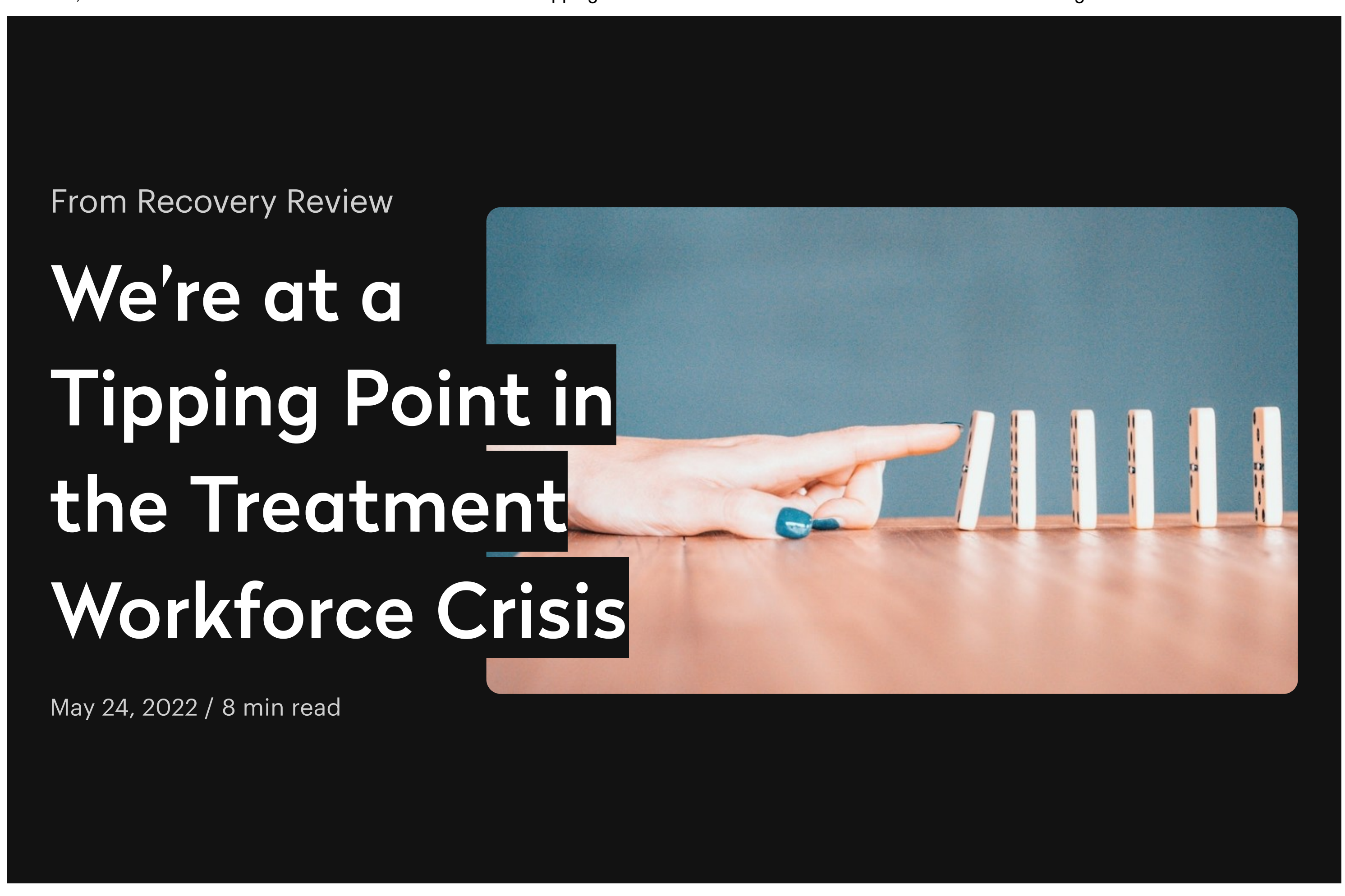

From Recovery Review

We're at a Tipping Point in the Treatment Workforce Crisis

May 24, 2022 / 8 min read

What's at stake? Nothing less than the loss of institutional knowledge

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By William Stauffer

Our substance use care system workforce has long faced very high turnover rates. One of the studies from years ago that always stuck with me as framing out the challenges and value of working in our field, was from 2003, the toughest job you'll ever love: A Pacific Northwest Treatment Workforce Survey. It identified turnover rates of around 25% annually. It was part of a systematic review of workforce challenges conducted through our Addiction Technology Transfer Center (ATTC) system funded by SAMHSA.

