Recruitment and Retention Issues for Counselors in Rural Pennsylvania Substance Use Disorder Treatment Programs

By: Jennifer Murphy, Ph.D., Penn State Berks

October 2021

This project was sponsored by a grant from the Center for Rural Pennsylvania, a legislative agency of the Pennsylvania General Assembly. The Center for Rural Pennsylvania is a bipartisan, bicameral legislative agency that serves as a resource for rural policy within the Pennsylvania General Assembly. It was created in 1987 under Act 16, the Rural Revitalization Act, to promote and sustain the vitality of Pennsylvania's rural and small communities. Information contained in this report does not necessarily reflect the views of individual board members or the Center for Rural Pennsylvania. For more information, contact the Center for Rural Pennsylvania, 625 Forster St., Room 902, Harrisburg, PA 17120, telephone (717) 787-9555, www.rural.pa.gov.

Executive Summary

Key Findings:

- Recruiting high quality counselors is a major problem for rural substance use disorder (SUD) treatment programs.
- Treatment program directors linked recruitment problems to low salary, the rural location of the facility, and applicants lacking adequate training in the SUD field.
- Counselor turnover was not a major problem for most rural treatment programs.
- Surveys of counselors revealed that emotional exhaustion was the strongest predictor of intent to quit. Low job satisfaction, poor management communication, and having a high percentage of clients on medication assisted treatment were also related to intent to quit.

Policy Considerations

- Treatment programs should get reimbursed for services at the same rate as other mental health providers. This would allow programs to offer higher starting salaries to attract more counselors into the substance use disorder treatment field.
- Student loan forgiveness programs should be expanded to allow more counselors in treatment programs to qualify for the benefit. This could improve both recruitment and retention in the field.
- Students in counseling programs (undergraduate and graduate) should receive more direct education and training in addiction.
- The Pennsylvania Department of Drug and Alcohol Programs (DDAP) should consider increasing the variety of its counselor trainings and including more trainings related to emotional exhaustion and trauma. DDAP also should consider consulting with programs about implementing management strategies associated with better counselor retention.

Background

The Bureau of Labor Statistics predicts that the number of jobs related to behavioral health counseling (which includes alcohol/drug treatment counselors) will increase 23 percent by the year 2026.[1] Considering the growth nationally, and the rate of overdose deaths in Pennsylvania, there may be an even higher demand for substance use disorder (SUD) treatment counselors, particularly in rural areas most impacted by the opioid crisis.

One of the most challenging issues facing the SUD treatment field is turnover. Research consistently shows high voluntary turnover rates among counselors. High turnover rates are a problem because they can have negative effects on the organization as well as those receiving treatment. Research has found that clients stay in treatment longer and do better when they remain in contact with the same therapist (McCarty et al., 1998; McCaul and Svikis, 1991).

This project examined recruitment and retention issues for counselors in rural SUD treatment programs through a multi-method research design that included: an online, anonymous survey administered to current SUD counselors; open-ended qualitative interviews conducted with program and clinical directors; an assessment of higher education institutions in rural Pennsylvania counties to understand how well they prepare those entering the profession; and an analysis of the effectiveness of state-level incentives, like the student loan repayment program.

The study had three overarching goals. The first was to assess the characteristics of professional SUD counselors in rural Pennsylvania counties and how those characteristics relate to recruitment and retention issues. The second was to determine if the current pipeline of high-quality SUD counselors is sufficient for the current and projected demand for workers in rural Pennsylvania counties. The last was to identify strategies at the program level and state level that could improve the recruitment and retention of quality counselors in rural programs.

---

[1] Bureau of Labor Statistics (BLS). (2019). Occupational Outlook Handbook. https://www.bls.gov/ooh/community-and-social-service/substance-abuse-behavioral-disorder-and-mental-health-counselors.htm.

The results indicated that counselor recruitment is a major problem for SUD treatment programs in rural Pennsylvania counties. Interviews with program and clinical directors revealed their concerns about the number of qualified applicants for open positions. The three most common reasons cited for recruitment problems were: salary, the facility's location, and applicants lacking the required training in SUD treatment.

Salary issues tended to be related to reimbursement rates, so programs felt there was little they could do to raise counselor pay significantly.

Some programs viewed their location as a barrier for recruitment because the rural areas where they were located did not produce enough educated people who could apply. Related to the training problem was a lack of educational opportunities in rural areas that could lead to SUD counseling. Very few bachelor's or master's programs existed with a concentration in addiction studies. Given the requirement for a SUD counselor to have significant clinical experience, more opportunities need to be created to link their educational experiences and internships to SUD treatment.

While recruitment was a major issue, most clinical and program directors felt that turnover was not a major problem for their facility. Still, they felt that the SUD treatment field has lost many counselors due to stress and burnout. To address these issues, many facilities attempted to improve retention through various structural efforts. Those with high retention emphasized that their programs had supportive management who were involved in the day-to-day operations of the program, sometimes even carrying their own caseload of clients. The programs created a positive working environment where clinical staff and management worked as a team. They also promoted professional development opportunities for the staff. An additional factor that clinical and program directors cited to improve retention was to promote self-care among the clinical staff. Supportive management emphasized that counselors should be able to use paid time off to help alleviate their stress. One facility administered a questionnaire twice a year to measure burnout, stress, and job satisfaction.

The survey of counselors reflected many of the themes analyzed in the qualitative interviews with clinical/program directors. Just as the directors felt turnover was not a major problem, the survey

respondents scored high on job satisfaction; very few were currently looking for another job. Emotional exhaustion was the strongest predictor of intent to quit. Additional significant predictors were job satisfaction and management communication. These findings suggest that workplaces that emphasize teamwork, management involvement, and a positive culture can have low turnover.

Salary was not a significant predictor of intent to quit, even though it may be a barrier to recruiting high quality counselors who have more lucrative options.

The other significant predictor of intent to quit was the percentage of clients receiving medication assisted treatment (MAT). While this was not as strong a predictor as emotional exhaustion or job satisfaction, it remained significant in the multivariate analysis after controlling for many individual and work-level characteristics. It is not entirely clear why having more clients on MAT would lead to a stronger desire to leave the job. Future research should attempt to discover why having clients on MAT relates to intent to quit.

Given the difficulty in recruiting high quality counselors, and the high levels of emotional exhaustion in the profession, efforts should be made to improve recruitment and retention of rural treatment counselors. One strategy that would improve recruitment and retention of high-quality counselors would be better pay. Given that salary is directly related to reimbursement rates for SUD treatment services, various Pennsylvania agencies (Department of Drug and Alcohol Programs, the Department of Health) should consider evaluating ways to increase reimbursement rates. Student loan forgiveness is another strategy that could result in improved recruitment and retention. Analysis of the Pennsylvania program showed that very few who applied were accepted into the program and that the requirements were too strict. Given that the student loan repayment program was suspended at the time of the study, due to lack of federal funding, it was not possible to gauge the impact it could have on future recruitment and retention issues. It was suggested that the program be revised and fully funded, and that the qualifications be expanded.

The Department of Drug and Alcohol Programs (DDAP) should consider promoting internship opportunities in rural SUD treatment programs for undergraduate and graduate students. If possible, interns should receive a stipend to encourage them to enter the SUD treatment field.

DDAP and the Pennsylvania Department of Health should consider working together to promote careers in the SUD treatment field, especially in rural areas. They could develop a marketing campaign that describes the work, emphasizing how rewarding it could be, and feature people who are in recovery.

DDAP and the Pennsylvania Department of Health should also consider working with clinical and program directors in rural facilities to implement features that are associated with better retention. These include management styles that improve communication and create positive working environments. One example is the "Sanctuary Model," which recognizes that counselors also experience trauma in the course of their work and promotes a culture that mitigates the negative effects and stress of that work[2]. Having these features could reduce the burnout and stress associated with SUD treatment.

These state agencies should consider encouraging clinical directors to use the Professional Quality of Life Measure (ProQOL, https://proqol.org/ProQol_Test.html) to monitor job satisfaction, compassion fatigue, and burnout among their clinical staff. The measure is free to use and could identify the issues associated with turnover. Management could then develop strategies to help improve staff experiences.

DDAP should also consider expanding its trainings for counselors. New training programs should be developed every year so that counselors can improve their skills, learn new areas, and feel like they are receiving adequate professional development. Required trainings should also include components related to recognizing stress and burnout and strategies to cope with the emotional aspects of counseling in SUD treatment programs.

The Pennsylvania Department of Health could also work with treatment programs to create employee wellness programs aimed at reducing job stress and burnout. The financial savings of retaining

[2] For more information on the Sanctuary Model, go to https://www.thesanctuaryinstitute.org/about-us/the-sanctuary-model/.

staff and improving treatment outcomes should be considered when the state discusses increased funding for treatment.

This research revealed a need for more educational programs in rural counties related to SUD counseling. There were very few undergraduate and graduate programs that offered a major, concentration, or certificate in addiction studies. These programs can create a pipeline of workers into the rural SUD treatment programs. The Pennsylvania General Assembly should consider working with the state university system (PASSHE) to expand programs in this area. Associate degree programs at community colleges that focus on practical experience in SUD counseling would also help create a pipeline of qualified applicants.

To improve recruitment by expanding the pool of eligible applicants, DDAP should also consider analyzing its current requirements for counselors and evaluate whether recovery experience could be used to satisfy part or all of the experience requirement. It should look at SUD treatment programs that have high success rates and examine the counselor's education and training because these are likely contributing to success. DDAP could then revise its requirements if it would help programs recruit the highest quality counselors.

Table of Contents

Introduction

Pennsylvania had the fifth-highest death rate from drug overdoses in the country in 2019, according to the Centers for Disease Control and Prevention. While overdose death rates declined in Pennsylvania from 2017 to 2019, preliminary data for 2020 show an increase (Pennsylvania Data Dashboard, 2021).[3] This increase has been linked to the COVID-19 pandemic and the isolation from social distancing which could increase the risk of overdose.[4] COVID-19 also created additional barriers to accessing treatment during the state shutdown because outpatient treatment programs shifted to virtual therapy. Most outpatient programs were able to resume in-person treatment by late summer 2020.

In response to the overdose crisis, Governor Wolf has signed multiple "opioid disaster declarations," including the 14th renewal in May 2021. As a result, state and federal funding for drug treatment has expanded, especially for medication assisted treatment and county funding to support treatment access for the uninsured or underinsured. These initiatives have assisted more people in Pennsylvania to access drug treatment. Since 2015 there has been a steady increase in the number of Medicaid recipients receiving medication assisted treatment (Pennsylvania Data Dashboard, 2021).[5] Data from the Substance Abuse and Mental Health Services Administration indicate that admissions into drug treatment programs in Pennsylvania increased by 5 percent between 2016 and 2019.[6]

Given the increase in people accessing treatment for a substance use disorder (SUD), treatment programs need to have the required staff to meet that demand. It is especially important to study the treatment workforce in rural counties, given that they are often impacted the most by the opioid crisis. In 2018, six of the 10 counties with the highest opioid overdose death rates in Pennsylvania were rural, including the county with the highest overdose death rate that year (Montour).[7] If opioid overdose death rates are an indicator of the need for drug treatment, then it stands to reason that the highest growth in

[3] https://data.pa.gov/Opioid-Related/Estimated-Accidental-and-Undetermined-Drug-Overdos/m3mg-va8e.
[4] https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html .
[5] https://data.pa.gov/stories/s/Treatment/fvkx-eumb.
[6] Treatment Episode Data Set, 2015-2019, https://wwwdasis.samhsa.gov/webt/newmapv1.htm#.
[7] https://www.overdosefreepa.pitt.edu/know-the-facts/death-data-overview/.

treatment demand in Pennsylvania will be found in rural counties. This project used a mixed-methods research design to examine the barriers for the recruitment and retention of skilled SUD counselors in rural Pennsylvania.

The Need for SUD Treatment Workers

The Bureau of Labor Statistics (2019) predicts that the number of jobs related to behavioral health counseling (which includes alcohol/drug treatment counselors) will increase by 23 percent by the year 2026. This increase is much higher than the average job growth, indicating that there will be many jobs for those seeking counselor positions. Considering the growth nationally, and the rate of overdose deaths in Pennsylvania, we can expect an even higher demand for SUD treatment counselors in Pennsylvania, particularly in rural areas most impacted by the opioid crisis.

In its 2013 report to Congress on the status of the field, the Substance Abuse and Mental Health Services Administration (SAMHSA) indicated that there would be an increased demand for drug treatment counselors due to the aging of the workforce, the need for more racial/ethnic diversity among counselors, and a lack of counselors in rural areas (Hyde, 2013). In addition, it predicted higher need because of an increase in substance use disorder among older adults. Despite this growth, a national sample of clinical directors in drug treatment programs found that almost half of the facilities surveyed had difficulty filling open positions, most often due to a lack of qualified applicants (Ryan et al., 2012). In response to this problem, in May 2019, Pennsylvania launched a student loan repayment program for people working in alcohol/drug treatment programs in highly impacted counties. However, the program was suspended in August 2020 due to lack of funding.

Retention in the SUD Treatment Field

One of the most challenging issues facing the SUD treatment field is turnover among clinical staff. Research consistently shows high voluntary turnover rates among counselors, typically ranging from 25-35 percent, with some studies showing rates as high as 50 percent (Eby and Rothrauff-Laschober, 2012; Gallon et al, 2003; Garner et al., 2012; Garner and Hunter, 2013; Garner and Hunter, 2014; McLellan et al., 2003; McNulty et al., 2007). Turnover rates are also high for clinical supervisors

(Eby et al., 2010). These rates are substantially higher than the annual turnover rate for all health and human services occupations reported by the Bureau of Labor Statistics (White and Garner, 2011).

