Working Conditions, Worker Health and Wellbeing & Turnover in Residential Addiction Treatment Organizations in Massachusetts

Findings from the Substance Use Provider Occupational Wellbeing Study

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EXECUTIVE SUMMARY

Our workplaces shape our health, whether through the stress of our workloads, pay and benefits we receive, interacting with physical surroundings, or obtaining support from colleagues and supervisors. This is as true for addiction treatment organizations as it is for any other workplace. However, the implications of working conditions in these settings are wider since how these workplaces shape worker health also impacts the health of clients seeking addiction treatment. Creating working conditions that support the health and wellbeing of the addiction treatment workforce is therefore central to providing consistent and effective addiction treatment for clients.

The considerable rise in substance use disorders has strained addiction treatment services across the United States, and this strain can be noticeably felt in organizations operating across Massachusetts—a state with one of the highest rates of overdose deaths in the country. The addiction treatment workforce has long been characterized by high rates of turnover and attrition, but with the rising rates of addiction, workforce shortages have greater implications for people seeking addiction care. This may be particularly true for residential addiction treatment facilities, which provide 24/7 care for individuals as they move into recovery.

The *Substance Use Provider Occupational Wellbeing (SUPOW) Study* aimed to understand how working conditions and larger socio-political influences impact the health and wellbeing of Massachusetts residential addiction providers working in state-funded facilities. This study also sought to identify how the health and wellbeing of providers impacted the organizations at which they worked and client care. As part of this community-initiated study, frontline providers, supervisors, and executive leaders participated in interviews and focus groups to share their perspectives and observations working in residential treatment across Massachusetts regions. As such, all analyses presented in this report are from the perspective of providers and leaders with first-hand experience working in residential addiction treatment.

Key Findings from the SUPOW Study

- The addiction treatment workforce is different than other health and social service workforces since many providers are in recovery from addiction themselves or have a close family member with an addiction. These backgrounds often motivate providers to join the addiction treatment workforce. These backgrounds also mean that many providers in this field have specific health, financial, and educational considerations, which influences their ability to continue to work in and advance in the field.
- Residential providers frequently experience both direct trauma (such as witnessing or responding to client overdoses or death) as well as indirect trauma (listening to traumatic past experiences of clients), which may affect their mental and physical health.
- Provider pay and staffing ratios set by the Commonwealth of Massachusetts have largely stayed stagnant while the demands of the job and qualifications to do the work have increased. Job demands have particularly grown with changes in the lethality of controlled substances, greater number of overdose events, and increased client needs.

- The emotional toll of the work without sufficient pay is a primary driver of turnover within organizations and attrition within the field of addiction services. High rates of turnover exacerbate workloads for remaining providers, which creates a feedback loop adding further strain to organizations and staff.
- Organizations are working hard to provide supervisory, coworker, and trauma supports within their organizations, and providers see these organizational practices as critical to their work.
- Many organizations are also developing programs and practices that benefit their employees such as:
    1) Providing time for staff to access therapy sessions during their workdays without losing pay
    2) Covering therapy copays for workers to reduce cost barriers
    3) Creating incentive programs that reward workers with additional vacation days if they quit or do not use tobacco products
    4) Varying shifts (while keeping weekly schedules consistent) so as to allow staff to have off-time during the week
    5) Over hiring for roles with high turnover to make workloads more manageable when turnover occurs
    6) Developing affinity groups for staff to discuss specific topics and receive support
- Organizational efforts to increase supports for their staff are important, but not sufficient to reduce turnover. Many of the working conditions that would likely reduce turnover, such as pay and staffing ratios, are set by states and therefore are not in the full control of organizations.

Moving Forward

Addressing rising rates of addiction in Massachusetts communities requires improvement to the working conditions of addiction treatment providers, especially providers working in around-the-clock residential treatment settings. Based on findings in this study, organizations are providing the supports to staff that they can, but the working conditions that have the most significant impact on providers' lives are controlled by the Commonwealth of Massachusetts. Increased pay would likely be the most effective way to stabilize the workforce, reduce turnover, and protect the health and wellbeing of these essential workers. Since the Commonwealth of Massachusetts controls addiction treatment reimbursement rates, supplemental funding, and wage guidelines for provider positions, it is the responsibility of state policy makers and the legislature to ensure that wages are commensurate with job demands and requirements in this field. Increasing wages that also account for differences in cost of living across Massachusetts is a critical and time-sensitive first step to take.

The current efforts in Massachusetts to increase qualifications and skills of frontline providers are important to providing consistent and effective addition treatment. However, such changes in qualification requirements must consider the composition of this workforce. Not only are there behavioral and physical health considerations for a workforce largely motivated by their own shared and personal experiences, but many likely have fewer financial and educational resources compared to those in other social service fields. Without the intentional and accessible development of education and advancement ladders, new qualification requirements may structurally discriminate against workers who possess important attributes and skills to build rapport and connect with clients.

A LETTER FROM ONE ADDICTION TREATMENT PROVIDER TO ANOTHER

To my addiction treatment provider colleagues:

If you are reading this report, you may be a person who has dedicated your career to helping people find their way into recovery. Many of us have chosen this path with intention, whether it be from our own experience surviving addiction, witnessing a person we love battle it, or a passion to help people fight this insidious, overwhelming, and powerful disease. Making the decision to do this work is one that is questioned by many, evident by the typical reaction that is given when you share information about the population you serve.

The difficult thing about addiction is that once it is visible, the destruction has often surpassed the stage where it is manageable by that person; it is inherently a disease that thrives on isolation and those suffering from it need connection and community to find recovery. We see statistics about rapidly growing rates of overdose deaths and desperate attempts from the state to manage resulting homelessness that has become so painfully visible in our cities. There is legislation passed to increase the availability of detox beds, develop co-occurring enhanced programming, increase standards for licensure to provide clinical care, put restrictions on prescribers, and deliver multi-disciplinary education about addiction. While all these measures are a logical response to resolving, or even reaching a plateau on the issue, there is a key component that has been overlooked; a component that is the heart of shifting the trajectory of recovery in our community: treating the workforce that makes up the treatment community.

I have worked in this field for 12 years, from a residential counselor to a clinical director. I have witnessed miracles and tragedies and watched the impact of both on the people with whom I work. Between the daily responses to fatal and non-fatal overdoses and the stressors of a chronically traumatized work environment, I watched my coworkers having breakdowns, showing signs of burnout and compassion fatigue, and at times returning to the active addiction, the source of pain that brought them to this field of work to begin with.

These experiences and observations led me to present to the *Harvard Chan School of Public Health Center for Work, Health, & Well-being* on the correlation between the state's response to Opioid Epidemic and the health and well-being of substance use providers in Massachusetts. At the time, I was working as the assistant director at a program on Mass Ave. in Boston as the fentanyl surge and crystal meth revival was taking down more people than could be counted. My presentation centered around the immediate and long-term effects of compassion fatigue on the physical, emotional, and mental health of addiction treatment providers, high rates of turnover, difficulty hiring, and likely impact on client outcomes. Members of this research center expressed an interest in further exploring the scope of this issue, which resulted in a community-academic collaboration and establishment of the Substance Use Provider Occupational Wellbeing Study.

In developing this community-academic collaboration, we sought to make visible the pressures being placed on direct care providers in residential addiction treatment work environments and how this affects us as deeply-committed providers. I am confident that a comprehensive understanding of the vital role that direct care providers have in combatting the addiction epidemic will enable professionals in decision-making roles to implement well-informed and deliberate interventions to support our workforce since this is key to supporting individuals with addiction.

Sincerely,

Lauren Sabbath-Clayton

Director of Community Engagement, *Substance Use Provider Occupational Wellbeing Study*
Program Director, *Clearhaven Recovery Center*

INTRODUCTION

ORIGINS OF THE SUBSTANCE USE PROVIDER OCCUPATIONAL WELLBEING (SUPOW) STUDY

In March 2020, Lauren Sabbath, LICSW, LADC-1, an organizational leader in the field of addiction treatment, presented to the *Harvard Chan School of Public Health Center for Work, Health, & Well-being* on how the addiction treatment work environment, pressures that providers experience, and the rising rates of addiction affect the health and wellbeing of staff working in nonprofit residential services in the Commonwealth of Massachusetts. Ms. Sabbath also spoke about the Commonwealth's current response to substance use, which focuses on services for people addiction, and overlooks the needs of the workforce providing for these individuals. This presentation spurred the development of the Substance Use Provider Occupational Wellbeing (SUPOW) Study. The research team, which was a partnership among Ms. Sabbath and occupational health and social work scholars, developed a qualitative study to systematically identify how socio-political factors and working conditions within residential facilities affect the health and wellbeing of residential providers in Massachusetts. The team was also interested in assessing how these factors may precipitate workforce turnover as well as client care and outcomes.

Having a community-academic collaboration enabled the team to directly capture the voices and perspectives of residential staff working in a variety of roles across Massachusetts. By exploring the workplace factors that characterize residential level of care, this study aimed to introduce a different narrative than is typically represented in research on the opioid epidemic and other substance use. Between February and May 2021, interviews and focus groups of residential treatment providers, including frontline staff, supervisors, managers, and executives, were conducted to capture the lived experiences and perspectives of individuals in the field. These personal accounts provide an important perspective to help researchers, organizations, and policy makers support this critical workforce, which is essential to helping people with addiction move towards recovery.

The primary aims of the SUPOW Study were to:

- Identify challenging and supportive working conditions in residential treatment programs in Massachusetts from the perspectives of addiction treatment providers and leaders.
- Ascertain how these identified challenges and supports affect providers' psychological and physical safety, health, and general wellbeing at work and at home.
- Determine how identified challenges and supports affect organizational dynamics and workforce turnover at the treatment facilities, and providers' intentions to leave the field of addiction services.
- Explore how workplace challenges and supports, organizational dynamics, and staff turnover influence client outcomes.

STRUCTURE OF REPORT & CONSIDERATIONS FOR THE READER

This report has been written specifically for organizations to summarize key findings from the SUPOW Study to be used to inform organizational policies and procedures, future grants and funding, and points of advocacy. This study focused on staff working in residential level of care as defined by the American Society of Addiction Medicine (ASAM). It was a qualitative study, and the data that was analyzed in this study came from interviews and focus groups of people employed in residential treatment programs. As such, there are no numbers or statistics presented in this report, and evidence for conclusions drawn from the analyses are presented in the form of written quotations from study participants.

The goal of qualitative work is to hear directly from people with substantial experience and knowledge, and capturing the diversity of experiences is a primary goal. Thus, qualitative studies are particularly useful to identify key factors about a topic for which little research has been conducted, such as the work experiences of providers in the residential level of care. Since the "data" come directly from the observations and experiences of providers who participated in the study, many of the results presented in this report may seem unsurprising to those working in addiction treatment and are likely regular points of conversation among staff. However, by systematically capturing and analyzing participant perspectives, we hope to document these experiences to provide evidence that can be used for policies, interventions, and advocacy.

The research team sought to recruit participants across professional roles, Massachusetts regions, and different life experiences. However, this does not mean that the perspectives and experiences of all staff in the field are represented in this report. Since this study only included staff working in residential programs, the results may not carry over to other ASAM-identified levels of care, such as detox, stabilization, intensive outpatient, Medication Assisted Treatment Programs, or out-patient therapy, although some of the findings may be true for these setting as well.

The remainder of this report is organized in five sections:

- *Background* section summarizes the existing literature on the working conditions, health and wellbeing, and turnover of addiction treatment providers.
- *Methods* section provides an overview of the design of the SUPOW Study, who participated, and how the data was analyzed.
- *Results* section details the salient factors that affected residential providers in this study with quotes that demonstrate these factors as supporting data. A conceptual model visually indicating how these different factors relate to each other as well as promising practices from residential treatment programs across the state are also provided in the *Results* section.
- *Summary* section reviews implications of the findings of this study.
- *Citing the Report & Future Data Inquiries* provides information for individuals who may have additional data needs from the SUPOW Study.

