
Maryland Workforce Survey 2005

*Results of a Statewide Needs Assessment of
Behavioral Health Professionals*

Prepared for

Central East Addiction Technology Transfer Center

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Executive Summary

A growing body of quantitative data concerning the substance abuse treatment workforce is being collected throughout the country. In 2005, RMC Research Corporation, in collaboration with the Central East Addiction Technology Transfer Center and the Mid-Atlantic Addiction Technology Transfer Center, conducted a workforce study for the state of Maryland. A 50% stratified random sample of agencies in the state was selected, resulting in a final sample of 138 agencies. The sampling list was then divided by whether or not the agency received state funding, a key variable of interest. In the end, surveys were sent to the agency directors of 70 state-funded alcohol and drug agencies and 68 alcohol and drug agencies not funded by the state. Follow-up efforts resulted in a response rate of 42%, yielding responses from 31 agency directors and 155 clinical staff from funded agencies, and 27 agency directors and 106 clinical staff from nonfunded agencies.

Survey results were primarily examined by “setting” (funded versus nonfunded agencies) and by “role” (agency director versus clinical staff responses). When informative, data for directors and clinical staff were examined by geographic area (urban, suburban, or rural). Highlights of the report are provided below.

Demographics and Professional Background

- Results indicate that in funded agencies a statistically significant larger proportion of clinical staff (38%) than directors (23%) are African American. Results also indicate that a statistically significant larger proportion of directors and staff in urban agencies are African American.
- In funded agencies, the average age for those surveyed was 50 years old for directors and 46 years old for clinical staff. In nonfunded agencies, the average age for those surveyed was 49 years old for directors and 47 years old for clinical staff. Across the workforce, average age of entry into the field varied from early to late thirties.

- In funded agencies, 39% of agency directors and 41% of clinical staff indicated that substance abuse treatment was a second career. In nonfunded agencies, 59% of agency directors and 36% of clinical staff indicated that substance abuse treatment was a second career. A personal or family experience with addictions and a personal interest in the field were the most frequently cited reasons for entry across the workforce.
- In funded agencies, 32% of both directors and clinical staff reported being in recovery. In nonfunded agencies, 22% of directors and 36% of clinical staff reported being in recovery. Interestingly, across the workforce, a statistically significant higher percentage of males (45%) report being in recovery than females (24%).
- Overall, the degree status of the workforce in Maryland is quite comparable to that of other states. In funded agencies, 84% of agency directors and 68% of clinical staff have a Bachelor's degree or above. In nonfunded agencies, 78% of agency directors and 64% of clinical staff have a Bachelor's degree or above. Analysis indicates that in both funded and nonfunded agencies a statistically significant larger proportion of nonrecovering staff have a Bachelor's degree or above (84%) than do recovering staff (49%).
- In funded agencies, 61% of agency directors and 54% of clinical staff reported currently being certified, while 32% of agency directors and 20% of clinical staff reported currently being licensed. In nonfunded agencies, 63% of agency directors and 45% of clinical staff reported currently being certified, while 33% of agency directors and 28% of clinical staff reported currently being licensed.
- In funded agencies, agency directors reported an average of 18 years experience in the field, while clinical staff reported an average of 9 years experience. In nonfunded agencies, agency directors reported an average of 14 years experience in the field, while clinical staff reported an average of 11 years experience. Interestingly, a statistically significant larger proportion of clinical staff

at urban agencies (61%) reported having 3 or fewer years in their current position than do clinical staff at rural (43%) and suburban (42%) agencies.

Turnover and Staffing

- In funded agencies, 60% of directors reported their agency was understaffed, with 40% reporting that if all budgeted positions were filled they would still be understaffed. On average, directors of funded agencies reported a staff vacancy of 1.03 FTE. In nonfunded agencies, 36% of directors reported their agency was understaffed, with 18% reporting that if all budgeted positions were filled they would still be understaffed. On average, directors of nonfunded agencies reported a staff vacancy of 0.55 FTE.
- Based on directors' reports of staffing in the past year, the average turnover rate for clinical staff in funded agencies was 16%, while the average turnover rate for clinical staff in nonfunded agencies was 10%. Statewide, the average turnover rate was 13%. Reported turnover appears to be highest in urban agencies, especially in funded settings. The majority turnover across all settings was voluntary (quitting).
- Across the workforce, the most frequently cited reasons why staff have voluntarily left their agency were better work opportunities elsewhere within the field and inadequate salaries. Clinical staff in both settings also frequently cited the lack of career advancement and burnout as important factors. On average, directors and staff have worked for 2 to 3 different agencies, voluntarily changing agencies 1 to 2 times.
- In funded agencies, 71% of directors and 58% of clinical staff reported difficulties recruiting qualified staff. In nonfunded agencies, 59% of directors and 51% of clinical staff reported similar difficulties.

Salary and Compensation

- Across the entire workforce, 78% of directors reported making over \$45,000 a year, while 74% of clinical staff reported making under \$45,000 a year. Analysis indicates that these differences in director and staff salaries are statistically significant. Overall, 66% of respondents indicated being the primary wage earner for their family.
- Results indicate that four factors are statistically significant predictors of salary in Maryland: role (director vs. clinical staff), years of experience, degree status, and geographic setting of agency (urban, suburban, rural). Being in the role of agency director, having more years experience, having higher degree status, and working in an urban setting are all related to higher salary in Maryland.
- A statistically significant larger proportion of directors and staff in funded agencies than nonfunded agencies report receiving health insurance, sick leave, vacation, and retirement benefits. In addition, a higher proportion of clinical staff at funded agencies report maternity leave and tuition reimbursement benefits than do clinical staff at nonfunded agencies.

Job Detail

- In funded agencies, clinical staff reported spending approximately 61% of their time on client-related tasks, while agency directors reported spending 86% of their time on administrative tasks. In nonfunded agencies, clinical staff reported spending approximately 63% of their time on client-related tasks, while agency directors reported spending 68% of their time on administrative tasks. Analysis indicates that for directors, the mean amount of time spent on administrative and client-related tasks varies significantly by size of agency, as directors at smaller agencies spend significantly more time on client-related tasks than do directors at larger agencies.
- The majority of the workforce rates their job satisfaction as above average. For agency directors in both settings, the most frequently cited sources of satisfaction

were their role of a change agent and their commitment to treatment. For clinical staff in both settings, one-on-one interactions with clients was the most frequently cited source of satisfaction. Interestingly, job-related stress is also rated quite high, with 62% of directors and 51% of clinical staff rating job stress as above average.

- According to directors and clinical staff across the state, the most frequently cited treatment models playing a major role in their agency's approach are relapse prevention, 12-step, cognitive behavioral, and biopsychosocial.
- Drug pharmacology/pharmacotherapy was rated as a top training priority for directors and staff in both settings. Other high priority areas included gender-specific treatment, co-occurring disorders, and clinical supervision.
- Reported attitudes regarding technology reflect that the majority of the workforce feels that technology contributes to their effectiveness at their job. Over 89% of the workforce in Maryland reported feeling comfortable using computers and web-based technologies to obtain information about substance use. However, a statistically significant larger proportion of staff in funded agencies than staff in nonfunded agencies reported using technology to conduct AOD research for client information/clinical issues and for web-based professional development.

Introduction

The Maryland Alcohol and Drug Abuse Administration (ADAA) is the single state agency responsible for the provision, coordination, and regulation of the statewide network of substance abuse prevention, intervention, and treatment services. ADAA 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. ADAA provides treatment, intervention, and prevention services across several different levels of care including early intervention, outpatient services, partial hospitalization, halfway houses, long term residential care, therapeutic community, medically monitored services, and medication-assisted services. ADAA also licenses and monitors all substance abuse agencies throughout the state. Most of the training and technical assistance for professionals and the public is carried out by the Office of Education and Training for Addiction Services (OETAS) within ADAA. OETAS sponsors courses, workshops, seminars, and conferences throughout the year in both commuter and residential settings for addiction professionals.

In recent years, ADAA has become concerned about the decreasing number of professionals entering the field of substance abuse treatment as well as other workforce related issues. To begin addressing these issues, OETAS, under the guidance of the ADAA Director, began the process of strategic planning around issues related to workforce development. The goal of this initiative is to improve the quality of addiction treatment in the state of Maryland by continuing to build and develop a competent and professional workforce.

As part of this initiative, the Central East Addiction Technology Transfer Center (Central East) and the Mid-Atlantic Addiction Technology Transfer Center (Mid-Atlantic) in conjunction with Maryland's ADAA and RMC Research Corporation (RMC) developed and implemented a survey for addiction treatment professionals in the state of Maryland. The Central East and Mid-Atlantic jointly share responsibility for the provision of services in Maryland. The Central East focuses on continuing education training for

treatment professionals and the Mid-Atlantic focuses on higher education coursework for treatment professionals.

This survey was designed to obtain much needed information from agency directors and clinical staff on matters related to retention, recruitment, and the training needs of professionals in the field. The main purpose of the survey effort was to assist the Maryland ADAA in identifying goals (a) to help improve the quality of the substance abuse treatment workforce and (b) to retain qualified professionals in this field.

Instrumentation

The survey used in the Maryland Substance Abuse Treatment Workforce Development Survey 2005 was a modified version of a survey developed for the Addiction Technology Transfer Center (ATTC) network in the summer of 2004. The ATTC network is composed of 14 regional centers and a national office funded by the Substance Abuse and Mental Health Services Administration, and is dedicated to identifying and advancing opportunities for improving addiction treatment throughout the country.

The survey asked questions in several key content areas including demographics, academics and professional background, agency setting, staff size and turnover, recruitment and retention, job satisfaction, technology, and proficiency and training interests. In the spring of 2005, representatives from Central East, Mid-Atlantic, OETAS, RMC, and the Director of ADAA began discussing the survey process. During this time, modifications and additions were made to the survey instrument based on the recommendations of the Central East, Mid-Atlantic, OETAS staff, and other key stakeholders, in order to meet the specific needs and interests of Maryland's substance abuse workforce.

After discussions with OETAS staff and other key stakeholders, it was decided for the purposes of this study that the most appropriate targets of this survey were substance abuse treatment agency directors and substance abuse treatment personnel, which were defined as clinical and/or medical staff that spent at least 50% of their time with patients who were diagnosed with a primary substance abuse problem. Two versions of the survey instrument were developed: a version for clinical staff and one for agency directors. The director survey was identical to the clinical staff survey, except for a set of questions related to administrative issues more appropriately answered by agency directors.

Sampling

The sampling unit for this project was substance abuse treatment agency. After discussions with OETAS and RMC, it was determined that the agency sampling percentage would be 50%. The sample would include half of the 275 agencies in the state of Maryland ($n = 138$). With the sampling percentage in mind, a stratified random sample was selected based on level of care provided to assure a representative sample. The sampling list was then split by funded and nonfunded status (the funded versus nonfunded distinction refers to whether the agency is funded by the state of Maryland) to assure equal representation of each (key variable of interest). Based on the preliminary information gathered by OETAS, it was determined that surveys would be sent to seven staff members at each agency in the sample along with the directors' survey.

Survey Administration

An agency director survey, along with seven staff surveys, was sent to all 138 of the substance abuse treatment agencies in the sample. A cover letter from the Director of the Maryland ADAA explaining the survey process and pre-paid envelopes for return of the surveys were sent to each agency director. An instruction sheet with guidance on the criteria for including a staff member in the survey was also included in this packet. In cases where agencies operated multiple program sites, agency directors were asked to distribute the staff surveys across their program sites. Each survey included a unique identification code which maintained the confidentiality for all respondents. Once completed, surveys were placed in the pre-paid envelopes and returned to the Central East, where they were then logged into a tracking database.

Follow-up Strategy and Response Rate

In order to assure an appropriate response rate, a follow-up strategy was implemented. This strategy consisted of mailing follow-up letters and subsequent phone calls to agency directors by ATTC staff reminding them to return the surveys to the Central East. In order to further encourage the completion and return of surveys for this project,

an incentive plan was used. In the information sent to all agency directors, they were informed that each agency that completed and turned in all of the surveys sent to them would be included in a drawing to potentially win a 20" TV/VCR/DVD combo for their agency. The survey response rate was tracked through the use of database software at the Central East. Once the data collection period was completed, the surveys were sent to RMC Research for analysis.