Most of the research on turnover uses national or large regional samples to estimate turnover rates so little is known about how geographical location might be related to turnover rates. One study of treatment providers in Tennessee found that rural programs had higher turnover rates (Knudsen et al., 2005). Other research on mental health providers finds higher rates of burnout and exhaustion in rural areas, suggesting that SUD treatment staff in rural areas might also experience higher stress and turnover than their urban counterparts (Hargrove and Curtin, 2012; Kee et al., 2002). Clearly, more research is needed to better understand the experiences of rural SUD treatment workers.

High turnover rates are problematic because they can have negative impacts on the organization as well as those receiving treatment. One issue is financial; it costs more to recruit and hire a new employee than to retain an existing one (Cascio, 2000). Programs with high turnover rates also show low employee morale (Johnson and Roman, 2002). Counselor turnover can also be disruptive to the treatment process. Research has found that clients stay in treatment longer and do better when they remain in contact with the same therapist (McCarty et al., 1998; McCaul and Svikis, 1991).

One of the most consistent predictors of turnover is job satisfaction (Eby and Rothrauff-Laschober, 2012; Kulesza et al., 2017; Young, 2015). Other characteristics of the organization, including perceived support, salary, level of clinical supervision, perception of fairness, and leadership effectiveness have been shown to predict turnover rates (Garner and Hunter, 2014; Rothrauff et al., 2011). Individual characteristics are also related; younger staff and those with higher education have higher turnover rates (Garner et al., 2007; McNulty et al., 2007). However, some factors, including gender and recovery status (whether the counselor is also a person in recovery) have not been consistent predictors of turnover and require further study.

Counselor stress and exhaustion (“burnout”) has been consistently linked to increased turnover intention (Garner and Hunter, 2013; Knudsen et al., 2008; Landrum et al., 2012). Recent studies show that burnout is most often associated with job-related demands, such as workload (Beitel et al., 2018;

Landrum et al., 2012). Most research findings agree that coworker support, increased clinical supervision, and self-care were important strategies for managing burnout (Beitel et al., 2018; Fukui et al., 2019; Oser et al., 2013). It is not known, however, if treatment programs in rural Pennsylvania use any of these strategies.

Current Study

Despite the number of research studies on counselor turnover, more research is needed to understand recruitment and retention issues in rural SUD treatment programs. Most of the previous research used national samples and did not account for regional differences in turnover. This project examines recruitment and retention issues of rural SUD treatment counselors through a multi-method research design: a survey was administered to current SUD counselors, open-ended qualitative interviews were conducted with program and clinical directors, and educational programs across Pennsylvania were analyzed.

Goals and Objectives

This research project had three overarching goals. The first was to assess the characteristics of professional SUD treatment counselors in rural Pennsylvania counties and how those characteristics relate to recruitment and retention issues. The second was to determine if the current pipeline of high-quality SUD treatment counselors is sufficient for the current and projected demand for workers in rural Pennsylvania counties. The last was to identify strategies at the program-level and state-level that could improve the recruitment and retention of quality treatment counselors in rural programs. This project focused primarily on counselors because they are most often the ones providing treatment in SUD treatment programs and have the most frequent interactions with clients. They counsel clients enrolled in treatment programs in both individual and group settings. They are primarily responsible for monitoring the clients' behavior and how well they are adhering to a treatment plan. They also have frequent communication with physicians if medication is being used as part of treatment as well as criminal justice professionals if the client has been referred into treatment from the criminal justice system. Counselors

are often also involved in the initial evaluation of a client's drug treatment and mental health needs and the development of the client's treatment goals.

Five objectives related to the goals. The first was to create a demographic profile of the current SUD counseling workforce in rural Pennsylvania counties and determine how individual and organizational characteristics relate to turnover. Part of this objective is to identify programs and counties with higher turnover risk. The second objective was to analyze the major problems that rural SUD treatment programs are having with recruiting and retaining quality counselors and to identify strategies that programs have implemented to improve recruitment and retention. The third was to understand the major reasons why rural counselors leave their positions. The fourth was to assess the scope of educational programs related to SUD treatment to evaluate the pipeline for future counselors into the field. The last was to evaluate state-level incentives aimed at recruiting and retaining SUD treatment staff.

Methodology

Sampling Frame for Data Collection

A list of the SUD treatment facilities licensed by the Pennsylvania Department of Drug and Alcohol Programs (DDAP) was obtained and sorted to exclude urban counties (per the urban/rural definition provided by the Center for Rural Pennsylvania). The remaining 240 facilities, located in the 48 rural counties, were included in the sampling frame for qualitative interviews and a survey of clinical staff.

Qualitative Interviews

From the list of 240 facilities, 30 facilities were randomly selected for qualitative interviews with clinical supervisors or program directors. After reaching out via phone and email to the initial 30 facilities randomly selected, 14 interviews were scheduled. Four facilities' staff declined to be interviewed. The remaining facilities were contacted multiple times and received multiple messages about the project. After two weeks of not hearing back from the facilities, an additional 30 facilities were randomly selected to contact. From this list, the facilities were first sorted by county and attempts were made to reach facilities

located in counties where nobody had yet been interviewed. All of these facilities were contacted multiple times, resulting in 11 scheduled interviews. The program director for one additional facility declined to be interviewed due to not having spare time but agreed to answer questions via email.

These efforts resulted in 26 completed interviews, including the one via email. The principal investigator of the project conducted all interviews. The purpose of these interviews was to gather information about recruitment and retention issues within the facility so the person who would be most knowledgeable about these issues was contacted. For some programs, especially smaller ones, the program director was the appropriate person to interview (several interviewees served as both the program director and clinical supervisor). For other programs, especially larger ones, the clinical supervisor was contacted when possible. Some programs did not have a clinical supervisor position so the person who had experience hiring and supervising clinical treatment staff was approached. Of the 26 interviewees, 10 were clinical supervisors and 12 were program or facility directors. Two interviewees were both the program and clinical directors. The other two interviewees were the human resources directors for their organizations.

Many of those interviewed oversaw multiple programs that appeared on the master list. As a result, 59 programs were represented by these interviews (about 25 percent of the total population of programs). In addition, because some oversaw programs in multiple counties, these interviews yielded data from programs in 36 of Pennsylvania's 48 rural counties. As a result, 75 percent of rural counties were represented in these interviews.

Each interview was done via phone and recorded (except for the one emailed). Interviewees were asked open-ended questions about the structure of their facility, recruitment and retention strategies, and experience in the field. Interviews typically lasted between 35-45 minutes and were transcribed verbatim by a research assistant. See Appendix 1 for the interview guide.

Table 1 lists the characteristics of the programs that were represented by these interviews. As the table shows, programs of varying types and sizes were represented in these interviews. There are two main categories of SUD treatment programs: inpatient and outpatient. Inpatient programs include short-

term hospitalization programs where detoxification occurs, along with longer term residential programs. Most residential programs are designed to last several weeks although some can last several months. Recovery houses (also known as "halfway houses") are also categorized as "inpatient," according to DDAP's classification. Recovery houses vary in their structure but are supposed to be home-like environments where people with SUD live and often attend 12-step meetings or other group therapy. In some recovery houses, there is a period of time where the resident cannot leave or have visitors. Afterward, the resident is typically allowed to leave the recovery house to work and attend appointments. The goal of a recovery house is typically to transition people into independent living.

Outpatient programs are community-based treatment programs. An ordinary outpatient program entails one-on-one counseling while intensive outpatient programs include both individual and group counseling sessions. For many insurance programs, the person's drug use severity dictates whether they go to an inpatient or outpatient program. Other factors could also determine the type of treatment, including employment status and treatment history.

Table 1. Characteristics of Programs where Persons Interviewed Worked.

		Number
Program Type (programs could offer multiple treatment types in the same facility)	Inpatient (residential, partial hospitalization, recovery house)	10
	Outpatient (OP, IOP)	19
	Medication Assisted Treatment	12
# clients/patients in program	30 or fewer	8
	31-50	10
	51-99	11
	100 or more	28
# counselors	1-4	20
	5-8	15
	9 or more	11

Medication assisted treatment (MAT) is a term that refers to the integration of pharmaceutical treatment for SUD. There are currently three FDA-approved medications for the treatment of opioid use disorder: methadone, buprenorphine (Suboxone), and naltrexone (Vivitrol). There are also several MATs approved for alcohol use disorder, although they are less common in treatment programs today. A person

can participate in MAT through either inpatient or outpatient treatment programs, although there are restrictions for prescribing and licensing MAT, which limits its use.

Clinical Staff Survey

To create the demographic profile of counselors and to assess issues related to retention, an anonymous, online survey was administered to clinical staff. Questions asked about individual characteristics (i.e., gender, race, education, etc.), job characteristics (i.e., type of treatment program, types of clients, hours worked, salary, etc.), and job-related attitudes (i.e., job satisfaction, perception of management support, emotional exhaustion, intent to quit, etc.). The survey was hosted by Qualtrics and was estimated to take about 15 minutes to complete. See Appendix 2 for a copy of the survey questionnaire.

Multiple attempts were made to reach counselors in as many of the 240 rural treatment programs as possible. All the clinical, facility, and human resources directors who participated in a qualitative interview agreed to send the survey link to their clinical staff. Other programs were emailed about the survey and were asked to send it to all counselors in their facility. Additional attempts were made to reach programs via phone to obtain email addresses for either the program or clinical director. When possible, these people were emailed asking them to forward the survey link to their counseling staff. At the end of the survey, respondents were asked to forward the survey to other clinical staff in their networks.

For programs that did not have any email addresses listed, either in the list provided by DDAP or on their website, multiple phone attempts were made to contact people there to forward the survey. In addition, all of the executive directors of the Single County Authorities in the rural counties were emailed and asked to forward the survey link to the programs in their county.

From these efforts, 280 individuals completed the online survey. However, some worked in urban treatment programs (likely because they received a forwarded link) and were excluded from the analyses: 229 rural treatment workers were included in the final analysis. It is difficult to know what proportion of all Pennsylvania rural clinical workers this sample represents because there is no master list of staff available. DDAP does not collect data on the number of counselors in state-licensed facilities. Not having

a master list also made it impossible to conduct a random sample of counselors. As a result, caution should be used in generalizing the results to all rural SUD counselors.

Other Analysis

To evaluate the pipeline of future workers into SUD treatment and state-level incentives aimed at recruiting and retaining counselors, data were collected from college/university websites along with the websites of DDAP and the Department of Health. Email communication with a representative from the Department of Health also contributed to the evaluation of its loan forgiveness program targeting SUD treatment workers.

Results

Demographics of SUD Treatment Workers

The first objective of this project was to create a demographic profile of the current SUD treatment workforce in rural Pennsylvania counties. This was accomplished by administering a quantitative survey to counselors in rural programs. Surveys were completed by counselors in 39 different rural counties (counselors in nine rural counties did not respond to the survey request). Due to the small number of respondents in various counties, it was not possible to compare results between counties. Appendix 3 shows the number of survey respondents by county. Table 2 summarizes many of the demographic variables that were gathered by the survey.

Table 2. Individual Characteristics.

		N	%
Age Mean=41.2 (Standard Deviation = 11.3)	22-30	35	15.3%
	31-40	63	27.5%
	41-50	42	18.3%
	51-60	28	12.2%
	61 and older	11	4.8%
	No answer	50	21.8%
Gender	Female	149	65.1%
	Male	41	17.9%
	Other	2	0.9%
	No answer	37	16.2%
Race*	Black/African American	7	3.1%
	White/Caucasian	179	78.2%
	Asian/Asian American/Pacific Islander	1	0.4%
	Latino/Hispanic	4	1.7%
	Native American	1	0.4%
	No Answer	39	17.0%
Education	Associate Degree	5	2.2%
	Bachelor's Degree	88	38.4%
	Master's Degree	97	42.4%
	Doctoral Degree	3	1.3%
	No Answer	36	15.7%
College Major	Psychology/Behavioral Science	86	37.6%
	Social Work/Counseling	29	12.7%
	Sociology/Criminal Justice	29	12.7%
	Human Development	14	6.1%
	Rehabilitation Science/Human Services	12	5.2%
	Other	23	10.0%
	No Answer	36	15.7%
Internship in SUD treatment	Yes	84	36.7%
	No	103	45.0%
	No answer	42	18.3%
Marital Status	Married	92	40.2%
	Divorced/Separated/Widowed	44	19.1%
	Single, never married	56	24.5%
	No Answer	37	16.2%
In recovery	Yes	53	23.1%
	No	139	60.7%
	No answer	37	16.2%
Certified Alcohol/Drug Counselor	Yes	57	24.9%
	No	136	59.4%
	No answer	36	15.7%
Salary	Less than $30,000	27	11.8%
	$30,000-40,000	75	32.8%
	$40,000-50,000	50	21.8%
	$50,000-60,000	15	6.6%
	More than $60,000	23	10.0%
	No answer	39	17.0%

*Respondents could check off more than one option; the percentage indicates the proportion of the whole sample that indicated each option.

As shown in the table, the mean age of respondents was about 41 years, however many respondents did not indicate their age. Several other questions in this section also had a high number of non-responses, possibly because the questions appeared at the end of the survey and the individual did not have time to complete them.

The majority of survey respondents were female (65 percent) and white (78 percent). For education, a large proportion (42 percent) held a master's degree while another large number (38 percent) had a Bachelor's degree. This is not surprising, given the educational requirements for obtaining a counselor job in SUD treatment. About 37 percent indicated they had completed an internship in the SUD treatment field, either as part of their bachelor's or master's program. More than half of the respondents majored in Psychology or a related counseling-type program (such as social work) when they were in college.

About 23 percent of respondents indicated that they were in recovery for a SUD and about 25 percent had obtained a certificate in drug and alcohol counseling (such as a Certified Alcohol Drug Counselor). Most had salaries that fell in the $30,000-50,000 range. About 17 percent earned more than $50,000.

