Can We Go Beyond Rhetoric to Action? Opportunities at the Executive Level to Support the Wellbeing of the Substance Use Health Care Workforce and Reduce Substance Use Stigma

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EQUIP Health Care
Equipping Health & Social Services for Equity

Acknowledgement of Territory

We gratefully acknowledge that our work in the province of British Columbia is primarily carried out on the unceded, ancestral, and continually occupied territories of the xʷməθkʷəy̓əm (Musqueam) Nation. We work in solidarity with Indigenous Peoples to support an anti-racist approach to healthcare and social services, and actions to actively address the intergenerational harms of colonization and promote greater health equity.

Table of Contents

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Executive Summary

At the behest of Health Canada, EQUIP Health Care undertook this project to identify opportunities at a structural and policy level for use by Executive Leaders to support the wellbeing of the substance use health care workforce. We conducted an environmental scan of published and grey literature and consulted with leaders in health care with relevant expertise.

The environmental scan provided an orientation to existing literature, and a foundation for conducting the consultations, informing both our questions and our interpretation. The themes included:

- Burnout, compassion fatigue, and vicarious trauma are pervasive
- Grief and loss are disproportionately experienced
- Working conditions are precarious
- Current supports are inadequate
- The workforce is stigmatized
- The workforce is siloed

The consultants extended the analysis well beyond what was seen in the literature reviewed for this project and highlighted particular areas for action for Executive Leadership in Canada. The features of the substance use health care workforce and the context within which the work is done create unique challenges. These features include:

- The work is highly complex and poorly understood by many in health care and the public: “We can’t tinker around the edges anymore”
- Grief and loss are profound and pervasive: “The workers are living and breathing trauma”
- The current state of the workforce is not sustainable: “We can’t grind on”
- System and structural barriers are the greatest challenges: “Fighting the system and structures are harder than anything else”
- The substance use health care workforce is stigmatized: “We have to correct the pervasiveness of public misperceptions”
- Data, data sharing and approaches to measurement are inadequate: “People aren’t going to share information willingly”
- Funding determines possibilities: “You can only be as flexible as your budget”

The unique circumstances of the substance use health care workforce include: a) the harms of the drug toxicity crisis experienced disproportionately relative to other sectors of the health care work force, b) structures and organizational policies that do not adequately reflect the complex realities and needs, and often are counter to fostering the wellbeing of those who come for services and the workforce, c) the fact that many of these services are delivered within organizations marginalized by funding structures, leading to precarity of programs and organizations, lower wages and fewer benefits relative to other health care workers, and a consequent time-consuming quest for funding, and d) stigma directed toward the workers, their work, their clients and sometimes their organizations. The current circumstances of the substance use health care workforce are exactly those that give rise to moral distress and burnout/compassion fatigue, which the consultants described as endemic.

Both the environmental scan and the consultations pointed to the following opportunities for action. Although the goal of this project was to identify opportunities for actions to be taken by Executive

Leaders in the substance use health care workforce, it is clear that Executive Leaders cannot affect change alone.

All parties (researchers, policy makers, Executive Leaders, advocates, people with lived and living experience (PWLLE) of substance use and substance use stigma, the workforce, funders, and government agencies) should work together to:

- ✓ Widen 'who' is considered part of the substance use health care workforce
- ✓ Implement strategies to better connect and coordinate across sectors (e.g., Executive Leaders can work with related systems, such as worker's compensation organizations, to implement strategies to prioritize mental health care)
- ✓ Focus on improving the working conditions of the workforce at structural and policy levels (e.g., foster supportive leadership and teams; provide adequate compensation, benefits and training; reduce exposure to trauma by rotating staff through different areas)
- ✓ Ensure that PWLLE of substance use and substance use stigma are involved with all initiatives and supported equitably to guide all facets of service provision, policy development, and strategies to support the wellbeing of the substance use health care workforce
- ✓ Embed PWLLE and the broader substance use health care workforce in decision making processes, particularly relating to policy development
- ✓ Identify, increase understanding of, and meet the needs of specific sectors of the substance use health care workforce, including peer workers and those who are likely to be overlooked as doing substance use health care (e.g., by formalizing peer job titles; creating formal job descriptions; and creating workplace substance use policies)
- ✓ Normalize mental health support of all workers, taking a universal approach so that all workers are expected to access and are provided with supportive mental health care (e.g., mandate monthly check-ins for all staff; hire mental health support staff who understand the work and context; train staff in critical incident stress debriefing)
- ✓ Create and/or participate in destigmatizing campaigns
- ✓ Work with media to present constructive framing in public discourse regarding substance use, rather than the stereotypical portrayal of substance use

Provincial and national level bodies such as governments and funding bodies should:

- ✓ Invest in strategies for coordinated responses for implementing legislation and policy direction (e.g., legislation for workplace mental health)
- ✓ Provide funding opportunities aimed at designing multilevel, intersectoral strategies to support long-term sustainability of workforce wellbeing
- ✓ Invest in technology to facilitate communication across sectors related to individual patients
- ✓ Identify standardized measures for monitoring the wellbeing of the substance use health care workforce
- ✓ Create platforms for data collection and data sharing (e.g., a National Database to understand the scale of the drug toxicity crisis at a federal level; data base for monitoring workforce wellbeing)
- ✓ Actively partner with media outlets to produce counter-narratives that emphasize positive return on investment of policy and health-system responses, and non-stigmatizing key messages

Introduction

This report describes an undertaking by EQUIP Health Care (EQUIP) to identify opportunities at a structural and policy level for use by Executive Leaders to support the wellbeing[1] of the substance use health care workforce. The extent to which different sectors of the health care system are understood to be providing substance use health care varies; thus, we understand that the substance use health care workforce includes those in any health care setting serving people who use substances heavily – in other words, any setting. However, we intentionally focused on literature and input from those with expertise regarding services explicitly focused on substance use (e.g., safe consumption sites, needle exchanges, opioid replacement clinics), and more general services providing care to high proportions of people using substances heavily and/or at risk of overdose (e.g. Emergency Departments (EDs), Emergency Health Services (ambulance paramedics), Mental Health Services and Primary Health Care (PHC)). Following Rehm et al. (2), the term self-identified "heavy use" will be used rather than other more value-laden terms such as "problematic", "addiction", "abuse" or "misuse".

Project activities were completed between November 2023 and March 2024, and included a series of in-depth consultations with health care Executive Leadership, and those with expertise in substance use health care; and an environmental scan of extant literature focused on promising practices and principles for effective organizational and policy approaches to supporting wellbeing in the workforce. This project focuses on the health care workforce as it pertains to substance use; given the scope of this project, the discussion presented in this report is not intended to be inclusive of the social services sector workforce. Thus, we explicitly use the term "substance use health care workforce".

Overall, the themes reflected in the environmental scan mirrored issues raised during consultations. However, the consultations extended the analysis well beyond what was seen in the literature reviewed for this project and highlighted particular areas for action for Executive Leadership in Canada. This report provides a summary of the results from the environmental scan and presents further findings from an Executive Leadership perspective, including areas for ongoing consideration and opportunities for action.

Background

About the Project

Over several decades, based on intervention and implementation research in multiple contexts, EQUIP Health Care designed and evaluated an implementation framework to increase organizational capacity for equity-oriented care in health and social service sectors. EQUIP identified the key dimensions of equity-oriented health care as cultural safety/anti-racism, harm reduction and substance use health[2],

[1] In line with the intention to identify opportunities at a structural and policy level, we understand workforce "wellbeing" as a relational concept (1), not only concerned with the intrapersonal wellbeing of individual staff, but also the interpersonal wellbeing of relationships between and among staff and between staff and those served, and the wellbeing of the organizations, communities and systems within which people work and receive services.

[2] The EQUIP Health Care Research Team has been partnering with people who have extensive lived experience of substance use stigma (SUS) – including a nationally active organization, the Community Addictions Peer Support Association (CAPSA). CAPSA has provided leadership in reframing "Substance Use" and "addiction" to reflect a broader conceptualization of Substance Use Health (SUH). SUH encompasses harm reduction, but intentionally expands beyond harm reduction to promoting health, well-being and equitable access to and treatment within

and trauma- and violence-informed care. Most recently, in partnership with service providers and people with lived and living experience (PWLLE) of anti-Indigenous racism, substance use stigma, and intersecting forms of discrimination, EQUIP strengthened attention to cultural safety, substance use stigma, and trauma-and violence-informed care, creating an "Equity Action Kit". The Action Kit provides a road map to increase capacity for equity-oriented care while promoting better outcomes for people coming for care *and the wellbeing of service providers*. The Action Kit packages equity-oriented planning, implementation (including online training and action resources), and evaluation resources geared to organizational leaders and direct care staff.

