

Kentucky Workforce Survey 2002

Results of a statewide needs assessment of substance abuse treatment professionals.

Prepared for

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Executive Summary

Very little quantitative data concerning the substance abuse treatment workforce is currently available. This study, conducted by RMC Research Corporation for the Central East Addiction Technology Transfer Center (CEATTC), offers a comprehensive look at the workforce in the state of Kentucky.

The implications of this report are many and far reaching. The empirical results presented provide long needed information concerning the composition, skills, concerns, and needs of the substance abuse treatment workforce. Challenges and lessons learned are abundant, and present multiple opportunities for improving the current state of addiction treatment.

Conducted in 2002, surveys were sent to the agency directors of the 13 certified private agencies and to the regional directors of the 14 regional facilities in the state of Kentucky . Follow-up efforts resulted in a response rate of 69%, yielding responses from 20 agency and regional directors and 298 agency and regional treatment staff. Data were examined by role (director versus treatment staff) and by setting (agency versus region), covering multiple topical areas. Significant findings highlighted by topical area are presented below.

Workforce Demographics

- The majority of directors in both settings are male, while the majority of treatment staff in both settings are female. The majority of both directors and treatment staff in both settings are white.
- In the agency setting, the average age for those surveyed was 51 years old for directors and 43 years old for treatment staff. In the regional setting, the average age for those surveyed was 49 years old for directors and 45 years old for treatment staff.

- In both settings, the largest proportion of directors fall into the 41- 60 year old range. This is also the case for treatment staff in the regional setting. For treatment staff in the agency setting however, the largest proportion fall into the 31- 50 year old range.

Academic & Professional Background

- Over 80% of the workforce in both settings have a Bachelors degree or above.
- The majority of the workforce does not hold a degree specific to alcohol and other drugs(AOD). In the agency setting, only 10% of directors and 20% of treatment staff report having an AOD specific degree. In the regional setting, no directors and only 20% of treatment staff report having an AOD specific degree. A large proportion of the workforce in both settings reports having no AOD specific coursework.
- Nearly 90% of directors and treatment staff in both settings have participated in AOD related training or workshops over the past year.
- Differences in the number of training hours exist both between role, and across setting. In the past two years, agency treatment staff report an average of 88 training hours and agency directors report an average of 42 hours. Regional treatment staff report an average of 60 training hours and regional directors report an average of 58 training hours over the same period of time.
- Less than half of all treatment staff report being currently certified. In the agency setting, 67% of directors and 41% of treatment staff report currently being certified, while in the regional setting, 90% of directors and 49% of treatment staff report being currently certified.

- Neither directors nor staff show much variation between the number of years between years in the field and years in their role, indicating that most enter the field in the role they currently hold.
- The entire workforce reports sizably less time in their current position than years in the field, indicating some changing of positions over the years.
- Agency directors (36 years old), regional directors (29 years old), agency treatment staff (34 years old), and regional treatment staff (36 years old) all display a relatively high mean age of entry into the field. In addition, both groups also demonstrate a large range, indicating people in all stages of life are entering the field for the first time.
- A relatively large percentage of the workforce indicate that substance abuse treatment is a second career. In the agency setting, 70% of directors and 30% of treatment staff indicate that substance abuse treatment is a second career. In the regional setting, 40% of directors and 39% of treatment staff indicate that substance abuse treatment is a second career.
- A personal or family experience with addictions, personal interest in addictions, and experience in a like field are the most frequently cited reasons for entry into the field.

Job Detail

- In general, treatment staff show more time spent on client-related tasks than do directors who spend more time on administrative tasks. This is especially true in the regional setting, where directors spend approximately 87% of their time on administrative tasks.
- Treatment staff in both settings report more time spent on individual counseling than on group counseling.

- Treatment staff report spending just under a fifth of their time doing paperwork, constituting almost one day each week.

Compensation

- The majority of directors in both settings report making between \$40,000-74,999 a year, while the majority of treatment staff in both settings report making \$15,000- 34,999 a year. This difference is statistically significant ($p < .001$).
- Results demonstrate that salary is fairly predictable, with higher degree status, management role, more years in the field, and working in a more urban area all related to higher salary. Interestingly, having sick leave is related to lower salary.
- A higher proportion of directors than treatment staff in both settings have health insurance fully provided.

Staff Turnover, Recruitment, & Retention

- Based on directors reports of staffing in the past year, agencies experienced an average turnover rate of .18, while regions experienced an average turnover rate of .16. Overall, the average turnover rate for agencies/regions in Kentucky is .17, with most turnover across both settings being voluntary (resignation).
- Overall, agency and regional settings across the state are short approximately 1 direct service treatment staff. Results do indicate that the staff shortage is approximately twice as large in the regional setting as it is in the agency setting.
- Directors and treatment staff in both settings indicate that salary increases are the number one thing that could be done to promote retention. Two

other ideas that were cited by a large number of individuals were promoting career growth and more individual recognition/appreciation.

- In terms of recruitment, a large percentage of the workforce report difficulties recruiting qualified staff. In the agency setting, 40% of directors and 59% of treatment staff report difficulties. In the regional setting the numbers are higher with 100% of directors and 71% of treatment staff reporting difficulties.

Multiple Certification & Licensure

- Overall, the substance abuse treatment workforce in Kentucky indicates support for a tiered certification system, and/or licensure.
- A statistically significant higher proportion of regional directors than regional staff support licensure ($p < .01$).
- A significantly higher proportion of directors ($p < .01$) and treatment staff ($p < .05$) in the regional setting support licensure, than do directors and treatment staff in the agency setting.

Job Satisfaction

- Directors and staff in both settings cite many more sources of satisfaction than they cite sources of dissatisfaction.
- Commitment to treatment, role as a change agent, and 1 to 1 interactions with clients are all frequently cited sources of satisfaction.
- Interestingly, opportunities for personal growth is frequently cited as a source of satisfaction, but opportunities for career growth are not.
- Salary is the only source of dissatisfaction cited with any frequency, although no agency directors report salary as dissatisfying. In fact, 60% of agency report that nothing leaves them dissatisfied.

Treatment Models, Counselor Proficiencies, & Training Interests

- On average, agencies/regions in Kentucky implement 6-7 models that play a major role in their overall treatment approach. Directors and staff in both settings show a great deal of consistency in the major models reported, with the overall treatment approach consisting of a combination of 12-step, relapse prevention, integrated substance abuse and mental health, cognitive behavioral, and psycho-educational.
- Proficiencies and training interest in 28 competency areas vary by both setting and by role, indicating the need for specialized workforce development plans.

Introduction

The Kentucky Division of Substance Abuse (DSA) within the Kentucky Department of Mental Health /Mental Retardation is the agency that oversees substance abuse treatment and prevention in the Commonwealth of Kentucky. DSA offers a wide variety of services to the community including the full range of treatment, intervention services, prevention efforts and training for professionals and the public. All of these services are offered through the DSA's network of Regional Prevention Centers and Community Mental Health Centers. The DSA also collaborates with the Department of Corrections and the Department of Juvenile Justice in an effort to meet the needs of those in the community who are affected by substance use or abuse problems.

In recent years the DSA has become concerned about the decreasing numbers of professionals entering the field of addictions. To begin addressing this issue, the Division of Substance Abuse with the help of Linda Kaplan, Director of the Central East Addiction Technology Transfer Center (CEATTC), formed a Workforce Development Task Force to begin the process of strategic planning around issues related to workforce development. The goal of the Workforce Development Task Force is to improve the quality of addiction treatment in Kentucky by continuing to build and develop a competent and professional workforce. During this process, the Task Force identified three major areas of need: development of a career path, professional development opportunities, and resource allocation.

As part of this initiative, the CEATTC in conjunction with the DSA and RMC Research, Corporation developed a survey for professionals in the field of substance abuse. 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 substance abuse. The data obtained from this survey will assist the Division of Substance Abuse in identifying goals to help improve the quality of the substance abuse treatment and prevention workforce and in retaining qualified professionals in this field.

The survey developed by the CEATTC in conjunction with the DSA and RMC Research was sent out to the directors and substance abuse treatment staff of the publicly funded 14 regional Mental Health centers and the 13 privately run facilities. The 14 regional mental health centers are the larger private, non-profit agencies responsible for providing substance abuse and mental health services in their regions. They maintain service sites in most counties in their respective regions and offer a variety of services including detoxification, residential, outpatient and transitional living. The privately operated agencies are somewhat smaller and focused in their geographical location.

Methods

Surveys were sent to the directors of the 13 privately run facilities (referred to as “agencies”) and the 14 regional mental health centers (referred to as “regions”). The directors then disseminated the surveys to all of their substance abuse treatment personnel. For the purposes of this study substance abuse treatment personnel were defined as all clinical staff that spent at least 50% of their time with patients who were diagnosed with a primary substance abuse problem.