Tables 3 and 4 summarize characteristics related to the program where the respondent worked as well as job specifications, including their clients' characteristics.[8] The survey description invited any staff member with clinical responsibilities to complete the survey. When asked about their position, respondents could select multiple options, reflecting the multifaceted nature of their job. About 67 percent of respondents indicated that their primary position was counselor/therapist and about 19 percent were a clinical/counselor supervisor (with counseling responsibilities of their own). Only six respondents indicated they were a counselor assistant. The most common "other" positions listed in a follow-up question included intake specialist and case manager. The majority (66 percent) worked in outpatient treatment programs and indicated that their treatment programs were non-profit entities (51 percent).

[8] In some programs, individuals in treatment were called "clients" while in other programs, they were called "patients." For simplicity, individuals in treatment are called "clients" throughout the report.

Interestingly, many respondents (11.5 percent) did not know whether the program where they worked would be considered a private company or a public entity. Most of the programs where respondents worked were free-standing treatment facilities and not part of a larger organization or health system.

Regarding job structure, almost the entire sample (93 percent) indicated that they worked full time. About one-third had supervisory duties as part of their job and about 30 percent had to travel to multiple programs to see clients. The majority (55 percent) had been in their position for more than three years, while a sizeable number (14 percent) had been in their position for less than one year. The majority (about 75 percent) indicated that they felt like they had received the necessary training to do their job well.

Table 4 shows how the clinical staff spent time, between counseling responsibilities and administrative activities, such as paperwork. Many (44 percent) spent more than 20 hours each week in individual/group counseling sessions. About 23 percent spent more than 20 hours each week on administrative tasks.

Most counselors surveyed (77 percent) had clients with co-occurring SUD and mental health issues and about 71 percent said they had clients using MAT. The majority (51 percent) counseled both adults and adolescents, while 48 percent counseled only adults. Half of respondents indicated that the majority of their clients were referred from the criminal justice system (including probation, drug court, diversion, etc).

Table 3. Counselors' Job-Related Characteristics.

		N	%
Position*	Counselor/Therapist	153	66.8%
	Counselor Assistant	6	2.6%
	Counselor Supervisor	43	18.8%
	Other	28	12.2%
Program Type*	Inpatient/Detox	57	24.9%
	Outpatient	152	66.4%

	Recovery House/Halfway house	14	6.1%
Program Structure	Private, for profit	64	29.5%
	Private, not-for-profit	111	51.2%
	Public	17	7.8%
	Not sure	25	11.5%
Program Affiliation	Part of a Larger Corporation	83	38.2%
	Part of Hospital/Medical Center	12	5.5%
	None	122	56.2%
Received Necessary Training	Strongly Agree	97	47.3%
	Somewhat Agree	56	27.4%
	Neither Agree nor Disagree	26	12.7%
	Somewhat Disagree/ Strongly Disagree	26	12.7%
Has to Travel to Multiple Programs	Yes	64	29.6%
	No	152	70.4%
Has Supervisory Duties	Yes	75	34.6%
	No	142	65.4%
Work Hours	Less than 35 hours/week	16	7.4%
	35 or more hours/week	201	92.6%
Time in current position	Less than 1 year	30	13.8%
	1-2 years	59	27.2%
	3-5 years	47	21.7%
	More than 5 years	70	32.3%

*Respondents could check off more than one option; the percentage indicates the proportion of the whole sample that indicated each option.

Table 4. Counselors' Job Duties and Client Characteristics

		N	%
Average hours each week spent counseling (individual or group therapy sessions)	Less than 10 hours	43	19.7%
	10-20 hours	79	36.3%
	More than 20 hours	96	44.0%
Average hours each week on administrative activities (i.e. paperwork, meetings)	Less than 10 hours	92	42.2%
	10-20 hours	75	34.4%
	More than 20 hours	51	23.4%
Types of Clients *	Alcohol/Drug Treatment	188	82.1%
	Mental Health	47	20.5%
	Co-Occurring SUD and Mental Health	176	76.9%
	MAT	163	71.2%
Client Age	Adults only	105	48.4%
	Adolescents only (<18)	2	0.9%
	Combination adults and adolescents	110	50.7%
% of Clients on MAT	0	9	4.2%
	1-9%	52	24.1%
	10-25%	69	31.9%
	25-50%	51	23.6%
	More than 50%	35	16.2%
% Clients Criminal Justice Referrals	0	9	4.2%
	1-9%	17	7.9%
	10-25%	29	13.4%
	25-50%	53	24.5%
	More than 50%	108	50.0%

Job Satisfaction and Intent to Quit

Related to the first objective of creating a profile of the current treatment workforce, the third objective for this project was to identify the major reasons why rural treatment workers leave their positions. The survey asked questions about job satisfaction, management support, emotional exhaustion, perceived stigma, and intent to quit. These items were analyzed to identify the individual and job characteristics related to retention.

Overall, job satisfaction was high for respondents, as 84.5 percent said they somewhat or strongly agreed with the statement, "All in all I am satisfied with my job." Only 8.2 percent indicated that they were currently looking for another job in SUD treatment, although 18 percent indicated that there was a "good chance" they "would leave this job within the next year or so." About 9 percent indicated that they wanted to remain in counseling, but not in SUD treatment, while 13.6 percent indicated they wanted to find a job in "another field."

Factors Related to Intent to Quit (Bivariate Analysis)

Several composite variables were created from the survey items. See Appendix 4 for a detailed description of the individual items used in the construction of the composite/scale variables. Intent to Quit was computed by using the mean scores on four variables related to planning or looking for another job (Cronbach's alpha = .877). Job autonomy (two items), management communication (three items), perceived distributive justice (two items), co-worker support (two items), emotional exhaustion (three items), and perceived stigma (seven items) also had good reliability, as measured either through Cronbach's alpha or correlation analysis (for two items). On all the composite variables, a higher score indicated stronger agreement with the concept. For example, a higher score on job autonomy meant that the respondent felt like they had a great deal of autonomy in their job.

Previous research on job retention has found that intent to quit is a strong predictor of leaving a job in the future. The composite created for this project had scores from one to five, with a higher score indicating a stronger intent to quit. The mean score for intent to quit was 1.9 among rural treatment workers (s.d. = 1.05), indicating that, on average, workers were not thinking about or looking for a new job.

Demographic variables were first analyzed in relationship to intent to quit by means tests (analysis of variance and t-tests) and correlation analysis. Significance tests indicated that a relationship would likely occur in the larger population. Only salary ($r = -.232$, $p < .001$), age ($r = -.233$, $p < .001$), and whether the respondent was a certified counselor ($r = -.183$, $p < .05$) were significantly related to intent to quit. Those with higher salaries reported lower scores on the intent to quit scale. Younger individuals scored significantly higher on the intent to quit scale. If the respondent was a certified counselor, they scored lower on the intent to quit scale. Other variables were analyzed but were shown to not be significantly related to intent to quit, including race, gender, education, recovery status, and marital status.

Job and client characteristics were then analyzed to see if there were any significantly related to intent to quit. The three variables significantly related to intent to quit were length of time working in the field ($r = -.143$, $p < .05$), percentage of clients receiving MAT ($r = .221$, $p < .01$), and if the respondent had

supervisory duties (r = -.212, p <.01). While those who have been working in the drug/alcohol treatment field longer reported lower scores on the intent to quit scale, time in current position was not significantly related to intent to quit. As their percentage of clients receiving MAT increased, so did a counselor's intent to quit. Interestingly, there was a moderate correlation between percentage of clients receiving MAT and time working in the field (r = .195, p < .01), where those who have been working in the field longer also have more clients receiving MAT. If the counselor had supervisory duties, they had lower intent to quit scores. None of the other job or client characteristics were significantly related to intent to quit, including hours spent counseling, hours on administrative duties, percentage of clients referred from criminal justice, working with adults/adolescents, treatment structure (private/public), treatment type (inpatient/outpatient), or working at multiple facilities.

The last bivariate analysis analyzed job-related attitudes with intent to quit. The index variables of job autonomy, management communication, distributive justice, job satisfaction, co-worker support, emotional exhaustion, and perceived stigma were correlated with intent to quit.[9] The only variable that did not significantly relate was perceived stigma. The other variables are listed in Table 5 along with their correlation coefficient.

Table 5. Correlations of Job Attitudes and Intent to Quit (Pearson's r and significance level).

	Intent to Quit
Sense of Autonomy	- .436***
Management Communication	- .578***
Perceived Justice	- .517***
Job Satisfaction	- .669***
Co-Worker Support	- .473***
Emotional Exhaustion	.666***

** p < .001

As shown in the table, these variables were related more strongly to intent to quit than demographic or job/client characteristics. Respondents who felt a higher level of autonomy in their work, felt that management communicated well, perceived workplace justice, had higher job satisfaction, and rated

[9] Appendix 4 details the variables used to create these composite/scale variables.

positive co-worker support all reported lower scores on the intent to quit scale. Those who scored high on the emotional exhaustion scale also scored high on the intent to quit scale.

Multivariate Analysis

Given the bivariate results, the researchers conducted a linear multiple regression analysis to better understand the independent effects of the variables on a counselor's intent to quit. Table 6 presents the results of the multivariate regression analysis.

Table 6. Regression Analysis of Intent to Quit (N = 175).

Variable	B (SE)	Standardized Beta	Sig.
Age	-.006 (.005)	-.061	n.s.
Salary	-.003 (.042)	-.004	n.s.
Time in Field	-.085 (.064)	-.078	n.s.
Supervises others	-.086 (.120)	-.039	n.s.
Certified	-.042 (.119)	-.019	n.s.
% Clients MAT	.147 (.046)	.155	$p < .01$
Job Autonomy	-.041 (.084)	-.029	n.s.
Emotional Exhaustion	.265 (.051)	.312	$p < .001$
Coworker Support	-.086 (.072)	-.070	n.s.
Justice	-.054 (.059)	-.058	n.s.
Job Satisfaction	-.318 (.069)	-.304	$p < .001$
Communication	-.176 (.079)	-.156	$p < .05$
(Constant)	3.946 (.519)		$p < .001$
R-Squared = .649			

As presented in the table, the model overall was statistically significant and R-Squared shows that nearly 65 percent of the variance in intent to quit can be explained by the independent variables. This indicates that these variables together provide powerful explanations about a counselor's intent to quit. Many of the variables were no longer significant in the multiple regression analysis, indicating that they do not independently impact intent to quit. The four variables that remained significantly related to intent to quit were job satisfaction, emotional exhaustion, management communication, and percentage of clients receiving MAT. The standardized betas show the relative strength that each variable has in predicting intent to quit. The strongest predictor of intent to quit was level of emotional exhaustion followed by job satisfaction.

These results are important for understanding why counselors may be thinking of leaving their job. Emotional exhaustion and job satisfaction were the biggest predictors of intent to quit. Management

communication was also significant, which is important for considering what can be done organizationally to improve retention. Management communication was a composite variable created from three survey items that asked counselors to indicate if they felt their concerns were heard, if they would be consulted about major decisions, and if their supervisor shares information. Program and clinical directors can adopt strategies that improve communication with counselors.

It is noteworthy that, even when controlling for other factors, the percentage of a counselor's clients receiving MAT impacted their intent to quit. It is not entirely clear why this would increase a counselor's intent to quit because this item was not highly correlated with other job-related characteristics. It appears to have an independent effect on whether counselors want to leave their job.

These survey results relate to the recruitment and retention issues that were discovered via qualitative interviews with program and clinical directors, which are discussed in the next section.

Program-Level Perspectives on Recruitment and Retention Issues

The second objective of this project was to analyze the major problems that rural SUD treatment programs have had with recruiting and retaining quality treatment staff as well as strategies that programs have done to improve staff recruitment and retention. The analysis for this objective was done through qualitative interviews with program directors and clinical directors in rural Pennsylvania counties.

Program/Clinical Directors Views on Recruitment

> *"It's not like there's a lot of positive energy out there in the news that's saying, hey, don't you want to be a drug and alcohol counselor?"*
>
> *(Facility Director, Inpatient Treatment Program)*

The majority of interviewees (21, or 81 percent) indicated that recruiting high quality counselors was a significant problem for their program(s). Only five interviewees claimed that recruitment was not a problem. Most who were interviewed mentioned that they used a combination of internet-based recruiting sites (like "Indeed") and personal networking to fill open positions. The biggest hurdle they faced was that not enough qualified people would apply when they had open positions. Several interviewees related this issue to there not being enough new people entering the field. As one clinical director explained:

"*A lot of times we're just recycling people…It's not like we're bringing new blood in from out of the area…We're hiring somebody that's working in a different clinic down the road…*"

One clinical director who said recruitment was not a problem said that she saw a good "pipeline" of applicants from two universities located within 20 miles of her facility.

Salary/Pay

When asked why they thought recruiting was a problem, the most common reason offered was salary/pay. As one clinical director said:

"*The one sticking point that we always hear from applicants is the pay. Drug and alcohol pay is not good.*"

While several interviewees felt that they offered a good benefits package, they did not see it as sufficient in dealing with the salary issue. Some also lamented how poorly drug and alcohol services were reimbursed and found a general lack of respect toward the field.

Rural Location

Another frequent issue mentioned for recruitment problems was their facility being in a rural location. This led to recruitment issues because people might have to commute to a more remote area and because the rural locations did not necessarily have people nearby with the required higher education for the position.