BACKGROUND

Substance use in the U.S. & Massachusetts

- In 2020, 40.3 million people living in the United States met the criteria for a substance use disorder (SUD) in the past year, representing 14.5 % of the population.[1]
- Massachusetts has the fourth-highest rate of opioid overdose deaths in the United States (29.3 per 100,000 people). This rate has increased over 6-fold over the last two decades.[2]
- Researchers predict that opioid-related overdoses will grow by over 60% in the next 5 years.[3]
- Since the beginning of the COVID-19 pandemic and resulting economic recession, there has been an additional increase in opioid-related deaths and demand for treatment in most states, including Massachusetts.[4–6]

Addiction provider workforce shortages & treatment system strain

- Increased rates of substance use and demand for services have strained addiction treatment services across the U.S., especially public and nonprofit services that rely on public funding.[7]
- The U.S. Health Resources Service Administration (HRSA) anticipates that the US will fall 250,000 workers short of the addiction treatment providers needed to meet treatment demands by 2025.[7,8]
- High rates of turnover—which may be as high as 77% among frontline providers in MA—contributes to workforce shortages.[7–10]

Challenges working across addiction treatment settings and levels of care

- Addiction treatment providers have been found to have high rates of burnout (33-50%),[11–14] secondary traumatic stress (20-56%),[15–17] psychological distress (82%),[12] PTSD-related symptoms (56%),[10,16] and worker substance use (38%),[18] although it should be noted that most of these estimates come from small studies measured at one point in time.
- Higher levels of secondary traumatic stress are associated with lower job satisfaction and occupational commitment to working in addiction treatment.[10]
- Over half of frontline providers experience physical or verbal violence by clients—impacting their sense of safety and client care—and experience of violence was associated with younger age, identifying as non-White, tenure, and proportion of caseload with co-occurring mental health conditions.[19]
- Low pay is a primary concern for providers and is associated with higher rates of burnout and decreased job satisfaction.[20–23]
- Increased client caseloads are associated with higher rates of burnout and secondary traumatic stress[11,14,15,24] as well as staff turnover when measured over time.[25]

Supporting addiction treatment providers at work

- Stronger levels of supervisor and coworker support are correlated with improved provider health and wellbeing, job satisfaction, and staff turnover.[14,15,26–30]
- Reflective supervision and coworker support are key components to professional satisfaction across different provider roles and backgrounds.[26]
- Organizational cultures and policies that encourage job latitude and autonomy have been found to decrease burnout[23,31] and turnover in addiction treatment settings.[28]

- Perception of organizational leadership strength, fairness, and openness from the perspective of frontline providers has been correlated with a decrease in burnout,[24,31] increase in job satisfaction,[24] and decrease in turnover.[32]

Gaps in the existing research & contribution of the SUPOW Study

Most of the research on addiction treatment work environments and provider health and wellbeing has been conducted among workers from a mix of treatment settings or focused on outpatient settings. Therefore, little is known about the residential treatment work environment. Despite being largely absent from the occupational and addiction workforce literature, these residential facilities are an essential component in the addiction treatment continuum and their "around-the-clock" operations create a different type of work environment compared to outpatient settings. Most previous studies looking at the health and wellbeing of providers were also conducted before the most recent rise in substance use disorders, which has added stress to organizations and providers working within them. Moreover, these studies often present their findings without taking into consideration the larger social and geographic contexts in which these providers live and work. Since addiction treatment services vary by city and state, understanding the local context is important to understanding how the work impacts providers' health and wellbeing.

With these research gaps in mind, this study focused only on state-funded residential programs in Massachusetts to better understand the experience of providers working in this specific setting. That said, some findings may be transferable to treatment facilities in other locations and offering different levels of care. As part of this study, we also aimed to capture providers' perceptions and observations about how larger social, political, and geographic environments impacted their organizations, their work, and their lives.

METHODS

DESIGNING THE STUDY

This qualitative study uses data from semi-structured interviews and focus groups to understand how socio-political and organizational factors affect the health and wellbeing of addiction treatment providers working in residential treatment programs in Massachusetts. Interview guides and focus group guides were developed with several theories and frameworks in mind: the Sorensen et al. social-contextual model for worker safety, health and wellbeing,[33] psychosocial theories of stress and resilience,[34–37] and literature on social service and addiction treatment providers.[10,19,31,38–42] Interview and focus group guides were developed with similar questions, and were modified with feedback from experts in *Total Worker Health®* approaches, qualitative methods, and addiction treatment. These guides were then piloted with participants and slightly modified based upon interview and focus group piloting.

ETHICS

This study was approved by the Harvard Longwood Campus Institutional Review Board. This study was a community-initiated study designed to capture the lived experience of people providing addiction treatment in Massachusetts residential treatment facilities. As a community-academic collaboration, an addiction treatment provider was a key member of the research team, helping to shape all stages of the research process. All research participants received a gift certificate as an indication of the study team's appreciation for their time.

RECRUITING PARTICIPANTS & CONDUCTING INTERVIEWS AND FOCUS GROUPS

Providers working in licensed nonprofit residential treatment facilities in Massachusetts were recruited to participate in interviews or focus groups. This sample was recruited to ensure different Massachusetts regions and occupational roles were represented in this study. To recruit participants and in collaboration with The Recovery Homes Collaborative (a state-wide collation of residential facilities), the research team contacted 42 residential programs across Massachusetts. Some of these were stand-alone organizations and some were programs of larger multi-service organizations or had several residential programs under the umbrella of a parent organization. If the individual program or parent organization was interested in participating, the organization shared information about the study with their staff. Any staff who was interested in participating was sent a brief online survey to collect contact information. The research team then followed up with any staff who expressed interest in the study to provide informed consent (See Figure 1 for how participants were recruited).

To capture a range of perspectives, staff who were in executive leadership, middle management and supervisors, and frontline service providers positions were recruited for the study. Frontline service

providers were comprised of counselors, case managers, intake coordinators, medication coordinators, residential assistants (RAs), and peer recovery specialists. Executive leadership and middle management/ supervisors participated in individual interviews that were either conducted over the phone or with a secure video conferencing platform. Frontline service provider participants were given the option to participate in either a focus group (conducted over a secure video conferencing platform) or interview. Those who chose to participate in a focus group were grouped by occupational role so as to focus on the diversity of experiences within that role and minimize power differentials. Participants who were in less common positions were allowed to self-select into the group closest to their job description. Focus groups were 90 minutes in length, and interviews ranged from 30-127 minutes.

ASSESSING DATA SATURATION

In qualitative research, "saturation" of the data refers to the point in which enough data has been collected to adequately understand the topic or phenomenon being researched. The research team initially anticipated enrolling 8-12 participants per occupational role to reach both thematic saturation and saturation within each theme by occupational role. During data collection, the research team iteratively recorded new topics and differences in perspectives that emerged so as to monitor saturation level. Data collection was stopped at the point in which no new data appeared to be collected with each subsequent interview or focus group.

ANALYZING THE DATA

FIGURE 1: RECRUITMENT PROCESS OF ADDICTION TREATMENT PROVIDERS TO PARTICIPATE IN INTERVIEWS AND FOCUS GROUPS

All interviews and focus groups were audio recorded and transcribed verbatim with the exception of one interview in which the participant requested not to be recorded. During this interview, a member of the research team wrote detailed notes with direct quotations to be used in analysis. Thematic analysis was facilitated using NVivo12 (QSR International Pty Ltd.), software designed to facilitate qualitative analysis. As a first step, the
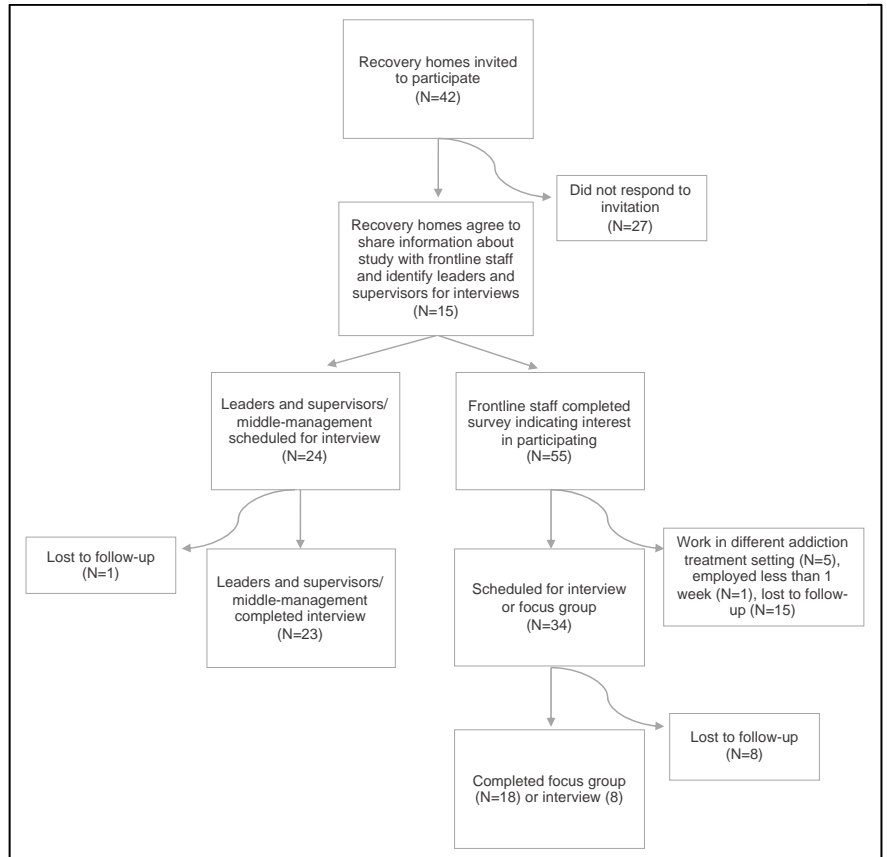
research team open-coded a sample of focus group and interview transcripts to identify key topics or considerations that emerged directly from the data. Using results from this open-coding process as well as the theory and frameworks used to inform the interview and focus group guides, the research team developed a code book to organize the data. This code book was then piloted by two independent coders, who then compared coding and modified the code book for conceptual clarity. This code book was then used to code all transcripts.

A quarter of transcripts were coded by two independent coders so as to identify differences in data interpretation as well potential coding inconsistencies. Inter-coding reliability was calculated using the Kappa statistic as a measure of agreement between the two coders. When Kappa was less than 0.6 for any code within a transcript, the two coders met to resolve coding discrepancies and come to consensus. The final mean Kappa across all codes was 0.82 (range: 0.61–1.0), demonstrating excellent coding agreement.[43]

Data within and between codes were then grouped and summarized to allow themes and subthemes of the experiences and perspectives of the provider workforce to surface. Using these themes and how participants described the ways in which themes influenced each other, the research team then constructed a conceptual model to visualize the relationship between themes (See Figure 2, Conceptual Model).[44]

From the study design and data collection stages to later stages of analysis, the research team routinely documented how their respective positions, shared and different experiences, and personal backgrounds influenced the research choices, how they interacted with participants (and how participants interacted with them), and how they analyzed the data. This iterative documentation was used to inform all stages of study development and analysis.[45–47]

RESULTS

ORGANIZATION AND CONSIDERATIONS FOR SUPOW STUDY QUALITATIVE RESULTS

Results from the SUPOW Study are organized into nine parts:

- **Part 1** details the characteristics of the participants recruited to the SUPOW Study.
- **Part 2** describes overarching consensus and points of divergence among participants.
- **Part 3** provides an overview of how participants described the residential workforce.
- **Part 4** describes a conceptual model developed to illustrate how larger contextual factors influence residential facility working conditions, worker health and wellbeing, workforce turnover, and client care and outcomes.
- **Part 5** provides a more in-depth look at the "downstream" effects of larger social, political, economic, historical, and geographic factors on residential program work environments and client and staff outcomes.
- **Part 6** focuses on interpersonal support for staff as well as organizational patterns of communication and decision-making.
- **Part 7** details specific working conditions, client history and behaviors, and how these affect staff mental and physical health and coping.
- **Part 8** identifies common barriers to accessing employee benefits and self-care supports for staff.
- **Part 9** provides descriptions of promising practices currently implemented by some residential programs, which hold potential for implementing at other organizations.

In an effort to best capture a diversity of perspectives, the research team tried to include a balanced number of participants across occupational roles and geographic locations. However, it is important to recognize that this study is not a random sample of workers from residential care settings. While the research team believes that this study captured a substantial amount of the perspectives of workers at this level of care, there may be other experiences and perspectives that were not included in this study and therefore are not found in this report.

Study findings are substantiated with example participant quotes throughout each section. Qualitative data collection is an interactive process whereby additional questions are often asked in response to a participant's statement so as to better understand their perspectives. As such, no statistical, quantitative data can be derived from this study and findings should not be considered generalizable of the residential treatment workforce. Only people who work in a residential care setting or oversee residential treatment were included in this study, and while many of the findings may hold true for other levels of care, not all findings may be transferable.

PART 1: OVERVIEW OF WHO PARTICIPATED IN THE STUDY

A total of 49 participants completed either an interview (N=31) or one of four focus group (N=18). Participants were fairly evenly distributed by gender, age, and occupational roles, and most of the participants identified as White (See Table 1 for participant characteristics). To ensure that responses

could not be re-identified, participants with less common roles, such as a medication coordinator or intake coordinator, are classified as either counselor/ case manager or RA/ peer recovery specialists, depending on the closest fit with job descriptions. Some participants in this study reported working at another residential program as a second job, and these individuals held the same type of position at this second organization.

Staff from a total of 15 residential programs were included in the study representing western Massachusetts, central Massachusetts, southern Massachusetts/ Cape Code, the greater Boston area, and the City of Boston regions. Due to the concentration of programs in the greater Boston area, about half of the sample came from this area. Some of the residential programs represented in this study were part of large, multiservice organizations providing programs other than addiction treatment. Others were smaller, independently operating programs with fewer than 10 staff. The number of clients residing at these facilities ranged from fewer than 20 to approximately 100. A few participants described working in facilitates with newly established dedicated co-occurring mental health and addiction programming.

