Sidelining Our Recovering Counselors...

In the Midst of an Unfolding SUD Workforce Disaster

By: William Stauffer, LSW, CCS, CADC

Our substance use service workforce is facing an unmitigated disaster. We are hemorrhaging staff, particularly experienced ones. Programs across the nation are experiencing unprecedented staffing shortages that reduce capacity to treat people who need our help. We were in a crisis for at least the preceding twenty years, but turnover and workforce shortages have deepened, while burdens and barriers to recruiting and retaining our SUD workforce have increased. It is now more of an unfolding disaster than a mere crisis.

Structural stigma is perhaps the most significant driver of this dynamic. A recent national stigma survey found that 7 in 10 Americans perceive people who use drugs as unable to improve their situation (Fleming et.al. 2022). As a result, we have made it increasingly difficult for our workers to do their jobs in part because we do not think the population is worthy of help or even capable of getting better. We put arbitrary rules and administrative barriers in place that reinforce bias against persons experiencing substance misuse issues and those of us who serve them. The challenges are particularly evident in rural and marginalized communities they experience a greater impact there compared to urban, well to do communities.

The crisis plays out even as we have a whole community of people with lived recovery experience who are eager to serve those in need yet face significant recruitment and advancement barriers. People who we could nurture and develop, but whom we have tended to set up additional barriers to employment due to the structural stigma that underpins everything that occurs in the addiction harm reduction, prevention, treatment, and recovery space.

Our substance use care system workforce has long faced very high turnover rates. A 2003 survey, "The toughest job you'll ever love: A Pacific Northwest Treatment Workforce Survey" identified turnover rates of around 25 percent annually (Gallon, S.; Gabriel, R.; & Knudsen, J. 2003). It was part of a systematic review of workforce challenges conducted through our Addiction Technology Transfer Center (ATTC) system funded by SAMHSA. A 2021 New York report found that program administrators identified a 44 percent of their counseling staff and 38 percent of support staff turn over every one to three years. These are unstainable rates of loss.

Back in 2013, my organization, the Pennsylvania Recovery Organizations Alliance conducted a workforce survey, the Systems Under Stress for our Single State Agency (SSA). Even in 2013, the SUD workforce was overburdened and not feeling like they had time to do the work to help people. They were stuck in piles of paperwork. We asked about goodness of fit between client needs and program capacity. Just under half of the respondents indicated that clients got lower levels of care than the clinicians thought were needed. They indicated that the people they served needed more care than they were allotted to provide. In short, they did not have the time, resources, or support that they needed to do the work to effectively help people get better. For those leaving the field, it came down to facing too many barriers that got in the way of helping people get better. They could not do the jobs they signed up to do, so they left.

In 2020, SAMHSA released a Behavioral Health Workforce Report focused on our pre-pandemic behavioral health workforce needs, which even then was showing an increased demand for services. The report calculated that we will need an additional 1,436,228 behavioral health counselors, 96,614 social workers or case managers, and 1,103,338 additional peer specialists to meet the demands as there were measured prior to COVID. The Pandemic has roiled the entire labor pool and increased demand for behavioral health services, including SUD services.

As we come to terms with a severe workforce challenge that is unfolding under the specter of unprecedented demand, one would think that our systems would be looking at ways to expand our pool of qualified workers and to strengthen our decaying workforce infrastructure. To deepen the bench of experienced staff and supervisors vital to stabilizing and developing the next generation of SUD workers. We are moving in a far different direction.

The ASAM 4th edition draft standards which recently were put out for review and comment, substantively limit those who can do the work of counseling across our national care system. It requires psychotherapy services to be provided only by master's level psychologists, social workers, and other master's level behavioral health professionals (e.g., licensed professional clinical counselors (LPCC), licensed marriage and family therapist). It flies in the face of our own history and what the literature shows about the pathways of non-degreed recovering people in our field. This move, if adopted, will force many of our current counselor workforce out of the field, with perhaps the greatest impact on our recovering counselor workforce. We will drive our care system

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into the ground at the moment we need it the most.

