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Training addiction professionals in empirically-supported treatments: Perspectives from the treatment community

Bryan Hartzler, Ph.D. and Carl Rabun, M.S.W.

Alcohol & Drug Abuse Institute, University of Washington, Seattle, WA 98105

Abstract

Background—Large-scale dissemination efforts seek to expand opportunities for the addiction treatment community to receive training in empirically supported treatments (ESTs). Prospective consumers of such training are valuable sources of input about content of interest, preferences for how training events are structured, and obstacles that deter receipt of training.

Methods—In this mixed method study, data were collected in 64 semi-structured individual interviews with personnel during site visits to 16 community opioid treatment programs (OTPs). At each OTP, interviews were completed with the executive director, a clinical supervisor, and two direct-service clinicians. Topical interests were analyzed qualitatively in a cultural domain analysis. Likert ratings of training event preferences were analyzed via generalized linear mixed models (GLMM), and unstructured interviewee comments were analyzed via narrative analysis. Obstacles to training receipt were analyzed qualitatively with both content coding and narrative analysis.

Results—Based on topics of reported interest, cultural domain analysis suggests as ESTs of note: Multidimensional Family Therapy, Motivational Enhancement Therapy, Relapse Prevention Therapy, ‘Seeking Safety,’ and broad addiction-focused pharmacotherapy. Regarding training event preferences, GLMM and narrative analysis revealed clear preferences for time-distributed trainings and use of participatory activities (e.g., trainer demonstrations, role plays, small group exercises). Content coding identified cost as the primary obstacle to receipt of EST trainings, followed by lack of time, logistical challenges, and disinterest, and narrative analysis elaborated on contextual issues underlying these obstacles.

Conclusions—As primary consumers of EST technologies, the treatment community has valuable input to offer. Dissemination efforts may be enhanced by greater consideration of their preferences for training content and event structure, as well as practical obstacles that challenge their receipt of training.

INTRODUCTION

Dissemination of empirically supported treatments (ESTs) receives much attention, and perhaps nowhere more than in addiction treatment. Since the Institute of Medicine (IOM) challenged community treatment personnel to implement ESTs¹, large-scale efforts support their dissemination. The National Institute on Drug Abuse (NIDA) formed a Clinical Trials Network (CTN) to conduct multisite trials at affiliate community clinics². While its principal focus is testing ecological validity of ESTs, the CTN also hoped to serve as a

Corresponding author: Bryan Hartzler, Ph.D., Alcohol & Drug Abuse Institute, University of Washington, Box 354805, 1107 NE 45th Street, Suite 120, Seattle, WA 98105-4631, U.S.A. 206.543.8369, 206.543.5473 (fax) hartzb@u.washington.edu.

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vehicle for EST training at these clinics. Further, the Substance Abuse and Mental Health Services Administration supports EST dissemination via a National Registry of Evidence Based Programs and Practices (NREPP), regional Addiction Technology Transfer Centers, and joint effort with NIDA to develop ‘blending products’ to promote EST exposure³. Despite these collective efforts, questions persist about how effective EST dissemination is to occur.

Technology transfer models^{4,5} delineate phases of EST dissemination, including: 1) exposure, or initial learning of concepts and skills via training, 2) adoption, or stated intention to attempt use, 3) implementation, or a trial period of use, and 4) practice, or durable inclusion in routine care. This sequence places high importance on initial training exposure, with a need for training events to not only develop EST delivery skills but also curry favorable and proactive attitudes for subsequent adoption and implementation in daily practice. Garner⁶ notes progress of the past decade in improving treatment community attitudes toward ESTs and increasing adoption intentions, but acknowledges little is yet known about what training methods robustly or reliably develop EST delivery skills. Coaching and performance-based feedback are suggested adjuncts to traditional workshop training⁷, but studies testing their impact offer equivocal findings⁸⁻¹⁰. For those seeking best training practices, the waters are muddled.

