ATTC

Addiction Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

VITAL SIGNS:

Taking the Pulse of the Addiction Treatment Profession

A NATIONAL REPORT – VERSION 1

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At the time of this publication, Pamela Hyde, J.D., served as SAMSHA Administrator. Peter Delany, Ph.D., LCSW-CH, served as CSAT Director; Andrea Kopstein, Ph.D., M.P.H., served as Director of CSAT's Division of Services Improvement; and Donna Doolin, LSCSW, served as the CSAT Project Officer for the ATTC Network.

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EXECUTIVE SUMMARY

Since 2007, national reports sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) have repeatedly identified a lack of nationally representative data describing the specialty workforce that serves individuals with substance use disorders (SUDs) (SAMHSA, 2006; Annapolis Coalition, 2007). These reports suggest that the dearth of nationally representative data negatively impacts the ability of SAMHSA and other federal agencies to institute meaningful workforce development programs for SUD professionals. In response, SAMHSA instructed the Addiction Technology Transfer Center (ATTC) Network to carry out a national workforce study. The purpose of the study is to inform the development of strategies to successfully prepare, recruit and retain a sufficient number of professionals able to effectively care for individuals with SUDs. This report presents the findings of the ATTC Network's national study, *Vital Signs*: *Taking the Pulse of the Addiction Treatment Profession.* Although SAMHSA is the primary audience for the study's findings, the ATTC Network expects that comprehensive, nationally representative data about the specialty SUD treatment workforce will be useful to Single State Agencies, provider and professional organizations, training and education entities, individuals in the workforce, and other stakeholders.

| BACKGROUND |

For nearly 20 years SAMHSA has funded the ATTC Network to develop the SUD treatment workforce and to promote the adoption and implementation of evidence-based clinical practices for the treatment of SUDs. As part of the 2007-2012 ATTC cooperative agreements, SAMHSA charged the ATTC National Office with leading the ATTC Regional Centers in the development and implementation of a nationwide workforce study. SAMHSA instructed the ATTC Regional Centers to collect and report regional data from the study. Through an agency-wide workforce development workgroup, SAMHSA provided guidelines to the ATTC Network for conducting the study, including the primary questions to be answered:

- What are the basic demographics of the workforce?
- What are the common strategies and methodologies to prepare, retain, and maintain the workforce?
- What are the anticipated workforce development needs in the next five years?

| SUMMARY OF METHODOLOGY |

The ATTC Network designed a mixed-methods approach to answering the primary questions. The approach included the following components: survey of clinical directors;[1] telephone interviews with clinical directors; telephone interviews with thought leaders;[2] and a review of existing literature and data sets. The sample for the survey, a 57-item instrument distributed by ATTC Regional Centers either online or in hard copy, was drawn from the Inventory of Substance Abuse Treatment Services (I-SATS) using a dual sampling method to ensure that data would be both nationally and regionally representative. Once data collection ended, the responses were cleaned and then analyzed using the reporting functions available in the survey software as well as Microsoft Excel functions. A response rate of 88%

[1] For the purposes of this study, clinical director was defined as the person whose role it is to oversee direct clinical service delivery for a particular facility.
[2] For the purposes of this study, a thought leader was defined as a futurist, meaning a person in the field of SUD and recovery services who is recognized for innovative ideas in the field, and demonstrates the confidence to promote or share those ideas as actionable, distilled insights.

was achieved for the survey. In addition, 27 telephone interviews were conducted with clinical directors whose survey responses indicated that they were highly satisfied with their facilities' efforts to prepare, maintain and retain employees. Using a semi-structured protocol, the interviews gathered information on successful workforce development strategies. Moreover, another 25 telephone interviews were conducted with national thought leaders identified by the ATTC Network and SAMHSA. Using a semi-structured protocol, the thought leader interviews elicited the mega-trends that respondents thought would likely affect the SUD treatment workforce in the next five years. In separate processes, both sets of interviews were transcribed and then analyzed using Nvivo software. Two researchers developed codes and identified emerging themes and patterns from the transcripts. Finally, existing data sets were reviewed to model the growth and retraction, as well as to inform the workforce development needs, of the SUD treatment workforce over the next five years.

| SUMMARY OF THE NATIONAL FINDINGS |

What are the basic demographics of the workforce?

- Clinical directors in a nationally representative sample of facilities included in the I-SATS are predominantly white, middle-aged women with no military affiliation. These clinical directors are educated professionals who began their career in the SUD treatment field and have, on average, 17 years of experience in the field. About one third identify as being in recovery from a SUD.

- Direct care staff members supervised by the clinical director respondents are also mostly white women with no military affiliation. Direct care staff members tend to be younger, on average, than clinical directors and have less years of experience at their current places of employment. Direct care staff members are also educated professionals. The highest degree status of direct care staff that was most commonly reported was a Master's degree. Furthermore, the majority of direct care staff is currently licensed/certified or is seeking licensure/certification. Slightly less than one third of direct care staff are in recovery from SUDs as estimated by their clinical directors.

- Almost one third of clinical directors are only somewhat proficient in web-based technologies, and almost half of SUD facilities do not have an electronic health record system in place.

What are the common strategies and methodologies to prepare, retain, and maintain the workforce?

- SUD treatment facilities most commonly offer professional development for staff through new employee orientation, ongoing training, and direct supervision. When facilities do not provide for staff training and continuing education, the most commonly reported reason was a lack of funds. Nevertheless, the majority of survey respondents reported that staff at their facility had been trained in both culturally responsive and gender responsive SUD treatment. These findings were substantiated by interviews with clinical directors who reported that limited funding can often hinder a facility's ability to provide ongoing education.

- Recruitment continues to be a significant issue for many SUD treatment facilities. According to survey respondents, facilities primarily use web-based classified advertisements to recruit new staff and almost half of facilities have difficulty filling open positions, mostly due to an insufficient number of applicants who meet minimum qualifications. Through interviews, clinical directors emphasized the

positive effects that developing relationships with colleges and universities can have on recruiting qualified professionals.

- Retention also continues to be an ongoing challenge for SUD treatment facilities. According to survey respondents, the average staff turnover rate is 18.5%. Some of the most successful retention strategies employed by treatment facilities include the provision of healthcare benefits, implementation of a supportive culture, and access to ongoing training. Satisfaction with salary level, which is often cited as a factor in employee retention, varied among clinical directors. Half of respondents reported satisfaction with their income while half reported being unsatisfied.

What are the anticipated workforce development needs in the next five years?

- More SUD treatment professionals will be needed in the next five years. While there is limited data to track the projected growth, retraction, and composition of the SUD workforce over the next five years, it is anticipated that the implementation of the Affordable Care Act in 2014 will result in a significant increase in the need for professionals who are able to care for individuals with SUDs in a variety of managed healthcare settings.

- Applicants for open positions in SUD treatment facilities need to be better qualified. Clinical directors reported that their facilities face significant challenges in filling open positions due to a lack of qualified applicants.

- The workforce needs to be diversified. The current workforce is predominantly white, female, and over the age of 45. Younger professionals from diverse racial/ethnic backgrounds who are able to work in integrated settings will be needed.

- In addition, six mega-trends will affect the SUD treatment workforce in the next five years, as follows:
  1. Macro-level changes to healthcare and treatment delivery;
  2. A push for enhanced pre-service training, professional development, and uniform credentialing;
  3. Increased use of evidence-based and recovery-oriented methods of SUD treatment targeted for a changing client population and emerging drugs of abuse;
  4. Workforce recruitment and retention efforts;
  5. The recognition of substance use disorders as a valid health issue;
  6. Implementation and use of health information technology.

| SUMMARY OF RECOMMENDATIONS |

- SUD treatment facilities should consider recruiting professional or pre-professional individuals in their 20s and 30s from diverse backgrounds to the workforce. Federal and state policymakers and other stakeholder groups should support programs that promote the SUD treatment field as a career choice for young graduates. SUD treatment facilities should consider establishing relationships with colleges and universities in order to recruit new staff members. They should also continue to draw from the recovery community in their recruitment efforts.

- SUD treatment practitioners should continue to earn degrees in higher education as well as professional credentials.

- SUD treatment practitioners should also increase their technological competency. Educational opportunities related to building the computer and web-based technology skills of SUD treatment practitioners should be made available to facilities at low or no cost. Also, pre-service educational programs for SUD treatment practitioners should include training on computer and web-based technology skills, including the use of EHR systems.
- SUD treatment practitioners should become familiar with online learning, including how to navigate e-learning software and how to get the most out of web-based courses.
- SUD treatment facilities should adopt a collaborative learning culture and support staff members in their ongoing education, providing financial support if possible.
- Federal and state policy makers should continue to support programs, such as the ATTC Network, that provide low or no cost training opportunities, including online training.
- To save on training costs, SUD treatment facilities should consider sending qualified staff to “training of trainers” events, such as those often offered through the ATTC Network, so that they can develop internal capacity to provide training.
- SUD treatment facilities should consider increasing efforts to retain direct care staff.
- Leadership training, including how to develop and lead positive teams, should be made available to executive and clinical directors of SUD treatment facilities.
- Management training, including how to provide constructive feedback and how to establish a positive work environment, should be made available for administrators and managers of SUD treatment facilities.
- SUD treatment facility directors should investigate strategies that have been shown to help employees achieve a healthy work/life balance and should consider implementing such benefits as appropriate in their organizations.
- SUD treatment facilities should provide regular, ongoing support for clinical supervision.
- Since 60% of clinical directors are over age 50, focused efforts to develop individuals who can replace existing clinical directors in their leadership positions should be a priority for the SUD treatment field.
- Clinical directors should consider integrating observation methods such as role play and tape review into their work.
- Policymakers and other stakeholders should continue to work to educate SUD treatment facilities about the impact healthcare reform will have on the way they do business. These activities should include efforts to build relationships between specialty SUD treatment facilities and primary care organizations. Also, SUD treatment providers should consider gaining an understanding of the culture of primary care and how best to work in integrated healthcare environments.
- As healthcare reform changes the reimbursement structure for SUD treatment services, advocates for

the field should consider mounting a concerted effort to ensure that SUD treatment practitioners are reimbursed on an equal level with other healthcare professionals.

- SUD treatment facilities need to better understand EBP implementation models. Training alone is never enough. Facilities need to support the breadth and depth of changes that need to occur to ensure successful EBP implementation efforts.

- The SUD treatment field should continue to develop a shared understanding of the components of a recovery-oriented system of care. Localities should consider identifying facilitators that can help guide systems toward a recovery orientation. Stakeholders at all levels need to maintain an unwavering commitment to recovery-oriented care.

- Members of the SUD treatment workforce should become strong advocates for the recognition of SUDs as a valid healthcare issue. The health of the nation will depend on a greater understanding of the ways in which SUDs complicate, if not cause, other health issues such as heart disease. The roll out of the ACA offers a unique opportunity for screening and treatment for SUDs to become a regular part of healthcare.

- SUD treatment facilities must adopt and implement EHR systems in order to survive. Current and future SUD treatment practitioners need to have the skills to operate EHR systems in order to continue working in healthcare. Federal and state policymakers should consider supporting programs that assist SUD treatment facilities to utilize HIT.

Vital Signs: Taking the Pulse of the Addiction Treatment Profession was a collaborative effort of the 2007-2012 ATTC Network to provide an overview of the characteristics and workforce development needs of the SUD treatment field. In the full national report, the ATTC Network provides a unique picture of the state the SUD treatment field in a variety of topics across the country. Moreover, the ATTC Network taps into the considerable experience and expertise of clinical directors and thought leaders to illustrate the challenges that lay ahead for the field and the ways the workforce will change to overcome those difficulties and remain viable in the future. Finally, the ATTC Network contextualizes the *Vital Signs* data and recommends action steps to move the workforce forward so that quality care of SUDs can be assured for all Americans.

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SECTION I: INTRODUCTION

Established in 1993 by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Addiction Technology Transfer Center (ATTC) Network is a nationwide, multidisciplinary resource for professionals in the substance use disorders (SUD) treatment and recovery services field. The ATTC Network serves to: raise awareness of evidence-based and promising treatment and recovery practices; build skills to prepare the workforce to deliver state-of-the-art addictions treatment and recovery services; and change practice by incorporating these new skills into everyday use for the purpose of improving addictions treatment and recovery outcomes. SAMHSA has configured the ATTC Network in various ways in order to serve the 50 U.S. states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Jurisdictions. During the 2007-2012 grant period, the Network was comprised of 14 Regional Centers and a National Office (see map in Attachment 6).

In order to accomplish its goals, SAMHSA has supported the ATTC Network in utilizing a variety of technology transfer strategies, including facilitating alliances among stakeholders; providing skills training, academic education, and conferences; and working with state systems in large-scale change initiatives. Building on this comprehensive approach to meeting the emerging needs of the field, SAMHSA directed the ATTC Network to develop and implement a national study of the SUD workforce in the 2007 Request for Applications (RFA) for the ATTC program. In response, the ATTC Network, in cooperation with SAMHSA, developed and implemented the study, *Vital Signs*: *Taking the Pulse of the Addiction Treatment Workforce.*

The ATTC National office led the process to complete the *Vital Signs* study. SAMSHA provided guidance throughout the project. In the first years of the grant period (2008-2009), the National Office employed an outside research firm to assist in collecting background data to inform the development of the *Vital Signs* study. Activities that were part of this preliminary data collection effort included an expert panel meeting, key stakeholder discussions, roundtable discussions, and a literature review. Next, in 2010 and 2011, the ATTC Network used the initial research to collaboratively develop all aspects of the *Vital Signs* study. Throughout the design process, the ATTC Network worked to strike a balance between creating an academically rigorous study with the limited resources available to the Network for its implementation. Once the plan was finalized, all applicable federal data collection applications and human subjects' protection approvals were submitted and obtained. Data collection launched in November 2011 and completed in May 2012. A detailed timeline of all activities related to the development and implementation of the *Vital Signs* study is provided in Attachment 5.

This report presents only the national findings from the *Vital Signs* study. While data was collected on both the national and ATTC regional level, regional data is presented in fourteen separate regional reports per the requirements of the 2007 RFA. A new funding period begins for the ATTC program in October, 2012. In the new funding period, SAMHSA has reconfigured the ATTC Network such that the ATTC Regional Centers align with the ten Department of Health and Human Services (DHHS) regions. The ATTC Network anticipated this realignment and made sure to utilize a sampling strategy that would allow the data to be analyzed according to the ten new ATTC regions. While this report includes only the national data, the ATTC Network may prepare a second version of the report, incorporating comparisons of the data at the HHS (and now ATTC) regional level. At the time of the writing of this report, awards for the 2012-2017 ATTC funding period have yet to be announced.

| ORGANIZATION OF REPORT |

This report is organized into six sections. Section II provides an overview of the methodology used in conducting the *Vital Signs* study. The report then provides the study findings for each of the three primary study questions. Section III presents the basic characteristics of the workforce. Section IV identifies the common strategies to prepare, maintain and retain the workforce. Section V presents the findings from the secondary data analysis and the interviews with thought leaders to provide an understanding of the workforce development needs over the next five years. Finally, the report ends with overall conclusions and recommendations of the study. Attachments are provided at the end of the report.

SECTION II: METHODOLOGY

SAMHSA provided the ATTC Network with the primary questions to answer in the *Vital Signs* study, the preferred sampling frame (the I-SATS), and the units of analysis (the nation and the 2007-2012 ATTC regions[3]). Utilizing these guidelines and building on previous experience in conducting workforce studies,[4] the ATTC Network designed a mixed-methods approach for the *Vital Signs* study. The data collection effort was approved by the Office of Management and Budget (OMB # 0903-0328) per federal guidelines and by Institutional Reviews Boards (IRBs) for each of the ATTC programs (fourteen separate IRB approvals in total).[5]

| OVERVIEW OF DATA COLLECTION |

The study collected original data using three different instruments:

- Clinical director survey (in paper and online formats);
- Key informant telephone interviews of clinical directors;
- Key informant telephone interviews of national thought leaders.

The study also utilized existing data sets to model the projected growth or retraction and characteristics of the SUD treatment workforce. Figure 1 shows the study components, participants, and how each component is linked to the primary questions.

FIGURE 1: Schedule of Study Components

COMPONENT & PARTICIPANTS	RELATION TO QUESTIONS
SURVEY: clinical directors or a designated direct care supervisor	*What are the basic demographics of the workforce?* The survey asked participants to report demographic information about themselves and those they supervise. Questions also covered information about the current facility/agency for which they work, professional development, job satisfaction, retention strategies, clinical supervision practices and use of technology (Attachment 1).
TELEPHONE INTERVIEWS: clinical directors	*What are the common strategies and methodologies to prepare, retain, and maintain the workforce?* The interviews were designed to garner an enriched understanding of the survey data on effective workforce development, recruitment, and retention strategies (Attachment 3).
TELEPHONE INTERVIEWS: thought leaders	*What are the anticipated workforce development needs in the next five years?* The interviews were designed to garner an enriched understanding of existent data sets and to elicit mega-trends that will affect the SUD treatment workforce in the next five years (Attachment 3).
SECONDARY DATA ANALYSIS	*What are the anticipated workforce development needs in the next five years?* The study utilized existing data sets (Attachment 4) to model the projected growth or retraction and characteristics of the SUD treatment workforce. This analysis informed the projection of the demographics of the workforce and treatment program needs over the next five years.

[3] See Attachment 6 for a map of the 2007-2012 ATTC regions.
[4] The ATTC Network has been conducting workforce surveys for approximately 10 years. The Network has developed instruments to collect state level data and provided reports to SAMHSA for a number of states across the U.S. These reports are available on the ATTC Network website http://www.attcnetwork.org/explore/priorityareas/wfd/overview/surveys.asp.
[5] Two ATTC offices are located at the same university and only one IRB approval was needed to cover both.

| CLINICAL DIRECTOR SURVEY |

The survey (Attachment 1) contains 57 questions to be answered by the clinical director or a designated direct care supervisor.[6] For the purposes of this study, clinical director was defined as the person whose role it is to oversee direct clinical service delivery for a particular facility. Clinical directors were selected due to the availability of a sampling frame for this population and the limited resources available for creating a sampling frame for direct care staff.[7] Respondents were required to have administrative knowledge of personnel issues (related to demographics and recruitment and retention), but also some practical knowledge of everyday clinical activities (such as caseloads).

The survey had eight sections: **Demographics and Professional Background,** which included questions on demographics, education/training, areas of licensure, and years of experience; **Your Work,** which included questions on hours worked, roles, setting, practice area, and salary; **Clinical Supervision,** which included questions on methods and time spent on different activities; **Direct Care Staff,** which included questions related to the demographics of direct care staff, education/training, areas of licensure, and years of experience; **Your Treatment Facility,** which included questions about staff roles and caseloads; **Recruitment, Retention, and Staff Development,** which included questions related to approaches toward retaining, recruiting, and developing and enhancing staff skills; **Technology,** which included questions related to access to technology and electronic health records; and **Staff Competency Related to Diversity,** which included questions about gender and culturally responsive training and practice.

SURVEY DESIGN

A team of researchers and workforce experts from the ATTC Network designed the survey, building on questions included in other workforce questionnaires, including past ATTC regional workforce studies. The survey instrument was uploaded into a web-based software (Qualtrics) and was available in an online and paper format. A small group of nine potential respondents was chosen to consult and pre-test the survey instrument.[8] These individuals provided feedback on the survey response burden, the quality of the questions, the quality of the response choices, and general thoughts about the information being gathered by the survey. Once the survey and questionnaire instruments were developed online, another small group of nine individuals piloted the instrument to ensure there were no technical issues.

SAMPLING UNIVERSE

As instructed by SAMHSA, the survey sampled facilities used in the I-SATS for the National Survey of Substance Abuse Treatment Services (N-SSATS). As of November 2011, the I-SATS database listed 13,057 facilities. N-SSATS collects data from each physical location where treatment services are provided. Accordingly, a “facility” is defined as the point of delivery of SUD treatment services (i.e., physical location). Treatment facilities that are licensed, certified, or otherwise approved by the State SUD treatment agency to provide SUD treatment make up the largest group of facilities. The survey also includes programs operated by Federal agencies—the Department of Veterans Affairs (VA), the Department of Defense, and the Indian Health Service. Together, these facilities represent about 80% of the total. The remaining facilities surveyed by the N-SSATS are those that are not licensed or certified

[6] Direct care refers to staff members who spend a majority of their time providing clinical care for clients with SUDs as their primary diagnosis.
[7] The ATTC Network performed this study without supplemental funding from SAMHSA. All work for the study was performed in addition to regular ATTC activities to promote the adoption and implementation of evidence-based practices.
[8] The small number of field testers was due to OMB restrictions for data collection involving the federal government.

through State SUD treatment agencies or Federal agencies. These facilities are usually hospital-based or private-for-profit facilities. N-SSATS does not include treatment programs in facilities that have solo practitioners or that are located in jails or prisons (SAMHSA—Office of Applied Studies, 2008). Each year, new facilities are added to the I-SATS by State agencies or when they are identified by examination of databases such as the one maintained by the American Hospital Association (SAMHSA—Office of Applied Studies, 2003).

SAMPLING METHODS

A dual sampling method was used to ensure a dataset that is representative both nationally (Level 1) and regionally (Level 2), based on the 14 ATTC regions of the 2007-2012 grant cycle. The purpose of the *Vital Signs* study is to collect data related to understanding and guiding the United States' (US) SUD treatment workforce development efforts. The intent of the survey data is that it will be useful at both a national and regional (ATTC) level. While a national dataset could show how effective staff members perceive specific recruitment and retention strategies to be, a regional and national study could show which strategies work for specific populations and what professional development needs are across the US, but also in specific areas. This would allow for more targeted training and recruitment approaches that meet the needs of the current workforce while at the same time enabling the ATTC Network to prepare for future workforce needs identified by regions. In addition, study developers believed that collecting data that is useful to the regions would increase response rates and the likelihood that results would be used.

> Level 1: National Sample

Overview

The Level 1 sample was a simple random national sample of 487 SUD treatment facilities. The simple random sample ensured a representative sample of US SUD treatment organizations so that data from the survey could be generalized and used to provide a snapshot of the current state of the workforce across the country. The power of the survey sample is its ability to estimate the distribution of different characteristics in the SUD treatment workforce population by obtaining information from relatively few organizations.

Determining Sample Size

Decisions on final sample size to acquire a nationally representative sample were based on level of precision, anticipated response rates, and estimates of costs at different levels of precision. To determine the sample size needed to ensure a representative sample of the 13,057 SUD treatment organizations listed in I-SATS, the ATTC National Office conducted an a priori power analysis to take into account a +/- 5% sampling error, 95% confidence level, and maximum variance (50/50) within the SUD treatment workforce across the US. Sampling error is the type of error that occurs due to not collecting information from all SUD treatment organizations. This equates to how precise the estimates should be. Confidence level describes the amount of confidence one wishes to have in the estimates made from the sample for the entire population. Based on previous surveys, the ATTC Network anticipated a response rate of approximately 80%. A national sample of 487 SUD treatment facilities was selected to account for any issues of closed facilities, non-response or potentially unusable data.

> Level 2: Regionally Representative Sample

Overview

The Level 2 sample allowed for targeted sampling of facilities across the 14 ATTC regions of the 2007-2012 grant cycle to enable comparisons across regions on specific variables, such as workforce

turnover rates, success in recruitment strategies, and direct care staff demographics. Level 1 of this data collection involved a simple random sample of 487 SUD treatment facilities for a nationally representative sample. In Level 2, this sample was supplemented by a stratified random sample that was regionally representative to ensure a minimum of 41 facilities per region.

Determining Sample Size

In contrast to the national random sample that allowed every SUD treatment facility equal weighting to create a nationally representative sample, the regional sample sought equal variance across regions to allow for comparisons to be made. Creating equal sample sizes allowed ATTC Regional Centers to conduct their own analyses without the need for highly skilled statistical consultants.

To determine sample size, a conservative analysis of covariance (ANCOVA) model with fixed effects, main effects, and interactions was utilized using G*Power 3.1 (Faul, Erdfelder, Lang, & Buchner, 2007). This model was selected above a basic ANOVA as it allows for a more conservative estimate of the sample size needed. As questions regarding interventions and other strategies may arise post data collection, it is prudent to allow for a conservative sample in order to have the statistical power to defend comparisons at the regional level (Cohen, 1988).

Decisions on final sample size to acquire a regionally representative sample were based on level of precision, anticipated response rates, and estimates of costs at different levels of precision. Based on this ANCOVA model and using the same variance (50/50), sampling error range (±5%), and 95% confidence level as in the national sample, a range of sample estimates to demonstrate the sample size needed to detect small to medium effect sizes (0.15 to 0.25) resulted in a conservative decision to select at least 41 facilities per region.

SAMPLING DESIGN

Facilities were removed if I-SATS showed them to be a single provider facility (meaning one direct care staff member) or a facility not currently providing SUD treatment. This filtering left 12,151 of the original 13,057 in the sampling framework. Those 12,151 facilities were given independent identifiers and included in a general sampling frame that also denoted region and state. A random sample of 487 facilities was selected from this database using the independent identifiers. Once these 487 facilities were drawn and noted, the Level 2 sample stratified facilities by ATTC region and ensured each region had a minimum of 41 facilities to create a regional sample with approximately equal sample sizes that could allow for regional comparisons (without using complex statistical techniques). Facilities were selected at random from within each regional stratification. The sample was then analyzed for duplicate names, which were eliminated and replaced with other randomly selected names. Figure 2 shows the breakdown for the Level 1 and 2 samples.

FIGURE 2: Breakdown of Level 1 (National) and Level 2 (Regional) Samples

REGION NAME	NATIONAL	REGIONAL	TOTAL
Caribbean/Hispanic (PR, VI)	8	33	41
Central East (DC, DE, MD, NJ)	22	19	41
Great Lakes (IL, OH, IN, MI)	48	None needed	48
Gulf Coast (TX, LA, NM)	21	20	41
Mid-America (NE, MO, KS, OK, AR)	22	19	41
Mid-Atlantic (VA, KY, TN, WV)	38	3	41
Mountain West (NV, MT, WY, UT, CO, ID)	27	14	41
New England (ME, NH, VT, MA, CT, RI)	31	10	41
Northeast (NY, PA)	76	None needed	76
Northwest Frontier (AK, WA, OR, HI, Pac. Isl.)	34	7	41
Pacific Southwest (CA, AZ)	82	None needed	82
Prairielands (IA, ND, SD, MN, WI)	21	20	41
Southeast (GA, SC, NC)	25	16	41
Southern Coast (AL, FL, MS)	32	9	41
TOTAL	**487**	**170**	**657**

DATA COLLECTION PROTOCOLS

A team of researchers and workforce experts from the ATTC Network designed protocols for the data collection process (Attachment 2). The protocols involved a tiered contact approach. First, each ATTC Regional Center contacted the executive director of each facility in its region that was part of the sample in order to further refine the sampling frame by gathering contact information for the clinical director at the facility. During this process, ATTC Regional Centers identified and reported to the ATTC National Office closed facilities and facilities that were ineligible due to having only one staff member doing direct care work. When this occurred, the National Office provided randomly selected supplemental facilities to the Regional Centers. Time constraints kept some Regional Centers from reaching out to their full sample. Therefore, not all closed and ineligible facilities were supplemented, resulting in a final total sampling frame of 631 facilities with contact information for clinical directors. ATTC Regional Centers then contacted these 631 clinical directors and invited them to participate in the survey.

SURVEY RESPONSE RATES

Figure 3 shows the final sample breakdown by region along with response rates for each region. The highest response rate was the Mid-America ATTC Regional Center with 100% and the lowest was the Central East ATTC Regional Center with 68%. The average response rate across all regions was 88%.

FIGURE 3: Response Rates by Region Based on Final Sample

ATTC REGION NAME	TOTAL NUMBER	NUMBER OF RESPONSES	RESPONSE %
Caribbean/Hispanic (PR, VI)	41	37	90%
Central East (DC, DE, MD, NJ)	41	28	68%
Great Lakes (IL, OH, IN, MI)	41	30	73%
Gulf Coast (TX, LA, NM)	37	28	76%
Mid-America (NE, MO, KS, OK, AR)	39	39	100%
Mid-Atlantic (VA, KY, TN, WV)	44	43	95%
Mountain West (NV, MT, WY, UT, CO, ID)	43	38	88%
New England (ME, NH, VT, MA, CT, RI)	41	40	98%
Northeast (NY, PA)	63	61	97%
Northwest Frontier (AK, WA, OR, HI, Pac. Isl.)	41	40	98%
Pacific Southwest (CA, AZ)	84	76	90%
Prairielands (IA, ND, SD, MN, WI)	41	39	95%
Southeast (GA, SC, NC)	35	26	74%
Southern Coast (AL, FL, MS)	40	28	70%
TOTAL	**631**	**553**	**88%**

FINAL SURVEY DATASET EXCLUSION AND FILTERING

The initial data were cleaned for invalid responses, missing data, and incomplete survey responses. If respondents were missing more than 30% of the survey questions and/or essential information related to direct care staff, then responses were deemed invalid. One hundred forty responses were removed from the original dataset to create a final dataset of 491 respondents.

Figure 4 shows the total valid responses (regionally and nationally) along with the percentage of total responses each region represented in the data collection effort. As would be expected based on size, the Pacific Southwest ATTC region represented 14% of the total sample, while smaller regions, such as Southeast and Southern Coast, represented only 5% of the total sample.

FIGURE 4: Valid Responses by Region and Nationally

REGION NAME	VALID RESPONSE	% OF TOTAL RESPONSES
Caribbean/Hispanic (PR, VI)	37	8%
Central East (DC, DE, MD, NJ)	25	5%
Great Lakes (IL, OH, IN, MI)	24	5%
Gulf Coast (TX, LA, NM)	24	5%
Mid-America (NE, MO, KS, OK, AR)	35	7%
Mid-Atlantic (VA, KY, TN, WV)	35	7%
Mountain West (NV, MT, WY, UT, CO, ID)	37	8%
New England (ME, NH, VT, MA, CT, RI)	32	7%
Northeast (NY, PA)	50	10%
Northwest Frontier (AK, WA, OR, HI, Pac. Isl.)	37	8%
Pacific Southwest (CA, AZ)	70	14%
Prairielands (IA, ND, SD, MN, WI)	37	8%
Southeast (GA, SC, NC)	23	5%
Southern Coast (AL, FL, MS)	25	5%
TOTAL	**491**	**100%**

Data were primarily analyzed using Qualtrics reporting and Microsoft Excel functions. A number of variables were transformed. For example, respondents included the last two digits of the year in which they were born. This variable was transformed to reflect the current age of the respondent to enable averages and percentages to be calculated in Excel. All variables were analyzed at the national and regional level. All variables were analyzed based on responses to the data except where the variable needed a proxy number, such as number of staff in recovery. In these instances, total responses to direct care staff numbers (full time/part-time/PRN) reported was the number used as a proxy. Each ATTC Regional Center received a copy of the appropriate cleaned regional dataset (devoid of any contact information beyond state and region) and a full set of descriptive data tables for each variable in the survey.

| KEY INFORMANT TELEPHONE INTERVIEWS OF CLINICAL DIRECTORS |

The key informant telephone interviews of clinical directors were intended to provide qualitative data to enrich understanding on key strategies to prepare, maintain, and retain the workforce (as outlined in Figure 1). While the survey collected some basic information on potentially effective strategies used to prepare and recruit individuals to enter the workforce and to encourage them to remain in the workforce, the qualitative data further outlined how treatment facilities implement those strategies. A semi-structured interview script was developed to guide the question formation for the interviews (Attachment 3).

SAMPLING METHODS

For the key informant interviews of clinical directors, an extreme case, purposive, sampling strategy was used. Extreme case sampling is used to focus on cases that are special or unusual, typically in the sense that the cases highlight notable outcomes. One of the prime objectives of this study was to identify potentially effective strategies used to prepare and recruit individuals to enter the workforce, and encourage them to remain in the workforce and stay current on clinical and other job related skills. Extreme cases were selected from the respondents to the clinical director survey that fell within the nationally representative sample of SUD treatment facilities. Extreme cases were selected by analyzing responses to questions 44, 47 and 51 of the survey, which asked about levels of success in a number of strategies related to efforts to prepare, maintain, and retain the workforce. Respondents who scored an average of 4 or greater (on a scale of 1 to 5) in relation to those questions were invited to participate in interviews. An average score of 4 or greater on those questions suggested that the respondents were highly satisfied with their agency's recruitment and retention strategies. A total of 81 respondents were selected to participate in the interviews. The 81 respondents were sent an initial email inviting them to participate, and a follow up email if they did not respond. Interviews were scheduled with each respondent via telephone. Twenty-seven interviews were conducted in total by staff of the ATTC National Office. All telephone interviews were recorded, transcribed and reviewed for clarity.