Throughout, EQUIP has explored organizational and structural factors that impact the wellbeing of the health care workforce. While we have developed a few tools and resources for health care workers (e.g., the Trauma- & Violence-Informed Care and Provider Wellbeing tool), and measures of patient experiences of care, our emphasis has been on supporting organizations to improve care delivery to service users. Our research shows that when organizations and the staff within those organizations are supported in their wellbeing through an equity lens, capacity for equity-oriented, non-stigmatizing and trauma- and violence-informed care is increased. Thus, our research has identified a need for a suite of tools to support organizations to foster the wellbeing of health care workers and a need for strategies that are more structural in nature.

Health Canada sought to explore barriers, facilitators, and best practices to support the wellbeing of the substance use health care workforce, especially from the perspective of health care Executive Leadership, with the ultimate goals of reducing stigma, increasing the quality of care, and improving the wellbeing of the substance use health care workforce.

The project outlined the following deliverables:

- An environmental scan on effective, equity-oriented organizational practices to support wellbeing in the substance use health care workforce.
- A series of consultations with Executive Leaders to identify priorities and key metrics for supporting and measuring wellbeing in the workforce.
- A brief report, summarizing:
    - The results from the environmental scan regarding effective and promising approaches to supporting wellbeing in the substance use health care workforce.
    - Findings from an Executive Leadership perspective regarding organizational facilitators, priorities, and evaluation considerations.
    - Opportunities for next steps.

services in relation to substance use. Briefly, SUH frames substance use in relation to a spectrum encompassing non-use, beneficial uses, occasional risks or harms, use that has ongoing consequences, and substance use disorders that are recognized as medical diagnoses in the current DSM-5 biomedical classification system. Providing substance use health care requires (a) deprioritizing abstinence as the primary success outcome of health care; (b) removing barriers to care, including intersecting forms of stigma; and (c) facilitating access to social determinants of health for those with limited access (3).

Approach

The environmental scan was initiated to inform our consultations with Executive Leaders, but both were completed concurrently, one informing the other. In both, we focused largely on the health care workforce. As recently shown in the 2023 Canadian Academy of Health Sciences landmark report (4), the current state of the health care workforce is unsustainable. The workforce is experiencing inequities, burnout, and moral distress, which are contributing to turnover, extended sick leave, resignations, and poor health outcomes for patients (4). The substance use health care workforce is a microcosm of this, and experiences heightened burnout and moral distress due to the complexity of their work, and experiencing profound grief and loss in relation to their work (5-14).

We chose to begin our consultation with leaders based in British Columbia (BC), in part because, being based in BC we have the strongest relationship there, and in part because BC has been the site of groundbreaking advocacy, research, and policy responses to substance use issues for decades, with many of our consultants being leaders nationally and internationally in related areas. Focusing in BC initially provided access to people who have led research and policy change and have been at the forefront of health care responses to the drug toxicity crisis. BC has experienced disproportionate harms related to the drug toxicity crisis relative to other provinces and territories (15-17), with a total of 13,112 preventable deaths having been recorded between April 14, 2016, and November 1, 2023 (18). This is the fraught context within which the BC substance use health care workforce is working.

In BC, both prior to and since the onset of the current drug toxicity crisis, advocates including PWLLE of substance use, researchers, organizational leaders, and policy leaders have launched (and critiqued in an ongoing effort toward health and wellbeing of all) a variety of systems-level interventions and novel policy approaches (e.g., safe consumption, piloting of decriminalization and advances in safe supply), which are informing policies, practices and political debates in other regions across Canada. The debates continue to rage: most recently, in late 2023, the then-Chief Coroner, Lisa Lapointe, recommended moving to a non-prescriber-based model of pharmaceutical alternatives to eliminate barriers to access (18). Shortly after the Coroner's report was released, and rejected by government, Lisa Lapointe announced her resignation. In addition, policy leaders in BC released the 2024 Vision for Drug Policy, which calls for radical change to drug policy in BC by all levels of government (19). Other jurisdictions continue to watch how the system responses evolve in BC. Meanwhile, the substance use health care workforce labours within these troubled waters.

Those we initially consulted recommended other executive-level thought-leaders also based in BC, but whose spheres of influence extend nationally and internationally. We thus consulted with a total of 10 BC leaders. To provide some diversity provincially, we also consulted with seven Executive Leaders in Ontario, again, beginning with our known contacts and using a snowball approach. Ontario also has experienced high mortality rates related to the drug toxicity crisis (15) and associated political and policy challenges. For example, despite the harms being experienced in the province, supervised consumption sites across the province are facing possible closures (20). In March 2024, The Canadian Drug Policy Coalition urged Ontario's Minister of Health to provide emergency funding for safe consumption sites to continue operations (20). As in BC, across Ontario, PWLLE, policy makers, researchers, and service providers continue to implement innovative strategies to support substance use health, including novel coordinated care models and harm reduction approaches such as drug checking and prescribed safer supply (21-24). Regardless of the location of consultations, there was consensus in thinking and themes

across and beyond provincial boundaries. While each consultant described their context, and how its unique features created challenges to the wellbeing of the workforce in detail, there was clear agreement across these diverse sectors in the two provinces.

Environmental Scan

Process

The environment scan focused on structural and organizational practices and principles that may be effective in supporting workforce wellbeing including those specific to supporting the substance use health care workforce. Terms used in the literature and documents we reviewed to capture relevance to the substance use health care workforce included 'overdose prevention workforce', 'harm reduction workforce', 'peers' and 'harm reduction workers'. As discussions with consultants proceeded, we heard their repeated concerns about the overwhelming grief and loss experienced by the substance use health care workforce, particularly as the death toll from the drug toxicity crisis continues to rise. Hence, for the scan, we also sought consultation in this direction and explored literature on experiences of grief and approaches to supporting workers in the health care sector in a wide range of settings.

In total, 54 documents were reviewed in the environmental scan process. This included peer-reviewed articles, government reports, organizational reports, and news stories. Of the 54 documents, 28 were specific to the Canadian context; approximately 16 were concerned with those providing harm reduction services. To see the search terms and a detailed review of the environmental scan, see Appendix A.

Themes from the Environmental Scan

The environmental scan provided an orientation to existing literature, and a foundation for conducting the consultations, informing both our questions and our interpretation. The themes included:

- Burnout, compassion fatigue and vicarious trauma are pervasive
- Grief and loss are disproportionately experienced
- Working conditions are precarious
- Current supports are inadequate
- The workforce is stigmatized
- The workforce is siloed

As these themes suggest, the scan provided context for understanding the challenges experienced by the substance use health care workforce in the context of the wider health care system. The scan also pointed to organizational practices and strategies with potential to support the wellbeing of the substance use health care workforce. Organizational and federal level strategies identified included:

- Promoting supportive Executive Leadership and teams to foster safe and equitable environments
- Providing adequate compensation, benefits and training
- Increasing mental health supports tailored to the workforce, including organizational mental health mandates
- Legitimizing the peer workforce
- Increasing data availability and using standardized measures
- Implementing federal level strategies, such as legislation for workplace mental health

The consultants echoed, built upon, and extended the themes and strategies identified in the environmental scan in ways that went beyond and suggested how to operationalize what was in the literature. Thus, in what follows, we present the areas of concern and opportunities for action identified from the consultations drawing on the environmental scan where useful.

Consultations

Process

Using connections from the various EQUIP projects, the team developed a list of potential consultants who were employed in positions of leadership, interface with the substance use health care workforce, and are widely recognized for their contributions. These leaders were invited to consult with the project team and refer additional Executive Leaders who would be appropriate to consult. We prioritized recommended consultants, and the project leads sent out invitation emails, including a brief overview of the project aims and guiding questions for interviews:

- What is needed to better support the health and wellbeing of the "substance use health care workforce" that is, those serving people who are using substances heavily?
- What is required to support staff who themselves experience substance use stigma, and racism (especially anti-Indigenous racism as it intersects with substance use stigma and/or heavy use)?
- What are the challenges to implementing your advice?
- What are some existing metrics for gauging workforce wellbeing within organizations (including existing administrative data and standardized measures)? [3]

Overview of Invited Consultations

Consultations were conducted with leaders in primary care, emergency departments, Indigenous people's health and antiracist pedagogy, emergency health services (ambulance), palliative care services, community health centres, mental health services, substance use services including drug checking services, health policy and other interrelated sectors. In doing so, the team engaged with thought-leaders, Executive Leaders, researchers, and policy advisors who are working with various levels of government regarding the substance use health care workforce. Table 1 provides an overview of the completed consultations. We exceeded the goal of 10 consultations for a total of 17 consultations.

Table 1. Completed consultations

Region	Role and Setting
British Columbia	Program director of a large tertiary hospital
	Director of clinical operations at a large tertiary hospital
	Executive leader in a health authority
	Executive leader for *Emergency Health Services*
	Clinical expert and leader in the substance use health care workforce in the primary care sector
	Past executive leader in Indigenous people's health
	Executive director of a substance use treatment portfolio
	Scientist and policy leader in substance use and drug checking

[3] This question was added in 2024 consultations, as suggested by Health Canada.

