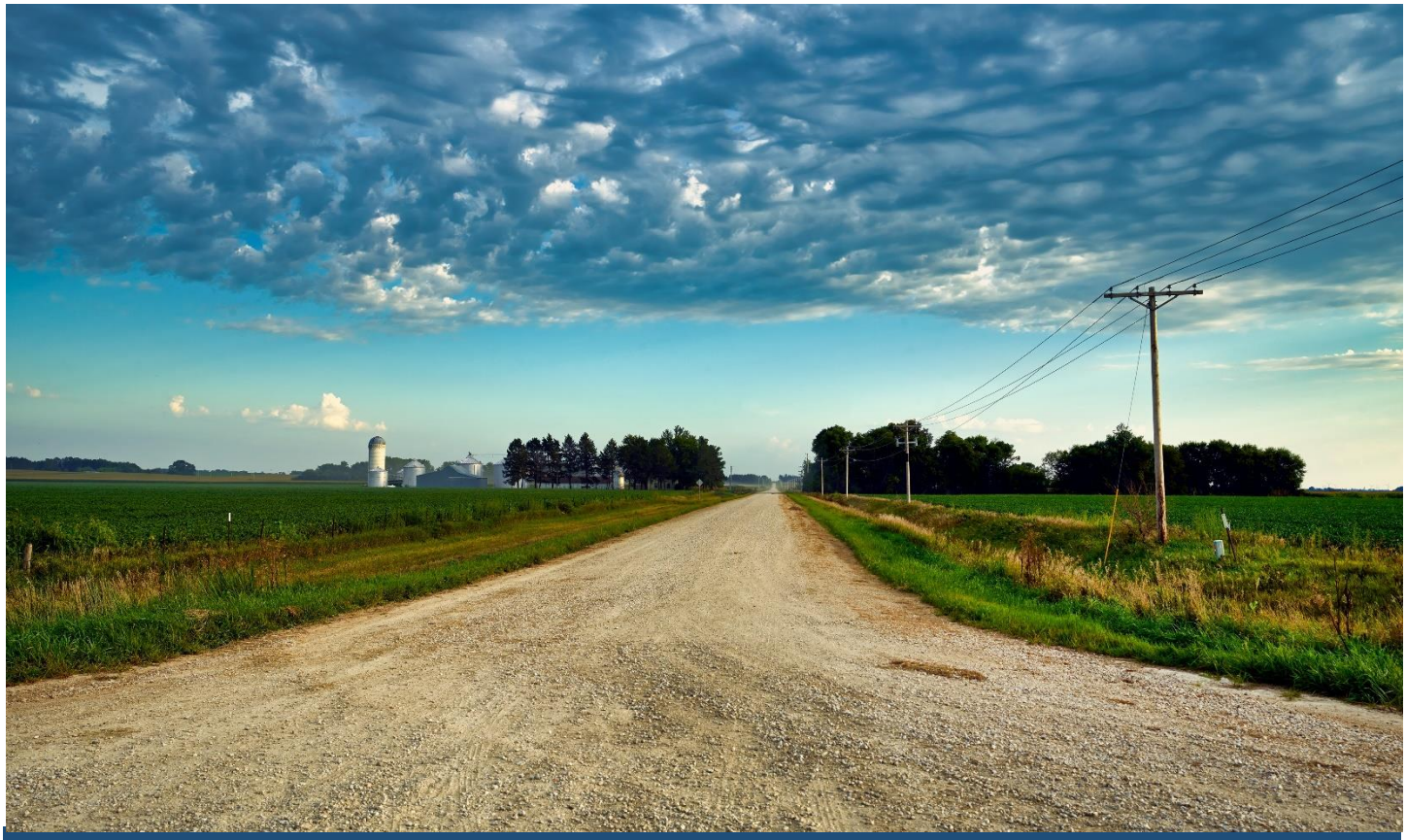
Workforce Survey Results: Iowa Substance Abuse and Problem Gambling Prevention



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Executive Summary

As part of Iowa's strategy to recruit, retain, and strengthen a diversely skilled and highly competent prevention workforce, the Iowa Department of Public Health's Bureau of Substance Abuse (IDPH) and members of the Workforce Development (WFD) Task Force partnered with JBS International to design, distribute, and analyze the Iowa Substance Abuse and Problem Gambling Prevention Workforce Survey. The goal of the survey was to measure the characteristics of the workforce and their knowledge, skills, and abilities in the Strategic Prevention Framework (SPF) and other competencies needed to successfully address substance use and problem gambling priorities. These included seven core competencies and two technical domains:

- Communication
- Needs assessment
- Assessing readiness and capacity
- Mobilization and capacity building
- Strategic planning
- Implementation
- Evaluation
- Substance abuse technical domain
- Problem gambling technical domain

The survey results will be used to direct Iowa's training and technical assistance (T/TA) resources toward the most pressing workforce needs within each level of the workforce.

Methods

The competencies of individuals working at various levels within a prevention provider agency were measured. JBS collaborated with IDPH to develop a survey questionnaire with branched questions for the three tiers of the workforce:

- Tier 1: Entering the field
- Tier 2: Prevention professionals
- Tier 3: Prevention leadership

The division into three tiers helped ensure that the survey questions were relevant to each respondent. Those in Tier 3 were asked all questions, while those in Tiers 1 and 2 responded to a subset of questions. Survey questions were created to correspond to identified core competencies for the prevention workforce. JBS implemented the survey using the SurveyMonkey® online platform. The final survey included a total of 30 questions and took an average of 15 minutes to complete. All data are presented in aggregate to protect the confidentiality of respondents. IDPH distributed the survey in September 2019 via a network of partners. Due to the decentralized nature of distribution, a response rate could not be calculated. The final dataset included a total of 132 completed surveys.

Results

Most respondents self-selected into Tier 2: Established Prevention Professional (52%), while 27% identified as Tier 3: Prevention Leadership, and 20% identified as Tier 1: Entering the Field. The majority of respondents were women (77%), most were over the age of 40 (58%), and nearly all were White (95%). Most respondents had a bachelor's degree (62%). A plurality categorized themselves as prevention specialists (45%). Most (76%) indicated that they are members of coalitions, mostly substance abuse coalitions (57%). Most respondents (59%) had over 5 years of experience in the field.

Overall, respondents rated themselves as proficient or highly proficient in most competency domains that were relevant to their tier. The gambling technical domain had the lowest overall proficiency, for which between 23% and 41% of respondents agreed that they were proficient or highly proficient in each knowledge area or skill. The highest proficiency ranges were in the competency and technical domains of mobilization and capacity building, assessing readiness and capacity, evaluation, and substance abuse, where between 55% and 92% of respondents rated themselves as proficient or highly proficient in each knowledge area or skill. For all competency and technical domains, the percentage of respondents who chose higher proficiency levels generally increased by tier.

Recommendations

Based on the findings of the survey, JBS International recommends that workforce development resources be directed toward ongoing training and intensive technical assistance to increase:

1. Problem gambling–specific competencies.
2. Substance use prevention competencies, especially within those new to the prevention field.
    - Knowledge of current prevention methods, strategies, and programs.
    - Using research to expand knowledge of factors/intervening variables that create protection or resilience against substance use disorders.
3. SPF competencies across the workforce, specifically:
    - Identifying ways to include the relevant needs of culturally diverse groups into their work *(Needs Assessment).*
    - Identifying key partners needed to achieve desired outcomes *(Mobilization and Capacity Building).*
    - Contributing to prevention planning efforts *(Strategic Planning).*
    - Describing priority substance use problems and the populations impacted by or involved in them *(Strategic Planning).*
    - Using research to identify the strategies and activities most likely to reduce substance use problems and consequences for the populations targeted by prevention efforts *(Strategic Planning).*
    - Locating resources to find evidence-based prevention programs, practices, and policies to address substance use *(Strategic Planning).*

Iowa is also encouraged to use the results from this assessment to create a workforce development plan and to conduct ongoing assessment to measure the state's progress in building the competencies that are needed within the workforce to address Iowa's substance use and problem gambling priorities.

Introduction

Many states deal with the challenge of maintaining a competent substance abuse and gambling prevention workforce that is diverse in talent and culture, and geographically accessible. To address this challenge, IDPH convened a WFD Task Force to provide feedback and guidance on the development of a statewide workforce survey. In collaboration with IDPH and the WFD Task Force, JBS International designed and administered the Iowa Substance Abuse and Gambling Prevention Workforce Survey.

The Iowa Workforce Survey was designed to provide information to help IDPH and the WFD Task Force:

1. Understand the characteristics of the substance abuse and gambling prevention workforce.
2. Understand the degree to which the substance abuse and gambling prevention workforce has the core competencies needed to achieve priority outcomes.
3. Create a plan to build needed workforce competencies, recruit and retain a quality workforce, and target T/TA toward the most pressing workforce needs.

This report describes the process of designing, implementing, and analyzing this survey, and synthesizes findings on workforce demographics, core competencies by domain, and core competencies for substance abuse and gambling prevention.

Description of Core Competencies

The development of the seven core competency domains was guided by the SPF. The SPF begins with identifying local prevention needs based on data (assessment and readiness), involves building local resources and readiness to address prevention needs (mobilization and capacity building), finding out what works to address prevention needs and how to do it well (planning), delivering evidence-based interventions as intended (implementation), and finally examining the process and outcomes of interventions (evaluation.) The principles of cultural competence and sustainability were also included in the competencies.

Substance Abuse Prevention Core Competencies

JBS International used a two-step process to develop substance abuse prevention core competencies that aligned with the SPF.

First, JBS conducted an extensive international and domestic literature search and review to identify existing frameworks for workforce development in substance abuse prevention practice areas. The 10 Essential Public Health Services was used as an organizing framework for comparing competency domains across the different workforce frameworks, given its broad applicability and long tenure as the standard for health services in the United States. Two additional areas not specifically covered by the 10 Essential Public Health Services but found in multiple workforce frameworks include: (1) Job Knowledge, and (2) Management and Leadership, therefore these were both added to the organizing framework.

The frameworks included in the analysis consist of the following:

- **International Certification & Reciprocity Consortium** (IC&RC)[1]—Comparing IC&RC domains and competencies with those within other behavioral health workforce frameworks is an efficient way of identifying any core competencies and knowledge, skills, and abilities not currently addressed by the state but considered to be key to workforce development.
- **Core Competencies for Public Health Professionals**[2]—This framework is based on the 10 Essential Public Health Services and includes three tiers of competencies representing career stages.
- **Alaska Core Competencies for Direct Care Workers**[3]—This framework was developed by the Alaska Mental Health Trust's Credentialing and Quality Standards Subcommittee, with broad stakeholder input. While most of the competencies are relevant nationally, others have special significance for rural and frontier areas.
- **Core Competencies for Health Promotion Practitioners**[4]—This framework was developed by the Australian Health Promotion Association to identify beginner-level competencies.
- **Core Competencies for Integrated Behavioral Health and Primary Care**[5]**—**This framework was developed by the Substance Abuse and Mental Health Services Administration–Health Resources & Services Administration (SAMHSA-HRSA) Center for Integrated Health Solutions for mental health and substance use service providers in both behavioral health and primary care provider settings.
- **CompHP Core Competencies**[6]—This framework was developed by the Developing Competencies and Professional Standards for Health Promotion Capacity Building in Europe Project, funded by the European Agency for Health and Consumers.

Second, the Massachusetts Technical Assistance Partnership for Prevention, Workforce Development Continuum developed in August 2017, was reviewed against the core competencies created from the

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[1] International Certification & Reciprocity Consortium. (n.d.). *About IC&RC's Credentials*. Retrieved October 23, 2019, from https://internationalcredentialing.org/creds

[2] Public Health Foundation. (2014). *Core Competencies for Public Health Professionals*. Retrieved October 23, 2019, from http://www.phf.org/resourcestools/pages/core_public_health_competencies.aspx

[3] Alaska Mental Health Trust Authority, State of Alaska Department of Health and Social Services, Western Interstate Commission on Higher Education, The Annapolis Coalition on the Behavioral Health Workforce, Committee on Workforce Competencies, & The Alaska Training Cooperative. (2016). *Alaska Core Competencies for Direct Care Workers in Health and Human Services*. Retrieved October 23, 2019, from http://files.aktc.org/ACC%202016%20Booklet.pdf

[4] Australian Health Promotion Association. (2012). *Core Competencies for Health Promotion Practitioners.* Retrieved October 23, 2019, from https://www.healthpromotion.org.au/images/docs/core_competencies_for_hp_practitioners.pdf

[5] SAMHSA-HRSA, Center for Integrated Health Solutions. (2014). *Core Competencies for Integrated Behavioral Health and Primary Care*. Retrieved October 23, 2019, from https://www.integration.samhsa.gov/workforce/integration_competencies_final.pdf

[6] Dempsey, C., Battel-Kirk, B., Barry, M.M. (2011). *The CompHP Core Competencies Framework for Health Promotion Handbook*. Retrieved October 23, 2019, from http://www.szu.cz/uploads/documents/czzp/nerovnosti/2011/5._CompHP_Core_Competencies_Framework_for_Health_Promotion_Handbook_revised.pdf

workforce development frameworks reviewed in the first step to ensure that any missing competencies were included that fit with IDPH's feedback regarding Iowa's substance abuse prevention workforce.

Gambling Prevention Competencies

Two sources were used to develop the gambling prevention competencies. The first source was developed for the Oregon Department of Human Services, Office of Mental Health and Addiction Services.[7] This guide includes background on the research relating to risk and protective factors for problem gambling behaviors based on the research of Dickson, Derevensky, and Gupta (2002)[8] and problem gambling prevention programs that have been developed, packaged, and are exportable. The second source used is from the New York State Office of Alcoholism and Substance Abuse Services, Credentialed Problem Gambling Counselor website.[9] This credential is intended for individuals who provide problem gambling counseling services in approved work settings in the State of New York. Education and training requirements are listed on the website and address the full range of knowledge, skills, and professional techniques related to problem gambling counseling.

Methods

Survey Design

JBS and the WFD Task Force collaborated to clearly define the core competencies and workforce characteristics to be measured in line with the SPF. Survey questions were based on the seven competencies and two technical domains identified by JBS and IDPH. To ensure that the survey questions were relevant to each respondent's experience, JBS created branched questions for three different tiers of the workforce which were defined as follows.

- **Tier 1: Entering the field—**Tier 1 includes individuals who have worked in the field less than a year or who work in prevention in a limited capacity (e.g., as a volunteer or coalition member only, as an intern, or as a small part of a job that is focused on prevention).
- **Tier 2: Established prevention professional—**Tier 2 includes individuals who have worked in the field for a year or more and have experience with utilizing the continuum of prevention services through the SPF, not in a supervisory role.
- **Tier 3: Prevention leadership—**Tier 3 includes experienced prevention professionals with a leadership role (i.e., people who actively supervise, mentor, direct, or build the prevention capacity of others).

[7] Marotta, J. & Hynes, J. (2003, August). Problem Gambling Prevention Resource Guide for Prevention Professionals. Salem, OR: Oregon Department of Human Services, Office of Mental Health & Addiction Services.
[8] Dickson, L.M., Derevensky, J.L., & Gupta, R. (2002). The prevention of gambling problems in youth: A conceptual framework. *Journal of Gambling Studies, 18,* 97-159. Retrieved October 23, 2019, from hhttp://www.jogoremoto.pt/docs/extra/rEwZKH.pdf
[9] New York State, Office of Alcoholism and Substance Abuse Services, Credentialed Problem Gambling Counselor Education and Training Requirements. Retrieved October 23, 2019, https://www.oasas.ny.gov/sqa/credentialing/CPGC/CPGCreq.cfm#education

The survey included a question guiding respondents to self-select into a workforce tier, and survey skip logic was used so that respondents were only asked questions relevant to their tier.

For each question, respondents were asked to rate their proficiency using the following criteria:

- **None—**I am unaware or have very little knowledge of the skill.
- **New/beginning proficiency—**I have heard of, but have limited knowledge or ability to apply the skill.
- **Proficient—**I am comfortable with my knowledge or ability to apply the skill.
- **Highly proficient—**I am very comfortable, am an expert, or could teach this skill to others.

The final survey included a total of 30 questions and took approximately 15 minutes on average to complete. Competency questions were in matrix format and listed multiple topics within each question; the number of topics listed varied by tier. Therefore, the average time to completion varied between approximately 5 minutes (for Tier 1) to approximately 20 minutes (for Tier 3). Respondents were ensured of the confidentiality of their responses and the data in this report are presented in aggregate. Respondents were informed that that they could skip any questions they did not understand, did not know the answer to, or were uncomfortable answering.

Survey Administration

JBS utilized the SurveyMonkey® online platform to administer the survey. JBS researchers pilot tested the survey in the online platform to identify confusing items, test survey skip logic and self-assignment into tiers, and reduce the opportunity for respondent error. Respondents were able to take the survey either via a computer or a mobile device. Respondents were informed that, upon completion of the survey, they would receive a link to a certificate for 0.25 Continuing Education Units (CEUs) as an incentive for completion.

IDPH sent several communications through a distributed network of partners, including: 1) an introductory email to invite potential respondents in advance of the survey; 2) a communication email to provide potential respondents with the link to the survey; and 3) three follow-up reminder emails to prompt those who had not completed the survey to respond. JBS created email templates that IDPH used to communicate with potential respondents. The online survey was open from August 26 to September 22, 2019.

Survey invitations were sent to prevention professionals and others including Drug Abuse Resistance Education (DARE) law enforcement officials, coalition networks and volunteers, and members of Drug Free Community (DFC) Coalitions. Because IDPH did not have a central list of potential respondents, state and federal partners were asked to distribute a survey invite and reminders. This included individuals from the Alliance of Coalitions for Change, DARE, DFC Grantees, Evidence-based Practices workgroup, Iowa Behavioral Health Association, Iowa Board of Certification, IDPH Tobacco Community Partnership Contractors, Iowa State Extension PROSPER, Iowa Prevention & Treatment Supervisors Association, Iowa Office of Drug Control Policy Byrne Justice Assistance Grant contractors, Midwest Counterdrug Training Center, Prevention Partnerships Advisory Council/State Epidemiological Workgroup, Iowa Mentoring Partnership, and IDPH substance abuse prevention and problem gambling contractors. Though intentional, the choice to distribute the survey through a decentralized network resulted in an inability for JBS to track the total number of participants to calculate a response rate or to send out targeted and individualized reminder emails to encourage responses.

