Workforce Development Priorities and Learning Preferences For Evidence-Based Practices and Care Processes

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Introduction

Research-to-practice gaps continue to plague the addiction field. This has been widely-recognized for now more than two decades, with a prominent Institute of Medicine (1998) outlining bases for the historically ineffective collaboration of scientists/researchers and community-based treatment providers. Principally, this schism was suggested to result from scientists too rarely addressing in their research the interests of the treatment community, and community-based treatment providers too rarely adopting available, empirically-supported. This spawned a wave of community-based effectiveness trials, such as those that continue to be conducted via the NIDA Clinical Trials Network (Hanson et al., 2002). However, the SAMHSA-funded national network of Addiction Technology Transfer Centers (ATTCs) aslo emerged as a more direct vehicle to facilitate the adoption and implementation of evidence-based practices (EBPs) and care processes by the addiction workforce. Increasingly, the ATTC network is emphasizing the vital role of technical assistance, which encompasses an umbrella of educational and consultative services beyond initial training exposure, in such efforts. In the interest of not recreating the noted historical schism, it is critical that perspectives be gathered from members of the addiction workforce regarding EBPs and care processes of greatest interest as well as corresponding learning preferences to support their adoption and implementation.

Herein the Northwest Addiction Technology Transfer Center (NWATTC) offers results of an online needs assessment survey that in 2018 tapped the perspectives of addiction workforce members providing services in Health and Human Services Region 10, which encompasses the great states of Alaska, Idaho, Oregon, and Washington. Corresponding findings encompass the perceived importance of ten EBPs and six care processes, as well as preferences among six learning activities to aid their adoption and implementation.

Methods

Survey content was iteratively developed by a multidisciplinary team of NWATTC staff, with additional input from its regional advisory board. In addition to respondent demography and professional background, survey items used a five-point Likert-style scale (1 = Not At All, 5 = Extremely) to rate the importance of specific EBPs and care processes, or benefit of particular learning activities. The ten EBPs included in the survey were: Acceptance and Commitment Therapy (ACT); Cognitive-Behavioral Therapy (CBT); Contingency Management (CM); Dialectical Behavior Therapy (DBT); Medication-Assisted Treatment for Alcohol; Medication-Assisted Treatment for Opioids; Mindfulness-Based Relapse Prevention (MBRP); Motivational Interviewing (MI); Screening, Brief Intervention, and Referral to Treatment (SBIRT); and Twelve-Step Faciliation (TSF). Six broader care processes were: Culturally-Responsive Services (CRS); Effective Clinical Supervisory Practices (ECSP); Mental Health and Substance Use Disorder Service Integration (MH/SUD); Recovery-Oriented Systems of Care (ROSC); Team-Based Care (TBC); and Trauma-Informed Care (TIC). Six learning activities were: academic detailing; case consultation; clinical demonstration; coaching/performance-based feedback; didactics; and role-play/rehearsal.

In February 2018, a link to this survey was posted on the publicly-available NWATTC website where it remained accessible through the following September. The Survey Monkey data collector was set to disallow multiple responses, to prevent a given respondent from completing the survey multiple times. During the noted 7+ month span, the survey was completed by 324 respondents, of which 306 affirmed current employment as a health professional in an HHS Region 10 state (AK, ID, OR, WA). Demography and professional background of the resulting regional workforce sample are summarized in Table 1 below.

Table 1. Sample Demography and Professional Background (N=306 survey respondents)

Age-Range		Primary Educational Discipline	
18-25 yrs	1%	Psychology/Mental Health	46%
26-35 yrs	13%	Social Work	28%
36-45 yrs	19%	Public Health	7%
46-55 yrs	24%	Medicine	3%
56-65 yrs	34%	Nursing	5%
66-75 yrs	9%	Other	11%
76+ yrs	1%	Chemical Dependency*	54%
Gender		Employment State	
Female	72%	Alaska	13%
Male	27%	Idaho	6%
Transgender	0%	Oregon	32%
Gender-Nonconforming	1%	Washington	49%

*Chemical Dependency represented an independent survey item

Multivariate analysis of variance were computed separately for respondent ratings of the ten EBPs, six care processes, and six learning activities, with primary education discipline and state of employment included as covariates in each analysis. No significant between-discipline or between-state variability was revealed. Consequently, Figures 1-3 present descriptive statistics concerning ratings from the full sample (N=306).

Figure 1. Mean Sample Ratings for Ten Evidence-Based Practices

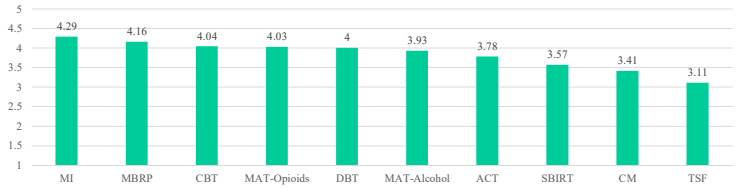
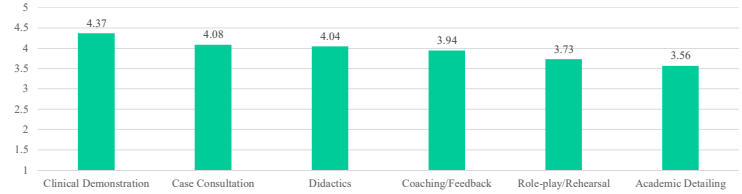


Figure 2. Mean Sample Ratings for Six Care Processes

Figure 3. Mean Sample Ratings for Six Learning Activities



Discussion and Conclusion

On average, this sample of 306 HHS Region 10 addiction workforce members rated educational events for five of the ten EBPs (MI, MBRP, CBT, MAT-Opioids, DBT) and five of the six care processes (MH/SUD, TIC, CRS, ECSP, TBC) as very-to-extremely important for their work. As for educational methods to facilitate adoption and implementation of such practices/processes, the sample on average rated three of six learning activities (clinical demonstration, case consultation, didactics) as very-to-extremely beneficial. Notably, all remaining EBPs and care processes were on average rated as at least somewhat important, and likewise the remaining learning activities were on average rated as at least somewhat beneficial. Collectively, these data identify diverse workforce development needs in our region, and suggest that these may be addressed by a combination of learning methods targeting individual workforce members and their employment settings.

In accord with the ATTC network emphasis on supplementing training resources with ongoing technical assistance, we are utilizing these findings to inform our prospective workforce development efforts with state and community partners in Alaska, Idaho, Oregon, and Washington. To what extent these findings generalize to workforce development needs outside of our region awaits further study. We see great value in the prospect of inter-regional data-sharing within the national ATTC network, and believe this can only benefit network-level efforts to support EBP adoption and implementation.

Acknowledgements

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