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Staff Turnover in Addiction Treatment: Toward Science-Based Answers to Critical Questions

William L. White, MA and Bryan R. Garner, PhD

Workforce development in the addiction treatment industry includes the duration, breadth, and depth of preparatory education people receive before entering the treatment field; the screening, selection, orientation, and ongoing training and supervision process; and the circumstances under which addiction professionals end their tenure within a particular organization and the larger field. Given the status of staff turnover as one of the key performance measures related to workforce development (Kaplan, 2003), it is surprising how few scientific studies have been conducted on its prevalence, patterns, effects, and remediation strategies. This paucity is surprising in light of the potentially profound effects this issue exerts on the quality of addiction treatment and the quality of work life in addiction treatment organizations. The purpose of this article is to give addiction professionals a thumbnail sketch of what is being learned about staff turnover within recent scientific studies.

What are the different types of staff turnover?

Defining staff turnover in addiction treatment would seem a relatively simple task, but the precise meaning and consequences of someone leaving an organization may be hard to interpret. People leave positions in addiction treatment under voluntary (employee-initiated) and involuntary (employer-initiated) circumstances, and even these categories may be hard to interpret. For example, voluntary resignation may include factors such as family circumstances that have nothing to do with the work place per se, and involuntary termination may span discharge for performance issues, supervisor-supervisee personality conflicts, and layoffs due to budget cuts or even program closure (Gallon, Gabriel, & Knudsen, 2003). Staff turnover may be viewed as desirable or undesirable depending on the level of performance of the person leaving. Individual counselors exert a significant effect on clinical outcomes (McLellan, Woody, Luborsky, & Goehl, 1988). Such responses to addiction treatment and to a particular addiction counselor span optimum benefit, partial benefit, no measurable effects, or harmful effects. Losing counselors whose clients consistently achieve optimum benefits is a much different situation than losing counselors whose clients consistently experience minimal or harmful effects. Finally, it is important for us to distinguish between organizational turnover and occupational turnover—a person leaving a particular organization versus a person leaving the field of addiction treatment.

So, do we know the nature of such patterns in the addictions field? Studies to date suggest three tentative findings. First, a substantial portion of addiction counselors

(22.4%) and clinical supervisors (31.8%) who leave treatment organizations do so involuntarily; 15.1% of exiting counselors and 15.9% of exiting clinical supervisors are terminated (Eby, Burk, & Maher, 2010). Second, most addiction counselors (64%) and clinical supervisors (89%) who leave an addiction treatment organization remain working in the addictions treatment field (Eby et al., 2010). Third, in contrast to this high level of commitment to the field, some studies note high (e.g., 76%) intention of addiction counselors to leave their current position or organization in the next five years (Evans & Hohenshil, 1997).

Although 36% of counselors turning over are leaving the field (Eby et al., 2010), we do not know at this point in time, and need to know, whether we as a professional field are losing our most or least effective addiction counselors. Without such data, it is impossible to know what portion of staff turnover represents a significant problem for the field and what portion represents the field's effort to resolve problems of ineffectual or harmful professional performance. The data we do have available suggest potential indicators of widespread problems related to staff screening, recruitment, training, and supervision as well as the potential prevalence of person-field mismatch, person-organization mismatch, and person-role mismatch—mismatches that all exert a potentially significant effect on clinical outcomes and organizational health.

What is the rate of staff turnover in the addiction treatment field?

Most of the figures on staff turnover in addiction treatment are based on surveys of administrators who estimate annual turnover (Gallon et al., 2003; Knudsen, Ducharme, & Roman, 2006; McLellan, Carise, & Kleber, 2003; McNulty, Oser, Johnson, Knudsen, & Roman, 2007), with such rates varying across reports from 16% to 57%. Such variation is compounded by studies of different sectors (private vs. public programs), different regions of the country, varying scopes (counselors only versus all staff), different formulas for calculating turnover, and the rather amazing lack of longitudinal studies of actual staff turnover in addiction treatment (Eby et al., 2010).