Resulting response rates for both agency directors and clinical staff are displayed below in Exhibits 1 and 2. In total, directors from 58 agencies responded to the survey, yielding a 42% response rate. A total of 261 staff surveys were returned, yielding a response rate of 34%.

**Exhibit 1
Response Rate for Agency Directors**

Type of Agency	Number of Agencies	Included in Sample	Returned Surveys	Response Rate
Funded	115	70	31	44%
Nonfunded	156	68	27	40%
Unknown ^a	4	0	0	0%
Total	275	138	58	42%

^aExcluded from final sample.

**Exhibit 2
Response Rate for Clinical Staff**

Type of Agency	Number of Clinical Staff Surveys Sent^a	Returned Surveys
Funded	490	155
Nonfunded	476	106
Total	966	261

^a7 staff surveys were sent to each agency.

Results

Survey results are presented by topical category. Descriptive results are reported by staff “role” (agency director versus clinical staff responses). Agency director and clinical staff responses are also examined by “setting” (funded versus nonfunded agencies). The funded versus nonfunded distinction refers to whether the agency is funded by the state of Maryland. When informative, data for directors and clinical staff are reported by geographic area (rural, suburban, or urban). Further, text boxes are provided throughout the report to illustrate areas where Baltimore City agencies, directors, and clinicians vary significantly from the rest of the state.

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 across geography are reported if significant. Analysis of variance was also utilized to examine differences between groups when appropriate. 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.

Work Setting

Based on provision of zip code information, the primary geographic area of agencies was determined. Zip codes were grouped in three categories: rural, suburban, and urban. Exhibit 3 displays the results. Data indicate that half of state funded agencies are located in an urban setting. The majority of nonfunded agencies are located in urban and suburban settings. It should be noted that 45% of funded directors and 26% of

nonfunded directors report that their agency has multiple locations. In both settings, the number of locations ranges from 1 to 7.

Exhibit 3 Geographic Area of Agencies

Geographic Area Served	Funded agencies ^a	Nonfunded agencies ^b
Rural	7 (23%)	2 (8%)
Suburban	8 (27%)	12 (46%)
Urban	15 (50%)	12 (46%)

^an = 30. ^bn = 27.

Baltimore City Fast Fact

Sixty-seven percent of all urban treatment agencies in Maryland reside in Baltimore City.

Directors in both settings were asked to indicate the number of direct service clinical staff who worked in their respective agencies; agency size was estimated using this information. Results, displayed in Exhibit 4, show that agency size in Maryland was quite variable based on setting, with a larger proportion of smaller agencies operating in the nonfunded setting. Across both settings, reported agency size varied from 1 direct service clinical staff member to 80 direct service clinical staff. Size of agency does not show any direct relationship to the geographic area (rural, suburban, urban) in which the agency is located. Compatibility of results may be checked against the National Survey of Substance Abuse Treatment Services.

Exhibit 4 Agency/Regional Staff Size

Number of Direct Service Staff	Funded agencies ^a	Nonfunded agencies ^b
2 or fewer	1 (3%)	5 (23%)
3–5	7 (23%)	4 (18%)
6–11	8 (27%)	6 (27%)
12 or more	14 (47%)	7 (32%)

^an = 30. ^bn = 22.

Exhibit 5 displays financial setting and use of public moneys of agencies. The majority of funded agencies are best characterized as nonprofit, composed of both private (54%) and public (18%) agencies. The majority of nonfunded agencies are best characterized as private, composed of both for-profit (44%) and nonprofit (40%) agencies. A statistically significant larger proportion of for-profit agencies exist in the nonfunded setting ($p < .001$). Not surprisingly, a statistically significant larger proportion ($p < .001$) of funded agencies (81%) receive State Alcohol and Drug Authority (SADA) funding from ADAA than do nonfunded agencies (15%).

Exhibit 5
Financial Setting and Use of Public Monies by Agencies

Predominate Financial Setting	Funded agencies^a	Nonfunded agencies^b
Private, for profit	2 (7%)	11 (44%)
Private, nonprofit	15 (54%)	10 (40%)
Public, nonprofit	5 (18%)	2 (8%)
Government—local, county, community	2 (7%)	1 (4%)
Government—state	4 (14%)	1 (4%)

^a $n = 31$. ^b $n = 27$.

In addition to describing their financial setting, agency directors provided their annual operating budgets. Exhibit 6 displays this information. Overall, the average budgets of agencies in funded and nonfunded agencies are quite comparable. Agencies in both settings show a considerable range of operating budgets, with annual budgets as a low as \$6,000 and as high as \$4,500,000 being reported. It should be noted however that the standard deviation is much higher in the nonfunded setting reflecting more variation in budgets from agency to agency than in the funded setting.

Exhibit 6 Annual Operating Budgets

Annual Operating Budgets	Funded agencies ^a	Nonfunded agencies ^b
Average budget	\$1,135,429	\$1,249,913
Standard deviation	\$838,092	\$1,638,035
Range	\$3,365,767	\$4,494,000

^an = 31. ^bn = 27

Interestingly, directors of funded agencies report serving a higher average number of clients each year than do directors of nonfunded agencies. Directors of funded agencies report an average of 637 clients served per year, with numbers ranging from 40 to 2,500 clients. Directors of nonfunded agencies report an average of 372 clients served per year, with numbers ranging from 6 to 2,000 clients. The number of clients served per year may vary significantly based on the level of care provided. Exhibit 7 displays the percentage of agencies providing various levels of care. The majority of agencies in

Exhibit 7 Level of Care Provided

Agencies Providing Level of Care:	Funded agencies ^a	Nonfunded agencies ^b
Early Intervention	8 (26%)	4 (15%)
Outpatient Treatment	20 (65%)	16 (59%)
Outpatient Detox	3 (10%)	3 (11%)
Intensive Outpatient	9 (29%)	5 (19%)
Partial Hospitalization	0 (0%)	2 (7%)
Intensive Outpatient—Detox	2 (7%)	2 (7%)
Halfway House	6 (19%)	3 (11%)
Long Term Residential	3 (10%)	3 (11%)
Therapeutic Community	2 (7%)	0 (0%)
Medically Monitored Inpatient Intensive Care Facility (ICF)	5 (16%)	2 (7%)
Medically Monitored Inpatient (ICF)—Detox	4 (13%)	5 (19%)
Detoxification Services	3 (10%)	2 (7%)
Medication Assisted Treatment	4 (13%)	7 (26%)
Medication Assisted Treatment—Detox	2 (7%)	1 (4%)

^an = 31. ^bn = 27.

both funded and nonfunded settings report providing outpatient treatment, with other levels of care being provided at a smaller proportion of agencies.

Directors also reported what special populations their work setting serves. Results indicate that the majority of agencies in both funded and nonfunded agencies treat many of the special populations listed in Exhibit 8. It is unclear if these populations are treated with specialized treatment models, or receive care that is different from other populations.

Exhibit 8 Special Populations Served

Agencies Providing Level of Care:	Funded agencies ^a	Nonfunded agencies ^b
Adolescents	11 (65%)	5 (82%)
Persons with COD	26 (84%)	20 (74%)
HIV/AIDS	25 (81%)	14 (52%)
Lesbian/Gay/Bisexual/Transsexual	20 (65%)	13 (48%)
Seniors/Older Adults	14 (45%)	13 (48%)
Pregnant/Postpartum	17 (55%)	13 (48%)
Women	29 (94%)	17 (63%)
Men	26 (84%)	18 (67%)
DUI/DWI	17 (55%)	15 (56%)
Other Criminal Justice	27 (87%)	15 (56%)

^an = 31. ^bn = 27.

Workforce Demographics

Workforce demographics are displayed in Exhibit 9. In funded agencies, 52% of agency directors and 60% of clinical staff reported being female. In nonfunded agencies, 52% of agency directors and 65% of clinical staff reported being female. The majority of directors in funded agencies (71%) and nonfunded agencies (70%) reported being white. The same holds true for clinical staff, as 56% of clinical staff in funded agencies and 72% of clinical staff in nonfunded agencies reported being white. A few statistically significant differences are present in terms of race. Chi-square analysis indicates that the difference in race of directors and clinical staff at funded agencies is statistically

significant ($p < .05$). Chi-square analysis also indicates that the difference in race of clinical staff at funded and nonfunded agencies is statistically significant ($p < .05$).

Exhibit 9 Gender and Race of Respondents

Characteristic	Funded Agency		Nonfunded Agency	
	Agency Directors ^a	Treatment Staff ^b	Agency Directors ^c	Treatment Staff ^d
Gender				
Female	16 (52%)	92 (60%)	14 (52%)	69 (65%)
Male	15 (48%)	62 (40%)	13 (48%)	37 (35%)
Race				
American Indian	0 (0%)	0 (0%)	1 (4%)	0 (0%)
Alaska Native	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Asian American	2 (7%)	1 (1%)	0 (0%)	1 (1%)
Black or African American	7 (23%)	59 (38%)	7 (26%)	26 (25%)
Native Hawaiian/Other Pacific Islander	0 (0%)	0 (0%)	0 (0%)	0 (0%)
White or Caucasian	22 (71%)	86 (56%)	19 (70%)	76 (72%)
Other	0 (0%)	8 (5%)	0 (0%)	2 (2%)
Hispanic	1 (3%)	2 (1%)	0 (0%)	1 (1%)

Note. Respondents were asked to check all that apply.

^a $n = 31$. ^b $n = 155$. ^c $n = 27$. ^d $n = 106$.

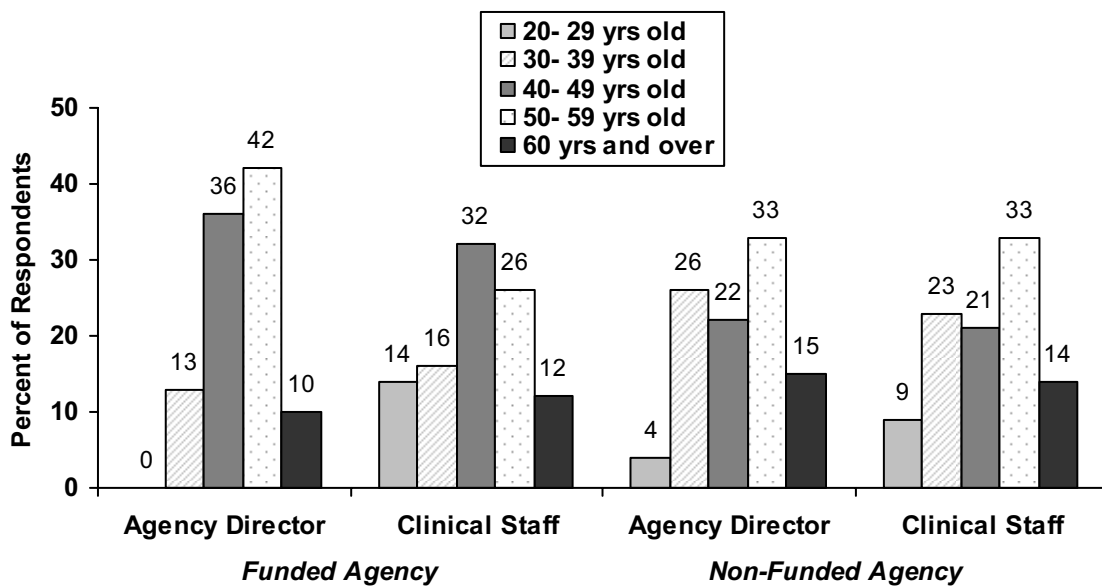
Differences in director and staff race are also present between rural, suburban, and urban parts of the state. Chi-square analysis indicates that a statistically significant higher proportion of directors and staff in urban agencies are African American ($p < .05$). Very few directors and clinical staff in either setting reported being Hispanic.

Baltimore City Fast Fact

In Baltimore City treatment agencies, 47% of directors and 58% of clinical staff reported being African American. In all other agencies across the state, only 15% of directors and 21% of clinical staff reported being African American. These differences are statistically significant.