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My organization, PRO-A, did a similar survey here in PA in 2013. Similar results have been found year in and year out nationally. That perpetual churn was associated with high-stress work, low pay, and high administrative burden. This 2021 New York report found that program administrators identified that 44% of their counseling staff and 38% of support staff turn over every 1 to 3 years. They believe it is consistent with current national rates. Our capacity to sustain and strengthen our SUD workforce remains a significant challenge. When a crisis is measured in decades, we norm it. This is our situational normal. It is not the standard of workforce we need to have to serve those in need of our help across the nation moving forward.

> **We now have a debilitating strain on our public sector SUD programs that struggle to keep their census rates high enough to sustain their narrow margins of operation.**

On the eve of COVID-19, in May of 2019, the Annapolis Coalition released a report commissioned by SAMHSA noting that we needed an additional 1,103,338 peer support workers and 1,436,228 behavioral health counselors, as part of the 4,486,865 behavioral health workers conservatively estimated as our workforce gap. Enter the Great Resignation of 2021 and 2022. Looking back, such estimates ring as optimistic. We now have a debilitating strain on our public sector SUD programs that struggle to keep their census rates high enough to sustain their narrow margins of operation.

Data from beyond the SUD service system suggests that U.S. workforce resignation rates are highest among mid-career employees and are now being termed boss loss in some circles. It may have a link to a loss of a sense of well-being, as a recent report found that one in four workers left their jobs for mental health reasons. I recently wrote about this dynamic through the lens of a moral wounding to our SUD field.

Our SUD workforce was in a decades-long crisis before the “great resignation.” Those dynamics got much worse and were shouldered by fewer workers, increasing the strain on key staff. The challenges may not go away in the foreseeable future. Left unchecked, they may have a synergistic effect, a negative feedback loop in which newer workers are hired into programs that have lost the capacity to prepare them to be effective as a result of severe turnover—programs unable to sustain a focus of helping people heal from an S

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SUD service programs find themselves in a perpetual state of orienting new staff while experiencing a dearth of seasoned staff who have the institutional knowledge to transfer critical knowledge and skills to these new staff members. This churn is being exacerbated by the aging out of our existing SUD workforce and the loss of mid- and entry-level staff who are leaving for other positions either inside our SUD care system at higher resourced programs focused on private insurance clients or outside of the field to pursue more lucrative work not related to the SUD field.

Additionally, the destabilization of our SUD workforce is leading to the cannibalization of our field, particularly in the public sector. Struggling public-funded treatment programs either undermine their fiscal stability in bidding wars with other such wounded programs, to recruit staff to avoid cutting patient census numbers, or choose not to increase pay because they do not have the resources to do so, and reduce their program capacity. This sets up longer-term program deficits as their economies of scale are reduced. Both options lead to death from a slow bleed. These dynamics may not be things we readily see. We do not monitor the fiscal health of our public SUD treatment programs. This last point may be a thing to begin to do to get ahead of these trends and understand the implications of what is happening.

> **Let's make it easier for persons with lived experience to get into and to stay engaged in the SUD care system over an entire career.**

Programs are left with a Hobson's choice of going broke now as they cannot admit patients who need help because they lack staff or go broke later by paying staff more than the program can sustain to keep the doors open right now. Join the boss loss and abandon the work, go broke now, or go broke later. These are the choices administrators of public-funded SUD service system programs are faced with in our era. It is not a sustainable dilemma.

So, what do? Some thoughts for discussion:

Recruitment

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- Flip our workforce crisis lens from a deficit focus to a strength focus. People with lived experience are deeply committed to the community served. Let's make it easier for persons with lived experience to get into and stay engaged in the SUD care system over an entire career.
- Prioritize workforce development strategies that focus on making our SUD workforce more representative of the population it serves based on race, gender and lived recovery experience.
- Build a bridge into the field. Remove barriers for recovering persons who are passionate about doing this work, such as degree requirements for entry-level positions, criminal justice history barriers and other formidable front-end career-blocking polices so that we can get those eager to do this work into our field.

Workforce Development

- Support worker development at all stages of an SUD workforce career from entry-level to CEO. Every public program in the nation should be funded to support tuition reimbursement for their staff to help them stick, stay and grow.
- Supervision is the cornerstone for our entire field, yet it is unfunded and only supported as a peripheral need. Fund it, support it. Develop supervisors over the long term to improve the effectiveness of our whole service system.
- Establish a system-wide national mentoring infrastructure to nurture supervisors as the key to more effective care.

> **I hear reports of new staff, eager to help, turning into jaded workers in a matter of a few weeks.**

Workforce Retention

- Acknowledge and support SUD workforce wellness as a collective responsibility of our entire service system.

