CADPAAC Alcohol and Other Drug Abuse Treatment Workforce Survey

Survey Conducted by:
County Alcohol and Drug Program Administrators' Association of California (January-June 2007) in partnership with the California Association of Alcoholism and Drug Abuse Counselors (CAADAC) and Orion Healthcare

Survey Analysis and Summary Report Prepared by:
The Pacific Southwest Addiction Technology Transfer Center (2009)

CADPAAC Alcohol and Other Drug Abuse Treatment Workforce Survey Summary

According to recent estimates from the National Survey on Drug Use and Health, California has a significant treatment gap – 7 percent of the state's population (or 2,123,000 California residents) needs alcohol abuse treatment but does not receive it. Further, 3 percent of the state's population (or 861,000 California residents) needs illicit drug abuse treatment but does not receive it (SAMHSA, 2006a).

A main factor contributing to the treatment gap is the severe shortage of trained and certified substance abuse counselors in the state. According to the U.S. Bureau of Labor Statistics, California employs 2.54 substance abuse counselors per 10,000 people – only slightly higher than the national average of 2.2 substance abuse counselors per 10,000 people (U.S. Department of Labor, 2006). Other challenges facing the substance abuse workforce include poor working conditions in many agencies, the lack of competitive salaries and opportunities for advancement, and the heavy caseloads and paperwork requirements in the field.

A report from the Annapolis Coalition on the Behavioral Health Workforce states that the national workforce crisis is "characterized, in part, by problems of recruitment and retention; minimal workforce diversity; inadequate access to training; the questionable relevance and effectiveness of many educational programs; and a lack of cultural competence among those providing care." A document entitled, "*Action Plan for Behavioral Health Workforce Development*" (Hoge, et al., 2006) is available at: http://www.annapoliscoalition.org/national_strategic_planning.php.

In another report developed by Abt. Associates, Inc., the workforce crisis the addictions treatment field is facing is based, in part, on "worker shortages, inadequate compensation, and stigma. Increasingly, treatment and recovery support providers also struggle with issues related to recruitment, retention, and professional development for staff…Without investment in human infrastructure, this critical public health function will not be equipped to respond effectively to the overwhelming need for services." A

document entitled, "*Strengthening Professional Identify: Challenges of the Addictions Treatment Workforce–A Framework for Discussion*" (Abt. Associates, Inc., 2006) is available at: http://www.samhsa.gov/workforce/workforcereportfinal.pdf. The *Action Plan* and *Strengthening Professional Identity* documents may serve as useful resources for addressing substance abuse treatment workforce issues in the state of California.

In an effort to better understand the conditions and the needs of the substance abuse treatment workforce in California, the County Alcohol and Drug Program Administrators' Association of California (CADPAAC), in partnership with the California Association of Alcoholism and Drug Abuse Counselors and Orion Healthcare, set forth to conduct a statewide survey of alcohol and drug abuse treatment providers working throughout California. The purpose of this voluntary, anonymous survey was to better understand the changing demography of the statewide addiction workforce, to identify key workplace conditions and benefits affecting turnover rates, and to identify the educational technical assistance needs of the programs operating within the state.

The workforce survey included questions on the background of the workforce, their working conditions, their training and technical assistance needs and barriers to receiving necessary training and technical assistance, along with factors associated with their job tenure and turnover. Respondents were asked questions about their demographic characteristics, educational and professional background, agency characteristics, professional experience, compensation, and training preferences, needs, and barriers.

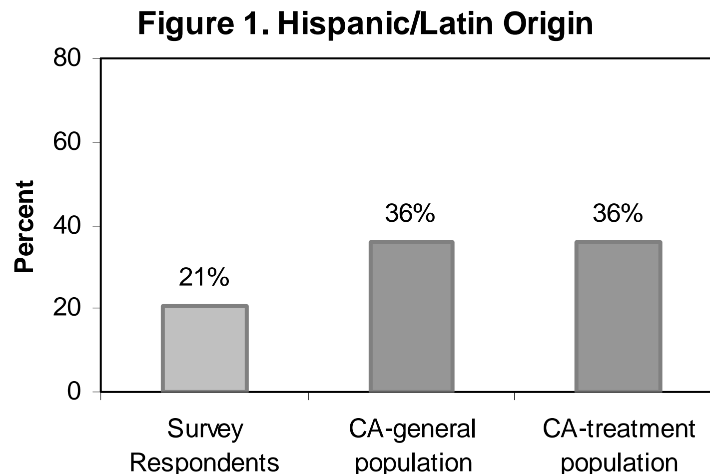
A hardcopy version of the workforce survey (Appendix 3) was distributed at the county level between January-June 2007 to contract and directly operated treatment program staff. Approximately 100 surveys were completed and returned to Thomas Renfree, CADPAAC Executive Director, through this method of administration. In an effort to increase data accuracy, validity, and response rate, Orion Healthcare partnered with CAADAC and CADPAAC to develop an online version of the workforce survey. As a result, more than 1,500 additional surveys were completed, bringing the total number

of surveys collected to 1,761. All survey respondents indicated that they work in California. Forty-three of the 58 counties (74%) were represented among the completed surveys. The highest percentages of surveys were completed by providers in Los Angeles (28%), San Bernardino (12%), Orange (10%), and Santa Clara (9%) counties. The surveys were analyzed by the Pacific Southwest Addiction Technology Transfer Center (Pacific Southwest ATTC) for basic descriptive respondent characteristics. The results of these analyses are included in this summary report.

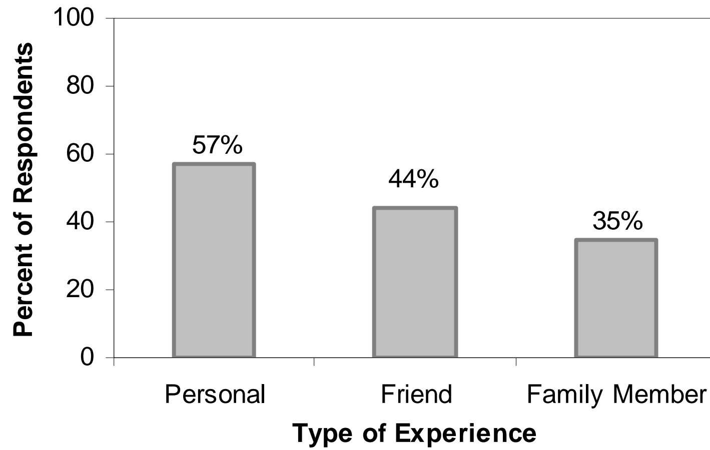
Section 1: Demographic Characteristics of the Survey Respondents

- Nearly 7 out of 10 (68%) of the respondents were 41 years of age or older. The median age of respondents was 48 (compared to a median age of 40 for the total U.S. labor force).
- Respondents were more likely to be female (62%) than male (37%).
- The ethnic breakdown as indicated by respondents is generally reflective of the ethnic diversity of the state, but individuals of Hispanic or Latino origin were underrepresented in the provider sample. See *Figure 1* below.
- According to recent findings from the Treatment Episode Data Set (SAMHSA, 2008), 36% of clients admitted to treatment in California in 2007 were of Hispanic/Latino origin. The notion that clients are almost twice as likely to be of Hispanic/Latino origin as agency staff may pose a challenge to California-based treatment agencies with regards to the provision of culturally competent services to their Hispanic/Latino clients.

Figure 1. Hispanic/Latin Origin



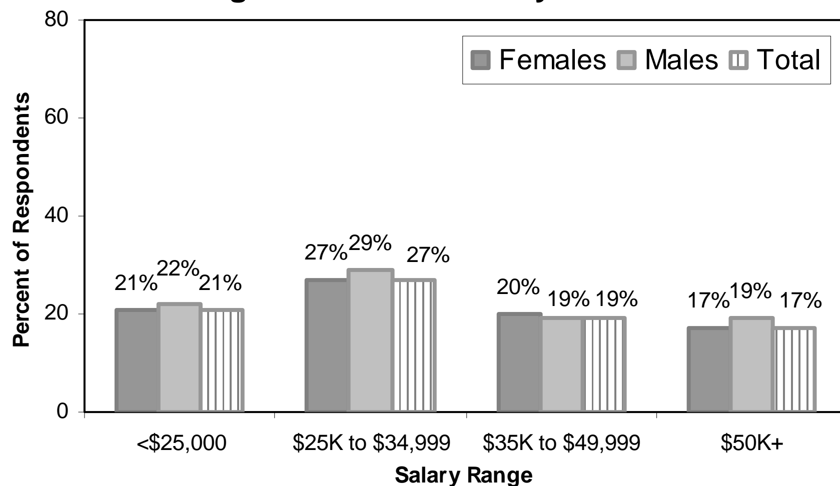
- A significant percentage of the survey respondents have had some type of experience with recovery. See *Figure 2* below.



Please refer to Tables 1-3 in Appendix 1 for additional information regarding "respondent demographic characteristics."

