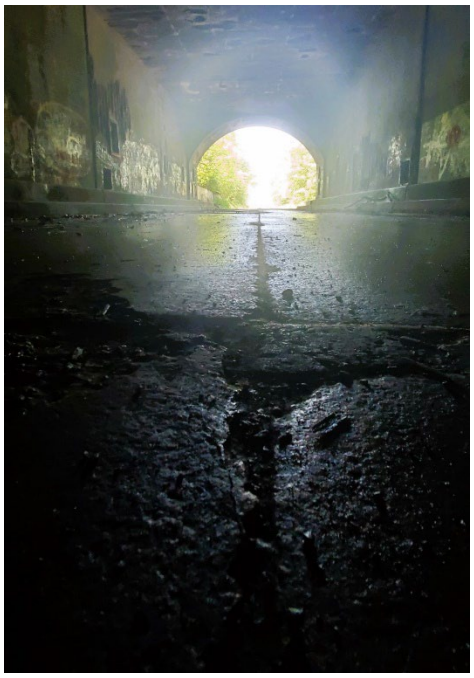
Parallels on Burnout & Buffering Across the Healthcare & SUD Care Systems



The entire US Labor force was devastated by the COVID Pandemic, which created new workforce challenges and exacerbated long standing concerns. Because of the nature of the pandemic, the healthcare sector faced some of the most profound challenges. It is important to understand the impact that these strains have had on the healthcare workforce. Negative public perceptions related to vaccinations also created difficulties within healthcare similar to those endemic in our SUD workforce sector, where workers regularly experience courtesy stigma. Research on burnout in these workers under severe strain may also help us understand challenges within the substance use disorder (SUD) workforce, which face similar dynamics but not been studied to the same degree as the healthcare sector.

An article recently published in the Journal of Applied Psychology, "Boundary Work as a Buffer Against Burnout: Evidence from Healthcare Workers During the COVID-19 Pandemic" explores what health care workers experienced during the Pandemic. It uses a grounded theory design to explore the impact of the COVID-19 pandemic on the healthcare sector. By examining wellbeing in personal and professional contexts with a qualitative focus, it raises important considerations on buffering against burnout. They assert that buffering against burnout is highly individualized. Their recommendations for organizations and managers may also be potentially useful within the SUD service sector.

One of the things that can be so compelling about the article is that they include numerous direct quotes from study participants describing their experiences of being overworked surrounded by death in ways they had not been prior to the pandemic. Isolated from each other and dealing with a society that did not fully support their efforts. This is a parallel to the experiences of our SUD workforce in the midst of overwhelming loss that is continuing to worsen over the last 20 years. The quotes are likely to resonate with workers within the SUD workforce. One nurse described why his team was experiencing high rates of burnout:

> *"Our lack of success in helping people get better at the rates we're used to and seeing people die alone and at rapid rates has led to deep moral injury. It feels a lot like PTSD in some ways, so it's a lot of complicated emotions to try and articulate…I guess the easiest way to explain it would be, imagine getting a job solely on the skills you've been working for years, you are very confident in your skills, but a problem comes along where no matter how precisely you practice those skills, you fail repeatedly…now customize that to healthcare, no matter how precise you practice your skills to keep people alive and make them better, they continue to get worse, and they keep dying…at alarming rates. Now reduce the trained staff, reduce the resources, add in false and empty praise from management, take away lunch and bathroom breaks, don't provide any compensation for the change in workload, and take away important benefits and you have a frustrated, overworked, underpaid, and under-appreciated staff that quite literally can't continue to show up to work and feel like they are worth anything."*

The COVID pandemic resulted in death unprecedented in modern times experienced intimately by healthcare workers. The addiction epidemic over the last twenty years is similar for SUD workers, particularly in the public sector. It has been experienced as deeply traumatic for many. Those in SUD workforce showed up over long periods of their professional lives to provide care for people in need, far too often with limited resources for shorter durations and lower intensities of support than the literature shows people require to heal. The experience of the nurses in the midst of the pandemic can be quite illuminative in respect to the demoralizing and traumatic experience of loss that SUD care workers have long endured. As described by the workers in the healthcare study:

> *It just weighs on them. The enormity of what they're doing, especially during this pandemic…It's a weight on them…I think a lot of our healthcare personnel carry that. I don't think a lot of people really realize that, but the*

day's not over after your eight-hour shift. It's not over after your seven-and-a half-hour shift, if you're a CNA, or if you worked a double, it's not over after your 15 hours that you've been here. It stays with you. It goes home with you. Things that you see, things that you hear."