All survey respondents were anonymous, however each survey contained an identification code that indicated the respondent's treatment agency. Follow-ups were done with each of the facilities to ensure an adequate response rate. Once the surveys were completed, they were sent to RMC Research for analysis. In total, 318 treatment professionals responded to the survey. Exhibit 1 shows the distribution of these responses along with the response rate of each group.

Exhibit 1- Sample Size & Response Rate

	Agency Directors	Agency Staff	Regional Directors	Regional Staff	Total
Surveys Mailed	13	126	14	305	458
Total Responses	10	77	10	221	318
Response Rate	77%	61%	71%	72%	69%

Results

Survey results are presented by topical category. Descriptive results are reported by director and treatment staff responses (referred to as “role”), for both agency and regional settings (referred to as “setting”). Differences within role, across setting, are reported if significant. Chi square analyses were conducted on all cross tabs to identify statistically significant differences between presented groups. In addition, multiple linear regressions are provided to identify significant predictors of salary and turnover.

It should be noted that all significance testing, especially that involving directors, should be interpreted carefully as sample size for both agency directors (n= 10) and regional directors (n= 10) is quite small. Small sample size results in the lack of statistical power making it more difficult to detect significant differences.

Workforce Demographics

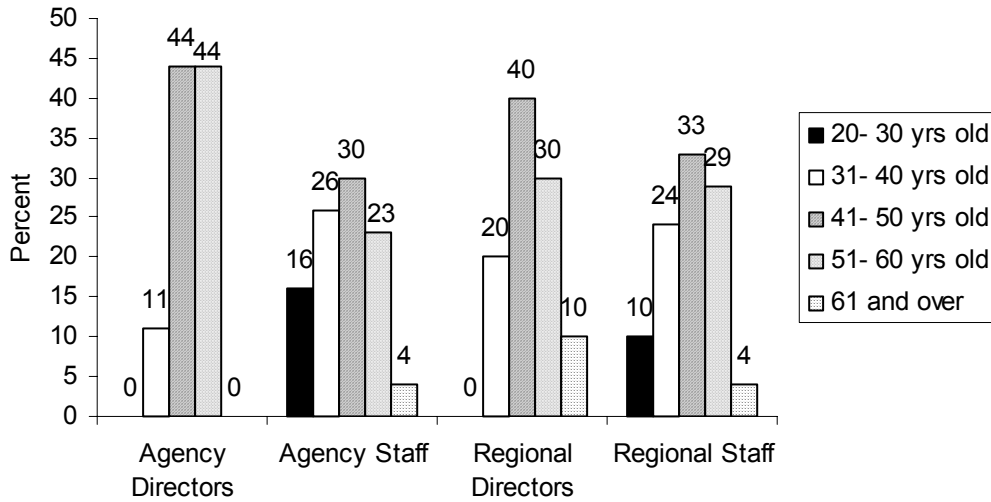
As displayed in Exhibit 2, the majority of directors in both settings are male, while the majority of treatment staff in both settings are female. This difference is statistically significant in the regional setting ($p < .05$). The majority of both directors and treatment staff in both settings are white. A higher proportion of treatment staff in both settings are non-white, although this difference is not statistically significant. No directors and very few treatment staff in either setting report being Hispanic.

Exhibit 2- Gender and Ethnicity

	Agency Directors (n=10)	Agency Staff (n=77)	Regional Directors (n=10)	Regional Staff (n=221)
Gender				
Female	3 (30%)	46 (60%)	3 (30%)	144 (66%)
Male	7 (70%)	31 (40%)	7 (70%)	73 (34%)
Ethnicity				
African American	0 (0%)	9 (12%)	0 (0%)	19 (9%)
Asian	0 (0%)	0 (0%)	0 (0%)	0 (0%)
White	10 (100%)	64 (84%)	10 (100%)	189 (87%)
Multi-Ethnic	0 (0%)	0 (0%)	0 (0%)	4 (2%)
American Indian/AK Native	0 (0%)	1 (1%)	0 (0%)	1 (<1%)
Native HI/ Pacific Islander	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Other	0 (0%)	2 (3%)	0 (0%)	4 (2%)
Hispanic	0 (0%)	1 (1%)	0 (0%)	2 (1%)

In the agency setting, the average age for those surveyed was 51 years old for directors and 43 years old for treatment staff. In the regional setting, the average age for those surveyed was 49 years old for directors and 45 years old for treatment staff. Exhibit 3 below displays age category by role for both settings. Results indicate that in both settings, the largest proportion of directors fall into the 41- 60 year old range. This is also the case for treatment staff in the regional setting. For treatment staff in the agency setting however, the largest proportion fall into the 31- 50 year old range. In both settings, a higher proportion of treatment staff than directors fall into the 20- 30 and 31- 40 year old age categories, however chi square analysis indicates that none of these differences in proportion are statistically significant.

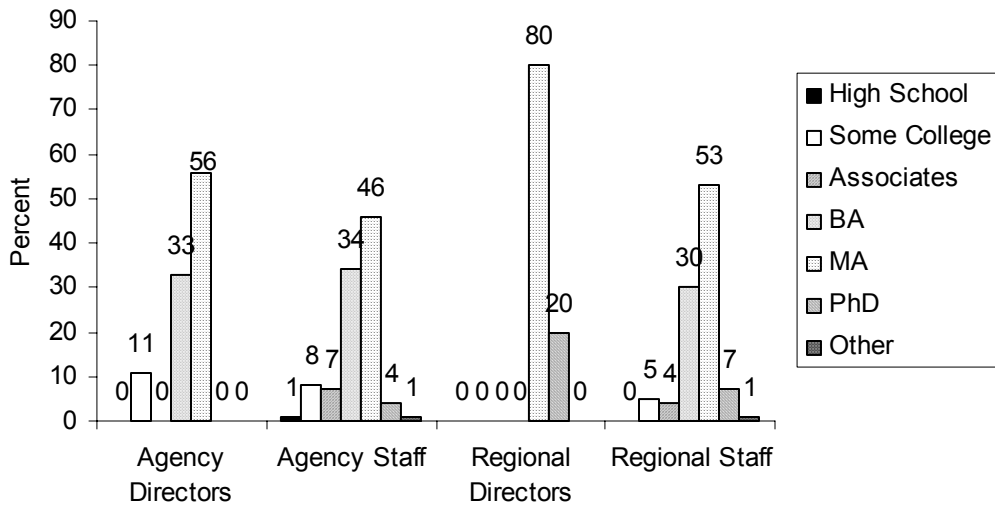
Exhibit 3- Age Category



Academic & Professional Background

Exhibit 4 displays degree status by role for both settings. Over 80% of the workforce in both settings have a Bachelors degree or above. In the regional setting, a higher proportion of directors than treatment staff have a Masters degree or above, although this difference is not statistically significant. In the agency setting, no difference in degree status exists between directors and treatment staff. A higher proportion of regional directors (100%) than agency directors (56%) have a Masters degree or above, a difference that is marginally statistically significant ($p = .08$). No differences in degree status exist between agency and regional treatment staff.

Exhibit 4- Degree Status



The amount of educational background specific to alcohol and other drugs (AOD) was also examined. As Exhibit 5 displays, the majority of the workforce does not hold a degree specific to AOD. In the agency setting, only 10% of directors and 20% of treatment staff report having an AOD specific degree. In the regional setting, no directors and only 20% of treatment staff report having an AOD specific degree. A higher proportion of treatment staff (20%) than directors (0%) in the regional setting report having an AOD specific degree, while a higher proportion of directors (60%) than treatment staff (28%) report having some AOD coursework. This difference is marginally significant. ($p = .057$). A large proportion of the workforce in both settings reports having no AOD specific coursework.

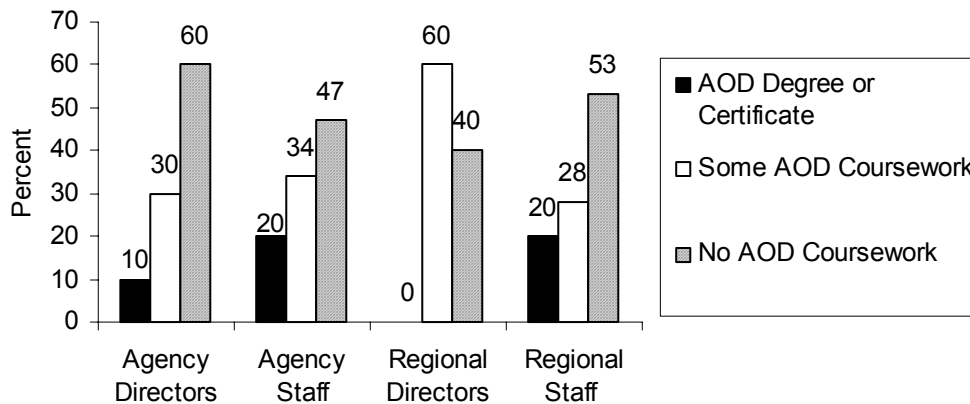


Exhibit 5- AOD Coursework

With a large proportion of the workforce without AOD specific degrees, the role of AOD training becomes extremely important. The majority of directors (90%) and treatment staff (88%) in the agency setting report attending AOD training in the past year. The majority of directors (100%) and treatment staff (89%) in the regional setting also report attending AOD training in the past year. However, differences in the number of training hours exist both between role, and across setting. In the past two years, agency treatment staff report an average of 88 training hours and agency directors report an average of 42 hours. Regional treatment staff report an average of 60 training hours and regional directors report an average of 58 training hours over the same period of time.

