Special Issue: Addiction Workforce

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News for policy and program decision-makers

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'Behavioral health workforce' will have shortage of addiction professionals: HRSA

Combining mental illness, mental well-being, and substance use disorders (SUDs) in the broad category of behavioral health may work for the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Council for Mental Well-being, but it's not useful on the ground. Patients with SUDs need treatment professionals trained in that category.

And there will be enough "behavioral health" workers in all categories except for two: psychiatry and addiction treatment, according to the federal Health Resources and Services Administration (HRSA), in a report released last August.

Bottom Line...
The shortage in "behavioral health" professionals will be in addiction and psychiatry, not other categories, according to HRSA.

Shortfall in addiction counselors

To shed light, the Senate Finance Committee reported in 2022 that HRSA projects a shortage of 24,060 behavioral health providers in 2030. HRSA projects this shortage to reflect insufficient adult psychiatrists and addiction counselors

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Pennsylvania providers say onerous regulations worsen workforce challenges

Many substance use treatment provider agencies in Pennsylvania consider state regulatory requirements to be their primary barrier to hiring more staff and operating at full capacity, but agency officials have said that they face state officials' unwillingness to budge from the longtime mandates.

Having aired their concerns in March at a state legislative hearing, representatives of treatment agencies said the only response they've received from the state Department of Drug and Alcohol Programs (DDAP) is an invitation for individual agencies to apply for an exception to a regulatory requirement. That, these treatment leaders contend, would only add to the administrative burden for a treatment workforce already awash in paperwork that detracts from clinical care.

Bottom Line...
Licensed substance use treatment providers in Pennsylvania say state regulators' rigid approach to staff-to-patient ratios hamper them from hiring enough staff to meet the community's demand for care.

"The regulators are not as willing as the provider community would hope to come to the table and look at reform," Jason Snyder, director of the behavioral health division of the Rehabilitation and Community

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in 2030 if there are no changes in behavioral health care utilization." HRSA anticipates an adequate supply of remaining behavioral health practitioners to meet the needs of Americans. As a result, the focus of policymakers must be on SUD professionals.

Psychiatrists are the only other category in HRSA's 9 categories of behavioral health providers, in addition to SUD counselors, projected to have a shortfall in 2030.

Nationally, two of the nine behavioral health occupations estimated in this report (psychiatrists and addiction counselors) are projected to experience shortages in supply by 2030 if there are no changes in behavioral health care utilization from today.

"Workforce policies continue to focus on [the] 'behavioral health' workforce rather than specifically the SUD workforce," said Andrew Kessler, J.D., federal policy liaison for the International Certification and Reciprocity Consortium (IC&RC). "This must change to reflect a priority on SUD professionals. When it comes to workforce, [we] must skew heavily towards the recruitment and retention of addiction counselors and psychiatrists above all others. No other 'behavioral health' professions are reflecting shortages in this analysis."

Barriers

Below are barriers to the SUD workforce:

- **Turnover rate:** The SUD workforce faces a 32% turnover rate and significant barriers to retaining their staff, outpacing several other provider types. The substance use disorders sectors of the health care workforce face relatively high rates of turnover (i.e., SAMHSA reported an average turnover rate of 32% in the substance use disorder space). For comparison, physicians' turnover rate of roughly 7% is considered a concern. The high turnover rate results in an annual cost of $100-200,000 for a large organization, taking into account the minimum cost of replacing a coworker at 30% of their annual salary.
- **Burnout:** Over 50% of behavioral health providers report experiencing symptoms of burnout, and this is likely to increase given continued growth in the number of people seeking behavioral health care along with behavioral health staffing and retention challenges.
- **Reimbursement:** Kessler said he also is concerned about reimbursement rates, noting that until reimbursement rates for the treatment of SUDs are increased to the levels seen by professionals who treat other chronic diseases, skilled workers will remain uninterested in the profession," said Kessler. Historically, reimbursement rates and consequently salaries for physicians, psychologists, social workers and counselors in the addiction field have been well below salaries for comparable professionals in other health care specialties that require the same level of education and training. For example, the average salary for social workers in the addiction field is $38,600, compared to $47,230 in the rest of the health care industry, according to the Bureau of Labor Statistics. "Rewards, recognition, pay and benefits all contribute to staff feelings of belonging and well-being," said Kessler. "Inconsistent or inequitably distributed rewards and recognition will contribute to an employee feeling their work is unimportant or undervalued, which can affect staff retention," he added. "We will never grow the SUD workforce via recruitment and retention if poor reimbursement, especially by Medicaid, continues to be allowed." •

For the HRSA report, go to https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand/behavioral-health.

