Delaware Workforce Survey 2003

Results of a Statewide Needs Assessment of Behavioral Health Professionals

Prepared for

Central East Addiction Technology Transfer Center
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Silver Spring, MD 20910

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January 4, 2005

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Executive Summary

A growing body of quantitative data concerning the substance abuse/mental health treatment workforce is being collected through out the country. In 2003, RMC Research Corporation, in collaboration with the Central East Addiction Technology Transfer Center (CEATTC), conducted a workforce study for the state of Delaware. Surveys were sent to the agency directors of 36 licensed alcohol and drug agencies and 8 certified mental health facilities. Follow-up efforts resulted in a response rate of 40%, yielding responses from 16 agency directors and 114 treatment staff. A comprehensive report describing the survey instrument, methodology, and results is available from the CEATTC. Highlights of the report are provided below.

- Survey results indicate that the majority of directors and treatment staff in Delaware were white. The average age for those surveyed was 52 years old for directors and 44 years old for treatment staff.
- Directors and treatment staff reported a relatively high mean age of entry into the field, with 31% of directors and 25% of treatment staff indicating that substance abuse/mental health treatment was a second career.
- Agency directors reported an average of 16 years experience in the field, while treatment staff reported an average of 8 years experience in the field.
- In terms of primary professional status, 43% of treatment staff identified themselves as alcohol and other drug (AOD) professionals, 25% as mental health (MH) professionals, and 23% as AOD/MH professionals.
- In general, the workforce was well educated, with approximately 4 out of 5 agency directors (81%) and treatment staff (80%) reporting a Bachelors degree or above. However, the majority of degrees were not specific to AOD or MH. In fact, a large proportion of the workforce reports having no AOD or MH specific coursework.
- Overall, 29% of directors and 33% of treatment staff reported currently being certified, and 7% of directors and 9% of staff reported currently being licensed. In

total, 64% of directors and 58% of treatment staff had neither current certification nor current licensure.

- Treatment staff reported spending approximately 60% of their time on client related tasks, while agency directors reported spending 85% of their time on administrative tasks.
- Overall, 50% of directors reported making between $40,000–74,999 a year, with 31% making over $75,000 a year. Treatment staff report statistically significant lower salaries, with 50% making between $15,000–34,999 a year, and 40% making $35,000–49,999.
- A statistically significant larger proportion of MH and AOD/MH professionals report higher level salaries than AOD professionals.
- Two statistically significant predictors of workforce salary in Delaware were identified: role (being an agency director was related to higher salaries) and professional status (being an AOD professional was related to lower salary).
- Based on directors' reports of staffing in the past year, the average annual turnover for agencies employing AOD staff was 21%, while the average annual turnover rate for agencies employing MH staff was 39%. In agencies employing both AOD and MH professionals the combined annual turnover rate was 34%.
- Overall, agencies reported an average AOD staff shortage of 1.1 FTE, and an average MH staff shortage of 3.0 FTE.
- Direct supervision and in-service training were the most frequently cited staff development activities reported by agency directors and treatment staff.
- Directors and treatment staff reported that more frequent salary increases and more/improved on-going training were the top activities that could be done to promote retention.
- In total, 91% of directors reported difficulties recruiting qualified staff.
- The most frequently cited barriers to entry into the workforce were salary and competition from other fields (in terms of salary).

- Overall, the majority of directors and staff saw addiction counselors as having lower status than other helping professionals, and mental health professionals as having the same status as other helping professionals.
- The most frequently cited source of satisfaction for agency directors was being in a change agent role. For treatment staff, the most frequently cited source of satisfaction was one on one interactions with clients.
- For both directors and treatment staff, salary was the only source of dissatisfaction cited with high frequency.
- Agencies in Delaware implemented an average of 6 treatment models that played a major role in their overall treatment approach. The most frequently cited models were: relapse prevention, 12-step, and behavior modification.
- Based on self-rated proficiency and interest in 31 counseling competency areas, directors and treatment staff had multiple overlapping training priorities. Client family and community education, gender specific treatment, and racial/ethnic specific treatment were identified as high training priorities by both groups.

Introduction

The Delaware Division of Substance Abuse and Mental Health (DSAMH) within the Delaware Department of Health and Social Services is the agency that oversees mental health and substance abuse treatment and prevention services in the state of Delaware. DSAMH offers a wide variety of services to the community including the full range of treatment, intervention services, prevention efforts, technical assistance and training for professionals and the public. All of these services are offered through the 36 licensed alcohol and drug agencies and 6 certified mental health agencies. These agencies maintain service sites in most counties and offer a variety of services including detoxification, residential, outpatient and transitional living. DSAMH contracts with most of these agencies for services, however DSAMH also operates 1 alcohol and drug detoxification facility and an alcohol and drug facility that serves court mandated clients. DSAMH also operates 4 stand-alone mental health clinics and the state mental institution.

In recent years the DSAMH has become concerned about the decreasing numbers of professionals entering the field of behavioral health and other workforce related issues. To begin addressing these issues, the Office of Training within the Division of Substance Abuse and Mental Health formed a Workforce Development Work Group to begin the process of strategic planning around issues related to workforce development. The goal of the Workforce Development Work Group is to improve the quality of addiction and mental health treatment in Delaware by continuing to build and develop a competent and professional workforce.

As part of this initiative, the Central East Addiction Technology Transfer Center (CEATTC) in conjunction with DSAMH and RMC Research Corporation, developed a survey for professionals in the fields of substance abuse and mental health. This survey was designed to obtain much needed information from directors and counselors on matters related to retention, recruitment and the training needs of professionals in the field of behavioral health. The data obtained from this survey will assist the Division of

Substance Abuse and Mental Health in identifying goals to help improve the quality of the behavioral health treatment and prevention workforce and in retaining qualified professionals in this field.

The survey developed by the CEATTC in conjunction with the DSAMH and RMC Research was sent out to all the directors and a representative sample of substance abuse treatment staff and mental health practitioners at the 36 licensed alcohol and drug agencies and the 6 certified mental health facilities respectively.

Methods

Instrumentation

The survey used in Delaware Behavioral Health Workforce Development Survey 2003 is a modified version of the instrument originally used in 1999–2000 by RMC Research Corporation and the Northwest Frontier Addiction Technology Transfer Center (NFATTC). In the spring of 2003, the CEATTC met with the DSAMH workforce development workgroup to discuss the survey process. During the course of the spring modifications, additions were made to the survey instrument based on the recommendations of the workgroup, DSAMH staff, and other key stakeholders. Questions were added, deleted or changed in order to meet the specific needs and interests of Delaware's behavioral health workforce. Two versions of the survey instrument were created, a version for staff and a director's version. The staff survey is identical to the director's survey with the exception of a set of questions related to administrative issues, which were more appropriately answered by the agency director.

Sampling

After discussions with DSAMH staff, the DSAMH workgroup and other key stakeholders it was decided that the directors and the full time clinical staff at the licensed alcohol and drug agencies and the certified mental health agencies were the most appropriate targets of this survey. Once this was decided, information was obtained regarding the total number of full-time clinical staff at each of the licensed and certified agencies in the state. Based on the total number of full time clinical treatment staff, a sampling percentage was determined for both certified and licensed agencies. Director's surveys were sent to all of the directors at the licensed and certified agencies. A total of 44 agencies were included in the sample (36 licensed alcohol and drug agencies; 8 certified mental health agencies) with 2 certified agencies being removed later because of closure.

Survey Administration

An agency director survey was sent to all 36 of the licensed alcohol and drug agencies and to the 6 certified mental health agencies. In addition, 8 staff surveys were sent to each of the licensed alcohol and drug agencies, and 20 staff surveys were sent to each of the 6 certified mental health agencies. A cover letter from the DSAMH director explaining the survey process and pre-paid envelopes for return of the surveys were also sent to each agency director. In these cases where agencies operated from multiple program sites, agency directors were asked to distribute the staff surveys across their program sites. Each survey was coded using a unique identification code maintaining confidentiality for all respondents. Once completed, surveys were placed in the pre-paid envelopes and returned to the CEATTC.

Follow Up Strategy & Response Rate

In order to assure an appropriate response rate, a follow-up strategy was implemented. This strategy consisted of follow-up phone calls to agency directors reminding them to return the surveys to the CEATTC. Survey response rate was tracked through the use of database software at the CEATTC. Once the data collection period was completed, the surveys were sent to RMC Research for analysis.

Response rates for both agency directors and treatment staff are displayed below in Exhibits 1 and 2. In total, directors from 17 agencies responded to the survey, yielding a 40% response rate. A total of 112 staff surveys were returned, yielding a response rate of 28%.

Exhibit 1
Response Rate for Agency Directors

Type of Agency	Number of Agencies	Sampling	Sample		Response	
			Final	Adjusted	Number	Rate
Licensed	36	100%	36	36	15	42%
Certified	8	100%	8	6	2	33%
Combined	44	100%	44	42	17	40%

Exhibit 2
Response Rate for Treatment Staff

Agency Type	Number of		Sampling Goal		Adjusted Sample	Responses	
	Agencies	Treatment Staff	Number	Percent		Number	Rate
Licensed	36	608	203	33%	287	69	24%
Certified	8	313	157	50%	119	45	36%
Combined	44	921	360	39%	406	114	28%

Results

Survey results are presented by topical category. Descriptive results are reported by staff "role" (director versus treatment staff responses). Treatment staff responses are also examined by "agency type" (certified versus licensed agencies). Agency director responses are not examined by agency type due to small sample size. Due to the integrated nature of alcohol and drug treatment and mental health treatment in Delaware, treatment staff responses are also split by primary professional status (referred to as "professional discipline") when relevant. Treatment staff were asked to identify their primary professional status as either alcohol and drug treatment (AOD) professional, mental health treatment (MH) professional, or both (AOD/MH). Treatment staff by role and treatment staff by professional status are displayed in Exhibit 3 and 4 below.

