

Tennessee Workforce Survey 2004

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

Prepared for
Central East Addiction Technology Transfer Center
8737 Colesville Road, Suite 300
Silver Spring, MD 20910

Prepared by
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December 1, 2005

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December 1, 2005

Executive Summary

Today's workforce development implies more than employment training in the narrow sense: it means substantial employer engagement, deep community connections of the agency, career advancement, best-practice education and training, and substance-abuse focused college programs. This conclusion implicates three areas of workforce development: (a) retention and advancement, (b) race and labor markets, and (c) best practices and replication.

Retention and advancement must be a priority for the entire field of substance abuse. To replace the aging baby-boomer generation of management, it is essential that management training and mentoring be an active component of our long term strategy.

Race and labor markets are not only about representation. In reality the challenge is more than that. It is about building a multicultural community, one that goes beyond toleration and even celebration of differences; but to a full inclusion and integration of socially constructed differences and differential treatment, including the allocation of resources along the lines of gender, economic class, job status, sexual orientation, age or generational status, physical ability and religion.

Best-practice guidelines and training are necessary elements of professional and program development, but these alone are not sufficient to bring about substantive improvements in practice and programming. Research and experience teach us that a range of other factors also influence practice and need to be considered as part of the broader notion of "workforce development".

These include a coherent context for planning and practice (i.e., a drug reduction strategy), professional affiliation, program accreditation and practitioner licensure schemes, academic scholarship programs and, at the organizational level, performance-monitoring systems, job specifications, resource allocation and management priorities, and support strategies for skills and knowledge acquisition.

In short, we need to educate our workforce to be competent and we need to educate our providers in how to sustain competency. It will not be enough to educate providers in the theory of competent care. We also have to develop new organizational policies and procedures that will support, facilitate, and reward competent care in practice. We must make certain that competency at any level is defined by accountability, capacity-building, and effectiveness in supporting positive outcomes for the individuals we serve.

In an effort to document the current state of the workforce, the Bureau of Alcohol & Drug Abuse Services supported a survey of behavioral health professionals in Tennessee. In 2004, RMC Research Corporation, in collaboration with the Central East Addiction Technology Transfer Center (CEATTC) conducted a statewide workforce study. Surveys were sent to the agency directors of 51 state contract agencies and 72 licensed agencies. Follow-up efforts resulted in a response rate of 42%, yielding responses from 52 agency directors and 247 clinical staff. Highlights of the report include:

- In contract agencies, 50% of agency directors and 62% of clinical staff reported being female. In licensed agencies, 52% of agency directors and 57% of clinical staff reported being female.
- The majority of directors in contract agencies (85%) and licensed agencies (83%) reported being white. The same holds true for clinical staff, with 64% of clinical staff in contract agencies and 75% of clinical staff in licensed agencies reported being white. A higher proportion of clinical staff than directors in both settings reported being African American.
- Very few directors and clinical staff in either setting reported being Hispanic.
- At contract agencies, the average age for those surveyed was 51 years old for directors and 46 years old for clinical staff. At licensed agencies, the average age for those surveyed was 50 years old for directors and 45 years old for clinical staff. Overall, directors and staff exhibit an age range of 22–72 years old.
- In contract agencies, 78% of agency directors and 66% of clinical staff had a Bachelors degree or above. In licensed agencies, 78% of agency directors and 86% of clinical staff had a Bachelors degree or above.

- A statistically significant larger proportion of clinical staff at licensed agencies reported having a Masters degree than did clinical staff at contract agencies ($p < .001$).
- The majority of agency directors and clinical staff in both settings did not hold a degree or certificate specific to AOD. Nearly 40% of clinical staff across both settings reported not having any formal coursework specific to AOD.
- In contract agencies, the 77% of directors and 85% clinical staff reported attending AOD training in the past year. In licensed agencies, 87% of directors and 83% of clinical staff reported attending AOD training in the past year.
- In the past 2 years, clinical staff at contract agencies reported an average of 55 training hours while clinical staff at licensed agencies reported an average of 39 training hours, a difference that is statistically significant.
- Overall, fewer than 50% of the workforce reported currently being licensed. In contract agencies, 54% of agency directors and 37% of clinical staff reported currently being licensed. In licensed agencies, 50% of agency directors and 40% of clinical staff reported currently being licensed.
- A significant proportion of clinical staff at both contract agencies (25%) and licensed agencies (18%) reported pending licensure status.
- In both contract and licensed agencies a statistically significant larger proportion of agency directors reported having 10 or more years experience in the field, in their role, and in their current position than did clinical staff.
- In contract agencies, 35% of agency directors and 43% of clinical staff indicated that substance abuse treatment was a second career. In licensed agencies, 30% of agency directors and 48% of clinical staff indicated that substance abuse treatment was a second career.
- 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.
- In contract agencies, clinical staff reported spending approximately 63% of their time on client-related tasks, while agency directors reported spending 83% of

their time on administrative tasks. In licensed agencies, clinical staff reported spending approximately 65% of their time on client-related tasks, while agency directors reported spending 78% of their time on administrative tasks.

- Consistent with results from other survey efforts, reported time spent on paperwork constituted approximately a day a week for clinical staff. Clinical staff in both settings also reported spending approximately a day a week providing individual counseling and a day a week providing group counseling.
- Agency size in Tennessee was quite variable based on setting. Across setting, reported agency size varied from 1 direct service clinical staff member to 75 direct service clinical staff.
- Both contract and licensed agencies in Tennessee are predominately located in urban areas.
- Overall, 77% of contract agency directors and 65% of licensed agency directors described their predominate financial setting as private, non-profit. Interestingly, only 4% of contract agency directors compare to 30% of licensed agency directors described their predominate financial setting as private, for profit.
- 70% of contract agencies reported that their operating budgets are comprised of 60% or more of public money (i.e., Medicaid, state general funds, federal block grants, state agency grants). Only 21% of licensed agencies receive the same percentage of public monies, and difference that is statistically significant ($p < .01$).
- Results indicate that a statistically significant higher proportion of contract agencies reported receiving state alcohol and drug abuse (SADA) funds from the Tennessee Bureau of Alcohol and Drug Abuse Services than did licensed agencies ($p < .001$).
- In contract agencies, 70% of directors reported making between \$40,000–\$74,999 a year, with 15% making over \$75,000 a year. Reported clinical staff salaries were much lower, with 72% making between \$15,000–\$34,999 a year. In licensed agencies, 48% of directors reported making between \$40,000–\$74,999 a year, with 14% making over \$75,000 a year. Reported clinical staff salaries

were again much lower, with 69% making between \$15,000–\$34,999 a year. Results indicate that differences in director and staff salaries were statistically significant ($p < .001$).

- Results indicate that two significant predictors of workforce salary exist in Tennessee—role (director versus clinical staff) and years of experience. Both being an agency director and having more experience predict higher salary.
- Results indicate that in both settings, a higher proportion of clinical staff than directors had health insurance fully provided.
- The majority of both directors and staff reported being fully provided with sick leave and other paid leave, most commonly defined as paid vacation.
- Based on directors' reports of staffing in the past year, the average turnover rate for clinical staff in contract agencies was 22%, while the average turnover rate for clinical staff in licensed agencies was 15%. Reported turnover appears to be worse in rural agencies.
- Interestingly, the majority of turnover across all settings was voluntary (quitting).
- Contract agencies reported an average clinical staff shortage of 1.50 full time employee (FTE), while licensed agencies reported a shortage of 0.94 FTE. Overall, agencies in Tennessee reported a clinical staff shortage of 1.27 FTE.
- Directors and clinical staff in both settings indicated that more frequent salary increases was the number one action agencies could take to promote retention. In addition, more individual recognition/appreciation, better health coverage and other benefits, promoting career growth, and providing support regarding paperwork were also frequently cited.
- Overall, director reports of recruiting difficulties in Tennessee are quite low compared to other states. In contract agencies, 63% of directors but only 34% of clinical staff reported recruiting difficulties. In licensed agencies, 48% of directors and 39% of clinical staff reported recruiting difficulties.
- A statistically significant higher proportion of directors than staff in contract agencies reported recruiting difficulties due to an insufficient number of

applicants meeting qualifications ($p < .01$). A statistically significant higher proportion of directors than staff in contract agencies also reported recruiting difficulties due to insufficient funding for open positions ($p < .05$).

- Directors and staff who identified an insufficient number of applicants meeting qualifications as a reason for recruiting difficulty most frequently reported that applicants had little or no experience in the field and had insufficient or inadequate training or education.
- Across the workforce, salary and competition from other fields in terms of salary, paperwork, and negative preconceptions were the most frequently cited barriers to entering the substance abuse treatment field.
- The majority of the workforce in Tennessee saw addiction counselors as having lower status than other helping professionals. The most frequently cited reason for lower status of addiction counselors by both directors and clinical staff was less formal education or training and more often having a history of own substance abuse.
- Directors and staff were asked to report the methods of recruitment used at their agency. Overall, more traditional techniques such as newspaper advertisement, personal contacts, and agency human resource departments were cited most frequently.
- For agency directors in both settings, the most frequently cited source of satisfaction was 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, opportunities for personal growth was a reason frequently cited as a source of satisfaction for clinical staff, but opportunities for career growth was not.
- In terms of areas of dissatisfaction, a statistically significant higher proportion of clinical staff than directors in contract agencies ($p < .001$) and licensed agencies ($p < .01$) cited salary as a source of dissatisfaction. Interestingly, a statistically

significant higher proportion of directors than clinical staff in contract agencies ($p < .001$) and licensed agencies ($p < .05$) reported no source of dissatisfaction.

