of the target population responding also substantially improved, from just over 50% in 2002 to nearly 70% in 2005.

While this affords much more statistical precision in looking at current survey results, the change in sampling method in the region's two largest states suggests some caution in looking at changes in survey results over time there. Is the survey estimating the same population in Oregon and Washington in 2005 as it was in 2002? Has the more thorough census sample in 2005 included segments of the agency population that were inadvertently excluded in 2002? If it has, comparisons of results across the two years are less meaningful because they are estimating results from different populations. If it has not, however, the comparisons are valid and the estimates in 2005 will be significantly more precise.

To address this, some fundamental agency characteristics from the 2002 and 2005 samples were compared for each state to determine if both samples were drawn from essentially the same population of treatment agencies. Confidence intervals were constructed around sample estimates of characteristics from both years and revealed no significant differences between the 2002 and 2005 samples from Oregon (Exhibit 5). Results indicate that confidence intervals for 2002 and 2005 sample estimates overlap, indicating that the 2005 sample is measuring the same population in Oregon as the 2002 sample. Results also reveal that due to the increased sample size, the precision of measurement has increased in 2005.

Exhibit 5
Equivalence of 2002 and 2005 Samples—Oregon

	2002 Dataset (*n* = 41 directors)		2005 Dataset (*n* = 101 directors)	
	Sample Estimate (%)	Confidence Interval (95%)	Sample Estimate (%)	Confidence Interval (95%)
Geography				
Pop. less than 5,000	15	4–26	5	1–9
Pop. 5,001 to 50,000	35	20–50	35	26–44
Pop. 50,001 to 500,000	28	14–42	39	29–49
Pop. over 500,000	23	10–36	20	12–28
Agency Type				
Private, for profit	27	13–41	26	17–35
Nonprofit (public or private)	54	39–69	53	43–63
Government (federal)	0	–	0	–
Government (state)	0	–	0	–
Government (local, county, community)	12	2–22	17	10–24
Tribal (Indian Health Services; tribal government)	5	0–12	4	0–8
Other	2	0–6	0	–
Agency Size				
2 or fewer staff	14	3–25	19	11–27
3 to 5 staff	29	15–43	23	15–31
6 to 11 staff	19	7–31	27	19–35
12 or more staff	38	23–53	28	19–37

Data Interpretation
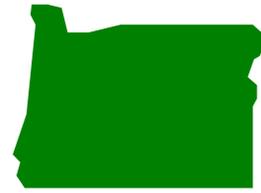
Survey results are presented by topical category. Descriptive results are reported by agency director and clinical staff responses (referred to as *role*). Other cross-tabs of interest are described when applicable. Unless otherwise noted, only valid cases are included in analysis; therefore sample sizes may vary from variable to variable.

Chi-square analyses are conducted on all cross-tabs to identify statistically significant differences between groups. Only statistically significant findings are presented in the body of the report, with full data provided in the Technical Appendix. Multiple linear regressions are provided to identify significant predictors of salary and agency turnover. Logistic regression analysis examines predictors of individual-level turnover.

When available, comparative data from 2002 is provided. Interpretation of differences between 2002 and 2005 data is guided by confidence intervals. Instances where the 95% confidence intervals around the sample estimates measured in 2002 and 2005 do not overlap will be noted, as this is equivalent to an indication that the 2002 and 2005 values are (statistically) significantly different from each other. When the 95% confidence intervals overlap, differences between 2002 and 2005 are likely due to sampling error and not a true change in the population value. Note that the confidence intervals around the 2005 estimates will always be smaller than those of 2002 due to the larger sample sizes for, and hence greater confidence in, the 2005 results.

Agency Characteristics
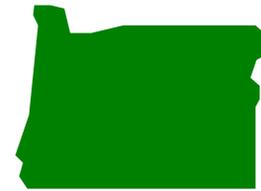
Geography

Based on agency director responses, the majority of Oregon substance abuse treatment agencies reside in geographic areas with populations of 5,001 to 50,000 (35%) and 50,001 to 500,000 (39%). To provide another look at geography, agency zip codes are grouped using Rural Urban Commuting Area (RUCA) codes (Morrill, Cromartie, & Hart, 1999). Results indicate that while the majority of agencies reside in Oregon's urban core (59%), a fair number also reside in large towns (24%).

Exhibit 6
Geographic Area of Agencies

Population	Agencies[a]
Less than 5000	5 (5%)
5,001 to 50,000	35 (35%)
50,001 to 500,000	39 (39%)
Greater than 500,000	20 (20%)

[a]n = 99 (2 directors did not respond to this item).

Exhibit 7
Rural Urban Commuting Area (RUCA) of Agencies

RUCA Code	Agencies[a]
Urban core	60 (59%)
Rural urban fringe	4 (4%)
Large town	24 (24%)
Small town/isolated rural	13 (13%)

[a]n = 101.

Agency Size and Structure

Agency directors were asked to indicate the number of direct service clinical staff that work in their respective agencies, from which agency size was calculated. Exhibit 8 shows the distribution of agency size across the state. Results indicate that agency size is extremely diverse in Oregon.

Exhibit 8
Agency Size

Number of Direct Clinical Staff	Agencies[a]
2 or fewer staff	19 (20%)
3 to 5 staff	23 (24%)
6 to 11 staff	27 (28%)
12 or more staff	28 (29%)

[a]n = 97 (4 directors did not provide staffing numbers).

Nearly all directors (91%) report that their agency is accredited and/or licensed. Over one half of directors (56%) report that their agency has multiple locations or facilities. The majority of directors in Oregon report that their agency is either private, nonprofit (48%) or private, for-profit (26%). Full agency setting results are provided in Exhibit 9.

Exhibit 9
Agency Setting

Primary Agency Setting	Agencies[a]
Private, for-profit	25 (26%)
Private, nonprofit	46 (48%)
Public, nonprofit	5 (5%)
Government (federal, state, county, community)	16 (17%)
Tribal	4 (4%)

[a]n = 96 (5 directors did not respond to this item).

In total, 41% of directors report that their agency receives state alcohol and drug authority (SADA) funds. On average, directors receiving SADA money report that these funds account for 30% to 40% of their agency's operating budget. Annual operating budgets as well as the number of clients served each year both vary dramatically by agency size, as displayed in Exhibit 10. It should be noted, however, that within each agency size category, both operating budgets and clients served demonstrate a large range. This likely indicates a relationship of both to other variables such as level of service(s) provided and agency setting.

Exhibit 10
Agency Budget and Client Numbers

Agency Size	Mean Annual Operating Budget (min; max)	Mean Number of Clients Served Annually (min; max)
2 or fewer	$403,921 (26,000; 3,000,000)	111 (30; 300)
3 to 5 staff	$325,877 (90,000; 1,038,000)	521 (50; 2600)
6 to 11 staff	$1,053,751 (300,000; 3,657,754)	312 (80; 900)
12 or more staff	$6,250,000 (100,000; 10,000,000)	1,925 (30; 13,700)
Overall Mean	$1,479,548	811

Treatment Services

Agency director reports indicate a wide range of services available in facilities across the state. As presented in Exhibit 11, facilities providing outpatient care are by far the most common, as 80% of directors report that their agency provides some outpatient treatment. Interestingly, nearly one third of directors indicate that their agency provides residential treatment (32%). Mental health facilities are also quite common, with 29% of agency directors reporting that they provide mental health treatment. As displayed in Exhibit 12, director data also indicate that agencies across the state serve multiple special populations, although it is not clear if the service provided to these groups is tailored to the unique challenges present with each.

Exhibit 11
Facility Types

Modality	Agencies[a]
Detoxification	12 (12%)
Outpatient	81 (80%)
Residential	32 (32%)
Mental health center	29 (29%)
Shelter	3 (3%)
Solo or group practice	4 (4%)
General hospital	1 (1%)
Psychiatric	0 (0%)
Criminal justice	12 (12%)
Community or religious	2 (2%)
Community health center	4 (4%)
Halfway house	1 (1%)
Therapeutic community	6 (6%)
Opioid replacement	6 (6%)
Other	6 (6%)

Note. Percentages do not add to 100% because respondents
were asked to check all that apply.
[a]*n* = 101.

Exhibit 12
Special Populations Served

Population	Agencies[a]
Adolescents	55 (55%)
Persons with co-occurring disorders	92 (91%)
Persons with HIV/AIDS	56 (55%)
Gay and lesbians	61 (60%)
Seniors/older adults	55 (55%)
Pregnant/post-partum women	57 (56%)
Women	76 (75%)
Men	72 (71%)
DUI/DWI	68 (67%)
Other criminal justice clients	76 (75%)

Note. Percentages do not add to 100% because respondents were
asked to check all that apply.
[a]*n* = 101.

Workforce Demographics
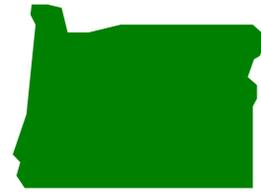
Gender and Ethnicity

Overall, 55% of agency directors and 60% of clinicians are female, and the majority of both agency directors (86%) and clinicians (79%) are white. Only 15% of directors and 21% of clinicians are nonwhite, and only 2% of directors and 4% of clinicians report being Hispanic. Interestingly, chi-square analysis indicates that a significantly larger proportion of male than female clinicians report being nonwhite ($p < .05$). Neither gender nor ethnicity of directors or clinicians show any significant shift from 2002 to 2005.

Exhibit 13
Gender

Gender	Directors		Clinicians	
	2005[a] (*n* = 101)	2002[b] (*n* = 41)	2005[c] (*n* = 452)	2002[d] (*n* = 147)
Female	55%	55%	60%	60%
Male	45%	45%	40%	40%

Note. 95% confidence intervals around these estimates are: [a] ± 10; [b] ± 15; [c] ± 5; [d] ± 8.

Exhibit 14
Ethnicity

Ethnic Group	Directors		Clinicians	
	2005[a] (*n* = 101)	2002[b] (*n* = 41)	2005[c] (*n* = 452)	2002[d] (*n* = 147)
American Indian	5%	2%	4%	2%
Alaskan Native	0%	0%	0%	0%
Asian American	0%	2%	2%	3%
Native Hawaiian/ Other Pacific Islander	1%	1%	1%	1%
Black/African American	1%	0%	4%	2%
White or Caucasian	86%	83%	79%	78%
Multi-Ethnic*	–	7%	–	3%
Other	7%	2%	11%	6%

Note. 95% confidence intervals around these estimates are: [a] ± 10; [b] ± 15; [c] ± 5; [d] ± 8.
*Not included on 2005 survey.

Age

The average age for those surveyed is 53 years old for agency directors and 48 years old for clinicians. Exhibit 15 displays age category by role. Results indicate that 73% of directors and 50% of clinicians are 50 years old or older. Further, 25% of directors are 60 years old or older. Some significant age differences are present within the workforce. Differences in age from 2002 to 2005 all seem to be due to the aging of the workforce. However, it should be noted that the percentage of 20 year olds in 2005 is half of what it was in 2002, perhaps indicating that fewer young people are entering the field. Overall, a significantly larger proportion of clinicians (23%) than directors (6%) are under the age of 40 (p < .001). In addition, a significantly larger proportion of recovering than nonrecovering clinicians belong to older age categories (p < .001).