TABLE 1: CHARACTERISTICS OF SAMPLE OF RESIDENTIAL ADDICTION TREATMENT PROVIDERS IN MASSACHUSETTS

Participant Characteristic	N=49
Position	
RA/Peer Recovery Counselor	13 (27%)
Counselor/ Case Manager	13 (27%)
Middle Manager/ Supervisor	13 (27%)
Executive Leader	10 (20%)
Self-disclosed SUD history*	26 (53%)
Gender	
Woman	26 (53%)
Man	23 (47%)
Nonbinary/ gender-queer	0 (0%)
Age (years)	
18-34	16 (30%)
35-44	10 (20%)

45-54	8 (16%)
55+	15 (31%)
Racial-ethnic identification**	
White	40
African American/ Black	5
Latinx/ Hispanic	4
American Indian/ Native American	1
Asian/ Pacific Islander	1
Caribbean	1
Time worked at residential program***	
<1 year	8 (16%)
1-2 years	15 (31%)
3-5 years	15 (31%)
6-10 years	5 (10%)
10-15 years	2 (4%)
15+ years	4 (8%)
Time worked in current role***	
<1 year	13 (27%)
1-2 years	16 (33%)
3-5 years	12 (24%)
6-10 years	5 (10%)
10-15 years	2 (4%)
15+ years	1 (2%)
Time worked in addiction treatment field	
<1 year	3 (6%)
1-2 years	7 (14%)
3-5 years	12 (24%)
6-10 years	13 (27%)

10-15 years	4 (8%)
15+years	10 (20%)
Location of Participant's residential treatment program	
Boston	16 (33%)
Greater Boston Area	9 (18%)
Southern MA/ Cape Cod	8 (16%)
Central MA	12 (24%)
Western MA	4 (8%)
Size of Participant's residential treatment program****	
<20 beds	4 (8%)
20-29 beds	12 (24%)
30-39 beds	7 (14%)
40-49 beds	0 (0%)
50+ beds	26 (53%)

* No participant was asked if they had a SUD history. As part of interviews and focus groups, participants often freely disclosed this background and how it influenced their work.

** Participants self-recorded multiple racial-ethnic identities and frequencies exceed total number of participants. No percentage calculated.

*** For participants working at more than one residential program, this is based on what the participant considered their "primary" job.

**** For organizations managing multiple residential programs, total number of beds provided under the parent organization are represented

PART 2: CONSENSUS AND DIVERGENCE ACROSS RESIDENTIAL PROGRAM ROLES

Participants shared a diversity of experiences, often specific to their own occupational histories and the residential programs at which they worked. However, when looking across roles, organizational leaders, supervisors, and frontline providers often shared similar perspectives on the working conditions that were particularly challenging, what motivated and supported them in their work, and

how contextual factors and working with clients shaped their work environments and the subsequent impact on their health, staff turnover, and client care. Participants in leadership or supervisor positions often discussed the role of state policies and practices at greater length and direct service providers often spoke in detail about interactions with staff, coworkers, and how this affected their lives. Participants in different occupational roles often had different points of emphasis. However, there was substantial overlap in how they identified the consequences of working in residential treatment, especially how many challenging working conditions and the effect on worker turnover and health was rooted in a mismatch between job responsibilities, skills required for addiction treatment, and the pay and benefits provided as compensation. That said, there was a difference in perspective in the amount of participation frontline service workers had in generating effective organizational policies and the degree to which they felt listened to by members of their organization's leadership teams (this is described in greater detail in Part 6).

This overarching consensus across roles could be due to several factors and/or a combination thereof:

1) Many people in leadership often started in frontline positions and have first-hand experience in this work.
2) Many residential programs are small organizations, facilitating communication across roles.
3) Programs in this study were all subject to the same state policies and funding systems.

This overall consensus among members of this diverse workforce is a promising finding and demonstrates strong alignment in describing both the experience working in this field and what changes might be made for this workforce to be sustainable and successful.

PART 3: DESCRIBING THE RESIDENTIAL ADDICTION WORKFORCE

At the beginning of interviews, leaders and supervisors were asked to describe the staffing structure of their organizations. All programs in this study had relatively similar structures: RAs worked across clients, fulfilling key safety, administrative, and logistical roles during day and night shifts as well as sometimes helping to co-facilitate clients groups. Some organizations also specifically employed peer recovery specialists or coaches, and some RAs were trained in the recovery coach model and embedded this orientation in their RA work. Residential programs also employed counselors and case managers to work individually on treatment goals with an assigned number of clients as well as facilitate group counseling sessions. Supervisory and leadership structures and job descriptions varied according to size of organizations. In smaller organizations, clinical supervisors/ directors often managed a caseload in addition to staff supervision responsibilities while larger organizations may have team supervisors and assistant directors who report to a clinical director. Program directors were responsible for overseeing the non-clinical components of the residential facility. Executive directors of smaller organizations may fill this program director role, while at larger organizations, executive directors and chief operating officers may oversee program directors. Across residential programs and roles, participants often had multiple responsibilities and "wore multiple hats." This tended to be even more true at smaller organizations with fewer staff. Some larger organizations described developing specific positions for

scalable tasks, such intake coordinator or medication coordinator, and these positions were not required for state compliance.

Participants were not asked directly whether or not they themselves were in SUD recovery, but over half of participants chose to voluntarily self-disclose this personal history. Both participants who were and who were not in recovery estimated that a large percent—if not the majority—of those working in residential facilities had SUD histories. Many participants described how their struggles with addiction motivated them to join the field of addiction treatment. As one RA disclosed: "I myself have been sober for four years and have been in sober housing and all that. And until I dealt with part of my own trauma from my childhood, I was not going to get better. And when I was in treatment, I had a counselor then that helped me realize that... I wanted to try and give back to those who might need that guiding hand that pushed that perspective that I might be able to offer and hopefully someone else can be okay or get onto that better path." According to the participant, the high prevalence staff in recovery is partly due to the fact that for decades, most addiction treatment options were based in self-help, 12-step, and/or social care models. With professionalization of the addiction treatment field, many providers come to the field through educational experiences while those with addiction histories often seek additional training and education. One leader described how personal histories as well as historical development of the treatment field informs the workforce:

> You have to look at what type of employees the addiction field attracts. And the addiction field came out of the self-help movement... professionalized, or I should say a lot more professionalized. So, you have people who kind of come from the educational knowledge and want to really come from a therapeutic point of view, and that's where kind of their expertise is. Or you have people who have lived experience. And then you have people who have both, lived experience, and then they went to school because they really wanted to kind of go further in this field.

Some supervisors and residential program leaders described how they tried to ensure that both staff with SUD recovery and staff without this shared history were represented at the organizations while others reported preferences for hiring workers who completed the residential treatment program at which they worked. A counselor described this hiring tendency: "And most of them, most of our staff come from the program itself. We grow people, you know, we grow them... So there's a lot of gratitude with these guys, and they see that they have a future." Across roles, participants described how this shared experience could help build rapport with clients since they understood the treatment experience intimately. One RA described how this rapport manifests with clients: "I think the clients look at it as, 'they know what I'm going through because they're in recovery, and someone doesn't know what I'm going through because they haven't been through the situation.'" By the same token, participants also shared how some staff with SUD histories could struggle with boundaries with clients going through similar recovery experiences or the work environment could make maintaining recovery challenging. Reflecting on the occupational challenges posed by shared recovery experience, one RA stated:
> Burnout is really prevalent, and especially people I think with substance abuse because I mean, not in everybody's case, but that could lead to a relapse. That could lead to going back to square one all over again. Not for everybody in recovery, but there may be people that may not

be as steady in their recovery as others, and that's what scares me is having friends that I work with that are in recovery and have them relapse. I've seen it happen, so it makes me sad when that happens.

The prevalence of SUD recovery among staff in the residential level of care contributed to organizational cultures that recognized and valued this shared history, making both the organizations and the workforce compositionally and culturally different than other social service and healthcare facilities.

PART 4: MAPPING THE RELATIONSHIPS BETWEEN ORGANIZATIONAL CONTEXT, WORKING CONDITIONS, WORKER AND CLIENT WELLBEING, AND TURNOVER

As part of the analysis, the research team recorded how participants described the factors that affected worker health and wellbeing—whether based within the organization or originating in the larger social, political, and economic environments in which the organizations were located—and how these factors influence worker health and wellbeing, staff turnover, and client outcomes from the perspective of the providers at this level of care. The relationship between these factors, including feedback loops, were visually mapped to develop a conceptual model to describe the cascading effects of these factors (See **Figure 2** for the conceptual model).

FIGURE 2: CONCEPTUAL MODEL DESCRIBING THE RELATIONSHIPS BETWEEN CONTEXTUAL FACTORS, WORKING CONDITIONS, PROVIDER HEALTH AND WELLBEING, TURNOVER, AND CLIENT CARE AND OUTCOMES
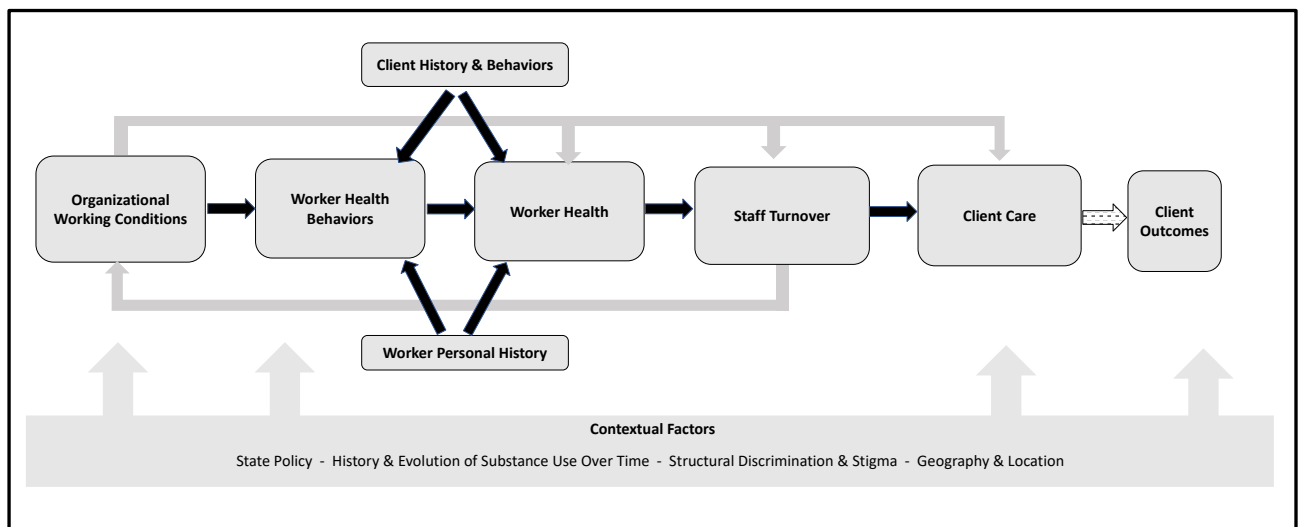
As can be seen from this model, contextual factors outside of the organizations affected all other constructs in the model, including working conditions, worker health behavior and health outcomes, worker and client histories, staff turnover, and client care and outcomes. Four primary themes within contextual factors emerged as influencing "downstream" parts of this model: state policies and

funding, history and evolution of substance use and treatment over time, structural discrimination and stigma, and geographic locations.

Throughout interviews and focus groups, participants described a range of working conditions that they identified as affecting the health and wellbeing of the workforce, either directly or indirectly. The working conditions that surfaced through data collected from this study are listed below.

- Pay (salaries and hourly wages)
- Employee benefits (paid time off, health insurance, employee assistance programs, etc.)
- Workforce training
- Policies and practices around hiring, firing, and opportunities for advancement
- Schedules, on-call responsibilities, and coordinating time-off work
- Multiple role responsibilities and complexity of tasks
- Psychologically demanding work
- Culture of teamwork and support
- Physical office space
- Supervision practices
- Debrief sessions after traumatic events
- Treatment orientation and modalities of the program
- Treatment modalities of colleagues
- Staffing ratio practices and open positions
- Client drug-testing and discharge policies

Participants also described how client histories and behaviors had additional effects on worker health and wellbeing, namely through:

- Trauma and addiction history disclosure
- Trauma and addiction-responsive behaviors
- Verbal aggression towards staff
- Verbal and physical altercations between clients
- Relapse, returning to active addiction
- Overdose, both fatal and non-fatal
- Expressions of gratitude
- Successful milestones (e.g. completion of the program, obtaining stable housing, accumulating time in recovery)

The personal histories and backgrounds of staff also influenced their individual health behaviors and health outcomes, primarily through:

- Recovery and shared experience
- Trauma history
- Systems of social and recovery support
- Education and training
- Personal finances

Analysis for this study distinguished between "health behaviors" and "worker health" in that "health behaviors" refer to the actions and practices that staff do regularly or intermittently that produce a

consequent physical or mental health condition. These physical or mental health conditions are captured as "worker health." Among participants in this study, 10 primary health behaviors were identified as having a particular affect—either in their presence or their absence—on workers' health:

- Rest
- Taking time-off from work
- Exercise
- Social connection
- Accessing behavioral health care
- Accessing physical health care
- Spiritual care
- Eating & nutrition
- Recovery maintenance
- Smoking, substance use, gambling & other addictive behaviors

Specific behavioral/ mental health and physical health conditions emerged from data analysis, including the following behavioral/ mental health conditions:

- Stress, burnout, compassion fatigue, and vicarious trauma
- Grief and loss
- Anxiety, depression, and PTSD
- Relapse and/or overdose
- Compassion satisfaction, vicarious growth, and confidence

Three primary types of physical health concerns surfaced as important among this workforce:

- Somaticized symptoms (i.e. mental distress that is expressed as physical symptoms), specifically gastro-intestinal complaints
- Occupational injury and toxic substance exposure
- Health concerns associated with addiction history (e.g. HIV, Hepatitis C Virus, COPD)

The aforementioned factors contributed to workers choosing to leave their organizations, leave non-profit addiction treatment and seek positions in for-profit addiction settings, or leave the field of addiction entirely. Organizational turnover (leaving the organization for a similar job elsewhere) and workforce attrition (leaving the addiction treatment field altogether) were sometimes hard to disentangle since participants did not always know whether former colleagues stayed in the field. Therefore, attrition and turnover will be discussed together in this report. Relatedly, many participants shared how rewards within this field or their specific organization contributed to their tenure.