DATA ANALYSIS

The analysis of the clinical director interviews occurred in a multiphase process between two coders. The first phase involved an open-coding process, where the coders reviewed 12 (out of 27) transcripts to develop an initial round of codes in the software program, NVivo. After the initial round of codes was developed, the coders and a research consultant met to discuss code definitions and variance. Seventy-seven codes were identified with only 19 reflected across each coder (25%). After discussing definitions for each code, the team identified 36 out of 50 (72%) common codes. The second phase of the process required the coders to use the common code to review the remaining 15 transcripts. Through this process, an additional 5 codes were identified. The code list was then organized into a spreadsheet which included agreed-upon code definitions as well as exemplary quotes for each code. Four major themes emerged from the analysis of the clinical director interviews (Attachment 8): (1) recruitment challenges, (2) recruitment strategies, (3) retention challenges, and (4) retention strategies. Codes were clustered under each theme and the average frequency (number of times the code was found in the transcripts/two coders) and source (number of references) were identified. The total count for each frequency and source was also identified (Attachment 8).

| KEY INFORMANT TELEPHONE INTERVIEWS OF NATIONAL THOUGHT LEADERS |

For the purposes of this study, a thought leader was defined as a futurist, meaning a person in the field of SUD and recovery services who is recognized for innovative ideas in the field and demonstrates the confidence to promote or share those ideas as actionable, distilled insights. Thought leader interviews were conducted to enrich understanding surrounding current and future trends in SUD treatment (Figure 1). These interviews were intended to provide a national perspective on what mega-trends are expected to affect the SUD treatment workforce in the next five years. A semi-structured interview script was developed to guide the question formation for the interviews (Attachment 3).

SAMPLING METHODS

For the thought leader interviews, the emphasis was on a deeper and more contextualized understanding of the workforce and their experiences. Therefore, there were less restrictions surrounding sampling, and the emphasis was on encouraging as much response as possible to build a more comprehensive picture of the workforce and gain enriched insights. Thought leaders were identified by SAMHSA in conjunction with the ATTC Network. Each ATTC Regional Center, the ATTC National Office, and SAMHSA provided the names and contact information for up to 5 national and/or regional experts that had a minimum of 10 years in the SUD or related field; represented diverse groups (i.e., gender, age, race/ethnicity, professional position); were culturally relevant to the ATTC regions; and who could provide regional, as well as national, input. This approach generated a list of 68 individuals. The ATTC National Office then used a purposive sampling strategy to identify a sample of thought leaders that was diverse in terms of their areas of expertise and geographic location. Thirty-six thought leaders were identified and invited to participate in interviews. Twenty-five thought leaders agreed to participate in the interviews, and, due to time and resource limitations, it was deemed that 25 responses were sufficient to address the anticipated workforce development needs of the next five years. The final list of thought leaders was comprised of academics, direct care providers, state and federal policymakers, leaders of national organizations, advocates, and other stakeholders with expertise to speak to the mega-trends that are likely to influence the SUD treatment field in the next five years. Interviews were scheduled with each thought leader via telephone and ranged from 30-60 minutes in length. All telephone interviews were recorded, transcribed and reviewed for clarity.

DATA ANALYSIS

To ensure inter-rater reliability and validate emerging themes, analysis occurred in a multiple phase process with a 3-member team. In the first phase, the team reviewed 13 initial interviews and used the software, NVivo, to recognize patterns within the text and encode these patterns into a series of initial codes. More than 45 combined codes were identified by the team. These were reviewed to ensure that each team member was capturing similar codes. Employing a thematic analysis approach (Fereday & Muir-Cochrane, 2006), codes were organized into a conceptual model of emerging themes. This process allowed the team to visualize how codes began to cluster and form relationships around specific themes. Guiding questions such as, “Does this code really capture what is indicated in the interview?” and “What are major differences and consistencies among initial codes?” assisted the team in modifying and revising codes. After agreeing upon the initial coding scheme and themes, 37 codes were identified and used to guide the coding process of the remaining 12 interviews. In the second phase of analysis, each team member used NVivo to generate a code report to compare frequencies (the number of times a code was represented in the data). Team members carefully reviewed the report to discuss common and different codes and their definitions. At the conclusion of phase two, 35 codes were identified and clustered into 6 emergent themes: (1) macro-level changes to healthcare and treatment delivery; (2) a push for enhanced pre-service training, professional development, and uniform credentialing; (3) increased use of evidence-based and recovery-oriented methods of SUD treatment targeted for a changing client population and emerging drugs of abuse; (4) workforce recruitment and retention efforts; (5) the recognition of substance use disorders as a valid health issue; (6) implementation and use of health information technology. The themes, codes, frequencies and definitions were organized into a table (Attachment 9) to ensure corroboration and consistency among team members.

| DATA LIMITATIONS |

As explained above, the *Vital Signs* survey was completed by clinical directors at SUD treatment facilities listed in the I-SATS. A key concern in this study is in the validity of the data presented on direct care staff, as they were not direct respondents to the survey instrument. Questions related to direct care staff were completed, on their behalf, by clinical directors. While the ATTC Network did send informational materials to clinical directors asking them to have accurate information collected on the direct care staff they supervise prior to completing the *Vital Signs* questionnaire, the ATTC Network cannot be certain that all information is accurate. Items such as the recovery status of direct care staff may not have been accurately reported by clinical directors, as that information is not always readily available. Additionally, limitations to the data arise from the variability in response rates on questions related to direct care staff. As certain questions in the survey were not mandatory, respondents did not evenly answer all questions on direct care staff. Additionally, the questions did not require direct care staff numbers to add to the same total for each question. In order to best represent response rates for each number, and to enhance the reliability of the question, the Attachments include the number of respondents (N) for each variable reported. Finally, true randomness of the sample of facilities from the I-SATS may have been jeopardized as the Network had to substitute certain facilities that were closed or ineligible to participate. Substitution was necessary, however, in order to build a reliable sampling frame. While limitations to the data certainly do exist, the ATTC Network is confident that the findings of this report present an accurate national perspective of the SUD treatment workforce.

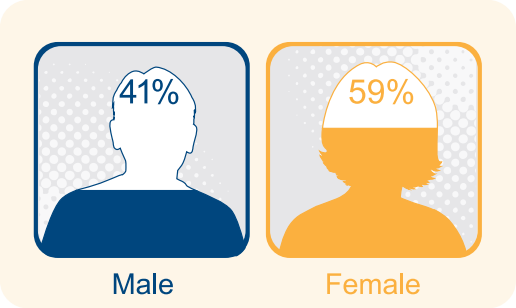
SECTION III: WORKFORCE CHARACTERISTICS

One of the key purposes of the clinical director survey was to answer the primary study question, "What are the basic demographics of the workforce?" (Figure 1). The ATTC Network broadly defined this question to mean that the study would provide a comprehensive description of the demographics, professional background, technological competency, and functional role of clinical directors in facilities represented in the I-SATS, as well as a comprehensive description of the demographics and professional background of direct care staff in those facilities. Data collected about demographics included items such as gender, race, age, ethnicity, military affiliation, and recovery status. Data collected on professional background included items such as highest degree status achieved, certification/licensure status, and years of experience. Data collected about technological competency included the self-reported proficiency of clinical directors in computer technology, the access to technology of both clinical directors and direct care staff, and the status of the facilities' implementation of electronic health records. Data collected about the work of clinical directors included items such as the setting of and the frequency with which clinical supervision is commonly provided, the primary observation methods used for clinical supervision, client caseloads of clinical directors, and the ability of treatment facilities to bill for clinical supervision. In this section of the report, the findings from the nationally representative sample of respondents to the demographic items (as broadly defined) on the questionnaire are presented.

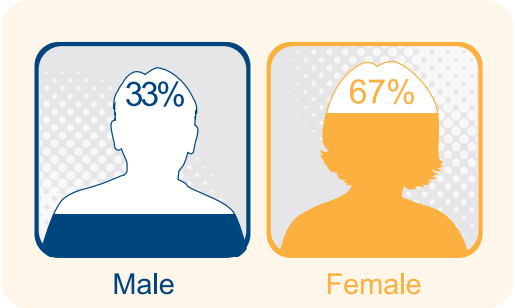
| DEMOGRAPHIC PROFILE |

According to *Vital Signs* survey respondents, clinical directors in SUD treatment facilities across the nation are predominantly white (86%) females (59%) with an average age of 52 years (60% of respondents reported being 50+). In terms of direct care staff, the *Vital Signs* study found that an even higher proportion is female (67%). Direct care staff are also younger than clinical directors with over half (51%) between the ages of 25 and 44. Like clinical directors, direct care staff are predominantly white (64%), but a greater proportion of direct care staff are African American (19%) than clinical directors (10%). For complete survey findings on demographics see Data Tables 1 and 5 in Attachment 7: Survey Data.

GENDER:
CLINICAL DIRECTORS

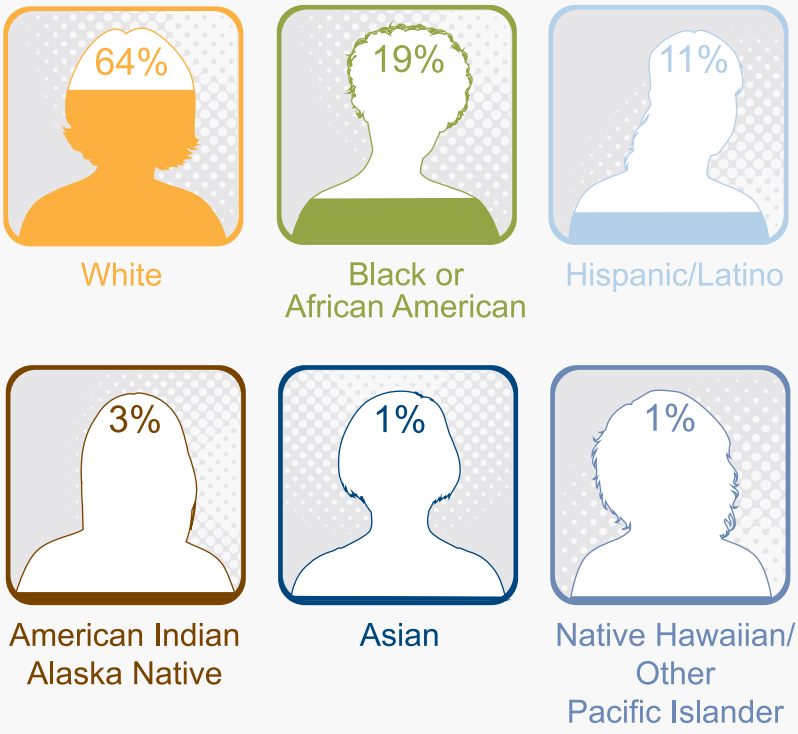


GENDER:
DIRECT CARE STAFF



ETHNICITY: CLINICAL DIRECTORS

ETHNICITY: DIRECT CARE STAFF



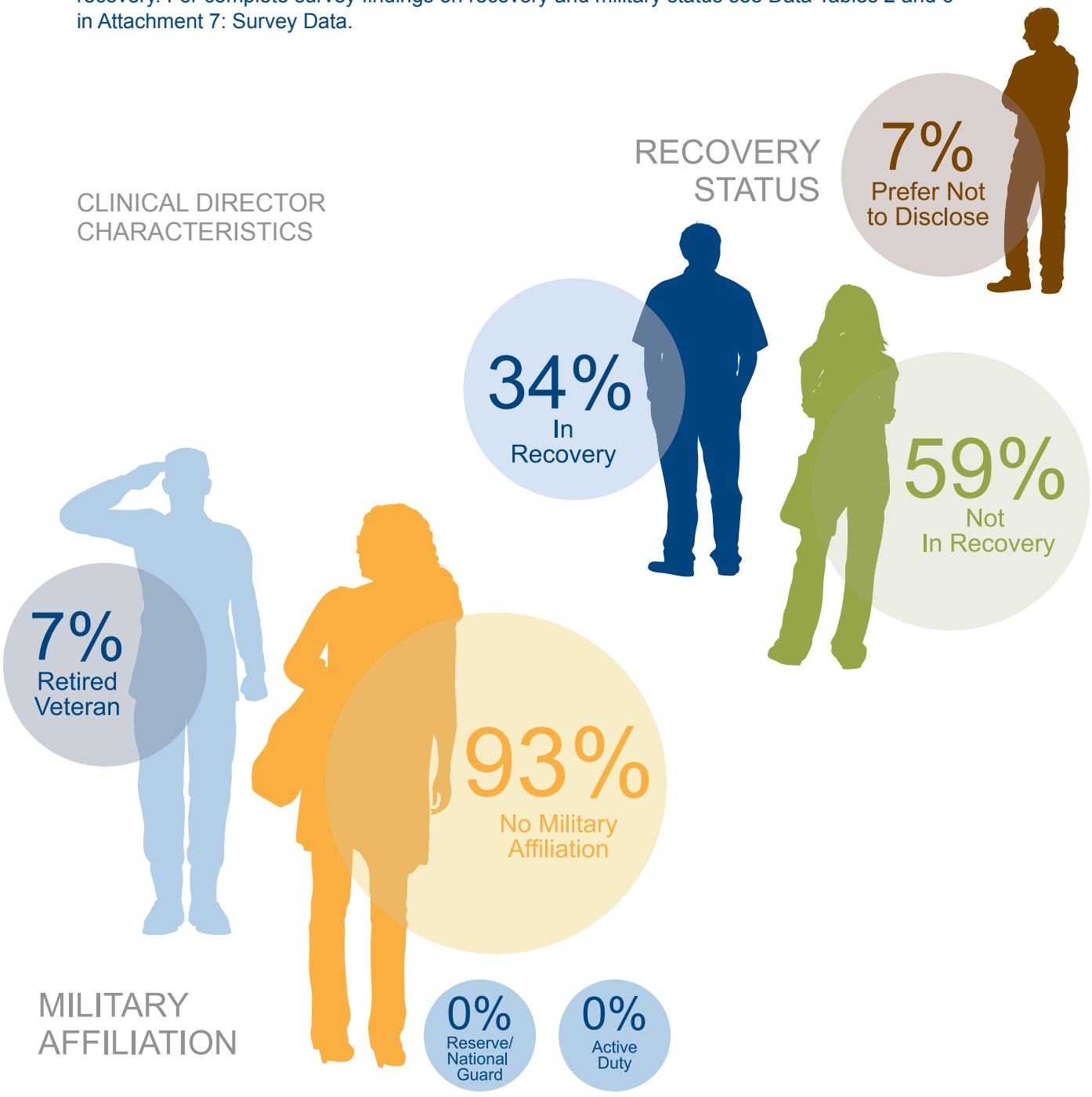
AGE : CLINICAL DIRECTORS

Aged 50 or older
Average age 52

AGE : DIRECT CARE STAFF

Aged younger than 54 years

Additionally, the *Vital Signs* study collected information about the military and recovery statuses of clinical directors and direct care staff. Few clinical directors and direct care staff have any military affiliation. For clinical directors, 93% have no affiliation, and for direct care staff, over half (59%) have no military affiliation. Clinical directors reported that just over one third are in recovery (34%) and when asked to report the recovery status of direct care staff they estimated that just under one third (29%) are in recovery. For complete survey findings on recovery and military status see Data Tables 2 and 6 in Attachment 7: Survey Data.



| PROFESSIONAL BACKGROUND |

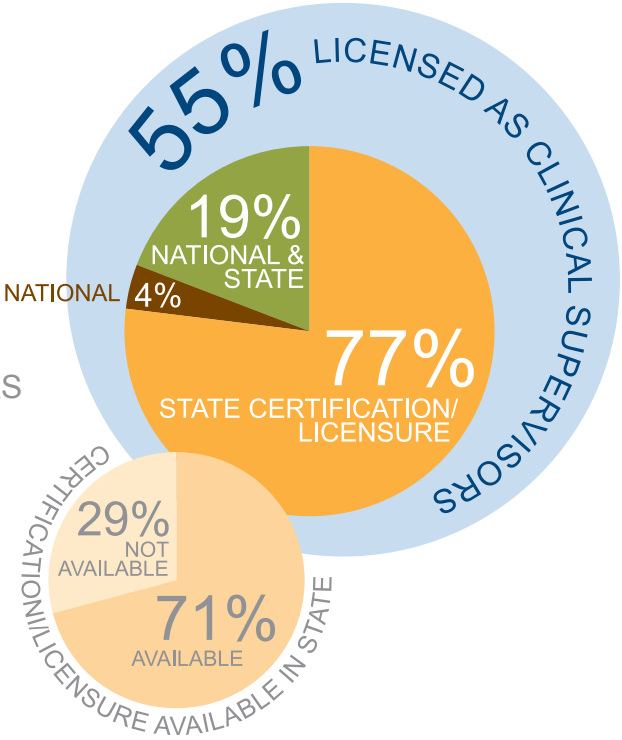
The majority of clinical directors, according to *Vital Signs* respondents, are well educated, with a large number holding graduate degrees (master's 57%, doctoral or equivalent 8%, medical degree 1%). Of those who do not have graduate degrees, 15% have a bachelor's degree, 7% have an associate's degree, and 7% have some college but no degree. Clinical directors reported that of the direct care staff they supervise, 24% have bachelor's degrees and 36% have master's degrees. For complete survey findings on education levels see Data Tables 3 and 7 in Attachment 7: Survey Data.

The *Vital Signs* study also provides information about the licensure/certification status of clinical directors and direct care staff across the country. Clinical directors are overwhelmingly licensed/certified professionals. More than three-quarters (84%) of clinical directors are licensed/certified in substance abuse counseling, and over half are licensed/certified as clinical supervisors (55%). Of those licensed/certified as clinical supervisors, most hold licensure/certification at the state level (77%). For direct care staff, most are already licensed/certified (54%) or are currently pursuing licensure/certification (18%). For complete survey findings on credentialing and licensure see Data Tables 3 and 7 in Attachment 7: Survey Data.

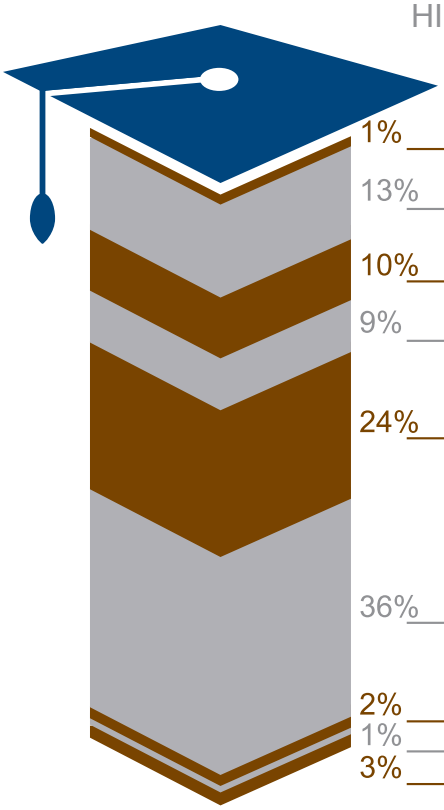
HIGHEST DEGREE: CLINICAL DIRECTORS

57% MASTER
8% DOCTORAL
1% M.D.

LICENSURE: CLINICAL DIRECTORS

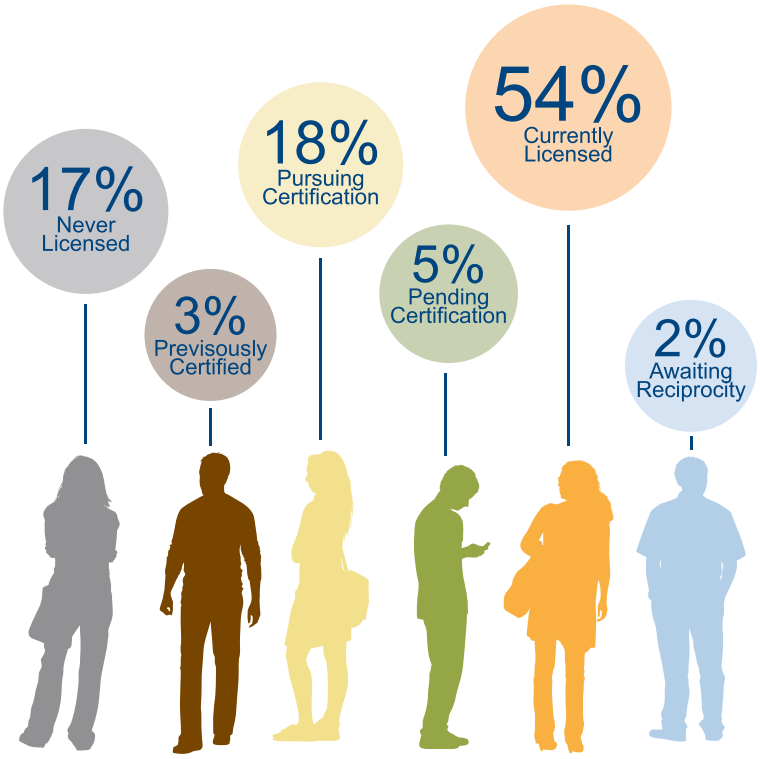


HIGHEST DEGREE: DIRECT CARE STAFF



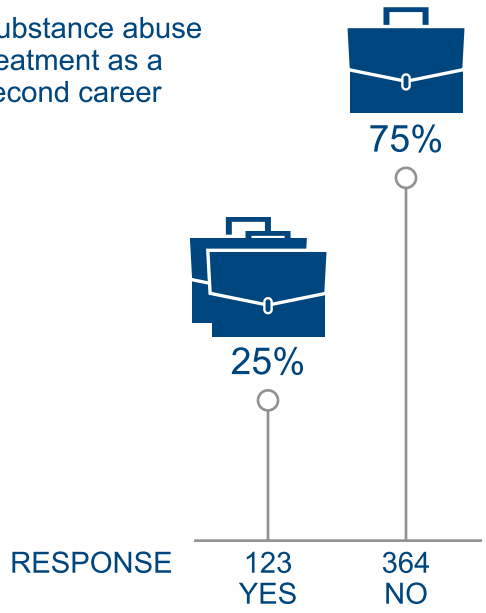
1%	NO HIGH SCHOOL DIPLOMA OR EQUIVALENT
13%	HIGH SCHOOL DIPLOMA OR EQUIVALENT
10%	SOME COLLEGE, NO DEGREE
9%	ASSOCIATES DEGREE
24%	BACHELOR'S DEGREE
36%	MASTERS DEGREE
2%	DOCTORAL DEGREE OR EQUIVALENT
1%	DOCTOR OF MEDICINE
3%	OTHER

LICENSURE : DIRECT CARE STAFF

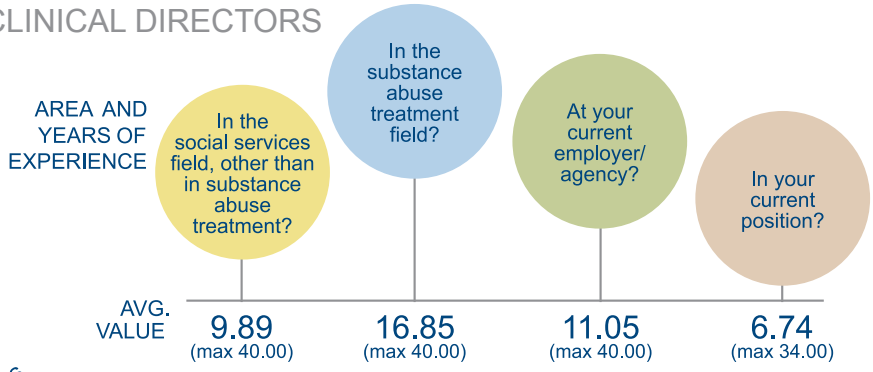


In presenting the professional background of the SUD treatment workforce, it is also important to look at years of experience in the field. The *Vital Signs* study collected information on years of experience for both clinical directors and direct care staff, and found that the majority of clinical directors are long-term employees of their current work setting. According to *Vital Signs* respondents, three-quarters of clinical directors (75%) began their career in the SUD treatment field and, on average, have 17 years of experience. Moreover, although many (67%) clinical directors have worked at more than one treatment facility, the average number of years that they have been with their current employer was 11 and the average number of years that they have held their current position was almost 7. Not surprisingly, the younger direct care staff have less years of experience than clinical directors. According to *Vital Signs* respondents, the majority (54%) of direct care staff have been working at their facility for less than 5 years, with just under a quarter (24%) having worked with their employer for 5-10 years. For complete survey findings on years of experience see Data Tables 4 and 7 in Attachment 7: Survey Data.

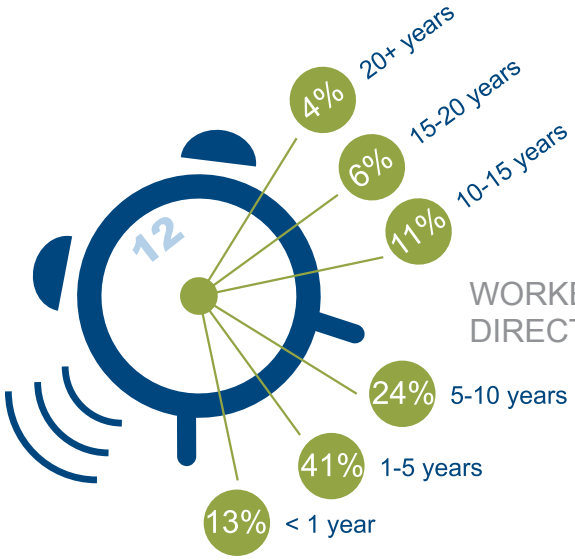
SECOND CAREER: CLINICAL DIRECTORS



EXPERIENCE: CLINICAL DIRECTORS

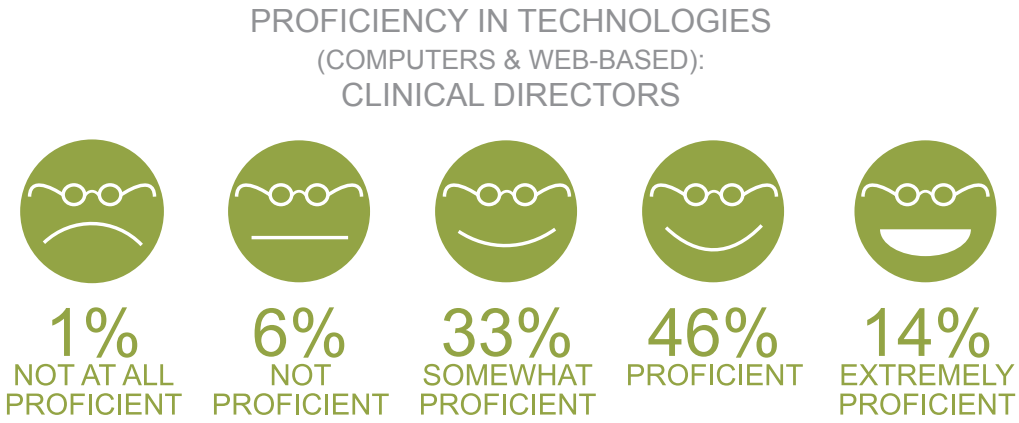


WORKED AT FACILITY: DIRECT CARE STAFF



| TECHNOLOGICAL COMPETENCY |

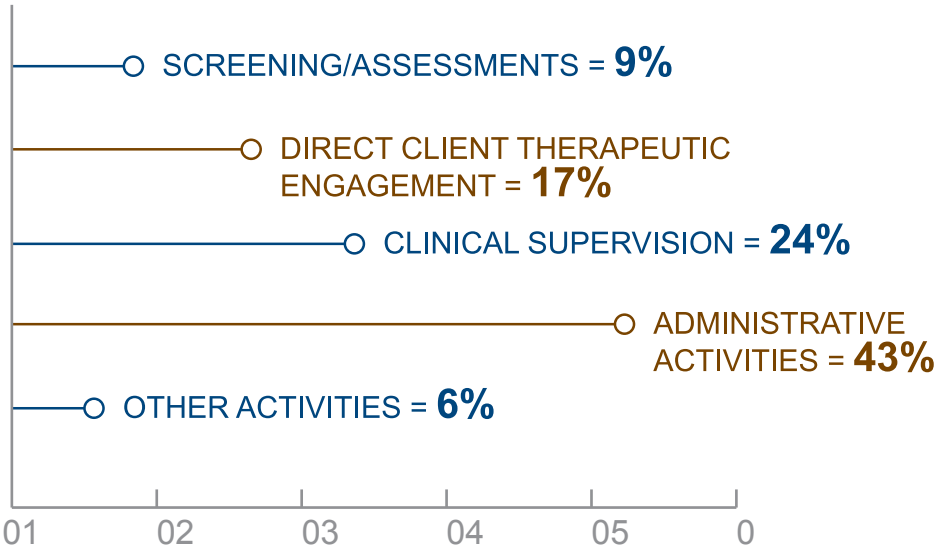
Data collected from *Vital Signs* about technological competency included the self-reported proficiency of clinical directors in computer technology, the technology access of both clinical directors and direct care staff, and the status of the facilities' implementation of electronic health records (EHR). According to survey respondents, while the majority (60%) of clinical directors categorize themselves as being proficient or extremely proficient in computers and web-based technologies, 33% report being only "somewhat" proficient and 7% report that they are either "not" or "not at all" proficient. In terms of technology access, most clinical directors and direct care staff have individual email accounts at work (93%; 83%) and use the Internet for web-based learning (89%; 83%). Clinical directors also reported that direct care staff members have access to the internet during work hours (89%). However, the use of EHR remains limited. Nearly half (42%) of survey respondents reported that the SUD treatment facility at which they work does not have an EHR system. The principal reported barrier to EHR implementation was the amount of capital needed (80%), followed by concerns about the ongoing cost of maintaining an EHR system (45%), and the lack of adequate technical staff to implement and maintain a system (33%). For complete survey findings on technological competency and technology use see Data Table 10 in Attachment 7: Survey Data.



| FUNCTIONAL ROLE (CLINICAL DIRECTORS) |

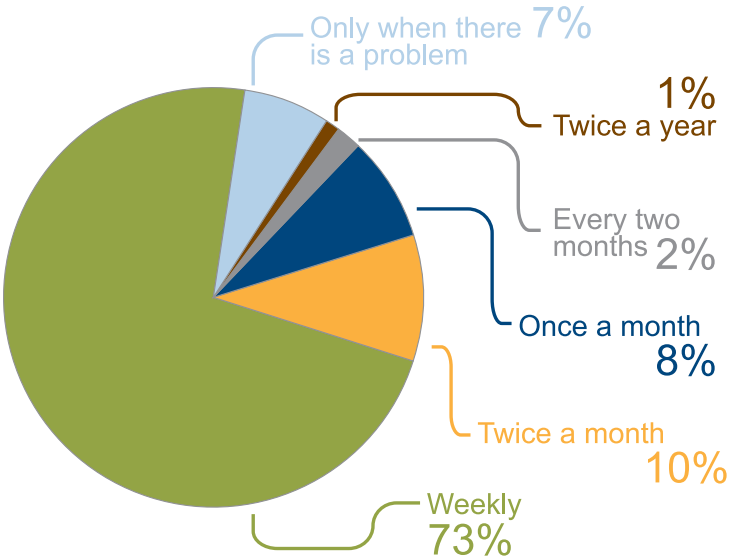
The *Vital Signs* study illustrates how clinical directors, in particular, spend their time at work. This data is limited to clinical directors only, as it was deemed unreliable to have clinical directors report on the daily activities of direct care staff. When asked about percentage of time spent on various activities, clinical directors reported that the majority of their time is spent on administrative activities (43%), followed by clinical supervision (24%), direct client therapeutic engagement (17%), screening and assessment (9%) and other activities (6%).

TIME SPENT ON ACTIVITIES: CLINICAL DIRECTORS

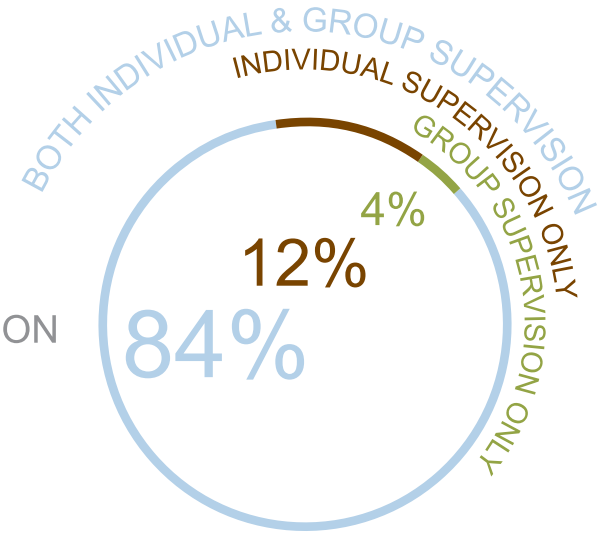


Clinical supervision is necessary to ensure that clinical staff members adopt skill-based learning and stay in their jobs, yet, a lack of research has left the field with little understanding about the state of clinical supervision (SAMHSA, 2003). In order to better understand how clinical supervision is provided in treatment settings, the *Vital Signs* study asked clinical directors to report the setting, method, and frequency with which clinical supervision is conducted. Survey respondents reported that they supervise an average of 23 staff. Most clinical directors conduct clinical supervision on a weekly basis (73%) in both individual and group clinical supervision sessions (84%) by either reviewing charts/progress notes (88%) or observing staff live (72%). Clinical directors reported that other observation methods, such as role play (28%), videotape review (7%) and audiotape review (6%), are much less commonly used. During clinical supervision sessions, clinical directors focus their time on discussing counselor problems and challenges (26%), listening to counselors present cases (20%), reviewing treatment discharge plans (17%), training specific counseling skills (16%), and giving feedback on observed performance (15%).

