OPTIMIZING CANADA'S ADDICTION TREATMENT WORKFORCE:

RESULTS OF A NATIONAL SURVEY OF SERVICE PROVIDERS

Alan C. Ogborne PhD
and **Greg Graves MA**

CCSA · CCLAT

Table of Contents

This document was published by the Canadian Centre on Substance Abuse (CCSA) and was made possible in part through a financial contribution from Health Canada. The views expressed herein do not necessarily reflect the views of Health Canada.

Suggested citation: Ogborne, A.C., & Graves, G. (2005). *Optimizing Canada's addiction treatment workforce: Results of a national survey of service providers*. Ottawa, ON: Canadian Centre on Substance Abuse.

For additional copies, contact
CCSA, 75 Albert St., Suite 300, Ottawa, ON K1P 5E7
Tel.: 613 235-4048 E-mail: info@ccsa.ca

This document can also be downloaded as a PDF at www.ccsa.ca

Ce document est également disponible en français sous le titre : *Optimisation de la main-d'œuvre affectée au traitement des toxicomanies au Canada : résultats d'une enquête nationale auprès des fournisseurs de services*

ISBN 1-896323-48-0

Executive summary

Overview

A confidential mail survey of executive directors or agency heads, and staff of specialized substance abuse treatment agencies and services was conducted during May–November 2004. The objectives were to explore issues related to workforce development: 1) Staff training, recruitment and retention; 2) Professional development; and 3) Support for service enhancement mechanisms. A secondary objective was to assess the influence of a number of best practice reports published by Health Canada

The survey targeted random samples of agencies/services in British Columbia, Ontario and Quebec, and all eligible agencies/services in other provinces and in the Northwest Territories. Two hundred and eighty-one (281) agencies/services were surveyed along with 2,720 staff working in these agencies/services. Completed questionnaires were received from 170 (60%) executive directors/service heads and 1,214 (44.6%) other staff. Responses were received from a large number of individuals in all regions and are viewed as providing a reasonably valid picture of professional development issues facing substance abuse treatment agencies in most parts of Canada.

Agency accreditation

Fifty-nine percent (59%) of executive directors/agency heads indicated that their sites were "accredited". The respondents further identified the specific organizations responsible for accreditation in the following order: Canadian Council on Health Services Accreditation (CCHSA) (28%), the Commission on Accreditation of Rehabilitation Facilities (CARF) (6%), and the Alcohol and Drug Recovery Association of Ontario (ADRAO) (3%). "Other" was chosen as the accreditation body by 21% of respondents.

Respondents' characteristics and qualifications

The average age reported by executive directors/agency heads in different regions ranged from 40 to 50. In BC/NWT and Ontario, the majority of the respondents were women (70% and 60% respectively), but elsewhere the percentage of women ranged from 30% to 46%. In all regions, the majority of executive directors/agency heads reported working in the addictions field for 8–14 years and held their present positions for 6–10 years. Across regions, the majority had either a BA/BSc or MA degree with a smaller proportion at the community college level. The majority also reported formal education in human services. The percentage of executive directors/agency heads indicating a personal history of alcohol or drug problems ranges from 28% to 35% in the Prairies, BC/NWT and Quebec. This percentage is lower in Ontario (17%) and lowest in the Atlantic region (5%).

Questionnaires completed by other staff show that, on average, respondents from all regions were in their early 40s. The majority in all regions (55%–70%) were female and had worked in the addictions field for 8–10 years. These respondents had an average of five years in their current positions, with the exception of the Atlantic region at 8.9 years. The majority of respondents in all regions also reported having some post-secondary education, except for the Prairie region. At least 60% had a university degree and at least 17% had a Masters degree. The majority in all regions also reported having some formal education in the health or human service field. Between 19% and 46% of front-line staff across different regions reported a history of personal problems with alcohol and drugs.

High percentages of respondents in some regions reported having or working towards a *certificate in substance abuse studies*, but this was lower in other regions. For example, the rate was high within the Addictions Foundation of Manitoba (AFM) (63%) and Ontario (43%), but less so within the Alberta Alcohol and Drug Abuse Commission (AADAC) (20%) and the Atlantic region (16.1%).

The percentages reporting *certification as a substance abuse counsellor* or working towards such certification varied considerably (9% in the Atlantic region to 42% within the AFM). However, written responses to a question about the certifying body indicated that many respondents did not distinguish

between having a *certificate* from a university or college and being *certified as an addiction counsellor*. Certification with the Canadian Addiction Counsellors Certification Board (CACCB) or any other recognized certifying body in the field of substance abuse was only indicated by 3% or less in most regions except Ontario where 15% of respondents indicated the CACCB as their certifying body.

Between 24% and 57% of respondents in all regions indicated that they were certified by another professional body (mainly nursing or social work) and similar proportions indicated that they were members of professional associations (again, mainly nursing or social work).

Work satisfaction and intentions to remain in the field

More than 90% of all respondents indicated that they derived "quite a lot" or "a great deal of satisfaction" from their work. However, a few written comments indicated frustrations with workloads, paper work and other bureaucratic issues. A question about the number of years that respondents expected to remain in the treatment field was unfortunately left blank on almost 40% of the questionnaires returned by program managers/supervisors and front-line staff. However, among those who did answer this question, 39% indicated that they intended to leave the substance abuse field before they reached age 55. Thirty percent (30%) of those aged 40 or less also indicated that they intended to leave the field within the next five years.

Managers' expectation for staff education and training

Among those who indicated that they were managers and supervisors, almost all indicated a strong preference for counsellors to have some level of post-secondary education (e.g., college or university). A preference for counsellors to have a *certificate in addiction studies* was indicated by 27%–50% of respondents and 38%–62% indicated that they preferred counsellors to be *certified*. The majority of respondents in all regions (56%–70%) indicated that all current counsellors met minimum qualifications for their work.

Managers' preferences for academic qualifications of attendants and support workers were generally split between a high school and college-level education, with a slightly stronger preference for college. From 40% to 50% of respondents indicated that attendants/support workers met minimum qualifications for their work.

Staff recruitment and retention

A sizeable minority or, in some cases, a majority of respondents in all regions indicated concerns about staff recruitment and retention and about wages and benefits, job security among staff and opportunities for staff advancement. There were some statistically significant differences across and between regions.

Professional development issues

There were some significant regional differences concerning the provision of financial support for external courses of study, offering in-house seminars, and staff access to the Web.

The majority (73%–85%) of the executive directors/agency heads form BC/NWT, Ontario and the Atlantic region agreed with questionnaire items pointing to a lack of resources and limited opportunities for professional development. Only about half of the respondents in the Prairies and Quebec agreed with these items.

Many respondents to both questionnaires indicated concerns about limited budgets, lack of money, funding, and professional development support. Still, staff in all regions indicated that they had engaged in some professional development activities in the past year and that many had spent more than five or six days participating in professional development activities. The majority of staff in all regions/jurisdictions also reported that they had participated in outside training in the past year. This was mainly funded by the employer, but in some cases respondents indicated that they also paid for at least part of this training.

The majority of respondents indicated that staff members were encouraged to set professional development goals during annual performance reviews. At the same time, a substantial

minority (30%–46%) also indicated that staff did not always make use of professional development opportunities. Across all regions, 15%–29% of respondents indicated that their agencies had not developed, and were not currently developing, written professional development policies.

Staff was asked to rate the priority of items in a long list of professional development needs. Most were rated as high priority by a substantial minority of respondents from all regions. The areas of substance use and mental health and counselling skills were rated as a high priority by at least 40% of respondents in most regions/jurisdictions. There were statistically significant differences in responses across regions and between some pairs of regions for items. However, no clear response pattern is evident and the results indicate many unmet needs in all areas.

Initiatives to enhance service delivery

The majority of all respondents indicated that several listed treatment initiatives could enhance service delivery and especially a "Canadian website", "national standards", "accreditation", "Bachelor's and Master's degrees" "distance education", "scholarships", and "electronic and written bulletins", "counsellor certification", a "professional association" and a "national conference" on addictions.

Influence of best practice reports

All respondents were asked to indicate if any of seven best practice documents published by Health Canada had influenced their service/programs. The responses indicated that these reports had, where appropriate, generally supported existing practice or led to positive change. These influences were more likely to be indicated by executive directors/agency heads than by other staff, but were common in both groups.

Sectoral differences

A number of bi-variate analyses were used to explore sectoral differences with respect to selected issues. There were few large (>20%) differences among responses from executive directors/agency heads in different sectors. Those working in outpatient services (96%) were more likely to report that staff had at least good access to a Web-linked computer compared with all other sectors (70%–82%).

There were many statistically significant differences among staff working in different sectors, but most were not large enough to be of any clear practical significance for workforce development initiatives. It is noteworthy that those working in outpatient services (82%) were more likely than others to have a university degree compared with all other sectors (57%–62%). Those working in outpatient (75%) were more likely to have education plans compared with all other sectors (19%–64%). In addition, those working in residential service (7.2%) were more likely than all other sectors (2–3%) to have or to be working toward certification by CACCB.

Background

In the human services field, workforce development is clearly growing in importance in Canada and internationally and those concerned with this issue include policy makers, researchers, public and private sector practitioners and ultimately the general public (Ogborne, Braun, and Schmidt, 2001; Velleman, Heather, Hay, Kemm, 2001; Roach, 2001). In the field of substance abuse treatment, workforce development initiatives would ideally encompass all settings in which treatment takes place. This includes specialized treatment agencies and other agencies that provide counselling to people with substance abuse problems among more general caseloads.

Workforce development measures go beyond practice development and addictions education to include standard-setting, certification, accreditation, and related schemes designed to enhance the effectiveness of treatment delivery. Workforce development seeks to enhance policies, systems and structures that create and sustain the capacity of work environments to deliver cost-effective services. It includes the full gamut of factors that influence professional performance—structural factors in the workplace, information supports, work incentives (and disincentives) as well as education and training issues, and building capacity to sustain good practice (Roach, 2001; Hough, 2004).

In the current study, priority is directed to workforce development efforts that target specialized alcohol and drug services. These form a large and costly component of the Canadian addiction workforce and it is important to ensure that their professional practices reflect the significant expansion in the knowledge base concerning substance abuse treatment that has occurred in the past two decades.

In Canada, there are a number of important measures and initiatives concerning workforce development in the area of substance abuse treatment, but there is much that is not known. The need for leadership and coordination at the national level is also widely acknowledged. Thus, commensurate with its mandate, and with Canada's renewed drug strategy, the Canadian Centre on Substance Abuse (CCSA) is working with those in the addictions field to address these issues. The current vision that shapes CCSA's work in this area is one of an addictions treatment workforce that is and will remain optimized for the benefit of its clients.