- Contract agency directors and clinical staff cite an average of 5 treatment models playing a major role in their overall approach. Licensed agency directors and clinical staff cite an average of 6–8 treatment models playing a major role in their overall approach.
- A good deal of consistency was apparent in the major models identified by directors and staff in both settings. Overall, Tennessee directors and clinicians frequently cited relapse prevention, 12-step, cognitive behavioral, and integrated AOD/mental health as major models in their agency's approach.
- Results indicate that the workforce in Tennessee has multiple overlapping training priorities. Clinical staff in both settings identified drug pharmacology/ pharmacotherapy, gender specific treatment, racial/ethnic specific treatment, and marriage and family therapy as high level training priorities. Agency directors in both settings identified co-occurring disorders and drug pharmacology/ pharmacotherapy as high level training priorities.

Introduction

The Tennessee Bureau of Alcohol and Drug Abuse Services of the Tennessee Department of Health oversees substance abuse treatment and prevention services in the state of Tennessee. The Bureau 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. The Bureau contracts with a number of substance abuse treatment and prevention agencies to provide the full range of treatment, intervention and prevention services. However, most of the training and technical assistance for professionals and the public is carried out by the State Training Director, who coordinates these activities through 6 Regional Training Coordinators who are located strategically throughout the state. The Bureau also licenses and monitors all contract and non-contract substance abuse agencies throughout the state.

In recent years the Bureau has become concerned about the decreasing numbers of professionals entering the field of behavioral health and other workforce related issues. To begin addressing these issues, the Training Office within the Tennessee Bureau of Alcohol and Drug Abuse Services, under the guidance of the Deputy Commissioner of Health 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 Tennessee by continuing to build and develop a competent and professional workforce.

As part of this initiative, the Central East Addiction Technology Transfer Center (CEATTC) in conjunction with the Tennessee Bureau of Alcohol and Drug Abuse Services and RMC Research Corporation (RMC) developed a workforce survey for professionals in the field of substance abuse treatment. 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 treatment. The data obtained from this survey will assist the Bureau of Alcohol and Drug Abuse Services in identifying goals to help improve the quality of the

substance abuse treatment workforce and in retaining qualified professionals in this field.

The workforce survey was sent out to all the directors and a representative sample of substance abuse treatment staff at the 53 contract substance abuse treatment agencies in the state. Surveys were also sent to a representative sample of directors and staff at the licensed non-contract substance abuse treatment agencies in the state.

Instrumentation

The Tennessee Substance Abuse Treatment Workforce Development Survey 2004 was a modified version of the instrument originally used in 1999–2000 by RMC Research Corporation and the Northwest Frontier Addiction Technology Transfer Center (NFATTC). In the spring of 2004, the CEATTC met with the Deputy Commissioner of Health and the Bureau's Office of Training to discuss the survey process. During the course of the spring, modifications and additions were made to the survey instrument based on the recommendations of the CEATTC, Bureau staff, and other key stakeholders. Questions were added, deleted or changed in order to meet the specific needs and interests of Tennessee's substance abuse treatment workforce. Two versions of the survey instrument were created, an agency director's version and a version for clinical staff. The clinical staff survey is identical to the director's survey with the exception of a set of questions related to administrative issues, which were more appropriately answered by agency directors.

Sampling

After discussions with Bureau staff and other key stakeholders it was decided that for the purposes of this study, the most appropriate targets of this survey were: substance abuse treatment agency directors and substance abuse treatment personnel which 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. It was also decided that all state contracted substance abuse treatment agencies and a representative sample of all licensed non-contract substance abuse treatment agencies would be surveyed. Once this was decided; information was obtained regarding the total number of staff at each of the contract agencies that fit the previously mentioned definition. Based on the number of staff meeting the criteria at each agency, a sampling percentage was determined for both contract and licensed non-contract agencies.

Survey Administration

An agency director survey was sent to all 53 of the contract substance abuse treatment agencies and a representative sample of all the licensed non-contract substance treatment agencies in the state ($n = 78$). A cover letter from the Deputy Commissioner of Health explaining the survey process and prepaid envelopes for return of the surveys were sent to each agency director. An instruction sheet with guidance on how many surveys should be passed out based on the number of substance abuse counselors meeting criteria in each particular agency 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 was coded using a unique identification code to maintain confidentiality for all respondents. Once completed, surveys were placed in the prepaid envelopes and returned to the CEATTC where they were then logged into a tracking database. In total, 739 substance abuse treatment professionals at 131 agencies (53 contract; 78 licensed) were sent surveys. Two contract agencies and 6 licensed agencies, along with corresponding clinical staff, were later removed from the sample because of closures.

Follow Up Strategy & Response Rate

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

Response rates for both agency directors and clinical staff are displayed below in Exhibits 1 and 2. In total, directors from 52 agencies responded to the survey, yielding a 42% response rate. A total of 247 staff surveys were returned, yielding a response rate of 34%.

Exhibit 1
Response Rate for Agency Directors

Type of Agency	Number of Agencies	Sampling	Sample		Response	
			Final	Adjusted	Number	Rate
Contract	53	100%	53	51	29	56%
Licensed	78	100%	78	72	23	32%
Combined	131	100%	131	123	52	42%

Exhibit 2
Response Rate for Clinical Staff

Type of Agency	Number of		Adjusted Sample ^a	Completed Surveys	
	Agencies	Clinical Staff		Number	Rate
Contract	53	336	324	143	44%
Licensed	78	403	403	104	26%
Combined	131	739	727	247	34%

^aSample was adjusted due to agency closures.

Results

Survey results are presented by topical category. Descriptive results are reported by staff “role” (director versus clinical staff responses). Agency director and clinical staff responses are also examined by “setting” (contract versus licensed agencies).

All data was examined using cross-tabulations. Chi square analyses were conducted on all cross tabulations to identify statistically significant differences. Analysis of variance (ANOVA) was also utilized to examine differences between groups when appropriate. Statistical differences within role and across agency type are reported if significant. In addition, multiple linear regression was used to identify significant predictors of salary.

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

Workforce Demographics

Workforce demographics are displayed in Exhibit 3. In contract agencies, 50% of agency directors and 62% of clinical staff reported being female. In licensed agencies, 52% of agency directors and 57% of clinical staff reported being female. The majority of directors in contract agencies (85%) and licensed agencies (83%) reported being white. The same holds true for clinical staff, with 64% of clinical staff in contract agencies and 75% of clinical staff in licensed agencies reported being white. A higher proportion of clinical staff than directors in both settings reported being African American. Very few directors and clinical staff in either setting reported being Hispanic. No statistically significant differences in gender or race/ethnicity appeared by role or setting.

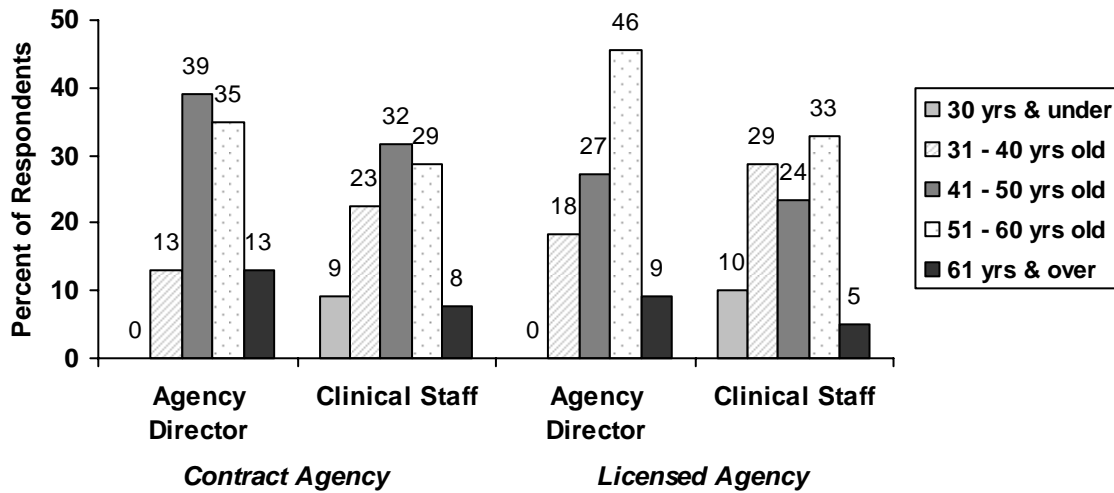
Exhibit 3
Gender and Ethnicity of Respondents

Characteristic	Contract Agency		Licensed Agency	
	Agency Directors ^a	Treatment Staff ^b	Agency Directors ^c	Treatment Staff ^d
Gender				
Female	13 (50%)	87 (62%)	12 (52%)	59 (57%)
Male	13 (50%)	54 (38%)	11 (48%)	45 (43%)
Ethnicity				
Not Hispanic	26 (90%)	117 (82%)	17 (74%)	92 (88%)
Cuban	0 (0%)	1 (1%)	0 (0%)	0 (0%)
Mexican	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Puerto Rican	1 (3%)	1 (1%)	0 (0%)	0 (0%)
Other Hispanic	0 (0%)	1 (1%)	0 (0%)	0 (0%)
Unknown	2 (7%)	23 (16%)	6 (26%)	12 (13%)
Race				
African American	3 (12%)	44 (31%)	3 (13%)	21 (20%)
African American/other	0 (0%)	2 (1%)	0 (0%)	1 (1%)
Asian	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Asian/other	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Caucasian	22 (85%)	90 (64%)	19 (83%)	78 (75%)
Caucasian/other	1 (4%)	3 (2%)	1 (4%)	3 (3%)
American Indian	0 (0%)	1 (1%)	0 (0%)	0 (0%)
American Indian/other	0 (0%)	0 (0%)	0 (0%)	1 (1%)
Multi	0 (0%)	1 (1%)	0 (0%)	0 (0%)
Other	0 (0%)	0 (0%)	0 (0%)	0 (0%)

Note. Respondents were asked to check all that apply.
^an = 29. ^bn = 143. ^cn = 23. ^dn = 104.

At contract agencies, the average age for those surveyed was 51 years old for directors and 46 years old for clinical staff. At licensed agencies, the average age for those surveyed was 50 years old for directors and 45 years old for clinical staff. Overall, directors and staff exhibit an age range of 22–72 years old. Exhibit 4 below displays age category by role for both settings.