	Scientist in inner-city palliative care
Ontario	Executive leader of a large tertiary hospital network
	Executive director for a community agency
	Executive director for a community health centre
	Executive director for a community health organization
	Director of harm reduction services for a community health organization
	Strategic director at a community health centre
	Two directors of a mental health and addictions program in a large, urban hospital

Features of the Workforce and Actions Recommended

All consultants identified concern for the wellbeing of the workforce in relation to substance use as critical. Each described their context, and how its unique features created challenges to the wellbeing of the workforce in detail, yet, as noted, there was clear consensus across these diverse sectors in both provinces. The concerns raised, and areas for action articulated below reflect what we heard during the consultation process. While we have organized them as separate areas, they are all interrelated and overlapping.

The work is highly complex and poorly understood by many in health care and the public: "We can't tinker around the edges anymore"

Consultants described the work as highly complex and as often framed by public misconceptions (e.g., that the substance use health care workforce is contributing to the diversion of drugs for illegal sale in communities, that providing substance use services is a gateway to drug use for youth or contributes to the current public health crises). Against the backdrop of these broader contexts, one consultant said, *"The impacts, on top of the stigma, the pressure, the barriers, the impact of death of folks on the street and the number of overdoses, [there is a] need for resources that 'understand' this work"* (Participant 9). Another, speaking about the intense challenges of the work, said "*People are also working outside of the scopes of their roles and they know they're [doing so and] that they could get in trouble…if somebody found that out. But we're all morally compelled to do something when we're placed in a situation where there's nobody else to do it*" (Participant 5). This points to the added burden of stress when structures (funding and policies) do not enable meeting the health care needs of those seeking service.

> *"…it's hard to tell who has whatever secret sauce to be able to witness the suffering of others and to have it not cause them the level of distress that leads them to not continuing in the work"*
>
> (Participant 1)

> *"The workforce needs to know that they and their community are accepted by society"... [specifically] "a lot of the work [peers] do is invisible and can't be talked about"*
>
> (Participant 5)

Consultants spoke about this work and what it requires as "not being suitable for everyone". One consultant, when discussing who is suited, said *"You want to kind of bring in people who can practice heart-centered care, but it's hard to tell who has whatever secret sauce it is to be able to witness the suffering of others and to have it not cause them the level of distress that leads them to not continuing in the work"* (Participant 1).

Importantly, consultants stressed that the wellbeing of the workforce depends on proactive actions at a structural and policy level in order to effectively address the wellbeing of those being served. In other words, the distress will not lessen as long as the toxic drug supply persists, people continue to die, and overdose and inequities continue to impact some groups disproportionately. Without upstream planning and resources, consultants pointed to a feeling of hopelessness about the sustainability of the work and the workforce.

> *"Because the work is not going to get easier. And the government's not going to change. I mean, that's the reality. So how do we keep a workforce staying in place that is well supported? And it's not about money, it's about what kind of relational capacity do we have to support people in the everyday work that we're doing in ways that work for them?"* (Participant 5)
>
> *"We can't tinker around the edges" any more, or we will never shift the end results. We will keep reporting on deaths in coroners' reports".* (Participant 13)

Grief and Loss are Profound and Pervasive: "The workers are living and breathing trauma"

> *"The workers are living and breathing trauma"…"there is so much vicarious trauma, it affects their clinical judgements"* (Participant 17)

Leaders described the level of distress of the substance use health care workforce as "unprecedented" in their experience; each had decades of experience related to substance use health care. Many of the people we consulted commented on how the profound grief and loss experienced by the workforce was not well enough acknowledged or understood by funders, health authorities or government in terms of system-level impacts and overall costs to society, as such understanding was not reflected in programs, policies or resources. For example, one consultant who had worked in HIV care for decades contrasted the current situation as "hopeless" compared to what they framed as a more hopeful time toward the end of the worst of the HIV/AIDs crisis. Another consultant stated, *"[The workforce] is in deep compounded grief due to unjust deaths and government inaction"* (Participant 5).

Providing services to people who use substances heavily and those at high risk of overdose and death is exceptionally stressful for many reasons. First, people drawn to such work generally have high levels of compassion. One consultant who works in a direct care context emphasized that, "*The quality of your outcomes is proportional to the depth of your relationships*" (Participant 17). Second, because the stress, attrition and turnover are high, there is instability in the workforce, a constant revolving door requiring endless recruitment, hiring, training and mentoring, and a low level of experience for many. Third, many, if not all of the sectors represented are under-resourced and stretched over capacity. Fourth, and perhaps most important, the stress of witnessing avoidable harms created by inequities is ongoing.

In summary, the stress, grief and loss experienced by the workforce was described as largely due to the challenging circumstances, witnessed inequities and constrained resources within which people provide service, not to the characteristics of the clients they serve.

> *"There's a whole complex piece about grief and loss; it's about anticipated grief and multiple losses. It's in the sector too: burnout, the moral distress people are facing – how do we build supports for people who are experiencing that multiple loss and grief journey?"* (Participant 12)
>
> *"…[its] a perpetual state of grief that we're all living through"…"[Some] people who just are so impacted by the stories of suffering and loss that [come with] the job, it becomes intolerable"* (Participant 1)
>
> *"The workforce is engaging with a dying population"* (Participant 8)

The Current State of the Workforce is not Sustainable: "We Can't Grind On – it's not Sustainable"

Most of the consultants expressed high levels of dismay and concern about not being able to sustain good quality care under the current circumstances. One consultant said, *"[Worker's] heads are sore all the time from hitting this brick wall*" (Participant 11), while another said *"We can't grind on – it's not sustainable"* (Participant 7). All consultants pointed towards the unsustainability of continuing the work without system level change. One consultant, speaking about the frustration of working in the substance use health care workforce, said: "*The relationship that the health care system has with its staff is not healthy. It's relentless. It's not reciprocal. And it takes so much from you*" (Participant 7). Another said, *"You shouldn't be predicating your system on individuals going above and beyond all the time"* (Participant 1).

> *"A lot of the workforce is just working to survive themselves"* (Participant 5)
>
> *"It feels a lot sometimes like you're dealing with crisis after crisis and you can't see the forest for the trees… You're constantly trying to dig yourself out of a hole, and then there's expectations for you to think long-term"* (Participant 14)

Consultants provided numerous examples of how better coordination could be achieved if all relevant parties were involved in decision-making. Because the consultants were senior leaders, many of them had crossed various sectors in their careers and pointed to specific examples of decisions being made without understanding the subsequent impact. One consultant described Executives being "*kept out of the loop*", referring to how decisions are made above them or in other departments and jurisdictions. For example, some described policy innovations such as decriminalization, the 'decampment' of parks where people were living, or the decision to pair mental health nurses with police as being made without any opportunity for planning in their sectors. For some, this means that even when they have data regarding inequities and impacts on wellbeing, they "*can't roll up the data they do have access to*" (Participant 17) to create accountability mechanisms. For example, when people coming for service are mistreated, stigmatized and racialized, reports are generated, but consequences are weak, inconsistent or absent. One consultant identified inaction as being promoted with a frequent, disturbing refrain among Executive Leaders that, *"We can't do anything about it… everyone is doing their best"* (Participant 17). In alignment with evidence presented in the Environmental Scan, they urged instead to

make efforts to set up accountability mechanisms, so that issues such as adverse events and complaints (both of which are often related to substance use and intersecting forms of discrimination) are reviewed with a view to building meaningful consequences at the individual and organizational level.

System and Structural Barriers are the Greatest Challenges: "Fighting the System and Structures is Harder than Anything Else"

Consultants described the relationship between the substance use health care workforce and the wider systems within which they work as profoundly unhealthy, but thought that the systems are operating as designed. As one consultant said, *"We tinker around the edges and expect significant change. And unless we actually create a response that is commensurate to the size of the issue, we will never adequately address the issue"* (Participant 13). They all pointed to the inherent struggle of trying to do the work while fighting the system, and the distress this causes. One consultant said, *"Fighting the system and structures is harder than anything else"* (Participant 7), and another said, *"Even if you are meeting with people where they are at, the system often does not"* (Participant 10), and *"It wears you down when you feel you are in conflict with the system and individuals in those systems"* (Participant 10). While consultants spoke about the stress of fighting the system, they also acknowledged that the system could be understood as operating "as intended"; in the words of one consultant, *"We're getting the outcomes for which the system was designed"* (Participant 14). Many pointed to the inequitable consequences of the fact that much substance use health care is provided by non-profit, non-governmental organizations that rely on time-limited grants and other forms of discontinuous funding. This is a well-documented phenomenon in health care (25-27), which challenges workforce capacity to regenerate, sustain, transform and mobilize.

> *"Staff are burning out because they are feeling hopeless and helpless in the system"* (Participant 11)
>
> *"The team can start to feel like they're doing harm by connecting people to that system – the moral distress that there's not many options that embody the values they work within"…"One of the challenges of supporting people who use substances heavily is we're working within systems and structures that highly stigmatize the population"* (Participant 10)

The Substance Use Health Care Workforce is Stigmatized: "We Have to Correct the Pervasiveness of Public Misperceptions"

Stigma was a pervasive theme throughout the consultations. Multiple consultants referred to negative public perceptions of harm reduction and substance use work and the consequent shifting political

tides. One consultant said, *"The culture of the politicizing polarization; there's this fear underneath everything, and we are wondering - are we going back 10 years?"* (Participant 11).