This report concerns one of CCSA's main workforce development initiatives—a national survey of treatment agency/service directors and staff. The aims are to determine the levels and types of education and professional development experiences among directors and front-line workers in specialized treatment agencies and services, to identify training and professional development needs, and to explore factors that influence the ability of the workforce to provide services of the highest quality. The findings will serve as a primary reference for a national meeting of stakeholders tasked with developing a national workforce development agenda. They will also serve as a baseline against which CCSA and our partners can measure outcomes of activities undertaken to address issues arising from the survey. Finally, the results of the study will also clarify the need for further research into the training and professional development issues facing this workforce.

Survey objectives

The survey had five objectives concerning three distinct issues:

A. Concerning staff training, recruitment and retention in addiction treatment services

1. To examine inter-regional and inter-sectoral differences in the educational and training experiences of clinical staff in specialized addiction treatment programs with various types and levels of work experiences;

2. To determine the expectations of program managers in different regions and sectors for levels of education and training among staff with different levels of work experience;

3. To describe the experiences in different regions and sectors with respect to staff recruitment and retention.

B. Concerning professional development issues

4. To determine the views of service providers in different regions and sectors on various issues pertaining to professional development (e.g,. adequacy of resources, needs, policies, methods).

C. Concerning support for various service enhancement mechanisms

5. To determine the views of service providers in different regions and sectors on various options for enhancing the capacity of the addiction treatment programs (e.g,. program accreditation, counsellor certification, national association).

Methods

Survey instruments and implementation

The survey featured two self-completion questionnaires and associated cover letters (see Appendix A).[1] The first was for directors of specialized agencies or heads of distinct substance abuse treatment services within other agencies. The second questionnaire was for managers/supervisors and front-line clinical staff providing treatment for substance abuse in these agencies and services. These questionnaires were developed following a review of the literature and in collaboration with key informants in the field, and were pilot-tested in several provinces.

Several attempts were made to ensure the highest possible response rate for the two questionnaires. A copy of the first questionnaire was sent with a customized version of the associated cover letter to directors of specialized treatment agencies and heads of distinct services in other agencies for self-completion. Follow-up telephone calls were made to the executive directors/agency heads after two weeks to encourage the return of their questionnaire and to seek their agreement to distribute a second questionnaire to their staff for completion and return. Packages of the second questionnaires and associated cover letters were then prepared and mailed out to the respective agencies.

A fax or e-mail reminder was sent out to executive directors/agency heads four weeks after the initial mailing, to request the completion of the questionnaire. A second reminder was sent four to six weeks later as a final reminder for returns.

1 Codes unique to each agency were written on all questionnaires to monitor data collection. With this approach, respondents remained confidential and did not write their names on the questionnaires.

The survey started on May 1, 2004 and was completed on November 1, 2004.[2]

Target agencies and sample selection

The survey targets all free-standing substance abuse treatment agencies in all provinces and regions as potentially eligible. The following types of agencies were excluded because of their small numbers and specialized nature (and in some cases a lack of up-to-date listings):

- those that only serve people convicted of drinking and driving
- supportive/transitional housing services with no distinct addiction programming
- those that only offer smoking cessation programs
- those that only offer programs for gamblers
- those that only offer programs for people referred by employers
- individuals in private practice
- those that only provide needle exchange or outreach services
- free-standing methadone programs
- those that only serve the military or other special groups (nurses, doctors, clergy, people with HIV/AIDS, prisoners).

Agencies funded by the First Nations and Inuit Health Branch of Health Canada or other First Nations agencies were also excluded because other initiatives that targeted these agencies were ongoing or being discussed at the time of the survey.

Services provided by non-specialized agencies with specific addiction treatment services were included in the survey.[3] Non-specialized agencies that served people with alcohol/drug problems but did not have a distinct addiction treatment service/program were therefore excluded. This extended to a wide range of services, including school boards, family service agencies, community counselling and health agencies, and the Elizabeth Fry or John Howard Society. There was no complete listing of such services and their diversity would have complicated the process of contact and engagement in the survey.

There was no complete national listing of eligible agencies or services at the time of the survey. However, various types of lists or databases were available and these were used to select samples as shown in Table 1. For British Columbia, Ontario and Quebec the sample sizes were chosen to ensure that the results would be accurate within 10 percentage points 95% of the time. In total, 590 agencies or services were considered eligible for the survey and 281 (47.6%) were selected as indicated in Table 1.[4]

Table 1 shows that agency/service heads that responded to the survey identified a total of 3,871 staff and were sent a total of 2,720 questionnaires for distribution. Questionnaires were sent to 70% of identified staff. Cut-off levels were established to determine the number of questionnaires sent to each agency/service based on the size and type of site. In a few cases, the directors of these programs indicated the staff were "too busy" to participate in the survey.

2 The original completion date of the survey was September, 2004, but this date was extended to November due to delays in responding during summer months when managers and staff were on vacation.

3 If these agencies included a listing of addiction treatment services in their directories.

4 If possible, replacements were selected for those sites that could not be contacted to verify eligibility.

TABLE 1: Listings and sample selection for each province/region

PROVINCE/REGION	LISTINGS	SAMPLE SELECTION
British Columbia	List purchased from Information Service Vancouver showed 192 eligible agencies.	Stratified random sample of 63 agencies. Stratification by type as indicated in listing: counselling, intensive day, detoxification or residential.
Northwest Territories	Two agencies identified by local contacts.	Both agencies selected.
Alberta	23 eligible agencies identified with assistance from the Alberta Alcohol and Drug Commission (AADAC)—including AADAC and AADAC-funded agencies.	All 23 agencies selected, including AADAC.
Saskatchewan	25 eligible agencies identified on Saskatchewan Health website	All 24 agencies selected.
Manitoba	13 agencies identified with assistance from the Addictions Foundation of Manitoba (AFM)—including AFM and AFM-funded agencies.	All 13 agencies selected, including AFM.
Ontario	Updated listing of 172 eligible agencies obtained form the Ontario Drug and Alcohol Registry of Treatment.	Stratified random sample of 63 agencies. Stratification by type as indicated in listing: multi-service, outpatient, detoxification, residential.
Quebec	List of 12 detoxification centres and 127 treatment agencies obtained from the Association des intervenants en toxicomanie du Québec (AITQ).	Selected all 12 detoxification centres and a stratified random sample of 55 treatment agencies. Stratification was by region.
New Brunswick	Each Regional Addiction Service of New Brunswick (N= 7) was regarded as a distinct agency for the survey. Two other agencies were also identified by a regional manager.	All seven regions and the other two identified agencies were selected.
Nova Scotia	Each District Addiction Service of Nova Scotia (N= 4) was regarded as a distinct agency for the survey. No other agency was identified.	All four districts were selected.
Prince Edward Island	Each Regional Addiction Service of Prince Edward Island (N= 5) was regarded as a distinct agency for the survey. No other agency was identified.	All five regions were selected.
Newfoundland and Labrador	Each Regional Addiction Service of Newfoundland and Labrador (N=6) was regarded as a distinct agency for the survey. Three other agencies were also identified by a regional manager.	All six regions and the other three identified agencies were selected.

Results

Response rates

All tables referenced in this section are included in Appendix B.

One hundred and seventy executive directors/agency heads (170) completed the survey while six declined to participate. As such, there is a 60% response rate with 170 of 281 agencies completing the survey. For 50 other agencies (17%), at least one questionnaire was received from a program manager/supervisor or front-line staff, but not from the executive director/agency head. Overall, at least one questionnaire was received from 220 (78%) of selected agencies.

At least one manager/staff questionnaire was completed by 178 agencies or 93% of those that had at least one staff member. Of the 2,720 manager/staff questionnaires mailed to these agencies, 1,214 (44.6%) were completed by an appropriate respondent[5]. Questionnaires were discarded from the sample when ineligible respondents returned a questionnaire for the survey (e.g., cooks, secretaries, summer students and one chauffeur).

Table 2 shows a summary of response rates by region and jurisdiction. The two "Provincial Agencies" referenced in this table are the Alberta Alcohol and Drug Abuse Commission (AADAC) and the Addictions Foundation of Manitoba (AFM). The table entries for "Atlantic regional services" encompass responses from regional managers at provincial addiction and/or addiction and mental health services in Newfoundland and Labrador, Nova Scotia, Prince Edward Island and New Brunswick. All free-standing substance abuse treatment agencies and treatment services provided by agencies other than AADAC, AFM, or by an Atlantic regional service are grouped under "All Other".

In summary, the overall response rate for executive directors/agency heads was 60% and the response rate for managers/supervisors and front-line clinical staff was 45%. Questionnaires for executive directors/agency heads were completed and returned by 19 (86%) regional managers in the Atlantic provinces and by each of the representatives of AADAC and AFM. Table 2 also shows the response rates for executive directors/agency heads and response rates for front-line staff in all jurisdictions. Where the sample size is small, caution should be exercised when interpreting differences. Quebec had the lowest response rate (48% for executive directors/agency heads and 23% for staff) among provincial jurisdictions with the largest samples. AADAC and AFM have the highest response rate for staff at 64% and 87% respectively.

Selected characteristics of responding agencies

This section presents executive directors/agency heads across selected characteristics (e.g., clients served, funding sources, and accreditation) for agencies participating in the survey (N=170). Table 3 shows that almost all responding agencies targeted services to men and women with both alcohol and drug problems.[6] In addition, the table shows that several special populations received services from these agencies, including seniors, youth, people with concurrent disorders and gambling problems, injection drug users, alcohol clients, drug clients, and other types.

Table 3 shows the funding sources for the responding agencies. Provincial/territorial ministries of health and social services are clearly the largest funding source (59%) followed by regional health authorities and addiction services (32%). The remaining funding sources are spread across federal, provincial, and local levels of government.

Table 3 shows that the Canadian Council on Health Services Accreditation (CCHSA) is the largest organization responsible for accreditation in Canada (28%) followed by the Commission on Accreditation of Rehabilitation Facilities (CARF) (6%) and the Alcohol and Drug Recovery Association of Ontario (ADRAO) (3%)[7]. A sizeable proportion of agencies cited

5 Based on self-description, but excluding four questionnaires completed by self-identified executive directors/agency heads.

6 Due to differences in the wording of items between the two questionnaires developed for the survey, no comparable data are available for other agencies where only managers/supervisors of staff returned questionnaires (N=50). However, information on staffing levels obtained for all agencies at the time they were first contacted showed that staffing levels among agencies where the executive director/service head returned a questionnaire were similar to others.

"Other" as the accreditation body (21%). These other bodies included the Salvation Army and an accreditation agency unique to Quebec.[8] All together, CCHSA, CARF, ADRAO, and "Other" account for 59% of all accreditation sources.