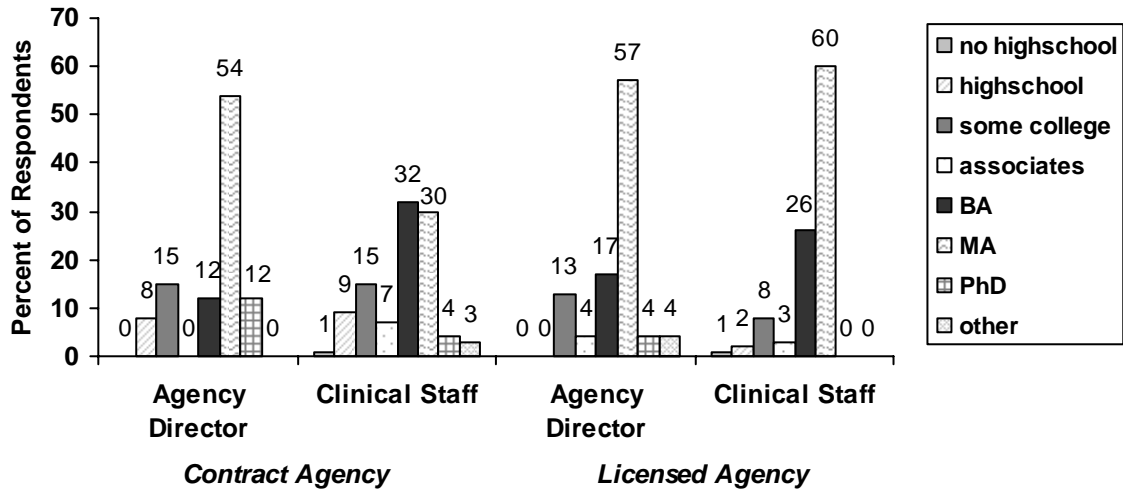
Exhibit 4 Age of Respondents



Academic & Professional Background

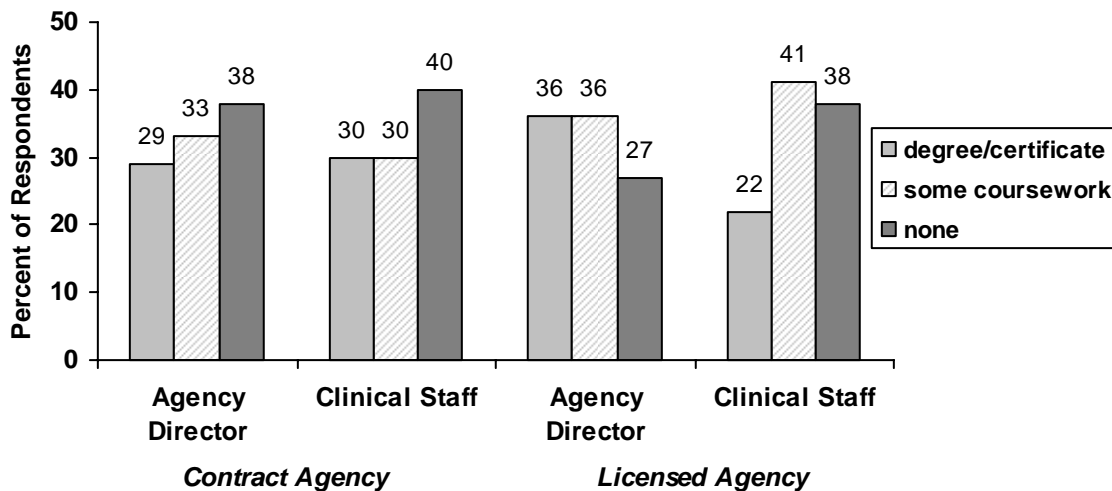
Exhibit 5 displays degree status by role for both contract and licensed settings. In contract agencies, 78% of agency directors and 66% of clinical staff had a Bachelors degree or above. In licensed agencies, 78% of agency directors and 86% of clinical staff had a Bachelors degree or above. The difference in degree status between clinical staff at contract and licensed agencies is significant. Chi square analysis indicates that a statistically significant larger proportion of clinical staff at licensed agencies reported having a Masters degree than did clinical staff at contract agencies ($p < .001$). No significant differences in degree status existed between agency directors at contract and licensed agencies.

Exhibit 5 Degree Status of Respondents



In addition to degree status, the amount of educational background specific to alcohol and other drugs (AOD) was also examined. As Exhibit 6 displays, the majority of agency directors and clinical staff in both settings did not hold a degree or certificate specific to AOD. In fact, a large proportion of the workforce reported having no AOD specific coursework. Nearly 40% of clinical staff across both settings reported not having any formal coursework specific to AOD. No significant differences exist between directors and clinical staff or by agency setting.

**Exhibit 6
AOD Coursework Completed by Respondents**

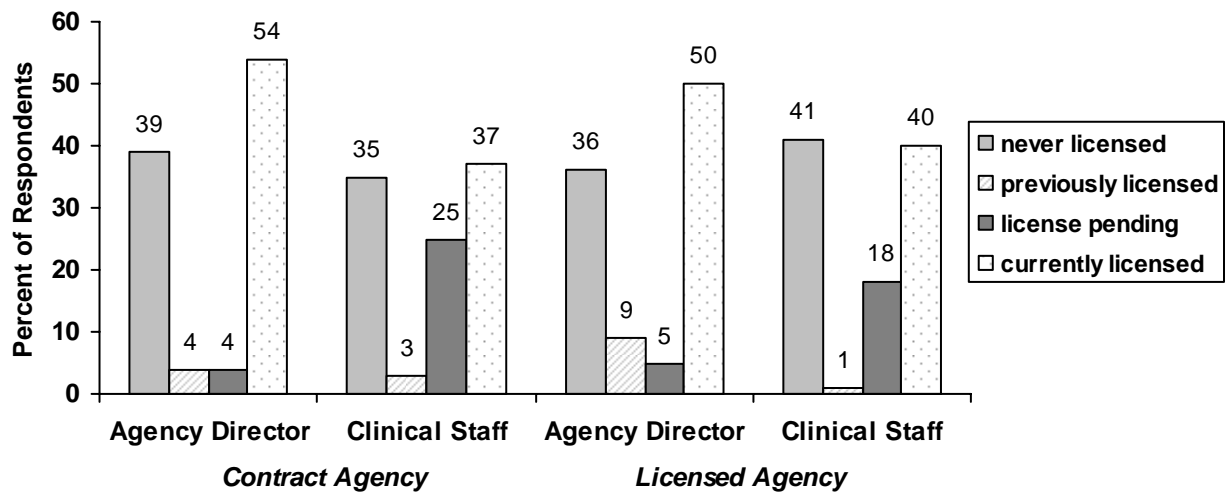


With a large proportion of the workforce without AOD specific degrees and/or coursework, the role of training becomes extremely important. In contract agencies, the 77% of directors and 85% clinical staff reported attending AOD training in the past year. In licensed agencies, 87% of directors and 83% of clinical staff reported attending AOD training in the past year. In the past 2 years, agency directors at contract agencies reported an average of 45 training hours while agency directors at licensed agencies reported an average of 39 training hours. In the past 2 years, clinical staff at contract agencies reported an average of 55 training hours while clinical staff at licensed agencies reported an average of 39 training hours. Analysis of variance (ANOVA) indicates that this difference between clinical staff is statistically significant ($F = 7.024$; $p = .009$).

Exhibit 7 displays licensure status by role across both settings. Overall, fewer than 50% of the workforce reported currently being licensed. In contract agencies, 54% of agency directors and 37% of clinical staff reported currently being licensed. In licensed agencies, 50% of agency directors and 40% of clinical staff reported currently being licensed. A significant proportion of clinical staff at both contract agencies (25%) and licensed agencies (18%) reported pending licensure status. Those citing pending

licensure most frequently reported pursuing the following: Licensed Professional Counselor (LPC), Licensed Alcohol and Drug Abuse Counselor (LADAC), and Certified Masters in Social Work (CMSW). No significant difference existed between the licensure status of agency directors and clinical staff by setting.

**Exhibit 7
Licensure Status of Respondents**



As displayed in Exhibit 8, 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. Multiple differences are apparent in these numbers. Chi square analysis indicates that in contract agencies a statistically significant larger proportion of agency directors reported having 10 or more years experience in the field ($p < .05$), in their role ($p < .001$), and in their current position ($p < .001$) than did clinical staff. Chi square analysis indicates that in licensed agencies a statistically significant larger proportion of agency directors reported having 10 or more years of experience in the field ($p < .05$) and in their role ($p < .01$) than did clinical staff. A large difference in years in their current position was reported between agency directors at contract and licensed agencies, although this difference was not statistically significant.