ALCOHOLISM & DRUG ABUSE WEEKLY
News for policy and program decision-makers

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Blurring the lines: 'behavioral' health

The argument goes back decades, but the most painful memory is of the time when the Substance Abuse and Mental Health Services Administration (SAMHSA) leadership tried to use the concept of "behavioral health" to wrest the SUD block grant away from SUDs and share it with mental illness (see *ADAW* https://onlinelibrary.wiley.com/doi/epdf/10.1002/adaw.20278).

And it is no longer happening — the opioid overdose epidemic has made it clear that every penny is needed for the SUD field — not that mental health doesn't need more funding. But blurring the lines between mental illness and substance use doesn't help anyone plan for the future in terms of workforce.

It matters whether a patient goes to a behavioral health provider with schizophrenia, depression, alcohol use disorder, opioid use disorder or a combination, perhaps including other diseases as well. Just calling someone a "behavioral health" provider doesn't qualify to treat "any or all of the above."

Still, behavioral health pervades as terminology in some quarters. Below is what SAMHSA and the National Council have recently r eleased.

SAMHSA's description of the "behavioral health workforce":

"The behavioral health workforce functions in a wide range of prevention, health care and social service settings. These settings include prevention programs, community-based programs, inpatient treatment programs, primary care health delivery systems, emergency rooms, criminal justice systems, schools or higher education institutions. This workforce includes, but is not limited to:

- Psychiatrists;
- Psychologists;
- Social workers;
- Advanced-practice psychiatric nurses;
- Marriage and family therapists;
- Certified prevention specialists;
- Addiction counselors;
- Mental health/professional counselors;
- Psychiatric rehabilitation specialists;
- Psychiatric aides and technicians;
- Paraprofessionals in psychiatric rehabilitation and addiction recovery fields (e.g., case managers, homeless outreach specialists or parent aides);
- Peer support specialists; and
- Recovery coaches.

"Although the field is growing due to increases in insurance coverage for mental health and substance use services and the rising rate of military veterans seeking behavioral health services, serious workforce shortages exist for health professionals and paraprofessionals across the United States," according to SAMHSA. "To support anticipated demands, the SAMHSA-Health Resources and Services Administration (HRSA) Center for Integrated Health Solutions (CIHS) promotes the development of integrated, bidirectional primary and behavioral health services to better address the needs of people with mental health and substance use conditions. HRSA-CIHS also provides guidelines on how to provide culturally relevant services."

National Council survey

Last month the National Council released a survey referring always to the "behavioral health workforce." There are concerns about both mental health and substance use treatment, based on the survey, which found:

- Increased demand for both is colliding with the lack of resources, raising concerns that people — especially those most in need — aren't receiving the treatment and care they need.
- There is an urgent need for policy solutions to address a crippling workforce shortage so organizations can meet demand for mental health and substance use treatment and care.

Here are few of the findings from the survey, released April 25:

- More than 9 in 10 behavioral health workers (93%) said they have experienced burnout, and a majority report suffering from moderate or severe levels of burnout (62%);
- More than 8 in 10 (84%) of behavioral health professionals and more than 7 in 10 (78%) of the general public said people most in need of care have the most difficulty receiving it.
- The vast majority (83%) of the nation's behavioral health workforce believes that without public policy changes, provider organizations won't be able to meet the demand for mental health or substance use treatment and care.
- More than 4 in 5 behavioral health employees (83%) and three-quarters of the general public (75%) worry that workforce shortages in mental health and substance use treatment will negatively impact society.
- The House Committee on Energy and Commerce's Subcommittee on Health recently held a hearing on several workforce related bills, including the Strengthening Community Care Act of 2023 (H.R. 2559), the National Nursing Workforce Center Act of 2023 (H.R. 2411), and several draft bills all related to workforce.
- The Senate Health, Education, Labor and Pensions (HELP) Committee held a hearing last month titled, "Examining Health Care Workforce Shortages: Where Do We Go From Here?"