Further analyses (not reported in a table) showed that CCHSA accreditation was reported by some agencies in all regions, but the percentages varied considerably. Of those in the Atlantic region 80% (N=16) reported CCHSA accreditation, but this was reported by only 6% (N=2) of agencies in Quebec. Of agencies in British Columbia, 11% (N=4) were reportedly accredited by CCHSA while for the Prairies and Ontario the percentage of CCHSA-certified agencies was 37% (N=15) and 27% (N=11) respectively. Accreditation by ADRAO was limited to agencies in Ontario at 14% (N=6) while CARF accreditation was only reported by agencies in British Columbia at 26% (N=9) and Ontario at 5% (N=2).

The next sections present data related to each of the main objectives of the study.

Respondent demographics, education and training and related issues—analysis by region

Table 4 shows that the average age of executive directors/agency heads[9] in different regions ranged from 40 to 50 years old and were lowest in Ontario and highest in the Prairies. The majority of the respondents in BC/NWT (71%) and Ontario (60%) were women while this proportion drops to slightly less than half in the Prairies (46%) and the Atlantic region (40%) while the lowest level is in Quebec (30%). Across Canada, the majority of respondents had worked in the addictions field for about 8–14 years and held their current positions for about 6–10 years.

Table 4 shows that executive directors/agency heads are very well educated as a whole. Across regions, the majority of the respondents had either a BA/BSc or Master's degree with a smaller proportion at the community college level. The Prairie region follows this trend, but is more spread out across a wide range, from the high school to PhD level, with a much lower proportion of MA graduates (12%).

The professional experiences of the respondents appears well suited to a management role in the addictions field. The majority have formal education in the human service field while smaller proportions have experience in the health field. Not surprisingly, notable proportions have a background in business education, ranging from 20% in BC/NWT to 39% in Ontario. The majority of executive directors/agency heads cited "a lot of relevant experience" for their work and the percentage reporting a personal history of alcohol or drug problems ranged from 28% to 35% in the Prairies, BC/NWT and Quebec. This percentage is lower in Ontario (17%) and lowest in the Atlantic region (5%).

Table 5 shows demographic and certification information on managers/supervisors and front-line clinical staff by region (N=1,214)[10]. This table uses weighted data so that sample estimates are converted to project a full population.[11] Given the large sample, most of the overall differences across regions were statistically significant as were differences between many pairs of regions/jurisdictions. The table shows that, on average, respondents from all regions were in their early 40s. The majority have worked in the addictions field in the range of 8-11 years and have been in their current positions for four to seven years. The majority of respondents in all regions also reported having some post-secondary education, except for the

7 Since the start of the survey, ADRAO is now called "Addictions Ontario".

8 In a few cases, funding agencies were erroneously identified as accrediting agencies.

9 For reasons of confidentiality, the two respondents from AADAC and AFM are included with others from the Prairies.

10 A large number of questionnaires were returned from AADAC (N=200) and AFM (N=68). As a result, the data for the agencies are separated from other Prairie agencies in this and all other tables that use data from questionnaires completed by staff.

11 The weights applied were computed to reflect the probability of selection and response rate for the sample.

Prairie region. At least 60% had a university degree and at least 17% had a Master's degree.

Table 5 also shows that the majority of respondents in all regions reported having some formal education in the health or human service field. Unlike executive directors/agencies heads, many managers/supervisors and front-line clinical staff did report a history of personal problems with alcohol and drugs. The percentages reporting a history of personal problems ranged from 33%–46% in the Prairies, AFM, and BC/NWT. This rate is slightly lower in Ontario, Quebec, the Atlantic region, and AADAC where 20%–30% reported such a history.

A high percentage of respondents with the AFM (63%) and in Ontario (43%) reported working toward a certificate in substance abuse studies while this rate drops slightly in Quebec and "Other Prairies" (37%) and BC/NWT (35%). The lowest rates of certification for substance abuse studies are found with AADAC (20%) and the Atlantic region (16 %). The percentages reporting certification as a substance abuse counsellor or working towards such certification varied considerably (from 9% in the Atlantic region to 42% with the AFM).

It must be cautioned that written responses to a question about the certifying body indicated that many respondents did not distinguish between having a *certificate* from a university or college and being *certified as an addiction counsellor*. The only certifying bodies in Canada are the Canadian Addiction Counsellors Certification Board (CACCB), the Canadian Society of Addiction Medicine (CSAM), the Employee Assistance Professionals Association (EAPA), the Canadian Counselling Association (CCA) and the US Department of Transportation (DOT) Substance Abuse Professionals (SAP). If only those who indicated one of these bodies are considered, then percentages of those working towards certification drops below 3% in all regions except Ontario (where 15% of respondents indicated the CACCB as their certifying body).

Between 24% and 57% of respondents in all regions indicated that they were certified by another professional body (mainly nursing or social work) and similar proportions indicated that they were members of professional associations (again mainly nursing or social work). A wide range of other certifying bodies and professional associations were self-reported.

Further analyses showed that, as might be expected, those who indicated that they were managers/supervisors, nurses, social workers, counsellors or therapists were more likely to report having a university degree than those who indicated that they were attendants or support workers (81.8% versus 33%; $P < .0001$). This same group of addiction workers were also more likely to report having had formal education in the human service field (71% versus 29%; $P < .0001$) and to being a member of a professional association (46% versus 13%; $P < .0001$). However, they were not significantly more likely to report having a certificate in addiction studies (34% versus 28%) or to report being certified by a recognized certifying body as addiction counsellors (4% in each case).

There were no statistically significant age-related differences in responses concerning education and experiences among executive directors/agency heads, but there were for managers/supervisors and front-line clinical staff. For the latter group, age was found to be related to education and experience and certification status. Table 6 shows that younger respondents were more likely than older respondents to report having a university degree and formal education in the human service field, but less likely to report having had formal business education. A history of personal problems with alcohol or drugs was more likely to be reported by older respondents. Few respondents were certified (e.g., CACCB) although this was more common with increasing age. Registration or certification by another professional body is equally spread out across age grouping.

Expectation for staff education and training—analysis by region

Table 7a summarizes managers'/supervisors' (N=167) responses to items about the preferred qualification for counsellors/therapists and attendants/support workers.[12] The overwhelming majority of respondents in all regions indicated a strong

12 The cell sizes with small regional differences should be viewed with caution. Overall, there were no statistically significant differences in responses across all regions.

preference for counsellors to have some level of post-secondary education (college or university). Respondents from Ontario, Quebec and "Other Prairies" were equally split in their preference for either a college or university education. A significant minority of respondents from BC/NWT (37%) and the Atlantic region (23%) indicated that they preferred counsellors to have a Master's degree. A significant minority (27%–50%) of the respondents indicated they preferred counsellors to have a certificate in addiction studies and 38%–62% indicated they preferred counsellors to be certified. The corresponding percentages for attendants/support workers with addiction studies and professional certification were 35% and 18% respectively. The majority of respondents in all regions (56%–70%) stated that all current counsellors met minimum qualifications for their work.

Table 7b shows that the preference for academic qualifications of attendants and support workers is generally split between a high school and college-level education, with a slightly stronger preference for college. Close to half (40%–50%) of the respondents indicated that attendants/support workers met minimum qualifications for their work.

Staff recruitment and retention—analysis by region

Table 8 summarizes responses by region from executive directors/agency heads to a number of statements concerning staff recruitment and retention. This table indicates that a sizeable minority or, in some cases, a majority of respondents are concerned about staff recruitment and retention in all regions. The cell numbers in this table have small differences across regions and therefore should be interpreted with caution. The only variable for which the overall difference in responses across regions was statistically significant ($p < .03$) concerned retention of attendants. Those from BC/NWT and the Atlantic region were less likely to indicate this as a concern than were those from other regions (7% and 17% respectively compared with 29%–44%).

Table 9 summarizes responses to some related work enhancement issues (e.g., wages and benefits, job security and opportunities for advancement). This table shows that a majority of respondents in all regions indicated that they were at least "somewhat concerned" about their ability to offer competitive benefits and opportunities for staff advancement. The majority of respondents from BC/NWT, Ontario and Quebec also indicated that they were at least somewhat concerned about staff job security. The overall differences were statistically significant for each of the three items ($p < .003$). In all cases, respondents from Quebec were the most likely to indicate that they were "significantly concerned" about benefits, job security and staff advancement opportunities. Those from the Atlantic region were the most likely to chose "not sure" or "not a concern" in response to items about benefits and job security.

The questionnaire for program managers/supervisors and front-line staff included similar items regarding salaries, job security and opportunities for advancement. Weighted responses are summarized in Table 10. These responses indicate that salaries, job security and opportunities for advancement are of some concern to a substantial proportion of all respondents. For all items in this table, the overall differences in responses across regions/jurisdictions were statistically significant ($P < .0001$) as were differences between most pairs of regions/jurisdictions. This is not unexpected given the large sample sizes. In all cases, respondents from AADAC were the most likely to chose "not sure" or "not a concern" in response to the items in the table. Those from AFM were also among those most likely to choose these responses to the items concerning benefits and opportunities for advancement.

Professional development issues—analysis by region

Table 11 shows professional development opportunities and activities reported by executive directors/agency heads by region. Differences across regions in responses to items concerning the provision of financial support for external courses of study and offering in-house seminars were statistically significant ($P < .05$ in each case). The overall difference for the item concerning access to the World Wide Web was highly significant ($P < .001$). The main exception in the latter case was Quebec where the highest percentage of respondents indicated that staff had no access or only limited access to the Web.

It is of note that some respondents in all regions (15%–29%) indicated that their agencies had not developed, and were not

currently developing, written professional development policies. Almost all respondents in all regions indicated that their agencies provided financial support for staff to attend professional development events or conferences.

Table 11 also shows agency support for a range of professional development activities. Many supported "in-house seminars/workshops", "subscriptions to journals", and "supervision". Some also supported "in-house training", "unpaid study leave", "financial assistance for external study", and "accessing information on website", but fewer supported structured "self-directed study", "paid study leave", and "mentoring". The majority of respondents from all of the regions report that their staff had access to the Web with the exception of Quebec where access was reported as limited.

Table 12 summarizes executive directors'/agency heads' concerns about a number of professional development issues. The majority of the respondents in BC/NWT, Ontario, and the Atlantic region agreed that there is a lack of resources and limited opportunities for professional development. This proportion drops in the Prairies and Quebec where about half of the respondents agree that there is a lack of resources and only about one-third agree that there are limited opportunities for professional development. For both of these items the differences across all regions were statistically significant ($P < .05$) although differences for other items were not statistically significant.