Exhibit 6 displays certification status by role for both settings. In the agency setting, 67% of directors and 41% of treatment staff report currently being certified. In the regional setting, 90% of directors and 49% of treatment staff

report being currently certified, a difference that is marginally significant ($p=.086$). Although a larger proportion of directors in the regional setting than directors in the agency setting report current certification, this difference is not statistically significant. A high proportion of treatment staff in both settings report never being certified.

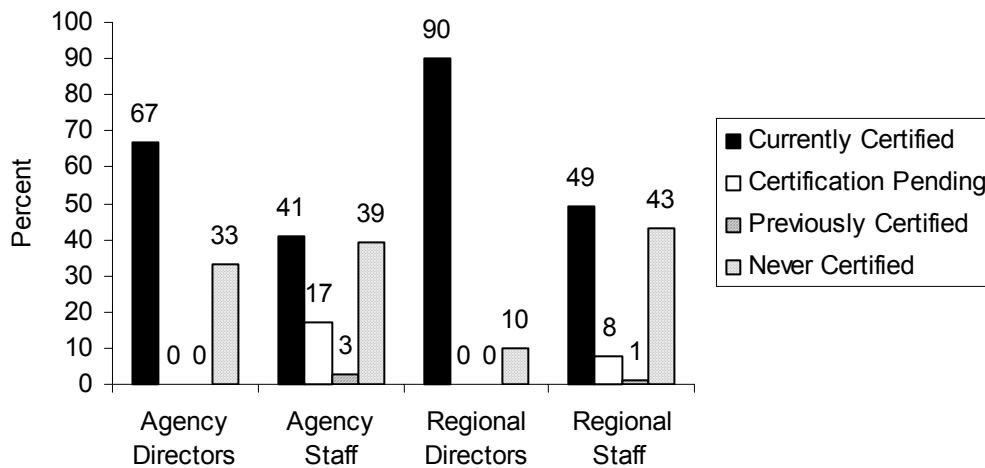


Exhibit 6- Certification Status

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 7 displays means for each of these. In both settings, directors show more experience in the field, as well as in their current role. Interestingly, neither directors nor staff show much variation between the number of years between years in the field and years in their role, indicating that most enter the field in the role they currently hold. In fact, agency treatment staff indicate slightly more time in role than in the field, indicating that some treatment staff served in a similar role prior to entering the substance abuse treatment workforce. The entire workforce reports sizably less

time in current position than years in field, indicating some changing of positions over the years. Finally, directors in the regional setting indicate more experience in the field and the role than do directors in the agency setting. No such differences exist between agency and regional treatment staff.

Exhibit 7- Years Experience

	Agency Directors	Agency Staff	Regional Directors	Regional Staff
	Mean (n= 10)	Mean (n= 77)	Mean (n= 10)	Mean (n= 221)
Years in Field	13	9	20	9
Years in Role	12	10	18	10
Years in Position	6	4	9	5

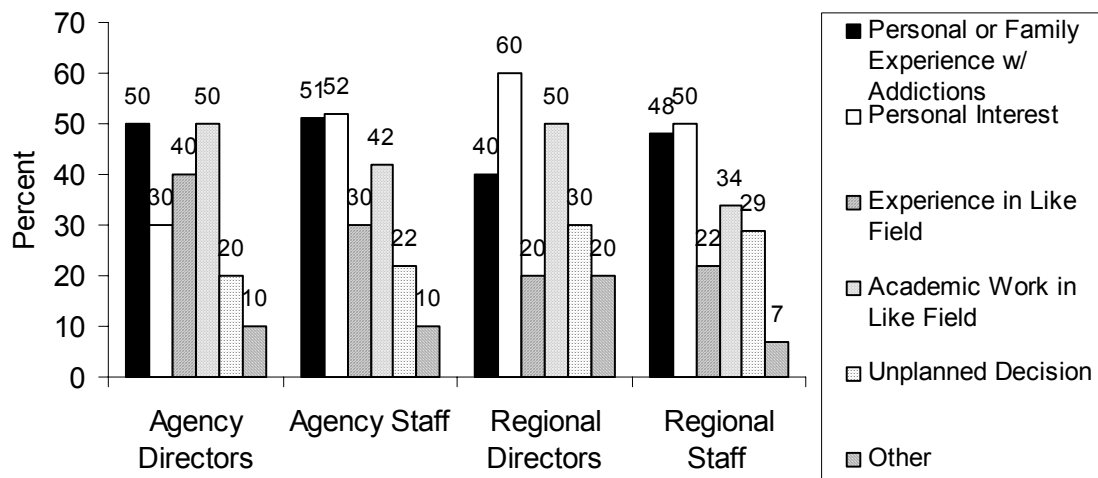
Overall, directors and treatment staff in both settings have a relatively high mean age of entry into the substance abuse treatment field. Exhibit 8 displays mean age of entry into field by role, for both settings. All groups demonstrate a large range, indicating people in all stages of life are entering the field for the first time.

Exhibit 8- Age of Entry into Field

	Agency Directors	Agency Staff	Regional Directors	Regional Staff
	Mean (n= 10)	Mean (n= 77)	Mean (n= 10)	Mean (n= 221)
Mean: Age of Entry	36	34	29	36
Minimum: Age of Entry	29	20	22	20
Maximum: Age of Entry	49	56	37	57

One reason for the high age of entry into the field is that a relatively large proportion of the workforce indicates that their current work is a second career. In the agency setting, 70% of directors and 30% of treatment staff indicate that substance abuse treatment is a second career. In the regional setting, 40% of directors and 39% of treatment staff indicate that substance abuse treatment is a second career.

Exhibit 8 displays reason for entry into the field by role for both settings. Reasons vary slightly by role and by setting, although variations are not statistically significant. For agency directors, the most cited reasons for entry into the field are a personal or family experience with addictions and academic work in a like field. Regional directors most frequently cite personal interest and academic work in a like field. Regional directors most frequently cite personal interest and academic



work in a like field. Treatment staff in both settings most frequently cite personal interest or a personal or family experience with addictions.

Exhibit 8- Reason for Entry into Field by Role

Job Detail

Directors and treatment staff were asked if in the past year they have conducted any of the following client related tasks: screened, diagnosed, treated, or made referrals for clients. Exhibit 9 displays client related tasks by role for each setting. In the agency setting, chi square analysis reveals that a statistically higher proportion of treatment staff than directors have treated clients ($p < .05$) and made referrals ($p < .05$). In the regional setting, a significantly higher proportion of treatment staff than directors have performed all four client related tasks ($p < .05$). Huge differences in the proportion of treatment staff who have screened or diagnosed clients exist based on what setting they work in. A significantly higher proportion of treatment staff in the regional setting than the agency setting have screened and diagnosed clients in the past year ($p < .001$).

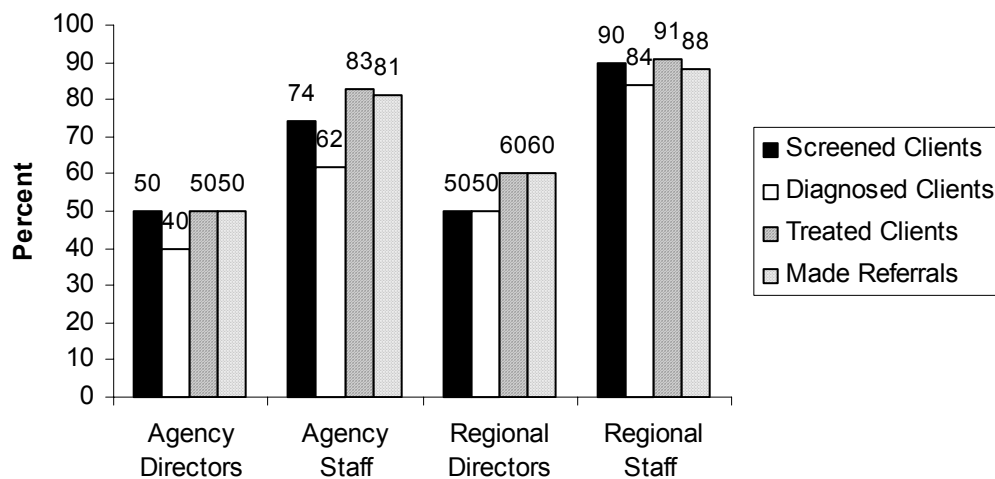


Exhibit 9- Client Related Tasks

Directors and treatment staff were also asked to identify the amount of time spent on various tasks in a typical week. Exhibit 10 displays the average

percentage of time per task by role for each setting. In general, treatment staff show more time spent on client-related tasks than do directors who spend more time on administrative tasks. This is especially true in the regional setting, where directors spend approximately 87% of their time on administrative tasks. Treatment staff in both settings report more time spent on individual counseling than on group counseling despite the cost difference associated between the two. This may partially be due to the difficulty of conducting group sessions in rural areas.

