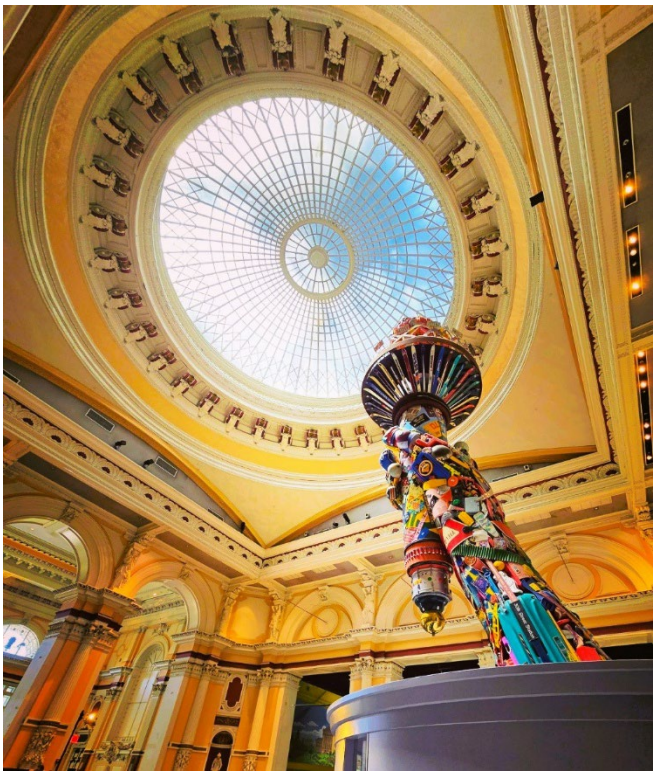
Hope Carriers in a System That Doesn't Walk Its Own Talk on Recovery

"Not everything that is faced can be changed, but nothing can be changed until it is faced." – James Baldwin



Workforce attrition in addiction care is about much more than burnout. It is often more a result of moral dissonance created by systems that profess recovery but operationalize something far less. As an example, the other day, I met a peer worker with several years' experience in the field. The person disclosed that they were actively looking for work outside of the field. They had lost hope in the work they did because it was not valued. They increasingly saw that the systems they interface with do not really care about recovery. In the next breath they said they were planning to go back to school to get into a medical tech role as it seemed like a wiser investment in their own future.

This is a narrative I have heard hundreds of times over the years, not just in the peer space or the recovery community organization world but widely in the treatment realm as well. People become tired of the Sisyphean work of dispensing hope and support in a system of care in which it is a thin veneer of ambivalence for people who become addicted. What William White in his essay on flourishing terms recovery pessimism.

While there are a lot of well documented reasons why our addiction service workforce is in trouble, it is an interesting facet every person I can recall who has left our field or is thinking about doing something else as a vocation say that they love the work but actually doing it in ways that are authentic runs against the grain of the system. This becomes that deep dissonance not easily resolved that leads people to abandon our field.

We have a system designed to fail those served. Complexities of care like medical, pharmacological and psychological support when included are done so contractually but not with corresponding resources. We rarely include recovery community in meaningful ways in policy development and implementation. Family engagement is not compensated for. Supervision is not compensated. Follow-up is not funded. This is how our systems of care don't walk that talk of recovery in what it actually does in practice. It is an unfortunate charade. Many people abandon the field when they see what is behind the curtain. As the quote above reflects, we will face these truths we will not headway with as they remain behind the curtain of acknowledgement.

It is very difficult to do work that is not actually supported and for which a great deal of effort goes into doing. The challenges result from a system that makes it difficult to help people by placing burdensome rules and regulations, perpetual authorizations and an ever-present push to move people through the service system and declare them served even as they are not truly supported in the process.

Those of us in the field feel these things even when we cannot always name them. That can be deeply demoralizing as these dynamics become visible. When we do not measure recovery longitudinally, when we do not fund follow-up, when we discharge people as 'served' rather than authentically supported, we should not be surprised by poor outcomes. These are not incidental features; things function exactly as they were designed to do. We do not lead to look any further as to why our field has high turnover rates.

Those who walk away from the field are often people who were deeply motivated to the mission of expanding recovery opportunities, but who get worn down by the machinations of a system of care not really focused on recovery but on minimal stabilization goals. Each time I hear one of these stories, my heart breaks a bit because of the impact that this has on each and every person served.

I have interviewed thousands of people in recovery, and I ask them how they got on the recovery pathway. Invariably the answer is that through despair, they had a sense of hope and possibility for something different in their lives. They found a person who believed in them and believed that recovery was within their grasp. This is the heart of the work. "Hope carriers" who operate within systems not designed to take people where they need to go. Those served have little knowledge of all these challenges unfolding behind the curtain, but it puts their recovery chances at grave risk. How can hope carriers operate in systems mired in despair? That is the crux of our challenge.