Exhibit 15
Age Category

Age Category	Directors		Clinicians	
	2005[a] (*n* = 101)	2002[b] (*n* = 41)	2005[c] (*n* = 452)	2002[d] (*n* = 147)
20–29 years old	1%	5%	7%	14%
30–39 years old	5%	2%	16%	17%
40–49 years old	21%	36%	28%	37%
50–59 years old	48%	48%	37%	29%
60 + years old	25%	10%	13%	3%

Note. 95% confidence intervals around these estimates are: [a] ± 10; [b] ± 15; [c] ± 5; [d] ± 8.

The entire workforce also demonstrates a high average age of entry into the field. Results indicate that the average age of entry was 37 years for directors and 39 years for clinicians. In fact, 75% to 80% of the workforce indicates entering the field after the age of 30. These numbers parallel the finding that 52% of directors and 47% of clinicians report that substance abuse treatment is a second career. Interestingly, a significantly larger proportion of recovering clinicians enter the field after the age of 40 than do nonrecovering clinicians (p < .001). This may indicate that choosing substance abuse treatment as a career later in life may be motivated not by just a personal interest in addictions, but a personal experience with addiction.

Recovery Status

Exhibit 16 displays recovery status for both directors and clinicians and reveals that 38% of directors and 43% of clinicians report being in recovery. These estimates could be higher with 5% of directors and 8% of clinicians not disclosing their recovery status. Results indicate that a significantly larger proportion of male than female clinicians report being in recovery (p < .001). Also of interest, a significantly larger proportion of minority directors report being in recovery (p < .05). Differences between the recovering and nonrecovering segments of the workforce are quite prevalent across multiple variables including age,

degree status, years experience, certification/licensure, and likelihood of leaving the field. These differences are cited throughout the report.

Exhibit 16
Recovery Status

Recovery Status	Directors (*n* = 101)	Clinicians (*n* = 452)
Recovering	38%	43%
Nonrecovering	41%	33%
Nonrecovering with family experience with addictions	14%	11%
Prefer not disclose	5%	8%
Other	1%	4%

Academic and Professional Background

Reason for Entry into the Field

As displayed in Exhibit 17, the most frequently cited reasons for entering the field for both directors (57%) and clinicians (60%) are a previous experience with addiction or recovery (personal or family) and a personal interest in substance abuse treatment (49% and 54%, respectively).

Exhibit 17
Reason for Entry Into the Field

Reason	Directors		Clinicians	
	2005[a] (*n* = 101)	2002[b] (*n* = 41)	2005[c] (*n* = 452)	2002[d] (*n* = 147)
Previous experience with addiction or recovery (personal or family)	57%	57%	60%	61%
Personal interest	49%	64%	54%	64%
Experience in a similar field	25%	29%	25%	28%
Academic work or degree in a similar field	30%	29%	24%	32%
Role as a change agent*	35%	–	26%	–
Desire to lead*	20%	–	13%	–
Unplanned decision	21%	12%	20%	16%
Career progression*	28%	–	20%	–
Compensation*	4%	–	3%	–
Other	8%	17%	9%	14%

Note: Respondents asked to check all that apply. 95% confidence intervals around these estimates are: [a] ± 10; [b] ± 15; [c] ± 5; [d] ± 8.
*Not included in 2002 survey.

Years Experience

Years experience of the workforce was measured in three different ways: (a) years experience in the substance abuse field, (b) years in current role (director or clinician), and (c) years in current position with agency. Exhibit 18 displays the mean years experience for each of these by role. Directors average 16 years in the field and 7 years in their current position, while clinicians average 9 years in the field and 5 years in their current position. It should be noted that years experience is extremely variable for clinicians, ranging from less than 1 year to 35 years across the sample. Interestingly, both directors and clinicians indicate considerably more time in the field than time in their current role, potentially indicating some change in roles over time.

Exhibit 18
Years Experience

	Mean Years	
	Directors	**Clinicians**
Experience	**(n = 97)**	**(n = 441)**
Years in field	16.3	9.2
Years in role	7.3	5.3
Years in position	6.7	5.2

Note. 4 directors and 11 clinicians did not respond.

Due to significant variance, years experience in the field is also examined categorically (Exhibit 19). Results indicate that a significantly larger proportion of directors (60%) than clinicians (25%) report 15 or more years experience in the field ($p < .001$). Also of interest, a significantly larger proportion of recovering directors ($p < .01$) and clinicians ($p < .05$) report more years experience in the field than their nonrecovering colleagues.

Despite an average of 9 years experience in the field, approximately one third of clinicians (32%) have only 0 to 4 years experience. Further, as displayed in Exhibit 20, examination of the average age of clinicians who have 0 to 4 years experience is also quite variable, again

highlighting that clinicians are entering the field at all ages. It is important to note that more than half of these recent entries into the field (56%) are over 40 years old.

Exhibit 19
Years Experience in Field

Years Experience in Field	Directors (*n* = 94)	Clinicians (*n* = 441)
0 to 4 years	9%	32%
5 to 9 years	15%	27%
10 to 14 years	16%	17%
15 to 19 years	23%	13%
20 + years	37%	12%

Note: 7 directors and 11 clinicians did not respond.

Exhibit 20
Age of Clinicians with 0 to 4 Years Experience

60 + yrs old 3%
20 to 29 yrs old 17%
50 to 59 yrs old 23%
30 to 39 yrs old 27%
40 to 49 yrs old 30%

- 20 to 29 yrs old
- 30 to 39 yrs old
- 40 to 49 yrs old
- 50 to 59 yrs old
- 60 + yrs old
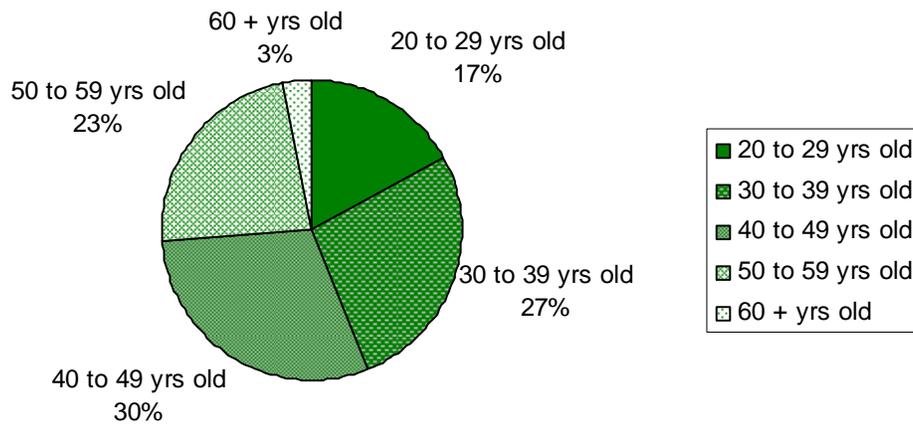
Degree Status and Alcohol and Other Drug Coursework

Exhibit 21 displays degree status by role. Results indicate that 81% of directors and 65% of clinicians have a Bachelor's degree or above. Further, 59% of directors and 34% of clinicians have a Master's degree or above. Analysis indicates that the difference in the proportion of directors and clinicians with a Master's degree or above is significant (p < .001). Interestingly, a significantly larger proportion of male (76%) than female (45%) directors have a Master's degree or above (p < .01).

Analysis also indicates that a significantly smaller proportion of minority directors (p < .05) have a Bachelor's degree or above. However, a significantly larger proportion of minority directors have a Ph.D. (p < .05). Also of interest, a significantly smaller proportion of recovering (52%) than nonrecovering (76%) clinicians (p < .001) have a Bachelor's degree or above. Further, only 20% of clinicians in recovery have a Master's degree or above, compared to 44% of clinicians not in recovery.

Exhibit 21
Degree Status

	Directors		Clinicians	
	2005[a]	2002[b]	2005[c]	2002[d]
Level of Education	(n = 101)	(n = 41)	(n = 452)	(n = 147)
Less than high school	0%	0%	<1%	0%
High school	1%	0%	5%	3%
Some college	12%	10%	17%	17%
Associate's degree	6%	10%	13%	14%
Bachelor's degree	23%	21%	30%	27%
Master's degree	49%	43%	33%	29%
Ph.D.	10%	14%	<1%	1%
M.D.*	0%	–	<1%	–
Other professional degree*	0%	–	1%	–
Other	0%	0%	1%	5%

Note. 95% confidence intervals around these estimates are: [a] ± 10; [b] ± 15; [c] ± 5; [d] ± 8.
*Not included in 2002 survey.

Directors and clinicians were also asked to report the amount of college or university coursework they have completed in four content areas: (a) substance abuse, (b) mental health, (c) administration/management, and (d) human service field. Results, displayed in Exhibit 22, indicate that while many members of the workforce have taken some specialized coursework, fewer have obtained a specialized minor/certificate or degree. Fewer than 20% of the workforce in Oregon report having a substance abuse-specific degree. Interestingly, more directors and clinicians report having mental health degrees than substance abuse degrees. This finding does vary significantly by recovery status however. In fact, 36% of nonrecovering clinicians compared to only 14% of recovering clinicians have a degree in mental health. Interestingly, this finding holds true for directors as well, as 44% of nonrecovering directors versus 32% of recovering directors have a mental health degree.

Overall, 68% of directors and 51% of clinicians have a degree in at least 1 of the 4 afore-mentioned content areas. It should also be noted that 18% of directors and 32% of clinicians report currently participating in an academic degree or certification program.

Exhibit 22
Specialized Coursework, Certificates, and Degrees

Content Area	Directors (*n* = 101)	Clinicians (*n* = 452)
Substance abuse		
Coursework	57%	62%
Minor/certificate	27%	30%
Degree	17%	18%
Mental health		
Coursework	62%	46%
Minor/certificate	13%	10%
Degree	40%	26%
Administration/management		
Coursework	43%	16%
Minor/certificate	11%	3%
Degree	19%	5%
Human service		
Coursework	41%	36%
Minor/certificate	10%	9%
Degree	26%	23%

Certification/Licensure

The certification and licensure status of directors and clinicians is reported in Exhibit 23. Respondents were placed in 3 categories: current, active, and inactive. The current category includes respondents with current certification and/or licensure. The active category aggregates all respondents who are currently pursuing or are awaiting certification and/or licensure. Finally, the inactive category represents the segment of the workforce that does not have and are not actively pursuing certification and/or licensure. It is unclear based on available data what national and local certification and licensing organizations are represented in the data below.

Overall, 57% of directors and 69% of clinicians report current certification. In addition, 30% of directors and 21% clinicians report current licensure. Estimates indicate that

approximately 16% of directors and 24% of clinicians have both active/current certification and licensure. Conversely, estimates indicate that approximately 24% of directors and 9% of clinicians have neither active/current certification nor licensure.