Consultants described how the substance use health care workforce is stigmatized in several ways. One consultant expressed major concerns about the exacerbation of stigma by media portrayals emphasizing the most extreme end of the continuum in relation to heavy use and street-involved activities,

> *"Executive leaders need to play a role in correcting the pervasiveness of public misperceptions about substance use. We have to get rid of the "B roll" in news media portraying the most extreme caricatures of substance use and substance use health care. We need to find ways to meet with big media to shift public myths and misinformation, so that we can have constructive dialogues within city councils and our communities. Let's emphasize the community-level economic benefits, and mobilize evidence-based information instead of myths. Let's emphasize the positive impacts on peoples' health when substance use services are made accessible and available in our communities, including the reduced levels of crime, the shorter emergency department wait times, the 'return on investment' in terms of economics and other community-level benefits. We need to "show up" for these kinds of civic events and dialogues. This is highly political work, and Executive Leadership must play a role, engage with media, and influence public discourses" [emphasis in original].*
>
> (Participant 13)

overlooking the pervasiveness of substance use as a 'whole-of-community' issue that impacts diverse people. Another described how, in the sector for which the consultant was responsible, media attention had blamed workers for exacerbating untimely deaths. They urged Executive Leaders to attend community forums and partner with media to counteract these often unidimensional, stigmatizing portrayals. They suggested that Health Canada and other agencies/institutions could actively partner with media outlets to produce counter-narratives and key messages – to help the public understand substance use as a public health issue affecting all facets of community life and wellbeing. They also urged Executive Leaders to play an active role in counteracting the myths and public misperceptions that contribute to fear-based dialogues within communities about substance use, and the substance use health care workforce. One consultant at a large institution said *"Myth busting is a big component of our jobs"* (Participant 15), with their coworker adding *"We are trying to negotiate harm reduction in a medical model of care"* (Participant 16), pointing to the tension between dominant approaches to care and harm reduction approaches.

Stigma affects the workforce negatively in a number of ways. First, nimbyism affects the location and quality of the location of services. Second, stigma shapes the reception to services and staff by the public and other local services. Third, in line with what is shown in the literature, people working with those who are stigmatized become stigmatized by association. On a structural level, stigma shapes programming, policy and legislation, which directly impact the ability of the substance use health care workforce to provide quality care, thereby contributing to experiences of moral distress and ultimately burnout.

Consultants also raised concern about people within the substance use health care workforce themselves being stigmatized and marginalized due to their own lived and living experience of

substance use. As one consultant said, when referring to working in this context, *It's almost safer to be quiet [about your own substance use]"* (Participant 2). This quote underscores the relationship between stigma and people's sense of safety in the workplace.

When asked about what is required to support staff who experience substance use stigma, one consultant said, "*I have a tremendous amount of flexibility to accommodate people who use substances…we [leadership] take those risks because it's the ethical thing to do*" (Participant 10). Another consultant, when considering how to best support staff, said *"How do we support someone who has the courage to disclose their current use? Are there opportunities for creating a system where they can have someone they can go to for mentoring?"* (Participant 12). Consultants described their own struggles as Executive Leaders to support their staff who identified as PWLLE of substance use and coming up against organizational policies, including Human Resources policies, suggesting that they too have to work outside their scope of work, against policy, and "*take risks*".

> "*I think about the people who we don't employ because their drug use is criminalized – particularly if you are working in an environment where you are regulated by a professional college: ongoing criminalization denies people the opportunity to provide their talent to this important work."*
>
> (Participant 10)

Data, Data Sharing and Approaches to Measurement are Inadequate: "People Aren't Going to Share Information Willingly"

Consultants were invited to discuss how to mobilize existing metrics for gauging workforce wellbeing within organizations (including, for example, existing administrative data and standardized measures). Many of the consultants expressed frustration with a lack of data to guide decision-making. One consultant specifically emphasized the importance of workers and leaders being able to see outcomes and positive changes that are a result of their hard work. Several suggested that a framework for data collection and sharing could improve coordination across jurisdictions. Further, they identified the need for compatibility of platforms to facilitate data sharing across jurisdictions. One consultant urged Health Canada and other government bodies to review the existing evidence-base on the value-added to society of having a robust substance use health care workforce, for example, from NAOMI (North American Opiate Medication Initiative) and SALOME (The Study to Assess Longer-term Opioid Medication Effectiveness). This consultant urged a return on investment (ROI) lens – not only to highlight the economic benefits to communities (which are often overlooked in public/civic debates) but to emphasize the benefits to the health care system as a whole from reduced wait times, reduced sick days, reduced worker's compensation claims that stem from the ongoing public health emergency, among others.

Consultants also acknowledged the importance of finding ways to respectfully measure and gauge the wellbeing of the workforce. Many argued for the importance of standardized data, such as turnover, sick time, workers compensation claims, and stress leave to better understand the diverse manifestations of stress (and conversely, wellbeing) on the substance use health care workforce. Several consultants referred to the value of workplace wellbeing surveys distributed regularly to staff to gauge perception of stress and perception of supervisor support, so they could understand trends to better support staff. Others raised concerns that measurement of wellbeing implied a need for disclosure of workers'

substance use. For example, when asked about existing metrics for measuring workplace wellbeing, one consultant who works as a Director of harm reduction for a community organization said, "*Metrics feels a bit cart-before-the-horse because there's so much stigma we're dealing with. The environment is one where people aren't going to share information willingly"* (Participant 11). This points to the importance of measurement of the wellbeing of the workforce being destigmatizing and confidential.

Funding Determines Possibilities: "You Can Only Be as Flexible as Your Budget"

All of the consultants working in community organizations brought up the issue of funding that was short-term and prohibitive in terms of continuity and effectiveness. One consultant aptly said that *"People should not be working at a discount"* (Participant 1), while another said *"We're killing our entire workforce by not providing fair wages and certainty in employment"* (Participant 10). Consultants themselves experienced distress and instability, attempting to manage multiple, short-term funding sources. And any successes described were grounded in adequate funding. For example, one Executive offered examples of how they are building strategies to address the ongoing trauma experienced by paramedics who may attend multiple deaths and overdoses in a single shift (see the concluding exemplar). This Executive stressed that it was an adequate budget and union-level wages that permitted and made these strategies effective.

Consultants identified the need for funding sufficient to adequately support the entire workforce; however, they especially stressed the importance of adequate funding and recognition of the peer workforce. Consultants recognized that the peer workforce is not adequately recognized or compensated, with one consultant saying *"Structures can look at peer work as cost-saving – [the work] is not easy, it's not different, [and the pay] should be equitable"* (Participant 11).

"We're killing our entire workforce by not providing fair wages and certainty in employment" (Participant 10)

"*Short-term grant funded interventions to try and run a system causes a level of distress and instability amongst the workforce*"… *"People are drawn to the nonprofit world because there are values and there is a sort of mandate that agrees with you, but in the end he who pays the piper, calls the tune, so you wind up having to deliver what the funders want and try to kind of make it fit, and a bit of the artistry of giving the funders what they're looking for, but at the same time doing the work that you find meaningful and is meeting the needs of who you are trying to serve, it's a juggle, and then it's a huge time suck"* (Participant 1)

"*In order to even help create safer emotional space, there has to be the financial resources to support; we're all trying to do this without dying; you can only be as flexible as your budget"* (Participant 9)

"Because of the scarcity [of staff] and the level of burn out it sometimes feels insurmountable to start investing in some longer-term things" (Participant 14)

"We don't have the time or resources for a more systematic response [to the drug toxicity crisis]" (Participant 3)

Limitations

This project was small in scope and short in timeframe. An environmental scan was conducted in contrast to a more rigorous review of the literature (i.e., a systematic review or scoping review). Consultations were conducted with 17 leaders in only two provinces. **Future efforts could be directed toward conducting a more targeted and detailed literature review to better support the suggested areas for action. It also may be useful to consult more widely in other provinces and territories, especially to identify unique challenges and strategies**. That said, the consensus between the environmental scan and the consultants' input, and among the consultants across diverse settings in two different provinces suggests that the promising areas for action are worth pursuing.

While we consulted with a diversity of leaders within the two provinces, many sectors were not represented. In the process, we recognized several key sectors of the health care workforce that may be overlooked as "substance use health care" workers. These included emergency health services workers (ambulance paramedics, dispatchers and staff) and palliative care outreach workers. There are likely other sectors that are similarly overlooked. **It would be valuable to more deeply investigate the experiences and needs of the workers in these sectors**.

We consulted only with professionals in health care and/or substance use services. Importantly, this Report is not informed by **consultation with peer workers or with service users and advocates**. Most effectively supporting the substance use health care workforce will necessarily require consultation with such groups.