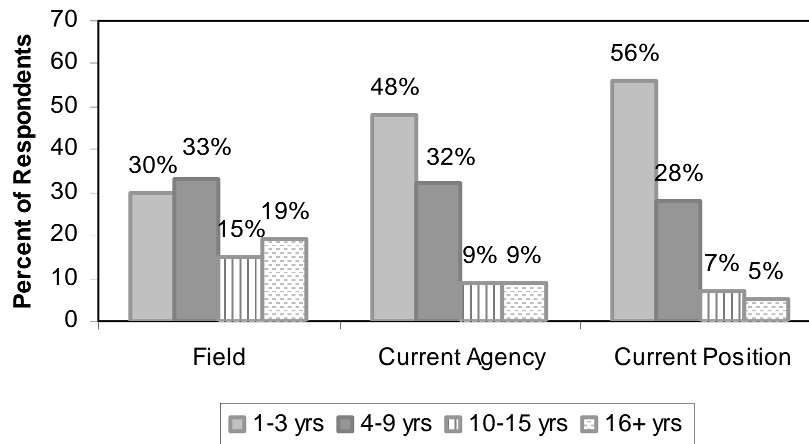
Section 2: Work and Professional Background

- Nearly three quarters (73%) of respondents listed "*addictions counseling*" as their current discipline/profession. Other specified disciplines/professions indicated by at least 10% of the respondents include: social work/human services (14%), psychology (12%), other counseling (11%), and adolescent treatment (10%).
- Approximately half of all respondents (48%) indicated an annual salary of less than $35,000. When the salary levels were broken down by gender, the percentages were comparable at each indicated salary level. See *Figure 3* below.



- Slight more than 1 in 10 (12%) of respondents do not receive health insurance (either full or partial) as a benefit of employment. And slightly more than one-third (34%) do not receive any level of retirement contribution.
- Respondents were most likely to have entered the substance abuse treatment field either because of previous experience (59%) or because of personal interest (55%). Additional reasons and their corresponding percentages are included in *Table 7* in the Appendix.
- About one-third (34%) of respondents indicated that substance abuse treatment was a second career.
- In general, substance abuse treatment professionals tend to stay in the field for an extended period of time, but change their place of employment and position frequently. This is absolutely the case among the survey respondents. Approximately 30% of respondents have worked in the substance abuse treatment field for three or less years. But 48% of respondents have worked at their current agency for three or less years, and an even higher percentage (56%) has worked in their current position for three or less years. See *Figure 4* below.

Figure 4. Years of Experience with Substance Abuse Treatment



- Twenty percent (20%) of respondents indicated that it was very likely (highly probable/definite) that they will be changing their place of employment within the next two years, and 13% indicated that it was very likely that they would leave the substance abuse treatment field altogether. The most frequently indicated reasons

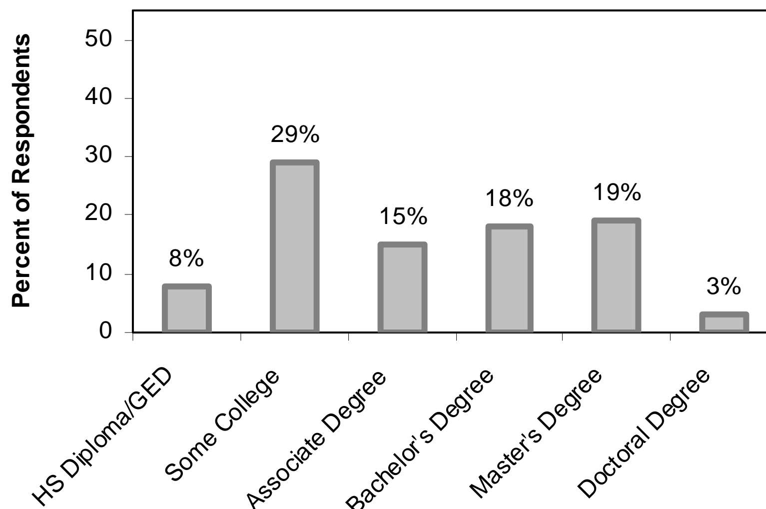
for changing place of employment (but staying in the field) include: greater pay and/or benefits (260 responses; 15%), greater responsibility/authority (137 responses; 8%), and better management/administration (124 total responses; 7%). And the most frequently indicated reasons for changing place of employment (and leaving the field) include: greater pay and/or benefits (136 responses; 8%), better management/administration (65 responses; 4%), and greater responsibility/authority (55 responses; 3%).

Please refer to Tables 4 through 9 in Appendix 1 for additional information regarding "work and professional background."

Section 3: Education and Training Background

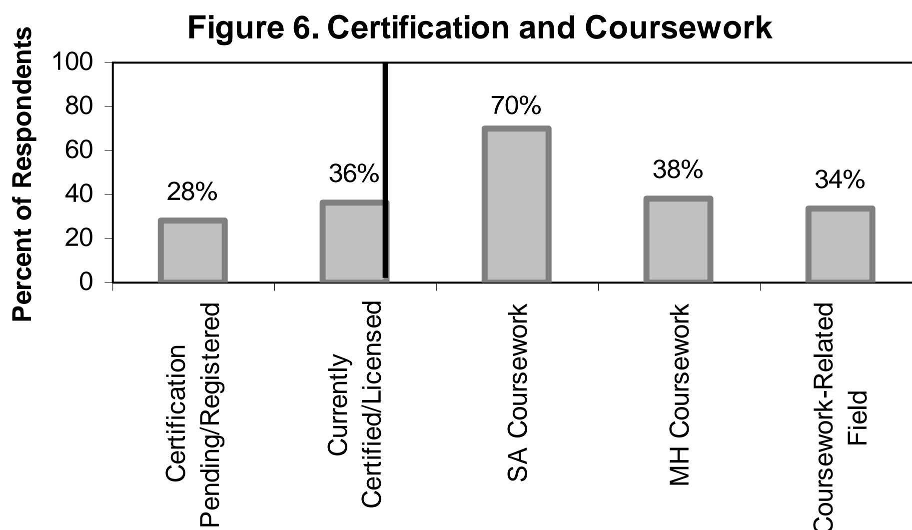
- More than 90% of respondents reported having at least a high school diploma or equivalent (GED). Fifteen percent (15%) earned an Associate's degree (and an additional 40% attained a Bachelor's, Master's, or Doctoral degree). See *Figure 5* below for a full breakdown.

Figure 5. Highest Level of Education



- Nearly fifty percent of respondents (49%) are either currently certified or licensed in the substance abuse treatment field, and an additional 28% are registered or are in the process of becoming certified. See *Figure 6* below.

- Seventy percent (70%) of respondents completed specialized educational substance abuse treatment coursework. A lower percentage of respondents completed specialized coursework in either the mental health field (38%) or a related field (34%). See *Figure 6* below.



- When asked about additional training in the substance abuse treatment field, the vast majority of respondents (98%) indicated that they had completed workshops or other types of training. Of those, 50% completed at least 20 contact hours of continuing education in the past year.

Please refer to Tables 10 through 12 in Appendix 1 for additional information regarding "education and training background."

Section 4: Agency Characteristics

- Respondents reported working in a variety of programs. The most frequently specified program types were outpatient (less than three times per week/ non-methadone; 38%), intensive outpatient (three or more times per week/non-methadone; 35%), and inpatient/residential programs (13%). A complete breakdown of program type is provided in *Table 13* in Appendix 1.
- According to Table 13a, respondents were most likely to work for non-profit organizations (69%), followed by public agencies (24%) and for profit organizations (6%).

- The preferred treatment models/program orientations that were most likely to be reported by respondents include: social model (21% as primary and 9% as secondary), AA/Twelve Step (18% as primary and 24% as secondary), client-centered (18% as primary and 9% as secondary), and behavioral (13% as primary and 14% as secondary). Refer to *Table 14* in Appendix 1 for the full set of preferred models/orientations.

Please refer to Tables 13 through 14 in Appendix 1 for additional information on "agency characteristics."

Section 5: Educational Needs and Barriers to Training and Technical Assistance

- The top five agency training and technical assistance needs reported by respondents include: (1) accessing effective training programs and resources for staff OR retaining qualified staff (tied at 52%); (2) selecting new treatment interventions and strategies for which program staff need training OR recruiting qualified staff (tied at 46%); (3) obtaining information that can document program effectiveness (41%); (4) tracking and evaluating performance of clients over time (37%); and (5) evaluating program staff performance and organizational functioning (35%). See *Figure 7 below.* A full listing of agency needs is provided in *Table 15* in Appendix 1.

Figure 7. Top Five Agency Training and Technical Assistance Needs	
Accessing effective **training programs and resources** for staff	917 (52.1%)
Retaining qualified staff	910 (51.7%)
Selecting new treatment interventions and strategies for which program staff need training	811 (46.1%)
Recruiting qualified staff	802 (45.5%)
Tracking and evaluating **performance of clients** over time	659 (37.4%)
Evaluating **program staff performance** and organizational functioning	617 (35.0%)

- Further, the top five personal training and technical assistance needs indicated by respondents include: (1) providing trauma informed or trauma sensitive services (48%); (2) providing services for co-occurring disorders (47%); (3) providing clients with integrated treatment services of addiction and mental health disorders (43%); improving client problem solving skills (40%); (4) improving behavioral management of clients OR improving client thinking skills (tied at 39%); and (4) improving cognitive focus of clients during group counseling (38%). See *Figure 8 below.* A full listing of agency needs is provided in *Table 16* in Appendix 1.

Figure 8. Top Five Personal Training and Technical Assistance Needs	
Providing **trauma informed or trauma sensitive** services	838 (47.6%)
Providing services for **co-occurring disorders**	824 (46.8%)
Providing clients with **integrated treatment services** of addiction and mental health disorders	757 (43.0%)
Improving client **problem solving skills**	696 (39.5%)
Improving **behavioral management** of clients	691 (39.2%)
Improving client **thinking** skills	679 (38.3%)
Improving **cognitive focus** of clients during group counseling	675 (38.3%)

- The vast majority of respondents (97%) are familiar with the Treatment Improvement Protocols (TIPS) and Technical Assistance Publications (TAPS) disseminated free of charge by the Substance Abuse and Mental Health Administration, but unfortunately do not utilize them when working with substance-abusing clients.
- Face-to-face, on-site trainings and off-site workshops and conferences were the most frequently accessed and preferred modes of receiving training and continuing education. Nearly seven out of ten respondents (69%) of respondents accessed face-to-face, on-site training in the past year, and an even higher percentage (76%) accessed off-site workshops conferences during the same time frame. Less popular training methods included telemedicine/satellite broadcast, Internet/web-based sessions, and videotapes/DVDs/CD ROMs. It is possible that the current

technological capacity and accessibility of treatment agencies serves as a potential barrier for staff wishing to access these types of training methods.