A recent and well-designed study by Eby and colleagues (2010) examined turnover rates over a two-year period within 27 geographically dispersed addiction treatment organizations in the United States. The average annual turnover rate within these sites was 33.2% for counselors and 23.4% for clinical supervisors—rates substantially higher than the 19.6% annual turnover rate reported by the Bureau of Labor Statistics for all health and human services and the rates reported for nurses (12%) and teachers (12%, comparison rates cited in Knudsen, Johnson, & Roman, 2003). Such comparisons provide objective confirmation of the instability of the addiction treatment workforce—an instability key leaders see as reflecting broader organizational and leadership instability within the field (McLellan et al., 2003).

What is less clear is how turnover rates vary across counselor demographics (e.g., age, gender, race, education, certification, recovery status), geographical areas of the country, treatment modalities and levels of care, caseload size, clinical populations (e.g., adolescent versus adult services, caseload type such as percentage with prior treatment or

criminal justice involvement), other direct service roles (e.g., physicians, nurses, case managers, outreach workers, recovery coaches), and non-treatment organizational units (e.g., prevention, research, training, administration). Also unclear is the benchmark rate of annual turnover that could be used by organizations and organizational units to measure their relative stability and health. If prolonged low turnover (a potential indicator of closed incestuous organizational systems) and persistent high turnover (a potential indicator of low cohesion and weak organizational cultures) both signal potential problems of organizational health (White, 1997), what is a normal and even desirable level of annual turnover within addiction treatment organizations? The only preliminary answers to such questions are that:

- Addiction counselors working in hospital settings report a lower intention to leave than staff working in other community settings—a factor likely linked to salary differentials across the two settings (Rothrauff, Abraham, Bride, & Roman, 2010).
- Younger staff and male staff have been found to have higher rates of burnout (work-related emotional distress and depletion), which may influence intention to quit and subsequent turnover (Garner, Knight, & Simpson, 2007).
- Lower rates of turnover are associated with four linked factors: professional certification, age, tenure in the organization/field, and higher salaries (Knudsen, Ducharme, & Roman, 2008; Knudsen, Johnson, & Roman, 2003; Mulvey, Hubbard, & Hayashi, 2003; Rothrauff et al., 2010). Minority status is also associated with a lower level of turnover among addiction counselors (McNulty et al., 2007).
- The status of recovery predicts a higher commitment to the field, but not necessarily a higher commitment to a particular organization (Curtis & Eby, 2010; Knudsen et al., 2006; Rothrauff et al., 2010).
- Being female, having a graduate education, and being in recovery are all associated with higher rates of turnover among counselors working in addiction treatment (McNulty et al., 2007).
- There is a high reported turnover of program directors, with more than half of directors reporting in one survey that they had been in their current position less than one year (McLellan et al., 2003).

The limitations of these early studies and their lack of replication make it difficult to draw definitive conclusions and implications. Furthermore, acknowledging the demands of working as an addiction counselor and global problems in workforce development in the addictions field may obscure the fact that surveyed addiction counselors report high rates of overall personal satisfaction with their work and low rates of burnout (Broome, Knight, Edwards, & Flynn, 2009).

What factors contribute to turnover in addiction treatment organizations?

Staff turnover within addiction treatment organizations can occur in the best workplace conditions (e.g., greater outside professional/financial opportunities), the worst conditions (e.g., dissatisfaction, emotional distress, inadequate performance, breaches in ethical conduct), and in conditions unrelated to the workplace (e.g., illness, pregnancy, retirement, disability, death).

The best single predictor of future staff turnover is, not surprisingly, self-reported intention to quit (Griffeth, Hom, & Gaertner, 2000). The most recent study of intention to leave an organization (Rothrauff et al., 2010) found less than 8% of addiction counselors expressing intent to leave the field of addiction counseling. The major organizational factors contributing to intention to quit within addiction treatment institutions include perceived:

- ambiguity or organizational mission (Garner et al., 2007; Knudsen, Ducharme, & Roman, 2009),
- inadequacy of salaries and benefits (Knudsen et al., 2003),
- inadequate frequency and quality of clinical supervision (Knudsen et al., 2008),
- lack of access to training and professional development (Eby et al., 2010),
- excessive caseloads and paperwork (Broome et al., 2009),
- lack of autonomy and control (Knudsen et al., 2003, 2006, 2008),
- unfairness of supervisory/administrative decision-making (Knudsen et al., 2008), and
- role-person mismatch and other work-related stressors (e.g., role overload, role ambiguity, role conflict) (Eby et al., 2010; White, 1997).