Exhibit 3
Treatment Staff Response by Agency Type

	Responses	
Agency Type	**Number**	**Percentage**
Certified	45	39%
Licensed	69	61%
Total	114	100%

Exhibit 4
Treatment Staff by Professional Discipline

Professional Discipline	Number and Percent of Total Treatment Staff Respondents	
AOD	49	(43%)
MH	29	(25%)
AOD and MH	26	(23%)
Missing	10	(9%)
Total	114	(100%)

All data was examined using cross-tabulations. Chi square analyses were conducted on all cross tabulations to identify statistically significant differences. Statistical differences within role, across agency type, and professional status are reported if significant. In addition, multiple linear regression was used to identify significant predictors of salary.

It should be noted that all significance testing, especially that involving directors, should be interpreted carefully as sample sizes were small. Small sample size results in the lack of statistical power making it more difficult to detect significant differences. In addition, data was reported only for valid cases. Missing data was not included in the analysis due to the small number of missing cases.

Workforce Demographics

As displayed in Exhibit 5, a larger proportion of treatment staff (77%) than directors (50%) were female. This finding is meaningful, and approaches conventional standards for statistical significance. The majority of both directors and treatment staff were white. Very few directors and treatment staff in either setting reported being Hispanic. No significant differences in gender or race/ethnicity appeared for treatment staff by agency type or by professional status.

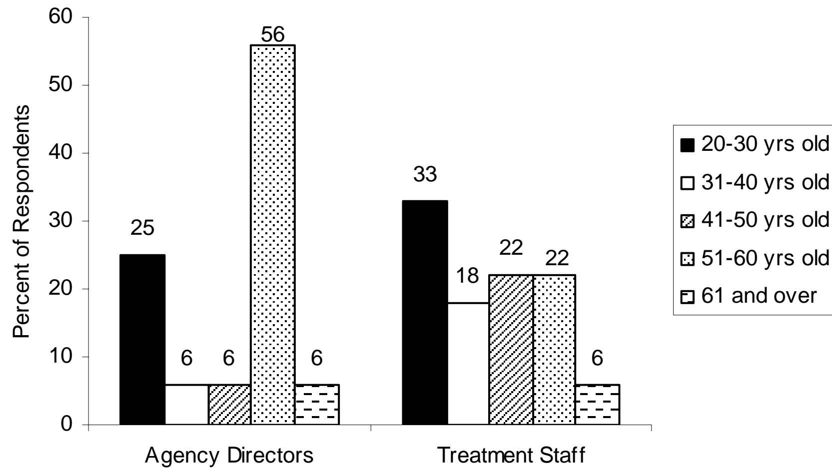
Exhibit 5
Gender and Ethnicity of Respondents

	Agency Directors[a]		Treatment Staff[b]	
Gender				
Female	8	(50%)	87	(77%)
Male	8	(50%)	26	(23%)
Ethnicity				
Not Hispanic	14	(86%)	101	(89%)
Mexican	0	(0%)	1	(1%)
Puerto Rican	1	(6%)	2	(2%)
Other Hispanic	0	(0%)	3	(3%)
Unknown	1	(6%)	7	(6%)
Race				
African American	1	(7%)	23	(20%)
African American/other	1	(7%)	4	(4%)
Asian	0	(0%)	1	(1%)
Asian/other	0	(0%)	0	(0%)
Caucasian	11	(73%)	77	(68%)
Caucasian/other	2	(13%)	5	(4%)
Multi	0	(0%)	2	(2%)
Other	0	(0%)	0	(0%)

Note. [a]*n* = 16. [b]*n* = 114.

The average age for those surveyed was 52 years old for directors and 44 years old for treatment staff. Exhibit 6 below displays age category by role. Results indicate that the largest proportion of directors fell into the 41–60 year old range, while for treatment staff the largest proportion fell into the 30 year old and under range. Chi square analysis indicates that this difference in proportion is marginally statistically significant ($p = .052$). No significant differences in age appeared for treatment staff by agency type or by professional status.

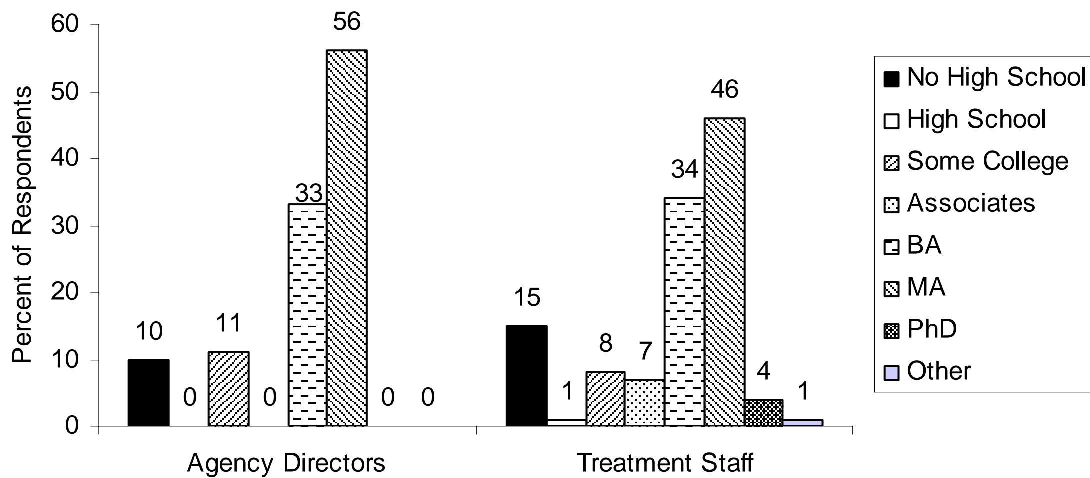
Exhibit 6
Age of Respondents



Academic & Professional Background

Exhibit 7 displays degree status by role. Approximately 4 out of 5 agency directors (81%) and treatment staff (80%) had a Bachelors degree or above. No differences in degree status existed between treatment staff by agency type, however differences existed by professional status. Chi square analysis indicates that a statistically significant smaller proportion of AOD professionals reported having a graduate level degree than do MH and MH/AOD professionals ($p < .01$). A higher proportion of AOD professionals reported some college or an Associates degree than did MH or AOD/MH professionals ($p < .01$).

Exhibit 7
Degree Status of Respondents



The amount of educational background specific to alcohol and other drugs (AOD) and mental health (MH) was also examined. As Exhibits 8 & 9 display, the majority of agency directors and treatment staff did not hold a degree or certificate specific to AOD or MH. In fact, a large proportion of the workforce reported having no AOD or MH specific coursework. The workforce has however had significantly more coursework related to mental health treatment than alcohol and drug treatment. While a higher proportion of staff than directors had AOD related coursework or degrees, this difference was not statistically significant. Differences did exist between treatment staff by both agency setting and professional status. A higher proportion of treatment staff at certified agencies reported having AOD specific degrees ($p < .05$) and MH specific degrees ($p < .01$). A high proportion of treatment staff in both agency settings reported having no AOD or MH specific degrees or coursework. The proportion of AOD specific degrees was consistent when examined by professional status, although differences in MH degrees did exist. A statistically significant smaller proportion of AOD professionals had a MH specific degree when compared to MH and AOD/MH professionals ($p < .001$).

Exhibit 8
AOD Coursework Completed by Respondents

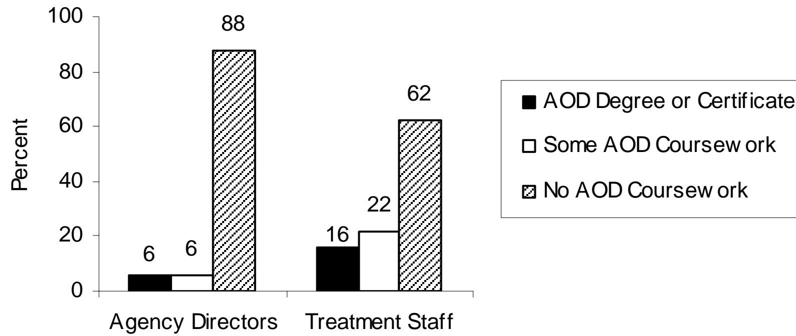
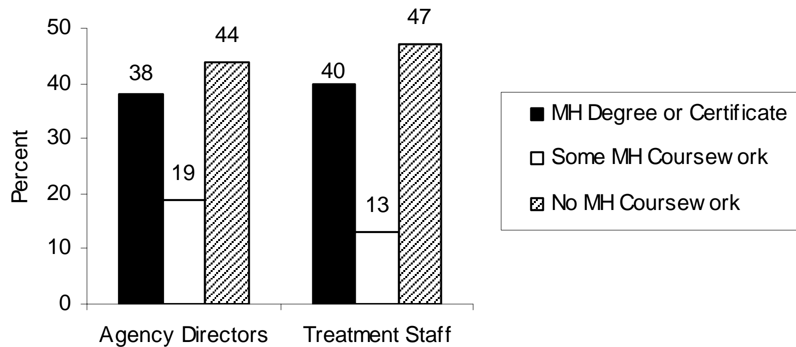