"My brain doesn't stop out. I don't know if someone is making something wrong [at the assisted living], and I can't protect them, so I feel all the time I'm worried."

"I tried to really separate them more than I do normally, just to keep myself sane and keep from burning out…but I've proven to be burnt out. Like we have three shifts a week, and then I have four days off, and usually, I will work extra shifts, but during COVID, I was like, 'No, I can't handle more than three, and then I would have four days off to relax, and I would just literally sleep and do nothing on the four days. Made my husband do all the cleaning and grocery shopping because I was so exhausted, but it was a good way for me to prevent being burnt out. Three days, you can really do anything for three days, but more than that, I was like, 'no way!'"

SUD workers were also physically exposed to COVID and were a lower priority for Personal Protective Equipment (PPE) than healthcare workers. They also faced anxiety because of the risks of working in direct care setting to their own wellbeing and also for their families, as one nurse in the study describes the stain on her:

"It was really stressful, just never knowing whether a patient with a cough had COVID. And not knowing if you were walking into a death trap, you know, that's how I felt. And I was pregnant, for the worst part of it. So that was pretty scary for me…There is this level of fear, like, does my mask have the virus on it? And am I touching it when I take it off?"

Like the healthcare workers in this study SUD workers experienced isolation from each other and even from the persons they were serving as a result of physical distancing requirements. The widespread use of telehealth to serve persons remotely further isolated SUD workers. As described by two different nurses interviewed for the study:

"Especially the isolating, we used to have a team meeting every other week where we get together and have lunch and discuss patients with the doctor, kind of debrief. You know, because you lose people, you're close to all the time, so when you compound death and isolation and all these new requirements…some of our folks really struggled."

"Those kinds of policy changes have been frustrating because it's like now the one sense of camaraderie that you're going to have, now you can't have…There can only be one person in the break room. That's frustrating because if you want to take a break or talk to somebody, you've got to go somewhere else…you can't even have a human connection with your coworkers that are going through the same thing you are and sharing the same risk. So, I think there's the right theory behind it…but it's now just another thing that is out of our control…and your job is hard as it is."

Antivax sentiments in some ways replicate the long-standing negative societal views on addiction. Helpers far too often viewed in society as harmers. We live in a society that views persons with SUDs as morally flawed. At fault for having an SUD. Unable to heal and unworthy of help. These sentiments can place profound stains on those of us who work in these professions in ways like what healthcare workers experienced during the pandemic in respect to antivax sentiments:

"I don't get into it too much with these people. I've learned through the years with anti-vaxers…that getting into that type of debate or trying to persuade or change their mind, it's never that productive, and it usually ends badly."

"It's kind of frustrating, and it's almost not even worth bringing up when people are arguing about masking and social distancing and stuff. It's just it's become this, like, I don't even want to argue with you anymore. I think that those kinds of relationships with people have suffered."

"Arguing endlessly with people who have these things in their mind isn't worth it. You just, again, you just feel exhausted, and you're like, you know what, it's not. It's not worth my time, my effort, my breath, to try to change your mind because I can't."

