

Recruiting and Retaining a Diverse and Skilled Addiction Treatment Workforce

Ranjani K. Paradise, PhD¹  and Sarah E. Wakeman, MD^{2,3} 

Substance Use & Addiction Journal
2024, Vol. 45(1) 10–15
Copyright © 2023 by AMERSA, Inc.
(Association for Multidisciplinary
Education and Research in
Substance use and Addiction)
Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/29767342231210210
journals.sagepub.com/home/saj



Abstract

National drug overdose deaths have been rising for decades, with particularly significant increases in recent years among populations of color. There is an urgent need for timely, accessible substance use disorder treatment, but workforce shortages across roles and settings impede the ability of the treatment system to meet the rising and evolving demand. In this Commentary, the authors discuss reasons for workforce shortages across roles, and offer recommendations for 8 areas of investment to grow and sustain a substance use and addiction care workforce prepared to address the overdose crisis in a racially equitable manner.

Keywords

race equity, addiction treatment workforce, workforce development, employee retention, employee recruitment, peer support specialists

Highlights

- Lack of SUD curricula in training programs, low salary scales, and insufficient mentorship contribute to a shortage of clinicians who are equipped to provide substance use and addiction care.
- Though there is growing recognition of the value of roles like outreach workers and peer support specialists for engaging marginalized communities in care, there is insufficient sustainable funding for this work.
- People who have lived experience with SUD face added barriers to entering and staying in the workforce, and these barriers are more pronounced for people of color.
- To address the overdose crisis *and improve racial equity, systems must invest in comprehensive workforce development* strategies to attract and retain people with diverse identities and experiences; train specialists; build capacity among generalists; support employee training, professional fulfillment, and well-being; and ensure competitive compensation across roles.

Drug overdose deaths have been rising for 2 decades,¹ with recent significant increases among Black and Native American populations.² In 2021, 106 699 Americans died from overdose.¹ Decades of research have identified clinical and public health interventions that reduce overdose

and mortality,³ yet a massive implementation gap persists. Only a small minority of people with past year substance use disorder (SUD) receive treatment annually⁴ and full integration of SUD treatment into healthcare settings is uncommon. While ideological barriers, stigma, and outdated policies remain challenges, a major reason for the continued access gap is a workforce shortage across roles. Making inroads on the drug overdose crisis will require far-reaching investments in the substance use and addiction workforce, with a focus on racial equity.

Roles and Skills Needed in the Substance Use and Addiction Treatment Workforce

A robust workforce prepared to address the full spectrum of the overdose crisis requires a range of roles, including addiction medicine and primary care physicians, psychiatrists, advanced practice practitioners (APPs), nurses, therapists, social workers, case managers, resource specialists,

¹Institute for Community Health, Malden, MA, USA

²Massachusetts General Hospital, Boston, MA, USA

³Harvard Medical School, Boston, MA, USA

Corresponding Author:

Ranjani K. Paradise, Institute for Community Health, 350 Main Street, Malden, MA 02148-5089, USA.

Email: rparadise@icommunityhealth.org

outreach workers, and peer support specialists. More than 20 million Americans have a SUD, but as of 2019 there were only 3171 addiction medicine physicians and addiction psychiatrists nationwide.⁵ There are significant projected shortages in psychiatrists and addiction counselors by 2030⁶ and in primary care physicians by 2034,⁷ and hundreds of millions of people live in regions that are designated as health professional shortage areas for primary care or mental health, both of which are necessary for comprehensive addiction treatment.⁸ Further, health professional shortage areas are often colocated with areas of high poverty and other social determinants of health needs,⁹ and are more likely to be areas with higher proportions of Black or African American residents.^{10,11} As the overdose crisis has become more concentrated in historically marginalized and underserved populations, there is a growing need for staff who can bridge gaps, build trusting relationships, and make connections to care. Skills in trauma-informed and culturally responsive approaches are critical across roles, and research has also emphasized that people with SUD are most likely to trust and engage with staff who share their racial and cultural identities and/or elements of their lived experiences, including experiences with drug use, recovery, incarceration, and homelessness.^{12,13} However, people of color remain underrepresented in many healthcare occupations^{14,15} and many SUD treatment facilities do not employ peer support specialist staff.¹⁶