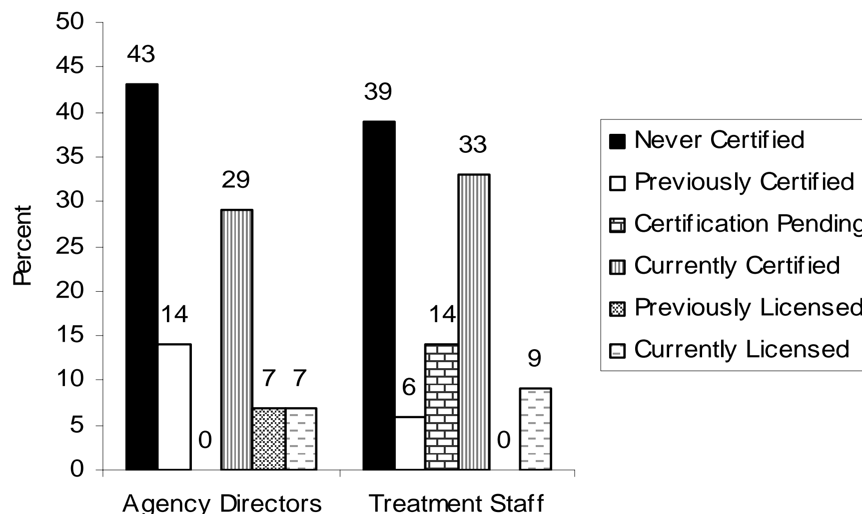
Exhibit 9
MH Coursework Completed by Respondents



With a large proportion of the workforce without AOD or MH specific degrees and/or coursework, the role of training becomes extremely important. The majority of directors (88%) and treatment staff (90%) reported attending AOD or MH training in the past year. In the past 2 years, agency treatment staff reported an average of 51 training hours and agency directors reported an average of 42 training hours. No significant differences existed in training attendance for treatment staff by agency type or by professional status.

Exhibit 10 displays certification and licensure status by role. Overall, 29% of directors and 33% of treatment staff reported currently being certified, and 7% of directors and 9% of staff reported currently being licensed. In total, 64% of directors and 58% of treatment staff had neither current certification nor current licensure. A high proportion of both directors (43%) and treatment staff (39%) reported never being certified. No significant difference existed between the certification/licensure status of treatment staff by agency type. Not surprisingly, a statistically significant higher proportion of MH professionals reported current licensure and a statistically significant higher proportion of AOD professionals reported current certification ($p < .05$).

Exhibit 10
Certification Status of Respondents



The number of years of experience in the workforce was measured in three different ways–years in the substance abuse field, years in current role (director or staff), and years in current position. Exhibit 11 displays means for each of these. Agency directors showed more experience in the field, as well as in their current role. Interestingly, neither directors nor staff showed much variation between the number of years in the field and years in their role, indicating that most entered the field in the role they held at the time. In fact, treatment staff indicated slightly more time in the role than in the field,

indicating that some treatment staff served in a similar role prior to entering the substance abuse/mental health treatment workforce. The entire workforce reported sizably less time in their current positions than years in their fields, indicating some changing of positions over the years.

Exhibit 11
Work Experience of Respondents

	Mean Years of Experience	
Variable	**Agency Directors[a]**	**Treatment Staff[b]**
AOD Field	16	8
MH Field	17	8
Current Role	16	11
Current Position	9	4

[a]*n* = 16. [b]*n* = 114.

Overall, directors and treatment staff had a relatively high mean age of entry into the substance abuse/mental health treatment field. Exhibit 12 displays mean age of entry into field by role. All groups demonstrated a large range, indicating people in all stages of life were entering the field for the first time.

Exhibit 12
Age of Respondents at Entry into Field

	Age at Entry	
Variable	**Agency Directors[a]**	**Treatment Staff[b]**
AOD Field[c]	32	36
MH Field[c]	35	35
Minimum	19	20
Maximum	62	66

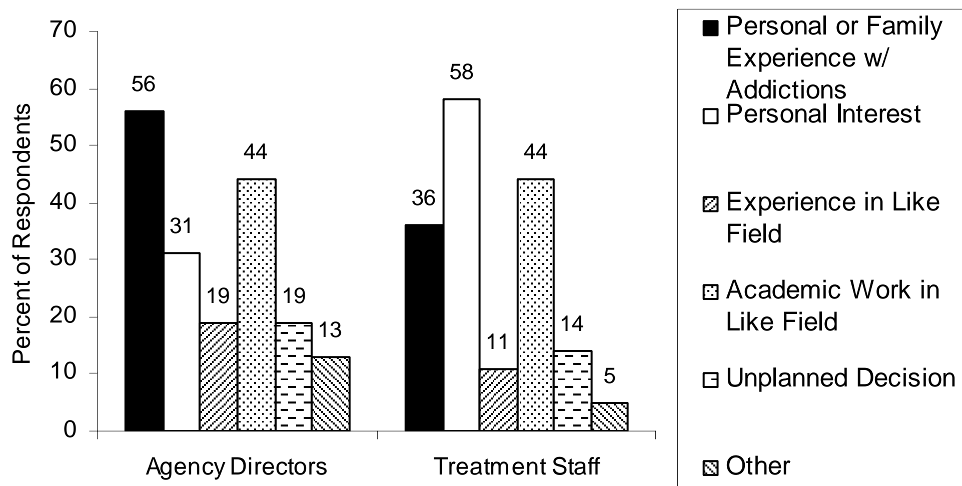
[a]*n* = 16. [b]*n* = 114. [c]Ages listed are means.

One reason for the high age of entry into the field is that a relatively large proportion of the workforce indicated that their current work was a second career. Overall, 31% of directors and 25% of treatment staff indicated that substance abuse treatment was a

second career. A higher proportion of treatment staff at licensed agencies (30%) reported that their current work was a second career than treatment staff at certified agencies (18%), although this finding was not statistically significant.

Exhibit 13 displays reason for entry into the field by role. For agency directors the most frequently cited reason for entry into the field was a personal or family experience with addictions. Overall, treatment staff most frequently cite personal interest in the field. A statistically significant higher proportion of treatment staff than agency directors reported personal interest as a reason for entering the field ($p < .05$). For treatment staff, a significantly higher proportion of AOD professionals reported a personal or family experience in addictions as a reason for entry into the field than did MH professionals (57% of AOD professionals verses 3% of MH professional; $p < .001$).

Exhibit 13
Respondents' Reasons for Entry into Field



Job Detail

Directors and treatment staff were asked if in the past year they had conducted any of the following AOD or MH client-related tasks: screened, diagnosed, treated, or made referrals for clients. Exhibit 14 & 15 display client related tasks by role for both AOD and MH. For AOD client related services, chi square analysis revealed that a statistically

significant higher proportion of treatment staff than directors had screened ($p < .05$) and treated clients ($p < .001$). For MH client related services, chi square analysis revealed that a statistically significant higher proportion of treatment staff than directors had treated clients ($p < .001$). Multiple significant differences existed between treatment staff by agency type and by professional status. Overall, a higher proportion of staff at certified agencies reported providing AOD client related services, and a higher proportion of staff at licensed agencies reported providing MH client related services. Not surprisingly, a higher proportion of AOD professionals reported providing AOD client related services, while a higher proportion of MH professionals reported providing MH client related services.

Exhibit 14
AOD Client-Related Tasks Conducted by Respondents

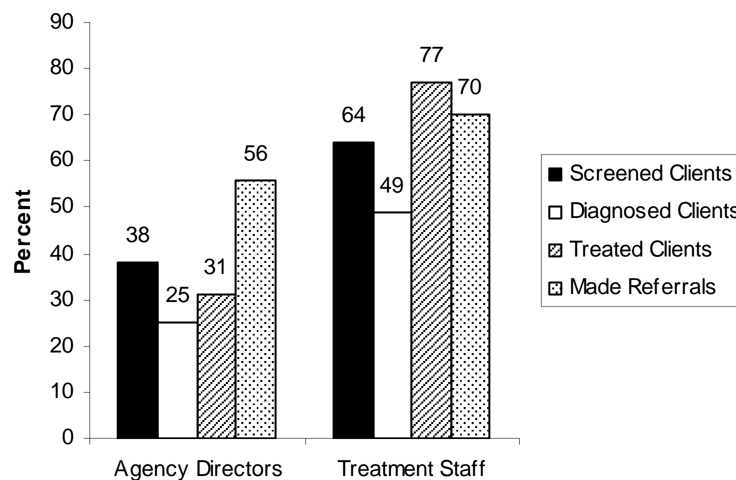
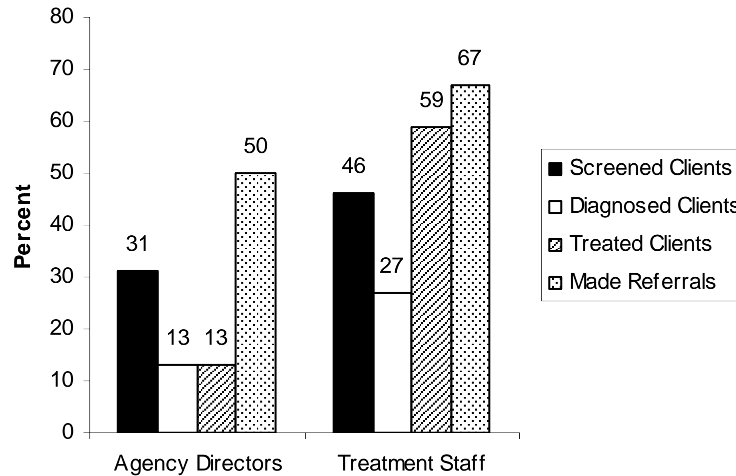


Exhibit 15
MH Client-Related Tasks Conducted by Respondents



Directors and treatment staff were also asked to identify the amount of time spent on various tasks in a typical week. Exhibit 16 displays the average percentage of time per task by role. In general, treatment staff showed significantly more time spent on client-related tasks than did directors who spent more time on administrative tasks. Treatment staff reported spending approximately 60% of their time on client-related tasks, while agency directors reported spending 85% of their time on administrative tasks. Time spent on various tasks by treatment staff, as displayed in Exhibit 17 and 18, did vary by agency type and by professional discipline. These differences seemed to be related to more micro level differences in job detail, as the total time spent on client-related tasks was quite consistent across all groups.