Exhibit 10- Percent Time on Task

		Agency Directors	Agency Staff	Regional Directors	Regional Staff
Task Type	Task	<i>Mean (n= 9)</i>	<i>Mean (n= 70)</i>	<i>Mean (n= 10)</i>	<i>Mean (n=195)</i>
Client-Related	Screening & Assessments	4.4	10.6	1.3	12.2
	Individual Counseling	8.3	19.9	1.2	25.8
	Group Sessions	3.9	16.8	9.9	16.2
	Family Counseling	2.7	2.1	0.1	2.7
	Case Management	2.0	8.7	0.1	7.5
Administrative	Clinical Supervision	10.3	7.5	15.4	4.4
	Paperwork	16.1	16.6	19.3	19.4
	Other Admin. Activities	36.7	11.5	52.7	10.1
	Other Activities	15.6	6.3	0	1.7

Percentages add to 100%. Responses where time did not add to 100% were excluded.

Work Setting

Directors were asked to indicate the number of direct service substance abuse treatment staff work in their respective agencies or regions, from which agency/region size was estimated. Exhibit 11 displays agency/region size by setting, and shows that the predominate agency/region size in both settings is 12 or more direct service staff. Compatibility of results may be checked against the National Survey of Substance Abuse Treatment Services (N-SSATS).

Exhibit 11: Agency/Region Size by Setting

	Setting: Agency	Setting: Region	Total
	N (%)	N (%)	N (%)
2 or fewer direct service staff	0 (0)	0 (0)	0 (0)
3- 5 direct service staff	0 (0)	1 (10)	1 (5)
6- 11 direct service staff	3 (30)	1 (10)	4 (20)
12 or more direct service staff	7 (70)	8 (80)	15 (75)
Total	10 (100)	10 (100)	20 (100)

Directors also identified the primary geographic setting of their agency or region. Exhibit 12 displays the results. As data indicate, agency and region settings seem to serve primarily different geographic areas, with regional directors reporting more rural settings.

Exhibit 12- Geography by Setting

	Setting: Agency	Setting: Region	Total
	N (%)	N (%)	N (%)
Small communities or towns (population < 5000)	0 (0)	5 (56)	5 (26)
Large towns & surrounding community (population 5100- 50,000)	2 (20)	3 (33)	5 (26)
Small city (population 51,000-	5 (50)	0 (0)	5 (26)

500,000)			
Large city (population > 500,000)	3 (30)	1 (11)	4 (21)
Total	10 (100)	9 (100)	19 (100)

Note: 1 regional director did not answer this question.

In terms of the predominate financial setting, 70% of agency directors and 100% of regional directors described their setting as private, non-profit. The remaining agency directors described their agencies as private, for profit (20%) and church supported, non-profit (10%). In addition, directors identified the predominate funding sources for their agencies or regions. Exhibit 13 displays funding source by setting. Differences exist in the percentage of public monies reported by agency and region directors, as well as the percentage that receive State Alcohol and Drug Authority (SADA) funds.

Exhibit 13- Funding Sources by Setting

	Setting: Agency	Setting: Region	Total
% of Public Monies*			
0%	1 (10%)	0 (0%)	1 (5%)
1- 20%	2 (20%)	0 (0%)	2 (10%)
21- 40%	1 (10%)	0 (0%)	1 (5%)
41- 60%	2 (20%)	0 (0%)	2 (10%)
61- 80%	2 (20%)	2 (20%)	4 (20%)
81- 100%	2 (20%)	8 (80%)	10 (50%)
Receive SADA Funding*	3 (30%)	10 (100%)	13 (65%)

Finally, directors were asked what percentage of their treatment staff are (1) female and (2) minority. Exhibit 14 displays the percentage of female and

minority staffing by setting. While females tend to be generally well represented, minority staff do not. In fact, 50% of all directors indicated having no minority treatment staff. No significant differences between settings exist in terms of treatment staff composition.

Exhibit 14- Staff Composition: Female & Minority

	Setting: Agency	Setting: Region	Total
<i>% of staff: female</i>			
Don't know	1 (11%)	0 (0%)	1 (6%)
0%	0 (0%)	0 (0%)	0 (0%)
1- 20%	0 (0%)	0 (0%)	0 (0%)
21- 40%	2 (22%)	5 (55%)	7 (39%)
41- 60%	3 (33%)	2 (22%)	5 (28%)
61- 80%	3 (33%)	2 (22%)	5 (28%)
81- 100%	0 (0%)	0 (0%)	0 (0%)
<i>% of staff: minorities</i>			
Don't know	0 (0%)	1 (11%)	1 (5%)
0%	4 (40%)	6 (66%)	10 (50%)
1- 20%	3 (30%)	1 (1%)	4 (20%)
21- 40%	2 (20%)	1 (1%)	3 (15%)
41- 60%	1 (10%)	0 (0%)	1 (5%)
61- 80%	0 (0%)	0 (0%)	0 (0%)
81- 100%	0 (0%)	0 (0%)	0 (0%)

Compensation

Salary and benefit information was collected from both directors and treatment staff. Exhibit 15 and 16 display salary by role for each settings. The majority of directors in both settings report making between \$40,000- 74,999 a year, while the majority of treatment staff in both settings report making \$15,000- 34,999 a year. Chi square analysis reports that this difference is highly significant (p<.001). No setting differences were detected for director or staff salaries, indicating that both roles make the same money regardless of the setting they work in.

Exhibit 15- Salary: Agency Setting

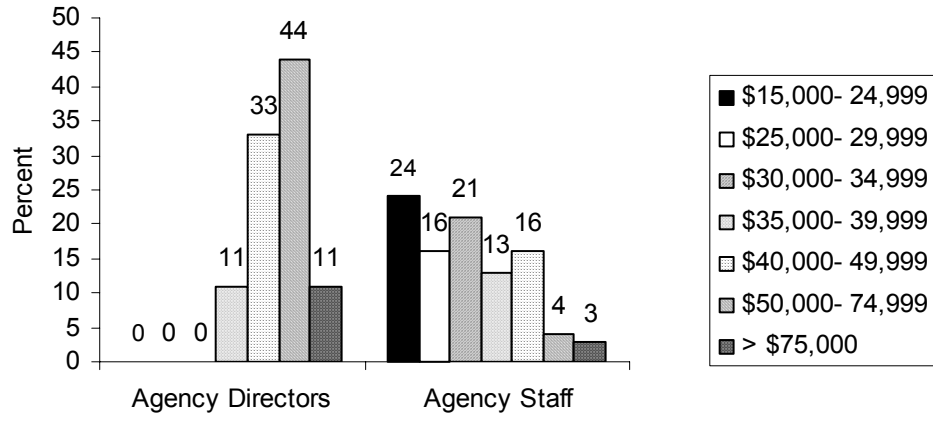
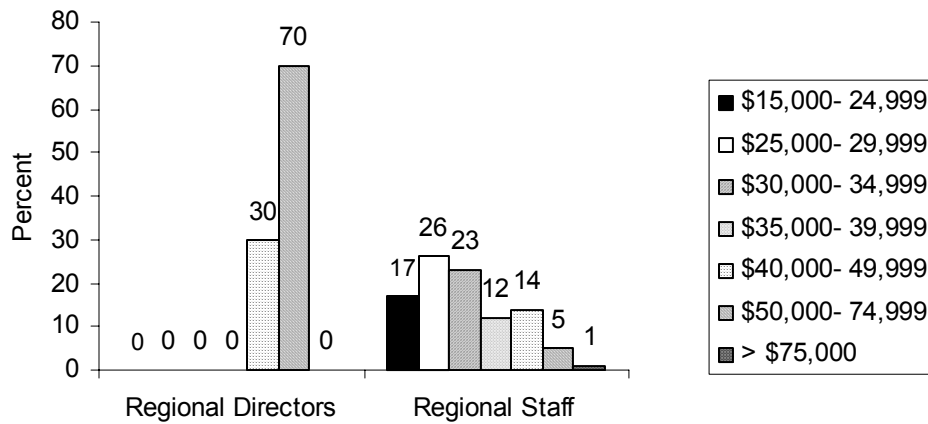


Exhibit 16- Salary: Regional Setting



Multiple linear regression was run to examine potential predictors of salary for the workforce in Kentucky. 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 setting distinction (agency versus regional) were included as predictors. Results, displayed in Exhibit 17, show that workforce salary is quite predictable.