- The number one training barrier identified by respondents was that their agency's budget does not allow most program staff to attend professional conferences annually. More than half of all respondents (51%) responded in the affirmative to this barrier. Other frequently mentioned training barriers are included in *Figure 9* below; a full list is included in *Table 19* in Appendix 1.

Figure 9. Top Five Barriers to Training	
The **budget** does not allow most program staff to attend professional conferences annually	904 (51.3%)
The **workload and pressures** at this program keep motivation for new training low	655 (37.2%)
Limited resources (e.g., office space and budget) make it difficult to adopt new treatment ideas	620 (35.2%)
Training interests for program staff are mostly due to **licensure or certification requirements**	604 (34.3%)
There are **too few rewards** for trying to change treatment or other procedures here	496 (28.2%)

Please refer to Tables 15 through 19 in Appendix 1 for additional information on "training and technical assistance needs, training/continuing education preferences, and barriers to training and technical assistance."

Supplemental Data Analyses

The supplemental data analyses section (Appendix 2) explores possible correlations among several of the major workforce survey themes, including: certificate status by select participant characteristics; years in the field by select participant characteristics; certification status by agency training and technical assistance needs; salary level by agency and individual training and technical assistance needs; salary level by training barriers; gender by agency and individual training and technical assistance needs; ethnicity by agency and individual training and technical assistance needs; ethnicity by training barriers; years in the field by agency and individual training

and technical assistance needs; and years in the field by training barriers. Detailed data tables and summaries are included for each chi-square and ANOVA analysis.

Please refer to Tables 1 through 8 in Appendix 2 for additional information pertaining to the supplemental data analyses.

Survey Highlights and Summary

Understanding the characteristics of individuals in the substance abuse workforce is critical to retaining people in the field and recruiting new practitioners. This descriptive workforce survey found that California-based substance abuse providers are older than the workforce in general, and significantly less likely to be Hispanic or Latino than the clients they serve. Males and females were nearly equally likely to state that they earn an annual salary of $35,000 or more per year.

In addition, a high percentage of survey respondents (57%) have personal experience with addiction and are in recovery. And while many respondents were likely to have worked in the substance abuse treatment field for an extended period of time (more than three years), they were less likely to have worked at their current agency or in their current position for more than three years.

Considerable variability exists in terms of the highest academic degree attained by survey respondents. The modal level of education was “some college;” 29% had moved on from receiving a high school diploma or equivalent to complete at least some college coursework. An additional 54% of respondents went on to receive an Associate’s, Bachelor’s, Master’s, or Doctoral degree. No differences existed between males and females with regards to educational attainment.

More than one-third of respondents (36%) are currently certified in the field and many respondents had some level of specialized training (e.g., coursework (70%), college minor or certificate (41%), or terminal degree (7%)) in substance abuse treatment. Between 55% and 60% of respondents entered the field either because of previous personal experience with or because of a personal interest in addiction. About

one in five respondents intends to leave his/her place of employment in the next two years (but will remain in the substance abuse treatment field).

Face-to-face on-site training or off-site workshops and conferences are the most commonly utilized and most preferred methods of training/continuing education. The greatest agency need with regards to training and technical assistance is accessing effective training programs and resources for staff. And the top personal need is the provision of trauma informed or trauma sensitive services. Lastly, the number one barrier to training is that agency budgets do not allow most program staff to attend professional conferences annually.

In closing, the results included within this summary report should provide CADPAAC with the information needed to address the training and technical assistance needs of individuals working for contract and directly operated programs throughout California. Further, the results can be used to provide a snapshot of the needs of the CA-based substance abuse treatment workforce. Immediate next steps include sharing these results with CADPAAC, CAADAC, and Orion Healthcare. In addition, the Pacific Southwest ATTC will work with CADPAAC and CAADAC to identify upcoming regional and statewide conferences and training events in which the details of this report can be shared with the field at-large. Lastly, the Pacific Southwest ATTC will partner with CADPAAC, CAADAC, and Orion Healthcare to support the analysis of additional surveys and dissemination of future findings.

Acknowledgements

The Pacific Southwest ATTC wishes to recognize the following individuals for their role in developing, conducting, and analyzing the CADPAAC workforce survey: Tom Renfree (CADPAAC), Warren Daniels and Rhonda Messamore (CAADAC), Paul Le (Orion Healthcare), and Beth Rutkowski, Thomas E. Freese, and Sarah J. Cousins (Pacific Southwest ATTC). We also wish to thank the county administrative staff who disseminated the survey and encouraged their contract and directly operated providers to participate, and to the program staff who took the time to complete the survey.

References

Abt. Associates, Inc. (2006). *Strengthening Professional Identity: Challenges of the Addictions Treatment Workforce – A Framework for Discussion.* Bethesda, MD: Abt. Associates.

Hoge, M. A., Morris, J. A., Daniels, A. S., Stuart, G. W., Huey, L. Y., & Adams, N. (2006). *An Action Plan for Behavioral Health Workforce Development: A Framework for Discussion.* Report prepared for the Substance Abuse and Mental Health Services Administration, Contract No. 280-02-0302. Cincinnati, OH: Annapolis Coalition on Behavioral Health Workforce.

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2008). *Treatment Episode Data Set (TEDS): Administrative data report by states to TEDS through October 6, 2008.* Detailed tables available online at: http://www.dasis.samhsa.gov/webt/quicklink/CA07.htm.

Substance Abuse and Mental Health Service Administration, Office of Applied Studies. (2006a). *Results from the 2005 National Survey on Drug Use and Health: National Findings,* NSDUY Series: H-30, DHHS Publication No. (SMA) 06-4194, Rockville, MD.

U.S. Census Bureau. *California Data Profile Highlights.* Available online at: www.census.gov.

U.S. Department of Labor, Bureau of Labor Statistics. *Workforce Statistics.* Available online at: http://www.bls.gov/.

Appendix 1: Detailed Summary Tables

NOTE: The following summary tables include responses from a total of 1,761 surveys that were either returned to Tom Renfree, CADPAAC Executive Director or completed online.

Respondent Demographic Characteristics

Table 1: Survey Respondents by County

County Name **Number of Respondents (Percent of All Respondents)**				
Alameda 16 (0.9%)	**Amador** 4 (0.2%)	**Butte** 12 (0.7%)	**Calaveras** 5 (0.3%)	**Colusa** 1 (0.1%)
Contra Costa 22 (1.2%)	**Del Norte** 5 (0.3%)	**Fresno** 93 (5.3%)	**Glenn** 1 (0.1%)	**Imperial** 14 (0.8%)
Inyo 3 (0.2%)	**Kern** 44 (2.5%)	**Kings** 10 (0.6%)	**Lake** 13 (0.7%)	**Lassen** 2 (0.1%)
Los Angeles 488 (27.7%)	**Madera** 13 (0.7%)	**Marin** 19 (1.1%)	**Mariposa** 6 (0.3%)	**Mendocino** 14 (0.8%)
Merced 13 (0.7%)	**Monterey** 7 (0.4%)	**Nevada** 1 (0.1%)	**Orange** 182 (10.3%)	**Placer** 3 (0.2%)
Riverside 9 (0.5%)	**San Bernardino** 205 (11.6%)	**San Diego** 89 (5.1%)	**San Francisco** 46 (2.6%)	**San Joaquin** 15 (0.9%)
San Luis Obispo 16 (0.9%)	**San Mateo** 14 (0.8%)	**Santa Clara** 161 (9.1%)	**Santa Cruz** 11 (0.6%)	**Solano** 12 (0.7%)
Sonoma 59 (3.4%)	**Stanislaus** 23 (1.3%)	**Sutter** 2 (0.1%)	**Trinity** 3 (0.2%)	**Tulare** 73 (4.1%)
Tuolumne 2 (0.1%)	**Ventura** 1 (0.1%)	**Yolo** 29 (1.6%)		

Table 2: Basic Demographics

Demographic	Number	Percent
Gender		
Male	652	37.0%
Female	1,085	61.6%
Age Range		
18 to 25 years old	48	2.7%
26 to 40 years old	451	25.6%
41 to 59 years old	953	54.1%
60 years and older	245	13.9%
Median Age	48	--
Ethnicity		
Black/African American	259	14.7%
White	887	50.4%
Hispanic/Latino	366	20.8%
American Indian/Alaska Native	28	1.6%
Asian/Native Hawaiian/Pacific Islander	54	3.1%
Multi-Ethnic	61	3.5%
Other	82	4.7%
Fluent in another language other than English	424	24.1%

Non-response rates: gender: 1.4%; age: 3.6%; ethnicity: 4%

Table 3: Experience with Addiction

Type of Experience	Number	Percent
Personal/In Recovery	995	56.5%
Family Member	776	44.1%
Friend	608	34.5%
None	189	10.7%

NOTE: Percentages may add up to more than 100%, since respondents were able to check "all that apply."