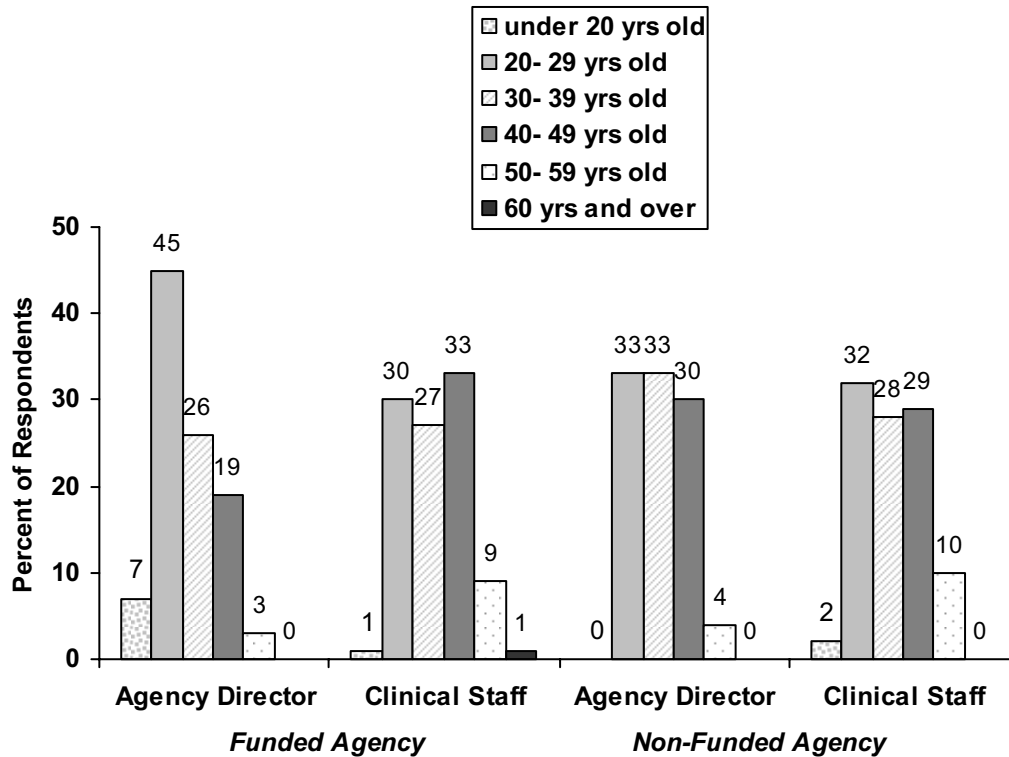
At funded agencies, the average age for those surveyed was 50 years old for directors and 46 years old for clinical staff. At nonfunded agencies, the average age for those surveyed was 49 years old for directors and 47 years old for clinical staff. Overall, directors and staff exhibit an age range of 23 to 72 years old. Exhibit 10 displays age category by role for both settings. Differences across age category are not statistically significant.

**Exhibit 10
Age of Respondents**



Average age of entry into the substance abuse treatment workforce was also examined. At funded agencies, the average age of entry into the field was 32 years old for directors and 37 years old for clinical staff. At nonfunded agencies, the average age of entry into the field was 35 years old for directors and 36 years for clinical staff. Exhibit 11 displays age of entry by role for both settings.

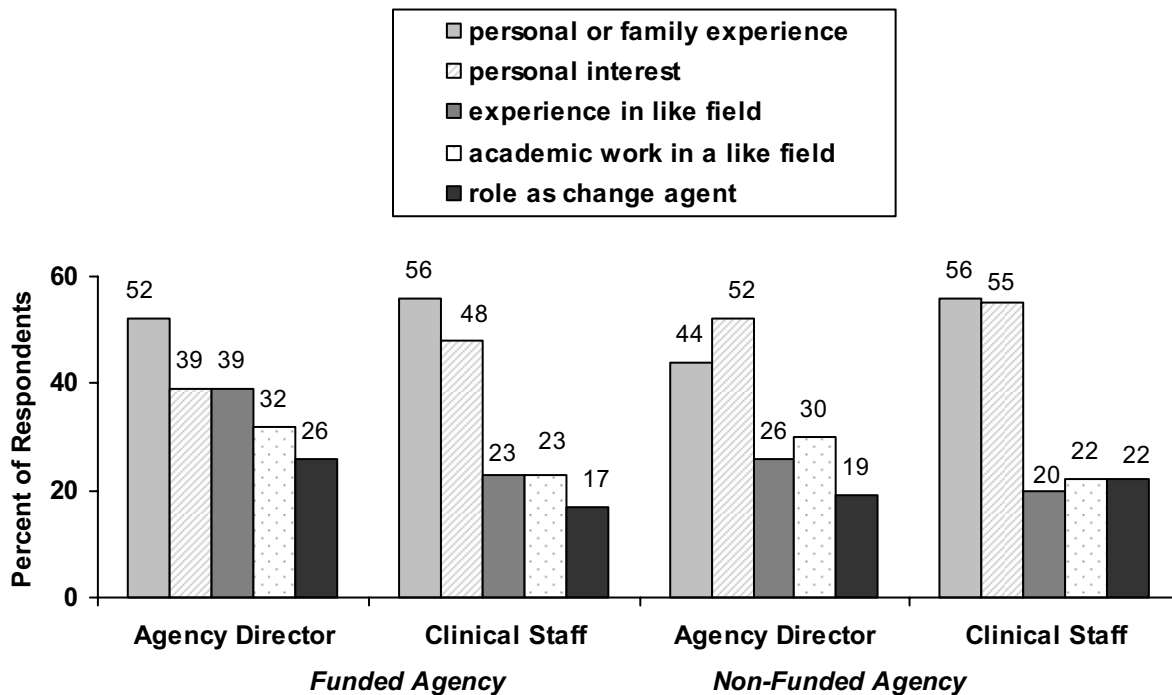
Exhibit 11 Age of Entry Into the Field



Related to age of entry, a relatively large proportion of the workforce indicated that their current work was a second career. In funded agencies, 39% of agency directors and 41% of clinical staff indicated that substance abuse treatment was a second career. In nonfunded agencies, 59% of agency directors and 36% of clinical staff indicated that substance abuse treatment was a second career.

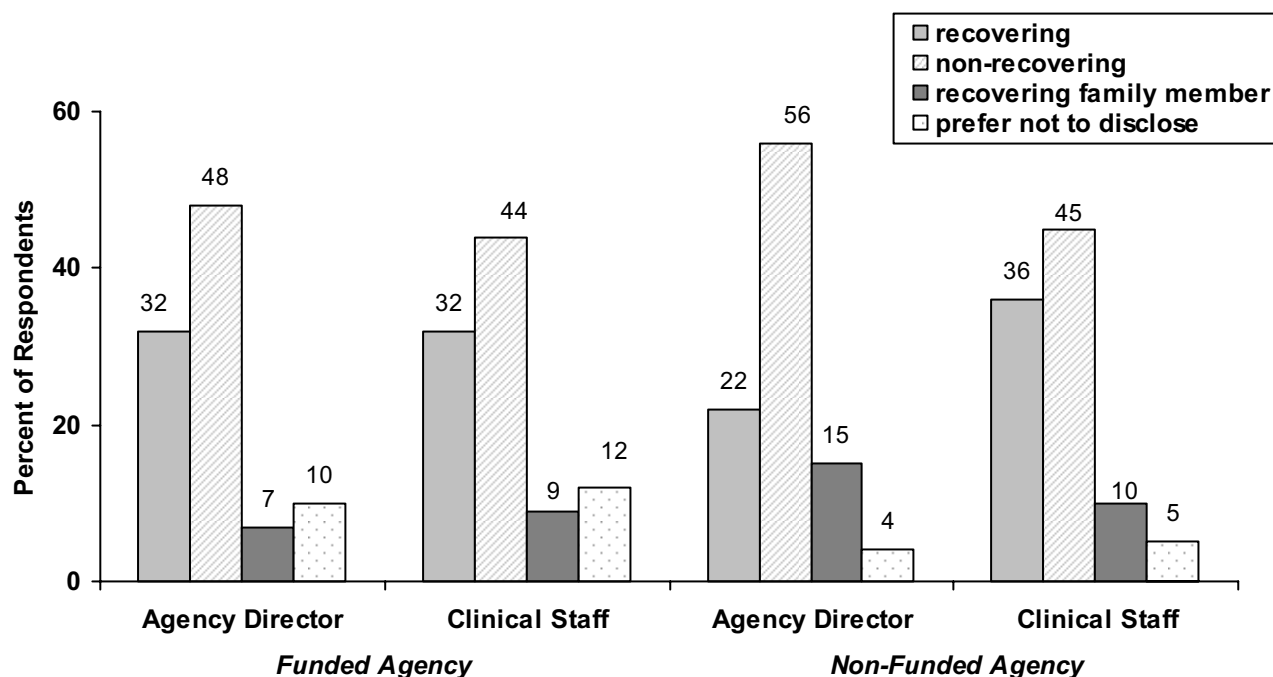
Exhibit 12 displays the most common reasons for entry into the field by role for both settings. Overall, a personal or family experience with addictions and a personal interest in the field were the most frequently cited reasons for entry across the workforce.

Exhibit 12
Respondents' Reasons for Entry into Field



It is clear that having a personal or family experience with addictions is a motivating factor for entering the substance abuse treatment field. Respondents were also asked to indicate their recovery status. As displayed in Exhibit 13, in funded agencies, 32% of both directors and clinical staff reported being in recovery themselves. In nonfunded agencies, 22% of directors and 36% of clinical staff reported being recovery. Differences between directors and clinical staff, and across setting are not significant. Interestingly, across the workforce, a statistically significant ($p < .001$) higher percentage of males (45%) report being in recovery than females (24%).

Exhibit 13 Recovery Status

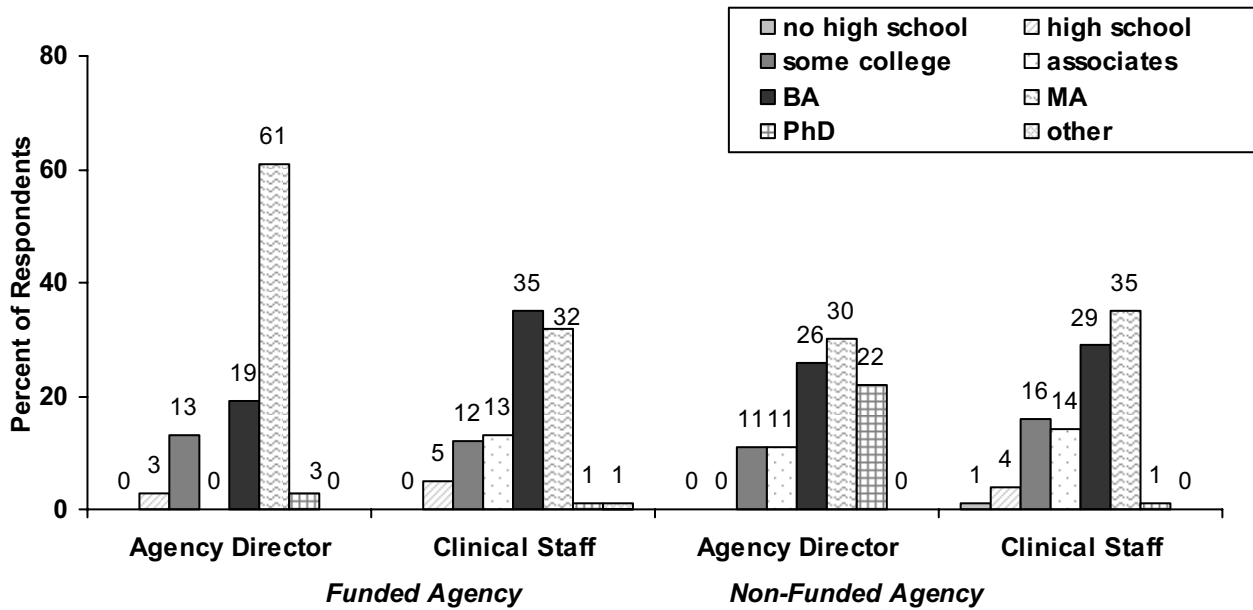


Academic and Professional Background

Exhibit 14 displays degree status by role for both funded and nonfunded settings. In funded agencies, 84% of agency directors and 68% of clinical staff had a Bachelors degree or above. In nonfunded agencies, 78% of agency directors and 64% of clinical staff had a Bachelors degree or above. Chi-square analysis indicates that the difference in degree status between directors at funded and nonfunded agencies is statistically significant ($p < .05$). No significant differences in degree status exist between clinical staff at funded and nonfunded agencies.