Exhibit 17- Predictors of Salary

Variable	Simple Correlation (r) With Salary	Multiple Linear Regression (R = .795***)	
		Standardized Regression Coefficient	t statistic
Demographics			
Gender	.037		.080
Age	.084		.970
Ethnicity	.028		.000
Professional/Academic Background			
Role (director versus staff)	-.037	-.265	-4.482***
Years in Role	.145*		.320
Years in Field	.135*	.331	3.543***
Years in Position	.061		1.166
Second Career?	.037		1.208
Certification Status	.100		1.503
Degree Status	.093	.427	7.890***
Amount of AOD Education	-.008		1.504
Other Compensation/Benefits			
Health Insurance	-.009		.459
Sick Leave	-.069	-.175	-2.031*
Other Paid Leave	-.026		.710
Retirement	.033		.086
Agency Characteristics			
Setting (Agency or Region)	.066		-.369
SADA Funds at Agency	.225		.433
Proportion of Public Monies	.037		.329
Agency Financial Setting (Private non-profit, etc)	-.909		-1.335
Geographic Setting	.302	.187	3.299***
Agency Size	.174		1.132

Note. Raw regression coefficients displayed only for statistically significant predictors.

*p < .05, **p < .01, ***p < .001

Results indicate that five factors are significant predictors of salary. The strongest predictor overall is degree status ($p < .001$). Higher degree status is significantly related to higher salary. The second strongest predictor is role ($p < .001$). This finding is not surprising as being in the role of an agency/regional director is related to higher salary than being in the role of a clinician. Also, the number of years in the field ($p < .001$) and geographic setting of the agency or region ($p < .001$) are strong predictors of salary. Specifically, having more experience in the field and working in a more urban setting are related to higher salary. Finally, sick leave is also a significant predictor ($p < .05$) of salary. Interestingly, having sick leave as a benefit is related to lower salary.

In addition to salary, benefits were also examined. Exhibit 18 below displays benefits by role for each setting. Results indicate that a higher proportion of directors than treatment staff in both settings have health insurance fully provided. This difference, while meaningful, is not statistically significant. A statistically significant higher proportion of regional treatment staff than agency treatment staff report some form of other paid leave ($p < .05$). A larger proportion of directors in the regional setting report full provision of retirement than directors in the agency setting, although this difference is not statistically significant.

Exhibit 18- Benefits

	Agency Directors (n=10)	Agency Staff (n=77)	Regional Directors (n=10)	Regional Staff (n=221)
Health Insurance				
Fully provided	7 (78%)	43 (57%)	5 (50%)	78 (38%)
Partially provided	2 (22%)	28 (37%)	5 (50%)	114 (56%)
Not provided	0 (0%)	5 (7%)	0 (0%)	12 (6%)
Sick Leave				
Fully provided	7 (88%)	59 (80%)	10 (100%)	180 (87%)
Partially provided	1 (13%)	10 (14%)	0 (0%)	16 (8%)
Not provided	0 (0%)	5 (7%)	0 (0%)	11 (5%)
Other paid leave				

Fully provided	9 (90%)	47 (69%)	10 (100%)	168 (85%)
Partially provided	0 (0%)	12 (18%)	0 (0%)	18 (9%)
Not provided	0 (0%)	9 (13%)	0 (0%)	12 (6%)
Retirement				
Fully provided	2 (22%)	27 (40%)	6 (60%)	77 (39%)
Partially provided	5 (56%)	33 (49%)	4 (40%)	108 (55%)
Not provided	2 (22%)	8 (12%)	0 (0%)	13 (7%)

Staff Turnover, Recruitment, & Retention

Agency and regional 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 have experienced. Turnover was defined in three ways: laid off, terminated, and quit (voluntary turnover). Total turnover was then calculated, and a compared against treatment staff size to determine an agency/regional level turnover rate.

Exhibit 19 displays average staffing numbers for each setting, as well as average agency/region level turnover rates. Based on directors reports of staffing in the past year, agencies experienced an average turnover rate of .18, while regions experienced an average turnover rate of .16. Overall, the average turnover rate for agencies/regions in Kentucky is .17. Interestingly, most turnover across both settings is voluntary (quitting), although agencies have had to terminate more treatment staff than regions have.

Exhibit 19- Staffing & Turnover by Setting

	Setting: Agency (n= 10)	Setting: Region (n= 9)	Total (n= 19)
# Direct Staff	19.00	24	21.4
# Laid Off	0.10	0.00	0.05
# Terminated	1.40	0.11	0.79
# Quit	2.40	3.33	2.84
Turnover Rate	0.18	0.16	0.17

Mean number of staff laid off, terminated, and quit within each setting may represent duplicate counts, and therefore should not be used to calculate turnover rates. Turnover rates as presented represent mean agency/regional level rates.

Directors in both settings 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 in each agency/region. Exhibit 20 displays staff shortage estimates for both settings, and for the state as a whole. Overall, agency and regional settings across the state are short approximately 1 direct service treatment staff. Results do indicate that the staff shortage is approximately twice as large in the regional setting as it is in the agency setting.

Exhibit 20- Staff Shortage by Setting

	Setting: Agency (n= 10)	Setting: Region (n= 9)	Total (n= 19)
# Direct Staff Needed for Full Staff	19.7	25.6	22.5
# Direct Staff Currently Employed	19.0	24.0	21.4
Staff Shortage	0.7	1.6	1.1

Multiple linear regression was conducted to test whether or not predictors of turnover, previously cited as significant in the Pacific Northwest (Alaska, Hawaii, Idaho, Oregon, Washington), are significant for the workforce in Kentucky. Results of the Northwest Frontier Addiction Technology Transfer Center (NFATTC) workforce survey, conducted in 2002 with the same survey instrument, identified that directors with more experience in the field, but who have been in the management role for a shorter period of time, were more likely to experience low staff turnover (Knudsen & Gabriel, 2003). Number of years in the field and number of years in the management role were included in the regression analysis in this study to test their impact in Kentucky. Results, displayed in Exhibit 21, reveal that neither years in field or years in role are significant predictors of turnover for Kentucky. This indicates

that the significant factors related to staff turnover are different for the pacific northwest and Kentucky.

Exhibit 21- Predictors of Salary for Treatment Staff

Variable	Simple Correlation (r) With Director Salary	Multiple Linear Regression (R = .050)	
		Standardized Regression Coefficient	t statistic
Years in Role	.056	.038	.082
Years in Field	.041	.015	.033

*p < .05, **p < .01, ***p < .001

Directors and treatment staff in both settings were asked to report on retention and recruitment efforts. Perceptions of staff development activities are displayed in Exhibit 22 below. Direct supervision and in-service training were the most frequently cited staff development activities reported by all groups. Chi square analysis reveals that a statistically significant higher proportion of regional directors than regional treatment staff report an in-house mentoring program (p<.05). In addition, a significantly higher proportion of agency treatment staff than regional treatment staff report in-house mentoring (p<.01). Both findings reflect that some regional staff may be unaware of available in-house mentoring, perhaps due to the satellite facility composition of the regional setting.

Exhibit 22- Perception of Staff Development Activities

	Agency Directors (n=10)	Agency Staff (n=77)	Regional Directors (n=10)	Regional Staff (n=221)
Staff development: what does agency do?				
No method/ program to develop skills	0 (0%)	2 (3%)	0 (0%)	5 (2%)

In house mentoring program	4 (40%)	28 (36%)	5 (50%)	47 (21%)
In-service training	9 (90%)	64 (83%)	10 (100%)	174 (79%)
Provides direct supervision	10 (100%)	60 (78%)	7 (70%)	181 (82%)
Pays cost of continuing education	0 (0%)	2 (3%)	0 (0%)	6 (3%)

Directors and staff were also asked to report on what they thought their agency/region could do to promote the retention of good substance abuse treatment staff. Exhibit 23 displays ideas for promoting retention by role for each setting. Directors and treatment staff in both settings indicate that salary increases are the number one thing that could be done to promote retention. Two other ideas that were cited by a large number of individuals were promoting career growth and more individual recognition/appreciation. No statistically significant differences exist between directors and treatment staff in either setting, although some ideas show some considerable difference in support. Statistically significant differences do exist between agency and regional treatment staff. Specifically, a significantly higher proportion of agency staff than regional staff report that more/improved on-going training ($p<.01$) and an improved physical work environment ($p<.05$) would improve retention. In addition, a significantly higher proportion of regional staff than agency staff report that lessening or providing assistance with paperwork would promote retention ($p<.01$). No statistically significant differences exist between agency and regional directors, although some differences in proportion exist.