Data Cleaning and Analysis

Upon closing the survey, JBS cleaned and analyzed the survey data using SPSS Version 22. To ensure that cases analyzed were as complete as possible, analysts removed those with less than 50% response to the survey, resulting in a total of 132 cases.[10] JBS then analyzed the data by competency domain and tier and ran basic analyses on demographic variables. The main analyses included frequencies and descriptive statistics, including mean, median, mode, and range. Complete results by tier are reported in the Appendixes.

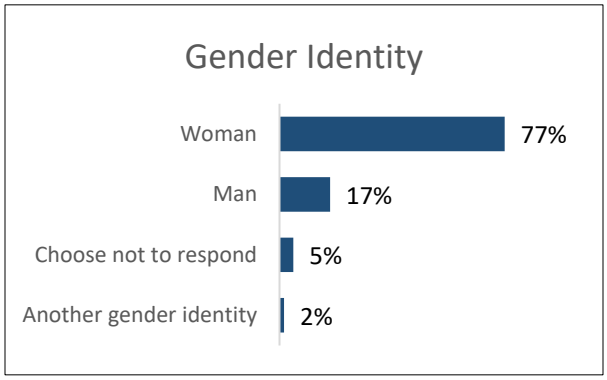
Results

Demographic Findings

GENDER IDENTITY

Of the 128 survey respondents who reported their gender identity, 77% (n=98) were women, 17% (n=22) were men, 2% (n=2) identified with another gender, and 5% (n=6) chose not to answer this question. Men constituted a larger percentage of Tier 2 respondents than other tiers.

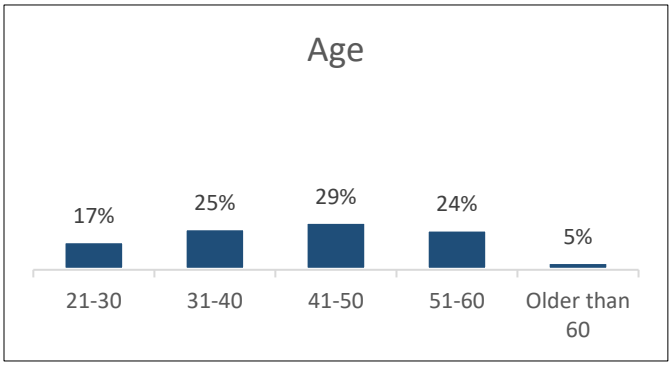
Figure 1: Gender Identity of Respondents



AGE RANGE

A total of 128 respondents selected the age range into which they would fall on their next birthday. The results indicate that 17% (n=22) of respondents were aged 21–30, 25% (n=32) of respondents were aged 31–40, 29% (n=37) of respondents were in the 41–50 year age range, 24% (n=31) of respondents were aged 51-60, and 5% (n=6) of respondents were older than 60 years of age. Age varied by tier, with a greater percentage of Tier 1 respondents under 30 than other tiers, a greater percentage of Tier 2 respondents between 31 and 40 than other tiers, and a greater percentage of Tier 3 respondents over 40 than other tiers, although all age ranges were represented in all tiers.

Figure 2: Age Range of Respondents

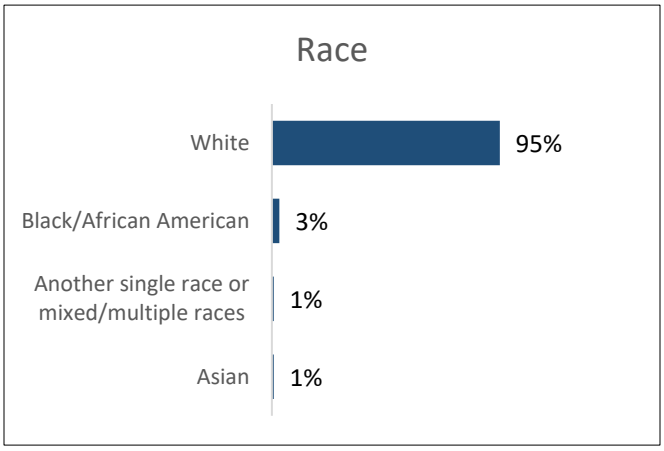


[10] It was estimated that there were up to 700 individuals working in Iowa's substance abuse and problem gambling prevention workforce at the time the survey began.

RACE AND ETHNICITY

Respondents were asked which racial identity best described them. Of the 128 respondents who answered this question, 95% (n=122) identified as White, 3% (n=4) identified as Black, and 1% (n=1) identified as either Asian or as another single race or multiple/mixed race. Ninety-seven percent (n=123) of respondents identified as not Hispanic or Latino while 3% (n=4) identified as Hispanic or Latino. Due to the small numbers of participants not identifying as White, there were few differences in responses by tier.

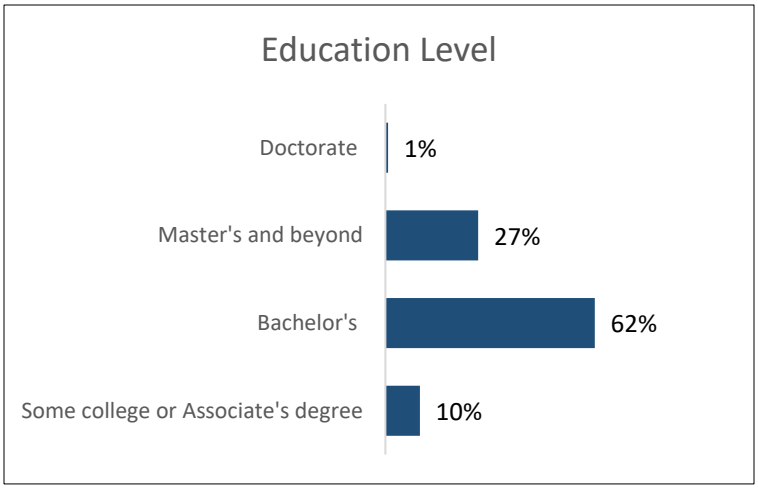
Figure 3: Racial Identity of Respondents



EDUCATION

In total, 128 respondents answered a question about their level of education completed. Sixty-two percent (n=79) had a bachelor's degree, 27% (n=35) of respondents had a master's degree or beyond, 10% (n=13) had some college education or an associate's degree, and 1% (n=1) of respondents held a doctorate degree. Bachelor's was the most frequently attained degree across all tiers, but a much greater percentage of Tier 3 respondents had master's degrees.

Figure 4: Education Levels of Respondents

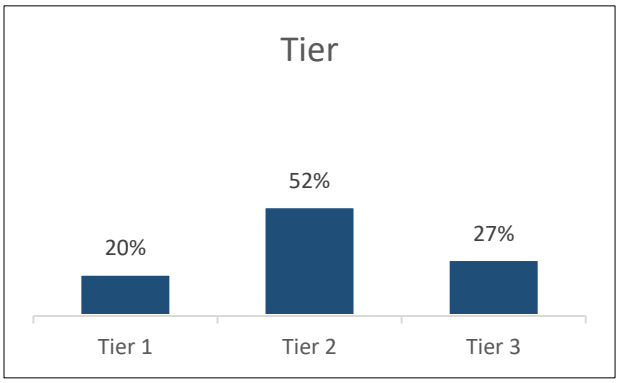


Job Characteristics

TIERS

Respondents answered an initial question asking them which of three tiers best described their current position within the prevention field. Most respondents self-selected into Tier 2: Established Prevention Professional (52%, n=69), while 27% (n=36) identified as Tier 3: Prevention Leadership, and 20% (n=27) identified as Tier 1: Entering the Field.

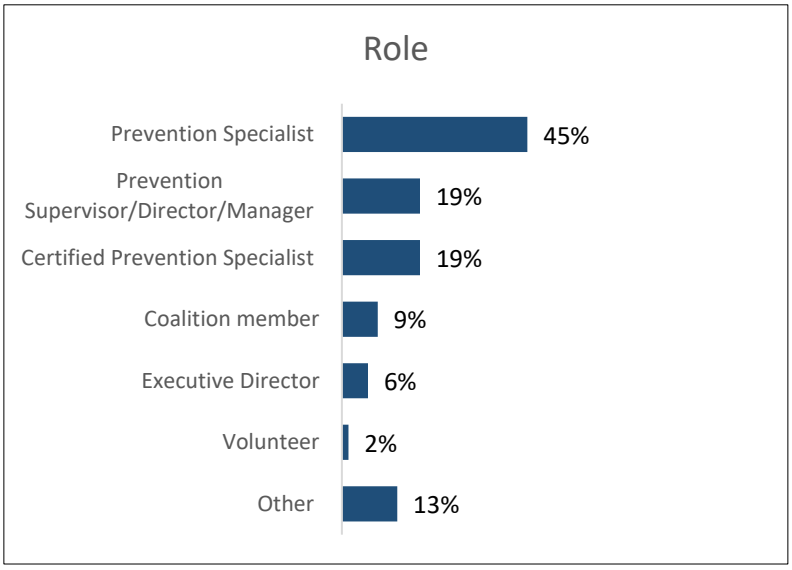
Figure 5: Respondents by Tier



ROLE

Respondents were asked to select their role(s) in prevention efforts and were able to select multiple options. Of 128 respondents, 45% (n=57) were prevention specialists, 19% (n=24) were certified prevention specialists and prevention supervisors/directors/managers, respectively, 6% (n=8) were executive directors, 9% (n=11) were coalition members, 2% (n=2) were volunteers, and 13% (n=17) served in another capacity. More than half of Tier 1 and Tier 2 respondents identified as prevention specialists, while most Tier 3 respondents identified as prevention supervisors, directors, or managers. Slightly more than 10% of Tier 1 and Tier 3 respondents identified as executive directors; presumably Tier 1 executive directors work primarily in a field other than prevention.

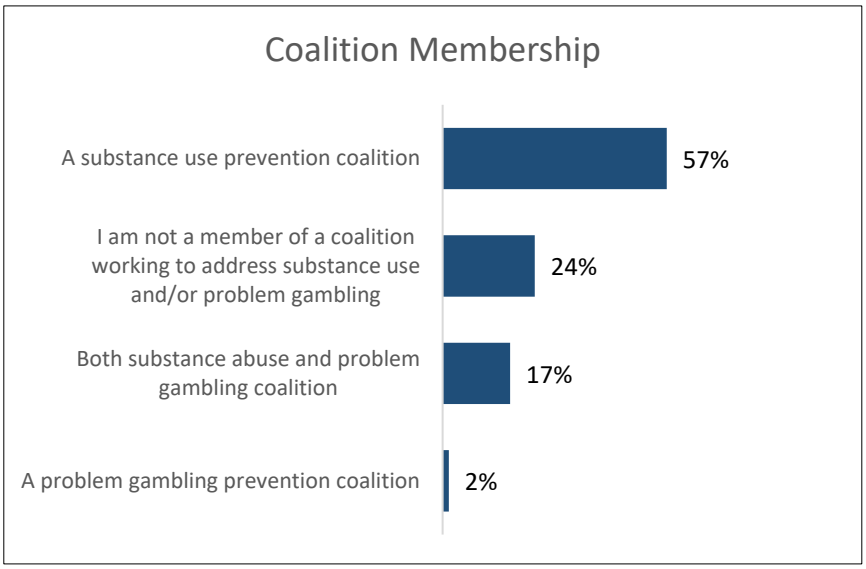
Figure 6: Respondents by Role



MEMBERSHIP

In total, 127 respondents indicated whether they were a member of a substance use prevention coalition, a problem gambling prevention coalition, both, or neither. Fifty-seven percent (n=73) of respondents are members of substance use prevention coalitions, 17% (n=22) of respondents are members of both types of prevention coalitions, 2% (n=2) of respondents are members of problem gambling prevention coalitions, and 24% (n=30) of respondents are not members of either type of coalition.

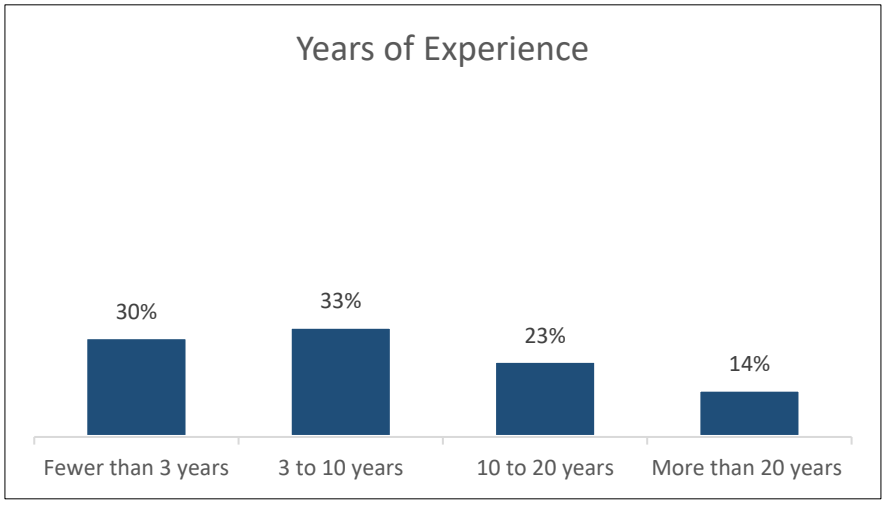
Figure 7: Coalition Membership



YEARS OF EXPERIENCE

Overall, 127 respondents indicated how long they had been employed or volunteered in their profession. Thirty percent (n=38) of respondents had fewer than 3 years of experience, 33% (n=42) of respondents had between 3 and 10 years, of experience, 23% (n=29) of respondents had between 10 and 20 years of experience, and 14% (n=18) of respondents had more than 20 years of experience.

Figure 8: Number of Respondents by Years of Experience



Opportunities Provided to the Workforce

Respondents answered questions about the opportunities and benefits offered through the programs or organizations for which they work and were able to select multiple response options. Of the 127 respondents who answered a question about benefits, between 93% (n=118) and 94% (n=120) had benefits, including paid vacation time, group health insurance, and retirement plans, while 2% (n=2) said that they were volunteers rather than paid employees. Of the 124 respondents reporting on other opportunities provided by their organization, most reported that they had access to prevention-specific training (81%, n=100) and a healthy work–life balance (76%, n=94), while less than a third reported paid educational assistance (32%, n=40) or promotion opportunities and a defined career path (27%, n=34). Figure 9 shows opportunities provided.

Opportunities were largely similar across all tiers, with Tier 3 respondents somewhat more likely than Tier 2 and Tier 1 respondents to report that they had access to most opportunities, and much more likely to report that they were able to provide program input until prevention services.

Figure 9: Opportunities Offered by Programs and Organizations

Findings by Core and Technical Domains

The survey asked respondents to report on their proficiency in seven core competency domains and two technical domains. Respondents were only asked questions relevant to their tier and had the option of indicating whether items were not applicable to their work. Percentages were calculated only among those who gave proficiency ratings. Overall, respondents rated themselves as proficient or highly proficient in most competency domains applicable to their work. The lowest proficiency was found in gambling, where between 23% and 41% of respondents agreed that they were proficient or highly proficient in each knowledge area or skill relevant to their tier, and the highest proficiency ranges were in mobilization and capacity building, assessing readiness and capacity, evaluation, and substance abuse provider specific competencies, where between 55% and 92% of respondents rated themselves as proficient or highly proficient in each knowledge area or skill relevant to their tier.

This section will describe the results of the workforce's proficiency in the core competency and technical domains. Results are reported by core or technical domain as well as skills and abilities within the domains. This section reports key findings by respondent tier in each of the core competency and technical domains.[11]

[11] Since respondents classifying themselves as Tier 1 or Tier 2 were not asked all questions, charts depicting proficiency note which groups of questions were included for All Tiers vs. those that were included only for Tiers 2

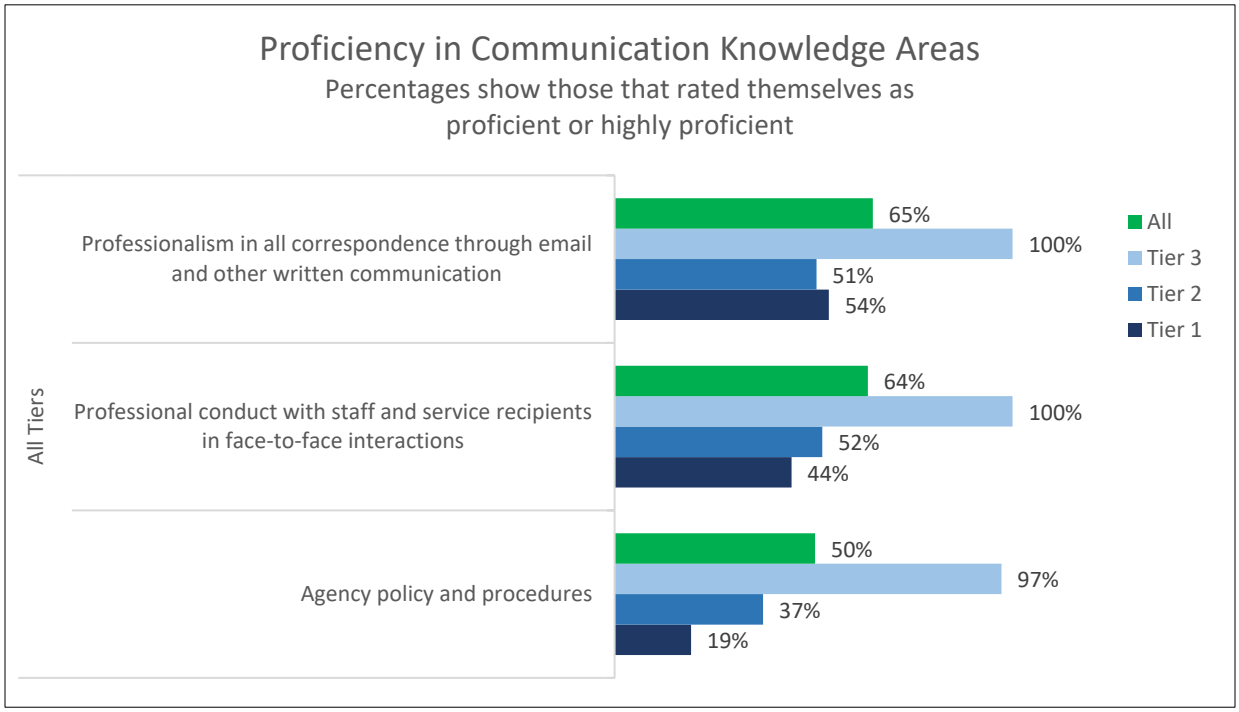
Core Competencies

Communication Skills

Respondents ranked their knowledge of communication policies and practices (see Figure 10, below). For all respondents, the communication skill in this category with the highest percentage of respondents (65%) who ranked themselves as proficient or highly proficient was *professionalism in all correspondence through email or other written communication* (n=85). The communication skill in this category with the lowest percentage of overall respondents (50%) who rated themselves as proficient or highly proficient was *agency policy and procedures* (n=65).