Exhibit 16
Respondents' Time Spent per Task

Task Type	Task	Mean Percentage of Work Time	
		Agency Directors[a]	Treatment Staff[b]
Client-Related	Screening & Assessments	4.5	13.7
	Individual Counseling	3.4	24.1
	Group Sessions	3.4	7.5
	Family Counseling	0.3	1.6
	Case Management	3.1	11.3
Administrative	Clinical Supervision	5.1	6.3
	Clinical Paperwork	3.8	12.8
	Internal & external clinical meetings	3.4	4.3
	Internal & external administrative meetings	17.8	4.5
	Training activities with staff/peers/supervisees	7.0	3.6
	Other Admin. Activities	35.2	5.8
	Other Activities	6.8	2.4

Note. Percentages given by each respondent needed to add to 100%; responses where time did not add to 100% were excluded.
[a]*n* = 16. [b]*n* = 114.

Exhibit 17
Treatment Staff Members' Time Spent per Task by Agency Type

Task Type	Task	Mean Percentage of Work Time: Certified Agencies[a]	Mean Percentage of Work Time: Licensed Agencies[b]
Client-Related	Screening & Assessments	11.0	15.4
	Individual Counseling	30.2	20.1
	Group Sessions	7.1	7.7
	Family Counseling	0.6	2.3
	Case Management	7.7	13.6
Administrative	Clinical Supervision	3.9	7.9
	Clinical Paperwork	14.3	11.9
	Internal & external clinical meetings	3.8	4.6
	Internal & external administrative meetings	4.7	4.4
	Training activities with staff/peers/supervisees	3.3	3.7
	Other Admin. Activities	7.2	4.9
	Other Activities	3.2	1.8

Note. Percentages given by each respondent needed to add to 100%; responses where time did not add to 100% were excluded.
[a] $n = 44$. [b] $n = 68$.

Exhibit 18
Treatment Staff Members' Time Spent per Task by Professional Discipline

Task Type	Task	Mean Percentage of Work Time		
		AOD[a]	MH[b]	AOD/MH[c]
Client-Related	Screening & Assessments	16.1	8.3	16.5
	Individual Counseling	25.8	32.6	20.4
	Group Sessions	8.6	3.6	10.7
	Family Counseling	1.9	1.4	2.0
	Case Management	11.9	6.1	7.3
Administrative	Clinical Supervision	4.7	9.0	8.9
	Clinical Paperwork	13.2	15.6	10.4
	Internal & external clinical meetings	5.0	4.1	4.4
	Internal & external administrative meetings	5.5	4.2	3.4
	Training activities with staff/peers/supervisees	3.1	4.2	4.0
	Other Admin. Activities	2.0	9.1	6.3
	Other Activities	1.4	2.5	4.2

Note. Percentages given by each respondent needed to add to 100%; responses where time did not add to 100% were excluded.
[a]$n = 48$. [b]$n = 28$. [c]$n = 26$.

Work Setting

Directors were asked to indicate the number of direct service substance abuse treatment and/or mental health treatment staff who worked in their respective agencies; agency size was estimated using this information. Results are displayed in Exhibit 19, and show that agency size in Delaware was quite variable. Reported agency size varied from 1 direct service treatment staff member to 60 direct service treatment staff, with some agencies employing just AOD or MH staff, and some employing 50% AOD staff, and 50% MH staff. Compatibility of results may be checked against the National Survey of Substance Abuse Treatment Services (N-SSATS).

Exhibit 19
Agency/Regional Staff Size

Number of Direct Service Staff	Number of Agencies[a]
2 or fewer	2 (14%)
3–5	4 (29%)
6–11	3 (21%)
12 or more	5 (36%)

[a]*n* = 14.

Directors also identified the primary geographic setting of their agency. Exhibit 20 displays the results. As data indicate, agencies were predominately located in large towns and small cities.

Exhibit 20
Geographic Setting of Agencies

Geographic Setting Serving	Number of Agencies[a]
Small communities or towns (population < 5000)	2 (13%)
Large towns & surrounding community (population 5100–50,000)	6 (38%)
Small city (population 51,000–250,000)	8 (50%)
Large city (population > 250,000)	0 (0%)

[a]*n* = 16.

In terms of the predominate financial setting, 69% of agency directors described their setting as private, non-profit. The remaining agency directors described their agencies as private, for profit (19%), and state government (13%). In addition, directors identified the predominate funding sources for their agencies, as displayed in Exhibit 21.

Exhibit 21
Use of Public Monies by Agencies

Percentage of Total Funding Provided by Public Monies	Number of Agencies[a]
0%	1 (6%)
1–20%	5 (31%)
21–40%	0 (0%)
41–60%	3 (19%)
61–80%	1 (6%)
81–100%	6 (38%)
Receive SADA Funding*	10 (63%)

[a]*n* = 16.

Finally, directors were asked what percentage of their treatment staff were (1) female and (2) minority. Exhibit 22 displays the percentage of female and minority staffing. Both females and minority staff tend to be well represented across all agencies.

Exhibit 22
Gender and Minority Composition of Treatment Staff

Percentage of Treatment Staff	Number of Agencies	
	Female[a]	Minority[b]
Don't know	0 (0%)	0 (0%)
0%	0 (0%)	1 (6%)
1–20%	0 (0%)	1 (6%)
21–40%	2 (13%)	7 (44%)
41–60%	3 (20%)	3 (19%)
61–80%	6 (40%)	1 (6%)
81–100%	4 (27%)	3 (19%)

[a]*n* = 15. [b]n = 16.

Compensation

Salary and benefit information was collected from both directors and treatment staff. Exhibit 23 displays salary by role. Overall, 50% of directors reported making between

$40,000–$74,999 a year, with 31% making over $75,000 a year. Treatment staff salaries were much more diverse, with 50% making between $15,000–$34,999 a year, and 40% making $35,000–$49,999. Chi square analysis indicated that these differences in director and staff salaries were highly significant ($p < .001$). No setting differences were detected for staff salaries, indicating that treatment staff made the same money in both certified and licensed agencies. Differences in staff salary did exist however by professional status. This difference is displayed in Exhibit 24. A statistically significant larger proportion of MH and AOD/MH reported higher level salaries. In fact, 52% of MH professionals and 46% of AOD/MH professionals reported making $40,000–$74,999 a year. Only 10% of AOD professionals reported salaries in the same range, a finding that is statistically significant ($p < .001$).

Exhibit 23
Salaries of Respondents by Role

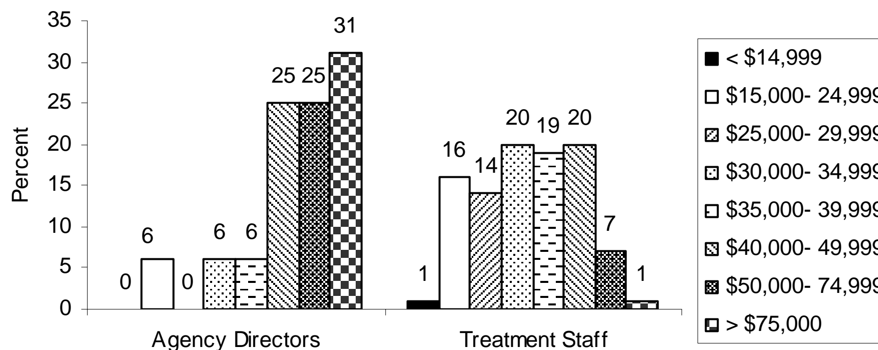
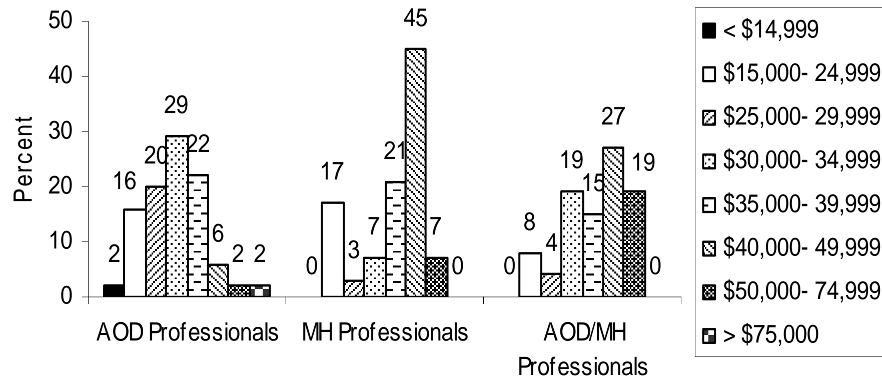


Exhibit 24
Salaries of Respondents by Professional Discipline



Multiple linear regression was run to examine potential predictors of salary for the workforce in Delaware. Four categories of predictors were included in the analysis: demographic, professional/academic background, additional compensation/benefits, and agency characteristics. Both the role distinction (director versus treatment staff) and agency type distinction (certified versus licensed) were included as predictors. Results are displayed in Exhibit 25.