Participants spoke to four primary ways in which staff turnover and attrition affected the care of clients residing in residential programs:
- Open positions produced higher client-staff ratios, resulting in a higher volume of work per worker
- Less experienced or less engaged staff were employed at the program

- The focus was on retraining staff and not on advancing skills
- Substantial human and financial resources were dedicated to hiring for positions with high turnover

While this study did not extend to measuring client outcomes, such as recovery rates, these client care themes would theoretically affect client outcomes. Moreover, participants described how these client care themes influenced the working conditions of remaining staff, producing a feedback loop, described in greater detail in

PART 5: CONTEXTUAL FACTORS, "DOWNSTREAM" EFFECTS & THE WORKFORCE TURNOVER FEEDBACK LOOP

Changes in substances and client base

In interviews and focus groups, participants frequently described how the substances that clients used had changed substantially in recent years in terms of toxicity, addictive properties, and availability. One counselor described the shift: "Rarely do we get an old-fashioned alcoholic. We still get them, but that's a much smaller percentage of the people we have here, whereas it was the majority of people we had here for a long time." Reflecting on changes in toxicity, one supervisor observed:

> I didn't hear about overdoses as much when I first started [in 2012]. And that was also when, as some of the clients will tell you, when heroin was heroin and before fentanyl took over the scene and became more dangerous. So that has been a huge change is the way that substances are laced with things... So I think that has really changed the scene in regards to the overdoses and how easy it is to overdose. People are still dying pretty often, or if they're not dying, they are overdosing and coming to treatment and saying, yeah, I've had 50 overdoses in my life... I didn't used to hear that. I would probably hear a lot of, no, I haven't overdosed or one or two times... So that's really changed the substance use treatment game for sure."

Participants also reported how the evolution of substances corresponded with a shifting of their client base. Workers who had been in the field for a number of years described how the clients seeking treatment services now tended to be younger with fewer life-skills, sometimes coming from families with intergenerational drug use. A leader observed:

> For the last eight to ten years, you know, it's been younger people with opioid use disorder. And what's different about that population is we used to say, we would kind of teach people how to live life again, but now oftentimes we're teaching people how to live almost for the first time. And what I mean by that is, they really lack the kind of fundamental life skills to live independently, because they never learned them in the first place. A lot of our clients are second generation users. And so a lot of them have never lived independently or they, you know, were incarcerated at a really young age.

Participants also described more co-occurring mental health problems among clients, although these participants questioned whether this could be attributed to better training to assess for mental health conditions as well as more dedicated co-occurring treatment options.

Participants identified how the evolution in the availability and toxicity of substances, coupled with changes in the client base, increased work demands and intensity which subsequently impacted worker mental and physical health. Participants described how frequent crisis management, overdose response, and a growing number of training requirements to equip them to respond added to their responsibilities. As one supervisor described the additional work:

> Overdose reversal is a huge component. And that's one of the major traumas on the job. And that doesn't exist as much when opiates weren't in the picture. So again, it comes down to training, making sure that people are aware. Even now, the landscape changes pretty regularly as to what we're needing to be aware of as new drugs of choice that are being used and what their effects are in terms of health and safety.

One RA remarked on the unpredictability of the workday due to increasing job demands: "What you thought was going to be just kind of an uneventful day turns into the police coming or having to search the house for Fentanyl or somebody needs to be hospitalized, or whatever it might be. Anything can happen. So that can be draining, like never really knowing what your day is going to look like." Providers also reported how they needed to work more intensely with clients since they often had more complex life and medication needs but possessed fewer resources and life-skills to manage their recovery. One leader explained the change in workload-per-client: "So not only are we treating people clinically, we're literally teaching guys how to do laundry or how to prepare a meal, and these are considerations we didn't necessarily have to worry about before. I think those are some of the biggest changes."

Participants also explained how changes in job demands, work intensity, and physical and occupational exposures affected their physical and mental health. One leader noted new risks of occupational injury: "One of my clinicians was doing a ride along with the police…They were trying to figure out where [the client] was. They [the clinician] went into the sleeping bag. They opened foil – a piece of tinfoil, and there was Fentanyl in there. And they barely made it out of the woods. They were on a 24-hour drip of Narcan." Participants also noted how the addiction treatment workforce had more complex physical health considerations stemming from many staffs' personal addiction history. At the same time, changes in work demands due to more toxic substances and increased client needs made it hard for staff to prioritize their own health. One supervisor observed: "People will be like, 'Oh, I have a doctor's appointment, that's okay, I can stay.' And it's like, 'No, you need to go to your doctor's appointment.' Or we spend all day trying to find someone a therapist, and then someone's like, 'Oh, I haven't seen my therapist in like three weeks'… If I've been on the phone with doctors all day and stuff, and to get home and have to continue doing this work for myself, then it's very difficult."

Participants also frequently shared how their mental health was directly impacted by exposure to traumatic events, exhaustion, and grief from clients who had overdosed. One RA shared her grieving

process after a client's death: "There are times when you remember somebody that you worked with in the program, and they did really well, then you find out they overdosed and they're gone. And then there are times when it just hits you and you cry." Some participants shared how working in the recovery field provided consistent reminders of the importance of maintaining their personal SUD recovery and was a source of strength and structure to maintain sobriety. At the same time, other participants shared concern about coworkers struggling with their recovery in response to increased work demands and intensity. One counselor shared, "I've lost friends in the field that didn't manage a healthy life balance and relapsed, and then they're gone. And it's brutal."

Balancing state requirements with state-provided resources

Participants who were in leadership and supervisory positions frequently described how regulations and mandates by the state dictated many of the working conditions at residential facilities. Participants described how low reimbursement rates for client care were set by the state, but were insufficient to cover many costs associated with other state regulations, namely 1) minimum staffing ratios; 2) increased hiring qualifications; and 3) ad hoc "unfunded mandates.

Participants often reported frustration with how the state set low reimbursement rates for the state's Medicaid program (the primary insurance for clients accessing these facilities) in addition to not providing enough supplemental program funding. These funding sources were used to cover staff pay and benefits, which were in turn regulated by a state minimum wage guideline for these positions. Participants reported that reimbursement rates were informed by staffing costs projected by these state wage guidelines, which were, according to participants, themselves based on outdated cost of living and inflation calculations. One leader lamented the circular rational that led to insufficient reimbursement and subsequent low wages, "So, when we would go up for a new rate review, what the state was doing was using that information from years prior, so it's not even accurate information... That's been a discussion for 15 years."

Inadequate state reimbursement for services interacted with other state requirements to determine working conditions in these facilities. A leader described how the minimum staffing ratios had not been modified despite changes in substances and client needs, and now the facility had to choose between operating with fewer staff or struggle to find additional money to hire for positions unfunded by the state:

> One of the big things is the regulations when it comes to staffing pattern, it has not changed in decades. So when we're saying we have a different clientele than 20 years ago but [state agency] is saying that the same staffing pattern matches, it doesn't...We have two people who are solely [managing] the medication room... That was a choice that we had to make knowing that we weren't going to get reimbursed necessarily for that position.

At the same time, participants also reported struggling to hire staff at competitive rates given that the state had increased qualifications to hold supervisory positions but reimbursement rates had not commensurately changed. As one leader worried: "There's new regulations coming through this

summer that on their face are a good thing. They're upping requirements for our clinical directors.... But how are we supposed to pay for a [licensed clinical social worker] with the rates that we have now?... We can't find candidates now with those [current] rates."

Leaders also described the organizational burden of ad hoc "unfunded mandates," with which they were expected to comply without additional resources to do so. One leader complained: "These changes include a lot of unfunded mandates. So, these are things where the state says, we want you to do this, we know it's going to cost you more money, but we're not giving you any more money." According to these participants, "unfunded mandates" further depleted available funds to improve working conditions at their facilities.

Nearly all participants across all roles described how low wages were one of the primary drivers of staff turnover and workers' decisions to leave the field of addiction treatment. Participants often emphasized how this workforce was motivated to work in this field by factors other than pay. However, the wages were insufficient to allow them to continue to work in the field while supporting themselves or their families, and it often required them to work a second job if they were RAs or recovery coaches. One RA described her predicament: "So I'm a single mother. I have three kids and my husband's passed away, so I have no choice but to work. So sometimes it's like, I could go be a waitress and probably make the same amount in a week that I make every two weeks. So I love doing this to help people, and it's very satisfying, but sometimes it's undoable for someone that needs to meet a financial obligation, working 70, 80 hours a week."

Participant leaders and supervisors often shared how they sincerely wanted to pay their staff more, but could not afford to do so due to the low reimbursement rates that funded their services. One leader described the organization's tight budget:

> Our concern almost always comes down to money. If we had the money, we would be paying these staff 60 to 70 grand a year to work direct care. That's what they deserve. That's what they've earned...But the reality is, these programs are not funded that way... Our bed-rate is something like $80 a day. We can barely keep the doors open on that. The insurance payments have helped, but we basically have to hire another staff just to manage insurance billing. It's that complicated. And we're not able to provide our staff with what we would like to assist that process of maintaining their mental and physical health in the workplace.

From the perspective of participants across organizations and roles, low-pay contributed to high turnover and attrition, often leaving positions unfilled. While managing reimbursement and minimum pay rates, the state office had also increased the qualifications to hold clinical and supervisory positions, but pay was not commensurate with these qualifications compared to other social service and behavioral health fields. As one supervisor shared, "If you were to ask me the number one challenge of my job it would be hiring. Right? Because it's so hard to attract a good applicant, and then they hear the pay, and they just ghost you, you know?" Thus the high turnover, increased qualifications, and low pay coalesced to generate chronic understaffing at some organizations, which risked their compliance with the state's staffing ratios. With vacant positions in these 24-hour facilities, work was redistributed to the remaining workers, thereby increasing their work demands. One counselor described this feedback

loop: "The ratio is like 10-to-1 counselor... If a counselor leaves or moves on, then you're picking up somebody else's clients, so then it's like a ratio of 15-to-1. That's a lot." One leader described how this feedback loop then drives more people to leave the field: "There are plenty of things that can lead to burnout here, and if you throw being overworked on top of all of the other challenges, it's very easy to get burned out and decide, I can go do something else for this kind of money."

In addition to the pay-turnover-workload feedback loop, the state reimbursement rates and resources dedicated to hiring and training new staff left little funding to improve other working conditions, such as physical space and benefits. As such, organizational leaders often had little power to improve the working conditions of their staff, despite being responsible for these conditions. One supervisor reflected, "I have a ton of ideas of what could be some of those programs. But the reality is until the state raises reimbursement rates for Medicaid and other services, we can't afford to do these things. I mean staff only get 10 vacation days a year. That's crazy... I truly believe we have an executive team that has the best interest of staff at heart, and they provide what they can financially. Sometimes the reimbursement rate for the services we're providing just don't cover the cost of what we're doing."

Across roles, participants described how increased pay would disrupt this feedback loop and ultimately improve patient care. Some supervisors described direct service staff who needed to work multiple jobs falling sleep on their shift. Direct service staff and supervisors noted how hard it was to engage with patients when the worker was emotionally and physically exhausted. As one leader summarized: "If you have a healthier, better rested, more able workforce, they're going to be able to provide better services to the clients, without a doubt. So, when you put all of these other strains and stresses on the system and the people within it...it just becomes more and more difficult to make sure you are maintaining that appropriate level of care....So, I think all those supports would trickle down to better health of our workforce and, therefore, better client care."

Structural discrimination and stigma

As noted in Part 2, a substantial portion of this workforce are themselves in SUD recovery. Some participants connected the social and structural patterning of substance availability and addiction, trauma exposures, and economic resources with many direct service workers' personal situations, observing how these structural factors shaped the addiction treatment workforce. These participants noted that while these backgrounds may have motivated these workers to join the addiction treatment field, these workers often had more complex health conditions as well as fewer financial resources, which impacted their ability to seek out additional education and training. As one leader observed:

> Unfortunately that all kind of leads to one of the big frustrations for folks as they're trying to grow within the field. They're trying to go to school and get to that next job, that next level kind of thing. On what? At $15 an hour? That's $30,000 a year. So, unfortunately at that salary, you probably have a second job. And it becomes a real barrier to having people advance when they say that... 'I can only do it very part time, it's going take me six or more years to get this done.'

