The Current State of Addiction Treatment

Results from the 2005 NFATTC
Substance Abuse Treatment Workforce Survey

State of Alaska

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At the time of this printing, Terry L. Cline, Ph.D., served as the SAMHSA Administrator. H. Westley Clark, MD, JD, MPH, served as the Director of CSAT, and Catherine D. Nugent, M.S., M.S., LGPC, CP, served as the CSAT Project Officer.

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We would also like to thank the State Division of Behavioral Health for engaging in the survey process. The value of this collaboration can be seen throughout the report, especially in the fantastic response rates 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, Hawai'i, 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 managed. A 68% response rate was obtained across the region, with 459 agency director responses returned along with 1,564 clinician responses. In Alaska, 41 agency directors and 137 clinicians completed the survey, resulting in a 65% response rate. Results provide rich detail regarding the demographic, academic, and professional background of the substance abuse treatment workforce in Alaska, 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 & Benefits
- Staffing and Turnover
- Recruitment and Retention
- Job Satisfaction and Stress
- Training
- Technology Access and Use

Workforce Demographics

- Overall, 46% of agency directors and 58% of clinicians are female, and the majority of both agency directors (85%) and clinicians (64%) are white. The finding that only 15% of directors (compared to 36% of clinicians) are nonwhite, is statistically significant.
- The average age for those surveyed was 52 years old for agency directors and 48 years old for clinicians. Results indicate that 64% of directors and 48% of clinicians are 50 years old or older. Further, 22% of directors are 60 years old or older.
- The percentage of 20 year olds in 2005 is less than half of what it was in 2002, perhaps indicating that fewer young people are entering the field.
- Results indicate that the average age of entry is 40 years for directors and 39 years for clinicians. In fact, 89% of directors and 75% of clinicians indicate entering the field after the age of 30. These numbers parallel the finding that 44% of directors and 43% of clinicians report that substance abuse treatment is a second career.
- Data indicate that only 13% of directors and 36% of clinicians report being in recovery. Interestingly, a significantly larger proportion of male than female clinicians report being in recovery.

Academic and Professional Background

- Only 20% of directors, compared to 60% in 2002, cite a previous experience with addictions as a reason for entry into the field.
- Directors average 13 years in the field and 6 years in their current position, while clinicians average 8 years in the field and 4 years in their current position.
- Despite an average of 8 years experience in the field, 40% 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 (62%) are over 40 years old.
- Results indicate that 98% of directors and 67% of clinicians have a Bachelor's degree or above. Further, 83% of directors and 41% of clinicians have a Master's degree or above.
- A significantly smaller proportion of recovering than nonrecovering clinicians have a Bachelor's degree or above.
- Fewer than 20% of the workforce report having a substance abuse-specific degree.
- Overall, 20% of directors and 39% of clinicians report currently participating in an academic degree or certification program.
- Overall, 38% of directors and 49% of clinicians report current certification. In addition, 38% of directors and 13% of clinicians report current licensure.

Work Detail

- On average, directors report spending 86% of their time on administrative tasks, while clinicians report spending 62% of their time on client-related tasks.
- Clinicians report spending 18% of their time conducting individual counseling sessions, and 12% of their time leading group counseling sessions. Clinicians report spending only 2% 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 (76%) report carrying a caseload, with an average caseload size of 24 clients. Only 8% of clinicians report that their caseload is not manageable.
- From directors' and clinicians' perspectives, relapse prevention, integrated substance abuse/mental health, cognitive-behavioral therapy, and strengths-based treatment are the most frequently endorsed models playing a major role in their agencies approach. While these data do not address fidelity of implementation, it is encouraging that these models are considered to be evidence-based practices.
- Overall, 73% of directors and 59% of clinicians report weekly clinical supervision. Another 8% of directors and 15% clinicians report daily clinical supervision. Clinicians report spending an average of 3% (just over 1 hour) of their time each week receiving clinical supervision.

Salary and Benefits

- Director salaries are quite high in Alaska, as 61% of directors report earning $65,000 or more a year. Clinician salaries are more variable, with 68% of clinicians earning less than $45,000 a year.
- Overall, 98% of directors and 89% of clinicians report receiving full or partial health insurance benefits, while 83% of directors and 72% of clinicians report receiving retirement benefits.
- Both sick leave and vacation/other paid leave are provided to the vast majority of the workforce. A sizeable portion of the workforce is provided with maternity leave, but tuition assistance is less common.
- Regression analysis results indicate that multiple factors appear to be significant predictors of salary in Alaska: role (director vs. clinician), age, degree status, licensure, provision of health insurance, agency geography, and agency size.

Staffing and Turnover

- Alaska agencies employ 27 clinical staff on average. Agency size ranges from 1 to 200 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 19% of their staff. Consistent with 2002 data is the fact that most turnover (61%) in agencies across the state is voluntary (quitting).
- Reported turnover rates appear to be significantly elevated in the rural-urban fringe as agencies in these areas report an average turnover rate of 41%. Agencies with 2 or fewer clinical staff also report elevated turnover rates of 38%.
- Overall, 63% of directors report that their agency is understaffed, with an average staff vacancy of 2.88 FTE (1.88 FTE after all budgeted positions are filled). Based on this data, the average staff vacancy across all agencies is 2.02 FTE.
- Data indicate that 48% of directors reporting a staff shortage would still be understaffed if all budgeted positions were filled.
- Across the workforce, 49% of directors indicate that they expect to hire staff, reporting an average of 3.50 FTE in planned hires. Within these agencies, the number of planned hires range from 1 to 20 FTE.
- Results indicate that 61% of directors and 57% of clinicians have worked for more than one agency, with 51% of directors and 48% of clinicians voluntarily changing agencies at least one time. Overall, data indicate that 40% of director movement and 50% of clinician movement within the field is voluntary in nature.
- Overall, 86% of directors and 63% of clinicians rate their likelihood of changing agencies within the next two years as *remote* or *not at all*. In addition, 75% of directors and 73% 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 (22%) or in the field (20%).
- 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 29% of directors compared to 51% of clinicians indicated 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, 62% of directors and clinicians indicate that their agency has difficulty filling open positions.
- An insufficient number of clinicians meeting minimum requirements is the most frequently cited reason for recruiting difficulties. The most frequently cited reasons why applicants are failing to meet minimum qualifications are applicants having little or no experience and having insufficient or inadequate training/education.
- Salary is identified as the number one barrier to entering the substance abuse treatment field by both directors and clinicians. In addition, both stigma and negative preconceptions about the nature of addicted clients are frequently cited by both directors and clinicians.
- Overall, 62% of directors and 61% 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 less formal education and training, lower credentialing/licensure requirements, and lower salary 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.
- Both directors and clinicians frequently cite more individual recognition and appreciation, more frequent salary increases, and formal steps to reduce emotional burnout as retention strategies.

Job Satisfaction and Stress

- Eighty-nine percent of directors and 69% of clinicians report their job satisfaction as above average. Only 3% of clinicians reported 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 high. In fact, 77% of directors and 57% of clinicians report above average job stress.

Training

- Results indicate that 85% of directors and clinicians have participated in substance abuse workshops or training in the past two years. On average, both directors and clinicians report having attended 7 workshops/trainings in the past two years.
- Based on self-rated proficiency and training interest in 28 Addiction Counseling Competency areas, 3 areas are identified as training priorities for directors: clinical supervision, drug pharmacology, and racial/ethnic-specific treatment.
- Based on self-rated proficiency and training interest in 28 Addiction Counseling Competency areas, 3 areas are identified as training priorities for clinicians: clinical supervision, drug pharmacology, and marriage and family therapy.