Prevention leadership (Tier 3) were the most likely to rate themselves as proficient or highly proficient in all three areas. About half of prevention professionals (Tier 2) rated themselves as proficient or highly proficient on *professionalism in correspondence* and *professional conduct with service recipients*, but only 37% rated themselves as proficient or highly proficient in *agency policies and procedures*. Similarly, those entering the field rated themselves the highest on *professionalism in all correspondence*, with 54% saying they felt proficient or highly proficient. Only 19% of Tier 1 said that they were proficient or highly proficient in *agency policy and procedures*.

Figure 10: Proficiency in Communication Knowledge Areas by Tier



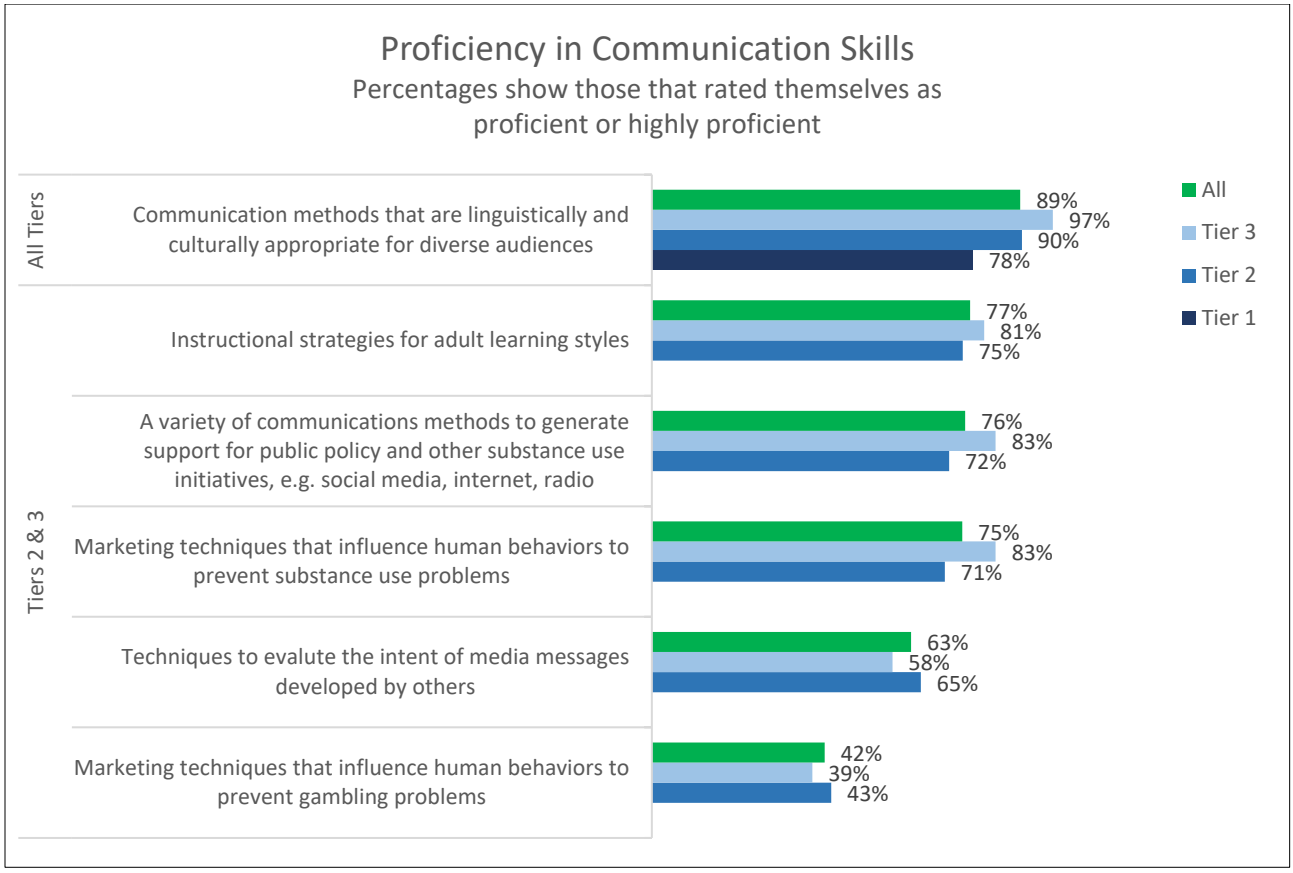
The other six communication-focused questions asked respondents to rank their ability to use certain communication skills (see Figure 11, below). For all respondents, the communication skill in this category with the highest percentage of respondents (89%) who selected proficient or highly proficient was *using communication methods that are linguistically and culturally appropriate for diverse audiences* (n=117). The

& 3 and those that were included only for Tier 3. For some competency areas such as Figure 10, all questions were asked of all tiers.

communication skill in this category with the lowest percentage of overall respondents (42%) who selected proficient or highly proficient *was marketing techniques that influence human behaviors to prevent gambling problems* (n=44).

Tier 1 was asked only one of the six questions; the other two tiers were asked all six questions. Prevention leadership (Tier 3) respondents were the most likely to rate themselves as proficient or highly proficient in four of the six areas, with most choosing *communication methods that are linguistically and culturally appropriate for diverse audiences* (97%) and the fewest choosing *marketing techniques that influence human behaviors to prevent gambling problems* (39%). Prevention professionals (Tier 2) were more likely than prevention leadership to rate themselves as proficient or highly proficient in *marketing techniques that influence human behaviors to prevent gambling problems* and *techniques to evaluate the intent of media messages developed by others.*

Figure 11: Proficiency in Communication Skills by Tier



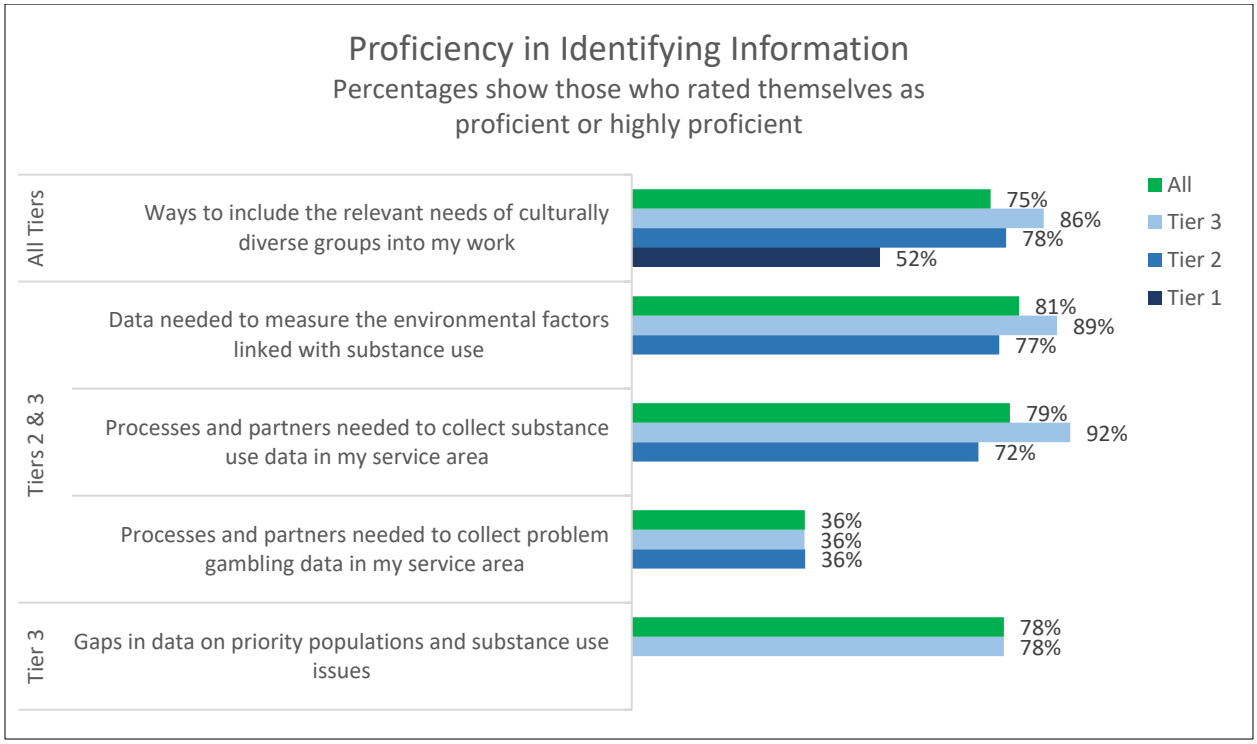
Needs Assessment

Five of the 14 questions in the needs assessment section inquired about respondent skills in identifying key types of information for needs assessments (see Figure 12, below). Over half of respondents rated themselves as proficient or highly proficient in four of the five questions. For all respondents, the skills for which respondents most often selected proficient or highly proficient (81%) was *the ability to identify the data needed to measure the environmental factors linked with substance use* (n=85). The needs assessment skill in this category with the fewest overall respondents (36%) who rated themselves as proficient or highly

proficient was *the ability to identify processes and partners needed to collect problem gambling data in their service area* (n=38).

Prevention leadership (Tier 3) was the most likely to rate themselves as proficient or highly proficient in three of the four areas to which multiple tiers responded. Nearly all leadership (92%) indicated they were proficient or highly proficient in *the ability to identify processes and partners needed to collect substance use data in my service area*. Like the other two tiers, fewer selected proficient or highly proficient for *the ability to identify processes and partners needed to collect gambling data in my service area* (36% for all tiers). Tier 2 respondents felt most proficient in *ways to include the relevant needs to culturally diverse groups into my work* (78%). Tier 1 respondents were only asked about their proficiency in *the ways to include the relevant needs of culturally diverse groups into my work*. Half reported being proficient or highly proficient in this skill, significantly fewer than both of the other tiers.

Figure 12: Ability to Identify Information by Tier

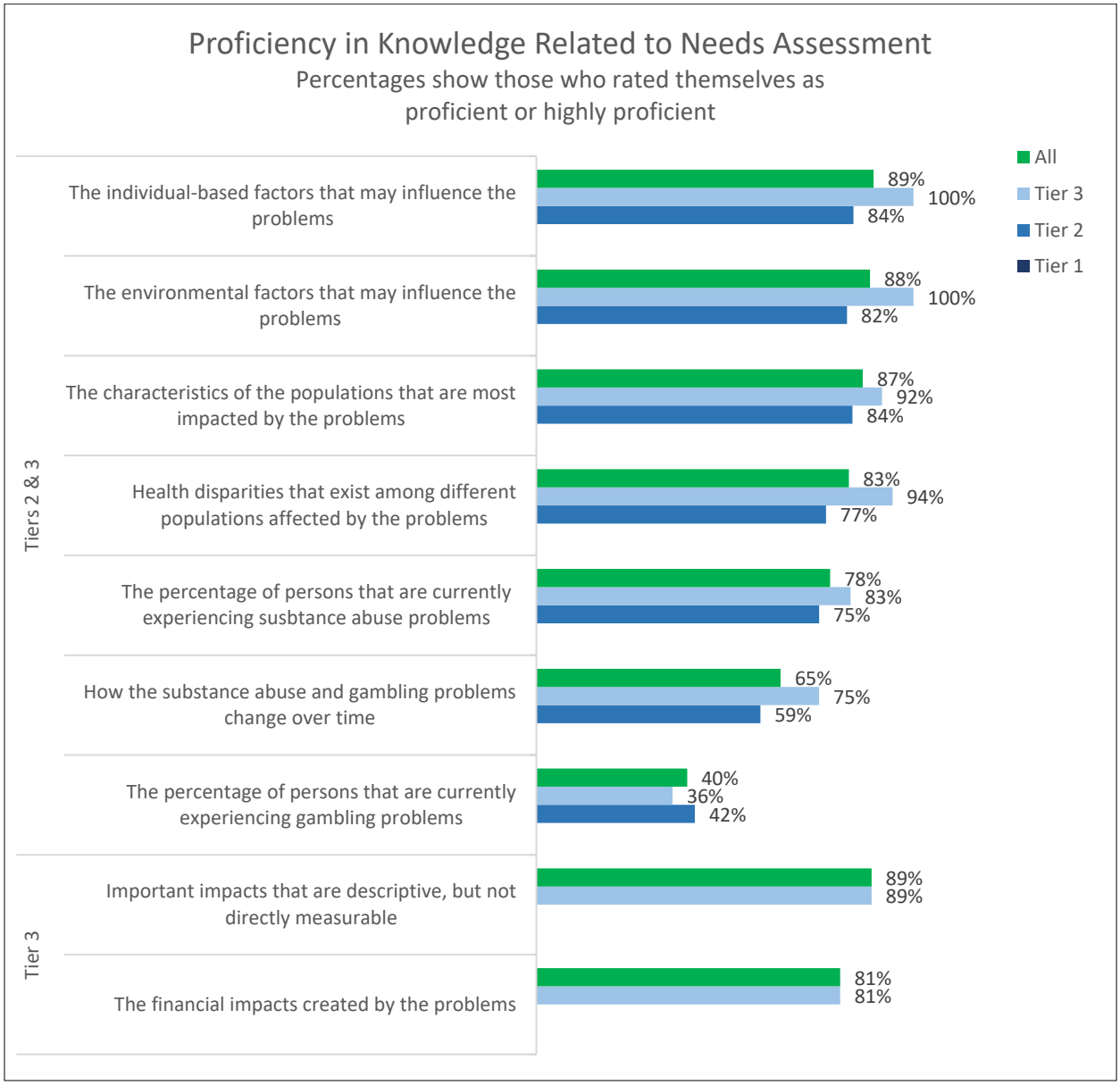


Respondents rated their knowledge related to needs assessment requirements (see Figure 13, below). For all respondents, the areas of knowledge in this category with the highest percentage of respondents (89%) who ranked themselves as proficient or highly proficient were *knowledge related to the individual-based factors that may influence the problems* (n=93) and *important impacts that are descriptive, but not directly measurable* (n=32). The area of knowledge in this category with the lowest percentage of overall respondents (40%) who rated themselves as proficient or highly proficient was *knowledge of the percentage of persons that are currently experiencing gambling problems* (n=42).

Only Tiers 2 and 3 responded to questions about knowledge related to needs assessment. Prevention leadership (Tier 3) respondents were the most likely to rate themselves as proficient or highly proficient in all except for one area in this category (*knowledge of the percentage of persons that are currently experiencing*

substance abuse problems). Prevention professionals (Tier 2) were more likely than prevention leadership to rate themselves as proficient or highly proficient in *knowledge of the percentage of persons currently experiencing gambling problems* (42% of prevention professionals compared to 36% of prevention leaders).

Figure 13: Knowledge Related to Needs Assessment by Tier



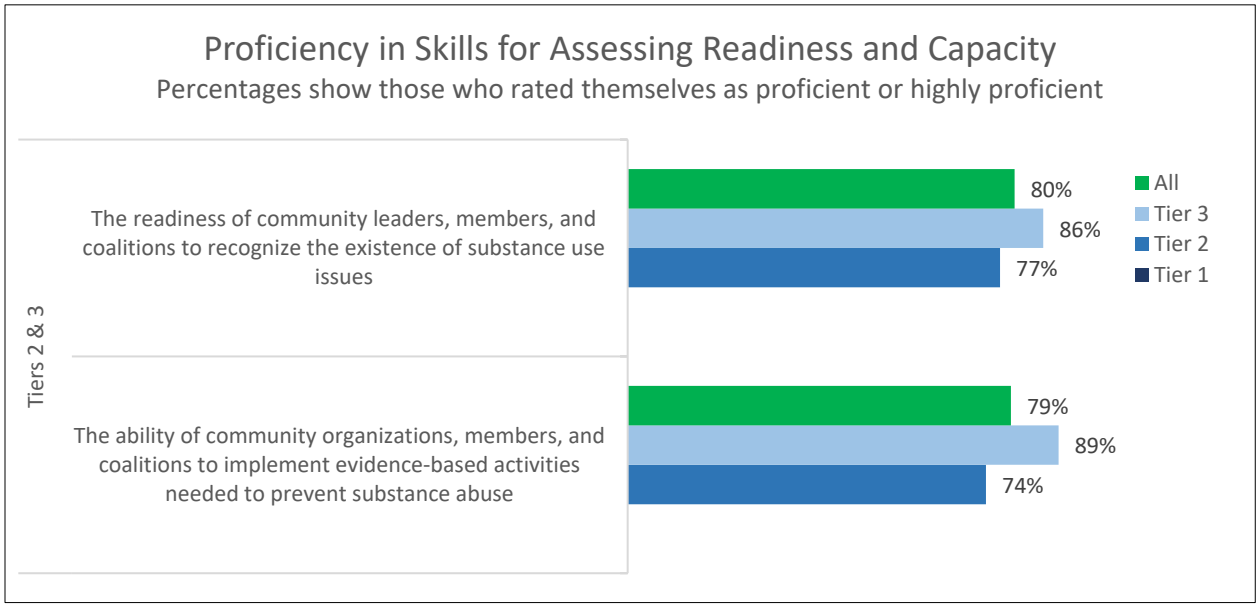
Assessing Readiness and Capacity

Respondents ranked their skills in assessing readiness and capacity. Two of the five questions in this category asked respondents if they were able to assess 1) the readiness of community leaders, members, and coalitions to recognize the existence of substance use issues; and 2) the ability of community organizations, members, and coalitions to implement evidence-based activities needed to prevent substance abuse (see Figure 14, below). For all respondents, the assessment skill in this category with the highest percentage of respondents (80%) who ranked themselves as proficient or highly proficient was *readiness of community*

leaders, members, and coalitions to recognize the existence of substance use issues (n=83). The assessment skill in this category with the lowest percentage of respondents (79%) who ranked themselves as proficient or highly proficient was *the ability of community organizations, members, and coalitions to implement evidence-based activities needed to prevent substance abuse* (n=83).