Promotional efforts to disseminate ESTs should not overlook community treatment personnel as sources of input. As 200+ ESTs are available in addiction treatment alone (www.nrepp.samhsa.gov), community treatment personnel are in a sense consumers and ESTs the products for which decisions are made to invite or avoid exposure, to adopt or reject, to implement or abandon, and to sustain or discontinue use¹¹. Extant research has addressed ESTs of interest to the addiction treatment community, with practitioner surveys identifying motivational interviewing, relapse prevention, and twelve-step facilitation as ESTs for which strong familiarity and motivation to adopt exist¹²⁻¹⁴. But what ESTs might community treatment personnel self-generate as training topics of interest? Community treatment personnel may also be sources of valuable feedback about optimal training environments, formats, and methods as well as common obstacles they experience to receipt of EST trainings.

Because treatment community perspectives about training practices are filtered through a myriad of personal and contextual influences, there is need to apply research strategies that allow broader comparison among a set of these perspectives as well as exploration of deeper thematic material held in individual perspectives. This is the spirit of mixed method research, defined as “an intellectual and practical synthesis based on qualitative and quantitative research.”¹⁵(pg.129). Benefits of such synthesis include convergent validation and conceptual elaboration¹⁶, such that a fuller picture of community treatment perspectives about EST training is painted. Herein, we present data from a mixed method study with convergent design¹⁷ that involved semi-structured individual interviews with executive, supervisory, and direct service personnel during site visits to 16 opioid treatment programs (OTPs). The resulting data offer a consumer marketing perspective on training practices to inform more effective EST dissemination.

METHODS

Study recruitment

Study recruitment occurred at clinic and personnel levels. The OTPs were stratified by CTN affiliation, geographic region, and local population density. Eight U.S. regions (Pacific Northwest, Southwest, Rocky Mountain, Midwest, South, Northeast, Mid-Atlantic, Southeast) were designated *a priori* from which 16 OTPs were drawn. Due to considerable

EST exposure at CTN affiliate OTPs¹⁸, the sample was stratified to include a CTN and non-CTN OTP in each region. Regional OTPs in proximity were sought to account for population density, with comparable representation between regions of three levels (i.e., $x < 750,000$; $750,001 < x < 1,500,000$; $x > 1,500,000$, per census bureau statistics). Recruitment was initiated by a letter inviting interested clinic directors to contact investigators, who then outlined a procedural template for the site visit, requested a letter of cooperation, and negotiated a site visit date. Nineteen OTPs were contacted, of which two did not respond and another was deemed inappropriate due to discontinued opiate maintenance services.

Interviewee recruitment was informed by research indicating strong executive influence on EST adoption decisions¹⁹, and uniquely important roles of clinical supervisors and direct service clinicians in implementation^{20,21}. At each OTP, interviewees were stratified to include the executive director, a clinical supervisor, and two direct service clinicians (aggregate $n=64$). After negotiation of the site visit date, executive directors were asked to apprise clinic personnel of their study opportunity and to circulate a consent form. Beyond stratification by personnel tier, interest and availability during the site visit were the lone selection criteria.

Participants and procedures

All procedures were approved by a university Institutional Review Board. The lead author visited all 16 OTPs, with regional clinics usually seen the same week. A private room was designated for semi-structured interviews, with informed consent provided prior to audio-recording. Interviewees were assured no comments would be shared with clinic management, and were asked to avoid identifying references. Content included: 1) training topics of perceived staff interest, 2) preferences for training location, format, and activities, and 3) perceived training obstacles. Interviews were audio-recorded and 50-60 minutes long, and interviewees received \$50 compensation. Clinics received \$500 at conclusion of the site visit to account for lost staff time and clinic space. After each site visit, all materials were securely transported back to the home university where audio-recordings were transcribed in their entirety.