Exhibit 25
Predictors of Respondents' Salaries

Variable	Simple Correlation (*r*) With Salary	Multiple Linear Regression (*R* = .697**)	
		Standardized Regression Coefficient	*t* statistic
Demographics			
Gender	-.052		.926
Age	.092		-1.800
Ethnicity	-.047		-.915
Professional/Academic Background			
Role (director versus staff)	-.019	-.795	***-3.053****
Years in Role	.122		.087
Years in Field	.125		-.501
Years in Position	.033		1.876
Professional Status (AOD; MH; AOD/MH)	***.245*****	.732	***2.451****
Certification Status	.099		1.422
Degree Status	.110		1.978
Amount of AOD Education	-.016		-2.169
Amount of MH Education	.081		.779
Other Compensation/Benefits			
Health Insurance	.022		-1.366
Sick Leave	-.057		-1.643
Retirement	.097		1.788
Agency Characteristics			
Agency Type (certified or licensed)	-.037		-.126
SADA Funds at Agency	-.069		-.444
Proportion of Public Monies	***.294*****		-.375
Agency Financial Setting (e.g. Private non-profit)	***.316*****		.375
Geographic Setting	***.285*****		.021
Agency Size	-.112		.400

Note. Raw regression coefficients displayed only for statistically significant predictors. *$*p < .05$, $**p < .01$, $***p < .001$*

Results indicate that two factors were significant predictors of workforce salary in Delaware. The strongest predictor was role ($p < .05$). This finding is not surprising as

being in the role of an agency director was related to higher salary. In addition, professional status was a significant predictor of salary. Specifically, being a mental health professional or an alcohol and drug/mental health professional was related to higher salary. Being primarily an AOD professional was related to lower salary. The amount of educational background in AOD as well as years in current position were also relatively strong predictors, with both approaching conventional levels of statistical significance. Perhaps surprisingly, degree status and certification status were not significant predictors of salary. Although as previously noted, a higher proportion of MH and AOD/MH professionals did have advanced degrees.

In addition to salary, benefits were also examined. Exhibit 26 below displays benefits by role. Results indicate that a higher proportion of treatment staff than directors had health insurance fully provided. A larger proportion of directors than treatment staff report full retirement benefits, although this finding was not statistically significant. The majority of both directors and staff reported being fully provided with sick leave and other paid leave, most commonly defined as paid vacation. No significant differences in benefits existed between treatment staff by agency type or professional status.

Exhibit 26
Benefits Provided to Respondents by Agencies

Degree of Provision	Number of Respondents: Agency Directors[a]	Number of Respondents: Treatment Staff[b]
Health insurance		
Full	7 (47%)	68 (61%)
Partial	8 (53%)	38 (34%)
Not provided	0 (0%)	5 (5%)
Sick leave		
Full	13 (93%)	98 (91%)
Partial	0 (0%)	6 (6%)
Not provided	1 (7%)	4 (4%)
Other paid leave		
Full	12 (92%)	87 (88%)
Partial	1 (0%)	7 (7%)
Not provided	0 (0%)	5 (5%)
Retirement		
Full	7 (50%)	36 (38%)
Partial	4 (29%)	39 (41%)
Not provided	3 (21%)	21 (22%)

Note. Missing data excluded.
[a]n = 16. [b]n = 114.

Staff Turnover, Recruitment, & Retention

Agency directors were asked to report staffing numbers from the past year. Specifically, directors were asked to indicate the size of their treatment staff, and the amount of turnover they had experienced. Turnover was defined in three ways: laid off, terminated, and quit (voluntary turnover). Total turnover was then calculated and compared against treatment staff size to determine an agency/regional level turnover rate. All turnover numbers were provided and calculated for both AOD and MH staff.

Exhibit 27 displays calculated turnover rates for AOD staff, MH staff, and combined AOD and MH staffs. Based on directors reports of staffing in the past year, the average

turnover rate for AOD staff in agencies was .21, while the average turnover rate for mental health staff was .39. In agencies where both professions were needed, agencies experienced a combined turnover rate of .34. Interestingly, most turnover across all settings was voluntary (quitting). The turnover rate for AOD staff was quite comparable to rates calculated the same way in other states. For example, in the Pacific Northwest 5 states reported an average turnover rate for AOD staff of .23 (ranging from .20–.28), and in Kentucky, the average turnover rate for AOD staff was .17 (Knudsen & Gabriel, 2003).

Exhibit 27
Staff Turnover Rates of Agencies

Professional Field	*n*	Turnover Rate
AOD	14	.21
MH	8	.39
Combined[a]	8	.34

[a]These agencies reported having (or needing) both AOD and MH staff.

Directors also provided counts of how many direct service treatment staff they needed to have a full staff. This number was compared against current staff sizes to generate an estimate of staff shortage for both AOD and MH staff. Overall, agencies reported an average AOD staff shortage of 1.1, and an average MH staff shortage of 3.0 (excluding 1 agency which reported a surplus of 15).

Directors and treatment staff were asked to report on retention and recruitment efforts. Perceptions of staff development activities are displayed in Exhibit 28 below. Directors and treatment staff reported various staff develop activities, with direct supervision and in-service training the most frequently cited staff development activities reported by both groups. A statistically significant smaller proportion ($p < .05$) of treatment staff at certified agencies (53%) reported provision of direct supervision as a staff development activity compared to treatment staff at licensed agencies (74%). In addition, a statistically significant higher proportion ($p < .05$) of AOD/MH professionals reported their agencies having an in-house mentoring program (35%) compared to AOD

professionals (10%). Finally, a statistically significant smaller proportion ($p < .05$) of MH professionals (52%) reported provision of direct supervision as a staff development activity than AOD professionals (80%).

Exhibit 28
Respondents' Perceptions of Staff Development Activities Provided by Agencies

	Respondents Indicating	
Development Activity	**Agency Directors[a]**	**Treatment Staff[b]**
No method/program to develop skills	0 (0%)	4 (4%)
In house mentoring program	5 (31%)	20 (18%)
In-service training	10 (63%)	90 (79%)
Provides direct supervision	12 (75%)	75 (66%)
Pays cost of continuing education	9 (56%)	39 (34%)

Note. Respondents were asked to check all that apply.
[a]*n* = 16. [b]*n* = 114.

Directors and staff were also asked to report on what they thought their agency could do to promote the retention of good treatment staff. Exhibit 29 displays ideas for promoting retention by role. Directors and treatment staff in both indicate that more frequent salary increases and more/improved on-going training were the top activities that could be done to promote retention. In addition, more frequent promotions, promoting career growth and more individual recognition/appreciation were also ideas supported by a large proportion of both directors and staff. No statistically significant differences existed between directors and treatment staff, although some ideas showed some considerable difference in support. Statistically significant differences did exist between treatment staff by agency type. A statistically significant larger proportion ($p < .05$) of treatment staff at licensed agencies (83%) indicated that more frequent salary increases would promote retention than did treatment staff at certified agencies (62%). In addition, a statistically significant larger proportion ($p < .05$) of treatment staff at licensed agencies (33%) indicated that better health coverage and other benefits would promote retention than did treatment staff at certified agencies (11%). Interestingly, this finding appears by

professional status as well, as statistically significant larger proportion ($p < .05$) of AOD professionals (37%) indicated that better health coverage and other benefits would promote retention than did MH professionals (14%) and AOD/MH professionals (12%). No other statistically significant differences appeared for treatment staff by professional status.

Exhibit 29
Respondents' Ideas for Promoting Staff Retention

Ideas for Promoting Retention	Respondents Indicating: Agency Directors[a]	Respondents Indicating: Treatment Staff[b]
More frequent salary increase	10 (63%)	85 (75%)
Less mgmt/supervision	0 (0%)	6 (5%)
More individual recognition/appreciation	7 (44%)	61 (54%)
Increased opportunities for staff input	4 (25%)	38 (33%)
More varied work opportunities	2 (13%)	20 (18%)
Better health coverage & other benefits	7 (44%)	28 (25%)
Lessen/provide assistance w/ paperwork	7 (44%)	41 (36%)
Promote career growth	8 (50%)	46 (40%)
More frequent promotions	8 (50%)	56 (49%)
More/improved on-going training	12 (75%)	76 (67%)
Better mgmt/supervision	4 (25%)	28 (25%)
More supportive agency culture	5 (31%)	40 (35%)
Improved physical work environment	7 (44%)	27 (24%)
Smaller caseloads	5 (31%)	28 (25%)
Shorter hrs/flex time/job sharing	2 (13%)	22 (19%)

Note. Respondents were asked to check all that apply.
[a] $n = 16$. [b] $n = 114$.

In terms of recruitment, a large percentage of the workforce reported difficulties recruiting qualified staff. In total, 91% of directors but only 46% of treatment staff reported difficulties. A total of 22% of treatment staff reported not knowing whether or not recruiting difficulties existed. Chi square analysis indicates that this difference in the perception of directors and treatment staff was statistically significant ($p < .01$).

Exhibit 30 below displays reasons for recruiting difficulties by role. A statistically significant higher proportion of directors than staff reported recruiting difficulties due to an insufficient number of applicants meeting qualifications ($p < .01$). Examining the responses of treatment staff, a statistically significant larger proportion ($p < .05$) of MH professionals (65%) reported difficulties due to insufficient funding for open positions compared to AOD professionals (39%) and AOD/MH professionals (46%). No other statistically significant differences were present surrounding perceptions of recruiting difficulties.