Exhibit 8 Work Experience of Respondents

Number of Years	Contract Agency		Licensed Agency	
	Agency Directors ^a	Clinical Staff ^b	Agency Directors ^c	Clinical Staff ^d
In AOD Field				
0–3 yrs	5 (19%)	41 (29%)	1 (4%)	31 (30%)
3–5 yrs	0 (0%)	17 (12%)	1 (4%)	10 (10%)
5–10 yrs	3 (11%)	25 (18%)	4 (17%)	18 (18%)
10 + yrs	18 (69%)	58 (41%)	17 (74%)	44 (43%)
In Current Role				
0–3 yrs	3 (10%)	24 (17%)	0 (0%)	19 (18%)
3–5 yrs	0 (0%)	33 (23%)	1 (4%)	19 (18%)
5–10 yrs	3 (10%)	27 (19%)	4 (17%)	19 (18%)
10 + yrs	23 (79%)	59 (41%)	18 (78%)	47 (45%)
In Current Position				
0–3 yrs	9 (35%)	72 (53%)	6 (27%)	53 (51%)
3–5 yrs	1 (4%)	23 (17%)	5 (23%)	20 (19%)
5–10 yrs	3 (12%)	29 (21%)	6 (27%)	20 (19%)
10 + yrs	13 (50%)	13 (10%)	5 (23%)	9 (9%)

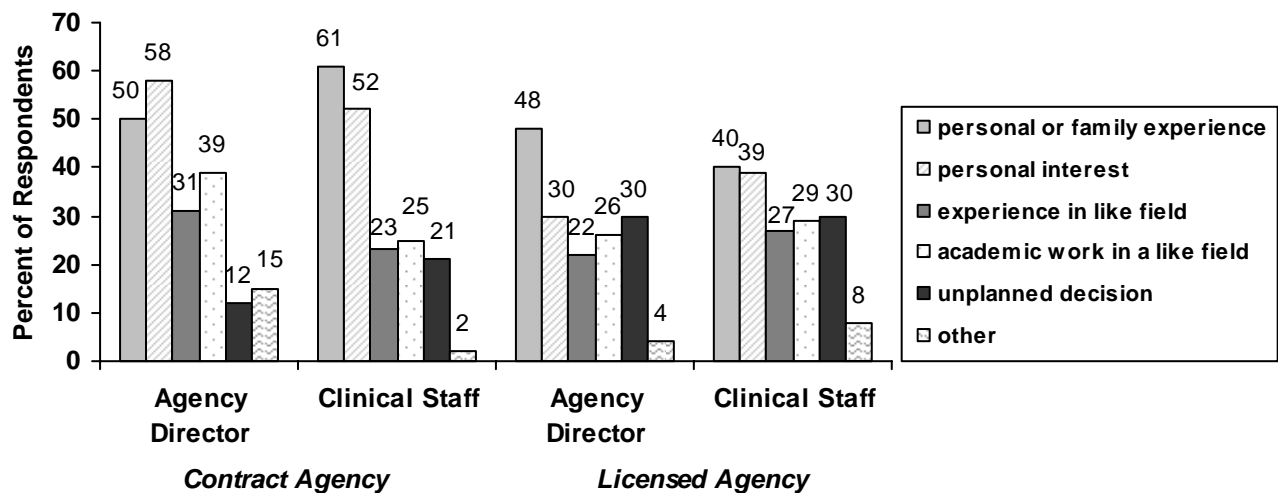
Note. ^an = 29. ^bn = 143. ^cn = 23. ^dn = 104.

A relatively large proportion of the workforce indicated that their current work was a second career. In contract agencies, 35% of agency directors and 43% of clinical staff indicated that substance abuse treatment was a second career. In licensed agencies, 30% of agency directors and 48% of clinical staff indicated that substance abuse treatment was a second career.

Exhibit 9 displays reason 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 as a whole. A few significant differences exist however. A statistically significant higher proportion of directors at contract agencies reported a personal interest in the field ($p < .05$) as a reason for entering the field than did directors at licensed agencies. In addition, a statistically significant higher proportion of clinical staff at contract agencies reported a

personal or family experience with addictions ($p < .001$) and a personal interest in the field ($p < .05$) as a reason for entering the field than did clinical staff at licensed agencies. Finally, a larger proportion of the workforce in the licensed setting reported entry into the field as being an unplanned decision than did the workforce in contract agencies, although this difference is not statistically significant.

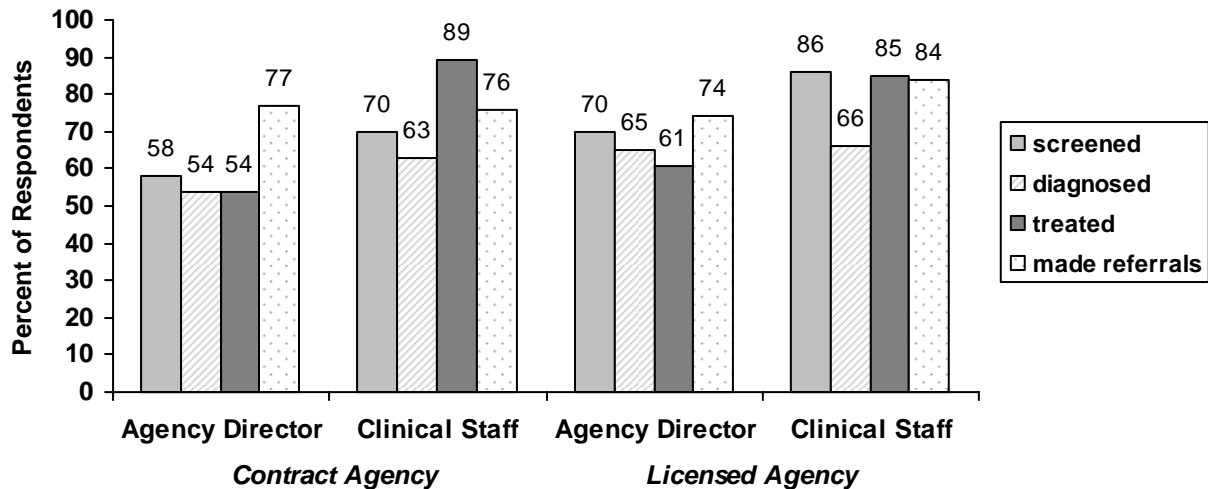
**Exhibit 9
Respondents' Reasons for Entry into Field**



Job Detail

Directors and clinical staff in both settings were asked if in the past year they had conducted any of the following client-related tasks: screened, diagnosed, treated, or made referrals for clients. Exhibit 10 displays client related tasks by role for both settings. A few interesting differences are apparent. Not surprisingly, a statistically significant higher proportion of clinical staff in contract agencies ($p < .001$) and in licensed agencies ($p < .01$) reported treating clients in the past year than did agency directors. Interestingly, a statistically significant larger proportion of clinical staff in licensed agencies reported screening in the past year than did clinical staff in contract agencies ($p < .01$).

Exhibit 10 Client-Related Tasks Conducted by Respondents



Directors and clinical staff were also asked to identify the amount of time spent on various tasks in a typical week. Exhibit 11 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 contract agencies, clinical staff reported spending approximately 63% of their time on client-related tasks, while agency directors reported spending 83% of their time on administrative tasks. In licensed agencies, clinical staff reported spending approximately 65% of their time on client-related tasks, while agency directors reported spending 78% of their time on administrative tasks. Interestingly, directors in rural zip codes reported spending 34% of their time on client-related tasks, compared to directors in urban and suburban zip codes who reported spending 15% of their time on client-related tasks. Clinical staff in both settings reported spending equal time providing individual and group counseling. Interestingly, very little time is spent providing family counseling. Consistent with results from other survey efforts, reported time spent on paperwork constituted approximately a day a week for clinical staff (Knudsen, Williams, Lucas, and Poplawski, 2004; Knudsen & Gabriel, 2003; Knudsen, 2003). Directors at licensed agencies reported more time spent on the provision of clinical supervision (18%) than did directors at contract agencies (12%).

Exhibit 11
Respondents' Time Spent per Task

Task Type	Task	Mean Percentage of Work Time			
		Contract Agency		Licensed Agency	
		Agency Directors ^a	Treatment Staff ^b	Agency Directors ^c	Treatment Staff ^d
Client-Related	Screening & Assessments	5	11	9	14
	Individual Counseling	5	21	4	24
	Group Sessions	5	20	5	18
	Family Counseling	1	3	1	4
	Case Management	2	8	2	6
Administrative	Clinical Supervision	12	6	18	5
	Clinical Paperwork	20	23	13	19
	Other Admin. Activities	35	6	44	8
	Other Activities	15	2	3	3

Note. Included in sample if total time added to 90–110.
^a*n* = 25. ^b*n* = 125. ^c*n* = 18. ^d*n* = 94.

Work Setting

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 are displayed in Exhibit 12, and show that agency size in Tennessee was quite variable based on setting. Chi square analysis indicates that a statistically significant larger proportion of agencies in the licensed setting fall into the 3–5 staff category than agencies in the contract setting ($p < .05$). Across setting, reported agency size varied from 1 direct service clinical staff member to 75 direct service clinical staff. Compatibility of results may be checked against the National Survey of Substance Abuse Treatment Services (N-SSATS).

Exhibit 12
Agency/Regional Staff Size

Number of Direct Service Staff	Agency Directors	
	Contract Agencies ^a	Licensed Agencies ^b
2 or fewer	3 (10%)	3 (13%)
3–5	3 (10%)	9 (39%)
6–11	11 (38%)	3 (13%)
12 or more	12 (41%)	8 (35%)

^an = 29. ^bn = 23.

Based on provision of zip code information, the primary geographic setting of agencies was determined. Zip codes were grouped in three categories: rural, suburban, and urban. Exhibit 13 displays the results. As data indicate, both contract and licensed agencies are predominately located in urban areas.

Exhibit 13
Geographic Setting of Agencies

Geographic Setting Served	Agency Directors	
	Contract Agencies ^a	Licensed Agencies ^b
Rural	5 (17%)	6 (26%)
Suburban	6 (21%)	2 (9%)
Urban	18 (62%)	15 (65%)

^an = 29. ^bn = 23.

Exhibit 14 displays financial setting and use of public moneys of agencies. Overall, 77% of contract agency directors and 65% of licensed agency directors described their predominant financial setting as private, non-profit. Interestingly, only 4% of contract agency directors compare to 30% of licensed agency directors described their predominant financial setting as private, for profit. This difference, while large, is not statistically significant. In terms of receiving public monies (i.e., Medicaid, state general funds, federal block grants, state agency grants), 70% of contract agencies reported that their operating budgets are comprised of 60% or more of public money. Only 21%

of licensed agencies receive the same percentage of public monies, and difference that is statistically significant ($p < .01$). In addition, chi square analysis indicates that a statistically significant higher proportion of contract agencies reported receiving state alcohol and drug abuse (SADA) funds from the Tennessee Bureau of Alcohol and Drug Abuse Services than did licensed agencies ($p < .001$).