Technology Access and Use

- Overall, 98% of directors and clinicians reported having computer access in the workplace. In addition, 98% of directors and 100% of clinicians reported having internet access in the workplace.
- The vast majority of both directors (100%) and clinicians (93%) reported feeling proficient using technology to obtain information about substance abuse.

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 Hawaii 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

	Survey Version	
Key Content Areas	**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, Hawaii, 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 analysis was used to examine potential predictors of salary for agency directors and for clinical staff. 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 Alaska (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 Alaska 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

	2002 Dataset (*n* = 30 directors)		2005 Dataset (*n* = 41 directors)	
	Sample Estimate (%)	Confidence Interval (95%)	Sample Estimate (%)	Confidence Interval (95%)
Geography				
Pop. less than 5,000	50	32–68	24	11–37
Pop. 5,001 to 50,000	10	0–21	34	19–49
Pop. 50,001 to 500,000	40	22–58	39	24–54
Pop. over 500,000	0	–	2	0–6
Agency Type				
Private, for profit	0	–	0	–
Nonprofit (public or private)	73	57–89	71	57–85
Government (federal)	0	–	0	–
Government (state)	0	–	0	–
Government (local, county, community)	10	0–21	12	2–22
Tribal (Indian Health Services; tribal government)	10	0–21	17	6–28
Other	7	0–16	0	–
Agency Size				
2 or fewer staff	32	15–49	12	2–22
3 to 5 staff	14	2–26	21	9–33
6 to 11 staff	25	10–40	21	9–33
12 or more staff	29	13–45	46	31–61

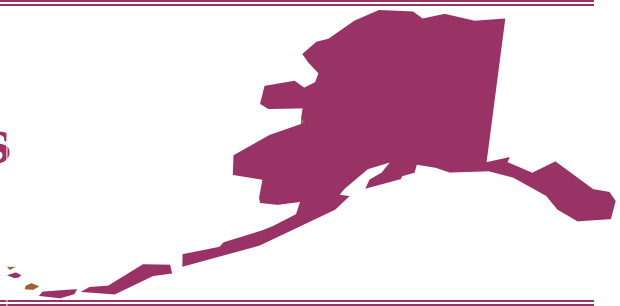
Data Interpretation

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 were conducted on all cross tabs to identify statistically significant differences between groups. Only statistically significant findings are presented in the body of the report. Multiple linear regressions are provided to identify significant predictors of salary, and 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 Alaska's substance abuse treatment agencies reside in geographic areas with populations of 5,001 to 50,000 (34%) 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 the majority of agencies reside in Alaska's urban core (34%) and in small town/isolated rural areas (39%).

Exhibit 6
Population of Agency by Geographic Area

Population	Agencies[a]
Less than 5000	10 (24%)
5,001 to 50,000	14 (34%)
50,001 to 500,000	16 (39%)
Greater than 500,000	1 (2%)

[a]*n* = 41.

Exhibit 7
Rural Urban Commuting Area (RUCA) of Agencies

RUCA Classification	Agencies[a]
Urban core	14 (34%)
Rural urban fringe	3 (7%)
Large town	8 (20%)
Small town/isolated rural	16 (39%)

[a]*n* = 41.

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 is calculated. Exhibit 8 shows the distribution of agency size across the state. Results indicate that the majority of treatment agencies in Alaska employ 12 or more staff.

Exhibit 8
Agency Size

Number of Direct Clinical staff	Agencies[a]
2 or fewer staff	6 (15%)
3 to 5 staff	8 (20%)
6 to 11 staff	7 (17%)
12 or more staff	20 (49%)

[a]*n* = 41.

Overall, 76% of directors report that their agency is accredited and/or licensed. Just over half of directors (56%) report that their agency has multiple locations or facilities. As displayed in Exhibit 9, the majority of agencies in Alaska are private, nonprofit (63%).

Exhibit 9
Agency Setting

Primary Agency Setting	Agencies[a]
Private, for-profit	0 (0%)
Private, nonprofit	26 (63%)
Public, nonprofit	3 (7%)
Government (federal, state, county, community)	5 (12%)
Tribal	7 (17%)

[a]*n* = 41.

In total, 51% of directors report that their agency receives state alcohol and drug authority (SADA) funds. Directors of agencies receiving SADA money report that these funds

average 38% 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	Mean Number of Clients Served Annually
2 or fewer	$516,456	200
3 to 5 staff	$772,875	143
6 to 11 staff	$822,487	351
12 or more staff	$3,961,002	1,307
Overall mean	$2,252,572	771

Treatment Services

Agency director reports indicate a wide range of services available in facilitates across the state. As presented in Exhibit 11, facilities providing outpatient care are the most common, as 68% of directors report that their agency provides some outpatient treatment. Interestingly, 56% of directors indicate that their agency provides mental health treatment. In addition, 46% of directors report that their facility provides residential services. 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. Perhaps due to the integration of substance abuse and mental health treatment, 93% of directors report serving clients with co-occurring disorders.

Exhibit 11
Facility Types

Modality	Agencies[a]
Detoxification	6 (15%)
Outpatient	28 (68%)
Residential	19 (46%)
Mental health center	23 (56%)
Shelter	1 (2%)
Solo or group practice	0 (0%)
General hospital	2 (5%)
Psychiatric	0 (0%)
Criminal justice	2 (5%)
Community or religious	1 (2%)
Community health center	4 (10%)
Halfway house	1 (2%)
Therapeutic community	3 (7%)
Opioid replacement	2 (5%)
Other	0 (0%)

Note. Percentages do not add to 100% because respondents were asked to check all that apply.
[a]*n* = 41.

Exhibit 12
Special Populations Served

Population	Agencies[a]
Adolescents	24 (59%)
Persons with co-occurring disorders	38 (93%)
Persons with HIV/AIDS	23 (56%)
Gay and lesbians	20 (49%)
Seniors/older adults	26 (63%)
Pregnant/post-partum women	21 (51%)
Women	32 (78%)
Men	30 (73%)
DUI/DWI	25 (61%)
Other criminal justice clients	26 (63%)

Note. Percentages do not add to 100% because respondents were asked to check all that apply.
[a]*n* = 41.

Workforce Demographics

Gender and Ethnicity

Overall, 46% of agency directors and 58% of clinicians are female, and the majority of both agency directors (85%) and clinicians (64%) are white. Only 15% of directors compared to 36% of clinicians are nonwhite, a difference that is statistically significant ($p < .01$). In addition, only 2% of both directors and clinicians report being Hispanic. Interestingly, a significantly smaller proportion of clinicians in agencies located in the small town/isolated rural parts of the state are female ($p < .05$) or minority ($p < .05$). Estimates of gender and ethnicity appear to have shifted to some degree from 2002 to 2005, although it is unclear if shifts represent real change due to the confidence intervals around each estimate.

Exhibit 13
Gender

	Directors		Clinicians	
Gender	2005[a] (*n* = 41)	2002[b] (*n* = 30)	2005[c] (*n* = 137)	2002[d] (*n* = 90)
Female	46%	63%	58%	71%
Male	54%	37%	42%	29%

Note. 95% confidence intervals around these estimates are: [a] ± 15; [b] ± 18; [c] ± 9; [d] ± 9.

Exhibit 14
Ethnicity

Ethnic Group	Directors		Clinicians	
	2005[a] (*n* = 41)	2002[b] (*n* = 30)	2005[c] (*n* = 137)	2002[d] (*n* = 90)
American Indian	0%	0%	5%	0%
Alaskan Native	2%	14%	17%	14%
Asian American	0%	0%	1%	1%
Native Hawaiian/ Other Pacific Islander	0%	0%	0%	0%
Black/African American	5%	10%	5%	7%
White or Caucasian	85%	72%	64%	68%
Multi-Ethnic*	–	0%	–	9%
Other	7%	3%	9%	0%

Note. 95% confidence intervals around these estimates are: [a] ± 12; [b] ± 14; [c] ± 8; [d] ± 9.
*Not included on 2005 survey.