Exhibit 23
Certification/Licensure Status

Status	Directors (n = 101)		Clinicians (n = 452)	
	Certification	Licensure	Certification	Licensure
Current	57%	30%	69%	21%
Active (pending, awaiting, pursuing)	3%	2%	15%	11%
Inactive (never, previous)	40%	68%	16%	68%

Some significant differences exist in reported certification/licensure status. A significantly larger proportion of directors than clinicians report inactive certification status (40% vs. 16%; p < .001). However, a significantly larger proportion of directors than clinicians report current licensure status (30% vs. 21%; p < .01). Results also indicate that a significantly larger proportion of directors (82%) and clinicians (77%) in recovery have current certification than directors (41%) and clinicians (63%) who are not in recovery (p < .001). Interestingly, a significantly larger proportion of nonrecovering clinicians (41%) than recovering clinicians (19%) report active/current licensure (p < .001). This finding could be the result of the higher percentage of nonrecovering clinicians who have a mental health degree.

Work Detail
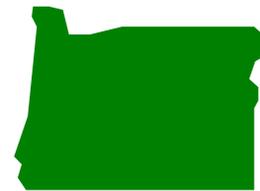
Time Spent

Directors and clinicians were asked to report the amount of time spent on various client-related and administrative tasks in a typical week (Exhibit 24). Overall, directors report spending the majority of their time on administrative tasks (83%), while clinicians report spending the majority of their time on client-related tasks (64%). Perhaps not surprisingly, directors' time on these tasks varies significantly based on the size of their agency, with directors at smaller agencies spending significantly more time on client-related tasks (p < .01).

Exhibit 24
Percentage of Time Spent on Client-Related and Administrative Tasks

Task Type	Task	Directors (*n* = 90)	Clinicians (*n* = 379)
Client-Related	Screening and assessment	5%	13%
	Diagnosing	<1%	3%
	Individual counseling	5%	18%
	Group counseling	3%	16%
	Family counseling	1%	3%
	Case management	2%	8%
	Making referrals	0%	2%
	Total Client Related Time	**17%**	**64%**
Administrative	Participating in training	0%	2%
	Providing clinical supervision	13%	5%
	Receiving clinical supervision	1%	3%
	Overseeing personnel	11%	<1%
	Paperwork/documentation	14%	14%
	Meetings	18%	6%
	Other administrative	25%	<1%
	Other activities	2%	5%
	Total Administrative Time	**83%**	**35%**

Note. Responses included in analysis if total time added from 90% to 110%.

Interestingly, clinicians report nearly equal amounts of time performing individual counseling sessions (18%) as they do group counseling sessions (16%) despite the cost differences associated with the two. This finding contrasts with anecdotal beliefs that face-to-face time with clients is composed strictly of group sessions. Little time, however, is devoted to family counseling (3%), which may be of concern considering increasing literature that indicates the value of engaging the family in treatment activities (Center for Substance Abuse Treatment, 2004). Also worth noting, clinicians report spending just 14% of their time (a little over 1 hour each day) on paperwork/documentation, far below anecdotal reports indicating that clinicians spend upwards of 50% of their time on paperwork.

Consistent with past reports (Knudsen, Gallon, & Gabriel, in press), results of multivariate analysis of variance do little to dispel concerns that substance abuse treatment trainees or clinicians with less experience or education are doing the same work as their more experienced or educated counterparts. Results indicate that clinicians' time spent on client-related and administrative tasks does not vary in a practically meaningful way based on academic and professional background characteristics (degree status, degree specific to substance abuse, certification/licensure status, years experience).

Caseload Detail

Both directors and clinicians provided detail regarding their client caseloads. Just under one third of directors (30%) report carrying a caseload, with an average caseload size of 23 clients. The majority of clinicians (81%) report carrying a caseload, with an average caseload size of 35 clients. Only 14% of clinicians carrying a caseload report that their caseload is not manageable.

Interestingly, the 19% of clinicians who reported not carrying a caseload still report spending 39% of their time on client-related tasks. The full meaning of this result is unclear,

but it may point out that some clinicians are being utilized in a different capacity than others.

Treatment Models in Use

Directors and clinicians were asked to report which treatment models are in use in their agency and to identify how heavy an emphasis each had in their agencies' approach (minor, moderate, major). Exhibit 25 displays the percentage of directors and clinicians endorsing various treatment models as having a major emphasis in their agencies' approach. From both directors' and clinicians' perspectives, relapse prevention, motivational interviewing, cognitive-behavioral therapy, and strengths-based treatment are the most frequently endorsed models playing a major role. While these data do not address fidelity of implementation, it is encouraging that all 4 of these models are considered evidence-based practices.

Exhibit 25
Treatment Models that Play a Major Role in Agency Approach

Treatment Models	Directors (*n* = 101)	Clinicians (*n* = 452)
12-Step Principles	36%	37%
Behavior Modification/Token Reinforcement	16%	13%
Biopsychosocial	30%	21%
Cognitive Behavioral Therapy	61%	50%
Community Reinforcement	17%	20%
Coping Skills Therapy	23%	32%
Culture Specific	19%	14%
Developmental Model	3%	4%
Dialectical Behavior Therapy	5%	10%
Family	29%	24%
Gender Specific	27%	28%
Harm Reduction/Containment Skills	17%	16%
Integrated Substance Abuse & Mental Health	35%	29%
Intensive Case Management	26%	20%
Minnesota Model	4%	3%
Moral Recognition Therapy	2%	4%
Motivational Interviewing	55%	62%
Motivational Enhancement Theory	25%	22%
Opiate Substitution	6%	8%
Pharmacotherapy	11%	6%
Psycho-Educational	33%	21%
Psychotherapy	14%	8%
Rational Emotive Therapy	2%	8%
Rational Recovery	0%	2%
Reality Therapy	4%	8%
Relapse Prevention	58%	66%
Self-Regulating "Therapeutic" Community	8%	10%
Social Model	4%	6%
Social Skills Training	16%	16%
Solution Focused	19%	25%
Strengths Based	40%	39%
Systems Theory	9%	9%

Clinical Supervision
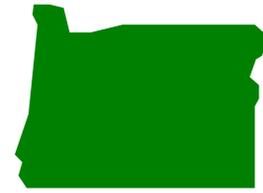
Frequency of Clinical Supervision

Given the importance of clinical supervision in assuring treatment quality, directors and clinicians were asked to provide estimates of how frequently clinical supervision is occurring at their agency. Overall, 64% of directors and 54% of clinicians report daily or weekly clinical supervision. Another 32% of directors and 38% clinicians report biweekly or monthly clinical supervision. Interestingly, 4% of directors and 8% of clinicians report *not applicable* when asked about the frequency of clinical supervision at their agency. Analysis indicates that the differences in director and clinician reports of clinical supervision are significant ($p < .05$), perhaps indicating some confusion over the delivery of clinical supervision.

Overall, clinicians report spending an average of 3% (approximately 1½ hours) of their time each week receiving clinical supervision. As displayed in Exhibit 26, results indicate that clinicians reporting more frequent clinical supervision also report more clinical supervision in terms of time. In total, clinicians across the state report receiving 3 to 8 hours of clinical supervision per month. Unfortunately, the survey did not ask respondents to describe the clinical supervision activities provided. It is not known if what is reported to be clinical supervision is actually administrative in nature as opposed to clinical feedback, mentoring, or skill improvement.

Exhibit 26
Clinical Supervision Time Provided to Clinicians

Frequency of Clinical Supervision	Percentage of Clinicians Receiving[a]	Total Clinical Supervision Time Provided Each Week[b]	Total Clinical Supervision Time Provided Each Month[b]
Daily	6	2 hours	7.9 hours
Weekly	48	Approx. 1.5 hours	5.5 hours
Biweekly	15	Approx. 1 hour	4.5 hours
Monthly	23	Approx. 42 minutes	2.8 hours

[a]Clinicians reporting *not applicable* were not included (8%). [b]Numbers calculated from clinician reports of time spent receiving clinical supervision each week.

Salary and Benefits
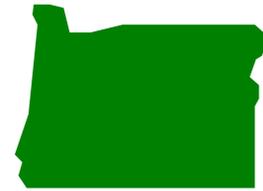
Salary

Exhibit 27 displays reported salary by role. Director salaries are quite variable in Oregon, although 80% of directors report earning $45,000 or more each year. Clinician salaries are less variable, with 86% of clinicians earning less than $45,000 each year. The difference in reported director and clinician salaries is significant ($p < .001$). Overall, 72% of directors and 69% of clinicians report being the primary wage earner for their family.

Exhibit 27
Salary

Salary	Directors (n = 258)	Clinicians (n = 778)
Less than $15,000	4%	6%
$15,000–$24,999	2%	25%
$25,000–$34,999	4%	34%
$35,000–$44,999	11%	21%
$45,000–$54,999	20%	8%
$55,000–$64,999	31%	3%
$65,000–$74,999	15%	2%
$75,000 or higher	14%	<1%

Note. Comparisons to 2002 salaries are not possible due to different categories.

Analysis indicates that salary does vary by agency size. A significantly larger proportion of directors at agencies with 12 or more staff report earning $65,000 or more each year ($p < .05$). A significantly larger proportion of clinicians at agencies with 12 or more staff report earning $55,000 or more each year ($p < .01$). Clinician salaries also vary significantly

by agency type, with a significantly larger proportion of clinicians at government agencies (local, county, and community) reporting higher salaries ($p < .001$). In fact, 63% of clinicians at government agencies report earning between $35,000 and $54,999. Both director and clinician salaries also appear to be lower at agencies that do not receive state alcohol and drug authority (SADA) funding. A significantly larger proportion of directors at agencies who do not receive SADA funds (33%) than agencies who do receive SADA funds (4%) earn less than $45,000 ($p < .05$). In addition, a significantly larger proportion of clinicians at agencies who receive SADA funds (17%) than agencies who do not receive SADA funds (8%) earn more than $45,000 ($p < .01$).

Benefits

Exhibit 28 displays reported benefits for directors and clinicians. Overall, 92% of directors and clinicians report receiving full or partial health insurance benefits, while 79% of directors and 77% of clinicians report receiving retirement benefits. Both sick leave and vacation/other paid leave are provided to the vast majority of the workforce, while a sizeable portion of the workforce is not provided with maternity leave or tuition assistance. Some positive trends are evident in the provision of benefits since 2002. It appears that since 2002, fewer directors are without health insurance benefits. In addition, it appears that a larger proportion of clinicians are now being fully provided with retirement benefits.

Some important statistical differences are present in the provision of benefits. A significantly larger proportion of male clinicians (68%) than female clinicians (57%) report having health insurance fully provided ($p < .05$). Also of interest, a significantly larger proportion of nonminority directors (88%) than minority directors (57%) report having sick leave fully provided ($p < .01$). Finally, a significantly larger proportion of clinicians at agencies with 12 or more staff have fully or partially provided retirement benefits ($p < .05$).