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- Examine regulatory standards and all relevant policies to expand the ability for SUD workforce employers to be flexible around employee hours and functions, to meet the needs of a workforce that expects such flexibility.
- Include all staff in decision-making processes so they know they are part of the outcome! Ensure that workers are included in decision-making across all of our organizations and across all of our government partners.

Is there a tipping point in respect to loss of institutional knowledge as a result of our workforce turnover? A point of no return? The thing about tipping points is far too often one does not know it has been reached until after it has occurred. What happens to those fresh faces if what they quickly learn is that the programs are ill-prepared to help them meet those objectives? I hear reports of new staff, eager to help, turning into jaded workers in a matter of a few weeks under such conditions. Building out a supportive infrastructure and healing these programs would take a lot of time, resources and commitment, and well as seasoned staff who know what to do to turn them around. All are things in short supply.

> **The less effective we become at helping people heal, the more some in our society see this as evidence that we do not get better, and so helping us is not worth it.**

We should also always remember that there is a reservoir of implicit bias in the general public against persons with substance use disorders and the systems that serve them. It is our inconvenient truth, as is discussed in How Bad is it Really? Stigma against Drug and Alcohol Use and Recovery in the United States, our recent collaborative report from PRO-A, RIWI and Elevyst. The less effective we become at helping people heal, the more some in our society see this as evidence that we do not get better, and so helping us is not worth it. Funding and support decrease, and effectiveness spirals even further. History shows us fairly clearly that when this happens, we shift back towards a punitive model. "Lock 'em up." This is the ultimate risk of the tipping point, the other side of that seesaw of history. Let's not go in that direction.

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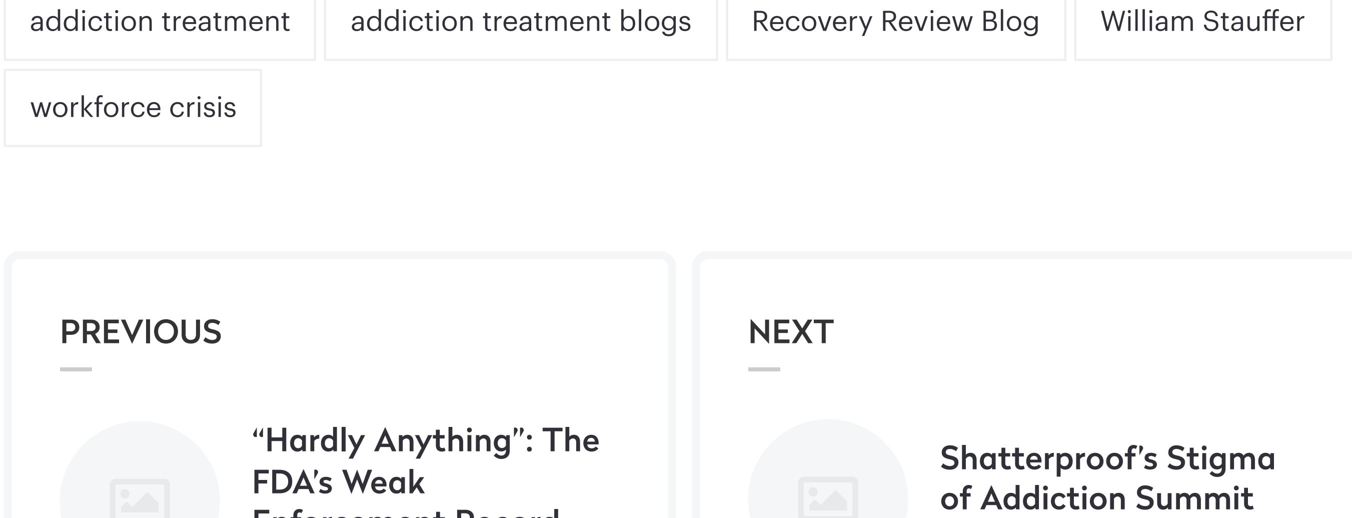
There's a popular Chinese proverb that says: "The best time to plant a tree was 20 years ago. The second-best time is now." Let's plant, and nurture, these trees now.

This Recovery Review post is by William Stauffer, who has been executive director of Pennsylvania Recovery Organization Alliance (PRO-A), the statewide recovery organization of Pennsylvania. He is in long-term recovery since age 21 and has been actively engaged in public policy in the recovery arena for most of those years. He is also an adjunct professor of Social Work at Misericordia University in Dallas, Pa. Find more of his writing, as well as a thought-provoking range of articles, insights and expert opinions on treatment and addiction at RecoveryReview.blog.

Photo: Bradyn Trollip



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