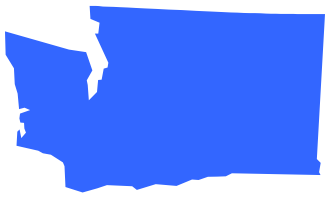
The Current State of Addiction Treatment



Results from the 2005 NFATTC Substance Abuse Treatment Workforce Survey

State of Washington

Jeffrey R.W. Knudsen, M.A.
Research Associate
RMC Research Corporation

Steve Gallon, Ph.D.
Principal Investigator
Northwest Frontier ATTC
Oregon Health & Science University

Roy M. Gabriel, Ph.D.
Senior Research Associate
RMC Research Corporation

attc northwest frontier addiction technology transfer center
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RMC

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Jeffrey R.W. Knudsen, M.A.

RMC Research Corporation
111 SW Columbia Street, Suite 1200
Portland, OR 97201

Steven L. Gallon, Ph.D.

Northwest Frontier
Addiction Technology Transfer Center
810 D St., NE
Salem, OR 97301-1212

Roy M. Gabriel, Ph.D.

RMC Research Corporation
111 SW Columbia Street, Suite 1200
Portland, OR 97201

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810 D Street
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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.

Contents

Exhibits

Acknowledgements

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

We would also like to thank the Division of Alcohol and Substance Abuse 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 Washington, 263 agency directors and 791 clinicians completed the survey, resulting in a 70% response rate. Results provide rich detail regarding the demographic, academic, and professional background of the substance abuse treatment workforce in Washington, 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, 50% of agency directors and 60% of clinicians are female, and the majority of both agency directors (79%) and clinicians (78%) are white.
- The average age for those surveyed is 54 years old for agency directors and 48 years old for clinicians. Results indicate that 70% of directors and 52% of clinicians are 50 years old or older. Further, 27% of directors are 60 years old or older.
- The average age of entry in the field is 37 years old for directors and 39 years old for clinicians. These numbers parallel the finding that 43% of directors and 48% of clinicians report that substance abuse treatment is a second career.
- Results indicate that 44% of directors and 48% of clinicians are in recovery. These estimates could be low however, as 8% of directors and 13% of clinicians did not choose to disclose their recovery status.

Academic and Professional Background

- The most frequently cited reasons for entering the field for both directors and clinicians are a personal or family experience with addiction or recovery (53% and 67%, respectively) and a personal interest in substance abuse treatment (48% and 59%, respectively).
- Directors average 16 years in the field and 8 years in their current position, while clinicians average 9 years in the field and 5 years in their current position.
- Despite an average of 9 years experience in the field, over one third of clinicians (35%) have 0 to 4 years experience in the field. Further, the average age of clinicians who have 0 to 4 years experience is also quite variable, highlighting that clinicians are entering the field at all ages. In fact, over half of clinicians recently entering the field (54%) are over 40 years old.
- Results indicate that 76% of directors and 60% of clinicians have a Bachelor's degree or above. Further, 49% of directors and 24% of clinicians have a Master's degree or above.
- A significantly smaller proportion of minority directors and clinicians have a Bachelor's degree or above. Also of interest, a significantly smaller proportion of recovering directors and clinicians have a Bachelors degree or above.
- Overall, 65% of directors and 61% of clinicians report current certification. In addition, 53% of directors and 54% clinicians report current licensure.
- Estimates indicate that approximately 40% of the workforce has both active/current certification and licensure. Conversely, estimates indicate that approximately 21% of directors and 7% of clinicians have neither active/current certification nor licensure.

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

Work Detail

- On average, directors report spending 73% their time on administrative tasks, while clinicians report spending 69% their time on client-related tasks. Not surprisingly, how directors spend their time varies significantly based on the size of their agency, with directors at smaller agencies spending significantly more time on client-related tasks.
- Clinicians report spending 17% of their time performing individual counseling sessions and 18% of their time performing group counseling sessions. Clinicians report spending only 2% of their time providing family counseling. Also worth noting it that clinicians report spending just 13% of their time (approximately 1 hour per 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 (83%), report carrying a caseload with an average caseload size of 34 clients. Only 17% of clinicians report that their caseload is not manageable.
- Based on both director and clinician responses, relapse prevention, 12-step, cognitive-behavioral therapy, bio-psychosocial, motivational interviewing, and strengths-based treatment are the most frequently used treatment models playing a major role in Washington agencies.
- Overall, 72% of directors and 65% of clinicians reported that daily or weekly clinical supervision is occurring at their agency. Clinicians report spending an average of 3% of their time each week (approximately 1½ hours) receiving clinical supervision.

Salary and Benefits

- Directors' salaries are extremely variable in Washington with 66% of directors earning $45,000 or more a year. Clinician salaries are less variable with 88% of clinicians earning less than $45,000 a year. The difference in reported director and clinician salaries is statistically significant.
- Overall, 81% of directors and 88% of clinicians report receiving full or partial health insurance benefits, while 67% of directors and 70% of clinicians report receiving retirement benefits.
- Both sick leave and vacation/other paid leave are provided to the vast majority of the workforce, while a sizeable portion of the workforce is not provided with maternity leave or tuition assistance.

- Provision of benefits is strongly linked to agency size, as a significantly larger proportion of directors and clinicians at larger agencies receive benefits.
- Multiple factors appear to be significant predictors of salary. For directors, gender, degree status, years experience in the field, certification, provision of health insurance, and agency size are all related to earning a higher salary. For clinicians, gender, degree status, years experience in the field, provision of health insurance, retirement benefits, agency geography, agency setting, and agency size are all related to earning a higher salary.

Staffing and Turnover

- On average, agencies in Washington employ 10 clinical staff. Agency size ranges from 1 to 200 direct clinical staff.
- Data indicate that on average agencies employ 3 to 5 trainees for every 10 clinicians on staff.
- Data indicate that trainees and other clinicians vary on a few fundamental characteristics: trainees are on average (a) younger, (b) as or more educated, (c) less likely to be in recovery than the general population of clinicians in the state, and (d) earn lower salaries.
- Based on agency director reports of staffing in the past year, agencies experience an average turnover rate of 26% of their staff. This rate is slightly elevated from the 22% turnover rate reported in 2002. Consistent with 2002 data is the fact that most turnover (over 60%) in agencies across the state is voluntary (quitting).
- Reported agency-level turnover in Division of Alcohol and Substance Abuse (DASA) Region 4 is lower than in other regions across the state. Turnover rates also vary by agency size, with smaller agencies reporting significantly higher turnover rates.
- Regression analysis results indicate that agency and agency director characteristics account for only 13% of the variability associated with turnover in Washington agencies.
- Staffing and turnover numbers indicate that many agencies are operating with a staff shortage. Overall, 40% of agency directors report that their agency is understaffed, with an average staff vacancy of 1.10 FTE. Across all agencies, this translates to an average staff vacancy of .53 FTE.
- Data indicate that while a large percentage of reported staff shortages are primarily budget-related (54%), the remaining 46% of directors reporting a staff shortage state that they 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 1.92 FTE in planned hires. The number of planned hires per agency

ranged from 1 to 10 FTE, with chemical dependency professionals accounting for 79% of all planned hires.

- Agencies reporting receipt of state dollars from DASA reported a decrease in the number of staff vacancies from 2002 through 2005, while agencies not receiving state dollars report an increase. Data also show that the number of planned hires is also higher for agencies receiving state dollars.
- Results indicate that 79% of directors and 66% of clinicians have worked for more than one agency, with 68% of directors and 59% of clinicians voluntarily changing agencies at least one time. Overall, data indicate that 64% of director movement and 61% of clinicians movement within the field is voluntary in nature.
- Results indicate that while a relatively small proportion of directors (12%) and clinicians (16%) report a high or definite likelihood of changing agencies or leaving the field (9% and 10%, respectively), another substantial segment of respondents indicate uncertainty regarding their future. This is especially true for clinicians, as 17% of clinicians report being not sure about their future with their agency, and 13% report being not sure about their future in the field.
- 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 15% of directors compared to 38% of clinicians indicate that burnout is a factor in clinicians' decisions to quit.
- Logistic regression results indicate that certain factors are predictive of directors and clinicians planning on changing agencies (and those not), and between those planning on leaving the field (and those not). Overall, individual turnover seems to be strongly related to financial considerations (being the primary wage earner for your family), mobility considerations (degree status, previous experience in another field), past turnover behavior, and job satisfaction and stress. Interestingly, simply earning a higher salary does not appear to be a significant predictor of staying at an agency or staying in the field.

Recruitment and Retention

- In terms of staff recruitment, 57% of directors and 52% of clinicians indicate that their agency has difficulty filling open positions.
- A significantly larger proportion of directors at larger agencies report recruiting difficulties. Additionally, a significantly larger proportion of directors of agencies receiving single state agency funds from DASA report recruitment difficulties.

- Differences in agency setting are also evident, as a larger proportion directors of private nonprofit, public nonprofit, state government and tribal agencies report recruiting difficulties.
- The most frequently cited reason for the reported difficulties filling open positions is an insufficient number of applicants meeting minimum qualifications . The most frequently cited reasons why applicants are failing to meet minimum qualifications are applicants having little or no experience, insufficient or inadequate training/ education, and a lack of appropriate certification/licensure.
- Salary is identified as the number one barrier to entering the substance abuse treatment field by both directors and clinicians. Other frequently cited barriers include paperwork, large caseloads, and the cost of education or training.
- Overall, 64% of directors and 68% of clinicians report that, from the perspective of other helping professionals, addiction professionals are thought to have lower status. Reasons for the perception of lower status are numerous, but lower salary is the most frequently cited by both directors and clinicians.
- Interestingly, little consistency exists between the perceptions of directors and clinicians as to what staff development activities are occurring in their agencies.
- In addition to more frequent salary increases, both directors and clinicians frequently cite more individual recognition and appreciation, assistance with paperwork (or lessening the amount of paperwork), and better health coverage and benefits as retention strategies.
- Interestingly, only 28% of directors compared to 43% of clinicians endorse taking formal steps to reduce emotional burnout as a strategy to retain staff.

Job Satisfaction and Stress

- Fewer than 2% of directors and 7% of clinicians report their job satisfaction as below average. However, a significantly larger proportion of directors (85%) than clinicians (70%) report above 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.
- Job stress is rated as relatively high across the workforce. However, a significantly larger proportion of directors than clinicians rate their job stress as very high.

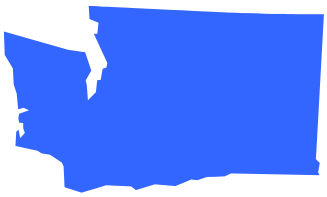
Training

- Results indicate that 93% of directors and 91% of clinicians have participated in workshops or training in substance abuse in the past two years. On average, directors report having attended 8 workshops/trainings in the past two years, while clinicians report having attended 6 workshops/trainings in the past two years.
- Directors and clinicians self-rated both their proficiency and training interest in 28 Addiction Counseling Competency areas. Results indicate that self-rated proficiencies and training interest are both significantly different between directors and clinicians.
- The proficiencies and training interests of agency directors and clinical staff do not vary by DASA region, but rather are common across the state.
- Comparison of 2002 and 2005 data shows some interesting trends in proficiencies and training interests. Directors report a significant increase in proficiency in marriage and family therapy since 2002. Clinicians report a significant increase in proficiency in administration/management and client, family, and community education since 2002.
- For directors, two areas are identified as training priorities: drug pharmacology and racial/ethnic-specific treatment. For clinicians, four areas are identified as training priorities: co-occurring disorders, drug pharmacology, gender-specific treatment, and racial/ethnic-specific treatment.

Technology Access and Use

- Overall, 99% of directors and 95% of clinicians report having computer access in the workplace. In addition, 93% of directors and 81% of clinicians report having internet access in the workplace.
- The vast majority of both directors (88%) and clinicians (86%) report feeling proficient using technology to obtain information about substance abuse. However, a significantly larger proportion of directors than clinicians report that their agency encourages the use of computers and web-based technology.
- Results indicate some opportunities for web-based training modalities. While only 33% have used web-based technology for training, 64% of clinicians agree or strongly agree to the statement, "I am interested in web-based professional education."

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 substance abuse counselors.

Administration of the NFATTC Workforce Survey

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

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

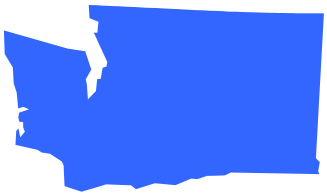
The current study reports on results from the 2005 NFATTC Workforce Survey. Where possible, results are compared to those from the 2002 survey, offering for the first time a look at movement and change in the substance abuse treatment field in the Pacific Northwest. The authors believe that needs assessment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

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

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

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

Methods



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

Instrumentation

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

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

Exhibit 1
2005 NFATTC Workforce Survey: Content by Version

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

Exhibit 2
Final Sampling Numbers

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

Survey Administration and Follow Up

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

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

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

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

Exhibit 3
Key Survey Administration and Follow-up Dates

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

Response Rate

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

Exhibit 4
2005 NFATTC Workforce Survey Response Rate

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

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

Analysis Strategy

Data were analyzed using an array of methods available in the Statistical Package for the Social Sciences (SPSS), Version 13.0 (SPSS, Inc., 2005). Because of the categorical nature of much of the data collected, data were examined using primarily cross-tabulations. Chi-square analyses were conducted on all cross-tabulations to identify statistically significant differences. Differences were examined across role (director vs. clinical staff), as well as across theoretically meaningful respondent characteristics (including gender, ethnicity, and recovery status) and agency characteristics (including agency size and geography), and are reported if significant. Multiple linear regression analyses were used to examine potential predictors of salary for agency directors and for clinical staff and to examine predictors of staff turnover at the agency level. Individual turnover was examined using logistic regression analyses, resulting in odds ratios for characteristics predicting directors' and clinicians' likelihood of changing agencies or leaving the field. Finally, multivariate analysis of variance was used to examine differences in proficiency and training interest in 28 Addiction Counseling Competency areas.

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 Single State Agencies 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.

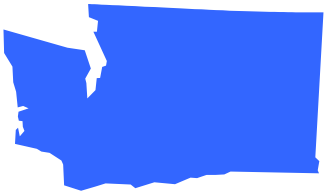
While this affords much more statistical precision in looking at current survey results, the change in sampling method in the region's two largest states suggests some caution in looking at changes in survey results over time there. Is the survey estimating the same population in Oregon and Washington 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 Washington (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 Washington 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—Washington

	2002 Dataset (*n* = 50 directors)		2005 Dataset (*n* = 263 directors)	
	Sample Estimate (%)	Confidence Interval (95%)	Sample Estimate (%)	Confidence Interval (95%)
Geography				
Pop. less than 5,000	14	4–24	8	5–11
Pop. 5,001 to 50,000	26	14–38	43	37–49
Pop. 50,001 to 500,000	42	28–56	31	25–37
Pop. over 500,000	18	7–29	18	13–23
Agency Type				
Private, for-profit	38	25–51	37	31–43
Nonprofit (public or private)	38	25–51	48	42–54
Government (federal)	0	–	2	0–4
Government (state)	4	0–9	2	0–4
Government (local, county, community)	8	0–16	5	2–8
Tribal (Indian Health Services; tribal government)	8	0–16	5	2–8
Other	4	0–9	0	–
Agency Size				
2 or fewer staff	33	20–46	28	21–31
3 to 5 staff	27	15–39	28	24–34
6 to 11 staff	22	11–33	19	16–26
12 or more staff	18	7–29	24	20–30

Data Interpretation

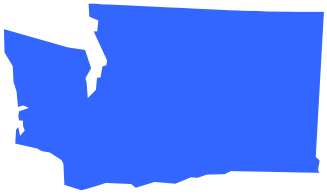


Survey results are presented by topical category. Descriptive results are reported by agency director and clinical staff responses (referred to as *role*). Other cross-tabs of interest are described when applicable. Unless otherwise noted, only valid cases are included in analysis, therefore sample sizes 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, with full data provided in the Technical Appendix. Multiple linear regressions are provided to identify significant predictors of salary and agency turnover, and logistic regression analysis examines predictors of individual-level turnover. Multivariate analysis of variance is provided to examine differences in competencies.