Differences do exist however in the degree status of recovering and nonrecovering clinical staff. Chi-square analysis indicates that a statistically significant ($p < .001$) larger proportion of nonrecovering staff have a BA degree or above (84%) than do recovering staff (49%). This finding is present in both funded and nonfunded agencies.

Exhibit 14 Degree Status of Respondents



Overall, the degree status of the workforce in Maryland is quite comparable to that of other states. Exhibits 15 and 16 display degree status for Maryland directors and clinical staff as they compare to other states served by the Central East, as well as the five state service area of the Northwest Frontier Addiction Technology Transfer Center (Alaska, Hawaii, Idaho, Oregon, Washington).

Exhibit 15 Comparative Degree Status—Directors

Degree Status	MD (n = 58)	KY (n = 20)	DE (n = 42)	TN (n = 52)	NFATTC (n = 159)
Less than high school	0%	0%	0%	0%	0%
High school	2%	0%	5%	4%	1%
Some college	12%	5%	5%	14%	11%
Associate's degree	5%	0%	5%	2%	10%
Bachelor's degree	22%	16%	26%	14%	22%
Master's degree	47%	68%	57%	55%	47%
Ph.D.	12%	11%	2%	8%	10%
Other	0%	0%	0%	2%	0%

Note. NFATTC is the Northwest Frontier Addiction Technology Transfer Center

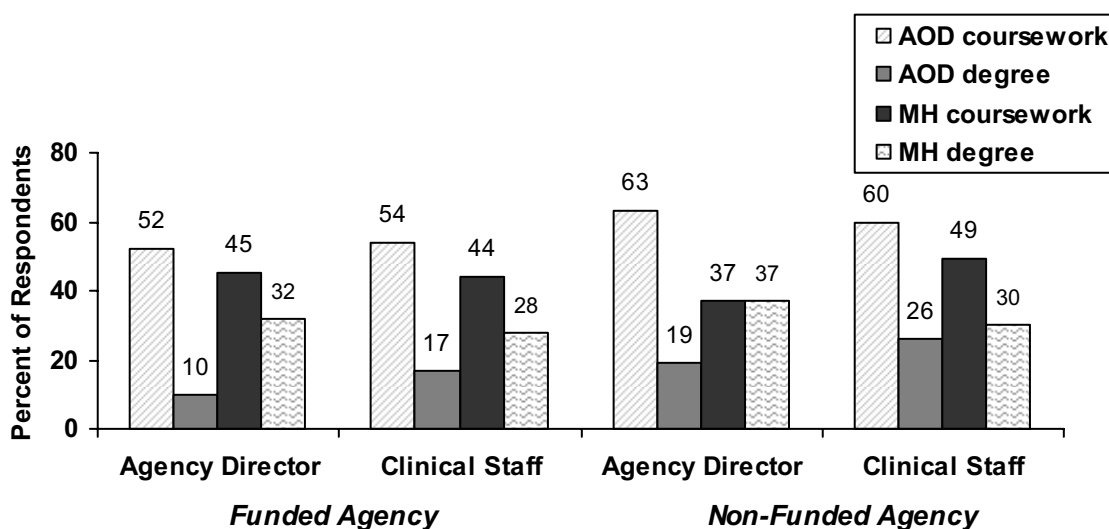
Exhibit 16 Comparative Degree Status—Staff

Degree Status	MD (n = 261)	KY (n = 298)	DE (n = 85)	TN (n = 247)	NFATTC (n = 450)
Less than high school	<1%	0%	0%	1%	0%
High school	5%	<1%	4%	6%	3%
Some college	13%	6%	7%	12%	20%
Associate's degree	13%	5%	11%	5%	16%
Bachelor's degree	30%	31%	39%	30%	25%
Master's degree	35%	51%	30%	43%	31%
Ph.D.	1%	6%	8%	3%	3%
Other	1%	1%	1%	2%	3%

Note. NFATTC is the Northwest Frontier Addiction Technology Transfer Center

In addition to degree status, the amount of educational background specific to alcohol and other drugs (AOD) and mental health was also examined. As Exhibit 17 displays, a relatively large proportion of agency directors and clinical staff in both settings report completing some college or university coursework in AOD and mental health, but few hold a degree specific to AOD or mental health. No significant differences exist between directors and clinical staff or by agency setting.

Exhibit 17 AOD and Mental Health Coursework and Degree Status



With a proportion of the workforce without AOD-specific degrees and/or coursework, the role of training becomes extremely important. Over 90% of the workforce reports participating in AOD workshops/training in the past 2 years, with the majority attending 5 to 8 workshops. No significant difference in training participation are present across role or setting.

Exhibits 18 and 19 display certification and licensure status by role across both settings. In funded agencies, 61% of agency directors and 54% of clinical staff reported currently being certified, while 32% of agency directors and 20% of clinical staff reported currently being licensed. In nonfunded agencies, 63% of agency directors and 45% of clinical staff reported currently being certified, while 33% of agency directors and 28% of clinical staff reported currently being licensed. Chi-square analysis indicate that a statistically significant larger proportion of clinical staff in nonfunded agencies than funded agencies are not certified ($p < .05$). No significant differences exist in terms of licensure. Interestingly, 8% of clinical staff in both funded and nonfunded agencies report that certification/licensure is not required for their position.

Exhibit 18
Certification Status of Respondents

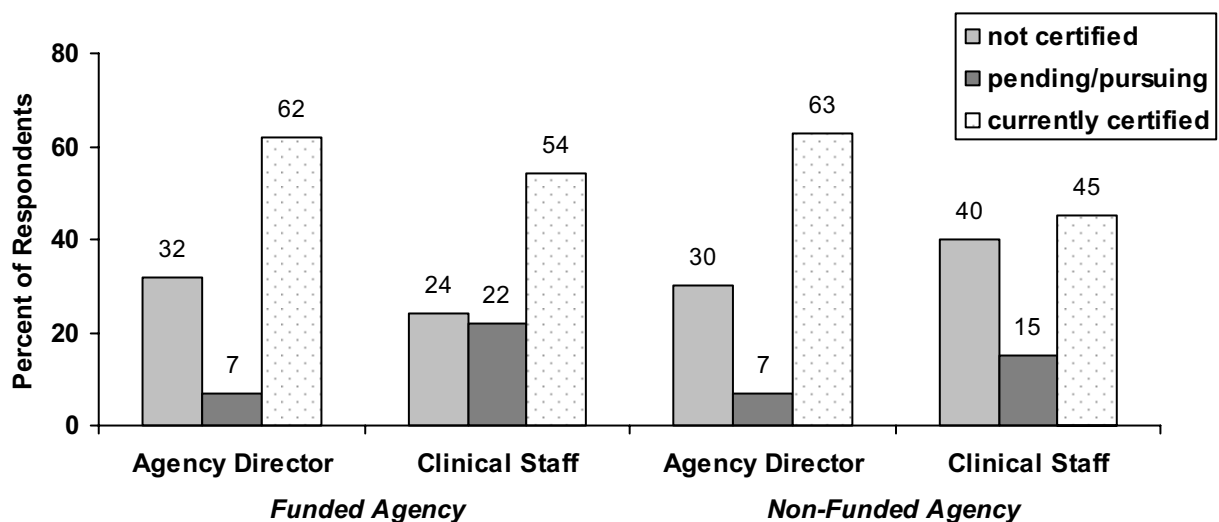
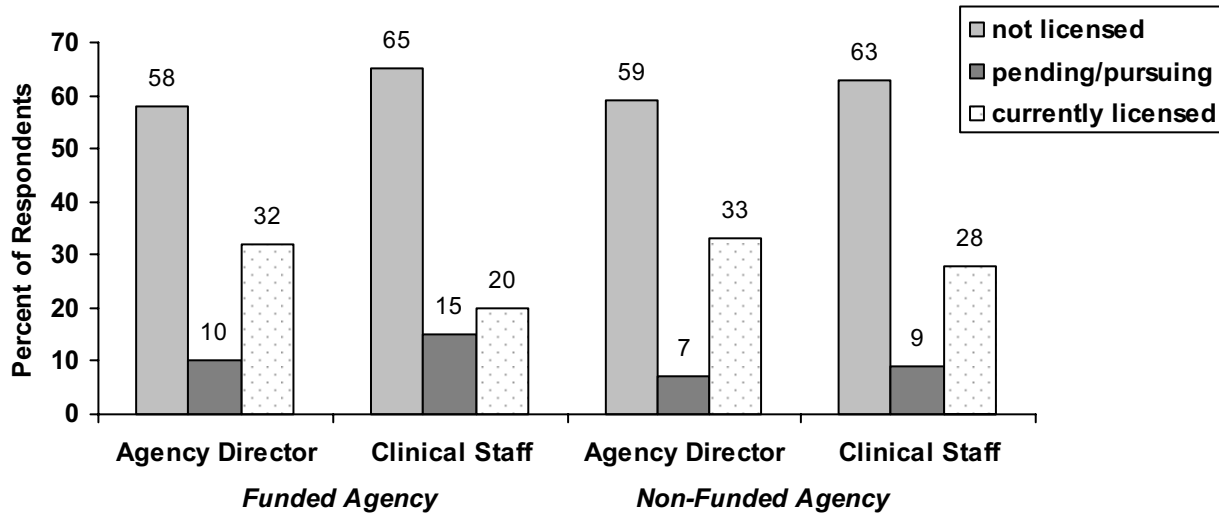


Exhibit 19 Licensure Status of Respondents



As displayed in Exhibit 20, 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. A few statistically significant differences are apparent in these numbers. Chi-square analysis indicates that in funded agencies a statistically significant larger proportion of clinical staff reported having 5 or fewer years experience in the field ($p < .001$) and in their role ($p < .05$) than did agency directors. No statistically significant differences are apparent between directors and staff at nonfunded agencies, or between directors and staff across settings. Differences are apparent between clinical staff across geographic setting. A statistically significant larger proportion of clinical staff at urban agencies (61%) report having 3 or fewer years in their current position ($p < .001$) than do clinical staff at rural (43%) and suburban (42%) agencies.

**Baltimore
City
Fast Fact:**

A statistically significant larger proportion of clinical staff at Baltimore City agencies (67%) report having 3 or fewer years in their current position ($p < .001$) than do clinical staff at all other agencies (44%).

Interestingly, the fact that directors have spent less time in their current role than time in the field indicates that directors in Maryland may have entered the field in some other capacity. Additionally, the fact that years in position is significantly less than years in field validates the perception of movement within the field.

Exhibit 20 Work Experience of Respondents

Number of Years	Funded Agency		Nonfunded Agency	
	Agency Directors ^a	Clinical Staff ^b	Agency Directors ^c	Clinical Staff ^d
In AOD Field				
0–3 years	2 (7%)	46 (30%)	4 (15%)	23 (22%)
3–5 years	1 (3%)	36 (24%)	3 (11%)	22 (21%)
5–10 years	9 (29%)	42 (28%)	10 (37%)	28 (26%)
10 + years	19 (61%)	29 (19%)	10 (37%)	33 (31%)
In Current Role				
0–3 years	7 (25%)	76 (56%)	8 (33%)	52 (53%)
3–5 years	7 (25%)	34 (25%)	6 (25%)	25 (25%)
5–10 years	8 (29%)	20 (15%)	6 (25%)	16 (16%)
10 + years	6 (21%)	7 (5%)	4 (17%)	6 (6%)
In Current Position				
0–3 years	11 (36%)	70 (52%)	8 (33%)	48 (51%)
3–5 years	9 (29%)	34 (25%)	6 (25%)	24 (25%)
5–10 years	7 (23%)	25 (18%)	5 (21%)	17 (18%)
10 + years	4 (13%)	7 (5%)	5 (21%)	6 (6%)

^an = 31. ^bn = 155. ^cn = 27. ^dn = 106.