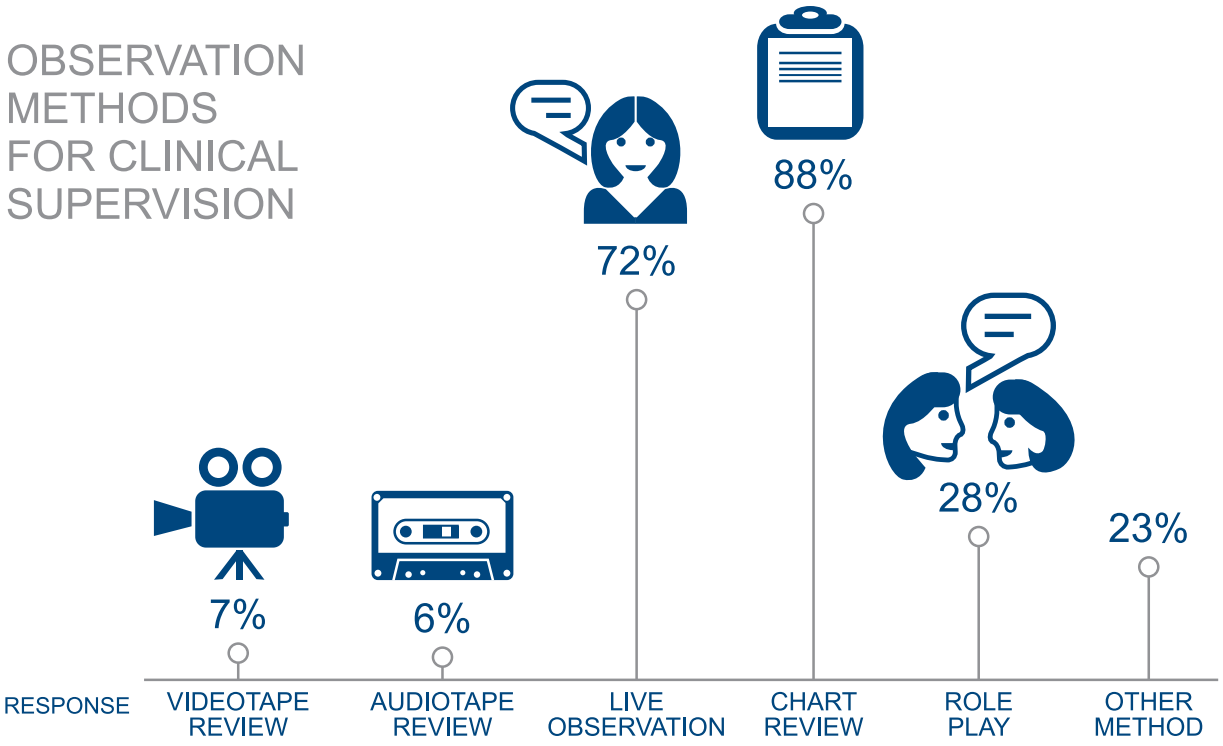
FREQUENCY OF CLINICAL SUPERVISION



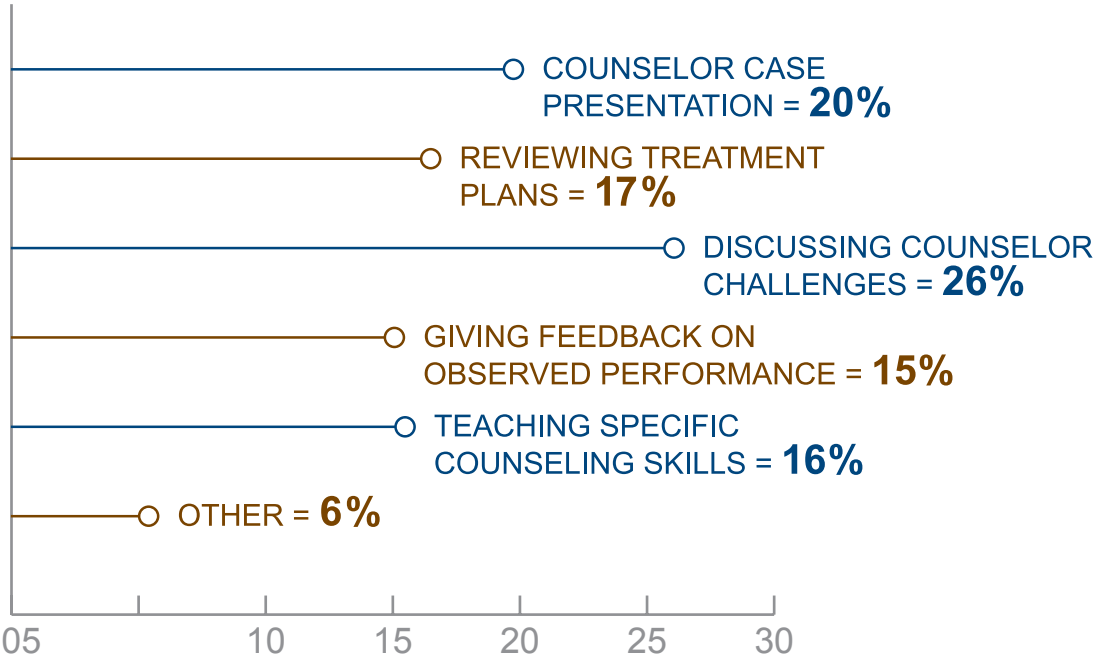
SETTING FOR CLINICAL SUPERVISION



OBSERVATION METHODS FOR CLINICAL SUPERVISION



TIME SPENT ON ACTIVITIES: CLINICAL DIRECTORS



Vital Signs also asked clinical directors to report the caseloads held by various staff at their facility. According to respondents, the majority of program directors (54%) and approximately one third (32%) of clinical supervisors do not have any clients. Licensed counselors, on the other hand, had the most clients with 30% having 30 or more. Clinical directors were also asked their opinion about the case load of the direct care staff they supervise. Three-quarters (72%) reported that they felt direct care staff case loads are "about right," while a fifth (21%) reported they were too large. For complete survey findings on clinical supervision see Data Table 11 in Attachment 7: Survey Data.

OPINION OF STAFF CASELOADS BY CLINICAL DIRECTOR

6% TOO SMALL

72% ABOUT RIGHT

21% TOO LARGE

2% DONT KNOW

| SECTION SUMMARY |

- Clinical directors are primarily white women over the age of 50 who are not in recovery and have not served in the military. Clinical directors are overwhelmingly well educated and either licensed or certified. They have an average of 17 years of experience in the field with an average of 11 years working with their current employer. A significant number of clinical directors are not proficient in computers and/or web-based technologies. Clinical directors spend most of their time on administrative activities. When they provide clinical supervision, clinical directors primarily do so in both group and individual sessions on a weekly basis.

- Direct care staff members are also primarily white women, but are generally younger than clinical directors. Clinical directors estimated that most of the direct care staff they supervise have no military affiliation and are not in recovery. Direct care staff members are educated and are either already licensed/certified or are pursuing licensure/certification.

SECTION IV: STRATEGIES TO PREPARE, RETAIN AND MAINTAIN THE WORKFORCE

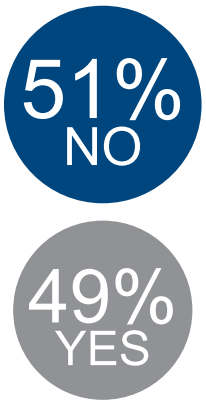
The second primary question that SAMHSA requested the ATTC Network to answer in the *Vital Signs* study was, "What are the common strategies and methodologies to prepare, retain, and maintain the workforce?" The ATTC Network defined this question to mean that the study would identify potentially effective strategies used to recruit individuals to enter the workforce, and encourage them to remain in the workforce and stay current on clinical and other job related skills (e.g., evidence-based practices [EBPs]). In order to address this question, the ATTC Network collected both quantitative survey data and qualitative interview data. Data collected in the *Vital Signs* survey included the difficulties facilities had in filling open positions, the primary source used for staff recruitment, clinical directors' opinions of the recruitment strategies of their facilities, available employee benefits, clinical directors' opinions of the retention strategies of their facilities, methods facilities use to develop staff skills and abilities, barriers to offering continuing professional development to staff, areas of training need, staff competency related to diversity, and clinical directors' opinions of the staff development strategies of their facilities. As described in Section III of this report, the ATTC National Office performed follow-up interviews with 27 clinical directors who reported in the survey that they felt their facilities were successful in their recruitment, retention and staff development strategies. The purpose of these interviews was to gain an enriched understanding of what facilities are doing well in terms of recruitment, retention and staff development. In this section of the report, the findings from the nationally representative sample of respondents to the workforce development items on the questionnaire as well as the emergent themes from the interviews of clinical directors (as described above) are presented.

| WORKFORCE RECRUITMENT |

RECRUITMENT CHALLENGES

The *Vital Signs* survey findings confirm that facilities across the nation continue to struggle to recruit qualified professionals. Almost half (49%) of all survey respondents reported that the treatment facility at which they work has difficulties filling open positions for direct care staff. When asked why their facility had difficulties filling those open positions, clinical directors most frequently cited a lack of qualified applicants (63%) and insufficient funding (43%). Additionally, clinical directors indicated that many applicants do not meet minimum job requirements because they have little or no experience in SUD treatment (50%) and insufficient or inadequate training or education (49%). Treatment facilities are also struggling to recruit staff from diverse populations. Only 13% of respondents "strongly agree" that their facility has made a concerted effort to recruit from underrepresented minority groups in the past year. Overall, only 34% of clinical directors "agree" or "strongly agree" that the recruitment efforts employed by their treatment facility have actually been effective. For complete survey findings on recruitment challenges, see Data Tables 12 and 13 in Attachment 7: Survey Data.

DIFFICULTIES FILLING OPEN POSITIONS



ATTC interviews with clinical directors further elucidated national workforce recruitment challenges. First, clinical directors discussed how financial and structural resources needed for recruitment in the SUD treatment field can often act as a barrier to attracting the best job candidates. Financial barriers do not allow treatment facilities to offer competitive salaries, one of the key elements in successful recruitment. Additionally, structural barriers, such as the amount of paperwork and documentation expected of clinicians, affect successful recruitment. One clinical director described the effect of the paperwork burden, "…with all the systems you have to use for documentation, the paperwork is just ridiculously long in the substance abuse field compared to a chart that you would do in a CPS or in mental health. It's so much more documentation. [With]…different funding sources, everybody wants certain information. And so, the clinicians spend an enormous amount of time doing paperwork, with the client there, filling out the treatment plan, master treatment plan and you have to have a discharge plan. And it takes away…. from them giving better services to the client because your pay is even driven by getting your documentation in within 24 hours."

Clinical directors also suggested that stigma and misunderstanding of SUD treatment play a role in recruitment challenges. They noted that SUDs are often not considered a legitimate healthcare issue and have not been traditionally integrated into mainstream healthcare; therefore, individuals who may be interested in a career in healthcare do not necessarily investigate careers in SUD treatment. One clinical director described this challenge, "A big contributor [to difficulties in recruitment]…is how substance abuse treatment and substance abuse clinicians are viewed by the public and especially by others in the healthcare field. I frequently describe it as we are the 'red-headed step child' when it comes to mental health. So when clinicians are approached and asked if they want to go into SUD treatment, they have a preconceived notion of what it is, the failure rate and the population, they just tend to steer away from it."

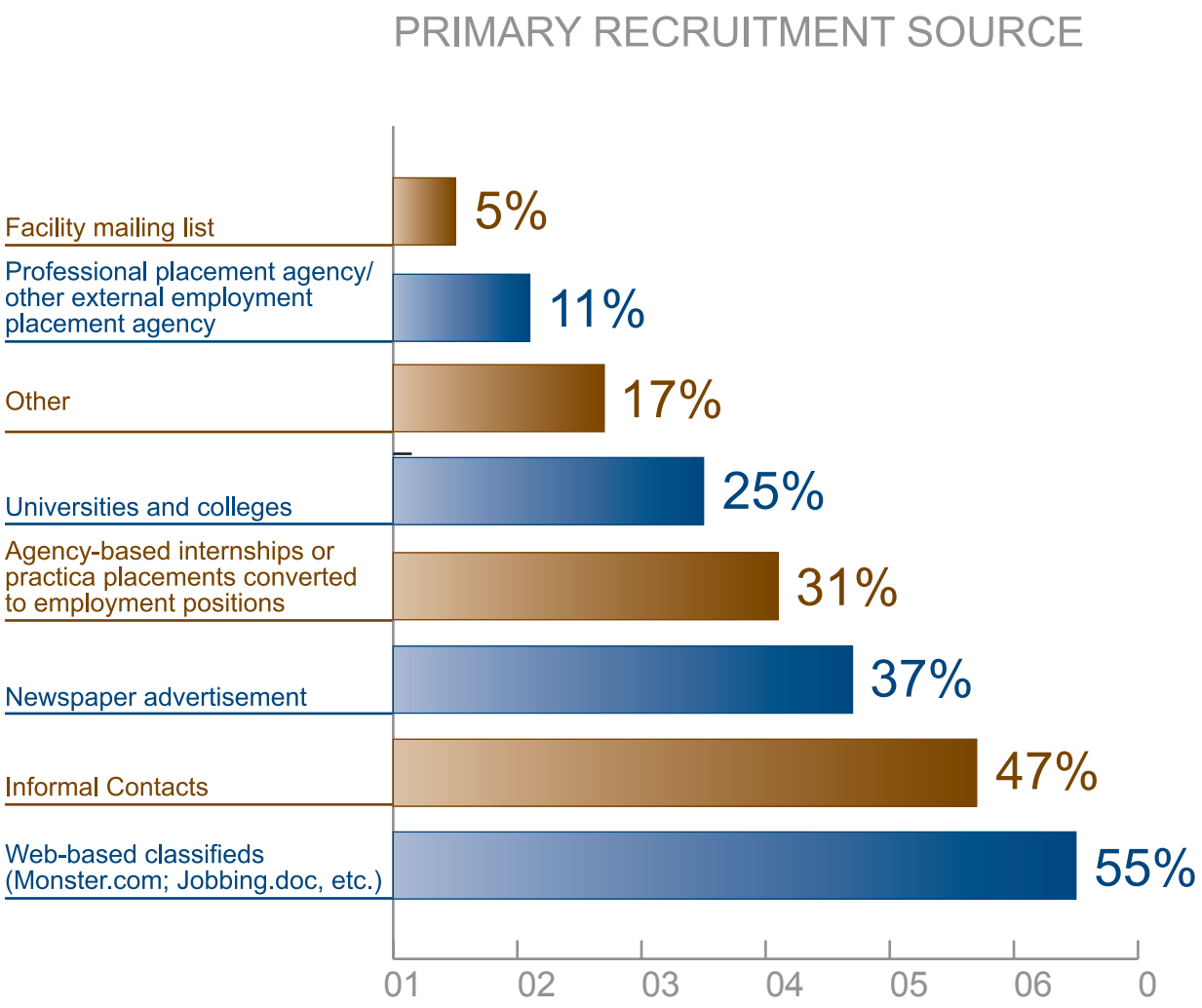
Moreover, clinical directors interviewed in the *Vital Signs* study made clear, as other studies have also shown (Annapolis Coalition on Behavioral Health, 2007; Kaplan, 2003; SAMHSA, 2006), that the compensation rate available to SUD treatment professionals serves as a deterrent to attracting individuals into the field. For some, the lack of adequate compensation is the biggest obstacle. As one interviewee said, "One of the challenges to retain them as well as recruit them is just the knowledge that there's no financial payoff, really, which makes it incredibly difficult. That is definitely, probably the biggest barrier, just the financial end of it." Figure 5 provides a list of the codes and definitions of the codes related to recruitment challenges used to analyze the interview data.

FIGURE 5: Recruitment Challenges Identified by Clinical Directors in Interviews

CODES	DEFINITION
Resource barriers	The financial (adequate compensation) and structural (paperwork burden) resources that limit the ability to recruit and retain individuals in the SUD field.
The need to align substance use with mental illness	Ensure that counselors know that SUD treatment also addresses the issues of individuals who have mental illness. Recognizing that SUD treatment is part of mainstream healthcare.
Inadequate compensation	Pay provided to providers and staff that does not support their retention in the SUD field.
Challenge of substance use stigma	The challenge associated with the stigma that substance use is not a disorder and a legitimate healthcare issue; serves as barriers.

RECRUITMENT STRATEGIES

In the *Vital Signs* study, the ATTC Network aimed to flesh out common methodologies currently being used by facilities in the SUD treatment field to recruit employees. According to survey respondents, the most common recruitment resource used by treatment facilities is web-based classifieds (55%), although traditional newspaper advertisements also continue to play a significant role (37%). For complete survey findings on recruitment strategies see Data Tables 12 and 13 in Attachment 7: Survey Data.



Clinical directors responding to the survey highlighted the importance of relationships in recruiting new employees. Nearly half (47%) claimed that their facilities recruited employees through informal relationships, while almost a third (31%) identified agency-based internships or practicum placements as important avenues for attracting employees. Three-quarters (74%) of respondents reported formalized relationships with universities and colleges, but only a quarter (25%) cited the use of universities and colleges as recruitment resources. In interviews, however, clinical directors stressed that building relationships with universities and higher education institutions was extremely beneficial to recruitment and overall program processes at their facilities. One clinical director described how they created linkages with universities in their region, "Myself as the Clinical Director and our Executive Director, sort of network with one of the local universities. I taught classes just as a part-time thing in the counseling department and the social work department." Such networking strategies can lead to strong linkages with universities and the opportunity to provide practicum/internship training, with the possibility to then recruit those interns into open positions.

Another important strategy highlighted through the *Vital Signs* study is recruiting employees from the recovery community. According to survey respondents, SUD treatment facilities work to recruit from the recovery community, with 41% of clinical directors reporting that they "agree" or "strongly agree" that their facility has made a concerted effort to recruit individuals in recovery in the past year. Similarly, in interviews, clinical directors emphasized accessing the recovery community as a recruitment strategy used by facilities. Clinical directors discussed the importance of recognizing that clients can often transition into roles as peer recovery specialists or other staff positions. This recruitment was described as a gradual process, with recovering clients beginning in part-time roles and gradually transitioning to a more permanent position. One clinical director commented, "When people get out of treatment and are successful in their recovery, sometimes they will come back and maybe put in an application for part-time work. If they work out in the part-time position, then when we have a vacancy on the night shift, or weekend shift, or whatever, a lot of times, if they are interested, then they will get the first shot at that position."

Finally, another approach to recruitment clinical directors discussed in interviews was the power of "word-of-mouth" referrals that comes from the reputation of the facility at which they work. Clinical directors explained that a positive facility reputation often helps in recruiting qualified professionals. As one clinical director discussed, "I do think that because of the high level of care and word of mouth, through the schools and internship programs that we participate in, that this is an excellent program and that the staff is well taken care. I do believe that that adds to the applications I get. I don't do anything other than that; it's really word-of-mouth." Figure 6 illustrates the codes and code definitions used to identify recruitment strategies discussed by clinical directors in interviews.

FIGURE 6: Recruitment Strategies Identified by Clinical Directors in Interviews

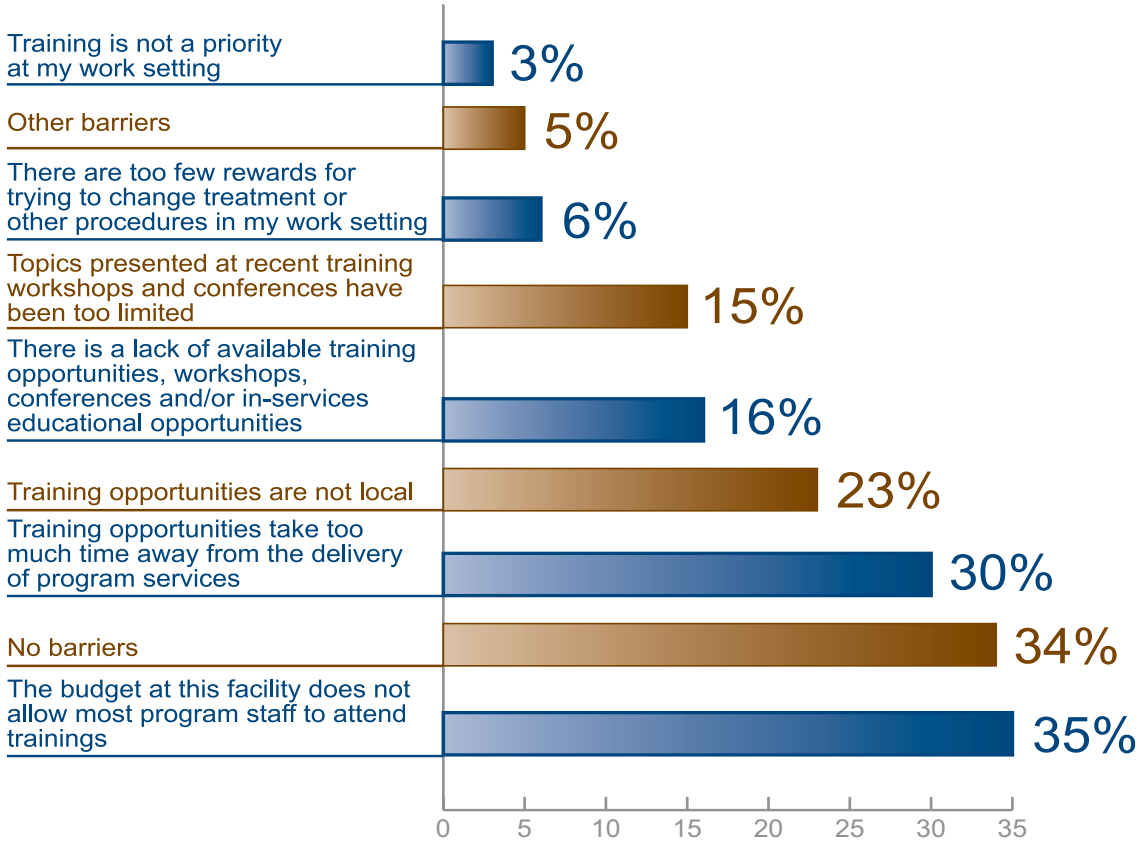
CODES	DEFINITIONS
Openness to change	A site/provider being able to adapt to the externally driven changes in order to foster sustainability.
Valuable external relationships	External relationships with partners, other agencies and institutions that are perceived as valuable.
Positive relationships with universities	Relationships with universities and higher education institutions that are beneficial to recruitment and overall program processes.
Internship opportunities	Providing internship opportunities that lead to permanent employment within the SUD field.
Clients transition to employees	A recovered client moving into a SUD treatment position.
Creating pipeline/pathway for internal promotion	Agency/organization has opportunities for individuals to enter into the profession and advance to upper level positions.
Effective interview strategies	Strategies that are used during interviews to evaluate the best applicants.
Loan repayment plan	Loan repayment plan provided to employees who work within the mental health field.
Positive reputation	A positive reputation that supports recruitment and retention.
Communicating success stories	Using communication channels to tell other agencies and larger society about staff and their success with clients.

| WORKFORCE TRAINING AND DEVELOPMENT |

TRAINING AND DEVELOPMENT NEEDS AND CHALLENGES

In responding to the *Vital Signs* survey, 68% of clinical directors reported that their facility experienced barriers in providing staff training and professional development. Similar to training barriers listed in other reports (Annapolis Coalition on the Behavioral Health Workforce, 2007), *Vital Signs* data shows that barriers to training for direct care staff include an insufficient budget (35%), followed by the amount of time training takes away from the delivery of direct program services (30%), and the lack of training opportunities in the locality (23%). When asked to identify specific areas of training need, the majority of clinical directors "agree" or "strongly agree" that their staff needed training in identifying and using evidence-based practices (EBPs; 61%), improving behavioral management of clients (61%), and increasing program participation by clients (59%). Additionally, 42% of clinical directors reported that their facility did not implement staff training to build competency in gender responsive SUD treatment in the past year. For complete survey findings on training and development needs see Data Tables 14 and 15 in Attachment 7: Survey Data.

BARRIERS TO STAFF TRAINING AND CONTINUING EDUCATIONAL OPPORTUNITIES



In interviews, clinical directors provided more details about training and development needs and challenges. They discussed the struggle to keep staff up-to-date so that they can effectively respond to the changing treatment needs of the client population and so that they can utilize the latest EBPs. They also noted that financial and resource restrictions limit the amount of training they can provide. According to those interviewed, tight budgets and a limited number of staff members make it challenging to find the funding and time to send staff for training. One clinical director explained, "Every state is hurting right now financially and you know, there is not an abundance of resources…I don't have enough personnel; there's never enough time for everything; and there's never enough resources for everything. And so, you do what you can do with what little resources that you do have."

TRAINING AND DEVELOPMENT STRATEGIES

As SAMHSA has suggested, SUD treatment staff need ongoing and continuing pre-service and in-service training in order to provide SUD treatment in a knowledgeable and comprehensive manner (Kaplan, 2003). It is important, therefore, to identify for SUD treatment facilities specific strategies to successfully train and develop the workforce. The *Vital Signs* survey found that the three most common strategies to develop skills and enhance the abilities of direct care staff were providing direct supervision (92%), offering ongoing staff training (91%), and providing new staff orientation (88%). The majority of respondents also indicated that they "agree" or "strongly agree" that their facility has a formalized policy regarding continuing education requirements for staff (70%). Other staff development strategies, however, are less common. Less than half of respondents (48%) said that their facilities had budgetary targets for training, while only 38% reported formal policies that provide tuition reimbursement and only 29% identified formalized strategies for career progression of staff. In terms of preparing staff for the needs of a diverse client population, the majority of clinical directors (73%) reported that their facilities provide staff training related to culturally responsive SUD treatment, but less (58%) reported that their facilities provide training in gender responsive SUD treatment. Clinical directors also reported that they "agree" or "strongly agree" that their facility considers cultural and linguistic differences in developing treatment practices (75%), that their facility has program forms and documents available in the languages of their service population (66%), and that their facility systematically reviews procedures to ensure delivery of culturally competent services (65%). For complete survey findings on training and development strategies see Data Tables 14 and 15 in Attachment 7: Survey Data.

In interviews, clinical directors were asked to expand on the successful staff development strategies implemented by their facilities, including methods applied by their facilities to provide ongoing training and education to staff. The majority of clinical directors noted that continuously identifying and developing education and training opportunities will lead to improved knowledge and ability of staff. Clinical directors also noted that commitment to training and educational opportunities should be achieved throughout the organization. One clinical director discussed the provision of continuing education in more detail, "We do pay for the education of our staff if they want to be certified counselors, or go on to become licensed. We will pay for their education if they agree to stay on once they get through with their education. Then we also pay for their certification and so that's a lot of incentive to retain them and it tends to get them more loyalty to the program and more consistency in their professional roles."

One cost effective strategy recommended by clinical directors in providing ongoing professional development is to allow staff to attend outside trainings and then bring that information back to other staff in the organization through internal training. That is, a small number of staff members are trained by outside educators and then those staff return to the organization to teach what they have learned to their colleagues. One clinical director noted, “It was very expensive to get people retrained when we had new people coming on. We had people trained to be trainers and so when new people came along, instead of having to hire someone on the outside to come train, we could train them ourselves.” Clinical directors also discussed how they organize and mandate trainings at their facility, “We set the training, we make our trainings mandatory, for all our employees, our clinical staff, and set aside time just for the training. Then, after the initial training, we do our own ongoing training to assure that all the employees continue to have, I guess, booster sessions on the information presented.”

Another strategy used to develop employees, according to clinical directors interviewed, is to provide ongoing supervision and feedback. Clinical directors described how providing regular supervision will help direct care staff members to recognize areas of service provision that need improvement. They described how they mentor and guide direct care staff in skill development resulting in improved skills, better treatment outcomes, and staff satisfaction.

Finally, clinical directors discussed the value of online and remote learning opportunities for employees. Online training and continuing education provide treatment facilities with staff development strategies that are not as costly or time consuming as sending staff to external training. Remote learning opportunities can be accessed more regularly than a face-to-face training, and more staff can participate. Figure 7 illustrates the codes and code definitions used to identify training and development strategies discussed by clinical directors in interviews.

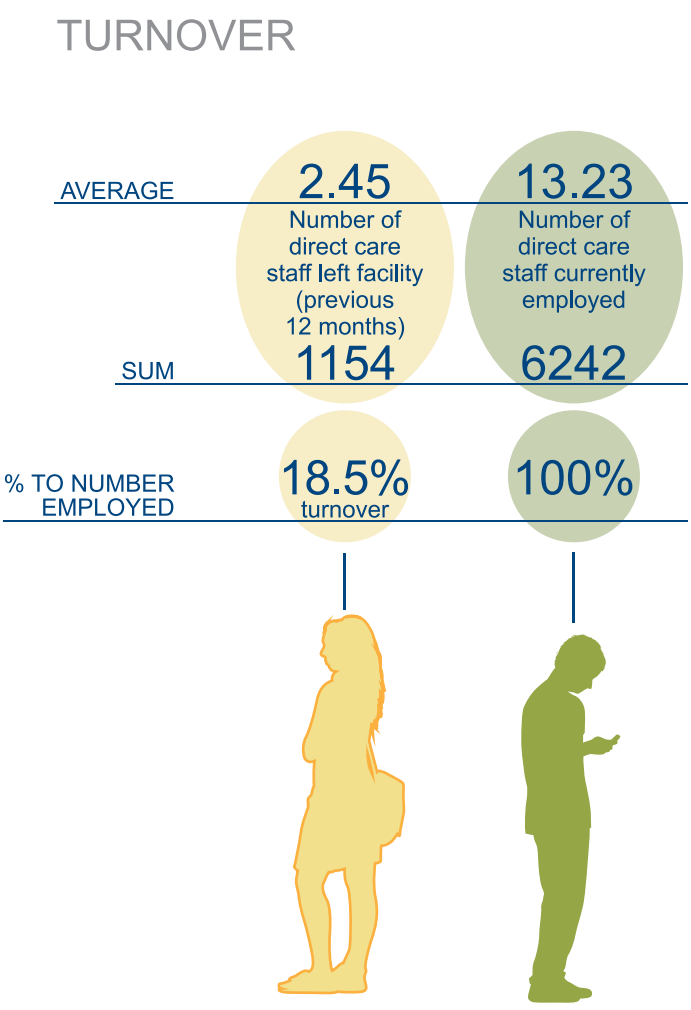
FIGURE 7: Training and development strategies identified in Clinical Director Interviews

CODES	DEFINITIONS
Commitment to continuing/ ongoing education opportunities	Agency/organization is committed to developing staff through opportunities for continued and ongoing education.
Internal training	Providing training from within the agency/organization and allowing externally trained staff to train other staff.
Valuable online and remote courses	Courses available to staff through online and remote agencies and institutions that are valuable.
Ongoing supervision and monitoring of performance	Process within organizations/agencies that allows employees to be supervised, receive feedback, and monitor annual performance.
Value of cross-training	Collaborating with other sites and agencies to offer training across staff and providers.
Orientation provided to new employees	Orientation program provided to new employees to acclimate them to the agency.

| WORKFORCE RETENTION |

RETENTION CHALLENGES

Once a facility recruits and develops employees, retaining them is important to the success of the organization. The *Vital Signs* survey found that facilities experienced an average turnover rate of 18.5% in the past year. According to clinical directors, factors that may affect successful retention efforts include a lack of paid educational assistance for employees (44%) and a lack of available retirement plans (24%). When asked how well their facility implements a variety of retention strategies, clinical directors reported "not well at all" or only "somewhat well" for salary increases (64%), efforts to reduce the paperwork burden (64%), smaller caseloads (43%), promotion opportunities (32%), and mentoring opportunities (39%). For complete survey findings on retention challenges see Data Tables 14 and 15 in Attachment 7: Survey Data.