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 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 Washington substance abuse treatment agencies reside in geographic areas with populations of 5,001 to 50,000 (43%) and 50,001 to 500,000 (31%). To provide another look at geography, agency zip codes were grouped using Rural Urban Commuting Area (RUCA) codes (Morrill, Cromartie, & Hart, 1999). Results indicate that the majority of agencies reside in Washington's urban core (76%).

Exhibit 6
Geographic Area of Agencies

Population	Agencies[a]
Less than 5000	20 (8%)
5,001 to 50,000	107 (43%)
50,001 to 500,000	77 (31%)
Greater than 500,000	46 (18%)

[a] *n* = 250 (13 directors did not respond to this item).

Exhibit 7
Rural Urban Commuting Area (RUCA) of Agencies

RUCA Code	Agencies[a]
Urban core	201 (76%)
Rural urban fringe	9 (3%)
Large town	31 (12%)
Small town/isolated rural	22 (8%)

[a] *n* = 263.

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 agency size is quite diverse in Washington, as was the case in 2002.

Exhibit 8
Agency Size

Number of Direct Clinical Staff	Agencies[a]
2 or fewer staff	73 (28%)
3 to 5 staff	73 (28%)
6 to 11 staff	50 (19%)
12 or more staff	63 (24%)

[a]*n* = 259 (4 directors did not provide staffing numbers).

Nearly all directors (95%) report that their agency is accredited and/or licensed. Over a third of directors (38%) report that their agency has multiple locations or facilities. The majority of directors in Washington report that their agency is either private, nonprofit (39%) or private, for-profit (37%). Full agency setting results are provided in Exhibit 9.

Exhibit 9
Agency Setting

Primary Agency Setting	Agencies[a]
Private, for-profit	96 (37%)
Private, nonprofit	101 (39%)
Public, nonprofit	22 (9%)
Government (federal, state, county, community)	27 (10%)
Tribal	12 (5%)

[a]*n* = 258 (5 directors did not respond to this item).

Only 30% of directors reported that their agency receives state alcohol and drug authority (SADA) funds. On average, directors receiving SADA money report that these funds account for 63% of their agency's operating budget. Nine directors report that 100% of their agency's budget is funded by SADA. Annual operating budgets for agencies across the state vary dramatically by agency size. Size of agency and operating budget are also directly related to the number of clients served each year, as displayed in Exhibit 10.

Exhibit 10
Agency Budget and Client Numbers

Agency Size	Mean Annual Operating Budget	Mean Number of Clients Served Annually
2 or fewer	$204,517	181
3 to 5 staff	$475,471	239
6 to 11 staff	$777,741	477
12 or more staff	$3,039,495	1,590
Total	$1,905,111	993

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 by far the most common, as 81% of directors report that their agency provides some outpatient treatment. Mental health is the next most common, but with only 19% of agency directors reporting that they provide mental health treatment. As displayed in Exhibit 12, director data also indicates that agencies across the state serve multiple special populations, although it is not clear if the service provided to these groups is tailored to the unique challenges present with each.

Exhibit 11
Facility Types

Modality	Agencies[a]
Detoxification	23 (9%)
Outpatient	212 (81%)
Residential	45 (17%)
Mental health center	50 (19%)
Shelter	4 (2%)
Solo or group practice	11 (4%)
General hospital	8 (3%)
Psychiatric	10 (4%)
Criminal justice	26 (10%)
Community or religious	6 (2%)
Community health center	5 (2%)
Halfway house	7 (3%)
Therapeutic community	7 (3%)
Opioid replacement	12 (5%)

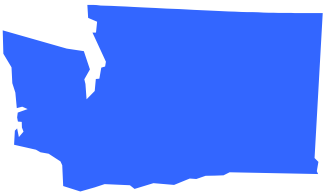
Note. Percentages do not add to 100% because respondents were asked to check all that apply.
[a]*n* = 263.

Exhibit 12
Special Populations Served

Population	Agencies[a]
Adolescents	127 (48%)
Persons with co-occurring disorders	189 (72%)
Persons with HIV/AIDS	141 (54%)
Gay and lesbians	150 (57%)
Seniors/older adults	148 (56%)
Pregnant/post-partum women	121 (46%)
Women	202 (77%)
Men	205 (78%)
DUI/DWI	204 (78%)
Other criminal justice clients	213 (81%)

Note. Percentages do not add to 100% because respondents were asked to check all that apply.
[a]*n* = 263.

Workforce Demographics



Gender and Ethnicity

Overall, 50% of agency directors and 60% of clinicians are female, and the majority of both agency directors (79%) and clinicians (78%) are white. Fewer than 25% of directors and clinicians are nonwhite, and only 5% of directors and 6% of clinicians report being Hispanic. Neither gender nor ethnicity of directors or clinicians show any significant shift from 2002 to 2005.

Interestingly, while the majority of the workforce reports being white, some significant differences are apparent across Division of Alcohol and Substance Abuse (DASA) regions. A significantly larger proportion of clinicians in DASA Regions 4, 5, and 6 are African American ($p < .01$). Also, a significantly larger proportion of clinicians in Region 1 are American Indian ($p < .01$). Finally, although not statistically significant, a larger proportion of directors in Region 6 (37%) are an ethnic minority.

Exhibit 13
Gender

	Directors		Clinicians	
Gender	2005[a] (*n* = 263)	2002[b] (*n* = 51)	2005[c] (*n* = 791)	2002[d] (*n* = 120)
Female	50%	53%	60%	60%
Male	50%	47%	40%	40%

Note. 95% confidence intervals around these estimates are: [a]± 6; [b]± 14; [c]± 3; [d]± 9.

Exhibit 14
Ethnicity

Ethnic Group	Directors		Clinicians	
	2005[a] (*n* = 259)	2002[b] (*n* = 51)	2005[c] (*n* = 769)	2002[d] (*n* = 120)
American Indian	4%	6%	4%	4%
Alaskan Native	0%	0%	<1%	0%
Asian American	2%	0%	2%	0%
Native Hawaiian/Other Pacific Islander	1%	0%	<1%	3%
Black/African American	4%	0%	7%	4%
White or Caucasian	79%	83%	78%	74%
Multi-Ethnic*	–	8%	–	6%
Other	11%	2%	9%	10%

Note. 95% confidence intervals around these estimates are: [a] ± 6; [b] ± 12; [c] ± 3; [d] ± 8.
*Not included on 2005 survey.

Age

The average age for those surveyed is 54 years old for agency directors and 48 years old for clinicians. Exhibit 15 displays age category by role. Results indicate that 70% of directors and 52% of clinicians are 50 years old or older. Further, 27% of directors are 60 years old or older. Some significant age differences are present within the workforce. A significantly larger proportion of clinicians (25%) than directors (6%) are under the age of 40 ($p < .001$). A significantly larger proportion of recovering than nonrecovering clinicians belong to older age categories ($p < .001$). Regionally, a statistically significant larger proportion of clinicians in DASA Region 1 are in their twenties ($p <. 05$). These results are presented in more detail in the Technical Appendix.

Exhibit 15
Age Category

Age Category	Directors		Clinicians	
	2005[a] (*n* = 258)	2002[b] (*n* = 51)	2005[c] (*n* = 782)	2002[d] (*n* = 120)
20–29 years old	<1%	12%	8%	13%
30–39 years old	6%	10%	17%	16%
40–49 years old	24%	26%	23%	29%
50–59 years old	42%	41%	37%	30%
60 + years old	27%	12%	15%	13%

Note. 95% confidence intervals around these estimates are: [a] ± 6; [b] ± 12; [c] ± 3; [d] ± 8.

The entire workforce also demonstrates a high average age of entry into the field. Results indicate that the average age of entry is 37 years for directors and 39 years for clinicians. These numbers parallel the finding that 43% of directors and 48% of clinicians report that substance abuse treatment is a second career. Interestingly, a significantly larger proportion of male than female directors and clinicians report that substance abuse treatment is a second career ($p < .001$).

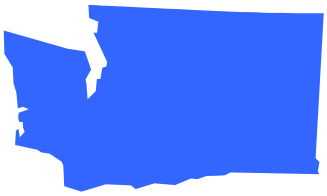
Recovery Status

Exhibit 16 displays recovery status for both directors and clinicians and reveals that 44% of directors and 48% of clinicians report being in recovery. This number could be significantly higher with 8% of directors and 13% of clinicians not disclosing their recovery status. Interestingly, a significantly larger proportion of male directors and clinicians report being in recovery ($p < .01$). Differences between the recovering and nonrecovering segments of the workforce are quite prevalent across multiple variables including age, degree status, years experience, salary, certification/licensure, likelihood of leaving the field, and technology use. These differences are cited throughout the report.

Exhibit 16
Recovery Status

Recovery Status	Directors (*n* = 250)	Clinicians (*n* = 766)
Recovering	44%	48%
Nonrecovering	34%	27%
Nonrecovering with family experience with addictions	11%	10%
Prefer not to disclose	8%	13%
Other	4%	3%

Academic and Professional Background



Reason for Entry into the Field

As displayed in Exhibit 17, the most frequently cited reasons for entering the field for both directors (53%) and clinicians (67%) are a previous experience with addiction or recovery (personal or family) and a personal interest in substance abuse treatment (48% and 59%, respectively). It should be noted that both reasons are cited by a significantly larger proportion of clinicians than directors ($p < .001$). Interestingly, reasons such as compensation, leadership, and career progression are not frequently cited reasons for entering the field.

Exhibit 17
Reason for Entry Into the Field

	Directors		Clinicians	
Reason	**2005[a] (*n* = 263)**	**2002[b] (*n* = 51)**	**2005[c] (*n* = 789)**	**2002[d] (*n* = 120)**
Previous experience with addiction or recovery (personal or family)	53%	39%	67%	71%
Personal interest	48%	35%	59%	65%
Experience in a similar field	16%	16%	19%	26%
Academic work or degree in a similar field	23%	31%	21%	31%
Role as a change agent*	22%	–	25%	–
Desire to lead*	21%	–	9%	–
Unplanned decision	19%	20%	13%	16%
Career progression*	20%	–	18%	–
Compensation*	2%	–	3%	–
Other	12%	18%	8%	4%

Note. Respondents asked to check all that apply. 95% confidence intervals around these estimates are: [a] ± 6; [b] ± 12; [c] ± 3; [d] ± 8.

*Not included in 2002 survey.

Years Experience

Years experience of the workforce is measured in three different ways: (a) years experience in the substance abuse field, (b) years in current role (director or clinician), and (c) years in current position with agency. Exhibit 18 displays the mean years experience for each of these by role. Directors average 16 years in the field and 8 years in their current position, while clinicians average 9 years in the field and 5 years in their current position. It should be noted that years experience is extremely variable for clinicians, ranging from less than 1 year to 36 years across the sample. Interestingly, both directors and clinicians indicate considerably more time in the field than time in their current role, potentially indicating some change in roles over time.

Exhibit 18
Years Experience

	Mean Years	
Experience	Directors (*n* = 263)	Clinicians (*n* = 791)
Years in field	16.0	9.0
Years in role	8.9	5.2
Years in position	8.4	4.7

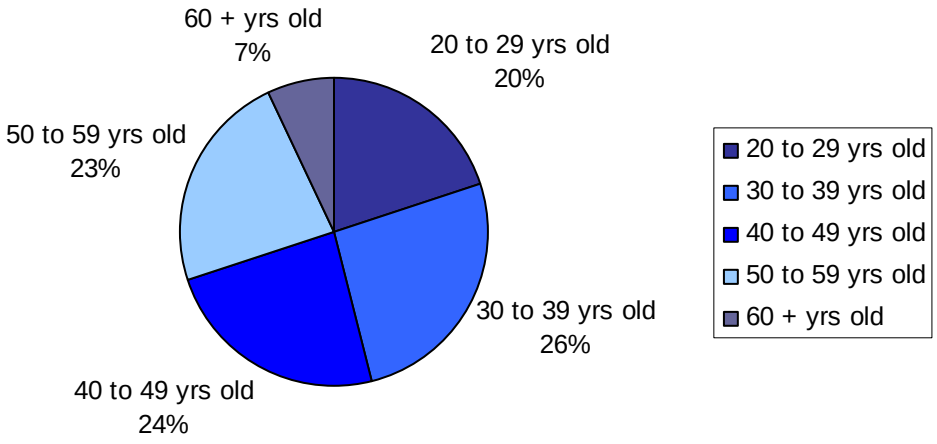
Due to significant variance, years experience in the field is also examined categorically (Exhibit 19). Results indicate that a significantly larger proportion of directors (58%) than clinicians (23%) report 15 or more years experience in the field ($p < .001$). Also of interest, a significantly larger proportion of recovering directors and clinicians report more years experience in the field ($p < .001$).

Despite an average of 9 years experience in the field, over one third of clinicians (35%) have only 0 to 4 years experience. Further, as displayed in Exhibit 20, examination of the average age of clinicians who have 0 to 4 years experience is also quite variable, again highlighting that clinicians are entering the field at all ages. It is important to note that more than half of these recent entries into the field (54%) are over 40 years old.

Exhibit 19
Years Experience in Field

Years Experience in Field	Directors (*n* = 263)	Clinicians (*n* = 791)
0 to 4 years	8%	35%
5 to 9 years	16%	22%
10 to 14 years	19%	19%
15 to 19 years	22%	12%
20 + years	36%	11%

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 76% of directors and 60% of clinicians have a Bachelor's degree or above. Further, 49% of directors and 24% 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 or above is significant ($p < .001$). Comparison of 2002 and 2005 data indicates some shift in clinicians' degree status, with more Bachelor's

degrees and fewer Associate's degrees reported in 2005. Since respondents were asked to report the highest degree obtained, this finding could indicate that some clinicians with Associate's degrees have completed a Bachelor's degree since the 2002 survey. Another explanation may be that hiring standards have risen and that a greater proportion of new hires have Bachelor's degrees. Analysis regarding turnover does not support a competing explanation that multiple clinicians with Associate's degrees have left the field since 2002.

Analysis also indicates that a significantly smaller proportion of minority directors ($p < .05$) and clinicians ($p < .001$) have a Bachelor's degree or above. Also of interest, a significantly smaller proportion of recovering directors ($p < .001$) and clinicians ($p < .001$) have a Bachelor's degree or above.

Exhibit 21
Degree Status

	Directors		Clinicians	
Level of Education	**2005[a] (*n* = 262)**	**2002[b] (*n* = 51)**	**2005[c] (*n* = 786)**	**2002[d] (*n* = 120)**
Less than high school	0%	0%	<1%	0%
High school	1%	0%	2%	2%
Some college	11%	16%	13%	17%
Associate's degree	13%	14%	24%	33%
Bachelor's degree	27%	22%	34%	23%
Master's degree	41%	45%	22%	19%
Ph.D.	8%	2%	2%	3%
M.D.*	<1%	–	<1%	–
Other professional degree*	<1%	–	1%	–
Other	0%	0%	1%	3%

Note. 95% confidence intervals around these estimates are: [a] ± 6; [b] ± 12; [c] ± 3; [d] ± 8.
*Not included in 2002 survey.