Participants across roles also described their frustration with a larger societal acceptance of low-pay and undervaluing addiction treatment work, even compared to other social services. These participants suggested that this was in part due to the perception that these clients were "undeserving" populations, who brought their disease upon themselves. As one counselor summarized: "Not having additional resources, again, because people – society doesn't want to. Who wants to help an addict, you know? It's their choice. These things are still being said." One leader linked this stigma to the pay difference between addiction treatment professionals and mental health professionals: "Look at Department of Mental Health's rate, because we're from the same pool of staff and the same credentials, and they are getting paid more for the same staff level. That just doesn't make sense." However, some participants also noted how this societal undervaluing was shifting with greater recognition and spread of the opioid epidemic. As one counselor reflected: "I think we've come a long way. A few years back, the stigma was real tough. So when I told people what I did for a living...it was kind of like that shrug off like, oh, you deal with those people kind of thing. Which was a little disheartening, but I think the way the community and just the change in philosophy of people to be more accepting. Because addiction affects everybody. But for years it was sort of hidden, and now it's so much more out in the public forum."

As described earlier, participants reported how the state agency had increased the qualification to hold clinical and supervisory positions in efforts to strengthen the consistency and quality of care provided to clients. These qualification requirements—coupled with the underpay of a workforce with limited economic resources often due to histories of addiction—exacerbated inequities in the workforce, since direct service workers with lived experience were less likely to be able to advance in the field. One leader described this structural inequality: "That's really hard when you have people who've been in the field for 20 or 30 years that have this lived experience that know what they're doing, but now they don't qualify for those positions." In essence, changes in qualification with this specific workforce structured two classes of addiction treatment providers. A supervisor contemplated: "The requirements are weeding you out. I'm sure there are plenty of people that'd be really good at the job that are being weeded out... I always think about the social class and racial implications of that. People of color that have had less opportunity to return to school than I did. Are we holding those folks back?... We're making it harder for them to become those people [clinicians and supervisors]." A different supervisor speculated about how frontline staff may absorb the societal devaluing of the field—potentially interacting with workers' personal experiences being devalued as a person in recovery—and this could perpetuate low wages with limited advancement:

It's a really low paying job. It's a really grueling job. Right? It's almost like you're gas lit—like the type of person who stays at that job almost has to *not* know their worth. Because you'd just wake up and be like "Oh my God, I'm not getting paid enough for this. I'm not doing this." Any sane person would come to that conclusion. So it takes a special type of person who is able to almost convince themselves. I'm not saying that it isn't worth it for the kind of gratification and fulfillment that you get emotionally from doing the job. But really, we're severely underpaid, and it's not cool, you know. So I think that that is maybe attracts a certain type of person to stay.

Geography and location of organizations shape work and quality of life

Throughout interviews and focus groups, the role of geography and the location of residential facilities frequently surfaced as another contextual theme that affected working conditions and the workforce. According to these participants, geography and location affected them in three primary ways:
1) Exposure to substances and activities in the larger community
2) Availability of additional social services
3) Variation in the cost of living for workers.

Ensuring that communities with higher SUD prevalence have access to addiction treatment services is imperative. In this study, participants working in Boston-based facilities frequently described the availability of substances and prevalence of SUDs in their organization's immediate surroundings. One RA recounted the amount of community substance use: "We have another house over here next to our back parking lot, and sometimes [people in the neighborhood] would be sitting in the stairwell shooting dope when our clients were right outside…I'd have to run outside because people were OD'ing in the parking lot. So to actually see someone turn blue and to give someone Narcan, it was like I didn't sign up for this, you know? And so for me it became my norm working here." One leader noted how funding constraints dictated affordable locations for services, which created distinct safety concerns for staff: "We've had folks who have nearly been missed by a gunshot that came from outside and went through the window."

When describing the organization's surrounding areas, participants often described how greater SUD prevalence and availability of substances increased exposure to traumatic events of staff as they responded to overdoses and witnessed substance use in the proximity of the organization. As one RA disclosed, "When you're responding to an overdose—I'm a creature of habit. I'm just running to the person. I want to get him breathing. I want to get 911 there and do my part until they come and take over. And you do it over and over again, but then afterwards, man, after a while, that stuff take a toll on you, man. It doesn't just *affect* you. If you don't get the service you need, it will begin to *infect* you."

The location of the organization also had the potential to increase job demands and work intensity. Not only were staff in urban areas ethically responsible for responding to overdoses in their neighborhoods, the density of substance use could also make supporting clients in the program more challenging as they helped them to navigate triggers and find safe ways to be in the neighborhood. As one leader observed: "The staff have had to be a lot more diligent on watching for people's vulnerabilities, especially when they're going outside of the house. That's obviously where they're at more risk… Staff has had to be a lot more diligent in supervising that." Location in urban areas with greater density of social services made it easier to connect clients with supportive services that they could actually access (although these services may have waiting lists), and this made jobs such as case management and counseling more manageable for workers compared to workers in rural areas. Participants working in non-urban areas described that it was sometimes tough to meet the underlying social and resource needs of their clients because of the dearth and geographic dispersion of ancillary social services. One counselor shared, "So if they're not a good fit for our program, that's a challenge. Where can they go,

because again, in north-central MA where we are, there's not a lot of programs. And there's also not a lot of quality programs." These workers describe great effort in finding outside services to support their clients, adding to their workload: "I think what you tend to do then is you take on a lot of the work yourself, right.... You're hustling hard. Because you know that this person...burned all their bridges. They don't have a job. They don't have any money. There's no shelters. Where are they going to go?... There's so few resources for a lot of things like, for example, shelters in this area."

Participants also mentioned how the geographic area surrounding the organization could also buffer stress and support coworker connection. Participants working in neighborhoods with restaurants described the importance to taking a break from the intensity of the work environment to grab lunch with coworkers. Other participants described how a "neighborhood-like" feel or the greenery on the campus could provide a calming respite. One supervisor described the benefits of their location: "Our physical environment, there's actually space outside so the guys and the staff can go outside, go for walks. So, for us, we were lucky that we're in a community... So having that experience for us, for ourselves I think made a big difference, just having the space and not feeling like – it kind of felt peaceful at times."

As mentioned earlier, concerns over low wages frequently emerged in interviews and focus groups, but how this affected staff varied by geographic location of the organization. Leaders reported how state-authorized pay and reimbursement rates governed the entire state, despite substantial differences in cost-of-living and operation costs across the state, the greater Boston area being much more expensive to live and work in than other areas. One leader recalled when this issue surfaced at a state-wide meeting: "And I had somebody from western Mass saying, 'Well, we can't say that we want our direct care staff to be paid $15 an hour because we only pay $10 an hour. And if our staff find out that other people are going to pay $15 an hour that will look bad on us.'... We're in Boston paying more for our property and our utilities and everything else, and you're in western Mass – like it doesn't really connect." The state-wide wage requirements that did not vary according to geographic differences in cost-of-living affected workers' wellbeing and attrition. While workers in Boston were often reportedly paid slightly more by their organizations than other parts of the state, it did not keep pace with these workers' personal expenses, and organizations were not compensated by the state agency for the mild increase in pay they provided. Throughout the interviews and focus groups, workers across the state lamented low pay, but workers specifically described frustration with wages in more expensive parts of the state. When describing what drives understaffing and turnover at their organization, one RA shared, "I think it's just the pay rate in recovery is just so low for staff. But if you're not clinical, the pay rate for an RS is just so low, some places it's only $14 an hour. And especially in the Boston area!"

PART 6: INTERPERSONAL SUPPORTS, COMMUNICATION & DECISION MAKING

As described in Part 5, participants described how the organizations at which they worked often had little control over the working conditions, such as pay and staffing ratios, that substantially influenced their day-to-day work. The primary exception to this was in the development of interpersonal supports for staff through supervision, coworker support, and debrief session following traumatic events. Participants routinely described the importance of these supports and how interpersonal connection and guidance from supervisors, other staff, and outside clinicians were instrumental to managing challenging work environments. While there was overall consensus that interpersonal supports within organizations were strong, frontline workers identified opportunities to improve communication channels and decision making within organizations.

Supervision

While occasionally disclosing differences in opinions or conflict over policies with leadership at their organizations, on the whole, frontline staff described routinely meeting with their supervisors as key to developing their skillsets as well as emotional support when navigating challenges at work. Participants often described how supervisors were available to reflect on a conversation with a client or how they learned from observing their supervisor manage a difficult client situation. Others described how sharing their personal emotional struggles with the work with their supervisor could help validate their experiences and depersonalize the client-provider processes. One counselor described her connection with her supervisor:

> Especially lately, work has been a real struggle. I sometimes feel like I'm the only person that's feeling that way. Like I'm the only person who puts their head down on their desk and cries or cries going into work, because it's such a drain and it's so stressful. And having supervisors that say, "Oh, no, no, you're not alone in that. I just did that yesterday." Just knowing that, okay, this isn't me...This is not something that you personally can't handle or you are just not strong enough or good enough to do this. It's like no, this is the reality of where we are all at right now. So yes, being able to validate that, I have found that to be really helpful.

One supervisor describes how they recognize that supervision time is critical to their team and how they tried to identify what providers may need to help sustain them in their work: "Utilizing supervision is like almost how people cope with like, 'Oh, my god, I can't wait for like my hour with my supervisor or whatever.' Or like I'm somebody who's like if I can sense the room is like dark, I'm like, all right, let's talk about it. And that, to me, is like kind of some talk-therapy kind of thing...Yeah. Release it from your own brain."

While difficulty separating work-life and home-life frequently emerged due to physical and emotional exhaustion, on-call responsibilities, and worry about clients, direct service staff and supervisors also described how supervision was helpful for at least encouraging self-care. Supervisors routinely described how they explored with their supervisees how to try to manage "work-life-balance" and often encouraged them to take vacation time to rest and recuperate. One supervisor stated: "One of the things that I tried to do as much as I could as a supervisor was I would look at how long it has been since

one of my staff had had a vacation or a personal day. And I would actively confront them in supervision and say, 'You're going to need to pick a day in the next three weeks when you're going to go on vacation.'" Staff also described how supervisors intervened for themselves when they needed time off, as one RA recounted:

> I was in the office and I just lost it. I started to cry. I had an anxiety attack. I had a panic attack. I was just like - I couldn't make words. And my boss was like "You're done. You're going to go home. You're done." And I'm like "No, I'm sorry." And he's like, "No, you're done. You need to go home and relax." I'd just had it. I had just had burnout. I wasn't really doing a lot of self-care. There were times where I was not taking my meds properly... My boss drove me home. He gave me a week off and was just like, "It's going to be okay. Just you can't work. You're not allowed to work. Call your mental health providers and get some help." And I said okay, and that's what I did.

Coworker Support

In addition to support from supervisors, participants often mentioned how they derived substantial support from other staff. While both direct service providers and those in leadership and supervisory positions sometimes mentioned divisions between RAs/ recovery coaches and counselors/ case managers due to different training and orientation to the work or ineffective communication channels, participants consistently described relying on coworkers for both emotional and instrumental support. One RA described how important it was for them to disclose how the work was emotionally impacting them to get the support they needed from their colleagues:

> And I've learned over the years to tell people, like, if I'm not doing good, I'll tell you I'm not doing good... Someone will stop and take five minutes to listen to me so I can share with them what's going on with me. And I know that the people that I talk to in depth at my job, no matter what it is, it stays there. It stays there. And that's really helpful, too. Like my stuff doesn't get spread all around the building, because I can talk to particular people about particular things, and that's very helpful. Very helpful.

One counselor described how purposefully structuring coworker support through group supervision helped to generate a "safe space":

> We also have the clinical once a week where all the counselors get together, and I think we're pretty supportive of each other in that environment, too. For me comparing to other places, it's generally a safe space where you can say where you're at mentally. We talk about our clients and their issues first and foremost, but if someone's off or something's going on, they might need a little emotional support.

Throughout interviews and focus groups, participants frequently described relying on their coworkers to help them with their job responsibilities. At no time was this more important than when responding to client emergencies, especially overdoses. Describing how they work with their coworkers to respond to an overdose, one RA shared:

So it's like when that happens, everybody has their own little job, too. So it's like somebody will be like "Get me Narcan. I'll stay here." It's always a team effort. There's always a team, like, I've never been in a situation of an overdose where it's just been me dealing with it. I've always had a partner or at least a group of people in the building that's ready to help. So I've never really done it on my own. But panic, anxiety, because you don't want anything to happen to the person. You don't want anything catastrophic to happen, and plus you're also trying to calm down residents that are probably in the building while it's happening, so you've got to kind of do damage control while you're trying to take care.... I don't feel alone when I'm in one of those situations. There's always someone there to be like "What do you need? What can I do? How can I help you?" So it's nice to have that team effort when there's that panicky situation going on.

Traumatic Event Debriefing

Participants from different residential programs often described how following traumatic incidents, such as a death of a resident, the organization invited outside specialists to help the staff process the event. While some staff stated that they prefer to process these events one-on-one instead of in group settings, all staff reported being grateful for having the debriefing process available. One supervisor reflected on how this service was helpful as a first step to processing what had happened, but that they also understood the need to revisit with staff about how they are doing.

Of course we had a debriefing with...the staff also. And we offered counseling – outside counseling, some grief counseling. But I mean, from my experience, I found it – I find it very helpful to continually talk about it and break it down, and do it in more small intervals. So I think it becomes very traumatic, but the trauma lessens a little bit. The trauma's still there from the experience, but it lessens a little bit and people absorb a little bit more of the debriefing as you are able to circle back around. Because again, immediately in any trauma, there's a level of shock that does occur. And the process itself speeds up in your head. So I think the debriefing process itself loosens a little bit. It's good to initially voice what you're feeling. But again, to circle back around to see how people are doing and what they're feeling, and if they're feeling anything additional.