Job Detail

Directors and clinical staff were asked to identify the amount of time spent on various tasks in a typical week. Exhibit 21 displays the average percentage of time per task by role for both settings. In general, clinical staff showed significantly more time spent on client-related tasks than did directors who spent more time on administrative tasks. In funded agencies, clinical staff reported spending approximately 61% of their time on client-related tasks, while agency directors reported spending 86% of their time on administrative tasks. In nonfunded agencies, clinical staff reported spending approximately 63% of their time on client-related tasks, while agency directors reported spending 68% of their time on administrative tasks. Analysis of variance indicates that for directors, the mean amount of time spent on administrative and client-related tasks varies significantly ($p < .05$) between funded and nonfunded agencies. Analysis of variance results also indicate that for directors, the mean amount of time spent on administrative and client-related tasks varies significantly ($p < .001$) by size of agency. This finding indicates that agency directors at smaller agencies spend significantly more time on client-related tasks than do directors at larger agencies.

Clinical staff in both settings reported spending equal time providing individual and group counseling. Interestingly, very little time is spent providing family counseling. Reported time spent on paperwork and attending meetings constituted approximately a day a week for clinical staff. Little clinical supervision time is reported, despite approximately two thirds of clinical staff in both settings reporting that they receive daily or weekly clinical supervision. This finding may indicate that clinicians over reported how frequently they receive clinical supervision, or that the activities constituting clinical supervision are insignificant in terms of time. It is also possible that clinicians may perceive clinical supervision occurring during staff meetings, and reflected this in the meetings category.

Exhibit 21
Mean Percentage of Work Time Spent per Task

Task Type	Task	Funded Agency		Nonfunded Agency	
		Agency Directors ^a	Treatment Staff ^b	Agency Directors ^c	Treatment Staff ^d
Client-Related	Screening & assessment	2	13	9	14
	Diagnosing	–	3	–	2
	Individual counseling	6	18	12	18
	Group counseling	2	15	5	18
	Family counseling	<1	1	1	1
	Case management	2	8	4	7
	Making referrals	–	4	–	2
Total Client Related Time		13	61	32	63
Administrative	Participating in training	–	2	–	2
	Providing clinical supervision	11	8	5	5
	Receiving clinical supervision	–	4	–	2
	Overseeing personnel	15	–	11	–
	Paperwork	22	14	22	13
	Meetings	13	4	8	5
	Other admin.	16	–	14	–
	Other activities	9	6	8	7
Total Administrative Time		86	38	68	36

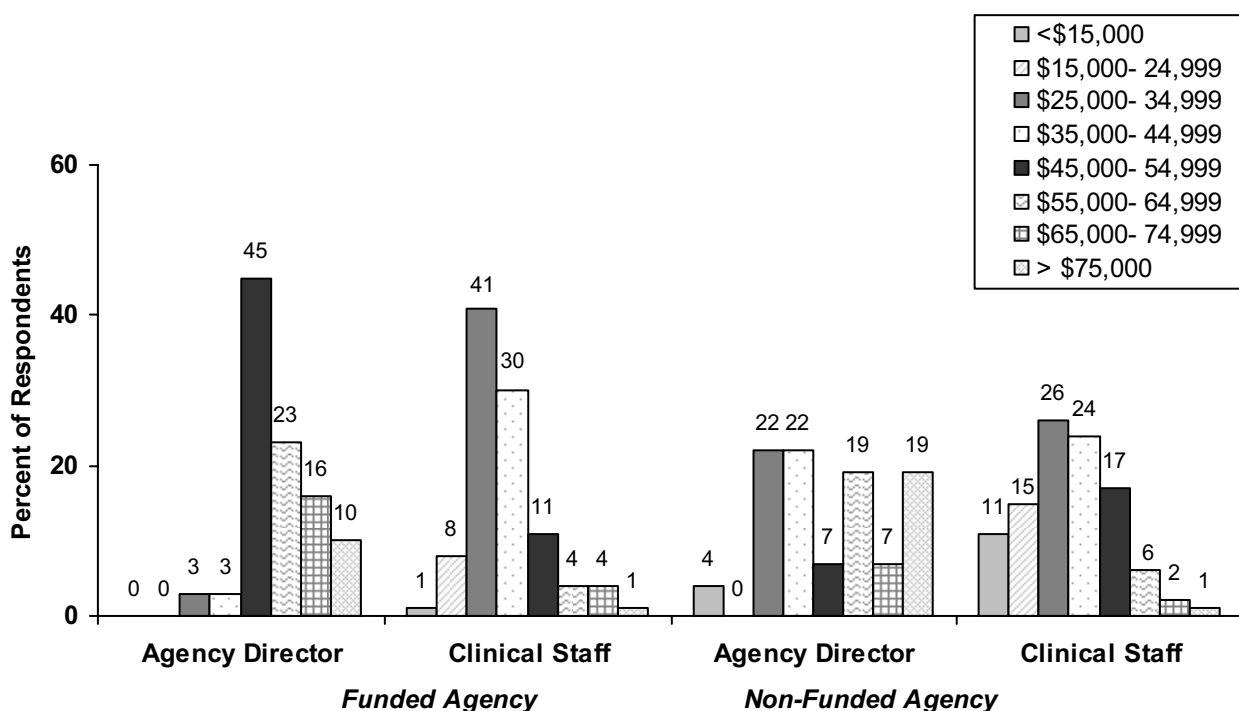
Note. Response included in sample if total time added to 90–110.
^an = 31. ^bn = 155. ^cn = 27. ^dn = 106.

Compensation

Salary and benefit information was collected from directors and clinical staff. Exhibit 22 displays salary by role and by setting. Across the entire workforce, 78% of directors reported making over \$45,000 a year, while 74% of clinical staff reported making under \$45,000 a year. Chi-square analysis indicated that these differences in director and staff salaries are highly significant ($p < .001$). Differences in directors' salaries are present across setting. A statistically significant larger proportion of directors in nonfunded agencies report making under \$45,000 a year than do directors at funded agencies

($p < .01$). Additionally, in nonfunded settings, director salaries appear less uniform as 26% of directors report making under \$35,000 a year while 19% report making more than \$75,000. Reported clinical staff salaries also varied across setting, as a statistically significant larger proportion of staff in nonfunded agencies reported making less than \$25,000 a year ($p < .01$). Across the workforce, 66% of respondents indicated being the primary wage earner for their family.

Exhibit 22
Salaries of Respondents by Role



Multiple linear regression was run to examine potential predictors of salary for the workforce in Maryland. 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 clinical staff) and setting distinction (funded versus nonfunded) were included as predictors. Results are displayed in Exhibit 23.

Exhibit 23
Predictors of Respondents' Salaries

Predictor	Simple Correlation (<i>r</i>) with Salary	Multiple Linear Regression (<i>R</i> = .663)	
		Standardized Regression Coefficient	<i>t</i> statistic
Demographics			
Gender	.059		1.215
Age	.176**		1.577
Ethnicity	.021		0.178
Recovery Status	-.180***		-1.962
Professional/Academic Background			
Role (director vs. staff)	-.437***	-.281	-5.299***
Years in Field	.314***	.246	3.965***
Degree Status	.342***	.160	2.822**
AOD Degree	-.085		-1.009
MH Degree	.184***		1.717
Certification Status	-.095		-1.784
Licensure Status	.168**		0.135
Caseload Size	-.209***		-1.391
Other Compensation/Benefits			
Health Insurance	-.225***		-1.035
Sick Leave	-.221***		-0.377
Vacation	-.242***		-1.047
Retirement	-.256***		-1.164
Retirement Contribution	-.238***		-0.421
Maternity Leave	-.292***		-1.944
Tuition	-.201***		0.241
Agency Characteristics			
Agency Type (funded vs. nonfunded)	-.076		-0.256
Geographic Setting (rural, suburban, urban)	-.007	-.119	-2.291*

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

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

Results indicate that four factors were statistically significant predictors of workforce salary in Maryland. The strongest predictor was role ($p < .001$). This finding is not surprising as being in the role of an agency director was related to higher salary. Years experience in the field was also a significant predictor of salary ($p < .001$). Specifically, having more years experience in the field was related to higher salary. In addition, degree status is a significant predictor of salary ($p < .01$). Having a higher degree status was a statistically significant predictor of higher salary. Finally, the geographic setting of the agency was also a statistically significant predictor of salary ($p < .05$). Results indicated that working in a more urban setting was related to higher salary. Interestingly, recovery status was identified as a marginally significant predictor of salary ($p = .051$), with being in recovery related to lower salary. This finding is likely tied to the previously described relationship between recovery status and degree status which indicated that a smaller proportion of the workforce in recovery held a Bachelor's degree or above.

In addition to salary, benefits were also examined. Exhibit 24 displays benefits by role for both settings. Results indicate that multiple significant differences exist across setting. A statistically significant larger proportion of directors and staff in funded agencies report receiving health insurance, sick leave, vacation, and retirement benefits. In addition, a higher proportion of clinical staff at funded agencies report maternity leave and tuition reimbursement benefits than do clinical staff at nonfunded agencies.

Exhibit 24
Benefits Provided to Respondents by Setting

Degree of Provision	Funded Agency		Nonfunded Agency	
	Agency Directors ^a	Clinical Staff ^b	Agency Directors ^c	Clinical Staff ^d
Health insurance				
Full	23 (74%)	96 (62%)	14 (52%)	49 (46%)
Partial	7 (23%)	44 (28%)	4 (15%)	26 (25%)
Not provided	1 (3%)	15 (10%)	9 (33%)	31 (29%)
Sick leave				
Full	28 (90%)	128 (83%)	19 (70%)	72 (68%)
Partial	2 (7%)	18 (12%)	1 (4%)	7 (7%)
Not provided	1 (3%)	9 (6%)	7 (26%)	27 (26%)
Vacation				
Full	30 (97%)	135 (87%)	21 (78%)	75 (71%)
Partial	0 (0%)	11 (7%)	0 (0%)	5 (5%)
Not provided	1 (3%)	9 (6%)	6 (22%)	26 (25%)
Retirement				
Full	14 (45%)	62 (40%)	8 (30%)	28 (26%)
Partial	9 (29%)	26 (17%)	5 (19%)	15 (14%)
Not provided	8 (26%)	67 (43%)	14 (52%)	63 (59%)
Retirement Contribution				
Full	13 (42%)	46 (30%)	6 (22%)	15 (14%)
Partial	7 (23%)	35 (23%)	2 (7%)	15 (14%)
Not provided	11 (36%)	74 (48%)	19 (70%)	76 (72%)
Maternity Leave				
Full	15 (48%)	67 (43%)	12 (44%)	21 (20%)
Partial	7 (23%)	15 (10%)	3 (11%)	13 (12%)
Not provided	9 (29%)	73 (47%)	12 (44%)	72 (68%)
Tuition Reimbursement				
Full	10 (32%)	45 (29%)	8 (30%)	14 (13%)
Partial	10 (32%)	42 (27%)	8 (30%)	26 (25%)
Not provided	11 (36%)	68 (44%)	11 (41%)	66 (62%)

^an = 31. ^bn = 155. ^cn = 27. ^dn = 106.

Staff Turnover

Agency directors were asked to report staffing numbers from the past year. Specifically, directors were asked to indicate the size of their clinical 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 clinical staff size to determine an agency/regional level turnover rate.

Exhibit 25 displays agency staffing numbers and calculated turnover rates by setting, as well as for the entire state. Exhibit 26 displays turnover split by geography. Based on directors' reports of staffing in the past year, the average turnover rate for clinical staff in funded agencies was 16%, while the average turnover rate for clinical staff in nonfunded agencies was 10%. Statewide, the average turnover rate is 13%. Reported turnover appears to be highest in urban agencies, especially in funded settings. Interestingly, the majority turnover across all settings was voluntary (quitting).