Age

The average age for those surveyed was 52 years old for agency directors and 48 years old for clinicians. Exhibit 15 displays age category by role. Results indicate that 64% of directors and 48% of clinicians are 50 years old or older. Further, 22% of directors are 60 years old or older. Differences in age from 2002 to 2005 all seem to be due to the aging of the workforce, but it should be noted that the percentage of 20 year olds in 2005 is less than half of what it was in 2002, perhaps indicating that fewer young people are entering the field.

Exhibit 15
Age Category

Age Category	Directors		Clinicians	
	2005[a] (*n* = 41)	2002[b] (*n* = 30)	2005[c] (*n* = 137)	2002[d] (*n* = 90)
20 to 29 years old	0%	0%	8%	21%
30 to 39 years old	12%	17%	15%	23%
40 to 49 years old	24%	33%	29%	23%
50 to 59 years old	42%	47%	35%	22%
60 + years old	22%	3%	13%	10%

Note. 95% confidence intervals around these estimates are: [a] ± 15; [b] ± 18; [c] ± 9; [d] ± 9.

The entire workforce also demonstrates a high average age of entry into the field. Results indicate that the average age of entry was 40 years for directors and 39 years for clinicians. In fact, 89% of directors and 75% of clinicians indicated entering the field after the age of 30. These numbers parallel the finding that 44% of directors and 43% of clinicians report that substance abuse treatment is a second career.

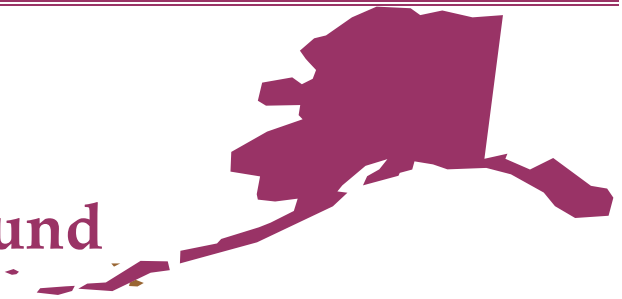
Recovery Status

Exhibit 16 displays recovery status for both directors and clinicians, and reveals that 13% of directors and 36% of clinicians report being in recovery. These estimates could be higher with 10% of directors and 13% of clinicians not disclosing their recovery status. Chi-square analysis indicates that the difference in recovery status between directors and clinicians is significant ($p < .01$). Results indicate that a significantly larger proportion of male (61%) than female (39%) clinicians report being in recovery ($p < .01$). Also of interest, a significantly larger proportion of minority clinicians report being in recovery ($p < .05$).

Exhibit 16
Recovery Status

Recovery Status	Directors (*n* = 41)	Clinicians (*n* = 137)
Recovering	13%	36%
Nonrecovering	54%	32%
Nonrecovering with family experience with addictions	21%	14%
Prefer not to disclose	10%	13%
Other	3%	5%

Academic and Professional Background



Reason for Entry into the Field

As displayed in Exhibit 17, differences exist in why directors and clinicians entered the field. For directors, the most frequently cited reasons are role as a change agent, personal interest, and academic work or degree in a similar field. Interestingly only 20% of directors, compared to 60% in 2002, cited a previous experience with addictions as a reason for entry into the field. This finding is statistically significant ($p < .05$). For clinicians, the most frequently cited reasons for entering the field for were a personal interest in substance abuse treatment or a previous experience with addiction or recovery (personal or family).

Exhibit 17
Reason for Entry Into the Field

Reason	Directors		Clinicians	
	2005[a] (*n* = 41)	2002[b] (*n* = 30)	2005[c] (*n* = 137)	2002[d] (*n* = 90)
Previous experience with addiction or recovery (personal or family)	20%	60%	54%	54%
Personal interest	37%	53%	58%	69%
Experience in a similar field	29%	37%	23%	31%
Academic work or degree in a similar field	37%	47%	27%	37%
Role as a change agent*	39%	–	17%	–
Desire to lead*	22%	–	11%	–
Unplanned decision	12%	17%	13%	21%
Career progression*	29%	–	22%	–
Compensation*	2%	–	6%	–
Other	17%	13%	12%	10%

Note. Respondents asked to check all that apply. 95% confidence intervals around these estimates are: [a] ± 15; [b] ± 18; [c] ± 9; [d] ± 9.
*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 13 years in the field and 6 years in their current position, while clinicians average 8 years in the field and 4 years in their current position. It should be noted that years experience is extremely variable for clinicians, ranging from less than 1 year to 33 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

Experience	Mean Years	
	Directors (*n* = 38)	Clinicians (*n* = 125)
Years in field	13.1	8.3
Years in role	6.9	4.5
Years in position	6.1	4.1

Note. 3 directors and 12 clinicians did not respond.

Due to significant variance, years experience in the field was also examined categorically (Exhibit 19). Results indicate that a larger proportion of directors (34%) than clinicians (15%) report 20 or more years experience in the field, although this finding is not statistically significant.

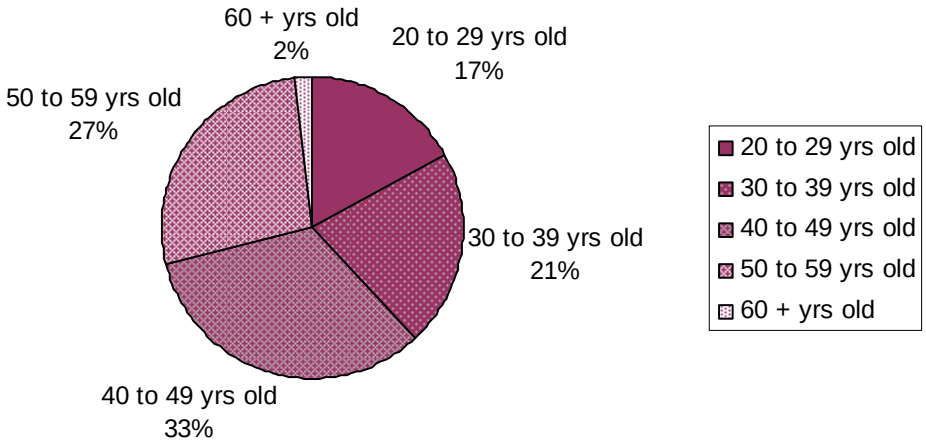
Exhibit 19
Years Experience in Field

Years Experience in Field	Directors (*n* = 35)	Clinicians (*n* = 125)
0 to 4 years	26%	40%
5 to 9 years	20%	26%
10 to 14 years	11%	9%
15 to 19 years	9%	10%
20 + years	34%	15%

Note. 6 directors and 12 clinicians did not respond.

Despite an average of 8 years experience in the field, 40% of clinicians 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 well over half of these recent entries into the field (62%) are over 40 years old. Also worth noting is the fact that nearly half of all directors in the state (46%) report having less than 10 years experience in the field. Further, 44% of directors report having less than 5 years experience in their current role as director.

Exhibit 20
Age of Clinicians with 0 to 4 Years Experience



Degree Status and Alcohol and Other Drug Coursework

Exhibit 21 displays degree status by role. Results indicate that 98% of directors and 67% of clinicians have a Bachelor's degree or above. Further, 83% of directors and 41% 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, the percentage of directors with a Masters degree has significantly increased since 2002 ($p < .05$). Analysis also indicates that a significantly smaller proportion of recovering (52%) than nonrecovering (77%) clinicians have a Bachelor's degree or above ($p < .05$). Finally, analysis indicates that a significantly smaller proportion of minority clinicians (44%) than nonminority clinicians (81%) have a Bachelor's degree or above ($p < .001$).