In interviews, clinical directors further discussed retention challenges. Clinical directors suggested that the changing treatment needs of the patient population effect staff turnover. As treatment needs change, ongoing education and training is needed. According to those interviewed, some treatment staff would rather leave the field than face being retrained in new EBP protocols. Other barriers to retention that emerged from the interviews included inadequate compensation, the challenge of balancing career and family, and heavy caseloads resulting from unfilled staff positions and limited resources. One clinical director described the difficulties in changing staff mentality about training, "….you look at the people who came into the field more than… ten years ago….it was really considered just normal to go in and yell at your staff [and] your client and be really confrontational and [then] when we were really looking at motivational interviewing, which has a very different approach and, a client-centered approach, people were like, 'Ah! Well, they're addicts, they're gonna lie to you and you can't treat 'em like that. They're just gonna get one over on you.' So there's that whole shift of thinking that had to happen." Figure 8 illustrates the codes and code definitions used to identify retention challenges discussed by clinical directors in interviews.

FIGURE 8: Retention Challenges Identified by Clinical Directors in Interviews

CODES	DEFINITIONS
Resource barriers	The financial and structural resources that limit the ability to recruit and retain individuals in the SUD field.
Changing treatment needs	Aware of the multiple needs of clients and changing treatment to be responsive to these trends.
Staff not reimbursed for services	The process of staff and employees in substance use not being reimbursed for all of the services they provide to clients through insurance claims.
Managing family and career	The issue of trying to manage the demands of family and career.

RETENTION STRATEGIES

The *Vital Signs* study highlights common strategies used to retain employees in SUD treatment facilities nation-wide. For permanent employees, benefits such as paid vacation time (83%), paid sick time (82%) and group health insurance (74%) are widely available. Survey respondents also indicated that facilities engage in the following retention strategies either "well" or "very well": implement opportunities for program input (78%), provide access to ongoing training (74%), institute a supportive facility culture (72%), and provide better management and supervision (70%). For complete survey findings on retention strategies see Data Table 16 in Attachment 7: Survey Data.

The most common retention strategy discussed by clinical directors in interviews was the creation of a team-oriented, democratic approach to daily operations and practices within the organization. One clinical director described the benefits of a team approach at their organization, “When we are talking about implementation we don’t just sit in a room and make all the decisions for everybody. When it comes to something like treatment, we get all of the therapists and say, ‘here’s a treatment program, here’s a website, see what it is that you think that you would like the most and then we will look at it and make a decision that’s best for us’.” Other successful retention strategies mentioned in interviews included staff recognition, such as providing incentives, lunches, or other events for staff; the use of technology to support the needs of patients, staff, and the organization; and the creation of a positive or collegial work environment. One director discussed such strategies, “We would give parties to people who were leaving. They would give two-week’s notice and we would have a little get-together. We would have a potluck, give them a card, and everyone would say their goodbyes...then we started celebrating people’s anniversaries. If they were here one year, you know, we would celebrate one year anniversaries and have a potluck.” Figure 9 illustrates the codes and code definitions used to identify retention strategies discussed by clinical directors in interviews.

FIGURE 9: Retention Strategies Identified by Clinical Directors in Interviews

CODES	DEFINITIONS
Retention strategies	Strategies associated with an agency/organization's ability to retain current and new staff.
Team-oriented practices	Using a team approach in daily operations and practices within the agency/organization.
Democratic and inclusive work environment	The use of an inclusive and fair work environment that integrates staff input in programming and treatment.
HIT implementation	The use of technology in supporting the needs of the agency and staff.
Positive staff recognition	Recognition such as incentives, lunches, or events for staff appreciation to recognize staff and their work.
Provide a collegial and positive work environment	A supportive and positive work environment where individuals work together during every day and functional tasks.
Staff autonomy	The ability of staff to be self-governing and contribute new ideas in substance use treatment.
Improved client satisfaction	An outcome associated with recruiting and retaining the right staff.
Leadership model	An effective leadership model that promotes inclusion and reliance on EBPs.
Value cross-training	Collaborating with other sites and agencies to offer training across staff and providers.
Emphasis on staff well-being	Agency committed to the well-being and health of its staff.
Creating pipeline/pathway for internal promotion	Agency/organization has opportunities for individuals to enter into the profession and advance to upper level positions.
Working with other providers	The relationship and connection with other providers in the field.
Motivation to conduct research on what works	Individual motivation to find research that supports practices and treatment in substance use.
Leader supports professional development of staff	Leaders that encourage, support, and provide resources to promote the professional development of staff.
Positive reputation	A positive reputation that supports recruitment and retention.
Program fidelity	Program effectiveness and sustainability.
Orientation provided to new employees	Orientation program provided to new employees to acclimate them to the agency.

| SECTION SUMMARY |

- Recruitment Challenges and Strategies: The *Vital Signs* study brought to light many challenges related to workforce recruitment, including a shortage of qualified applicants, the lack of a concerted effort to recruit professionals from underrepresented minority groups, and a lack of adequate compensation. The most common recruitment strategy used by SUD treatment facilities is web-based classifieds and job banks. In interviews, clinical directors reported success recruiting employees through relationships with universities and the recovery community.

- Training and Development Challenges and Strategies: Clinical directors reported that staff most commonly need training in EBPs and behavioral management of clients, but there are often challenges to providing such training, including insufficient budgets, time constraints, and a lack of training opportunities offered in close proximity to the facilities. In order to develop staff, the most common strategies reported involved providing direct supervision, ongoing training, and new staff orientation. In addition, some clinical directors reported that other cost effective training strategies utilized by their facilities involved online and remote learning opportunities as well as sending a small number of staff to be trained by outside educators so that when they return they can teach the training topic to the rest of the organization.

- Retention Challenges and Strategies: According to the *Vital Signs* study, SUD treatment facilities experience a turnover rate of nearly 20%. Clinical directors reported that the main challenges to retaining qualified staff were a lack of paid educational assistance, no retirement plans, inadequate compensation, and difficulties staff members face in balancing career and family. Furthermore, clinical directors suggested that facilities struggle implementing possible retention strategies such as providing for salary increases, reducing the paperwork burden, and offering promotion opportunities. To address these challenges, clinical directors reported that the creation of a team-oriented, democratic approach to daily facility operations can enhance retention. Also, benefits such as paid vacation time, paid sick time, and group health insurance are widely available and attractive to permanent employees. Finally, clinical directors suggested that staff recognition, the use of technology, and the creation of a positive, collegial work environment can also help with retention.

SECTION V: WORKFORCE DEVELOPMENT NEEDS

The third primary question that SAMHSA requested the ATTC Network to answer in the *Vital Signs* study was, "What are the anticipated workforce development needs in the next five years?" To better answer the question, the ATTC Network separated it into two components:

(1) What is the projected growth, retraction, and composition of the substance use disorder workforce in the next five years?

(2) What are the projected mega-trends that will impact the workforce in the next five years?

The ATTC Network responded to these components by analyzing existing data sets (Attachment 4), by reviewing the *Vital Signs* survey data, and by conducting interviews with 25 thought leaders in the field. In this section of the report, the ATTC Network uses these data sources to anticipate the workforce development needs for the next five years.

| COMPONENT #1 |

What is the projected growth, retraction, and composition of the substance use disorder workforce in the next five years?

GROWTH OF THE SUD WORKFORCE

Data from the Bureau of Labor Statistics (BLS) archives shows that SUD and Behavioral Counselors increased from 56,080 in 2000 to 77,940 in 2010. The most recent BLS data indicate there are currently 76,600 substance abuse and behavioral disorder counselors employed in the United States (BLS, 2011). Based on an overall change of about 38% from 2000 to 2011, the BLS projections suggest there could be an influx of up to 30,000 more counselors by 2020.

Data from the 2005 to 2009 Treatment Episode Dataset (TEDS) shows a 4% increase in admissions to providers of substance abuse treatment. However, as the Patient Protection and Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (MHPAEA) expand health insurance coverage, it is expected that increasingly more individuals will have access to SUD treatment services. In 2014, when the ACA takes effect, it is anticipated that an additional 6 to 10 million Americans with previously untreated mental or substance use disorders will be covered by health insurance (SAMHSA, 2011). As one thought leader explained, "…the big game changer for everybody across the country is the impact that the Affordable Care Act will have; especially in January of 2014 when the coverage aspect of the Affordable Care Act kicks in, so that's with the expansion of Medicaid and that's the expansion of the health insurance exchanges and it's also the requirement that employers provide coverage for their employees and as we know, inside of the Affordable Care Act…one of the ten essential health benefits is substance abuse and mental health treatment and rehab services, so its identified right in the affordable care act."

The ACA will result in the need for a greater number of qualified professionals, but it may also change the location where these professionals work as SUD treatment becomes integrated with mainstream healthcare. "I think that the intent of the way healthcare reform was written is to bring substance abuse care into the physician's clinic or the ER, or the other…Federally Qualified Health Centers; so that as opposed to our field having a lot more doctors in it, I think that…what we'll see, is that a lot more healthcare entities will contract out or hire substance abuse professionals to work there," explained a thought leader.

Consequently, while the BLS projections suggest an influx of up to 30,000 more counselors by 2020, this is based on expectations that the treatment population will increase by only 4%. The impact of the MHPAEA and more importantly, the ACA, may result in a significantly increased treatment population and the need for SUD counselors who can work in a variety of healthcare settings.

RETRACTION OF THE SUD WORKFORCE

The BLS data suggests that the SUD workforce will continue to grow and, with the ACA and MHPAEA, the rate of this growth may need to increase significantly as more people access treatment. The data from the *Vital Signs* survey, however, indicates that there may be challenges in keeping up with this projected growth. According to survey respondents, 49% of facilities already have problems filling open positions (49%) primarily due to a lack of qualified applicants (63%). Moreover, the current SUD workforce is aging; 60% of clinical directors are over the age of 50 and 46% of direct care staff are over the age of 45.

SUD WORKFORCE COMPOSITION

While there is no comprehensive data to track the changing composition of the SUD workforce, the *Vital Signs* survey data shows that the current workforce is predominantly comprised of white (64%) females (67%) over the age of 45. A 2003 CSAT study (Mulvey, Hubbard, & Hayashi, 2003) described the SUD workforce as white (85%), 40-55 years old (60%), with slightly more females (51%) than males (49%). With caution (based on the limited data points available), this suggests that over the next five years, the workforce may become more diverse in terms of race/ethnicity, but will continue to be comprised primarily of women. As noted earlier, the aging of the workforce coupled with the need to recruit direct care staff to cope with increased admissions emphasizes the need for SUD facilities to recruit younger and more diverse applicants.

Data noted from Harwood (2002) and from the Annapolis Coalition Action Plan for Behavioral Health Workforce Development (2007) reveals that the majority of healthcare professionals licensed or credentialed in SUD treatment continue to come from social work. According to the 2002 data, while there were 67,000 people working in the SUD workforce, only approximately 60% were licensed or credentialed in SUD treatment. Seventy percent of those with licenses or credentials were social workers, complemented by those in nursing, general and specialty medicine, psychiatry, and clinical psychology (Figure 10).

FIGURE 10: Healthcare Professionals Licensed or Credentialed in SUD Treatment *(Harwood, 2002)*

DISCIPLINE	# OF CERTIFIED ADDICTION SPECIALISTS
General and specialty medicine	2,790 ASAM certified
Psychiatry	1,067 addiction psychiatrists
Clinical psychology	950 APA substance-abuse certified
Social work	29,400*
Nursing	4,100*
Physician assistant	185*

**These numbers are based on those who self-described as addiction specialists*

| COMPONENT #2 |

What are the projected mega-trends that will impact the workforce in the next five years?

The telephone interviews with national thought leaders reveal key insights into the mega-trends that will impact workforce development over the next five years. Employing a thematic analysis approach, data from the interviews were organized into six emerging themes: macro-level changes to healthcare and treatment delivery; enhanced pre-service training, professional development, and uniform credentialing; increased use of evidence-based and recovery-oriented methods of SUD treatment targeted for a changing client population and emerging drugs of abuse; workforce recruitment and retention efforts; the recognition of substance use disorders as a valid health issue; and implementation and use of health information technology. Attachment 9 shows the themes and definitions, the codes (and definitions of codes) related to each theme, and the sources and frequencies of the codes.

THEME 1: MACRO LEVEL CHANGES TO HEALTHCARE AND TREATMENT DELIVERY

Over 90% of thought leaders referenced macro level changes to healthcare and SUD treatment delivery in interviews. Most of the changes discussed centered on healthcare reform (HCR). HCR is the term used to describe major healthcare policy changes, such as the ACA and MHPAEA, which have recently been enacted in the US. HCR is expected to impact the ways in which SUD treatment is delivered.
Through analysis of the thought leader interviews, two key trends emerged under this theme. First, macro level changes will require the reimbursement methods used for SUD services to move to a managed care model. Thought leaders suggested that SUD treatment has not generally been delivered using managed care principles, but that this will likely change with HCR. This shift emphasizes the need to ensure the workforce is prepared to work in a managed care environment.

Second, macro level changes will also hasten the integration of SUD treatment services with other forms of healthcare, including hospitals, primary care settings, and other community-based organizations. According to those interviewed, SUD treatment has historically occurred in isolation from mainstream healthcare. Weak referral systems have existed between SUD treatment and other healthcare arenas. Integrated delivery will see primary care and emergency room providers effectively screening and providing brief interventions for SUDs. Also, more SUD treatment professionals will work in integrated settings such as Federally Qualified Health Centers (FQHCs). As one thought leader explained, “Really the key is the integration with primary care. So, there are these things called Medical Homes and the concept there would be that a person gets all of their healthcare at one site. It would be integrated primary care so that they would get their OB/GYN services, pediatric service, their internal medicine services, dentistry, all that type of thing, and they would get their behavioral health services in the same clinic and then be integrated as part of a team.”

However, while thought leaders explained that SUD treatment will become integrated into other healthcare settings, they also commonly discussed the need to maintain specialty care for SUDs. Currently, most SUD treatment is provided in specialty treatment settings, very much isolated from the rest of healthcare. With HCR, thought leaders asserted that those specialty centers will not survive unless they connect with mainstream healthcare. Thought leaders emphasized that there will always be a need for specialty treatment, but they also made clear that facilities that do not have strong referral systems with generalist treatment centers will not survive.

THEME 2: ENHANCED PRE-SERVICE TRAINING, PROFESSIONAL DEVELOPMENT, AND UNIFORM CREDENTIALING

Eighty percent of national thought leaders discussed the importance of training, developing, and credentialing the incoming and current SUD treatment workforce, especially as healthcare service systems become more integrated. Topics that emerged from this theme included the type of training needed, uniform licensure and credentialing of SUD treatment professionals, the professionalization of the workforce, and SUD credentialing for interdisciplinary professionals.

Thought leaders addressed the current and ongoing training needs of the workforce. A number of training topics emerged from the interviews. Thought leaders expressed that the workforce needs enhanced knowledge in areas such as measurement and data analysis, health behavior models, options for treatment, health information technology, specific treatment modalities, and the development of treatment plans. One thought leader spoke to the scope of the training needs as they relate to HCR, "We need counselors re-trained to provide brief treatment services…85% of the people who have substance use disorders are not in treatment and they are the 85% that need treatment [and] in 2014, no matter what happens with Health Reform, there will be a large number of people eligible for insurance, a very large number that will need treatment. We know what the numbers are now and it seems to me that the workforce has to get prepared in how to handle that. However, they are not the same people that are in addiction treatment now. It's a different population. And we know that now. And so what needs to happen starting now, starting yesterday, as far as I'm concerned, is beginning to bring counselors to the table and other clinicians, functioning in substance use settings, treatment settings, and say to them, 'what do you want to do?' 'What are you ready to do?' 'How are you going to retrain yourself?'"

Thought leaders also discussed the credentialing and licensure of the SUD treatment workforce. They recognized the need for uniformity in credentialing and licensure. They suggested that such standardized policies may need to be in place in order for the workforce to be recognized by new payers coming into the system, such as Medicaid and private insurance. Thought leaders also emphasized, however, that the field has already been moving toward a more credentialed, licensed and professional workforce even though that credentialing is not yet uniform. Several interviewees expressed that while the field developed from a recovery model of peer-to-peer counseling, recent studies have shown that those in the SUD treatment field are earning increasingly higher education levels and more professional credentials. They expressed a need for this trend to continue. "The need for a more professionalized service worker is going to be critical, the need for management that is technically proficient in information systems… the fact that we will now be part of a larger healthcare network means that the need to professionalize the service workers that hold greater credentialing, the need for greater and higher degrees is…it's going to be inevitable… and the question for the field will be how to preserve what we in the past have cherished, our recovering people who are not necessarily after the degrees of social work, may not be credentialed depending on the state and the requirements thereof, but who offer very valuable service in terms of understanding the disease, understanding the culture of it, and understanding how to exchange and interchange with clients coming in the system. So, we are going to have [to] find tiers of advanced education and training, absolutely credentialing has to be a major part now of everybody and it seems to me that's the obvious and one of the most onerous challenges that we've got."

Furthermore, thought leaders discussed the need to educate other healthcare providers in the treatment of SUDs. As healthcare reform expands access to treatment, it is expected that other healthcare providers will begin offering SUD services. Primary care and emergency room practitioners will need to have the capacity to provide some types of SUD treatment. Mental health professionals will also need to become

more familiar with treating SUDs specifically and not solely in patients with co-occurring disorders. As the education and credentialing system for mental health professionals currently stands, mental health practitioners are not necessarily qualified to provide SUD treatment as a part of their qualifications to provide mental health services. Thought leaders explained that it will be necessary for many of those practicing in the mental health arena to earn specific, additional credentials in SUD treatment.

THEME 3: INCREASED USE OF EVIDENCE-BASED AND RECOVERY-ORIENTED METHODS OF SUD TREATMENT TARGETED FOR A CHANGING CLIENT POPULATION AND EMERGING DRUGS OF ABUSE

More than 75% of national thought leaders felt that SUD treatment in the future will focus on increased use of evidence-based and recovery-oriented methods of SUD treatment which are targeted for the changing client population and new and emerging drugs of abuse. Thought leaders discussed several key trends related to this theme that they believe will impact the workforce over the next five years.

Thought leaders emphasized the importance of implementing and sustaining the use of EBPs in the field. They discussed the role EBPs play in reducing stigma, demonstrating treatment effectiveness, and justifying continued funding support. Thought leaders recognized that EBP implementation will be essential in the new healthcare environment. In order for the provision of SUD treatment services to be reimbursed, payers, such as Medicaid and private insurance, will require uniformity in the treatment of SUDs through EBPs. As one thought leader described, "[We need to] have a workforce that is doing the treatment that patients need based on what has been shown to be effective and somewhat standardized so that it can be replicated in organizations and coordination with the primary care providers … [there needs to be] some level of effective standardization based on evidence so that the work force can be trained and available in a more effective manner."

Additionally, thought leaders made special mention of one EBP in particular, medication-assisted treatment (MAT). Thought leaders emphasized that while MAT has been repeatedly shown to be successful in treating SUDs, there is still a hesitancy associated with using medications to treat addiction. They asserted that this prejudice against the use of MAT will need to be overcome before it will be widely adopted as it has been for different diseases in other healthcare fields. Discussing the future of MAT, one thought leader said, "I mean I know that there's lots of people in this field that are very unhappy about the 'medicalization' but it's gonna happen and it has to happen and then it will, you know, ten years from now, it will be a different story...look at the history of what happened in the mental health field when medications came in after I guess it was in the 50's [and] 60's and it was in the 70's that CMHC's [Community Mental Health Centers] were really being developed and moving along. Yes that's a field that got medicalization too…I mean it's very interesting … if you look at history; this is our first, first time … to get medicalized; because it's the first time that we have had medications that work. And there are more, so many more to come."

According to 76% of those interviewed, SUD treatment in the future will also be affected by the increased use of peer specialists in the field. Thought leaders recognized peer recovery specialists as an asset to the field. They highlighted the continued development of this group as an essential component of workforce development over the next five years, and they suggested that peer specialists should be incorporated into newly integrated treatment settings as a key component in delivering effective SUD treatment. One thought leader explained, "… we really need to take advantage and expand the whole concept of peer counselors and peer support. Another thing they are calling them is whole healthcare

counselors. So that's the other thing that we are trying to work on right now is to actually develop the curriculum that can be used that are certifiable at the state level and recognized at the Federal level by CMS [Center for Medicaid and Medicare Services]; so that we can bring in more peer counselors and then, what we have to do is we have to re-define the work teams, so that the peer counselors understand what their role is on the work team and then the existing professional staff understands what that role is."

Finally, thought leaders underscored that, in the future, in addition to ensuring EBPs are ubiquitously implemented and that care for SUDs is recovery-oriented, treatment should respond to the needs of a changing client population and emerging drugs of abuse. While thought leaders did not readily provide evidence of the changing client population in the relatively brief key informant interviews, other studies have shown that the needs of individuals with SUDs are indeed evolving. Longitudinal findings from the 2005 to 2009 Treatment Episode Data Set (TEDS) show increases in those entering treatment with mental health problems (26% to 29%), along with shifts in the primary drug of abuse (SAMHSA, 2005-2009). The use of crack and cocaine decreased (14% to 11.5%) and abuse of alcohol (40% to 42%) and opiates and synthetics increased (3.5% to 6%). Data from the National Survey on Drug Use and Health supports the TEDS data, demonstrating a decreased use of cocaine and a slight increase in alcohol, marijuana, OxyContin and pain relievers (SAMHSA, 2006-2010). More mental health problems associated with SUDs along with differences in the types of drugs abused reinforces the need, expressed by the thought leaders interviewed as part of the *Vital Signs* study, for direct care staff training related to dual diagnosis and new drugs of abuse (such as prescription pain medications).

THEME 4: WORKFORCE RECRUITMENT AND RETENTION EFFORTS

Another theme revealed through the thought leader interviews involved the composition of the workforce, with 76% of respondents discussing the changing demographics of the workforce. Key trends coming out of this theme largely relate to recruitment and retention efforts to build a workforce with the capacity to meet future service needs.

Many thought leaders pointed to the critical and rising need for practitioners to reflect the diversity of the client population in terms of characteristics such as age, ethnicity, and sexual orientation. They highlighted the need to recruit new, young professionals from a variety of backgrounds. One thought leader summed up this sentiment in this way, "We need to have people of various racial, and ethnic origins in the field. We also need diversity [in terms of] LGBT and other minorities providing treatment. You have to have all backgrounds in all levels within the treatment system. These groups are underrepresented." Thought leaders, however, also recognized that there are significant obstacles to attracting young, diverse professionals to the field. For example, they discussed that SUD treatment is often not considered a career path by college graduates since it is not often promoted as an option to this audience.

THEME 5: RECOGNITION OF SUBSTANCE USE DISORDERS AS A VALID HEALTHCARE ISSUE

During interviews, 70% of national thought leaders referenced the importance of recognizing substance use disorders as a valid healthcare issue. Thought leaders explained that in the past SUDs have regularly been considered by many groups to be the result of poor personal choices rather than a "true" health concern like diabetes or heart disease. They observed that this stigmatizing legacy persists today. Thought leaders emphasized that strategies are needed to reduce stigma in order for the larger society

to recognize the value of the substance abuse field to the overall health of the populace. As one national leader noted, "I would hope to see more acceptance of the work that those in addiction do as a core part of the health team as we continue…to chip away at some stigma issues, hopefully, specific references in legislation and regulation help and that has a trickledown effect so to speak, to those providing the care."

In conversations related to this theme, thought leaders commonly covered several topics. First, those interviewed repeatedly discussed the positive effects that treating an individual's SUD can have on his or her overall health. They argued that more emphasis needs to be placed on research surrounding addiction as a brain disease in order to facilitate the treatment of SUDs alongside other health problems. Moreover, thought leaders highlighted that healthcare professionals outside of the SUD field do not often know or understand the benefits that treating an individual's SUD can have on his or her ability to recover from other health issues. Summing up these interrelated ideas, one thought leader stated, "We need to stay as an independent specialty, but demonstrate our value-added. We need to effectively convince payers, colleagues, etc. that what addiction professionals do is important and has value. We need to show that here's what happens when patients have access to services; costs go down, in general. There are huge cost offsets on the healthcare side. If we are absent, providers will be marginalized. Therefore, this is a huge challenge. We need to rethink and reframe what we do."

Next, interviewees also regularly discussed that in the near future practitioners who have not necessarily been trained in SUD treatment will provide screening and brief interventions for SUDs in generalist settings. They expressed concern that these individuals may bring with them prejudices around treating "addicts" and the disease of addiction. Thought leaders made clear that the field needs to vigilantly monitor evidence of this potential challenge and to respond appropriately. In fact, many thought leaders felt a need for the current SUD treatment workforce to act as advocates for the field and those they serve across systems. They believe that the current workforce should proactively work to reduce stigma by educating the public, including other health professionals, about addiction, while emphasizing that substance use disorders are a valid healthcare issue and that addiction is a disease.

THEME 6: IMPLEMENTATION AND USE OF HEALTH INFORMATION TECHNOLOGY

Sixty-five percent of thought leaders stressed the importance of health information technology (HIT) to the future success of the SUD field. HIT involves the exchange of health information in an electronic environment. According to the Department of Health and Human Services (HHS), "Widespread use of health IT within the health care industry will improve the quality of health care, prevent medical errors, reduce health care costs, increase administrative efficiencies, decrease paperwork, and expand access to affordable health care" (HHS, 2012). Thought leaders emphasized the need for the SUD field to embrace HIT and support its implementation in order to be integrated into mainstream healthcare.

Findings from the thought leader interviews revealed that while there is an awareness of the importance of HIT to the development of the SUD workforce, there are also some major obstacles which may delay the full integration of HIT over the next five years. Thought leaders described specific barriers to HIT implementation, including fear of the unknown, a lack of technical knowledge and understanding, and a shortage of funding and infrastructure to support the implementation process. These insights are corroborated by the *Vital Signs* survey data (Section III) in that 42% of clinical directors reported that their facilities do not currently have an EHR system. Also, 80% of clinical directors in facilities without an EHR system stated that the primary reason for not having one is the amount of capital needed to purchase and implement this system. Other major concerns identified in the survey data related to the ongoing

cost of maintaining a system and the lack of adequate information technology staff to support a system. One thought leader described the obstacles to the SUD workforce establishing widespread use of HIT in this way: "I think there is going to be some training needs, because any time you're integrating a new technology into somebody's work, at a very basic level they have to learn how to use it… the Affordable Care Act would love to see the greater implementation of electronic health medical records but I think it's going to be a slow process in part because it's expensive to do and you know there will be some organizations that have the resources to really get going with that … I think it's going to take longer than people are anticipating."

| SECTION SUMMARY |

- Summary of the Projected Growth, Retraction and Composition of the Substance Use Disorder Workforce in the Next Five Years: While there is limited data to track the projected growth, retraction, and composition of the SUD workforce over the next five years, we can cautiously anticipate that, with the implementation of the Affordable Care Act in 2014, there will be a significant increase in the need for qualified counselors and other direct care staff who are able to work in a variety of healthcare settings. This demand for workers may be challenged by an aging workforce as well as a lack of qualified applicants to fill open positions. Furthermore, the demographic characteristics of the current workforce have implications in relation to recruiting diverse, young, qualified direct care staff that are able to work in integrated settings.

- Summary of the Mega-trends that will Impact the Workforce in the Next Five Years: Study interviews conducted with national thoughts leaders led to the identification of six mega-trends that will impact the SUD treatment workforce in the future.

    1. Macro Level Changes to Healthcare and Treatment Delivery: The number of SUD counselors is expected to increase; however, this increase will not be sufficient to cope with the increase in treatment population due to the ACA and MHPAEA. Also, with the introduction of HCR, the delivery of SUD treatment will likely happen in a managed care environment. Additionally, SUD treatment services will likely integrate with other forms of healthcare. The importance of specialty care SUD treatment facilities will remain, but in order to survive specialty treatment facilities will have to connect with mainstream healthcare.

    2. Enhanced Pre-Service Training, Professional Development, and Uniform Credentialing: The workforce will need training in areas such as measurement and data analysis, health behavior models, options for treatment, HIT, specific treatment modalities, and treatment plan development. While the workforce has become increasingly professionalized, there is a need for more uniform licensing and credentialing. As other healthcare professionals begin providing SUD treatment in generalist settings, they will need specific training and education in SUD treatment.

    3. Increased Use of Evidence-Based and Recovery-Oriented Methods of SUD Treatment: SUD treatment in the future will focus on increased use of evidence-based and recovery-oriented methods of treatment. The hesitancy that is associated with using MAT will have to be overcome and MAT should be widely adopted as it has been for diseases in other fields. Peer specialists will need continued development and are an essential component of successful SUD treatment.

4. Workforce Recruitment and Retention Efforts: There will be a rising need for practitioners to reflect the diversity of the client population in terms of characteristics such as age, ethnicity, and sexual orientation. This will necessitate the recruitment of new, young professionals from a variety of backgrounds.

5. Recognition of Substance Use Disorders as a Valid Healthcare Issue: Strategies will be needed to reduce stigma in order for the larger society to recognize the value of the SUD field to the overall health of the populace. More emphasis will need to be focused on research surrounding addiction as a brain disease in order to facilitate the treatment of SUDs alongside other health problems.

6. Implementation and Use of Health Information Technology: The SUD treatment field will need to embrace HIT and support its implementation in order to be integrated into mainstream healthcare.

SECTION VI: CONCLUSIONS & RECOMMENDATIONS

The ATTC Network, at the direction of SAMHSA, designed, developed and implemented a national study of the SUD treatment workforce in the 2007-2012 grant cycle. This study, *Vital Signs*: *Taking the Pulse of the Addiction Treatment Workforce*, utilized a mixed-methods approach to answer three primary questions: (1) What are the basic demographics of the workforce?; (2) What are common methodologies used to prepare, retain and maintain the workforce?; and (3) What are the anticipated workforce development needs in the next five years? This report described the findings of the national data collected as part of the study. Fourteen separate regional reports were also prepared and submitted to SAMHSA by the 2002-2012 ATTC Regional Centers.

What are the basic demographics of the workforce?

The ATTC *Vital Signs* study contributes to the understanding of the characteristics of the SUD treatment workforce on a national level. First, previous studies have shown that the SUD treatment workforce is older, white, and predominantly female. Data from an environmental scan conducted by Kaplan (2003) describes the SUD workforce as being 45-50 years old, 70-90% non-Hispanic whites, and over 50% female. A Center for Substance Abuse Treatment study (Mulvey, Hubbard, & Hayashi, 2003) surveyed 3,267 Single State Agency (SSA) Directors, facility directors, clinical supervisors, and program counselors and found that most of the SUD workforce is white (85%), 40-55 years old (60%), and slightly more are female (50.5%). More recently, Knight et al. (2011) found in a study of 353 clinical staff at 63 outpatient SUD treatment facilities that the majority of staff were female (60%), white (76%), and had a mean age of 48 years. (Knight, Landrum, Becan, & Flynn, 2011). The *Vital Signs* study found similar demographic patterns in a nationally representative sample of clinical directors and the direct care staff they supervise. According to *Vital Signs* study findings, the workforce is primarily white (86% clinical directors, 64% direct care), female (59% clinical directors, 67% direct care) and middle-aged (60% are 50+).

RECOMMENDATION

- Recruit professional or pre-professional individuals in their 20s and 30s from diverse backgrounds to the workforce.

Next, although past studies agree that most SUD programs do not have full-time staff with medical degrees or other advanced graduate degrees, there has been significant variation in the reported education levels of the workforce. Previous research indicated that 60 to 80% of direct-service staff members have at least a bachelor's degree, and almost 50% have a master's degree. Multiple studies support that approximately 80% of the workforce hold a bachelor's degree (Johnson et al., 2002; Knudsen et al., 2003; Mulvey et al., 2003; RMC 2003a). In contrast, the Northwest Frontier ATTC reported in a regional workforce studies that only 60% of staff members have bachelor's degrees (Gallon et al., 2003; RMC 2003a). In terms of graduate degrees, Harwood (2002) reported that 53% of direct service staff members hold master's degrees, Gallon et al. (2003) found 57% of directors have graduate degrees, and Mulvey et al. (2003) found that 49% of staff possessed master's degrees and 7.4% held doctoral degrees. Moreover, SAMHSA (Kaplan, 2003) has shown that 17% of full-time staff, 17% of part-time staff, and 32% of contracted staff have graduate degrees. More recently, Rothrauff et al. (2010) found that 51% of counseling staff in private SUD treatment facilities held a master's degree or higher and 63% were certified substance abuse counselors (Rothrauff, Abraham, Bride, & Roman, 2011). Findings from the *Vital Signs* study provide a clearer picture of the educational level of the workforce at the national.

Clinical directors reported that 60% of the staff members providing direct care services at their facility have Bachelor's or Master's degrees. Also, the majority of direct care staff members are either currently licensed/certified (54%) or pursuing licensure/certification (18%).