Directors and clinicians were also asked to report the amount of college or university coursework they have completed in four content areas: (a) substance abuse, (b) mental health, (c) administration/management, and (d) human service field. Results, displayed in Exhibit 22, indicate that while many members of the workforce have taken some specialized

coursework, fewer have obtained specialized certificates or degrees. Overall, 55% of directors and 54% of clinicians have a degree in at least one of the 4 aforementioned content areas. It should also be noted that 10% of directors and 27% of clinicians report currently participating in an academic degree or certification program.

Exhibit 22
Specialized Coursework, Certificates, & Degrees

Content Area	Directors (*n* = 263)	Clinicians (*n* = 791)
Substance abuse		
Coursework	78%	88%
Certificate	44%	52%
Degree	21%	28%
Mental health		
Coursework	47%	36%
Certificate	9%	8%
Degree	24%	17%
Administration/management		
Coursework	32%	16%
Certificate	8%	5%
Degree	11%	4%
Human service		
Coursework	38%	39%
Certificate	8%	14%
Degree	21%	24%

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.

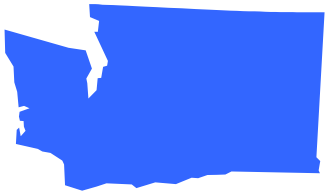
Overall, 65% of directors and 61% of clinicians report current certification. In addition, 53% of directors and 54% clinicians report current licensure. Estimates indicate that approximately 40% of the workforce has both active/current certification and licensure. Conversely, estimates indicate that approximately 21% of directors and 7% of clinicians have neither active/current certification nor licensure.

Exhibit 23
Certification/Licensure Status

	Directors (*n* = 263)		Clinicians (*n* = 791)	
Status	**Certification**	**Licensure**	**Certification**	**Licensure**
Current	171 (65%)	139 (53%)	486 (61%)	428 (54%)
Active (pending, awaiting, pursuing)	7 (3%)	4 (2%)	150 (19%)	87 (11%)
Inactive (never, previous)	77 (29%)	112 (43%)	135 (17%)	256 (32%)
Missing	8 (3%)	8 (3%)	20 (3%)	20 (3%)
Total	263 (100%)	263 (100%)	791 (100%)	791 (100%)

Some significantly differences exist in reported certification/licensure status. A significantly larger proportion of directors than clinicians report inactive certification (29% vs. 17%; $p < .001$) and inactive licensure (43% vs. 32%; $p < .001$) status. Also, a significantly larger proportion of recovering directors and clinicians have current certification ($p < .001$) and current licensure ($p < .001$).

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 reported spending the majority of their time on administrative tasks (73%), while clinicians reported spending the majority of their time on client-related tasks (69%). Not surprisingly, directors' time on these tasks varies significantly based on the size of their agency, with directors at smaller agencies spending significantly more time on client-related tasks ($p < .001$).

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

Task Type	Task	Directors (*n* = 230)	Clinicians (*n* = 669)
Client-Related	Screening & assessment	9%	13%
	Diagnosing	1%	4%
	Individual counseling	6%	17%
	Group counseling	6%	18%
	Family counseling	1%	2%
	Case management	4%	12%
	Making referrals	< 1%	2%
	Total Client Related Time	27%	69%
Administrative	Participating in training	< 1%	1%
	Providing clinical supervision	10%	5%
	Receiving clinical supervision	1%	3%
	Overseeing personnel	11%	< 1%
	Paperwork/documentation	14%	13%
	Meetings	11%	4%
	Other administrative	21%	< 1%
	Other activities	5%	5%
	Total Administrative Time	73%	31%

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

Interestingly, clinicians report nearly equal amounts of time performing individual counseling sessions (17%) as they do group counseling sessions (18%), despite the cost differences associated with 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 13% of their time (approximately 1 hour a day) on paperwork/documentation, far below anecdotal reports indicating that clinicians spend upwards of 50% of their time on paperwork.

Size of caseload plays an interesting role in clinicians' time devoted to client-related tasks. Analysis of variance results indicate that clinicians with larger caseloads report significantly more time performing screening and assessments ($F = 2.139$; $p < .001$), diagnosing clients ($F = 1.238$; $p < .05$), and providing individual counseling ($F = 1.586$; $p < .01$), and significantly less time making referrals ($F = 1.593$; $p < .01$) and receiving clinical supervision ($F = 1.706$; $p < .001$).

Consistent with past reports (Knudsen, Gallon, & Gabriel, in press), results of multivariate analysis of variance (MANOVA) 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 experience). While analysis indicates some statistically significant differences, closer inspection of results reveals that these differences are negligible in terms of practical significance. As an example, results indicate that clinicians with degrees specific

to substance abuse spend a statistically significant larger amount of time providing individual counseling each week. Examination of data reveals, however, that the difference in practical terms translates to less than 5 minutes per day.

Caseload Detail

Both directors and clinicians provided detail regarding their client caseloads. Just over one third of directors (38%) report carrying a caseload, with an average caseload size of 32 clients. Most directors carrying a caseload (65%) work at agencies with 5 or fewer direct service clinical staff. The majority of clinicians (83%) report carrying a caseload, with an average caseload size of 34 clients. Only 17% of clinicians carrying a caseload report that their caseload is not manageable.

Interestingly, the 17% of clinicians who reported not carrying a caseload still reported spending 48% 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. For example, clinicians not carrying a caseload report spending 20% of their time on *other activities*.

Treatment Models in Use

Directors and clinicians were asked to report which treatment models are in use in their agency and to identify how heavy an emphasis each had in their agencies approach (minor, moderate, or 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, 12-step, cognitive-behavioral therapy, bio-psychosocial, motivational interviewing, and strengths-based treatment are the most frequently endorsed models playing a major role. While these data

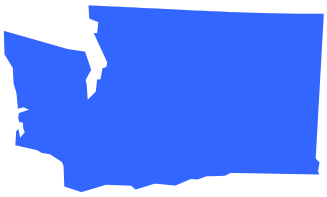
do not address fidelity of implementation, it is encouraging that at least 4 of these 6 models are considered evidence-based practices.

Some interesting differences across respondent roles, DASA regions, and agency size are present in reported use of various treatment models. Reported use of 12-step principles in particular varies, as a larger proportion of directors (43%) than clinicians (36%) report that it plays a major role in their agency's approach ($p < .05$). Use of 12-step is also report to be higher in DASA Regions 2, 3, and 6 than in other DASA regions ($p < .001$), and in agencies with 2 or fewer direct clinical staff ($p < .01$). A larger proportion of directors (41%) than clinicians (33%) report that cognitive behavioral therapy plays a major role in their agency's approach ($p < .05$). Use of culture-specific treatment ($p < .01$) is reported to be higher in DASA Regions 1 and 2, while use of both the Minnesota Model ($p < .01$) and moral recognition ($p < .01$) is reported to be higher in DASA Region 2. Culture-specific treatment is reported more frequently in smaller agencies ($p < .001$). A larger proportion of agencies with 2 or fewer clinical staff report that family ($p < .01$) and Rational Emotive Therapy ($p < .01$) play a major role in their agency's approach, while a larger proportion of agencies with 12 or more clinical staff report use of gender-specific techniques ($p < .001$).

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

Treatment Models	Directors (*n* = 263)	Clinicians (*n* = 791)
12-Step Principles	43%	36%
Behavior Modification/Token Reinforcement	14%	16%
Biopsychosocial	33%	34%
Cognitive Behavioral Therapy	41%	33%
Community Reinforcement	17%	15%
Coping Skills Therapy	26%	31%
Culture Specific	16%	11%
Developmental Model	6%	5%
Dialectical Behavior Therapy	10%	9%
Family	21%	15%
Gender Specific	13%	12%
Harm Reduction/Containment Skills	10%	11%
Integrated Substance Abuse & Mental Health	26%	21%
Intensive Case Management	20%	21%
Minnesota Model	10%	5%
Moral Recognition Therapy	6%	6%
Motivational Interviewing	29%	27%
Motivational Enhancement Theory	11%	14%
Opiate Substitution	4%	5%
Pharmacotherapy	5%	6%
Psycho-Educational	21%	16%
Psychotherapy	9%	6%
Rational Emotive Therapy	8%	9%
Rational Recovery	3%	4%
Reality Therapy	8%	12%
Relapse Prevention	61%	58%
Self-Regulating “Therapeutic” Community	6%	6%
Social Model	5%	5%
Social Skills Training	14%	17%
Solution Focused	26%	22%
Strengths Based	28%	26%
Systems Theory	8%	8%
Other	5%	3%

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, 72% of directors and 65% of clinicians report that daily or weekly clinical supervision is occurring at their agency. Interestingly, 11% of directors and 17% of clinicians report *not applicable* when asked about the frequency of clinical supervision at their agency. Analysis indicates that the differences in director and clinician reports of clinical supervision are significantly ($p < .05$), perhaps indicating some confusion over the delivery of clinical supervision. Also of interest, both director and clinician reports of clinical supervision vary by agency size. Analysis indicates that a significantly larger proportion of directors of agencies with 2 or fewer staff report that clinical supervision is not applicable ($p < .001$). Analysis also indicates that a significantly larger proportion of clinicians at agencies with 2 or fewer staff report receiving monthly clinical supervision ($p < .05$).

Overall, clinicians reported spending an average of 3% of their time each week (approximately 1½ hours) receiving clinical supervision. As displayed in Exhibit 26, results indicate that clinicians reporting more frequent clinical supervision also report more clinical supervision in terms of time. In total, clinicians across the state report receiving 1½ to 10 hours of clinical supervision per month. Unfortunately, the survey did not ask respondents to describe the clinical supervision activities provided. It is not known if what is reported to

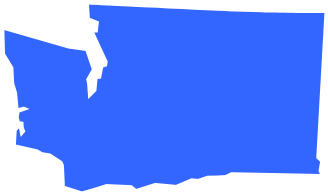
be clinical supervision is actually administrative in nature as opposed to clinical feedback, mentoring, and skill improvement.

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	22	2 ½ hours	10 hours
Weekly	43	1 hour	4 hours
Biweekly	7	30 minutes	2 hours
Monthly	11	Approx. 23 minutes	1.5 hours

[a]Clinicians reporting *not applicable* were excluded. [b]Numbers calculated from clinicians reports of time spent receiving clinical supervision a week.

Salary and Benefits



Salary

Exhibit 27 displays reported salary by role. Directors salaries are extremely variable in Washington with 66% of directors earning $45,000 or more per year. Clinician salaries are less variable, with 88% of clinicians earning less than $45,000 each year. The difference in director and clinician salaries is significant ($p < .001$). Approximately two thirds of directors and clinicians report being the primary wage earner for their family.

Exhibit 27
Salary

Salary	Directors (*n* = 258)	Clinicians (*n* = 778)
Less than $15,000	5%	9%
$15,000–$24,999	4%	19%
$25,000–$34,999	12%	39%
$35,000–$44,999	14%	21%
$45,000–$54,999	20%	7%
$55,000–$64,999	18%	2%
$65,000–$74,999	14%	1%
$75,000 or higher	14%	<1%

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

Analysis indicates a few differences in salary across the state. A significantly larger proportion of directors at agencies with 2 or fewer staff (as compared to directors at larger agencies) report making less than $35,000 per year ($p < .001$). Related, a significantly larger proportion of clinicians at agencies with 2 or fewer staff report making less than $15,000 per

year ($p < .001$). Also of interest, a larger proportion of nonrecovering directors ($p < .01$) and nonrecovering clinicians ($p < .01$) report higher salary levels than do recovering directors and clinicians.

Benefits

Exhibit 28 displays report benefits for directors and clinicians. Overall, 81% of directors and 88% of clinicians report receiving full or partial health insurance benefits, while 67% of directors and 70% of clinicians reported receiving retirement benefits. Both sick leave and vacation/other paid leave are provided to the vast majority of the workforce, while a sizeable portion of the workforce is not provided with maternity leave or tuition assistance.

Some important statistical differences are present in the provision of benefits. Overall, a significantly larger proportion of directors than clinicians do not have health insurance benefits ($p < .01$). Examination of benefit data over time indicates that there may be fewer directors fully provided with health insurance in 2005 than in 2002. Provision of benefits is also strongly linked to agency size as a significantly larger proportion directors and clinicians at smaller agencies ($p < .001$) do not receive benefits (Exhibit 29). Regionally, some differences in benefits are apparent for clinicians. A significantly larger proportion of clinicians in DASA Regions 4 and 5 are fully provided with health insurance ($p < .001$). A significantly larger proportion of clinicians in Region 4 are fully provided with retirement benefits ($p < .001$). Conversely, a significantly smaller proportion of clinicians in Region 1 and Region 3 do not receive retirement benefits ($p < .001$).

Exhibit 28
Benefits

Benefit	Directors		Clinicians	
	2005[a] (*n* = 263)	2002[b] (*n* = 51)	2005[c] (*n* = 791)	2002[d] (*n* = 120)
Health insurance				
Fully provided	59%	78%	57%	63%
Partially provided	22%	13%	32%	30%
Not provided	19%	10%	12%	7%
Sick leave				
Fully provided	80%	85%	84%	89%
Partially provided	6%	8%	7%	5%
Not provided	14%	8%	9%	6%
Vacation/other paid leave				
Fully provided	83%	82%	84%	77%
Partially provided	6%	8%	6%	14%
Not provided	11%	10%	10%	10%
Retirement plan				
Fully provided	42%	55%	40%	44%
Partially provided	25%	21%	30%	33%
Not provided	34%	24%	30%	24%
*Maternity leave**				
Fully provided	53%	–	49%	–
Partially provided	18%	–	18%	–
Not provided	29%	–	32%	–
*Tuition assistance**			%	
Fully provided	19%	–	18%	–
Partially provided	35%	–	33%	–
Not provided	46%	–	49%	–

Note. 95% confidence intervals around these estimates are: [a] ± 6; [b] ± 12; [c] ± 3; [d] ± 8.
*Not included in 2002 survey.

Exhibit 29
Benefit Provision by Agency Size

Role/Agency Size	Benefit (% receiving fully or partially)			
	Health Insurance	Retirement	Sick Leave	Vacation/Other Paid Leave
Directors				
2 or fewer staff	58	42	67	73
3 to 5 staff	79	63	86	90
6 to 11 staff	94	78	96	96
12 or more staff	98	88	98	98
Clinicians				
2 or fewer staff	67	57	73	73
3 to 5 staff	73	53	81	78
6 to 11 staff	91	75	93	91
12 or more staff	97	77	98	98

Predictors of Salary

Multiple linear regression is run to examine potential predictors of salary for the workforce in Washington. Four categories of predictors are included in the analysis: (a) demographic, (b) professional/academic background, (c) additional compensation/benefits, and (d) agency characteristics. Results indicate that the regression model accounts for 42% of the variability in directors' salary ($R^2 = .423$) and 39% of the variability in clinicians' salary ($R^2 = .390$).

For both directors and clinicians multiple factors appear to be significant predictors of salary (Exhibit 30). For directors, gender, degree status, years experience in the field, certification, provision of health insurance, and agency size are all related to earning a highly salary. Director results are best interpreted in the following way: (a) all other things being equal, male directors earn a higher salary, (b) all other things being equal, directors with higher degree status earn a higher salary, (c) all other things being equal, directors with more years experience earn a higher salary, (d) all other things being equal, directors with current certification earn a higher salary, (e) all other things being equal, directors

provided with health insurance earn a higher salary, and (f) all other things being equal, directors at larger agencies earn a higher salary.