Exhibit 21
Degree Status

Level of Education	Directors		Clinicians	
	2005[a] (*n* = 41)	2002[b] (*n* = 30)	2005[c] (*n* = 137)	2002[d] (*n* = 90)
Less than high school	0%	0%	0%	0%
High school	0%	0%	3%	2%
Some college	0%	10%	20%	26%
Associate's degree	2%	17%	10%	7%
Bachelor's degree	15%	27%	22%	26%
Master's degree	68%	27%	39%	31%
Ph.D.	15%	20%	2%	7%
M.D.*	0%	–	1%	–
Other professional degree*	0%	–	2%	–
Other	0%	0%	2%	1%

Note. 95% confidence intervals around these estimates are: [a] ± 15; [b] ± 18; [c] ± 9; [d] ± 9.
*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 Alaska 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, 50% of nonrecovering directors and clinicians compared to 20% of recovering directors and clinicians have a degree in mental health.

Overall, 66% of directors and 54% of clinicians have a degree in at least 1 of the 4 afore-mentioned content areas. It should also be noted that 20% of directors and 39% of clinicians report currently participating in an academic degree or certification program.

Exhibit 22
Specialized Coursework, Certificates, and Degrees

Content Area	Directors (*n* = 41)	Clinicians (*n* = 137)
Substance abuse		
Coursework	37%	59%
Minor/certificate	10%	34%
Degree	7%	19%
Mental health		
Coursework	59%	56%
Minor/certificate	7%	4%
Degree	49%	39%
Administration/management		
Coursework	54%	23%
Minor/certificate	12%	5%
Degree	24%	10%
Human service		
Coursework	34%	43%
Minor/certificate	0%	12%
Degree	24%	26%

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, 38% of directors and 49% of clinicians report current certification. In addition, 38% of directors and 13% clinicians report current licensure. Worth noting is that nearly one

third of clinicians report inactive certification status. Also of interest, results indicate that a significantly larger proportion directors (80%) and clinicians (62%) in recovery have current certification than directors (30%) and clinicians (44%) who are not in recovery ($p < .05$).

Exhibit 23
Certification/Licensure Status

	Directors (*n* = 41)		Clinicians (*n* = 137)	
Status	**Certification**	**Licensure**	**Certification**	**Licensure**
Current	38%	38%	49%	13%
Active (pending, awaiting, pursuing)	10%	5%	19%	11%
Inactive (never, previous)	52%	57%	32%	76%

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 (86%), while clinicians report spending the majority of their time on client-related tasks (62%).

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

Task Type	Task	Directors (*n* = 32)	Clinicians (*n* = 108)
Client-Related	Screening and assessment	5%	9%
	Diagnosing	2%	4%
	Individual counseling	4%	18%
	Group counseling	2%	12%
	Family counseling	<1%	2%
	Case management	2%	14%
	Making referrals	0%	3%
	Total Client Related Time	14%	62%
Administrative	Participating in training	0%	1%
	Providing clinical supervision	12%	5%
	Receiving clinical supervision	0%	3%
	Overseeing personnel	12%	<1%
	Paperwork/documentation	19%	14%
	Meetings	15%	7%
	Other administrative	27%	0%
	Other activities	3%	8%
	Total Administrative Time	86%	38%

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

Interestingly, clinicians report more time performing individual counseling sessions (18%) than group counseling sessions (12%), despite the cost differences associated between the two. This finding contrasts with anecdotal beliefs that face-to-face time with clients is comprised strictly of group sessions. Little time, however, is devoted to family counseling (2%), 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, or years of experience).

Caseload Detail

Both directors and clinicians provided details regarding their client caseloads. Just over one third of directors (34%) report carrying a caseload, with an average of caseload size of 13 clients. The majority of clinicians (76%) report carrying a caseload, with an average caseload size of 24 clients. Only 8% of clinicians carrying a caseload report that their caseload is not manageable.

Interestingly, the 24% of clinicians who report not carrying a caseload still report spending 36% 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 have 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, integrated substance abuse/mental health, 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 these models are considered to be evidence-based practices.

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

Treatment Models	Directors (*n* = 41)	Clinicians (*n* = 137)
12-Step Principles	34%	30%
Behavior Modification/Token Reinforcement	17%	18%
Biopsychosocial	37%	25%
Cognitive Behavioral Therapy	39%	45%
Community Reinforcement	20%	18%
Coping Skills Therapy	32%	39%
Culture Specific	34%	34%
Developmental Model	7%	8%
Dialectical Behavior Therapy	2%	8%
Family	22%	18%
Gender Specific	12%	14%
Harm Reduction/Containment Skills	24%	25%
Integrated Substance Abuse & Mental Health	46%	48%
Intensive Case Management	27%	29%
Minnesota Model	2%	4%
Moral Recognition Therapy	0%	7%
Motivational Interviewing	27%	31%
Motivational Enhancement Theory	7%	12%
Opiate Substitution	2%	6%
Pharmacotherapy	12%	19%
Psycho-Educational	32%	31%
Psychotherapy	24%	15%
Rational Emotive Therapy	5%	8%
Rational Recovery	2%	5%
Reality Therapy	10%	11%
Relapse Prevention	54%	58%
Self-Regulating “Therapeutic” Community	7%	8%
Social Model	5%	9%
Social Skills Training	29%	31%
Solution Focused	20%	23%
Strengths Based	46%	39%
Systems Theory	17%	10%

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, 73% of directors and 59% of clinicians report weekly clinical supervision. Another 8% of directors and 15% clinicians report daily clinical supervision. Interestingly, 5% of directors and 17% of clinicians report *not applicable* when asked about the frequency of clinical supervision at their agency.

Overall, clinicians report spending an average of 3% (approximately 1½ hours) of their time each week receiving clinical supervision. As displayed in Exhibit 26, clinicians across the state report receiving 1 to 5 hours of clinical supervision a 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, and 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	15	Approx. 1.3 hours	5.2 hours
Weekly	59	Approx. 1.4 hours	5.6 hours
Biweekly	7	Approx. 1.0 hour	4.0 hours
Monthly	3	Less than 10 minutes	Less than 1 hour

[a]Clinicians reporting *not applicable* were not included (17%). [b]Numbers calculated from clinicians' reports of time spent receiving clinical supervision each week.

Salary and Benefits

Salary

Exhibit 27 displays reported salary by role. Director salaries are quite high in Alaska, as 61% of directors report earning $65,000 or more a year. In fact, 39% of directors report earning $75,000 or more a year. Clinician salaries are more variable, although 68% of clinicians earn less than $45,000 a year. The difference in reported director and clinician salaries is significant ($p < .001$). Overall, 81% of directors and 64% of clinicians report being the primary wage earner for their family.

Exhibit 27
Salary

Salary	Directors (*n* = 41)	Clinicians (*n* =137)
Less than $15,000	0%	5%
$15,000–$24,999	0%	5%
$25,000–$34,999	0%	25%
$35,000–$44,999	5%	33%
$45,000–$54,999	7%	15%
$55,000–$64,999	27%	12%
$65,000–$74,999	22%	2%
$75,000 or higher	39%	4%

Benefits

Exhibit 28 displays reported benefits for directors and clinicians. Overall, 98% of directors and 89% of clinicians report receiving full health insurance benefits, while 83% of directors and 72% of clinicians report receiving full or partial retirement benefits. Both sick leave and

vacation/other paid leave are provided to the vast majority of the workforce. Finally, a sizeable portion of the workforce is provided with maternity leave, but tuition assistance is less common.