Finally, we did not consult with the wider social services sector (e.g. shelters, antiviolence workers, child protection), all of whom work in key ways with people at risk of substance use stigma, overdose and/or death related to toxic drugs and or substance use. **Wider consultation and a literature review related to these contexts would be useful**.

Summary and Key Strategies

The unique circumstances of the substance use health care workforce include:

a) the harms of the drug toxicity crisis experienced disproportionately relative to other sectors of the health care work force,

b) structures and organizational policies that do not adequately reflect the complex realities and needs, and often are counter to fostering the wellbeing of those who come for services and the workforce,

c) the fact that many of these services are delivered within organizations marginalized by funding structures leading to precarity of programs and within organizations, lower wages and fewer benefits relative to other health care workers, and a consequent time-consuming quest for funding, and

d) stigma directed toward the workers, their work, their clients and sometimes their organizations.

Because stigma is a cultural phenomenon, a multi-pronged approach is required to support meaningful change. The 2019 Chief Public Health Officer's Report on the State of Public Health in Canada includes a "Stigma Pathways to Health Outcomes Model" that identifies four levels of stigma: individual, interpersonal, institutional, and population (28). Action and ongoing evaluation are needed to address each level of stigma and stigma reduction initiatives. Because different levels and forms of stigma

intersect and compound, meaningful stigma reduction efforts will benefit by bringing an intersectional lens to understanding and addressing stigma in the workplace and beyond (28, 29).

The current circumstances for the substance use health care workforce are exactly those that give rise to moral distress and burnout/compassion fatigue, which the consultants described as endemic. Moral distress is created when practitioners are unable to provide care and services commensurate with their professional values and standards; this inability stems from the sociopolitical and cultural context of the workplace environment (30). Burnout, a psychological response to chronic job stressors, is associated with both moral distress and vicarious trauma (31, 32). Vicarious trauma, referring to negative experiences when working with survivors of violence and trauma and exposure to others' trauma experiences (33) is inevitable for those in the substance use health care workforce, given the high association of trauma and heavy substance use. Compassion fatigue, a term that is sometimes used as synonymous with burnout can be distinguished, according to Henson (2020), as follows: "while burnout is an accumulation of stress related to work environment, compassion fatigue is depletion of compassion resulting from exposure to suffering and trauma" (34, p.81). It is clear that urgent action is required, if we are not to, in the words of one consultant *"kill our entire workforce"* (Participant 10).

Although the goal of this project was to identify opportunities for actions to be taken by Executive Leaders in health care, it is clear that Executive Leaders can not affect change alone.

All parties (researchers, policy makers, Executive Leaders, advocates, PWLLE, the substance use health care workforce, funders and government agencies) should work together to:

- ✓ Widen 'who' is considered part of the substance use health care workforce
- ✓ Implement strategies to better connect and coordinate across sectors (e.g., Executive Leaders can work with related systems, such as worker's compensation organizations, to implement strategies to prioritize mental health care)
- ✓ Focus on improving the working conditions of the workforce at structural and policy levels (e.g., have supportive leadership and teams; and provide adequate compensation, benefits and training; reduce exposure to trauma by rotating staff through different areas)
- ✓ Ensure that PWLLE of substance use and substance use stigma are involved with all initiatives and supported equitably to provide guidance on all facets of service provision and strategies to support the wellbeing of the substance use health care workforce
- ✓ Embed PWLLE and the broader substance use health care workforce in decision making processes, particularly relating to policy development
- ✓ Identify, increase understanding of and meet the needs of specific sectors of the substance use health care workforce, including peer workers and those who are likely to be overlooked as doing substance use health care (e.g., formalize peer job titles; creating formal job descriptions; and creating workplace substance use policies)
- ✓ Normalize mental health support of all workers, taking a universal approach so that all workers are expected to access and are provided with supportive mental health care (e.g., mandated monthly check-ins for all staff; hire in-house support staff that understand the work; train staff in critical incident stress debriefing)
- ✓ Create and/or participate in destigmatizing campaigns
- ✓ Work with media to present constructive framing around public discourse regarding substance use, rather than the stereotypical portrayal of substance use

Provincial and national level bodies such as governments and funding bodies should:

- ✓ Invest in strategies for coordinated responses for implementing legislation and policy direction (e.g., legislation for workplace mental health)
- ✓ Provide funding opportunities aimed at designing multilevel, intersectoral strategies to support long-term sustainability of workforce wellbeing
- ✓ Invest in technology to facilitate communication across sectors related to individual patients
- ✓ Identify standardized measures for monitoring the wellbeing of the substance use health care workforce
- ✓ Create platforms for data collection and data sharing (e.g., a National Database to understand the scale of the drug toxicity crisis at a federal level; data base for monitoring workforce wellbeing)
- ✓ Actively partner with media outlets to produce counter-narratives that emphasize positive return on investment of policy and health-system responses, and non-stigmatizing key messages

The wellbeing of the substance use health care workforce in the health and social services will best be served by structural changes, which require policy change at all levels. Involving PWLLE and members of the substance use health care workforce will be integral to achieving such changes. The following exemplar, provided by one of our consultants (and shared with permission) demonstrates the practical operationalization of the above strategies, an example of 'how to' do what is written about in literature and espoused by the consultants.

An exemplar toward effectiveness: BC's Emergency Health Services

Amidst the distress that the consultants both conveyed and experienced themselves, one example stood out as a hopeful operationalization of a structural approach to supporting the substance use health care work force. The BC Emergency Health Services are being dramatically enhanced toward this goal. Dr. Leanne Heppell, Executive Vice President & Chief Ambulance Officer for BC Emergency Health Services described multiple strategies they are undertaking. Ambulance paramedics and staff (for example, dispatchers) exemplify a sector of the workforce that might not be well recognized as being a key part of the "substance use health care workforce"; yet, across BC, these workers have been central to health care and the response to the drug toxicity crisis, daily providing overdose responses and dealing with drug-related deaths.

First, Dr. Heppell stressed that she had the **resources**, the **authority** and the **support of management** to implement the innovations she outlined. Second, the innovations align with a recent union contract that has facilitated better **pay, benefits and working conditions** for staff creating structural conditions for success.

Importantly, working to **improve effectiveness of and equity in responses** is a key upstream strategy that will ultimately reduce stress for the workforce. For example, she described a series of strategies to improve service in rural and remote communities, including engaging high school students and providing funding for initial training and clear career ladders. In urban areas, bike squads are being deployed to improve response times. These strategies rely on meaningful connections – with communities, non-profit organizations and diverse mainstream services.

In line with strategies suggested in the literature offered in the environmental scan, to **reduce exposure to trauma**, paramedics are now rotated in and out of areas where there is a concentration of people experiencing overdoses. Further, new staff are exposed gradually to more distressing calls.

As noted, a key strategy is more **effectively supporting mental health** of all workers. They have developed an enhanced critical incident stress debriefing where over 230 of their own staff (as opposed to external experts who would not necessarily know the work) trained as critical incident stress supporters. They are working on a toolkit to support the mental health of early career paramedics, and described developing a "resilience package" to prioritize the mental health of staff. A central feature is regularly scheduled routine mandatory check-ins with a counsellor, which can effectively **reduce the stigma** staff often encounter when accessing mental health supports. Another strategy is a gradual, supportive return to work program for staff coming back from mental health leave.

At the same time, Dr. Heppell described the executive's role in **advocating with related systems**. For example, she is working with WorkSafeBC (the worker's compensation organization) to find strategies to prioritize mental health care for paramedics and extend that care to their families.

Echoing the literature in the environmental scan demonstrating the need to **address siloed decision-making**, Dr. Heppell called for 'everyone' to be at the table.

Appendices

Appendix A: Environmental Scan

Opportunities at the Executive Level to Support the Wellbeing of the Substance Use Health Care Workforce and Reduce Substance Use Stigma: An Environmental Scan

March 21, 2024

Prepared By: Colleen Varcoe & Annette J. Browne

Introduction

Overview: This environmental scan of published and grey literature focuses on structural and organizational practices and principles that have potential to support the wellbeing of the substance use health care workforce. The environmental scan highlights opportunities for executive level leaders to implement strategies to improve wellbeing and to inform the development of tools and resources.

Goal: The initial goal of this environmental scan was to review literature, including grey literature, regarding any interventions, resources, best practices, strategies, organizational characteristics/culture that have potential for preventing and/or mitigating the impact of vicarious trauma, burnout/compassion fatigue, and moral distress[4] among service providers in the substance use health care workforce, with a particular focus on structural and organizational actions.

Scope: The environmental scan focused on the literature addressing the wellbeing of people working directly and explicitly in providing substance use health care, informed by literature describing promising practices to support wellbeing more broadly in the health care and social service workforce. While we understand that the entire health care and social service workforce provides services to people using substances heavily[5], most literature of relevance is related to those providing harm reduction services. In the literature reviewed for this environmental scan, the substance use health care workforce was designated by other terms, such as harm reduction workforce, harm reduction service providers, peers, and overdose response workforce. Thus, we began with harm reduction services literature, additionally drawing from more general literature on health care workforce wellbeing. Consequently, we included literature pertinent to counselors, nurses, mental health care providers, outreach workers, peer workers, physicians, psychologists, social workers, and therapists among others.