Lack of Proper Training

Interviewees also commented on the lack of professionalism of applicants and shortcomings in their training. Two mentioned issues with applicants not showing up to scheduled interviews. Another cited issues with their educational training:

"*The students coming out of [Master's programs] are…I don't know what they're being taught…They lack professionalism and they lack people skills. They lack compassion and clinical skills as well.*"

Similarly, a clinical director of a residential facility felt that the education of potential applicants might not have kept up with the state of the field:

"*From where I started in the field, in the mid-80s, to where we are today, there's just a different level of sophistication that a clinician needs. The significance of trauma… The understanding of what medication assisted therapy is and how to determine who is best for that angle of care… So it's been very challenging [finding counselors].*"

This facility also started recruiting counselor assistants so that they could train them to have the experience they were seeking. This facility was fortunate to be able to afford this strategy; most programs mentioned that they did not want to hire people at the counselor assistant level because of the supervision (and, hence, the cost) that is necessary.

Passion/Commitment

Related to professionalism, several mentioned that more recent applicants did not have a passion for the field, which they viewed as necessary. As one facility director put it:

"*I don't know where the people are anymore that really care to come in and help people instead of being out for the money.*"

Similarly, a clinical director lamented:

"*It was really hard to get people to see that there is a higher level of commitment.*"

Another facility director shared this perspective:

"*And I want people that are called to counseling. I don't want anybody working for me that does it for a job. They're not going to last long in the field and their clients will pay that.*"

One human resources director explained it similarly:

"*What I found with recruitment for drug and alcohol, it's passion. Like people are just passionate about drug and alcohol… It just takes a certain person and it's a life experience lots of times that drives them into the program.*"

All of the clinical/program directors interviewed had extensive experience in the field, often starting their career as a counselor and moving up into administrative positions. They also cited their own passion as what has kept them in the drug/alcohol field for so long. Below are two statements that illustrate their own passion and commitment for the work:

"*I feel like once you get in drug and alcohol and you know that that's your niche, that you couldn't go anywhere else. I can't imagine working with a different population." (Clinical Director)*

"It's a mission that I have. It is not a job for me, this is not employment... I would do it for money or I would do it voluntarily." (Program Director)

Stigma

Four interviewees mentioned that clients in drug and alcohol treatment might not be viewed as the most desirable population to work with, which could impact recruitment. One program director saw this as a problem for recruiting counselors to work in medication assisted treatment (MAT) programs:

"Some people are very opposed to MAT and some aren't so that would impact some facilities"

Another program director related it to perception:

"I think some people go to counseling and they think that they're going to change the world and they're going to have doctors and lawyers and like these upper-class people that are coming to see them in an office with a couch and that kind of stuff... And drug and alcohol is not that. You're going to have the roughest of the rough coming in. So I think that's a big barrier."

This same program director saw part of the issue to be the stigma around drug and alcohol addiction more generally, especially by the media. As she explained,

"I think that a lot of it has to do with the stigma that's still out there… The stigma that the media portrays, that society portrays… Who wants to go into a field where you're not going to get any praise, you're not going to feel like you're doing something good…"

Another facility director referred to drug/alcohol clients as "difficult," implying that they are a harder group to counsel than those with other mental health issues. She elaborated that the patients/clients in their program were "not like private practice." Similarly, another program director referred to their patients/clients as "manipulative." This negative view of clients is what one program director saw as pervasive among the public as well:

"Every time somebody asked me where I work and I say [Treatment Center], they're like, oh my gosh, how do you do that? And I always respond super positive, and I say, you know what, I love it. I can't imagine doing something else… I love the people that I work with, I love the patients that I work with, and I enjoy everything about it. I think if people are able to portray that more than it would be a different story but that's just not how it is."

Interns

One of the strategies for improving recruitment was the use of interns. Eighteen (69 percent) of the interviewees reported that their facilities frequently hosted interns, most often Master's-level students. All these programs had at least one intern end up working for them when a counselor position opened, so they were all positive about having interns. As one program director put it:

"*There's nothing better than hiring your star intern, because you've trained them in a year's time and you've already developed those relationships.*"

At least one facility mentioned that they were strategic about using interns to train for open positions. One program director explained:

"*We've had a heck of a time getting qualified people to respond to ads. And that's why we take on interns, which is a good way to get someone in. That's what we did with the one we have now. Brought him in as an intern, he was doing a great job, hired him and then we'll see how he does and then he can go full time if the supervisor decides that he's doing well enough.*"

Having interns was also mentioned as important for exposing potential counselors to the field. One program director mentioned that she did an undergraduate internship in a drug treatment facility and fell in love with the field. Another clinical director had a similar experience:

"So many people I know that have stayed with drug and alcohol treatment started off interning and worked their way up throughout the system… So I think establishing healthy programs with colleges and educators, that back and forth, would be really crucial."

Several programs had cultivated relationships with the administrators of local educational institutions with counseling programs, which led to a pipeline of interns into their facilities. Most facilities, however,

did not have formal relationships with nearby institutions and would coordinate internships only when individual interns contacted them about a possible internship.

The few facilities that did not offer internships usually cited the work involved mentoring interns as being too great, especially if they had a small staff. Two interviewees mentioned that they would like to have interns but had not had anyone contact them in recent years.

Strategies to Improve Recruitment

A common strategy mentioned to improve recruitment was to find ways to increase counselor salary. Several mentioned that increasing reimbursement rates for treatment would be one way to do this, especially for smaller facilities. As one program director put it:

> "*For agencies that are connected with a large system, like UPMC or Pinnacle or Geisinger, they have a broader range of programs that have a cushion of money that can be shifted over to support the less profitable programs. For small, freestanding agencies, there is no fiscal safety net, so reimbursement becomes a key factor.*"

All of the program directors who mentioned salary as a recruiting problem indicated that the only way they could increase salaries would be to receive higher reimbursement for treatment services from the state.

Some interviewees mentioned specific ways that the Pennsylvania Department of Drug and Alcohol Programs (DDAP) could help with recruitment. One clinical director suggested that DDAP could work with the Pennsylvania Department of Education to coordinate a plan for recruitment and better pay. Another clinical supervisor mentioned having issues hiring someone they felt was qualified because of the restrictions on which degree is acceptable in the DDAP requirements.

The most frequent complaint about DDAP's requirements for hiring had to do with its degree requirement's impact on recruiting people in recovery. Several felt that people in recovery should be able to start working as a counselor while they are finishing a degree. They also discussed that a person's recovery process should be able to be counted as part of the required experience.

Related to the problem about inadequate training, several interviewees suggested that there could be more education about drug/alcohol treatment for those studying counseling. They also suggested that more colleges could offer drug and alcohol treatment certifications in their curriculum. Part of that education was also making sure students in the programs would have a realistic understanding of the counseling profession. As one clinical director explained,

> "*A lot of it needs to start in undergrad. They kind of need to prepare people a little better by letting people know what to expect… Making sure that students getting ready for their senior internship have a logical and reasonable goal for when they graduate. They're not going to be making 100,000 a year with a bachelor's… This is very rewarding work, and you can get to a point where you make a good living. But it might be something that you have to work pretty hard to do. So, just making sure people really know what they're getting into so you're not surprised when you're offered a certain salary.*"

Two of the interviewees who said they did not have a problem with recruitment described their facility as being attractive to applicants because of its reputation. As one program director described,

> "*People want to go where they hear there's a good reputation there, like a good name in the community. Because the town is small, you pretty much know who the healthier centers are. And if there's a center that doesn't do well or there's a lot of disgruntled workers, trust me everybody knows it. You don't want to work there.*"

Another unrelated strategy would be the timing of posting job announcements. One of the human resources directors interviewed mentioned that they would get more applicants around graduation months (May, December) and would use that as a recruiting strategy.

Program/Clinical Directors Views on Retention

In contrast to their expressed difficulty in recruiting quality treatment staff, only six interviewees (23 percent) said that turnover was a major problem in their facility. Two said that it could sometimes be an issue, and 18 (69 percent) were confident that it was not a problem at all in their programs. One of the

few interviewees who said that retention was a problem in their program explained how he saw it negatively impacting those in treatment:

> *"Three [current clients] are on their fourth counselor… I feel bad for them. I mean, how do you open up to four different people? And they're already struggling with trust issues." (Clinical Director)*

Burnout/Stress

For those who viewed retention as an issue in their program, or in programs they worked for in the past, the most common problem cited was counselor burnout or fatigue. Related to burnout was the stress involved in being a counselor in the drug/alcohol field. As one program director explained,

> *"I think it's a super rewarding profession. It's just, it's very stressful, too. I had a colleague one time saying we deal in people's pain and misery. That's our business."*

Related to burnout and stress was the frustration counselors could feel. Many of the interviewees related this frustration to the severe problems that clients/patients in drug and alcohol treatment had. The implication was that this work is more difficult than other types of mental health treatment:

> *"Our clients have a lot going on, you don't' always see a lot of those things changing. So I think people become very frustrated because they want it all to change right now and they want them to be sober…" (Program Director)*
>
> *"It's stressful, it's tiring. Sometimes you get stuck in feeling like you're fighting a losing battle… If you have a bunch of clients that relapsed at the same time… Just seeing the opioid epidemic in the news and still seeing people dying… It feels like it just never changes, and you're doing the same thing over and over again." (Clinical Director)*
>
> *"The populations are getting more difficult to work with. We're seeing more dual diagnosed clients…The level of clients that we're seeing have more severe issues than what they've had five years ago." (Program Director)*

"It's a very difficult field. A lot of times our therapists can feel defeated because if somebody relapses or passes away or gets arrested again. Like all that hard work, they feel like they failed." (Program Director)

Many of the interviewees placed some of the blame for burnout/stress on the counselors, for not taking more conscious efforts to alleviate these issues. Below are a couple of examples:

"Some therapists aren't the best at self care." (Human Resources Director)

"When you can't separate yourself from the client, emotionally, then you kind of get very burned out very quickly." (Program Director)

"Extremely high burnout, things like that. So, we have a counselor for a year and a half, maybe two, and then they're off to something else. Probably Walmart because they can't cut it as a counselor." (Clinical Director)

Two interviewees mentioned age specifically as a possible correlation with burnout:

"I think that younger individuals that come into this field think that they are going to solve all the problems of our clients and then they get burned out very quickly." (Outpatient Program Director)

Some of the interviewees suggested that different types of treatment programs had higher turnover rates. Those who had worked in methadone maintenance facilities thought counselor stress and burnout was higher there; one mentioned the work hours of a methadone facility as less desirable (they worked 5:30am – 1:30pm). One human resources director said that turnover was worse in inpatient facilities because of the stress involved. Of the six interviewees who said retention was a problem for their facility, half were located in inpatient programs, suggesting turnover might not be worse in any particular type of treatment program.

Another common reason mentioned for turnover was the high workload for drug and alcohol treatment counselors. Many interviewees mentioned intense paperwork requirements that could lead to job fatigue.

"[DDAP] is always putting in some kind of new program, and staff need to be trained, and then it lasts for a little bit and then it's not good anymore. It's a real problem." (Facility Director)

Several also said that counselors' caseloads could be high and therefore lead to more stress and fatigue.

Private Practice/Other Agencies

Another common theme in the interviews regarding retention was the issue that counselors would leave a facility to go into private practice. Four interviewees specifically discussed this problem. As one program director explained,

"I'm seeing a trend where people will graduate, they'll do their two years and get supervision and get licensed and go into private practice. And my mind says, I don't think you know enough to go into private practice."

Going into private practice appeared to be related to a counselor wanting to make more money. Two facilities also mentioned having counselors leave who went to work for state agencies that could pay higher wages.

Support from Management

By far, the most frequently discussed reason for low turnover by those who did not see retention problems in their facilities was that counselors were supported by management. This typically involved good communication between management and counselors, a sense that counselors' views were heard, and empathy from management about counselors' responsibilities and well-being. As one facility director said:

"I think the retention really falls on the leadership of the center… If you treat your employees well, and they feel that support from each other…then they'll stay. I want people to come and I want them to stay because I know that's going to be good for the client."

Similarly, one clinical director who saw turnover as an issue cited poor support as a reason why counselors left within the past year:

"The three most recent ones were just poor support from corporate. Yeah, when they leave, they're like, oh I hope you can stick it out."

Management support was seen as one way to combat the high stress involved in the field:

"We had a guy leave here and then he died two days later from an overdose. That really affects a person. So it would be nice to have support." (Clinical Director)

Strategies for having management be more supportive of their staff included good communication with counselors about their strengths and interests as well as what was happening in their job:

"Our owner has been really dedicated to aligning people's roles with what they wish to be doing, what their passion is, or what their strength is…rather than making people do something they don't want to be doing." (Program Director)

"We're cohesive, engaged in open communication... [Counselors'] voices are heard, it's not run as a dictatorship; it's run more of a democracy." (Program Director/Clinical Supervisor)

One Human Resource Director cited the management style of having an open-door policy to promote good communication:

"Truly listening and hearing people's feedback."

Several other facilities also saw management as "taking care" of the staff, which led to improved retention.

Only one facility director who oversaw two programs mentioned that they administered the ProQOL measure twice each year to identify possible issues among their staff with burnout, stress, and job satisfaction. This was a tool they used to support their staff's needs and to improve retention.

Culture/Environment

Related to management support is that facilities with low turnover promoted a better work culture or environment. Several interviewees mentioned "culture" specifically when talking about why their facility had low turnover.

"I think the atmosphere, the culture. Culture has a lot to do with it. It's more of a family type feel, the flexibility we offer." (Human Resources Director)

"The turnover issue in my previous facility ended up being culture. The culture at times did not end up making you feel included or a part of the solution. You didn't have an opportunity for

input… We felt dictated to… I think that employees will have resiliency as long as they feel a part of, listened to, and have an opportunity to be about the solution." (Clinical Director)

"We're a nonprofit, which is why we can't pay as much. But it's a great place to work and people that have been here for a little while stay because they realize that." (Facility Director)

The positive work culture included feeling valued and supported. It could also include feeling safe, as one clinical supervisor explains:

"*I have been here a long time so people feel safe. They feel this sense, they know what's expected of them. They know they can come to me. They know they don't have to be perfect… You stay where you feel safe."*

Two of the interviewees who oversaw residential treatment programs mentioned that the campus could also promote a good work environment and a positive work culture. This might be by staff eating together in the cafeteria or playing games together on the grounds of the facility (i.e., basketball, tennis).