Only Tier 2 and Tier 3 respondents rated their skills in assessing readiness and capacity in this category. Prevention leadership (Tier 3) were more likely than prevention professionals (Tier 2) to rate themselves as proficient or highly proficient in both of these skill areas, though this gap was narrower for *skill in assessing readiness of community leaders, members, and coalitions to recognize the existence of substance use issues*.

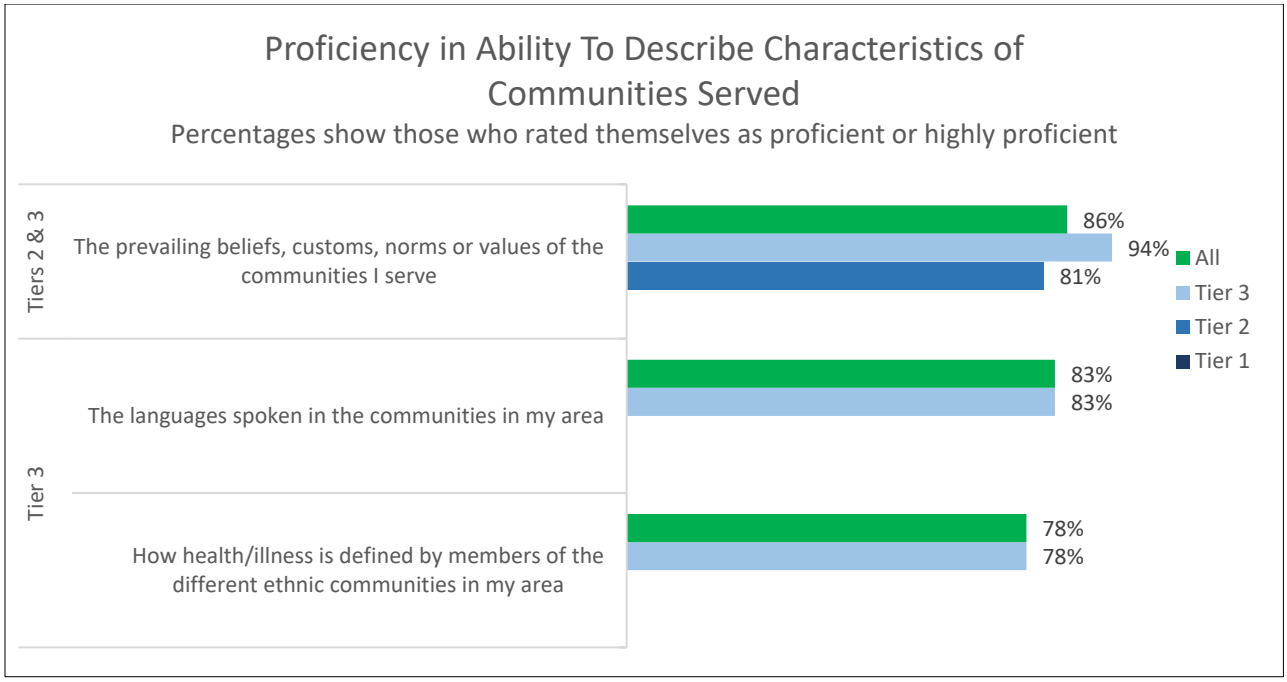
Figure 14: Skills for Assessing Readiness and Capacity by Tier



Another three questions asked respondents to rank their ability to describe characteristics of the communities that they serve (see Figure 15, below). For all respondents, the skill in this category with the highest percentage of respondents (86%) who ranked themselves as proficient or highly proficient was *the ability to describe the prevailing beliefs, customs, norms or values of the communities served* (n=90). The skill in this category with the lowest percentage of overall respondents (78%) who rated themselves as proficient or highly proficient was *the ability to describe how health/illness is defined by members of the different ethnic communities in my area* (n=28).

Respondents in Tiers 2 and 3 responded to questions about their proficiency in describing the characteristics of the communities they serve. Prevention leadership (Tier 3) was more likely than prevention professionals (Tier 2) to rate themselves as proficient or highly proficient for the one skill to which both tiers responded (*the ability to describe prevailing beliefs, customs, norms, or values of the communities they serve*), with 94% and 81%, respectively.

Figure 15: Ability to Describe Characteristics of Communities Served by Tier

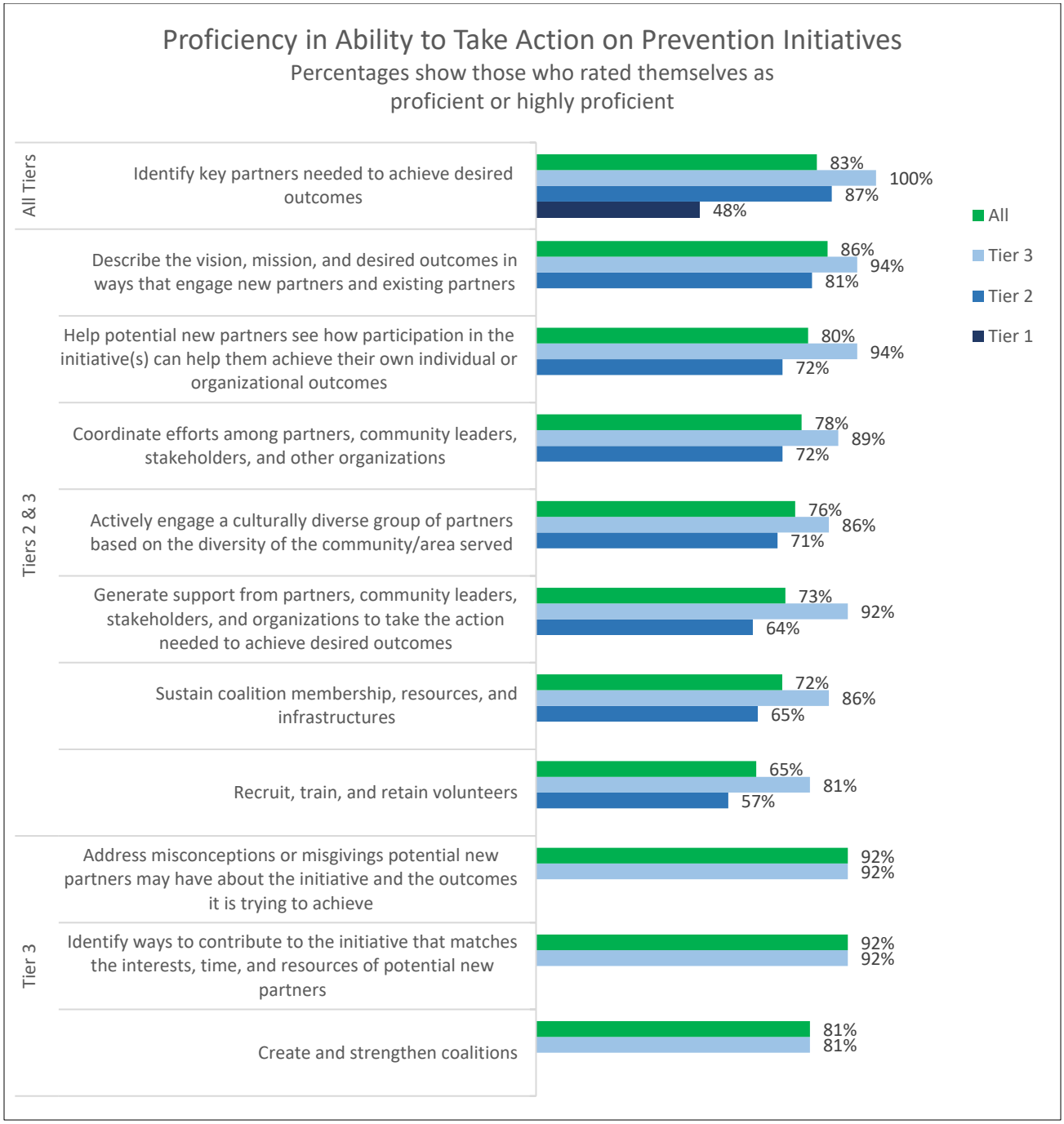


Mobilization and Capacity Building

Respondents also ranked their ability to employ mobilization and capacity building skills for their prevention initiative(s) (see Figure 16, below). For all respondents, the mobilization skill in this category with the highest percentage of respondents (92%) who ranked themselves as proficient or highly proficient was *the ability to identify ways to contribute to the initiative that matches the interests, times, and resources of potential new partners* (n=33) and *the ability to address misconceptions or misgivings potential new partners may have about the initiative and the outcomes it is trying to achieve* (n=33). The mobilization skill in this category with the lowest percentage of overall respondents (65%) who rated themselves as proficient or highly proficient *was the ability to recruit, train, and retain volunteers* (n=68).

Prevention leadership (Tier 3) were most likely to rate themselves as proficient or highly proficient for all of the areas assessed in this category, with over 80% of Tier 3 respondents ranking themselves as proficient or highly proficient in all of these areas. Over 70% of prevention professionals (Tier 2) ranked themselves as proficient or highly proficient in five of the areas assessed, but a lower percentage of respondents ranked themselves as proficient or highly proficient in other areas, including *sustaining coalition membership, resources, and infrastructures* (65%); *generating support from partners, community leaders, stakeholders, and organizations to take the action needed to achieve desired outcomes* (64%); and *recruiting, training, and retaining volunteers* (57%). Only 48% of those entering the prevention field (Tier 1) rated themselves as proficient or highly proficient in *identifying key partners to achieve desired outcomes*, compared to 100% of prevention leadership and 87% of prevention professionals.

Figure 16: Ability to Take Action on Prevention Initiatives by Tier



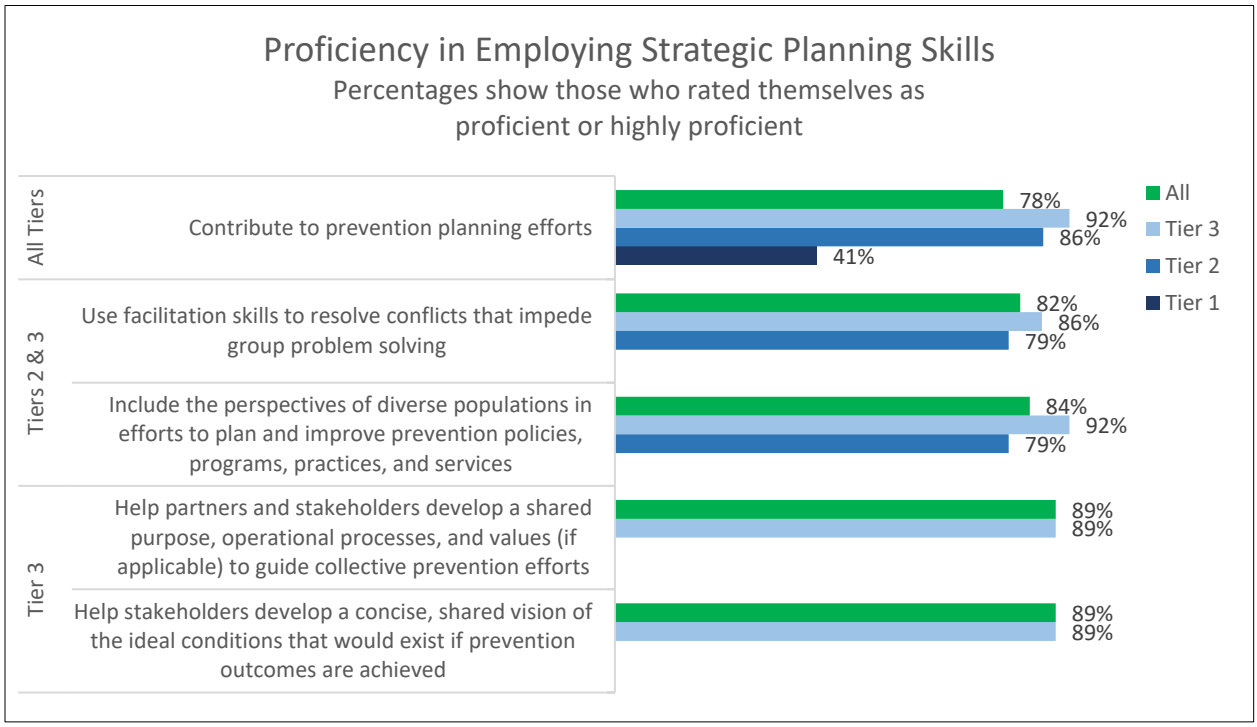
Strategic Planning Skills

Respondents ranked their skills related to strategic planning (see Figure 17, below). Five of these questions asked respondents about their ability to employ specific skills related to strategic planning. Over 78% of total respondents reported that they were proficient or highly proficient in each of these skill areas. For all respondents, the strategic planning skills with the highest percentage of respondents (89%) who ranked themselves as proficient or highly proficient were: *helping partners and stakeholders develop a shared*

purpose, operational processes, and values (if applicable) to guide collective prevention efforts (n=32) and *helping stakeholders develop a concise, shared vision of the ideal conditions that would exist if prevention outcomes were achieved* (n=32). The strategic planning skill in this category with the lowest percentage of overall respondents (78%) who ranked themselves as proficient or highly proficient was *contributing to prevention planning efforts* (n=101).

Prevention leadership (Tier 3) were most likely to rate themselves as proficient or highly proficient in all areas assessed in this category. Only 41% of those entering the prevention field (Tier 1) ranked themselves as proficient or highly proficient in *contributing to prevention planning efforts* as compared to 92% of prevention leadership and 86% of prevention professionals (Tier 2).

Figure 17: Ability to Employ Strategic Planning Skills by Tier

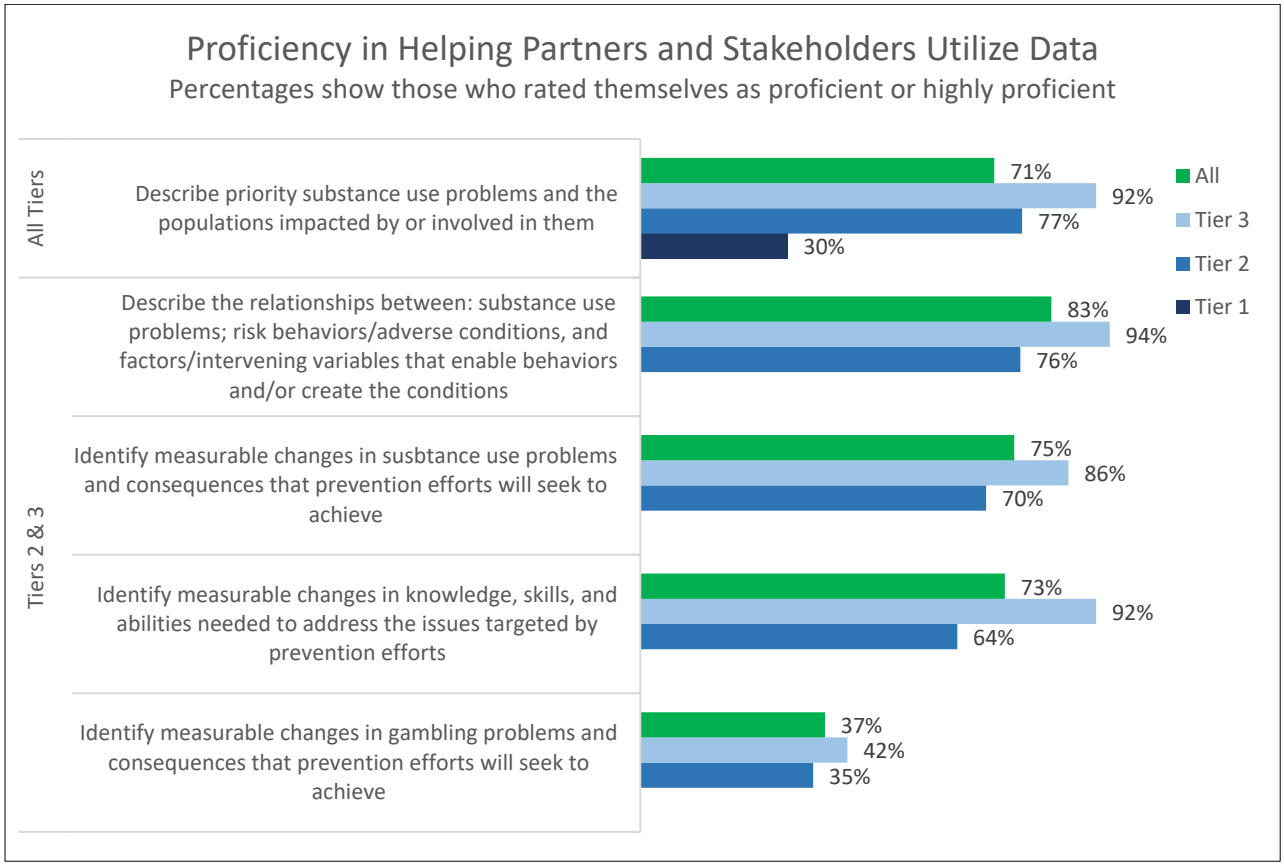


In another five questions, respondents ranked their ability to help partners and stakeholders utilize data (see Figure 18, below). In four of the five questions, over 70% of overall respondents ranked themselves as proficient or highly proficient. For all respondents, the skill in this category with the highest percentage of respondents (83%) who ranked themselves as proficient or highly proficient was *the ability to describe the relationships between: substance use problems, risk behaviors/adverse conditions, and factors/intervening variables that enable behaviors and/or create the conditions* (n=86). The skill in this category with the lowest percentage of overall respondents (37%) who rated themselves as proficient or highly proficient was *the ability to identify measurable changes in gambling problems and consequences that prevention efforts will seek to achieve* (n=39).

