Don't Forget the Workforce

Henrick Harwood

Although the behavioral health workforce numbers several hundred thousand credentialed professionals, little research has been done on this critical group. With few exceptions, research on substance abuse treatment regards staff members as virtually interchangeable elements in the delivery of interventions. In this issue of *Psychiatric Services*, McCarty and colleagues (1) make an insightful contribution. The Clinical Trials Network (CTN) is a major initiative of the National Institute on Drug Abuse to translate evidence-based therapies into practice. McCarty and colleagues' research reminds us that delivery of evidence-based therapies involves human factors. Their findings raise the prospect that particular evidence-based therapies may be grudgingly accepted by the field or that effectiveness may be compromised by adverse sentiment in the workforce. These are important issues to address.

Perhaps the best news is that the CTN workforce was positively disposed toward evidence-based therapies. There appears to be a reservoir of goodwill that the field can draw on as these therapies become more widely available. For several therapies for which sentiment was weak or even adverse, staff at clinics that had participated in trials for those therapies were more supportive than staff at nonparticipating clinics, suggesting that support for implementation can positively affect attitudes and knowledge.

The most disappointing and puzzling findings concern the lack of knowledge of and support among the CTN workforce for medications in addiction treatment. Overall, staff members were essentially neutral—or perhaps evenly divided between agreement and disagreement—in their support for or knowledge about the effectiveness of methadone and buprenorphine for opiate dependence and naltrexone for alcohol dependence. Medical staff and managers reported only marginally stronger knowledge and support than counselors and support staff. Because the clinics volunteered for and participated in the CTN to translate new evidence-based therapies into practice, we might expect that staff would be predisposed to support evidence-based therapies and more knowledgeable about them.

McCarty and colleagues found strong divisions in the field about the use of methadone, even though it has long been recognized as one of the most effective addiction therapies and is perhaps the single most extensively researched medical therapy—never mind addiction therapy.

The survey item "Buprenorphine is an effective treatment for opiate dependence" elicited a low level of knowledge or agreement (3.23 out of 5, marginally above 3, neither agree nor disagree). This finding is surprising and disheartening. Buprenorphine received Food and Drug Administration approval as a treatment for opiate addiction in October 2002, and the CTN network conducted three separate clinical trials between 2001 and 2005 that translated this evidence-based therapy to community-based practice. The survey also found an essentially neutral balance of sentiment (3.11 out of 5) for use of naltrexone. The recent approval of a 30-day depot administration of naltrexone should raise new hopes for this evidence-based therapy.

McCarty and colleagues found strong support for provision of mental health services at substance abuse clinics. This finding should be considered good news, given the evidence that among individuals who seek addiction treatment, a sizeable minority—20%—have diagnosable concurrent mental disorders. Moreover, the study by McCarty and colleagues and studies by others show that a majority of counselors with graduate-level training have taken courses in behavioral health disciplines; thus they have a foundation to learn about and deliver future evidence-based therapies that involve supportive mental health services.

Unfortunately, it is difficult to foresee the widespread introduction of mental health services in substance abuse treatment settings for two primary reasons. First, treatment protocols for patients with both addictive and mental disorders are still working their way through the research and translation-to-practice stages. The only protocols for comorbid drug addiction and mental disorders selected for CTN testing, translation, and dissemination have been for adolescent substance abusers with attention-deficit hyperactivity disorder (ADHD) and smokers with ADHD (osmotic-release methylphenidate). Second, the public reimbursement systems for treatment of addictions and mental disorders are distinct, and payment models must be developed for pharmacologic treatment of persons with comorbid disorders.

Because CTN clinics are a selective group, it will be useful to extend research on workforce characteristics and attitudes to a more general sample of community-based providers.

Reference

1. McCarty D, Fuller BE, Arfken C, et al: Direct care workers in the National Drug Abuse Treatment Clinical Trials Network: characteristics, opinions, and beliefs. Psychiatric Services 58:181–190, 2007

Mr. Harwood is affiliated with The Lewin Group, 3130 Fairview Park Dr., Suite 800, Falls Church, VA 22042 (e-mail: rick.harwood@lewin.com).