About one-third of the interviewees mentioned having team-building events with their staff. These included lunch or dinner events, retreats, coordinating fundraisers together, and other social events (such as a "Paint Night"). One program mentioned having a yearly "Staff Appreciation Day" that included food and games. Another went offsite once a year for "Vision Day" where the staff worked collaboratively on the program's strategic plan.

<u>Supervisor/Management Involvement</u>

Another characteristic cited as being related to low turnover was having supervisors and other management team members being present and interacting with staff. It was seen as beneficial to have those in managerial roles also do some of the same tasks as the staff, such as counseling patients/clients. Here are some examples from the interviews:

"I would never tell any of my staff to do something that I wouldn't do myself… If they're sick and I have to jump in and call their people for the rest of the day, I'll do that. It's not a huge issue so anything that I can help them with I really try to do." (Clinical Director)

"When we had our [other] office, I feel like turnover was higher. I think that was more of a management issue…I was the treatment supervisor for two sites. So, to try to split my time equally, and be there for everybody as needed, I think that at times people didn't feel supported." (Clinical Director)

"[The staff] say to me how happy they are all the time. And I think it's… I'm very positive. And I'm there all the time and they've said to me that other places they've worked, most owners aren't there… If you're telling people what to do and you're not there, I think that impacts the morale of your staff." (Clinical Supervisor/Owner)

"I am on the front lines with them, not just dictating what to do but I actually get in the nitty gritty with them. That may help up morale… I can better understand what they are going through and experiencing." (Program director/clinical supervisor)

The interviewee above also carried a caseload of 15 clients and felt that it made him more accessible to the counseling staff he oversaw.

Related to their involvement, it was seen as important to offer positive feedback and reinforcement to the counseling staff. As one program director shared:

"I always try to give them high fives and kind of be a cheerleader for them. Because I want them to feel appreciated because they certainly are. It's not fake, it's real. I want to just verbalize it."

Working as a Team

Another common characteristic of facilities that claimed to have good retention was that the counseling staff worked well together. About half of those interviewed described their counseling staff as a "team" or "family" and indicated that this dynamic was essential to creating a good workplace environment. These interviewees described counselors supporting each other, as well as receiving support from management, as another way to alleviate stress. As one facility director said,

"It's a very stressful job… And the counselors need support themselves, from other staff."

Another program director described the collaborative environment as everyone taking care of each other:

"Because we're small…because our owner's a social worker…we are focused on taking care of each other."

Professional Development

Another strategy for improving retention that several interviewees mentioned was that the facility would offer professional development opportunities as well as the opportunity to move up into other positions within the organization. As one clinical director explained:

"As far as the professional development goes, management staff are expected to put on webinars and trainings and things like that. So the therapists here find it to be very beneficial because they can continue to grow within their careers."

Two other interviewees mentioned that the opportunities for advancement were good in their organization.

Several interviewees indicated that part of the benefits of working in their program was paying for all or part of the process of certification. One program mentioned also paying to have the certification renewed every two years.

Promoting Self Care

The interviewees discussed how good management promoted self-care among its staff. This would frequently be mentioned as counselors taking a day off from work in order to alleviate stress. As one program director explained,

"I want them to take care of themselves and I told them that from the jump. Like, please, please, please take care of yourself. Our jobs are intense and so hard but you have to be able to balance that…You earn your time and take it off… Because, some days, you just, you wake up and you're just like 'f' this, I'm not doing it today."

This program director also mentioned that her previous employer would make counselors feel bad for taking a day off, which added to retention issues. A clinical director in another facility had a similar perspective:

"I try to make sure it's clear to my therapists that I'm here for you if you need to just come in my office and vent or cry about something, let me know. If you need a day off for self-care, we'll make it happen, we'll figure things out."

A Human Resources Director also mentioned paid time off for alleviating stress:

"If you need a day and you tell them, they'll give you a day off with pay."

This same interviewee said that it was company practice to discuss self-care with counselors during weekly supervision sessions. Similarly, one facility director mentioned using the "Sanctuary Model" during counselor staff meetings where counselors would "check in" at the beginning of their weekly meetings to discuss issues they were having. While only one interviewee mentioned the strategy of using a sanctuary model in their facility, others appeared to be using some of the elements, even if not explicitly labeled as such.

Counselor Trainings

Many of those interviewed mentioned that one area of improvement that the state and/or DDAP could assist with concerned required trainings. Some interviewees related trainings to giving staff the skills required to deal with the stress of the job, which would improve retention:

"Better equipped staff are going to stay around longer or have the skills to stay around longer. Burnout prevention is a major skill and unfortunately, most people don't have that skill." (Clinical Director)

A related issue was that many interviewees felt that the trainings were not accessible to the staff due to the rural location of the facility and the travel required to attend trainings. At least seven interviewees (27 percent) mentioned this as a problem, along with the costs that they would have to incur to get their staff trained. One solution proposed was to offer more online trainings. Another suggestion was to increase the diversity of offerings so that counselors who had been in the field for a long time could feel like they were learning something new and useful. As one clinical director framed it:

"The DDAP version of things…if you've had it once you've had it, because it never changes. In 20 years it hasn't changed a bit."

Similarly, some felt that while DDAP imposes more training requirements and has increased standards for becoming a counselor, they don't provide the necessary support to recruit, train, and retain staff.

Loan Forgiveness

The interviewees were asked explicitly about loan forgiveness programs and the clinical/program directors' knowledge about their staff using these programs. While the vast majority agreed that this could be a good strategy for improving recruitment and retention in the field, many cited difficulties their staff had in accessing the benefit. Difficulties included too many restrictions that made certain people or the place where they worked ineligible. One mentioned being rejected because she had supervisory responsibilities. Another mentioned that the program required counselors to be licensed but none who worked in her facility had their license.

Also, very few knew about the state's program announced in 2019, which was different from the federal loan forgiveness program for nonprofit counselors more generally. For those who had counselors receive this benefit, they saw it as a very positive tool for retention:

> *"I know that my counselor that got it was extremely happy and now we have her for at least two more years." (Clinical Director)*
>
> *"I think it's great because it's not always the highest paying positions and there's a lot of stress and demand and I think that's definitely an incentive for sure." (Facility Director)*

Other Considerations

The program and clinical directors interviewed also responded to questions about the flow of patients/clients into their facilities. Most had relatively stable numbers of patients/clients while a large number reported increased admissions in the past few years (pre-COVID). One noteworthy finding was that, while not asked about it directly, five interviewees (almost 20 percent) commented that they had seen a dramatic increase in the number of patients/clients entering treatment with methamphetamine or other stimulants as their primary drug of choice. As one facility director put it:

"People are afraid…they don't want to overdose and die. So, they're switching to something else and not necessarily a better choice. That's what we're hearing from clients."

While not directly related to recruitment or retention, this shift from opioids to stimulants as a main drug of choice is important to consider for the context of treatment programs today.

Educational Programs and Recruitment

The fourth objective of this project was to assess the scope of educational programs related to SUD treatment to evaluate the pipeline for future professionals into the field. Almost all the program/clinical directors interviewed mentioned issues with hiring high-quality counselors. The most common problem was that not enough qualified people would apply for an open position. Therefore, it is important to look at the programs offered in nearby higher educational institutions to see if the current educational landscape is adequate to meet the demand for SUD counselors.

Pennsylvania requires that a SUD counselor have certain educational credentials and work experience (see Appendix 5). Counselors need to have at least an associate degree in a related field, although higher levels of education (bachelor's, master's) translate to lower experience requirements. Many of those interviewed said that applicants often had the required education but lacked direct experience in the SUD treatment field. This created a burden for the treatment programs because they would have to do extra training or sometimes hire a person who served as a "counselor assistant" until they completed the required training. A counselor assistant could not carry a typical caseload of clients and required many hours of supervision. Thus, program/clinical directors would prefer candidates who had the required experience so they could start work as a "counselor" and carry a full caseload of clients. Unfortunately, even applicants with clinical experience often lacked the necessary experience in a drug/alcohol treatment setting.

To examine the issue more closely, higher education programs across Pennsylvania were analyzed to uncover the number and types of programs related to obtaining a counselor position. Only educational institutions that were state-owned (community colleges and those in the Pennsylvania State

System of Higher Education), or state-related (such as Penn State and the University of Pittsburgh campuses), were included for analysis.

There are 53 institutions of higher education of the above types located in rural counties in Pennsylvania. Fifteen rural counties do not have any public higher educational institution located in their county. See Appendix 6 for a list of the educational institutions by county.

Of the 53 higher education institutions, 29 (55 percent) are community colleges (some are branches of the same institution located in different counties). Nineteen of the community colleges (66 percent) offered an associate degree in a field that would meet Pennsylvania's educational requirement, such as psychology, human services, and social work[10]. Only one of the community colleges (Blair County), however, offered a certificate in addiction studies. It is important to note that the counselor qualifications also specify at least two years of clinical experience for someone with an associate degree. It would be unlikely for someone to achieve that much experience through their associate degree program alone, given the short duration of those programs.

Twenty-four colleges and universities affiliated with the Pennsylvania State System of Higher Education (PASSHE), Penn State, and the University of Pittsburgh were located in rural Pennsylvania counties. All but two of these campuses offered a degree in fields that would meet the counselor requirements. The two campuses that did not offer any related programs were specialized branches of other universities, offering only medical-related degrees. One branch campus of the University of Pittsburgh (located in Crawford County) only offered associate degrees in qualifying fields (psychology and human services). Similarly, a branch campus of Clarion University located in Venango County only offered an associate degree in Rehabilitations and Human Services. For campuses offering a bachelor's degree, the most common major offered that fit the counselor qualifications was Psychology (17 campuses). Seven campuses offered a bachelor's degree in social work while several other campuses had

[10] While nursing is listed as an acceptable field of study for the educational requirements, nursing programs were not included in this analysis because it is very uncommon for somebody with a nursing degree to go into counseling (according to the survey results and the interviews with program/clinical directors).

degrees in rehabilitation and human services, which is similar to social work. Criminal justice and human development/family studies were other qualifying degrees offered at many of these campuses. Only one campus (Clarion University, Clarion County) offered a bachelor's degree specific to addictions: a Bachelor of Science in Rehabilitative Science with a concentration in Addictions.

While these programs meet the educational requirements to become a counselor, it does not appear that any program includes training that would satisfy the 1,820 hours of clinical experience also required for being hired as a counselor. Many programs did not require internships and for those that did, the required hours were much lower and not necessarily in a clinical setting. The one exception might be the Rehabilitative Science degree with a concentration in Addictions offered at Clarion University; a review of the educational requirements showed at least 15 credits in field experience as part of that major.

Of the 24 colleges/universities in rural Pennsylvania counties, only seven listed a master's program that would meet the educational qualifications for a counselor position. Most are in counseling, with several offering master's degrees in social work or psychology. Only one counseling program (Slippery Rock University, Butler County) has a concentration in Addictions. While those who apply for a counselor position with a qualifying master's degree do not need to have had clinical experience in a drug and alcohol treatment setting, it is preferred. Many clinical/program directors who were interviewed felt that many of those working on a master's degree in counseling were not adequately prepared to work with clients in alcohol/drug treatment because they tended to complete their internships/practicums in other mental health settings.

This analysis suggests that the current scope of undergraduate and master's programs in rural Pennsylvania counties likely does not meet the demand for counselors. Several program/clinical directors also specified that they desired students to get more education in addiction issues, which does not appear to be offered in many programs. The National Institute on Drug Abuse (NIDA) has a listing on its website for college programs in Addiction.[11] For Pennsylvania, it listed two associate degrees (both at community

[11] https://www.drugabuse.gov/drug-topics/college-age-young-adults/college-addiction-studies-programs?field_clinical_trial_address_administrative_area=PA&field_degree_certificate_select_value=associate%27s+degree.

colleges in urban counties), three bachelor's degrees (only one is located in a rural county, the program described above at Clarion University), and nine counseling-related certificates (six are in urban counties). There are only two master's level counseling programs with a concentration in addictions: one is the program at Slippery Rock University, the other is at a private college in Philadelphia.

State-level Incentive Programs for SUD Staff

The fifth objective for this project was to evaluate state-level incentive programs aimed at recruiting and retaining high quality counselors. The only known program in Pennsylvania that was in operation during this project's timeline was a loan forgiveness program through the Pennsylvania Department of Health that was announced in May 2019. Its website describes the program:

> "The substance use disorder (SUD) loan repayment program (LRP) offers educational loan repayment to practitioners who provide behavioral health care and treatment for substance use disorder and opioid addiction in designated high substance use counties and Health Professional Shortage Areas and designated high substance use counties. The program aims to increase access to behavioral health care services associated with opioid use in high-use and underserved communities and improve recruitment and retention of health practitioners in underserves and opioid high-use communities."[12]

In addition to the geographical restrictions, the requirements for counselors to apply for the program included that the counselor had to be licensed (LCSW, LSW, LPC) and have worked for at least two years in the SUD treatment field. If approved, the counselor would have to commit to working for at least two more years in SUD treatment and could receive up to $60,000 toward student loan debt for full-time service and up to $30,000 for part-time service. The Pennsylvania Department of Health website currently indicates that, as of August 25, 2020, the loan repayment program has been suspended because of a lack of federal funding (https://www.health.pa.gov/topics/Health-Planning/Pages/SUD-LRP.aspx).