University-based procedures occurred in secure laboratory space. Numeric interview data were entered into an electronic database. Regarding interview transcripts, study investigators initially reviewed a subset of twelve interviews independently and then met to develop a coding scheme to enable narrative and latent content analyses (later described). Transcript reviews were then completed (in blocked sets, per clinic), with content codes applied independently followed by conjoint extrapolation of narrative themes and choice of text excerpts for presentation.

Measurement processes and dimensions

At interview outset, demographic (i.e., gender, age, ethnicity/race) and background data (i.e., clinic role, tenure) were elicited. Free listing of training topics of perceived staff interest was prompted, followed by open-ended probes to identify clinical issues spurring staff interests. To assess training event preferences, a Likert scale (1=Not at all, 7=Extremely) placard was presented to elicit rating of the impact of eight specific event dimensions on learning. After each rating, a standard probe ("what led you to rate that a...?") encouraged elaboration. Ratings targeted on- vs. off-site locations, intensive (e.g., full-day workshop) vs. distributed (e.g., brief sessions over many weeks) formats, and didactic (e.g., conceptual presentation), observational (e.g., trainer demonstration), experiential (e.g., group exercise), and performance feedback (e.g., role-play) activities. Open-ended probes then elicited discussion of perceived training obstacles.

Data analysis

Description of interviewee background/demography occurred via descriptive statistics and analysis of variance (ANOVA). For perceived training interests, a cultural domain analysis was employed to examine how treatment personnel think about their training needs. Cultural domain analysis²² is a qualitative research methodology tailored to eliciting and understanding how persons in a population group (e.g., addiction treatment personnel) think about individual elements in a salient content domain (e.g., available treatment approaches for use with substance abusers). This involved an initial scree plot that identified five training topics of prevalent interest from those freely listed by interviewees, and then cluster matrices (based on subsample frequency counts) that determined similarity of interest in these topics within OTPs. Generated topics were often broad (encompassing multiple ESTs), which prompted investigators to review relevant portions of transcripts to identify clinical issues (e.g., intervention method, clinical index, target population) underlying each topic. Corresponding scree plots were then created to identify among current NREPP listings the EST best representing the identified clinical issues.

Due to nested data structures (e.g., staff within clinics) and use of ordinal ratings, training event preferences were explored with three generalized linear multilevel models (GLMM). In each GLMM: 1) linked ratings (of perceived utility of specific training locations, formats, or activities) were a fixed effect of training preference, 2) CTN affiliation status (clinic level) and personnel tier (staff level) were also fixed effects, and 3) clinic was a random effect accounting for possible clustering of co-worker ratings. Investigators also conducted a narrative analysis of interviewee rationales for their preference ratings, which was phenomenological in nature with transcripts used as ‘windows into lived experience’²². Investigators conjointly reviewed transcripts to identify common reasons for training preferences, after which representative excerpts were selected for each personnel tier. To examine obstacles to receipt of EST training, investigators first independently reviewed transcripts and applied content codes for: 1) cost (e.g., fiscal expense), 2) time (e.g., personal availability, coverage), 3) logistics (e.g., travel/technology requirements), 4) disinterest (e.g., philosophical congruence) and 5) ‘other’ (e.g., not fitting another category). Prevalence of these codes was computed for the sample, after which investigators conjointly selected representative transcript excerpts for each personnel tier.

RESULTS

Sample description

Interviewees were 16 executives, 16 clinical supervisors, and 32 direct service clinicians (91% addiction therapists, 9% medical providers). Mean age was 46.97 years ($SD=12.43$), and 69% were female. Seven persons (11%) identified as Hispanic ethnicity. Racial distribution was 69% Caucasian, 19% African-American, 11% Latino, and 2% Iranian. Clinic tenure differed by personnel tier, $F(2,63) = 4.53$, $p < .05$; with more service years among executives ($M=13.28$, $SD=11.35$) than supervisors ($M=8.12$, $SD=7.28$) or clinicians ($M=5.92$, $SD=6.17$).