Factors Impacting Recruitment and Retention

Clinical Roles

Widespread stigma and insufficient training around SUD persists, and this deters people from seeing addiction care as an attractive career path. Medical schools lack comprehensive addiction medicine curricula and robust faculty, making it unlikely that students will encounter mentors in this space. While medical students and trainees may recognize the overdose crisis as an urgent public health and social justice issue, underinvestment in addiction training has left them feeling underprepared.¹⁷ Additionally, low salary scales send the message that addiction medicine has less value than other specialties. In many institutions, addiction-specialized physicians may have lower salaries than primary care physicians, begging the question of why one should invest in additional training only to end up with less earning potential. Further, because structural racism has decreased generational wealth among people of color and increased the likelihood of graduating with debt, low salaries are a more significant barrier for underrepresented in medicine students. Lastly, most addiction medicine fellowship programs are grant- or philanthropy-funded, as

the federal government has not added durable funding akin to other Centers for Medicare & Medicaid Services (CMS)-funded residency and fellowship slots. This leaves programs in a state of financial uncertainty and prevents growth in fellowship training slots.

Many of these same factors are relevant for nonphysician roles. While exemplar SUD training programs exist, such as those funded through the Health Resources and Services Administration Integrated Substance Use Disorder Training Program grant, consistent and comprehensive SUD curricula and experiential learning in nursing, APP, social work, mental health counselor, and psychology training programs are generally lacking. Compensation packages are generally not competitive, and mentorship programs are not consistently available. Additionally, career pathways and job sustainability may not be evident to students and early career practitioners, given the lack of robust implementation of SUD treatment models in many healthcare settings.

Loan repayment programs can incentivize providers to work in community-based or rural settings, and the National Health Service Corps reports an investment of more than \$450 million in loan repayment for fiscal year 2022, including \$104 million for the SUD workforce.¹⁸ With the high cost of medical or graduate training, which presents a particularly significant barrier for historically marginalized communities, loan repayment is an important and deeply appreciated strategy for diversifying the workforce and attracting providers to high-need areas. However, while loan repayment can be effective as a short-term recruitment and retention strategy, there is limited evidence of effectiveness for promoting long-term retention,¹⁹ as even providers who are deeply committed to caring for underserved communities find positions to be unsustainable due to burnout and insufficient compensation.

Nonclinical Roles

There is growing recognition of the value of roles like outreach workers and peer support specialists for engaging marginalized communities in care, yet there is insufficient sustainable funding for this work. Though peer support specialists and community health worker services (including outreach) are Medicaid-reimbursable in many states,^{20,21} reimbursement rates and structures vary and do not always cover the full extent of services provided or support competitive salaries.²²⁻²⁵ Further, billing can be complicated and administratively burdensome^{24,26} and there is no comprehensive coverage with private insurance plans.²⁷ In cases where positions are not reimbursable or where billing is not administratively feasible, staff are often grant-funded through federal block grants or other funding sources, making it challenging for organizations to guarantee long-term job security or hire enough staff to

meet community needs.²³ This negatively impacts individuals in these critical frontline roles, who experience trauma and burnout, but lack coverage or flexibility to take time off or care for their own well-being. This leads to a turnover and organizations absorbing the costs of hiring and onboarding new people. Turnover also disrupts patient relationships and can diminish trust, which may already be fragile, especially for people from historically marginalized communities or those who have had negative experiences with care in the past.

People With Lived Experience

People who have lived experience with SUD face additional barriers to entering and staying in the workforce, and many of these barriers are more pronounced for people of color. Lived experience is traditionally not valued as highly as professional or educational experience in hiring processes and salary determinations, and peer support specialist roles tend to have low wages with limited opportunities for advancement.^{24,26,28-30} For candidates with criminal legal system involvement, Criminal Offender Record Information (CORI) or other background check policies limit job opportunities,^{22,24,26} and the CORI process and experience of being asked about this history can be traumatizing and stigmatizing. Furthermore, people with nontraditional backgrounds may not have experience or training in areas such as computer skills and documentation, and often do not receive sufficient onboarding or training support from employers.^{23,24,26} Finally, while burnout and trauma are challenges across roles, this presents particular risks to people who are in recovery themselves.^{24,31,32} Worries about job protection in the event of a SUD recurrence can discourage people from disclosing if they need additional support for their health and well-being,²³ and this is heightened for people of color because of the possibility of racial bias. All of these factors can be barriers or deterrents to entering the workforce, and also make it harder to succeed and stay retained in positions.