Exhibit 28
Benefits

Benefit	Directors (*n* = 41)	Clinicians (*n* =137)
Health insurance		
Fully provided	73%	64%
Partially provided	25%	25%
Not provided	2%	11%
Sick leave		
Fully provided	93%	78%
Partially provided	7%	8%
Not provided	0%	15%
Vacation/other paid leave		
Fully provided	98%	85%
Partially provided	2%	7%
Not provided	0%	8%
Retirement plan		
Fully provided	68%	52%
Partially provided	15%	20%
Not provided	17%	28%
Maternity leave		
Fully provided	61%	55%
Partially provided	22%	15%
Not provided	17%	30%
Tuition assistance		
Fully provided	29%	24%
Partially provided	42%	34%
Not provided	29%	42%

Predictors of Salary

Multiple linear regression was run to examine potential predictors of salary for the workforce in Alaska. 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 salary is quite predictable in Alaska, with the regression model accounting for 64% of the variability in salary (R^2 = .636).

Exhibit 29
Predictors of Salary

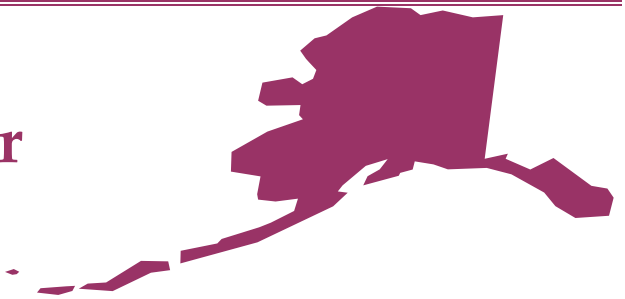
Model Details[a]	Significance of Predictor to Model	t-value
Role (director vs. staff)	p < .001	-7.516
Age category	p < .05	1.980
Degree status	p < .001	3.525
Licensure	p < .05	2.563
Health insurance	p < .01	-2.632
Geography of agency (Rural Urban Commuting Area category)	p < .05	2.057
Agency size	p < .05	2.541

[a]R^2 = .636.

Results indicate that multiple factors appear to be significant predictors of salary. Overall, role (director vs. clinician), age, degree status, licensure, provision of health insurance, agency geography, and agency size are all related to earning a highly salary. Results are best interpreted in the following way: (a) all other things being equal, directors earn a higher salary than clinicians; (b) all other things being equal, older members of the workforce earn a higher salary; (c) all other things being equal, members of the workforce with higher degree status earn a higher salary; (d) all other things being equal, members of the workforce with current licensure earn a higher salary; (e) all other things being equal, members of the workforce provided with health insurance earn a higher salary; (f) all other

things being equal, members of the workforce in more remote parts of the state earn a higher salary; and (g) all other things being equal, members of the workforce at larger agencies earn a higher salary. These results point out that while Alaskan agencies are putting a premium on degree and licensure status, other factors such as agency size and geography also drive what salary a member of the workforce will earn.

Staffing and Turnover



Agency Staffing Numbers

The size of substance abuse treatment agencies across the state varies from individually run treatment facilities to agencies employing 200 clinical staff. Average staffing numbers as provided by directors are provided in Exhibit 30. On average agencies employ 27 clinical staff, over 70% of which have full time status. Agencies report employing an average of 2 substance abuse treatment trainees. While it is unclear whether substance abuse treatment trainees are included in estimates of clinical staff, data indicate that on average agencies employ approximately 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)	26.95 (0, 200)
Full time	18.59 (0, 200)
Part time	5.63 (0, 95)
On call	1.10 (0, 10)
Trainees	2.14 (0, 20)

Note: Directors reporting 0 staff do not employ anyone besides themselves.
[a]*n* = 41.

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

Exhibit 31
Agency-Level Staff Turnover

Reason for Staff Turnover	Mean (min, max)[a]
Laid off	0.51 (0, 6)
Terminated	0.75 (0, 6)
Quit	1.73 (0, 10)
Total turnover	2.85 (0, 14)
Turnover rate	19% (0%, 150%)

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* = 41.

Based on agency director reports of staffing in the past year, agencies experience an average turnover rate of 19% of their staff. This rate is significantly lower than the 28% turnover rate reported in 2002. Interestingly, 37% of directors report no turnover in the past year, while 11% of directors report turnover rates of 50% or higher. Consistent with 2002 data is the fact that most turnover (61%) in agencies across the state is voluntary (quitting).

As displayed in Exhibit 32 and Exhibit 33, reported turnover rates appear to be significantly elevated in agencies on the urban fringe (suburbs) and in smaller agencies.

Exhibit 32
Turnover Rates by Rural Urban Commuting Area (RUCA)

RUCA Classification	Turnover Rate[a]
Urban core	18%
Rural urban fringe	41%
Large town	21%
Small town/isolated rural	16%

Note. Turnover rates as presented represent mean agency-level rates.
[a]*n* = 41.

Exhibit 33
Turnover Rates by Agency Size

Agency Size	Turnover Rate[a]
2 or fewer staff	38%
3 to 5 staff	22%
6 to 11 staff	14%
12 or more staff	16%

Note. Turnover rates as presented represent mean agency-level rates.
[a]*n* = 41.

Workforce Shortages and Planned Hires

Staffing and turnover numbers indicate that many agencies are operating with a staff shortage. Overall, 63% of directors report that their agency is understaffed, with an average staff vacancy of 2.88 FTE (1.88 FTE after all budgeted positions are filled). It is important to note that not all staff shortages are budget related, as 48% of directors reporting a staff shortage report that they would still be understaffed if all budgeted positions were filled. Overall, across all agencies, this data translates into an average staff vacancy of 2.02 FTE.

Across the workforce, 49% of directors indicate that they expect to hire staff, reporting an average of 3.50 FTE in planned hires. Within these agencies, the number of planned hires range from 1 to 20 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 34), and (b) number of times voluntarily leaving an agency (Exhibit 35). Results indicate that 61% of directors and 57% of clinicians have worked for more than one agency, with 50% of directors and 48% of clinicians voluntarily changing agencies at least one time. Overall, data indicate that 40% of director movement and 50% of clinician movement within the field is voluntary in nature.

Exhibit 34
Number of Agencies Worked For

Number of Agencies	Directors (*n* = 41)	Clinicians (*n* = 137)
1 agency (current)	39%	43%
2 agencies	15%	26%
3 to 4 agencies	24%	15%
5 or more agencies	22%	16%

Exhibit 35
Number of Times Voluntarily Leaving Agency

Number of Times	Directors (*n* = 41)	Clinicians (*n* = 137)
N/A (have worked for only 1 agency)	40%	43%
Never	10%	9%
1 time	7%	27%
2 times	12%	7%
3 or 4 times	20%	11%
5 or more times	12%	3%

In addition to reporting past turnover, directors and clinicians were asked to report on their likelihood of changing agencies (Exhibit 36) and their likelihood of leaving the field (Exhibit 37) within the next two years. Overall, 86% of directors and 63% of clinicians rate their likelihood of changing agencies within the next two years as *remote* or *not at all*. In addition, 75% of directors and 73% 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 approximately a fifth of all clinicians indicate not being sure about their future with their agency or in the field. Interestingly, those not sure about their future span all age groups and all years of experience.