Exhibit 25
Mean Staffing Numbers and Turnover Rates by Agency Setting

Staffing Variable	Funded Agencies (n = 30)	Nonfunded Agencies (n = 22)	Overall (N = 52)
<i>Number of Direct Tx Staff</i>	14.67	13.64	14.23
Full time staff	12.03	8.45	10.52
Part time staff	2.17	4.23	3.04
On-call staff	0.60	1.14	0.83
<i>Turnover</i>	1.77	1.41	1.62
Laid off	0.00	0.09	0.04
Terminated	0.57	0.32	0.46
Quit	1.20	1.00	1.12
<i>Turnover Rate</i>	16%	10%	13%

**Baltimore
City
Fast Fact:**

Overall, turnover is higher in agencies located in Baltimore City (19%) than agencies outside of Baltimore City (9%).

Exhibit 26
Staff Turnover Rates by Geographic Setting

Geographic Setting	Funded Agencies (n = 30)	Nonfunded Agencies (n = 22)	Overall (N = 52)
Rural	6%	15%	8%
Suburban	10%	2%	6%
Urban	25%	16%	21%

Maryland’s overall turnover rate is considerably lower than rates calculated the same way in other states. In the Pacific Northwest, for example, 5 states reported an average turnover rate for AOD clinical staff of 23% (ranging from 20% to 28%). In Kentucky, the average turnover rate for AOD clinical staff was 17% (Knudsen & Gabriel, 2003). In Delaware the average turnover rate for AOD staff was 21% (Knudsen, Williams, Lucas, & Poplawski, 2004). And in Tennessee the average turnover rate for AOD staff was 19% (Knudsen, Williams, & Perry, 2005).

Directors also indicated whether or not their agency was understaffed. In funded agencies, 60% of directors reported their agency was understaffed, with 40% reporting that if all budgeted positions were filled they would still be understaffed. On average, directors of funded agencies reported a staff vacancy of 1.03 FTE. In nonfunded agencies, 36% of directors reported their agency was understaffed, with 18% reporting that if all budgeted positions were filled they would still be understaffed. On average, directors of nonfunded agencies reported a staff vacancy of 0.55 FTE.

With much of the turnover issue created by clinical staff leaving voluntarily, directors and staff were asked to indicate reasons why direct service staff have quit. The two most frequently cited reasons across the entire workforce were better work opportunities elsewhere within the field and inadequate salaries. Clinical staff in both settings also frequently cited the lack of career advancement and burnout as reasons for quitting.

Directors and staff also addressed their own movement within the field, and their future plans for staying or leaving their agency or the field. Exhibit 27 displays how many agencies directors and staff have worked for, and how many times they have voluntarily changed agencies. On average, directors and staff have worked for 2 to 3 different agencies, voluntarily changing agencies 1 to 2 times. Results do indicate that some members of the workforce have worked for a large number of agencies, and have voluntarily changed agencies multiple times. Salary was the most frequently cited reason for voluntarily changing agencies. Other frequently cited reasons included benefits, better agency, better management, and agency location.

**Exhibit 27
Movement Within the Field**

Variable	Funded Agency		Nonfunded Agency	
	Agency Directors ^a	Clinical Staff ^b	Agency Directors ^c	Clinical Staff ^d
Number of agencies worked for	2.55 (1; 7)	2.13 (1; 7)	2.74 (1; 6)	2.38 (1; 8)
Number of times voluntarily changed agencies	1.79 (0; 6)	1.27 (1; 7)	1.70 (0; 5)	1.39 (1; 8)

Note. Numbers displayed are Average (minimum; maximum)
^an = 31. ^bn = 155. ^cn = 27. ^dn = 106.

As displayed in Exhibit 28, many members of the workforce are considering leaving their current agency, and many are considering leaving the field altogether in the next 2 years. Better pay, better benefits, and better management were the most frequently cited reasons for why workforce members are considering changing agencies in the future. Better pay, better benefits, a different client population, and a less stressful work culture were the most frequently cited reasons for why workforce members are considering leaving the field. Interestingly, those considering leaving the field vary in terms of age, gender, years of experience, and academic degree.

Exhibit 28
Percentage Reporting Definite or High Likelihood of Leaving Agency or Field

Variable	Funded Agency		Nonfunded Agency	
	Agency Directors ^a	Clinical Staff ^b	Agency Directors ^c	Clinical Staff ^d
Leaving agency in next 2 years	10%	31%	19%	39%
Leaving the field in next 2 years	7%	24%	11%	17%

^an = 31. ^bn = 155. ^cn = 27. ^dn = 106.

Recruitment and Retention

Directors and clinical staff were asked to report on retention and recruitment efforts. Perceptions of staff development activities are displayed in Exhibit 29. In funded agencies, a statistically significant smaller proportion of clinical staff reported the provision of in-service training ($p < .05$) and that their agency pays the cost of continuing education ($p < .001$) than did agency directors. In both funded and nonfunded agencies, a statistically significant smaller proportion of clinical staff reported that their agency provides direct supervision than did agency directors ($p < .05$). All of these differences may represent a lack of communication regarding staff development activities available for clinical staff, and in turn may represent an opportunity to promote retention. Across agency settings, a statistically significant larger proportion of directors in funded agencies reported their agency providing in-service training ($p < .01$) than did directors in nonfunded agencies.

Exhibit 29
Respondents' Perceptions of Staff Development Activities
Provided by Agencies

Development Activity	Funded Agency		Nonfunded Agency	
	Agency Directors ^a	Clinical Staff ^b	Agency Directors ^c	Clinical Staff ^d
In-house mentoring program	6 (19%)	17 (11%)	7 (26%)	19 (18%)
In-service training	28 (90%)	109 (70%)	16 (59%)	66 (62%)
Provides direct supervision	28 (90%)	106 (68%)	22 (82%)	66 (62%)
Pays cost of continuing education	27 (87%)	79 (51%)	18 (67%)	51 (48%)
Provides staff orientation	28 (90%)	139 (90%)	27 (100%)	87 (82%)
Provides on-going training	28 (90%)	133 (86%)	22 (82%)	77 (73%)

Note. Respondents were asked to check all that apply.

^an = 31. ^bn = 155. ^cn = 27. ^dn = 106.

Directors and staff were also asked to report on what they thought their agency could do to promote the retention of good clinical staff. The most frequently cited activities were: (a) more frequent salary increases, (b) more individual recognition and appreciation, (c) make staff feel ideas are valued and implemented by management, (d) provide better benefits, (e) lesson and/or provide assistance with paperwork, (f) promote career growth, (g) more and improved ongoing training, and (h) take formal steps to reduce emotional burnout.

In addition to retention, the topic of recruitment was also addressed. Directors and staff were asked to report the methods of recruitment used at their agency. Results are displayed in Exhibit 30. Overall, more traditional techniques such as newspaper advertisement, personal contacts, and agency human resource departments were cited most frequently. A larger proportion of directors at nonfunded agencies reported utilizing professional journals than did directors at funded agencies ($p < .05$), although the percentage of directors using this resource was still very low.

Exhibit 30 Agency Methods for Staff Recruitment

Recruitment Method/Resource	Funded Agency		Nonfunded Agency	
	Agency Directors ^a	Treatment Staff ^b	Agency Directors ^c	Treatment Staff ^d
Agency HR department	16 (52%)	72 (47%)	11 (41%)	26 (25%)
Professional journals	0 (0%)	6 (4%)	4 (15%)	1 (1%)
Newspaper advertisement	26 (84%)	97 (63%)	21 (78%)	80 (76%)
Email networking	9 (29%)	24 (16%)	9 (33%)	13 (12%)
Agency newsletter	0 (0%)	8 (5%)	1 (4%)	3 (3%)
Personal/informal contacts	15 (48%)	49 (32%)	15 (56%)	45 (43%)
Website	11 (36%)	37 (24%)	9 (33%)	34 (32%)
Agency/regional mailing list	1 (3%)	7 (5%)	1 (4%)	8 (8%)
State HR department	6 (19%)	32 (21%)	2 (7%)	8 (8%)

Note. Respondents were asked to check all that apply.

^an = 31. ^bn = 155. ^cn = 27. ^dn = 106.

Directors and clinical staff were both asked to report if their agency experienced difficulties filling open positions for direct treatment staff. In funded agencies, 71% of directors and 58% of clinical staff reported difficulties. In nonfunded agencies, 59% of directors and 51% of clinical staff reported difficulties. The difference between director perceptions at funded and nonfunded agencies is quite large, but is not statistically significant. Interestingly, 80% of directors at suburban agencies compared to 67% of directors at rural agencies and only 56% of directors at urban agencies reported difficulties filling open positions.

The fact that fewer directors at urban agencies report difficulties filling open positions, along with the fact that urban agencies experience the highest level of staff turnover and have the least seasoned staff in terms of years experience, may indicate that urban agencies serve as a starting point for many newer clinical staff, who then move on once obtaining some level of experience.

Exhibit 31 displays reasons for recruiting difficulties by role. A statistically significant higher proportion of directors than staff in funded agencies reported recruiting difficulties due to an insufficient number of applicants meeting qualifications ($p < .01$) and a small

applicant pool due to geography ($p < .001$). In nonfunded agencies, a statistically significant higher proportion of staff than directors reported recruiting difficulties due to insufficient funding for open positions ($p < .05$) and a lack of interest in the position due to the nature of work and/or stigma ($p < .05$). Interestingly, a statistically significant higher proportion of directors in funded agencies perceive difficulties in recruitment due to insufficient funding for open positions ($p < .05$) and a lack of interest in the position due to the nature of work and/or stigma ($p < .05$) than do directors in nonfunded agencies. As one would expect, a statistically significant larger proportion of directors from rural agencies reported that a small applicant pool due to geography was a reason for recruiting difficulties ($p < .01$).

Exhibit 31

Respondents' Perceptions of Reasons for Recruiting Difficulties

Reasons	Funded Agency		Nonfunded Agency	
	Agency Directors ^a	Treatment Staff ^b	Agency Directors ^c	Treatment Staff ^d
Insufficient number of applicants meeting qualifications	19 (86%)	52 (58%)	12 (75%)	30 (56%)
Insufficient funding for open positions	13 (59%)	43 (48%)	3 (19%)	28 (52%)
Small applicant pool due to geographic area	9 (41%)	13 (14%)	6 (38%)	14 (26%)
Lack of interest (nature of work, stigma)	6 (27%)	14 (16%)	0 (0%)	14 (26%)
Lack of interest (salary)	10 (46%)	51 (57%)	8 (50%)	36 (67%)
Lack of interest in location of agency	2 (9%)	7 (8%)	1 (6%)	2 (4%)
Reputation of agency/region	0 (0%)	5 (6%)	0 (0%)	3 (6%)
Lack of opportunity for advancement	6 (27%)	24 (27%)	2 (13%)	12 (22%)

Note. Respondents were asked to check all that apply.

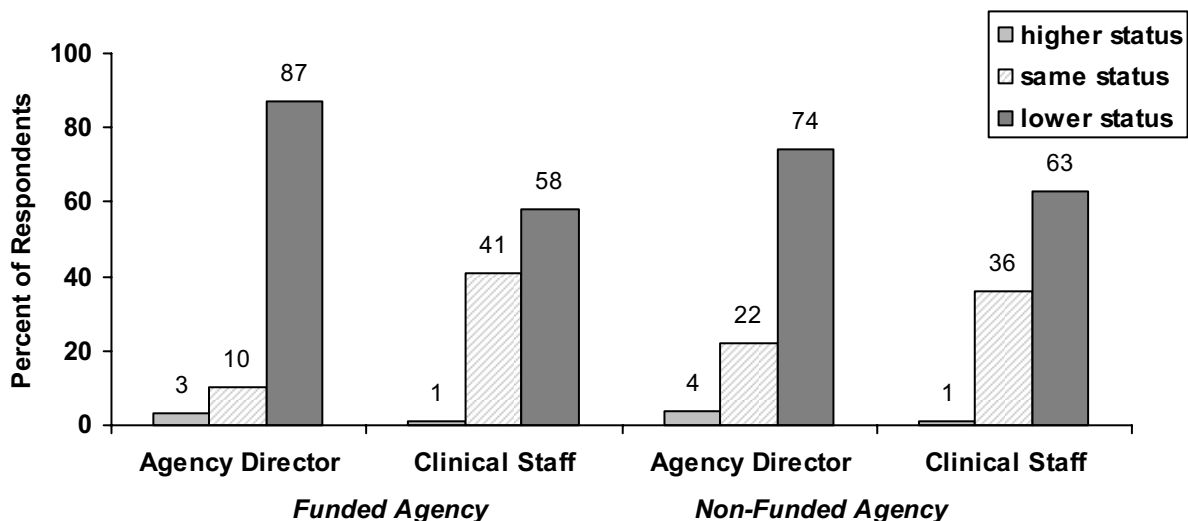
^a $n = 22$. ^b $n = 90$. ^c $n = 16$. ^d $n = 54$.