Work and Professional Background

Table 4: Current Discipline/Profession

Type of Discipline/ Profession	Number	Percent
Addictions Counseling	1,280	72.7%
Vocational Rehabilitation	33	1.9%
Social Work/Human Service	247	14.0%
Medicine (Primary Care)	9	0.5%
Nursing	44	2.5%
Psychology	209	11.9%
Adolescent Treatment	182	10.3%
Other Counseling	189	10.7%
Education	122	6.9%
Criminal Justice	119	6.8%
Other	327	18.6%

NOTE: Percentages may add up to more than 100%, since respondents were able to check “all that apply.”

Table 5: Current Annual Salary Range

Annual Salary Range	Number	Percent
Less than $25,000	375	21.3%
$25,000 to $34,999	469	26.6%
$35,000 to $49,999	338	19.2%
$50,000 or more	434	24.6%

Not applicable/refused to respond/non-response: 8.2%.

Table 6: Employer-Provided Benefits and Compensation

Type of Benefit/ Compensation	Number	Percent
Health Insurance		
Full Coverage	904	51.3%
Partial Coverage	597	33.9%
No Coverage	216	12.3%
Sick Leave		
Full Leave	1,364	77.5%
Partial Leave	146	8.3%
No Leave	195	11.1%
Vacation Leave		
Full Leave	1,441	81.8%
Partial Leave	97	5.5%
No Leave	163	9.3%
Other Paid Leave		
Full Leave	870	49.4%
Partial Leave	134	7.6%
No Leave	561	31.9%
Retirement Contributions		
Full Contribution	422	24%
Partial Contribution	595	33.8%
No Contribution	594	33.7%

Non-response rates: health insurance: 2.5%; sick leave: 3.2%; vacation leave: 3.4%; other paid leave: 11.1%; retirement contributions: 8.5%.

Table 7: Reason(s) for Entering the Substance Abuse Treatment Field

Reason for Entering Substance Abuse Treatment Field	Number	Percent
Previous Experience with Addiction or Recovery	1,055	59.9%
Personal Interest	968	55.0%
Experience in Like Field	371	21.1%
Academic Work/ Degree in Like Field	427	24.2%
Unplanned Decision	354	20.1%
Other	101	5.7%

Alcohol and Other Drug Abuse Treatment as a Second Career

598 individuals responded “Yes” (34%)

Table 8: Years of Experience

Years Worked	Number	Percent
Years Worked in the Alcohol and Drug Treatment Field		
1-3 years	535	30.4%
4-9 years	585	33.2%
10-15 years	261	14.8%
More than 15 years	326	18.5%
Years Worked at Current Agency		
1-3 years	843	47.9%
4-9 years	555	31.5%
10-15 years	150	8.5%
More than 15 years	156	8.9%
Years Worked in Current Position		
1-3 years	981	55.7%
4-9 years	498	28.3%
10-15 years	115	6.5%
More than 15 years	92	5.2%

Non-response rates: years worked in alcohol and drug treatment field: 3.1%; years worked at current agency: 3.2%; and years worked in current position: 4.3%.

Table 9: Likelihood of Changing Place of Employment

Likelihood of Changing Employment	Number	Percent
…And Staying in Substance Abuse Treatment Field		
Likelihood		
Not at all likely	745	42.3%
Remote possibility	259	14.7%
Not sure	388	22.0%
Highly probable	***285***	***16.2%***
Definitely	***60***	***3.4%***
…And Leaving Substance Abuse Treatment Field		
Likelihood		
Not at all likely	936	53.2%
Remote possibility	257	14.6%
Not sure	314	17.8%
Highly probable	***172***	***9.8%***
Definitely	***51***	***2.9%***

Desired Changes (if staying in field):

Greater responsibility/authority (137 responses; 7.8%)
Greater pay and/or benefits (260 responses; 14.8%)
Better management/administration (124 responses; 7%)
Less paperwork (67 responses; 3.8%)
Different client population (67 responses; 3.8%)
Different geographic location (66 response; 3.7%)
Other (51 responses; 2.9%)

Desired Changes (if leaving field):

Greater responsibility/authority (55 responses; 3.1%)
Greater pay and/or benefits (136 responses; 7.7%)
Better management/administration (65 responses; 3.7%)
Less paperwork (37 responses; 2.1%)
Different geographic location (71 responses; 4%)
Other (38 responses; 2.2%)

Education and Training Background

Table 10: Certification Status and Highest Academic Degree

Status	Number	Percent
Certification Status		
Never certified	337	19.1%
Previously certified, but not currently	30	1.7%
Certification pending or Registered	495	28.1%
Currently certified	636	36.1%
Exempt License (i.e., LCSW/MFT, Psychologist)	294	13.3%
Highest Degree		
No high school diploma or equivalent	30	1.7%
High school diploma or equivalent	136	7.7%
Some college	511	29.0%
Associate Degree	262	14.9%
Bachelor's Degree	308	17.5%
Master's Degree	333	18.9%
Doctoral Degree	57	3.2%
Other	97	5.5%

Certification status non-response: 1.6%; Highest degree non-response: 1.5%.

Table 11: Specialized Coursework in Substance Abuse Treatment, Mental Health Treatment, and a Related Field

Specialized Educational Coursework	Number	Percent
Substance Abuse Treatment		
Completed coursework	1,233	70.0%
Received minor in college or certificate	722	41.0%
Received terminal degree (e.g., Bachelor's or Master's)	118	6.7%
Mental Health Treatment		
Completed coursework	660	37.5%
Received minor in college or certificate	154	8.7%
Received terminal degree (e.g., Bachelor's or Master's)	295	16.8%
Related Field		
Completed coursework	605	34.4%
Received minor in college or certificate	197	11.2%
Received terminal degree (e.g., Bachelor's or Master's)	205	11.6%

Non-response rates: Substance abuse treatment coursework: 3.9%; Mental health treatment coursework: 20.3%; Related field coursework: 28.3%.

Table 12: Additional Training in Substance Abuse Treatment

Additional Training in Substance Abuse Treatment	Number	Percent
Completed Workshops or Training	1,731	98.3%
Number of Continuing Education Contact Hours		
0 to 9 hours	164	9.3%
10-19 hours	265	15.0%
20-39 hours	493	28.0%
40-79 hours	301	17.1%
80 or more hours	91	5.2%

Non-response rates: completed workshops or training: 1.7%; number of CE hours: 25.4%.

Agency Characteristics

Table 13: Program Description

Program Description	Number	Percent
Intensive Outpatient (3x per wk or more) – non-methadone	622	35.3%
Outpatient (less than 3x per week) – non-methadone	663	37.6%
Outpatient Methadone	139	7.9%
Therapeutic Community	227	12.9%
Inpatient/Residential	520	29.5%
Halfway House/Work Release	24	1.4%
Intensive Supervision/Revocation	39	2.2%
Other	211	12.0%

Table 13a: Program Type

Program Type	Number	Percent
Non-Profit	1,207	68.5%
For Profit	98	5.6%
Public Agency	424	24.1%

Table 14: Preferred Treatment Models/Program Orientations

Treatment Model/ Program Orientation	First Preference Number (%)	Second Preference Number (%)
AA/Twelve Step	322 (18.3%)	416 (23.6%)
Behavioral	234 (13.3%)	254 (14.4%)
Client-Centered	309 (17.5%)	163 (9.3%)
Cognitive	179 (10.2%)	143 (8.1%)
Social Model	372 (21.1%)	155 (8.8%)
Eclectic	78 (4.4%)	37 (2.1%)
Existential/Humanistic	16 (0.9%)	11 (0.6%)
Psychodynamic	14 (0.8%)	26 (1.5%)
Brief Treatment	35 (2.0%)	28 (1.6%)
Medical Model	88 (5.0%)	55 (3.1%)
Other	35 (2.0%)	10 (0.6%)

Non-response rates: primary orientation: 4.5%; secondary orientation: 26.3%.

Training and Technical Assistance Needs

Table 15: Agency Training and Technical Assistance Needs

Agency Training and Technical Assistance Needs**	
Accessing effective **training programs and resources** for staff	917 (52.1%)
Retaining qualified staff	910 (51.7%)
Selecting new treatment interventions and strategies for which program staff need training	811 (46.1%)
Recruiting qualified staff	802 (45.5%)
Obtaining information that can document **program effectiveness**	713 (40.5%)
Tracking and evaluating **performance of clients** over time	659 (37.4%)
Evaluating **program staff performance** and organizational functioning	617 (35.0%)
Automating client records for **billing and financial** applications	532 (30.2%)
Generating timely **"management" reports** of clinical, financial, and outcome data	444 (25.2%)
Documenting **service needs** of clients for making treatment placements	389 (22.1%)
Improving recording and retrieval of **financial information**	365 (20.7%)

** NOTE: The numbers and percentages correspond to respondents who selected "*agree*" or "*strongly agree*" as their response to each agency training/technical assistance need.

Table 16: <u>Personal</u> Training and Technical Assistance Needs

Personal Training and Technical Assistance Needs**	
Providing **trauma informed or trauma sensitive** services	838 (47.6%)
Providing services for **co-occurring disorders**	824 (46.8%)
Providing clients with **integrated treatment services** of addiction and mental health disorders	757 (43.0%)
Improving client **problem solving skills**	696 (39.5%)
Improving **behavioral management** of clients	691 (39.2%)
Improving client **thinking** skills	679 (38.6%)
Improving **cognitive focus** of clients during group counseling	675 (38.3%)
Using **pharmacological interventions** with clients	646 (36.7%)
Using **computerized** client assessments	620 (35.2%)
Increasing client **participation** in treatment	610 (34.6%)
Providing **culturally competent services**	603 (34.2%)
Working with staff on **other units/agencies**	513 (29.1%)
Monitoring client **progress**	383 (21.7%)
Assessing client **problems and needs**	371 (21.1%)
Improving **rapport** with clients	310 (17.6%)

** NOTE: The numbers and percentages correspond to respondents who selected "*agree*" or "*strongly agree*" as their response to each personal training/technical assistance need.

