Embracing Recovery Capital Within Our Care System to Save It

There have been devastating impacts on our entire helping systems workforce over the long siege of the COVID Pandemic. Recently, I read the Ohio PHP Executive Report, the Impact of the Covid-19 Pandemic on the Health and Well-being of Ohio's Healthcare Workers. The report summarizes data collected from 13,532 respondents across 13 of Ohio's Professional Licensing Boards between July 7, 2021, and August 20, 2021. As far as I can tell, it is the largest state sample in the nation of the impact on COVID-19 on our helping professionals to date.

The report notes that helping professionals who think about death or suicide have nearly doubled. It includes a 375% increase in those who feel hopeless and overwhelmed and a 25% increase in substance use as a way to cope during the pandemic. Our Health and Human Service care systems first need to acknowledge there is a problem, and then embrace our healing assets, deep reservoirs of which reside within those very same institutions and in recovery community organizations across the United States.

There may be reflex to see Ohio as different from everywhere else. It is not. This survey of 8,000 healthcare workers from Australia found that 10% of respondents have had thoughts of self-harm or suicide during the pandemic, but fewer than half had sought help from a mental health professional. A survey from the American Nurses Foundation in October of 202 suggests that during the pandemic, around one in five nurses said their alcohol consumption had increased, and 3% said they had increased their substance use. They indicate that among critical care or intensive care nurses, estimates of increased alcohol consumption jump to one in three. This article from the University of Utah suggests that about half of our national healthcare workforce could be at risk for mental health issues.

In military culture, people are trained to be mission oriented. To get the job done no matter what. This means sucking it up and powering through traumatic events. We do that in our health and human service systems as well. In all these cultures, there is a tendency to ignore the cumulative costs of the work and then seeing our colleagues who experience difficulties as flawed or inferior. We stigmatize and isolate our own people. We perpetuate a culture of denial to sustain a business-as-usual model that is killing our very own workforce.

This is a culture of denial fostered by management focused on the short-term goals of getting through the next shift, the next day or the next week to the long-term detriment to all of our fields. This is at the heart of why these same systems are now struggling to serve their missions. These dynamics were bad before the pandemic, but COVID-19 pushed our care delivery systems beyond the breaking point. If there is a silver lining here, perhaps we will address our own wellbeing on a systems level as we are left with no other choice.

There has been some well-deserved criticism for placing all of the responsibility for self-care on the individual. We have a system of care that sets people up for burnout. We push people to perform and deemphasize supervision. We do not mentor younger workers to successfully navigate the challenges they face. Instead, we tend to bring in new workers, we watch many burnout, and then we replace them. Those who survive a few rounds become hardened veterans, well-schooled in suck it up. It is a trauma infused system steeped in denial of what is occurring. Wounded healers, who have navigated through addiction into recovery hide their status to avoid mistreatment instead of being harnessed as resources to help others.

Twenty years into the new recovery advocacy movement and our systems have not fully grasped the deep reservoir of healing that exists within and across our communities and care institutions. We forget that our

recovery community organizations are comprised of members of our communities, including professionals within these very same systems. This includes doctors, nurses, pharmacists, social workers and every other profession. These people and the recovery community resources they are connected to remain largely untapped as resources within the very systems who desperately need their expertise on recovery. The solution is right under our noses! Harness existing community recovery capital to help heal our wounded healers working in and across our care systems. Community is a primary agent of healing in respect to mental health and substance use recovery, yet generally, we do not center strategies on connecting people to these healing forces within our own institutions.

We have a cultural problem of "us" and "them:" a healer /patient orientation. We need to change this. What can we do? A recovery orientation would require us to think about the healing of our helpers as well as the persons they serve. We can acknowledge the existing recovery capital within our own health and human service systems, nurture it and use it help save our own workforces.

- We need to reorient to a recovery model, that is omnidirectional and inclusive of our own workers.
- We need to acknowledge that substance use and mental health issues are occupational hazards of our work and then normalize recovery from these conditions in our own workplaces.
- Administrators across our health and human service organizations should identify their recovering staff who can serve as mentors and utilize them as resources within these same systems.
- There are organizations for recovering doctors, nurses, and other professionals across the nation. They are often held at arm's length because of stigma, we need to embrace and hold them up as vital resources.
- Recovery community organizations should engage the traditional care systems and offer support for the workforce using their expertise of the recovery capital within their respective communities.

We have festering addiction and mental health issues within our healing institutions. Dedicated professionals pushed through crisis after crisis and ended up using drugs and alcohol to numb out the very real pain associated with the work. They sucked it up day after day and experience mental health consequences. These are occupational hazard of the work. We can no longer afford to pretend this is not a reality. They did it to serve our communities and now we must help them. We need to support our own people. We must embrace the ethos of leaving no one behind.

We cannot heal or help anyone when we ignore our own wounds. That starts with acknowledging that there remains profound stigma against addiction and recovery inside our care systems. There is no "us" and "them." Those "others" are us; and we need to heal our own within our medical and human service systems or we cannot help anyone else effectively.

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