Exhibit 28
Benefits

Benefit	Directors		Clinicians	
	2005[a] (*n* = 101)	2002[b] (*n* = 41)	2005[c] (*n* = 452)	2002[d] (*n* = 147)
Health insurance				
Fully provided	61%	64%	61%	54%
Partially provided	31%	17%	31%	35%
Not provided	8%	17%	8%	6%
Sick leave				
Fully provided	84%	79%	79%	74%
Partially provided	6%	7%	12%	13%
Not provided	10%	10%	9%	7%
Vacation/other paid leave				
Fully provided	85%	74%	85%	66%
Partially provided	7%	12%	8%	14%
Not provided	8%	12%	6%	8%
Retirement plan				
Fully provided	48%	55%	53%	37%
Partially provided	31%	14%	24%	35%
Not provided	21%	24%	22%	15%
*Maternity leave**				
Fully provided	69%	–	54%	–
Partially provided	13%	–	17%	–
Not provided	18%	–	30%	–
*Tuition assistance**				
Fully provided	14%	–	15%	–
Partially provided	37%	–	25%	–
Not provided	49%	–	60%	–

Note. 95% confidence intervals around these estimates are: [a] ± 10; [b] ± 15; [c] ± 5; [d] ± 8.
*Not included in 2002 survey.

Predictors of Salary

Multiple linear regression was run to examine potential predictors of salary for the workforce in Oregon (Exhibit 29). Four categories of predictors are included in the analysis: (a) demographic, (b) professional/academic background, (c) additional compensation/benefits, and (d) agency characteristics. Results indicate that the regression model accounts for 34% of the variability in directors' salaries ($R^2 = .343$), and 46% of the variability in clinicians' salaries ($R^2 = .458$).

Exhibit 29
Predictors of Salary

Model Details	Significance of Predictor to Model	t-value
Directors[a]		
Agency size	$p < .01$	3.215
Clinicians[b]		
Recovery status	$p < .05$	2.082
Degree status	$p < .001$	4.464
Years experience in field	$p < .001$	6.988
Licensure status	$p < .001$	3.371
Health insurance	$p < .05$	-2.394
Retirement benefit	$p < .001$	-3.605
Agency geography (RUCA category)	$p < .001$	-3.932

Note. RUCA = Rural Urban Commuting Area
[a]$R^2 = .343$. [b]$R^2 = .458$.

Results indicate that a few individual factors appear to be significant predictors of salary. For directors, managing a larger agency (in terms of staff size) is strongly related to earning a higher salary. So, all other things being equal, directors in charge of larger agencies earn more money in Oregon. For clinicians, results indicate that multiple factors appear to be significant predictors of salary. Overall, recovery status, degree status, years experience in the field, licensure, provision of health insurance, retirement benefits, and agency

geography are all related to earning a higher salary. Clinician results are best interpreted in the following way: (a) all other things being equal, clinicians not in recovery earn a higher salary, (b) all other things being equal, clinicians with higher degree status earn a higher salary, (c) all other things being equal, clinicians with more years experience earn a higher salary, (d) all other things being equal, clinicians with current licensure earn a higher salary, (e) all other things being equal, clinicians provided with health insurance earn a higher salary, (f) all other things being equal, clinicians provided with retirement benefits earn a higher salary, and (g) all other things being equal, clinicians in more urban parts of the state earn a higher salary.

These results are a positive sign that agencies are compensating clinicians for professional background characteristics such as degree status and experience. The relationship between current licensure and higher clinician salary may be explainable if reported licensure is in mental health. Past reports (Arrasmith, Pantages, & Gallon, 1999) have shown that mental health professional earn higher salaries in the region. The relationship of salary to health insurance and retirement benefits is interesting and likely points to the fact that agencies able to afford paying high salaries are also those better able to pay for benefits. Finally, the relationship of agency geography and salary is likely due to economic forces such as cost of living.

Staffing and Turnover
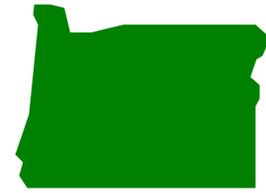
Agency Staffing Numbers

As previously reported, the size of substance abuse treatment agencies across the state is quite variable. Agencies vary in size from individually run treatment facilities to agencies employing over 50 clinical staff. Average staffing numbers as provided by directors are provided in Exhibit 30. On average agencies employ 13 clinical staff, over two thirds of which have full time status. Agencies report employing an average of 1½ substance abuse treatment trainees. While it is unclear whether substance abuse treatment trainees were included in estimates of clinical staff, data indicate that on average agencies employ 1 trainee for every 10 clinicians on staff.

Exhibit 30
Agency Staffing Numbers

Staffing Numbers (people)	Mean (min, max)[a]
Total staff size (direct clinical staff)	13.23 (0, 90)
Full time	9.14 (0, 60)
Part time	2.56 (0, 23)
On call	0.82 (0, 30)
Trainees	1.57 (0, 18)

Note. Directors reporting 0 staff do not employ anyone besides themselves.
[a]*n* = 101.

Agency-Level Turnover

Past reports demonstrate turnover to be a substantial problem for substance abuse treatment agencies across the country. Workforce reports consistently place staff turnover estimates between 16% to 26% (Gabriel & Knudsen, 2003; Knudsen, 2003, 2004, 2005, 2006), with some estimates projecting agency level turnover being as high as 50% (McClellan, Carise, & Kebler, 2003).

Agency directors in Oregon, in addition to indicating the size of their clinical staff, were asked to report the amount of turnover they experienced in the past year (Exhibit 31). Turnover is defined in 3 ways: (a) laid off, (b) terminated, and (c) quit (voluntary turnover). Total turnover is then calculated and compared against clinical staff size to determine an agency-level turnover rate.

Based on agency director reports of staffing in the past year, agencies experience an average turnover rate of 23% of their staff. This rate is slightly elevated from the 20% turnover rate reported in 2002. Interestingly, 42% of directors report no turnover in the past year, while 14% of directors report turnover rates of 50% or higher. Consistent with 2002 data is the fact that most turnover (60%) in agencies across the state is voluntary (quitting).

Exhibit 31
Agency-Level Staff Turnover

Staffing Numbers (people)	Mean (min, max)[a]
Laid off	0.29 (0, 5)
Terminated	0.89 (0, 13)
Quit	1.75 (0, 35)
Total turnover	2.93 (0, 48)
Turnover rate	23% (0%, 225%)

Note. Mean number of staff laid off, terminated, and quit within each state may represent duplicate counts and, therefore, should not be used to calculate turnover rates. Turnover rates as presented represent mean agency-level rates.
[a]*n* = 101.

As displayed in Exhibit 32, reported turnover rates are significantly larger at agencies employing 3 to 5 direct clinical staff with a mean turnover rate of 39%. In addition, turnover rates also appear to be significantly elevated in small towns (Exhibit 33).

Exhibit 32
Turnover Rates by Agency Size

Agency Size	Turnover Rate[a]
2 or fewer staff	20%
3 to 5 staff	39%
6 to 11 staff	17%
12 or more staff	16%

Note. Turnover rates as presented represent mean agency-level rates.
[a]$n = 101$.

Exhibit 33
Turnover Rates by Rural Urban Commuting Area

Agency Size	Turnover Rate[a]
Urban core	20%
Rural urban fringe	18%
Large town	22%
Small town/isolated rural	38%

Note. Turnover rates as presented represent mean agency-level rates.
[a]$n = 101$.

Predictors of Agency-Level Turnover

Multiple linear regression was run to examine potential predictors of agency-level turnover in Oregon. Four categories of predictors are included in the analysis: (a) demographic characteristics of the agency director, (b) professional/academic background characteristics of the agency director, (c) agency characteristics, and (d) provision of clinical supervision. Results indicate that the regression model used accounts for approximately 25% of the variability associated with turnover in Oregon agencies ($R^2 = .254$).

Within the model, five factors are identified as significant predictors of turnover (Exhibit 34): (a) gender (all other things being equal, agencies led by female directors experienced more turnover), (b) minority status (all other things being equal, agencies led by minority directors experienced less turnover), (c) recovery status (all other things being equal, agencies led by directors in recovery experienced more turnover), (d) agency size (all other things being equal, smaller agencies experienced more turnover), and (e) receipt of SADA funds (all other things being equal, agencies receiving single state agency funds experienced higher turnover). It is important to keep in mind that while these variables all make significant contributions to the regression model, the model as a whole accounts for only 25% of the variability in agency turnover rates across the state.

Exhibit 34
Predictors of Agency-Level Turnover

Model Details[a]	Significance of Predictor to Model	t-value
Gender	$p < .05$	-2.383
Minority status	$p < .05$	-2.143
Recovery status	$p < .01$	2.743
Agency size	$p < .05$	-2.150
SADA funds	$p <. 05$	2.042

Note. SADA = State alcohol and drug authority.
[a]R^2 = .254.

Workforce Shortages and Planned Hires

Staffing and turnover numbers indicate that many agencies are operating with a staff shortage. Overall, 45% of agency directors report that their agency is understaffed, with an average staff vacancy of 1.89 FTE after all budgeted positions are filled. Across all agencies, this translates to an average staff vacancy of 1 FTE. Based on this data, the total staff shortage across the state is estimated to be approximately 150 full-time clinicians. Data

indicate that 71% of directors reporting a staff shortage would still be understaffed if all budgeted positions were filled.

Across the workforce, 44% of directors indicate that they expect to hire staff, reporting an average of 1.95 FTE in planned hires. Within these agencies, the number of planned hires range from 1 to 7 FTE.

Individual-Level Turnover

To further clarify the issue of turnover, both directors and clinicians were asked to report on their own turnover history and to speculate on their future in the field. This data represents a first look at individual turnover in the state and across the Pacific Northwest region.

Past turnover behavior is reported in two ways: (a) number of agencies worked for (Exhibit 35), and (b) number of times voluntarily leaving an agency (Exhibit 36). Results indicate that 71% of directors and 61% of clinicians have worked for more than one agency, with 68% of directors and 56% of clinicians voluntarily changing agencies at least one time. Overall, data indicate that 67% of director movement and 62% of clinician movement within the field is voluntary in nature.

Exhibit 35
Number of Agencies Worked for

Number of Agencies	Directors (n = 101)	Clinicians (n = 452)
1 agency (current)	29%	39%
2 agencies	24%	24%
3 to 4 agencies	29%	26%
5 or more agencies	19%	11%

Exhibit 36
Number of Times Voluntarily Leaving Agency

Number of Times	Directors (*n* = 101)	Clinicians (*n* = 452)
N/A (have worked for only 1 agency)	26%	35%
Never	6%	9%
1 time	24%	22%
2 time	13%	15%
3 or 4 times	21%	15%
5 or more times	11%	4%

In addition to reporting past turnover, directors and clinicians were asked to report on their likelihood of changing agencies (Exhibit 37) and their likelihood of leaving the field (Exhibit 38) within the next two years. Overall, 89% of directors and 71% of clinicians rate their likelihood of changing agencies within the next two years as *remote* or *not at all*. In addition, 85% of directors and 77% of clinicians rate their likelihood of leaving the field within the next two years as *remote* or *not at all*. It is worth noting that a number of clinicians indicate not being sure about their future with their agency (13%) or in the field (9%).

Exhibit 37
Likelihood of Changing Agency

Likelihood	Directors (*n* = 101)	Clinicians (*n* = 452)
Not at all	69%	46%
Remote possibility	20%	25%
High probability	2%	13%
Definitely	1%	3%
Not sure	7%	13%

Exhibit 38
Likelihood of Leaving Field

Likelihood	Directors (*n* = 101)	Clinicians (*n* = 452)
Not at all	64%	55%
Remote possibility	21%	22%
High probability	9%	11%
Definitely	3%	3%
Not sure	3%	9%

Some significant differences are apparent in directors' and clinicians' reported likelihood of changing agencies or leaving the field. A significantly larger proportion of directors (69%) than clinicians (46%) report that their likelihood of changing agencies is *not at all* (p < .001). Also, a statistically significant larger proportion of clinicians in recovery report their likelihood of leaving the field as *not at all* (p < .05).