Perceived Staff Training Interests

Training interests varied by content and in number (range of 0-8, $M = 2.2$). Scree plots identified five topics: dual diagnosis treatment (31%), motivational interviewing (23%), cognitive-behavioral therapy (22%), trauma treatment (22%), and pharmacotherapy (20%). Based on cluster matrices, rates of shared interest within OTPs (defined as free-listing by at least two interviewees) were highest for cognitive behavioral therapy (86%), followed by trauma treatment (69%), motivational interviewing (67%), pharmacotherapy (46%) and dual diagnosis treatment (40%). Based on NREPP listings, dual diagnosis treatment interests

were for family-based approaches with a coping skills component, like Multidimensional Family Therapy²³. Motivational interviewing interest was in client engagement via patient-centered communication and feedback, as in Motivational Enhancement Therapy²⁴. Cognitive behavioral therapy interests were for functional review of high-risk situations and promotion of healthy client responses, as in Relapse Prevention Therapy²⁵. Trauma treatment interests were for approaches tailored for female clientele, like ‘Seeking Safety’²⁶. Pharmacotherapy interests broadly sought effective client management via established addiction medications.

Preferences for EST Training Events

Table 1 lists GLMM parameter estimates for training location, format, and learning activity preferences. In model 1, GLMM failed to identify a location preference. On-site ($M=5.31$, $SD=1.30$) and off-site ($M=5.44$, $SD=1.30$) location ratings did not differ, clinic CTN affiliation or interviewee personnel tier did not predict or interact with ratings (p -values $>.47$), and ratings did not cluster within clinics ($ICC=.00$). In model 2, GLMM revealed a preference, $F(1,120) = 11.77$, $p=.001$; with distributed formats considered more useful ($M=5.47$, $SD=1.20$) than intensive ones ($M=4.80$, $SD=1.17$). CTN affiliation and personnel tier did not predict or interact with ratings (p -values $>.20$), nor did ratings cluster by clinic ($ICC=.00$). In model 3, GLMM also revealed a preference, $F(3,120) = 20.74$, $p<.001$. Specifically, didactic activities were perceived less useful ($M=4.80$, $SD=1.35$) than were observational ($M=5.95$, $SD=.84$), experiential ($M=5.93$, $SD=1.27$), and performance feedback ($M=5.75$, $SD=1.26$) activities. Again, CTN affiliation and personnel tier did not predict or interact with ratings, nor did ratings cluster in clinics ($ICC=.00$). Collectively, these models identify a preferred training format and learning activities, and suggest consistent preferences within and between OTPs.

Narrative analysis offered conceptual elaboration beyond the null GLMM effects for location. Despite equivalent mean ratings for the utility of on- and off-site trainings, unique issues informed interest in each. Practical conveniences of on-site trainings (greater accessibility, audience familiarity) were acknowledged as an attribute by many. In contrast, off-site trainings were widely valued by treatment personnel as opportunities to gain temporary distance from the busy clinic milieu and connect with treatment professionals from other clinics.

Executive Director: “We’re social creatures. Off-site events are a way to reconnect, to see peers in a different light and meet people and hear what they are doing.”

Clinical Supervisor: “If [training] is at the clinic, it’s hard to separate yourself from work responsibilities. If you’re off-site, the #1 priority is on that training.....so you get more from it.”

Front-Line Clinician: “To get away from what you do here every day and go somewhere where you can concentrate.....where you’re not working, where instead you’re learning.....it’s a definite shift.”

Narrative analysis corroborated and elaborated on the GLMM effects for training format. Most treatment personnel voiced support for trainings distributed over time, and disappointment with the rare availability of this format. Discussions often implicated issues of personal attention span and benefits of applied practice, with distributed training thought to enhance initial learning of EST delivery skills as well as opportunity for skill retention via discussion of applied practice.

Executive Director: “When information is crammed in, you only capture some of that—and only retain **some of that**. Distributing it over time lets you take what you learn, go apply it, come back and learn a little more, go and apply it, and so on.”