Exhibit 23- Ideas for Promoting Retention

	Agency Directors (n=10)	Agency Staff (n=77)	Regional Directors (n=10)	Regional Staff (n=221)
Promoting retention: what could agency/region do?				
More frequent salary increase	7 (70%)	64 (83%)	8 (80%)	182 (82%)
Less mgmt/supervision	0 (0%)	1 (1%)	0 (0%)	11 (5%)

More individual recognition/appreciation	7 (70%)	32 (42%)	4 (40%)	108 (49%)
Increased opportunities for staff input	2 (20%)	15 (20%)	1 (10%)	42 (19%)
More varied work opportunities	2 (20%)	8 (10%)	1 (10%)	36 (16%)
Better health coverage & other benefits	4 (40%)	34 (44%)	4 (40%)	85 (39%)
Lessen/provide assistance w/ paperwork	2 (20%)	18 (23%)	5 (50%)	89 (40%)
Promote career growth	6 (60%)	35 (46%)	7 (70%)	88 (40%)
More frequent promotions	1 (10%)	19 (25%)	0 (0%)	49 (22%)
More/improved on-going training	4 (40%)	40 (52%)	3 (30%)	79 (36%)
Better mgmt/supervision	3 (30%)	18 (23%)	3 (30%)	43 (20%)
More supportive agency culture	1 (10%)	16 (21%)	3 (30%)	65 (30%)
Improved physical work environment	0 (0%)	15 (20%)	1 (10%)	24 (11%)
Smaller caseloads	1 (10%)	15 (20%)	2 (20%)	55 (25%)
Shorter hrs/flex time/job sharing	4 (40%)	17 (22%)	3 (30%)	56 (25%)

In terms of recruitment, a large percentage of the workforce report difficulties recruiting qualified staff. In the agency setting, 40% of directors and 59% of treatment staff report difficulties. In the regional setting the numbers are higher with 100% of directors and 71% of treatment staff reporting difficulties. The difference in the perception of directors by setting is statistically significant ($p < .01$).

Exhibit 24 below displays difficulties in recruiting by role, for both settings. A statistically significant higher proportion of directors than staff in the regional setting report recruiting difficulties due to an insufficient number of applicants meeting qualifications ($p < .05$) and a lack of interest in the rural location of the agency/region ($p < .01$). Multiple significant differences exist between the perceptions of agency and regional directors. A higher proportion of regional directors report recruiting difficulties due to an insufficient number of applicants meeting qualifications ($p < .01$), a small applicant pool due to geography ($p < .01$), a lack of interest in position due to salary ($p < .01$), and a lack of interest in the rural location of the agency/region ($p < .01$). These differences are largely due to the smaller percentage of agency directors reporting difficulties recruiting qualified staff. A statistically higher proportion of regional staff than

agency staff report difficulties due to the reputation of the agency/region ($p < .01$) and rural location of the agency/region ($p < .001$).

A large proportion of regional directors (80%) reported difficulties due to insufficient number of applicants meeting qualifications. The most common reasons they gave as to why applicants failed to meet minimum qualifications were insufficient or inadequate education or training (70%), and little to no experience in the field (60%).

Exhibit 24- Recruiting Difficulties

	Agency Directors (n=10)	Agency Staff (n=77)	Regional Directors (n=10)	Regional Staff (n=221)
Reasons for recruiting difficulties:				
Insufficient # applicants meeting qualifications	2 (20%)	33 (43%)	8 (80%)	106 (48%)
Insufficient funding for open positions	2 (20%)	22 (29%)	6 (60%)	75 (34%)
Small applicant pool due to geographic area	0 (0%)	12 (16%)	5 (50%)	52 (24%)
Insufficient facilities	0 (0%)	0 (0%)	0 (0%)	3 (1%)
Reputation of agency/region	0 (0%)	2 (3%)	1 (10%)	25 (11%)
Lack of interest (nature of work, stigma)	2 (20%)	12 (16%)	3 (30%)	49 (22%)
Lack of interest (salary)	2 (20%)	35 (46%)	8 (80%)	112 (51%)
Lack of interest in rural location of agency/region	0 (0%)	1 (1%)	6 (60%)	36 (16%)
Lack of opportunity for advancement	0 (0%)	10 (13%)	3 (30%)	42 (19%)

Directors and staff in both settings identified barriers to entering the substance abuse treatment field, and then rated each on a 5 point severity scale indicating if the barriers were major, moderate, or minor. Exhibit 25 displays the most frequently cited barriers by role for each setting. Across the workforce, salary is the most frequently cited barrier, although some barriers are rated higher in severity by some groups. Competition from other fields in terms of

salary is also frequently cited as a barrier. Overall, directors in both settings see more things as barriers than do treatment staff.

Exhibit 25- Barriers

	Agency Directors (n=10)		Agency Staff (n=77)		Regional Directors (n=10)		Regional Staff (n=221)	
	%	rating	%	rating	%	rating	%	rating
Barriers to entering field (5-major ⇒ 1-minor)								
Lack of encouragement	60	3.3	31	3.2	60	3.7	48	3.4
Competition from other fields (compensation)	90	4.2	55	4.2	70	4.6	68	4.1
Paperwork	30	3.0	30	3.4	40	4.0	48	3.5
Large caseloads	40	3.2	34	3.7	40	4.5	47	3.6
Evening work hours	60	4.0	61	3.8	40	4.3	44	3.5
Stigma	40	3.6	39	3.2	60	4.2	52	3.6
Low salary	70	3.9	68	4.2	80	4.5	78	4.3
Cost of education	70	3.6	27	4.0	70	3.6	34	3.6
Amount of education	60	4.1	23	3.7	50	3.6	40	3.6
Negative preconceptions	50	3.8	51	3.6	70	4.3	64	3.7

Related to barriers such as stigma and negative preconceptions, directors and staff were asked to report on the status of addiction counselors compared to other helping professionals. In the agency setting, half of directors (50%) and just over half of treatment staff (57%) responded that addiction counselors have lower status. In the regional setting, the findings are more resounding, with 100% of directors and 69% of treatment staff reporting lower status. This difference between directors by setting is statistically significant ($p < .05$). Reasons for lower status are displayed in Exhibit 26 below. Overall, the most frequently cited reason for lower status is less formal education or training. Interestingly, while the quantity of education was cited frequently, the quality of training was not. No role differences exist in either setting. A statistically significant higher proportion of regional treatment staff than agency treatment staff felt that being more likely to work in a public agency was a reason for lower status ($p < .05$). No

statistically significant differences exist between directors in the two settings, although some relatively large differences in percentages exist.

Exhibit 26- Reasons for Lower Status

	Agency Directors (n=10)	Agency Staff (n=77)	Regional Directors (n=10)	Regional Staff (n=221)
Why lower status?				
Less formal education or training	4 (40%)	22 (29%)	6 (60%)	85 (39%)
Lower quality formal education or training	1 (10%)	14 (18%)	4 (40%)	38 (17%)
More likely to work in public agency	2 (20%)	20 (26%)	2 (20%)	84 (38%)
Stigmatized by association w/ substance abusers	1 (10%)	26 (34%)	4 (40%)	78 (35%)
More often had history of own substance abuse	3 (30%)	24 (31%)	1 (10%)	67 (30%)

Directors and staff were asked to report the methods of recruitment used at their agency or in their region. Results are displayed in Exhibit 27 below. Overall, more traditional techniques such as newspaper advertisement and personal contacts are cited most frequently. Results indicate that a statistically significant higher proportion of agency directors than agency treatment staff report that their agency uses email networking as a recruitment technique ($p < .05$). Despite some interesting differences in responses, no other statistically significant role differences exist. Across setting, directors show similar reports of recruitment techniques used, with one major exception. A statistically significant higher proportion of agency directors than regional directors report use of email networking ($p < .05$). While multiple differences occur between treatment staff across setting, most reflect the differences in recruitment method reported by the directors. The one exception to this is that a higher proportion of treatment staff in the agency setting report personal/ informal contacts than do regional treatment staff ($p < .05$). This again may be due to the satellite composition of the regional setting, where these contacts may not be as visible.