RECOMMENDATION

- SUD treatment practitioners should continue to earn degrees in higher education, especially graduate degrees. They should also continue to earn professional credentials. However, practitioners should keep aware of the types of degrees and credentials that will be recognized by payers once the ACA takes full effect.

In presenting the professional background of the SUD treatment workforce, it is also important to look at years of experience in the field. Previous studies have demonstrated that SUD treatment professionals have limited experience in their current work settings. For example, Harwood (2002) noted that 70% of SUD professionals had worked with their current employer for 5 years or less. Mulvey et al. (2003) found that 62% of SUD treatment professionals had worked in the field for more than 10 years, but that 51% had worked in their current position for less than 5 years. Meanwhile, McLellan, Carise, & Kleber (2003) found that 54% of treatment program directors had been in their position for less than 1 year. The *Vital Signs* study collected information on years of experience for both clinical directors and direct care staff, and, in contrast to previous studies, found that the majority of clinical directors are long-term employees of their current work setting. Clinical directors have an average of 17 years of experience in the field with 11 of those years at their current employer and 7 of those years in their current position. Direct care staff members, however, have less stability in their positions, with 54% having worked with their employers for five years or less.

RECOMMENDATIONS

- Although clinical directors seem to be relatively stable in their positions, there remains instability among direct care staff members. Facilities should consider increasing efforts to retain direct care staff. Retention strategy recommendations are discussed later in this section under the second primary study question.

- Since 60% of clinical directors are over age 50, focused efforts to develop individuals who can replace existing clinical directors in their leadership positions should be a priority for the SUD treatment field.

As part of describing the workforce, the *Vital Signs* study collected information about the functional role of clinical directors. In Technical Assistance Publication (TAP) 21A, SAMHSA acknowledges that implementing clinical supervision in line with the guidelines they provide will likely lead to "an improvement-oriented approach to the monitoring and development of clinical services that likely will lead to improved staff retention, enhanced counselor skills, and better clinical outcomes" (CSAT, 2007). However, little is known as to how clinical supervision is carried out on a national level and if treatment facilities are using the competencies of TAP 21A. Previous ATTC regional workforce studies collected information on the daily activities carried out by the SUD treatment workforce. These studies

demonstrated that while program directors focus primarily on administrative work, clinicians and treatment staff spend most of their time with clients (Gallon et al., 2006; Murdock et al., 2005). According to past studies, although most of clinicians' time is spent with clients, a significant amount is also spent on other non-direct care activities. For example, the Mid-America ATTC found that treatment staff in Missouri spent nearly 16% of their time on documentation (Wendler & Murdock, 2004). Also, SAMHSA has reported that direct service treatment staff spend over one fifth of their time, or approximately one working day per week, doing paperwork (Kaplan, 2003). The *Vital Signs* study brings to light how clinical directors, in particular, spend their time at work. Findings from the *Vital Signs* study indicate that most clinical directors conduct clinical supervision on a weekly basis (73%) in both individual and group clinical supervision sessions (84%) by either reviewing charts/progress notes (88%) or observing staff live (72%). Clinical directors reported that other observation methods, such as role play (28%), videotape review (7%), and audiotape review (6%), are much less commonly used.

RECOMMENDATIONS

- While clinical directors report providing regular clinical supervision, they should consider integrating observation methods such as role play and tape review into their work.
- The ATTC Network should consider integrating information about ways to implement underutilized clinical supervision techniques into existing training programs.

Finally, given the focus on HIT as a key component of healthcare reform, the *Vital Signs* study was interested in describing the technological competency of the workforce, including their access to technology and the degree to which EHRs have been implemented by specialty SUD treatment facilities. Previous ATTC regional workforce reports have shown that access to and proficiency with web-based technologies among providers varied. For example, in a report prepared by the Mid America ATTC for the state of Arkansas in 2004, low numbers of treatment staff reported having access to the internet (47.6%) and e-mail (54.5%) in the workplace (Wendler & Murdock, 2004). In contrast, a report from 2006 prepared by the Northwest Frontier ATTC showed that technology use was high: 97% of treatment staff had access to a computer in the workplace and 81% reported access to the internet during the workday. Furthermore, in the Northwest Frontier study, 64% of clinicians reported being interested in web-based professional education (Knudsen, Gallon, & Gabriel, 2006). Results of the *Vital Signs* study provide information about the technological competency of the workforce in 2012. According to survey respondents, 40% of clinical directors do not consider themselves proficient in computers and web based technologies. Additionally, while access to technology was generally high, almost half (42%) of all respondents reported that their facility has not implemented an EHR system.

RECOMMENDATIONS

- The basic technological competency of the current workforce needs to be enhanced. Educational opportunities related to building the computer and web-based technology skills of SUD treatment practitioners should be made available to facilities at low or no cost. The ATTC Network should consider developing and implementing such training programs.

- SUD treatment facilities need to implement EHR systems. Federal and state policymakers should consider policies and programs that will support facilities in EHR implementation efforts.

- Pre-service educational programs for SUD treatment practitioners should include training on computer and web-based technology skills, including the use of EHR systems. Academic units specializing in addiction studies should look to other healthcare fields, such as nursing, for guidance on how to incorporate teaching students about EHR systems into existing educational programs.

What are the common strategies and methodologies to prepare, retain, and maintain the workforce?

The *Vital Signs* study reveals the common strategies and methodologies SUD treatment facilities use to recruit, prepare, retain, and maintain the workforce. First, *Vital Signs* survey findings confirm that facilities across the nation continue to struggle to recruit qualified professionals. Respondents reported that those difficulties are generally due to a lack of funding (43%) and an insufficient number of qualified applicants (63%). Moreover, although inadequate salaries have long been cited as barriers to recruitment and retention in the SUD treatment workforce, only about half (46%) of *Vital Signs* respondents reported being satisfied with their income. Additionally, the majority of respondents (87%) did not strongly agree that their facility has made a concerted effort to recruit individuals from minority backgrounds in the past year.

Recruitment challenges are not new to the SUD treatment field (Kaplan, 2003; Annapolis Coalition on the Behavioral Health Workforce, 2007; RMC, 2003a). For example, inadequate compensation and stigma have been shown to be significant obstacles to recruitment (Kaplan, 2003; OASAS, 2002; RMC, 2003a). Moreover, since addiction is a complex, chronic disease often requiring treatment utilizing a variety of evidence-based strategies, professionals who enter the field must meet minimum job requirements, including a certain degree of education/training and field experience. Previous studies have shown that SUD treatment facilities have difficulty recruiting employees with the requisite knowledge and skills (RMC, 2003a).

According to *Vital Signs* respondents, the most common strategy SUD treatment facilities currently use to recruit new staff is web-based classified and job boards. Additionally, some clinical directors reported that their facilities successfully attract new staff through relationships, especially with colleges and universities. SAMHSA, provider and professional associations, and other stakeholders have also put forth potential recruitment strategies. For example, in the 2006 *Strengthening Professional Identities* report, SAMHSA outlined four key recruitment priorities: expand recruitment for addictions medicine; improve recruitment in educational institutions, particularly for under-represented groups; employ marketing strategies to recruit staff; and reduce the stigma of the field (SAMHSA, 2006). Other reports on the workforce have suggested that expanding peer recovery support services may be a successful strategy for filling open positions (Annapolis Coalition on the Behavioral Health Workforce, 2007) as a significant number of individuals currently working in the field got their start due to their own paths to recovery. Furthermore, to offset inadequate compensation, stakeholders have proposed loan forgiveness, tuition assistance, salary and compensation research, and career advancement options as needed recruitment strategies (Annapolis Coalition on the Behavioral Health Workforce, 2007; SAMHSA 2006).

RECOMMENDATIONS

- SUD treatment facilities should consider establishing relationships with colleges and universities in order to recruit new staff members. The ATTC Network should consider assisting facilities in establishing those linkages.
- Federal and state policymakers and other stakeholder groups should support programs that promote the SUD treatment field as a career choice for young graduates.
- As healthcare reform will result in new payers reimbursing for SUD treatment services, advocates should consider mounting a concerted effort to ensure that SUD treatment practitioners are reimbursed on an equal level with other healthcare professionals.
- SUD treatment facilities should continue to draw from the recovery community in their recruitment efforts, especially with an increased emphasis on recovery-oriented care.

Training and development is also a key workforce concern across the SUD treatment field. In fact, findings from the *Vital Signs* study show that inadequate training may be a primary workforce recruitment challenge. Clinical directors reported that a key reason that SUD treatment facilities have difficulty filling open positions is that applicants are not qualified due to limited experience in the field of SUD treatment (50%) and insufficient or inadequate training and education (49%). Such deficiencies are pertinent because SUD treatment staff members need ongoing and continuing pre-service and in-service training in order to provide SUD treatment in a knowledgeable and comprehensive manner (Kaplan, 2003).

The treatment field appears to support and encourage continuous education when possible. For example, a study of early career SUD counselors found that the majority (84%) not only pursue ongoing education and training through universities and college courses, but also through internal trainings at their place of employment. This study also found that SUD treatment facilities provided support for ongoing education of treatment staff. The majority of respondents (84%) claimed that the facilities at which they worked allotted paid time off to attend conferences or participate in trainings and paid educational costs (66%) (NAADAC, 2003). While workforce development is not SAMHSA's primary role, it is integrated throughout the Eight Strategic Initiatives in *Leading Change: A Plan for SAMHSA's Roles and Actions, 2011-2014* (SAMHSA, 2011). For example, in SAMHSA's first initiative, Prevention of Substance Abuse and Mental Illness, one of the action steps is to "enhance workforce capacity to deliver specialized prevention services."

While its benefits are evident, *Vital Signs* respondents reported a number of barriers to providing ongoing training and education for staff members. Respondents listed insufficient funds (35%), the time training takes away from program services (30%), and a lack of training opportunities in the locality (23%) as the primary reasons. Additionally, clinical directors identified that their staff needed training in identifying and using EBPs (61%), improving behavioral management of clients (61%), and increasing program participation by clients (59%).

Vital Signs respondents did, however, also identify strategies to overcome training barriers. The most common strategies for training staff involved the provision of new staff orientation, direct supervision, and regular training opportunities. In addition, some clinical directors described other cost effective training

strategies. These included online and remote learning opportunities, as well as sending a small number of staff to be trained by outside educators so that when those staff members return they can teach the training topic to the rest of the organization.

RECOMMENDATIONS

- Federal and state policy makers should continue to support programs, such as the ATTC Network, that provide low or no cost training opportunities, including online training.
- SUD treatment facilities should send qualified staff to "training of trainers" events, such as those often offered through the ATTC Network, so that they can develop internal capacity to provide training.
- SUD treatment practitioners should become familiar with online learning, including how to navigate e-learning software and how to get the most out of web-based courses.
- SUD treatment facilities should provide regular, ongoing support for clinical supervision.
- SUD treatment facilities should adopt a collaborative learning culture and support staff members in their ongoing education, providing financial support if possible.

Once a facility recruits and develops employees, retaining them is important to the success of the organization. Studies on turnover rates at SUD treatment facilities have ranged widely from 13.2% to 72% (SAMHSA, 2006; Annapolis Coalition on the Behavioral Health Workforce, 2007; SAMHSA, 2003). The most commonly reported turnover rates range from 18.5% to 25% (Knudsen, Johnson & Roman, 2003; Gallon, Gabriel & Knudsen, 2003). These rates are high compared to those across other professions, which average about 11% (Knudsen, Johnson & Roman, 2003). In a number of studies, low salaries have repeatedly been cited as the major cause of staff turnover and the biggest issue in staff recruitment and retention (RMC 2003a; RMC 2003b; Gallon, Gabriel & Knudsen, 2003; NAADAC 2003; Knudsen, Johnson & Roman, 2003). In focus groups conducted throughout New York State, salary was identified by the eleven workforce development focus groups as the single most important issue for staff recruitment and retention (OASAS, 2002). Indeed, salary and benefits for SUD treatment workers are lower than mental health and nursing (U.S. Department of Labor, 2000). Salary level is not, however, the only barrier to retaining employees. Other retention challenges identified in past studies have included the amount of documentation and paperwork, long hours, and large caseloads (McLellan, Carise & Kleber, 2003; OASAS 2002; RMC 2003a; RMC, 2003b).

In the *Vital Signs* study, clinical directors reported a national staff turnover rate for treatment facilities of 18.5%. Clinical directors reported that the main challenges to retaining qualified staff were a lack of paid educational assistance, no retirement plans, inadequate compensation, and difficulties staff members face in balancing career and family. Furthermore, clinical directors suggested that facilities struggle implementing possible retention strategies such as providing for salary increases, reducing the paperwork burden, and offering promotion opportunities.

Despite the significant difficulties described by *Vital Signs* respondents in this area, clinical directors were able to identify several potential strategies to improve retention rates. Clinical directors reported that the creation of a team-oriented, democratic approach to daily facility operations can enhance retention. Also, benefits such as paid vacation time, paid sick time, and group health insurance are widely available and attractive to permanent employees. Furthermore, clinical directors suggested that staff recognition, the use of technology, and the creation of a positive, collegial work environment can also help with retention. Finally, some of the same recommendations offered for training staff members can also be applied to retaining staff. For example, providing ongoing supervision and training is an effective retention strategy as it allows staff members to grow within their positions and achieve greater job satisfaction.

RECOMMENDATIONS

- Leadership training, including how to develop and lead positive teams, should be made available to executive and clinical directors of SUD treatment facilities. Federal policymakers should consider supporting leadership programs, such as the Partners for Recovery/ATTC Network Leadership Institute and Advanced Leadership Institute, to fulfill this need.
- Management training, including how to provide constructive feedback and how to establish a positive work environment, should be made available for administrators and managers of SUD treatment facilities. The ATTC Network should consider helping facilities to locate such training at low or no cost.
- Corporations have experience innovating to help staff members manage a balance between their work and life responsibilities. Such programs as flexible work hours, onsite daycare, and free or low cost exercise programs are becoming more and more common in business. SUD treatment facility directors should investigate strategies that have been shown to help employees achieve a healthy work/life balance and should consider implementing such benefits as appropriate in their organizations.

What are the anticipated workforce development needs in the next five years?

As part of the *Vital Signs* study, the ATTC Network has identified the anticipated development needs of the SUD treatment workforce in the next five years. Through analysis of existing data sets, the ATTC Network found that the US will require a significant increase in the number of professionals who are able to effectively treat SUDs in integrated healthcare environments. Moreover, interviews with national thought leaders revealed six mega-trends that are likely to impact the SUD treatment field in the next five years. First, recent policy changes, such as the Affordable Care Act, will significantly impact the field by hastening the integration of SUD services with other healthcare services and changing the payment structure for SUD services to a manage care model. Second, as the substance use disorder workforce professionalizes, there will be an ongoing push toward more uniform credentialing of counselors. SUD education and counseling will need to be grounded in evidence-based practice and should account for the increasing complexities of SUDs in relation to co-occurring substance use, mental health, and physical disorders and emerging drugs of abuse. Next, SUD treatment in the future will increasingly incorporate evidence-based and recovery-oriented methods of treatment, including the use of medication-assisted treatment and peer specialists. Furthermore, TEDS data shows that the current treatment population is

predominantly male, young, and diverse (SAMHSA, 2005-2009). As repeatedly suggested throughout this report, the SUD treatment field will need to better reflect the treatment population by recruiting and retaining young, diverse, males to the profession. One way to enhance recruitment efforts is by targeting stigma associated with SUDs. Accordingly, another mega-trend impacting the field in the future will be the enhanced awareness that SUDs are valid healthcare issues. This improved understanding will be particularly important as healthcare services become more integrated and individuals with SUDs receive care from professionals who may not necessarily have specific training in addiction. Finally, while the field is generally aware of the importance of HIT to the development of the SUD workforce, there are major barriers related to costs and technology expertise which may delay the full integration of HIT in SUD treatment facilities over the next five years. These gaps will need to be addressed to ensure that SUD treatment facilities can fully participate in newly developed healthcare infrastructure.

RECOMMENDATIONS

Recommendations, especially those related to recruitment and retention efforts, already listed previously in this report also apply to this primary study question. In addition, the ATTC Network recommends:

- Policymakers and other stakeholders, including SAMHSA programs like the ATTC Network, should continue to work to educate SUD treatment facilities about the impact HCR will have on the way they do business. These activities should include efforts to build relationships between specialty SUD treatment facilities and primary care organizations, such as FQHCs. Also, SUD treatment providers should consider gaining an understanding of the culture of primary care and how best to work in integrated healthcare environments. The ATTC Network should consider developing training programs to address this consideration with SUD practitioners.

- SUD treatment facilities need to better understand EBP implementation models. Training alone is never enough. Facilities need to support the breadth and depth of changes that need to occur to ensure successful EBP implementation efforts. Funders, too, need to better understand how costly and how much time is needed to fully implement EBPs with fidelity. The ATTC Network should continue to help facilities, policymakers, and other stakeholders better understand the implementation process. The ATTC Network should also continue to facilitate EBP implementation in SUD treatment facilities and other healthcare settings.

- The SUD treatment field should continue to develop a shared understanding of the components of a recovery-oriented system of care. Localities should consider identifying facilitators, such as the ATTC Network, that can help guide their systems toward a recovery orientation. Stakeholders at all levels need to maintain an unwavering commitment to recovery-oriented care.

- Members of the SUD treatment workforce should become strong advocates for the recognition of SUDs as a valid healthcare issue. The health of the nation will depend on a greater understanding of the ways in which SUDs complicate, if not cause, other health issues such as heart disease. The roll out of the ACA offers a unique opportunity for

screening and treatment for SUDs to become a regular part of healthcare. Everyone who cares deeply about this issue, including the workforce, recovery community, and friends and families of those struggling with addiction, should work to address this challenge.

- SUD treatment facilities must adopt and implement EHR systems in order to survive. Current and future SUD treatment practitioners need to have the skills to operate EHR systems in order to continue working in healthcare. Federal and state policymakers should consider supporting programs that assist SUD treatment facilities to utilize HIT. The ATTC Network should develop educational programs to assist the workforce in learning HIT.

Vital Signs: Taking the Pulse of the Addiction Treatment Profession was a collaborative effort of the 2007-2012 ATTC Network to provide an overview of the characteristics and workforce development needs of the SUD treatment field. In this report, the ATTC Network has provided a unique picture of the state the SUD treatment field on the national level in a variety of topics. Moreover, the ATTC Network has tapped into the considerable experience and expertise of clinical directors and thought leaders across the country to illustrate the challenges that lie ahead for the field and the ways the workforce will change to overcome those difficulties and remain viable in the future. Finally, a summary of the workforce needs of the next five years would feel incomplete without suggestions for meeting those needs in the future. In the last section of this report, the ATTC Network contextualizes *Vital Signs* data and recommends action steps to move the workforce forward so that quality care of SUDs can be assured for all Americans.

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ATTACHMENTS

Attachment 1: Vital Signs Survey Instrument

Attachment 2: Data Collection Protocols

Attachment 3: Key Informant Telephone Interview Questionnaire

Attachment 4: List of Secondary Data Sets

Attachment 5: Workforce Study Development Timeline

Attachment 6: Map of ATTC Network Regional Centers

Attachment 7: Survey Data

Attachment 8: Clinical Directors Interview Analysis

Attachment 9: Thought Leaders Interview Analysis

ATTACHMENT 1:
VITAL SIGNS SURVEY INSTRUMENT

ATTC

Addiction Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

VITAL SIGNS

taking the PULSE of the Addiction Treatment Profession

WORKFORCE SURVEY 2012

OMB Number: 0903-0328

Expiration date: 09-30-2014

CONTACT INFORMATION

We are going to ask you for the contact information for your facility so we have a record of participating facilities. The contact information of your facility will be kept separately from any data collected. All data will be aggregated at the regional level and/or state level (if a sufficient number of facilities in one state are collected to prevent any facility from being identified).

1.) Your Name _____

2.) Name of Program _____

3.) Facility _____

4.) Address _____

5.) Address 2 _____

6.) City _____

7.) State _____

8.) Zip Code _____

9.) Email Address _____

10.) Phone Number _____

Please indicate the region for your facility (states are written in parentheses):

____ New England (ME, NH , VT, MA, CT, RI)
____ Northeast (NY, PA)
____ Central East (DC, DE , MD, NJ)
____ Mid-Atlantic (VA, KY, TN, WV)
____ Southeast (GA, SC, NC)
____ Southern Coast (AL, FL, MS)
____ Gulf Coast (TX, LA, NM)
____ Caribbean/Hispanic (PR, VI)
____ Mid-America (NE, MO, KS, OK, AR)
____ Prairielands (IA, ND, SD, MN, WI)
____ Great Lakes (IL, OH, IN, MI)
____ Mountain West (NV, MT, WY, UT, CO, ID)
____ Northwest Frontier (AK, WA, OR, HI, Pac. Isl.)
____ Pacific Southwest (CA, AZ)

DEMOGRAPHICS & PROFESSIONAL BACKGROUND

1.) Gender: _____ Female _____ Male

2.) Year of your birth: 19_____

3.) Are you Hispanic or Latino? _____ Yes _____ No

4.) Race: *(Select one or more)*

____ American Indian/ Alaska Native
____ Asian
____ Native Hawaiian/Other Pacific Islander
____ Black or African American
____ White

5.) Military affiliation? *(Please check only one)*

____ No Affiliation
____ Reserve/National Guard
____ Active Duty
____ Veteran/Retired Military

6.) Highest degree status: *(Please check only one)*

____ No high school diploma or equivalent
____ High school diploma or equivalent
____ Some college, but no degree
____ Associate's degree
____ Bachelor's degree
____ Master's degree
____ Doctoral degree or equivalent
____ Doctor of medicine
____ Other *(Please specify)*_____

7.) Would you describe yourself as a person in recovery?

____ Yes

____ No

____ I prefer not to disclose this information

8.) Please indicate below the areas of practice for which you are licensed or certified within the state in which you work:

Yes	No	
____	____	Substance Abuse Counseling
____	____	Marriage & Family Therapy
____	____	Social Work/Clinical Social Work
____	____	School Psychology/Educational Psychology
____	____	General Counseling
____	____	Other (*Please specify)* _____

9.) Licensed or certified as a Clinical Supervisor?

____ No *(Please specify reason)* _____

(Please Go to question 10b)

____ Yes *(Please go to question 10)*

10.) Please indicate State and/or National Clinical Supervision certification/licensure

____ STATE certification/licensure

OR

____ NATIONAL certification/licensure

OR

____ NATIONAL and STATE certification/licensure

10b.) Please indicate whether Clinical Supervisor certification or licensure is available in your state.

____ Yes

____ No

11.) Currently registered in a formal program of study resulting in a certificate or academic degree:

____ Yes *(Please specify)* _____

____ No

12.) Years of experience: *(If less than one year, please record as one)*

Number of years

12a.) In the social services field, other than in substance abuse treatment? _____

12b.) In the substance abuse treatment field? _____

12c.) At your current employer/agency? _____

12d.) In your current position? _____

13.) What is your official job title? _____

14.) Is substance abuse treatment a second career for you? _____Yes _____ No

14a.) If yes, please specify your previous career: _____

15.) Is your current place of employment the only substance abuse treatment agency for which you have worked?

____ Yes

____ No

16.) Within the next 12 months, how likely is it you will?
(Please mark one response for each of the following items)

	Not at All Likely	Not Likely	Not Sure	Likely	Extremely Likely
16a.) Change job but stay at current agency	1	2	3	4	5
16b.) Change employer but stay in field	1	2	3	4	5
16c.) Leave substance abuse treatment field	1	2	3	4	5
16d.) Continue working for current employer	1	2	3	4	5

YOUR WORK

17.) Employment status – Are you considered a:

____ Full-Time ____ Part-time or ____ Contract employee?

18.) What is the annual salary for your current position?
(Please check only one of the categories below)

____ Less than $15,000 per year (less than $1,250 per month)

____ $15,000 to $24,999 per year ($1,250 to $2,083 per month)

____ $25,000 to $34,999 per year ($2,084 to $2,916 per month)

____ $35,000 to $44,999 per year ($2,917 to $3,479 per month)

____ $45,000 to $54,999 per year ($3,750 to $4,583 per month)

____ $55,000 to $64,999 per year ($4,584 to $5,415 per month)

____ $65,000 to $74,999 per year ($5,416 to $6,250 per month)

____ $75,000 per year or higher ($6,251 per month or higher)

____ I prefer not to disclose this information.

19.) At this point in my career, I am making *(please fill in the blank)*:

____ much less than expected

____ less than expected

____ about what expected

____ more than expected

____ much more than expected

20.) What percentage of time do you spend in a typical week on the following activities? *(Numbers must add up to 100 percent)*

____ % Screening and assessments

____ % Direct client therapeutic engagement

____ % Clinical Supervision

____ % Administrative activities

____ % Other activities *(Please specify)* _____

100% Total

21.) How proficient are you in computers and web-based technologies for professional development?

Not at All Proficient	Not Proficient	Somewhat Proficient	Proficient	Extremely Proficient
1	2	3	4	5

CLINICAL SUPERVISION

22.) In what setting do you provide clinical supervision?

____ In individual clinical supervision sessions only

____ In group clinical supervision sessions only

____ In both individual and group clinical supervision sessions

23.) How frequently do you provide clinical supervision?

____ Only when there is a problem

____ Twice a year

____ Every two months

____ Once a month

_____ Twice a month

_____ Weekly

24.) What observation methods do you use for conducting clinical supervision? *(check all that apply)*

____ Videotape Review

____ Audiotape Review

____ Live Observation

____ Chart Review/Review of Progress Notes

____ Roll play

____ Other *(Please specify)* _____

25.) In a typical clinical supervision session, approximately what percentage of time do you spend on each of the following? *(Numbers must add up to 100%)*

____ % Counselor case presentation

____ % Reviewing treatment/discharge plans

____ % Discussing counselor problems/challenges

____ % Giving feedback on observed performance

____ % Training/teaching specific counseling skills

____ % Other _____

100% Total

DIRECT CARE STAFF

Questions in this section are about the direct care staff you supervise. For the purposes of this survey, "direct care staff" are those staff members who spend a majority of their time providing clinical care for clients with substance use disorders as their primary diagnosis.

26.) Number of direct care staff you supervise? _____

26.b) How many are:

____ Full-time staff

____ Part-time staff

____ On call or PRN (as needed) staff

27.) Number of direct care staff members who are:

____ Female ____ Male

28.) Number of direct care staff members who are of the following age ranges?

____ 18-24

____ 25-34

____ 35-44

____ 45-54

____ 55-64

____ 65+

____ Unknown

29.) Number of direct care staff who are of Hispanic or Latino/a background: _____

30.) Number of direct care staff who are of the following races/ethnicities:
(Please count all staff who represent each category. This may mean counting certain staff twice if they represent more than one ethnic group. If you are unsure of a certain person's race please tick "Missing")

____ American Indian

____ Alaska Native

____ Asian American

____ Native Hawaiian/Other Pacific Islander

____ Black or African American

____ White

____ Missing

31.) Number of direct care staff with one of the following military affiliations:
(Please only count each staff person once)

____ No Affiliation

____ Reserve/National Guard

____ Active Duty

____ Veteran/Retired Military

____ Do not know

32.) Number of direct care staff that you are aware are in recovery from a substance use disorder

____

33.) Number of direct care staff with the following certification and/or licensure status in the substance abuse treatment field:

____ Never certified/licensed

____ Previously certified/licensed, but not currently

____ Pursuing certification/licensure

____ Certification/licensure pending

____ Currently certified/licensed

____ Awaiting reciprocity

____ Unknown

34.) The choices in this question relate to the highest level of education achieved. Please indicate the number of direct care staff who fall into each category.
(Please count each staff member once)

____ No high school diploma or equivalent

____ High school diploma or equivalent

____ Some college, but no degree

____ Associate's degree

____ Bachelor's degree

____ Master's degree

____ Doctoral degree or equivalent

____ Doctor of medicine

____ Unknown

____ Other *(Please specify)* _____

35.) Number of direct care staff who have worked at your facility for each period of time.
(Please only count each staff person once)

	Number of staff
Less than 1 year	_____
1-5 years	_____
5-10 years	_____
10-15 years	_____
15-20 years	_____
20+ years	_____
Unknown	_____

YOUR TREATMENT FACILITY

Questions in this section should be completed only for the treatment facility or program at the location indicated on the front cover of this questionnaire.

For the purposes of this survey, "this facility" means the specific treatment facility or program whose name and location are printed on the front cover.

36.) Number of staff in your agency with the following roles:
(Please only count each staff person once based on their main function)

____ Clinical Supervisor

____ Other Supervisor

____ Certified Counselor

____ Non-certified Counselor

____ Case Manager

____ Counselor Aide/Technician

____ Social Worker

____ Nurse

____ Recovery/peer support specialist

____ Other (Please specify) _____

37.) Over the past six months, what is the average client caseload carried by individuals in each of the following staff categories? *(Please place a check mark in the appropriate column for each staff category)*

Staff Category	Average Caseload				
	0 CLIENTS	1-10 CLIENTS	10-20 CLIENTS	20-30 CLIENTS	30+ CLIENTS
Program Director					
Clinical Supervisor					
Certified/licensed counselor					
Non-Certified counselor					
Case manager					
Counselor Aide/technician					
Social worker					
Nurse					
Recovery/peer support specialist					

38.) Do you consider the caseload carried by direct care staff at your program to be:

_____ Too Small _____ About Right _____ Too Large _____ Don't know

39.) Total number of individuals in your facility who provide clinical supervision as part of their job function? _____

40.) Is your treatment facility able to bill for clinical supervision?

____ Yes

____ No

RECRUITMENT, RETENTION & STAFF DEVELOPMENT

For the purposes of this survey, "direct care staff" are those staff members who spend a majority of their time providing clinical care for clients with substance use disorders as their primary diagnosis.

41.) Please answer the following based on your facility's full time positions over the past 12 months:

How many direct care staff are needed in order to be fully staffed at this program or facility?

____

How many direct care staff were hired for this program or facility? ____

How many direct care staff left (terminated, resigned, laid-off) from this program or facility? ____

On the date that you are completing this survey, how many direct care staff are employed for this program or facility? ____

42.) Does your facility have any difficulties filling open positions for direct care staff?

____ Yes ____ No

If yes, why? *(Please check all that apply.)*

____ Insufficient number of applicants who meet minimum qualifications

____ Insufficient funding for open positions

____ Small applicant pool due to geographic area surrounding work setting

____ Lack of interest in position (nature of work, stigma)

____ Lack of interest in position (salary)

____ Lack of interest in location of facility

____ Reputation of the facility

____ Lack of opportunity for advancement

____ Don't know

____ Other *(Please specify)* _____

43.) If applicants do not meet the minimum qualifications, what are some of the reasons? *(Please check all that apply.)*

____ Little or no experience in substance abuse treatment

____ Insufficient or inadequate training and education

____ Lack of social or interpersonal skills

____ Lack of practical applied skills

____ Lack of appropriate certification

____ Don't know

____ Other *(Please specify)* _____

____ Not applicable, generally applicants are qualified

44.) Please indicate the degree to which you agree or disagree with the following statements about your facility's recruitment strategies:

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
My facility has formalized relationships with community colleges and/or universities which provide internship and/or practica placements for students at this facility.	1	2	3	4	5
My facility has made a concerted effort to recruit individuals from under-represented groups (including minorities, LGBTQ, etc.) in the past year.	1	2	3	4	5
My facility's efforts to recruit individuals from under-represented groups in the past year have been effective.	1	2	3	4	5
My facility has designated positions for peer-recovery specialists and/or other positions specifically for persons in recovery.	1	2	3	4	5
My facility has made a concerted effort to recruit individuals in recovery in the past year at this facility.	1	2	3	4	5
My facility's efforts to recruit persons in recovery in the past year have been effective.	1	2	3	4	5

45.) Of the new employees hired at this facility in the past 12 months, please identify the primary recruitment source(s): *(Please check all that apply)*

____ Newspaper advertisement

____ Web-based classifieds (e.g., Monster.com; Jobbing.doc,etc.)

____ Informal contacts

____ Professional placement agency/other external employment placement agency

____ Agency-based internships or practica placements converted to employment positions

____ Facility mailing list

____ Universities and colleges

____ Other *(Please specify):* _____

46.) Which of the following employee benefits are available in your facility? *(Please check all that apply)*

Benefits	Available for some, but not all permanent employees	Available all permanent employees	Not available at this facility
Paid vacation			
Paid sick time			
Flex time scheduling			
Group health insurance			
Life insurance			
Retirement/Annuity			
Paid educational assistance			

47.) In your opinion, how well does your facility do in implementing the following staff retention strategies?