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 that applicants had little or no experience in the field, lacked appropriate certification, and had insufficient or inadequate training or education.

Directors and staff 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. Across the workforce, 4 barriers were cited most frequently: (a) low salary and poor benefits; (b) competition from other fields in terms of compensation; (c) large caseloads; and (d) negative preconceptions about the nature of addicted clients/chemically dependent populations.

Related to barriers to entry, the perceived status of addiction counselors compared to other helping professionals was examined. Results are displayed in Exhibit 32. Overall, the majority respondents saw addiction counselors as having lower status than other helping professionals. Interestingly, a significantly larger proportion of directors than staff at funded agencies reported that addiction counselors are perceived to have lower status than other helping professionals ($p < .01$). No differences in perceived status were apparent between members of the workforce who are in recovery and those who are not.

Exhibit 32
Status of Addiction Counselors by Role



Reasons for perceived lower status are provided in Exhibit 33. Overall, the most frequently cited reasons for the perceived lower status of addiction counselors were

(a) lower salaries, (b) less formal education or training, and (c) stigmatized by association with substance abusers. Some interesting differences are apparent in the perceptions of directors and staff at funded agencies. A significantly larger proportion of directors than staff at funded agencies report that reasons for lower status are due to addiction counselors having less formal education or training ($p < .05$) and lower quality formal education and training ($p < .05$) than other helping professionals.

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

Reasons	Funded Agency		Nonfunded Agency	
	Agency Directors ^a	Treatment Staff ^b	Agency Directors ^c	Treatment Staff ^d
Less formal education or training	19 (73%)	43 (48%)	11 (55%)	24 (38%)
Lower quality formal education or training	11 (42%)	17 (19%)	7 (35%)	12 (19%)
More likely to work in public agency	11 (42%)	31 (35%)	3 (15%)	22 (34%)
Stigmatized by association w/ substance abusers	15 (58%)	58 (65%)	12 (60%)	37 (58%)
More often had history of own substance abuse	12 (46%)	42 (47%)	8 (40%)	32 (50%)
Have lower credentialing/licensure requirements	7 (27%)	14 (16%)	6 (30%)	18 (28%)
Are not required to take an exam for credentialing/licensure	0 (0%)	1 (1%)	0 (0%)	3 (5%)
Have lower salaries than other people in the helping professions	22 (85%)	66 (74%)	13 (65%)	53 (83%)

Note. Respondents were asked to check all that apply.

^a $n = 26$. ^b $n = 89$. ^c $n = 20$. ^d $n = 64$.

Job Satisfaction

Directors and staff in both settings were asked to rate their job satisfaction and job-related stress, and to identify what in their work contributes to their satisfaction and dissatisfaction. Job satisfaction and job stress ratings are displayed in Exhibit 34. Data suggest the majority of the workforce rates their job satisfaction as above average. In fact only 3% of directors and 9% of clinical staff rate their job satisfaction as below average. Job-related stress is also rated quite high, with 62% of directors and 51% of

clinical staff rating job stress as above average. Sources of job satisfaction are displayed in Exhibit 35, and sources of job dissatisfaction are displayed in Exhibit 36. For agency directors in both settings, the most frequently cited sources of satisfaction were their role of a change agent and their commitment to treatment. For clinical staff in both settings, one-on-one interactions with clients was the most frequently cited source of satisfaction. Multiple significant differences in satisfaction exist between directors and staff in both settings.

Exhibit 34 Job Satisfaction and Job Stress Ratings

Ratings	Funded Agencies		Nonfunded Agencies	
	Directors (n = 31)	Staff (n = 155)	Directors (n = 27)	Staff (n = 104)
Job Satisfaction	4.2	3.8	4.0	3.8
Job Stress	3.8	3.4	3.6	3.5

Note. Rating scale is from 1 to 5 (1 = Very Low, 5 = Very High).

Exhibit 35 Sources of Job Satisfaction for Respondents

Sources of Job Satisfaction	Funded Agency		Nonfunded Agency	
	Agency Directors ^a	Treatment Staff ^b	Agency Directors ^c	Treatment Staff ^d
Nothing—I am not satisfied	0 (0%)	2 (1%)	1 (4%)	2 (2%)
Salary/benefits	11 (36%)	40 (26%)	8 (30%)	26 (25%)
Career growth opportunities	3 (10%)	26 (17%)	5 (19%)	14 (13%)
Role as a change agent	22 (71%)	80 (52%)	18 (67%)	53 (50%)
Commitment to treatment	24 (77%)	82 (53%)	18 (67%)	59 (56%)
1 to 1 interaction with clients	10 (32%)	116 (75%)	13 (48%)	73 (69%)
Opportunities for personal learning/growth	13 (42%)	98 (63%)	14 (52%)	45 (43%)
Agency/co-workers	12 (39%)	71 (46%)	12 (44%)	48 (45%)
Ability to influence agency decisions	20 (65%)	45 (29%)	10 (37%)	35 (33%)
Policy development and implementation	20 (65%)	13 (8%)	10 (37%)	15 (14%)
Leadership	21 (68%)	22 (14%)	12 (44%)	32 (30%)
Overtime pay	0 (0%)	5 (3%)	1 (4%)	3 (3%)
Flexible work schedule	12 (39%)	45 (29%)	10 (37%)	28 (26%)

Note. Respondents were asked to check all that apply.

^an = 31. ^bn = 155. ^cn = 27. ^dn = 106.

In terms of areas of dissatisfaction, salary was the only area cited with high frequency. Other factors cited by directors in both settings included too many external regulations on agency and consistently working overtime (unpaid). Other factors cited by staff in both settings included the inability to influence agency decisions and a lack of career growth opportunities.

Exhibit 36 Sources of Job Dissatisfaction for Respondents

Sources of Job Dissatisfaction	Funded Agency		Nonfunded Agency	
	Agency Directors ^a	Treatment Staff ^b	Agency Directors ^c	Treatment Staff ^d
Nothing—I am satisfied	5 (16%)	22 (14%)	8 (30%)	18 (17%)
Limited role as a change agent	3 (10%)	14 (9%)	2 (7%)	6 (6%)
Salary/Benefits	14 (45%)	88 (57%)	9 (33%)	55 (52%)
Agency/co-workers	3 (10%)	25 (16%)	3 (11%)	15 (14%)
Lack of career growth opportunities	7 (23%)	40 (26%)	1 (4%)	29 (27%)
Lack of commitment to treatment	2 (7%)	9 (6%)	2 (7%)	9 (9%)
Lack of 1-to-1 interaction with clients	1 (3%)	7 (5%)	1 (4%)	3 (3%)
Inability to influence agency decisions	3 (10%)	41 (27%)	3 (11%)	27 (26%)
Lack of opportunities for personal learning/growth	2 (7%)	17 (11%)	0 (0%)	10 (9%)
Consistently working overtime (paid)	1 (3%)	1 (1%)	0 (0%)	3 (3%)
Consistently working overtime (nonpaid)	8 (26%)	15 (10%)	5 (19%)	13 (12%)
Expected to work weekends	1 (3%)	12 (8%)	1 (4%)	12 (11%)
Too many external regulations on agency	10 (32%)	43 (28%)	11 (41%)	25 (24%)

Note. Respondents were asked to check all that apply.

^a*n* = 31. ^b*n* = 155. ^c*n* = 27. ^d*n* = 106.

Treatment Models

To get a sense of what treatment models are actively being used in Maryland, 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 to indicate the degree to which the model played a role in the agency/region's approach (major, intermediate, or minor). In funded agencies, directors and clinical staff cite an average

of 5 treatment models playing a major role in their overall approach. In nonfunded agencies, directors and clinical staff cite an average of 6 treatment models playing a major role in their overall approach. Overall, a good deal of consistency was apparent in the major models identified by directors and staff in both settings. The most frequently cited treatment models playing a major role in Maryland agencies are displayed in Exhibit 37. Maryland directors and clinicians in both funded and nonfunded settings frequently cited relapse prevention, 12-step, cognitive behavioral, and biopsychosocial as major models in their agency’s approach. This mix of major treatment models is very consistent with the mix reported in other states, as directors and clinicians in multiple states report relapse prevention, 12-step, and cognitive behavioral therapy constituting a major part of their treatment approach (Knudsen & Gabriel, 2003; Knudsen, Williams, Lucas, & Poplawski, 2004; Knudsen, Williams, & Perry, 2005).

Exhibit 37
Major Treatment Models Implemented

Funded Agencies		Nonfunded Agencies	
Models Most Frequently Cited as Playing a Major Role	Percent Indicating ^a	Models Most Frequently Cited as Playing a Major Role	Percent Indicating ^a
1. Relapse Prevention	68%	1. Relapse Prevention	68%
2. 12-Step	46%	2. 12-Step	51%
3. Cognitive Behavioral	39%	3. Cognitive Behavioral	45%
4. Biopsychosocial	33%	4. Biopsychosocial	43%
5. Integrated AOD & MH	33%	5. Coping Skills Therapy	40%

^aDirectors and Staff at funded agencies (*n* = 186) and nonfunded agencies (*n* = 133)

Proficiencies and Training Interests

Directors and clinical staff self-rated their proficiency and training interest in 28 counseling competency areas representing the Addiction Counseling Competencies (ACC’s). The ACC’s have been adopted nationally and were documented in CSAT’s Technical Assistance Publication (TAP) 21 in 1998. Proficiency was rated on a scale from 1 (*no proficiency*) to 7 (*complete proficiency*), while training interest was rated on a scale from 1 (*no interest*) to 5 (*maximum interest*). Exhibits 38 and 39 display mean ratings for both directors and clinical staff in both settings.

Exhibit 38
Respondents' Ratings at Funded Agencies of Personal Proficiency
and Interest in the Addiction Counseling Competencies

Competency Area	Mean Rating ^a			
	Agency Directors ^b		Clinical Staff ^c	
	Proficiency	Interest	Proficiency	Interest
Administrative/management	6.10	3.93	5.03	3.19
Adolescent treatment	4.58	2.65	4.55	3.43
Client, family, and community education	5.81	3.38	5.49	3.93
Clinical supervision	5.90	3.96	4.53	3.67
Co-occurring disorders	5.63	4.04	5.68	4.36
Detoxification	4.44	3.08	4.46	3.71
Documentation	6.40	2.81	6.27	3.39
Drug pharmacology/pharmacotherapy	5.38	3.63	5.16	4.03
Gender-specific treatment	5.40	3.44	5.32	3.87
Group counseling	6.00	3.22	6.07	4.05
Individual counseling	6.50	3.22	6.32	4.07
Interpersonal communication	6.60	3.59	6.32	3.87
Intervention skills	6.14	3.38	5.94	4.04
Lesbian/gay/bisexual/transsexual-specific tx	4.17	2.96	4.42	3.65
Marriage and family therapy	4.55	3.04	4.39	3.98
Offender treatment	5.43	3.26	5.07	3.67
Patient placement criteria	6.07	3.00	5.58	3.63
Professional/ethical responsibilities	6.47	3.48	6.43	3.73
Racial/ethnic-specific treatment	5.48	3.70	5.50	3.90
Referral skills	6.23	2.81	5.90	3.70
Relationship between SA and medical problems	5.70	3.75	5.73	4.04
Screening/assessment	6.23	3.23	6.16	3.78
Service coordination and case management	6.07	3.37	5.91	3.60
Signs and symptoms	6.13	3.22	6.22	3.83
Staff recruitment	5.74	4.18	4.36	2.96
Staff retention	5.97	4.22	4.33	3.15
Treatment engagement	5.83	3.93	6.00	3.90
Treatment planning	5.90	3.48	6.15	3.82

^aProficiency range is 1 (none) to 7 (completely); Interest range is 1 (no interest) to 5 (maximum interest). ^bn = 30. ^cn = 156.