Chuck Ingoglia, National Council president and CEO, said that the findings call for "the continued expansion of Certified Community Behavioral

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Health Clinics" that will give organizations that provide mental health treatment and substance use care the resources they need to meet capacity."

Solutions, according to the National Council, include

- Creation of a behavioral health workforce demonstration to help recruit and retain mental health and substance use treatment staff at critical safety net provider organizations. Given the high turnover and burnout rates, funding options to support retention bonuses, hazard pay, overtime and more could significantly support the retention and well-being of behavioral health workers.
- Increased funding for, and expansion of, national loan repayment programs, including the National Health Service Corps (NHSC), the NHSC Substance Use Disorder Workforce Loan Repayment Program (LRP) and the Substance Use Disorder Treatment and Recovery (STAR) LRP, to include those who provide care outside of clinic walls, and increased access to tuition assistance for the mental health and substance use fields similar to the Nurse Corps Scholarship Program. Currently, no such equivalent exists for the behavioral health workforce.
- Further support the implementation and financing of Certified Community Behavioral Health Clinics (CCBHCs) to ensure access to services nationwide. The CCBHC model transforms the traditional reimbursement rate model by allowing clinics to include the actual costs of expanding access to care in their reimbursement rate, including measuring appropriate staffing and service needs unique to their community, plus potential salary and benefits changes.
- With the help of this innovation, clinics that became CCBHCs hired an average of 27 new positions per clinic and experienced an average 16% increase in their workforce.
- Support implementation of the Mental Health Access Improvement Act, legislation that was supported by the National Council and passed into law in late 2022. This legislation would allow marriage and family therapists and licensed professional counselors to bill Medicare and provide support for this sector of the workforce as they prepare for new billing structures and more.
- Work with the administration to reduce unnecessary administrative burdens that contribute to burnout. The research found a third of the workforce reported spending most of their time on administrative tasks, with 68% of those who provide care to patients saying the amount of time spent on administrative tasks takes away from time they could be directly supporting clients. •

From addict to patient to counselor: Shannon's story

Shannon Hall, *whom ADAW* met at the Rx and Illicit Drug Summit in Atlanta last month, grew up in Kentucky and has a family history of addiction. He became addicted to pain pills, and couldn't stop. He thought, like many, that since he wasn't using needles, he was okay. "I think that's a phase for everyone who's gotten into this — I hear it all the time — 'At least I didn't use a needle.'" But the pills were expensive, his wife wondered where his money was going, and he was afraid of embarrassing his parents. "They hated drugs so much," so he never told them he needed help. He did go to treatment six times, and those visits weren't wasted, he said. "Each time, the seeds were planted" for the future, Hall said.

The first time he went to treatment in Lexington, Kentucky, he kept hearing "If nothing changes, nothing changes." He thought that he could get out and just avoid needles and benzodiazepines. He had to go back into treatment, but had a friend bring him drugs.

He finally did tell his parents — not that he had an addiction, but that he had lost his job. "I didn't know how to talk about it," he said of his addiction. "But what I found when I went to treatment was how comfortable I felt there, I was talking to people like me, who didn't judge me. I found that just talking to somebody else helped me."

Five years afterwards he was still off of the opioids but substituted alcohol. "I kept telling everyone I was clean," he said. He was driving his daughter to her after-school ball games drunk, sick with a hangover at work the next day. Drinking brought on gout, and the doctor gave him a prescription for Percocet. "So I'm back to the races," he said. "I ended up going to a Suboxone clinic." For Shannon, both methadone and buprenorphine were good drugs, but he only wanted them so he could get high, he said. "I think people should be on a taper." He ended up taking Vivitrol, which worked.