Exhibit 36
Likelihood of Changing Agency

Likelihood	Directors (*n* = 37)	Clinicians (*n* = 132)
Not at all	43%	39%
Remote possibility	43%	24%
High probability	5%	11%
Definitely	2%	4%
Not sure	5%	22%

Exhibit 37
Likelihood of Leaving Field

Likelihood	Directors (*n* = 37)	Clinicians (*n* = 132)
Not at all	51%	48%
Remote possibility	24%	25%
High probability	11%	7%
Definitely	3%	1%
Not sure	11%	20%

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 29% of directors compared to 51% of clinicians indicated that burnout is a factor in clinicians' decisions to quit.

Predictors of Individual-Level Turnover

To further examine characteristics or traits that may predict who in the workforce may be planning on changing agencies or leaving the field in the next two years, logistic regression is used to examine differences (a) between those planning on changing agencies (and those not), and (b) between those planning on leaving the field (and those not). For the purposes of the logistic regression, "changers" and "leavers" were defined dichotomously as those respondents expressing a high probability or definite likelihood of changing agencies or leaving the field. For the purpose of clarity, respondents indicating *not sure* are 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 Exhibit 38 and Exhibit 39.

Exhibit 38
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 39
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, and directors expressing higher levels of job satisfaction are only one third as likely to anticipate changing agencies.

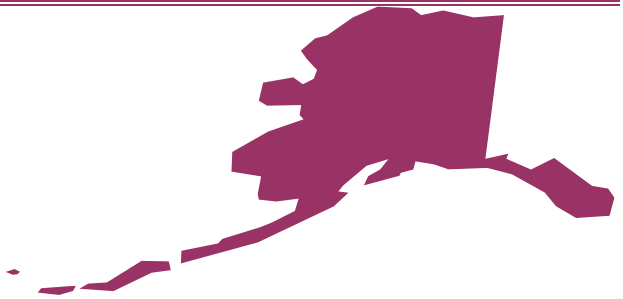
Being the primary wage earner for your family, second career status, and job satisfaction are all significant predictors for directors' high likelihood of leaving the field entirely. Directors who are the primary wage earner for their family are over 5 times as likely to anticipate leaving the field 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, 62% of directors and clinicians indicate 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, 87% of directors who reported difficulties filling open positions indicate that an insufficient number of applicants meeting minimum qualifications is a major issue, while only 35% indicate that insufficient funding is an issue. Geography is also an issue, as 65% of directors indicate difficulties filling open positions due to the small applicant pool. The most frequently cited reasons why applicants are failing to meet minimum qualifications are applicants having little or no experience and having insufficient or inadequate training/education.

When asked what techniques they used to advertise open positions, 70% of directors report using ads in the newspaper, 54% report using their agency human resources department, 46% report posting on a web site, and 41% report using personal/informal contacts and/or e-mail networking.

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 40). Both salary and benefits offered in the field and competition from other fields in terms of compensation are cited by the majority

of respondents. In addition, both stigma and negative preconceptions about the nature of addicted clients were frequently cited by both directors and clinicians.

Exhibit 40
Barriers to Entry into the Field

	Directors (*n* = 41)		Clinicians (*n* = 137)	
Barriers to Entering Field	**%**	**Rating[a]**	**%**	**Rating[a]**
Lack of recruitment	35	3.85	38	3.14
Lack of encouragement (from educators, friends, family)	32	3.67	37	3.11
Competition from other fields in terms of compensation	62	4.62	57	4.10
Paperwork	43	4.27	52	3.79
Large caseloads	54	3.63	49	3.87
Evening and weekend work hours	49	3.82	45	3.91
Discrimination (age, disability, ethnicity, or gender)	16	2.33	23	2.00
Stigma and lack of respect for the field	51	4.19	54	3.59
Geographic constraints	24	3.78	31	3.32
Low salary or poor benefits	78	3.92	62	4.05
Cost of education or training	30	3.30	39	3.49
Amount of education or training	41	3.07	35	3.41
Quality of work environment in terms of professionalism	22	3.38	32	3.49
Negative preconceptions about the field	46	3.60	50	3.62
Certification/licensure tests are difficult to pass	19	2.50	28	2.81
Negative preconceptions about the nature of addicted clients	62	3.90	57	3.74

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

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, 62% of directors and 61% 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 less formal education and training, lower credentialing/licensure requirements, and lower salary 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. Interestingly, a significantly larger proportion of minority (58%) than white (28%) clinicians report that substance abuse clinicians are seen as having the same or higher status as other helping professionals ($p < .01$).

Retention

Due to the voluntary nature of staff turnover and reported difficulties recruiting qualified applicants, retention of skilled clinicians is of utmost importance 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 agency's current staff development activities and to make suggestions as to what could be done to encourage retention. Exhibit 41 displays current staff development activities by role. Interestingly, differences exist 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 41
Perception of Staff Development Activities

Staff Development Methods/Programs	Directors (*n* = 41)	Clinicians (*n* = 137)
Has no method/program to develop skills	5%	7%
Offers in-house mentoring program	35%	20%
Provides in-service training	75%	60%
Provides direct supervision	75%	66%
Pays cost of continuing education	75%	61%

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 42). Both directors and clinicians frequently cite more individual recognition and appreciation, more frequent salary increases, and formal steps to reduce emotional burnout. It is important to note that these retention strategies are also among the most frequently endorsed in 2002.

Exhibit 42
Frequently Cited Retention Strategies

Proposed Retention Strategy	Directors (*n* = 41)	Clinicians (*n* = 137)
More frequent salary increases	49%	58%
More individual recognition and appreciation	62%	35%
More or improved ongoing training	43%	40%
Lessen/provide assistance with paperwork	46%	41%
Better health coverage and benefits	35%	28%
Promote career growth	32%	32%
Formal steps to reduce emotional burnout	49%	57%
More teambuilding with staff	30%	32%
Ideas valued by management team	38%	38%

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 43, 89% of directors and 69% of clinicians reported their job satisfaction as above average. No directors and only 3% of clinicians report below average job satisfaction.

Exhibit 43
Job Satisfaction

Job Satisfaction Rating	Directors (*n* = 41)	Clinicians (*n* = 137)
1 – Very low	0%	1%
2	0%	2%
3 – Average	11%	29%
4	53%	42%
5 – Very high	36%	27%

Exhibit 44 displays the most frequently cited factors contributing to directors' and clinicians' satisfaction, while Exhibit 45 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 44
Factors Contributing to Job Satisfaction

Directors (*n* = 41)	Clinicians (*n* = 137)
1. Role as a change agent (92%)	1. One-on-one interaction with clients (74%)
2. Leadership (87%)	2. Opportunities for personal learning and growth (56%)
3. Policy development & implementation (70%)	3. Role as a change agent (55%)
4. Ability to influence work setting decisions (65%)	4. Agency/coworkers (54%)
5. Commitment to treatment (62%)	5. Commitment to treatment (53%)

Exhibit 45
Factors Contributing to Dissatisfaction

Directors (*n* = 41)	Clinicians (*n* = 137)
1. Too many external regulations on agency (54%)	1. Salary and benefits (43%)
2. Consistently working nonpaid overtime (35%)	2. Too many external regulations on agency (38%)
3. Salary and benefits (27%)	3. Inability to influence agency decisions (21%)
4. Other (16%)	4. Consistently working nonpaid overtime (20%)
5. Lack of one-on-one interactions with clients (11%)	5. Lack of career growth opportunities (19%)

Job Stress

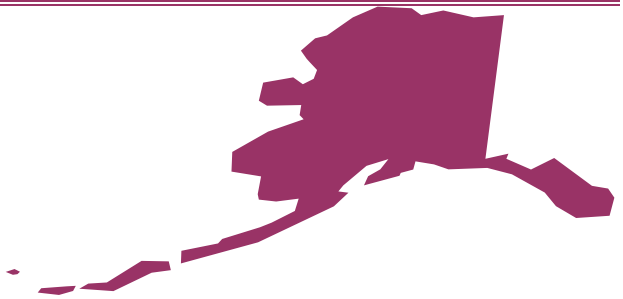
In addition to rating their job satisfaction, directors and clinicians also rated their job stress. As displayed in Exhibit 46, directors and clinicians report job stress as relatively high. In fact, 77% of directors and 57% of clinicians report above average job stress. This creates an interesting dynamic 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 46
Job Stress

Job Stress Rating	Directors (*n* = 41)	Clinicians (*n* = 137)
1 – Very low	3%	4%
2	3%	7%
3 – Average	17%	33%
4	43%	39%
5 – Very high	34%	18%

Training



Training Participation and Barriers

Results indicate that 85% of directors and clinicians have participated in workshops or training in substance abuse in the past two years. On average, both directors and clinicians report having attended 7 workshops/trainings in the past two years. Analysis indicates no differences in training attendance based on agency characteristics (e.g., agency size, agency setting, geography, etc.) or demographic/ professional characteristics (e.g., degree status, years experience, etc.).