We use a critical structural lens that draws attention to organizational, cultural and social factors, in this case, shaping the wellbeing of the workforce. Specific to substance use we were informed by our understanding that substance use policy, including both drug and alcohol policy, has been a highly politicized issue since before the 1800s (19, 36), with deep divisions within the public. As articulated by the Canadian Drug Policy Coalition, "the earliest attempts at prohibition on these lands date back to the Indian Act, the Opium wars, and an early 20th century rise in anti-Chinese and anti-Japanese racism" (37). Heavy substance use continues to be seen as a moral failing despite the increasing popularity of the disease model, or, more recently, the learning model (3, 38-41).

The scan was conducted in parallel with consultations with Executive Leaders who have responsibilities related to the substance use health care workforce. As discussed in the report to which this

[4]These terms are defined variously in the literature (35), including the literature reviewed in what follows. We define **vicarious trauma** or secondary trauma as the impact of being exposed to and repetitive invasion of others' trauma experiences experienced by those working with the survivors of violence and trauma (33). We define **moral distress** as "the experience of being seriously compromised as a moral agent in practicing in accordance with accepted professional values and standards… a relational experience shaped by multiple contexts, including the socio-political and cultural context of the workplace environment" (30, p.59). **Burnout** is a psychological response to chronic job stressors (31, 32) including vicarious trauma, racism and moral distress. Burnout is associated with **compassion fatigue**, the depletion of compassion resulting from exposure to suffering and trauma, the final cumulative result of prolonged exposure to workplace stress (34, p.81)

[5]Following Rehm et al. (2), we use the terms "heavy use" or "using heavily" instead of more pejorative terms.

environmental scan is appended, in initial discussions these leaders overwhelmingly pointed to the profound impact of loss and grief being experienced within the work force. Thus, we drew on the palliative care literature to more deeply consider approaches to supporting workers experiencing grief and loss in the context of the drug toxicity crisis.

Beginning with MESH Term-driven searching, we additionally used reference lists in promising documents and reviewed documents drawn upon by our consultants. In total, 54 documents were reviewed in the environmental scan process. This included peer-reviewed articles, government reports, organizational reports, and news stories. Of the 54 documents, 28 were specific to the Canadian context. Approximately 16 were concerned with those providing harm reduction services.

What is the "Substance Use Health Care Workforce"?

The Canadian health care workforce employs more than 10% of Canadians (4) encompassing regulated, unregulated, unionized, non-unionized, public and private delivery employees working in diverse contexts. This workforce varies in terms of the extent to which each worker is explicitly and directly engaged in providing services to people *because* of substance use (e.g. harm reduction services) and the extent to which they are providing care to a high proportion of people who use heavily (e.g. mental health care providers). Given that 76% of the Canadian population reported alcohol use, 21% reported cannabis use, 23% reported psychoactive pharmaceutical[6] use in a way not intended by the prescriber, and 3% reported illicit substance use (42), and given the increasing rates of use (43), most of the insights gained in this scan are applicable to the entire health and social services workforce. However, as underscored by the consultants, the level of urgency for action is most acute for those most directly involved. Throughout this document we use the term "substance use health care workforce" to refer to those most directly involved in providing services to people using substances heavily, either by virtue of the services provided or the population served. This includes both the 'obvious' (e.g. those working in harm reduction services) and those who may be less obvious (e.g. paramedics).

The Broader Context: Health Care Workforce Wellbeing

The health care workforce is increasingly experiencing inequities in pay and benefits, poor working conditions, and high levels of burnout and moral distress, which contribute to negative impacts such as high turnover, extended sick leave, resignations, and ultimately, poor health outcomes for patients (4, 14, 44-46). Working in a context of high and increasing workloads increases the risk of burnout, anxiety, depression, PTSD, and increased substance use, compared to those working in other sectors (47). Lack of resources and inadequate support from leadership contribute to these negative impacts (4). The workforce was struggling before the COVID-19 pandemic, and the challenges to the wellbeing of the workforce have been exacerbated by both the pandemic and the ongoing drug toxicity crisis, with specific impacts on the substance use health care workforce.

To date, strategies to support health care workforce wellbeing have been largely focused at the individual level, despite evidence and recommendations to support organizational and structural change (45, 48, 49). The emphasis is on "self-care", access to counselling, employee assistance supports, gym

[6] The three classes of psychoactive pharmaceutical substances include opioid pain relievers, stimulants, tranquillizers and sedatives.

memberships and mindfulness and resilience programs (6, 48, 50). This focus on the individual level ignores and obscures the root causes of burnout, compassion fatigue, and vicarious trauma in the workplace (35). This project was intended to illuminate actions that can be taken at a structural and policy level to create circumstances for a "well" health care workforce.

Substance Use Health Care Workforce Wellbeing

Those working directly in the substance use health care workforce have always faced challenges to their wellbeing because a) they often work in marginalized organizations and thus are often less well compensated and supported than counterparts in mainstream health care, b) they often work with people who are marginalized and stigmatized, thus they are exposed to structural violence and inequities and stigmatized by association, c) their work is often undervalued or even despised by the public, and public opinion is predominantly not supportive of such work (51, 52).

The challenges faced by the substance use work force were exacerbated by both COVID-19 and the ongoing drug toxicity crisis, both of which escalated workers'exposure to trauma, overdose and death exponentially. Throughout the COVID-19 pandemic and public health measures calling for social distancing, the substance use health care workforce found it increasingly more challenging to connect with and build trust with clients, and provide adequate harm reduction services (6). In 2019, The Canadian Centre on Substance Use and Addiction (CCSA) began consultations with organizations providing harm reduction services across Canada to better understand how the drug toxicity crisis was impacting the substance use health care workforce, in addition to understanding the impacts of COVID-19 (6). They invited harm reduction service providers to complete a survey, with the first cycle of 651 respondents collected in 2019, and the second cycle of 1360 respondents collected in 2021. In this report, the CCSA found that the substance use health care workforce found meaning in the work and care they provided, but overall experienced high levels of burnout and vicarious trauma due to the context of their work (6). Burnout and compassion fatigue were exacerbated by the lack of support and resources within the system. Prior to the COVID-19 pandemic, the substance use health care workforce was already feeling deeply unsupported and underfunded, which contributes to feelings of moral distress and vicarious trauma due to structural factors outside of their control. Respondents indicated that their quality of life was impacted by the failure of government policies to properly support their work (6). It was noted that substance use health care is inherently political, and therefore comes with implementation and sustainability challenges. Differing and often conflicting political landscapes affect the adoption and uptake of harm reduction strategies. It can be difficult to implement evidence-based strategies when existing policies (and underlying philosophical perspectives) or funding sources do not align (9).

Impacts of the increasingly constrained working conditions have been especially harmful for peer workers who are often marginalized within their organizations (5, 10-13, 53-55). Mamdami et al., among others, found that peer workers experienced high levels of stress because of financial insecurity, lack of respect and recognition at work; housing challenges, the inability to access and/or refer people they served to resources, and constant exposure to death and trauma (6, 10, 12, 13, 53, 55).

There is also an economic argument to be made for investing in the wellbeing of the substance use health care workforce. In 2019 (notably pre-pandemic) business analysts Deloitte Insights analyzed three years of data from ten Canadian corporations with long standing mental health programs to better understand returns on investment of these programs. They found that corporations with effective mental health programs saw a return on investment of $1.62 CDN for every $1 spent due to increased productivity and fewer mental health days (50, 56). The 2022 CCSA report states that supporting the substance use health care workforce is an "investment in our healthcare system we cannot afford not to make" (6, p.5). Responding to burnout and compassion fatigue may lead to improved system capacity and reduced health care costs.

Reports and Policy-Discourses Arising from the British Columbia Context: National Relevance

In the context of diversity in substance use policy, including drug, alcohol and prescription drug policies, across Canada's provinces and territories, British Columbia (BC) has been a site of groundbreaking substance use research and practice and policy innovation for decades (57). Most recently, BC has been the site of disproportionate harms related to the drug toxicity crisis (15-17); since the Public Health Emergency in BC was announced on April 14, 2016, 13,112 deaths have been recorded due to drug toxicity up to November 1, 2023 (18). Consequently, research and policy responses in BC have been spotlighted in the Canadian and international landscape. The environmental scan illuminates some of the systems level interventions and novel approaches that policy leaders, policy advocates and grassroots organizations (including those with lived and living experiences) have launched that are informing policies, practices and political debates in other regions across Canada (5). Responses have been diverse, including some efforts toward decriminalization, lobbying for legalization, drug checking programs and efforts to engage people with lived and living experience (PWLLE) of substance use in meaningfully guiding responses to the toxic drug supply crisis. For example, demonstrating efforts to bring research and policy innovation together, BC was the first Canadian province to implement a prescriber-based safer supply model for people who use drugs (PWUD). A recently published study (58) investigated the effect of prescribed safer supply on mortality and emergency department (ED) visits in BC. This research found that those who had access to prescribed safer supply were at a significantly lower risk of mortality (either by any cause or due to substances), and that prescribed safer supply shows promise as an intervention to reduce the deaths caused by the drug toxicity crisis.