The large majority of respondents indicated that staff were encouraged to set professional development goals during annual performance reviews. A substantial minority (30%–46%) also indicated that staff did not always make use of professional development opportunities. The majority of the respondents viewed staff as taking advantage of self-study materials whereas there is a split in beliefs about staff preferences for external versus internal training events. The majority of respondents (59%–63%) indicated that they believed that colleges and universities should take the lead in education and training for work in the substance abuse treatment field and the highest percentage indicating this belief was in Ontario (70%).

Table 13 shows that a large majority of managers and staff in all regions/jurisdictions reported that they had participated in outside training in the past year. This was mainly funded by the employer, but in some cases respondents indicated that they also paid for at least part of this training. The percentage of respondents reporting attending an external course of study ranged from 25% to 33% with slightly higher percentages in Ontario and in the Prairies (39%). Funding for external study was reportedly split between agency and staff. The parentage of respondents attending in-house training was in the 40%–60% range, but lower in Quebec (20%). Few reported participating in "on-line work", "paid study leave", or "unpaid study leave".

Table 13 indicates that the majority of respondents in all regions had engaged in some professional development activities in the past year and that many had more than five or six days of professional development activities. There were considerable differences in the percentages engaging in specific activities, but regional differences were small. Consistent with reports from executive directors/agency heads, the majority of respondents indicate that they had at least "good" access to a Web-linked computer. There were statistically significant differences in responses across regions and between some pairs of regions for items in Table 13. This is not unexpected given the large sample sizes. Overall, no pattern of responses was clearly evident.

Table 14 shows that managers/supervisors and front-line clinical staff generally reported a high level of concern about the lack of financial resources and lack of opportunities for professional development. The highest level of concern is in BC/NWT and the Atlantic region (60%–65%) and lowest in Quebec (17%–37%). The table also shows that there were some large regional differences with respect to the percentages of respondents who reported discussing professional development needs during annual performance reviews, with the lowest rate in British Columbia (39%) and highest in AADAC (83%). Large regional differences also apply to respondents reporting having a personal education plan, with the lowest rate in Quebec (39%) and the highest in British Columbia (79%).

Respondents in different regions indicated a preference for outside training events that ranged from the lowest level with the AFM (28%) and the highest level in Ontario (58%). The percentages indicating satisfaction with professional develop-

ment opportunities were lowest in the Atlantic region (32%) and BC/NWT (36%), but over 50% in all other regions. A majority of all respondents indicated that universities and colleges should take the lead in education and training. There were statistically significant differences in responses across regions and between some pairs of regions.

Table 15 shows the professional development issues rated as "high priority" by managers and front-line staff. Those rated as high priority by at least 40% of respondents in most regions/jurisdictions areas were:

- Substance use and mental health
- Group counselling skills
- Individual counselling skills
- Assessment and treatment planning
- Models/methods of treatment
- Professional ethics and responsibilities.

A substantial minority of respondents in most regions indicated highest priority on most other topics. The main exception was a small percentage of respondents from BC/NWT (6%) that indicated the need for education on gambling treatment. There were statistically significant differences in responses across regions and between some pairs of regions for items, given the large response rate. The results indicate many unmet needs in all area.

Many respondents to both questionnaires wrote comments pertaining to the professional development issues. Typically the written comments concerned limited budgets, lack of money, funding, and professional development support. There were several comments about wage disparity between addiction and mental health workers and some reference to having a "flat organization" with no opportunities for advancement. There were concerns from agencies in British Columbia pertaining to recent mergers between addiction and mental health services, and some frustration from Ontario agencies that have had wage freezes since 1992. Some front-line staff also indicated that they felt "unappreciated" and "unrecognized" by managers and others in the field.

Initiatives to enhance service delivery

All respondents were asked to indicate if any of 14 initiatives for enhancing service delivery could have a positive influence. Responses for executive directors/agency heads are summarized in Tables 16 and those for managers and front-line staff are summarized in Table 17. In each case, the tables show the percentages of respondents in each region indicating which initiatives could have "some positive influence" or "a significant positive influence".

Both tables show that a majority of respondents indicated that all of the initiatives could enhance service delivery. The highest level of support was reserved for initiatives such as a "Canadian website", "national standards", "accreditation", "Bachelor's and Master's degrees" "distance education", "scholarships", and "electronic and written bulletins". As well, in addition to "counsellor certification", there was widespread support for a "professional association" by staff as well as a "national conference" on addictions. Education was considered as likely to have a significant positive influence by at least 40% of executive directors/agency heads and/or staff. "Media campaigns to promote work in the field" received the fewest endorsements overall, but even this was indicated as likely to have a positive impact on service delivery by more than 60% of executive directors/agency heads and other staff.

Job satisfaction and intentions to continue working in the treatment field

Despite that lack of funding base and professional recognition, the vast majority of those who completed the questionnaire for program managers and front-line staff (92%) and those completing the questionnaire for executive directors/agency heads (95%) indicated that they derived "quite a lot" or "a great deal" of satisfaction from their work. Still, a few written comments indicated frustrations with workloads, paper work and other bureaucratic issues.

A question about the number of years respondents expected to remain in the treatment field was unfortunately left blank on almost 40% of the questionnaires returned by program managers/supervisors and front-line staff. Among those who did answer this question, 39% indicated that they intended to leave the substance abuse field before they reached age 55. Thirty percent (30%) of those aged 40 or less also indicated that they intended to leave the field within the next five years.

Among those responding to the executive director/agency head questionnaire, the majority (78%) indicated that they

intend to stay in the field until at least age 55, but 25% of those under 30 indicated that they did not intend to work in the field for more than five years.

Influence of best practice reports

All respondents were asked to indicate if each of seven best practice documents published by Health Canada had influenced their service/programs. Tables 18 and 19 display the responses from the executive directors/agency heads and managers and front-line staff respectively.

Both tables show that there is a considerable level of support for the practical value of the best practices reports as confirming practices or contributing to significant changes in service delivery. At the same time, both tables also show that many respondents may have a lack of awareness/attention to the reports. For all of the best practices reports except one (Cocaine Use)[13], a significant minority of respondents from all regions indicated that they were "not sure" how or if these reports had influenced their work.

Sectoral differences

A number of bi-variate analyses were used to explore sectoral differences with respect to selected issues. Sectors were defined as follows and used information from items concerning the kinds of service provided:

- **Multi-service:** Provides residential and detoxification with or without outpatient services
- **Residential:** Provides residential service with or without outpatient service
- **Detoxification:** Provides detoxification services with or without outpatient services
- **Outpatient:** Only provides outpatient services.

Dependent variables were all dichotomies as follows:
Executive directors/agency heads:

- Has a university degree
- Salary and wages a significant concern
- Has written professional development policy
- Has structured in-house training
- Most or all staff have Web-linked computers
- Difficulty retaining counsellors
- Do not have enough resources for professional development

Managers/supervisors, front-line staff:

- University degree
- Certificate in substance abuse
- Certified (CACCA/ICADC)
- Salary and wages a significant concern
- More than five days professional development last year
- Has a Web-linked computer
- Agency does not have enough resources for professional development
- Not satisfied with professional development opportunities

Executive directors/agency heads of outpatient services were more likely than others to report that their staff had at least good access to the World Wide Web (96% vs. 82%; $p < .01$). However there were no other statistically significant differences involving Executive directors/agency heads for the other variables considered.

There were many statistically significant differences among staff working in different sectors, but most were not large enough to be of any clear practical significance for workforce development initiatives. It is noteworthy that those working in outpatient services were more likely than others to have a university degree (82% versus 57%–62% in other sectors) and more likely to have education plans (75% versus 19%–64% in other sectors). It is also noteworthy that those working in residential service were more likely than others to have or to be working toward certification by CACCA (7.2% versus 2%–3% in other sectors).

13 The majority of managers and front-line staff were "not sure" about the influence of the Cocaine Use Best Practices Report (28%–65%).

Comments on results

Type of analysis

The current report is intended to provide an overview of the main results of this survey. Additional reports, with more detailed and nuanced analyses, are anticipated and will be guided by feedback and suggestions from readers. For example, the application of multivariate statistics is required to more fully explore differences by sector and to also examine differences among respondents with different characteristics and responsibilities. It is beyond the scope of the current report to conduct this type of analyses at this stage.

Response rates

The survey response rate for executive directors/agency heads was 60%. This rate is similar to or higher than the response rates of the few other surveys of this kind from Canada, Australia and the United States (Ogborne, Braun, and Schmidt, 2001; Wolinski, et al. 2003; Adams and Gallon, 1997; Gallon, 2003). Non-respondents were similar to others with respect to the number of staff employed. The response rates varied by region and jurisdiction (48%–86%)[14] and were lowest for Quebec.

The response rate for staff was 45% and again this is similar to or higher than the response rates in the few other surveys of this kind both nationally and internationally (Morgenstern and McCrady, 1992; Knudsen, et al., 2003; Gallon, 2003). The response rates for staff varied by region/jurisdiction, but the rate was still above 30% in all regions with the exception of Quebec (23%). Lower response rates limit the validity of some inter-regional comparisons. However, responses were received from a large number of individuals in all regions and can therefore be regarded as providing a useful perspective on professional development issues facing substance abuse treatment agencies in most parts of Canada.

Professionalism within the addictions workforce

The survey showed that a high percentage of respondents from all regions have university degrees. The highest percentages are found among executive directors/agency heads and those staff who identified themselves as counsellors/therapists. Most managers in all regions viewed a university degree as a minimum qualification as well as management or counselling experience. The survey also found that 40% of staff with management and counselling responsibilities reported being members of a professional association.

These combined factors lend support to a growing professionalism of the substance abuse treatment workforce in Canada (Ogborne, Braun, and Schmidt, 2001) This trend is likely to continue given that some managers view a Master's degree as the minimum requirement for counsellors. A growing professionalism among addictions staff could also lead to organizational shifts in the workforce whereby, for example, new staff seek compensation and opportunities due to the acquisition of new skills, knowledge and experience.

Certification

There was considerable variation across regions/jurisdictions with respect to the percentages of staff reporting that they had, or were working toward, a certificate in addiction studies. The lowest percentage of respondents with certification in addiction studies is found in the Atlantic region (18%) and AADAC (20%) while the highest percentage is found among respondents from the AFM (63%). This wide range reflects variations in the availability and accessibility of certificate programs and differences in agency expectations among different regions/jurisdictions.

Between 25% and 62% of managers in different regions indicated a preference for counsellors and/or attendants/support workers to have a certificate in addictions studies. The database of addiction education programs maintained by the Canadian Centre on Substance Abuse suggests that certificate programs vary considerably with respect to standards and competencies. This includes different prerequisites for field experience, educational and skill level, and evaluation and monitoring mechanisms. More research is therefore required to learn about the varying levels of management support and what program managers expect from certification in addiction studies.