Directors and clinicians also report encountering barriers when trying to obtain substance abuse training or skills. Overall, 41% of directors and 43% of clinicians report encountering barriers when trying to obtain substance abuse training or skills (Exhibit 47).

Exhibit 47
Barriers to Training

Barrier	Directors (*n* = 16)	Clinicians (*n* = 55)
Lack of available training opportunities	63%	56%
The budget does not allow most program staff to attend trainings	75%	75%
Topics presented at recent trainings have been too limited	44%	33%
Training opportunities take too much time away from the delivery of program services	31%	31%
Training is not a priority at my work setting	6%	13%
There are too few rewards for trying to change treatment or other procedures in my work setting	0%	13%
Training opportunities are not local	75%	58%

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 48 displays mean ratings for both directors and clinicians.

Exhibit 48
Self-Reported Proficiency and Training Interest in 28 Addiction Counselor Competency Areas

Competency Area	Proficiency		Interest	
	Directors (*n* = 41)	Clinicians (*n* = 137)	Directors (*n* = 41)	Clinicians (*n* = 137)
Administrative/management	6.08	5.00	3.91	3.25
Adolescent treatment	4.68	4.50	3.10	3.40
Client, family, and community education	5.58	5.37	3.30	3.83
Clinical supervision	5.68	4.70	3.74	3.66
Co-occurring disorders	5.76	5.36	4.00	4.23
Detoxification	4.09	4.02	3.23	3.41
Documentation	5.89	5.75	3.45	3.52
Drug pharmacology/pharmacotherapy	4.78	4.60	3.61	3.95
Gender-specific treatment	5.19	4.98	3.37	3.45
Group counseling	5.97	5.75	3.19	3.83
Individual counseling	6.30	6.05	3.13	3.86
Interpersonal communication	6.19	6.09	2.97	3.66
Intervention skills	6.03	5.73	3.10	3.83
Lesbian/gay/bisexual/transsexual-specific treatment	4.34	4.34	3.10	3.29
Marriage and family therapy	5.21	4.44	3.09	3.65
Offender treatment	4.74	4.40	3.30	3.50
Patient placement criteria	5.48	5.35	3.35	3.66
Professional/ethical responsibilities	6.64	6.24	3.58	3.54
Racial/ethnic-specific treatment	5.61	5.51	3.45	3.78
Referral skills	6.36	5.87	3.00	3.51
Relationship between substance abuse and medical problems	5.91	5.46	3.43	3.84
Screening/assessment	6.03	5.86	3.26	3.85
Service coordination and case mgmt.	5.88	5.88	3.17	3.46
Signs and symptoms	5.79	5.74	3.27	3.71
Staff recruitment	6.08	4.47	3.41	3.13
Staff retention	5.97	4.63	3.73	3.33
Treatment engagement	5.82	5.47	3.32	3.91
Treatment planning	6.03	5.71	3.43	3.97

Note. Proficiency is rated from 1 to 7 (1 = *not proficient*; 2 = *mostly lacking*; 3 = *somewhat lacking*; 4 = *unsure*; 5 = *somewhat proficient*; 6 = *mostly proficient*; 7 = *completely proficient*). Interest scale is rated 1 to 5 (1 = *no interest*, 2 = *very little interest*, 3 = *moderate interest*, 4 = *considerable interest*; 5 = *maximum interest*).

Training Priorities

In order to further clarify training priorities for Alaska, competency areas are examined via a training priority matrix (Exhibit 49) 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 49
Training Priority Matrix

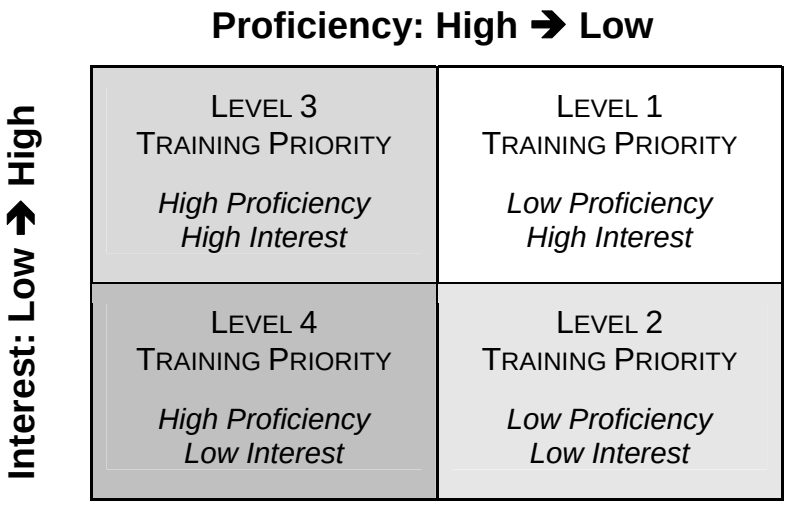


Exhibit 50 and Exhibit 51 display training priorities separately for directors and clinicians to better match their differing (self-rated) proficiencies and interests. Results indicate that for directors, clinical supervision, drug pharmacology, and racial/ethnic specific treatment are all identified as Level 1 priorities. For clinicians, results point to clinical supervision, drug pharmacology, and marriage and family therapy as Level 1 training priorities.

Exhibit 50
Training Priorities for Directors

Priority Level 1: Higher Interest, Lower Proficiency

Clinical supervision

Drug pharmacology

Racial/ethnic-specific treatment

Priority Level 2: Lower Interest, Lower Proficiency

Adolescent treatment

Client, family, and community education

Detoxification

Gender-specific treatment

Lesbian/gay/bisexual/transsexual-specific treatment

Marriage and family therapy

Offender treatment

Patient placement criteria

Priority Level 3: Higher Interest, Higher Proficiency

Co-occurring disorders

Documentation

Professional/ethical responsibilities

Relationship between substance abuse & medical problems

Staff recruitment

Staff retention

Treatment planning

Priority Level 4: Lower Interest, Higher Proficiency

Administrative/management

Group counseling

Interpersonal communication

Individual counseling

Intervention skills

Service coordination and case management

Referral skills

Screening/assessment

Signs and symptoms

Treatment engagement

Note. Proficiency range is 1 (*none*) to 7 (*completely*); Interest range is 1 (*no interest*) to 5 (*maximum interest*). Median total proficiency (5.75) and interest (3.39) are used as cut-off scores for higher/lower distinctions.