Importantly, BC is home to a wide variety of community groups undertaking innovative action to address the harms of the drug toxicity crisis. Longstanding groups led by PWLLE of substance use continue to drive advocacy, harm reduction, and policy reform. In 2017, a new provincial structure was introduced to support community coordination: the BC Overdose Emergency Response Centre. The Response Centre supports provincial, cross-sectoral collaboration amongst public agencies, community groups, and PWLLE. The Response Centre uses a "World Health Organization/Global Fund approach to program implementation, capitalizing on evidence-based interventions with proven efficiency across a Comprehensive Package of Interventions" (59). For example, the Response Centre includes funding for Community Action Teams wherein locally-based community tables bring together diverse membership spanning service providers, PWLLE, first responders, government representatives, and other community

representatives, to support response coordination and implementation of novel strategies to reduce the harms of the drug toxicity crisis (59). Notably, in 2023, under the auspices of "decriminalizing people who use drugs", a groundbreaking provincial decriminalization pilot was launched in British Columbia (60). Effective January 2023 through January 2026, via a Health Canada exemption under the Controlled Drugs and Substances Act, "adults in B.C. [will not be] subject to criminal charges for the personal possession of small amounts of certain illegal drugs" (60). Evaluation of the decriminalization pilot will provide insight and recommendations for future policy development at the regional and national level.

The environmental scan also highlights the ways in which BC has been the site of challenge and controversy. For example, in late 2023, the then Chief Coroner, Lisa Lapointe, called for urgent action to reduce substance-related deaths in BC. With the release of this report, the Chief Coroner recommended moving to a non-prescriber-based model of pharmaceutical alternatives to eliminate barriers to access. Shortly after this report was released, and rejected by government, Lisa Lapointe announced her resignation. In January 2024, in part in response to the ongoing public health crisis in BC, the 'Vision for BC Drug Policy' was released and endorsed by many organizations delivering substance use health care services, and related legal, grassroots and social service advocacy organizations (19). The Vision calls for radical change to drug policy in BC by all levels of government. The areas they call to be reformed include: drug regulation; decriminalization, addressing substantive equality in drug policy reform; and detox, recovery and treatment. Because of this context, BC is home to Executive Leaders and researchers leading knowledge development and mobilization, and policy innovation, a fruitful starting point for our consultations. Further, while generated in the BC context, these landmark reports, policy debates, and broader public discourses are prompting dialogues across Canada, and thus, signal some of the key issues that resonate in a wide range of Canadian jurisdictions

Themes from the Environmental Scan

Burnout, Compassion Fatigue, Vicarious Trauma are Pervasive

The literature reviewed for this environmental scan unequivocally shows that the substance use health care workforce experiences high levels of burnout, compassion fatigue, and vicarious trauma[7] (5-14). The work is defined by high levels of emotional labour (e.g., responding to overdose; dealing with death, often of well-known clients; interacting with law enforcement; and performing medical procedures, such as frequent overdose reversals) and an intimate connection to the community in which they work. The literature also shows that the substance use health care workforce must navigate "complex and inefficient systems" (7, p.9), while experiencing perceived helplessness due to continually fighting against the systems within which they work (6, 7, 54), and myriad policies at organizational, municipal, provincial and federal levels.

As noted in the national survey of the substance use health care workforce conducted by CCSA, workers are passionate and find meaning in their work (6), a finding echoed in other literature (5, 53). Despite passion and commitment, the measured levels of burnout and secondary trauma stress were higher than established benchmarks among other health care professionals. Respondents indicated that

[7] Definitions of these terms can be found on p.3 of this report.

burnout is normalized in their workplaces. A workforce experiencing constant burnout and/or compassion fatigue likely has diminished capacity to engage compassionately with the clients they serve, therefore creating dynamics with the potential to cause harm (44, 61).

Grief and Loss are Constant and Disproportionately Experienced

A profound theme in both the substance use health care workforce and palliative care literature was the constant disproportionate grief and loss experienced by the substance use health care workforce, as they routinely witness **unjust** and **preventable** deaths (6, 7, 11, 13, 54, 62), features of circumstances that are definitional of moral distress (30). One Canadian study found moderate levels of "vulnerability to grief" among the Canadian substance use health care workforce; the authors speculated that these lower-than-expected levels are a consequence of survival mechanisms employed by the workforce to deal with constant loss (6). In the same study, PWLLE of substance use working in the substance use health care workforce experienced significantly higher scores on vulnerability-to-grief compared to the substance use health care workforce that did not self-identify as PWLLE, in part because they are deeply embedded in their communities and therefore often close to people who die. This finding aligns with multiple studies showing that grief is inequitably experienced among different sectors of the workforce (6, 7, 11, 62). Because funding and policies are inadequate to meet the needs of the clientele, the PWLLE workforce often goes above and beyond their scope of practice due to their moral obligations to their communities, and thus, the boundaries between work and life can become tenuous (5, 7, 8, 10, 13). Working beyond the scope of defined roles often makes the work invisible and in turn there are few organizational mechanisms to provide support. For example, workers may see their community and clients as "de facto family" (62, p.2), and therefore make themselves available outside of working hours. Rather than supporting workers with this invisible work, some workplaces may blame workers for not maintaining professional boundaries.

Working Conditions are Precarious

Precarious work is defined as including nonstandard work arrangements, job insecurity, below market wages, and no benefits (53). A commonly cited characteristic of the substance use health care workforce, including, but not limited to peer workers, is the precarious conditions in which they work. As with other services for people who are marginalized (by poverty, racism, stigma related to mental health or substance use and so on) (25), substance use services are often provided by non-governmental organizations that rely on grant funding with grants typically being short-term and piecemeal. Consequently, the substance use health care workforce is chronically underfunded (9, 14). This threatens the stability of the workforce, and leads to increased burnout as staff do not have adequate job security. Workers also experience stress due to sparsely funded services, therefore they are unable to adequately support clients or refer to appropriate resources (13, 54).

Within that context, even regulated professionals often receive lower pay and fewer benefits than those working in mainstream health care. Further, the workforce includes many unregulated workers and volunteers who are not offered benefits, job security or pay commensurate with the demands (5-7, 10, 12, 53).

Peer workers who identify as PWLLE of substance use are often employed to contribute their expertise to program development and policy making, and to provide advocacy and outreach services. These roles include harm reduction work, peer education, front line service, or advisory committee assistance, and more. Peer workers bring unique strengths to the substance use health care workforce, as they have experiential knowledge and expertise, are able to build safe spaces for client engagement, are able to build and maintain trust and rapport with clients, and may be able to draw on their networks and kinship groups in the community to facilitate their work (5, 7, 13, 55). Multiple studies reported that peer workers find social benefits in their work, including inclusion, connection, empowerment and agency; however, as noted, these benefits come at the cost of significant burnout (5, 6, 11-13, 53).

Peer workers experience a myriad of structural disadvantages, such as a lack of resources to properly fund their positions (resulting in disparate compensation and no benefits); instability due to the short-term nature of pilot projects; lack of recognition of PWLLE in the workforce; substance use stigma; and housing insecurity (6, 10, 12, 13, 53, 55). Peer workers work alongside employees who receive salaries, benefits and social capital, while their roles are seen as cost-efficient (13, 53). However, lacking organizational support and infrastructure, as noted, peer workers experience significant burnout and secondary trauma.

Current Supports are Inadequate

The CCSA report (6) outlined multiple deficits in supports for the substance use health care work force, with respondents calling for more employee-specific supports, including enhanced benefits; increased counselling and mental health supports; improved staffing capacity; better harm reduction resources; increased government funding of programs; and more access to education. While some supports exist, they are not always adequate (6). For example, Employee Assistance Programs (EAP) may not offer enough sessions to adequately support staff, and counsellors may not be well-trained in trauma, grief and loss, stigma or substance use issues. Often staff need to educate the counsellors regarding the complexities of grief and loss, as EAP programs are not designed or funded to support the level of complexity experienced in substance use health care work (54). Further, accessing support, such as debriefing, counselling and/or stress leave can be stigmatizing due to possible ostracization from colleagues, fear of contravening organizational policies and/or repercussions from management (63, 64). The potential for mental health stigma deters staff from accessing supports (64). Emphasizing individual self-care places responsibility on staff and can increase the stigma and blame for burn-out on the individual. These dynamics ultimately can cause more harm (49, 65).

The Workforce is Stigmatized

Due to the nature of their work, those working directly with people using substances heavily are at risk of “courtesy” stigma, which is defined as stigma by association of working in a highly stigmatized context (6, 7, 14). In the CCSA study, respondents indicated they experienced stigma due to public lack of awareness and limited education regarding what the work entails. There is also minimal support in communities, including from other health and social care professionals. Both in the CCSA Report (6) and in EQUIP research, workers who are specifically part of the substance use health care workforce report poor treatment of themselves and their clients in mainstream health care settings, such as hospital Emergency Departments.