A counselor at one organization described how the program had expanded the debrief model to structure time to discuss national events that affect the staff and clients: "When there's bigger things that happen in the U.S., like when there was the Black Lives Matter movement happening. Right now with the attacks on a lot of Asian populations. So, we'll make sure we bring it up in our all-staff meeting and have a moment where people can talk about what's springing up for them."

Communication Channels & Decision Making

Communication between staff and across levels of the organization about administrative and client needs varied by organizations. Some participants, usually RAs and recovery coaches, described frustration with inadequate communication about client behaviors and histories, describing the communication as siloed within different roles and departments. This proved a particular challenge since, as participants across roles noted, clients displayed different behaviors at different times in the day, which corresponding to different work shifts. Participants also noted how clients may treat leadership and clinicians with more respect than RAs or peer recovery specialists. One RA bemoaned the lack of integrated communication across organizational levels at their organization:

> Like we have three different sets of meetings. Like we have the directors' meeting, then we have a team meeting, then we have a recovery specialist meeting. And within all those meetings, information is not transferred. And then from department to department, it's like information is departmentalized, right? And then when something falls like on the [RA]'s lap, we'll say like, "Well, we didn't know about that." Or if something falls on the counselor in the team meeting that's something that happened in the [RA] meeting and the counselors will say, "Well, we didn't know about that." And then upper management will say, "Well, how come you didn't know about this?" And we'll say, "Well, we didn't hear about that in our meeting, but you all heard about that in your meeting." ...I don't know why they just don't have an all-staff meeting. I just don't understand why they departmentalize meetings. And key information does not get communicated and transferred from department to department, and that kind of like inhibits, like especially [RAs], from doing their job, because we're like frontline, right? In my opinion, we should be in directors' meetings, right? So we can transfer our information to them and let them know really what's going on.

Some participants attributed siloed communication to issues of confidentiality and challenges identifying *who* needs to know *what*. An RA described how they wanted to adopt a trauma-informed approach to working with residents, but did not always feel like they had the information they needed to do so, leading to safety implications for both clients and staff: "You don't know what kind of trauma they have. And so, it's very difficult, because if I go in and try to wake somebody up who's been sleeping all morning, and they might have had a very, very traumatic past and they might get up violent. I don't know these things, right? So we don't have access to client background information, which would make our jobs a lot easier." One participant who had been promoted from an RA position noted that RAs might not be trusted with sensitive information, but believes there is not good grounds for this: "If a counselor can know it, then why shouldn't an [RA] know? But then that comes back to professionalism. And back in the day, maybe some of the [RAs] wouldn't be able to handle some of that information. That could be very traumatic if you say it the wrong way or bring it up when you're having a stressful moment and throw it in the client's face or something like that. With the [RAs] that we have now, [we're] working real hard to bring professionalism, and we're doing a good job."

Other participants described communication challenges at their respective organizations as byproducts of staff turnover and staffing ratios. One supervisor observed how communication and coordination

challenges emerged with new staff needing to be trained: "I know my clinicians get very frustrated. We had some turnover recently on the day shift 7-3. And they're still learning. They're still in training, and the clinicians get very frustrated that they're trying to kind of keep structure. We're trying to kind of keep things rolling, and the training issues is kind of, you know, been problematic with medications and staff not observing the medication passes very well... So there can be a lot of blame I think thrown around in the setting." An RA at a smaller organization described how RAs sometimes supplemented the clinical team, and even with a well-functioning team, communication was not easily transferred:

> I also agree that a couple more case managers to give more individualized care to the residents rather than the three or four case managers...so they could get more individualized, more time, more focus on them, that would make my job easier, because I wouldn't be a buffer for, "I didn't get a chance to see my case manager today, and this is what's going on with me." And I sit there, and I take my notes and I'm like, "All right. I'll let them know in the morning." And then they don't come in until 11:00, and I'm gone by then. And I have to leave a note on their desk, and I don't know if they read the note. And then I can't follow up, because they leave before I get there.

Participants noted how fractured communication could drive a wedge between staff, decreasing the collegial tenor of the organization. One supervisor noted tensions between RAs and recovery coaches and clinicians, sharing:

> The [RA] staff will see a client not showering or you know, having some behaviors and their inclination is, "Well the clinician's obviously not doing anything about it. And the clinicians aren't being strict enough, and they're not implementing any sort of consequences for this client. And then on the opposite side, the clinician will see multiple emails about a client not showering and their first inclination is to say, "Well, did the [RA] staff say anything? Did they do anything about it? Why is it falling on me?" So I feel like there's a lot of tension that way, I mean, because they both do very different jobs, which I think are both equally difficult, just in different ways.

This supervisor continued on to describe how integrated all-staff meetings could help workers in different roles respect each others' contributions while coordinating client response: "I think sometimes when we have a staff meeting when we talk about the client, and we're able to kind of hear both sides of it, then it's kind of like this eye-opening like, 'Oh, I didn't realize that you had addressed this, and I apologize. I didn't realize that you had said something to the client and really tried to engage with them.'" Some RAs and counselors described using Excel databases that were updated after every shift to ensure communication was transferred, and with staff training around this, this was an effective tool for these organizations. In larger organizations, the role of the team lead was also described as a successful method to efficiently funnel important information to teams. Informal communication channels sometimes filled in communication gaps, as one RA shared: "I think communication where I work is pretty key, and I think we usually get a bunch of it across. And some of them might slip through the cracks with the staff. Usually the client might whisper it in my ear or something like that."

While communication divisions sometimes emerged between direct service workers in different roles, participants from both of these roles occasionally also described wanting to be included more in organizational decisions made by leadership. One counselor shared how involving workers across positions to develop organizational policies and practices could improve implementation: "So based on my cumulative knowledge of all the different places, it would be the higher ups—the powers that be— actually inviting us into the decision-making and the policy-making. Because there is a disconnect sometimes – even with the good ones, and we've got really good supervisors here—but just kind of hearing how we think it's going to work."

PART 7: MENTAL AND PHYSICAL HEALTH OF STAFF

As described in Parts 3, 4, 5, and 6, work environments in residential treatment programs contributed to the mental and physical health of workers, which could influence whether they continued to work at the program or left the organization and/or the addiction treatment field. Across roles and organizations, participants frequently described how stress, burnout, compassion fatigue, and vicarious trauma were natural biproducts of providing addiction treatment. Of note, while these terms all refer to different (albeit similar) experiences, participants often did not distinguish between these terms. For this reason, the research team chose to analyze these terms as synonyms and group this data together. Participants also shared personal experiences of grief and loss following clients relapse and deaths; pre-existing and new development of anxiety, depression, and PTSD-related symptoms; as well as risk of relapse and overdose for staff who were in recovery. In addition to adverse mental health experiences, participants also described positive experiences of compassion satisfaction, vicarious growth, and increased confidence through their work.

While mental health challenges surfaced more frequently than physical health concerns, three types of physical health experiences did emerge:

1) Somatic disorders, specifically gastro-intestinal complaints, which participants attributed to high stress levels;
2) Higher levels of chronic health conditions compared to other professions as a result of staff addiction history; and
3) Risk of on-the-job injury.

Emotional & Behavioral Health Experience

Discussions around stress, burnout, compassion fatigue, and vicarious trauma permeated nearly every interview and focus group. One RA described their experience of how both acute events as well as chronic stressors from the job accumulated:

> I think that I am dealing with a stressful situation almost the entire day. There's some kind of stressor happening. And then, yeah, like I said, just these big adrenaline moments and then not really being able to fall asleep. And then who knows – I mean, obviously, the person who passed

away was a big moment. But there's also like a million other smaller little things that are probably adding to my emotional stress that I'm not really aware of. Whenever somebody who I care about gets discharged or relapses and I know that they're going back to the street, whenever a client who I care about is having trouble with [child protective services] or is in an abusive relationship and won't leave, all those things obviously affect me.

This RA spoke to not only spikes in adrenaline—which when chronic can have adverse health consequences over time—but also how this most noticeably affected their sleep. One supervisor described how saturated their team was with the endemic traumatic histories for clients and the personal toll this took on their staff:

So you're handling the latent trauma of every client that walks through our door and their personal experience... Something like 50% of users have some sort of an adverse childhood event, sexual trauma, abuse, trauma, something like that. You're typically hearing those stories as a counselor. That's what counselors are there for. You're there to flush out where your addiction comes from, and what you need to fully achieve recovery. And so they're hearing these stories every day. I can't tell you how many traumatic stories I've heard of people's lives. Whether it's active, happening while you're with them and while you're working with them or whether it's something in the past. And that stuff builds on you. And you really need to be able to process through it as an employee. Because hearing dark, dark things, day-in and day-out every day is really challenging.

Chronic traumatic exposure at work was coupled with specific instances of grief and loss following client deaths. With the increased toxicity and availability of substances, participants described entering the grieving process with increased frequency: "I went to eight funerals [in 2019]. It's hard like when you work with a client, and they go out into the world, and they're doing good, doing good, and all of a sudden you hear, 'Oh, they died. That happened.' And you wonder, did I do my best to guide her the right way? Or she could have called me. She knows, she has my number. And I don't know. That always bothers me."

Participants described how the day-to-day stressors and specific events could exacerbate or contribute to staff mental health. One supervisor reflected: "I'm thinking about a lot of people seem to have like panic-like symptoms, whether it's panic attacks or anxiety – that's a big one. And then I think depression, as well, is something that comes to mind." Another supervisor noticed the connection between overwork and mental health: "And I think that like when people are in that burnout-stage that's also probably just like some straight-up like depression." An RA disclosed in a focus group: "I mean, personally for me, it has been my stress level. I'm worried about having to struggle. I've got to be very honest about that. And I cannot believe I'm saying that out loud. I talk to my therapist about it, but only my therapist. And my anxiety levels have been – I don't know if other people can identify, but it has been through the roof." One supervisor suggested how the work exacerbated a former staff member's PTSD, leading to her resignation: "She was so scared and terrified like every day that she came to work. There was one weekend that a client of hers told her his trauma history... She couldn't stop thinking about it the whole weekend. She said that she couldn't remember how she got home. She couldn't

remember driving home. She couldn't stop thinking about it, and she came in on Monday and gave me her resignation, because she knew at that point that it was too much for her."

Many of the participants in this study shared concerns about how mounting stress and frequent trauma exposures at work could jeopardize the recovery of staff with SUD histories. An RA described these concerns in an interview: "Burnout's really prevalent, and especially people I think with substance abuse because I mean, not in everybody's case, but that could lead to a relapse. That could lead to going back to square one all over again. Not for everybody in recovery, but there may be people that may not be as steady in their recovery as others. And that's what scares me is having friends that I work with that are in recovery and have them relapse. I've seen it happen, so it makes me sad when that happens."

Participants tended to focus on the negative effects of the work on mental health and recovery; however some also described experiences of compassion satisfaction, vicarious growth, and development of personal confidence and how this motivated them to continue to stay in the field. One RA shared their emotional response to client successes: "When I see someone graduate, that makes me super, duper happy, and I usually cry, because that's just me, because it makes me happy that they've completed and they've done everything they're supposed to have done. One of the perks about working there is you get to see someone flourish, and you get to see someone totally change their life... I'm just so proud of them when they get those things accomplished." A recovery coach succinctly stated: "But recovery coaching gives it life. It really fills you up. You can identify. You can connect." Describing their promotion as a staff who was in recovery, one participant shared: "Never thought in my wildest dreams that I would ever be able to be like an intake coordinator or be a functioning member of society, for that matter. Just learning that it's not always going to be peaches and cream, and I've got to do what I've got to do, but it feels good to accomplish something like that. I never thought I could do that before."

Interrelationship between stress, physical health, and health behaviors

When describing their personal health experiences or those of their colleagues, some participants described how the emotional stress of the work affected their physical health. One supervisor described how they noticed the correlation between increased stress when starting to work in residential settings and gastrointestinal issues: "I think at least timeframe-wise it sort of lines up with my own health stuff, and it's stuff like – that is directly impacted by stress, known to be, such as GI stuff. And so the timeframe definitely lines up with – not becoming a manager but being at [residential program] in general.... So thinking about like how stress can impact, for example, your digestive system. And so my own struggles to set boundaries around – especially at the [residential program] it became really challenging." Several leaders also mentioned concerns about chronic stress on their staff, noting the relationship between stress and cardiovascular health.

Exhaustion and fatigue surface frequently in the data, and participants usually described how exhaustion was a combination of both the emotional and the physical response to the work. A

supervisor observed how they have seen the exhaustion manifest with staff and its effect on their home life:

> I've seen people who on their days off they literally just like lie in bed all day because they need to like recuperate. Their bodies are like filled with just kind of someone else's pain and suffering, and so they're just kind of like needing that time to just sit and do nothing.... It's just kind of one of those things where they're just kind of so flattened by the work. And then that ripples into family and loved ones. Kind of like, "You're prioritizing work over me," like that kind of thing.

Some of the fatigue described by participants was also due to working multiple jobs, working the night shift at a program, or being on-call. Others described interrupted sleep due to stress at work: "I think that there's those pieces of like being on call that like you can't really sleep well at night because you're like, well, I don't want to go too far into a sleep because what if something happens and I need to wake to be there for it." One RA described sleep as the most significant health concern they see among their colleagues: "I think that's the biggest health concern, because listening to all of my coworkers it's all like, 'Oh, I slept like crap last night. Oh, I hardly got any sleep. Oh, I'm so tired.' We all have the bags under our eyes, and we all get the six- to eight-hours of sleep at night as we're supposed to, but it's not restful sleep, I don't think. I think it's just exhaustion."