Exhibit 39
Respondents' Ratings at Nonfunded Agencies of Personal Proficiency
and Interest in the Addiction Counseling Competencies

Competency Area	Mean Rating ^a			
	Agency Directors ^b		Clinical Staff ^c	
	Proficiency	Interest	Proficiency	Interest
Administrative/management	6.07	3.62	5.21	3.15
Adolescent treatment	4.00	2.77	4.32	2.86
Client, family, and community education	5.52	3.30	5.47	3.59
Clinical supervision	5.23	3.61	5.08	3.37
Co-occurring disorders	5.71	3.83	5.50	3.96
Detoxification	4.17	3.04	4.52	3.36
Documentation	6.26	2.96	6.20	3.10
Drug pharmacology/pharmacotherapy	5.05	3.59	5.19	3.84
Gender-specific treatment	5.09	3.35	5.06	3.53
Group counseling	5.65	3.29	6.09	3.79
Individual counseling	6.43	3.19	6.19	3.78
Interpersonal communication	6.09	3.50	6.13	3.73
Intervention skills	5.25	3.23	5.74	3.86
Lesbian/gay/bisexual/transsexual-specific Tx	3.68	2.64	4.13	3.34
Marriage and family therapy	4.74	2.86	4.36	3.42
Offender treatment	4.68	3.18	4.84	3.59
Patient placement criteria	5.48	3.04	5.46	3.33
Professional/ethical responsibilities	6.69	3.30	6.19	3.51
Racial/ethnic-specific treatment	4.86	3.30	5.20	3.45
Referral skills	5.96	3.32	5.78	3.30
Relationship between SA and medical problems	5.57	3.32	5.63	3.82
Screening/assessment	6.25	3.26	6.07	3.53
Service coordination and case management	5.67	2.86	5.79	3.39
Signs and symptoms	6.23	3.09	6.14	3.55
Staff recruitment	5.48	3.38	4.60	2.92
Staff retention	5.71	3.46	4.62	2.98
Treatment engagement	5.86	3.39	5.80	3.67
Treatment planning	5.77	3.46	5.97	3.67

^aProficiency range is 1 (none) to 7 (completely); Interest range is 1 (no interest) to 5 (maximum interest). ^bn = 27. ^cn = 103.

In order to identify training priorities for Maryland, it is important to consider both the relative proficiency and interest in each competency area. Competency areas are examined via a training priority matrix (Exhibit 40) which places competency areas in 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.

**Exhibit 40
Training Priority Matrix**

Proficiency: High → Low

Interest: Low → High	Level 2 Training Priority High Proficiency High Interest	Level 1 Training Priority Low Proficiency High Interest
	Level 4 Training Priority High Proficiency Low Interest	Level 3 Training Priority Low Proficiency Low Interest

Exhibits 41 through 44 display training priorities separately for agency directors and clinical staff in funded and nonfunded agencies to better match needs.

Exhibit 41 Training Priorities for Agency Directors—Funded Setting

Priority Level 1: Higher Interest, Lower Proficiency

- Client, family, and community education
- Co-occurring disorders
- Drug pharmacology/pharmacotherapy
- Gender-specific treatment
- Racial/ethnic-specific treatment
- Relationship between substance abuse and medical problems
- Staff recruitment
- Treatment engagement

Priority Level 2: Lower Interest, Lower Proficiency

- Adolescent treatment
- Detoxification
- Lesbian/gay/bisexual/transsexual-specific treatment
- Marriage and family therapy
- Offender treatment

Priority Level 3: Higher Interest, Higher Proficiency

- Administrative/management
- Clinical supervision
- Interpersonal communication
- Intervention skills
- Professional/ethical responsibilities
- Service coordination and case management
- Staff retention
- Treatment planning

Priority Level 4: Lower Interest, Higher Proficiency

- Documentation
- Group counseling
- Individual counseling
- Patient placement criteria
- Referral skills
- Screening/assessment
- Signs and symptoms

Note. Proficiency range is 1 (*none*) to 7 (*completely*); Interest range is 1 (*no interest*) to 5 (*maximum interest*). Median total proficiency (5.84) and interest (3.36) were used as cut-off scores for higher/lower distinctions.

Exhibit 42

Training Priorities for Agency Directors—Nonfunded Setting

Priority Level 1: Higher Interest, Lower Proficiency

- Clinical supervision
- Drug pharmacology/pharmacotherapy
- Gender-specific treatment
- Staff recruitment

Priority Level 2: Lower Interest, Lower Proficiency

- Adolescent treatment
- Client, family, and community education
- Detoxification
- Group counseling
- Intervention skills
- Lesbian/gay/bisexual/transsexual-specific treatment
- Marriage and family therapy
- Offender treatment
- Patient placement criteria
- Racial/ethnic-specific treatment
- Relationship between substance abuse and medical problems
- Service coordination and case management

Priority Level 3: Higher Interest, Higher Proficiency

- Administrative/management
- Co-occurring disorders
- Interpersonal communication
- Staff retention
- Treatment engagement
- Treatment planning

Priority Level 4: Lower Interest, Higher Proficiency

- Documentation
- Individual counseling
- Professional/ethical responsibilities
- Referral skills
- Screening/assessment
- Signs and symptoms

Note. Proficiency range is 1 (*none*) to 7 (*completely*); Interest range is 1 (*no interest*) to 5 (*maximum interest*). Median total proficiency (5.71) and interest (3.32) were used as cut-off scores for higher/lower distinctions.

Exhibit 43
Training Priorities for Clinical Staff—Funded Setting

Priority Level 1: Higher Interest, Lower Proficiency

- Drug pharmacology/pharmacotherapy
- Gender-specific treatment
- Marriage and family therapy

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

- Client, family, and community education
- Co-occurring disorders
- Group counseling
- Individual counseling
- Interpersonal communication
- Intervention skills
- Racial/ethnic-specific treatment
- Relationship between substance abuse and medical problems
- Screening/assessment
- Signs and symptoms
- Treatment engagement
- Treatment planning

Priority Level 4: Lower Interest, Higher Proficiency

- Documentation
- Patient placement criteria
- Professional/ethical responsibilities
- Referral skills
- Service coordination and case management

Note. Proficiency range is 1 (*none*) to 7 (*completely*); Interest range is 1 (*no interest*) to 5 (*maximum interest*). Median total proficiency (5.46) and interest (3.75) were used as cut-off scores for higher/lower distinctions.

Exhibit 44 Training Priorities for Clinical Staff—Nonfunded Setting

Priority Level 1: Higher Interest, Lower Proficiency

- Co-occurring disorders
- Drug pharmacology/pharmacotherapy

Priority Level 2: Lower Interest, Lower Proficiency

- Administrative/management
- Adolescent treatment
- Client, family and community education
- Clinical supervision
- Detoxification
- Gender-specific treatment
- Lesbian/gay/bisexual/transsexual-specific treatment
- Marriage and family therapy
- Offender treatment
- Patient placement criteria
- Racial/ethnic-specific treatment
- Staff recruitment
- Staff retention

Priority Level 3: Higher Interest, Higher Proficiency

- Group counseling
- Individual counseling
- Interpersonal communication
- Intervention skills
- Relationship between substance abuse and medical problems
- Treatment engagement
- Treatment planning

Priority Level 4: Lower Interest, Higher Proficiency

- Documentation
- Professional/ethical responsibilities
- Referral skills
- Screening/assessment
- Service coordination and case management
- Signs and symptoms

Note. Proficiency range is 1 (*none*) to 7 (*completely*); Interest range is 1 (*no interest*) to 5 (*maximum interest*). Median total proficiency (5.54) and interest (3.61) were used as cut-off scores for higher/lower distinctions.

Using this matrix approach, it appears that directors and clinical staff in both funded and nonfunded agencies may have quite different training priorities. It should be emphasized, however, that drug pharmacology/pharmacotherapy appeared as a Level 1 training priority for directors and staff in both settings.

<p>Baltimore City Fast Fact:</p>	<p><i>Training priorities for clinicians in Baltimore City may be different from those in other parts of the state. While no significant differences appear in terms of proficiencies, clinicians in Baltimore City express significantly more interest in receiving training in clinical supervision, LGBT treatment, offender treatment, and racial/ethnic specific treatment.</i></p>
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Technology Access and Use

Directors and clinical staff were asked a series of questions regarding the availability of computers and other web-based technology and how that technology is utilized. Exhibit 45 displays the reported access of computers and internet at both work and home. Overall, a high percentage of both directors and staff reporting having access to computers and internet at home and at work.

**Exhibit 45
Access to Technology**

Technology	Funded Agency		Nonfunded Agency	
	Agency Directors ^a	Treatment Staff ^b	Agency Directors ^c	Treatment Staff ^d
Computer access at work	31 (100%)	151 (97%)	27 (100%)	98 (93%)
Internet access at work	31 (100%)	143 (92%)	27 (100%)	82 (77%)
Computer access at home	28 (90%)	138 (89%)	25 (93%)	96 (91%)
Internet access at home	28 (90%)	124 (80%)	23 (85%)	90 (85%)

Note. Respondents were asked to check all that apply.
^an = 31. ^bn = 155. ^cn = 27. ^dn = 106.

Exhibit 46 displays the frequency of directors and staff reporting use of technology for common work related tasks. In both funded and nonfunded settings, a statistically significant larger proportion of directors than staff report using technology for billing ($p < .01$) and email/correspondence ($p < .01$). Interestingly, a statistically significant larger proportion of staff in funded agencies than staff in nonfunded agencies reported

using technology to conduct AOD research ($p < .05$), for client information/clinical issues ($p < .001$), and for web-based professional development ($p < .05$). Despite this difference in technology use, over 89% of the entire workforce in Maryland reported feeling comfortable using computers and web-based technologies to obtain information about substance use.

Exhibit 46 Use of Technology

Reason for using computer and web-based technologies	Funded Agency		Nonfunded Agency	
	Agency Directors ^a	Treatment Staff ^b	Agency Directors ^c	Treatment Staff ^d
Billing	10 (32%)	18 (12%)	11 (41%)	18 (17%)
AOD research	22 (71%)	104 (67%)	20 (74%)	59 (56%)
E-mail/correspondence	31 (100%)	118 (76%)	20 (74%)	46 (43%)
Client information/clinical issues	22 (71%)	102 (66%)	20 (74%)	57 (54%)
Web-based professional development	17 (55%)	69 (45%)	11 (41%)	32 (30%)

Note. Respondents were asked to check all that apply.

^a $n = 31$. ^b $n = 155$. ^c $n = 27$. ^d $n = 106$.

As displayed in Exhibit 47, reported attitudes regarding technology reflect that the majority of the workforce feels that technology contributes to their effectiveness at their job. Interest in web-based education and further integrating technology is more varied however. Perceived organizational support for technology use also appears to be quite varied. Interestingly, these differences are not significantly related to age, gender, degree status, or recovery status.

Exhibit 47
Attitudes Toward Technology

Variable	Funded Agency		Nonfunded Agency	
	Agency Directors ^a	Treatment Staff ^b	Agency Directors ^c	Treatment Staff ^d
Using computers and web-based technology helps me be more effective at my job	27 (87%)	130 (86%)	22 (82%)	80 (77%)
I am interested in web-based professional education	16 (51%)	95 (64%)	19 (70%)	62 (61%)
I would like to use the computer and web-based technology in my work more	20 (67%)	19 (52%)	14 (53%)	59 (57%)
My organization encourages the use of computers and web-based technologies	22 (71%)	102 (67%)	15 (56%)	51 (49%)

Note. Responses represent those who agree or strongly agree.

^a*n* = 31. ^b*n* = 155. ^c*n* = 27. ^d*n* = 106.

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