Limiting our understanding of the dynamics surrounding intention to quit and subsequent turnover is the fact that most studies have been conducted in settings (e.g., private treatment programs, clinical research sites) that may not be typical of conditions and circumstances in most addiction treatment programs. Similar studies are needed of differences in turnover rates across the field's diverse practice settings. Much more knowledge also is needed on how intention to leave a treatment agency is influenced by such worker characteristics as age, race, gender, education, certification, and recovery status and by such work environment factors as salary and benefit levels, supervision, organizational culture, particular role stressors, and caseload size and type.

What are the consequences of staff turnover?

The literature on staff turnover in addiction treatment consistently alludes to potential negative effects of staff turnover on clients and the financial costs of staff turnover related to recruitment, hiring, and training of new staff and lost billings associated with open staff positions. In spite of such consistent references, we found no

studies that actually reported data on the existence, nature, or degree of harm experienced by clients as a result of staff turnover or quantified financial costs of turnover in the addiction treatment setting. Also missing are studies reporting the effects of staff turnover on other members of the treatment team, (e.g., emotional distress, increased workloads, intentions-to-quit). The decision to leave an organization is a highly personal one, but also may flow out of larger processes within the organization. We have observed many organizations with a stable workforce go through a period of organizational turmoil characterized by a contagion of demoralization and mass turnover. These larger processes and their effects on the health and performance of staff and clients also have not been studied. However, the most critical questions related to staff turnover in addiction treatment regard its effects on clients and families being served. We need to know if there are such effects, the nature and severity of such effects, and strategies though which such effects can be ameliorated.

What strategies can be used to help prevent staff turnover?

Most of the strategies recommended to reduce staff turnover in addiction treatment are derived from the studies that identify correlates of high intentions–to-quit and high rates of turnover rather than from controlled experiments that test the effectiveness of different strategies. A 2003 survey of treatment administrators generated recommendations to reduce staff turnover that included increasing salaries, improving benefits, reducing paperwork, providing ongoing training, providing personal recognition, enhancing career development, and shortening working hours (Gallon et al., 2003). Studies of broader organizational factors linked to turnover also note that:

- Participatory management practices enhance organizational commitment, which in turn fosters counselor retention (McNulty et al., 2007).
- Administrative support and clinical supervision enhance retention by reducing burnout, increasing job satisfaction, and increasing organizational commitment (Broome et al., 2009; Knudsen et al., 2003).
- Management practices linked to enhanced staff retention include long-term strategic planning, decentralized decision-making, and the presence of non-tangible rewards (Knudsen et al., 2003, 2009).

Conclusions

Implications drawn from scientific studies of staff turnover in addiction treatment are suggestive and offer starting places for action by program administrators and supervisors, but from the standpoint of science we do not know what strategies work best in particular types of treatment settings and with particular types of staff. We believe it is time for researchers to provide definitive answers to two of the most critical turnover-related questions within the addictions field:

1) What are the effects of staff turnover on the treatment outcomes of clients and their families?
2) What are the best strategies and/or interventions to reduce the high rates of staff turnover?

Fortunately, research is currently underway to address these questions. Indeed, the National Institute on Drug Abuse just recently funded a three-year study entitled "Impact, Predictors, and Mediators of Therapist Turnover." This will be the first known study to quantify the impact of staff turnover on quality of care and client outcomes. Upon the completion of this study, we look forward to sharing the results and their implications with the readers of *Counselor*.

As a final note, we believe it also might be of benefit for the field to shift its focus from why counselors and other addiction professionals leave employment in addiction treatment to why people stay working within particular organizations and within the field. Ironically, while there is much to learn about staff turnover, we know a lot more about turnover than we know about retention. A balanced approach of problem- and solution-focused studies would likely not only enhance the quality of addiction treatment, but also enhance the quality of work life for addiction professionals.

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About the Authors: William White is a Senior Research Consultant at Chestnut Health Systems. Bryan R. Garner is a Research Scientist at Chestnut Health Systems.

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