Clinical Supervisor: “If you stay engaged in training over time and are able to gather a bit to implement as you go, it becomes more comfortable as you continue. It is more empowering.”

Front-Line Clinician: “When training is broken into smaller pieces, I digest it better. When you get it all at once, it’s like it goes into a funnel and only a certain amount is really sticking.”

Narrative analysis also corroborated and elaborated GLMM effects for learning activities. In particular, the common use of didactic presentations was critiqued as less useful and far less engaging than other activities. The value of offering a mix of practically-minded participatory activities was frequently emphasized, with similarly supportive opinions voiced for trainer demonstrations, small group exercises, and role-plays involving performance-based feedback.

Executive Director: “The most effective trainings my staff go to have hands-on components. The longer you sit and all you do is listen, the less effective it becomes.....*very quickly, too.*”

Clinical Supervisor: “Though some people have stage fright about performing [role-plays] in front of peers, it is very effective. And it promotes self-evaluation by counselors.”

Front-Line Clinician: “Most of us are not ‘auditorium learners.’ We need to touch it, taste it, talk it, you know. Interaction helps a lot, much more than just listening to someone talk about a theory.”

Perceived Training Obstacles

Reliability for training obstacle codes was strong ($\kappa = .92-.95$), with cost the most frequently-cited (by 55% of the sample) followed by lack of time (50%), personal disinterest (30%), and logistical challenges (23%). Unavailability of training was an ‘other’ obstacle cited, mainly by staff at OTPs in areas of lesser population density. When asked to specify the most prominent training obstacle, cost again was most often cited (by 37% of sample), followed by time and logistics (both 20%), personal disinterest (17%), and lack of availability (5%).

Salient themes emerged from narrative analysis of training obstacles. Regarding costs, OTPs and their personnel had been hard-hit by recent economic woes as reduced staffing and budget inflexibility compromised resources available to support EST training. This was a grave concern, and source of frustration, for many. Staff time to provide clinical services was seen as a precious commodity, with the salience of service reimbursement and reduced staffing requiring greater efficiency. Often, this amplified the justification required for staff to attend trainings as well as interest in ESTs delivered in brief, cost-effective formats. Staggered training of personnel was seen as a logistical necessity at most OTPs, given public demand that base operation of daily medication dosing be maintained. Notably, staggered training may complicate implementation of structural ESTs that rely on staff coordination. While on-site training may mitigate concerns about some obstacles, a lesser quality of learning experience was fervently discussed by some interviewees. Pertaining to disinterest, there remain some treatment personnel who view EST training as aversive and unnecessary. While such views were cast as a minority perspective, they were discussed (mostly from a 3rd-party perspective) at all 16 OTPs and the personnel who maintain such views constitute a significant challenge to EST dissemination. Table 2 offers select interviewee excerpts by personnel tier, as identified in narrative analysis.

DISCUSSION

This mixed method study examined issues at play in addiction professionals' training in ESTs, specifically: 1) topics they are interested to learn, 2) preferences for how training events are structured, and 3) obstacles to receipt of training. What was learned? One clear lesson is that topics of interest vary greatly, as the most common of broadly conceptualized topics were noted by 20-30% of the sample. Also, topics were nearly always defined by stated clinical needs, not name recognition or strength of empirical support for specific ESTs. In both respects, the current findings offer valuable information about the self-generated topics of interest among community treatment personnel that would not be evident from extant, survey-based literature (wherein a set of pre-determined focal topics were rated)¹²⁻¹⁴. Shared interest within OTPs for some topics (i.e., cognitive behavioral therapy, trauma treatment, motivational interviewing) has dissemination implications. First, it may reflect congruence with clinic mission, a correlate of favorable adoption attitudes²⁷ and attribute of innovations adopted more frequently and successfully¹¹. Second, it suggests training of intact groups of clinic personnel, enabling trainers to attend to contextual influences and adapt EST content for use at a particular OTP²⁸.