Prevention leadership (Tier 3) were most likely to rate themselves as proficient or highly proficient in all of the areas assessed in this category, though both prevention leadership and prevention professionals (Tier 2) were markedly less likely to rank themselves as proficient or highly proficient in *identifying measurable changes in gambling problems and consequences that prevention efforts will seek to achieve* than in other

skills assessed in this category. Only 30% of those entering the prevention field ranked themselves as proficient or highly proficient *in describing priority substance use problems and the populations impacted by or involved in them* as compared to 92% of prevention leadership and 77% of prevention professionals.

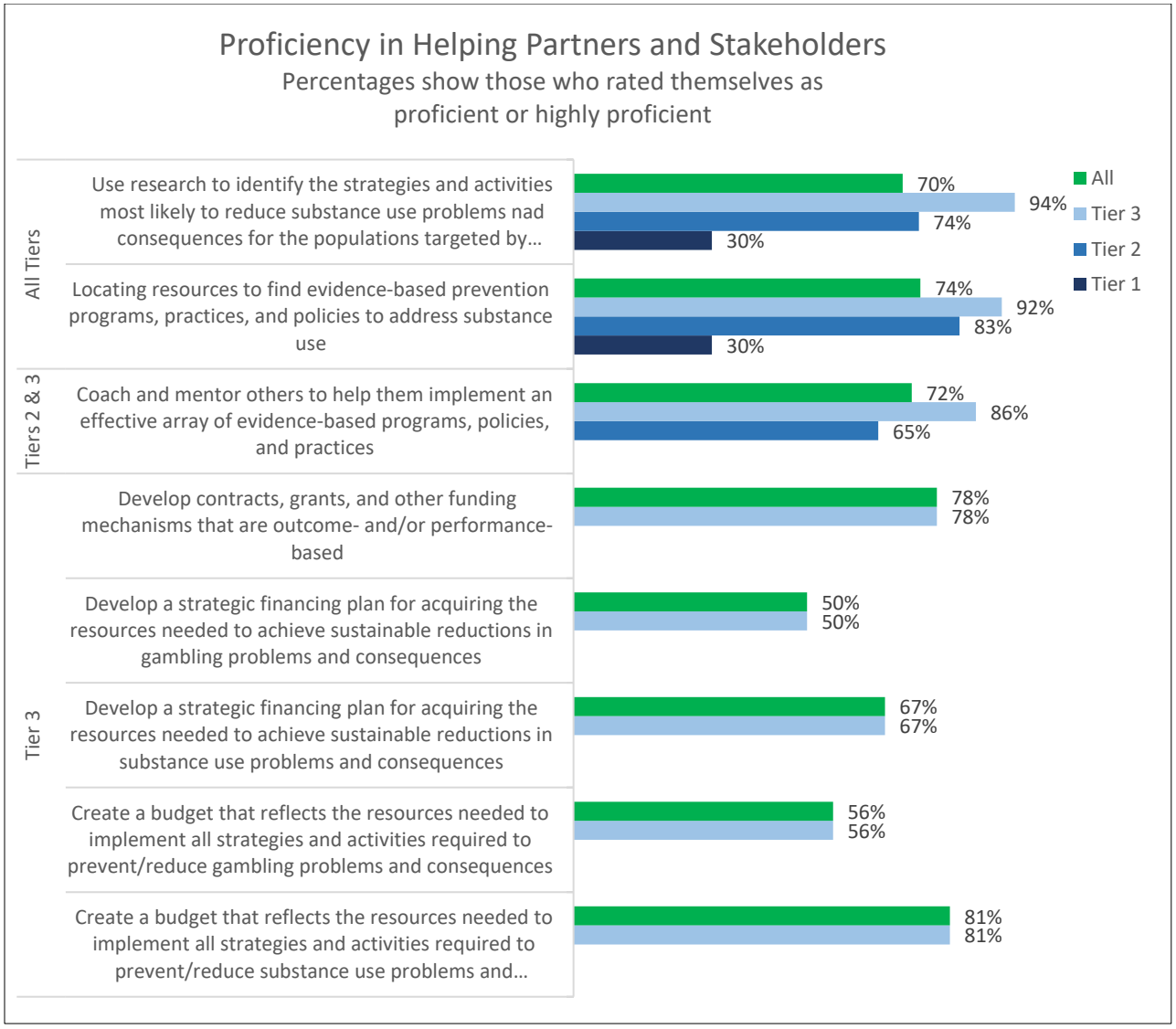
Figure 18: Ability to Help Partners and Stakeholders Utilize Data by Tier



Respondents ranked their proficiency in helping partners and stakeholders in other ways (see Figure 19, below). For five of these eight questions, at least 70% of overall respondents ranked themselves as proficient or highly proficient. For all respondents, the skill in this category with the highest percentage of respondents (81%) who ranked themselves as proficient or highly proficient was *the ability to create a budget that reflects the resources needed to implement all strategies and activities required to prevent/reduce substance use problems and consequences* (n=29). The skill in this category with the lowest percentage of overall respondents (50%) who ranked themselves as proficient or highly proficient was *the ability to develop a strategic financing plan for acquiring the resources needed to achieve sustainable reductions in gambling problems and consequences* (n=18).

Prevention leadership (Tier 3) were most likely to rate themselves as proficient or highly proficient in all areas assessed in this category. Only 30% of those entering the prevention field (Tier 1) ranked themselves as proficient or highly proficient in the two skill areas that were assessed in the survey (*using research to identify strategies and activities most likely to reduce substance use problems and consequences* and *locating resources to find evidence-based prevention programs, practices, and policies to address substance use*), whereas at least 74% of prevention leadership and prevention professionals (Tier 2) rated themselves as proficient or highly proficient in these areas.

Figure 19: Ability to Help Partners and Stakeholders by Tier



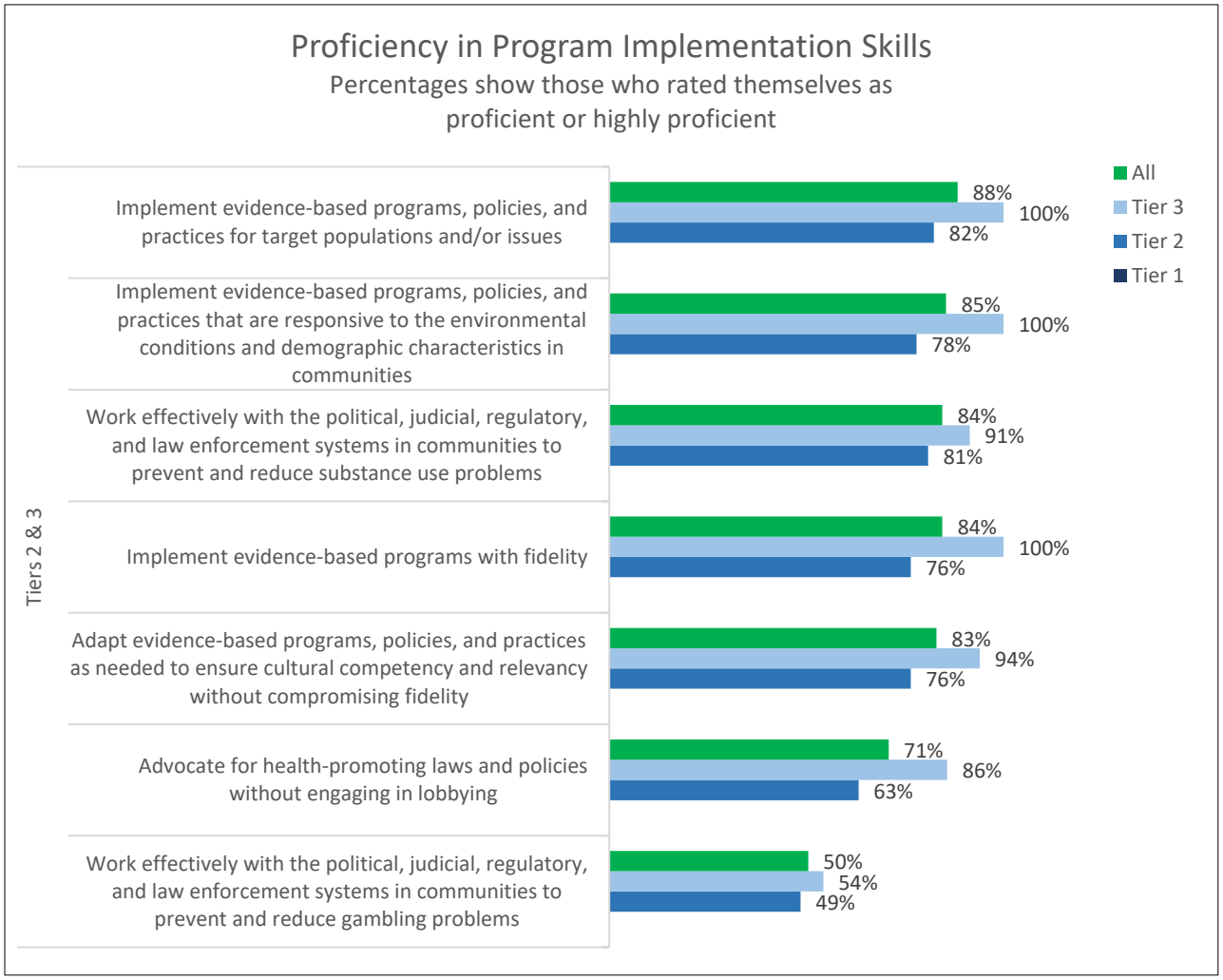
Implementation

Respondents also ranked their skills related to program implementation (see Figure 20, below). Over 70% of overall respondents ranked themselves as proficient or highly proficient for six of the seven questions. For all respondents, the implementation skill in this category with the highest percentage of respondents (88%) who ranked themselves as proficient or highly proficient was *the ability to implement evidence-based programs, policies, and practices for target populations and/or issues* (n=91). The implementation skill in this category with the lowest percentage of overall respondents (50%) who rated themselves as proficient or highly proficient was *the ability to work effectively with the political, judicial, regulatory, and law enforcement systems in communities to prevent and reduce gambling problems* (n=52).

Respondents in Tiers 2 and 3 answered questions about their proficiency in skills related to program implementation. Prevention leadership (Tier 3) were most likely to rate themselves as proficient or highly proficient in all of the areas assessed under this category. While over 75% of prevention professionals (Tier 2)

ranked themselves as proficient or highly proficient in most of the skill areas assessed in this category, a lower percentage of this tier ranked themselves as proficient or highly proficient in *advocating for health-promoting laws and policies without engaging in lobbying* (63%) as well as in *working with the political, judicial, regulatory, and law enforcement systems in communities to prevent and reduce gambling problems* (49%).

Figure 20: Abilities Related to Program Implementation by Tier

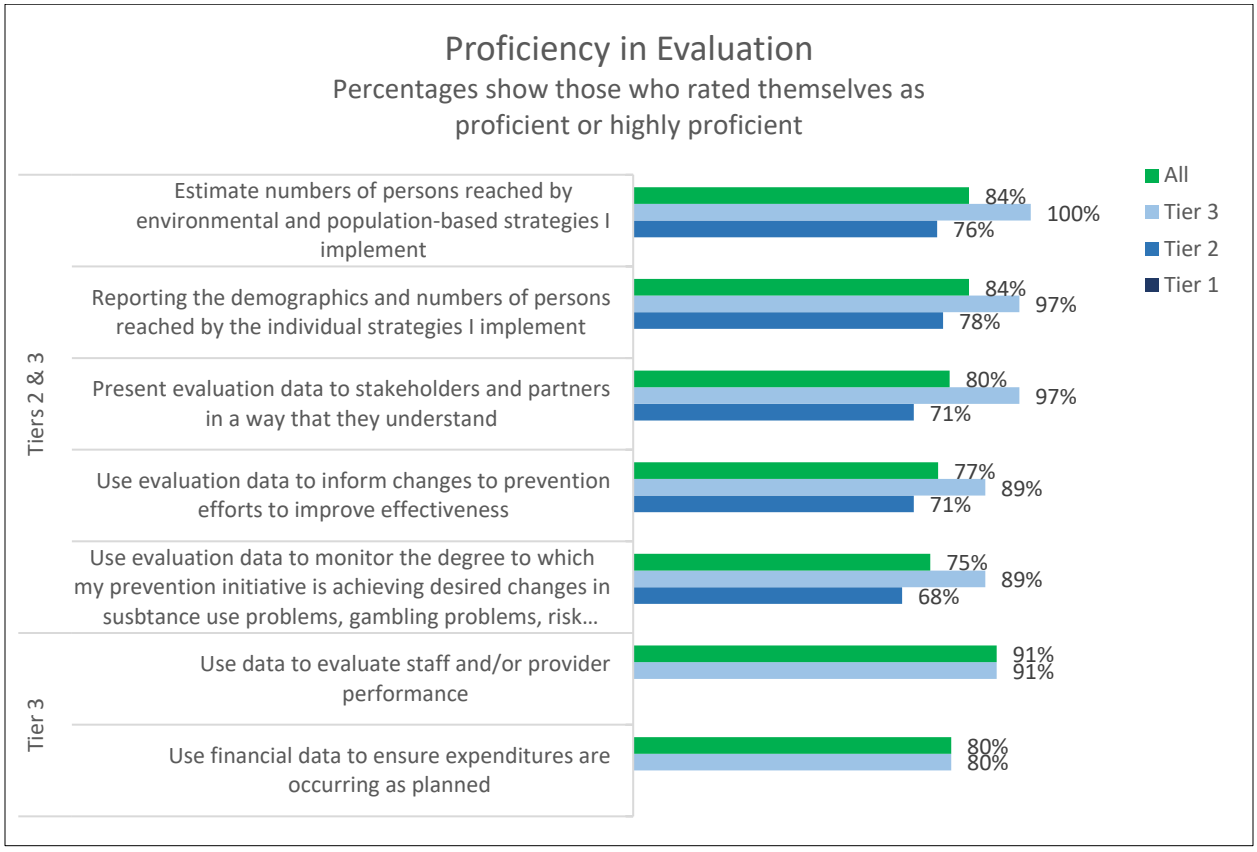


Evaluation

Respondents rated their skills related to evaluation (see Figure 21, below). Over 70% of overall respondents ranked themselves as proficient or highly proficient for all of these skill areas. For all respondents, the evaluation skills in this category with the highest percentage of respondents (91%) who ranked themselves as proficient or highly proficient was *using data to evaluate staff and/or provider performance* (n=32). The evaluation skill in this category with the lowest percentage of respondents (75%) who rated themselves as proficient or highly proficient was *using evaluation data to monitor the degree to which my prevention initiative is achieving desired changes in substance use problems, gambling problems, risk behaviors, and related factors* (n=77).

Respondents in Tiers 2 and 3 answered questions about their proficiency in evaluation-related skill areas. Prevention leadership (Tier 3) were most likely to rate themselves as proficient or highly proficient in all of the areas assessed in this category. In fact, 100% of respondents selected proficient or highly proficient in *ability to estimate numbers of person reached by environmental and population-based strategies I implement*. Tier 2 most often selected proficient or highly proficient in *reporting the demographics and number of persons reached by the individual strategies I implement* (78%).

Figure 21: Abilities Related to Evaluation by Tier



Findings by Technical Domain

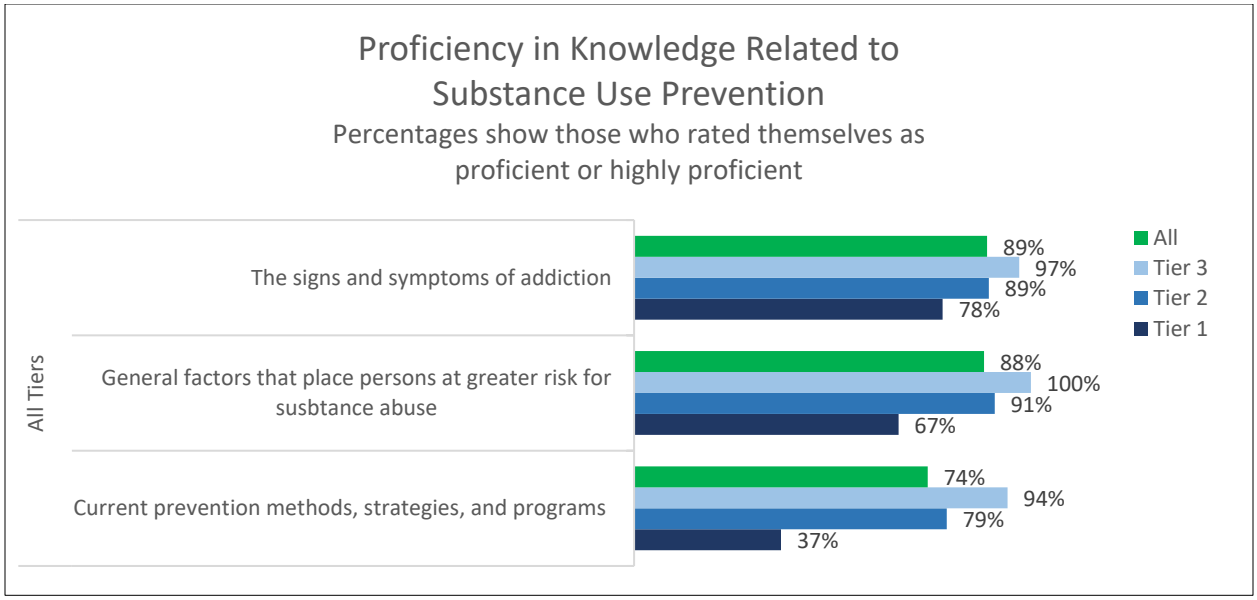
Substance Use

A specific question set asked about specific competencies for substance use prevention providers. Three of these questions asked about specific knowledge related to substance use prevention (see Figure 22, below). Over 70% of overall respondents ranked themselves as proficient or highly proficient in each of these knowledge categories. For all respondents, the substance use competency in this category with the highest percentage of respondents (89%) who ranked themselves as proficient or highly proficient was *knowledge of the signs and symptoms of addiction* (n=113). The substance use competency in this category with the lowest percentage of overall respondents (74%) who rated themselves as proficient or highly proficient was *knowledge of current prevention methods, strategies, and programs* (n=94).