When his son was born in 2010, the baby was born without a pulmonary valve, which would have been completely reparable with open heart surgery. Hall was still on drugs; no longer drinking. The son recovered well, but it turned out that the surgeon was in trouble for botching infant surgeries. So he had to go to another hospital in Michigan in 2012 to have the problem repaired. There, the child died.

Hall's depression was so bad that he said he wanted to commit suicide.

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FROM THE FIELD

Addiction professionals: Fight the American 'hatred for people who use drugs'

By John de Miranda

The February 26, 2023, edition of *The New York Times* devoted almost the entire Sunday Opinion section to one article titled "One Year Inside a Radical New Approach to America's Overdose Crisis." The narrative and dramatic photos detailed the operation and challenges of OnPoint, a safe drug consumption program in Manhattan's Harlem neighborhood.

The "radical new approach" is harm reduction, which I have written about previously in this space. What jumped out at me was the quote from a well-respected, Stanford University-based addiction researcher who stated, "There's still deep hatred in this country for people who use drugs."

In my youth I came to believe that our field's embrace of criminal justice responses to people who used drugs was a pact with the devil. Certainly, it provided us credibility and clients, but the cost included tacit agreement with the broader culture's demonization of drug use. As a field we much prefer our drug users to be in recovery or at least trying to stop.

When I read the Times article, I called my colleague Dr. Tom Horvath whose thinking about drugs has often guided me. His immediate response was to suggest that maybe addiction and recovery professionals bear some responsibility to try and lead the public away from this "deep hatred."

There was a time in our collective history when leadership and resources were devoted to helping Americans embrace a compassionate view of people with addiction disorders. The National Council of Alcohol and Drug Dependence, founded by Alcoholics Anonymous pioneer Marty Mann, is no longer. Today, Faces and Voices of Recovery tends to focus on creating respect for those in recovery, but has recently embraced harm reduction strategies for recovery community organizations.

Lately, there has been much hand-wringing because our efforts to stem the opioid crisis have been only partially successful. One of the barriers has been the separation of care for drug users from the care for those willing to embrace abstinence as a goal. We have thousands of outpatient treatment programs in the United States that serve the latter population, but harm reduction programs that serve active users on the other hand are few and far between.

What if we could integrate full harm reduction services into all addiction treatment programs? Could that create a scale of care that could have a major impact on the status quo?

Addiction treatment organizations that include active engagement with street-level drug users are rare.

Boston's Victory Programs (www.vpi.org) has a robust presence on the streets and counts as one of its many missions to serve people who may never enter one of its treatment services. Their mobile prevention team distributes syringes, kits filled with hygienic supplies, wound care kits, safer smoking kits, condoms and lubricants, as well as Narcan and fentanyl test strips. At the Victory Connector, in the heart of what used to be known as Boston's 'Combat Zone,' women-centered and transgender individuals can use bathrooms and receive free, confidential HIV, hepatitis C, and sexually transmitted disease testing and navigation to treatment or prevention services.

Victory's harm reduction services are not delivered with the expectation or hope that recipients will enter treatment. The agency's philosophy of care states unequivocally all individuals are welcome and will receive care.

Individuals come to our programs because they have serious problems with "living," and we work for them. We welcome them for who they are, and not who we would like them to be. Underlying our philosophy of care is what we consider to be common sense: No person who is struggling should be asked to do the hardest thing first — whether that's stopping substance use, addressing mental health issues, or finding permanent housing and a job — on their own before they are offered the fundamental support they truly need.

So, if there's still 'deep hatred in this country for people who use drugs,' can we, as a collective field, continue to remain bystanders?

I believe that our goal should be to transform our traditional outpatient services to look more like Victory Programs, where care is provided to all.

Modelling unconditional positive regard for active drug users is an antidote to the American aversion to people who use drugs.

John de Miranda, Ed.M., is an independent consultant specializing in substance use disorder, recovery and disability issues. He can be reached at 650-218-6181; solanda@sbcglobal.net.

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"I asked the doctor for an antidepressant, and they said it would take two to four weeks to work," he said. "I just wanted something that would take the pain away right away. So I started to self-medicate even more."

