EXECUTIVE SUMMARY
XXX PROGRAM TRAINING NEEDS SURVEY
Texas Institute of Behavioral Research at TCU
(insert date)
[NOTE: This summary report can also be applied to ORC survey results.]

During (*insert month/year*), (*name XXX*) program staff completed the Texas Christian University (TCU) Program Training Needs (PTN) survey. The data were collected by the Texas Institute of Behavioral Research (IBR) at TCU with ongoing support from XXX. In order to focus on issues most relevant to each group, different versions of the forms were designed for Program Directors (PTN-D) and Program Clinical Staff (PTN-S). Directors and counseling staff from all three agencies responded resulting in a sample of 6 directors and 20 staff.

Data Collection Instruments

The initial portion of the Program Director's (PTN-D) survey provides information about program structure, services provided, and client demographics. The remainder of the survey (35 items) focuses on four content domains – Program Needs, Training Needs, Pressures to Change, and Diagnostics and Billing Issues. The Program Clinical Staff (PTN-S) version consists of 54 items organized into seven domains – Facilities and Climate, Satisfaction with Training, Training Content Preferences, Counseling Staff Training Needs, Training Strategy Preferences, Computer Resources, and Barriers to Training.

Responses to each item were scored as follows: "strongly disagree" = 10, "disagree" = 20, "undecided" = 30, "agree" = 40, and "strongly agree" = 50. Summary scores computed by averaging the item responses within each domain had good psychometric properties and therefore can be used to assess general levels of needs across the domains. Responses to individual items within each domain provide more specific information regarding needs that might be addressed by additional training.

Results

***Program Demographics*:** Information provided by the directors revealed that all three of the programs had been in operation eight or more years. The majority (50%) reported employing between 3 and 7 counselors. The most common caseload size was 21-30 clients per counselor (83%), with 16% having a caseload of 31-40 clients per month. Primary service area for the programs was distributed between urban (60%) and suburban (40%).

***Personal demographics*:** Demographics of directors and staff were fairly similar, but staff were slightly younger and more diverse in their characteristics. The average age of staff respondents was 47 years, versus 55 for directors. Seventy-five percent of staff were male (versus 83% for directors), 50% were white (versus 67%) and 44% were African American (versus 16%). Twenty-five percent reported eight or more years experience in the drug treatment field versus 83% for directors; 50% reported only one year with the program versus 17% for directors; 60% reported one year in their current position versus 17% for directors. Only 5% of the staff had been with the program for 8 or more years, compared to 67% for the directors.

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Program Directors Survey

Overall, XXX program directors (Table 1) emphasized the needs for *documenting patient and program performance*, as well as for staff training on *cognitive and engagement strategies*. More specifically, they uniformly agreed that the most important program needs (100% agreement) include obtaining information that can document program effectiveness, tracking and evaluating performance of clients over time, selecting new treatment strategies for staff training, and generating timely management reports on clinical, financial, and outcome data. In most cases, the table (far right margin) shows indeed these ratings represented "strong" agreement.

Priorities for training needs of counseling staff (all at 100% agreement) included assessing client problems and needs, increasing client participation in treatment, monitoring client progress, improving rapport with clients, improving client thinking skills, improving client problem solving skills, and improving cognitive focus of clients during group counseling. The most important sources of pressure they feel for program change originates from agency board members/central administration (100%) and program supervisors or managers (83%).

In the area of diagnostics and billing issues, formal DSM diagnoses were seen as necessary for preparing client treatment plans (83%) as well as reimbursement for services and documentation of program needs (67%). Only about half the program staff was seen as being adept at using formal DSM diagnoses (50%), so staff training in the use of brief diagnostic tools would be regarded as helpful (83%). Cost benchmarks and guidelines for interpreting costs would be helpful to 67% of directors.

Program Staff Survey

As shown in Table 2, staff generally rated the facilities and climate at their programs as favorable (55% to 65% agreement for the individual climate items) and 50% indicated that their offices, equipment, and supplies were adequate. However, very few 5% staff agreed that their program had enough counselors to meet client needs and had adequate resources for meeting most medical and psychiatric client needs (30%).

Staff were satisfied with the in-house (inservice) training opportunities provided (75%), while 55% found good outside events to attend last year. Staff were less enthusiastic about state-funded and regional training (35 and 30%, respectively).

Staff gave high priority to getting training dealing with improving family/social involvement (90%), dual diagnosis (75%), and the use of brief diagnostic screening tools (75%). The highest reported staff training needs were for assessing client problems and needs (90%), improving thinking skills (90%), improving client problem-solving skills (85%), and improving the cognitive focus of clients during group counseling (80%), and client rapport (80%).

Procedurally, 80% preferred group training activities with role-playing, 75% preferred training that uses a conceptual treatment process model relating treatment to recovery, and 70% agreed that training should include evidence-based interventions. There also was a strong interest in exchanging ideas with staff at other programs with similar interests (75%). Receiving on-site consultation after training (70%) and having specialized training made available over the

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Internet (65%) were also of interest. Almost half (45%) agreed that training workshops should be based on manual-guided interventions.