Training and Technical Assistance Needs

Table 17: Familiarity with Treatment Improvement Protocols (TIPS) and Technical Assistance Publications (TAPS)

TIPS/TAPS Familiarity Level	Number	Percent
Not familiar	0	0.0%
Familiar, but not utilized	1,700	96.5%
Familiar, used occasionally	0	0.0%
Familiar, used extensively	0	0.0%

Non-response: 3.5%.

Table 18: Training/Continuing Education Preferences

Training Preferences	Number	Percent
Face to Face, on site		
Accessed for training/continuing education in past year	1,221	69.3%
Preferred approach for training/continuing education	935	53.1%
Off-site workshops/conferences		
Accessed for training/continuing education in past year	1,337	75.9%
Preferred approach for training/continuing education	1,006	57.1%
Internet/Web-based		
Accessed for training/continuing education in past year	678	38.5%
Preferred approach for training/continuing education	401	22.8%
Telemedicine/Satellite broadcast		
Accessed for training/continuing education in past year	108	6.1%
Preferred approach for training/continuing education	39	2.2%
Videotape/DVD/CD-ROM		
Accessed for training/continuing education in past year	696	39.5%
Preferred approach for training/continuing education	317	18.0%

Table 19: Barriers to Training

Barriers to Training	
The **budget** does not allow most program staff to attend professional conferences annually	904 (51.3%)
The **workload and pressures** at this program keep motivation for new training low	655 (37.2%)
Limited resources (e.g., office space and budget) make it difficult to adopt new treatment ideas	620 (35.2%)
Training interests or program staff are mostly due to **licensure or certification requirements**	604 (34.3%)
There are **too few rewards** for trying to change treatment or other procedures here	496 (28.2%)
Topics presented at recent training workshops and conferences have been too limited	460 (26.1%)
The **background and training of program staff** limits the kind of treatment changes possible here	388 (22.0%)
Training activities take **too much time** away from the delivery of program services	379 (21.5%)
It is often **too difficult to adapt** things learned at workshops so they will work in this program	263 (14.9%)
The **quality of trainers** at recent training workshops and conferences has been poor	184 (10.4%)

** NOTE: The numbers and percentages correspond to respondents who selected "*agree*" or "*strongly agree*" as their response to each training barrier.

Appendix 2: Supplemental Data Analyses

NOTE: Numbers and percentages for certain variables may differ slightly from the workforce survey report narrative and main data tables presented in Appendix 1, due to special data cleaning that was done to prepare for the supplemental data analyses.

The chi-square test (X^2 Test) of association is used to test the null hypothesis that there is no association between two nominal scale variables. ANOVA (analysis of variance) is a statistical test of whether the means of several groups are all equal.

Table 1: X^2 Test between Certificate Status and Participant Characteristics

	Currently Licensed/Certified (n=870)	Certification Pending (n=267)	Not Certified (n=367)
Total	50.2	28.6	21.2
Within Sex (%)**			
Males (n=649)	54.7	27.6	17.7
Females (n=1,078)	47.5	29.2	23.3
Within Certification**			
Males (n=649)	40.9	36.2	31.4
Females (n=1078)	59.1	63.8	68.6
Within Ethnicity1 (%)***			
White (n=882)	55.9	24.8	19.3
Hispanic/Latino (n=364)	37.9	33.2	28.8
Black/African American (n=257)	51	35	14
Other (n=225)	47.6	28	24.4
Within Ethnicity2 (%)***			
American Indian/Alaska Native (n=28)	57.1	21.4	21.4
Asian/Native Hawaiian or Pacific Islander (n=54)	40.7	31.5	27.8
Other (n=143)	48.3	28	23.8

$^+$ $p \leq .1$ (marginal); *$p \leq .05$; **$p \leq .01$; ***$p \leq .001$;

A majority of survey respondents were female (62.4%) and White (51%), and over half (50.2%) of which were currently licensed/certified.

Within Sex and Within Certification

- Over half (47.5%) of all female attendees were certified, while a third (29.2%) had a pending certificate, and less than quarter (23.3%) were not certified.
- Over half (54.7%) of the male attendees were currently certified, while almost one third (27.6%) had a pending certificate, and less than eighteen percent (17.7%) were uncertified.
- Among those certified, females had a higher proportion of certification than males (59.1% compared to 40.9%). However, among all males, they were more likely to be certified than females (54.7% compared to 47.5%). On the other hand, females had a higher representation of uncertified attendees than males (68.6% vs. 31.4%)

Within Ethnicity1 and Ethnicity2

- Whites represented more than one half (56.7%) of all certificated attendees, and almost half of all pending (44.4%) and not certified attendees (46.4%).
- Among all racial and ethnic groups, American Indians/Alaska Natives had the highest representation of certified attendees (57.1%), followed by Whites (55.9%) and Blacks/African Americans (51.0%).
- On the other hand, Hispanics had the highest representation of uncertified attendees (28.8%), followed by Asians/Native Hawaiians and Pacific Islanders (27.8%), those who reported Other as their race/ethnicity (23.8%), American Indians/Alaska Natives (21.4%), Whites (19.3%), and Blacks/African Americans (14%).

Table 2: X^2 Test between Years in Field and Participant Characteristics

	0-3 Years In the Field (n=553)	4-15 Years In the Field (n=846)	16+ Years In the Field (n=326)
Total	31.3	49.6	19.1
Within Gender (%)**			
Males (n=643)	28.1	50.4	21.5
Females (n=1059)	33.2	49.1	17.7
Ethnicity1 (%)***			
White (n=868)	26.7	50.9	22.4
Hispanic/Latino (n=359)	41.5	46	12.5
Black/African American (n=256)	24.6	58.2	17.2
Other (n=220)	40.5	40.9	18.6
Ethnicity2 (%)***			
American Indian/Alaska Native (n=27)	11.1	55.6	33.3
Asian/Native Hawaiian or Pacific Islander (n=52)	51.9	38.5	9.6
Other (n=141)	41.8	39	19.1

$^{+}$ $p \leq .1$ (marginal); *$p \leq .05$; **$p \leq .01$; ***$p \leq .001$;

Approximately half (49.6%) of survey respondents reported working four to fifteen years in the field.

Within Gender

- A higher proportion of females than males reported working 0-3 years in the field (66% vs. 34%), 4-15 years in the field (61.6% compared to 38.4%) and 16+ years in the field (57.5% compared to 42.7%).
- However, among all males, males were more likely than females to report working 4-14 years (50.4% compared to 49.1%), and 16+ years in the field (21.5% compared to 17.7%).

- No significant differences were seen between Gender and Ethnicty1 or between Gender and Ethnicity2.

Within Ethnicity1 and 2

- Whites represented almost half (43.5%) of those who reported working 0-3 years in the field, and more than half of those who reported working 4-15 years (52.2%) and 16+ years in the field (59.9%).
- Among all racial and ethnic groups, Blacks/African Americans had the highest representation among those who reported working 4-15 years in the field (58.2%). Asians/Native Hawaiians, and Pacific Islanders had the highest representation of those who reported working 0-3 years in the field (51.9%). American Indians and Alaska Natives had the highest representation of those working 16+ years in the field (33.3%).

Table 3: *ANOVA* Tests: Mean Score of 32 items by Certification Status

	Currently Licensed/Certified (n=870)	Certification Pending (n=267)	No Certification (n=367)
Agency Needs Guidance In:		*M* (SE)	
Obtaining information that can document program effectiveness [+]	---[a]	1.32 (.06)	1.56 (.07)
Selecting new treatment interventions and strategies for which program staff need training**	1.70 (.05)	1.48 (.06)	1.49 (.07)
Accessing effective training programs and resources for The staff*	1.83 (.05)	1.64 (.06)	---[a]

[+] $p \leq .55$; *$p \leq .05$; **$p \leq .01$; ***$p \leq .001$; [a] Does not statistically differ on item

Certification Status and Agency Training and Technical Assistance Needs

Few differences existed among the survey items when the participants' certification status was examined, with exception to three items of perceived need for agency guidance. A slight trend ($p \leq .55$) indicated that uncertified attendees (1.56 ± .07) were more likely to report that their agency needs guidance to document program effectiveness than attendees with a pending certification (1.32 ± .06). On the other hand, certified attendees were more likely (1.7 ± .05) to report that their agency needed guidance in selecting new treatment interventions, compared to those pending certifications (1.48 ± .06) and those who are uncertified (1.49 ± .07). Certified attendees were also more likely (1.83 ± .05) than those pending certification (1.64 ± .06) to report that their agency needed guidance in accessing effective training programs.