In addition, there may be a self-reinforcing cycle of racial disparities between treatment program staffing and patient outcomes. Interviews and focus groups with key stakeholders and community members in the Boston area have highlighted that when local programs have predominantly White staff, they tend to be less welcoming to people of color. This contributes to an observed pattern in which White patients are more likely to engage in treatment,³³ which also makes them more likely to enter recovery and be eligible to join the peer support specialist workforce in the future, reinforcing the very staffing conditions that contribute to treatment disparities.

Recommendations for Recruitment and Retention Strategies

To grow and sustain a diverse and skilled substance use and addiction workforce, systems must invest in comprehensive solutions that value and prioritize this field. This includes supporting the frontline staff who are critical points of engagement, while simultaneously developing a robust cadre of culturally responsive treatment providers to ensure that outreach and engagement efforts result in smooth connections to care rather than being bottlenecked by workforce shortages. Many of these changes will require financial resources, which organizations may not currently have, particularly community-based agencies. However, as states prepare to receive billions of dollars in opioid settlement funds, now is the time to consider bold investments. We propose the following 8 areas for investment to address the recruitment and retention challenges identified above:

1. *Develop equitable hiring and promotion practices:* To attract and retain candidates with diverse identities and experiences, organizations need to develop policies and practices that prioritize equity in hiring and promotion. This includes incorporating lived experience as a desired qualification in job descriptions, removing unnecessary degree and professional work experience requirements, changing CORI policies and processes to reduce barriers, advertising positions through community-based networks, and developing application review and interview protocols that reduce or mitigate bias. Clinical social work may provide a model to follow, as this workforce has higher racial and ethnic diversity than many other healthcare professions.^{34,35}
2. *Provide supportive onboarding, training, and supervision:* Organizations providing SUD treatment must invest in onboarding, training, and supervision structures that provide staff with the support they need to succeed in their roles. While the specifics would necessarily vary across disciplines, examples include consistent supervision across role groups, including dedicated peer supervision for those functioning in peer support roles. This is particularly important for people with nontraditional backgrounds who are new to healthcare professions and may face a steeper onboarding and orientation curve than other employees. Onboarding, training, and supervision must also be culturally responsive,³⁶ to foster a supportive environment for employees with historically marginalized or