Then, a CNN reporter asked Hall and his wife if they would talk about the pediatric cardiac surgeon who had not done his son's surgery properly. "It turned out that the doctor was accused of doing surgeries on babies he wasn't qualified for, and our son was one of them," Hall said. "I think I was being punished for my life. After the interview was over, I overdosed in the parking lot of the Marriott in Lexington. No one found me. Thank God I woke up, I guess."

It turned out the mortality rate at the University of Kentucky for this surgeon was seven times the national average. Hall's anger kept fueling his addiction, he said. "In my mind this world owed me something."

But then, Hall started going to church, so that he could have a "mask," not because he really believed, he said. "But I said, 'I'm broken, I have more than I can bear.'"

That was the time that interview with the Halls and CNN aired. The pediatric cardiac surgeon had gone to work at the University of Florida, which fired him the next day. "They tried to settle with us," said Hall. "They tried every way in the world to get that doctor to keep his license."

While all of this was going on, Hall was still using drugs. He last went into treatment on Feb. 5, 2018, and has been sober ever since.

Why did he go into treatment that last time? "Because I wanted to quit," he said. "The cops were after me. They would camp out just waiting for me to mess up. One cop wanted to see me fail. I'd be out walking our dog or throwing a ball, trying to live my life. He'd point me out and say 'Put your dog on a leash or I'm taking you in.'"

Hall went back to the same treatment center in Lexington he had been to before, but transferred to a faith-based rehabilitation center called Addiction Recovery Care on the advice of his cousin. "So I walk into this place, and a bunch of men are coming up to me telling me they love me and hugging me — it was awful," he recalled, grinning. "I was willing to do whatever they wanted; I was tired of being suicidal. I had enough pain and misery — eight accidental overdoses, eight intentional."

Now Hall works for Addiction Recovery Care.

And here is a special story relating to a judge. Hall was facing 12 years in prison. He turned himself in. "It's the same judge I've sat in front of 30 times or more. He said 'I'm tired of seeing you. I'm going to make sure you do as much of this time as I can give you.'" Then, people from Addiction Recovery Care had written letters on his behalf, unbeknownst to Hall, and the judge read them, and released him. "That judge never gave up on me," Hall said.

When ADAW spoke to Hall, he had just taken on a new job as a spiritual life coach. He was also a certified drug and alcohol counselor associate, and planning on a career as a certified drug and alcohol counselor.

In December he will graduate with a degree in human services, and recently bought a house and a car. His father found out that he was an alcoholic and stopped drinking. And his parents "know everything about me." Hall looked and sounded happy and confident at last month's conference, and, like so many people in recovery that *ADAW* has interviewed, honest. We wish him the best for the future. He has certainly earned it. •

Peers in addiction treatment: An evolving profession

"It's what keeps me up at night." That's what one treatment provider told *ADAW* recently about the use of "peers" in treatment programs. While they are well-meaning, they are naïve. And this treatment provider spoke off the record, but echoed the sentiments of many, at least when it comes to this new, in many places completely unregulated, profession.

The Substance Abuse and Mental Health Services Administration (SAMHSA) recently hosted a technical expert panel on peer support certification, with a report expected to be released later this year. As with other licenses and certifications, each state is different, noted SAMHSA spokesman Chris Garrett. SAMHSA does list core competencies of peer workers as part of its Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) and these focus on recovery and being person-centered (https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers/core-competencies-peer-workers).

The National Association for Addiction Professionals does have a national certification for peers: National Certified Peer Recovery Support Specialist (NCPRSS). For more information, go to https://www.naadac.org/ncprss.

Still, every state is different.

The bottom line for Andrew Kessler, J.D., public policy liaison for the International Certification and Reciprocity Consortium (IC&RC), is the same for peers as it is for other substance use disorder (SUD) professionals: "For decades, policymakers didn't keep tabs on SUD professionals because for decades they didn't care; they didn't care about this population, and what goes along with that is they didn't care about who treated them." With the attitude of "whoever wants to treat can

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treat," in Kessler's words, it became obvious that the role of peers is no longer the old one in which a peer was someone who was in recovery, typically from alcohol use disorder, and would help someone trying to achieve recovery, but was not by any means a treatment professional.