	Not well at all	Somewhat well	Not Sure	Well	Very well
More frequent salary increases	1	2	3	4	5
Mentoring opportunities	1	2	3	4	5
Individual recognition and appreciation	1	2	3	4	5
Opportunities for program input	1	2	3	4	5
Varied work opportunities	1	2	3	4	5
Health coverage and other benefits	1	2	3	4	5
Reduce paperwork burden	1	2	3	4	5
Promote career growth	1	2	3	4	5
Promotion opportunities	1	2	3	4	5
Access to ongoing training	1	2	3	4	5
Better management and supervision	1	2	3	4	5
Supportive facility culture	1	2	3	4	5
Physical work environment	1	2	3	4	5
Smaller caseloads	1	2	3	4	5
Shorter hours/flextime/job sharing	1	2	3	4	5

48.) How does your facility develop skills and enhance the abilities of direct care substance abuse treatment staff? *(Please check all that apply)*

____ Provides new staff orientation

____ Ongoing staff training (in-service, off site)

____ Offers in-house mentoring program

____ Provides direct supervision

____ Pays cost of continuing education

____ Don't know

____ Other *(Please specify)* _____

____ Has no method/program to develop skills of staff

49.) Which of the following barriers have you encountered in an effort to offer training and continuing educational opportunities to your staff in the past 12 months? *(Please check all that apply)*

____ There is a lack of available training opportunities, workshops, conferences and/or in-services educational opportunities.

____ The budget at this facility does not allow most program staff to attend trainings.

____ Topics presented at recent training workshops and conferences have been too limited.

____ Training opportunities take too much time away from the delivery of program services.

____ Training is not a priority at my work setting.

____ There are too few rewards for trying to change treatment or other procedures in my work setting.

____ Training opportunities are not local.

____ Other barriers *(Please specify)* _____

____ None of the above

50.) Please indicate the degree to which you agree or disagree that your staff need training in the following common practice areas.

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
Assessing client needs	1	2	3	4	5
Using client assessments to guide clinical care and program decisions	1	2	3	4	5
Using client assessments to document client improvements	1	2	3	4	5
Matching client needs with services	1	2	3	4	5
Increasing program participation by clients	1	2	3	4	5
Improving rapport with clients	1	2	3	4	5
Improving client thinking and problem solving skills	1	2	3	4	5
Improving behavioral management of clients	1	2	3	4	5
Improving cognitive focus of clients during group counseling	1	2	3	4	5
Identifying and using evidence-based practices	1	2	3	4	5

51.) Please indicate the degree to which you agree or disagree with the following statements about your facility's staff development strategies:

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
This facility has formal policies that provide tuition reimbursement	1	2	3	4	5
This facility has a formalized policy regarding continuing education requirements for staff	1	2	3	4	5
This facility has budgetary targets (set-asides) for continuing education of staff	1	2	3	4	5
This facility has a formalized strategy for career progression of staff	1	2	3	4	5
This facility provides a salary differential for bilingual staff	1	2	3	4	5

TECHNOLOGY

52.) Does your facility have an electronic health records (EHR) system for encoding and tracking in the following areas. *(Please check all that apply)*:

____ My facility does not have an EHR system. *(Please proceed to question 53)*

____ Intake/ Assessment

____ Patient Demographics

____ Clinical notes

____ Lab Reports

____ Discharge Summaries

____ Referrals

53.) If your facility has NOT implemented an EHR system, please indicate which of the following are barriers to its implementation. *(Please check all that apply):*

____ The amount of capital needed to purchase and implement an EHR system

____ Uncertainty about the return on investment (ROI) from an EHR system

____ Concerns about the ongoing cost of maintaining an EHR system

____ Resistance to implementation from staff

____ Resistance to implementation from other providers

____ Lack of capacity to select, contract for, and implement an EHR system

____ Disruption in clinical care during implementation

____ Lack of adequate IT staff to implement and maintain an EHR system

____ Concerns about inappropriate disclosure of patient information

____ Concerns about illegal record tampering or "hacking"

____ Finding an EHR system that meets your organization's needs

____ Concerns about a lack of future support from vendors for upgrading and maintaining the EHR system

54.) Please check all that apply regarding technology access at your facility.

____ I have access to an individual email account at work.

____ I have access to a shared email account at work.

____ I use the Internet for web learning (webinars, information gathering, research, etc.).

____ Direct care staff have access to the Internet during work hours.

____ Direct care staff have access to individual email accounts at work.

____ Direct care staff have access to shared email accounts at work.

____ Direct care staff use the Internet for web learning (webinars, information gathering, research, etc.).

STAFF COMPETENCY RELATED TO DIVERSITY

55.) Over the past 12 months, has your facility provided training to staff on culturally responsive substance abuse treatment (e.g., values, principles, practices, and procedures)?

_____ Yes _____ No

56.) Over the past 12 months, has your facility provided training to staff on gender responsive substance abuse treatment (e.g., values, principles, practices, and procedures)?

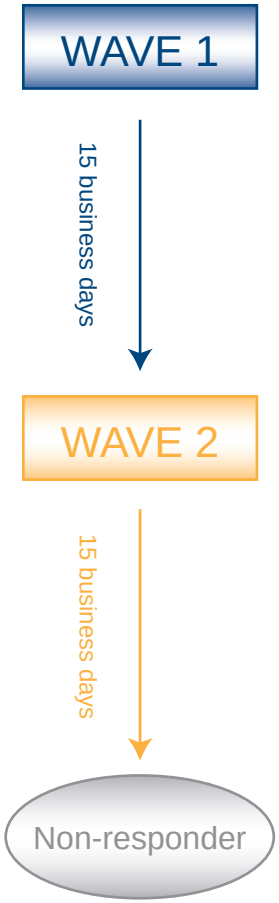
_____ Yes _____ No

57.) Please indicate the degree to which you agree or disagree with the following statements:

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
My facility considers cultural and linguistic differences in developing treatment practices	1	2	3	4	5
My facility systematically reviews procedures to ensure delivery of culturally competent services	1	2	3	4	5
My facility uses culturally and linguistically appropriate resource materials (including communication technologies) to inform diverse groups about substance use disorders	1	2	3	4	5
My facility has program forms and documents available in the languages of our service population	1	2	3	4	5
My facility provides individual or group counseling in the languages of our service population	1	2	3	4	5

ATTACHMENT 2:
DATA COLLECTION PROTOCOLS

Data Collection Protocol

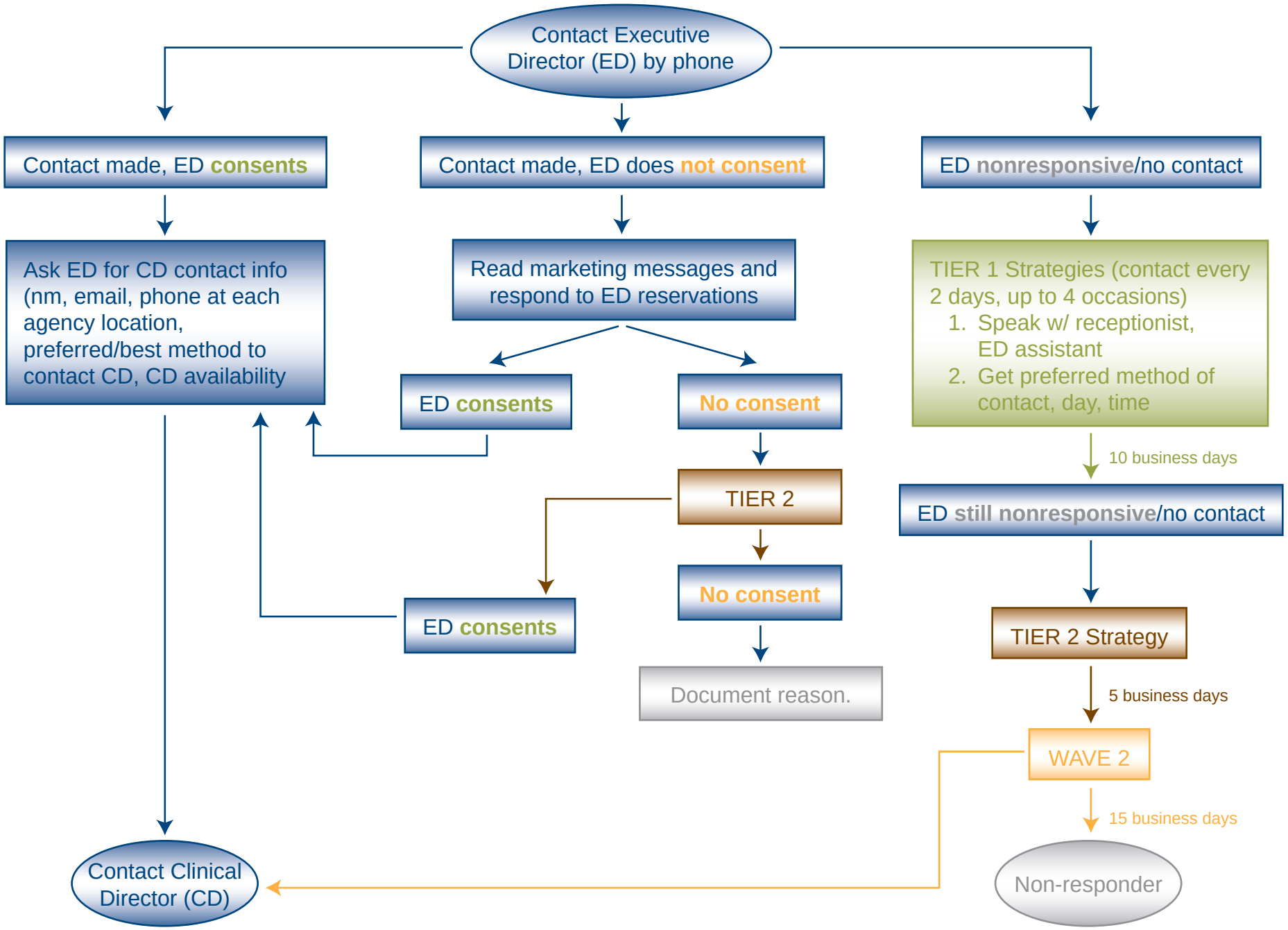


TIER 1
Contact every 2nd day, up to 4 occasions

TIER 2
Authority Contact — SSA or Facility/Agency ED
(use phone & email)

Repeat TIER 1 & TIER 2

Executive Director Contact Protocol



ATTC

Unifying science, education and services to transform lives.

Addiction Technology Transfer Center Network

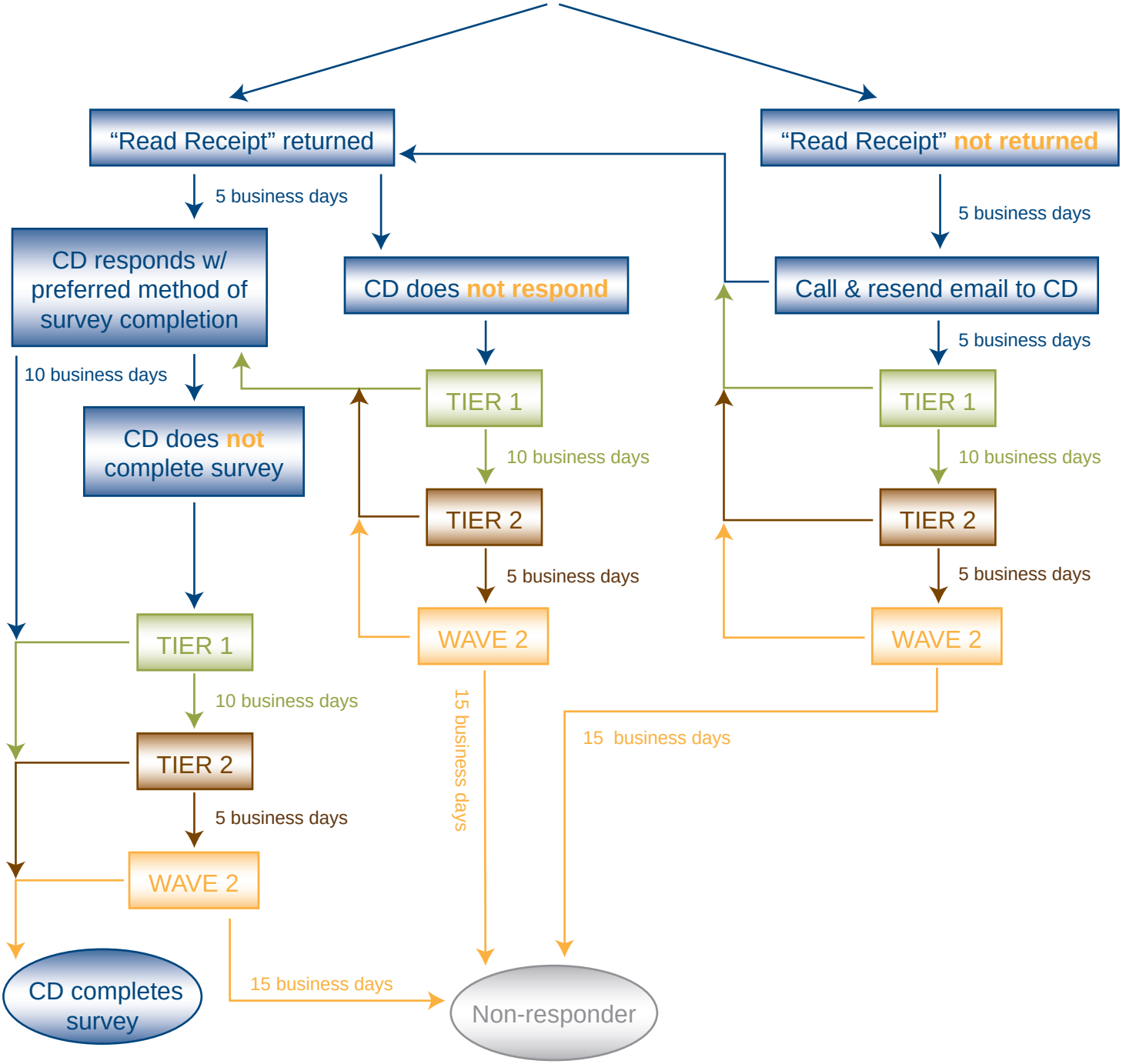
Funded by Substance Abuse and Mental Health Services Administration

Clinical Director Contact Protocol

METHOD 1: Email with Clinical Director

> send email (use HTML without graphic) with "Read Receipt" message with 3 options:

1. Link to online survey (preferred).
2. Mail paper survey to CD with stamped, addressed return envelope.



ATTC

Unifying science, education and services to transform lives.

Addiction Technology Transfer Center Network

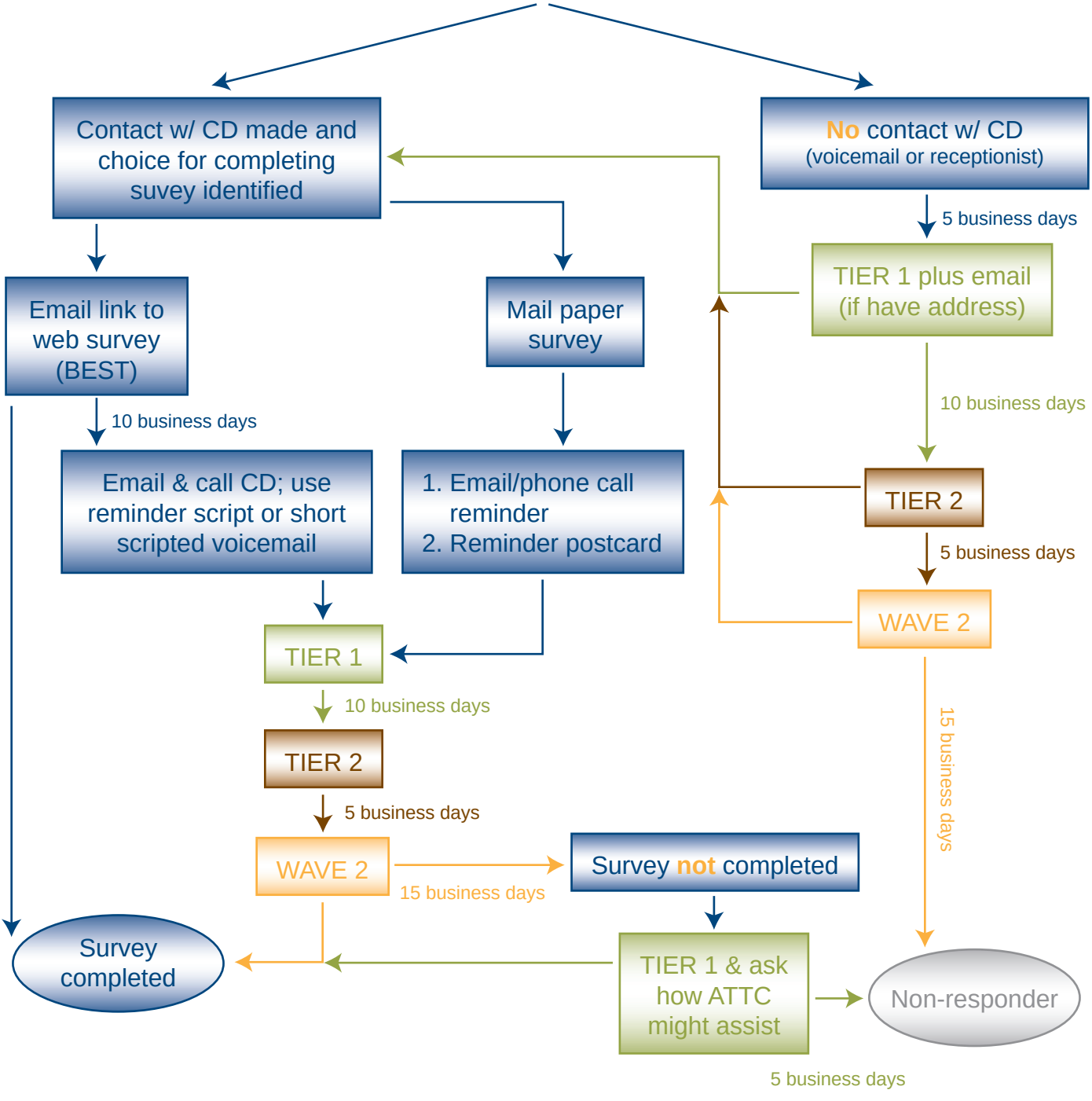
Funded by Substance Abuse and Mental Health Services Administration

Clinical Director Contact Protocol

METHOD 2: Phone Call with Clinical Director

> phone call script will indicate the options available to complete survey

1. Send link to online survey (preferred).
2. Mail paper survey to CD with stamped/addressed return envelope to return to RC. RC will send all received surveys to ATTC National Office.



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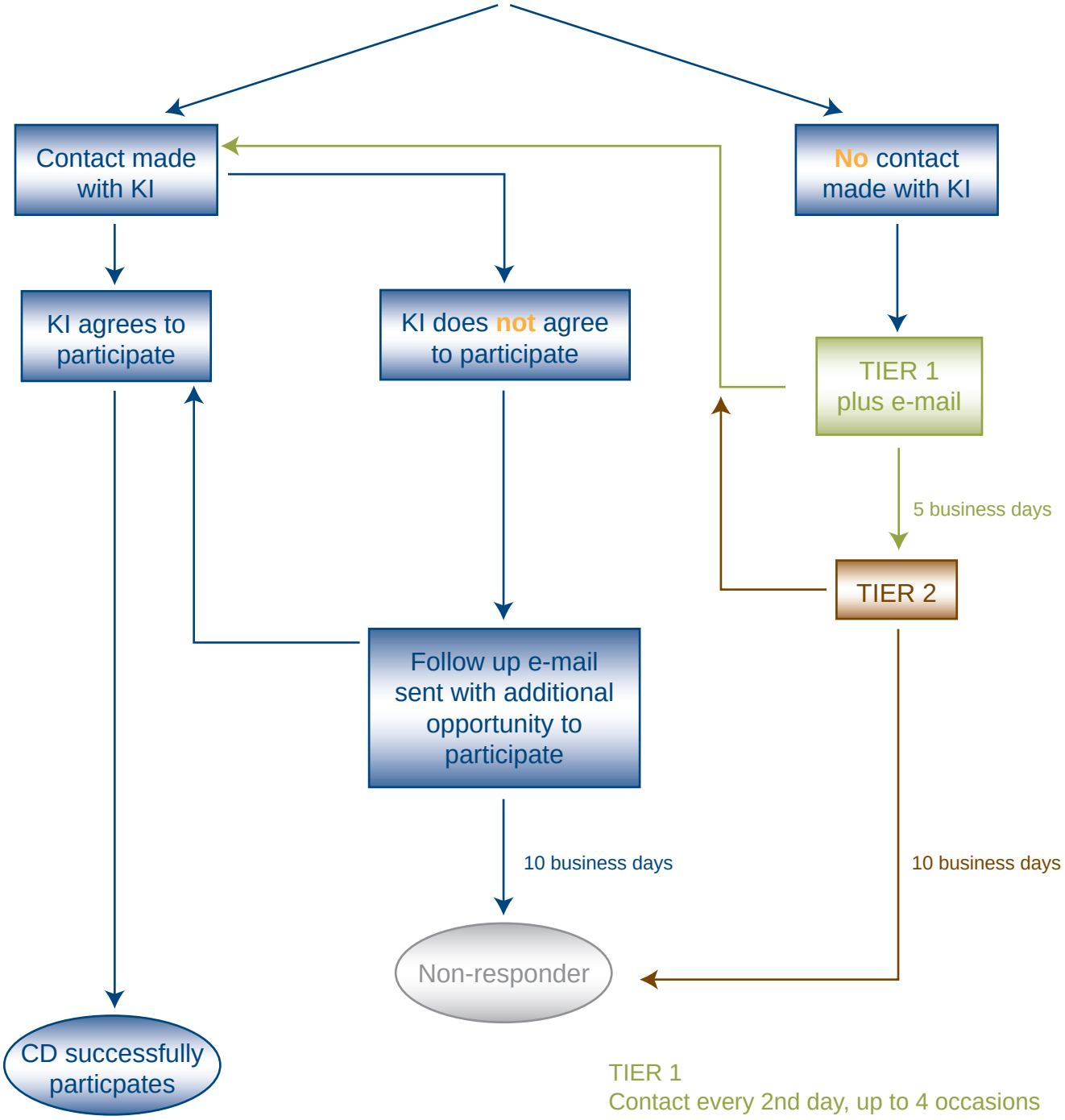
Key Informant Contact Protocol — Phone Interview

Phone Call with Key Informant
> phone call script with overview of process



TIER 1
Contact every 2nd day, up to 4 occasions

TIER 2
Authority Contact — SSA or Facility/Agency ED
(use phone & email)

ATTACHMENT 3:
KEY INFORMANT TELEPHONE INTERVIEW QUESTIONNAIRE

KEY INFORMANT TELEPHONE INTERVIEW QUESTIONNAIRE
(Clinical Director& Thought Leaders)

OMB Number: 0903-0328
Expiration date: 09-30-2014

> SEMI-STRUCTURED INTERVIEW W/ KEY INFORMANTS

PHONE INTERVIEW W/ KEY INFORMANT

"Hello, this is —**[name]**— from —**[ATTC NO]**— I am calling you to follow up on an email that was sent to you by the ATTC Network to participate in a key informant interview. Having received the response that you agree to participate, I would like to conduct a brief interview with you in order to provide some insight from your perspective on issues related to the substance abuse treatment workforce. The interview will take approximately 30 minutes and all the information that you provide will be kept private and used solely for the purpose of this data collection. The information that you provide will be used in further guiding our future efforts in supporting the addiction treatment workforce.

CLINICAL DIRECTOR'S KEY INFORMANT INTERVIEW SCRIPT

Q1
Based on your responses to the survey entitled "Vital Signs: Taking the Pulse of the Addiction Treatment Workforce", we have determined that the facility at which you work has employed effective strategies to prepare and recruit individuals to enter the workforce, and encourage them to remain in the workforce and stay current on clinical and other job related skills (e.g., evidence based practices). Please elaborate on these strategies.

Q2
Are these strategies that you currently use at your job setting? If so, how long have you been using this idea? If not, what were some of the reasons for not using it at your setting?

Q3
Please describe for me your experience in implementing this idea or at your work setting.

Q3a
What sorts of barriers did you experience when implementing this idea?

Q3b
When you implemented these strategies, what kinds of adaptations or changes were required at your organization?

Q3c
What kinds of changes did you make to the idea itself in order to successfully implement it?

Q3d
What sorts of positive changes did you (or your organization) experience when you implemented this strategy?

Q4
Is this a strategy that you feel has applicability to other organizations? If so, what kinds of resources would another organization need in order to successfully implement this strategy?

Q5
Do you have any other tips or advice you would offer to others in the field who are considering implementing similar efforts?

Q6
Is there anything else you would like to add?

FINISH
Thank you for your contribution to the data collection. Your input will help us in understanding the projected growth and needs of the addiction treatment profession. Have a nice day!

THOUGHT LEADER KEY INFORMANT INTERVIEW SCRIPT

Q1
Based on your experience in the substance abuse and addiction treatment field, what do you believe are the mega trends facing the substance abuse workforce over the next five years?

Q2
Which of these "Mega Trends" do you believe are most pertinent to the workforce?

Q3
Which trends do you believe will have negative effects on the workforce?

Q3b
Please explain what you think some of those effects will be?

Q4
Which trends do you believe will have positive effects on the workforce?

Q4b
Please explain what you think some of those effects will be?

*** IF THESE ISSUES HAVE NOT ALREADY BEEN DISCUSSED PLEASE ASK:*

Q5
How do you think the Affordable Care Act will affect the SA treatment field in the next five years?

Q6
What changes to the field do you predict as a result of the integration of mental health and substance abuse treatment?

Q7
How will the Mental Health Parity and Addiction Equity Act of 2008 affect the SA treatment field?

Q8
How do you think Health Information Technology will impact the SA treatment field in the next five years?

Q9
How do you envision the substance abuse treatment workforce in the next five years?

FINISH
Thank you for your contribution to the data collection. Your input will help us in understanding the projected growth and needs of the addiction treatment profession. Have a nice day!

ATTACHMENT 4:
LIST OF SECONDARY DATA SETS

LIST OF SECONDARY DATA SETS

> CENSUS 2000 DATASETS

The Decennial Census occurs every 10 years, in years ending in zero, to count the population and housing units for the entire United States. Its primary purpose is to provide the population counts that determine how seats in the U.S. House of Representatives are apportioned. Besides providing the basis for congressional redistricting, Census data are used in many other ways. Since 1975, the Census Bureau has had responsibility to produce small-area population data needed to redraw state legislative and congressional districts. Other important uses of Census data include the distribution of funds for government programs such as Medicaid; planning the right locations for schools, roads, and other public facilities; helping real estate agents and potential residents learn about a neighborhood; and identifying trends over time that can help predict future needs. Most Census data are available for many levels of geography, including states, counties, cities and towns, ZIP codes, census tracts and blocks, and much more.
http://factfinder.census.gov/jsp/saff/SAFFInfo.jsp?geo_id=01000US&_geoContext=01000US&_street=&_county=&_cityTown=&_state=&_zip=&_pageId=sp4_decennial&_submenuId=&_ci_nbr=null

> NSSATS

The National Survey of Substance Abuse Treatment Services (N-SSATS) is designed to collect information from all facilities in the United States, both public and private, that provide substance abuse treatment. N-SSATS provides the mechanism for quantifying the dynamic character and composition of the United States substance abuse treatment delivery system. The objectives of N-SSATS are to collect multipurpose data that can be used to assist the Substance Abuse and Mental Health Services Administration (SAMHSA) and state and local governments in assessing the nature and extent of services provided and in forecasting treatment resource requirements, to update SAMHSA's Inventory of Substance Abuse Treatment Services (I-SATS), to analyze general treatment services trends, and to generate the National Directory of Drug and Alcohol Abuse Treatment Programs and its online equivalent, the Substance Abuse Treatment Facility Locator. Data are collected on topics including ownership, services offered (assessment and pre-treatment, pharmacotherapies, testing, transitional, ancillary), detoxification, primary focus (substance abuse, mental health, both, general health, and other), hotline operation, methadone/buprenorphine dispensing, counseling and therapeutic approaches, languages in which treatment is provided, type of treatment provided, number of clients (total and under age 18), number of beds, types of payment accepted, sliding fee scale, special programs offered, facility accreditation and licensure/certification, and managed care agreements.
http://www.icpsr.umich.edu/icpsrweb/SAMHDA/studies/26221/detail

LIST OF SECONDARY DATA SETS

continued

> SAMSHA TREATMENT GAP PROJECTION ANALYSIS

National Survey on Drug Use and Health (NSDUH), an annual survey of the civilian, is the primary source of statistical information on the use of illegal drugs by the U.S. population. Conducted by the Federal Government since 1971, the survey collects data by administering questionnaires to a representative sample of the population through face-to-face interviews at the respondent's place of residence. The survey is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services, and is planned and managed by SAMHSA's Office of Applied Studies (OAS). Data collection and analysis are conducted under contract with RTI International, Research Triangle Park, North Carolina.
http://www.oas.samhsa.gov/NSDUH/2k7NSDUH/2k7results.cfm#1.1

> TREATMENT EPISODE DATA

The Treatment Episode Data Set (TEDS) is an administrative data system providing descriptive information about the national flow of admissions to providers of substance abuse treatment. The TEDS is a continuation of the former Client Data System (CDS) that was originally developed by the Alcohol, Drug Abuse, and Mental Health Services Administration (predecessor to SAMHSA) in consultation with representatives of the state substance abuse agencies and appropriate national organizations.
http://www.icpsr.umich.edu/icpsrweb/SAMHDA/series/56#summary

> BUREAU OF LABOR DATASETS SUCH AS CURRENT EMPLOYMENT STATISTICS

The Bureau of Labor Statistics (BLS) is a unit of the United States Department of Labor. It is the principal fact-finding agency for the U.S. government in the broad field of labor economics and statistics. The BLS is a governmental statistical agency that collects, processes, analyzes, and disseminates essential statistical data to the American public, the U.S. Congress, other Federal agencies, State and local governments, business, and labor representatives. The BLS also serves as a statistical resource to the Department of Labor. The BLS data must satisfy a number of criteria, including relevance to current social and economic issues, timeliness in reflecting today's rapidly changing economic conditions, accuracy and consistently high statistical quality, and impartiality in both subject matter and presentation. To avoid the appearance of partiality, the dates of major data releases are scheduled more than a year in advance, in coordination with the Office of Management and Budget.
http://www.bls.gov/data/

> ANNAPOLIS COALITION DATA

The Annapolis Coalition, comprised of a broad constituency of stakeholders, was charged by SAMHSA to develop a comprehensive plan addressing the workforce development crisis and issues surrounding recruitment, retention, and training of a prevention and treatment workforce in the mental health and addiction field.
The final plan, An Action Plan for Behavioral Health Workforce Development, reviews the current workforce and its environment; outlines a set of general findings; identifies seven core strategic goals; and outlines the objectives and actions necessary to achieve each goal. Now the Coalition is launching a major initiative to disseminate the Action Plan and promote the adoption and adaptation of the recommendations by individuals, organizations, and government agencies across all sectors of this field
http://attcnetwork.org/find/respubs/docs/WorkforceActionPlan.pdf

ATTACHMENT 5:
WORKFORCE STUDY DEVELOPMENT TIMELINE

WORKFORCE STUDY DEVELOPMENT TIMELINE

Below is a timeline and description of all activities carried out by the ATTC Network in the development and implementation of the national workforce study. For the 2007-2012 ATTC funding period the ATTC Network comprised of 14 Regional Centers and a National Office. The study was coordinated and lead by the National Office, with uniform implementation of the data collection protocols across all 14 Regional Centers.

> 2007: ATTC RFA RELEASED FOR 2007-2012 GRANT CYCLE.

As part of the 2007 ATTC funding awards, SAMHSA directed the ATTC Network to conduct a national study of the SUD treatment workforce. Implementation and development of this study were conducted without additional funding and in addition to all other ATTC Network activities. SAMHSA directed the national coordinating center to "Convene experts (including ATTC Regional Center experts) to design a national workforce survey methodology, develop the survey instrument to be used, provide for the analysis of the data and, based on the findings, prepare workforce reports. Prepare any needed OMB clearance package for the national workforce survey". (RFA 2007)

> 2008: SAMHSA WORKFORCE DEVELOPMENT WORKGROUP

In 2008 SAMHSA convened a Workforce development workgroup. Chaired by Cathy Nugent, the workgroup outlined the three research questions this national study was developed to answer. The workgroup also directed the ATTCs to use the Inventory of Substance Abuse Treatment Services (I-SATS) as a sampling frame for the study.

> 2008: ATTC EXPERT PANEL MEETING

The ATTC National Office and CSAT convened an expert panel made up of experts from both inside and outside the Network. During this meeting the group affirmed the three research questions outlined by SAMHSA. The expert panel outlined a plan for developing the national workforce study that incorporated four strategies, including: Literature Review and Data Base Identification and Analysis; Targeted Stakeholder Discussions; Focus Groups; and an Agency Directors Survey.