For clinicians, gender, degree status, years experience in the field, provision of health insurance, retirement benefits, agency geography, agency setting, and agency size are all related to earning a highly salary. Clinician results are best interpreted in the following way: (a) all other things being equal, male clinicians earn a higher salary, (b) all other things being equal, clinicians with higher degree status earn a higher salary, (c) all other things being equal, clinicians with more years experience earn a higher salary, (d) all other things being equal, clinicians provided with health insurance earn a higher salary, (e) all other things being equal, clinicians provided with retirement benefits earn a higher salary, (f) all other things being equal, clinicians in more urban parts of the state earn a higher salary, (g) all other things being equal, clinicians in government settings earn a higher salary, and (g) all other things being equal, clinicians in larger agencies earn a higher salary.

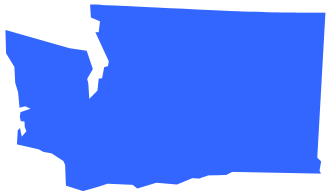
These results are a positive sign that agencies are compensating directors and clinicians for professional background characteristics such as degree status, experience, and certification. Conversely, it is disappointing to see gender playing a role in salary and, consequently, this may be a finding needing additional follow-up. The relationship of salary to health insurance and retirement benefits is interesting, and likely points to the fact that agencies able to afford paying higher salaries are also better able to pay for benefits. The relationship to salary and agency size may have a lot to do with the level of responsibility for directors, and the fact that being director at a larger agency is more of a management position than being a director at a smaller agency. As with benefits, clinicians at larger agencies may simply be profiting from the agencies' ability to pay more, although salary differences could also be due to job detail. The relationship of agency geography and salary is likely due to economic forces (such as cost of living). Available data does not shed any light on why government agencies are able to pay more than private and public agencies, although similar results are found in other states.

Exhibit 30
Predictors of Salary

Model Details	Significance of Predictor to Model	t-value
Directors[a]		
Gender	p < .001	3.790
Degree status	p < .001	3.946
Years experience in field	p < .01	3.164
Certification status	p < .01	-2.998
Health insurance	p < .01	-2.626
Agency size	p < .001	4.091
Clinicians[b]		
Gender	p < .05	2.174
Degree status	p < .001	5.141
Years experience in field	p < .001	8.788
Health insurance	p < .01	-2.642
Retirement benefit	p < .001	-6.161
Agency geography (RUCA Category)	p < .001	-4.042
Agency setting	p < .001	5.252
Agency size	p < .05	2.363

Note. R^2, when multiplied by 100, is interpreted as the percentage of the variability explained by the regression model.
[a]R^2 = .423. [b]R^2 = .390.

Staffing and Turnover



Agency Staffing Numbers

As previously reported, substance abuse treatment agencies across the state of Washington vary in size from 2 or fewer direct clinical staff to the largest agencies in the state employing 50 or more clinical staff. Average staffing numbers as provided by directors are provided in Exhibit 31. On average agencies employ 10 clinical staff, over two thirds 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 3 to 5 trainees for every 10 clinicians on staff.

Exhibit 31
Agency Staffing Numbers

Staffing Numbers (people)	Mean (min, max)[a]
Total staff size (direct clinical staff)	10.29 (0, 200)
Full time	7.32 (0, 128)
Part time	1.67 (0, 22)
On call	0.40 (0, 15)
Trainees	2.13 (0, 24)

Note. Directors reporting 0 staff do not employ anyone besides themselves.
[a]*n* = 263.

Description of Trainees

Given the prevalence of trainees in substance abuse treatment agencies in Washington, secondary analysis is conducted to describe their demographic and professional background characteristics. Unfortunately, the survey instrument did not provide respondents with an opportunity to indicate whether or not they are a trainee. In light of this oversight, trainees are secondarily identified as those clinicians reporting less than 4 years in the field, who have never been certified or are currently pursuing certification. This subgroup is then compared against certified clinicians with the same amount of experience, as well as the clinician population as a whole. Results (displayed in their entirety in the Technical Appendix) indicate that trainees and other clinicians vary on a few fundamental characteristics: (a) trainees, on average, are a bit younger; (b) trainees are as (if not more) educated; (c) fewer trainees are in recovery than the general population of clinicians in the state; and (d) trainees on average report earning lower salaries. Trainees and clinicians are, however, very similar in terms of caseloads and time spent providing treatment. This data should alleviate concerns that trainees being utilized in agencies are on a whole undereducated. However, concerns regarding how trainees are being utilized may be warranted as young trainees without certification report caseloads and client-related time comparable to certified clinicians.

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), although some estimates project agency-level turnover being as high as 50% (McClellan, Carise, & Kebler, 2003).

Agency directors in Washington, in addition to indicating the size of their clinical staff, were asked to report the amount of turnover experienced in the past year (Exhibit 32). Turnover is defined in 3 ways: (a) laid off, (b) terminated, and (c) quit (voluntary turnover). Total turnover is then calculated and compared against clinical staff size to determine an agency-level turnover rate.

Based on agency director reports of staffing in the past year, agencies experience an average turnover rate of 26% of their staff. This rate is slightly elevated from the 22% turnover rate reported in 2002. Interestingly, 40% of directors report no turnover in the past year, while nearly a quarter (24%) of directors report turnover rates of 50% or higher. Consistent with 2002 data is the fact that most turnover (over 60%) is voluntary (quitting).

Exhibit 32
Agency-Level Staff Turnover

Staffing Numbers (people)	Mean (min, max)[a]
Laid off	0.16 (0, 5)
Terminated	0.50 (0, 10)
Quit	1.16 (0, 20)
Total turnover	1.83 (0, 22)
Turnover rate	26% (0%, 300%)

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* = 251.

Agency-level turnover varies both by DASA Region (Exhibit 33), as well as by agency size (Exhibit 34). Overall, reported turnover is slightly lower in Region 4, and slightly elevated in Region 1. Reported turnover rates are also larger at smaller agencies.

Exhibit 33
Turnover Rates by DASA Region

DASA Region	Turnover Rate[a]
Region 1	32%
Region 2	27%
Region 3	28%
Region 4	20%
Region 5	27%
Region 6	26%

Note. Turnover rates as presented represent mean agency-level rates. DASA = Division of Alcohol and Substance Abuse.
[a]*n* = 251.

Exhibit 34
Turnover Rates by Agency Size

Agency Size	Turnover Rate[a]
2 or fewer staff	31%
3 to 5 staff	31%
6 to 11 staff	24%
12 or more staff	16%

Note. Turnover rates as presented represent mean agency-level rates.
[a]*n* = 251.

Predictors of Agency-Level Turnover

Multiple linear regression is run to examine potential predictors of agency-level turnover in Washington. Four categories of predictors are included in the analysis: (a) demographic characteristics of the agency director, (b) professional/academic background characteristics of the agency director, (c) agency characteristics, and (d) provision of clinical supervision. Results indicate that the regression model used accounts for approximately 13% of the variability associated with turnover in Washington agencies ($R^2 = .129$).

Despite the overall poor performance of the regression model, three factors appear to be significant predictors of turnover (Exhibit 35): (a) years experience of the director (more experience is associated with less turnover), (b) agency size (smaller agency size is associated with more turnover), and (c) clinical supervision (more frequent clinical supervision is associated with more turnover). The relationship between years experience and turnover is well established and is consistent with findings from the 2002 NFATTC Workforce Survey (Gabriel & Knudsen, 2003). The relationship between agency size and turnover is clear from turnover numbers, but the reasons for this are not as clear. One driving factor could be that clinicians at smaller agencies report lower salaries and fewer benefits. The relationship between clinical supervision and turnover is one needing more research, as it points to two potential problems: (a) clinicians may not be open to clinical supervision, and may leave as a result, or (b) clinical supervision is being utilized primarily as an administrative or disciplinary task instead of a mentoring/professional development task.

Exhibit 35
Predictors of Agency-Level Turnover

Model Details[a]	Significance of Predictor to Model	t-value
Years experience	$p < .05$	-2.114
Agency size	$p < .05$	-2.539
Frequency of clinical supervision	$p < .001$	-3.767

Note: R^2, when multiplied by 100, is interpreted as the percentage of the variability explained by the regression model.
[a]$R^2 = .129$.

Workforce Shortages and Planned Hires

Staffing and turnover numbers indicate that many agencies operate with a staff shortage. Overall, 40% of agency directors report that their agency is understaffed, with an average staff vacancy of 1.10 FTE. Across all agencies, this translates to an average staff vacancy of

.53 FTE. Data indicate that while a large percentage of reported staff shortages are budget-related (54%), the remaining 46% of directors reporting a staff shortage state that they 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 1.92 FTE in planned hires. The number of planned hires per agency range from 1 to 10 FTE, with chemical dependency professionals (CDPs) accounting for 79% of all planned hires (Exhibit 36).

Exhibit 36
Planned Hires

Position	Planned Hires[a]
Chemical dependency professionals (CDP), counselors, clinicians	185 (79%)
CDP trainees, interns	19 (8%)
Clinical supervisors	3 (1%)
Assessment/intake/case management	12 (5%)
Licensed practical nurses	7 (3%)
Specialists (prevention/intervention, social workers, etc.)	5 (2%)
Instructors	1 (<1%)
Support staff	3 (1%)
Total	**235 (100%)**

[a] *n* = 129 directors (49%) who indicate planned hires.

Senate Bill 5763, The Omnibus Treatment of Mental and Substance Abuse Disorders Act of 2005, provided nearly $40 million for chemical dependency treatment in the state of Washington. While this money was earmarked for treatment expansion purposes, it was anticipated that it would result in the hiring of additional clinical staff to serve the additional clients in treatment. Exhibit 37 displays the potential impact of this money, as agencies reporting receipt of state dollars report a decrease in the number of staff vacancies from 2002 through 2005, while agencies that do not receive state dollars reported an increase. Data also show that this money may still be having an effect, as the number of planned hires is also higher for agencies receiving state dollars.

Exhibit 37
Impact of State Dollars on Staff Shortage

Variable	Agencies Receiving SADA Funds	Agencies Receiving No SADA Funds
Staff shortage 2002 (# of staff vacancies)	0.95 FTE	0.40 FTE
Staff shortage 2005 (# of staff vacancies)	0.72 FTE	0.46 FTE
Planned hires 2005	1.25 FTE	0.82 FTE

Note. 51% of agencies reported receiving state alcohol and drug authority (SADA) funds in 2002; 30% of agencies reported receiving SADA funds in 2005.

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 38), and (b) number of times voluntarily leaving an agency (Exhibit 39). Results indicate that 79% of directors and 66% of clinicians have worked for more than one agency, with 68% of directors and 59% of clinicians voluntarily changing agencies at least one time. This data mirrors the voluntary nature of turnover evident in directors' reports of agency-level turnover. More specifically, data indicate that 64% of director movement and 61% of clinicians movement within the field is voluntary in nature.

Exhibit 38
Number of Agencies Worked for

Number of Agencies	Directors (*n* = 263)	Clinicians (*n* = 791)
1 agency (current)	21%	34%
2 agencies	24%	25%
3 to 4 agencies	33%	26%
5 or more agencies	22%	14%

Exhibit 39
Number of Times Voluntarily Leaving Agency

Number of Times	Directors (*n* = 263)	Clinicians (*n* = 791)
N/A (have only worked for 1 agency)	21%	34%
Never	11%	7%
1 time	19%	24%
2 times	19%	15%
3 or 4 times	22%	15%
5 or more times	7%	6%

In addition to reporting past turnover, directors and clinicians were asked to report on their likelihood of changing agencies (Exhibit 40) and their likelihood of leaving the field (Exhibit 41) within the next two years. Overall, 79% of directors and 67% of clinicians rate their likelihood of changing agencies within the next two years as *remote* or *not at all*. In addition, 84% of directors and 77% of clinicians rate their likelihood of leaving the field within the next two years as *remote* or *not at all*. It is worth noting that a number of clinicians indicate not being sure about their future with their agency (17%) or in the field (13%).

Exhibit 40
Likelihood of Changing Agency

Likelihood	Directors (*n* = 263)	Clinicians (*n* = 791)
Not at all	66%	45%
Remote possibility	13%	22%
High probability	10%	14%
Definitely	2%	2%
Not sure	9%	17%

Exhibit 41
Likelihood of Leaving Field

Likelihood	Directors (*n* = 263)	Clinicians (*n* = 791)
Not at all	61%	54%
Remote possibility	23%	23%
High probability	8%	8%
Definitely	<1%	2%
Not sure	8%	13%

Some significant differences are apparent in directors' and clinicians' reported likelihood of changing agencies or leaving the field. A significantly larger proportion of directors (66%) than clinicians (45%) report that their likelihood of changing agencies is *not at all* ($p < .001$). A statically significant larger proportion of minority clinicians report being not sure about their likelihood of leaving the field in the next two years ($p < .01$). A statistically significant larger proportion of clinicians in recovery report their likelihood of leaving the field is *not at all* ($p < .05$). Curiously, despite the higher turnover rates experienced in smaller agencies, a significantly larger proportion of clinicians at agencies with 2 or fewer staff report their likelihood of changing agencies is *not at all* ($p < .01$). Job satisfaction data presented elsewhere in this report may help clarify this finding, as clinicians working in smaller agencies report higher levels of job satisfaction.

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 15% of directors compared to 38% of clinicians indicate that burnout is a factor in clinicians' decisions to quit. For clinicians who quit (seeking better work opportunities elsewhere inside or outside of the field), 61% of directors report having clinicians leave for another agency, 49% report having clinicians leave for another allied field, 13% reported having clinicians going somewhere outside of substance abuse treatment and other allied fields, and 10% report not knowing where clinicians had gone.

Predictors of Individual-Level Turnover

To further examine characteristics or traits that may predict those in the workforce who may be planning on changing agencies or leaving the field in the next two years, logistic regression is used to examine differences between those planning on changing agencies (and those not), and between those planning on leaving the field (and those not). For the purposes of the logistic regression, "changers" and "leavers" are defined dichotomously as those respondents expressing a high probability or definite likelihood of changing agencies or leaving the field, and those not. For the purpose of clarity, respondents indicating *not sure* 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 Exhibits 42 and 43.

Exhibit 42
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

Note. R^2, when multiplied by 100, is interpreted as the percentage of the variability explained by the regression model.
[a]$R^2 = .341$. [b]$R^2 = .306$

Exhibit 43
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

Note. R^2, when multiplied by 100, is interpreted as the percentage of the variability explained by the regression model.
[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,

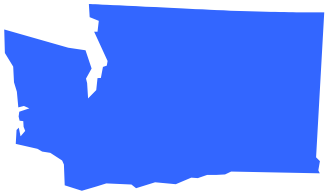
directors who report that substance abuse treatment is a second career are also 5 times more likely to anticipate leaving the field. Conversely, directors expressing higher levels of job satisfaction are only two fifths as likely to anticipate leaving the field.

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 filed, and clinicians expressing higher levels of job satisfaction are only one third as likely to anticipate leaving the field.

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

Recruitment and Retention



Recruitment Difficulties

When asked about staff recruitment, 57% of directors and 52% of clinicians indicate that their agency has difficulty filling open positions. Some significant differences exist in terms of reported recruitment difficulties. A significantly larger proportion of directors at larger agencies report recruiting difficulties ($p < .01$). Additionally, a significantly larger proportion of directors of agencies receiving SADA funds report recruitment difficulties ($p < .01$). Differences in agency setting are also evident, as a larger proportion directors of private nonprofit, public nonprofit, state government, and tribal agencies report recruiting difficulties.

The most frequently cited reason for the reported difficulties filling open positions is an insufficient number of applicants meeting minimum qualifications. In fact, 83% of directors who reported difficulties filling open positions indicate that an insufficient number of applicants meeting minimum qualifications is a major issue, while only 27% indicate that insufficient funding is an issue. The most frequently cited reasons why applicants are failing to meet minimum qualifications are applicants having little or no experience, insufficient or inadequate training/education, and a lack of appropriate certification/ licensure.