Exhibit 14
Financial Setting & Use of Public Monies by Agencies

Variable	Agency Directors Indicating	
	Contract Agencies ^a	Licensed Agencies ^b
Predominate Financial Setting		
Private, for profit	1 (4%)	7 (30%)
Private, non-profit	22 (77%)	15 (65%)
Govt.–federal	0 (0%)	0 (0%)
Govt.–state	2 (8%)	0 (0%)
Govt.–county/community	1 (4%)	1 (4%)
Govt.–tribal	0 (0%)	0 (0%)
Other	2 (8%)	0 (0%)
Percentage of Total Funding Provided by Public Monies		
0%	0 (0%)	5 (22%)
1–20%	4 (15%)	1 (4%)
21–40%	2 (8%)	2 (9%)
41–60%	1 (4%)	6 (26%)
61–80%	11 (39%)	1 (4%)
81–100%	9 (31%)	4 (17%)
Don't know	1 (4%)	4 (17%)
Receive SADA Funding	28 (96%)	11 (48%)

^a $n = 29$. ^b $n = 23$.

Finally, directors were asked to indicate what percentage of their clinical staff were (1) female and (2) minority. Exhibit 15 displays the percentage of female and minority staffing by agency setting. Both females and minority staff tend to be well represented across all agencies.

Exhibit 15
Gender and Minority Composition of Clinical Staff

Percentage of Female Treatment Staff	Agency Directors Indicating	
	Contract Agencies ^a	Licensed Agencies ^b
0%	0 (0%)	0 (0%)
1–20%	1 (4%)	2 (9%)
21–40%	2 (8%)	0 (0%)
41–60%	9 (31%)	11 (48%)
61–80%	10 (35%)	7 (30%)
81–100%	6 (19%)	2 (9%)
Don't know	1 (4%)	1 (4%)
Percentage of Minority Treatment Staff		
0%	0 (0%)	1 (4%)
1–20%	5 (17%)	8 (35%)
21–40%	8 (29%)	5 (22%)
41–60%	8 (29%)	5 (22%)
61–80%	5 (17%)	1 (4%)
81–100%	0 (0%)	2 (9%)
Don't know	2 (8%)	1 (4%)

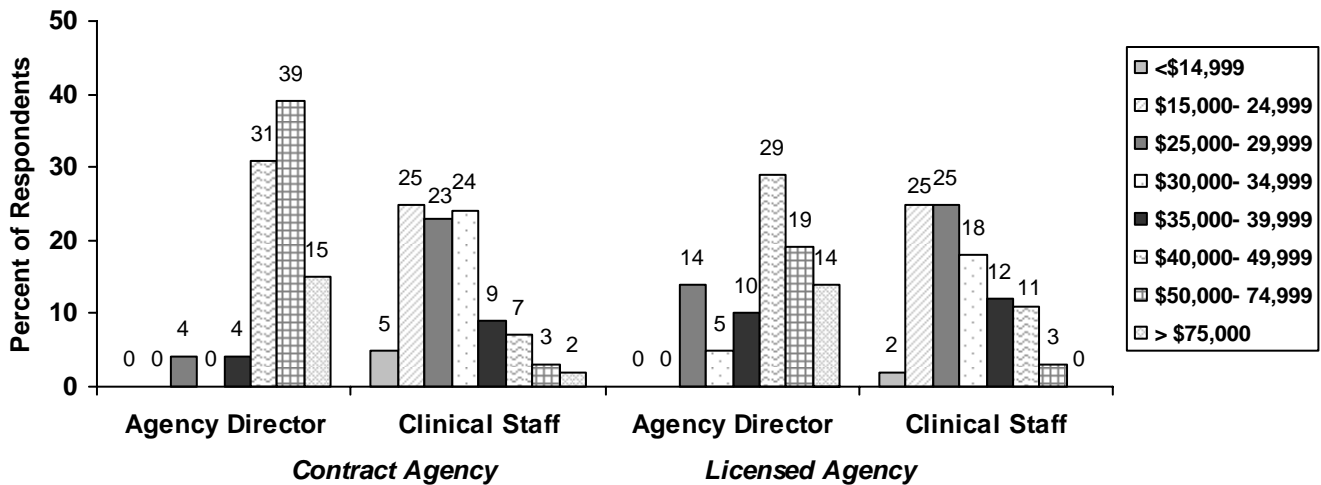
^a*n* = 29. ^b*n* = 23.

Compensation

Salary and benefit information was collected from directors and clinical staff. Exhibit 16 displays salary by role by setting. In contract agencies, 70% of directors reported making between \$40,000–\$74,999 a year, with 15% making over \$75,000 a year. Reported clinical staff salaries were much lower, with 72% making between \$15,000–\$34,999 a year. Chi square analysis indicated that these differences in director and staff salaries were highly significant ($p < .001$). In licensed agencies, 48% of directors reported making between \$40,000–\$74,999 a year, with 14% making over \$75,000 a year. Reported clinical staff salaries were again much lower, with 69% making between \$15,000–\$34,999 a year. Chi square analysis indicated that these differences in director and staff salaries were highly significant ($p < .001$). No setting differences were detected

for director or staff salaries, indicating that directors and staff made the same money in both contract and licensed agencies.

Exhibit 16
Salaries of Respondents by Role



Multiple linear regression was run to examine potential predictors of salary for the workforce in Tennessee. 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 agency type distinction (contract versus licensed) were included as predictors. Results are displayed in Exhibit 17.

Exhibit 17
Predictors of Respondents' Salaries

Predictor	Simple Correlation (<i>r</i>) with Salary	Multiple Linear Regression (<i>R</i> = .398)	
		Standardized Regression Coefficient	<i>t</i> statistic
Demographics			
Gender	.132*		.926
Age	.073		-1.800
Ethnicity	-.010		-.915
Professional/Academic Background			
Role (director vs. staff)	-.165**	-.252	-2.454*
Years in Role	.120*	.331	2.230*
Years in Field	.078		-.501
Years in Position	.063		1.876
Certification Status	-.010		1.422
Degree Status	-.067		1.978
Amount of AOD Education	.007		-2.169
Other Compensation/Benefits			
Health Insurance	-.056		-1.366
Sick Leave	.026		-1.643
Retirement	.018		1.788
Agency Characteristics			
Agency Type (contract vs. licensed)	.046		-.126
SADA Funds at Agency	.023		-.444
Proportion of Public Monies	.139*		-.375
Agency Financial Setting (e.g. Private non-profit)	.022		.375
Geographic Setting	.098		.021
Agency Size	-.058		.400

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

Results indicate that two factors were significant predictors of workforce salary in Tennessee. The strongest predictor was role ($p < .05$). This finding is not surprising as being in the role of an agency director was related to higher salary. In addition, years experience in your role was a significant predictor of salary. Specifically, having more

years experience as an agency director or clinician was related to higher salary. Perhaps surprisingly, degree status is a not significant predictors of salary. This finding is further detailed by the fact that clinical staff at licensed agencies reported having higher degree status, but reported making the same salary as clinical staff at contract agencies.

In addition to salary, benefits were also examined. Exhibit 18 below displays benefits by role for both settings. Results indicate that in both settings, a higher proportion of clinical staff than directors had health insurance fully provided. The majority of both directors and staff reported being fully provided with sick leave and other paid leave, most commonly defined as paid vacation. A smaller proportion of clinical staff in contract agencies reported full retirement benefits, and a large proportion reported having no retirement benefits at all (27%). Chi square analysis indicates that the difference in retirement benefits between clinical staff at contract and licensed agencies is marginally significant ($p = .055$).

Exhibit 18
Benefits Provided to Respondents by Setting

Degree of Provision	Contract Agency		Licensed Agency	
	Agency Directors ^a	Clinical Staff ^b	Agency Directors ^c	Clinical Staff ^d
Health insurance				
Full	11 (44%)	74 (54%)	7 (32%)	58 (57%)
Partial	14 (56%)	55 (40%)	12 (55%)	35 (35%)
Not provided	0 (0%)	7 (5%)	3 (14%)	8 (8%)
Sick leave				
Full	23 (89%)	127 (92%)	19 (86%)	79 (83%)
Partial	3 (12%)	7 (5%)	2 (9%)	10 (11%)
Not provided	0 (0%)	4 (3%)	1 (5%)	6 (6%)
Other paid leave				
Full	21 (84%)	107 (86%)	18 (86%)	74 (82%)
Partial	4 (16%)	9 (7%)	1 (5%)	10 (11%)
Not provided	0 (0%)	8 (7%)	2 (10%)	6 (7%)
Retirement				
Full	12 (50%)	44 (38%)	10 (46%)	43 (47%)
Partial	9 (38%)	42 (36%)	7 (32%)	37 (40%)
Not provided	3 (13%)	31 (27%)	5 (23%)	12 (13%)

Note. Missing data excluded.

^an = 29. ^bn = 143. ^cn = 23. ^dn = 104.

Staff Turnover, Recruitment, & Retention

Agency directors were asked to report staffing numbers from the past year. Specifically, directors were asked to indicate the size of their 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 19 displays calculated turnover rates by setting, as well as for the entire state. Exhibit 20 displays turnover split by geography as defined by zip code. Based on directors reports of staffing in the past year, the average turnover rate for clinical staff in contract agencies was .22, while the average turnover rate for clinical staff in licensed

agencies was .15. Reported turnover appears to be worse in rural agencies. Interestingly, the majority turnover across all settings was voluntary (quitting). The turnover rate for AOD staff was quite comparable to rates calculated the same way in other states. For example, in the Pacific Northwest 5 states reported an average turnover rate for alcohol and other drugs (AOD) clinical staff of .23 (ranging from .20–.28), in Kentucky, the average turnover rate for AOD clinical staff was .17 (Knudsen & Gabriel, 2003), and in Delaware the average turnover rate for AOD staff was .21 (Knudsen, Williams, Lucas, and Poplawski, 2004).