What has changed the definition appears to be the opioid overdose epidemic. Peers are needed for street outreach, for working in opioid treatment programs, for working in overdose prevention centers. It's a new industry, with states paying the bill.

In Rhode Island, for example, there is Project Weber/RENEW, which was originally two organizations based on supporting sex workers, and merged into one, which is now harm reduction central for the state.

In New York City, peers are at such high demand that it's difficult for treatment providers to find them.

And Rhode Island and New York both have some standards for peers, but they are very different.

"We're building this on the fly," said Kessler. "It's all over the map. I wish I could say I have a solution."

IC&RC already has enough to deal with getting SUD professionals recognized throughout the states. That is the purpose, for a certified alcohol and drug counselor (or whatever terminology the state uses) to be able to carry that certification to another state and to be licensed. "We're still not there yet," said Kessler.

The reason for standards, for any kind of health professional, is protection of the public. "Standards keep the public safe, so a patient knows care is coming from a qualified professional who has met that standard."

A peer can, first and foremost, help someone navigate the system; get into treatment, for example. The reason Mayor London Breed of San Francisco shut down the overdose prevention center there is that fewer than 1% of participants were being connected to treatment, so to the extent that peers were involved — and they are typically the entire workforce of an overdose prevention center — they were not helping with that navigation.

Finally, it's important to recognize that peers are not just a less expensive way of providing treatment, the way nurse practitioners and physician assistants are often viewed in physical medicine.

But for peers, the need for professionalism is particularly germane. "If we want the profession, key word being 'profession,' of peers being taken seriously and being reimbursed at their worth, they are going to have to meet standards," said Kessler. "A person who is meeting with a peer is incredibly vulnerable and incredibly scared. And, at the very least, if the person providing peer services does not, at the very least, have training in ethics, I can't be confident that the person seeking care is in the best of hands."

ADAW checked with states: Peer standards are completely out of line with each other. It's as if someone in the state bureaucracy decided standards were needed — but in some cases, not too strict because then there wouldn't be any, and in others, very strict so the public doesn't get harmed. If even treatment providers are worried about possible harms their well-meaning peer colleagues could do, what will the peer profession do to create trust, in the absence of regulations? •

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Providers Association (RCPA), told *ADAW*. "Their answer to regulatory relief is more administrative burden. They take a very paternalistic view of this."

Atop most licensed providers' list of regulatory concerns is the staff-to-patient ratios to which these agencies must adhere. For example, Snyder said, a 40-bed residential program that offers clinically managed intensive rehabilitation services would need five counselor-level clinicians to maintain the state's required 1-to-8 staff-to-patient ratio. If the agency was able to retain only three clinicians at a particular time, it would have to leave 16 beds open — at a time of dire need for treatment services in the community, he said.

The secretary of DDAP has the authority to allow blanket exceptions to these requirements based on current circumstances, Snyder said, but has shown no willingness to do so. Providers therefore are now working with state lawmakers who may be interested in enacting legislative remedies.

Longtime concern

Snyder, who spoke to *ADAW* last week from the site of the National Council for Mental Wellbeing's annual conference in Los Angeles, explained that treatment providers and their staff members are in many cases addressing today's challenges under decades-old regulations.

In 2017, the state transitioned from its own custom placement criteria for substance use treatment to the American Society of Addiction Medicine's (ASAM) Criteria, a move that the provider community largely supported, but one that added a new layer of compliance requirements, Snyder said. Providers now face audits tied to annual licensure and audits designed to determine compliance with the level-of-care criteria.

Mandated reviews and sometimes full rewrites of patient treatment plans also add to staff burden, Snyder said, with 30-day reviews required at the residential level and 60-day reviews in outpatient care. Staff members in provider agencies often report that little change will be captured during these time

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frames, he said. Varying requirements from the five Medicaid managed care organizations that oversee behavioral health services in the state add more complexity, he said.