When asked what techniques they used to advertise open positions, 65% of directors report using ads in the newspaper, 47% report using personal/informal contacts, 46% report posting on a web site, 39% reported using the state human resources department, and 30% report networking via e-mail.

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 44). Both salary and benefits offered in the field and competition from other fields in terms of compensation are cited by the majority of respondents. Other frequently cited barriers include paperwork, large caseloads, and the cost of education or training. It should be noted that while large caseloads may be a perceived barrier to entry, in an earlier section of this report only 17% of clinicians report that their caseloads are not manageable.

Exhibit 44
Barriers to Entry Into the Field

	Directors (*n* = 263)		Clinicians (*n* = 791)	
Barriers to entering field	**%**	**Rating[a]**	**%**	**Rating[a]**
Lack of recruitment	42	3.4	36	3.2
Lack of encouragement (from educators, friends, family)	36	3.4	34	3.2
Competition from other fields in terms of compensation	71	4.3	60	4.3
Paperwork	57	3.9	62	4.0
Large caseloads	51	3.8	62	4.0
Evening and weekend work hours	56	3.5	53	3.7
Discrimination (age, disability, ethnicity, or gender)	23	1.8	22	2.0
Stigma and lack of respect for the field	55	3.4	54	3.4
Geographic constraints	22	2.5	25	2.5
Low salary or poor benefits	80	4.3	82	4.4
Cost of education or training	48	3.7	46	3.8
Amount of education or training	46	3.6	42	3.4
Quality of work environment in terms of professionalism	34	3.1	35	3.2
Negative preconceptions about the field	54	3.4	54	3.6
Certification/licensure tests are difficult to pass	38	3.0	32	2.9
Negative preconceptions about the nature of addicted clients	54	3.4	56	3.5

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, 64% of directors and 68% of clinicians report that from the perspective of other helping professionals, addiction professionals are thought to have lower status. Reasons for the perception of lower status are numerous, but lower salary is the most frequently cited by both directors and clinicians. Other frequently cited reasons include having less formal education or training, stigma due to association with substance abusers, and the perception that addiction professionals often have a history of substance abuse problems themselves.

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 indicates that when clinicians change agencies, it is usually 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. Data also point out that clinicians with higher degree status and more experience are more likely to change agencies. Data further suggest opportunities for agencies to retain clinicians as job satisfaction and job stress are also related to their desire to change agencies and potentially leave the field. Also, many clinicians report being not sure about their future.

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 45 displays current staff development activities by role. Interestingly, little consistency exists between the perceptions of directors and clinicians as to what staff development activities are occurring in their agencies. This may indicate a lack of communication to clinicians as to what staff development is available and, therefore, may represent a great opportunity for staff retention. In a more general sense, 86% of directors and 84% of clinicians report that their agency provides ongoing

training. The impact of having a staff development plan is evident in turnover numbers, as the 3% of directors reporting no method or program to develop staff report an average turnover rate of 44%, nearly twice the state average.

Exhibit 45
Perception of Staff Development Activities

Staff Development Methods/Programs	Directors (*n* = 263)	Clinicians (*n* = 791)
Has no method/program to develop skills	3%	7%
Offers in-house mentoring program	33%	17%
Provides in-service training	69%	59%
Provides direct supervision	75%	60%
Pays cost of continuing education	69%	51%

Note. Respondents were asked to check all that apply.

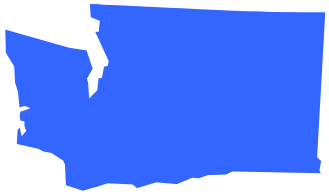
Directors and clinicians were also asked to report on what they thought their agency could do to promote the retention of qualified clinical staff. While more frequent salary increases is the most frequently cited retention strategy by both directors and clinicians, other viable strategies are also endorsed (Exhibit 46). Both directors and clinicians frequently cite more individual recognition and appreciation, assistance with paperwork (or lessening the amount of paperwork), and better health coverage and benefits as retention strategies. It is important to note that these retention strategies are also the most frequently endorsed in 2002. Interestingly, only 28% of directors (compared to 43% of clinicians) endorse taking formal steps to reduce emotional burnout as a strategy to retain staff. This finding is consistent with other data indicating that directors are underestimating the impact of burnout on clinicians.

Exhibit 46
Frequently Cited Retention Strategies

Proposed Retention Strategy	Directors (*n* = 263)	Clinicians (*n* = 791)
More frequent salary increases	58%	68%
More individual recognition and appreciation	41%	42%
Lessen/provide assistance with paperwork	40%	42%
Better health coverage and benefits	36%	37%
Formal steps to reduce emotional burnout	28%	43%

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 47, 85% of directors and 70% of clinicians report their job satisfaction as above average. Less than 2% of directors and 7% of clinicians report below average job satisfaction. Differences do exist in satisfaction levels, however, as a significantly larger proportion of directors (85%) than clinicians (70%) report above average job satisfaction ($p < .001$). Also of interest, a significantly larger proportion of clinicians working in agencies with 2 or fewer staff report above average job satisfaction ($p < .01$).

Exhibit 47
Job Satisfaction

Job Satisfaction Rating	Directors (*n* = 263)	Clinicians (*n* = 791)
1 – Very low	<1%	1%
2	1%	6%
3 – Average	12%	24%
4	39%	44%
5 – Very high	46%	26%

Exhibit 48 displays the most frequently cited factors contributing to directors' and clinicians' satisfaction, while Exhibit 49 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 48
Factors Contributing to Job Satisfaction

Directors (*n* = 263)	Clinicians (*n* = 791)
1. Ability to influence work setting decisions (65%)	1. One on one interaction with clients (77%)
2. Leadership (63%)	2. Agency/coworkers (58%)
3. Commitment to treatment (62%)	3. Role as a change agent (57%)
4. Role as a change agent (62%)	4. Commitment to treatment (57%)
5. Agency/coworkers (57%)	5. Opportunities for personal learning and growth (55%)

Exhibit 49
Factors Contributing to Dissatisfaction

Directors (*n* = 263)	Clinicians (*n* = 791)
1. Too many external regulations on agency (42%)	1. Salary and benefits (53%)
2. Salary and benefits (29%)	2. Too many external regulations on agency (24%)
3. Consistently working nonpaid overtime (22%)	3. Lack of career growth opportunities (23%)
4. Inability to influence agency decisions (8%)	4. Inability to influence agency decisions (19%)
5. Agency/coworkers (8%)	5. Consistently working nonpaid overtime (22%)

Job Stress

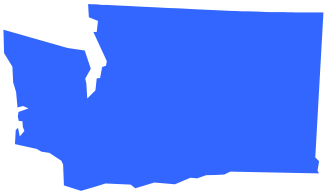
In addition to rating their job satisfaction, directors and clinicians also rated their job stress. As displayed in Exhibit 50, directors and clinicians report job stress as relatively high. In fact, 64% of directors and 52% of clinicians report above average job stress. This creates an interesting dynamic where substance abuse treatment is seen as both a stressful, but satisfying field. In other words, a career in substance abuse treatment can be viewed as the toughest job you will ever love (Gallon, Gabriel, & Knudsen, 2003).

Two significant differences in reported job stress are present. First, significantly larger proportion of directors than clinicians rate their job stress as very high ($p < .001$). Second, a significantly larger proportion of minority clinicians rate their job stress as very low ($p < .001$).

Exhibit 50
Job Stress

Job Stress Rating	Directors (*n* = 263)	Clinicians (*n* = 791)
1 – Very low	2%	4%
2	7%	8%
3 – Average	27%	37%
4	31%	36%
5 – Very high	33%	16%

Training



Training Participation and Barriers

Results indicate that 93% of directors and 91% of clinicians have participated in workshops or training in substance abuse in the past two years. On average, directors report having attended 8 workshops/trainings in the past two years, while clinicians report having attended 6 workshops/trainings in the past two years. The number of workshops and trainings attended in the past two years is quite variable for both groups however, with the number of workshops/trainings attended ranging from 1 to 100 for directors, and from 1 to 60 for clinicians. Variation in training attendance appears to be unrelated to agency (e.g., agency size, DASA Region, etc.) or demographic/professional (e.g., degree status, years experience, etc.) characteristics, and may be more related to agency philosophy.

Directors and clinicians also report encountering barriers when trying to obtain substance abuse training or skills. Overall, 33% of directors and 37% of clinicians reported training barriers, which are displayed in Exhibit 51.

Exhibit 51
Barriers to Training

Barrier	Directors (*n* = 87)	Clinicians (*n* = 288)
Lack of available training opportunities	39%	35%
The budget does not allow most program staff to attend trainings	58%	58%
Topics presented at recent trainings have been too limited	28%	21%
Training opportunities take too much time away from the delivery of program services	54%	41%
Training is not a priority at my work setting	6%	17%
There are too few rewards for trying to change treatment or other procedures in my work setting	7%	14%
Training opportunities are not local	46%	29%

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 was rated on a scale from 1 (*no proficiency*) to 7 (*complete proficiency*), while training interest was rated on a scale from 1 (*no interest*) to 5 (*maximum interest*). Exhibit 52 and Exhibit 53 display mean ratings for both directors and clinicians.

Exhibit 52
Self-Reported Proficiency in 28 Addiction Counselor Competency Areas

Competency Area	Directors		Clinicians	
	2005[a] (*n* = 263)	2002[b] (*n* = 51)	2005[c] (*n* = 791)	2002[d] (*n* = 120)
Administrative/management	6.06	6.03	4.86	4.24
Adolescent treatment	4.54	4.21	4.58	4.27
Client, family, and community education	5.79	5.36	5.50	5.13
Clinical supervision	5.90	5.95	4.69	4.38
Co-occurring disorders	5.30	5.18	5.01	4.89
Detoxification	3.90	3.92	4.04	4.20
Documentation	6.08	6.00	5.98	5.93
Drug pharmacology/pharmacotherapy	5.16	5.00	5.21	5.20
Gender-specific treatment	5.22	5.35	5.22	5.00
Group counseling	6.02	5.95	6.12	6.11
Individual counseling	6.25	6.05	6.22	6.17
Interpersonal communication	6.33	6.43	6.18	6.22
Intervention skills	5.71	5.65	5.58	5.52
Lesbian/gay/bisexual/transsexual-specific treatment	4.35	4.23	4.48	4.28
Marriage and family therapy	4.68	4.03	4.14	4.04
Offender treatment	4.84	4.61	4.39	4.21
Patient placement criteria	5.95	6.08	5.81	5.90
Professional/ethical responsibilities	6.58	6.56	6.33	6.38
Racial/ethnic-specific treatment	5.41	5.41	5.29	5.14
Referral skills	6.10	6.08	5.85	6.01
Relationship between substance abuse and medical problems	5.74	5.87	5.52	5.63
Screening/assessment	6.20	6.37	6.06	6.06
Service coordination and case mgmt.	5.99	6.14	5.88	5.88
Signs and symptoms	6.14	6.18	6.06	6.18
Staff recruitment	5.89	5.49	4.22	3.97
Staff retention	6.00	5.64	4.42	3.97
Treatment engagement	5.89	5.86	5.81	5.60
Treatment planning	5.95	5.78	5.94	5.85

Note. Proficiency range is 1 = *not proficient*; 2 = *mostly lacking*; 3 = *somewhat lacking*; 4 = *unsure*; 5 = *somewhat proficient*; 6 = *mostly proficient*; 7= *completely proficient*. 95% confidence intervals around these estimates are: [a] ± .20; [b] ± .45; [c] ± .10; [d] ± .26.

Exhibit 53
Self-Reported Training Interest in 28 Addiction Counselor Competency Areas

Competency Area	Directors		Clinicians	
	2005[a] (*n* = 263)	2002[b] (*n* = 51)	2005[c] (*n* = 791)	2002[d] (*n* = 120)
Administrative/management	3.83	3.95	3.12	3.05
Adolescent treatment	2.73	2.78	3.24	3.19
Client, family, and community education	3.31	3.31	3.72	3.72
Clinical supervision	3.71	3.66	3.58	3.53
Co-occurring disorders	3.79	3.89	4.21	4.26
Detoxification	2.53	2.54	3.08	3.18
Documentation	3.15	3.14	3.45	3.48
Drug pharmacology/ pharmacotherapy	3.59	3.33	3.99	3.87
Gender specific treatment	3.07	3.03	3.67	3.51
Group counseling	3.32	3.24	4.01	3.88
Individual counseling	3.24	3.03	4.04	3.93
Interpersonal communication	3.32	3.28	3.86	3.79
Intervention skills	3.21	3.19	3.91	3.81
Lesbian/gay/bisexual/transsexual-specific treatment	2.95	2.97	3.43	3.42
Marriage and family therapy	3.19	2.94	3.53	3.54
Offender treatment	3.15	2.97	3.38	3.44
Patient placement criteria	3.35	3.50	3.65	3.81
Professional/ethical responsibilities	3.66	3.50	3.69	3.83
Racial/Ethnic-specific Treatment	3.36	3.32	3.73	3.74
Referral skills	3.04	2.86	3.56	3.60
Relationship between substance abuse and medical problems	3.58	3.53	3.92	4.03
Screening/assessment	3.27	3.50	3.78	3.80
Service coordination and case management	3.24	3.44	3.67	3.66
Signs and symptoms	3.18	3.11	3.68	3.65
Staff recruitment	3.45	3.58	2.94	2.85
Staff retention	3.60	3.72	3.09	2.86
Treatment engagement	3.52	3.74	3.95	3.84
Treatment planning	3.54	3.65	4.03	4.13

Note. Interest range is 1 = *no interest*, 2 = *very little interest*, 3 = *moderate interest*, 4 = *considerable interest*; 5 = *maximum interest*. 95% confidence intervals around these estimates are: [a] ± .15; [b] ± .36; [c] ± .08; [d] ± .21.

Comparison of 2002 and 2005 data shows some interesting trends in proficiencies and training interests. Directors report a significant increase in proficiency in marriage and family therapy since 2002. Clinicians report a significant increase in proficiency in administration/management and client, family, and community education since 2002. Other competency areas such as co-occurring disorders and offender treatment also show upward trends, while some areas such as patient placement criteria are trending downward for both groups.

In addition to examining changes in proficiency and training interests since 2002, there is also interest in determining (a) on which ACC areas directors and clinicians differ in their ratings, and (b) whether DASA regions differ in the proficiency and interest ratings. MANOVA is used to examine main effects of region and role on ratings of proficiency and training interest in the 28 ACC areas. Results indicate an overall main effect of role [F (28, 717) = 11.051; $p < .001$] and DASA region [F (140, 3,577) = 1.334; $p < .01$] on training proficiencies, but detect no role by DASA region interaction [F (140, 3,577) = .971; $p = .580$]. In terms of training interests, results indicate an overall main effect of role [F (28, 736) = 6.942; $p < .001$], but detect no main effect of DASA region [F (140, 3,672) = .987; $p = 526$] or a role by DASA region interaction [F (140, 3.672) = .981; $p = .547$]. Broadly interpreted, these results indicate that self-rated proficiencies and training interests are both significantly different between directors and clinicians, and proficiencies also vary across DASA regions. The lack of significant interactions indicates that differences in the proficiencies and training interests of agency directors and clinical staff do not vary by DASA region, but rather are common across the state. Similarly, the absence of a regional main effect on training interests indicates that the same topics are of high interest across the state.

Univariate statistics for each competency area were examined to determine where significant role and DASA regional differences exist. Results are intended to help clarify training priorities by (a) identifying which differences between agency directors and clinical staff are significant, and (b) identifying training needs and/or interests that are specific to a

given DASA region. Results are summarized in Exhibit 54. Overall, it is apparent that the proficiency levels reported by directors and clinicians vary significantly on multiple competencies. Interest level in competency areas varies even more dramatically between directors and clinicians. The overall proficiency of the workforce varies significantly across DASA regions on 3 competency areas: patient placement criteria, screening and assessment, and service coordination and case management.