[12] https://www.health.pa.gov/topics/Documents/Health%20Planning/SUD%20LRP%20Fact%20Sheet.pdf

The Pennsylvania Department of Health shared data with the principal investigator about the number of applicants for the program by county and the number of awards granted. A total of 427 individuals applied for the program, of which 92 were awarded (21.5 percent). This small percentage of awards suggests that, while funding was limited for the program, there is a large number of individuals who could benefit from such a program.

One of the requirements to qualify for the program was that the individual worked in a high substance use county; the Pennsylvania Department of Health identified 30 counties in this category. Seventy-five percent, or 319, of the applicants came from one of the designated high substance use counties. All but one of the 92 individuals awarded the loan repayment was from one of these 30 counties. It is not clear why one individual from Columbia County was given the award; they were the only one who was awarded the grant and did not work in one of the 30 high substance use counties.

Half of the 30 high substance use counties designated by the Pennsylvania Department of Health were rural counties, according to the Center for Rural Pennsylvania's definition. There were 50 applicants from high substance use rural counties and 14 (28 percent) were awarded the program. An additional 73 individuals from rural counties not designated high substance use applied for the program but only one was given an award. While most rural counties had a very small number of applicants (between zero and two), three rural counties had more than 10 individuals apply for the program (Butler, Monroe, and Schuylkill). The Pennsylvania Department of Health did not share the individual-level data of the applicants, so it is not clear why these counties had a high number of applicants. Perhaps the treatment programs there communicated the benefit to their staff. Only Butler County, however, was a designated high substance use county, so no applicants from Monroe or Schuylkill were granted the award.

There is also a national loan repayment program for substance use disorder counselors through the National Health Services Corps (https://nhsc.hrsa.gov/loan-repayment/nhsc-sud-workforce-loan-repayment-program.html). One of the requirements for this program is that the individual works at a SUD

treatment facility in a designated Health Professional Shortage Area (HPSA).[13] While it is beyond the scope of this project to identify which rural treatment programs would qualify for this program, it is worth publicizing to treatment staff so they can determine if they are eligible to apply.

Conclusions

Recruitment Issues for SUD Treatment Staff

This project found that recruitment is a major problem for SUD treatment programs in rural Pennsylvania counties. Interviews with program and clinical directors revealed their concerns about the number of qualified applicants for open positions. Given the increased number of clients seeking SUD treatment in Pennsylvania in recent years, it is crucial to fully staff programs with counselors who can offer high quality treatment.

The three most common reasons cited for recruitment problems included salary, the facility's location, and applicants lacking the required training in the SUD treatment field. Salary issues tend to be related to reimbursement rates, so programs felt there was little they could do to raise counselor pay significantly. Some programs viewed their location as a barrier for recruitment because the rural areas where they were located did not retain enough people who met the educational and experience requirements. There was a lack of educational opportunities in rural areas that could lead to SUD counseling. Very few bachelor's or master's programs existed with a concentration in addiction counseling. One of the few program directors who said recruitment was not a problem discussed having two universities nearby that served as a pipeline for open positions. Given the requirement for a SUD counselor to have significant clinical experience, more opportunities need to be created to link their experiences to SUD treatment so that they become more familiar with the field.

Many of those interviewed also felt that younger graduates going into the counseling field lacked a passion or commitment to working in SUD treatment. The program/clinical directors often related this

[13] A designated "health professional shortage area" is a geographical area that is determined to have a shortage of dental, primary, or mental health professionals. For more information, see https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#hpsas

perception to salary, where some directors felt that money was the only motivation for some to work in the SUD treatment field. However, it could also be their lack of exposure to the SUD treatment field. Given that this project did not interview or survey counselors working in other fields, it is difficult to assess the role that passion/commitment plays in their decision-making process as far as where they seek a job. It is likely a financial decision, given that the pay in the SUD treatment field is often lower than other mental health fields.

All the clinical/program directors had positive experiences with interns, which could be one way to improve recruitment. An internship gives the candidate the necessary experience and also introduces them to an area they may not have previously considered. The program/clinical directors mentioned that more positive exposure to SUD treatment, either through education, an internship, or marketing, could help with recruitment issues.

Retention Issues for SUD Treatment Staff

Most clinical and program directors felt that turnover was not a major problem for their facility. This was confirmed by the survey analysis, where the vast majority of respondents had high job satisfaction and low scores on the intent to quit scale.

The interviews with clinical and program directors revealed several factors that were possibly related to good retention/low turnover. These directors felt that the SUD treatment field lost a lot of counselors due to stress and burnout. To address these issues, many facilities attempted to improve retention through various structural efforts. Those with low turnover emphasized that their programs had supportive management who were involved in the day-to-day operations of the program, sometimes even carrying their own caseload of clients. The programs created a positive working environment where clinical staff and management worked as a team. They also promoted professional development opportunities for the staff. An additional factor that clinical and program directors cited as a way to improve retention was to promote self-care among the clinical staff. Supportive management emphasized that counselors should be able to use paid time off to help alleviate their stress. One facility administered a questionnaire twice a year to measure burnout, stress, and job satisfaction.

The individual level survey results reflect many of the themes analyzed in the qualitative interviews with clinical and program directors. Just as the directors felt turnover was not a major problem, the survey respondents scored generally high on job satisfaction and very few were currently looking for another job. When analyzing intent to quit, emotional exhaustion was the strongest predictor. Additional significant predictors of intent to quit were job satisfaction and management communication. These findings suggest that workplaces that emphasize teamwork, management involvement, and a positive culture can have low turnover. Interestingly, salary was not a significant predictor of intent to quit, even though it may be a barrier to recruiting high quality counselors.

The other significant predictor of intent to quit was the percentage of clients receiving medication assisted treatment. While this was not as strong a predictor as emotional exhaustion and job satisfaction, it was one of the only variables to remain significant in the multivariate analysis after controlling for many individual and work-level characteristics. It is not entirely clear why having more clients on MAT would lead to a stronger desire to leave the job. Bivariate correlations showed that this variable was not significantly related to job satisfaction and only weakly related to emotional exhaustion, suggesting that there is something about having many clients on MAT that leads to counselor turnover. Future research should attempt to discover why having clients on MAT relates to intent to quit.

One incentive that may help improve clinical staff retention is student loan forgiveness. However, analysis of the Pennsylvania program shows that very few who applied were accepted into the program and many felt that the requirements were too strict. Given that the student loan repayment program is currently suspended due to lack of federal funding, it is not possible to gauge the impact it could have on future recruitment and retention issues.

Policy Considerations

Given the difficulty in recruiting high quality counselors, and the high levels of emotional exhaustion in the profession, efforts should be made to improve recruitment and retention of rural treatment staff.

One strategy that would improve recruitment and retention of high-quality counselors would be better pay and benefits. Given that salary is directly related to reimbursement rates for SUD treatment services, various Pennsylvania agencies (DDAP, the Department of Health) should consider evaluating ways to increase reimbursement rates. The increase in state and federal funding for SUD treatment could lead to improved working conditions, such as better pay, for treatment staff.

Student loan forgiveness is another strategy that could result in improved recruitment and retention. It was suggested that the program be revised and fully funded, and that the qualifications be expanded. For instance, counselors working in SUD treatment programs in rural areas should qualify regardless of whether that county is a high substance use area given the difficulties recruiting in rural areas. The requirement that the counselor must be licensed should be removed, given the difficulty (and cost) to achieve that status. Individuals should qualify after working in SUD treatment for one year, rather than two, making the benefit a recruitment tool for programs. This program should be made known to all treatment staff and those in counseling programs at state-affiliated colleges and universities. This program should be offered in addition to any federal loan forgiveness programs for public service or nonprofit workers. Those federal programs are notorious for being difficult to navigate, require particular types of student loans, and have other restrictions (like completing 10 years of student loan payments) that reduce the likelihood that they could be used as a recruiting tool.

DDAP should consider promoting internship opportunities in rural SUD treatment programs for undergraduate and graduate students. If possible, interns should receive a stipend to encourage them to enter the SUD treatment field. Having an internship experience in the field helps to expose people to the area and increase interest, leading to future employment. It could also assist in retention because the person will have experience in the field and understand the demands required.

DDAP and the Pennsylvania Department of Health should consider working together to promote careers in the SUD treatment field, especially in rural areas. They could develop a marketing campaign that describes the work, emphasizing how rewarding it could be, and feature people who are in recovery. This could expose people to the opportunities in the field that they were not aware of and reduce stigma associated with substance use issues and working in the SUD treatment field.

DDAP and the Pennsylvania Department of Health could also work with clinical and program directors in rural facilities to implement features that are associated with better retention. These include management styles that improve communication and create positive working environments. It could also include training in the "Sanctuary Model," which recognizes that counselors also experience trauma in the course of their work and promotes a culture that mitigates the negative effects and stress of that work.[14] Having these features could reduce the burnout and stress associated with SUD treatment.

These state agencies also should consider encouraging clinical directors to use the Professional Quality of Life Measure (ProQOL, https://proqol.org/ProQol_Test.html) to monitor job satisfaction, compassion fatigue, and burnout among their clinical staff. The measure is free to use and could identify the issues associated with turnover. Management could then develop strategies to help improve staff experiences.

DDAP should also consider expanding its trainings that are required for clinical staff. New training programs should be developed every year so that counselors can improve their skills, learn new areas, and feel like they are receiving adequate professional development. Required trainings should also include components related to recognizing stress and burnout and strategies to cope with the emotional aspects of counseling in SUD treatment programs.

The Pennsylvania Department of Health could also work with treatment programs to create employee wellness programs aimed at reducing job stress and burnout. The financial savings of retaining staff and improving treatment outcomes should be considered when the state discusses increased funding

[14] For more information on the Sanctuary Model, go to https://www.thesanctuaryinstitute.org/about-us/the-sanctuary-model/.

for treatment. Being strategic about where this money is placed could show a better return on investment. For instance, investing in programs that have high retention rates and better outcomes for patients will show more cost-savings in the future.

This research revealed a need for more educational programs in rural counties related to counseling in the SUD treatment field. There were very few undergraduate and graduate programs that offered a major, concentration, or certificate in addiction studies. These programs can create a pipeline of workers into rural SUD treatment programs. The Pennsylvania General Assembly should consider working with the state university system (PASSHE) to expand programs in this area, perhaps modeled on the programs at Clarion University and Slippery Rock University. Associate degree programs at community colleges that focus on practical experience in SUD counseling would also help create a pipeline of qualified applicants.

To improve recruitment by expanding the pool of eligible applicants, DDAP should also consider analyzing its current requirements for counselors and evaluating whether recovery experience could be used to satisfy part or all of the experience requirement. It should look at SUD treatment programs that have high success rates and examine their counselors' education and training because these are likely contributing to success. DDAP could then revise its requirements if it would help programs recruit the highest quality counselors.

References

Beitel, M., Oberleitner, L., Muthulingam, D., Oberleitner, D., Madden, L. M., Marcus, R., Eller, A., Bono, M., and Barry, D. T. (2018). Experiences of burnout among drug counselors in a large opioid treatment program: A qualitative investigation. *Substance Abuse*, *39*(2), 211–217.

Bureau of Labor Statistics (BLS). (2019). Occupational Outlook Handbook. https://www.bls.gov/ooh/community-and-social-service/substance-abuse-behavioral-disorder-and-mental-health-counselors.htm.

Cascio, W. F. (2000). Managing a virtual workplace. *Academy of Management Perspectives*, *14*(3), 81-90.

Centers for Disease Control and Prevention (CDCP). 2019. "Drug Overdose Mortality by State." https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm

Eby, L. T., Burk, H., & Maher, C. P. (2010). How serious of a problem is staff turnover in substance abuse treatment? A longitudinal study of actual turnover. *Journal of substance abuse treatment*, *39*(3), 264-271.

Eby, L. T., & Rothrauff-Laschober, T. C. (2012). The relationship between perceptions of organizational functioning and voluntary counselor turnover: A four-wave longitudinal study. *Journal of Substance Abuse Treatment*, *42*(2), 151-158.

Fukui, S., Wu, W., & Salyers, M. P. (2019). Impact of Supervisory Support on Turnover Intention: The Mediating Role of Burnout and Job Satisfaction in a Longitudinal Study. *Administration and Policy in Mental Health and Mental Health Services Research*, *46*(4), 488-497.

Gallon, S. L., Gabriel, R. M., & Knudsen, J. R. (2003). The toughest job you'll ever love: A Pacific Northwest treatment workforce survey. *Journal of Substance Abuse Treatment*, *24*(3), 183-196.

Garner, B. R., & Hunter, B. D. (2013). Examining the temporal relationship between psychological climate, work attitude, and staff turnover. *Journal of substance abuse treatment*, *44*(2), 193-200.

Garner, B. R., & Hunter, B. D. (2014). Predictors of staff turnover and turnover intentions within addiction treatment settings: Change over time matters. *Substance abuse: research and treatment*, *8*, SART-S17133.

Garner, B. R., Hunter, B. D., Modisette, K. C., Ihnes, P. C., & Godley, S. H. (2012). Treatment staff turnover in organizations implementing evidence-based practices: Turnover rates and their association with client outcomes. *Journal of substance abuse treatment*, *42*(2), 134-142.

Hargrove, D. S., & Curtin, L. I. S. A. (2012). Rural mental health practitioners: Their own mental health needs. *Rural mental health: issues, policies, and best practices. New York: Springer*.

Hyde, P. S. (2013). Report to Congress on the Nation's substance abuse and mental health workforce issues. *Rockville, MD: Substance Abuse and Mental Health Services Administration*.

Johnson, J. A., & Roman, P. M. (2002). Predicting closure of private substance abuse treatment facilities. *The journal of behavioral health services & research*, *29*(2), 115-125.