Prevention leadership (Tier 3) were most likely to rate themselves as proficient or highly proficient in all knowledge areas assessed in this category. While at least 67% of respondents from all tiers ranked

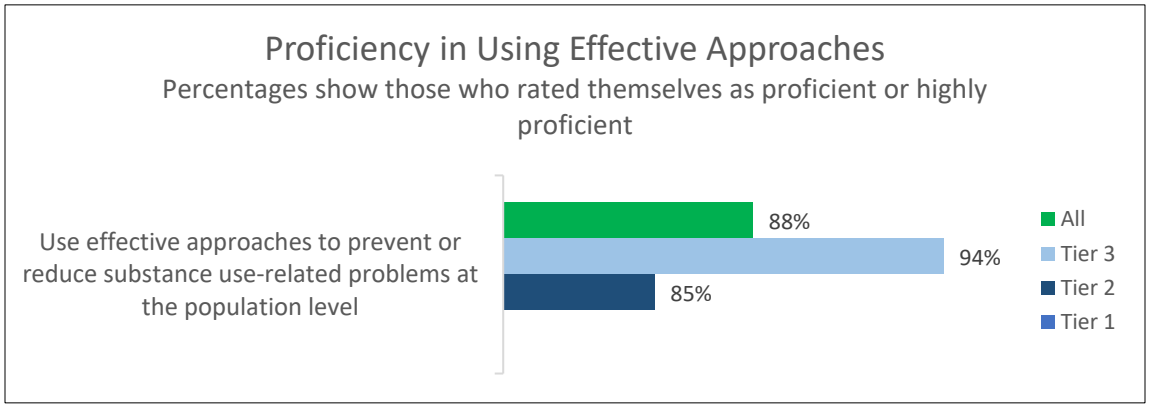
themselves as proficient or highly proficient in every other skill area, only 37% of those entering the prevention field (Tier 1) ranked themselves as proficient and highly proficient in *knowledge related to current prevention methods, strategies, and programs*.

Figure 22: Knowledge Related to Substance Use Prevention by Tier



Another question asked respondents about their *ability to use effective approaches to prevent or reduce substance use-related problems at the population level* (see Figure 23, below). Eighty-eight percent of overall respondents (n=92) said that they were proficient or highly proficient in this skill area, with 94% of prevention leadership (Tier 3) and 85% of prevention professionals (Tier 2) ranking themselves as proficient or highly proficient in this area.

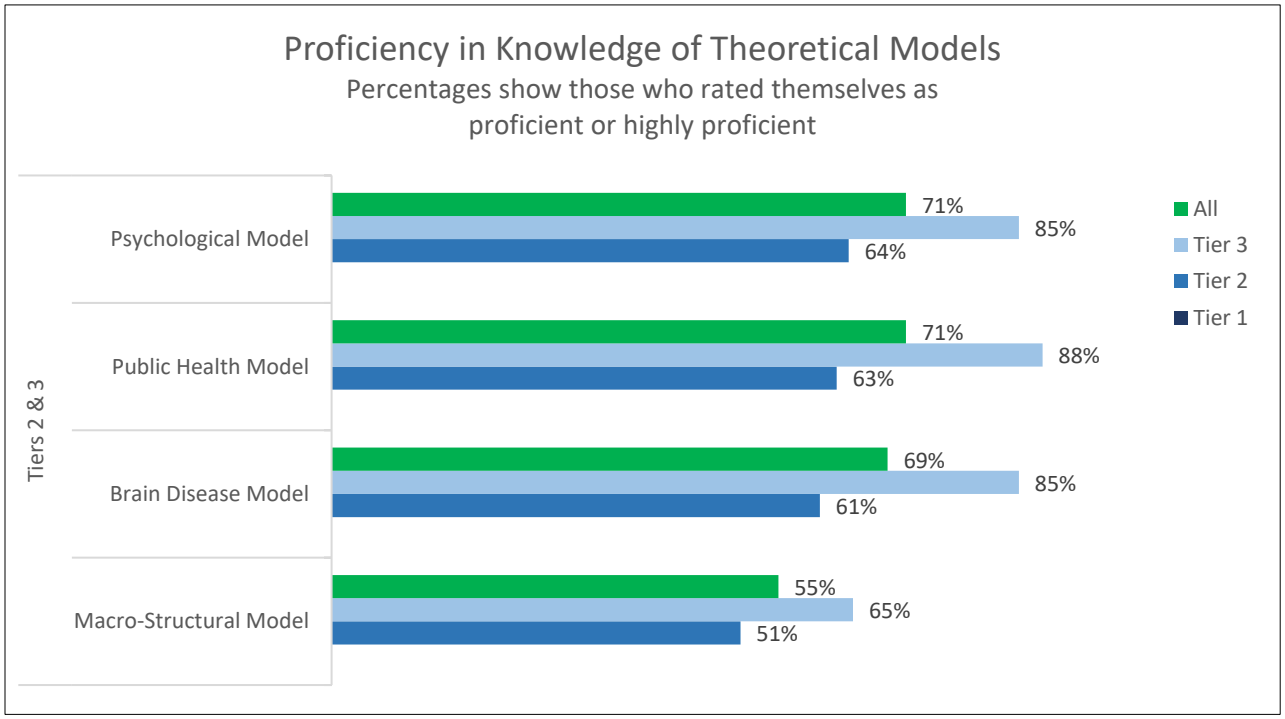
Figure 23: Ability to Use Effective Approaches by Tier



Respondents ranked their knowledge of how several theoretical models of substance use have influenced approaches to prevention over time (see Figure 24, below). For all respondents, the substance use knowledge areas with the highest percentage of respondents (71%) who ranked themselves as proficient or highly proficient were *the Public Health Model* (n=72) and *the Psychological Model* (n=72). The substance use knowledge area with the lowest percentage of overall respondents (55%) who ranked themselves as proficient or highly proficient was *the Macro-Structural Model* (n=56).

Respondents in Tiers 2 and 3 answered questions about their knowledge related to theoretical models. Prevention leadership (Tier 3) were most likely to rate themselves as proficient or highly proficient in knowledge of all four theoretical models, with both prevention leadership and prevention professionals (Tier 2) least likely to rank themselves as proficient or highly proficient in *knowledge of the Macro-Structural Model*, 65% and 51%, respectively.

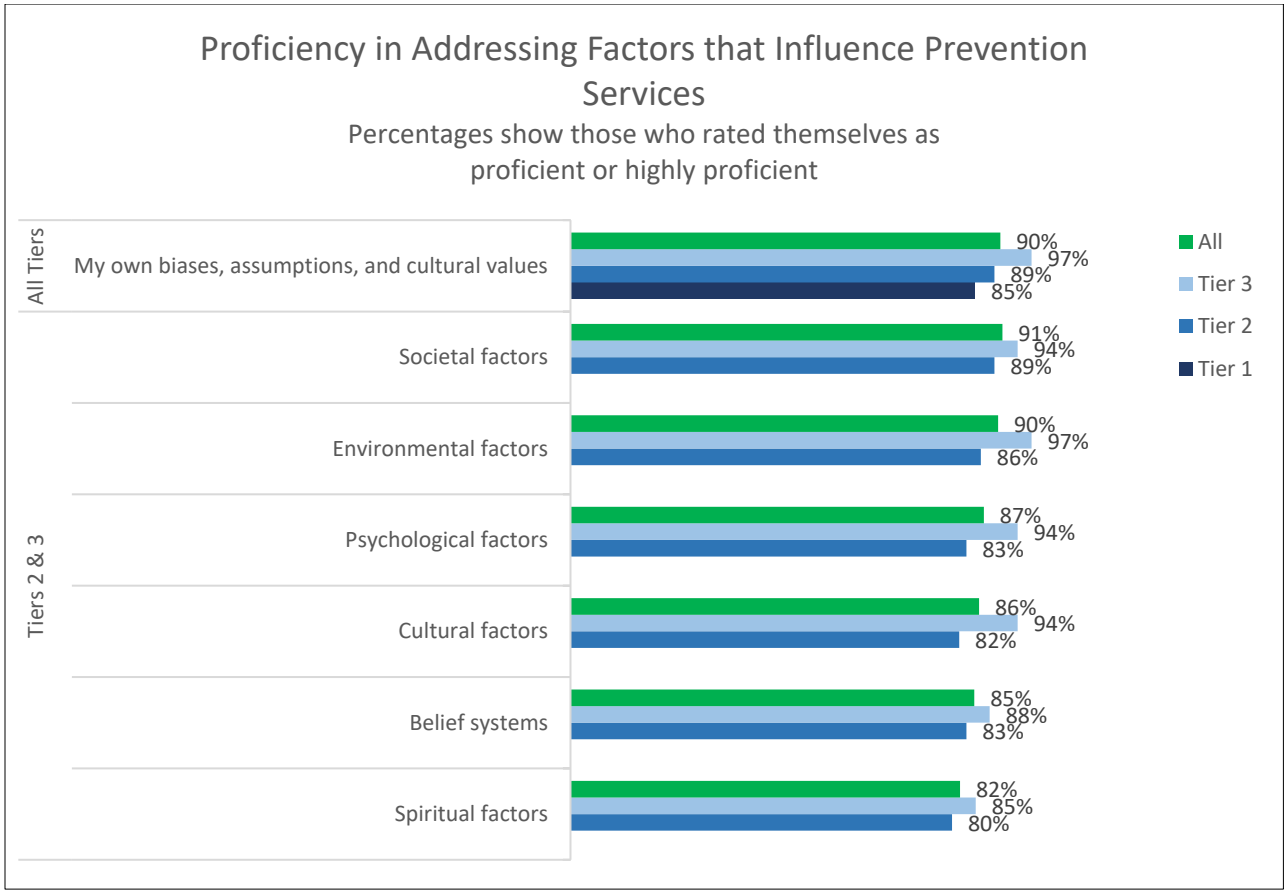
Figure 24: Knowledge of Various Theoretical Models and Their Influence on Approaches by Tier



Respondents also ranked their proficiency in addressing various factors that influence prevention services (see Figure 25, below). Overall, respondents largely consider themselves proficient or highly proficient in addressing all of these factors, with over 80% of overall respondents ranking themselves proficient or highly proficient in addressing each type of factor that influences prevention services. For all respondents, the skill in this category with the highest percentage of respondents (91%) who ranked themselves as proficient or highly proficient was *the ability to address societal factors* (n=90). The skill category with the lowest percentage of respondents (82%) who rated themselves as proficient or highly proficient was *the ability to address spiritual factors* (n=82).

Prevention leadership (Tier 3) were most likely to rank themselves as proficient or highly proficient in all of the skill areas assessed in this category.

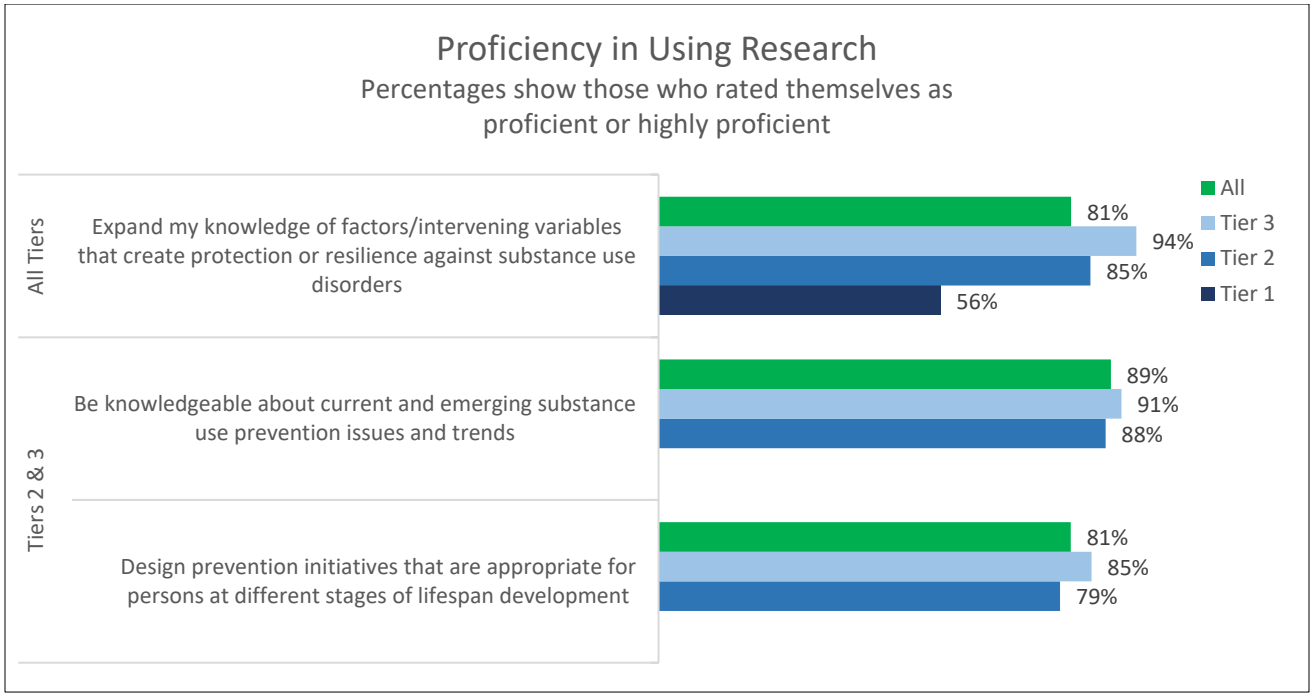
Figure 25: Ability to Address Factors that Influence Prevention Services by Tier



Respondents also ranked their ability to use research for specific purposes (see Figure 26, below). Overall, respondents again consider themselves proficient in these areas, with over 80% of overall respondents ranking themselves as proficient or highly proficient in their ability to use research for these three purposes. For all respondents, the skill category with the highest percentage of respondents (89%) who ranked themselves as proficient or highly proficient was *the ability to be knowledgeable about current and emerging substance use prevention issues and trends* (n=90). The skill categories with the lowest percentage of overall respondents (81%) who ranked themselves as proficient or highly proficient were *the ability to expand my knowledge of factors/intervening variables that create protection or resilience against substance use disorders* (n=104) and *the ability to design prevention initiatives that are appropriate for persons at different stages of lifespan development* (n=82).

Prevention leadership (Tier 3) were most likely to rate themselves as proficient or highly proficient in each of these skill areas. Only 56% of those entering the prevention field (Tier 1) ranked themselves as proficient or highly proficient in *expanding their knowledge of factors or intervening variables that create protection or resilience against substance use disorders* compared to 94% of prevention leadership (Tier 3) and 85% of prevention professionals (Tier 2).

Figure 26: Ability to Use Research by Tier

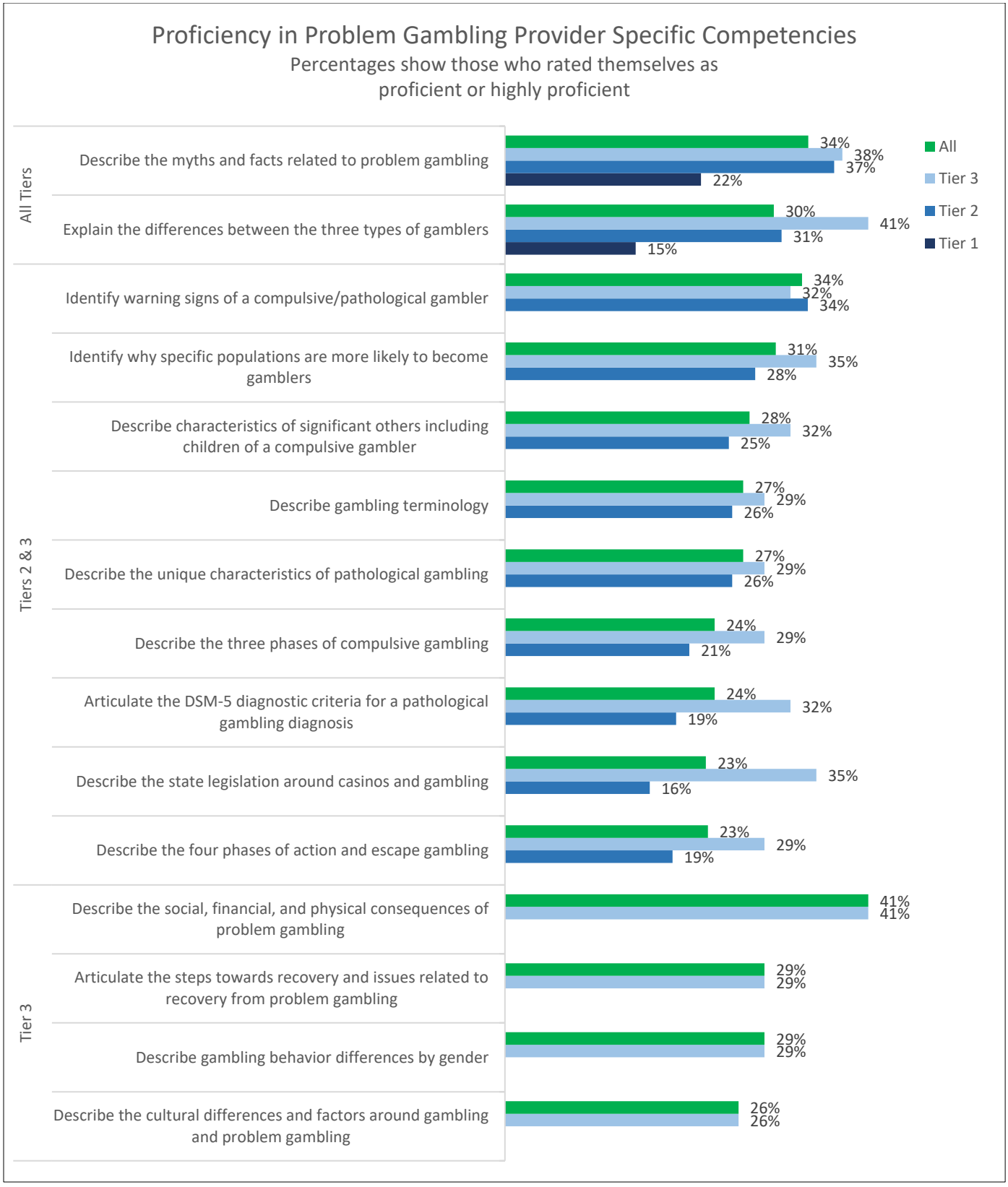


Gambling

Respondents ranked their specific competencies (see Figure 27, below). The percentage of providers who reported proficiency or high proficiency in these specific competencies were much lower than for other areas. In fact, fewer than 42% of all respondents ranked themselves as proficient or highly proficient for all fifteen of the competencies specific to problem gambling providers. For all respondents, the competency in this category with the highest percentage of respondents (41%) who ranked themselves as proficient or highly proficient *was the ability to describe the social, financial, and physical consequences of problem gambling* (n=14). The competencies in this category with the lowest percentage of overall respondents (23%) who rated themselves as proficient or highly proficient were *the ability to describe the four phases of action and escape gambling* (n=23) and *the ability to describe the state legislation around casinos and gambling* (n=23).