Exhibit 27- Methods of Recruitment

	Agency Directors (n=10)	Agency Staff (n=77)	Regional Directors (n=10)	Regional Staff (n=221)
Resources used to Announce Open Positions				
Agency/Region HR Dept.	4 (40%)	25 (33%)	7 (70%)	147 (67%)
Professional journals	0 (0%)	3 (4%)	0 (0%)	8 (4%)
Newspaper advertisement	9 (90%)	62 (81%)	10 (100%)	171 (77%)
Email networking	4 (40%)	6 (8%)	0 (0%)	31 (14%)
Agency newsletter	0 (0%)	13 (17%)	1 (10%)	54 (24%)
Personal/informal contacts	6 (60%)	47 (61%)	5 (50%)	79 (36%)
Website	2 (20%)	9 (12%)	4 (40%)	41 (19%)
Agency/Regional mailing list	0 (0%)	4 (5%)	0 (0%)	35 (16%)
State HR Dept.	2 (20%)	4 (5%)	0 (0%)	14 (6%)

Multiple Certification & Licensure

Directors and staff were asked to report whether or not they thought Kentucky needs multiple certification at the following levels: high school, Bachelors, and Masters. In addition, respondents were asked if they supported licensure at the Masters level. Results are displayed in Exhibit 28 below. Overall, results indicate support for a tiered system, and/or licensure. There is however, some meaningful variation in the support for licensure. In the regional setting, a large difference in support for licensure at the Masters level exists between directors and treatment staff. A statistically significant higher proportion of regional directors than regional staff support licensure ($p < .01$). Support for licensure also varies significantly between settings. A significantly higher proportion of

directors ($p < .01$) and treatment staff ($p < .05$) in the regional setting support licensure, than do directors and treatment staff in the agency setting.

Exhibit 28- Multiple Certification & Licensure

	Agency Directors (n=10)	Agency Staff (n=77)	Regional Directors (n=10)	Regional Staff (n=221)
Multiple Certification: high school	4 (40%)	31 (40%)	2 (20%)	78 (35%)
Multiple Certification: BA	8 (80%)	48 (62%)	6 (60%)	136 (62%)
Multiple Certification: MA	6 (60%)	41 (53%)	8 (80%)	122 (55%)
Licensure at MA?	4 (40%)	32 (42%)	10 (100%)	124 (56%)
I am currently a CADC.	6 (60%)	18 (23%)	6 (60%)	94 (43%)

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 29, and sources of job dissatisfaction are displayed in Exhibit 30. Overall, directors and staff in both settings cite many more sources of satisfaction than they cite sources of dissatisfaction. Commitment to treatment, role as a change agent, and 1 to 1 interactions with clients are all frequently cited sources of satisfaction. Interestingly, opportunities for personal growth is frequently cited as a source of satisfaction, but opportunities for career growth are not. Some interesting role differences appear in each setting as well. In the agency setting, a significantly higher proportion of directors than staff cite salary and benefits ($p < .01$) and the ability to influence agency decisions ($p < .001$) as sources of job satisfaction. In the regional setting, a significantly higher proportion of directors than staff report the ability to influence agency decisions

($p < .001$) as a source of job satisfaction, while a significantly higher proportion of staff than directors report 1 to 1 interactions with clients ($p < .001$) as a source of job satisfaction.

Chi square analysis also detects significant differences in staff responses by setting. A statistically higher proportion of agency staff than regional staff report career growth opportunities ($p < .05$), commitment to treatment ($p < .01$), and the ability to influence agency decisions ($p < .01$) as sources of satisfaction.

Conversely, a statistically higher proportion of regional staff than agency staff report 1 to 1 interaction with clients ($p < .05$) as a source of satisfaction.

Exhibit 29- Sources of Job Satisfaction

	Agency Directors (n=10)	Agency Staff (n=77)	Regional Directors (n=10)	Regional Staff (n=221)
What gives you job satisfaction?				
Nothing- I am not satisfied	0 (0%)	1 (1%)	0 (0%)	3 (1%)
Salary/ benefits	7 (70%)	17 (22%)	3 (30%)	42 (19%)
Career growth opportunities	2 (20%)	20 (26%)	2 (20%)	31 (14%)
Role as a change agent	8 (80%)	41 (53%)	7 (70%)	118 (53%)
Commitment to treatment	9 (90%)	59 (77%)	8 (80%)	135 (61%)
1 to 1 interaction with clients	5 (50%)	60 (78%)	3 (30%)	192 (87%)
Opportunities for personal learning/growth	6 (60%)	50 (65%)	6 (60%)	128 (58%)
Agency/co-workers	7 (70%)	38 (49%)	5 (50%)	132 (60%)
Ability to influence agency decisions	9 (90%)	25 (33%)	7 (70%)	35 (16%)

Salary is the only source of dissatisfaction cited with any frequency, although no agency directors report salary as dissatisfying. In fact, 60% of agency report that nothing leaves them dissatisfied.

Exhibit 30- Sources of Job Dissatisfaction

	Agency Directors	Agency Staff	Regional Directors	Regional Staff
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	(n=10)	(n=77)	(n=10)	(n=221)
What leaves you dissatisfied?				
Nothing- I am satisfied	6 (60%)	18 (23%)	2 (20%)	27 (12%)
Limited role as a change agent	1 (10%)	2 (3%)	0 (0%)	16 (7%)
Salary/ benefits	0 (0%)	38 (49%)	5 (50%)	143 (65%)
Agency/ co-workers	2 (20%)	11 (14%)	0 (0%)	29 (13%)
Lack of career growth opportunities	0 (0%)	7 (9%)	2 (20%)	22 (10%)
Lack of commitment to treatment	0 (0%)	17 (22%)	0 (0%)	59 (27%)
Lack of 1 to 1 interaction with clients	1 (10%)	5 (7%)	1 (10%)	15 (7%)
Inability to influence agency decisions	0 (0%)	19 (25%)	0 (0%)	79 (36%)
Lack of opportunities for personal learning/ growth	0 (0%)	4 (5%)	0 (0%)	23 (10%)

Treatment Models

To get a sense of what treatment models are actively being used in Kentucky, directors and staff in both settings were asked to identify which treatment models are being used in their agency/region. In addition, for each identified model, respondents were asked indicate the role that the model plays in the agency/region's approach (major, intermediate, or minor). Results, displayed in Exhibit 31, reveal a great deal of consistency between directors and staff, and across setting. On average, agencies/regions in Kentucky implement 6-7 models that play a major role in their overall treatment approach. A great deal of consistency is also apparent in the major models identified. Results indicate that the overall treatment approach being utilized in Kentucky is a combination of 12-step, relapse prevention, integrated substance abuse and mental health, cognitive behavioral, and psycho-educational.

Interestingly, in both settings, the percentage of directors reporting agency use of psycho-educational is higher than treatment staff reports. Also of interest is that only 20% of regional directors, compared to 42% of regional staff, report that integrated substance abuse and mental health is a major model. This may indicate an interpretation issue concerning what it means to provide truly

integrated service versus dealing with mental health issues as a component of substance abuse issues.

Exhibit 31 - Treatment Models

	Agency Directors (n=10)	Agency Staff (n=77)	Regional Directors (n=10)	Regional Staff (n=221)
# of models Playing Major Role	6.8	6.3	5.6	6.2
# of models Playing Intermediate Role	5.2	4.5	5.6	4.9
# of models Playing Minor Role	2.1	2.3	4.1	2.3
# of Models at Agency (total)	11.2	8.4	14.1	12.4
Most frequently cited models: major (% of respondents citing)				
Number 1	12-Step (100%)	12-Step (84%)	12-Step (80%)	12-Step (66%)
Number 2	Relapse Prevention (70%)	Relapse Prevention (68%)	Relapse Prevention (80%)	Relapse Prevention (64%)
Number 3	Integrated Substance Abuse/MH (50%)	Cognitive Behavioral (46%)	Psycho- educational (70%)	Cognitive Behavioral (51%)
Number 4	Psycho- educational (50%)	Integrated Substance Abuse/MH (35%)	Cognitive Behavioral (44%)	Integrated Substance Abuse/MH (42%)
Number 5	Cognitive	Psycho-	Gender	Psycho-

	Behavioral (40%); Gender Specific (40%); Solutions Focused (40%)	educational (35%)	Specific (30%); Intensive Case Mgmt (30%); Solution Focused (30%); Reality Therapy (30%)	educational (36%)
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Proficiencies & Training Interests

Directors and treatment staff self-rated their proficiency and training interest in 28 Addiction Counseling Competencies (ACCs) areas. Proficiency was rated on a seven point scale (0- 6) ranging from no proficiency to complete proficiency, while training interest was rated on five point scale (0- 4) ranging from no interest to maximum interest. Exhibit 32 displays mean ratings for the agency setting, and Exhibit 33 displays mean ratings for the regional setting.