Exhibit 54
Proficiency and Interest in 28 Addiction Counseling Competency Areas: Summary of Role and Regional Differences

	Proficiency		Training Interest	
Competency Area	**Role**	**Region**	**Role**	**Region**
Administrative/management	$p < .001$	ns	$p < .001$	ns
Adolescent treatment	ns	ns	$p < .001$	ns
Client, family, and community education	$p < .001$	ns	$p < .01$	ns
Clinical supervision	$p < .001$	ns	ns	ns
Co-occurring disorders	ns	ns	$p < .001$	ns
Detoxification	$p < .05$	ns	$p < .001$	ns
Documentation	$p < .05$	ns	$p < .01$	ns
Drug pharmacology/pharmacotherapy	ns	ns	$p < .001$	ns
Gender-specific treatment	ns	ns	$p < .001$	ns
Group counseling	ns	ns	$p < .001$	ns
Individual counseling	ns	ns	$p < .001$	ns
Interpersonal communication	$p < .001$	ns	$p < .001$	ns
Intervention skills	ns	ns	$p < .001$	ns
Lesbian/gay/bisexual/transsexual-specific treatment	ns	ns	$p < .001$	ns
Marriage and family therapy	$p < .001$	ns	$p < .01$	ns
Offender treatment	$p < .05$	ns	$p < .05$	ns
Patient placement criteria	ns	$p < .01$	$p < .01$	ns
Professional/ethical responsibilities	$p < .001$	ns	ns	ns
Racial/ethnic-specific Treatment	ns	ns	$p < .001$	ns
Referral skills	$p < .01$	ns	$p < .001$	ns
Relationship between substance abuse and medical problems	ns	ns	$p < .001$	ns
Screening/assessment	ns	$p < .05$	$p < .001$	ns
Service coordination and case management	ns	$p < .05$	$p < .001$	ns
Signs and symptoms	ns	ns	$p < .001$	ns
Staff recruitment	$p < .001$	ns	$p < .001$	ns
Staff retention	$p < .001$	ns	$p < .001$	ns
Treatment engagement	ns	ns	$p < .001$	ns
Treatment planning	ns	ns	$p < .001$	ns

Note. ns = not significant.

Training Priorities

In order to further clarify training priorities for Washington, competency areas are examined via a training priority matrix (Exhibit 55) 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 55
Training Priority Matrix

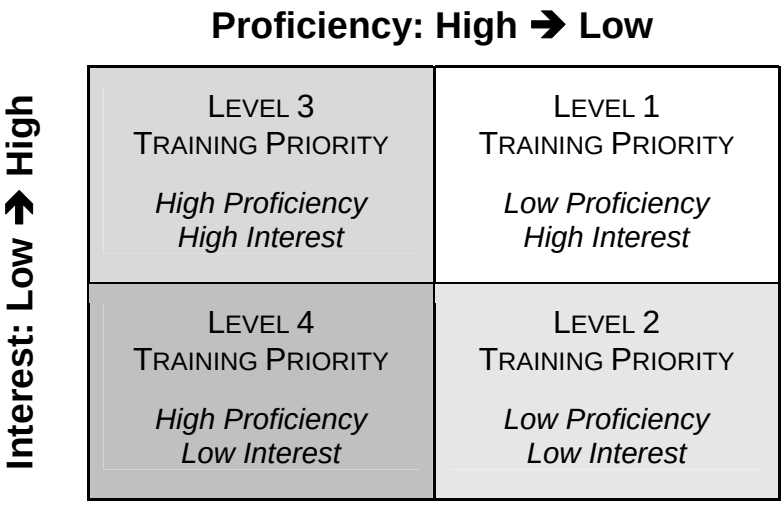


Exhibit 56 and Exhibit 57 display training priorities separately for directors and clinicians to better match their differing (self-rated) proficiencies and interests. Results indicate that, for directors, drug pharmacology and racial/ethnic-specific treatment are lower proficiency, higher interest areas and are, therefore, Level 1 training priorities. For clinicians, results point to co-occurring disorders, drug pharmacology, gender-specific treatment, and racial/ethnic-specific treatment as Level 1 training priorities. Despite multiple differences in self-reported proficiencies and training interests between directors and clinicians across the

state, drug pharmacology and racial/ethnic-specific treatment are identified as Level 1 priorities for both groups.

Exhibit 56
Training Priorities for Directors

Priority Level 1: Higher Interest, Lower Proficiency

- Drug pharmacology/pharmacotherapy
- Racial/ethnic-specific treatment

Priority Level 2: Lower Interest, Lower Proficiency

- Adolescent treatment
- Detoxification
- Gender-specific treatment
- Lesbian/gay/bisexual/transsexual-specific treatment
- Marriage and family therapy
- Offender treatment

Priority Level 3: Higher Interest, Higher Proficiency

- Administrative/management
- Clinical supervision
- Co-occurring disorders
- Patient placement criteria
- Professional/ethical responsibilities
- Relationship between substance abuse and medical problems
- Staff recruitment
- Staff retention
- Treatment engagement
- Treatment planning

Priority Level 4: Lower Interest, Higher Proficiency

- Client, family, and community education
- Documentation
- Group counseling
- Individual counseling
- Interpersonal communication
- Intervention skills
- Service coordination and case management
- Referral skills
- Screening/assessment
- Signs and symptoms

Note. Proficiency range is 1 (*none*) to 7 (*completely*); Interest range is 1 (*no interest*) to 5 (*maximum interest*). Median total proficiency (5.71) and interest (3.32) were used as cut-off scores for higher/lower distinctions.

Exhibit 57
Training Priorities for Clinicians

Priority Level 1: Higher Interest, Lower Proficiency

- Co-occurring disorders
- Drug pharmacology/pharmacotherapy
- Gender-specific treatment
- Racial/ethnic-specific treatment

Priority Level 2: Lower Interest, Lower Proficiency

- Administrative/management
- Adolescent treatment
- Clinical supervision
- Detoxification
- Lesbian/gay/bisexual/transsexual-specific treatment
- Marriage and family therapy
- Offender treatment
- Staff recruitment
- Staff retention

Priority Level 3: Higher Interest, Higher Proficiency

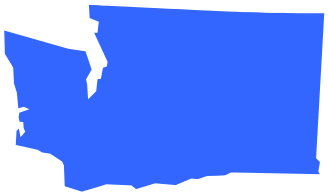
- Client, family, and community education
- Group counseling
- Individual counseling
- Interpersonal communication
- Intervention skills
- Patient placement criteria
- Professional/ethical responsibilities
- Relationship between substance abuse & medical problems
- Screening/assessment
- Service coordination & case management
- Signs & symptoms
- Treatment engagement
- Treatment planning

Priority Level 4: Lower Interest, Higher Proficiency

- Documentation
- Referral skills

Note. Proficiency range is 1 (*none*) to 7 (*completely*); Interest range is 1 (*no interest*) to 5 (*maximum interest*). Median total proficiency (5.36) and interest (3.64) were used as cut-off scores for higher/lower distinctions.

Technology



Technology Access

Across the state, the substance abuse treatment workforce reports having good access to technology. Overall, 99% of directors and 95% of clinicians report having computer access in the workplace. In addition, 93% of directors and 81% of clinicians report having internet access in the workplace. While overall access reports are good, it is still unclear how current the computer hardware and software are in agencies, and what the ratio of computers to employees is.

Directors and clinicians also reported on their technology access at home. These numbers almost mirror access at work, as 92% of directors report having computer access and 87% report having internet access. For clinicians, 88% report having computer access at home, and 82% report having internet access at home.

Technology Use

Reports of technology use are provided in Exhibit 58. In terms of technology usage that is directly related to substance abuse issues, 88% of directors and 86% of clinicians report feeling proficient using technology to obtain information about substance abuse.

Exhibit 58
Technology Use

Technology Use	Directors (*n* = 263)	Clinicians (*n* = 791)
Billing	59%	17%
Alcohol/drug research	76%	60%
Email/correspondence	88%	69%
Client information/clinical issues	65%	57%
Alcohol/drug web-based professional development	52%	33%

Note. Respondents were asked to check all that apply.

Attitudes toward technology and its potential role in substance abuse treatment are also reported (Exhibit 59). In general, attitudes reflect that technology is viewed as a positive feature in the work of a substance abuse treatment professional. Results indicate some challenges and opportunities for web-based training modalities. While only 33% have used web-based technology for training, 64% of clinicians agree or strongly agree to the statement, "I am interested in web-based professional education."

Exhibit 59
Attitudes Toward Technology

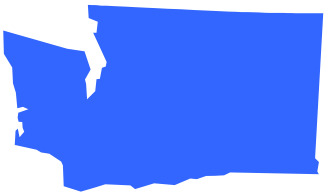
Technology Attitudes	Directors (*n* = 263)	Clinicians (*n* = 791)
Using computers and web-based technologies helps me be more effective at my job.	86%	82%
I am interested in web-based professional education.	61%	64%
I would like to use the computer and web-based technologies in my work more.	58%	59%
My organization encourages the use of computers and web-based technologies.	78%	58%

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

Some differences exist concerning technology use and attitudes. A significantly larger proportion of directors than clinicians report that they strongly agree that technology helps them be more effective at their jobs ($p < .01$). A significantly larger proportion of directors

than clinicians report that their agency encourages the use of computers and web-based technology ($p < .001$). In addition, a significantly larger proportion of directors than clinicians report using technology for alcohol and other drug (AOD) research ($p < .001$) and for web-based professional development ($p < .001$). Further, a significantly smaller proportion of directors at agencies with 2 or fewer staff report using technology for AOD research ($p < .001$). Finally, a significantly larger proportion of nonrecovering directors ($p < .05$) and clinicians ($p < .01$) report using technology for AOD research. It is unclear whether this difference is due to recovering directors and clinicians leaning more on personal experience than AOD research, or other demographic (age) or professional characteristics (years experience).

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 chemical dependency 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 there are now just as many women as men directing agencies and over half the clinical positions (60%) are filled by women. The age of the workforce is maturing, with 70% of directors and 52% of clinicians over the age of 50. This is somewhat to be expected because a career in chemical dependency treatment is often (48%) a second career. The average age of entry into the field for both directors and clinicians is between 37 and 39 years. The newest members of the workforce, those with 0 to 4 years experience, compose 35% 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 nearly as likely to be under forty (46%) as over (54%). So, while addiction treatment agencies employ an older workforce, the newer members of the workforce indicate an infusion of both younger and older workers.

Recovery status and experience with substance use problems continue to play important roles in the decision to become a chemical dependency professional. Fully two thirds of clinicians and over half the current directors are either in recovery or have previous personal experience with addiction. Clinicians who are in recovery tend to be older than their nonrecovering counterparts. This helps us understand the second career nature of the field. It has been true for years that when individuals enter stable recovery they often seek a career in helping others deal with similar problems. That situation does not appear to have changed.

One trend that is changing is the educational background of the workforce. Nearly 85% of today's clinicians have a college degree (60% have at least a Bachelor's degree and another 24% have an Associate's degree). It appears likely that some clinicians have improved their educational status while new hires are likely to already have at least a Bachelor's degree. In fact, the percentage of clinicians with at least a Bachelor's degree has increased over 12%. The emphasis on academic preparation as an important qualification for the Chemical Dependency Professional license is beginning to emerge in these results.

A final demographic worth noting is the relatively modest compensation received by clinicians in today's workforce. Approximately 90% of all clinicians report earning less than $45,000 per year, with a similar percentage receiving either full or partial health benefits. In addition, smaller agencies tend to pay lower salaries and offer fewer benefits than larger agencies. It is likely, therefore, that many of those reporting clinician salaries in the $15,000 to $25,000 range (28%) and $25,000 to $35,000 (39%) are employed in smaller agencies or are in the first 4 years of their career at a larger agency. 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 chemical dependency treatment despite the modest salaries available. The increasing educational requisites for licensure indicate a need to encourage those in recovery to complete an accredited academic program and get quality supervision during their field placement. The demand for such individuals remains high as the majority of agencies (57%), both large and small, report having difficulty finding qualified applicants for clinical positions.

In addition to recruiting recovering people, there is a need for more clinical staff at all 3 academic levels of preparation: Associate's, Bachelor's, and Master's. It appears that the number of people currently graduating from chemical dependency counselor training programs is insufficient to meet the needs of Washington agencies. Almost half the reporting agencies (49%) plan to hire an average of 2 additional employees in the next 12 months. Given that the total number of agencies in the state was 377 at the time of the survey, and that half the agencies are planning to hire 2 people each, the number of new chemical dependency professionals needed approaches 380. That figure does not factor in people who leave the profession and also need to be replaced, so the actual need may be higher. Add to these predictions the fact that the number of new professionals who graduate from training programs each year is unknown; the result is a need to gather information from academic and internship training programs about the number of graduates each year. Comparing the number of graduates with the number actually needed in the field will help determine the need for additional recruiting efforts.

Another piece of related information important to workforce planning is the fact that a large proportion of the workforce is composed of chemical dependency trainees. These are people practicing as clinicians who have not yet achieved their professional certification or license. They require more intensive clinical supervision and training than fully

credentialed clinicians. The survey does reveal that 22% of the clinicians reporting do spend about 5% of their time (2 to 2½ hours per week) in clinical supervision, while another 43% spend about 3% (1 hour per week). The remaining 35% receive something less. 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.

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

Workforce Retention

There are really two distinct populations of treatment providers in Washington. Over half (56%) of all the treatment agencies surveyed have 5 or fewer clinical staff. These are small agencies with budgets in the neighborhood of $200,000 to $450,000. On the other end of the continuum are larger agencies; approximately a quarter (24%) of the state's providers have 12 or more clinical staff with average budgets above $3,000,000. These are two very

different types of agencies. Larger agencies have more resources for clinical supervision, staff training, and opportunities for staff to develop specialized skills. Smaller agencies may have fewer resources for staff development, and service demands requiring clinical staff to be skillful in a variety of treatment services.

While statewide staff turnover averages 26% annually, the larger agencies have a rate of approximately 16%. Smaller agencies (5 or fewer clinical staff) account for 63% of the annual turnover. What might be fueling what appears to be a lot of staff movement in these smaller agencies? One factor appears to be the agency director; the data show that directors with a longer tenure in their position have lower staff turnover rates than those newer to their positions. Another variable might be the agency's investment in staff development; those agencies without a staff development plan had twice the turnover rate of agencies with such a plan. A third influence may be the degree to which staff feel recognized, appreciated, and emotionally supported by the agency. Those were 3 of the primary sources of dissatisfaction noted in the survey. The majority of clinicians describe their work as *high stress* and almost half (43%) endorse additional agency assistance to reduce emotional burnout.

Another factor in enhancing staff retention rates, and the most frequently cited source of dissatisfaction, is compensation. Improving salary and health benefits are frequently suggested ways of reducing turnover. Turnover is especially high in small agencies. It is likely that smaller agencies have fewer resources for staff development and clinical supervision, and results here show they have lower compensation packages than the larger treatment providers. The data also reveal that clinicians are more likely to be planning to leave their job if they describe their work as high stress, experience low job satisfaction, and have a higher academic degree. In addition, 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 don't have another wage earner in their family. Fortunately, a few variables appear to be significant

predictors of salary in Washington. For directors, gender, degree status, years experience in the field, certification, provision of health insurance, and agency size are all related to earning a highly salary. For clinicians, gender, degree status, years experience in the field, provision of health insurance, retirement benefits, agency geography, agency setting, and agency size are all related to earning a higher salary. While these results offer an encouraging message to the workforce that agencies are compensating directors and clinicians for professional background characteristics such as degree status, experience, and certification, they also point to the previously identified gap between small and large agencies and their ability to offer high salaries and benefits.