Exhibit 19
Staff Turnover Rates by Agency Setting

Agency Setting	<i>n</i>	Turnover Rate
Contract	24	.22
Licensed	22	.15
Total (statewide)	46	.19

Exhibit 20
Staff Turnover Rates by Geographic Setting

Geographic Setting	<i>n</i>	Turnover Rate
Rural	9	.28
Suburban	5	.13
Urban	28	.17

Directors also provided counts of how many direct service clinical staff they needed to have a full staff. This number was compared against current staff sizes to generate an estimate of staff shortage. Contract agencies reported an average clinical staff shortage of 1.50 full time employee (FTE), while licensed agencies reported a shortage of 0.94 FTE. Overall, agencies in Tennessee reported a clinical staff shortage of 1.27 FTE.

Directors and clinical staff were asked to report on retention and recruitment efforts. Perceptions of staff development activities are displayed in Exhibit 21 below. Directors and clinical staff reported various staff development activities, with in-service training

and direct supervision the most frequently cited staff development activities reported by both groups. In contract agencies, a statistically significant smaller proportion of clinical staff reported the provision of in-service training than did agency directors ($p < .01$). In licensed agencies, a statistically significant smaller proportion of clinical staff reported that their agency pays the cost of continuing education than did agency directors ($p < .05$). Both of these findings may represent a lack of communication regarding staff development activities available for clinical staff. Across agency settings, a statistically significant larger proportion of clinical staff in contract agencies reported their agency providing in-house mentoring ($p < .05$) and paying the cost of continuing education ($p < .05$) than did clinical staff in licensed agencies.

Exhibit 21
Respondents' Perceptions of Staff Development Activities
Provided by Agencies

Development Activity	Contract Agency		Licensed Agency	
	Agency Directors ^a	Clinical Staff ^b	Agency Directors ^c	Clinical Staff ^d
No method/program to develop skills	0 (0%)	9 (6%)	1 (4%)	6 (6%)
In house mentoring program	10 (35%)	46 (32%)	7 (30%)	22 (21%)
In-service training	28 (96%)	104 (73%)	19 (83%)	79 (76%)
Provides direct supervision	21 (73%)	93 (65%)	19 (83%)	72 (69%)
Pays cost of continuing education	20 (69%)	83 (58%)	16 (70%)	47 (45%)

Note. Respondents were asked to check all that apply.
^a $n = 29$. ^b $n = 143$. ^c $n = 23$. ^d $n = 104$.

Directors and staff were also asked to report on what they thought their agency could do to promote the retention of good clinical staff. Exhibit 22 displays ideas for promoting retention by role, for both settings. Directors and clinical staff in both settings indicated that more frequent salary increases was the number one thing agencies could do to promote retention. In addition, more individual recognition/appreciation, better health coverage and other benefits, promoting career growth, and providing support regarding paperwork were also frequently cited. A couple of significant differences are apparent however. A statistically significant larger proportion of clinical staff reported paperwork support as a retention strategy than did agency directors in licensed agencies ($p < .05$).

In addition, a statistically significant larger proportion of clinical staff in licensed agencies reported paperwork support as a strategy than did clinical staff at contract agencies ($p < .05$). In contract agencies, chi square analysis also indicates that a higher proportion of agency directors reported that a more supportive agency culture would promote retention than did clinical staff ($p < .05$). Conversely, in licensed agencies a statistically significant higher proportion of clinical staff reported that a more supportive agency culture would promote retention than did agency directors ($p < .01$). This same relationship holds true comparing roles across setting.

Exhibit 22
Respondents' Ideas for Promoting Staff Retention

Ideas for Promoting Retention	Contract Agency		Licensed Agency	
	Agency Directors ^a	Clinical Staff ^b	Agency Directors ^c	Clinical Staff ^d
More frequent salary increase	17 (65%)	101 (71%)	14 (61%)	80 (77%)
Less mgmt/supervision	0 (0%)	3 (2%)	0 (0%)	2 (2%)
More individual recognition/appreciation	10 (39%)	55 (39%)	12 (52%)	41 (39%)
Increased opportunities for staff input	4 (15%)	37 (26%)	3 (13%)	22 (21%)
More varied work opportunities	3 (12%)	17 (12%)	3 (13%)	12 (12%)
Better health coverage & other benefits	9 (35%)	47 (33%)	9 (39%)	34 (33%)
Lessen/provide assistance w/ paperwork	10 (39%)	42 (30%)	5 (22%)	44 (42%)
Promote career growth	9 (35%)	51 (36%)	8 (35%)	38 (37%)
Availability of educational funding	4 (15%)	24 (17%)	3 (13%)	24 (23%)
Competitive salary	8 (31%)	59 (42%)	8 (35%)	46 (44%)
More frequent promotions	2 (8%)	21 (15%)	4 (17%)	11 (11%)
More/improved on-going training	5 (19%)	24 (17%)	5 (22%)	16 (15%)
Better mgmt/supervision	1 (4%)	13 (9%)	2 (9%)	12 (12%)
More supportive agency culture	11 (42%)	33 (23%)	2 (9%)	36 (35%)
Improved physical work environment	7 (27%)	24 (17%)	3 (13%)	10 (10%)
Smaller caseloads	1 (4%)	10 (7%)	1 (4%)	6 (6%)
Shorter hrs/flex time/ job sharing	2 (8%)	6 (4%)	0 (0%)	5 (5%)

Note. Respondents were asked to check all that apply.

^an = 29. ^bn = 143. ^cn = 23. ^dn = 104.

Respondents were next asked a series of questions related to staff recruitment. To begin, directors and clinical staff were both asked to report if their agency experienced difficulties recruiting qualified staff. In contract agencies, 63% of directors but only 34% of clinical staff reported difficulties. Chi square analysis indicates that this difference in the perception of directors and clinical staff was statistically significant ($p < .05$). In licensed agencies, 48% of directors and 39% of clinical staff reported difficulties. The difference between director perceptions at contract and licensed agencies is quite large, but is not statistically significant. Overall, director reports of recruiting difficulties in Tennessee are quite low compared to other states (Knudsen & Gabriel, 2003; Knudsen, Williams, Lucas, and Poplawski, 2004). In addition, 22% of clinical staff overall reported not knowing whether or not recruiting difficulties existed.

Exhibit 23 below displays reasons for recruiting difficulties by role. A statistically significant higher proportion of directors than staff in contract agencies reported recruiting difficulties due to an insufficient number of applicants meeting qualifications ($p < .01$). This difference is also apparent between directors and staff at licensed agencies, but is not statistically significant. A statistically significant higher proportion of directors than staff in contract agencies also reported recruiting difficulties due to insufficient funding for open positions ($p < .05$).

Exhibit 23
Respondents' Perceptions of Reasons for Recruiting Difficulties

Reasons	Contract Agency		Licensed Agency	
	Agency Directors ^a	Treatment Staff ^b	Agency Directors ^c	Treatment Staff ^d
Insufficient # of applicants meeting qualifications	13 (50%)	32 (23%)	10 (44%)	26 (25%)
Insufficient funding for open positions	7 (27%)	17 (12%)	2 (9%)	23 (22%)
Small applicant pool due to geographic area	6 (23%)	16 (11%)	4 (17%)	11 (11%)
Insufficient facilities	0 (0%)	0 (0%)	0 (0%)	1 (1%)
Reputation of agency/region	0 (0%)	3 (2%)	0 (0%)	6 (6%)
Lack of interest (nature of work, stigma)	3 (12%)	11 (8%)	3 (13%)	15 (14%)
Lack of interest (salary)	8 (31%)	29 (20%)	5 (22%)	32 (31%)
Lack of interest in rural location of agency/region	4 (15%)	9 (6%)	3 (13%)	4 (4%)
Lack of opportunity for advancement	2 (8%)	13 (9%)	2 (9%)	2 (9%)

Note. Respondents were asked to check all that apply.

^a*n* = 29. ^b*n* = 143. ^c*n* = 23. ^d*n* = 104.

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 two reasons most frequently reported by both directors and staff were that applicants had little or no experience in the field 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. Exhibit 24 displays the most frequently cited barriers by role in both settings. Across the workforce, salary and competition from other fields in terms of salary, paperwork, and negative preconceptions were the most frequently cited barriers. However, chi square analysis indicates significant differences in perceptions. In licensed agencies a statistically significant larger proportion of directors than clinical staff reported amount of education as a barrier ($p < .01$). A larger number of clinical staff in licensed agencies reported barriers than did clinical staff at contract agencies. Results indicate that a statistically significant larger proportion of clinical staff in licensed

agencies reported treatment models are not tailored to needs of racial/ethnic groups ($p < .05$), paperwork ($p < .01$), evening work hours ($p < .05$), discrimination ($p < .01$), stigma ($p < .01$), geographic constraints ($p < .01$), negative preconceptions ($p < .01$), and substance abuse is not a real profession ($p < .05$) as barriers.