Exhibit 32
Self-Reported Proficiency & Interest in 28 Addiction Counseling Competency Areas: Agency Directors and Treatment Staff

Competency Area	Agency Directors (n= 10)		Agency Staff (n= 77)	
	Proficiency *	Interest*	Proficiency *	Interest*
1. Administrative/Management	5.20	3.00	4.23	2.53
2. Adolescent Treatment	2.67	1.63	3.34	2.21
3. Client Family & Community Education	4.67	2.00	4.29	2.75
4. Clinical Supervision	3.89	2.22	3.64	2.87
5. Co-Occurring Disorders	4.33	3.13	4.35	3.15
6. Detoxification	3.44	1.75	3.28	2.53
7. Documentation	4.89	2.11	5.08	2.19
8. Drug Pharmacology/Pharmacotherapy	3.67	2.63	3.60	3.10
9. Gender Specific Treatment	4.11	2.25	4.25	2.92

10. Group Counseling	4.78	2.44	4.86	3.15
11. Individual Counseling	4.33	1.63	5.05	3.15
12. Interpersonal Communication	5.44	2.38	5.20	2.97
13. Intervention Skills	5.25	2.38	4.75	3.11
14. Lesbian/Gay/Bisexual/Transsexual Specific Tx	3.33	1.75	3.51	2.56
15. Marriage & Family Therapy	2.78	1.75	3.45	2.60
16. Offender Treatment	3.33	2.00	3.77	2.53
17. Patient Placement Criteria	3.63	1.63	3.88	2.40
18. Professional/ Ethical Responsibilities	5.44	3.00	5.24	2.82
19. Racial/Ethnic Specific Tx	3.44	2.38	4.19	2.80
20. Referral Skills	4.44	1.63	4.80	2.41
21. Relationship Between Substance Abuse & Medical Problems	4.33	2.50	4.43	3.14
22. Screening/Assessment	5.11	2.33	4.95	2.74
23. Service Coordination & Case Mgmt	4.67	2.50	4.68	2.60
24. Signs & Symptoms	5.11	2.50	4.84	2.93
25. Staff Recruitment	5.00	2.50	3.36	2.36
26. Staff Retention	5.33	2.75	3.61	2.36
27. Treatment Engagement	4.67	3.00	4.77	2.89
28. Treatment Planning	5.22	2.50	4.97	2.82
Composite Proficiency	4.40	2.26	4.32	2.70

* Proficiency (0 none- 6 completely); Interest (0 no interest- 4 max. interest)

Exhibit 33
Self-Reported Proficiency & Interest in 28 Addiction Counseling Competency
Areas: Regional Directors and Treatment Staff

Competency Area	Regional Directors (n= 10)		Regional Staff (n= 221)	
	Proficiency *	Interest*	Proficiency *	Interest*
1. Administrative/Management	4.90	3.00	3.75	2.08
2. Adolescent Treatment	3.20	2.25	3.15	2.24
3. Client Family & Community Education	4.50	2.22	4.22	2.71
4. Clinical Supervision	5.30	3.00	3.18	2.36
5. Co-Occurring Disorders	5.00	3.11	4.59	3.33
6. Detoxification	3.80	2.11	3.50	2.59
7. Documentation	5.10	1.56	5.02	2.37
8. Drug Pharmacology/Pharmacotherapy	3.00	2.56	3.52	3.04
9. Gender Specific Treatment	4.90	2.67	4.30	2.97
10. Group Counseling	5.30	2.56	4.99	3.14
11. Individual Counseling	5.40	2.78	5.17	3.17
12. Interpersonal Communication	5.10	2.22	5.16	2.85

13. Intervention Skills	4.80	2.33	4.82	2.98
14. Lesbian/Gay/Bisexual/Transsexual Specific Tx	3.30	2.00	3.71	2.59
15. Marriage & Family Therapy	4.20	2.56	3.46	2.79
16. Offender Treatment	4.50	2.67	3.35	2.53
17. Patient Placement Criteria	5.00	2.00	4.33	2.33
18. Professional/ Ethical Responsibilities	5.70	2.44	5.42	2.67
19. Racial/Ethnic Specific Tx	4.50	2.22	4.16	2.82
20. Referral Skills	5.60	2.11	5.03	2.56
21. Relationship Between Substance Abuse & Medical Problems	4.70	2.89	4.56	3.18
22. Screening/Assessment	5.50	1.89	5.23	2.83
23. Service Coordination & Case Mgmt	5.10	1.38	4.70	2.46
24. Signs & Symptoms	5.30	1.75	5.11	2.83
25. Staff Recruitment	4.40	3.44	3.05	1.95
26. Staff Retention	4.70	3.44	3.15	2.09
27. Treatment Engagement	5.10	2.78	4.90	3.04
28. Treatment Planning	5.30	2.11	5.02	3.01
Composite Proficiency	4.76	2.33	4.33	2.68

* *Proficiency* (0 none- 6 completely); *Interest* (0 no interest- 4 max. interest)

In order to identify training priorities for Kentucky, it is important to consider both the relative proficiency and interest in each competency area. Exhibits 34- 37 categorize each competency area for directors and treatment staff in each setting 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. 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 34
Training Priorities for Agency Directors

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

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.

Using this framework, co-occurring disorders, drug pharmacology/pharmacotherapy, racial/ethnic specific treatment, and the relationship between substance abuse and medical problems appear as the highest training priorities for agency directors.

Exhibit 35
Training Priorities for Agency Treatment Staff

Priority Level 1: Higher Interest, Lower Proficiency
• Clinical Supervision
• Co-Occurring Disorders
• Drug Pharmacology/Pharmacotherapy
• Gender Specific Treatment
• Racial/Ethnic Specific Treatment
• Relationship Between Substance Abuse & Medical Problems
Priority Level 2: Lower Interest, Lower Proficiency
• Administrative/Management
• Adolescent Treatment
• Client Family & Community Education
• Detoxification
• Lesbian/Gay/Bisexual/Transsexual Specific Treatment
• Marriage & Family Therapy
• Offender Treatment
• Patient Placement Criteria
• Staff Recruitment
• Staff Retention
Priority Level 3: Higher Interest, Higher Proficiency
• Group Counseling
• Individual Counseling
• Interpersonal Communication
• Intervention Skills
• Professional/ Ethical Responsibilities
• Signs & Symptoms
• Treatment Engagement
• Treatment Planning
• Gender Specific Treatment
Priority Level 4: Lower Interest, Higher Proficiency
• Documentation
• Referral Skills
• Screening/Assessment
• 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 (4.50) & interest (2.79) were used as cut-off scores for higher/ lower distinctions.

Training priorities identified for agency treatment staff show a great deal of overlap with those identified for agency directors. Just as with agency directors, co-occurring disorders, drug pharmacology/pharmacotherapy, racial/ethnic specific treatment, and the relationship between substance abuse and medical problems are all identified as training priorities for agency staff. In addition, clinical supervision and gender specific treatment are also high priority areas for agency treatment staff.

Exhibit 36
Training Priorities for Regional Directors

Priority Level 1: Higher Interest, Lower Proficiency
• Adolescent Treatment
• Client Family & Community Education
• Drug Pharmacology/Pharmacotherapy
• Intervention Skills
• Marriage & Family Therapy
• Offender Treatment
• Racial/Ethnic Specific Treatment
• Relationship Between Substance Abuse & Medical Problems
• Staff Recruitment
• Staff Retention
Priority Level 2: Lower Interest, Lower Proficiency
• Detoxification
• Lesbian/Gay/Bisexual/Transsexual Specific Treatment
Priority Level 3: Higher Interest, Higher Proficiency
• Administrative/Management
• Clinical Supervision
• Co-Occurring Disorders
• Gender Specific Treatment
• Group Counseling
• Individual Counseling
• Interpersonal Communication
• Professional/ Ethical Responsibilities
• Treatment Engagement
Priority Level 4: Lower Interest, Higher Proficiency
• Documentation
• Patient Placement Criteria
• 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 (4.84) & interest (2.18) were used as cut-off scores for higher/ lower distinctions.

Multiple high priority training areas are present for regional directors. Highest priority areas as identified are: adolescent treatment, client family and community education, drug pharmacology/pharmacotherapy, intervention skills, marriage and family therapy, offender treatment, racial/ethnic specific treatment, relationship between substance abuse and medical problems, staff recruitment, and staff retention.

Exhibit 37
Training Priorities for Regional Treatment Staff

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

High priority training areas for regional staff as identified by this framework are client family and community education, drug pharmacology/pharmacotherapy, gender specific treatment, marriage and family counseling, and racial/ethnic specific treatment.

Overall, agency and regional settings show slightly different training priorities. For example, co-occurring disorders was identified as a high training priority for both agency directors and staff, but not for either regional directors or staff. Also of interest is that based on this framework, staff recruitment and staff retention only appear as a high training priority for regional directors but not for agency directors. This may need to be re-evaluated in light of the turnover problem in both settings.

Interestingly, many of the same training priorities that appear in Kentucky, also appear in the Pacific Northwest region of the country. Co-occurring disorders, drug pharmacology/pharmacotherapy, and racial/ethnic specific treatment all appeared as high training priorities in the Pacific Northwest (Knudsen & Gabriel, 2003).

References

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