Using the Social-Ecological Model to draw attention to the wider context of work, one study identified that the workforce was "working with a stigmatized population in a stigmatized field" (7, p.9). Another study discussed the phenomenon of community-level overdose compassion fatigue as collective distress that impacts the ability of communities to have a positive, empathetic response towards the drug toxicity crisis (14). Winstanley et al. also discusses how the media plays a large role in this when they sensationalize stories to garner a response, which contributes to and perpetuates substance use stigma (14). Media sharing of voyeuristic stories of overdose in public spaces fuels substance use stigma; in contrast, there are few news media stories about positive impacts of policies and programs, such as how many lives have been saved through overdose prevention programs (14).

In addition to working in a stigmatizing field, PWLLE in the workforce experience substance use stigma towards them directly (12). In one study, one third of participants indicated they had not disclosed their lived experience to their workplace due to anticipated judgment and stigma.

The Workforce is Siloed

Across Canada, the health care workforce often operates in silos of jurisdiction, sector and profession (4, 66). Siloed operations and planning also stem from complex organizational structures at the community, provincial and federal level, in addition to different funding models between provincially funded services and non-governmental organizations (67). Planning for the health care workforce is not integrated into the overall health system, and connections between sectors are not always considered (4). For example, there is a relationship between the substance use and mental health sectors, but due to different funding mechanisms, regulations, and reporting structures, it is challenging for them to collaborate and provide integrated services to clients (6).

One element of siloing is the lack of data related to substance use, drug toxicity and overdose that is shared across jurisdictions, which contributes to fractured planning by professions and organizations. For example, since jurisdictions across Canada track drug toxicity-related deaths and events differently, it is difficult to understand the extent of the crisis, and therefore make informed decisions about potential next steps (6), including the range of supports that may be needed to support the substance use health care workforce. A subset of the literature reviewed for this environmental scan (4, 6, 9) calls for more robust data collection measures, and a national database to collect standardized measures of overdose and toxicity-related harms to better understand the issue at a federal level. However, there are no suggestions on how to standardize and what data would specifically be collected.

Organizational Strategies to Support Wellbeing

For each issue, the literature reviewed for this environmental scan offered commensurate strategies. These include: supportive leadership and teams; adequate compensation, benefits and training; mental health supports; legitimizing peer work; increasing data availability and using standardized measures.

Supportive Leadership and Teams

Many of the following strategies and recommendations are actionable at the executive level, however, at the crux of all strategies is having supportive leadership at all levels. Having supportive supervisors and management who care for and affirm their staff can improve staff retention, and increase job

satisfaction, particularly in stressful environments (4, 7). Supportive leadership includes acknowledging work, building team rapport, valuing staff suggestions, and enhancing the roles of workers.

Executive Leadership can also foster safe and equitable workplace environments through manageable staffing levels and workloads (45, 63, 68, 69). Safe and equitable workplaces might include: hiring diverse leadership; integrating internationally trained staff; requiring mandated staffing levels; creating adequate infrastructure to properly share data across jurisdictions; and required anti-racism and discrimination training (4). However, with respect to the latter, as noted later, the impact of such training on practice has not been well studied, and may be quite limited, leading to calls for accountability mechanisms related to stigma and discrimination. Another organizational strategy includes rotating workers through different positions to limit their exposure to stress and trauma (70).

The literature reviewed for this environmental scan also suggests the importance of supportive teams, which are reinforced by leadership (7, 8). Teams that effectively support each other and debrief together are key to supporting workforce wellbeing. Peer support, in the form of debriefing, was identified as a protective factor against burnout (12, 46, 49, 63, 69, 71). Whether a formal or informal debriefing mechanism, peer debriefing allows teams to feel heard and validated. To avoid feelings of stigma and "trauma dumping", debriefing should be regular, scheduled and facilitated instead of ad hoc incident-driven debriefing (64).

Adequate Compensation, Benefits and Training

Tangible organizational supports, such as adequate pay and benefits, and opportunities for professional development were identified as foundational for adequately supporting the substance use health care workforce (7, 46, 49, 54, 63, 69). The literature reviewed for this environmental scan points to the nead for extended bereavement leave and sick leave due to the continuous experiences of grief, loss, and trauma; in addition to extended time off (7, 8). Khorasheh et al. suggests expanding employment policies to provide adequate compensation, benefit coverage, and sick/vacation days for part-time and contract workers. Education tailored to the workforce was also suggested, such as critical incident de-escalation, cultural safety, anti-racism, and trauma-informed care (7, 54). While training programs may be needed or even requested by workforce members, researchers analyzing the impact of educational interventions emphasize that cycling workforce members through training programs cannot transform systems or be adequately supportive of workforce members without organizational supports, resources, accountability mechanisms, and whole-system actions (72, 73).

Mental Health Supports

Organizational mental health supports that are easily accessible are key to supporting the wellbeing of the substance use health care workforce (6, 8, 46, 49, 63, 69). The broad recommendations identified in the literature included: comprehensive mental health strategies, mandatory mental health training for leadership roles, tailored mental health supports, and a supportive return-to-work process (4, 6, 45).

Also required are easily accessible mental health resources to support the workforce through grief and loss (7, 54, 62). Some of the suggested approaches include collective grieving, public mourning, and hiring in-house support staff who have the knowledge and capacity to support workers through their grief.

"**Perceived** organizational support" – that is, when employees believe their organization values their work and cares about their wellbeing while doing their work – can protect against burnout, compassion fatigue, and vicarious trauma. This suggests the importance of making strategies visible. Setting up and communicating organizational strategies to mitigate the effects of vicarious trauma may improve workforce wellbeing and career longevity.

Legitimizing Peer Work

Peer workers are regularly on the front lines of the drug toxicity crisis (5, 53), but often operate in unregulated roles which are not formally recognized. When discussing Peer work in the literature reviewed, many studies offered strategies for organizations to better support and integrate peer workers into the workforce (5, 6, 12, 53, 55). Organizational supports to foster environments that are safe and equitable for Peer work include: formalizing peer job titles; communicating role expectations and job descriptions; utilizing and celebrating experiential knowledge; and offering role support and training (5, 12, 55). Some studies suggest developing organizational mandates for the equitable inclusion of PWLLE in the workforce (5, 55). Taha et al. (2022) also suggest developing workplace substance use policies to support PWLLE in the workplace. The expertise of PWLLE of substance use should be included in all strategies developed. Because different levels and forms of stigma intersect and compound, meaningful stigma reduction efforts will benefit from using an intersectional lens (especially the intersections of substance use stigma with racism, mental health stigma, ableism, and poverty stigma) to understand and address stigma in the workplace and beyond (28, 29).

Increasing Data Availability and Using Standardized Measures

Due to a lack of coordinated data availability across jurisdictions, health care planning and workforce planning often occurs in silos (4, 6). The literature suggests that data on workplace wellbeing, compassion fatigue, burnout, and grief, in addition to standardized data on drug toxicity events, should be available across jurisdictions to better support planning and building capacity across the workforce (4). This could include policies for data access, storage, and sharing across jurisdictions. Taha et al. (2022) calls for a National Database to understand the need and severity of the drug toxicity crisis. By standardizing and improving data collection, and having all partners at the table, resources could be allocated more appropriately (9). Successfully supporting the workforce requires collaboration among stakeholders at multiple levels (45). This could lead to more informed decision-making.

Standardized data to compare trends across the country would be hugely beneficial. Of the literature reviewed for this environmental scan, two studies (6, 14) used the validated Professional Quality of Life scale (ProQOL), which includes subscales on compassion satisfaction and fatigue, burnout and vicarious trauma. One study (6) used the Adult Attitude to Grief Scale to assess how vulnerable the workforce is to grief. Another study used the Compassion Fatigue Short Scale (CF-Short) (14), while Singh et al. (2024) used the Oldenburg Burnout Inventory. A recent review of 66 workplace mental health assessments outlined standardized measures for burnout, general mental health and wellbeing, loneliness, psychosocial hazard and risk, resilience and stress (74). Such a review of measures across domains could support organizations to use measures that align with their organizational contexts.

Federal Level Strategies

While many of the suggested strategies were at the organizational level, Taha et al. (2022) noted government level supports that could contribute to the wellbeing of the substance use health care workforce. These included: funding for evidence-informed mental health services including psychotherapy; legislation for workplace mental health; tax incentives for employers who prioritize mental health of the workforce; standardized measures and development of a national database for substance use data, including, but not limited to drug toxicity related data; a decrease in siloes and support for transdisciplinary work; and regulation for providers of health and disability insurance to ensure adequate mental health benefits.

Other studies noted the importance of improved public education on the nature of this work (7). As it currently stands, the onus is on the workforce to educate the public on their everyday work. Public education and media campaigns are needed to shift the public perception of substance use.

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