14 Excluding very small jurisdictions (see Table 2)

Counsellor certification was indicated as a preference by 27%–50% of program managers and this was most common in Quebec. There were also large differences in the percentages of staff that reported being certified or working toward certification. The lowest percentage was among respondents from the Atlantic region (9%) and the highest was among respondents from the AFM (43%). Caution must be exercised with these latter percentages as there was an apparent confusion among respondents between *certification as applied to counsellors* and *certification in addiction studies*.

The percentage of certification dropped considerably in all regions when applied to respondents who were certified by a recognized addictions certification body. It is unknown if managers also confused this issue when responding to the survey, but this seems likely. Further research is required to clarify views on the issues and to learn why managers and staff both varied in their support for certification.

Retention

The results showed that respondents had several years of experience working in their agencies and working in the substance abuse field. The majority indicated the intention to stay in the field until age 55 or later. The vast majority also indicated that they gained "quite a lot" or "a great deal" of satisfaction from their work. At the same time, a substantial minority of respondents indicated that they intended to leave the substance abuse field before they reached age 55 (39%). In addition, 30% of respondents under the age of 40 also indicated that they intended to leave the field within the next five years. These retention figures raise concerns about the ability to keep addiction workers in the treatment field although it is not known how these percentages compare with workers in other sectors.

The retention of managers and counsellors was indicated to be of concern by a substantial minority and, in some cases, a majority of executive directors/agency heads and managers. Other results suggest that the retention of managers and counsellors reflects resource issues and limited opportunities for staff advancement. Further analyses are required to determine if agency size or type or funding are factors influencing retention.

Professional development

The survey results indicate that professional development issues are of concern to those working in the substance abuse treatment field. A substantial minority and, in some cases, a majority, of executive directors/agency heads and/or other staff were satisfied with professional development opportunities. These respondents did not agree that resources for professional development were insufficient or that opportunities for advancement were limited. The majority of managers and staff reported that they had participated in professional development activities/events and many had more than five or six professional development days in the past year.

Respondents expressed concerns about limited resources, especially among respondents from British Columbia and the Atlantic region. The respondents' written comments in the survey suggest that limited resources were a major concern in some cases. These concerns will need to be addressed to ensure that professional development needs can be met on an ongoing basis.

The survey instrument identified a variety of mechanisms for supporting and enhancing professional development and all were noted as being used by at least some agencies. Almost all agencies provided some support for external training events and conferences and the majority of staff reported receiving some support for these events in the past year. Other professional development mechanisms were used less often, such as in-house training programs.

Resource constraints and agency size likely influence the use of specific professional development mechanisms, such as external training, but some relatively low-cost options were reported as not used in several cases (e.g., subscription to professional journals or mentoring). Agencies should therefore be encouraged to review their professional development initiatives and consider how these could be enhanced even with limited resources. In this context, it is noteworthy that not all agencies had or were developing written personal development polices. In some regions, less than 50% of staff indicated that they discussed professional development needs during performance reviews.

Professional development topics/best practices

In all regions, professional development topics were indicated as a high priority for a majority or a substantial minority of the respondents in both questionnaires. The highest-rated topics included concurrent disorders, individual and group counselling, assessment and treatment planning, and models/methods of treatment. The topics rated as highest priority appear to mirror several high priority addiction issues that policy makers and practitioners are now addressing in several regions across Canada. For example, there is a growing recognition of the co-occurring nature of substance use and mental health problems. Over the past few years, programs and systems across the country have begun to realign to deal more effectively with the co-occurrence of mental health and substance use problems among people seeking support and treatment. The challenges associated with integrating the addictions and mental health sectors in Canada are viewed as a major health issue. These challenges, and some practical solutions, have been addressed in a recent Health Canada best practice report: Concurrent Mental Health and Substance Use Disorders (Health Canada, 2002).[15]

Many respondents indicated that access to the best practices reports confirmed or contributed to positive changes in service delivery. More can be done, however, to promote awareness of best practices in the field given the fact that several respondents indicated they were "Not Sure" about these documents.

The survey did not specifically address the gap between the availability of evidence-based research on treatment and the practical application of these services in the field. Nonetheless, the respondents in the survey did express interest in a wide range of professional development topics and were receptive to accessing best practices literature to confirm and enhance service delivery. It would be useful to consider how to extend the dissemination of best practices in the addictions field to the practical application of designing, implementing and monitoring treatment services given the current views on the best practice reports and the receptiveness for professional development in the field. Further analyses of needs by sector and staff position must be considered in order to give greater focus to the engagement of the field in training opportunities and related measures.

Workforce development initiatives

The majority of executive directors/agency heads and staff in all regions/jurisdictions indicated that all of the workforce development initiatives listed in the survey would have some positive impact on service delivery.

It is important to clarify the understanding and significance of some of these initiatives among different stakeholders such as a nationally recognized "counsellor certification" and "agency accreditation". These would be very challenging to develop and implement and could potentially conflict with the interests of some stakeholders, including provincial governments and existing bodies that certify counsellors and accredit treatment agencies. A higher priority might therefore be given to the development and promotion of other strongly supported initiatives, such as national standards and competencies for service delivery. These types of strategies have shown success in some international jurisdictions such as the United Kingdom (Hough, 2004).

The majority of respondents indicated a significant positive influence for a "national association" of addiction staff and a "Canadian website" devoted to best practices in substance abuse. These two initiatives offer potential for the development of infrastructure to assist coordinating the addictions field to implement a range of workforce development initiatives. These include national standards and competencies, post-secondary addiction studies, national conferences, evidence-based knowledge production and dissemination, and the design and implementation of addiction services according to a scientific standard.

Further analyses are needed to more fully examine sectoral differences. These might be expected given the nature of the work and historical differences among sectors in some regions. For example, many residential and detoxification

15 Health Canada's series of best practice reports match several of the professional development topics identified as highest priority by respondents, including individual and group counselling, assessment and treatment planning, and models/methods of treatment.

centres have traditionally employed people in recovery and they have tended to value life experiences over academic qualification and formal training. These sectoral differences might also offer clues on how to bridge the "research to practice gap" through the direct engagement of the field.

The analyses to date indicate that those working in outpatient services were more likely than others to have a university degree and that those working in residential services were more likely than others to have certification by a recognized certification board. Further analyses are required to determine if those working in different jobs in different sectors have different workforce development concerns and training needs.

Strengths and challenges

Overall, the results show several positive attributes of the current treatment workforce and existing supports for professional development. These include:

- The workforce is generally well educated and the majority of counsellors have university degrees.
- Age-related trends and preferences among managers are toward higher levels of staff education.
- Staff find their work rewarding.
- Many staff in all regions have or are working toward a certificate in addiction studies.
- Many staff are certified health professionals and many of the treatment delivery sites are accredited by reputable agencies.
- Many staff participated in some kind of professional development activities in the past year.
- Staff members have access to the World Wide Web in many cases.
- Best practice reports published by Heath Canada were reported as confirming current practices or leading to positive changes in service delivery in many agencies.
- Most respondents indicated support for a variety of initiatives to enhance service delivery.

The survey also raises a number of concerns including:

- Significant regional difference with respect to many of the issues addressed, including concerns about resources and indications that these concerns are especially common in British Columbia and the Atlantic region.
- Sector differences are also apparent with respect to many issues considered, including staff education levels. Further analyses are required to more fully explore these differences.
- In all regions, some agencies have concerns about limited resources for professional development, wages and benefits, opportunities for staff advancement, and staff recruitment and retention.
- A substantial minority and, in some regions, a majority of staff do not indicate that they are satisfied with professional development opportunities.
- A substantial minority of staff responding to relevant items did not intend to continue working in the field to age 55 while 30% of staff under 40 intend to leave within five years.
- There appears to be confusion about the meaning of the term "counsellor certification", despite widespread support for this initiative. Very few respondents indicated that they were certified as substance abuse counsellors by a recognized certification body.
- Counsellors in some agencies do not all have the qualifications considered minimum by managers.
- There is limited use of some relatively low-cost professional development options (e.g., Web-based learning, self-study on work time, mentoring).
- Basic issues considered a high priority for learning were unmet according to many of the respondents.

.

Recommendations

The results of this survey are intended to help draw attention to addiction workforce development at the national, regional, and agency/service levels. The findings indicate that there is much to be done at all levels to ensure that the treatment workforce is optimized to provide the highest quality of client service on an ongoing basis.

As Canada's national addictions agency, the Canadian Centre on Substance Abuse (CCSA) is well positioned to play a central brokerage role in coordinating workforce development at the national, provincial/territorial, non-profit and private, regional, and local levels. This coordinating function on workforce development is commensurate with CCSA's mandate and role within Canada's renewed drug strategy.

The following recommendations were developed after a meeting of an advisory committee established for this project. This meeting followed a review of the results of a preliminary analysis of the survey data in the fall of 2004. The recommendations also reflect the authors' subsequent analysis of the survey data for the purpose of this report. The recommendations principally concern actions that could be initiated by CCSA in collaboration with key stakeholders.

CCSA works with stakeholders from the field of substance abuse treatment and those involved in providing training and education to this field (e.g., colleges and universities) toward the development and implementation of a national agenda on workforce development, and promotes initiatives that increase and sustain support for workforce development by governments and other funding agencies.

There are 10 recommendations to support a national agenda.

Leadership and supportive strategies

1. Support the formation of a **Canadian treatment network** of front-line addictions treatment providers that will, among other things, promote and support workforce development in the field.
2. Provide leadership in the creation and ongoing maintenance of an interactive **website** that promotes best practices, encourages and supports ongoing learning, and promotes Canadian and international content.
3. Host a **national conference** on substance abuse treatment that includes presentations and workshops on workforce development.
4. Promote a wide range of workforce development activities that match the varying needs of treatment agencies, including low-cost activities (e.g., Web-based learning).
5. Continue to deliver and expand on the **National Summer Institute**[16] series, but extend these sessions throughout the fiscal year and across regions.
6. Promote the development of national standards and competences for the addiction workforce that can be tailored to meet the needs of provincial-territorial jurisdictions.

Training and education

7. Work toward the design of education and training curriculum that is responsive to the needs of the addictions workforce in Canada and translates into best practices across core competencies, including records management, professional ethics, screening and assessment, conceptual models of addictions, individual and group counselling, treatment planning and evaluation.
8. Monitor and evaluate academic curriculum and professional training services.

Research

9. Continue to conduct research on and create awareness about the workforce development needs of substance abuse treatment providers, including further analysis of the data from this survey and future investigations.
10. Continue to conduct research on best practices in the alcohol and drug field.

16 CCSA, in collaboration with the Addiction Research Centre, Correctional Service of Canada, has already delivered two separate National Summer Institutes on Addictions in Prince Edward Island (2003/2004). There are plans to deliver a third National Summer Institute on Assessment and Treatment Planning in P.E.I. (2005). These Institutes offer advanced learning on best practice topics that are tailored to the learning needs of senior addiction professionals from across Canada.