Prevention leadership (Tier 3) were most likely to rate themselves as proficient or highly proficient in all but one of the skill areas assessed in this category. Thirty-four percent of prevention professionals (Tier 2) ranked themselves as proficient or highly proficient *in identifying warning signs of a compulsive/ pathological gambler* compared to 32% of prevention leadership. While the percentage of respondents in all tiers ranking themselves as proficient or highly proficient in these skill areas was low compared to other skill areas, this was particularly striking for those entering the prevention field (Tier 1), with under 25% of respondents ranking themselves as proficient or highly proficient in the two skill areas that were assessed: *ability to describe the myths and facts related to problem gambling* and *ability to explain the differences between the three types of gamblers.*

Figure 27: Problem Gambling Provider Specific Competencies by Tier



Qualitative Findings

Workforce Challenges

Survey respondents had the opportunity to respond to an open-ended question asking for any additional feedback or insights based on their experiences. Of the relatively small number of respondents (n=22) who completed this open-ended question, many noted challenges experienced working in the fields of substance abuse and problem gambling prevention. The major themes regarding challenges centered on the needs for training and knowledge, informational materials and programming, and improved communication and collaboration.

- ### *The Need for Training and Knowledge*

  Five respondents explained that they needed additional training, knowledge, and information in order to better perform their jobs. One respondent, who had worked in the field for just 4 months noted, “There is very, very little training or direction when starting in this field. It is frustrating enough that I’m looking into other job opportunities.”

- ### *The Need for Informational Materials and Programming*

  Respondents also described a need for increased programming, training, and informational materials for the communities and schools with which they work. One respondent indicated the lack of informational materials available to students by stating, “Currently I’m spending more time searching for information than I would like.”

- ### *The Need for Improved Communication and Collaboration*

  Two of the respondents also indicated that there is a need for improved communication and collaboration at the state level. One respondent explained the high levels of frustration that some prevention-focused members of the workforce have experienced, noting, “What I hear the most now is that people in Iowa have lost passion for the field of prevention because of how the last two years have been handled in the field.” One respondent noted that collaboration between higher level staff at IDPH and prevention staff at the county level should be improved, stating, “Communication throughout ALL prevention staff throughout Iowa (IDPH and county staff) needs to happen in order to be as effective as possible.”

Positive Experiences in the Prevention Workforce

On the other hand, some members of the prevention workforce took the opportunity to provide positive feedback in the open-ended question. Several respondents noted the importance of the work in which they were engaged. One respondent stated, “I really enjoy being on the prevention side of health.” Another said, “I find this work rewarding and challenging—to help change the stigma of addiction to a compassionate response changes the conversation.” One respondent also noted how helpful webinars had been in enhancing his/her knowledge related to problem gambling prevention.

Limitations

This report has a relatively limited sample size, as only 156 respondents answered the invitation to complete the survey and only 132 of those respondents completed at least 50% of the survey. This was due in part to the fact that JBS was not able to use an email list to administer the survey. The choice to have survey administration done by IDPH was intentional in an effort to reduce costs, use the relationships and authority of IDPH partners, and survey a broader audience, as well as because Iowa also does not have a central email file for all who make up the prevention workforce. However, this made it impossible for JBS to send targeted and individualized reminders to non-respondents and to track the total number of participants to calculate a response rate.

JBS is not able to report on the response rate since JBS was not responsible for sending the survey to potential respondents and, therefore, does not know the number of potential respondents who were contacted. For similar reasons, it was not possible to compare characteristics of respondents to non-respondents.

Finally, it was not possible to conclusively determine that there are no duplicate respondents, though the research team does not believe this was a significant issue given that partial responses were omitted.

Conclusions

This report summarized the findings of the Iowa Substance Abuse and Problem Gambling Prevention 2019 Workforce Survey. This information is intended to help IDPH and the WFD Task Force understand the characteristics of the substance abuse and gambling prevention workforce; understand the degree to which the substance abuse and gambling prevention workforce perceives their level of competencies; and create a plan to build necessary workforce competencies, recruit and retain a quality workforce, and target T/TA toward pressing workforce needs.

Overall, respondents rated themselves as proficient or highly proficient in most domains. The lowest proficiencies overall were found in gambling, where between 23% and 41% of respondents agreed that they were proficient or highly proficient in each knowledge area or skill. The highest proficiencies were found in mobilization and capacity building, assessing readiness and capacity, evaluation, and substance abuse. As expected, the percentage of respondents who chose higher proficiencies generally increased by tier. In open-ended responses, respondents stressed the need for additional training and information, especially for those new to the workforce.

Moving forward, this survey provides evidence driving the following recommendations:

1. **The Iowa substance abuse and gambling prevention workforce needs additional T/TA in problem gambling–specific competencies.** The need for increased T/TA is suggested by the relatively lower levels of respondents ranking themselves as proficient or highly proficient in gambling-specific competencies and in respondents' open-ended feedback. T/TA gaps are observable among the responses to questions about problem competencies specific to gambling providers, but also in the core domains, where respondents were less likely to rate themselves as proficient or highly proficient in skills pertaining to addressing problem gambling.

2. **Within the various core domains, training should be directed at the competencies where professionals were least likely to rate themselves as proficient or highly proficient.** Nearly all of the skills within core competency and technical domains that had low percentages of respondents ranking themselves as proficient or highly proficient were related to addressing problem gambling. In addition, some specific skills within core domains that could be addressed through additional training include:
    - Knowledge of agency policy and procedures *(Communication)*
    - Knowledge of the Macro-Structural Model *(Substance Use)*
3. **Additional trainings should be directed at those new to the prevention field (Tier 1).** In several cases, respondents who are new to the prevention field were especially unlikely to rank themselves as proficient or highly proficient, indicating that there may be specific training needs for those new to the field. Some of these areas include:
    - Identifying ways to include the relevant needs of culturally diverse groups into the work *(Needs Assessment)*
    - Identifying key partners needed to achieve desired outcomes *(Mobilization and Capacity Building)*
    - Contributing to prevention planning efforts *(Strategic Planning)*
    - Describing priority substance use problems and the populations impacted by or involved in them *(Strategic Planning)*
    - Using research to identify the strategies and activities most likely to reduce substance use problems and consequences for the populations targeted by prevention efforts *(Strategic Planning)*
    - Locating resources to find evidence-based prevention programs, practices, and policies to address substance use *(Strategic Planning)*
    - Knowledge of current prevention methods, strategies, and programs *(Substance Use)*

Appendix A: Data Tables for Demographics and Job Characteristics by Tier

Table 1: Gender Identity[12]

Gender Identity	Tier 1 (n=27)	Tier 2 (n=67)	Tier 3 (n=34)	All Tiers (n=128)
Woman	85%	69%	85%	77%
Man	7%	24%	12%	17%
Another gender identity	4%	2%	0%	2%
Choose not to respond	4%	6%	3%	5%

Table 2: Age

Age	Tier 1 (n=27)	Tier 2 (n=67)	Tier 3 (n=34)	All Tiers (n=128)
21–30	37%	16%	3%	17%
31–40	11%	31%	24%	25%
41–50	30%	24%	38%	29%
51–60	19%	22%	32%	24%
Over 60	4%	6%	3%	5%

Table 3: Race

Race	Tier 1 (n=27)	Tier 2 (n=67)	Tier 3 (n=34)	All Tiers (n=128)
Other/mixed race	0%	2%	0%	1%
White	96%	94%	97%	95%
Black	0%	5%	3%	4%
Asian	4%	0%	0%	1%

[12] Please note that rounding may cause some numbers in the appendix tables to appear slightly different than reported in the main text of the report.

Table 4: Race Hispanic

Hispanic	Tier 1 (n=27)	Tier 2 (n=66)	Tier 3 (n=34)	All Tiers (n=127)
Hispanic	7%	3%	0%	3%
Non-Hispanic	93%	97%	100%	97%

Table 5: Education

Education	Tier 1 (n=27)	Tier 2 (n=67)	Tier 3 (n=34)	All Tiers (n=128)
Some college or Associates'	7%	12%	9%	10%
Bachelor's	70%	63%	53%	62%
Master's and beyond	19%	25%	38%	27%
Doctorate	4%	0%	0%	1%

Table 6: Role

Role	Tier 1 (n=27)	Tier 2 (n=67)	Tier 3 (n=34)	All Tiers (n=128)
Coalition Member	15%	9%	3%	9%
Volunteer	4%	2%	0%	2%
Prevention Specialist	59%	57%	9%	45%
Certified Prevention Specialist	0%	27%	18%	19%
Prevention Supervisor/Director/Manager	4%	2%	65%	19%
Executive Director	11%	2%	12%	6%
Other (law enforcement, business director, DARE instructor, coalition officer, coordinator, education sector)	15%	13%	12%	13%

*Respondents could choose multiple options, so percentages add up to more than 100%

Table 7: Coalition Membership

Coalition Member?	Tier 1 (n=27)	Tier 2 (n=66)	Tier 3 (n=34)	All Tiers (n=127)
Substance abuse coalition	52%	59%	59%	58%
Problem gambling coalition	0%	3%	0%	2%
Both SA and problem GAM coalitions	19%	17%	18%	17%
Not a coalition member	30%	21%	24%	24%

Table 8: Tiers

Tier 1 *Entering the Field* (n=27)	Tier 2 *Prevention Professional* (n=69)	Tier 3 *Prevention Leadership* (n=36)
20%	52%	27%

Table 9: Years of Employment

Years of Employment	Tier 1 (n=27)	Tier 2 (n=66)	Tier 3 (n=34)	All Tiers (n=127)
Less than 6 months	37%	5%	0%	10%
6 months to 3 years	37%	21%	3%	20%
3 to 5 years	7%	14%	9%	11%
5 to 10 years	7%	29%	21%	22%
10 to 15 years	4%	17%	18%	14%
15 to 20 years	4%	5%	21%	9%
More than 20 years	4%	11%	29%	14%

Table 10: Organization Benefits

Organization Benefits	Tier 1 (n=27)	Tier 2 (n=67)	Tier 3 (n=63)	All Tiers (n=128)
Volunteer (not paid)	0%	3%	0%	2%
Paid vacation	93%	93%	100%	95%
Group health insurance	93%	94%	91%	93%
Offers retirement plans	85%	96%	97%	94%

*Respondents could choose multiple options, so percentages add up to more than 100%

Table 11: Prevention Program Benefits

Prevention Program Benefits	Tier 1 (n=26)	Tier 2 (n=65)	Tier 3 (n=33)	All Tiers (n=124)
Provides staff orientation on prevention	69%	72%	73%	72%
Provides and onboarding process	69%	69%	85%	73%
Provides an agency-specific prevention handbook with agency expectations on prevention services	46%	55%	58%	54%
Funds staff to attend prevention-specific training	65%	80%	94%	81%
Allows prevention staff to provide input	54%	74%	94%	75%
Provides adequate supervision and coaching	65%	72%	82%	74%
Offers promotion opportunities and defined career path	23%	26%	33%	27%
Offers paid educational assistance	31%	34%	30%	32%
Cultivates supportive organizational culture	73%	59%	76%	66%
Creates a healthy work/life balance	77%	77%	73%	76%

*Respondents could choose multiple options, so percentages add up to more than 100%

Appendix B: Data Tables for Competencies by Tier

Table 1: Communication[13]

Communication	**Tier 1**					**Tier 2**					**Tier 3**					**All Tiers**				
Question	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**
2a. Professional conduct with staff and service recipients in face-to-face interactions	27	26%	30%	44%	0%	69	0%	48%	52%	0%	36	0%	0%	22%	78%	**132**	**5%**	**31%**	**42%**	**21%**
2b. Professionalism in all correspondence through email and other written communication	26	19%	27%	54%	0%	69	0%	49%	51%	0%	36	0%	0%	28%	72%	**131**	**4%**	**31%**	**45%**	**20%**
2c. Agency policy and procedures	26	38%	42%	19%	0%	67	1%	61%	37%	0%	36	0%	3%	33%	64%	**129**	**9%**	**41%**	**33%**	**18%**
3a. Communication methods that are linguistically and culturally appropriate for diverse audiences	27	4%	19%	56%	22%	68	1%	9%	59%	31%	36	0%	3%	58%	39%	**131**	**2%**	**9%**	**58%**	**31%**
3b. Marketing techniques that influence human behaviors to prevent substance use problems						69	6%	23%	54%	17%	36	3%	14%	67%	17%	**105**	**5%**	**20%**	**58%**	**17%**

[13] Please note that rounding may cause some numbers in the appendix tables to appear slightly different than reported in the main text of the report.

Communication	Tier 1					Tier 2					Tier 3					All Tiers				
Question	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**
3c. Marketing techniques that influence human behaviors to prevent gambling problems						69	25%	32%	36%	7%	36	25%	36%	36%	3%	**105**	**25%**	**33%**	**36%**	**6%**
3d. Instructional strategies for adult learning styles						69	3%	22%	52%	23%	36	3%	17%	39%	42%	**105**	**3%**	**20%**	**48%**	**30%**
3e. A variety of communications methods to generate support for public policy and other substance use initiatives.						68	0%	28%	47%	25%	36	3%	14%	50%	33%	**104**	**1%**	**23%**	**48%**	**28%**
3f. Techniques to evaluate the intent of media messages developed by others						69	3%	32%	55%	10%	36	8%	33%	39%	19%	**105**	**5%**	**32%**	**50%**	**13%**

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Table 2: Needs Assessment

Needs Assessment	Tier 1					Tier 2					Tier 3					All Tiers				
Question	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**
4a. Ways to include the relevant needs of culturally diverse groups (age, race, religion, disability, socioeconomic status, etc.) into my work	27	0%	48%	37%	15%	69	0%	22%	61%	17%	36	0%	14%	44%	42%	**132**	**0%**	**25%**	**52%**	**23%**
4b. Data needed to measure the environmental factors linked with substance use						69	3%	20%	58%	19%	36	0%	11%	53%	36%	**105**	**2%**	**17%**	**56%**	**25%**
4c. Processes and partners needed to collect substance use data in my service area						69	3%	25%	52%	20%	36	0%	8%	50%	42%	**105**	**2%**	**19%**	**51%**	**28%**
4d. Processes and partners needed to collect problem gambling data in my service area						69	28%	36%	26%	10%	36	22%	42%	31%	6%	**105**	**26%**	**38%**	**28%**	**9%**
4e. Gaps in data on priority populations and substance use issues											36		22%	50%	28%	**36**	**0%**	**22%**	**50%**	**28%**

Needs Assessment	Tier 1					Tier 2					Tier 3					All Tiers				
Question	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**
5a. The percentage of persons that are currently experiencing substance abuse problems						68	4%	21%	53%	22%	36	0%	17%	36%	47%	**104**	**3%**	**19%**	**47%**	**31%**
5b. The percentage of persons that are currently experiencing gambling problems						69	28%	30%	29%	13%	36	19%	44%	25%	11%	**105**	**25%**	**35%**	**28%**	**12%**
5c. How the substance abuse and gambling problems change over time						69	12%	29%	42%	17%	36	6%	19%	44%	31%	**105**	**10%**	**26%**	**43%**	**22%**
5d. The environmental factors that may influence the problems (e.g., schools, neighborhoods, communities, counties, tribal lands)						68	1%	16%	51%	31%	36	0%	0%	39%	61%	**104**	**1%**	**11%**	**47%**	**41%**

Needs Assessment	Tier 1					Tier 2					Tier 3					All Tiers				
Question	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**
5e. The individual-based factors that may influence the problems (e.g., knowledge, perceptions, attitudes, experiences)						69	1%	14%	55%	29%	35	0%	0%	43%	57%	**104**	**1%**	**10%**	**51%**	**38%**
5f. The characteristics of the populations that are most impacted by the problems						68	1%	15%	63%	21%	36	0%	8%	47%	44%	**104**	**1%**	**13%**	**58%**	**29%**
5g. Health disparities that exist among different populations affected by the problems						69	1%	22%	54%	23%	36	0%	6%	50%	44%	**105**	**1%**	**16%**	**52%**	**30%**
5h. Important impacts that are descriptive, but not directly measurable											36	0%	11%	53%	36%	**36**	**0%**	**11%**	**53%**	**36%**
5i. The financial impacts created by the problems											36	0%	19%	39%	42%	**36**	**0%**	**19%**	**39%**	**42%**