Both directors and clinicians cite better salary, better work opportunities (within the field), and burnout as significant factors in clinicians voluntarily leaving (i.e., quitting). Interestingly, the burnout experienced by clinicians appears to be largely underestimated by directors as only 16% of directors compared to 39% of clinicians indicate that burnout is a factor in clinicians' decisions to quit.

Predictors of Individual-Level Turnover

To further examine characteristics or traits that may predict those in the workforce who may be planning on changing agencies or leaving the field in the next two years, logistic regression was used to examine differences between those planning on changing agencies (and those not), and between those planning on leaving the field (and those not). For the purpose of the logistic regression, "changers" and "leavers" are defined dichotomously as those respondents expressing a high probability or definite likelihood of changing agencies or leaving the field, and those not. For the purpose of clarity, respondents

indicating *not sure* were excluded from analysis. Four categories of variables are included in the analysis: (a) demographic characteristics of the respondent, (b) professional/academic background characteristics of the respondent, (c) past turnover, and (d) job satisfaction and stress. In order to get a more global look at individual turnover behavior and to enhance sample size, data from all five states in the NFATTC region (Alaska, Hawai'i, Idaho, Oregon, and Washington) are included in the analysis. Regression models are, however, run separately for directors and clinicians given the implicit differences in job detail. Complete model summaries are provided in Exhibits 39 and 40.

Exhibit 39
Predictors of Individual Turnover—Directors

Model Details	Significance of Predictor to Model	Exp (B)/ Odds Ratio
Predictors of changing agency[a]		
Primary wage earner	$p < .05$	3.110
Field category	$p < .01$	0.577
Number of agencies worked for	$p < .01$	3.891
Job satisfaction	$p < .001$	0.336
Predictors of leaving field[b]		
Primary wage earner	$p < .05$	5.104
Second career	$p < .01$	5.114
Job satisfaction	$p < .001$	0.414

[a]$R^2 = .341.$ [b]$R^2 = .306.$

Exhibit 40
Predictors of Individual Turnover—Clinicians

Model Details	Significance of Predictor to Model	Exp (B)/ Odds Ratio
Predictors of changing agency[a]		
Primary wage earner	p < .01	1.885
Field category	p < .001	0.689
Number of times voluntarily changed agencies	p < .01	1.618
Job satisfaction	p < .001	0.300
Job stress	p < .001	1.680
Predictors of leaving field[b]		
Degree status	p < .05	1.189
Licensure status	p < .01	0.734
Job satisfaction	p < .001	0.353

[a]R^2 = .356. [b]R^2 = .221.

Results indicate that for directors, being the primary wage earner in the family, having fewer years experience in the field, having worked for more than one agency in the past, and having lower levels of job satisfaction are all predictors of a high likelihood of changing agencies within the field. Directors who are the primary wage earner for their family are over 3 times as likely to anticipate changing agencies as are those who are not the primary wage earner. In addition, directors who have worked for more than one agency in the past are nearly 4 times as likely to anticipate changing agencies. Conversely, directors who have more years experience in the field are approximately half as likely to anticipate changing agencies. Directors expressing higher levels of job satisfaction are only one third as likely to anticipate changing agencies.

Being the primary wage earner for your family, second career status, and job satisfaction are all significant predictors for directors' high likelihood of leaving the field entirely. Directors who are the primary wage earner for their family are over 5 times as likely to anticipate leaving the field as are those who are not the primary wage earner. In addition, directors who report that substance abuse treatment is a second career are also 5 times more

likely to anticipate leaving the field. Conversely, directors expressing higher levels of job satisfaction are only two fifths as likely to anticipate leaving the field.

Results indicate that for clinicians, being the primary wage earner in the family, having fewer years experience in the field, having voluntarily changed agencies in the past, having lower levels of job satisfaction, and having higher levels of job stress are all predictors of a high likelihood of changing agencies within the field. Clinicians who are the primary wage earner for their family are nearly twice as likely to anticipate changing agencies as are those who are not the primary wage earner. In addition, clinicians who have voluntarily changed agencies in the past are approximately 1½ times as likely to anticipate changing agencies, as are clinicians experiencing higher levels of job stress. Conversely, clinicians who have more years experience in the field are approximately two thirds as likely to anticipate changing agencies, and clinicians expressing higher levels of job satisfaction are approximately one third as likely to anticipate changing agencies.

Degree status, licensure status, and job satisfaction are all significant predictors for clinicians' high likelihood of leaving the field entirely. Clinicians with higher degree status are approximately 1.2 times as likely to anticipate leaving the field. Conversely, clinicians with current licensure are approximately three fourths as likely to anticipate leaving the field, and clinicians expressing higher levels of job satisfaction are only one third as likely to anticipate leaving the field.

Overall, individual turnover seems to be strongly related to financial considerations (being the primary wage earner for your family), mobility considerations (degree status, previous experience in another field), past turnover behavior, and job satisfaction and stress. Interestingly, simply earning a higher salary does not appear to be a significant predictor of staying at an agency or staying in the field.

Recruitment and Retention
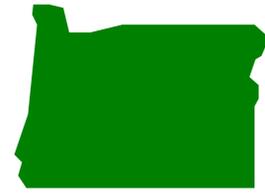
Recruitment Difficulties

When asked about staff recruitment, 57% of directors and 43% of clinicians indicated that their agency has difficulty filling open positions. The most frequently cited reason for the reported difficulties filling open positions is an insufficient number of applicants meeting minimum qualifications. In fact, 77% of directors who report difficulties filling open positions indicate that an insufficient number of applicants meeting minimum qualifications is a major issue, while only 34% indicate that insufficient funding is an issue. The most frequently cited reasons why applicants are failing to meet minimum qualifications are applicants having little or no experience, insufficient or inadequate training/education, a lack of appropriate certification/licensure, and a lack of practical applied skills.

When asked what techniques they used to advertise open positions, 82% of directors report using ads in the newspaper, 58% report posting on a web site, 57% report using their agency human resources department, and 54% use personal/informal contacts.

Barriers to Entering the Field

Salary is identified as the number one barrier to entering the substance abuse treatment field by both directors and clinicians (Exhibit 41). Both salary and benefits offered in the field and competition from other fields in terms of compensation are cited by the majority of respondents. Other frequently cited barriers include evening and weekend work hours, large caseloads, and negative preconceptions about the nature of addicted clients. It should

be noted that while large caseloads may be a perceived barrier to entry, in an earlier section of this report, only 14% of clinicians report that their caseloads are not manageable.

Exhibit 41
Barriers to Entry Into the Field

Barriers to entering field	Directors (*n* = 263)		Clinicians (*n* = 791)	
	%	Rating[a]	%	Rating[a]
Lack of recruitment	41	3.30	30	3.23
Lack of encouragement (from educators, friends, family)	42	3.52	35	3.25
Competition from other fields in terms of compensation	67	4.29	67	4.20
Paperwork	55	3.76	54	3.84
Large caseloads	52	3.89	60	4.15
Evening and weekend work hours	60	3.41	55	3.52
Discrimination (age, disability, ethnicity, or gender)	22	2.62	22	1.80
Stigma and lack of respect for the field	53	3.67	55	3.45
Geographic constraints	28	3.24	23	2.48
Low salary or poor benefits	86	4.10	79	4.35
Cost of education or training	50	3.45	37	3.50
Amount of education or training	33	3.50	32	3.21
Quality of work environment in terms of professionalism	34	3.00	37	3.33
Negative preconceptions about the field	54	3.62	56	3.42
Certification/licensure tests are difficult to pass	26	2.60	30	2.80
Negative preconceptions about the nature of addicted clients	58	3.61	61	3.60

Note. Respondents were asked to check all that apply.
[a]Ratings on a scale of 5 (*major barrie*r) to 1 (*minor barrie*r).

The salaries earned by the substance abuse treatment workforce are perceived not only as a barrier for entry, but a major factor in the perceived status of addiction professionals. Overall, 69% of directors and 68% of clinicians report that from the perspective of other helping professionals, addiction professionals are thought to have lower status. Reasons for the perception of lower status are numerous, with lower salary and less formal education and training the most frequently cited by both directors and clinicians. Stigma due to an

association with substance abusers and the perception that addiction professionals often have a history of substance abuse problems themselves are also frequently cited reasons for lower status.

Retention

Due to the voluntary nature of staff turnover and reported difficulties recruiting qualified applicants, retention of skilled clinicians is of utmost important to substance abuse treatment agencies. Previously discussed data indicate that when clinicians change agencies, it is quite often a voluntary decision and one driven to some degree by the desire to find a better work opportunity, to earn a better salary, and to escape burnout.

To help identify effective retention strategies, directors and clinicians were asked to report on their agencies' current staff development activities, and to make suggestions as to what could be done to encourage retention. Exhibit 42 displays current staff development activities by role. Interestingly, little consistency exists between the perceptions of directors and clinicians as to what staff development activities are occurring in their agencies. This may indicate a lack of communication to clinicians as to what staff development is available, and therefore may represent a great opportunity for staff retention.

Exhibit 42
Perception of Staff Development Activities

Staff Development Methods/Programs	Directors ($n = 101$)	Clinicians ($n = 452$)
Has no method/program to develop skills	2%	4%
Offers in-house mentoring program	34%	20%
Provides in-service training	74%	69%
Provides direct supervision	92%	75%
Pays cost of continuing education	71%	54%

Note. Respondents were asked to check all that apply.

Directors and clinicians were also asked to report on what they thought their agency could do to promote the retention of qualified clinical staff. While more frequent salary increases is the most frequently cited retention strategy by both directors and clinicians, other viable strategies are also endorsed (Exhibit 43). Both directors and clinicians frequently cite more individual recognition and appreciation, assistance with paperwork (or lessening the amount of paperwork), and better health coverage and benefits as retention strategies. It is important to note that these retention strategies were also the most frequently endorsed in 2002. Interestingly, only 25% of directors compared to 42% of clinicians endorse taking formal steps to reduce emotional burnout as a strategy to retain staff. This finding is consistent with other data indicating that directors are underestimating the impact of burnout on clinicians.

Exhibit 43
Frequently Cited Retention Strategies

Proposed Retention Strategy	Directors ($n = 101$)	Clinicians ($n = 452$)
More frequent salary increases	59%	64%
More individual recognition and appreciation	48%	43%
Lessen/provide assistance with paperwork	48%	42%
Better health coverage and benefits	48%	40%
Formal steps to reduce emotional burnout	25%	42%

Note. Respondents were asked to check all that apply.

Job Satisfaction and Stress

Job Satisfaction

Directors and clinicians were asked to identify their level of job satisfaction and to cite what in their work leaves them satisfied and dissatisfied. As displayed in Exhibit 44, 83% of directors and 71% of clinicians report their job satisfaction as above average. Only 3% to 4% of the workforce report below average job satisfaction. Differences do exist in satisfaction levels, however, as a significantly larger proportion of directors (40%) than clinicians (24%) report job satisfaction as very high (p < .01). Interestingly, a significantly larger proportion of minority directors (14%) than nonminority directors (1%) report below average job satisfaction (p < .05).