- minoritized identities. This may require managers and supervisors to learn new approaches and invest more time, but has the potential to improve job performance, employee satisfaction, and retention, which in turn will positively impact patient care.
3. *Address burnout and support employee well-being:* To support long-term workforce retention, it is imperative that health care and community-based organizations recognize and address factors that cause trauma and burnout. This includes adjusting unsustainable caseload and productivity expectations and offering schedules that allow staff to take breaks and attend to their own health and well-being. Employers can also consider offering paid mini sabbaticals so that clinicians can take a longer period of time away from direct patient care to rest and rejuvenate. In addition, organizations can invest in counseling services to help staff process trauma that they experience in their work, such as witnessing an overdose.
 4. *Provide recovery-oriented supports:* For employees who are in recovery or have lived experience with SUD, employers can develop policies and practices that foster a safe and supportive work environment, which includes both addressing workplace conditions that increase the risk of substance misuse as well as providing accommodations and recovery supports.³⁷ The National Institute for Occupational Safety and Health Workplace Supported Recovery recommendations³⁸ and the Employment and Training Administration Recovery-Ready Workplace resource hub³⁹ provide useful guidance and tools for employers.
 5. *Develop sustainable funding structures for addiction medicine training programs:* As with any health condition, building a skilled workforce requires both increasing capacity and comfort among generalists and developing enough specialists. Addiction medicine fellowships offer specialized training for physicians to develop expertise in substance use and addiction, and these programs require sustainable funding to thrive. While federal grants have been critical for establishing new fellowship programs, more durable funding is necessary. One possible avenue is the Resident Physician Shortage Reduction Act of 2023 (S. 1302), which proposes 1200 new Medicare-supported graduate medical education slots to address physician shortages. Taking that further, developing Medicare-funded slots specifically for addiction medicine and addiction psychiatry would ensure growth in this crucial workforce. Sustained funding for interprofessional addiction training programs for nurses, APPs, psychologists, and social workers is also needed. Fields like palliative care, which similarly embrace interprofessional team-based care and have implemented APP training programs, may provide a roadmap.
 6. *Relieve workforce strain with care integration:* By better integrating SUD care into primary care, hospitals, and other settings, healthcare organizations can relieve some of the load on SUD specialists, which can help address burnout, foster retention, and improve access to care. This will require training and support for providers and staff across departments and care settings to broaden the scope of their practice to incorporate SUD care competencies, in addition to institutional policy changes that set the expectation that SUD care should be part of standard practice.
 7. *Promote professional fulfillment and growth:* Helping clinicians pursue professional development interests and career growth opportunities can also increase satisfaction and retention. This includes providing mentorship and supported promotion pathways across role groups, as well as protected time or stipends for research, writing and publishing, continuing medical education, conferences, or other development opportunities.
 8. *Develop funding models that enable competitive compensation packages:* Compensation for addiction medicine and addiction psychiatry must include competitive salaries and benefits. When we pay addiction specialists less than other specialties, we are making an explicit value statement about what our society is willing to pay for. To support higher salaries, payers must reimburse addiction care at a higher rate. Federal and state funding could also be used to subsidize salaries to recruit and retain physicians and other clinical and non-clinical staff. This is needed for all clinical role groups, including psychologists, social workers, mental health counselors, nurses, and advance practice providers. Additionally, more robust reimbursement is needed for critical nonclinical roles like outreach workers and peer support specialists, for example through bundled payments. With the racial wealth gap in the United States, providing competitive compensation is absolutely essential for developing a racially diverse workforce across roles. With opioid settlement funds exceeding \$50 billion, the notion that there is insufficient funding to support a workforce to address the devastation of the overdose crisis is simply unacceptable.

Author Contributions

RKP and SEW originated the idea, contributed to the writing of the article, and approved the final article draft for submission.

Declaration of Conflicting Interests

The author(s) declared the following potential conflicts of interest with respect to the research, authorship, and/or publication of this article: RKP declares that there is no conflict of interest. SEW receives textbook royalties as an editor for Springer textbooks and is an author for UpToDate.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

Compliance, Ethical Standards, and Ethical Approval

Institutional Review Board's approval was not required.

ORCID iDs

Ranjani K. Paradise  <https://orcid.org/0009-0002-6385-9384>
 Sarah E. Wakeman  <https://orcid.org/0000-0002-5475-2713>