Exhibit 24
Respondents' Perceptions of Barriers to Entering Field

Perceived Barriers	Contract Agency				Licensed Agency			
	Agency Directors ^a		Treatment Staff ^b		Agency Directors ^c		Treatment Staff ^d	
	%	rating ^e	%	rating ^e	%	rating ^e	%	rating ^e
No barriers	19	3.50	13	2.83	13	1.67	25	2.83
Treatment models are not tailored to needs of racial/ethnic groups	23	2.63	17	3.05	13	2.33	29	2.81
Lack of encouragement	35	3.25	35	3.35	52	3.67	43	3.28
Competition from other fields (in terms of compensation)	65	4.05	56	4.10	57	4.23	60	4.02
Paperwork	50	3.80	37	3.48	65	3.73	53	3.72
Large caseloads	39	3.73	39	3.73	30	3.43	47	3.96
Evening work hours	42	3.43	29	3.26	44	3.20	43	3.44
Discrimination	8	1.75	8	2.00	17	2.50	19	2.10
Stigma	31	3.60	32	3.12	48	3.00	48	3.38
Geographic constraints	19	3.00	8	2.73	17	3.25	20	2.77
Low salary/poor benefits	58	4.00	66	4.32	65	4.08	73	4.30
Cost of education	31	3.58	33	3.70	52	3.45	41	3.86
Amount of education	46	3.79	31	3.71	70	3.86	40	3.67
Negative preconceptions (substance abuse)	46	3.57	47	3.53	70	3.65	64	3.78
Professionalism or work environment	12	2.60	23	3.35	35	3.25	30	2.75
Substance abuse not a 'real' profession	12	2.00	15	2.75	30	2.29	26	2.61

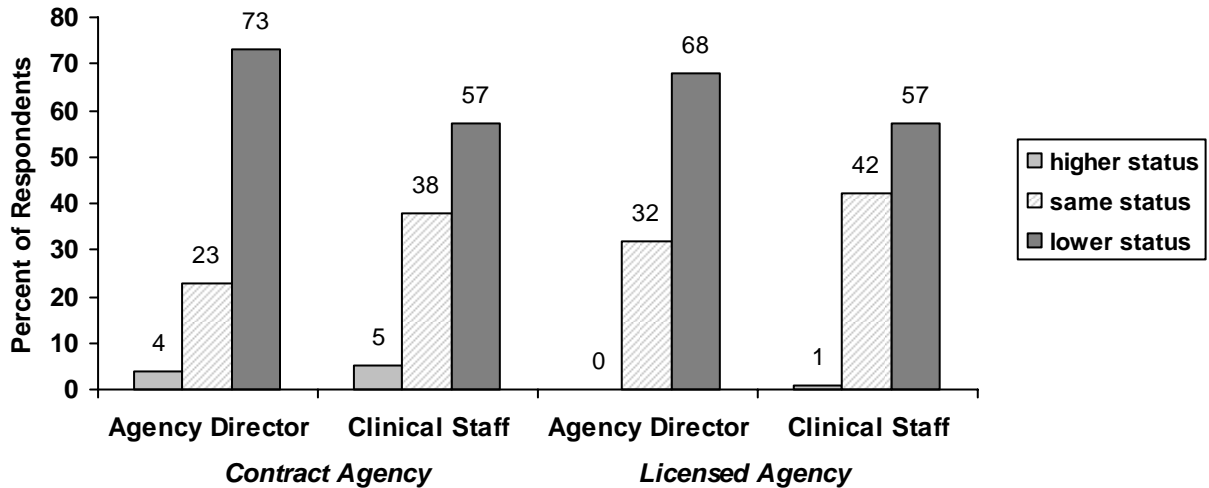
Note. Respondents were asked to check all that apply.

^a $n = 29$. ^b $n = 143$. ^c $n = 23$. ^d $n = 104$. ^eBarriers to entering field rated from 5 (major) to 1 (minor); mean rating listed.

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. Overall, the majority of the workforce in Tennessee saw addiction

counselors as having lower status than other helping professionals. Results are displayed in Exhibit 25.

**Exhibit 25
AOD Status by Role**



Reasons for the lower status of addiction counselors are displayed in Exhibit 26 below. Overall, the most frequently cited reason for lower status of addiction counselors by both directors and clinical staff was less formal education or training and more often having a history of own substance abuse. While some sizable differences are apparent across role and setting, none are statistically significant.

Exhibit 26
Respondents' Perceptions of Reasons for Lower Status of AOD Counselors

Reasons	Contract Agency		Licensed Agency	
	Agency Directors ^a	Treatment Staff ^b	Agency Directors ^c	Treatment Staff ^d
Less formal education or training	11 (58%)	50 (63%)	12 (80%)	32 (55%)
Lower quality formal education or training	5 (26%)	26 (33%)	7 (47%)	17 (29%)
More likely to work in public agency	5 (26%)	48 (60%)	5 (33%)	27 (47%)
Stigmatized by association w/ substance abusers	5 (26%)	37 (46%)	3 (20%)	30 (52%)
More often had history of own substance abuse	13 (68%)	46 (58%)	7 (47%)	38 (66%)

Note. Respondents were asked to check all that apply.
^a*n* = 19. ^b*n* = 80. ^c*n* = 15. ^d*n* = 58.

Directors and staff were asked to report the methods of recruitment used at their agency. Results are displayed in Exhibit 27 below. Overall, more traditional techniques such as newspaper advertisement, personal contacts, and agency human resource departments were cited most frequently. A larger proportion of contract agency directors reported utilizing a website to announce positions than did licensed agency directors, although this finding is not statistically significant. Results indicate that in contract agencies a statistically significant higher proportion of directors than clinical staff reported multiple techniques being utilized, indicating that staff may not have been aware of some of the recruitment techniques being used by their agency.

Exhibit 27 Agency Methods for Staff Recruitment

Recruitment Method/Resource	Contract Agency		Licensed Agency	
	Agency Directors ^a	Treatment Staff ^b	Agency Directors ^c	Treatment Staff ^d
Agency HR Dept.	12 (46%)	54 (38%)	12 (52%)	52 (50%)
Professional journals	2 (8%)	5 (4%)	1 (4%)	4 (4%)
Newspaper advertisement	21 (81%)	87 (61%)	18 (78%)	70 (67%)
Email networking	11 (42%)	30 (21%)	9 (39%)	32 (31%)
Agency newsletter	3 (12%)	19 (13%)	3 (13%)	17 (16%)
Personal/informal contacts	17 (65%)	65 (46%)	11 (48%)	47 (45%)
Website	15 (58%)	45 (32%)	8 (35%)	36 (35%)
Agency/Regional mailing list	4 (15%)	10 (7%)	1 (4%)	5 (5%)
State HR Dept.	1 (4%)	10 (7%)	1 (4%)	4 (4%)

Note. Respondents were asked to check all that apply.

^a*n* = 29. ^b*n* = 143. ^c*n* = 23. ^d*n* = 104.

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 28, and sources of job dissatisfaction are displayed in Exhibit 29. For agency directors in both settings, the most frequently cited source of satisfaction was 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, opportunities for personal growth was frequently cited as a source of satisfaction for clinical staff, but opportunities for career growth were not. Multiple significant differences in satisfaction exist between directors and staff in both settings. In contract agencies, a statistically significant larger proportion of directors reported salary ($p < .01$) and the ability to influence agency decisions as sources of satisfaction ($p < .001$) than did clinical staff. Conversely, a statistically significant larger proportion of clinical staff indicated one on one interactions with clients as a source of satisfaction ($p < .05$). In licensed agencies, a statistically significant larger proportion of directors reported commitment to treatment ($p < .01$) and the ability to influence agency decisions as sources of satisfaction

($p < .001$) than did clinical staff. Conversely, a statistically significant larger proportion of clinical staff indicated one on one interactions with clients as a source of satisfaction ($p < .01$). A statistically significant larger proportion of clinical staff at contract agencies reported commitment to treatment as a source of satisfaction than did clinical staff at licensed agencies ($p < .05$). Finally, a statistically significant larger proportion of clinical staff at licensed agencies reported role as a change agent as a source of satisfaction than did clinical staff at contract agencies ($p < .05$).

Exhibit 28 Sources of Job Satisfaction for Respondents

Sources of Job Satisfaction	Contract Agency		Licensed Agency	
	Agency Directors ^a	Treatment Staff ^b	Agency Directors ^c	Treatment Staff ^d
Nothing—I am not satisfied	0 (0%)	1 (1%)	1 (4%)	0 (0%)
Salary/Benefits	13 (48%)	32 (23%)	7 (30%)	18 (17%)
Career growth opportunities	10 (37%)	30 (21%)	4 (17%)	17 (16%)
Role as a change agent	16 (59%)	57 (40%)	14 (61%)	57 (55%)
Commitment to treatment	21 (78%)	93 (66%)	19 (83%)	55 (53%)
1 to 1 interaction with clients	16 (59%)	109 (77%)	12 (52%)	84 (81%)
Opportunities for personal learning/growth	20 (74%)	88 (62%)	12 (52%)	57 (55%)
Agency/co-workers	19 (70%)	73 (52%)	15 (65%)	56 (54%)
Ability to influence agency decisions	17 (63%)	33 (23%)	14 (61%)	23 (22%)

Note. Respondents were asked to check all that apply.

^a $n = 29$. ^b $n = 143$. ^c $n = 23$. ^d $n = 104$.

In terms of areas of dissatisfaction, salary was the only area cited with high frequency, although it was cited more frequently by clinical staff. A statistically significant higher proportion of clinical staff than directors in contract agencies ($p < .001$) and licensed agencies ($p < .01$) cited salary as a source of dissatisfaction. A statistically significant higher proportion of directors than clinical staff in contract agencies ($p < .001$) and licensed agencies ($p < .05$) reported no source of dissatisfaction.

Exhibit 29 Sources of Job Dissatisfaction for Respondents

Sources of Job Dissatisfaction	Contract Agency		Licensed Agency	
	Agency Directors ^a	Treatment Staff ^b	Agency Directors ^c	Treatment Staff ^d
Nothing—I am satisfied	13 (48%)	22 (16%)	9 (39%)	17 (16%)
Limited role as a change agent	1 (4%)	8 (6%)	3 (13%)	9 (9%)
Salary/ Benefits	6 (22%)	80 (57%)	6 (26%)	61 (59%)
Agency/co-workers	0 (0%)	13 (9%)	0 (0%)	10 (10%)
Lack of career growth opportunities	2 (7%)	23 (16%)	3 (13%)	23 (22%)
Lack of commitment to treatment	2 (7%)	17 (12%)	0 (0%)	12 (12%)
Lack of 1 to 1 interaction with clients	1 (4%)	3 (2%)	2 (9%)	2 (2%)
Inability to influence agency decisions	4 (15%)	31 (22%)	2 (9%)	25 (24%)
Lack of opportunities for personal learning/ growth	0 (0%)	13 (9%)	0 (0%)	10 (10%)

Note. Respondents were asked to check all that apply.

^an = 29. ^bn = 143. ^cn = 23. ^dn = 104.