Kee, J. A., Johnson, D., & Hunt, P. (2002). Burnout and social support in rural mental health counselors. *Journal of Rural Community Psychology*, *5*(1).

Knudsen, J., Williams, A., & Perry, S. (2005). Tennessee Workforce Survey 2004: Results of a statewide needs assessment of behavioral health professionals.

Knudsen, H. K., Ducharme, L. J., & Roman, P. M. (2008). Clinical supervision, emotional exhaustion, and turnover intention: A study of substance abuse treatment counselors in the Clinical Trials Network of the National Institute on Drug Abuse. *Journal of substance abuse treatment*, *35*(4), 387-395.

Kulesza, M., Hunter, S. B., Shearer, A. L., & Booth, M. (2017). Relationship between provider stigma and predictors of staff turnover among addiction treatment providers. *Alcoholism treatment quarterly*, *35*(1), 63-70.

Landrum, B., Knight, D. K., & Flynn, P. M. (2012). The impact of organizational stress and burnout on client engagement. *Journal of Substance Abuse Treatment*, *42*(2), 222–230.

McCarty, D., Greenlick, M. R., & Lamb, S. (Eds.). (1998). *Bridging the gap between practice and research: Forging partnerships with community-based drug and alcohol treatment*. National Academies Press.

McCaul, M. E., & Svikis, D. S. (1991). Improving client compliance in outpatient treatment: counselor-targeted interventions. *NIDA research monograph*, *106*, 204-217.

McLellan, A. T., Carise, D., & Kleber, H. D. (2003). Can the national addiction treatment infrastructure support the public's demand for quality care. *Journal of substance abuse treatment*, *25*(2), 117-121.

McNulty, T. L., Oser, C. B., Aaron Johnson, J., Knudsen, H. K., & Roman, P. M. (2007). Counselor turnover in substance abuse treatment centers: An organizational-level analysis. *Sociological inquiry*, *77*(2), 166-193.

Murphy, J. (2017). Addiction Frameworks and Support for Expanding Treatment for Drug Offenders. *Contemporary Drug Problems*, *44*(3), 232-245.

Oser, C., Biebel, E., Pullen, E., & Harp, K. H. (2013). Causes, Consequences, and Prevention of Burnout Among Substance Abuse Treatment Counselors: A Rural Versus Urban Comparison. *Journal of Psychoactive Drugs*, *45*(1), 17–27.

Pennsylvania Data Dashboard. 2019. "Opioid Data Dashboard." https://data.pa.gov/stories/s/Pennsylvania-Opioids/9q45-nckt/.

Pennsylvania Governor's Office. 2019. https://www.governor.pa.gov/newsroom/gov-wolf-signs-sixth-opioid-disaster-declaration-renewal-announces-new-initiatives/.

Rothrauff, T. C., Abraham, A. J., Bride, B. E., & Roman, P. M. (2011). Occupational turnover intentions among substance abuse counselors. *Journal of Substance Abuse Treatment*, *40*(1), 67-76.

Ryan, O., Murphy, D., Krom, L. (2012). *Vital Signs: Taking the Pulse of the Addiction Treatment Workforce, A National Report, Version 1*. Kansas City, MO: Addiction Technology Transfer Center National Office in residence at the University of Missouri-Kansas City.

White, W. L., & Garner, B. R. (2011). Staff turnover in addiction treatment: Toward science-based answers to critical questions. *Counselor*, *12*(3), 56-59.

Young, S. (2015). Understanding substance abuse counselor turnover due to burnout: A theoretical perspective. *Journal of Human Behavior in the Social Environment*, *25*(6), 675-686.

Appendix 1. Interview Questions.

Thank you for speaking with me today. I am going to ask you some questions about this treatment program. You can skip any question you prefer not to answer. All of your responses will be kept confidential and anonymous. I am conducting interviews with program directors across Pennsylvania and my final report will summarize these interviews as a group. No individual program director or treatment program will be named in that report. If you would like a copy of this final report, please let me know. I will email it to you when the project is complete.

And you agree that I can record this interview?

1. First, can you tell me about the structure of this treatment facility – what kinds of treatment do you offer?
[Probes: inpatient/outpatient programs, medication assisted treatments, length of treatment programs]

2. How many people are typically in treatment here at a given time? Has the treatment program grown recently or do you see fewer people seeking treatment here? How do people get referred to treatment (i.e., self, hospital, criminal justice, etc)? How do people pay for treatment (private insurance, self, Medicaid, etc.)?

3. Tell me a little bit about your background and how you came into this position.
[Probes: experience in SAT field, previous jobs, education, time in current position]

5. How do you think your treatment program has been impacted by the opioid crisis? How would you describe the opioid issue or substance abuse problems in general in this area?

6. How many therapists/counselors work here? [Probes: Fulltime/part time, increase or decrease] What are the requirements for getting a job as a therapist (education, work experience, etc)?

7. Do you offer ongoing educational or training opportunites for staff? Do you do any other activities together as an organization (i.e., staff retreats, meetings, team-building activities)?

8. Do you have an evaluation process for staff? How does it work? Are there incentives offered related to pay and/or benefits?

9. Do you have any open positions at the moment? Have you had any openings for counselors in the past year?

> If YES: What is the process for recruiting a new counselor? For recent openings, how many people applied that you thought were qualified for the position?
> If NO: When was the last time you hired a new counselor? What was that process like? How many people applied for the position that you thought were qualified?

10. Do you think recruiting high quality counselors is a problem for your program?

> If YES: Why do you think recruitment is difficult? Has it always been a problem?

If NO: That's great. Why do you think you don't have an issue with recruitment? [Probes: pipeline, local educational programs, internships]

11. Do you offer internships here for college or graduate students?
If YES: Have you had positive experiences with interns? Have people stayed and worked here afterward?
If NO: Why not?

12. Do you think the educational and training opportunities locally are sufficient to meet the demand for substance abuse treatment counselors in this area? For instance, universities and community colleges offer programs that can lead to working in the SAT field.

13. For the people currently working here, how long have they been in these positions?

14. How long do people usually work here as a counselor?

15. How many counselors have voluntarily left working here within the past two years? Do you know why they left or if they were going to work elsewhere?

16. Why do you think there is a high turnover in substance abuse counseling as a profession?

17. Do you think turnover is a problem at this facility? [Probes: why or why not?]

18. The state has a program where people who work as SAT counselors can get student loan forgiveness after a certain amount of time in the profession? Do you think this will be a good strategy for helping recruitment and retention issues in the field?

19. Are there other programs you could think of that would help?

20. Is there anything else you would like to mention about recruitment or retention issues you have here or for the profession as a whole?

[Ask about forwarding survey to staff.]

Thank you for your time!

Appendix 2. Survey Questionnaire.

Q106 In which county do you currently work? If you work in multiple counties, please indicate the county where you spend the most time working.

▼ Adams (1) ... York (67)

Q1 Which of the following describes your current position? (select all that apply)

- ☐ Counselor/Therapist (1)
- ☐ Counselor Assistant (2)
- ☐ Peer Recovery Specialist (3)
- ☐ Education or Prevention Specialist (4)
- ☐ Intake Coordinator (5)
- ☐ Counselor Supervisor (6)
- ☐ Other (please specify) (7) _____

Q2 In your current job, do you typically work

- ○ Less than 35 hours a week (1)
- ○ 35 or more hours per week (2)

Q4 How many hours each week, on average, do you spend in direct patient care (i.e., counseling, leading groups)?

- ○ Less than 5 hours (1)
- ○ 5-10 hours (2)
- ○ 10-15 hours (3)
- ○ 15-20 hours (4)
- ○ More than 20 hours (5)

Q5 How many hours each week, on average, do you spend on administrative activities, such as staff meetings and paperwork?

- ○ Less than 5 hours (1)
- ○ 5-10 hours (2)
- ○ 10-15 hours (3)
- ○ 15-20 hours (4)
- ○ More than 20 hours (5)

Q6 For how long have you been in this position?

- ○ Less than 1 year (1)
- ○ 1-2 years (2)
- ○ 3-5 years (3)
- ○ More than 5 years (4)

Q7 For how long have you been working in the substance abuse treatment field?

- ○ Less than 1 year (1)
- ○ 1-2 years (2)
- ○ 3-5 years (3)
- ○ More than 5 years (4)

Q8 Which type of treatment program do you work in? (select all that apply)

- ☐ Inpatient (1)
- ☐ Outpatient (2)
- ☐ Intensive Outpatient (3)
- ☐ Detoxification (4)
- ☐ Recovery House (5)
- ☐ Other (please specify) (6) _____

Q9 How many clients are typically on your caseload?

_____

Q11 What types of clients/patients do you work with? (select all that apply)

- ☐ Substance Abuse Treatment (1)
- ☐ Mental Health (not substance abuse-related) (2)
- ☐ Co-Occurring Substance Abuse and Mental Health (3)
- ☐ Patients receiving medication assisted treatment for opioid use (i.e., methadone, suboxone, etc.) (4)
- ☐ Other (please specify) (5)

_____

Q12 Do you work with adults, adolescents, or some combination of both?

- ○ Adults only (18+) (1)
- ○ Adolescents only (< 18) (2)
- ○ Combination of adult and adolescents (3)

Q13 What percentage of clients/patients that you work with receive medication assisted treatment as part of the program (i.e., methadone, buprenorphine, Suboxone, Vivitrol, etc.)?

- ○ 0 (1)
- ○ 1-9% (2)
- ○ About 10-25% (3)
- ○ 25-50% (4)
- ○ More than 50% (5)

Q14 What percentage of clients/patients that you work with are referred to treatment through the criminal justice system or court system (i.e., as a condition of probation/parole, drug court, diversion program, etc)?

- ○ 0 (1)
- ○ 1-9% (2)
- ○ About 10-25% (3)
- ○ 25-50% (4)
- ○ More than 50% (5)

Q15 Do you have to travel to multiple facilities as part of your job?

- ○ Yes (1)
- ○ No (2)

Q16 Do you have any supervisory duties as part of your job?

- ○ Yes (1)
- ○ No (2)

Q17 What is the structure of this treatment facility?

- ○ Private, for-profit (1)
- ○ Private, not-for-profit (2)
- ○ Public (run by the state, county, or other government entity) (3)
- ○ I'm not sure (4)

Q18 Is this treatment facility affiliated with a larger organization?

- ○ Yes, it is part of a larger corporation (1)
- ○ Yes, it is part of a hospital/medical center (2)
- ○ No (3)

	Strongly disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly agree (5)
I have enough freedom over how I do my job. (1)	○	○	○	○	○
I have enough authority to make decisions necessary to provide quality treatment. (2)	○	○	○	○	○
Management makes sure employee concerns are heard before decisions are made. (3)	○	○	○	○	○
Staff turnover is a major problem in this facility. (4)	○	○	○	○	○
Staff frustration is common here. (5)	○	○	○	○	○
Employees are involved in making decisions about how work is done. (6)	○	○	○	○	○
I trust that my supervisor will share important information with me. (7)	○	○	○	○	○
The amount of pay employees receive is distributed fairly. (8)	○	○	○	○	○
There are benefits that we do not have that we should have. (9)	○	○	○	○	○
I feel like I had a spiritual calling to work with clients in drug treatment. (10)	○	○	○	○	○

All in all I am satisfied with my job. (11)	○	○	○	○	○
The workload at this treatment center is fairly distributed. (12)	○	○	○	○	○
My coworkers are very helpful when I encounter difficulties with my work. (13)	○	○	○	○	○
In this treatment center, people show little interest in each other's work. (14)	○	○	○	○	○
I am emotionally drained from my work. (15)	○	○	○	○	○
I feel fatigued when I get up and have to face another day on the job. (16)	○	○	○	○	○
I feel burned out from my work. (17)	○	○	○	○	○
I frequently think about quitting this job. (18)	○	○	○	○	○
I have received the necessary training to do my job well. (19)	○	○	○	○	○
There is a good chance that I will leave this job in the next year or so. (20)	○	○	○	○	○
I am actively looking for a job at another drug treatment center. (21)	○	○	○	○	○
I want to find a job in another field. (22)	○	○	○	○	○

I would prefer to be a counselor for those who are not in drug treatment. (23)	○	○	○	○	○

	Strongly disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly agree (5)
Most people would willingly accept someone who has been treated for substance use as a close friend. (1)	○	○	○	○	○
Most people believe that someone who has been treated for substance use is just as trustworthy as the average citizen. (2)	○	○	○	○	○
Most people would accept someone who has been treated for substance use as a teacher of young children in a public school. (3)	○	○	○	○	○
Most people would hire someone who has been treated for substance use to take care of their children. (4)	○	○	○	○	○
Most people think less of a person who has been in treatment for substance use. (5)	○	○	○	○	○
Most employers will hire someone who has been treated for substance use if he or she is qualified for the job. (6)	○	○	○	○	○
Most people would be willing to date someone who has been treated for substance use. (7)	○	○	○	○	○

	Strongly disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly agree (5)
Every person with a substance use disorder is one drink or one hit away from a total relapse. (1)	○	○	○	○	○
People with substance use disorders have a distinct set of personality traits by which they can be identified. (2)	○	○	○	○	○
Drug addiction is a brain disease. (3)	○	○	○	○	○
If a person with a substance use disorder is not motivated, there is not much you can do to help him or her. (4)	○	○	○	○	○
Genetics is a major factor of addiction. (5)	○	○	○	○	○
A person's environment plays an important role in determining whether someone develops a drug or alcohol addiction. (6)	○	○	○	○	○
Lacking willpower is a major factor of addiction. (7)	○	○	○	○	○
A person can develop a drug addiction because of underlying psychological problems. (8)	○	○	○	○	○

Denial is part of the personality of a person with a substance use disorder. (9)	○	○	○	○	○
The use of prescription medications like methadone or suboxone just replaces one addiction for another. (10)	○	○	○	○	○
People with substance use disorders lack good moral values. (11)	○	○	○	○	○

Q27 What is your age?