Directors and staff who identified an insufficient number of applicants meeting qualifications as a reason for recruiting difficulty were asked to identify reasons why. The three reasons most frequently reported by both directors and staff were little or no experience in the field, insufficient or inadequate training or education, and lack of appropriate certification.

Exhibit 30
Respondents' Perceptions of Reasons for Recruiting Difficulties

	Respondents Indicating	
Reasons	**Agency Directors[a]**	**Agency Staff[b]**
Insufficient # applicants meeting qualifications	10 (63%)	28 (25%)
Insufficient funding for open positions	5 (31%)	35 (31%)
Small applicant pool due to geographic area	4 (25%)	12 (11%)
Insufficient facilities	0 (0%)	3 (3%)
Reputation of agency/region	0 (0%)	5 (4%)
Lack of interest (nature of work, stigma)	1 (6%)	12 (11%)
Lack of interest (salary)	7 (44%)	40 (35%)
Lack of interest in rural location of agency/region	2 (13%)	4 (4%)
Lack of opportunity for advancement	1 (6%)	22 (19%)

Note. Respondents were asked to check all that apply.
[a]*n* = 16. [b]*n* = 114.

Directors and staff identified barriers to entering the substance abuse/mental health treatment field, and then rated each on a 5-point severity scale indicating if the barriers were major, moderate, or minor. Exhibit 31 displays the most frequently cited barriers by role. Across the workforce, salary and competition from other fields in terms of salary were the most frequently cited barriers.

Exhibit 31
Respondents' Perceptions of Barriers to Entering SA/MH Treatment Field

	Respondents Indicating		Respondents' Mean Rating[a]	
Barriers	**Agency Directors[b]**	**Treatment Staff[c]**	**Agency Directors[b]**	**Treatment Staff[c]**
Lack of encouragement	56%	41%	3.4	3.3
Competition from other fields (compensation)	69%	66%	4.1	4.3
Documentation	63%	58%	4.0	3.8
Large caseloads	44%	63%	3.9	4.0
Evening work hours	63%	47%	3.6	3.6
Stigma	50%	45%	3.2	3.6
Low salary	75%	85%	4.3	4.6
Cost of education	50%	40%	3.1	3.9
Poor benefits	43%	33%	3.9	3.7
AOD negative preconceptions	38%	48%	3.7	3.4

Note. Respondents were asked to check all that apply.
[a]Barriers to entering field rated from 5 (major) to 1 (minor). [b]$n = 16$. [c]$n = 114$.

Related to barriers such as stigma and negative preconceptions, directors and staff were asked to report on the status of addiction counselors and mental health professionals compared to other helping professionals. Overall, the majority of directors and staff saw addiction counselors as having lower status than other helping professionals, and mental health professionals as having the same status as other helping professionals. Results are displayed in Exhibit 32. Interestingly, treatment staff at certified and licensed agencies saw this issue differently. A statistically significant higher proportion ($p < .01$) of treatment staff at licensed agencies (71%) saw addiction counselors as having lower status than did treatment staff at certified agencies (41%).

No statistically significant differences existed between the perceptions of treatment staff by professional status, although AOD and AOD/MH professionals generally saw addiction counselor status as lower, and mental health professional status as higher than did mental health professionals. Reasons for the lower status of addiction counselors are displayed in Exhibit 33 below. Overall, the most frequently cited reason for lower status of addiction counselors by both directors and treatment staff was less formal education or training. While the majority selection for both groups, a statistically significant higher proportion of directors than staff cited less formal education or training ($p < .05$). Interestingly, while the quantity of education was cited frequently, the quality of training was not. A statistically significant higher proportion of treatment staff in certified agencies (78%) than treatment staff in licensed agencies (50%) reported that addiction counselors having a history of substance abuse was a reason for lower status. No statistically significant differences existed between treatment staff by professional status.

Exhibit 32
AOD & MH Status by Role

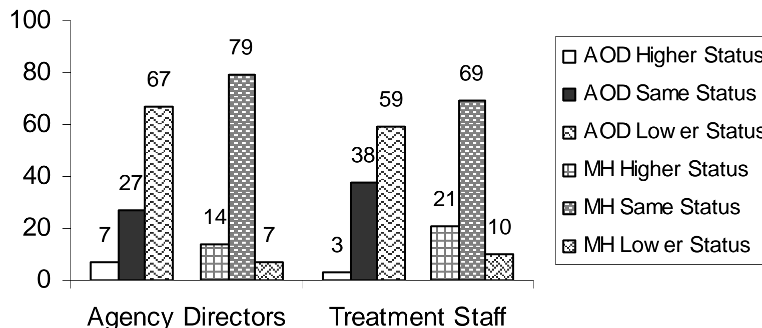


Exhibit 33
Respondents' Perceptions of Reasons for Lower Status of AOD Counselors

Reasons	Respondents Indicating	
	Agency Directors[a]	Treatment Staff[b]
Less formal education or training	9 (90%)	37 (56%)
Lower quality formal education or training	3 (30%)	17 (26%)
More likely to work in public agency	2 (20%)	26 (39%)
Stigmatized by association w/ substance abusers	3 (30%)	25 (38%)
More often had history of own substance abuse	3 (30%)	9 (14%)

Note. Respondents were asked to check all that apply.
[a]*n* = 10. [b]*n* = 66.

Directors and staff were asked to report the methods of recruitment used at their agency or in their region. Results are displayed in Exhibit 34 below. Overall, more traditional techniques such as newspaper advertisement and personal contacts were cited most frequently. Results indicate that a statistically significant higher proportion of directors than treatment staff reported multiple techniques being utilized, indicating that staff may not have been aware of some of the recruitment techniques being used by their agency.

Exhibit 34
Agency Methods for Staff Recruitment

Recruitment Method/Resource	Respondents Indicating	
	Agency Directors[a]	Treatment Staff[b]
Agency/Region HR Dept.	5 (31%)	42 (37%)
Professional journals	4 (25%)	7 (6%)
Newspaper advertisement	12 (75%)	78 (68%)
Email networking	5 (31%)	17 (15%)
Agency newsletter	7 (44%)	16 (14%)
Personal/informal contacts	11 (69%)	44 (39%)
Website	5 (31%)	23 (20%)
Agency/Regional mailing list	3 (19%)	3 (3%)
State HR Dept.	2 (13%)	24 (21%)

Note. Respondents were asked to check all that apply.
[a]*n* = 16. [b]*n* = 114.

Job Satisfaction

Directors and staff in both settings were asked to identify what in their work contributes to their satisfaction and dissatisfaction. Sources of job satisfaction are displayed in Exhibit 35, and sources of job dissatisfaction are displayed in Exhibit 36. For agency directors, the most frequently cited source of satisfaction was their role as a change agent. For treatment staff, one on one interactions with clients was the most frequently cited source of satisfaction. Interestingly, opportunities for personal growth was frequently cited as a source of satisfaction for treatment staff, but opportunities for career growth were not. Multiple significant differences in satisfaction existed between directors and staff. A statistically significant higher proportion of directors reported salary and the ability to influence agency decisions as sources of satisfaction ($p < .05$). Conversely, a statistically significant higher proportion of treatment staff indicated one on one interactions with clients as a source of satisfaction ($p < .001$). No significant differences in satisfaction existed in treatment staff by agency setting or by professional status.

Exhibit 35
Sources of Job Satisfaction for Respondents

	Respondents Indicating	
Sources of Job Satisfaction	**Agency Directors**[a]	**Treatment Staff**[b]
Nothing–I am not satisfied	0 (0%)	1 (1%)
Salary	7 (44%)	18 (16%)
Benefits	5 (31%)	34 (30%)
Career growth opportunities	5 (31%)	17 (15%)
Role as a change agent	10 (63%)	52 (46%)
Commitment to treatment	8 (50%)	65 (57%)
1 to 1 interaction with clients	5 (31%)	91 (80%)
Opportunities for personal learning/growth	8 (50%)	66 (58%)
Agency/co-workers	8 (50%)	50 (44%)
Ability to influence agency decisions	8 (50%)	26 (23%)

Note. Respondents were asked to check all that apply.
[a] $n = 16$. [b] $n = 114$.

For both directors and treatment staff, salary was the only source of dissatisfaction cited with high frequency. A statistically significant higher proportion of treatment staff than directors cited the inability to influence agency decisions as a source of dissatisfaction ($p < .05$). This dissatisfaction is statistically more prevalent ($p < .01$) for treatment staff at certified agencies (44%) than treatment staff at licensed agencies(20%), and more prevalent for MH professionals ($p < .05$) as well. A statistically significant higher proportion of MH professionals also reported that a lack of career growth opportunities were a source of dissatisfaction ($p < .05$).

Exhibit 36
Sources of Job Dissatisfaction for Respondents

	Respondents Indicating	
Sources of Job Dissatisfaction	**Agency Directors[a]**	**Treatment Staff[b]**
Nothing–I am satisfied	3 (19%)	18 (16%)
Limited role as a change agent	2 (13%)	11 (10%)
Salary	7 (44%)	74 (65%)
Benefits	4 (25%)	19 (17%)
Agency/co-workers	1 (6%)	16 (14%)
Lack of career growth opportunities	1 (6%)	31 (27%)
Lack of commitment to treatment	1 (6%)	5 (4%)
Lack of 1 to 1 interaction with clients	0 (0%)	3 (3%)
Inability to influence agency decisions	1 (6%)	34 (30%)
Lack of opportunities for personal learning/ growth	1 (6%)	13 (11%)

Note. Respondents were asked to check all that apply.
[a]*n* = 16. [b]*n* = 114.