References

- Spencer MR, Miniño AM, Warner M. Drug overdose deaths in the United States, 2001–2021. Centers for Disease Control and Prevention, National Center for Health Statistics; 2022. Accessed June 5, 2023. <https://www.cdc.gov/nchs/data/databriefs/db457.pdf>
- Opioid Overdose Deaths by Race/Ethnicity. KFF the independence source for health policy research, polling, and news. 2021. Accessed June 5, 2023. <https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-race-ethnicity>
- Carroll J, Green T, Noonan RK. *Evidence-Based Strategies for Preventing Opioid Overdose: What's Working in the United States*. Centers for Disease Control and Prevention; 2018. Accessed June 5, 2025. <https://www.cdc.gov/drugoverdose/pdf/pubs/2018-evidence-based-strategies.pdf>
- Substance Abuse and Mental Health Services Administration. *Key Substance Use and Mental Health Indicators in the United States: Results From the 2021 National Survey on Drug Use and Health*. Substance Use and Mental Health Services Administration; 2022. Accessed June 5, 2023. <https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFRRRev010323.pdf>
- Scutti S. 21 million Americans suffer from addiction. Just 3,000 physicians are specially trained to treat them. *AAMC*. 2019
- Health Resources & Services Administration Bureau of Health Workforce. Behavioral Health Workforce Projections, 2017–2030, HRSA Health Workforce. Accessed June 5, 2023. <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/bh-workforce-projections-fact-sheet.pdf>
- AAMC. AAMC report reinforces mounting physician shortage. *AAMC*. 2021. Accessed June 5, 2023. <https://www.aamc.org/news/press-releases/aamc-report-reinforces-mounting-physician-shortage>
- Health Resources and Services Administration. Health Workforce Shortage Areas. 2023. Accessed June 5, 2023. <https://data.hrsa.gov/topics/health-workforce/shortage-areas>
- Streeter RA, Snyder JE, Kepley H, Stahl AL, Li T, Washko MM. The geographic alignment of primary care health professional shortage areas with markers for social determinants of health. *PLoS One*. 2020;15(4):e0231443.
- Gaskin DJ, Dinwiddie GY, Chan KS, McCleary RR. Residential segregation and the availability of primary care physicians. *Health Serv Res*. 2012;47(6):2353–2376.
- Brown EJ, Polsky D, Barbu CM, Seymour JW, Grande D. Racial disparities in geographic access to primary care in Philadelphia. *Health Aff*. 2016;35(8): 1374–1381.
- Mercer F, Miler JA, Pauly B, et al. Peer support and overdose prevention responses: a systematic ‘state-of-the-art’ review. *Int J Environ Res Public Health*. 2021;18(22): 12073.
- Paradise R, Desmarais J, Clarke J, et al. Workforce considerations for improving racial equity in substance use disorder treatment. Presented at the American Public Health Association Annual Meeting & Expo; November 6–9, 2022; Boston, MA. Accessed June 5, 2023. <https://apha.confex.com/apha/2022/meetingapp.cgi/Paper/516116>
- Salsberg E, Richwine C, Westergaard S, et al. Estimation and comparison of current and future racial/ethnic representation in the US health care workforce. *JAMA Netw Open*. 2021;4(3):e213789.
- Jordan A, Jegede O. Building outreach and diversity in the field of addictions. *Am J Addict*. 2020;29:413–417.
- Videka L, Neale J, Page C, et al. *National Analysis of Peer Support Providers: Practice Settings, Requirements, Roles, and Reimbursement*. University of Michigan Behavioral Health Workforce Research Center; 2019.
- Bäck DK, Tammara E, Lim JK, Wakeman SE. Massachusetts medical students feel unprepared to treat patients with substance use disorder. *J Gen Intern Med*. 2018;33:249–250.
- Health Resource and Service Administration. FY 2022 NHSC program funding. 2023. Accessed June 5, 2023. <https://nhsc.hrsa.gov/fy22-nhsc-field-strength-funding>
- ASPE. National health service corps: an extended analysis. 2016. Accessed June 5, 2023. <https://aspe.hhs.gov/reports/national-health-service-corps-extended-analysis>
- Fortuna KL, Solomon P, Rivera J. An update of peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psych Quart*. 2022;93:571–586. doi:10.1007/s11126-022-09971-w
- Schmit CD, Washburn DJ, LaFleur M, et al. Community health worker sustainability: funding, payment, and reimbursement laws in the United States. *Public Health Rep*. 2022;137(3):597–603. doi:10.1177/00333549211006072
- Wallis R, Signorelli M, Linn H, Bias T, Allen L, Davis SM. Lessons learned from employing medicaid-funded peer recovery support specialists in residential substance use treatment settings: an exploratory analysis. *J Sub Use Addict Treat*. 2023;154:209136. doi:10.1016/j.josat.2023.209136
- Felton JW, Abidoguan TM, Senters K, et al. Peer recovery coaches perceptions of their work and their implications for training, support and personal recovery. *Comm Ment Heal Journ*. 2023;59:962–971. doi:10.1007/s10597-022-01080-z