Exhibit 51
Training Priorities for Clinicians

Priority Level 1: Higher Interest, Lower Proficiency

- Clinical supervision
- Drug pharmacology/pharmacotherapy
- Marriage and family therapy

Priority Level 2: Lower Interest, Lower Proficiency

- Administrative/management
- Adolescent treatment
- Detoxification
- Gender-specific treatment
- Lesbian/gay/bisexual/transsexual-specific treatment
- Offender treatment
- Staff recruitment
- Staff retention

Priority Level 3: Higher Interest, Higher Proficiency

- Client, family, and community education
- Group counseling
- Individual counseling
- Interpersonal communication
- Intervention skills
- Patient placement criteria
- Racial/ethnic-specific treatment
- Relationship between substance abuse and medical problems
- Screening/assessment
- Signs and symptoms
- Treatment engagement
- Treatment planning

Priority Level 4: Lower Interest, Higher Proficiency

- Co-occurring disorders documentation
- Professional/ethical responsibilities
- Referral skills
- Service coordination and case management

Note. Proficiency range is 1 (*none*) to 7 (*completely*); Interest range is 1 (*no interest*) to 5 (*maximum interest*). Median total proficiency (5.20) and interest (3.58) are 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, 98% of directors and clinicians report having computer access in the workplace. In addition, 98% of directors and 100% of clinicians report having internet access in the workplace. While overall access reports are good, it remains unclear as to how current the computer hardware and software are in agencies, and what the ratio of computers to employees is.

Technology access at home also appears to be good, as 95% of directors report having computer access and 98% report having internet access. For clinicians, 83% report having computer access at home, and 80% report having internet access at home.

Technology Use

Reports of technology use are provided in Exhibit 52. In terms of technology usage that is directly related to substance abuse issues, 100% of directors and 93% 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 (see Exhibit 53). In general, attitudes reflect that technology is viewed as a positive feature in the work of a substance abuse treatment professional.

Exhibit 52
Technology Use

Technology Use	Directors (*n* = 41)	Clinicians (*n* = 137)
Billing	65%	26%
Alcohol/drug research	80%	72%
E-mail/correspondence	98%	87%
Client information/clinical issues	70%	75%
Alcohol/drug web-based professional development	55%	42%

Note. Respondents were asked to check all that apply.

Exhibit 53
Attitudes Toward Technology

Technology Attitudes	Directors (*n* = 41)	Clinicians (*n* = 137)
Using computers and web-based technologies helps me be more effective at my job.	93%	84%
I am interested in web-based professional education.	60%	62%
I would like to use the computer and web-based technologies in my work more.	50%	50%
My organization encourages the use of computers and web-based technologies.	87%	72%

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

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 46% of director positions and 58% of clinical positions are filled by women. The ethnic background of directors is predominately white, while the ethnic background of clinicians is more diverse. The age of the workforce is maturing, with 64% of directors and 48% of clinicians over the age of 50. This is somewhat to be expected because a career in substance abuse treatment is often a second career. The average age of entry into the field for both directors and clinicians is between 39 to 40 years. The newest clinical members of the workforce, those with 0 to 4 years experience, comprise a staggering 40% of the workforce and their age is distributed more evenly across the 20 to 60 years spectrum. In fact, new members of the workforce are more likely to be over forty (62%) than under (38%). So, while addiction treatment agencies employ an older workforce, the newer members of the workforce indicate an infusion of both younger and older workers. It is also important to understand

that age and experience are distinct qualities in the substance abuse treatment field. So while clinicians in Alaska are on average 48 years old, 66% of clinical staff have fewer than 10 years experience.

Recovery status and experience with substance use problems continue to play important roles in the decision to become a substance abuse professional. Approximately one third of directors and one half of clinicians are either in recovery or have previous personal experience with addiction. While estimates of those in recovery vary from state to state, it has been true for years that when individuals enter stable recovery they often seek a career in helping others deal with similar problems.

Results continue to support the fact that the field is well educated. In fact, results indicate that 98% of directors and 67% of clinicians have a Bachelor's degree or above. Further, 83% of directors and 45% of clinicians have a Master's degree or above. The second career status of many directors and clinicians is evident in the content area of degrees however, as less than 20% of the workforce reports a degree specific to substance abuse.

A final demographic worth noting is the relatively modest compensation received by clinicians in today's workforce. Approximately 68% of all clinicians report earning less than $45,000 per year. Compounding the issue is the fact that nearly two thirds of the workforce reports 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

It seems clear from the data that recovering individuals continue to seek a career in substance abuse treatment, despite the modest salaries available. 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 (62%), 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 Alaskan agencies. Approximately half the reporting agencies (49%) plan to hire an average of 3.50 additional employees in the next 12 months. Given that the total number of agencies in the state was 63 at the time of the survey, and that half the agencies are planning to hire 3.50 people each, the number of new substance abuse professionals needed approaches 110. That figure does not factor in people who leave the profession and need to also 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.

Interestingly, approximately one third of new entries into the field in Alaska are not actively pursuing certification. This issue looms large as 40% of clinical workforce in Alaska are new entries (0 to 4 years experience). Related to this, these new entries into the field require more intensive clinical supervision and training than more experienced, fully credentialed clinicians. The survey reveals that 74% of clinicians receive approximately 5 hours of clinical supervision a month. The remaining 26% receive something less, or report that clinical supervision is not applicable. This is another area worthy of further study. 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 by both directors and clinicians are low salary and competition from other fields (in terms of compensation). The stigma that impacts public attitudes about those with substance abuse issues is seen by the current workforce to also influence attitudes about treatment providers. Many directors and clinicians believe addiction professionals have lower status than other health care providers. This perception of lower status is driven by the less formal educational qualifications needed to enter the field and the stigma of substance abuse issues. 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

One potentially important factor in staff retention is agency size. Nearly half (46%) of all treatment providers surveyed have 12 or more clinical staff. These large agencies average 51 direct service staff, and have an average budget size of nearly $4,000,000. These larger agencies are very different than their smaller counterparts. 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, and service demands requiring clinical staff to be skillful in a variety of treatment services. This may be part of the reason why the average turnover rate in the smallest agencies in the state was 38%, twice the state average.

In addition to agency size, agency geography appears to play a role in turnover. Agencies located in on the rural-urban fringe reported an average turnover rate of 41% over the past year. This finding warrants more study as little is known from the current study that would identify what is driving higher turnover in this part of the state.

Another major factor in enhancing staff retention rates, and the most frequently cited source of dissatisfaction, is compensation. Improving salary and health benefits were frequently suggested ways of reducing turnover. Fortunately for directors and clinicians in Alaska, salary appears to be quite predictable. In fact, 64% of the variability in workforce salary is predictable, with role, degree status, and licensure serving as statistically significant predictors. This provides a clear message that obtaining a higher degree and acquiring licensure in the field both lead to better salary. In addition, it appears that a willingness to work in more remote parts of the state, as well as in a larger agency are also related to higher 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 clinicians' 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 62% of their time on client-related services, including face-to-face services, case management, and making 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 2% 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 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. Reports indicate that only relapse prevention is playing a major role in over 50% of treatment agencies across the state. However, it is not known whether it is 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 clinical supervision, drug pharmacology, and marriage and family therapy. In addition there is significant interest in quite a large number of clinical skills with 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 Alaska. 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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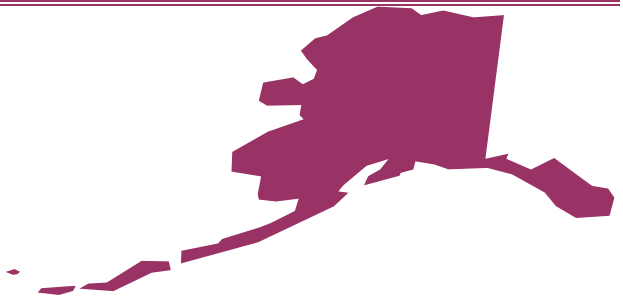

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