Table 4: *ANOVA* Tests: Mean Score of 32 items by Salary

	Salary of more than $35,000 (n=642)	Salary of Less than $35,000 (n=844)
Agency Needs Guidance In:	*M* (SE)	
Tracking and evaluating performance of clients over time***	1.52 (.06)	1.17 (.05)
Obtaining information that can document program effectiveness***	1.66 (.06)	1.27 (.05)
Automating client records for billing and financial applications***	1.04 (.05)	.92 (.04)
Evaluating program staff performance and organizational functioning*	1.39 (.06)	1.23 (.05)
Generating timely "management" reports of clinical, financial, and outcome data***	1.23 (.05)	.99 (.04)
Recruiting qualified staff ***	1.79 (.06)	1.43 (.05)
Retaining qualified staff***	1.95 (.05)	1.64 (.05)
Accessing effective training programs and resources for the staff***	1.93 (.05)	1.67 (.05)
Individual Needs Training In:		
Monitoring client progress*	.59 (.05)	.72 (.04)
Using computerized client assessments*	1.01 (.05)	1.15 (.05)
Barriers to Training:		
The workload and pressures at this program keep motivation for new training low***	1.47 (.05)	1.22 (.05)
The budget does not allow most program staff to attend professional conferences annually***	1.88 (.06)	1.64 (.05)
Training activities take too much time away from the delivery of program services***	1.09 (.05)	.65 (.04)
Training interests or program staff is mostly due to licensure or certification requirements**	1.40 (.06)	1.22 (.05)
It is often too difficult to adapt things learned at workshops so they will work in this program.**	.81 (.05)	.62 (.04)
Limited resources (e.g., office space or budget) make it difficult to adopt new treatment ideas^{+}	1.37 (.06)	1.24 (.05)
There are too few rewards for trying to change treatment or other procedures here.**	1.24 (.05)	1.03 (.04)

$^{+}p \leq .55$; $^{*}p \leq .05$; $^{**}p \leq .01$; $^{***}p \leq .001$;

Salary and Agency Training and Technical Assistance Needs

Attendees who reported earning over $35,000 (i.e., "higher earners;" "those earning more"), were more likely to report that their agency needed help on seven survey items, compared to those earning less. For instance, those earning more money were more likely to report that their agency needed help with tracking and evaluating performance of clients over time (1.52 ± .06) compared to those earning less (1.17 ± .05). In addition, higher earners were also more likely to report a need for help with obtaining information that can document program effectiveness (1.66 ± .06 compared to 1.27 ± .05), automating client records for billing and financial applications (1.04 ± .05 compared to .92± .04), evaluating program staff performance and organizational functioning (1.39 ± .06 compared to 1.23 ± .05), generating timely

“management” reports of clinical, financial, and outcome data (1.23 $\pm$ .05 compared to .99 $\pm$ .04), recruiting qualified staff (1.79 $\pm$ .06 compared to 1.43 $\pm$ .05), retaining qualified staff (1.95 $\pm$ .05 compared to 1.64 $\pm$ .05), and accessing effective training programs and resources for the staff (1.93 $\pm$ .05 compared to 1.64 $\pm$ .05).

Salary and Personal Training and Technical Assistance Needs

Those who earned less than $35,000 were more likely to report a need for personal training to monitor client progress (.72 $\pm$ .04 compared to .59 $\pm$ .05) and training to use computerized client assessments (1.15 $\pm$ .05 compared to 1.01 $\pm$ .05).

Salary and Barriers to Training

Attendees who reported earning over $35,000 were more likely to report barriers to training on seven survey items, compared to those earning less. For instance, higher earners were more likely (1.47 $\pm$ .05) to feel that the workload and pressures at their program kept motivation for new training low compared to those earning less (1.22 $\pm$ .05). Those earning more were also more likely to report that the budget did not allow most program staff to attend professional conferences annually (1.88 $\pm$ .06 compared to 1.64 $\pm$ .05), training activities took too much time away from the delivery of program services (1.09 $\pm$ .05 compared to .65 $\pm$ .04), the training interests of program staff is mostly due to licensure or certification requirements (1.40 $\pm$ .06 compared to 1.22 $\pm$ .05), it is difficult to adapt tools learned at workshops so that they will work in their program (.81 $\pm$ .05 compared to .62 $\pm$ .04), limited resources make it difficult to adopt new treatment ideas (1.37 $\pm$ .06 compared to 1.24 $\pm$ .05) and that there are too few rewards for trying to change treatment or other procedures here (1.24 $\pm$ .05 compared to 1.03 $\pm$ .04).

Table 5: *ANOVA* Tests: Mean Score of 32 items by Gender

	Males (n=652)	Females (n=1085)
Agency Needs Guidance In:	*M* (SE)	*M* (SE)
Selecting new treatment interventions and strategies for which program staff need training*	1.50 (.06)	1.66 (.04)
Individual Needs Training In:		
Increasing client participation in treatment+	.87 (.05)	.75 (.04)
Monitoring client progress***	.76 (.05)	.57 (.03)
Improving client thinking skills*	1.44 (.06)	1.30 (.04)
Improving behavioral management of clients**	1.45 (.06)	1.28 (.04)

+ $p \leq .55$ (marginal); * $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$; [a] Does not statistically differ on item

Gender and Agency Training and Technical Assistance Needs

Of the 1,737 respondents who indicated their gender, there were relatively few differences between men and women. Women (1.66 $\pm$ .04) were more likely than men

(1.50 ± .06) to report that their agency needed guidance in selecting new treatment interventions and strategies for which program staff need training.

Gender and Personal Training and Technical Assistance Needs

Men were more likely than women to report a need for training to increase client participation in treatment (.87 ± .05 compared to .75 ± .04), to monitor client progress (.76 ± .05 compared to .57 ± .03), improve client thinking skills (1.44 ± .06 compared to 1.30 ± .04) and to improve behavioral management of clients (1.45 ± .06 compared to 1.28 ± .04).

Table 6: *ANOVA* Tests: Mean Score of 32 items by Ethnicity1

	White (n=887)	Hispanic/ Latino (n=366)	Black/African American (n=259)	Other (n=225)
Agency Needs Guidance In:		*M* (SE)		
Documenting service needs of clients for making treatment placements***	.73 (.04)	---[a]	---[a]	1.08 (.09)
Barriers to Training:				
The budget does not allow most program staff to attend professional conferences annually.*	1.56 (.05)	---[a]	1.81 (.09)	---[a]
Topics presented at recent training workshops and conferences have been too limited.[+]	1.00 (.04)	---[a]	---[a]	1.26 (.09)
Training activities take too much time away from the delivery of program services.*	---[a]	.79 (.06)	.67 (.07)	1.11 (.09)
The background and training of program staff limits the kind of treatment changes possible here.*	.88 (.04)	---[a]	---[a]	1.11 (.09)

[+] p≤ .1 (marginal); *p≤.05; **p≤.01; ***p≤.001; [a] Does not statistically differ on item

Ethnicity1 and Agency Training and Technical Assistance Needs

Those who did not identify as White, Hispanic/Latino or Black/African American ("Other;" 1.08 ± .09) were more likely than Whites (.73 ± .04) to report that their agency needed guidance documenting service needs of clients for making treatment placements.

Ethnicity1 and Barriers to Training

Blacks/African Americans (1.81 ± .09) were more likely than Whites (1.56 ± .05) to report that the budget was a barrier to training.

Those who did not identify as White, Hispanic/Latino, or Black/African American ("Other") were more likely than Whites to report that the topics presented at the trainings were too limited (1.26 ± .09 compared to 1.00 ± .04) and that the background and training of program staff limited the kind of treatment change possible (1.11 ± .09 compared to (.88 ± .04). Compared to Hispanic/Latinos (.79 ± .06) and Blacks/African Americans (.67± .07, those who reported a race/ethnicity of Other (1.11 ± .09) were

more likely to report that training activities took too much time away from the delivery of program services. ****To better understand the differences of the individuals included in the "Other" group, please refer to the Ethnicity2 table.***

Table 7: *ANOVA* Tests: Mean Score of 32 items by Ethnicity2

	White (n=887)	Hispanic/ Latino (n=366)	Black/ African American (n=259)	American Indian/ Alaska Native (n=28)	Asian/ Native Hawaiian/ Pacific Islander (n=54)	Other (n=225)
Agency Needs Guidance In:				*M* (SE)		
Documenting service needs of clients for making treatment placements**	.73 (.04)	---[a]	---[a]	---[a]	1.23 (.18)	---[a]
Obtaining information that can document program effectiveness*	---[a]	1.32 (.07)	---[a]	---[a]	1.75 (.18)	---[a]
Individual Needs Training In:						
Assessing client problems and needs*	1.22 (.05)	1.09 (.07)	---[a]	.79 (.24)	1.84 (.19)	.94 (.11)
Increasing client participation in treatment**	.74 (.04)	.83 (.07)	.86 (.08)	.59 (.23)	1.46 (.19)	.7 (.1)
Monitoring client progress*	.58 (.04)	.65 (.06)	.75 (.08)	.57 (.20)	1.41 (.20)	.54 (.09)
Improving rapport with clients**	---[a]	---[a]	---[a]	---[a]	1.90 (.20)	1.08 (.11)
Improving client problem solving skills+	---[a]	---[a]	---[a]	---[a]	1.81(.19)	1.16 (.11)
Improving behavioral management of clients**	1.35 (.05)	1.29 (.07)	1.39 (.09)	---[a]	2.10 (.18)	1.14 (.11)
Improving cognitive focus of clients during group counseling*	1.24 (.05)	1.3 (.07)	---[a]	---[a]	1.90 (.018)	1.09 (.11)
Using computerized client assessments*	1.03 (.44)	---[a]	---[a]	---[a]	1.59 (.19)	.96 (.11)
Working with staff on other units/agencies***	1.51 (.05)	1.34 (.07)	---[a]	1.04 (.25)	2.12 (.18)	1.25 (.12)
Providing clients with integrated treatment services of addiction and mental health disorders*	---[a]	1.60 (.09)	1.68 (.05)	---[a]	2.24 (.17)	---[a]
Using pharmacological interventions with clients**	---[a]	1.12 (.07)	1.21[b] (.25)	---[a]	1.74[c] (.19)	.91 (.11)
Providing culturally competent services**	2.22 (.17)	1.5 (.07)	---[a]	---[a]	---[a]	1.4 (.12)
Barriers to Training:						
The budget does not allow most program staff to attend professional conferences annually.*	1.81 (.05)	---[a]	---[a]	---[a]	2.17 (.16)	---[a]
Topics presented at recent training workshops and conferences have been too limited.**	1.00 (.04)	1.06 (.07)	1.06 (.08)	---[a]	1.75 (.19)	1.15 (.11)
Training activities take too much time away from the delivery of program services.***	.88 (.04)	.79 (.06)	.67 (.07)	---[a]	1.4 (.19)	---[a]
Limited resources (e.g., office space or budget) make it difficult to adopt new treatment ideas.*	1.28 (.05)	---[a]	1.19 (.09)	1.14 (.24)	1.9 (.19)	---[a]
The background and training of program staff limits the kind of treatment changes possible here.**	.88 (.04)	.87 (.06)	---[a]	---[a]	1.5 (.18)	---[a]

+ $p \leq .1$ (marginal); * $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$; [a] Does not statistically differ on item; [b] African American/Black were different than Other; [c] Asian/Native Hawaiian/Other Pacific Islanders were different than Hispanic/Latinos and Other

Significant differences existed among the racial/ethnic group responses to several survey items pertaining to agency training/technical assistance needs, individual training/technical assistance needs, and barriers to training. To better understand the respondent differences of the “Other” racial/ethnic category as reported in Ethnicity1, a closer examination was performed.

