

Gatekeeping Out the Recovering Workforce: Repeating History – William Stauffer



A generation ago, in the early 1970s, the substance use treatment field was born. What it lacked in evidence base, which is a challenge for any emerging field, it more than made up for in vigor. People in recovery were eager to help others into recovery. Bill White noted pervasive volunteering in the field in the 1970s. A workforce survey in 1976 found that there were 1,000 full-time volunteers and 13,000 part-time volunteers (Dendy, 1979). It is clear, that [as White noted](#) the loss of volunteers from the addiction treatment milieu in the 1980s and 1990s, altered the very nature of our workforce. We have made it quite regimented and in many ways created gatekeeping structures that reduce access to employment for those who are most motivated to pursue careers in our field. We can't sustain viable care systems without a highly motivated workforce, yet our institutions have long sabotaged that effort for those who are most passionate to do it.

That process of professional credential gatekeeping shifted what in many ways was a calling into a profit driven industry that eroded recruitment and stunted retention over the long term. As this unfolded in the 1980s, the field also gradually lost its connection to the culture of recovery. The capacity to effectively support the transmission of recovery from person to person and into recovery community eroded. Instead, we grew an industry focused on acute services that became isolated from the very community grounded mutual aid, often necessary to sustain long term recovery. This is in part why it could no longer attract volunteers. It also reduced workforce retention rates in ways that haunt us today. Those most invested in the work could not get into the field and those with the right credentials but less passion to devote a career to the field migrated to other fields of interest. While we cannot transmute our field back to what it was before, we should understand what was lost and make effort to avoid repeating these mistakes. Repeating mistakes is also a historic theme.

As noted by White in a [2013 article in Counselor Magazine](#):

"The 1970s and 1980s marked the transition of the addiction counselor from the status of paraprofessional to that of a clinical professional on par with other recognized helping roles. Rarely noticed during this period of explosive growth was the decline in recovery representation in the addiction treatment workforce and among executive leadership and governing boards, the erosion of once strong volunteer and alumni programs, weakened connections to local communities of recovery, and a shift in orientation from long-term recovery to ever-briefer periods of treatment. Cyclical episodes of biopsychosocial stabilization became the norm with a growing portion of persons entering treatment with multiple prior admissions. Throughout the 1990s there was a sense of great pride in how far the field of addiction treatment had come in a few short decades, but there was also underlying unease that things of great value had been lost in the professionalization, industrialization, and commercialization of addiction treatment."

The vast majority of those who worked in the field in that early era of the 70's were in recovery, with general estimates hovering around 70%. The axiom then, as now, is that people recover in community. People in the field lived the culture of recovery present in that era. The first generation of our treatment workforce expanded recovery transmission efforts in ways that extended beyond rote clinical care. They understood how to be recovery carriers and support people seeking help to find recovery community. As the field shifted, the stat was turned on its head. A generation later, only around 30% of our counselor workforce were in recovery. The field lost fluency in the culture of recovery required to effectively help the very communities they served and increasingly focused on short term clinical interventions.

It got so bad in the early 90s that communities of recovery began to recognize how the narrowly focused professionalized conveyor belt of care that mostly benefited the profit driven industry was failing them. The SUD care system in that era was poorly equipped to meet the most basic needs of those served because it did not understand it from a lived perspective. It was failing to help them find recovery in community once the far too often brief service relationship was severed. Our field in that era was unable to support the most effective strategies to sustain long term addiction recovery. We know that engagement in mutual support programs in community is a stronger indicator of long-term wellness than even therapeutic alliance. It yields abstinence rates measured not in days but in years (Fiorentine 1999). Yet even as our systems espoused evidence bases, this is where our care system lost ground. The shift in our workforce led to a dearth of capacity to support people in care from identifying and developing vital networks of support in community beyond the professionalized relationship. If it happened before, it could certainly happen again.

The standard academic education of the profession is simply not aligned with work in the field. There are still significantly fewer clinicians in recovery in the addiction treatment field in comparison to that earlier era. It matters. The focus of effort is even more on defined interventions or short-term care counseling techniques than a person focused long term recovery transmission processes. Academic achievement rarely includes the kinds of things one needs to learn to be effective at this work or to navigate out of all the systemic negative attitudes about people who become addicted. [Contempt for those served](#) is far too often a byproduct of a workforce intrinsically different from those it serves, and we should always consider such factors when working with addiction which the World Health Organization and [ranked the most stigmatized condition in the world](#).

One of the pieces that Bill coauthored with Bryan Garner in that era considered that there were significant mismatches in respect to our field's workforce and the work they did. [Staff Turnover in Addiction Treatment: Toward Science-Based Answers to Critical Questions](#) noted in 2011 that "the data we do have available suggest potential indicators of widespread problems related to staff screening, recruitment, training, and supervision as well as the potential prevalence of person-field mismatch, person-organization mismatch, and person-role mismatch—mismatches that all exert a potentially significant effect on clinical outcomes and organizational health." I was a witness in that era to the turnstile of young social workers with little personal connection to the focus of the field who qualified to meet the barriers set up for new hires. Far too often they then quickly left for higher paying positions they had more affinity to do. The same dynamics are playing out now.