Treatment Models

To get a sense of what treatment models are actively being used in Delaware, directors and staff were asked to identify which treatment models were being used in their agency. In addition, for each identified model, respondents were asked indicate the degree to which the model played a role in the agency/region's approach (major, intermediate, or minor).Agency directors cited a mean total of 11 treatment models in

use at their agency, while treatment staff cited a mean total of 13. On average, agencies in Delaware implemented 6 models that played a major role in their overall treatment approach. A great deal of consistency was apparent in the major models identified, as displayed in Exhibit 37. Both directors and treatment staff frequently cited relapse prevention, 12-step, and behavior modification as major models in their agency's approach. Interestingly, 56% of directors cited community reinforcement as a major model, compared to only 21% of treatment staff. Conversely, 40% of treatment staff reported cognitive behavioral as a major model used in their agency, compared to 31% of agency directors.

Exhibit 37
Respondents' Perceptions of the Major Treatment Models Implemented in Their Agency

Agency Directors Responses[a]		Treatment Staff Responses[b]	
Models Most Frequently Cited as Playing a Major Role	**Percent Indicating**	**Models Most Frequently Cited as Playing a Major Role**	**Percent Indicating**
1. Relapse Prevention	63%	1. Relapse Prevention	46%
2. 12-Step	56%	2. Cognitive Behavioral	40%
3. Community Reinforcement	56%	3. Behavior Modification	39%
4. Behavior Modification	45%	4. 12-Step	39%
5. MET; Intensive Case Mgmt	41%	5. Integrated AOD & MH	32%

[a]*n* = 16. [b]*n* = 114.

Proficiencies & Training Interests

Directors and treatment staff self-rated their proficiency and training interest in 31 counseling competency areas. Twenty-eight of the 31 competencies represent the Addiction Counseling Competencies (ACC's). The ACC's have been adopted nationally and were documented in SAMHSA/CSAT's Technical Assistance Publication (TAP) 21 in 1998. Three additional competency areas were added to the survey by Delaware officials: family therapy, risk management, and research and application. Proficiency was rated on a 7-point scale (0–6) ranging from no proficiency to complete proficiency,

while training interest was rated on 5-point scale (0–4) ranging from no interest to maximum interest. Exhibit 38 displays mean ratings for both directors and treatment staff.

Exhibit 38
Respondents' Ratings of Personal Proficiency & Interest in 31 Counseling Competency Areas

Competency Area	Mean Rating[a]			
	Agency Directors[b]		Treatment Staff[c]	
	Proficiency	Interest	Proficiency	Interest
1. Administrative/Management	5.00	3.25	3.93	2.31
2. Adolescent Treatment	2.42	2.17	3.24	2.41
3. Client Family & Community Education	3.93	3.08	3.99	2.90
4. Clinical Supervision	4.33	2.33	3.55	2.68
5. Co-Occurring Disorders	3.62	2.83	4.09	3.11
6. Detoxification	2.08	1.82	2.56	2.31
7. Documentation	4.43	1.75	5.16	2.54
8. Drug Pharmacology/Pharmacotherapy	3.00	1.83	3.38	2.83
9. Gender Specific Treatment	3.85	2.50	3.62	2.86
10. Group Counseling	4.69	2.00	4.51	2.89
11. Individual Counseling	5.08	2.31	5.00	3.02
12. Interpersonal Communication	4.79	2.46	5.28	2.71
13. Intervention Skills	4.67	2.33	4.82	2.97
14. Lesbian/Gay/Bisexual/Transsexual Specific Tx	2.75	2.17	3.03	2.75
15. Marriage & Family Therapy	2.67	2.08	2.74	2.58
16. Offender Treatment	3.23	2.50	3.12	2.45
17. Patient Placement Criteria	3.92	1.83	3.66	2.41
18. Professional/ Ethical Responsibilities	5.21	2.25	5.42	2.70
19. Racial/Ethnic Specific Tx	4.00	2.58	3.90	2.74
20. Referral Skills	4.64	1.83	4.86	2.50
21. Relationship Between SA & Medical Problems	4.00	2.58	4.35	2.79
22. Screening/Assessment	4.43	1.83	4.91	2.66
23. Service Coordination & Case Mgmt	4.79	1.83	4.86	2.40
24. Signs & Symptoms	4.31	1.92	4.42	2.54
25. Staff Recruitment	3.93	3.31	3.20	1.93
26. Staff Retention	4.00	3.23	3.26	2.21
27. Treatment Engagement	4.00	2.83	4.43	2.96
28. Treatment Planning	4.23	1.92	4.60	2.82
29. Family Therapy	3.31	2.50	3.35	2.76
30. Risk Management	4.36	2.58	3.85	2.76
31. Research and Application	3.85	2.92	2.99	2.43

[a]*Proficiency* range is 0 (none) to 6 (completely); *Interest* range is 0 (no interest) to 4 (max. interest). [b]*n* = 16. [c]*n* = 114.

In order to identify training priorities for Delaware, it is important to consider both the relative proficiency and interest in each competency area. Exhibits 39–41 categorize each competency area for directors and treatment staff in terms of 4 proficiency/interest based categories: lower proficiency, higher interest; lower proficiency, lower interest; higher proficiency, higher interest; and higher proficiency, lower interest. Training priorities are reported separately for certified and licensed settings to better match needs. Training priorities for certified directors are not provided due to small sample size (2).

Examining competencies using this framework helps identify workforce training priorities for the region, starting with lower proficiency, higher interest areas. Lowest training priorities should be those rated as higher proficiency, lower interest. Those competency areas rated as lower proficiency, lower interest represent perhaps the largest training challenge, while those rated as higher proficiency, higher interest may be considered prime continual training areas.

Exhibit 39
Training Priorities for Agency Directors–Licensed Setting

Priority Level 1: Higher Interest, Lower Proficiency
• Client Family & Community Education
• Co-Occurring Disorders
• Family Therapy
• Gender Specific Treatment
• Offender Treatment
• Racial/Ethnic Specific Treatment
• Research & Application
• Staff Recruitment
• Staff Retention
• Treatment Engagement
Priority Level 2: Lower Interest, Lower Proficiency
• Adolescent Treatment
• Detoxification
• Drug Pharmacology/Pharmacotherapy
• Lesbian/Gay/Bisexual/Transsexual Specific Treatment
• Marriage & Family Therapy
• Patient Placement Criteria
Priority Level 3: Higher Interest, Higher Proficiency
• Administrative/Management
• Clinical Supervision
• Relationship Between Substance Abuse & Medical Problems
• Risk Management
Priority Level 4: Lower Interest, Higher Proficiency
• Documentation
• Group Counseling
• Individual Counseling
• Interpersonal Communication
• Intervention Skills
• Professional/ Ethical Responsibilities
• Referral Skills
• Screening/Assessment
• Service Coordination & Case Mgmt
• Signs & Symptoms
• Treatment Planning

Proficiency was measured on a 7-point scale, and training interest was measured on a 5-point scale. Median total proficiency (4.57) & interest (2.27) were used as cut-off scores for higher/ lower distinctions.

Exhibit 40
Training Priorities for Treatment Staff–Licensed Setting

Priority Level 1: Higher Interest, Lower Proficiency
• Client Family & Community Education
• Clinical Supervision
• Co-Occurring Disorders
• Drug Pharmacology/Pharmacotherapy
• Family Therapy
• Gender Specific Treatment
• Lesbian/Gay/Bisexual/Transsexual Specific Treatment
• Racial/Ethnic Specific Treatment
• Risk Management
Priority Level 2: Lower Interest, Lower Proficiency
• Administrative/Management
• Adolescent Treatment
• Detoxification
• Marriage & Family Therapy
• Offender Treatment
• Patient Placement Criteria
• Research & Application
• Staff Recruitment
• Staff Retention
Priority Level 3: Higher Interest, Higher Proficiency
• Group Counseling
• Individual Counseling
• Intervention Skills
• Professional/ Ethical Responsibilities
• Relationship Between Substance Abuse & Medical Problems
• Screening/Assessment
• Service Coordination & Case Mgmt
• Treatment Engagement
• Treatment Planning
Priority Level 4: Lower Interest, Higher Proficiency
• Documentation
• Interpersonal Communication
• Referral Skills
• Signs & Symptoms

Proficiency was measured on a 7-point scale, and training interest was measured on a 5-point scale. Median total proficiency (4.50) & interest (2.79) were used as cut-off scores for higher/ lower distinctions.

Exhibit 41
Training Priorities for Treatment Staff–Certified Setting

Priority Level 1: Higher Interest, Lower Proficiency
• Client Family & Community Education
• Clinical Supervision
• Drug Pharmacology/Pharmacotherapy
• Gender Specific Treatment
• Lesbian/Gay/Bisexual/Transsexual Specific Treatment
• Racial/Ethnic Specific Treatment
• Risk Management
Priority Level 2: Lower Interest, Lower Proficiency
• Adolescent Treatment
• Detoxification
• Family Therapy
• Marriage & Family Therapy
• Offender Treatment
• Patient Placement Criteria
• Research & Application
• Staff Recruitment
• Staff Retention
Priority Level 3: Higher Interest, Higher Proficiency
• Administrative/Management
• Co-Occurring Disorders
• Documentation
• Group Counseling
• Individual Counseling
• Interpersonal Communication
• Intervention Skills
• Professional/ Ethical Responsibilities
• Referral Skills
• Relationship Between Substance Abuse & Medical Problems
• Screening/Assessment
• Signs & Symptoms
• Treatment Engagement
• Treatment Planning
Priority Level 4: Lower Interest, Higher Proficiency
• Service Coordination & Case Mgmt

Proficiency was measured on a 7-point scale, and training interest was measured on a 5-point scale. Median total proficiency (4.32) & interest (2.68) were used as cut-off scores for higher/ lower distinctions.