Challenges like low pay, high stress and mountains of administrative burdens are ancillary, all known when people commit themselves to the field. Known at the front door. The thing that drives our workforce to despair and to abandon the field is the realization that beyond a thin layer of stated support, our systems have little commitment to long-term recovery or those who work tirelessly to help people on these journeys. This is why people We have built a low expectation system of care that markets itself as recovery oriented.

Recovery as a Stage Prop

If our systems truly cared about recovery, full recovery would be the universal goal. We would track and support people over the long term. We would have universal measures and adequate funding that supported these systemic and universal goals. We would stick with people beyond acute focused interventions until we had provided the tools they need to flourish. We would understand and support nuances such as recovery initiation in different stages of life or in the myriads of contexts culture and community variables. We would include family constellations in the care process. We would foster processes that support the very best outcomes. We would have a broadly informed recovery evidence base, and our field would reflect that science.

Can a system that fails to do these kinds of things be considered as optimistic of recovery or is it more likely grounded in recovery pessimism? I struggle to identify programs operating at scale that have meaningfully attempted long term recovery models. Those that do are the exception to the rule and are swimming against the current. One thing we could do for the next generation is remove these obstacles to resiliency.

Relatedly, Dr David Best of the UK describes "spray on recovery" as clinically oriented service providers who capture funding by marketing on a thin veneer of peer service practice and then brand themselves as recovery oriented. Here in the US, we have recovery capitalists who bring Wall Street dollars into the recovery space and erode care by trying to squeeze 20 cents out of each investment dollar. They largely achieve these goals not by maximizing recovery but by cutting corners so they can deliver cash to investors. Government gives lip service to recovery while focusing on more performative goals. Objectives more often than not that hold recovery community held at arm's length.

Workforce Retention

Turnover has become endemic. The average annual turnover rate for addictions counselors hovers at 33.2%, with some estimates soaring as high as 50% in certain regions. In parallel, as we have reduced the percentage of our substance use condition workforce who are in recovery, career long retention has withered. That we have huge barriers for recovering people to get into the very field they created is itself illustrative of the depth and breadth of systemic recovery pessimism. As our institutions fail to authentically support recovery, the workforce eventually stops believing that their work matters. They give up because over time they see what is behind the curtain. It can be very difficult to sustain hope when delivered by staff who experience it as being structurally unsupported.

As I wrote about five years ago in What Is "Moral Injury" in Addiction Care, there are few fields of work with the endemic level of implicit bias and systemic barriers as the substance use care system. A 2025 paper looking at turnover in peer workers found that association with a stigmatized group may subject us to harsher forms of discrimination even within the organizations we serve. That is recovery pessimism on the macro scale.

Recovery Realities and Lost Dividends of Return

And yet, the evidence tells us we could have a more robust and effective system design than the low expectation design we have now. The "85% recovery paradigm" drawn from decades of epidemiological research reminds us that the vast majority of people who experience substance use disorders will eventually achieve sustained recovery. It is typically gained across multiple pathways and over time within the vast local ecology of recovery community. Recovery is not rare; it is the norm. What is lacking is infrastructure designed and funded to recognize, measure, and support that long-term trajectory. When we organize care around acute stabilization rather than sustained recovery, we are not aligning with science, we are contradicting it. A system that truly believed in recovery would invest in continuity, relationships, community integration, and long-term follow-up. That is what the evidence base demands. It would treat hope, purpose and connections not as a vague aspirational concept, but as measurable and cultivatable targets that drive positive outcomes.

The broader societal implications are equally clear. Research consistently shows that recovery generates enormous public value: reductions in healthcare utilization, crime, and child welfare involvement; increases in employment, civic engagement, and community cohesion. People in recovery are not merely "former patients," they are parents, workers, taxpayers, and, often, they are the very hope carriers who help others find their way in our addictions treatment and recovery support infrastructure. Every person sustained into recovery represents a net gain to society that far exceeds the cost of that care.

What we actually do is penny wise and pound foolish. Fragmented and short-term care is actually more expensive for our society than providing people with what they need to flourish. The question, then, is not whether we can afford to build recovery-oriented systems, is whether we can afford not to. It costs more to our nation to have people stay mired in suffering than to help them, but we do not do so. Until our policies, funding structures, and performance measures reflect this reality, we will continue to lose both the workforce and the very outcomes we claim to value.

With such internalized negative perceptions about recovery and those who experience addiction could be expecting any different outcome than a demoralized workforce in perpetual transition? Why do our intuitions continue to fail to measure and invest in long term recovery?

Some questions to consider:

- What would a system look like if recovery were measured *and supported outcome*, not just the marketing language?
- Where does responsibility for change reside, the treatment and recovery support centers or within our funding and oversight structures?
- How much recovery pessimism exists at leadership levels, and how is it confronted in ways that lead to positive change?
- What would it take to build a system that internally mirrors the hope it asks workers to carry?

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