> 2009: UNDERSTANDING AMERICA'S SUBSTANCE USE DISORDERS TREATMENT WORKFORCE: A SUMMARY REPORT & ROUNDTABLE DISCUSSION REPORT

In 2009, though a subcontract with the ATTC Network the National Development and Research Institute (NDRI) created a summary report to gain a perspective on the substance use disorders treatment field's workforce. The report identified key resources which provided information relative to the three strategic research questions outlined by SAMHSA. The report highlighted gaps in knowledge in order to inform the agenda and content of the targeted stakeholder discussions in addition to aiding in the development of the survey instrument. Additionally in 2009 NDRI conducted five roundtable discussions with addiction treatment counselors and clinical supervisors in order to solicit input regarding the development of the survey instrument and to gather qualitative data relevant to the study's three research questions. The roundtable discussion report was released in February 2010.

> 2010: ATTC NETWORK WORKFORCE STUDY DESIGN MEETING

During this meeting the ATTC Network members worked to develop a study design that would strike a balance between creating an academically rigorous study design and the limited resources available to the Network. It was decided during that meeting that due to the limited resources of the Network, the study would collect data that was both nationally and regionally representative, but not state level data. During this meeting the decision was made that the focus would be on collecting a national sample and providing nationally representative findings on the SUD treatment workforce. Resources also allowed the opportunity to collect data that was representative on a regional level, allowing the ATTCs to better understand the workforce on a regional level. The ATTC Network also decided at this time to survey clinical directors. Due to limited resources and the lack of an existing sampling frame for front line staff, the survey was limited to a sample of clinical directors. For the purpose of the study, the clinical director is defined as the person whose role it is to oversee direct clinical service delivery for the facility at which they work. It was also decided during this meeting that the study will utilize a mixed-method design, integrating qualitative data with the quantitative survey data. Four workgroups, comprised of ATTC Regional Center Directors and key staff, were created at the study design meeting tasked with developing the following: (1) survey instrument design; (2) survey protocol design; (3) marketing; (4) qualitative design.

> 2010: OFFICE OF MANAGEMENT AND BUDGET (OMB) SUBMISSION

In October 2010, on behalf of the ATTC Network, the ATTC National Office submitted the workforce study for OMB clearance. Over an 11 month period the study went through SAMHSA review and the National Office made all SAMHSA recommended changes. The study was approved in September 2011.

WORKFORCE STUDY DEVELOPMENT TIMELINE continued

> 2011: ATTC WORKFORCE STUDY FEDERAL REGISTER NOTICE

In April 2011 SAMHSA published the ATTC Network workforce study in the Federal Register in order to allow public feedback or comment on the study.

> 2011: WORKFORCE STUDY ANALYSIS DESIGN MEETING

In September 2011 the ATTC National Office hosted a workforce study analysis design meeting. During this meeting attendants devised a Network wide plan for attaining IRB approval for the study across all 14 Regional Centers and the National Office. Templates for the national and regional workforce study reports were also created at this time.

> 2011: ATTCS INTERNAL REVIEW BOARD (IRB) APPLICATIONS SUBMITTED

The ATTC Network, coordinated by the National Office, submitted 14 individual IRB applications to institutions across the country. The applications sought clearance to recruit participants for the study, with all data returning to the National Office. All 14 applications were approved by January 2012.

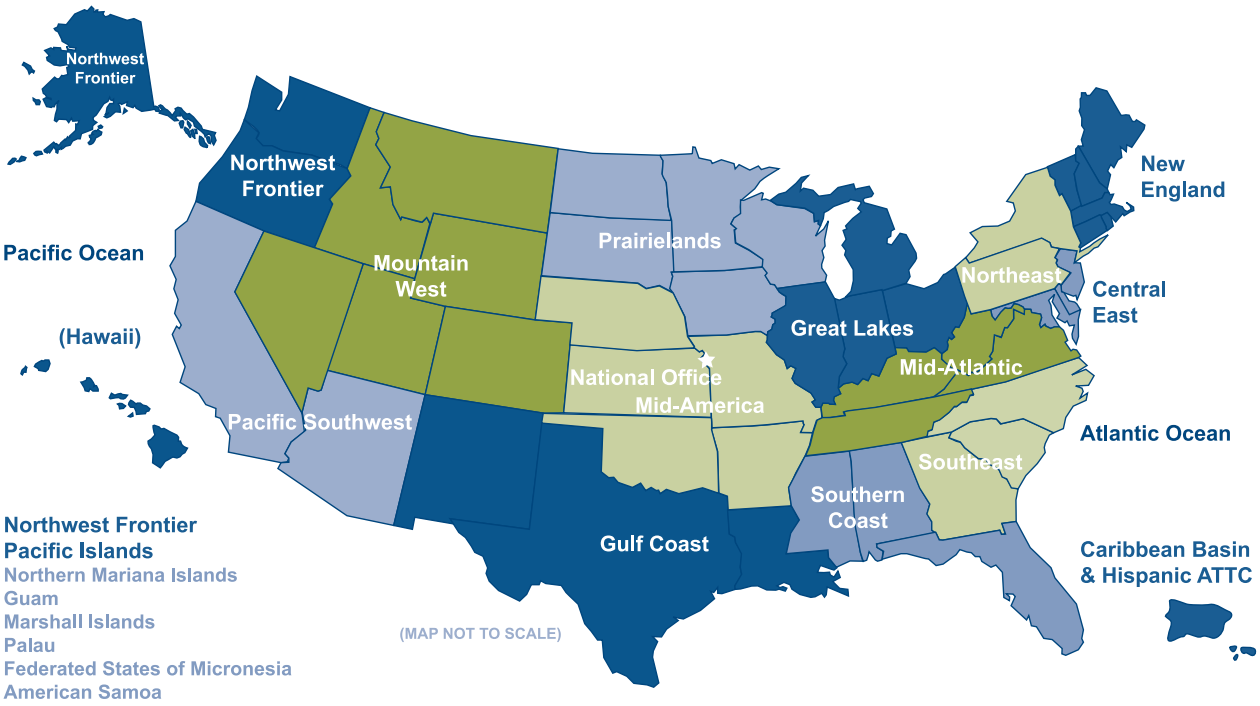
> NOVEMBER 2011-MAY 2012: DATA COLLECTION

In November 2011 the ATTC National Office pulled a random sample of facilities from the NSSATS. This sample comprised 657 facilities with two or more employees. The sample was both nationally and regionally representative. The National Office provided each ATTC Regional Center with a list of facilities in their region and the contact information provided by the I-SATS. Four protocols were developed to guide the ATTC Network in uniform data collection. ATTC Regional Centers conducted the executive director and clinical director protocols in order to recruit participants to complete the quantitative portion of the study, the clinical director survey. The ATTC National Office implemented the thought leader and clinical director key informant interview protocols in order to recruit participants for the qualitative portion of the study. The thought leader key informant interviews began in February 2012, and a total of 25 were conducted. The clinical director key informant interviews began in March 2012 and a total of 27 were conducted. The qualitative information gathered in those interviews was coded and analyzed using Nvivo9 software. The quantitative data collected from the survey was cleaned and analyzed by the National Office research consultant, Dr. Deena Murphy.

ATTACHMENT 6:
MAP OF ATTC NETWORK REGIONAL CENTERS

MAP OF ATTC NETWORK REGIONAL CENTERS

ATTCnetwork.org



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caribbeanbasin@ATTCnetwork.org
(787) 785-4211

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ATTACHMENT 7:
SURVEY DATA

SURVEY DATA

DATA TABLE NO. 1: Demographic Profile of Clinical Directors

GENDER (n=488)	
Male	41%
Female	59%
RACE (n=467)	
American Indian/ Alaska Native	4%
Asian	2%
Native Hawaiian/ Other Pacific Islander	0%
Black or African American	10%
White	86%
HISPANIC/LATINO	
Yes	14%
No	86%
AGE	
Average	52
Age Range <35	8%
35-49	33%
50+	60%

DATA TABLE NO. 2: Clinical Directors Military Affiliation and Recovery Status

MILITARY AFFILIATION (n=483)	
No Affiliation	93%
Reserve/National Guard	0%
Active Duty	0%
Veteran/Retired Military	7%
RECOVERY STATUS (n=481)	
In recovery	34%
Not in recovery	59%
Prefer not to disclose status	7%

DATA TABLE NO. 3: Clinical Directors Education and Licensure

CLINICAL DIRECTORS HIGHEST DEGREE STATUS (n=487)	
No high school diploma or GED	0%
High school diploma or GED	3%
Some college, no degree	7%
Associate's degree	7%
Bachelor's degree	15%
Master's degree	57%
Doctoral degree or equivalent	8%
Doctor of Medicine	1%
Other	1%
CLINICAL DIRECTORS AREA OF LICENSURE	
Substance Abuse Counseling (n=424)	84%
Marriage & Family Therapy (n=233)	29%
Social Work/Clinical Social Work (n=259)	41%
School Psychology/Educational Psychology (n=191)	6%
General Counseling (n=278)	55%
Other (n=144)	49%
CLINICAL DIRECTORS CLINICAL SUPERVISION EXPERTISE (n=488)	
Licensed as clinical supervisors	55%
Not licensed as clinical supervisors	45%
CLINICAL DIRECTORS CLINICAL SUPERVISION CERTIFICATION/LICENSURE SOURCE (n=488)	
State only certification/licensure	77%
State certification not available (n=476)	29%
National only certification/licensure	4%
Both National & State certification/licensure	19%

DATA TABLE NO. 4: Clinical Directors Professional Background

PROGRAM OF STUDY (n=482)					
% of Clinical Directors registered in a formal program of study	12%				
YEARS OF PROFESSIONAL EXPERIENCE (n=487)					
In social services field (other than substance abuse treatment)	9 years				
In the substance abuse treatment field	17 years				
% entered field as second career (n=487)	*25%*				
At current employer/agency	11 years				
% current employer/agency ONLY agency for which clinical director has worked (n=480)	*33%*				
In current position	7 years				
JOB SATISFACTION: (n=475+/-7)					
How likely is it that in the next 12 months the clinical director will…	**Not Likely at all**	**Not Likely**	**Not Sure**	**Likely**	**Extremely Likely**
Change jobs, but stay at current agency	61%	23%	9%	< 1%	< 1%
Change employer, but stay in field	63%	21%	10%	4%	2%
Leave substance abuse treatment field	67%	23%	7%	2%	< 1%
Continue working for current employer	4%	2%	7%	20%	66%

DATA TABLE NO. 5: Direct Care Staff Demographics

EMPLOYMENT STATUS (n=11135)	
Full-time	77%
Part-time	17%
PRN	7%
No answer	0%
GENDER (n=5385)	
Male	33%
Female	67%
RACE (n=5545)	
Hispanic or Latino/a	11%
American Indian/ Alaska Native	3%
Asian	1%
Native Hawaiian/Other Pacific Islander	1%
Black/African American	19%
White	64%
Unknown	2%
AGE RANGE (n=5370)	
<35	31%
35-44	25%
45-54	23%
55-64	14%
>65	2%

DATA TABLE NO. 6: Direct Care Staff Military Affiliation and Recovery Status

MILITARY AFFILIATION (n=3212)	
No Affiliation	59%
Reserve/National Guard	1%
Active Duty	0%
Veteran/Retired Military	10%
Do not know	29%
RECOVERY STATUS (n=5545)	
In recovery	29%

DATA TABLE NO. 7: Direct Care Staff Education and Licensure

DIRECT CARE STAFF HIGHEST DEGREE STATUS (n=479)	PERCENTAGE
No high school diploma or GED	1%
High school diploma or GED	13%
Some college, no degree	10%
Associate's degree	9%
Bachelor's degree	24%
Master's degree	36%
Doctoral degree or equivalent	2%
Doctor of Medicine	1%
Other	3%
DIRECT CARE STAFF LICENSURE (n=5545)	
Never licensed	17%
Previously certified	3%
Pursuing certification	18%
Pending certification	5%
Currently licensed	54%
Awaiting reciprocity	2%
Unknown	3%
AVERAGE LENGTH OF TIME AT FACILITY (n=5529)	
< 1 year	13%
1-5 years	41%
5-10 years	24%
10-15 years	11%
15-20 years	6%
20+ years	4%
Unknown	2%

DATA TABLE NO. 8: Work Environment: Employment Status and Salary

EMPLOYMENT STATUS (n=482)	
Full-time	95%
Part-time	3%
Contract employee	3%
ANNUAL SALARY (n=487)	
Less than $15,000 per year (less than $1,250 per month)	2%
$15,000 to $24,999 per year ($1,250 to $2,083 per month)	5%
$25,000 to $34,999 per year ($2,084 to $2,916 per month)	5%
$35,000 to $44,999 per year ($2,917 to $3,479 per month)	10%
$45,000 to $54,999 per year ($3,750 to $4,583 per month)	16%
$55,000 to $64,999 per year ($4,584 to $5,415 per month)	20%
$65,000 to $74,999 per year ($5,416 to $6,250 per month)	14%
$75,000 per year or higher ($6,251 per month or higher)	18%
Prefer not to disclose	11%
SATISFACTION WITH SALARY (n=485)	
Salary much less than expected	14%
Salary less than expected	32%
Salary about what expected	41%
Salary more than expected	11%
Salary much more than expected	2%

DATA TABLE NO. 9: Work Environment: Activities

% OF CLINICAL DIRECTORS TIME SPENT ON ACTIVITIES (n= 485)	
Screening and assessments	9%
Direct client therapeutic engagement	17%
Clinical supervision	24%
Administrative activities	43%
Other	6%

DATA TABLE NO. 10: Work Environment: Technology

PROFICIENCY IN COMPUTERS AND WEB-BASED TECHNOLOGIES (n=481)	
Not at All Proficient	1%
Not Proficient	6%
Somewhat Proficient	33%
Proficient	46%
Extremely Proficient	14%
AVAILABILITY OF EHR SYSTEM FOR ACTIVITIES (n=460)	
Lab Reports	32%
Referrals	33%
My facility does not have an EHR system	42%
Discharge Summaries	50%
Intake/ Assessment	53%
Clinical Notes	54%
Patient Demographics	55%
BARRIERS TO EHR IMPLEMENTATION (n=160)	
Resistance to implementation from other providers	4%
Disruption in clinical care during implementation	5%
Resistance to implementation from staff	11%
Concerns about inappropriate disclosure of patient information	11%
Concerns about illegal record tampering or “hacking” Finding an EHR system that meets your organization’s needs	13%
Lack of capacity to select, contract for, and implement an EHR system	17%
Uncertainty about the return on investment (ROI) from an EHR system	21%
Concerns about a lack of future support from vendors for upgrading and maintaining the EHR system	23%
Lack of adequate IT staff to implement and maintain an EHR system	33%
Concerns about the ongoing cost of maintaining an EHR system	45%
The amount of capital needed to purchase and implement an EHR system	80%

(cont.) DATA TABLE NO. 10: Work Environment: Technology

ACCESS TO TECHNOLOGY (n=463)	
Direct care staff have access to shared email accounts at work	33%
I have access to a shared email account at work	36%
Direct care staff have access to individual email accounts at work	83%
Direct care staff use the Internet for web learning (webinars, information gathering, research, etc.)	83%
Direct care staff have access to the Internet during work hours	89%
I use the Internet for web learning (webinars, information gathering, research, etc.)	89%
I have access to an individual email account at work	93%

DATA TABLE NO. 11: Clinical Supervision: Setting, Frequency and Method Used

SETTING FOR CLINICAL SUPERVISION (n=482)	
In individual clinical supervision sessions only	12%
In group clinical supervision sessions only	4%
In both individual and group clinical supervision sessions	84%
FREQUENCY OF CLINICAL SUPERVISION (n=480)	
Only when there is a problem	7%
Twice a year	1%
Every two months	2%
Once a month	8%
Twice a month	10%
Weekly	73%
OBSERVATION METHODS FOR CONDUCTING CLINICAL SUPERVISION (n=478)	
Videotape Review	7%
Audiotape Review	6%
Live Observation	72%
Chart Review/Review of Progress Notes	88%
Role play	28%
Other	23%

(cont.) DATA TABLE NO. 11: Clinical Supervision: Setting, Frequency and Method Used

PERCENTAGE OF TIME SPENT ON DIFFERENT ACTIVITIES (n=478)	
Counselor case presentation	20%
Reviewing treatment/discharge plans	17%
Discussing counselor problems/challenges	26%
Giving feedback on observed performance	15%
Training/teaching specific counseling skills	16%
Other	6%

CLIENT CASELOAD BY STAFF CATEGORY: (n=479)	% CLIENTS PER STAFF CATEGORY				
Staff Category	**0**	**1-10**	**10-20**	**20-30**	**30+**
Program Director	54%	26%	9%	5%	7%
Clinical Supervisor	32%	33%	18%	7%	11%
Certified/licensed Counselor	5%	25%	23%	18%	30%
Case Manager	33%	17%	18%	12%	19%
Counselor Aide/Technician	61%	13%	12%	6%	7%
Social Worker	42%	11%	12%	13%	22%
Nurse	51%	7%	9%	10%	23%
Recovery/Peer Recovery Specialist	62%	12%	9%	6%	9%
Non-certified Counselor	36%	25%	14%	9%	15%
Other	58%	11%	11%	10%	13%

OPINION OF CASELOADS BY CLINICAL DIRECTOR (n=479)	
Too Small	6%
About Right	72%
Too Large	21%
Don't know	2%

DATA TABLE NO. 12: Recruitment challenges

DIFFICULTIES FILLING OPEN POSITIONS FOR DIRECT CARE STAFF (n=466)	
Experience difficulty filling positions	49%
Do not experience difficulty filling positions	51%
REASONS FOR DIFFICULTY FILLING OPEN POSITIONS FOR DIRECT CARE STAFF (n=280)	
Reputation of the facility	3%
Don't know	6%
Other	10%
Lack of opportunity for advancement	11%
Lack of interest in location of facility	12%
Lack of interest in position (nature of work, stigma)	13%
Small applicant pool due to geographic area surrounding work setting	36%
Lack of interest in position (salary)	41%
Insufficient funding for open positions	43%
Insufficient number of applicants who meet minimum qualifications	63%
REASONS APPLICANTS DO NOT MEET MINIMUM REQUIREMENTS (n=404)	
Don't know	2%
Other	5%
Lack of social or interpersonal skills	20%
Not applicable, generally applicants are qualified	23%
Lack of practical applied skills	26%
Lack of appropriate certification	43%
Insufficient or inadequate training and education	49%
Little or no experience in substance abuse treatment	50%

DATA TABLE NO. 13: Recruitment Strategies

PRIMARY RECRUITMENT SOURCE (n=439)	
Facility mailing list	5%
Professional placement agency/other external employment placement agency	11%
Other (Please specify)	17%
Universities and colleges	25%
Agency-based internships or practicum placements converted to employment positions	31%
Newspaper advertisement	37%
Informal contacts	47%
Web-based classifieds (e.g., Monster.com; Jobbing.doc, etc.)	55%

DEGREE OF AGREEMENT WITH STATEMENTS ABOUT RECRUITMENT STRATEGIES (n=464-470)					
Statement	**Strongly Disagree**	**Disagree**	**Neither Agree nor Disagree**	**Agree**	**Strongly Agree**
My facility has formalized relationships with community colleges and/or universities, which provide internship and/or practica placements for students at this facility.	6%	9%	11%	34%	40%
My facility has made a concerted effort to recruit individuals from under-represented groups (including minorities, LGBTQ, etc.) in the past year.	3%	11%	37%	35%	13%
My facility's efforts to recruit individuals from under-represented groups in the past year have been effective.	4%	13%	49%	25%	9%
My facility has designated positions for peer-recovery specialists and/or other positions specifically for persons in recovery.	18%	24%	19%	21%	18%
My facility has made a concerted effort to recruit individuals in recovery in the past year at this facility.	9%	17%	33%	26%	15%
My facility's efforts to recruit persons in recovery in the past year have been effective.	8%	12%	41%	25%	14%

(cont.) DATA TABLE NO. 13: Recruitment Strategies

EMPLOYEE BENEFITS AVAILABLE (n=449)			
Benefit	**Available for some, but not all permanent employees**	**Available for all permanent employees**	**Not available at this facility**
Paid vacation	12%	83%	4%
Paid sick time	11%	82%	7%
Flex time scheduling	23%	48%	24%
Group health insurance	13%	74%	13%
Life insurance	10%	70%	20%
Retirement/Annuity	10%	67%	24%
Paid educational assistance	16%	40%	44%

DATA TABLE NO. 14: Professional Development challenges and strategies

WAYS FACILITIES DEVELOP SKILLS AND ENHANCE THE ABILITIES OF DIRECT CARE STAFF (n=467)	
Don't know	1%
Has no method/program to develop skills of staff	2%
Other	3%
Offers in-house mentoring program	39%
Pays cost of continuing education	48%
Provides new staff orientation	88%
Ongoing staff training (in-service, off site)	91%
Provides direct supervision	92%

STAFF DEVELOPMENT STRATEGIES (n=468+/-2)					
Statement	**Strongly Disagree**	**Disagree**	**Neither Agree nor Disagree**	**Agree**	**Strongly Agree**
This facility provides a salary differential for bilingual staff.	27%	27%	30%	11%	5%
This facility has formal policies that provide tuition reimbursement.	25%	23%	14%	22%	16%
This facility has a formalized strategy for career progression of staff.	13%	29%	29%	23%	6%
This facility has budgetary targets (set-asides) for continuing education of staff.	16%	17%	19%	33%	16%
This facility has a formalized policy regarding continuing education requirements for staff.	7%	13%	10%	43%	27%

DATA TABLE NO. 15: Training challenges & Strategies

BARRIERS TO STAFF TRAINING AND CONTINUING EDUCATIONAL OPPORTUNITIES (n=463)	
Training is not a priority at my work setting.	3%
Other barriers.	5%
There are too few rewards for trying to change treatment or other procedures in my work setting.	6%
Topics presented at recent training workshops and conferences have been too limited.	15%
There is a lack of available training opportunities, workshops, conferences and/or in-services educational opportunities.	16%
Training opportunities are not local.	23%
Training opportunities take too much time away from the delivery of program services.	30%
No barriers.	34%
The budget at this facility does not allow most program staff to attend trainings.	35%
STAFF TRAINING IN GENDER/CULTURAL RESPONSIVENESS	
Training implemented to build staff competency in culturally responsive substance abuse treatment (n=467)	73%
Training implemented to build staff competency in gender responsive substance abuse treatment (n=463)	58%

(cont.) DATA TABLE NO. 15: Training challenges & Strategies

STAFF COMPETENCY RELATED TO DIVERSITY (n=467+/-1)					
Statement	**Strongly Disagree**	**Disagree**	**Neither Agree nor Disagree**	**Agree**	**Strongly Agree**
My facility provides individual or group counseling in the languages of our service population	4%	17%	14%	43%	22%
My facility uses culturally and linguistically appropriate resource materials (including communication technologies) to inform diverse groups about substance use disorders	2%	12%	24%	43%	18%
My facility has program forms and documents available in the languages of our service population	3%	14%	17%	43%	23%
My facility systematically reviews procedures to ensure delivery of culturally competent services	< 1%	10%	23%	43%	22%
My facility considers cultural and linguistic differences in developing treatment practices	3%	7%	16%	53%	21%

(cont.) DATA TABLE NO. 15: Training challenges & Strategies

DEGREE OF AGREEMENT ABOUT STAFF TRAINING NEEDS (n=468+/-2)					
Statement	**Strongly Disagree**	**Disagree**	**Neither Agree nor Disagree**	**Agree**	**Strongly Agree**
Improving rapport with clients	12%	33%	14%	32%	9%
Matching client needs with services	6%	34%	18%	34%	9%
Assessing client needs	7%	30%	16%	37%	9%
Using client assessments to guide clinical care and program decisions	5%	28%	15%	42%	10%
Using client assessments to document client improvements	5%	26%	13%	46%	10%
Improving cognitive focus of clients during group counseling	5%	20%	17%	43%	14%
Improving client thinking and problem solving skills	5%	21%	13%	49%	12%
Increasing program participation by clients	5%	20%	15%	45%	14%
Improving behavioral management of clients	6%	19%	14%	46%	15%
Identifying and using evidence-based practices	6%	20%	13%	45%	16%

DATA TABLE NO. 16: Retention

TURNOVER (n=472)	
Direct care staff newly hired in past 12 months	52%
Past 12 month turn-over rate	18.5%

FACILITIES' IMPLEMENTATION OF RETENTION STRATEGIES (n=464+/-3)					
Retention Strategies	**Not Well At All**	**Somewhat Well**	**Not Sure**	**Well**	**Very Well**
More frequent salary increases	35%	29%	11%	21%	4%
Reduce paperwork burden	27%	37%	10%	19%	7%
Shorter hours/flextime/job sharing	23%	26%	20%	23%	8%
Smaller caseloads	14%	29%	20%	30%	7%
Promotion opportunities	12%	30%	14%	34%	11%
Mentoring opportunities	13%	26%	8%	41%	12%
Promote career growth	7%	25%	10%	43%	14%
Varied work opportunities	6%	21%	11%	43%	19%
Individual recognition and appreciation	6%	22%	6%	45%	20%
Health coverage and other benefits	13%	14%	3%	35%	36%
Better management and supervision	3%	16%	10%	50%	20%
Supportive facility culture	5%	14%	9%	45%	27%
Physical work environment	4%	13%	12%	48%	24%
Access to ongoing training	5%	16%	5%	43%	31%
Opportunities for program input	4%	14%	5%	46%	32%

ATTACHMENT 8:
CLINICAL DIRECTORS INTERVIEW ANALYSIS

CLINICAL DIRECTORS INTERVIEW ANALYSIS

Codes		Frequency	Source Count	Definitions	Quote(s)
Recruitment Challenges				**The challenges associated with recruitment of new professionals and employees in the substance use field.**	
	Resource barriers	14	13	The financial (adequate compensation) and structural (paperwork burden) resources that limit the ability to recruit and retain individuals in the substance use field.	Well, you know, one, always the money, and two, with all the systems you have to use for documentation, the paperwork is just ridiculously long, um, in the substance abuse field compared to a chart that you would do in a CPS or in mental health. It's so much more documentation. You know, from different funding sources, everybody wants certain information. And so, the clinicians spend an enormous amount of time doing paperwork – collaborative documentation. You know, with the client there, filling out the treatment plan, master treatment plan, you have to have a discharge plan. And it takes away, to be honest with you, it takes away from them giving better services to the client because your pay is even driven by getting your documentation in within 24 hours.
	The need to align substance use with mental illness	6	6	Ensure that counselors know that SUD treatment also addresses the issues of individuals who have mental illnesses. Recognizing that SUD treatment is part of mainstream healthcare.	It's that most people tend to think that smoking cigarettes is very harmful to your health, which, they are...but we also know for our clients, that oftentimes, smoking cigarettes, especially for schizophrenics, that it can calm down the voices...I mean, they may not agree with it, and I mean, we work with a very specific type of population. It's not just the dual diagnosis. I mean, it's not just substance abuse. But at the same time, I think it is our belief that probably the majority of people that are using drugs have some sort of mental illness too.
	Inadequate Compensation	6	6	Pay provided to providers and staff that does not support their retention in the substance use field.	Obviously, kind of one of the big things, one of the challenges to retain them as well as recruit them is just the knowledge that there's no financial payoff, really, which makes it incredibly difficult to recruit and also to retain. We have a lot of people come in – we have over the years – they come in and as soon as they find a way to either go into strictly mental health or private practice, or something like that, they are quickly out the door. That is definitely, probably the biggest barrier, just is the financial end of it.
	Challenge of substance use stigma	2	1	The challenge associated with the stigma that substance use is not a disorder and a legitimate health care issue; serves as barriers.	…A big contributor [recruitment challenges]…is how substance abuse treatment and substance abuse clinicians are viewed by the public and especially by others in the healthcare field. I frequently describe it as we are the "red-headed step child" when it comes to mental health. So when clinicians are approached as asked if they want to go into substance abuse and have that preconceived notion of what it is, the failure rate and the population, they just tend to steer away from it.

Codes		Frequency	Source Count	Definitions	Quote(s)
Recruitment Strategies				**The strategies associated with recruitment of new professionals and employees in the substance use field.**	
	Openness to change	17	12	A site/provider being able to adapt to the externally driven changes in order to foster sustainability.	I think the most important thing to do is to be open...what the goals and objectives are. Get some input....And, remain flexible, I mean, with what your ideas are, if they're not working? If you just can't dig in. You have that stability to say, 'This isn't working. Let's do something different' that goes from anything to staff, or new protocols, or how we write a treatment plan, or how we do updates or use of resources within the facility. I think you have to remain flexible. I mean you have to try things and if they're not working, you got to go to plan B.

CLINICAL DIRECTORS INTERVIEW ANALYSIS

continued

Codes		Frequency	Source Count	Definitions	Quote(s)
Recruitment Strategies				**The strategies associated with recruitment of new professionals and employees in the substance use field.**	
	Valuable external relationships	15	9	External relationships with partners, other agencies and institutions that are perceived as valuable.	Well, I think that what I mentioned...be willing to collaborate with other agencies. We don't want to feel like we're competing [with] them, but we have a working relationship with them...we also have a county board and a state division, and we have a pretty good relationship with the county board and we've always collaborated with them, too. I don't hide stuff from them and they don't tend to hide stuff from us.
	Positive relationships with universities	12	13	Relationships with universities and higher education institutions that are beneficial to recruitment and overall program processes.	Probably the first one I would talk about is, myself as the Clinical Director and our Executive Director. We both, um, sort of network with the one of the local universities. I taught classes, you know, just as a part-time thing in the counseling department and the social work department.
	Internship opportunities	12	11	Providing internship opportunities to lead to permanent employment within the SUD field.	We do have interns that come. I, myself, am a product of an internship years ago, and now many times, as I've said, many people are hired as interns, after they complete their internships.
	Clients transition to employees	5	3	A recovered client moving into a SUD treatment position.	When people get out of treatment and are successful in their recovery, sometimes they will come back and maybe put in an application for part-time work. – just to do prn work where you can fill-in at the desk, or heart monitoring – things like that… That's kind of…. If they work out in the part-time position, then when we have a vacancy on the night shift, or weekend shift, or whatever, a lot of times, if they are interested, then they will get the first shot at that position.
	Creating pipeline/pathway for internal promotion	4	5	Agency/organization has opportunities for individuals to enter into the profession and advance to upper level positions.	I was previously a supervisor and, um, when the job came open, I actually contacted my Executive Director and came in for the interview and was hired, basically, pretty much on the spot.
	Effective interview strategies	4	3	Strategies that are used during interviews to evaluate the best applicants.	It's pretty simple. We just have a series of questions that we ask, and also a lot of times what we will do also is have them sign a confidentiality statement, we will allow them to observe, see how things are going and then actually co-facilitate, just to see, as a final selection, to see who would be the best with the client and then we make the final choice.
	Loan repayment plan	3	2	Loan repayment plan provided to employees who work within the mental health field	...and then, once we hire people, we have quite a few staff who are on loan repayment programs, so we, um, participate in the National Health Service Corps, so, um, staff can get their student loans repaid if they sign a service commitment with us, because we're in a mental health shortage area.
	Positive reputation	3	4	A positive reputation that supports recruitment and retention.	So, I get all these applications and phone calls on a daily basis, but I do think that because of the high level of care and the word of mouth, through the schools and internship programs, that we are constantly participating, so word-of-mouth is out in the field, that this is an excellent program and that the staff is well taken care of and I do believe that that adds to the applications I get. I don't do anything other than that, it's really word-of-mouth.
	Communicating success stories	1	1	Using communication channels to tell other agencies and larger society about staff and their successes with clients	Well, we definitely celebrate our successes and then we also, on a newsletter that goes out to our agency. This is the process, this change happened and this is what it impacted. So, yeah, we definitely have celebrated our successes and share it with everybody. We share that these change teams are going on in the agency. They're working, things are moving, and that type of – and it's, it empowers the people on the change team. Wow, we did this. We even came up with shirts that had "Change Agents" on them and people would come up and say, "Wow. I want me one of those." You know, we definitely celebrate successes and announce things that are going on. Those shirts were very impactful. I was like, "Wow. They want a shirt that says 'Change Agent' on it."