Computer resources received mixed ratings, with 80% of staff indicating that more computer resources were needed and although 60% were comfortable using computers, few client records are currently computerized (20%). Consistently, 75% said they had easy access for using e-mail and the internet at work, and only 25% said there were policies that limit access and use of the internet and e-mail.

Workload and program pressures were considered the leading barrier to training for new innovations (55%). Other frequently cited barriers to program change included staff training interests being mostly related to licensure or certification requirements (50%), followed by limited program resources (35%) and lack of budget to attend conferences (35%).

Conclusions

The TCU Program Training Needs (PTN) survey was administered to staff in the three XXX treatment clinics in (month/year). Data were sent to the TCU Institute of Behavioral Research for analysis, part of a collaborative partnership recently established between XXX and TCU/IBR to address needs for enhancing clinical services. Although results of the PTN suggest generally positive staff attitudes about in-house training, there are some variations between the three clinics in terms of organizational functioning (an issue that might be considered for more detail study later). Highlights of the current findings are reported below for Directors/Supervisors and for Counseling Staff.

Major program needs identified from <u>Directors</u> surveys (6 respondents):

1. information to improve documentation of program effectiveness
2. better tools for tracking and evaluating performance of clients over time
3. selection of new treatment strategies for staff training
4. improved staff skills in using cognitive and engagement strategies

Major program needs identified from <u>Staff</u> surveys (20 respondents):

1. training for dealing with family issues, dual diagnosis, and brief diagnostic tools
2. training on ways to improve client cognitive skills and treatment engagement
3. requested more computer resources/training for computerizing client records
4. requested more staff to meet client demands and workload pressures

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Table 1
XXX Program Directors Survey Responses to PTN Items (N = 6)

	Summary Scores[1]	% Agree or Strongly Agree[2]	Strongly Agree[3]
Your program needs guidance in –			
17. documenting service needs of clients for making treatment placements.	40.0	67%	50%
18. tracking and evaluating performance of clients over time	45.0	100%	50%
19. obtaining information that can document program effectiveness.	48.3	100%	83%
20. automating client records for billing and financial applications.	30.0	33%	0%
21. evaluating program staff performance and organizational functioning.	40.0	83%	33%
22. selecting new treatment interventions and strategies for which program staff need training.	46.7	100%	67%
23. improving the recording and retrieval of financial information.	28.3	17%	0%
24. generating timely "management" reports on clinical, financial, and outcome data.	45.0	100%	50%

[1]Mean scores range from 10 to 50. Scores above 30 indicate *agreement*, below 30 indicates *disagreement*.

[2]Areas of strongest "needs" or "problems" are highlighted with shading.

[3] "Strongly Agree" percentages are computed from item responses of "5."

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Table 1 (Continued)

	Summary Scores	% Agree or Strongly Agree	Strongly Agree
Your counseling staff needs training for –			
25. assessing client problems and needs.	45.0	100%	50%
26. increasing client participation in treatment.	43.3	100%	33%
27. monitoring client progress.	43.3	100%	33%
28. improving rapport with clients.	41.7	100%	16%
29. improving client thinking skills.	46.7	100%	67%
30. improving client problem-solving skills.	46.7	100%	67%
31. improving behavioral management of clients.	45.0	83%	67%
32. improving cognitive focus of clients during group counseling.	46.7	100%	67%
33. using computerized client assessments.	41.7	67%	50%
34. working with staff in other units/agencies.	35.0	50%	17%
Current pressures to make program changes come from –			
35. clients in the program.	35.0	67%	17%
36. program staff members.	35.0	67%	17%
37. program supervisors or managers.	40.7	83%	17%
38. agency board members/central administration.	41.7	100%	17%
39. community action groups.	26.7	50%	17%
40. funding and oversight agencies.	28.3	17%	0%
41. accreditation or licensing authorities.	31.7	67%	0%
42. criminal justice administrators.	23.3	17%	0%

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Table 1 (Continued)

	Summary Scores	% Agree or Strongly Agree	Strongly Agree
Diagnostics and Billing Procedures			
43. Formal DSM diagnoses are necessary for reimbursement for services or documentation of your program needs.	35.0	67%	17%
44. Formal DSM diagnoses are necessary for preparing client treatment plans.	40.0	83%	33%
45. Most of your program staff are adept at using formal DSM diagnoses in planning treatment.	35.0	50%	17%
47. Charges/fees for services (e.g., individual/group counseling, intake assessment, etc.), are often based on standard reimbursement rates rather than real program costs.	20.0	0%	0%
Diagnostics and Billing Needs			
46. Training to use brief diagnostic screening tools would be helpful to program staff.	41.7	83%	50%
48. *Documented* costs for each *unit* of service (e.g., 1 hour of therapy, 1 day of treatment, etc.) would help negotiate reimbursement rates.	30.0	20%	0%
49. Brief accounting tools and training are needed to document all resources used in providing *units* of service.	31.7	33%	0%
50. Cost benchmarks from programs of similar size and type would improve decisions about services and program management.	38.3	67%	17%
51. You need guidelines for interpreting costs in relation to program effectiveness.	38.3	67%	17%