This occurred then as now even as we turned away people in recovery with deep passion for the work but who did not get into recovery with the requisite degrees. Nor whom could justify returning to college for a low pay high stress job that they then may qualify to do in a few years. This at a time in their lives when often they were also rebuilding their own lives in recovery. Our field withered. It has actually never fully recovered from these self-inflicted wounds.

I often think about what role systemic stigma against recovering people in our care system has in the kinds of dynamics that set up barriers to recovering people accessing a foothold in our field and serving to support the recovery of others. Stigma infuses everything we think and do. We are swimming in it. These negative perceptions are ever present in our field and a primary cause of the barriers we set up and the challenges we face in building and sustaining an effective workforce. We can't do much of anything without a dedicated, retained and properly trained workforce.

There are also still many recovering people who want to get into the field, but over the years we have made it increasingly more difficult for them to do so. There is most likely a relationship between that dynamic and our own fields negative views about people who have experienced addiction. How can a field help the group of people for whom it holds thinly veiled contempt?

The truth is that there is very little in the typical social work or other human service-related degree that prepares someone to do this work, yet paradoxically a great deal of things that prepare people to do the work that occurs in the

recovery journey. Our field turns over so very quickly because of that mismatch, in part a result of our systemic negative perception and barriers set up in respect to the capabilities of people in recovery to do this work. Both groups require mentoring on the job once hired. My experience is that it is easier to teach concrete tasks than affinity for the work.

The impetus in writing this piece is that we are replicating the over professionalization process now with our peer workers. States are increasingly considering licensure for peer workers. Peer workers doing unethical things are often used to justify such actions, even as few peers get trained beyond the entry level basic skills. Our field fails to fund supervision in nearly any way, but this is magnified at the lower pay rungs such as peer support services. They then often get thrust in the very earliest days of their career into high intensity environments with too little supervision. Funding structures fail to provide resources for supervision, which is the primary reason for deficits in this area. A dynamic we would not consider with any other kind of work requiring significant on the job learning. When bad things happen, we blame them and do not look in the direction the finger is pointing from, which is our field's policies and practices. When news stories surface like that of [this doctor in Pennsylvania who is alleged to have raped and sex trafficked patients](#), we do not consider raising service barriers for doctors because doctors are not a stigmatized group. We view things differently because of the stigma against recovering people and so apply a different yardstick. It is harming our efforts.

I certainly see some parallels between what we lost in our field historically when we took the road of professionalism over being grounded in community and what is unfolding now. Licensing and credentialing processes that cede both the energy and the control of our efforts away from the actual experts. Peer services (and in the generation before us was the rise of drug and alcohol counseling) came from the community. We lost a lot in the process of professionalizing the field of addiction counseling. Arguably, the rise of peer services was a direct result of the loss of inherent knowledge in clinical spaces, leaving a void for the rise of the [New Recovery Advocacy Movement](#) and the development of peer worker roles to support persons in establishing connections to recovery community.

If we go down this same garden path again, we will end up having to find alternative strategies as the professionally condoned peer workers become akin to mini clinicians. It is one of the things that Bill White warned about in his prophetic [State of the New Recovery Advocacy Movement](#) remarks to ARCO in Dallas, Texas, in 2013. He said if we took the road of focusing solely on peer services, the goals of the movement would be lost, and we would need to start over. We are well along that path to create hurdles to low pay, high stress jobs disconnected from the community it was intended to support. Just remember that the argument that was made back in the era when the counselor credentials were raised was that it would lead to higher wages. That did not happen, we just made it harder to do low wage work and barred the group with the most affinity for it from embarking on a career in the field.

To move forward and avoid historic mistakes, we must consider:

- Making transparent all conflicts of interest that groups may have in limiting the training and certification of people within the substance use treatment and recovery support care systems and ensure that conflicts are addressed ethically and with full inclusion of the impacted communities.
- Centering the training, certification and facilitation of peer support service in the communities of recovery in which these services are utilized in order to ensure that they meet the needs of the communities served.
- Consider the impact of stigma against recovering people that is systemic in all our care systems, including in how policies that limit access to our substance use treatment and recovery support care workforce.
- Requiring career pathways are in place for people in recovery to get into our workforce through nonacademic pathways.

The key area of focus we keep moving away from is recovery grounded in recovery communities. There is only so much that professional care models can deliver, and it has significant limitations. One of the things we can already see getting lost is one of the foundational areas of focus on peer work, which was essentially focused on recovery transmission grounded in community helping people find their pathways of recovery within community. That notion is being replaced by more limited services prescribed by a funder and billed as a unit of service. We should pause and consider what gets lost next on the road to peer licensure, history can be instructive here.

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