CLINICAL DIRECTORS INTERVIEW ANALYSIS

continued

Codes		Frequency	Source Count	Definitions	Quote(s)
Training and development strategies				**Strategies associated with an agency/organization's ability to train and develop current and new staff.**	
	Commitment to continuing/ongoing education opportunities	17	14	Agencies/organization is committed to developing their staff through opportunities for continued and ongoing education opportunities.	And another thing that we do, too, is we do pay for the education of our staff. If they choose to, if they want to be certified counselors, or go on to become licensed – well, we don't have a license in California, to be certified counselors, we will pay for their education if they agree to stay on once they get through with their education. And, I can't remember whether it's one year or two years, after they have completed their education. And, um, then we also pay for their certification. And so, that's a lot of, um, incentive to retain them. Um, it tends to get them more loyalty to the program and more constancy to their professional, um, roles. And then we also encourage continuing education on a regular basis and, um, bring in interesting speakers to talk to the staff.
	Internal training	9	11	Providing training from within the agency/organization and allowing externally trained staff to train other staff.	Well, for instance, the adult program we were using before, the fidelity just was not there. Because it was very expensive to maintain to get people retrained when we had new people coming on, and so, we changed to something where we could train people on our staff, so when new people came along, instead of having to hire someone on the outside to come train, we could train them ourselves. Um, same thing for the adolescent program. We got a program that retained the kids longer, which had a higher success rate, and we had people trained to be trainers, so when new staff that comes on, we can train them ourselves. That was the primary thing.
	Valuable online and remote courses	8	6	Courses available to staff through online and remote agencies and institutions that are valuable	No, it's very simple – the Essential Learning is very simple to navigate. If I could do it, anybody could do it (laughter). Uh, yeah, um, our HR director gave everybody a brief tutorial email and, you know, step-by-step, and she said, you know, if you have any problems with the system, but, you know, so far, I've been in and out of it quite frequently, and have had no trouble at all. It prints out a little certificate when you're all finished. You have to take an exam at the end, which is nice, and then you get, um, a survey – they want to know if the courses are relevant, and uh, if they're too difficult, too short, uh, whatever, and then you can print out a certificate, which can be used for licensure, because most of the licenses are approved by NBCC, approved by NADAC, so, uh, and other licensures, like LCSW, so that's really helpful, too, when it comes time to get re-licensed, they can supply a certificate.
	Ongoing supervision and monitoring of performance	7	5	Process within organizations/agencies that allows employees to be supervised, receive feedback, and minority annual performance	Well, what we do is, we have clinical supervision. Meet with group and individual…discuss in group supervision and in individual sessions with the clinicians…to determine if they're using their skills, what they're doing with their groups and individuals sessions, problems they might be having...they reviews cases...so, yeah, there's ongoing monitoring in supervision.
	Value of cross-training	6	5	Collaborating with other sites and agencies to offer training across staff and providers.	I think one of the best things we do deals with cross-training our staff. I just think, you know usually you just have people who are residential assistants, and just have people working in your halfway house and people working in a detox center. Our staff is like cross-trained in multiple programs, and what's awesome about that is, you know, with budget cuts, staffing cuts and everything – you know, when somebody calls in sick, it's like, "Oh gosh, oh no, what do we do now?" So, we can actually pull somebody from another milieu, from the same shift, somebody that may have an extra person or an intern working with them, you know, and we can shoot them into the milieu that the person called in sick for. So, I think this cross-training idea has kept people really interested because they get to work in a lot of different things and different areas and do a lot of different things, you know, sometimes interviewing people or sometimes group work or sometimes lecture.
	Orientation provided to new employees	2	1	Orientation program provided to new employees to acclamate them to the agency.	I think the other thing – and I hope a lot of the other agencies do it – but I think we also place a big emphasis, when folks do come, we put them through a pretty extensive orientation. So, they're well aware of, I mean, all the internal protocol, policies, and I mean, basically the requirements for which to accomplish their job tasks. I think there's a big emphasis early on in orientation and preparation before they actually start to do some work. Now, depending on their years of experience and level of experience in working with our population, that may happen a little bit quicker for some individuals.

CLINICAL DIRECTORS INTERVIEW ANALYSIS

continued

Codes		Frequency	Source Count	Definitions	Quote(s)
Retention Challenges				**Challenges associated with an agency/organization's ability to retain current and new staff.**	
	Resource barriers	14	13	The financial and structural resources that limit the ability to recruit and retain individuals in the substance use field.	These are most common things everybody runs into, you know -- I don't have enough personnel; there's never enough time for everything; and there's never enough resources for everything. And so, you do what you can do with what little resources that you do have. And, you know, when they say, occasionally when they say I'm a little bit of a task master, I push 100% out of every employee I have. I don't get it always, but then, of course, there are those overachievers that want to give you more. But, you know, this is Mississippi we're talking about here, and guess every state is hurting right now financially, but, you know, there is not an abundance of resources. So, you have to figure out how to do a whole lot with the little that you do have.
	Changing treatment needs	8	6	Aware of the multiple needs of clients and changing treatment to be responsive these trends.	Oh, yeah. You know, you look at the people who came into the field more than, I would say ten years ago, we were still doing what I call two by four treatment, it was really considered just normal to go in and yell at your staff – your staff! – your client and be really confrontive and, you know, so when we were really looking at motivational interviewing, which has a very different approach and, you know, a client-centered approach, people were like, "Ah! Well, they're addicts, they're gonna lie to you and you can't treat 'em like that." You know, "They're just gonna get one over on you." And so, you know, so there's that whole shift of thinking had to happen.
	Staff not reimbursed for services	2	2	The process of staff and employees in substance use not being reimbursed for all of the services they provide to clients through insurance claims.	Other barriers….sharing of staff and moving our staff bnack and forth and collaborating…some things we have our staff involved in, we can't get reimbursement for. That's a discourager, you know. Even if it's a very productive thing for staff, very productive for our relationship with that other agency, there's limits. And the limit is not only can that other staff not get reimbursed for any involvement, our staff can't get reimbursed for any involvement. That has to do with billing and how the Medicaid and we also do indigent care.
	Managing family and career	1	1	The issue of trying to manage the demands of family and career.	So, it's quite a commitment for them to go to school or college….we are requiring a high level of education for our counselors, because it's very difficult for people to make it through the educational process, when they have to take care of a family, so that's a barrier, that's definitely a barrier.

Codes		Frequency	Source Count	Definitions	Quote(s)
Retention Strategies		**8**	**8**	**Strategies associated with an agency/organization's ability to retain current and new staff.**	
	Team-oriented practices	22	16	Using a team approach in daily operations and practices within the agency/organization.	One of the other things, a tip I learned from some other things, you know the team process has been really good, where one person thinks of an idea and to have a really strong management team and that takes a lot of work. You know, sometimes you run through really good spots and sometimes you run through not so good spots. I think that's one of the things that's really helped here is, you know, the management team is very diverse. I've got people with different skillsets and that's really helped, in terms of being able to implement different staff support to evidence-based practice. And, of course, a basic sense of humor. We say humor and food goes a long way.
	Develop professional development and training opportunities for staff	22	22	The identification and development of professional development and training opportunities that improves the knowledge and ability of staff.	We set the training, we make our trainings mandatory, for all our employees, our clinical staff, and set aside time just for the training. Then, after the initial training, we do our own ongoing training to assure that all the employees continue to have, I guess, Booster sessions on the information presented. When I say that, it doesn't necessarily mean it has to be group, it could be individually by their supervisor and they can always ask the clinical supervisor about any questions they have regarding the information presented.

CLINICAL DIRECTORS INTERVIEW ANALYSIS

continued

Codes		Frequency	Source Count	Definitions	Quote(s)
Retention Strategies …cont.				**Strategies associated with an agency/organization's ability to retain current and new staff.**	
	Democratic and inclusive work environment	13	15	The use of an inclusive and fair work environment that integrates staff input in programming and treatment.	…when we were talking about implementation, we don't just sit back, just sit in a room and make all the decisions for everybody when it comes to something like treatment, we get all of the therapists and say, "here's a treatment program, here's a website, see what it is that you think that you would like the most and then we will look at it and make a decision that's best for us."
	HIT implementation	9	11	The use of technology in supporting the needs of the agency and staff.	Yeah, they were skeptical at first, they thought, "Oh you guys, this'll never –" but once they saw it, they saw that wasn't going to be the case. And the other side of it is, you know, as far as computerization, I would say that, in the last 7 years to 10 years, we have implemented a lot of electronics into the system. And, um, there's always a learning curve that comes with this, and you introduce something new and the clinicians'll say, "Aw, here's something else we have to…" but once they get into it and are supported and are monitored through that transition, it's proven to work well. So, you know, the introduction of computerization has really helped us. And, it has lowered some costs, increased other costs, but it's really made us more efficient.
	Positive staff recognition	9	7	Recognition such as incentives, lunches, or events for staff appreciation to recognize staff and their work	We would give parties to people who were leaving. They would give two-weeks notice and we would have a little get-together. We would have a potluck, give them a card, and everyone would say their goodbyes...then we started celebrating people's anniversaries. If they were here one year, you know, we would celebrate one year anniversaries and have a potluck – saying, "You know, so and so has been here a year this month." Or if there were two or three celebrating at the same time, we'd say "Wow, thanks for your service for a year. We really appreciate it," have a potluck.
	Provide a collegial and positive work environment	9	9	A supportive and positive work environment where individuals work together in during every day and functional tasks.	You know, and I hate to say this, because I've not spent a whole hell of a lot of time in the other existing agencies, but we – there's a good atmosphere here. It's almost collegial. It is collegial. And, staff are really supportive of one another. And we encourage that. This is an open door atmosphere and place. You probably heard the laughter in the back.
	Staff autonomy	8	7	The ability of staff to be self-governing and contribute new ideas in substance use treatment	You know, give them the information, the tools, and the resources to do their jobs and then kind of get out of their way. And just run the business side/the paperwork side.
	Improved client satisfaction	8	7	An outcome associated with recruiting and retaining the right staff.	when they move up in a level of care, or if they move down in a level of care, like when people move from treatment to the halfway house, you know, they're already familiar with the staff up there. It's not like a whole new thing, a whole different people, all new staff. They've already worked with them up there and they're comfortable and I would think, if I went into a new job or something, and I already knew some of the people, I would feel more comfortable.
	Applicable to other organizations	6	9	The strategies an agency implements that are applicable to other agencies/providers.	My Executive Director has run numerous facilities and he's actually the one who brought it to us. And he has used this in other facilities and I don't see why this – why what we're doing couldn't be utilized in hospitals, substance abuse facilities, um, regular, you know medical facilities. What we are doing could literally be utilized in any educational setting, where you want to provide your staff with any kind of further training.

CLINICAL DIRECTORS INTERVIEW ANALYSIS

continued

Codes		Frequency	Source Count	Definitions	Quote(s)
Retention Strategies *…cont.*				**Strategies associated with an agency/organization's ability to retain current and new staff.**	
	Adequate compensation	6	6	Compensation/pay that is perceived as comparable to other health service professionals	One is, at Providence, in general, I think, compensates people a little higher and is capable of doing that as opposed to some of the small more independent programs. So, the pay is either comparable or a little bit ahead of the market. And then, also, because we are part of a large organization, you know, we get the benefits of, of that – like in regards to paid time off and, um, sick time – that type of thing. So, I think this is one thing that helps us retain people.
	Leadership model	6	6	An effective leadership model that promotes inclusion and reliance on evidence-based practices.	And, you know, our Executive Director, Elmer Rosenthal, has a background in many areas, but one of his particular areas of expertise is in Human Resources, um, management – in HR. And, one of the things that we've worked really hard, and he's led the way, is to make sure that we have really, really good human resource development and management and policies in place and that we enforce them very, very fairly and across the board, that all of our employees are very clear in terms of where they stand, that if they're doing well they know it and we want them to know that.
	Emphasis on staff well-being	5	5	Agency committed to the well-being and health of their staff.	The staff, they feel that you care and they know that you've got their backs. And they know they are in an environment that they can all flourish in. If they have a situation or a personal problem arises, they know they can sit down and talk with me and we can work it out.
	Creating pipeline/pathway for internal promotion	5	5	Agency/organization has opportunities for individuals to enter into the profession and advance to upper level positions.	I was previously a supervisor and, um, when the job came open, I actually contacted my Executive Director and came in for the interview and was hired, basically, pretty much on the spot.
	Working with other providers	4	3	The relationship and connection with other providers in the field.	I think so, because where I've gotten a lot of my ideas is actually sharing and working with other providers to find things that are motivators for different level staff. You know, because not one motivator works for everybody, so you've got to try to take a number of different avenues that run generational lines, if you will. You know, everything from baby boomers all the way down to the NextGen, and then finding out ways to prove with evidence-based practice and get training. So, if it wasn't for the support that we have in the community mental health system for sharing information and tips and tools and ways to keep one's sanity as we're moving along, I don't know that we would have necessarily gotten along this far.
	Motivation to conduct research on what works	3	2	Individual motivation to find and search for research that support practices and treatment in substance use.	So I started researching other successful agencies who were working with clients, and so did this other counselor. So, it was really just looking online, just trying to figure out, understanding our clients, understanding the dual-diagnosis, types of mental illness. I don't want to say it was trial-and-error, because I think we were pretty successful. Just, okay? You know we watched this video, we read this book, we thought okay, this could work and it worked.
	Leader supports professional development of staff	3	2	Leaders that encourage, support, and provide resources to promote the professional development of staff	You know, it says a lot about the Executive Director, you know? It's always been that way. You know, when he does a training, he expects people to come to it and that's good, because that's good because then we're all trained, say, in CBT or something, and we apply it, you know? We use it.
	Positive reputation	3	4	A positive reputation that supports recruitment and retention.	So, I get all these applications and phone calls on a daily basis, but I do think that because of the high level of care and the word of mouth, through the schools and internship programs, that we are constantly participating, so word-of-mouth is out in the field, that this is an excellent program and that the staff is well taken care of and I do believe that that adds to the applications I get. I don't do anything other than that, it's really word-of-mouth.
	Program fidelity	2	2	Program effectiveness and sustainability	Because we wanted to keep the fidelity of the program, the adolescent program that we have now, fidelity visits, which is excellent, because there's a high accountability rate, which showed we were doing the program correctly. And, you know, when we had our first fidelity visit after the first year, there were just some minor things we needed to change, but it was enlightening because it was like a refresher course for someone who was actually in selling the program. That was the main goal: maintaining the fidelity of the program.

ATTACHMENT 9:
THOUGHT LEADERS INTERVIEW ANALYSIS

THOUGHT LEADERS INTERVIEW ANALYSIS

Theme				Definition	Quote (s)
1. Macro-Level Changes to Healthcare and Treatment Delivery Subthemes: - Expanded delivery settings. - Integrated substance use treatment. - Financial support for reimbursements and services. - Effect of health care reform.				Effect of health care reform on delivery settings describes the impact of national policy changes on the ways in which substance abuse treatment is delivered. This includes potential changes in the location of service delivery from substance use treatment organizations to expanded healthcare settings, billing and reimbursement mechanisms, and effects of the Affordable Care Act on services.	"Well I think the big game changer for everybody across the country is the impact that the affordable care act will have; especially in January of 2014 when the coverage aspect of the affordable care act kicks in, so that's with the expansion of Medicaid and that's the expansion of the health insurance exchanges and it's also the requirement that employers provide coverage for their employees and as we know, inside of the affordable care act, that one of the ten essential health benefits is a substance abuse and mental health treatment and rehab services so its identified right in the affordable care act" "I think that the intent of the way health care reform was written is to bring substance abuse care into the physician's clinic or the ER, or the, um,ya know, the other, ya know, federally qualified health centers; so that as opposed to our field having a lot more doctors in it, I think that the, what we'll see, is that a lot more health care entities will contract out or hire substance abuse professionals to work there"
	Codes	**Frequency**	**# of Respondents**		
	Integrated services.	44	22	The integration of other health care settings, to include hospitals, primary care settings, and other community-based organizations in substance use treatment. Historically SUD treatment has occurred in isolation from mainstream healthcare. Weak referral systems have existed between SUD treatment and other healthcare arenas. Integrated delivery will see primary care and emergency room providers effectively screening and providing brief interventions for SUDs and providers will now work in integrated settings such as Federally Qualified Health Centers (FQHCs).	They can be (unintelligible) a lot faster, so I think what's starting to happen is that even in the mental health side [we are] starting to recognize that right now and then the other piece of this that's really, really key is the integration with primary care. So, there are these things called Medical homes and the concept there would be is that a person goes and gets all of their health care at one site and it would be integrated primary care so that they would get their OB/GYN services, Pediatric service, their internal medicine services, dentistry, all that type of thing, and they would get their behavioral health services in the same clinic and then be integrated as part of a team.
	Health care reform.	19	20	The opportunities and challenges associated with the Health Care Reform Act, to include integrating substance use as a legitimate disease and covering care, expanding and integrating delivery settings, and credentialing providers and peer recovery specialist to receive reimbursements.	Well I think the big game changer for everybody across the country is the impact that the affordable care act will have; especially in January of 2014 when the coverage aspect of the affordable care act kicks in, so that's with the expansion of Medicaid and that's the expansion of the health insurance exchanges and it's also the requirement that employers provide coverage for their employees and as we know, inside of the affordable care act, that one of the ten essential health benefits is a substance abuse and mental health treatment and rehab services so its identified right in the affordable care act…"
	Expansion of peer recovery specialist.	18	19	The increase and growth of peer specialists in the field. This group was recognized as a great asset to the field and continued recognition and development of this group is essential.	And the second thing we need to do is we really need to take advantage and expand the whole concept of peer counselors and peer support. Another thing they are calling them is a whole health care counselors. So that's the other thing that we are trying to work on right now is to actually develop the curriculum that can be used that are certifiable at the state level and recognized at the Federal level by CMS; so that we can bring in more peer counselors and then, what we have to do is we have to re-define the work teams, so that the peer counselor understand what their role is on the work team and then the existing professional staff understands what that role is."
	Managed care.	17	15	The move of substance use treatment to a managed care system.	So one of the ways that we are planning on addressing this and this will actually be a little bit, maybe a national effort through the National Associations of Counties, hopefully, is what we want to be able to do is two things, we want to be able to...describe what the problem is to the field, and I think the field will understand this quickly, second thing is [to] making sure that when we have current professionals, that are working in the field right now, that their trained to be able to work in the managed care environment because assigning the risk is commonly referred to, they're going to be using managed care principles to do that, we've got to make sure that the current workforce we have, all of our folks that are working, case managers, all the way up to physicians, psychiatrists, all understand how to work in a managed care environment.
	Lack of funding.	8	5	The larger economic issues and its impact on diminishing federal and state resources for the substance use field.	
	Reimbursement mechanisms.	8	10	The mechanisms required for substance use treatment to be paid and reimbursed through medical insurance plans.	
	Parity	3	7	The mental health and addiction equity act and its relationship to substance use treatment.	
	Criminal justice.	2	2	A setting described for substance use treatment.	

Theme				Definition	Quote (s)
2. Enhanced Pre Service Training, Professional Development and Uniform Credentialing Sub-themes: - Training needs of current workforce. - Training needs of future workforce. - Credentialing.				Professional development and training describes the professional development and training needs of the incoming and current substance use treatment workforce. This encompasses credentialing, education, mentoring and pathways to leadership, training to support the move toward EBP, and the use of new health information technology. These training needs also include the staff that will be engaged in subtance use treatment delivery when integration happens.	I think that we have to continue to create opportunities for people who are in recovery, people who have lived [and] experience and provide a pathway for those people to come into the field and to progress and rise... through the ranks and in our treatment program and treatment systems. I think that is very important I think...we have to have a much stronger strategy bringing people [from] academia and [other] backgrounds and I think we also need to be [able to provide]academic training"
	Codes	**Frequency**	**# of Respondents**		
	Training needs.	55	20	Under health care reform, the needs of existing, new and incoming workforce, and other fields to provide SUD treatment. Including but not limited to training in measurement, data analysis, a practitioner-focus model, knowledge of health behavior models, knowledge of options for treatment of individuals, technology usage and transfer, training for specific treatment options, and development of treatment plans.	We need counselors re-trained to provide brief treatment services. There is 85% of the people who have substance use disorders and not in treatment and there the 85% that need treatment [and] in 2014, no matter what happens with Health Reform, there will be a large number of people eligible for insurance a very large number that will need treatment. We know what the numbers are now and it seems to me that the workforce has to get prepared in how to handle that. However, they are not the same people that are in addiction treatment now. It's a different population. And we know that now. And so what needs to happen starting now, starting yesterday, as far as I'm concerned, is beginning to bring counselors to the table and other clinicians, functioning and substance use settings, treatment settings, and say to them, "what do you want to do?", "What are you ready to do?", "How are you going to retrain yourself?"
	Credentialing substance use treatment provider.	20	17	The credentialing and licensure of the SUD treatment workforce. It also relates to striving for uniformity in credentialing and licensure and the need to have that in place in order for the workforce to be recognized by new payers coming into the system such as Medicaid and private insurance.	I think there are two choices; there's either we have to change the law and become a licensed profession, which I think is the preferable piece; the other way is, what will happen is mental health professionals who have [a] certain amount of experience working in addiction treatment will be counted, their a higher level now, so if you have LCSW or an LP licensed professional counselor...and you work in an addiction clinic then you'll be…your reimbursement rate is higher...
	Credentialing of other providers in substance use.	20	13	The need to educate other healthcare providers in the treatment of SUDs. As healthcare reform expands access to treatment, it is expected that other health care providers will begin offering SUD treatment. Primary care and emergency room providers will have to have some substance abuse credential and skills to provide treatment. This is also true for mental health professionals. While they may have MH credentials and education it does not mean they are qualified to provide SUD treatment and will need specific additional credentials in SA if they do not already have it.	"I think that the addiction providers need to do, and what SATTC is doing here is that we are trying to build bridges between addiction and primary care to get...practitioners to feel comfortable with addiction [and] be skilled at recognizing it, be skilled at know[ing] what [addiction is]… know what [and] when to refer and what they can handle themselves and...move addiction into a more broadly accepted part of the medical model."
	Professionalization	13	8	The movement of the field towards a more credentialed, licensed and professional workforce.	The need for a more professionalized service worker is going to be critical, the need for management that is technically proficient in information systems and obviously playing in that kind of thing as well as the fact that we will now be part of a larger health care network means that the need to professionalize the service worker that hold greater credentialing, the need for greater and higher degrees is…it's going to be inevitable and the question for the field will be how to preserve what we in the past have cherished our recovering people who are not necessarily after the degrees of social work, may not be credentialed depending on the state and the requirements thereof, but who offer very valuable service in terms of understanding the disease, understanding the culture of it, and understanding how to exchange and interchange with clients coming in the system. So, we are going to have [to] find tiers of advanced education and training, absolutely credentialing has to be a major part now of everybody and it seems to me that's the obvious (ist) and one of the most onerous challenges that we've got.
	Leadership trends and needs.	6	6	The need to create opportunities for leadership and development within the current substance use workforce.	
	Standardized education level.	5	8	The importance of having uniformed training/education among individuals in the substance use workforce.	
	Peer specialist development needs.	5	11	The need to provide education and licensure among peer specialist.	

Theme				Definition	Quote (s)
3. Increased use of Evidence Based and Recovery Oriented Methods of SUD Treatment Targeted for a Changing Client Population and Emerging Drugs of Abuse Subthemes: - Focused on evidence-based practice and treatment. - Approaches to treatment.				The future of treatment encompasses the expansion and use of evidence-based treatments to meet the diverse needs of clients. This includes a focus on evidence-based practice, medication-assisted treatment, more uniform delivery of treatment across agencies, the changing role of peer specialists as part of the treatment team, and treatment for new drugs of abuse.	So you have to work with that, and I think that substance abuse treatment organizations and the workforce will have to be effective organizations from a business standpoint in relations to this, so that's a part of the workforce and the workforce is impacted by how viable the organizations are in the environment [and] that we see evolving for substance abuse treatment and I think the whole issue of evidenced base practices and how we align that with the available work force is going to be absolutely critical. [We need to] have a workforce that is doing the treatment that patients need based on what has been shown to be effective and somewhat standardized so that can be replicated in organizations and coordination with the primary care providers whether its medication assisted, expert, cognitive behavioral, motivational interviewing, there should be some level of effective standardization based on evidence so that the work force can be trained and available in a more effective manner.
	Codes	**Frequency**	**# of Respondents**		
	Use of evidence-based practices.	25	13	The reliance and importance of integrating evidence-based practices in the field and its role in reducing stigma, demonstrating effectiveness, and justifying continued funding support.	I think that the use of evidence based practices is another one, most people come into the field have to be re-trained around the latest and greatest practices because they are not getting that in the training programs and then for [other] people were coming through the ranks who were in recovery, who are moving up through the ranks and becoming clinicians themselves [and] I think they have the same challenges, so they may not initially be coming out of sort of reactive...you really need to be trained around empirical treatments, evidence based practice and learn how to incorporate those in their programs.
	Expansion of peer recovery specialist.	18	19	The increase and growth of peer specialists in the field. This group was recognized as a great asset to the field and continued recognition and development of this group is essential.	...[The] thing we need to do is we really need to take advantage and expand the whole concept of peer counselors and peer support. Another thing they are calling them is a whole health care counselors. So that's the other thing that we are trying to work on right now is to actually develop the curriculum that can be used that are certifiable at the state level and recognized at the Federal level by CMS; so that we can bring in more peer counselors and then, what we have to do is we have to re-define the work teams, so that the peer counselor understand what their role is on the work team and then the existing professional staff understands what that role is.
	Expansion of medication assisted treatment.	13	13	The continued and increased use of medication assisted treatment.	I mean I know that there's lots of people in this field that are very unhappy about the quote unquote medicalization but it's gonna happen and it has to happen and then it will, you know, ten years from now, it will be a different story...look at the history of what happened in the mental health field when medications came in after I guess it was in the 50's [and] 60's and it was in the 70's that CMHC's were really being developed and moving along. Yes that's a field that got medicalization too…I mean it's very interesting… what you, if you look at history; this is our first, first time, this is substance abuse first time to get medicalized; because it's the first time that we have had medications that work. And there are more, so many more to come."
	Future of specialty treatment.	13	14	The future directions for the current substance use treatment workforce.	...it should be patient centered driven so that at a minimum, patients can access care where they seek it and get some level of substance abuse treatment; hopefully the range of treatment they need but when that's not possible, effective referral arrangements to an available workforce.
	Shift to recovery focus.	10	10	The ways in which providers move patients into long-termed and sustained recovery.	
	New drugs of use.	8	9	New and emerging drugs of use, such as synthetic marijuana, bath salts and other prescription medications; the geographic location of existing drug use is changing and rural providers need to develop skills to deal with drug use they may not have treated before, such as prescription opioid addiction.	
	Opposition to evidence-based treatment.	8	7	The resistance by members within the current workforce to implement evidence-based practices and move away from non-science-based practices.	
	Complementary forms of treatment.	4	4	The types of treatment that compliment evidence-based and science-based practice (e.g., accupuncture, cognitive behavior therapy, tele-behavioral health, etc.).	

Theme				Definition	Quote (s)
4. Workforce Recruitment and Retention Efforts Subthemes: - Recruitment and rentention needs. - Demographics.				Transitioning workforce describes the current demographics of the workforce along with the specific recruitment and retention challenges to build workforce capacity to meet future service needs. Demographics include the "aging out" of the current workforce. Recruitment and retention needs are associated with the recruitment and retention of young, diverse, credentialed professionals.	I think that the biggest is moving to main stream health and in many ways it provides an opportunity now for the field to come… transform itself as well and both in careers [and] how we are presently situated and also, for possible new careers...I mean its kinda the same sorta same issue you always have in the work force...around recruitment and retention and training and how you're building the next wave of leaders for the field.
	Codes	**Frequency**	**# of Respondents**		
	Need for diversity.	25	15	The rising need in the field for providers to represent the diverse needs of their clients, including age, ethnicity, and orientation. Historically this field has not been a diverse one and there is a need to recruit younger individuals with diverse ethnicities to provide treatment to a diverse population of patients.	We need to have people of various racial, ethnic, sexual orientation [in the field] and when you sort of sort [have] all backgrounds in all levels within the treatment system and program...people from racial ethnic groups tend to not be [at] different levels of organizations [and] are not represented in the organizations and systems.
	Recruitment challenges.	22	19	The challenges associated with bringing in young professionals and an educated workforce in the substance use field. Often a career in SUD treatment is not considered by individuals choosing a career path and it is not recognized as an option.	I think the field runs the risk of continuing this horrible trend of payment…being underpaid, if counselors and other folks don't decide there are going to do science based practices, evidence-based practices. That includes medications; why should anybody pay a counselor to do anymore to just continue to do group?
	Retention strategies.	11	11	The ways in which individuals can be retained in the substance use field.	
	Aging out.	10	8	The current substance use workforce that is getting older and reaching retirement.	
	Fear of losing professional license.	2	1	The feelings of fear by the current workforce of losing their professional license with the implementation of new standards and guidelines under health care reform.	
	TOTAL	**70**	**11**		

Theme				Definition	Quote (s)
5. Recognition of Substance Use and Addiction as a Valid Healthcare Issue Subthemes: - Reducing stigma. - Strategies to recognize substance use as a disease.				Recognition of substance abuse as a valid healthcare issue encompasses the ways to reduce stigma and strategies, such as provider advocacy, to recognize the value of the substance use field to overall health.	I think the trend towards people going and having an advanced degree will continue, be maintained and so that may show up in numbers as well, like Rick said, it's not as well-known with the numbers now with the Masters Degrees, with encouragement, discussions even kind of promotions from the guilds themselves, that, that may be a trend that we see more with advanced degrees providing direct care. I would hope to accept more, acceptance of the work, that those in addiction do as a core part of the health team as we continue, as Rick said, to chip away at some stigma issues, hopefully, specific references in legislation and regulation help and that has a trickledown effect sort of speak, to those providing the care and we would hope that there will be some, some give way to that, after that I (unin), I gotta to dust off the (unin) a little bit and think, but, it's been a wild ride and its only been a year plus since the affordable care passed so I know in three years, it will be even more fun, to look back.
	Codes	**Frequency**	**# of Respondents**		
	Recognizing the value of treating substance abuse disease.	21	17	The recognition and value of treating substance use disorders and its positive effects on the overall health of individuals. Traditionally SUD treatment has not been recognized as a mainstream part of healthcare and recognition needs to be given to SUDs as a brain disease and treated alongside other mainstream health problems. The value of treating an individual for SUDs is not known in the rest of healthcare and the benefits this can have in recovering from other healthcare issues.	We need to stay as an independent specialty, but demonstrate our value-added. We need to effectively convince payers, colleagues, etc. that what addiction professionals do is important and has value. We need to show that here's what happens when patients have access to services, costs go down, in general. There are huge cost offsets on the healthcare side. If we are absent, providers will be marginalized. Therefore, this is a huge challenge. We need to rethink and reframe what we do.
	Stigma among non-substance abuse providers.	8	7	The stigma among other health care providers towards substance use disorders.	
	Role of the workforce in reducing stigma.	5	4	The use of the current substance use workforce to provide education to other fields and work to reduce stigma within the larger society.	
	Public perception of substance abuse.	2	4	The stigma associated with substance use disorders and addiction treatment by the public.	

Theme				Definition	Quote (s)
6. Implementation and Use of Health Information Technology Subthemes: - Improved access to information. - Improved quality of record keeping. - Barriers to implementing health information technology.				Utilizing health information technology refers to the implementation of new technology in the workforce (i.e., software programs) to manage patient records, confidentiality, and report generation. This includes potential barriers to using HIT, improved access to allow for more sharing of information across delivery settings and report generation, and improved quality of record keeping.	Certainly there are many many people who see developments as a distinct plus, better record keeping fewer mistakes in the diagnosis and treatment [and] I don't know that it has a significant downside how likely is it going to be that this is going to be an important part of substance abuse assessment and treatment, I mean if we have inadequate resources to support the work force [and] are these going to be sufficient resources available to enable records to be electronically recorded. I don't know…I mean, I think such of what we can do comes down to the funds that are available and the motivation from administrators and others to allocate those funds, [and] again substance abuse is so much further down on the hierarchy of public esteem that I have great doubts about the new funding for whatever noble purposes.
	Codes	**Frequency**	**# of Respondents**		
	Health information technology barriers.	17	16	The specific barriers such as fear of unknown, lack of knowhow, funding and infrastructure to support the integration and use of health information technology.	I think there is going to be some training needs, because any time you're integrating a new technology into somebody's work, at a very basic level they have to learn how to use it. I mean, there are training needs there I think I'll admit I'm probably not the best person to talk a lot about health IT, I mean, I know that you know that the affordable care act would love to see the greater implementation of electronic health medical records but I think it's going to be a slow process in part because it's expensive to do and you know there will be some organizations that have the resources to really get going with that I think it's going to take longer than people are anticipating."
	Increased sharing and quality of information.	5	10	The dissemination and sharing of information across providers and through larger state and federal agencies.	
	Report generation.	4	4	The use of technology to develop medical/client reports and keeping records of substance use treatment.	
	Issues of accountability.	2	2	The use of health information technology in record sharing and confidentiality of patients among providers.	