But by far the primary complaint coming from the provider community involves the mandated staff-to-patient ratios, which vary depending on the level of care being delivered. They range from 1-to-5 for withdrawal management services to 1-to-35 in outpatient settings. Ironically, there are no specific staff-to-patient ratios for outpatient mental health providers in Pennsylvania, Snyder said.

"We have capacity, but we don't have the workforce," he said in assessing the current situation. "We are subject to ratio regulations that have no evidence to support them."

A March 9 public hearing hosted by the Center for Rural Pennsylvania, a bipartisan legislative agency, gave providers an opportunity to air their concerns about the factors contributing to workforce shortages. The *Pennsylvania Capital-Star* reported that Justin Wolford, director of outpatient services at RCPA member Cen-Clear child services, cited "low wages, concerns regarding irregular hours, paperwork demands and a desire for exclusively remote work" as complicating the effort to attract and retain clinicians, adding that regulatory requirements tied to program licensure are only exacerbating the crisis.

"While many entities are able to adjust their pay to attract qualified candidates, agencies functioning largely on Medicaid reimbursement struggle not only to offer the fringe benefits seen in other agencies, but with rates that are deemed competitive, as well," Wolford said in the article.

"You have to be under a rock not to know that we can't get enough people, from counselors to nurses," Snyder said. "Our agencies are paying exorbitant rates for traveling nurses to help meet the need."

Coming up...

The 2023 **American Psychiatric Association conference** will be held **May 20-24** in San Francisco, California. For more information, go to **https://www.psychiatry.org/psychiatrists/meetings/annual-meeting**

The National Association of Addiction Treatment Providers (NAATP) **Annual Leadership Conference** will be held **May 21-23** in Washington, DC. For more information, go to **https://www.naatp.org/**

The **College on Drug Dependence conference** will be held **June 17-21** in Denver, Colorado. For more information, go to **https://cpdd.org/meetings/current-meeting/**

The 2023 meeting of the **Research Society on Alcohol** will be held **June 24-28** in Bellevue, Washington. For more information, go to **https://researchsocietyonalcohol.org/future-meetings**

Possible responses

Snyder said a state House member has indicated interest in advancing legislation that would launch a comprehensive review of regulations applying to human-services organizations in the state. He said state Rep. Michael Schlossberg has sent out a memo to fellow lawmakers as he seeks legislative cosponsors for a measure that would create a regulatory reform commission.

The challenge in having a commission established, Snyder said, is that its work and any related follow-up activity could take many months. He remains hopeful that absent any administrative relief from state officials, legislators still might introduce bills this year to lessen providers' administrative burden. Snyder considers regulatory reform to be the logical pathway to improving the workforce shortage both in the short and long term.

DDAP officials did not respond by press time to a question from *ADAW* about providers' concerns and whether it was considering any changes in response.

Snyder said he believes there remains a sense in state government that the addiction treatment provider community requires more oversight, possibly because it is perceived to be not as advanced as other disciplines. He said that in a legislative hearing held after the March hearing, DDAP confirmed that it would not consider blanket exceptions to its regulations, but pledged to evaluate quickly any requests for exceptions it receives from individual treatment agencies. •

In case you haven't heard...

A $1.49 million renovation of a career center in Xenia Township, Ohio, will turn the facility into a recovery housing-to-career program. The "Emerge Recovery and Trade Initiative" focuses on helping people recover and work. The project is spearheaded by AKA Construction of Xenia. The American Rescue Plan Act funds were awarded to Emerge by Greene County, Ohio commissioners last year. More money will need to be raised, of course. "The price of everything has gone up," said Elaine Bonner, director of philanthropy at Emerge. "We will be looking to raise that money through a combination of ways — including donations from individuals, local businesses, corporations and other avenues." The facility will house and train 50 men in recovery. For more on the facility, see https://www.daytondailynews.com/local/work-on-15-million-addiction-to-workforce-facility-begins-in-greene-county/WAMG7FFRORBK5AJTEGFAMB7AA4/. For more on Emerge, see https://www.emergerecoverytrade.com/.