References

Adams, R.J., & Gallon, S.L. (1997). Are today's addiction counselors prepared for tomorrow?: The result of a 1997 survey of addiction counselors and supervisors. [Salem, OR]: Addiction Technology Transfer Center.

Gallon, S., Gabriel, R.M. and Knudsen, J.R.W. (2003). The toughest job you'll ever love: A Pacific Northwest treatment workforce survey. *Journal of Substance Abuse Treatment*, 24, (3), 183-196

Health Canada (1999). *Best practices in substance abuse treatment and rehabilitation*. Prepared for the Office of Alcohol, Drugs and Dependency Issues, Health Canada. Ministry of Public Works and Government Services. Cat. Number H39-438/1998E.

Health Canada (2000). *Cocaine Use: Recommendations in Treatment and Rehabilitation*. Minister of Public Works and Government Services Cat No. H49-155/2001E

Health Canada (2001a). *Best practices: treatment and rehabilitation for women with substance abuse problems.* Prepared for the Office of Alcohol, Drugs and Dependency Issues, Health Canada. Ministry of Public Works and Government Services. Cat. Number H49-153/2001E.

Health Canada (2001b). *Best practices: treatment and rehabilitation for youth with substance abuse problems*. Prepared for the Office of Alcohol, Drugs and Dependency Issues, Health Canada. Ministry of Public Works and Government Services. Cat. Number H49-154/2001E.

Health Canada (2002). *Best practices: concurrent mental heath and substance use disorders*. Prepared for the Office of Alcohol, Drugs and Dependency Issues, Health Canada. Ministry of Public Works and Government Services. Cat. Number H39-599/2001E.

Hough, J., (2004) *Developing your workforce: a guide for alcohol services and commissioners*. London: Alcohol Concern.

Knudsen, H.K, Johnson, J. A., Roman, P, M. (2003). Retaining counseling staff at substance abuse treatment centers: effects of management practices. *Journal of Substance Abuse Treatment*, 24 (2) 129-135.

Ogborne, A.C., Braun, K. and Schmidt, G., (2001). Who works in addictions treatment services? Some results from an Ontario survey. *Substance Use and Abuse*, 36 (13), 1821-1837.

Roche, A.M. (2001). *What Is This Thing Called Workforce Development?* In A.M. Roche, J. McDonald (Eds) Systems, Settings, People: Workforce Development Challenges for the Alcohol and Other Drugs Field. Adelaide: National Centre for Education and Training on Addiction (NCETA), pp 5–22.

Velleman, R., Heather, N., Hay, L., and Kemm, J. (2003). *Dissemination and Implementation of Research Findings*. Alcohol Concern Research Forum Papers. London, pp1–14.

Wolinski, K., O'Neill, M., Roche, A., Freeman, T. and Donald, A. (2003). Treatment of Alcohol Problems: A Survey of Managers of Alcohol and Drug Treatment Agencies. Australian National Centre for Addiction.

Appendix A: Questionnaires

NOTE: Refer to electronic version of the questionnaires (PDF) on the CCSA website (www.ccsa.ca) under Best Practices and Training.

Workforce Development Questionnaires:

1) Executive Directors/Agency Heads

2) Managers/Supervisors and Front-line Clinical Staff

Appendix B: Tables

TABLE 2: Summary of response rates by region and jurisdiction.

JURISDICTION	BC	AB	MAN	SASK	ONT	QUE	NWT	ATLANTIC	TOTAL
Response rate for Executive directors/ service heads									
Provincial agencies	–	100% (1/1)	100% (1/11)	–	–	–	–	–	100% (2/2)
Atlantic regional services	–	–	–	–	–	–	–	86% (19/22)	86% (19/22)
All other	52% (33/63)	72% (16/22)	50% (6/12)	66% (16/24)	65% (41/63)	51% (34/67)	100% (2/2)	25% (1/4)	58% (149/257)
Overall response rate									60% (170/281)
Staff response rates									
Provincial agencies	–	64% (220/339)	87% (68/78)	–	–	–	–	–	69% (288/417)
Addiction services	–	–			–	–	–	54% (282/514)	54% (282/514)
All other	33% (139/418)	37% (60/162)	47% (50/108)	46% (245/538)	45% (245/538)	23% (109/472)	50% (7/14)	40% (8/20)	35% (644/1,789)
Overall response rate									45% (1,214/2,720)

TABLE 3: Characteristics of participating agencies as reported by executive directors/agency heads.

	UNWEIGHTED N	PERCENT
Types of clients served		
Men	139	84%
Women	135	81%
Youth	88	53%
Seniors	81	49%
People with substance abuse and mental health problems	114	69%
People with alcohol problems	152	92%
People with drug problems	156	94%
Injection drug users	113	68%
People with gambling problems	101	61%
Other types of clients	1	1%
Funding sources		
Correctional Service of Canada	5	3%
Health Canada	9	6%
Other Federal Department	2	1%
Provincial/Territorial Ministry of Health/Social Services	95	59%
Provincial/Territorial Ministry of Justice/Corrections	7	4%
Provincial agency (e.g., AADAC, AFM, Addiction Services)	25	15%
Regional Health Authority/Addiction Services	51	31%
Local Municipality	4	2%
Charity	23	14%
Client fees	40	25%
Other sources of funding	22	14%
Accreditation		
CCHSA	48	28%
CARF	11	6%
ADRAO*	6	3%
Other	36	21%
Any accreditation	101	59%

* ADRAO is now called "Addictions Ontario"

TABLE 4: Demographic characteristics, education and experience of executive directors/agency heads.

	MAJOR REGIONS/AGENCIES				
	BC & NWT N=35	PRAIRIE N=40	ONTARIO N=41	QUEBEC N=34	ATLANTIC N=20
Mean age	48.5	50.4	40.4	45.2	49.0
Female	70.6%	46.2%	60.0%	30.3%	40.0%
Male	29.4%	53.8%	40.0%	69.7%	60.0%
Mean years working in field	12.1	13.4	14.4	11.8	8.3
Mean years in present position	6.4	6.2	9.7	5.6	6.4
Education					
Did not finish high school	0	2%	0	0	0
High school only	0	7%	0	0	0
Community college	20%	27%	20%	6%	5%
BA/BSc	40%	47%	30%	44%	25%
Master's degree	40%	12%	42%	50%	70%
PhD/MD	0	2%	7%	0	0
Other types of experience					
Formal education health field	23%	37%	32%	36%	15%
Formal education human services	77%	55%	78%	67%	80%
Business education	20%	37%	39%	33%	25%
A lot of relevant experience	69%	79%	78%	76%	50%
Personal history of problems	31%	28%	17%	35%	5%

TABLE 5: Demographic and certification information of those completing the questionnaire for managers and staff.

	MAJOR REGIONS/AGENCIES						
	BC & NWT	AADAC	AFM	PRAIRIE	ONTARIO	QUEBEC	ATLANTIC
Weighted N	445	253	105	478	514	453	596
Mean age	43.2	42.1	43.3	42.2	43.2	40.2	43.1
Female	70.0%	74.0%	66.0%	58.0%	76.0%	55.0%	66.0%
Male	30.0%	26.0%	34.0%	42.0%	24.0%	45.0%	34.0%
Mean years working in field	8.9	9.1	11.5	7.8	8.7	9.6	9.9
Mean years in present position	5.0	5.1	5.8	4.3	5.1	5.2	8.9
Education							
Did not finish high school	2%	1%	0	2%	1%	1%	3%
High school only	2%	2%	1%	6%	4%	4%	6%
Community college	28%	22%	19%	40%	30%	31%	21%
BA/BSc	44%	59%	63%	46%	47%	44%	46%
Masters degree	23%	17%	16%	3%	21%	19%	23%
PhD/MD	1%	0	0	1%	1%	1%	1%
Other types of experience							
Formal education health field	46%	24%	22%	16%	21%	28%	34%
Formal education human services	57%	74%	84%	60%	73%	75%	49%
Business education	13%	7%	7%	20%	12%	5%	6%
A lot of relevant experience	66%	53%	68%	75%	60%	43%	55%
Personal history of problems	42%	19%	34%	46%	30%	24%	30%
Other experiences	100%	100%	100%	100%	100%	100%	100%
Has/working on certificate in SA studies	35%	20%	63%	37%	43%	37%	18%
Has/working toward certification as SA counsellor	20%	14%	42%	23%	32%	27%	9%
Has/working toward certification by CACCB/ICADC	3%	1%	1%	3%	15%	0	2%
Registered/certified by other professional body	39%	42%	24%	35%	27%	40%	57%
Member of professional association	39%	51%	22%	25%	36%	42%	60%

TABLE 6: Age, education, experience and certification status among managers and front-line staff.

	30 OR UNDER	31-39	40-49	50 OR MORE	STATISTICAL SIGNIFICANCE
Has a university degree	70%	76%	86%	58%	P <.0001
Formal education in human service field	80%	75%	62%	58%	P <.0001
Business education	1%	8%	12%	17%	P <.0001
Personal history of substance abuse problems	25%	23%	32%	48%	P <.0001
Has or is working on a certificate in addiction studies	35%	31%	29%	37%	P <.01
Has or working toward CACCB/ICADC certification	2%	4%	5%	6%	P <.05
Registered or certified by other professional body	33%	43%	38%	42%	P <.01

TABLE 7A: Preferred qualifications for counsellors as indicated by program managers.

	MAJOR REGIONS/AGENCIES						
	BC & NWT	AADAC	AFM	PRAIRIE	ONTARIO	QUEBEC	ATLANTIC
Unweighted N	38	17	10	27	30	17	28
Preferred minimum qualification for counsellors							
No minimum	3%	0	0	0	0	0	0
High school only	0	0	0	2%	2%	0	6%
Community college	10%	32%	10%	52%	44%	56%	21%
Bachelor's Degree	50%	64%	90%	38%	42%	41%	49%
Master's degree	37%	4%	0	7%	12%	3%	23%
Prefer counsellors to have addiction certificate	37%	27%	50%	43%	47%	62%	31%
Prefer counsellors to be certified	50%	38%	50%	39%	50%	38%	39%
All counsellors meet minimum qualifications							
Yes	57%	79%	70%	64%	65%	76%	60%
No	40%	15%	30%	31%	31%	21%	39%
Not sure	3%	6%		5%	5%	3%	2%
There is a shortage of qualified counsellors in this area							
Agree/strongly agree	58%	31%	35%	42%	64%	42%	76%
Not sure	19%	17%	12%	12%	9%	16%	8%
Disagree/strongly disagree	24%	52%	53%	46%	26%	42%	16%
Retention of counsellors is a problem							
Agree/strongly agree	48%	25%	35%	59%	33%	42%	43%
Not sure	5%	14%	0	3%	3%	7%	3%
Disagree/strongly disagree	47%	61%	64%	37%	63%	51%	54%

TABLE 7B: Preferred qualifications for attendants/support workers as indicated by program managers.