A second lesson involves how training events can be structured to promote higher quality learning experiences. GLMM and narrative analyses revealed strong preferences for temporally-distributed trainings that include a variety of participatory activities focused on applied practice of clinical delivery skills. These current findings are consistent with findings of Baer and colleagues⁹, where community addiction treatment providers receiving a temporally-distributed training format that included skills-practice interviews reported greater satisfaction than those receiving an intensive, more didactic two-day training workshop. The convergent validity and robustness of the current findings is notable, as is that such training structure is consistent with training strategies^{7,29,30} and models of clinical supervision recommended for EST implementation^{20,21,31}. This preferred structure runs counter to prevailing training practices where massed learning is too often structured around didactic presentations and discussions of EST concepts³². The consumer preferences revealed about training structure by the current sample suggest a need to re-think this prevailing structure.

Other lessons relate to practical training obstacles at resource-challenged OTPs, where economic woes magnify staffing concerns—and perceived response costs of training attendance. Consequently, an opportunistic frugality was evident at many OTPs. Some partnered with linked health systems to share overhead costs of large annual staff trainings. Others ardently sought out free local or online training resources. Still others selected individuals to attend external trainings and impart highlights to co-workers via in-services, akin to a 'train-the-trainer' model³³. For some OTPs, these and other solutions were pursued in absence of formal clinic training policies, leading to ad-lib resolution of training requests that bred disdain among executives, supervisors and direct-service clinicians. Such job-related frustrations identified in the current study are notable, and complement those of extant research that detail positive associations between staff retention and training resources, exposure, and utilization^{34,35}.

Several caveats bear mention. Potential for selection bias for the involved OTPs and personnel is a reasonable concern. At a clinic level, sample stratification by geography and CTN affiliation status may mitigate concerns about generalizability to other OTPs. Clearly, philosophical and structural differences between OTPs and drug-free treatment settings make study findings less applicable to the latter. That participating OTPs allowed an investigator to visit their busy facility and interview staff during a routine clinical activity may reflect a way in which they differ from others less comfortable with similar intrusion.

At a personnel level, potential for impression management for one's clinic or self is acknowledged. Efforts to stratify the sample by personnel tier may similarly mitigate some concerns, but the absence of other interviewee selection criteria makes staff representativeness hard to know. While sample size was consistent that suggested for qualitative methods utilized herein³⁶, this was not a large group on which to conduct GLMM and other inferential statistics. Thus, caution should be exercised in generalizing the magnitude of reported effects to the broader treatment community.

Caveats notwithstanding, study findings prompt questions for future EST dissemination. One concerns a gap evident between the structure of most training events and that which is preferred by the treatment community for learning new clinical skills. Can such training methods be made available, and what is their cost-effectiveness? Another question concerns the number of available ESTs. While an ever-growing EST list offers more and more choices for addressing clinical challenges, some have suggested that improvement in health service delivery may result from actually consolidating EST listings³⁷ and focusing on dissemination of broader 'change principles'³⁸. Is consolidation needed, and if so by what mechanism? Finally, irrespective of how broadly or narrowly ESTs are construed or how training events are structured, a segment of the treatment community remains resistant to EST adoption. How is service quality to improve among those strongly allegiant to the static use of familiar clinical routines? Answers for these questions await further study. We hope this examination of EST training issues may spur further empirical attention to dissemination challenges that remain.

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Table 1**Model Parameter Estimates for EST Training Event Preferences**