Ethnicity2 and Agency Training and Technical Assistance Needs

For instance, Asians/Native Hawaiians, and Pacific Islanders (1.23 ± .18) were more likely than Whites (.73 ± .04) to report that their agency needed guidance in documenting service needs of clients to make treatment placements.

Hispanic/Latinos (1.32 ± .07) were more likely than Asians, Native Hawaiians, and Pacific Islanders (1.75 ± .18) to report that their agency need guidance on obtaining information that could document program effectiveness.

Ethnicity2 and Personal Training and Technical Assistance Needs

When compared to all other racial/ethnic groups, those who identified as Asian, Native Hawaiian, or Pacific Islander were most likely to report a need for individual training. For instance, Asians, Native Hawaiians, and Pacific Islanders (1.84 ± .19) were most likely to report a need for personal training to assess clients’ problem and needs, followed by Whites (1.22 ± .05), Hispanics/Latinos (1.09 ± .07), Others (.94 ± .11), and American Indians/Alaska Natives (.79 ± .24). In addition, Asians, Native Hawaiians, and Pacific Islanders (1.41 ± .20) were also most likely to report a training need to monitor clients progress, followed by Blacks/African Americans, (.75 ± .08), Hispanics/Latinos (.65 ± .06), Whites (.58 ± .04), and Others (.54 ± .09).

Whites (2.22 ± .05) were more likely than Hispanics/Latinos (1.5 ± .07) and Others (1.4 ± .12) to report a need for training to provide culturally competent services.

Ethnicity2 and Barriers to Training

In general, Asians, Native Hawaiians, and Pacific Islanders were more likely to report barriers to training when compared to other groups.

For instance, with regard to training provided, Asians, Native Hawaiians and Pacific Islanders (1.75 ± .19) were most likely to report that the topics presented at the trainings were too limited, followed by Others (1.15 ± .11), Hispanics/Latinos (1.06 ± .07), Blacks/African Americans (1.06 ± .08), and Whites (1.00 ± .04). Asians, Native Hawaiians, and Pacific Islanders (1.4 ± .19) were also most likely to report that the training activities took too much time away from the delivery of program services, followed by Whites (.88 ± .04), Hispanics/Latinos (.79 ± .06), and Blacks/African Americans (.67 ± .07).

With regard to agency barriers, Asians, Native Hawaiians, and Pacific Islanders (1.9 ± .19) were more likely to report that limited resources (e.g., office space or budget) made it difficult to adopt new treatment ideas, followed by Whites (1.28 ± .05),

Blacks/African Americans (1.19 ± .09), and American Indians/Alaska Natives (1.14 ± .24).

Table 8: *ANOVA* Tests: Mean Score of 32 items by Years in The Field

	0-3 Years (n=535)	4-15 years (n=846)	16+ years (n=326)
Agency Needs Guidance In:			
Tracking and evaluating performance of clients over time*	1.22 (.06)	---[a]	1.47 (.08)
Selecting new treatment interventions and strategies for which program staff need training**	1.46 (.06)	---[a]	1.76 (.08)
Recruiting qualified staff ***	1.32 (.06)	1.67 (.05)	1.74 (.08)
Retaining qualified staff***	1.51 (.06)	1.87 (.05)	1.80 (.08)
Personally Need Training In:			
Assessing client problems and needs**	1.34 (.06)	1.10 (.05)	---[a]
Increasing client participation in treatment**	.95 (.06)	.74 (.04)	.69 (.07)
Monitoring client progress*	.75 (.05)	.60 (.04)	---[a]
Using computerized client assessments*	---[a]	1.14 (.05)	.93 (.07)
Barriers to Training:			
The workload and pressures at this program keep motivation for new training low.***	1.12 (.06)	1.37 (.05)	1.46 (.08)
The budget does not allow most program staff to attend professional conferences annually.**	1.58 (.06)	1.83 (.05)	1.82 (.08)
Topics presented at recent training workshops and conferences have been too limited.*	.99 (.05)	---[a]	1.20 (.07)
The quality of trainers at recent training workshops and conferences has been poor.**	.59 (.04)	.42 (.03)	.58 (.06)
Training activities take too much time away from the delivery of program services.*	.81 (.05)	---[a]	1.02 (.07)
Training interests or program staff are mostly due to licensure or certification requirements.**	1.12 (.05)	1.36 (.06)	1.41 (.08)

[+] $p \leq .1$ (marginal); *$p \leq .05$; **$p \leq .01$; *** $p \leq .001$; [a] Does not statistically differ on item

Years in the Field and Agency Training and Technical Assistance Needs

Attendees differed in their responses to needs for agency guidance when years in the field were considered. For instance, those who reported working 16+ years in the field (1.47 ± .08) were more likely to report that their agency needed guidance to track and evaluate the performance of their clients over time when compared to those who reported working in the field for less than three years (1.22 ± .06). Those who reported being in the field for more than 16 years (1.74 ± .08) were most likely to report that their agency needed guidance in recruiting qualified staff, followed by those who had worked 4-15 years in the field (1.67 ± .05), and those who had worked less than three years (1.32 ± .06). On the other hand, those who had been in the field between 4-15 years (1.87 ± .05) and 16 + years (1.80 ± .08) were more likely to report that their agency

needed guidance in retaining qualified staff, compared to those who had worked in the field for less than three years (1.51 ± .06).

Years in the Field and Personal Training and Technical Assistance Needs

Attendees did not differ significantly in their perceived need for individual training, with the exception of responses to four items. As Table 8 illustrates, those with less than three years of training (1.34 ± .06) were most likely to report a need for training to assess client problems and needs, compared to those in the field 4-15 years (1.10 ± .05). Those with less experience (.95 ± .06) were also more likely to report a need for training to increase client participation in treatment and monitor client progress, followed by those with 4-15 years (.74 ± .04) and those with more experience (.69 ± .07). Compared to those who had been in the field for 16+ years (.93 ± .07), attendees with 4-16 years of experience (1.14 ± .05) were more likely to report a need for training to use computerized client assessments.

Years in the Field and Barriers to Training

Those with over 16 years of experience (1.46 ± .08) were most likely to report that the workload and pressures at their program kept motivation for new training low, followed by those with 4-15 years experience (1.37 ± .05), and those with less than three years experience (1.12 ± .06). Those with the most experience (1.41 ± .08) were also most likely to report that the training interests of the program staff was mostly due to licensure/certification requirements, followed by those with 4-15 years of experience (1.36 ± .06), and those with the least amount of experience (1.12 ± .05).

Those with less than three years of experience were least likely to report training barriers. When compared to those with more than 16 years of experience (1.20 ± .07), those with little experience (.99 ± .05) were least likely to report that the topics presented at the training workshops and conferences were too limited. Those with less experience (.81 ± .05) were also less likely to report that the training activities took too much time away from the delivery of program services, compared to those with over 16 years of experience (1.02 ± .07).

Appendix 3: CADPAAC Workforce Survey – Program Staff (Hard Copy Version)

Alcohol & Other Drug (AOD) Abuse Treatment
Workforce Survey 2007
Program Staff Questionnaire

Demographics

1. **What is your gender?** ❑ Male ❑ Female
2. **What is your birth year? 19**________________
3. **What is your ethnicity? (mark one)**
   - ❑ African American
   - ❑ Asian
   - ❑ White
   - ❑ Hispanic or Latino/a
   - ❑ American Indian/Alaska Native
   - ❑ Native Hawaiian or Other Pacific Islander
   - ❑ More than one race / multi–ethnic
   - ❑ Other (*specify*)_________________

   - ❑ I am fluent in another language other than English. Identify the language:____

4. **Please describe your personal experience with addiction (check all that apply)**
   - ❑ I am in recovery
   - ❑ A close family member has/had difficulties with addiction
   - ❑ A friend/acquaintance has/had difficulties with addiction
   - ❑ I have no personal experiences with addiction

Your Work & Professional Background

5. **What is your current discipline/profession? (*check all that apply*)**
   - ❑ Addictions counseling
   - ❑ Vocational rehabilitation
   - ❑ Social work/human service
   - ❑ Medicine (primary care)
   - ❑ Nursing
   - ❑ Psychology
   - ❑ Other counseling
   - ❑ Adolescent treatment
   - ❑ Education
   - ❑ Criminal justice
   - ❑ Other *(please specify)*____________________________________