	MAJOR REGIONS/AGENCIES						
	BC & NWT	AADAC	AFM	PRAIRIE	ONTARIO	QUEBEC	ATLANTIC
Unweighted N	38	17	10	27	30	17	28
Preferred minimum qualification							
No minimum	11%	0	0	8%	2%	15%	0
High school only	11%	37%	56%	45%	32%	43%	33%
Community college	61%	58%	44%	47%	66%	38%	48%
Bachelor's Degree	18%	4%	0	0	0	4%	19%
Master's degree	0	0	0	0	0	0	0
Prefer workers to have addiction certificate	53%	31%	25%	33%	44%	24%	35%
Prefer workers to be certified	12%	5%	0	15%	22%	13%	27%
All workers meet minimum qualification							
Yes	37%	47%	37%	58%	57%	66%	16%
No	44%	27%	62%	37%	30%	28%	69%
Not sure	18%	27%	0	5%	12%	6%	16%
There is a shortage of qualified attendants/support workers in this area							
Agree/strongly agree	47%	10%	11%	41%	36%	23%	58%
Not sure	21%	40%	28%	17%	30%	16%	30%
Disagree/strongly disagree	32%	50%	61%	42%	33%	61%	12%
Retention of attendants/support workers is a problem							
Agree/strongly agree	20%	17%	18%	54%	34%	35%	44%
Not sure	29%	26%	12%	3%	18%	12%	24%
Disagree/strongly disagree	51%	56%	71%	43%	48%	53%	31%

TABLE 8: Concerns about staff recruitment and retention indicated by executive directors/agency heads.

	MAJOR REGIONS/AGENCIES				
	BC & NWT N=35	PRAIRIE N=40	ONTARIO N=41	QUEBEC N=34	ATLANTIC N=20
Shortage of managers					
Agree/strongly agree	39%	47%	51%	28%	60%
Neither/not sure	27%	13%	13%	16%	15%
Disagree/strongly disagree	33%	39%	36%	56%	25%
Shortage of counsellors					
Agree/strongly agree	41%	22%	54%	34%	60%
Neither/not sure	15%	8%	5%	16%	
Disagree/strongly disagree	44%	69%	41%	50%	40%
Shortage of attendants					
Agree/strongly agree	21%	21%	29%	38%	28%
Neither/not sure	38%	23%	34%	10%	28%
Disagree/strongly disagree	41%	56%	37%	52%	44%
Retaining managers a problem					
Agree/strongly agree	28%	24%	10%	47%	30%
Neither/not sure	12%	13%	26%	12%	25%
Disagree/strongly disagree	59%	63%	64%	41%	45%
Retaining counsellors a problem					
Agree/strongly agree	25%	25%	31%	47%	25%
Neither /not sure	12%	17%	15%	9%	10%
Disagree/strongly disagree	62%	58%	54%	44%	65%
Retaining attendants a problem					
Agree/strongly agree	7%	44%	29%	34%	18%
Neither /not sure	39%	15%	29%	10%	29%
Disagree/strongly disagree	54%	41%	41%	55%	53%

TABLE 9: Concerns about employment conditions by executive directors/agency heads.

	MAJOR REGIONS/AGENCIES				
	BC & NWT N=35	PRAIRIE N=40	ONTARIO N=41	QUEBEC N=34	ATLANTIC N=20
Ability to offer competitive benefits					
Not sure/not a concern*	36%	37%	15%	9%	45%
Somewhat of concern	39%	18%	25%	27%	30%
Significant concern	24%	45%	60%	64%	25%
Ability to offer staff job security					
Not sure/not a concern	45%	60%	40%	12%	70%
Somewhat of concern	42%	35%	42%	33%	15%
Significant concern	13%	5%	17%	54%	15%
Limited opportunities for staff advancement					
Not sure/not a concern	19%	46%	30%	9%	15%
Somewhat of concern	56%	40%	60%	27%	60%
Significant concern	25%	13%	10%	64%	25%

* Less than 3% of respondents chose the "not sure" option when responding to this and to other items in this and the following tables.

TABLE 10: Concerns about salaries, job security and opportunities for advancement indicated by managers and front-line staff.

	MAJOR REGIONS/AGENCIES						
	BC & NWT	AADAC	AFM	PRAIRIE	ONTARIO	QUEBEC	ATLANTIC
Weighted N	445	253	105	478	514	453	596
Salary or wage benefits							
Not sure/not a concern	41%	54%	42%	32%	41%	33%	46%
Somewhat of concern	31%	34%	49%	43%	36%	43%	39%
Significant concern	26%	12%	9%	26%	23%	24%	15%
Job security							
Not sure/not a concern	29%	66%	48%	58%	52%	33%	37%
Somewhat of concern	36%	27%	33%	33%	35%	48%	44%
Significant concern	36%	7%	19%	9%	13%	19%	19%
Limited opportunities for advancement							
Not sure/not a concern	38%	58%	45%	45%	39%	40%	29%
Somewhat of concern	36%	29%	45%	28%	42%	42%	41%
Significant concern	25%	13%	11%	27%	20%	18%	29%

TABLE 11: Professional development activities and opportunities indicated by executive directors/agency heads.

	MAJOR REGIONS/AGENCIES				
	BC & NWT N=35	PRAIRIE N=40	ONTARIO N=41	QUEBEC N=34	ATLANTIC N=20
Agency has a written professional development policy					
Yes	57%	68%	66%	47%	45%
No	29%	19%	18%	28%	15%
Under development	14%	13%	16%	25%	40%
Agency supports for professional development					
Financial assistance to attend training events/conferences	86%	97%	95%	82%	100%
Financial assistance for external study courses	31%	55%	58%	38%	25%
Specific amount of time for self-directed study	23%	15%	20%	15%	15%
Structured in-house training programs	40%	52%	59%	35%	50%
In-house seminars/workshops as required	66%	55%	83%	53%	90%
Paid study leave	14%	11%	15%	12%	25%
Unpaid study leave	46%	33%	41%	23%	50%
Subscriptions to professional journals	60%	50%	61%	58%	75%
Information on work-related websites	54%	67%	54%	44%	60%
Mentoring	26%	45%	39%	20%	40%
Supervision	71%	75%	80%	53%	75%
Staff access to WWW					
No access	3%	3%	0	22%	0
Limited	6%	18%	3%	28%	10%
Good	29%	24%	28%	22%	15%
Most have Web-linked own computers	15%	21%	18%	20%	40%
All have Web-linked computers	47%	34%	51%	10%	35%

TABLE 12: Concerns about selected professional development issues indicated by executive directors/agency heads.

	MAJOR REGIONS/AGENCIES				
	BC & NWT N=35	PRAIRIE N=40	ONTARIO N=41	QUEBEC N=34	ATLANTIC N=20
Not enough PD resources					
Agree/strongly agree	76%	49%	73%	54%	85%
Neither	12%	8%	5%	9%	5%
Disagree/strongly disagree	12%	44%	22%	36%	10%
Limited opportunities for staff development					
Agree/strongly agree	71%	36%	49%	25%	85%
Neither	3%	5%	2%	3%	
Disagree/strongly disagree	26%	59%	49%	72%	15%
Staff make good use of self-study materials					
Agree/strongly agree	62%	65%	56%	66%	70%
Neither	18%	15%	24%	22%	20%
Disagree/strongly disagree	21%	20%	19%	12%	10%
Staff do not always make use of PD opportunities					
Agree/strongly agree	36%	35%	39%	45%	30%
Neither	3%	17%	12%	3%	30%
Disagree/strongly disagree	61%	47%	49%	51%	40%
Staff prefer outside PD events					
Agree/strongly agree	62%	50%	45%	44%	35%
Neither	19%	20%	30%	28%	45%
Disagree/strongly disagree	19%	30%	25%	28%	20%
Staff encouraged to set PD goals during performance reviews					
Agree/strongly agree	84%	80%	95%	72%	100%
Neither	12%	12%	2%	12%	0
Disagree/strongly disagree	3%	7%	2%	16%	0
Universities/colleges should take the lead in education and training					
Agree/strongly agree	60%	59%	70%	62%	63%
Neither	34%	23%	17%	22%	21%
Disagree/strongly disagree	6%	18%	12%	16%	16%

TABLE 13: Professional development activities in past year and access to WWW indicated by managers and front-line staff.

	MAJOR REGIONS/AGENCIES						
	BC & NWT	AADAC	AFM	PRAIRIE	ONTARIO	QUEBEC	ATLANTIC
Weighted N	445	253	105	478	514	453	596
Professional development activities							
Outside training	83%	81%	86%	86%	89%	76%	82%
Fully paid for by employer	62%	75%	77%	70%	73%	66%	64%
Fully paid for from my own funds	8%	4%	6%	2%	4%	3%	4%
Employer and own funds	11%	2%	3%	12%	9%	6%	11%
Formal external course of study	24%	30%	32%	39%	39%	30%	24%
Fully paid for by employer	8%	17%	18%	31%	23%	16%	16%
Fully paid for from my own funds	14%	12%	9%	6%	12%	9%	6%
Employer and own funds	2%	1%	6%	1%	3%	5%	2%
Agency approved self-study at work	17%	18%	5%	19%	13%	17%	13%
Attended structured in-house training program	41%	60%	43%	44%	41%	20%	45%
Attended in-house seminars/workshops	65%	70%	69%	49%	55%	32%	64%
On-line work-related course	10%	8%	1%	8%	8%	11%	5%
Been on paid study leave	2%	1%	1%	8%	4%	0	1%
Unpaid study leave	5%	2%	1%	4%	1%	1%	2%
Read a professional journal	57%	54%	57%	58%	48%	50%	52%
Looked at a work-related website	68%	67%	63%	67%	61%	48%	62%
Been mentored by a colleague/supervisor	30%	41%	41%	25%	29%	26%	20%
Time in professional development							
None or < 1 day	8%	8%	9%	24%	9%	23%	12%
1–2 days	16%	17%	25%	11%	20%	22%	14%
3–4 days	26%	26%	26%	21%	18%	22%	23%
5–6 days	13%	18%	13%	17%	20%	5%	21%
7–8 days	7%	6%	4%	3%	8%	4%	9%
9–10 days	10%	3%	4%	4%	4%	1%	6%
More than 10 days	15%	19%	16%	19%	18%	19%	12%
Not indicated	2%	4%	1%	1%	1%	3%	4%
Staff access to WWW							
No access	15%	0	8%	18%	17%	24%	17%
Limited access	9%	5%	38%	15%	7%	17%	16%
Good access	31%	27%	32%	27%	25%	25%	23%
Has Web-linked computer	44%	68%	23%	39%	51%	33%	44%

TABLE 14: Concerns about selected professional development issues indicated by managers and front-line staff.