Exhibit 44
Job Satisfaction

Job Satisfaction Rating	Directors ($n = 101$)	Clinicians ($n = 452$)
1 – Very low	1%	1%
2	2%	3%
3 – Average	13%	25%
4	43%	47%
5 – Very high	40%	24%

Exhibit 45 displays the most frequently cited factors contributing to directors' and clinicians' satisfaction, while Exhibit 46 displays the most frequently cited factors contributing to their dissatisfaction. Overall, directors and clinicians cite qualities in their work as more frequently contributing to their satisfaction than their dissatisfaction. This is

consistent with the relatively high satisfaction ratings presented. Some expected differences exist between factors that contribute to directors' and clinicians' satisfaction, as directors more frequently cite qualities such as decision making and leadership, while clinicians more frequently cite work with clients and colleagues.

Exhibit 45
Factors Contributing to Job Satisfaction

Directors (*n* = 101)	Clinicians (*n* = 452)
1. Role as a change agent (79%)	1. One-on-one interaction with clients (78%)
2. Ability to influence work setting decisions (68%)	2. Role as a change agent (69%)
3. Commitment to treatment (65%)	3. Opportunities for personal learning and growth (61%)
4. Leadership (65%)	4. Agency/coworkers (60%)
5. Agency/coworkers (65%)	5. Commitment to treatment (54%)

Exhibit 46
Factors Contributing to Dissatisfaction

Directors (*n* = 101)	Clinicians (*n* = 452)
1. Too many external regulations on agency (40%)	1. Salary and benefits (50%)
2. Salary and benefits (29%)	2. Too many external regulations on agency (20%)
3. Consistently working nonpaid overtime (20%)	3. Inability to influence agency decisions (17%)
4. Inability to influence agency decisions (10%)	4. Consistently working nonpaid overtime (15%)
5. Limited role as change agent (7%)	5. Lack of career growth opportunities (15%)

Job Stress

In addition to rating their job satisfaction, directors and clinicians also rated their job stress. As displayed in Exhibit 47, directors and clinicians report job stress as relatively high. In fact, 54% of directors and 52% of clinicians report above average job stress. This creates an interesting dynamic where substance abuse treatment is seen as both a stressful, but satisfying field. In other words, a career in substance abuse treatment can be viewed as the toughest job you will ever love (Gallon, Gabriel, & Knudsen, 2003).

Exhibit 47
Job Stress

Job Stress Rating	Directors (*n* = 101)	Clinicians (*n* = 452)
1 – Very low	2%	3%
2	11%	8%
3 – Average	32%	36%
4	31%	34%
5 – Very high	23%	18%

Training

Training Participation and Barriers

Results indicate that 89% of directors and 92% of clinicians have participated in workshops or training in substance abuse in the past two years. On average, directors report having attended 6 workshops/trainings in the past two years, while clinicians report having attended 7 workshops/trainings in the past two years. The number of workshops/trainings attended ranged from 1 to 20 for directors, and from 1 to 31 for clinicians. Analysis indicates no differences in training attendance based on agency characteristics (i.e., agency size, agency setting, geography, etc.) or demographic/professional characteristics (i.e., degree status, years experience, etc.).

Directors and clinicians also report encountering barriers when trying to obtain substance abuse training or skills. Overall, 36% of directors and 43% of clinicians report encountering barriers when trying to obtain substance abuse training or skills (Exhibit 48). Worth noting, a significantly larger proportion of clinicians at agencies with 2 or fewer staff report experiencing barriers than clinicians at larger agencies (p < .05).

Exhibit 48
Barriers to Training

Barrier	Directors (*n* = 36)	Clinicians (*n* = 195)
Lack of available training opportunities	31%	30%
The budget does not allow most program staff to attend trainings	39%	61%
Topics presented at recent trainings have been too limited	31%	21%
Training opportunities take too much time away from the delivery of program services	42%	30%
Training is not a priority at my work setting	6%	10%
There are too few rewards for trying to change treatment or other procedures in my work setting	0%	8%
Training opportunities are not local	47%	40%

Note. Only directors and clinicians who reported encountering barriers included. Respondents were asked to check all that apply.

Addiction Counseling Competency Proficiencies and Training Interests

Directors and clinicians self-rated both their proficiency and training interest in 28 Addiction Counseling Competency (ACC) areas. The ACC areas have been adopted nationally and are documented in the Center for Substance Abuse Treatment's Technical Assistance Publication (TAP) 21 (1998). Proficiency is rated on a scale from 1 (*no proficiency*) to 7 (*complete proficiency*), while training interest is rated on a scale from 1 (*no interest*) to 5 (*maximum interest*). Exhibit 49 and Exhibit 50 display mean ratings for both directors and clinicians.

Exhibit 49

Self-Reported Proficiency in 28 Addiction Counselor Competency Areas

Competency Area	Directors		Clinicians	
	2005[a] (*n* = 101)	2002[b] (*n* = 41)	2005[c] (*n* = 452)	2002[d] (*n* = 147)
Administrative/management	6.10	6.00	4.72	4.49
Adolescent treatment	4.23	3.86	4.56	4.31
Client, family, and community education	5.71	5.37	5.50	5.09
Clinical supervision	5.79	5.58	4.45	4.33
Co-occurring disorders	5.75	5.58	5.38	5.11
Detoxification	4.07	4.08	4.28	4.41
Documentation	6.09	5.95	6.11	6.12
Drug pharmacology/pharmacotherapy	4.99	4.89	5.29	5.39
Gender-specific treatment	5.47	5.03	5.58	5.45
Group counseling	5.92	5.71	6.12	6.01
Individual counseling	6.05	5.89	6.27	6.28
Interpersonal communication	6.40	6.08	6.20	6.19
Intervention skills	5.96	5.51	5.77	5.76
Lesbian/gay/bisexual/transsexual-specific treatment	4.18	4.03	4.46	4.29
Marriage and family therapy	4.91	4.58	4.50	4.22
Offender treatment	5.05	5.05	4.73	4.92
Patient placement criteria	5.80	5.76	5.85	5.56
Professional/ethical responsibilities	6.59	6.21	6.37	6.26
Racial/ethnic-specific treatment	5.11	4.92	5.27	5.08
Referral skills	6.05	5.78	5.85	5.74
Relationship between substance abuse and medical problems	5.66	5.65	5.50	5.49
Screening/assessment	6.08	5.86	6.10	5.99
Service coordination and case mgmt	5.94	5.89	5.87	5.78
Signs and symptoms	6.05	5.95	5.95	6.10
Staff recruitment	5.89	5.58	4.20	4.06
Staff retention	6.04	5.80	4.35	4.28
Treatment engagement	5.85	5.97	5.81	5.90
Treatment planning	5.83	5.86	5.95	6.00

Note. Proficiency range is 1 = *not proficient*; 2 = *mostly lacking*; 3 = *somewhat lacking*; 4 = *unsure*; 5 = *somewhat proficient*; 6 = *mostly proficient*; 7 = *completely proficient*. 95% confidence intervals around these estimates are: [a] ± .24; [b] ± .38; [c] ± .12; [d] ± .20.

Exhibit 50
Self-Reported Training Interest in 28 Addiction Counselor Competency Areas

	Directors		Clinicians	
Competency Area	**2005[a]** **(*n* = 101)**	**2002[b]** **(*n* = 41)**	**2005[c]** **(*n* = 452)**	**2002[d]** **(*n* = 147)**
Administrative/management	3.65	3.77	2.92	3.11
Adolescent treatment	2.66	2.69	3.26	3.23
Client, family, and community education	3.28	3.22	3.86	3.78
Clinical supervision	3.77	3.73	3.50	3.74
Co-occurring disorders	4.00	3.87	4.31	4.40
Detoxification	2.59	2.81	3.33	3.34
Documentation	2.72	3.00	3.29	3.59
Drug pharmacology/pharmacotherapy	3.38	3.32	3.96	4.11
Gender-specific treatment	3.30	3.39	3.89	3.84
Group counseling	3.25	3.19	4.05	4.18
Individual counseling	3.33	3.14	4.09	4.18
Interpersonal communication	3.24	3.31	3.90	3.99
Intervention skills	3.27	3.14	3.96	4.12
Lesbian/gay/bisexual/ transsexual-specific treatment	3.15	3.00	3.57	3.44
Marriage and family therapy	3.20	3.30	3.78	3.93
Offender treatment	3.01	3.33	3.56	3.71
Patient placement criteria	3.00	3.25	3.55	3.51
Professional/ethical responsibilities	3.44	3.50	3.59	3.76
Racial/ethnic-specific treatment	3.34	3.33	3.70	3.88
Referral skills	2.73	2.86	3.40	3.72
Relationship between substance abuse and medical problems	3.42	3.69	3.96	4.19
Screening/assessment	3.04[c]	3.14[b]	3.74[c]	3.80[d]
Service coordination and case mgmt.	2.97	3.14	3.52	3.78
Signs and symptoms	2.91	2.92	3.68	3.82
Staff recruitment	3.47	3.75	2.76	2.96
Staff retention	3.59	3.95	2.91	3.17
Treatment engagement	3.47	3.50	3.95	4.17
Treatment planning	3.20	3.23	3.89	4.16

Note. Interest range is 1 = *no interest*, 2 = *very little interest*, 3 = *moderate interest*, 4 = *considerable interest*; 5 = *maximum interest*. 95% confidence intervals around these estimates are: [a] ± .21; [b] ± .34; [c] ± .05; [d] ± .19

Based on comparisons of 2002 and 2005 data, clinicians report a significant increase in proficiency in client, family, and community education and co-occurring disorders since 2002. Proficiency in other competency areas such as adolescent treatment, marriage and family therapy, and patient placement criteria also show upward trends for clinicians since 2002. Director data does not show any significant changes from 2002, although multiple proficiencies are trending upward since 2002. These areas include adolescent treatment, client, family, and community education, gender-specific treatment, and intervention skills. Training interests appear to be quite stable for both directors and clinicians since 2002.

Training Priorities

In order to further clarify training priorities for Oregon, competency areas were examined via a training priority matrix (Exhibit 51) which places competency areas in 4 proficiency/interest-based categories: lower proficiency, higher interest; lower proficiency, lower interest; higher proficiency, higher interest; and higher proficiency, lower interest. Examining competencies using this framework helps identify workforce training priorities across the state, starting with lower proficiency, higher interest areas. It should be noted that since this approach prioritizes competency areas relative to the respondent group, it allows training needs to be prioritized despite overall high ratings.