6. How many years have you worked:

	Number of Years							
	Less than 1	1-3	4-6	7-9	10-12	13-15	15-17	17+
a. in the AOD treatment field	❑	❑	❑	❑	❑	❑	❑	❑
b. at this agency	❑	❑	❑	❑	❑	❑	❑	❑
c. in your current position	❑	❑	❑	❑	❑	❑	❑	❑

7. Which of the following benefits are provided, partially or fully, through your employment?

Benefit	Fully	Partially	Not provided
Medica/Dental insurance	❑	❑	❑
Sick leave _______# days	❑	❑	❑
Vacation _______# days	❑	❑	❑
Other paid leave ________#days	❑	❑	❑
Retirement contributions by your employer	❑	❑	❑
Other benefit (please specify)	❑	❑	❑
____	❑	❑	❑
Other benefit (please specify)	❑	❑	❑
____	❑	❑	❑

8. Why did you decide to enter the field of alcohol & other drug abuse treatment? *(check all that apply)*

❑ Previous experience with addiction or recovery (personal or family)
❑ Personal interest
❑ Experience in a like field
❑ Academic work/degree in a like field
❑ Unplanned decision
❑ Other *(please specify)*____

9. Is alcohol & other drug abuse treatment a second career? ❑ Yes ❑ No

10. What is your certification/license status in the alcohol & other drug abuse treatment field? (*check only one*)

❑ Never certified
❑ Previously certified, but not currently
❑ Certification pending or Registered
❑ Currently certified
❑ Exempt License (i.e. LCSW/MFT/Psychologist)

11. What is your highest academic degree status?

- ❑ No high school diploma or equivalent
- ❑ High school diploma or equivalent
- ❑ Some college, no degree
- ❑ Associate Degree
- ❑ Bachelor's Degree
- ❑ Master's Degree
- ❑ Doctoral Degree
- ❑ Other________________________

12. Have you ever completed specialized educational coursework in:	No	Yes	Minor in college or certificate ?	Terminal degree (Bachelor's, Master's)?
Alcohol & other drug abuse treatment	❑ No	❑ Yes	❑	❑
Mental health treatment	❑ No	❑ Yes	❑	❑
Related field	❑ No	❑ Yes	❑	❑

13. Have you completed workshops or training in alcohol and other drug abuse treatment in the last year? ❑ Yes ❑ No

a. If yes, please indicate approximately how many continuing education contact hours you have completed:

_____ Total hours last year

14. How likely is it that you will be changing your place of employment, but staying within the alcohol and other drug abuse treatment field within the next two years?

- ❑ Not at all likely
- ❑ Remote possibility
- ❑ Not sure
- ❑ Highly probably
- ❑ Definitely

a. If you answered "highly probably" or "definitely" to the preceding question, please identify the changes in your job that you will be looking for (check all that apply):

- ❑ Greater responsibility; authority
- ❑ Greater pay and/or benefits
- ❑ Better management/administration
- ❑ Less paperwork
- ❑ Different client population
- ❑ Different geographic location
- ❑ Other (please specify):____

15. How likely is it that you will be changing your career and leaving the alcohol and other drug abuse treatment field within the next two years?

- ❑ Not at all likely
- ❑ Remote possibility
- ❑ Not sure
- ❑ Highly probably
- ❑ Definitely

a. If you answered "highly probably" or "definitely" to the preceding question, please identify the changes in your job that you will be looking for (check all that apply):

- ❑ Greater responsibility; authority
- ❑ Greater pay and/or benefits
- ❑ Better management/administration
- ❑ Less paperwork
- ❑ Different client population
- ❑ Different geographic location
- ❑ Other (please specify):____

Your Agency

16. What is the zip code where you work?____________

a. In what county do you work?_________________________

17. Which of the following best describes this <u>program</u> (Check all that apply):

- ❑ Intensive outpatient – 3 times per week or more (non-methadone)
- ❑ Outpatient services – less than 3 times per week (non-methadone)
- ❑ Outpatient methadone
- ❑ Therapeutic community
- ❑ Inpatient/residential
- ❑ Halfway house/work release
- ❑ Intensive supervision/revocation
- ❑ Other (*please specify)*____

18. For what kind of program do you work?

- ❑ Non Profit
- ❑ For Profit
- ❑ Public Agency

19. Which treatment models does your agency currently use on a regular basis? (*from the list below, identify your first preferred or main orientation, and the second preferred approach for your agency)*

Primary orientation/First preferred **(Check only ONE)**	Secondary orientation/Second preferred **(Check only ONE)**
AA/Twelve Step ❑	AA/Twelve step ❑
Behavioral ❑	Behavioral ❑
Client-Centered ❑	Client-Centered ❑
Cognitive ❑	Cognitive ❑
Social Model ❑	Social Model ❑
Eclectic ❑	Eclectic ❑
Existential/Humanistic ❑	Existential/Humanistic ❑
Psychodynamic ❑	Psychodynamic ❑
Brief treatment ❑	Brief treatment ❑
Medical Model ❑	Medical Model ❑
Other (specify) ❑	Other (specify) ❑

Training and Technical Assistance Needs

20. In your opinion, does your agency need guidance in:	**Disagree Strongly (1)**	**Disagree (2)**	**Undecided (3)**	**Agree (4)**	**Agree Strongly (5)**
a. Documenting service needs of clients for making treatment placements	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
b. Tracking and evaluating performance of clients over time	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
c. Obtaining information that can document program effectiveness	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
d. Automating client records for billing and financial applications	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
e. Evaluating program staff performance and organizational functioning	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
f. Selecting new treatment interventions and strategies for which program staff need training	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
g. Improving recording and retrieval of financial information	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
h. Generating timely "management" reports of clinical,	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5

20. In your opinion, does your agency need guidance in:	Disagree Strongly (1)	Disagree (2)	Undecided (3)	Agree (4)	Agree Strongly (5)
financial, and outcome data					
i. Recruiting qualified staff	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
j. Retaining qualified staff	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
k. Accessing effective training programs and resources for the staff	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
l. Other (specify)	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5

21. Do you personally need training in:	Disagree Strongly (1)	Disagree (2)	Undecided (3)	Agree (4)	Agree Strongly (5)
a. Assessing client problems and needs	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
b. Increasing client participation in treatment	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
c. Monitoring client progress	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
d. Improving rapport with clients	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
e. Improving client thinking skills	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
f. Improving client problem solving skills	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
g. Improving behavioral management of clients	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
h. Improving cognitive focus of clients during group counseling	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
i. Using computerized client assessments	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
j. Working with staff on other units/agencies	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
k. Providing clients with integrated treatment services of addiction and mental health disorders	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
l. Providing trauma informed or trauma sensitive services	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
m. Using pharmacological interventions with clients	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
n. Providing culturally competent services	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
o. Providing services for Co-Occurring Disorders	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5

21. **Do <u>you personally need</u> training in:**	**Disagree Strongly (1)**	**Disagree (2)**	**Undecided (3)**	**Agree (4)**	**Agree Strongly (5)**
p. Other (specify)	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5

Training and Technical Assistance Resources & Barriers

22. Are your familiar with the Treatment Improvement Protocols (TIPs) and/or the Technical Assistance Protocols (TAPs) published by the Substance Abuse and Mental Health Services Administration (SAMHSA)?

- ❑ No I am not familiar with these materials
- ❑ Yes, I am familiar with these materials, but have not utilized them
- ❑ Yes, I am familiar with these materials and have used them occasionally
- ❑ Yes, I am familiar with these materials and have use them extensively

23. Training preferences	In the past year, have you accessed any of these sources for training or continuing education?		Which of these sources for training or continuing education are your <u>preferred approaches</u> (check no more than 3)
Face to face on site	❑ No	❑ Yes	❑
Off-site workshops/conferences	❑ No	❑ Yes	❑
Internet/web-based	❑ No	❑ Yes	❑
Telemedicine/Satellite broadcast	❑ No	❑ Yes	❑
Videotape/DVD/CD ROM	❑ No	❑ Yes	❑

24. Barriers to training:	**Disagree Strongly (1)**	**Disagree (2)**	**Undecided (3)**	**Agree (4)**	**Agree Strongly (5)**
a. The <u>workload and pressures</u> at this program keep motivation for new training low.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
b. The <u>budget</u> does not allow most program staff to attend professional conferences annually.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
c. <u>Topics</u> presented at recent training workshops and conferences have been too limited.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5

24. Barriers to training:	Disagree Strongly (1)	Disagree (2)	Undecided (3)	Agree (4)	Agree Strongly (5)
d. The quality of trainers at recent training workshops and conferences has been poor.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
e. Training activities take too much time away from the delivery of program services.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
f. Training interests or program staff are mostly due to licensure or certification requirements.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
g. It is often too difficult to adapt things learned at workshops so they will work in this program.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
h. Limited resources (e.g., office space or budget) make it difficult to adopt new treatment ideas.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
i. The background and training of program staff limits the kind of treatment changes possible here.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
j. There are too few rewards for trying to change treatment or other procedures here.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
k. Other (specify)	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5

25. What is your hourly pay rate at your current position? $____________/hour

OR (Alternatively)

26. What is your annual salary at your current position?

- ❑ <$14,999
- ❑ $15,000–$24,999
- ❑ $25,000–$29,999
- ❑ $30,000–$34,999
- ❑ Not applicable/refused
- ❑ $35,000–$39,999
- ❑ $40,000–$49,999
- ❑ $50,000–$74,999
- ❑ >$75,000

Thank you for your time and responses. Please return the completed survey via mail or fax to:

Thomas Renfree, Executive Director
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Sacramento, CA 95814
Fax: (916) 441-6178