	MAJOR REGIONS/AGENCIES						
	BC & NWT	AADAC	AFM	PRAIRIE	ONTARIO	QUEBEC	ATLANTIC
Weighted N	445	253	105	478	514	453	596
Not enough PD resources							
Agree/strongly agree	65%	35%	42%	43%	49%	37%	64%
Neither	11%	11%	26%	15%	19%	14%	10%
Disagree/strongly disagree	24%	54%	32%	42%	32%	49%	26%
Limited opportunities for staff development							
Agree/strongly agree	60%	35%	41%	39%	38%	17%	61%
Neither	4%	13%	8%	12%	13%	6%	7%
Disagree/strongly disagree	35%	52%	51%	49%	49%	77%	31%
I discuss PD needs during performance reviews							
Agree/strongly agree	39%	83%	65%	70%	68%	48%	45%
Neither	23%	8%	11%	7%	12%	13%	17%
Disagree/strongly disagree	38%	9%	24%	23%	20%	39%	38%
I have a personal education plan							
Agree/strongly agree	79%	78%	66%	62%	77%	39%	66%
Neither	9%	9%	12%	16%	8%	17%	12%
Disagree/strongly disagree	12%	13%	21%	22%	15%	43%	22%
I prefer outside PD events							
Agree/strongly agree	58%	38%	28%	50%	58%	41%	51%
Neither	23%	38%	38%	29%	24%	18%	27%
Disagree/strongly disagree	19%	24%	34%	21%	18%	41%	22%
On the whole I am satisfied with PD opportunities							
Agree/strongly agree	36%	55%	52%	57%	51%	52%	32%
Neither	14%	16%	17%	6%	11%	15%	13%
Disagree/strongly disagree	50%	29%	31%	37%	38%	34%	55%
Universities and colleges should take lead in training and education							
Agree/strongly agree	80%	76%	65%	79%	84%	56%	75%
Neither	16%	17%	32%	17%	12%	29%	18%
Disagree/strongly disagree	4%	8%	3%	4%	4%	14%	7%

TABLE 15: High priority professional development needs indicated by managers and front-line staff.

	MAJOR REGIONS/AGENCIES						
	BC & NWT	AADAC	AFM	PRAIRIE	ONTARIO	QUEBEC	ATLANTIC
Weighted N	445	253	105	478	514	453	596
Basic concepts in substance abuse	38%	27%	27%	49%	34%	30%	40%
Substance use and other problems	57%	46%	56%	63%	55%	58%	64%
Substance use and mental health	62%	62%	67%	64%	63%	67%	74%
Working with women	36%	35%	32%	28%	49%	26%	34%
Working with youth	34%	33%	41%	36%	29%	22%	42%
Working with First Nations clients	41%	33%	46%	47%	26%	15%	39%
Working with offenders	26%	22%	32%	29%	29%	32%	35%
Working with seniors	15%	16%	14%	20%	23%	17%	19%
Gambling treatment	5%	24%	14%	22%	20%	26%	37%
Pharmacotherapy	28%	26%	21%	16%	27%	40%	30%
Cultural competencies	33%	20%	44%	28%	24%	23%	26%
Interpersonal communication skills	43%	31%	43%	44%	48%	39%	42%
Models/methods of treatment	44%	45%	46%	40%	50%	49%	49%
Assessment and treatment planning	45%	38%	46%	57%	52%	49%	53%
Referral skills	27%	23%	27%	39%	30%	32%	28%
Individual counselling skills	50%	50%	48%	46%	57%	51%	55%
Group counselling skills	51%	52%	59%	40%	55%	49%	50%
Working with families	28%	48%	52%	37%	37%	35%	47%
Specific types of treatment	12%	11%	6%	11%	7%	11%	10%
Signs and symptoms	40%	30%	35%	54%	29%	40%	40%
Non-medical detoxification	29%	16%	22%	40%	23%	32%	33%
Medical detoxification	27%	17%	13%	15%	17%	26%	31%
Professional/ethical responsibilities	44%	40%	49%	60%	47%	44%	60%
Service coordination/case management	33%	28%	43%	50%	39%	40%	40%
Documentation skills	26%	22%	30%	47%	34%	16%	44%
Management/supervisory skills	30%	30%	30%	50%	39%	36%	34%

TABLE 16: Positive impact of initiatives on service delivery by executive directors/agency heads.

	MAJOR REGIONS/AGENCIES				
	BC & NWT N=35	PRAIRIE N=40	ONTARIO N=41	QUEBEC N=34	ATLANTIC N=20
National standards	77%	75%	88%	65%	100%
Agency accreditation	80%	82%	95%	71%	85%
Counsellor certification	63%	80%	85%	73%	80%
Association for staff	74%	85%	68%	59%	75%
Canadian website	89%	95%	95%	88%	100%
Printed bulletin	86%	90%	63%	79%	90%
Electronic bulletin	83%	90%	78%	73%	95%
Scholarships	80%	80%	83%	79%	95%
National conferences	74%	87%	78%	62%	95%
Media campaign to promote working in field	66%	70%	61%	62%	90%
Bachelor's degree	80%	82%	90%	88%	90%
Master's degree	77%	75%	88%	82%	95%
Distance education	86%	87%	83%	82%	90%
Distance consultation services	69%	77%	80%	71%	95%

TABLE 17: Positive impact of initiatives on service delivery by managers and front-line staff.

	MAJOR REGIONS/AGENCIES						
	BC & NWT	AADAC	AFM	PRAIRIE	ONTARIO	QUEBEC	ATLANTIC
Weighted N	445	253	105	478	514	453	596
National standards	78%	67%	75%	81%	72%	57%	72%
Agency accreditation	77%	74%	91%	85%	77%	74%	77%
Counsellor certification	76%	73%	91%	83%	81%	76%	80%
Association for staff	73%	66%	78%	79%	79%	69%	78%
Canadian website	91%	89%	93%	88%	91%	85%	88%
Printed bulletin	83%	75%	87%	85%	82%	83%	79%
Electronic bulletin	83%	80%	85%	80%	80%	81%	79%
Scholarships	89%	78%	79%	84%	83%	79%	80%
National conferences	88%	89%	93%	90%	89%	76%	90%
Media campaign to promote working in field	71%	57%	62%	58%	60%	62%	75%
Bachelor's degree	84%	80%	82%	84%	82%	79%	79%
Master's degree	88%	79%	81%	82%	80%	77%	79%
Distance education	84%	86%	88%	87%	87%	75%	83%
Distance consultation services	83%	74%	78%	72%	83%	63%	74%

TABLE 18: Influence of Health Canada's best practice documents as indicated by executive directors/agency heads.

	MAJOR REGIONS/AGENCIES				
	BC & NWT N=35	PRAIRIE N=40	ONTARIO N=41	QUEBEC N=34	ATLANTIC N=20
Best practices in treatment and rehabilitation					
Not applicable	0	8%	0	0	5%
Not sure	31%	42%	6%	24%	16%
Confirmed our practices	59%	28%	54%	34%	26%
Contributed to positive changes	10%	22%	40%	41%	53%
Cocaine use					
Not applicable	0	12%	3%	4%	0
Not sure	45%	39%	34%	41%	40%
Confirmed our practices	40%	21%	28%	27%	20%
Contributed to positive changes	15%	27%	34%	27%	40%
Treatment of youth with SA problems					
Not applicable	26%	30%	36%	32%	0
Not sure	26%	30%	18%	12%	11%
Confirmed our practices	35%	21%	21%	24%	44%
Contributed to positive changes	13%	18%	24%	32%	44%
Treatment for women with SA problems					
Not applicable	8%	16%	12%	21%	0
Not sure	20%	34%	21%	29%	17%
Confirmed our practices	52%	31%	45%	17%	22%
Contributed to positive changes	20%	19%	21%	33%	61%
Methadone treatment					
Not applicable	26%	42%	46%	56%	23%
Not sure	35%	26%	11%	16%	8%
Confirmed our practices	30%	16%	11%	20%	15%
Contributed to positive changes	9%	16%	31%	8%	54%
Treatment for mental health and addictions					
Not applicable	0	15%	3%	15%	5%
Not sure	36%	33%	9%	26%	10%
Confirmed our practices	39%	27%	23%	18%	5%
Contributed to positive changes	25%	24%	66%	41%	79%

TABLE 19: Influence of Health Canada's best practice documents as indicated by managers and front-line staff.

	MAJOR REGIONS/AGENCIES						
	BC & NWT	AADAC	AFM	PRAIRIE	ONTARIO	QUEBEC	ATLANTIC
Weighted N	445	253	105	478	514	453	596
Best practices in treatment and rehabilitation							
Not applicable	7%	3%	2%	7%	4%	28%	4%
Not sure	42%	27%	31%	49%	28%	16%	38%
Confirmed our practices	40%	57%	36%	34%	45%	30%	37%
Contributed to positive changes	12%	13%	31%	10%	23%	26%	21%
Cocaine use							
Not applicable	7%	1%	2%	8%	7%	36%	5%
Not sure	53%	33%	56%	62%	56%	28%	65%
Confirmed our practices	34%	46%	33%	23%	28%	14%	19%
Contributed to positive changes	5%	19%	9%	6%	9%	22%	11%
Treatment of youth with SA problems							
Not applicable	24%	22%	8%	31%	38%	49%	11%
Not sure	43%	25%	31%	44%	41%	16%	46%
Confirmed our practices	18%	41%	29%	17%	11%	13%	26%
Contributed to positive changes	14%	11%	31%	7%	9%	22%	17%
Treatment for women with SA problems							
Not applicable	13%	3%	4%	11%	16%	40%	11%
Not sure	43%	32%	45%	61%	31%	26%	45%
Confirmed our practices	35%	49%	23%	22%	34%	14%	29%
Contributed to positive changes	8%	17%	27%	6%	19%	19%	15%
Methadone treatment							
Not applicable	12%	14%	18%	39%	34%	45%	28%
Not sure	45%	35%	59%	46%	33%	8%	45%
Confirmed our practices	34%	34%	15%	11%	16%	27%	12%
Contributed to positive changes	8%	17%	8%	4%	17%	20%	16%
Treatment for mental health and addictions							
Not applicable	8%	1%	2%	9%	10%	30%	5%
Not sure	47%	39%	37%	47%	29%	23%	51%
Confirmed our practices	31%	37%	20%	20%	33%	14%	25%
Contributed to positive changes	14%	23%	41%	24%	27%	33%	19%