_____

Q19 What is the highest level of education you have completed?

- ○ I did not complete a high school degree (1)
- ○ High School Degree/G.E.D. (2)
- ○ Associate degree (3)
- ○ Bachelor's degree (4)
- ○ Master's degree (5)
- ○ Doctoral degree (6)

Q21 If you have a Bachelor's degree, please list the college/university where you received it:

_____

Q20 What was your major in college?

- ○ Psychology (1)
- ○ Sociology (2)
- ○ Criminal Justice (3)
- ○ Human Development (4)
- ○ Social Work (5)
- ○ Other (please specify) (6) _____

Q107 If you have a graduate degree, please list the college/university where you received it:
_____

Q108 Did you complete an internship in the substance abuse treatment field as part of your undergraduate or graduate program?

- ○ Yes (1)
- ○ No (2)

Q28 Are you...

- ○ Male (1)
- ○ Female (2)
- ○ Transgender (3)
- ○ Other (4)

Q29 What is your race? (select all that apply)

- ☐ African American/Black (1)
- ☐ Caucasian/White (2)
- ☐ Asian/Asian American (3)
- ☐ Latino/Hispanic (4)
- ☐ Native American (5)
- ☐ Other (6) _____

Q30 Are you personally in recovery for drug/alcohol problems?

- ○ Yes (1)
- ○ No (2)

Q31 Are you a certified alcohol and drug counselor?

- ○ Yes (1)
- ○ No (2)

Q32 Are you currently

- ○ Married (1)
- ○ Divorced (2)
- ○ Separated (3)
- ○ Widowed (4)
- ○ Single, never married (5)

Q33 What is your annual salary?

- ○ Less than $20,000 (1)
- ○ $20,000 - $30,000 (2)
- ○ $30,000 - $40,000 (3)
- ○ $40,000 - $50,000 (4)
- ○ $50,000 - $60,000 (5)
- ○ $60,000 - $70,000 (6)
- ○ More than $70,000 (7)

End of Block: Default Question Block

Appendix 3. Rural Counties Represented by Survey Respondents (N=229).

Q. In which county do you currently work? If you work in multiple counties, please indicate the county where you spend the most time working.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Adams	4	1.7	1.7	1.7
	Armstrong	8	3.5	3.5	5.2
	Bedford	1	.4	.4	5.7
	Blair	8	3.5	3.5	9.2
	Bradford	6	2.6	2.6	11.8
	Butler	7	3.1	3.1	14.8
	Cambria	13	5.7	5.7	20.5
	Carbon	6	2.6	2.6	23.1
	Centre	6	2.6	2.6	25.8
	Clarion	6	2.6	2.6	28.4
	Clearfield	10	4.4	4.4	32.8
	Columbia	4	1.7	1.7	34.5
	Crawford	10	4.4	4.4	38.9
	Elk	2	.9	.9	39.7
	Fayette	6	2.6	2.6	42.4
	Franklin	5	2.2	2.2	44.5
	Fulton	2	.9	.9	45.4
	Greene	1	.4	.4	45.9
	Huntingdon	3	1.3	1.3	47.2
	Indiana	12	5.2	5.2	52.4
	Jefferson	1	.4	.4	52.8
	Lawrence	7	3.1	3.1	55.9
	Lycoming	3	1.3	1.3	57.2
	McKean	5	2.2	2.2	59.4
	Mercer	17	7.4	7.4	66.8
	Monroe	8	3.5	3.5	70.3
	Northumberland	8	3.5	3.5	73.8
	Perry	3	1.3	1.3	75.1
	Pike	1	.4	.4	75.5
	Potter	3	1.3	1.3	76.9
	Schuylkill	10	4.4	4.4	81.2
	Snyder	7	3.1	3.1	84.3

	Somerset	13	5.7	5.7	90.0
	Tioga	5	2.2	2.2	92.1
	Union	1	.4	.4	92.6
	Venango	6	2.6	2.6	95.2
	Warren	3	1.3	1.3	96.5
	Washington	3	1.3	1.3	97.8
	Wayne	5	2.2	2.2	100.0
	Total	229	100.0	100.0	

Appendix 4. Construction of Composite/Scale Variables.

Composite Name	**Individual Survey Items (all measured on 5-item Likert scale from Strongly disagree to Strongly agree)**
Intent to Quit (Cronbach's alpha = .877)	I frequently think about quitting this job.
	There is a good chance that I will leave this job in the next year or so.
	I am actively looking for a job at another drug treatment center.
	I want to find a job in another field.
Job Autonomy (r = .651, p<.01)	I have enough freedom over how I do my job.
	I have enough authority to make decisions necessary to provide quality treatment.
Management Communication (Cronbach's alpha = .769)	Management makes sure employee concerns are heard before decisions are made.
	Employees are involved in making decisions about how work is done.
	I trust that my supervisor will share important information with me.
Distributive Justice (r = .494, p < .01)	The amount of pay employees receive is distributed fairly.
	The workload at this treatment center is fairly distributed.
Co-Worker Support (r = .522, p < .01)	My coworkers are very helpful when I encounter difficulties with my work.
	In this treatment center, people show little interest in each other's work (reverse scored).
Emotional Exhaustion (Cronbach's alpha = .926)	I am emotionally drained from my work.
	I feel fatigued when I get up and have to face another day on the job.
	I feel burned out from my work.
Perceived Stigma Scale (Cronbach's alpha = .861)	Most people would willingly accept someone who has been treated for substance use as a close friend (reverse scored).
	Most people believe that someone who has been treated for substance use is just as trustworthy as the average citizen (reverse scored).
	Most people would accept someone who has been treated for substance use as a teacher of young children in a public school (reversed scored).
	Most people would hire someone who has been treated for substance use to take care of their children (reverse scored).
	Most people think less of a person who has been in treatment for substance use.
	Most employers will hire someone who has been treated for substance use if he or she is qualified for the job (reverse scored).
	Most people would be willing to date someone who has been treated for substance use (reverse scored).

Appendix 5. Pennsylvania Requirements for Counselor and Counselor Assistant.

(from Pennsylvania Code:

http://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/028/chapter704/s704.7.html&d=reduce).

§ 704.7. Qualifications for the position of counselor.

(a) Drug and alcohol treatment projects shall be staffed by counselors proportionate to the staff/client and counselor/client ratios listed in §704.12 (relating to full-time equivalent (FTE) maximum client/staff and client/counselor ratios).

(b) Each counselor shall meet at least one of the following groups of qualifications:

(1) Current licensure in this Commonwealth as a physician.

(2) A Master's Degree or above from an accredited college with a major in chemical dependency, psychology, social work, counseling, nursing (with a clinical specialty in the human services) or other related field which includes a practicum in a health or human service agency, preferably in a drug and alcohol setting. If the practicum did not take place in a drug and alcohol setting, the individual's written training plan shall specifically address a plan to achieve counseling competency in chemical dependency issues.

(3) A Bachelor's Degree from an accredited college with a major in chemical dependency, psychology, social work, counseling, nursing (with a clinical specialty in the human services) or other related field and 1 year of clinical experience (a minimum of 1,820 hours) in a health or human service agency, preferably in a drug and alcohol setting. If a person's experience did not take place in a drug and alcohol setting, the individual's written training plan shall specifically address a plan to achieve counseling competency in chemical dependency issues.

(4) An Associate Degree from an accredited college with a major in chemical dependency, psychology, social work, counseling, nursing (with a clinical specialty in the human services) or other related field and 2 years of clinical experience (a minimum of 3,640 hours) in a health or human service agency, preferably in a drug and alcohol setting. If a person's experience was not in a drug and alcohol setting, the individual's written training plan shall specifically address a plan to achieve counseling competency in chemical dependency issues.

(5) Current licensure in this Commonwealth as a registered nurse and a degree from an accredited school of nursing and 1 year of counseling experience (a minimum of 1,820 hours) in a health or human service agency, preferably in a drug and alcohol setting. If a person's experience was not in a drug and alcohol setting, the individual's written training plan shall specifically address a plan to achieve counseling competency in chemical dependency issues.

(6) Full certification as an addictions counselor by a statewide certification body which is a member of a National certification body or certification by another state government's substance abuse counseling certification board.

Cross References

This section cited in 28 Pa. Code § 704.5 (relating to qualifications for the positions of project director and facility director); 28 Pa. Code § 704.9 (relating to supervision of counselor assistant); and 28 Pa. Code § 704.10 (relating to promotion of counselor assistant).

§ 704.8. Qualifications for the position of counselor assistant.

(a) A person who does not meet the educational and experiential qualifications for the position of counselor may be employed as a counselor assistant if the requirements of at least one of the following paragraphs are met. However, a project may not hire more than one counselor assistant for each employe who meets the requirements of clinical supervisor or counselor.

(1) A Master's Degree in a human service area.

(2) A Bachelor's Degree in a human service area.

(3) Licensure in this Commonwealth as a registered nurse.

(4) An Associate's Degree in a human service area.

(5) A high school diploma or General Education Development (GED) equivalent.

(b) A counselor assistant shall also complete the training requirements in § 704.11 (relating to staff development program).

(c) In addition to training, assignment of a full caseload shall be contingent upon the supervisor's positive assessment of the counselor assistant's individual skill level.

Cross References

This section cited in 28 Pa. Code § 704.9 (relating to supervision of counselor assistant).

APPENDIX 6. State-Owned and State-Related Colleges and Universities in Rural Pennsylvania Counties.

County	Institution
Adams	Harrisburg Area Community College
Armstrong	Butler County Community College, Armstrong
Bedford	NONE
Blair	Pennsylvania Highlands Community College, Blair Center
Blair	Penn State, Altoona
Bradford	NONE
Butler	Butler County Community College, Cranberry
Butler	Butler County Community College, Main
Butler	Slippery Rock University of Pennsylvania
Cambria	Pennsylvania Highlands Community College, Ebensburg Center
Cambria	Pennsylvania Highlands Community College, Main
Cambria	University of Pittsburgh, Johnstown
Cameron	Northern Pennsylvania Regional College
Carbon	Lehigh Carbon Community College
Centre	Pennsylvania State University, Main
Clarion	Clarion University of Pennsylvania, Main
Clearfield	Lock Haven University, Clearfield
Clearfield	Penn State, DuBois
Clinton	Lock Haven University, Main
Columbia	Bloomsburg University of Pennsylvania
Columbia	Luzerne County Community College, Berwick Center
Crawford	Edinboro University of Pennsylvania, Meadville
Crawford	University of Pittsburgh, Titusville
Elk	Northern Pennsylvania Regional College
Fayette	Penn State, Fayette
Fayette	Westmoreland County Community College, Fayette County Education Center
Forest	Northern Pennsylvania Regional College
Franklin	Penn State, Mont Alto
Fulton	NONE
Greene	NONE
Huntingdon	Pennsylvania Highlands Community College, Huntingdon Center
Indiana	Indiana University of Pennsylvania
Indiana	Westmoreland County Community College, Indiana County Education Center
Jefferson	Butler County Community College, Brockway
Juniata	NONE
Lawrence	Butler County Community College, Lawrence Crossing
Lycoming	Pennsylvania College of Technology
McKean	Northern Pennsylvania Regional College

McKean	University of Pittsburgh, Bradford
Mercer	Butler County Community College, Linden Pointe
Mercer	Penn State, Shenango
Mifflin	NONE
Monroe	East Stroudsburg University of Pennsylvania
Monroe	Northampton Community College, Monroe
Montour	NONE
Northumberland	Lackawanna College, Sunbury Center
Northumberland	Luzerne County Community College, Greater Susquehanna Center
Perry	NONE
Pike	NONE
Potter	Lock Haven University, Coudersport
Potter	Northern Pennsylvania Regional College
Schuylkill	Lehigh Carbon Community College, Morgan Center
Schuylkill	Penn State, Schuylkill
Snyder	NONE
Somerset	Clarion University of Pennsylvania, Somerset
Somerset	Pennsylvania Highlands Community College, Somerset Center
Sullivan	NONE
Susquehanna	NONE
Tioga	Mansfield University of Pennsylvania
Union	NONE
Venango	Clarion University of Pennsylvania, Venango
Venango	Northern Pennsylvania Regional College
Warren	Jamestown Community College, Warren
Warren	Northern Pennsylvania Regional College
Washington	California University of Pennsylvania
Washington	Community College of Allegheny County, Washington County Center
Wayne	NONE
Wyoming	NONE

Center for Rural Pennsylvania Board of Directors

Chairman
Senator Gene Yaw

Vice Chairman
Representative Eddie Day Pashinski

Secretary
Dr. Nancy Falvo
Clarion University of Pennsylvania

Treasurer
Stephen M. Brame
Governor's Representative

Senator Katie J. Muth

Representative Dan Moul

Richard Esch
University of Pittsburgh

Dr. Timothy Kelsey
Pennsylvania State University

Shannon M. Munro
Pennsylvania College of Technology

Dr. Charles Patterson
Shippensburg University of Pennsylvania

Susan Snelick
Northern Pennsylvania Regional College

Darrin Youker
Governor's Representative

Center for Rural Pennsylvania Staff
Dr. Kyle C. Kopko, Director
Jonathan Johnson, Senior Policy Analyst
Christine Caldara Piatos, Communications Manager
Pam Frontino, Program Manager for Grants
Linda Hinson, Office Manager
David W. Martin, Public Policy Data Analyst

625 Forster St., Room 902 Harrisburg, PA 17120
(717) 787-9555 www.rural.pa.gov
1021