Overall, results indicate that directors and treatment staff had multiple overlapping training priorities. Client family and community education, gender specific treatment, and racial/ethnic specific treatment were identified as Level 1 training priorities by all groups. Treatment staff in both settings also showed a great deal of overlap. In fact, 7 Level 1 training priorities were identified by treatment staff in both certified and licensed agencies: client family and community education, clinical supervision, drug pharmacology/ pharmacotherapy, gender specific treatment, LGBT specific treatment, racial/ethnic specific treatment, and risk management.

Discussion

Workforce has been and continues to be an issue in the behavioral health field. Multiple issues relating to clinician characteristics, recruitment and retention, and training are at play. Many of these issues are of critical importance to Delaware. Clinicians are leaving the field for opportunities in other disciplines, often for increased salaries. This in turn creates a need to recruit new staff, but recruitment difficulties are resulting in a shortage of qualified staff. Workforce consistency is also an obstacle. Staff that do remain in the field often cycle from one provider to another causing instability in staffing at agencies. Consistency and quality of staff are critical to service delivery, especially as agencies implement evidenced-based practices. The quantitative dataset acquired through the Workforce Survey is a important resource in light of these concerns, as it provides Delaware with the ability to make data-driven decisions to improve the current state of addiction treatment in the state.

Often workforce discussions focus on why individuals leave the field. When examining this, it is equally important to understand why individuals enter the field. Survey results indicate that directors entered the field for different reasons than staff. Agency directors most frequently cited a personal or family experience with addictions as the primary reason for entering the field, while treatment staff most frequently cited a personal interest in the field. In addition, AOD professionals seemed to enter the field for different reasons than MH professionals. A significantly higher proportion of AOD professionals, 57%, cited personal or family experience in addictions as the reason for entering the field.

Overall, survey results indicate that most people regardless of position entered the field due to a personal connection, whether it was personal experience or personal interest. This presents an interesting challenge when deciding on ways to attract new individuals to the field. Agencies can educate and promote the rewards and benefits of working to help improve the lives of others, but it is difficult to create a personal connection with

individuals and the field. In order to more effectively attract new staff, Delaware agencies need to be aware of the motivation of individuals in choosing a career.

Another variable impacting recruitment into the field is that 31% of directors and 25% of treatment staff indicated that substance abuse treatment was a second career. The mean age range for both directors and treatment staff entering both the AOD and mental health fields was the mid 30's. Through developing linkages with local universities and colleges, DSAMH and the field can do better to attract college graduates to the behavioral health field as a first career. This would be effective especially considering that 80% of treatment staff and 81% of directors had a bachelor's degree. In addition, Delaware would benefit from more effective recruitment efforts intended to diversify the workforce. According to the survey results, the majority of the behavioral health workforce in Delaware consisted of white females. The workforce should mirror as much as possible the demographics of the clients served in terms of age, gender, race and ethnicity.

Once individuals enter the field it is important to match their interests and skills with an appropriate position. Accomplishing this could improve the chances that content and challenged employees would remain in the field and perhaps even at their current agency. The survey results indicate that treatment staff spent approximately 60% of their time on client related tasks, while agency directors spent 85% of their time on administrative tasks. Staff at certified (MH) treatment agencies spent 30.2% of their time providing individual counseling and 14.4% of their time completing clinical paperwork. Staff at licensed (AOD) treatment agencies spent 13.6% of their time providing case management and 20% of their time providing individual counseling. With appropriate training staff can become skilled at balancing the demands of both client clinical interventions and paperwork from licensing and accreditation bodies.

Respondents also reported on various retention and recruitment efforts. Both treatment staff and directors reported direct supervision and in-service training as the most common staff development activities. Seventy-five percent of directors felt that more/improved on-going training would also promote retention. Some uncertainty

seemed to exist around what staff retention resources were available. DSAMH can begin to facilitate a new employee orientation program for new staff at treatment agencies. The training could provide an overview of the treatment system and its components. The training could also provide a networking opportunity for staff to meet other new staff and build connections. The training would benefit the providers in that the new employees would gain a broader picture of the resources available in meeting clients' needs.

Of course, salary is central to all recruitment and retention issues. Survey results indicate that 85% of treatment staff reported that more frequent salary increases would promote retention, while only 10% of directors reported the same. This discrepancy may have been due partially to the wide range of salaries across the behavioral health field in Delaware. Overall, 50% of directors reported making between $40,000–$74,999 a year, with 31% making over $75,000 a year. Treatment staff salaries also varied, but were significantly lower, with 50% making between $15,000–$34,999 a year and 40% making $35,000–$49,999 a year. In addition, a statistically significant larger proportion of MH and AOD/MH professionals reported higher level salaries than AOD professionals.

Historically, staff have complained about salaries and have often switched agencies to earn as little as $1.00 more per hour. Staff may not always consider the benefits of remaining at an agency–such as health benefits, pension, and accrual of sick/vacation time–and because they know the demand in the field, often feel they have a lot of opportunities to move to another agency. Providers voice concerns that when they encourage staff to perform and set target goals for performance, staff often become overwhelmed with perceived demands and leave the agency. This concern is supported by the survey results that indicate that most turnover in all settings was voluntary (quitting).

Recruitment and retention issues are paramount to the health of the behavioral health system in Delaware. Through a new wealth of quantitative data provided by the Workforce Survey, meaningful conversations regarding the needs of the field can take

place, and data-driven plans can be made. The issues at hand, including dealing with salary concerns surrounding recruitment and retention efforts, do not have easy solutions. But through the feedback provided directly from the field, DSAMH is in a better position to create solutions that may ultimately improve the health of the field, and the quality of care.

This study does have limitations to consider. First, the response rate was relatively low for both agency directors and staff. Second, sample sizes, especially for directors, was small resulting in a lack of statistical power making it more difficult to detect significant differences. Both limitations warrant extra caution when interpreting results. Third, and finally, sampling in the substance abuse treatment field was complicated by high staff turnover rates and agency closures, both of which resulted in inaccuracies in the sampling list used in this study.

References

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Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2002). *National Survey of Substance Abuse Treatment Services (N-SSATS): 2000. Data on Substance Abuse Treatment Facilities, DASIS Series: S–16*. (DHHS Publication No. SMA 02–3668). Rockville, MD: Author.

Appendix A
Participating Licensed Agencies

Participating Licensed Agencies

Advanced Treatment Systems of York, Inc. 212Blue Ball Ave. Elkton, MD. 21921	Latin American Community Center 403North Van Buren Wilmington, DE 19805
ANKH Inc. 431 East Market Street Georgetown, DE. 19947	Limen House, Inc. 624 North Broom Street Wilmington, DE 19801
Aquila of Delaware 2110 Duncan Road Wilmington, DE 19808	Martin Luther King Complaint/Referral Center, Inc. 435 Heald Street Wilmington, DE 19801
Big Brothers and Big Sisters of Delaware 102 Middleboro Rd. Wilmington, DE 19804	Neighborhood House 1218 B. St. Wilmington, DE 19801
Brandywine Counseling, Inc. 2713 Lancaster Avenue Wilmington, DE 19805	Northeast Treatment Center Suite A., 499 North 5th Street Philadelphia, PA 19123
Catholic Charities, Inc. 2601 West 4TH Street Wilmington, DE 19805	Open Door, Inc., An Affiliate of Holcomb Behavioral Health Systems 254 Main St. Newark, DE 19711
Central Delaware Committee on Drug/Alcohol Abuse, Inc. 1241 College Park Drive Dover, DE 19904	PACE, Inc. 5171 W. Woodmill Drive, Suite 9 Wilmington, DE 19808
Connections CSP, Inc. 500 West 10TH St., Wilmington, DE 19801	People's Place, Inc. 219 South Walnut Street Milford, DE 19963
Crossroads of Delaware, Inc. 2303 Lancaster Avenue Wilmington DE. 19805	Peoples Settlement 408 East Eighth Street Wilmington, DE 19801
Delmarva Rural Ministries, Inc. 26 Wyoming Avenue Dover, DE 19904	Sodat Delaware, Inc. Linden Building 2nd Floor 625 Orange Street Wilmington, DE 19801
Division of Substance Abuse and Mental Health 1901 N. Dupont Highway New Castle, DE 19720	Thresholds, Inc. 526 D. N. Dupont Highway Georgetown, DE 19947
Ferris School For Boys 959 Centre Road Wilmington, DE 19805	

*Listing indicates those agencies that returned at least one survey for analysis (director or staff survey).

Appendix B
Participating Certified Agencies

Participating Certified Agencies

Brandywine Counseling, Inc. Assertive Treatment Team Riverfront Center 350 S. Madison St. Wilmington, DE 19805	Fellowship Health Resources, Inc. Georgetown Group Home 16 Shorley Road Georgetown, DE 19947
Connections Community Support Programs, Inc. Cornerstones CTT; Level I 500 West 10th Street Wilmington, Delaware 19801	Psychotherapeutic Service, Inc. Felton Group Home 1563 Paradise alley Road Felton, DE 19943
Division of Substance Abuse and Mental Health 1901 N. Dupont Highway New Castle, DE 19720	

*Listing indicates those agencies that returned at least one survey for analysis (director or staff survey).