Treatment Models

To get a sense of what treatment models are actively being used in Tennessee, directors and staff were asked to identify which treatment models were being used in their agency. In addition, for each identified model, respondents were asked indicate the degree to which the model played a role in the agency/region's approach (major, intermediate, or minor). In contract agencies, directors and clinical staff cited a mean total of 8 treatment models in use at their agency. Contract agency directors and clinical staff cite an average of 5 treatment models playing a major role in their overall approach. In licensed agencies, directors cited a mean total of 14 treatment models being used in their agency, while clinical staff cited a mean total of 12 treatment models. Licensed agency directors cite an average of 8 treatment models playing a major role in their overall approach, while 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, as displayed in Exhibits 30 and 31. Overall, Tennessee directors and clinicians frequently

cited relapse prevention, 12-step, cognitive behavioral, and integrated AOD/mental health as major models in their agency's approach.

Exhibit 30
Perceptions at Contract Agencies of the
Major Treatment Models Implemented

Agency Director Responses ^a		Clinical Staff Responses ^b	
Models Most Frequently Cited as Playing a Major Role	Percent Indicating	Models Most Frequently Cited as Playing a Major Role	Percent Indicating
1. 12-Step	66%	1. 12-Step	66%
2. Relapse Prevention	62%	2. Relapse Prevention	56%
3. Cognitive Behavioral	45%	3. Cognitive Behavioral	40%
4. Integrated AOD & MH	35%	4. Solutions Focused	27%
5. Social Skills	31%	5. Behavior Modification	26%

^an = 29. ^bn = 143.

Exhibit 31
Perceptions at Licensed Agencies of the
Major Treatment Models Implemented

Agency Director Responses ^a		Clinical Staff Responses ^b	
Models Most Frequently Cited as Playing a Major Role	Percent Indicating	Models Most Frequently Cited as Playing a Major Role	Percent Indicating
1. Relapse Prevention	74%	1. Relapse Prevention	58%
2. 12-Step	57%	2. Cognitive Behavioral	54%
3. Psycho-educational	48%	3. Integrated AOD & MH	51%
4. Strengths Based	48%	4. 12-Step	45%
5. Integrated AOD & MH	44%	5. Solutions Focused	34%

^an = 23. ^bn = 104.

Proficiencies & 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 SAMHSA/CSAT's Technical Assistance Publication (TAP) 21 in 1998. Proficiency was rated on a 7-point scale (0–6) ranging from no proficiency to complete proficiency, while

training interest was rated on 5-point scale (0–4) ranging from no interest to maximum interest. Exhibits 32 and 33 display mean ratings for both directors and clinical staff in both settings.

Exhibit 32
Respondents' Ratings at Contract Agencies of Personal Proficiency
& Interest in the Addiction Counseling Competencies

Competency Area	Mean Rating ^a			
	Agency Directors ^b		Clinical Staff ^c	
	Proficiency	Interest	Proficiency	Interest
1. Administrative/Management	5.15	2.46	3.97	2.32
2. Adolescent Treatment	3.13	1.95	3.24	2.08
3. Client Family & Community Education	4.25	2.38	4.44	2.92
4. Clinical Supervision	4.38	2.73	3.56	2.65
5. Co-Occurring Disorders	4.00	2.62	4.23	3.23
6. Detoxification	3.09	1.81	2.64	2.56
7. Documentation	4.67	1.95	5.07	2.62
8. Drug Pharmacology/Pharmacotherapy	3.35	2.43	3.57	3.02
9. Gender Specific Treatment	4.08	2.38	4.16	3.02
10. Group Counseling	4.91	2.19	5.25	3.30
11. Individual Counseling	4.91	2.05	5.39	3.25
12. Interpersonal Communication	5.22	2.13	5.31	3.10
13. Intervention Skills	4.70	2.10	4.81	3.17
14. Lesbian/Gay/Bisexual/Transsexual Specific Tx	3.39	2.18	3.50	2.73
15. Marriage & Family Therapy	3.86	2.41	3.47	2.90
16. Offender Treatment	3.14	2.23	3.34	2.73
17. Patient Placement Criteria	4.48	2.10	4.29	2.55
18. Professional/ Ethical Responsibilities	5.30	2.59	5.31	2.97
19. Racial/Ethnic Specific Tx	4.28	2.55	4.33	2.99
20. Referral Skills	5.19	1.96	4.90	2.63
21. Relationship Between SA & Medical Problems	4.75	2.71	4.50	3.13
22. Screening/Assessment	4.78	2.40	4.96	2.87
23. Service Coordination & Case Mgmt	4.42	2.10	4.73	2.65
24. Signs & Symptoms	4.72	2.38	5.02	2.96
25. Staff Recruitment	4.63	2.26	3.36	2.05
26. Staff Retention	4.69	2.33	3.47	2.15
27. Treatment Engagement	4.77	2.45	4.73	3.07
28. Treatment Planning	4.79	2.23	5.17	3.14

^aProficiency range is 0 (none) to 6 (completely); Interest range is 0 (no interest) to 4 (max. interest). ^bn = 27. ^cn = 136.

Exhibit 33
Respondents' Ratings at Licensed Agencies of Personal Proficiency
& Interest in the Addiction Counseling Competencies

Competency Area	Mean Rating ^a			
	Agency Directors ^b		Clinical Staff ^c	
	Proficiency	Interest	Proficiency	Interest
1. Administrative/Management	5.43	2.45	4.13	2.10
2. Adolescent Treatment	3.64	1.95	3.51	2.21
3. Client Family & Community Education	4.57	2.18	4.63	2.68
4. Clinical Supervision	5.14	2.45	3.71	2.59
5. Co-Occurring Disorders	4.61	2.78	4.68	3.29
6. Detoxification	2.91	1.91	3.10	2.52
7. Documentation	5.00	1.91	5.05	2.21
8. Drug Pharmacology/Pharmacotherapy	3.65	2.43	3.60	2.92
9. Gender Specific Treatment	4.22	2.19	4.09	2.76
10. Group Counseling	5.09	2.36	4.99	2.99
11. Individual Counseling	5.57	2.36	5.22	3.10
12. Interpersonal Communication	5.48	2.23	5.19	2.80
13. Intervention Skills	5.39	2.41	4.81	3.06
14. Lesbian/Gay/Bisexual/Transsexual Specific Tx	3.65	2.09	3.34	2.34
15. Marriage & Family Therapy	3.87	1.91	3.75	2.79
16. Offender Treatment	3.91	2.18	3.41	2.35
17. Patient Placement Criteria	4.91	2.05	4.24	2.29
18. Professional/ Ethical Responsibilities	5.70	2.50	5.30	2.65
19. Racial/Ethnic Specific Tx	4.36	2.05	4.27	2.71
20. Referral Skills	5.26	2.05	4.77	2.32
21. Relationship Between SA & Medical Problems	4.74	2.36	4.38	3.03
22. Screening/Assessment	5.48	2.43	4.82	2.73
23. Service Coordination & Case Mgmt	5.22	2.09	4.60	2.19
24. Signs & Symptoms	5.26	2.23	4.81	2.82
25. Staff Recruitment	4.48	2.36	3.29	1.92
26. Staff Retention	4.61	2.41	3.45	2.01
27. Treatment Engagement	4.83	2.41	4.73	2.75
28. Treatment Planning	5.26	2.41	5.01	2.76

^aProficiency range is 0 (none) to 6 (completely); Interest range is 0 (no interest) to 4 (max. interest). ^bn = 23. ^cn = 103.

In order to identify training priorities for Tennessee, it is important to consider both the relative proficiency and interest in each competency area. Exhibits 34–37 categorize each competency area in terms of 4 proficiency/interest based categories: lower proficiency, higher interest; lower proficiency, lower interest; higher proficiency, higher interest; and higher proficiency, lower interest. Training priorities are reported separately for agency directors and clinical staff in contract and licensed settings to better match needs.

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—Contract Setting

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

Proficiency was measured on a 7-point scale, and training interest was measured on a 5-point scale. Median total proficiency (4.46) & interest (2.41) were used as cut-off scores for higher/ lower distinctions.

Exhibit 35
Training Priorities for Clinical Staff—Contract Setting

Priority Level 1: Higher Interest, Lower Proficiency
• Co-Occurring Disorders
• Drug Pharmacology/Pharmacotherapy
• Gender Specific Treatment
• Lesbian/Gay/Bisexual/Transsexual Specific Treatment
• Marriage & Family Therapy
• Offender Treatment
• Racial/Ethnic Specific Treatment
Priority Level 2: Lower Interest, Lower Proficiency
• Administrative/Management
• Adolescent Treatment
• Clinical Supervision
• Detoxification
• Patient Placement Criteria
• Staff Recruitment
• Staff Retention
Priority Level 3: Higher Interest, Higher Proficiency
• Client Family & Community Education
• 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
• 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 (4.43) & interest (2.73) were used as cut-off scores for higher/ lower distinctions.

Exhibit 36
Training Priorities for Agency Directors—Licensed Setting

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

Proficiency was measured on a 7-point scale, and training interest was measured on a 5-point scale. Median total proficiency (4.88) & interest (2.36) were used as cut-off scores for higher/ lower distinctions.

Exhibit 37
Training Priorities for Clinical Staff—Licensed Setting

Priority Level 1: Higher Interest, Lower Proficiency
• 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
• Patient Placement Criteria
• Relationship Between Substance Abuse & Medical Problems
• Staff Recruitment
• Staff Retention
Priority Level 3: Higher Interest, Higher Proficiency
• Co-Occurring Disorders
• Group Counseling
• Individual Counseling
• Interpersonal Communication
• Intervention Skills
• Screening/Assessment
• Signs & Symptoms
• Treatment Engagement
• Treatment Planning
Priority Level 4: Lower Interest, Higher Proficiency
• Client Family & Community Education
• Documentation
• 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 (4.46) & interest (2.71) were used as cut-off scores for higher/ lower distinctions.

Overall, results indicate that the workforce in Tennessee has multiple overlapping training priorities. Clinical staff in both settings identified drug pharmacology/ pharmacotherapy, gender specific treatment, racial/ethnic specific treatment, and marriage and family therapy as Level 1 training priorities. Agency directors in both settings identified co-occurring disorders and drug pharmacology/ pharmacotherapy as Level 1 training priorities.

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