Participants noted how the stress and fatigue from the work influenced eating and exercising habits. One supervisor reported: "People are suffering from high blood pressure, sugar issues. We have a lot of emotions coming from this job. Some of us eat sugar to an excess, or don't exercise, or we're tired at the end of the day." A different supervisor noticed: "Exercise is a big thing. I think that can be tricky, because when you're down in your worst burnout, exercise is like the last thing that we want to do sometimes."

To manage these stressors, two primary coping mechanisms emerged from the data: smoking and paid time off (PTO) for "self-care." Participants shared how treatment providers' characteristics, especially the prevalence of those with SUD histories, contributed to high rates of smoking among staff. One leader who self-disclosed being in recovery described the prevalence:

> In 2021 I still think there's too much tobacco use amongst our staff... I think that's part of employing a lot of people with lived-experience. You know that kind of tobacco use runs hand-in-hand with substance use, and a lot of times, people will recover from substance misuse, but they'll still kind of continue along with the cigarettes.

Frontline staff specifically described how smoking and cigarette breaks were key strategies to managing their stress. One RA shared how they relied on smoking as a coping mechanisms: "I smoke too many cigarettes. If I could say anything, when I'm there, I smoke too many butts... Like when the guys are being pains in the butts. Like as a collective effort, they can all collectively be pains in the butts... Yeah, you're just getting out the door for a minute, and you're like, 'All right. Just a minute. Just give me a minute.'"

Participants also noted that taking time off, whether for mental health days, vacation, or regular "self-care," was key to being able to continue to remain in the workforce. As one counselor shared: "My favorite saying is a Calvin and Hobbes cartoon, and it says, "I'll take care of me for you if you'll take care of you for me."... I've lost people that I've worked with that stopped that self-care. You know, most of the times it was self-care when it comes to their recovery. I still have to keep that important, otherwise

I'm not going to be able to do what I do." One leader observed: "And so, it's those people who really understand and focus on self-care who do the best with all of this." A counselor described how essential sufficient vacation time was for staff: "And again, the [residential program] is very generous with time off. When you start as a fulltime [RA], you're starting off with three weeks vacation. That's unheard of. Which, you know, you need that. You absolutely need that." However, participants routinely described several barriers to taking the necessary time off, which is discussed in greater detail in Part 8.

Occupational Injury

For the most part, participants described physical injury on the job as rare and infrequent, especially since staff were trained to deescalate altercations between clients. That said, participants did report injury from violence as a concern. One leader stated: "When you get your foot broken, and you get shot at, or you get punched at work, it's really hard to go back the next day and say, like, oh, yeah, this is fine. Go back to the McDonald's example, you're probably not getting punched in the face at McDonald's, working there.... But there are some inherent components of a residential program and of a substance use treatment program that are going to have those risks in it. They're unavoidable." One counselor described how violence in the community where the facility was located also increased risk of injury:

> There is an element of it that is unsafe. I mean, there was a shooting this year literally right outside the house. There have been times when I've walked to my car where I haven't necessarily felt safe. I've had an unknown man walk up to my window in my car after I got into it. There are things that happen outside the door that – like people fighting, people that are under the influence, and it's time for you to leave work but you're afraid to go outside because there's a commotion going on out there or there's somebody that's clearly either under the influence or suffering some type of mental health issue who was ranting and raving outside and you're not really sure whether it's safe to go out to your car. So yes, that does have an impact.

As described in Part 5, the substances that clients could use posed additional occupational health threats. This was especially true for Fentanyl, which if exposed, workers could inhale. As one leader identified: "Like with new substances and the increase in fentanyl, which has certainly happened a lot. When you find a substance, it's not so easy to just scoop it up with your gloved hand and dispose of it. You have to think about what your risk is just being in the same room with any substance, because there might be fentanyl in it, and because it can be airborne, you can get hurt from it. So I think it's increased staff worry." Exposure to needles also posed a threat, as recognized by one RA: "We did a room search, and I almost got stuck with a needle. You know? That was kind of devastating to me." While the frequency of these exposures and injuries seemed rare in these data, both instances and fear of these events surfaced in several interviews and focus groups.

Chronic Physical Health Conditions

As noted in Parts 1 and 3, participants described how a substantial proportion of the staff in residential programs is in recovery from addiction themselves. When asked about health challenges for staff, some participants described "wear and tear" on staff who had a history of addiction. Others noted specific chronic conditions among staff, such as HIV, Hepatitis C, or COPD. One leader observed: "So, when you have people who have lived experiences of homelessness, addiction, violence in the home that they're really kinda recovering from, we see a little bit more employees that may be diagnosed with Hepatitis C, HIV, AIDS, chronic heart conditions, COPD, or because of smoking cigarettes. So, there are some health conditions, diabetes, that you can see that are more prevalent in populations who utilize substances. And that would carry over to our staff." Another leader, who described her team as "not a bunch of personal trainers," stated: "A lot of my staff, too, when you're in recovery and like your likelihood of having contracted like a chronic illness, such as Hep C or something, is higher… They're people who have oftentimes overcome severe heroin or other addictions and are now working in the field. So that, from a physical health perspective, I do see that." While prevalence of these health conditions was not gathered as part of this study, chronic conditions associated with SUDs are likely more common in the residential workforce as a result of the shared addiction histories of many staff.

PART 8: BARRIERS TO BENEFITS & SELF-CARE

Aside from salaries and wages, participants' perspectives on the sufficiency of employee benefits and support at residential programs varied as did the benefits they received. Some participants described satisfaction with existing benefits, helpfulness of connecting with counseling through Employee Assistance Programs, and appreciation of their paid time off (PTO). However, a number of participants described barriers to fully accessing benefits, specifically healthcare, PTO, and support with their own SUD recovery.

Several participants in the study shared that while their health insurance provided through work technically covered the health care they needed, their copays were often unaffordable, especially for RAs and recovery coaches who were paid less. This most frequently came up when discussing the need across the workforce for readily available mental health care. For example, one counselor disclosed how after making a family budget, they chose to discontinue therapy to save on the copay. A supervisor stated: "I have staff that can't afford to go to therapy. Like they have copays and deductibles… With better insurance coverage, like having chiropractic covered, having acupuncture covered. None of those things are things that staff can afford to do out of pocket. And most of them aren't covered under our insurance."

Some participants also expressed concern that there were insufficient supports for staff who were struggling to maintain their own SUD recovery relative to the stressful, trauma-saturated nature of the environments in which they work. While addiction history is protected from discrimination under the Americans with Disabilities Act (ADA) during the hiring process, it does not protect workers against

termination should a worker's addiction interfere with their job responsibilities, which in residential treatment facilities, could have very real ramifications for clients and other staff. Numerous participants described the importance of sufficient time between receiving care for their own addiction and transitioning into direct care positions so as not to risk relapse. However, there were not a lot of supports for existing providers in recovery and who were struggling with relapse. Some participants described staff taking time off through the Family and Medical Leave Act (FMLA), but it should be noted that organizations are only required to provide FMLA should the worker be employed at that specific organizations for 12 months, work an average of at least 24 hours per week, and the organization employs at least 50 staff. Given the high turnover in the field, the number of part-time workers (especially for entry level positions), and that many residential programs employ fewer than 50 staff, many staff who might benefit from FMLA may not have access to it. Moreover, FMLA is *unpaid* leave, and given the low-pay across positions, taking FMLA may not be tenable for many workers.

A few participants also observed that even with access to time-off, policies of dismissal for relapsing on the job and organizational stigma of the staff requiring help discouraged disclosing the need for support. As one counselor shared: "I think it's very unfortunate that when someone in recovery is working in a recovery setting that they either have to quit their job, or something happened, they relapse and they get fired. I think it's very unfortunate while they were trying to support people who are in recovery… that they should feel like they need to quit just to be able to bear the day. They shouldn't feel like they're going to lose their job if they feel like they have somewhat of a mental relapse."

As discussed in Part 7, frontline staff relied heavily on PTO as a coping strategy so as to be able to rest and recuperate from work. However, participants noted numerous barriers to taking PTO, which made this coping mechanisms less effective. Three primary barriers emerged most frequently:
   1) they did not receive enough time-off as part of their benefits;
   2) they had to work multiple jobs due to low pay of their role; and
   3) work responsibilities made it hard to take dedicated PTO.

One supervisor decried the amount of PTO workers received relative to the demands of the job: "But the reality is like until the state raises reimbursement rates for Medicaid and other services, like we can't afford to do these things [increase benefits]. I mean, like, staff only get 10 vacation days a year. That's crazy!" Describing how low wages necessitated frontline staff to work additional jobs, which did not allow them time to rest and recover from work, one leader stated:

> You're barely getting by. So, a lot of our direct care staff might have a second job…and that second job is often in human services. So, when you're talking about burnout, you have a certain sect of staff members who are making enough money where they can have two days off [i.e. a weekend], and they can relax and disconnect. And then you have another subset of staff who are working a second job, so they're only working five days here….So, when you're saying, hey, I need that direct care staff to do the rounds, to be the first contact for our clients, yet they're working seven days a week? Come on. And then you're saying, hey, go on vacation, take care of yourself. They're working two jobs, and they can't afford the plane tickets.

One supervisor observed how members of their team felt they could not even take their allocated PTO because they were worried about meeting their clients' complex needs or burdening their coworkers who were already stretched thin: "I think the biggest barrier that I saw is still 'I don't want to let the team down. I don't want to burden people with it. Oh, I can wait a little bit longer until we hire somebody. I can wait until the craziness in the house dies down.'...It's always conditional on basically work not acting like work, which never comes."

Especially for supervisor and managers, regular built-in time off, such as weekends, were often interrupted with formal or informal on-call responsibilities. One supervisor described how on-call responsibilities interrupted her time off and disrupted her sleep: "So if something happens, it doesn't matter what time it is, we have to be able to answer that call and sometimes go in and handle a situation. And then, I mean, I have clients reaching out to me a good amount of time. And I get that I make myself available for them, but it is also an expectation. And I think probably just the stress of being able to go to sleep."

PART 9: PROMISING ORGANIZATIONAL POLICIES & PRACTICES

Through analysis of the content of focus groups and interviews, specific factors related to the work environment and staff health and wellbeing emerged as particularly salient. Some of these factors, such as wages and benefits, are discussed in Parts 5 and 8. Across organizations, participants also described common supports such as Employee Assistance Programs (EAPs) for staff to use on their own time, varying amounts of vacation time, professional debrief services after traumatic events, and trying to incorporate staff appreciation events, like team lunches or yoga. Participants at some organizations also described less common policies and practices that helped support workers—even if it did not fully address pay inequities and staff attrition—and these practices could be potentially implemented at other organizations. Promising practices that emerged from this study are described below.

Time for Staff Counseling During Working Hours

As noted earlier, some workers needed to work second jobs while others had exhausting on-call responsibilities or were so emotionally fatigued from coordinating client care that it was difficult for them to prioritize their own care. One organization described how especially since the COVID-19 pandemic and the spread of telehealth, they had encouraged their staff to schedule counseling appointments during their shifts without having to "clock-out." A leader from one organization described the rationale for the organization's policy:

> If you have counseling appointments or whatever, you want to go in the conference room and do that, you go right ahead...Take your computer, go in the conference room, log in, do not punch out, just don't worry about it. You know what I mean? It's a few bucks, for a few bucks to relieve them of that stress, it's not that big a deal. And don't get me in front of the bean

counters, because I'll just let them know. We have to take care of the people first. Because if we don't take care of the people, you're not gonna have any beans to count pretty soon."

Covering Staff Insurance Co-pays

Some direct service workers described how affording co-pays for ongoing care, like therapy appointments, could be a financial burden. This could deter some staff from engaging in therapy, which was often critical to their mental health and being able to continue to work in addiction treatment settings. One participant described how their organization decided to cover all staff co-pays so as to eliminate this barrier and normalize this as an essential component of self-care for workers:

> So if you have a therapist, and you're going to therapy, we pay your copay. I think when you're looking at the different positions, $10 a week for somebody making $15 an hour can add up, and we do not want that barrier. So that's another thing that we do is we make sure anybody who's getting therapy, we will pay your copay. I think it also takes away the stigma of like, hey, part of being a hero is knowing and taking care of yourself, too, and knowing that it is okay to see a therapist and kind of putting our money where our mouth is. And I think that years ago if you saw a therapist, something was wrong with you, where we're like, not necessarily. Seeing a therapist is a great tool, it's a great coping source, and it's a great benefit for you. So again, if we're normalizing it with clients, normalizing it with staff, too.