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

Service Delivery Issues

Clinicians report spending 69% 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 13%. 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 that 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 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. The only model used by over 50% of the agencies is relapse prevention. It is not known which relapse prevention strategies are being used and whether they are being used in a way that is consistent with the literature. The same is true for other models reported to be widely used throughout the state. Twelve-step models, cognitive behavior therapy, and coping skills training are all endorsed as primary methods by a significant number of agencies. Again, little is known about the faithfulness of the services being delivered to the original models. 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 drug pharmacology, co-occurring disorders, gender-specific treatment methods, and culturally appropriate treatment approaches for a number of specific populations. 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 Washington State. It raises issues relevant to the recruitment, development, and retention of qualified chemical dependency 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 chemical dependency treatment services.

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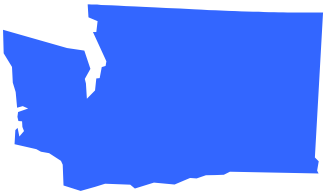

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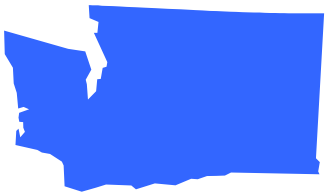
Technical Appendix



1. Gender by DASA Region—Directors

Gender (%)	Region 1 (*n* = 39)	Region 2 (*n* = 30)	Region 3 (*n* = 34)	Region 4 (*n* = 80)	Region 5 (*n* = 37)	Region 6 (*n* = 43)
Female	56	53	38	44	68	47
Male	44	47	62	56	32	53

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

2. Gender by DASA Region—Clinicians

Gender (%)	Region 1 (*n* = 120)	Region 2 (*n* = 83)	Region 3 (*n* = 102)	Region 4 (*n* = 232)	Region 5 (*n* = 98)	Region 6 (*n* = 156)
Female	60	64	55	58	64	59
Male	40	36	45	42	36	41

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

3. Gender by Agency Size—Directors

Gender (%)	2 or fewer staff (*n* = 59)	3–5 staff (*n* = 64)	6–11 staff (*n* = 46)	12 or more staff (*n* = 55)
Female	48	53	46	49
Male	52	47	54	51

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

4. Gender by Agency Size—Clinicians

Gender (%)	2 or fewer staff (*n* = 38)	3–5 staff (*n* = 151)	6–11 staff (*n* = 184)	12 or more staff (*n* = 280)
Female	66	57	61	60
Male	34	43	39	40

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

5. Gender by Recovery Status—Directors

Gender (%)	Recovering (*n* = 109)	Nonrecovering (*n* = 141)
Female	36	64
Male	51**	49

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

6. Gender by Recovery Status—Clinicians

Gender (%)	Recovering (*n* = 367)	Nonrecovering (*n* = 398)
Female	43	57
Male	55**	45

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

7. Ethnicity by DASA Region—Directors

Ethnicity (%)	Region 1 (*n* = 39)	Region 2 (*n* = 30)	Region 3 (*n* = 34)	Region 4 (*n* = 80)	Region 5 (*n* = 37)	Region 6 (*n* = 43)
American Indian	3	3	3	3	3	7
Alaskan Native	0	0	0	0	0	0
Asian American	0	7	0	1	0	2
Native Hawaiian/Other Pacific Islander	0	3	3	0	0	0
Black/African American	8	0	6	6	0	2
White or Caucasian	87	80	82	80	87	63
Other	3	7	6	10	11	26
Hispanic	3	0	6	3	5	12

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

8. Ethnicity by DASA Region—Clinicians

Ethnicity (%)	Region 1 (*n* = 120)	Region 2 (*n* = 83)	Region 3 (*n* = 102)	Region 4 (*n* = 232)	Region 5 (*n* = 98)	Region 6 (*n* = 156)
American Indian	10**	0	1	4	2	5
Alaskan Native	0	0	1	<1	0	0
Asian American	1	5	0	2	4	1
Native Hawaiian/Other Pacific Islander	0	0	1	<1	0	1
Black/African American	3	1	4	8**	9**	11**
White or Caucasian	79	83	86	77	74	74
Other	8	11	7	8	10	8
Hispanic	3	5	13	7	4	5

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

9. Ethnicity by Agency Size—Directors

Ethnicity (%)	2 or fewer staff (*n* = 59)	3–5 staff (*n* = 64)	6–11 staff (*n* = 46)	12 or more staff (*n* = 55)
American Indian	2	2	7	7
Alaskan Native	0	0	0	0
Asian American	2	2	2	2
Native Hawaiian/Other Pacific Islander	2	2	0	0
Black/African American	7	3	2	6
White or Caucasian	74	80	73	82
Other	14	13	16	4
Hispanic	7	5	7	2

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

10. Ethnicity by Agency Size—Clinicians

Ethnicity (%)	2 or fewer staff (*n* = 38)	3–5 staff (*n* = 151)	6–11 staff (*n* = 184)	12 or more staff (*n* = 280)
American Indian	5	5	5	4
Alaskan Native	0	0	1	0
Asian American	3	4	2	1
Native Hawaiian/Other Pacific Islander	0	0	0	0
Black/African American	8	6	6	8
White or Caucasian	76	76	78	79
Other	8	9	9	8
Hispanic	5	6	9	4

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

11. Age by DASA Region—Directors

Age Category (%)	Region 1 (*n* = 39)	Region 2 (*n* = 30)	Region 3 (*n* = 34)	Region 4 (*n* = 80)	Region 5 (*n* = 37)	Region 6 (*n* = 43)
20–29 years old	0	0	0	1	0	0
30–39 years old	0	10	3	4	5	14
40–49 years old	26	13	35	25	27	19
50–59 years old	55	10	35	42	38	42
60+ years old	18	37	27	28	30	26

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

12. Age by DASA Region—Clinicians

Age Category (%)	Region 1 (*n* = 120)	Region 2 (*n* = 83)	Region 3 (*n* = 102)	Region 4 (*n* = 232)	Region 5 (*n* = 98)	Region 6 (*n* = 156)
20–29 years old	14*	8	8	8	6	5
30–39 years old	10	23	12	22	19	13
40–49 years old	32	17	23	20	18	28
50–59 years old	33	40	45	33	42	38
60+ years old	11	12	13	17	16	16

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

13. Age by Agency Size—Directors

Age Category (%)	2 or fewer staff (*n* = 59)	3–5 staff (*n* = 64)	6–11 staff (*n* = 46)	12 or more staff (*n* = 55)
20–29 years old	2	0	0	0
30–39 years old	7	7	7	4
40–49 years old	24	31	22	24
50–59 years old	46	36	35	48
60+ years old	22	27	37	24

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

14. Age by Agency Size—Clinicians

Age Category (%)	2 or fewer staff (*n* = 38)	3–5 staff (*n* = 151)	6–11 staff (*n* = 184)	12 or more staff (*n* = 280)
20–29 years old	5	11	6	10
30–39 years old	11	15	16	17
40–49 years old	21	21	24	22
50–59 years old	53	40	37	38
60+ years old	11	13	18	14

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

15. Age by Recovery Status—Directors

Age Category (%)	Recovering (*n* = 109)	Nonrecovering (*n* = 137)
20–29 years old	0	1
30–39 years old	4	7
40–49 years old	26	26
50–59 years old	42	42
60+ years old	28	28

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

16. Age by Recovery Status—Clinicians

Age Category (%)	Recovering (*n* = 363)	Nonrecovering (*n* = 397)
20–29 years old	3	13
30–39 years old	9	24
40–49 years old	25	21
50–59 years old	44***	31
60+ years old	18***	11

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

17. Degree Status by DASA Region—Directors

Degree (%)	Region 1 (*n* = 39)	Region 2 (*n* = 30)	Region 3 (*n* = 34)	Region 4 (*n* = 80)	Region 5 (*n* = 37)	Region 6 (*n* = 43)
Less than high school	0	0	0	0	0	0
High school	3	0	0	0	0	2
Some college	15	7	12	10	5	14
Associate's	8	23	15	9	8	19
Bachelor's	28	20	29	27	32	26
Master's	41	40	38	41	51	33
Ph.D.	3	10	3	14	3	7
M.D.	3	0	0	0	0	0
Other professional degree	0	0	3	0	0	0
Other	0	0	0	0	0	0

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

18. Degree Status by DASA Region—Clinicians

Degree (%)	Region 1 (*n* = 120)	Region 2 (*n* = 83)	Region 3 (*n* = 102)	Region 4 (*n* = 232)	Region 5 (*n* = 98)	Region 6 (*n* = 156)
Less than high school	1	0	0	0	1	<1
High school	2	1	2	2	2	5
Some college	8	19	13	10	16	17
Associate's	26	27	20	24	16	28
Bachelor's	32	35	46	32	40	28
Master's	30	16	16	26	20	20
Ph.D.	1	1	1	4	1	1
M.D.	0	0	0	0	1	0
Other professional degree	0	1	2	1	1	2
Other	1	0	1	0	1	1

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

19. Degree Status by Agency Size—Directors

Degree (%)	2 or fewer staff (*n* = 59)	3–5 staff (*n* = 64)	6–11 staff (*n* = 46)	12 or more staff (*n* = 55)
Less than high school	0	0	0	0
High school	0	0	4	0
Some college	15	8	4	13
Associate's	22	14	9	4
Bachelor's	27	31	28	29
Master's	27	42	46	44
Ph.D.	9	5	9	9
M.D.	0	0	0	2
Other professional degree	0	0	0	0
Other	0	0	0	0

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

20. Degree Status by Agency Size—Clinicians

Degree (%)	2 or fewer staff (*n* = 38)	3–5 staff (*n* = 151)	6–11 staff (*n* = 184)	12 or more staff (*n* = 280)
Less than high school	0	0	1	0
High school	3	3	1	3
Some college	11	11	12	14
Associate's	24	29	24	23
Bachelor's	40	33	36	36
Master's	21	20	22	22
Ph.D.	0	3	1	1
M.D.	0	0	1	0
Other professional degree	3	1	2	1
Other	0	1	1	1

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

21. Degree Status by Minority Status—Directors

Degree (%)	Minority (*n* = 54)	Nonminority (*n* = 205)
Less than high school	0	0
High school	0	1
Some college	17	9
Associate's	7	14
Bachelor's	39	23
Master's	32	43*
Ph.D.	4	9
M.D.	2	0
Other professional degree	0	1
Other	0	0

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

22. Degree Status by Minority Status—Clinicians

Degree (%)	Minority (*n* = 167)	Nonminority (*n* = 600)
Less than high school	1	< 1
High school	5	2
Some college	19	11
Associate's	31	22
Bachelor's	26	36***
Master's	14	25***
Ph.D.	2	2
M.D.	0	<1
Other professional degree	1	1
Other	1	<1

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

23. Degree Status by Recovery Status—Directors

Degree (%)	Recovering (*n* = 109)	Nonrecovering (*n* = 137)
Less than high school	0	0
High school	1	1
Some college	19***	5
Associate's	18***	8
Bachelor's	23	30
Master's	33	48***
Ph.D.	5	9
M.D.	0	0
Other professional degree	1	0
Other	0	0

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

24. Degree Status by Recovery Status—Clinicians

Degree (%)	Recovering (*n* = 363)	Nonrecovering (*n* = 397)
Less than high school	0	1
High school	3	2
Some college	18	9
Associate's	28	20
Bachelor's	31	38***
Master's	17	27***
Ph.D.	1	2
M.D.	0	<1
Other professional degree	1	1
Other	<1	<1

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

25. Years Experience by DASA Region—Directors

Years Experience (%)	Region 1 (*n* = 39)	Region 2 (*n* = 30)	Region 3 (*n* = 34)	Region 4 (*n* = 80)	Region 5 (*n* = 37)	Region 6 (*n* = 43)
0–4 years	9	7	6	8	15	3
5–9 years	6	21	18	17	18	13
10–14 years	31	28	9	17	6	23
15–19 years	23	21	21	19	15	35
20+ years	31	24	46	40	46	28

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

26. Years Experience by DASA Region—Clinicians

Years Experience (%)	Region 1 (*n* = 120)	Region 2 (*n* = 83)	Region 3 (*n* = 102)	Region 4 (*n* = 232)	Region 5 (*n* = 98)	Region 6 (*n* = 156)
0–4 years	44	37	30	37	30	33
5–9 years	17	23	30	25	23	18
10–14 years	17	18	19	18	22	21
15–19 years	8	10	17	10	18	15
20+ years	14	12	5	11	7	13

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

27. Years Experience by Agency Size—Directors

Years Experience (%)	2 or fewer staff (*n* = 59)	3–5 staff (*n* = 64)	6–11 staff (*n* = 46)	12 or more staff (*n* = 55)
0–4 years	7	12	5	9
5–9 years	27	20	10	9
10–14 years	9	22	26	11
15–19 years	26	17	19	21
20+ years	31	30	42	49

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

28. Years Experience by Agency Size—Clinicians

Years Experience (%)	2 or fewer staff (*n* = 38)	3–5 staff (*n* = 151)	6–11 staff (*n* = 184)	12 or more staff (*n* = 280)
0–4 years	29	42	31	36
5–9 years	16	19	24	24
10–14 years	18	20	19	17
15–19 years	16	13	14	12
20+ years	21	6	12	11

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

29. Years Experience by Recovery Status—Directors

Years Experience (%)	Recovering (*n* = 108)	Nonrecovering (*n* = 130)
0–4 years	1	12***
5–9 years	10	19***
10–14 years	26	14
15–19 years	29	17
20+ years	34	38

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

30. Years Experience by Recovery Status—Clinicians

Years Experience (%)	Recovering (*n* = 362)	Nonrecovering (*n* = 390)
0–4 yrs	28	43***
5–9 yrs	22	23
10–14 yrs	22	16
15–19 yrs	14	11
20+ yrs	14	8

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

31. Recovery Status by DASA Region—Directors

Status (%)	Region 1 (*n* = 39)	Region 2 (*n* = 30)	Region 3 (*n* = 34)	Region 4 (*n* = 80)	Region 5 (*n* = 37)	Region 6 (*n* = 43)
Recovering	51	46	31	40	44	50
Nonrecovering	26	32	41	40	28	29
Nonrecovering with family experience with addictions	17	7	9	9	11	12
Prefer not disclose	6	4	19	8	8	5
Other	0	11	0	3	8	5

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

32. Recovery Status by DASA Region—Clinicians

Status (%)	Region 1 (*n* = 120)	Region 2 (*n* = 83)	Region 3 (*n* = 102)	Region 4 (*n* = 232)	Region 5 (*n* = 98)	Region 6 (*n* = 156)
Recovering	44	50	49	41	52	59
Nonrecovering	30	27	25	34	24	17
Nonrecovering with family experience with addictions	7	15	8	12	5	8
Prefer not disclose	15	7	15	10	16	13
Other	4	1	3	3	3	3

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

33. Recovery Status by Agency Size—Directors

Status (%)	2 or fewer staff (*n* = 59)	3–5 staff (*n* = 64)	6–11 staff (*n* = 46)	12 or more staff (*n* = 55)
Recovering	53	41	49	32
Nonrecovering	24	31	42	41
Nonrecovering with family experience with addictions	5	13	2	17
Prefer not disclose	14	12	2	4
Other	3	3	5	7

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

34. Recovery Status by Agency Size—Clinicians

Status (%)	2 or fewer staff (*n* = 38)	3–5 staff (*n* = 151)	6–11 staff (*n* = 184)	12 or more staff (*n* = 280)
Recovering	53	51	44	48
Nonrecovering	21	25	28	27
Nonrecovering with family experience with addictions	11	8	10	10
Prefer not disclose	13	14	13	13
Other	3	3	5	2