Drawing one further parallel between our addiction epidemic and the experience of health workers during COVID, both were grappling with constant death, meager resources, systemic negative perceptions about the work and too few workers created dynamics that negatively impact SUD care. This is particularly true in public sector programs. The quotes

below are taken directly from the journal article on the pandemic and the experiences of healthcare professionals, but could have just as easily been come out of the mouths of beleaguered SUD care workers experiencing the growing complexity of the addiction epidemic, but without the resources of healthcare workers during the much shorter COVID pandemic:

> *"When the testing got done, and everything else and they told me you've got 28 patients out of 89. I said, like almost a full third of my patients are positive. And then a couple that with 26 out of 145 staff members, 26 are positive. That rocked us…part of it, honestly was, we felt, as a whole, we felt like we failed our patients. We did have a few of the patients pass away because of COVID. And I feel responsible for that to a certain level, not personally responsible, but just healthcare, just in general like, dude, like, what could we have done differently to prevent that? And you wrack your brain thinking about it. You wrack your brain trying to figure out how it got in. There's a big sense of personal responsibility…I felt like I let my staff down. They felt that same way."*
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> *"We are not giving the best care. Not because we don't have the resources, but because we are [having an] attitude to those patients. And I have the feeling that it's because we are taking care of these critical care patients, like really, really, really long time. Then somebody is asking for a test or is complaining about something. That has really no importance. So, it's not an emergency diagnosis. And we are not giving our best to those patients now."*

The article describes the experiences in the experiences of healthcare workers during the pandemic in the context of the Jobs Demand – Resources (JD-R) model. The JD-R was developed in 2006 by researchers Arnold Bakker and Evangelia Demerouti. The model states that when job demands are high and job resources/positives are low, stress and burnout increase. Conversely, a high number of job positives can offset the effects of high job demands. They characterize the pandemic as a "shock event" and make the following recommendations that may also be helpful for our public sector SUD workforce and policymakers trying to improve care during the prolonged and deepening addiction epidemic:

Practical Recommendations for Organizations and Managers During Shock Events – Recommendations from the article:

1. In the presence of a shock event, organizational leaders ought to consider the second-order side effects of the organization's response(s) on the workforce. A new program or policy may be beneficial in one respect (e.g., reducing pathogen transmission), but harmful in another (e.g., reducing workforce interaction).
2. Organizational leaders ought to reconsider existing policies and procedures in light of a shock event. Shock events have the capability of transforming once-beneficial policies into counterproductive burdens on the workforce.
3. Organizational leaders ought to carefully re-evaluate employee workloads and resources following a systemic shock, realizing an imbalance in any one (or both) of these dimensions can contribute to increased feelings of exhaustion, detachment, cynicism, and inefficacy (i.e., burnout). It is important for organizational leaders to recognize that once-stable employees may begin to evidence signs and symptoms of burnout following a shock event (whether personal or systemic).
4. During and/or following a shock event, offer employees outlets with which to express newfound stressors to co-workers or similar others who can comprehend and empathize with their lived experience(s).
5. Train managers and workers to identify different facets of burnout. Workers with high levels of exhaustion may need more distance from work (i.e., timeoff). Workers evidencing symptoms of detachment and/or cynicism may benefit from additional resources that empower them to engage more with their work.
6. Empower workers to craft their job experience in ways that will encourage greater engagement on their part. Workers in lower-status positions might especially need empowerment to have their ideas heard and for them to feel included.
7. When resources are threatened by a shock event, organizational leaders may facilitate work and nonwork interaction like allowing voluntary opportunities to work from home or by inviting family/friends to social gatherings.
8. Consider increasing monetary or other benefits, even temporarily, to show appreciation for workers taking on additional burdens and responsibilities during shock events.
9. During shock events, organizational leaders may encourage the voluntary adoption of temporary routines, which serve to segment work and nonwork and reduce demands away from work.
10. Provide opportunities and psychological safety for workers to admit emotional exhaustion. Empower managers to encourage exhausted workers to take time off, leave early, or extend break times, whenever possible.

The shock event of the pandemic, including a lack of resources, significant loss and the context of a society who does not support the effort is not a shock event in our SUD Care system, but rather the normed state over a period of decades. We have long experienced a profound imbalance between resources and workloads, particularly in the public sector care system. Our capacity to help in the SUD sector is limited by the well-being of our workforce. Let's change that.

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