It is time to take a step back and evaluate the direction we are heading. To consider our history as a field largely created by the recovery community. We should consider how policy influenced by deep structural stigma and underlying biases against those of us who have experienced addiction and have dedicated our careers to help others like us to recover plays out in our policies. A helpful body of work to consider is a report titled "Peer-based addiction recovery support: History, theory, practice, and scientific evaluation" published by Bill White in 2009.

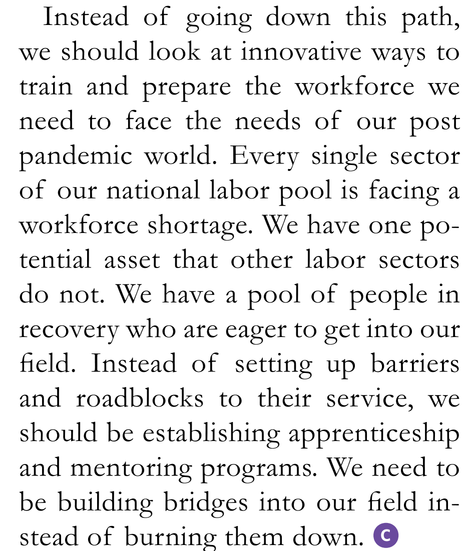
Among other findings, the paper examined facets of our recovering workforce and its history found that:

- The percentage of counselors in personal recovery within the specialty sector addiction treatment workforce declined from nearly 70 percent in the early 1970s to approximately 30 percent in 2008.
- Studies of addiction counselors in the US have found that recovering counselors are as effective as counselors who are not in recovery, with neither group showing superiority based only on the question of recovery status.
- Recovering people working in addiction treatment are paid less than people not in recovery for comparable work, even when their educational credentials are equal.
- The evaluation of treatment models delivered primarily by counselors in personal recovery report recovery outcome rates similar or superior to those of programs whose services are delivered by counselors without recovery backgrounds.

There are few if any more recent SUD care systems workforce studies in our current era that measure or examine career tracks typically followed by recovering people into our field. We should ask ourselves why we would limit access to the group of potential workers who are most eager to establish a career in our field. We should consider that there is little evidence that holding a master's degree is the best indicator of being qualified to be a counselor in the SUD field. We should consider our own history and what it says about a field that would close the door on the very community that established our field. One of the things we lose when we limit the professional SUD counselor workforce in this way is the loss of knowledge of recovery culture, something one cannot learn in any graduate degree program.

The pool of graduate level counselors does not look like the population we serve and are more concentrated in urban areas than in rural communities. Publicly funded treatment centers in rural communities and those serving the most marginalized populations are the hardest hit by these workforce shortages. The communities that are most deeply impacted by our national SUD counselor workforce shortage are the communities who most need these services. We risk shuttering programs in the very places we most need them. Let's not make it worse.

Instead of going down this path, we should look at innovative ways to train and prepare the workforce we need to face the needs of our post pandemic world. Every single sector of our national labor pool is facing a workforce shortage. We have one potential asset that other labor sectors do not. We have a pool of people in recovery who are eager to get into our field. Instead of setting up barriers and roadblocks to their service, we should be establishing apprenticeship and mentoring programs. We need to be building bridges into our field instead of burning them down. C



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About the Author

William Stauffer, LSW, CCS, CADC William Stauffer is the Executive Director of Pennsylvania Recovery Organization Alliance (PRO-A), the statewide recovery community organization of PA. He has run public SUD treatment and recovery community organizations for well over 3 decades and teaches Social Work at Misericordia University in Dallas PA. A person in long term recovery, in 2018, he testified to US Senate Special Committee on Aging on the opioid epidemic and older adults. William is the 2019 recipient of the Vernon Johnson Award Recovery Advocate of the year at the America Honors Recovery dinner. Recently, he served on Pennsylvania Governor Josh Shapiro's transition team.

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