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

35. Certification by DASA Region—Directors

Status (%)	Region 1 (*n* = 39)	Region 2 (*n* = 30)	Region 3 (*n* = 34)	Region 4 (*n* = 80)	Region 5 (*n* = 37)	Region 6 (*n* = 43)
Inactive	25	24	33	31	38	29
Active	3	3	3	0	3	7
Current	72	72	64	69	60	64

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

36. Certification by DASA Region—Clinicians

Status (%)	Region 1 (*n* = 120)	Region 2 (*n* = 83)	Region 3 (*n* = 102)	Region 4 (*n* = 232)	Region 5 (*n* = 98)	Region 6 (*n* = 156)
Inactive	15	16	20	18	19	17
Active	20	21	17	25	19	11
Current	65	63	62	57	63	72

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

37. Certification by Agency Size—Directors

Status (%)	2 or fewer staff (*n* = 59)	3–5 staff (*n* = 64)	6–11 staff (*n* = 46)	12 or more staff (*n* = 55)
Inactive	20	35	30	47
Active	3	2	0	2
Current	76	64	71	51

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

38. Certification by Agency Size—Clinicians

Status (%)	2 or fewer staff (*n* = 38)	3–5 staff (*n* = 151)	6–11 staff (*n* = 184)	12 or more staff (*n* = 280)
Inactive	11	20	13	19
Active	16	27	17	17
Current	73	54	69	65

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

39. Certification by Recovery Status—Directors

Status (%)	Recovering (*n* = 108)	Nonrecovering (*n* = 130)
Inactive	12	43
Active	3	2
Current	85***	55

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

40. Certification by Recovery Status—Clinicians

Status (%)	Recovering (*n* = 362)	Nonrecovering (*n* = 390)
Inactive	15	19
Active	14	25
Current	71***	56

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

41. Licensure by DASA Region—Directors

Status (%)	Region 1 (*n* = 39)	Region 2 (*n* = 30)	Region 3 (*n* = 34)	Region 4 (*n* = 80)	Region 5 (*n* = 37)	Region 6 (*n* = 43)
Inactive	56	45	49	44	41	33
Active	0	0	0	1	5	2
Current	44	55	52	55	54	64

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

42. Licensure by DASA Region—Clinicians

Status (%)	Region 1 (*n* = 120)	Region 2 (*n* = 83)	Region 3 (*n* = 102)	Region 4 (*n* = 232)	Region 5 (*n* = 98)	Region 6 (*n* = 156)
Inactive	29	43	34	35	31	29
Active	13	7	9	12	16	9
Current	57	49	57	52	54	62

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

43. Licensure by Agency Size—Directors

Status (%)	2 or fewer staff (*n* = 59)	3–5 staff (*n* = 64)	6–11 staff (*n* = 46)	12 or more staff (*n* = 55)
Inactive	41	46	50	49
Active	3	0	0	0
Current	56	54	50	51

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

44. Licensure by Agency Size—Clinicians

Status (%)	2 or fewer staff (*n* = 38)	3–5 staff (*n* = 151)	6–11 staff (*n* = 184)	12 or more staff (*n* = 280)
Inactive	27	37	32	32
Active	3	14	11	11
Current	70	50	57	58

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

45. Licensure by Recovery Status—Directors

Status (%)	Recovering (*n* = 108)	Nonrecovering (*n* = 130)
Inactive	30	53
Active	2	2
Current	68***	46

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

46. Licensure by Recovery Status—Clinicians

Status (%)	Recovering (*n* = 362)	Nonrecovering (*n* = 390)
Inactive	29	37
Active	6	16
Current	65***	47

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

47. Salary by DASA Region—Directors

Status (%)	Region 1 (*n* = 39)	Region 2 (*n* = 30)	Region 3 (*n* = 34)	Region 4 (*n* = 80)	Region 5 (*n* = 37)	Region 6 (*n* = 43)
Less than $15,000	3	10	3	4	14	2
$15,000–$24,999	0	3	6	4	3	5
$25,000–$34,999	10	21	3	13	11	9
$35,000–$44,999	23	7	16	11	11	14
$45,000–$54,999	21	24	25	18	11	23
$55,000–$64,999	21	10	25	18	17	16
$65,000–$74,999	10	17	13	15	17	9
$75,000 or higher	13	7	6	16	14	19

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

48. Salary by DASA Region—Clinicians

Status (%)	Region 1 (*n* = 120)	Region 2 (*n* = 83)	Region 3 (*n* = 102)	Region 4 (*n* = 232)	Region 5 (*n* = 98)	Region 6 (*n* = 156)
Less than $15,000	9	5	10	12	6	8
$15,000–$24,999	30	20	20	20	9	14
$25,000–$34,999	32	46	31	39	44	44
$35,000–$44,999	12	20	28	17	28	24
$45,000–$54,999	9	7	8	7	5	7
$55,000–$64,999	2	1	2	4	5	1
$65,000–$74,999	4	0	1	1	1	1
$75,000 or higher	1	0	0	2	0	0

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

49. Salary by Agency Size—Directors

Status (%)	2 or fewer staff (*n* = 59)	3–5 staff (*n* = 64)	6–11 staff (*n* = 46)	12 or more staff (*n* = 55)
Less than $15,000	19***	5	0	0
$15,000–$24,999	11***	2	0	0
$25,000–$34,999	18***	13	13	4
$35,000–$44,999	16	24	7	7
$45,000–$54,999	14	29	18	22
$55,000–$64,999	9	10	33	18
$65,000–$74,999	5	8	20	26
$75,000 or higher	5	11	9	22

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

50. Salary by Agency Size—Clinicians

Status (%)	2 or fewer staff (*n* = 38)	3–5 staff (*n* = 151)	6–11 staff (*n* = 184)	12 or more staff (*n* = 280)
Less than $15,000	28***	14	8	4
$15,000–$24,999	19	24	20	16
$25,000–$34,999	22	34	37	44
$35,000–$44,999	22	22	19	23
$45,000–$54,999	6	5	12	7
$55,000–$64,999	0	1	2	4
$65,000–$74,999	3	0	0	3
$75,000 or higher	0	0	0	<1

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

51. Salary by Recovery Status—Directors

Status (%)	Recovering (*n* = 108)	Nonrecovering (*n* = 130)
Less than $15,000	7	4
$15,000–$24,999	6	2
$25,000–$34,999	16	7
$35,000–$44,999	17	12
$45,000–$54,999	21	20
$55,000–$64,999	19	17
$65,000–$74,999	6	20**
$75,000 or higher	10	15**

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

52. Salary by Recovery Status—Clinicians

Status (%)	Recovering (*n* = 362)	Nonrecovering (*n* = 390)
Less than $15,000	10	9
$15,000–$24,999	17	21
$25,000–$34,999	39	40
$35,000–$44,999	26**	16
$45,000–$54,999	6	8
$55,000–$64,999	2	3
$65,000–$74,999	1	1
$75,000 or higher	0	1

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

53. Job Satisfaction by DASA Region—Directors

Status (%)	Region 1 (*n* = 39)	Region 2 (*n* = 30)	Region 3 (*n* = 34)	Region 4 (*n* = 80)	Region 5 (*n* = 37)	Region 6 (*n* = 43)
1 – Very low	0	0	0	1	0	0
2	0	0	3	1	0	0
3 – Average	24	7	13	14	17	10
4	32	39	44	39	42	38
5 – Very high	45	54	41	45	42	52

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

54. Job Satisfaction by DASA Region—Clinicians

Status (%)	Region 1 (*n* = 120)	Region 2 (*n* = 83)	Region 3 (*n* = 102)	Region 4 (*n* = 232)	Region 5 (*n* = 98)	Region 6 (*n* = 156)
1 – Very low	0	1	0	1	1	0
2	5	2	7	5	6	9
3 – Average	17	24	24	24	24	28
4	49	40	44	50	41	37
5 – Very high	29	33	26	21	27	27

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

55. Job Satisfaction by Agency Size—Directors

Status (%)	2 or fewer staff (*n* = 59)	3–5 staff (*n* = 64)	6–11 staff (*n* = 46)	12 or more staff (*n* = 55)
1 – Very low	0	2	0	0
2	0	0	0	4
3 – Average	22	13	14	12
4	33	41	41	39
5 – Very high	45	44	46	46

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

56. Job Satisfaction by Agency Size—Clinicians

Status (%)	2 or fewer staff (*n* = 38)	3–5 staff (*n* = 151)	6–11 staff (*n* = 184)	12 or more staff (*n* = 280)
1 – Very low	0	1	1	<1
2	5	4	5	7
3 – Average	11	21	27	26
4	43**	39	45	45
5 – Very high	41**	36	22	22

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

57. Job Stress by DASA Region—Directors

Status (%)	Region 1 (*n* = 39)	Region 2 (*n* = 30)	Region 3 (*n* = 34)	Region 4 (*n* = 80)	Region 5 (*n* = 37)	Region 6 (*n* = 43)
1 – Very low	0	11	0	3	3	0
2	0	4	9	14	0	7
3 – Average	24	36	28	27	31	19
4	37	32	38	26	25	31
5 – Very high	40	18	25	30	42	43

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

58. Job Stress by DASA Region—Clinicians

Status (%)	Region 1 (*n* = 120)	Region 2 (*n* = 83)	Region 3 (*n* = 102)	Region 4 (*n* = 232)	Region 5 (*n* = 98)	Region 6 (*n* = 156)
1 – Very low	5	0	4	4	3	5
2	9	10	7	8	5	9
3 – Average	39	30	40	35	36	40
4	33	41	32	37	37	34
5 – Very high	15	19	17	16	19	12

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

59. Job Stress by Agency Size—Directors

Status (%)	2 or fewer staff (*n* = 59)	3–5 staff (*n* = 64)	6–11 staff (*n* = 46)	12 or more staff (*n* = 55)
1 – Very low	5	3	2	0
2	12	3	5	4
3 – Average	24	29	41	25
4	19	32	30	37
5 – Very high	40	32	23	35

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

60. Job Stress by Agency Size—Clinicians

Status (%)	2 or fewer staff (*n* = 38)	3–5 staff (*n* = 151)	6–11 staff (*n* = 184)	12 or more staff (*n* = 280)
1 – Very low	5	5	5	3
2	24	12	6	6
3 – Average	30	33	35	40
4	24	36	33	38
5 – Very high	16	14	21	13

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

61. Job Stress by Minority Status—Directors

Status (%)	Nonminority (*n* = 197)	Minority (*n* = 50)
1 – Very low	2	4
2	6	10
3 – Average	28	24
4	30	30
5 – Very high	34	32

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

62. Job Stress by Minority Status—Clinicians

Status (%)	Nonminority (*n* = 584)	Minority (*n* = 162)
1 – Very low	2	10***
2	8	9
3 – Average	38	33
4	36	33
5 – Very high	16	15

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

63. Second Career by Gender—Directors

Second Career (%)	Female (*n* = 131)	Male (*n* = 131)
Yes	33	53***
No	67	47

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

64. Second Career by Gender—Clinicians

Second Career (%)	Female (*n* = 470)	Male (*n* = 318)
Yes	43	56***
No	57	44

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

65. Time Spent by Agency Size—Directors

Time (%)	2 or fewer staff (*n* = 59)	3–5 staff (*n* = 64)	6–11 staff (*n* = 46)	12 or more staff (*n* = 55)
Administrative time	49	72	84	93
Client-related time	51***	28	16	7

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

66. Time Spent by Agency Size—Clinicians

Time (%)	2 or fewer staff (*n* =38)	3–5 staff (*n* =151)	6–11 staff (*n* =184)	12 or more staff (*n* =280)
Administrative time	22	31	28	34
Client-related time	78	69	72	66

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

67. Clinical Supervision by Agency Size—Directors

Frequency of Clinical Supervision (%)	2 or fewer staff (*n* = 59)	3–5 staff (*n* = 64)	6–11 staff (*n* = 46)	12 or more staff (*n* = 55)
Daily	17	25	23	25
Weekly	34	54	53	58
Biweekly	6	16	11	7
Monthly	11	3	11	7
Not applicable	31***	3	2	3

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

68. Clinical Supervision by Agency Size—Clinicians

Frequency of Clinical Supervision (%)	2 or fewer staff (*n* = 38)	3–5 staff (*n* = 151)	6–11 staff (*n* =1 84)	12 or more staff (*n* = 280)
Daily	20	32	16	22
Weekly	33	36	45	47
Biweekly	9	7	8	5
Monthly	17*	9	14	9
Not applicable	22	15	17	18

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

69. Likelihood of Changing Agency by Agency Size—Directors

Likelihood of changing agency (%)	2 or fewer staff (*n* = 59)	3–5 staff (*n* = 64)	6–11 staff (*n* = 46)	12 or more staff (*n* = 55)
Not at all	68	59	69	68
Remote possibility	8	17	15	15
High probability	8	13	8	10
Definitely	3	1	0	3
Not sure	14	10	8	3

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

70. Likelihood of Changing Agency by Agency Size—Clinicians

Likelihood of changing agency (%)	2 or fewer staff (*n* = 38)	3–5 staff (*n* = 151)	6–11 staff (*n* = 184)	12 or more staff (*n* = 280)
Not at all	67**	50	39	41
Remote possibility	13	19	28	23
High probability	4	12	11	17
Definitely	2	1	0	4
Not sure	13	18	22	15

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

71. Likelihood of Leaving Field by Recovery Status—Directors

Likelihood of leaving field (%)	Recovering (*n* = 108)	Nonrecovering (*n* = 130)
Not at all	68	54
Remote possibility	20	26
High probability	6	10
Definitely	1	0
Not sure	5	10

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

72. Likelihood of Leaving Field by Recovery Status—Clinicians

Likelihood of leaving field (%)	Recovering (*n* = 362)	Nonrecovering (*n* = 390)
Not at all	58*	50
Remote possibility	23	24
High probability	6	9
Definitely	<1	3
Not sure	13	14

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

73. Recruiting Difficulties by Agency Size—Directors

Experience Recruiting Difficulties? (%)	2 or fewer staff (*n* = 59)	3–5 staff (*n* = 64)	6–11 staff (*n* = 46)	12 or more staff (*n* = 55)
No	66	37	27	32
Yes	34	63	73**	68**

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

74. Recruiting Difficulties by Agency Size—Clinicians

Experience Recruiting Difficulties? (%)	2 or fewer staff (*n* = 38)	3–5 staff (*n* = 151)	6–11 staff (*n* = 184)	12 or more staff (*n* = 280)
No	67	52	46	46
Yes	33	48	54	54

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

75. Comparison of Trainees to Other Clinicians

Variable (%)	Trainees (never certified/ pursuing certification; 0–4 yrs experience) (*n* = 134)	Currently Certified; 0–4 yrs experience (*n* = 99)	Overall Population of Clinicians (*n* = 791)
Age category			
20–29 years	24	14	8
30–39 years	30	21	17
40–49 years	25	23	23
50–59 years	17	30	37
60 and over	4	11	15
Gender			
Female	60	62	60
Ethnicity			
American Indian	3	6	4
Asian	3	4	2
Native Hawaiian	< 1	0	<1
African American	5	9	7
White	77	71	78
Other	10	10	9
Degree status			
High school	1	3	2
Some college	16	8	13
Associate's	17	30	24
B.A.	35	38	34
M.A.	28	16	22
Ph.D.	2	2	2
Other	<1	1	3
Salary			
Less than 15,000	22	8	9
15,000–24,999	35	30	19
25,000–34,999	34	47	39
35,000–44,999	4	8	21
45,000–54,999	1	2	7
55,000–64,999	<1	3	2
Second career?	49	56	48
In recovery?	29	47	48
Carry a caseload?	79	92	83