Incentivizing Smoking Cessation with Additional Vacation Days

A number of participants shared how they used smoking as a stress-relieving coping mechanism. RAs, counselors, and supervisors who worked at one of the residential programs in this study all separately described a smoking cessation program that was connected to additional vacation days, thereby linking these two common coping mechanisms. These participants described how this program was successful in not only decreasing smoking among staff, but also helping to meet the PTO needs that providers require to remain in the workforce. A counselor described the incentive scheme: "If you stop smoking while you work for the program for one month, they will give you $100 and a day off. And then if you do it for 11 more months, they will give you a week off. And they will continue to give you a week off every single year you don't smoke... Now, that may not seem like a big thing, but it's a huge thing." This incentive was based on the honor-system, which worked well for staff in recovery: "Well, anybody could really go off and smoke on their own. Yeah, but they wouldn't.... I mean, a lot of the people are in recovery, and it's just not something they would do. And they wouldn't want their coworkers to know that they were cheating. So it's the things that bonds and collects and saves breath. And it does a whole bunch of things." This incentive program was also reportedly cost-effective: "From a perspective of time out to go and smoke, productivity time, and also health—out with pneumonia or out with the respiratory illnesses that you get—the boss... felt it was money well spent." Participants at this program reported low-levels of turnover among their colleagues. Reflecting on policies such as this, another counselor indicated her inclination never to leave her job, proclaiming: "This is the last place I'll ever work."

Shifting Schedules

At most organizations, direct service and leadership had routine schedules that they worked, and these shifts were staggered to ensure sufficient staff-client coverage. For the most part, counselors, case managers and leaders worked hours similar to 9 am to 5pm. One leader described how they scheduled each worker—regardless of role—so they come in at different times during the week, but then replicated this shifting schedule so it was consistent across weeks. This scheduling allowed staff to see clients at different times during the day, provided job variety, reaffirmed and strengthened communication since staff had a chance to work with all staff and not just individuals on their regular shift. This varying schedule would also allow staff to have time to take care of personal things during normal business hours. This leader shared what a week might look like for a case manager:

> Say Mondays and Tuesdays they're there 9:00 to 5:00. They'll schedule most of their concrete case management for those days. So they'll see most of their clients, get most of their notes done. And then like maybe on 12:00 to 8:00 they're responsible for like the evening group and kind of helping them manage the floor, the environment, the community room. So I think it gives them a nice feel for like – so they're not always doing case management....It kinda makes it a little more exciting.

Over-Hiring Staff

A number of organizations in this study described frequent staff turnover, which when trying to stay in compliance with state staffing-ratio requirements, could make it hard to operate at full bed capacity. One organizational leader shared how with changes in insurance reimbursement as a source of funding, over-hiring for certain positions could be beneficial in the long-run even if it costs more upfront. This participant noted how it not only made workloads more manageable for staff, especially if a member of the team leaves the organization, but it also meant that the organization could operate at full capacity even during staffing transitions. This participant described their cost-benefit analysis:

> Now that we're billing insurance, and where occupancy is a direct driver of revenue, because we can now bill for 100 percent. It's not a limited contract. The only thing that limits us is the number of beds we have, and how well we keep them filled. So that's on us. So now that occupancy is a direct driver of revenue, I say, we spend some of that revenue in overstaffing on the case management side. Because if we go through what we went through before, we're looking at $60,000, $70,000, $80,000 in lost revenue, just by having to reduce the census so we can backfill that position. But if we overcompensate and we overstaff on that side of things, even though it's going to cost a little bit more money, maybe it's gonna cost us $10,000 or $15,000 a year, it prevents a loss of $60,000. Cost-benefit, right? So that's what we did. So we've invested that additional money [in] that additional staffing.

Affinity & Discussion Groups

Many participants described strong social support from supervisors and coworkers addressing client needs. At the time of this study, participants were not only navigating rising rates of addiction across the state, but also a global pandemic, national racial justice reckoning, and charged elections. These outside events permeated the workplace. When describing social support at their organization, one leader described how they had purposefully developed staff-directed spaces to process larger events impacting staff both as people and workers: "We had somebody else who did a clinical support group for staff who wanted to be part of it to be able to really talk about the election coming up and Black Lives Matter and kind of how that played into [Organization] and how that played into the City of Boston and our clients." A counselor from this same organization described how before the Pandemic, participating in a women's group was an important space for them to connect and process with other woman-identifying coworkers:

> The staff population was male-dominated, and it felt like sometimes the women didn't have a voice. So we would all meet in the room and just like chat about how we feel to be a woman working in the recovery center. And the fact there's only one women's bathroom, like all these things. So just taking a break from the actual hours of work for like an hour and just all come together and just talk, I think that was really helpful and knowing that this person feels just like you do, like you're not alone in that aspect.

SUMMARY OF KEY FINDINGS

The Substance Use Provider Occupational Wellbeing (SUPOW) Study aimed to identify how organizational and contextual factors influenced the health and wellbeing of addiction treatment providers employed in residential treatment programs across Massachusetts and how this subsequently impacted workforce turnover and client care. Through qualitative interviews and focus groups of direct service staff, supervisors, and leaders, participants described challenges addressing the growing needs of clients, the emotional toll that working in residential treatment takes, and examples of strong interpersonal support in the workplace.

ORGANIZATIONS HAVE LIMITED CONTROL OVER THEIR STAFF'S WORKING CONDITIONS

While participants described a number of working conditions that affected their day-to-day work, health, and wellbeing, the most prominent conditions were those controlled by the state, namely worker pay, staffing ratios, and qualifications. As such, organizational leaders had very little control over the work environments for which they were responsible and had minimal ability to improve the working conditions that matter most for the addiction treatment workforce.

Low pay for direct service workers in this study was one of most salient working condition identified by direct service workers, supervisors, and leaders. Participants described wages that were neither commensurate with the their job responsibilities nor qualifications—qualification requirements which had been increased by the state. Low pay for workers, especially those in residential assistant and peer recovery specialist positions, meant that many of these workers needed to work multiple jobs to support themselves and/or families and often could not afford insurance copays and additional education to progress in the field. At the same time, these workers performed the jobs of first responders, responding to client and community overdoses, while supporting the emotional and physical wellbeing of clients at an incredibly vulnerable point in their recovery process.

According to participants in this study, chronic exposure to workplace trauma and stress was often not worth the low compensation, leading many workers to leave their jobs in residential programs and the field of addiction treatment. The high levels of turnover at many of the organizations in this study produced a feedback loop that adversely affected the working conditions and wellbeing of the remaining staff. Not only did this increase work for the remaining staff—increasing stress and exposure to occupational trauma—but it also reduced their ability to take time off to recuperate, an essential coping mechanism for many workers. This feedback loop can be seen in the conceptual model developed from this data (Figure 2).

High turnover rates also led organizations to regularly reallocate resources for hiring and retraining instead of improving working conditions or client care. Some occupational health studies have found

that increased salaries for workers produce only a short-term psychological boost, often without long term benefits for retention or worker happiness.[48,49] However, such studies are usually among employees paid substantially higher than those in the addiction treatment field, whose pay is relatively commensurate with their qualifications, and who work considerably less stressful jobs.[48,49]

ORGANIZATIONS ARE INNOVATING TO SUPPORT PROVIDERS

While organizations in this study did not have the means to control many of the most important working conditions from the perspective of study participants, they were able to establish policies and practices to promote interpersonal supports at work. According to participants, these supports, such as reflective supervision, teamwork—especially when responding to client emergencies—and debrief sessions facilitated by outside experts following traumatic events, were implemented well by organizations and were critical sources of staff support.

A number of organizations also developed and innovated on several practices specific to their organizations to support their staff, and these promising practices have the potential to be shared and implemented across organizations. Such promising practices include:

1) Providing time for staff to access telehealth therapy sessions during their workdays without "clocking out"
2) Covering therapy copays for workers to reduce cost barriers
3) Incentivizing smoking cessation by providing additional vacation days for those who stop smoking or do not smoke
4) Creating varying work shifts (consistent from week-to-week) so as to allow staff to have off-time during the week and interact with staff who may work different shifts
5) Slightly over hiring for roles with high turnover to make workloads more manageable for staff, especially during staff transitions
6) Developing staff-led affinity groups for staff to discuss specific topics and receive support.

Participants in this study described these policies to be effective in supporting their work in meaningful ways. However, they unfortunately do little to change the overarching working conditions that shape lives of addiction treatment providers. It is the opinion of this research team that changes in reimbursement rates, which is controlled by the state, is key to substantively improving a variety of working conditions for this workforce.

THE MAKE-UP OF THE ADDICTION TREATMENT WORKFORCE MUST BE CONSIDERED IN ALL POLICIES AND PROGRAMS

The relationship between contextual factors, working conditions, and worker health must be considered within the context of providers who comprises the addiction treatment workforce. Along with other estimates, the study found that a substantial portion of residential program staff in Massachusetts are likely in SUD recovery themselves. These individuals were often motivated to work in this field as a way to "pay it forward" for the help and support they received when navigating their own recovery paths. Participants in this study described how having a portion of the workforce with experiences similar to clients helped clients to develop rapport and trust in residential treatment

facilities. At the same time, participants described how staff with this shared experience sometimes struggled with client boundaries, and at times, the direct and indirect trauma of the job could threaten the mental health and recovery of these participants. Some staff in this study disclosed concern for their coworkers as well as mourned staff who had relapsed and died, which they attributed in part to stressors and trauma at work. While not everybody in this workforce is in recovery, those who are may also be more likely to be managing chronic physical health conditions, such as HIV and Hepatitis C. The social patterning of and structural contributors to substance use and addiction is well established. As such, workers in recovery likely have fewer economic resources to manage their mental and physical health as well as to pursue higher education to advance in the addiction treatment field.

Considering the state-level structural determinates of working conditions in residential addiction treatment in conjuncture with the unique composition of the workforce, it is imperative for all future policies and practices to adopt an equity lens. Increased qualification requirements to advance in the addiction treatment field serve to strengthen the quality of care and availability of treatment options for clients. At the same time, some staff with lived experience and many years of addiction treatment experience are no longer qualified for these positions and do not have the personal resources for additional education. These direct service workers are also on the "frontlines" of residential care, and are more likely to be the ones responding to client overdoses and other traumatic events while receiving the lowest compensation for their work. As such, they may need to work multiple jobs, thus giving them even less time to rest, recuperate, and maintain their own recovery as needed. Participants in this study described coworkers, who when faced with whether to protect their and their family's resource and wellbeing needs or meet their own professional missions, opted to protect themselves and their families by leaving their jobs.

While participants in this study who were in leadership positions appreciated efforts to professionalize the field to improve care, they also described frustration that the increased qualifications were not accompanied by sufficient pay increases. This meant that even if they could find candidates who met these requirements, these applicants often turned down the job because of the low pay. As a result, many important supervisory positions were left unfilled, despite often having internal candidates, that with additional educational support, would be experienced and dedicated workers. Policies that increase qualification requirements without providing accessible supports for workers to meet these requirements run the very real risk of structuring two "classes" of workers within the addiction treatment field: one class of individuals with advanced degrees, more personal financial resources, and who, by virtue of their positions, are less exposed to occupational trauma, and a second class of individuals with neither advanced degrees nor options to advance in the field due to limited finances. The workers in this second "class" are more likely to be in SUD recovery as well as exposed and responding to the brunt of workplace trauma. The Commonwealth of Massachusetts currently funds two training programs to increase the number of African American and Latinx providers, but these programs were not mentioned in focus groups and interviews, potentially indicating limited reach. Without the intentional development of accessible education and advancement ladders, new qualification requirements may structurally discriminate against workers who possess important attributes and skills to build rapport and connect with clients.

IMPROVING WORKING CONDITIONS IS CRITICAL TO IMPROVING ADDICTION
TREATMENT SERVICES FOR MASSACHUSETTS RESIDENTS

Massachusetts is not alone in its struggle to try to improve addiction treatment with a workforce characterized by high turnover. Rates of workforce turnover may be as high as 77% in frontline positions in Massachusetts, and in 2016, the Health Resources & Services Administration estimated that the country will be 250,000 workers short of the number needed to safely and effectively operate addiction treatment facilitates by 2025.[7–10] Currently, high turnover rates and the need to constantly rehire and retrain for positions diverts important resources away from client services, increases the workload for remaining workers while decreasing the amount of care each provider can provide per client, and ruptures the continuity of client care and staff cohesion. The occupational trauma and grief experienced by addiction treatment providers may be an inherent component of work within the residential level of care, and it may not be possible to change this any time soon. However, improving working conditions and providing sustainable funds to do so will help workers to receive the resources they need to protect themselves and reduce some stressors in their lives, paying dividends by likely reducing turnover and improving client care and outcomes. It is only by caring for the direct care providers and recognizing that they are an essential component of addiction treatment that we will be able to consistently, effectively, and compassionately address the rising rates of addiction in Massachusetts communities.

CITING THE REPORT & FUTURE DATA INQUIRES

The Harvard Center for Work, Health, & Well-being encourages organizations to use this report for any future grants, reports, and other needs, and we recommend the following citation:

Stelson, E., Sabbath-Clayton, L.L., Sorensen, G., & Sabbath, E.L. (2022). Working conditions, worker health and wellbeing, and turnover of residential addiction treatment providers in Massachusetts. Harvard T.H. Chan School of Public Health Center for Work, Health, & Well-being. Retrieved from https://centerforworkhealth.sph.harvard.edu/sites/default/files/SUP_wellbeing_study_report.pdf .

This report provides an overview of some key findings from the SUPOW Study, and not all analyses were included in this report. The transcripts of the interviews and focus group data have been coded in a database that can be searched. Organizations with specific data needs or research questions are encouraged to reach out to Elisabeth Stelson at estelson@g.harvard.edu. While the study database and full transcripts cannot be shared due to confidentiality and protection of the study participants, the research team is happy to query the database to try to respond to data needs for organizations.

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