24. Stack E, Hildebran C, Leichtling G, et al. Peer recovery support services across the continuum: in community, hospital, corrections, and treatment and recovery agency settings – a narrative review. *J Addict Med.* 2022;16(1):93-100. doi:10.1097/ADM.0000000000000810
25. Halder W, Hinton E. State policies for expanding medicaid coverage of community health worker (CHW) services. *KFF.* January 23, 2023. Accessed October 5, 2023. <https://www.kff.org/medicaid/issue-brief/state-policies-for-expanding-medic-aid-coverage-of-community-health-worker-chw-services/>
26. Chapman SA, Blash LK, Mayer K, Spetz J. Emerging roles for peer providers in mental health and substance use disorders. *Am J Prev Med.* 2018;54(6):S267-S274. doi:10.1016/j.amepre.2018.02.019
27. Lovett L. Standardized Credentialing, Reimbursement Clarity Could Accelerate Use of Peers in Behavioral Health Care. *Behavioral Health Business;* 2023. Accessed October 5, 2023. <https://bhbusiness.com/2023/06/16/standardized-credentialing-reimbursement-clarity-could-accelerate-use-of-peers-in-behavioral-health-care/>
28. Gagne CA, Finch WL, Myrick KJ, Davis LM. Peer workers in the behavioral and integrated health workforce: opportunities and future directions. *Am J Prev Med.* 2018;54(6):S258-S266. doi:10.1016/j.amepre.2018.03.010
29. Cronise R, Teixeira C, Rogers ES, Harrington S. The peer support workforce: results of a national survey. *Psychiatr Rehabil J.* 2016;39(3):211-221. doi:10.1037/prj0000222
30. Lapidus A, Jester J, Ortquist M, Werner P, Ruffolo MC, Smith M. Survey of peer support specialists: professional activities, self-rated skills, job satisfaction, and financial well-being. *Psych Serv.* 2018;69(12):1264-1267. doi:10.1176/appi.ps.201800251
31. Williams C. To help others we must care for ourselves: the importance of self-care for peer support workers in substance use recovery. *J Addict Disord.* 2021;8(2):071. doi:10.24966/AAD-7276/100071
32. Englander H, Gregg J, Gullickson J, et al. Recommendations for integrating peer mentors in hospital-based addiction care. *Subst Abus.* 2020;41(4):419-424. doi:10.1080/08897077.2019.1635968
33. Dooley D, Wada R, Mehta A, et al. *Data Brief: Racial Differences in Accessing Substance Use Disorder Treatment Following an Opioid Overdose in Massachusetts and Boston.* Boston Public Health Commission; 2019.
34. Council on Social Work Education. The provision of behavioral health services by recent Master of Social Work (MSW) graduates. 2021. Accessed October 5, 2023. https://www.cswe.org/CSWE/media/Workforce-Study/WorkforceStudyBrief-MSW_Provision_of_Behavioral_Health_Services.pdf
35. Salsberg E, Quigley L, Richwine C, Sliwa S, Acquaviva K, Wyche K. The Social Work Profession: Findings From Three Years of Surveys of New Social Workers. Council on Social Work Education; 2020. Accessed October 5, 2023. <https://www.cswe.org/CSWE/media/Workforce-Study/The-Social-Work-Profession-Findings-from-Three-Years-of-Surveys-of-New-Social-Workers-Dec-2020.pdf>
36. DeAngelis T. Increasing supervisor savvy around culture, race, and identity. *Monit Psych.* 2023;54(1): 34.
37. Frone MR, Chosewood LC, Osborne JC, Howard JJ. Workplace supported recovery from substance use disorders: defining the construct, developing a model, and proposing an agenda for future research. *Occ Heal Sci.* 2022;6:475-511. doi:10.1007/s41542-022-00123-x
38. Centers for Disease Control and Prevention, The National Institute for Occupational Safety and Health (NIOSH). Workplace supported recovery program. 2023. Accessed October 5, 2023. <https://www.cdc.gov/niosh/topics/opioids/wsrp/default.html>
39. U.S. Department of Labor Employment and Training Administration. Recovery-ready workplace resource hub. Accessed October 5, 2023. <https://www.dol.gov/agencies/eta/RRW-hub>