Exhibit 51
Training Priority Matrix

Proficiency: High ➜ Low

LEVEL 3 TRAINING PRIORITY *High Proficiency* *High Interest*	LEVEL 1 TRAINING PRIORITY *Low Proficiency* *High Interest*
LEVEL 4 TRAINING PRIORITY *High Proficiency* *Low Interest*	LEVEL 2 TRAINING PRIORITY *Low Proficiency* *Low Interest*

Interest: Low ➜ High

Exhibit 52 and Exhibit 53 display training priorities separately for directors and clinicians to better match their differing (self-rated) proficiencies and interests. Results indicate that, for directors, drug pharmacology, gender-specific treatment, racial/ethnic-specific treatment, and the relationship between substance abuse and medical problems are lower proficiency, higher interest area and are, therefore, Level 1 training priorities. For clinicians, results point to co-occurring disorders, drug pharmacology, marriage and family therapy, and racial/ethnic-specific treatment as Level 1 training priorities. Despite differences in self-reported proficiencies and training interests between directors and clinicians across the state, drug pharmacology and racial/ethnic-specific treatment are identified as Level 1 priorities for both groups.

Exhibit 52
Training Priorities for Directors

Priority Level 1: Higher Interest, Lower Proficiency

Drug pharmacology/pharmacotherapy

Gender-specific treatment

Racial/ethnic-specific treatment

Relationship between substance abuse and medical problems

Priority Level 2: Lower Interest, Lower Proficiency

Adolescent treatment

Detoxification

Lesbian/gay/bisexual/transsexual-specific treatment

Marriage and family therapy

Offender treatment

Priority Level 3: Higher Interest, Higher Proficiency

Administrative/management

Client, family, and community education

Clinical supervision

Co-occurring disorders

Individual counseling

Intervention skills

Professional/ethical responsibilities

Staff recruitment

Staff retention

Treatment engagement

Treatment planning

Priority Level 4: Lower Interest, Higher Proficiency

Documentation

Group counseling

Interpersonal communication

Patient placement criteria

Service coordination and case management

Referral skills

Screening/assessment

Signs and symptoms

Note. Proficiency range is 1 (*none*) to 7 (*completely*); Interest range is 1 (*no interest*) to 5 (*maximum interest*). Median total proficiency (5.68) and interest (3.25) were used as cut-off scores for higher/lower distinctions.

Exhibit 53
Training Priorities for Clinicians

Priority Level 1: Higher Interest, Lower Proficiency

Co-occurring disorders

Drug pharmacology/pharmacotherapy

Marriage and family therapy

Racial/ethnic-specific treatment

Priority Level 2: Lower Interest, Lower Proficiency

Administrative/management

Adolescent treatment

Clinical supervision

Detoxification

Lesbian/gay/bisexual/transsexual-specific treatment

Offender treatment

Staff recruitment

Staff retention

Priority Level 3: Higher Interest, Higher Proficiency

Client, family, and community education

Gender-specific treatment

Group counseling

Individual counseling

Interpersonal communication

Intervention skills

Relationship between substance abuse and medical problems

Screening/assessment

Service coordination and case management

Signs and symptoms

Treatment engagement

Treatment planning

Priority Level 4: Lower Interest, Higher Proficiency

Documentation

Patient placement criteria
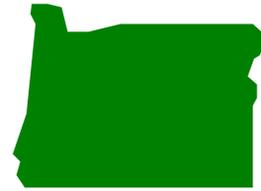
Professional/ethical responsibilities

Referral skills

Note. Proficiency range is 1 (*none*) to 7 (*completely*); Interest range is 1 (*no interest*) to 5 (*maximum interest*). Median total proficiency (5.46) and interest (3.64) were used as cut-off scores for higher/lower distinctions.

Technology

Technology Access

Across the state, the substance abuse treatment workforce reports having good access to technology. Overall, 100% of directors and 97% of clinicians report having computer access in the workplace. In addition, 96% of directors and 81% of clinicians report having internet access in the workplace. While overall access reports are good, it is still unclear how current the computer hardware and software are in agencies, and what the ratio of computers to employees is.

Directors and clinicians also reported their technology access at home. These numbers almost mirror access at work, as 93% directors report having computer access and 93% report having internet access. For clinicians, 86% report having computer access at home, and 80% report having internet access at home.

Technology Use

Reports of technology use are provided in Exhibit 54. In terms of technology usage that is directly related to substance abuse issues, 88% of directors and 89% of clinicians report feeling proficient using technology to obtain information about substance abuse. Attitudes toward technology and its potential role in substance abuse treatment are also reported (Exhibit 55). In general, attitudes reflect that technology is viewed as a positive feature in the work of a substance abuse treatment professional.

Exhibit 54
Technology Use

Technology Use	Directors (*n* = 101)	Clinicians (*n* = 452)
Billing	54%	15%
Alcohol/drug research	76%	61%
E-mail/correspondence	92%	68%
Client information/clinical issues	65%	61%
Alcohol/drug web-based professional development	47%	36%

Note. Respondents were asked to check all that apply.

Exhibit 55
Attitudes Toward Technology

Technology Attitudes	Directors (*n* = 101)	Clinicians (*n* = 452)
Using computers and web-based technologies helps me be more effective at my job.	90%	80%
I am interested in web-based professional education.	56%	55%
I would like to use the computer and web-based technologies in my work more.	46%	58%
My organization encourages the use of computers and web-based technologies.	79%	59%

Note. Percentage indicates those who *agree* or *strongly agree*.

Some differences exist concerning technology use and attitudes. A significantly larger proportion of directors than clinicians report using technology for alcohol and drug research (p < .01) and for web-based professional development (p < .05). Interestingly, a larger proportion of directors than clinicians report that their agency encourages the use of computers and web-based technology (p < .01). Despite a larger proportion of clinicians at smaller agencies (2 or fewer staff) indicating that their agency encourages the use of computers and web-based technology at their agency (p < .05), attitudes of these same clinicians toward technology appear to be more neutral than other clinicians. In fact, a smaller proportion of clinicians in agencies with 2 or more clinical staff indicate a desire to

use technology more in their work (p < .05) or express a strong interest in web-based professional education (p < .01). Interestingly, a significantly larger proportion of clinicians at agencies with 2 or fewer staff report having used web-based professional development (p < .01).

Discussion

The results presented here provide state decision-makers and local treatment providers with information that is potentially useful to planning for workforce development and system improvement. They provide insights into the nature of the current workforce and how best to meet a growing need for more clinically proficient substance abuse professionals. Four areas warrant a targeted discussion that might guide workforce development planning: characteristics of the current workforce, workforce development, retention of existing professionals, and the nature of treatment services currently provided.

Characteristics of the Workforce

The nature of the workforce continues to evolve. A current snapshot reveals that over half of director (55%) and clinical positions (60%) are filled by women. The age of the workforce is higher than many other professionals, with 73% of directors and 50% of clinicians over the age of 50. This is somewhat to be expected because a career in substance abuse treatment is often (50%) a second career. The average age of entry into the field for both directors and clinicians is between 37 and 39 years. The newest clinical members of the workforce, those with 0 to 4 years experience, comprise 32% of the workforce and their age is distributed evenly across the 20 to 60 years spectrum. In fact, new members of the workforce are more likely to be over forty (56%) than under forty (44%). So, while addiction treatment agencies employ an older workforce, the newer members of the workforce indicate an infusion of both younger and older workers. With the field so dependent on both younger and older workers, it is important to note that the percentage of clinicians in

their 20s in 2005 is half of what it was in 2002, perhaps indicating that fewer young people are entering the field.

Recovery status and experience with substance use problems continue to play important roles in the decision to become a substance abuse professional. Approximately 60% of clinicians and directors are either in recovery or have previous personal experience with addiction. Clinicians who are in recovery tend to be older and have more experience than their nonrecovering counterparts. Directors who are in recovery have more experience in the field than their nonrecovering counterparts. It has been true for years that when individuals enter stable recovery they often seek a career in helping others deal with similar problems. That situation does not appear to have changed for clinicians, but data suggests that a shift may be occurring for directors. Specifically, 91% of directors with less than 10 years experience report not being in recovery, compared to just 50% of those with over 10 years experience. The vast majority of the field's emerging leaders apparently do not come from a recovery background. It remains to be seen how this shift in personal experience with addiction will affect the field in coming years.

Results continue to support the fact that the field is becoming better educated. In fact, results indicate that 81% of directors and 65% of clinicians have a Bachelor's degree or above. Further, 59% of directors and 34% of clinicians have a Master's degree or above. Most of those degrees are in subjects related to the management and delivery of human services. Fully 68% of agency directors and 51% of clinicians have degrees in substance abuse, mental health, administration, or human services. The second career status of many directors and clinicians is evident in the fact that only 20% report a degree specific to substance abuse.

A final demographic worth noting is the relatively modest compensation received by clinicians in today's workforce. Approximately 86% of all clinicians report earning less than $45,000 per year, with a similar percentage receiving either full or partial health benefits.

Compounding the issue is the fact that nearly 80% of the workforce report being the primary wage earner for their family. Compared with other professions requiring a college degree, such compensation is considered low, making recruitment for education and training programs difficult.

Workforce Development

Despite some apparent shifting in leadership positions, it is clear from data that recovering individuals continue to seek a career in substance abuse treatment. The increasing educational requisites for certification indicate a need to encourage those in recovery to complete an accredited academic program and get quality supervision during their field placement. The demand for such individuals remains high as the majority of agencies (57%), both large and small, report having difficulty finding qualified applicants for clinical positions.

In addition to recruiting recovering people, there is a need for more clinical staff at all three academic levels of preparation: Associate's, Bachelor's, and Master's. It appears that the number of people currently graduating from substance abuse counselor training programs is insufficient to meet the needs of Oregon agencies. Almost half the reporting agencies (44%) plan to hire an average of 2 additional employees in the next 12 months. Given that the total number of agencies in the state was 150 at the time of the survey, and that half the agencies are planning to hire 2 people each, the number of new substance abuse professionals needed approaches 150. That figure does not factor in people who leave the profession and also need to be replaced, so the actual need may be higher. Add to these predictions the fact that the number of new professionals who graduate from training programs each year is unknown; the result is a need to gather information from academic and internship training programs about the number of graduates each year. Comparing the number of graduates with the number actually needed in the field will help determine the need for additional recruiting efforts.

Another piece of related information important to workforce planning is the fact that a large proportion of the workforce is composed of substance abuse trainees. These are people practicing as clinicians who have not yet achieved their professional certification or license. They require more intensive clinical supervision and training than fully credentialed clinicians. The survey does reveal that approximately 70% of clinicians receive 1 to 2 hours of clinical supervision per week. The remaining 30% receive something less, or report that clinical supervision is not available. This is another area worthy of further study. The nature of clinical supervision activities and their impact on counselor skills seems an important aspect of workforce development that deserves more attention. We need to know what specific supervisory activities are provided, for what purposes they are used, and whether they contribute to a continuous improvement of clinical proficiency.

Finally, the study addresses barriers to recruiting new professionals. The most frequently reported barriers include low salary, paperwork, caseloads, and the cost of education. However, reports of paperwork volume and caseload numbers did not seem excessive and they were not reported as significant sources of clinician dissatisfaction. More important barriers appear to be the negative outlook for salary increases, the considerable cost of education, and the negative perceptions that exist within related professions about addicted clients and treatment providers. The stigma that affects public attitudes about those with substance abuse issues is seen by the current workforce to also influence attitudes about treatment providers. In fact, over 67% of directors and clinicians combined believe addiction professionals have lower status than other health care providers. To remedy those circumstances, additional attention needs to be given to the development of an attractive career ladder that illustrates both the challenges and the potential rewards of becoming a substance abuse professional. Incentives such as loan forgiveness programs, tuition waivers, and foundation grants could also be explored with larger agencies, state administrators, and philanthropic organizations.