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Table 2
XXX Staff Survey Responses to PTN Items (N = 20)

	Summary Scores[1]	% Agree or Strongly Agree[2]	Strongly Agree[3]
Facilities and Climate	**31.4**		
5. Offices, equipment, and supplies are adequate at your program.	31.5	50	15
6. Your program has enough counselors and staff to meet current client needs.	19.5	5	0
7. Your program has adequate resources for meeting most medical and psychiatric client needs.	27.0	30	0
8. Most program staff feel positive and confident about the quality of services at your program.	34.5	60	15
9. Your program has a secure future ahead.	38.5	65	25
10. Program staff here get along very well.	35.0	55	15
11. Program staff morale is very good.	33.5	55	15
Satisfaction with Training	**34.5**		
12. Good in-house (inservice) training is provided to program staff.	40.0	75	40
13. You found good outside training events to attend last year.	35.0	55	25
14. Your state-funded drug or alcohol agency provided good training in the past year.	30.0	35	6
15. Regional authorities or groups (e.g., ATTC, ACA) provided good training in the past year.	31.1	30	11

[1]Mean scores range from 10 to 50. Scores above 30 indicate *agreement*; below 30 indicates *disagreement*.

[2]Areas of strongest "needs" or "problems" are highlighted with shading.

[3] "Strongly Agree" percentages are computed from item responses of "5."

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Table 2 (Continued)

	Summary Scores	% Agree or Strongly Agree	Strongly Agree
Training Content Preferences	**36.9**		
16. You want more scientific information on the neurobiology of addiction.	38.0	65	20
17. More pharmacotherapy information and training are needed on new medications.	36.5	65	10
18. Program staff need sensitivity training for dealing with special populations.	36.5	65	20
19. Program staff training is needed on ethics and confidentiality of information.	34.5	65	20
20. Specialized training is needed for improving family involvement and related issues.	40.5	90	25
21. Program staff training is needed on dual diagnoses and appropriate treatment.	37.5	75	25
22. Training to use brief diagnostic screening tools would be helpful to program staff.	37.5	75	25
23. Program staff need to be trained to understand other staff functions (e.g., correctional officer duties).	34.5	65	10
Counseling Staff Needs Training for –	**37.5**		
24. assessing client problems and needs.	3.9	90	5
25. increasing client participation in treatment.	35.5	70	5
26. monitoring client progress.	35.8	60	5
27. improving rapport with clients	37.0	80	5
28. improving client thinking skills.	40.0	90	15
29. improving client problem-solving skills.	39.0	85	10
30. improving behavioral management of clients.	36.0	70	10
31. improving cognitive focus of clients during group counseling.	37.5	80	10
32. using computerized client assessments.	38.0	65	20
33. working with staff in other units/agencies.	37.0	70	10

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Table 2 (Continued)

	Summary Scores	% Agree or Strongly Agree	Strongly Agree
Training Strategy Preferences	**37.0**		
34. General introductory sessions on multiple topics is an effective workshop format.	35.0	55	10
35. Intensive full-day training on special topics is an effective workshop format.	36.0	60	15
36. A conceptual treatment process model documenting how treatment activities contribute to "recovery" would be helpful.	39.0	75	15
37. Training workshops should be based on evidence-based interventions.	38.5	70	20
38. Training workshops should be based on manual-guided interventions.	34.0	45	5
39. Training workshops should include role playing and group activities.	38.5	80	5
40. Telephone consultations following specialized training would be useful.	33.7	40	5
41. Specialized training made available over the Internet would be useful.	37.0	65	10
42. Exchanging ideas with other programs that have interests similar to yours would be helpful.	39.0	75	20
43. On-site consultation following training would be helpful.	39.0	70	20
Computer Resources	**30.2**		
44. Most client records for this program are computerized.	23.0	20	5
45. Program staff here feel comfortable using computers.	35.5	60	10
46 More computer resources are needed here.	40.0	80	35
47 Program staff here have easy access for using e-mail and the Internet at work.	38.0	75	20
48. This program has policies that limit program staff access to the Internet and use of e-mail.	25.5	25	5

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Table 2 (Continued)

	Summary Scores	% Agree or Strongly Agree	Strongly Agree
Barriers to Training	**30.2**		
49. The workload and pressures at this program keep motivation for new training low.	36.0	55	20
50. The budget does not allow most program staff to attend professional conferences annually.	34.0	35	20
51. Topics presented at recent training workshops and conferences have been too limited.	28.5	20	0
52. The quality of trainers at recent workshops and conferences has been poor.	25.0	10	0
53. Training activities take too much time away from delivery of program services.	25.5	15	5
54. Training interests of program staff are mostly due to licensure or certification requirements.	35.0	50	10
55. It is often too difficult to adapt things learned at workshops so they will work in this program.	29.5	30	0
56. Limited resources (e.g., office space or budget) make it difficult to adopt new treatment ideas.	32.0	35	15
57. The background and training of program staff limits the kind of treatment changes possible here.	30.0	30	10
58. There are too few rewards for trying to change treatment or other procedures here.	27.5	20	10

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