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Table 3: Assessing Readiness and Capacity

Assessing Readiness and Capacity	Tier 2					Tier 3					All Tiers				
Question	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**
6a. The readiness of community leaders, members, and coalitions to recognize the existence of substance use issues	69	1%	22%	57%	20%	35	0%	14%	49%	37%	**104**	**1%**	**19%**	**54%**	**26%**
6b. The ability of community organizations, members, and coalitions to implement evidence-based activities needed to prevent substance abuse	69	1%	25%	51%	23%	36	0%	11%	53%	36%	**105**	**1%**	**20%**	**51%**	**28%**
7a. The prevailing beliefs, customs, norms, or values of the communities I serve	69	0%	19%	64%	17%	36	0%	6%	50%	44%	**105**	**0%**	**14%**	**59%**	**27%**
7b. How health/illness is defined by members of the different ethnic communities in my area						36	3%	19%	50%	28%	**36**	**3%**	**19%**	**50%**	**28%**
7c. The languages spoken in the communities in my area						36	3%	14%	64%	19%	**36**	**3%**	**14%**	**64%**	**19%**

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Table 4: Mobilization and Capacity Building

Mobilization and Capacity Building	**Tier 1**					**Tier 2**					**Tier 3**					**All Tiers**				
Question	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**
8a. Identify key partners needed to achieve desired outcomes.	27	4%	48%	37%	11%	69	1%	12%	58%	29%	36	0%	0%	31%	69%	**132**	**2%**	**16%**	**46%**	**36%**
8b. Describe the vision, mission, and desired outcomes in ways that engage new partners and existing partners.						69	1%	17%	62%	19%	36	0%	6%	47%	47%	**105**	**1%**	**13%**	**57%**	**29%**
8c. Help potential new partners see how participation in the initiative(s) can help them achieve their own individual or organizational outcomes						69	1%	26%	49%	23%	36	0%	6%	53%	42%	**105**	**1%**	**19%**	**50%**	**30%**
8d. Recruit, train, and retain volunteers						69	10%	33%	42%	14%	36	3%	17%	64%	17%	**105**	**8%**	**28%**	**50%**	**15%**
8e. Actively engage a culturally diverse group of partners based on the diversity of the community/ area served						69	1%	28%	57%	14%	36	0%	14%	69%	17%	**105**	**1%**	**23%**	**61%**	**15%**

Mobilization and Capacity Building	Tier 1					Tier 2					Tier 3					All Tiers				
Question	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**
8f. Generate support from partners, community leaders, stakeholders, and organizations to take the action needed to achieve desired outcomes.						69	1%	35%	45%	19%	36	0%	8%	56%	36%	**105**	**1%**	**26%**	**49%**	**25%**
8g. Coordinate efforts among partners, community leaders, stakeholders, and other organizations						69	1%	26%	57%	16%	36	0%	11%	39%	50%	**105**	**1%**	**21%**	**50%**	**28%**
8h. Sustain coalition membership, resources, and infrastructure						69	4%	30%	54%	12%	36	0%	14%	56%	31%	**105**	**3%**	**25%**	**54%**	**18%**
8i. Identify ways to contribute to the initiative that matches the interests, time, and resources of potential new partners											36	0%	3%	25%	54%	**36**	**0%**	**3%**	**25%**	**54%**
8j. Address misconceptions or misgivings potential new partners may have about the initiative and the outcomes it is trying to achieve											36	0%	8%	61%	31%	**36**	**0%**	**8%**	**61%**	**31%**

Mobilization and Capacity Building	Tier 1					Tier 2					Tier 3					All Tiers				
Question	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**
8k. Create and strengthen coalitions											36	3%	17%	44%	36%	**36**	**3%**	**17%**	**44%**	**36%**

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Table 5: Strategic Planning

Strategic Planning	Tier 1					Tier 2					Tier 3					All Tiers				
Question	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**
9a. Contribute to prevention planning efforts.	27	0%	59%	33%	7%	66	2%	12%	55%	32%	36	0%	8%	33%	58%	**129**	**1%**	**21%**	**44%**	**34%**
9b. Include the perspectives of diverse populations in efforts to plan and improve prevention policies, programs, practices, and services.						68	1%	19%	59%	21%	36	3%	6%	50%	42%	**104**	**2%**	**14%**	**56%**	**28%**
9c. Use facilitation skills to resolve conflicts that impede group problem-solving						68	1%	19%	57%	22%	36	0%	14%	47%	39%	**104**	**1%**	**17%**	**54%**	**28%**

Strategic Planning	Tier 1					Tier 2					Tier 3					All Tiers				
Question	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**
9d. Help stakeholders develop a concise, shared vision of the ideal conditions that would exist if prevention outcomes are achieved											36	0%	11%	53%	36%	**36**	**0%**	**11%**	**53%**	**36%**
9e. Help partners and stakeholders develop a shared purpose, operational processes, and values (if applicable) to guide collective prevention efforts											36	0%	11%	58%	31%	**36**	**0%**	**11%**	**58%**	**31%**
10a. Describe priority substance use problems and the populations impacted by or involved in them	27	0%	70%	30%	0%	69	1%	22%	52%	25%	36	0%	8%	42%	50%	**132**	**1%**	**28%**	**45%**	**27%**
10b. Describe the relationships among substance use problems, risk behaviors/adverse conditions, and factors/intervening variables that enable the behaviors and/or create the conditions						68	1%	22%	51%	25%	36	0%	6%	44%	50%	**104**	**1%**	**16%**	**49%**	**34%**

Strategic Planning	Tier 1					Tier 2					Tier 3					All Tiers				
Question	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**
10c. Identify the measurable changes in substance use problems and consequences that prevention efforts will seek to achieve						69	1%	29%	55%	14%	36	0%	14%	44%	42%	**105**	**1%**	**24%**	**51%**	**24%**
10d. Identify the measurable changes in gambling problems and consequences that prevention efforts will seek to achieve						69	26%	39%	23%	12%	36	19%	39%	25%	17%	**105**	**24%**	**39%**	**24%**	**13%**
10e. Identify measurable changes in knowledge, skills and abilities needed to address the issues targeted by prevention efforts						69	1%	35%	52%	12%	36	0%	8%	58%	33%	**105**	**1%**	**26%**	**54%**	**19%**
11a. Locate resources to find evidence-based prevention programs, practices and policies to address substance use	27	11%	59%	26%	4%	69	3%	14%	62%	20%	36	0%	8%	47%	44%	**132**	**4%**	**22%**	**51%**	**23%**

Strategic Planning	Tier 1					Tier 2					Tier 3					All Tiers				
Question	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**
11b. Use research to identify the strategies and activities most likely to reduce substance use problems and consequences for the populations targeted by prevention efforts	27	11%	59%	30%	0%	69	3%	23%	59%	14%	36	0%	6%	47%	47%	**132**	**4%**	**26%**	**50%**	**20%**
11c. Coach and mentor others to help them implement an effective array of evidence-based programs, policies, and practices						69	1%	33%	52%	13%	36	0%	14%	36%	50%	**105**	**1%**	**27%**	**47%**	**26%**
11d. Create a budget that reflects the resources needed to implement all strategies and activities required to prevent/ reduce substance use problems and consequences											36	6%	14%	36%	44%	**36**	**6%**	**14%**	**36%**	**44%**
11e. Create a budget that reflects the resources needed to implement all strategies and activities required to prevent/ reduce gambling problems and consequences											36	19%	25%	36%	19%	**36**	**19%**	**25%**	**36%**	**19%**

Strategic Planning	Tier 1					Tier 2					Tier 3					All Tiers				
Question	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**
11f. Develop a strategic financing plan for acquiring the resources needed to achieve sustainable reductions in substance use problems and consequences											36	8%	25%	53%	14%	**36**	**8%**	**25%**	**53%**	**14%**
11g. Develop a strategic financing plan for acquiring the resources needed to achieve sustainable reductions in gambling problems and consequences											36	19%	31%	44%	6%	**36**	**19%**	**31%**	**44%**	**6%**
11h. Develop contracts, grants, and other funding mechanisms that are outcome- and/or performance-based.											36	3%	19%	42%	36%	**36**	**3%**	**19%**	**42%**	**36%**

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Table 6: Implementation

Implementation	Tier 2					Tier 3					All Tiers				
Question	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**
12a. Implement evidence-based programs, policies, and practices for target populations and/or issues	68	3%	15%	46%	37%	35	0%	0%	37%	63%	**103**	**2%**	**10%**	**43%**	**46%**
12b. Implement evidence-based programs, policies, and practices that are responsive to the environmental conditions and demographic characteristics in communities	68	4%	18%	47%	31%	35	0%	0%	49%	51%	**103**	**3%**	**12%**	**48%**	**38%**
12c. Implement evidence-based programs with fidelity—the degree to which an intervention is delivered as intended	68	3%	21%	37%	40%	35	0%	0%	40%	60%	**103**	**2%**	**14%**	**38%**	**47%**
12d. Work effectively with the political, judicial, regulatory, and law enforcement systems in communities to prevent and reduce substance use problems	68	0%	19%	63%	18%	35	0%	9%	49%	43%	**103**	**0%**	**16%**	**58%**	**26%**

Implementation	Tier 2					Tier 3					All Tiers				
Question	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**
12e. Work effectively with the political, judicial, regulatory, and law enforcement systems in communities to prevent and reduce gambling problems	68	18%	34%	34%	15%	35	20%	26%	29%	26%	**103**	**18%**	**31%**	**32%**	**18%**
12f. Advocate for health-promoting laws and policies without engaging in lobbying	68	4%	32%	47%	16%	35	0%	14%	40%	46%	**103**	**3%**	**26%**	**45%**	**26%**
12g. Adapt evidence-based programs, policies, and practices as needed to ensure cultural competency and relevance without compromising fidelity.	68	4%	19%	51%	25%	35	0%	6%	40%	54%	**103**	**3%**	**15%**	**48%**	**35%**

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Table 7: Evaluation

Evaluation	Tier 2					Tier 3					All Tiers				
Question	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**
13a. Report the demographics and numbers of persons reached by the individual strategies I implement	68	1%	21%	44%	34%	35	0%	3%	46%	51%	**103**	**1%**	**15%**	**45%**	**40%**

Evaluation	Tier 2					Tier 3					All Tiers				
Question	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**
13b. Estimate numbers of persons reached by environmental and population-based strategies I implement	68	3%	21%	53%	24%	35	0%	0%	63%	37%	**103**	**2%**	**14%**	**56%**	**28%**
13c. Use evaluation data to monitor the degree to which my prevention initiative is achieving desired changes in substance use problems, gambling problems, risk behaviors, and related factors	68	7%	25%	54%	13%	35	0%	11%	54%	34%	**103**	**5%**	**20%**	**54%**	**20%**
13d. Use evaluation data to inform changes to prevention efforts to improve effectiveness	68	3%	26%	56%	15%	35	0%	11%	49%	40%	**103**	**2%**	**21%**	**53%**	**23%**
13e. Present evaluation data to stakeholders and partners in a way that they understand	68	3%	26%	51%	19%	35	0%	3%	49%	49%	**103**	**2%**	**18%**	**50%**	**29%**
13f. Use data to evaluate staff and/or provider performance						35	0%	9%	49%	43%	**35**	**0%**	**9%**	**49%**	**43%**
13g. Use financial data to ensure expenditures are occurring as planned						35	3%	17%	37%	43%	**35**	**3%**	**17%**	**37%**	**43%**

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Table 8: Substance Abuse

Substance Abuse	Tier 1					Tier 2					Tier 3					All Tiers				
Question	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**
14a. Current prevention methods, strategies and programs	27	11%	52%	33%	4%	66	0%	21%	48%	30%	34	0%	6%	47%	47%	**127**	**2%**	**24%**	**45%**	**29%**
14b. General factors that place persons at greater risk for substance abuse	27	4%	30%	59%	7%	66	0%	9%	55%	36%	34	0%	0%	35%	65%	**127**	**1%**	**11%**	**50%**	**38%**
14c. The signs and symptoms of addiction	27	0%	22%	56%	22%	66	2%	9%	44%	45%	34	0%	3%	35%	62%	**127**	**1%**	**10%**	**44%**	**45%**
15a. Prevent/reduce substance use-related problems at the population level						66	2%	14%	56%	29%	34	0%	6%	50%	44%	**100**	**1%**	**11%**	**54%**	**34%**
16a. Public Health model						67	4%	33%	46%	16%	34	0%	12%	41%	47%	**101**	**3%**	**26%**	**45%**	**27%**
16b. Psychological model						67	10%	25%	42%	22%	34	0%	15%	47%	38%	**101**	**7%**	**22%**	**44%**	**28%**
16c. Brain disease model						66	9%	30%	33%	27%	34	0%	15%	41%	44%	**100**	**6%**	**25%**	**36%**	**33%**
16d. Macro-structural model						67	12%	37%	42%	9%	34	6%	29%	44%	21%	**101**	**10%**	**35%**	**43%**	**13%**
17a. My own biases, assumptions, and cultural values	27	0%	15%	59%	26%	65	0%	11%	66%	23%	34	0%	3%	59%	38%	**126**	**0%**	**10%**	**63%**	**28%**
17b. Societal factors						65	0%	11%	66%	23%	34	0%	6%	53%	41%	**99**	**0%**	**9%**	**62%**	**29%**
17c. Cultural factors						66	2%	17%	61%	21%	34	0%	6%	59%	35%	**100**	**1%**	**13%**	**60%**	**26%**
17d. Psychological factors						66	3%	14%	61%	23%	34	0%	6%	56%	38%	**100**	**2%**	**11%**	**59%**	**28%**

Substance Abuse	Tier 1					Tier 2					Tier 3					All Tiers				
Question	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**
17e. Environmental factors						66	2%	12%	61%	26%	34	0%	3%	56%	41%	**100**	**1%**	**9%**	**59%**	**31%**
17f. Spiritual factors						66	5%	15%	62%	18%	34	0%	15%	53%	32%	**100**	**3%**	**15%**	**59%**	**23%**
17g. Belief systems						66	5%	12%	62%	21%	34	0%	12%	53%	35%	**100**	**3%**	**12%**	**59%**	**26%**
18a. Expand my knowledge of factors/intervening variables that create protection or resilience against substance use disorders	27	4%	41%	41%	15%	67	6%	9%	60%	25%	34	0%	6%	50%	44%	**128**	**4%**	**15%**	**53%**	**28%**
18b. Be knowledgeable about current and emerging substance use prevention issues and trends						67	4%	7%	58%	30%	34	0%	9%	38%	53%	**101**	**3%**	**8%**	**51%**	**38%**
18c. Design prevention initiatives that are appropriate for persons at different stages of lifespan development						67	7%	13%	57%	22%	34	0%	15%	50%	35%	**101**	**5%**	**14%**	**54%**	**27%**

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Table 9: Problem Gambling

Problem Gambling	Tier 1					Tier 2					Tier 3					All Tiers				
Question	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**
19a. Explain the differences between the three types of gamblers (Social, Problem, and Disordered Gambler)	27	37%	48%	7%	7%	67	30%	39%	18%	13%	34	21%	38%	29%	12%	**128**	**29%**	**41%**	**19%**	**12%**
19b. Describe the myths and facts related to problem gambling	27	41%	37%	15%	7%	67	33%	30%	24%	13%	34	18%	44%	24%	15%	**128**	**30%**	**35%**	**22%**	**13%**
19c. Articulate the DSM-5 diagnostic criteria for a pathological gambling diagnosis						67	45%	36%	6%	13%	34	18%	50%	18%	15%	**101**	**36%**	**41%**	**10%**	**14%**
19d. Describe the four phases of action and escape gambling						67	45%	36%	10%	9%	34	24%	47%	24%	6%	**101**	**38%**	**40%**	**15%**	**8%**
19e. Describe the three phases of compulsive gambling						67	40%	39%	10%	10%	34	24%	47%	21%	9%	**101**	**35%**	**42%**	**14%**	**10%**
19f. Describe the unique characteristics of pathological gambling						66	39%	35%	15%	11%	34	18%	53%	21%	9%	**100**	**32%**	**41%**	**17%**	**10%**
19g. Identify warning signs of a compulsive/ pathological gambler						67	34%	31%	22%	12%	34	18%	50%	24%	9%	**101**	**29%**	**38%**	**23%**	**11%**
19h. Describe gambling terminology						66	36%	38%	15%	11%	34	18%	53%	21%	9%	**100**	**30%**	**43%**	**17%**	**10%**
19i. Describe characteristics of significant others, including children of a compulsive gambler						67	40%	34%	15%	10%	34	21%	47%	24%	9%	**101**	**34%**	**39%**	**18%**	**10%**

Problem Gambling	Tier 1					Tier 2					Tier 3					All Tiers				
Question	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**	**N**	**None**	**New**	**P**	**H**
19j. Describe the state legislation around casinos and gambling						67	42%	42%	7%	9%	34	21%	44%	26%	9%	**101**	**35%**	**43%**	**14%**	**9%**
19k. Identify why specific populations are more likely to become gamblers						67	37%	34%	18%	10%	34	18%	47%	24%	12%	**101**	**31%**	**39%**	**20%**	**11%**
19l. Describe the cultural differences and factors around gambling and problem gambling											34	21%	53%	18%	9%	**34**	**21%**	**53%**	**18%**	**9%**
19m. Describe gambling behavior differences by gender											34	21%	50%	21%	9%	**34**	**21%**	**50%**	**21%**	**9%**
19n. Describe the social, financial, and physical consequences of problem gambling											34	18%	41%	32%	9%	**34**	**18%**	**41%**	**32%**	**9%**
19o. Articulate the steps towards recovery and issues related to recovery from problem gambling											34	21%	50%	21%	9%	**34**	**21%**	**50%**	**21%**	**9%**

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