Workforce Retention

There are really two distinct populations of treatment providers in Oregon. Nearly half (44%) of all the treatment agencies surveyed have five or fewer clinical staff. These are small agencies with budgets in the neighborhood of $300,000 to $400,000. On the other end of the continuum are larger agencies; 29% of the state's providers have 12 or more clinical staff with average budgets above $6,000,000. These are two very different types of agencies. Larger agencies have more resources for clinical supervision, staff training, and opportunities for staff to develop specialized skills. Smaller agencies may have fewer resources for staff development while service demands require clinical staff to be skillful in a variety of treatment services.

While statewide staff turnover averages 23% annually, the larger agencies have a rate of approximately 16%. Turnover does appear to be higher at smaller agencies. What might be fueling what appears to be a lot of staff movement in these smaller agencies? One factor may be the degree to which staff feel recognized, appreciated, and emotionally supported by the agency. In addition, financial considerations (being the primary wage earner for your family), mobility considerations (degree status, previous experience in another field), past turnover behavior, and job satisfaction and stress all seem to be related to individual turnover.

Another factor in enhancing staff retention rates, and the most frequently cited source of dissatisfaction, is compensation. Improving salary and health benefits are frequently suggested ways of reducing turnover. Fortunately, a few variables appear to be significant predictors of salary in Oregon. Directors' compensation appears to vary based on the size of agency they manage. Clinicians' salary appears to be predicated on multiple factors including degree status, years experience, and licensure. This provides a clear message that obtaining a higher degree, accumulating experience in the field, and acquiring licensure all lead to better salary. It is important to keep in mind that directors and clinicians who are

the primary wage earners for their family are more likely to be looking for a new agency or a new career, indicating that salary is a much more important factor for those who do not have another wage earner in their family.

The final factor to consider regarding retention is burnout. Results indicate that compared to clinicians, directors vastly underestimate the impact of burnout. Clinician reports clearly indicate that burnout plays a large role in clinician decisions to quit. These reports are certainly supported by data that suggests that substance abuse treatment is a high stress field, and that most turnover in the field is voluntary. With that said, most clinicians report very good job satisfaction, and very few express intentions of leaving. Being more proactive in dealing with burnout may help retain the balance of high stress/high job satisfaction that many clinician report.

Service Delivery Issues

Clinicians report spending 64% of their time on client-related services, including face-to-face services, case management, and referrals. The time devoted to paperwork and clinical documentation is 14%. Both these figures seem appropriate, paperwork taking approximately one-fifth the time spent on direct services. When clinicians complain about paperwork it may have more to do with the type of work they are required to do rather than the amount. A greater concern may be that clinicians report spending only 3% of their time in the delivery of family services. Since research supports the value of providing services to those who provide support to those entering recovery, it is alarming that so little attention is given to such services. The reasons for such a low volume of family services deserve further study.

Another finding which has been noted in previous studies is the fact that reported nature of services being delivered by clinicians does not vary with educational background or training. Staff with Master's degrees and multiple years experience report performing the

same clinical services as those who are trainees or have 0 to 4 years experience. There is some differentiation in the amount of clinical supervision provided, but it appears that direct service staff members perform the same types of services without regard to the amount of education and training they have received. This is another issue that merits further study. If agencies are not making direct service assignments based on the qualifications of individual clinicians, then questions arise about quality of care, impact on client engagement and retention, and treatment outcomes. If provider proficiency or competence does not make a measurable difference in key clinical outcomes, the implications for staff qualifications and compensation could be huge.

There is considerable variation in the treatment models being used throughout the state. Only relapse prevention, cognitive-behavioral therapy, and motivational interviewing are playing a major role in over 50% of treatment agencies across the state. However, it is not known whether they are being used in a way that is consistent with the literature. Here, too, additional study is needed to clarify what is being reported. However, what we do know is that without close monitoring, feedback, and coaching to help clinicians adhere to standardized protocols, the research shows consistently that what is reported and what is actually being delivered are two different things entirely.

With regard to developmental needs within the existing workforce, the survey reveals a small number of training issues for which clinicians report low proficiency and high interest. Those include co-occurring disorders, drug pharmacology, marriage and family therapy, and racial/ethnic-specific treatment. In addition there is significant interest in quite a large number of clinical skills which providers feel at least minimally proficient. To meet the workforce's desire to continue developing skills in those areas, the state may want to encourage the development of a source for continuous learning, perhaps using web- or CD-based materials that could be made available to providers on an as-needed basis.

In summary, this survey provides a snapshot of the substance abuse workforce in Oregon. It raises issues relevant to the recruitment, development, and retention of qualified substance abuse professionals. And the results suggest some system improvement strategies that could help stabilize, improve, and grow an important resource for engaging addicted and abusing individuals in recovery-oriented substance abuse treatment services.

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Technical Appendix

1. Minority Status by Gender—Clinicians

Status	Female (n = 267)	Male (n = 177)
Minority	18	25
Nonminority	82	75

Note. *p < .05; **p < .01; ***p < .001.

2. Age by Recovery Status—Clinicians

Age Category (%)	Recovering (n = 188)	Nonrecovering (n = 245)
20–29 years old	2	12
30–39 years old	10	20
40–49 years old	30	27
50–59 years old	42***	32
60+ years old	17***	9

Note. *p < .05; **p < .01; ***p < .001.

3. Age of Entry by Recovery Status—Clinicians

Age Category (%)	Recovering (n = 188)	Nonrecovering (n = 245)
20–29 years old	10	27***
30–39 years old	33	32
40–49 years old	41***	24
50–59 years old	13	13
60+ years old	2	1

Note. *p < .05; **p < .01; ***p < .001.

4. Recovery Status by Gender—Clinicians

Status (%)	Female (n = 267)	Male (n = 177)
Recovering	37	53***
Nonrecovering	63	47

Note. *p < .05; **p < .01; ***p < .001.

5. Recovery Status by Minority Status—Directors

Status (%)	Minority (*n* = 14)	Nonminority (*n* = 84)
Recovering	64*	35
Nonrecovering	36	65

Note. *p < .05; **p < .01; ***p < .001.

6. Years Experience by Recovery Status—Directors

Yrs Experience (%)	Recovering (*n* = 37)	Nonrecovering (*n* = 55)
0–4 years	0	15
5–9 years	5	22
10–14 years	11	20
15–19 years	35**	16
20+ years	49**	27

Note. *p < .05; **p < .01; ***p < .001.

7. Years Experience by Recovery Status—Clinicians

Yrs Experience (%)	Recovering (*n* = 187)	Nonrecovering (*n* = 246)
0–4 years	26	37*
5–9 years	26	27
10–14 years	18	16
15–19 years	18*	9
20+ years	12	12

Note. *p < .05; **p < .01; ***p < .001.

8. Degree Status by Gender—Directors

Degree (%)	Female (*n* = 56)	Male (*n* = 45)
Less than high school	0	0
High school	0	2
Some college	20	2
Associate's	9	2
Bachelor's	27	18
Master's	39	60**
Ph.D.	5	16**
M.D.	0	0
Other professional degree	0	0
Other	0	0

Note. *p < .05; **p < .01; ***p < .001.

9. Degree Status by Minority Status—Directors

Degree (%)	Minority (*n* = 14)	Nonminority (*n* = 84)
Less than high school	0	0
High school	0	1
Some college	21	11
Associate's	21	4
Bachelor's	21	23
Master's	14	55*
Ph.D.	21*	7
M.D.	0	0
Other professional degree*	0	0
Other	0	0

Note. *p < .05; **p < .01; ***p < .001.

10. Degree Status by Recovery Status—Clinicians

Degree (%)	Recovering (n = 188)	Nonrecovering (n = 245)
Less than high school	1	0
High school	8	2
Some college	22	13
Associate's	17	9
Bachelor's	30	30
Master's	20	42***
Ph.D.	0	1
M.D.	1	0
Other professional degree	1	1
Other	1	1

Note. *p < .05; **p < .01; ***p < .001.

11. Certification by Recovery Status—Directors

Status (%)	Recovering (n = 37)	Nonrecovering (n = 55)
Inactive	18	55
Active	0	4
Current	82***	41

Note. *p < .05; **p < .01; ***p < .001.

12. Certification by Recovery Status—Clinicians

Status (%)	Recovering (n = 188)	Nonrecovering (n = 245)
Inactive	12	19
Active	11	18
Current	77***	63

Note. *p < .05; **p < .01; ***p < .001.

13. Licensure by Recovery Status—Clinicians

Status (%)	Recovering (n = 188)	Nonrecovering (n = 245)
Inactive	81	59***
Active	6	15
Current	13	26

Note. *p < .05; **p < .01; ***p < .001.

14. Salary by Agency Size—Directors

Salary (%)	2 or fewer staff (n = 19)	3 to 5 staff (n = 23)	6 to 11 staff (n = 27)	12 or more staff (n = 28)
Less than $15,000	16	4	0	0
$15,000–$24,999	5	0	4	0
$25,000–$34,999	5	9	0	0
$35,000–$44,999	11	13	22	0
$45,000–$54,999	21	9	30	21
$55,000–$64,999	37	39	22	32
$65,000–$74,999	0	17	11	29*
$75,000 or higher	5	9	11	18*

Note. *p < .05; **p < .01; ***p < .001.

15. Salary by Agency Size—Clinicians

Salary (%)	2 or fewer staff (n = 23)	3 to 5 staff (n = 60)	6 to 11 staff (n = 108)	12 or more staff (n = 174)
Missing	9	2	0	1
Less than $15,000	4	8	6	8
$15,000–$24,999	26	10	26	30
$25,000–$34,999	35	32	32	35
$35,000–$44,999	26	32	27	12
$45,000–$54,999	0	13	8	5
$55,000–$64,999	0	0	2	6**
$65,000–$74,999	0	3	0	3**
$75,000 or higher	0	0	0	1**

Note. *p < .05; **p < .01; ***p < .001.

16. Likelihood of Leaving Field by Recovery Status—Clinicians

Likelihood of leaving field (%)	Recovering (n = 188)	Nonrecovering (n = 245)
Not at all	64*	48
Remote possibility	18	26
High probability	11	12
Definitely	2	4
Not sure	6	11

Note. *p < .05; **p < .01; ***p < .001.

17. Job Satisfaction by Minority Status—Directors

Satisfaction (%)	Minority (*n* = 14)	Nonminority (*n* = 84)
1 – Very low	7*	0
2	7*	1
3 – Average	14	12
4	57	42
5 – Very high	14	45

Note. *p < .05; **p < .01; ***p < .001.

18. Training Barriers by Agency Size—Clinicians

Experience training barriers? (%)	2 or fewer staff (*n* = 23)	3 to 5 staff (*n* = 60)	6 to 11 staff (*n* = 108)	12 or more staff (*n* = 174)
Yes	56*	43	39	51
No	44	57	61	49

Note. *p < .05; **p < .01; ***p < .001.