Model/Parameter	Fixed Effect	(df)	Variance Parameter	(SE)	Statistical Significance	95% CI Lower Upper
Model 1: Location (On-site, Off-site)						
Intercept = 5.38						5.14 5.62
Location Preference	.52	(1,120)			.47	
CTN Affiliation	.07	(1,120)			.79	
Personnel Tier	.01	(2,120)			.99	
Preference X CTN Affiliation	.00	(1,120)			1.00	
Preference X Personnel Tier	.34	(2,120)			.72	
Clinic (Random)			.00	(.04)		
Residual						
On-Site			1.76	(.32)		1.23 2.51
Off-site			1.75	(.32)		1.22 2.50
Model 2: Format (Intensive, Distributed)						
Intercept = 5.08						4.86 5.30
Format Preference	11.77	(1,120)			.00***	
CTN Affiliation	.28	(1,120)			.60	
Personnel Tier	1.48	(2,120)			.23	
Preference X CTN Affiliation	1.64	(1,120)			.20	
Preference X Personnel Tier	1.60	(2,120)			.21	
Clinic (Random)			.00	(.04)		
Residual						
Intensive			1.30	(.24)		.91 1.85
Distributed			1.46	(.27)		1.02 2.09
Model 3: Activities (Didactic, Observational, Experiential, Performance Feedback)						
Intercept = 5.47						5.31 5.62
Activity Preference	20.74	(3,120)			.00***	
CTN Affiliation	.41	(1,120)			.52	
Personnel Tier	.84	(2,120)			.43	
Preference X CTN Affiliation	.47	(1,120)			.71	
Preference X Personnel Tier	.23	(2,120)			.97	
Clinic (Random)			.00	(.03)		
Residual						
Didactic			1.85	(.34)		1.30 2.65
Observational			.73	(.13)		.51 1.05
Experiential			1.67	(.30)		1.17 2.38
Performance Feedback			1.64	(.30)		1.15 2.35

Notes: Interviewees (N=64) provided all ratings on Likert scale (7=Extremely, 1=Not At All) of perceived impact on staff learning. Each model included CTN affiliation (clinic-level) and personnel tier (staff-level) as fixed effect.

Table 2

Obstacles for EST Training

Type of Obstacle	Executive Director	Clinical Supervisor	Direct Service Clinician
Cost	"Giving staff time off for training costs more than the training. If someone would otherwise provide four bill-able clinical service hours, that's like \$300 revenue the clinic won't receive. Multiply that by several staff, it gets pretty high."	"The clinic sometimes pays for training but even then counselors first have to pay out of their own pocket and then be reimbursed. That's a struggle. So yeah, there are definitely financial obstacles."	"Finances are a really big part of it. Some wonderful trainings come out, but they're like \$300 and well...forget it. Most of us can't afford all these wonderful trainings, and clinic funding for it, it's just not there."
Time	"It's not like the average counselor has a lot of extra time to go to a training seminar, so there's a trade-off. If you go to a one-day seminar, you come back to work and have two days of work to catch up on. And staff already feel stretched by their caseloads."	"The biggest obstacle is time. We have productivity criteria to meet. If you go to training, it's not taken into account. If you miss seeing four clients, your count goes down and you get written up by [state officials]."	"I run groups every day, if I go to training somebody is going to have to fill in for me. I've got to consider that, to weigh benefits of that training against finding coverage. I mean, I love to go to trainings, but there's important work to do here."
Logistics	"Some trainings are popular, so several staff want to go. I can't always do that, you know. Like for a recent training, five staff asked to go. I couldn't afford to lose all five for multiple days, so we worked it out so three got to go."	"We're a small clinic, not everyone can be gone at once....we don't have ways to provide coverage. In case of emergency, problems, or whatever, someone needs to be here to address those things."	"The timing of many trainings is a barrier for OTPs, because we start so much earlier. I'm usually on the clock at 3:30am, so for a full-day training....I may not have much energy when the afternoon hits [laughs]."
Disinterest	"Staff can be kind of indifferent about training. Most of them have been doing this work for a while. Complacency can creep in, a feeling that there isn't much more to learn."	"Some staff would rather stay back and catch up on charts, you know. Like they see [training] as a burden, or think they know enough and don't need training."	"Our lives are busy, the clinic is busy. It's easy to say 'things work fine, let's just keep doing what we do. Why do we have to go to training? Some don't even like in-services,'"

Notes: Selected excerpts from interview discussion with 16 executive directors, 16 clinical supervisors, and 32 direct-service clinicians.