SUBSTANCE USE WORKFORCE WELLNESS: A BRIEF REPORT

Wellington Guelph Drug Strategy

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WGDS
WELLINGTON GUELPH DRUG STRATEGY

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INTRODUCTION

During the COVID-19 pandemic, large-scale changes were made to substance use care (harm reduction, treatment, and outreach services) in Canada (1). Innovative approaches to healthcare delivery, such as scaling up telemedicine and self-serve models (2) took place, in addition to disruptions to the availability and accessibility of services. Additionally, rates of drug poisonings and other substance use-related harms increased in communities across Ontario (3).

Access to services were also compounded by existing barriers, including stigma, social determinants of health (e.g., poverty and homelessness), and geographic disparities in service availability (3). Across Ontario, service providers had to ramp up efforts to mitigate accelerating rates of drug poisonings and other harms, especially among vulnerable groups (3-4).

This literature review will provide an overview of evidence related to the impacts of the drug poisonings crisis on the emotional well-being and health of workers in the substance use sector (5-6). This literature review is also intended to inform the future work of the Wellington Guelph Drug Strategy (WGDS) and will share information on organizational structures, cultures, and practices that will best support the substance use workforce using trauma- and grief-informed approaches.

METHODS

A traditional literature review was undertaken to synthesize existing information and data well-being of substance use professionals during the drug toxicity crisis and explore promising practices. The search strategy for the literature review involved five academic databases to retrieve relevant journal articles. A search of Google Scholar and Policy Commons was also conducted to identify any supporting grey literature.

For this review, the term “substance use workforce” was defined as comprising people from the following occupations: harm reduction workers (overdose prevention and supervised consumption site workers and satellite site workers), peer workers, non-emergency frontline social workers, healthcare staff, outreach staff, and case managers.

WORKFORCE WELLNESS IN CONTEXT OF THE DRUG TOXICITY CRISIS

Research indicates that those working within the substance use sector derive purpose and meaning from their work, feel a sense of belonging, and experience moderately high levels of compassion satisfaction (7-8, 15). Evidence also indicates that working in high-demand environments may also lead to the development of trauma-related stress and burnout.

This can have long-term implications for social, emotional, and mental well-being (9-10). In recent years, workers in harm reduction settings reportedly experienced higher levels of secondary traumatic stress (7). Levels of stress among harm reduction workers was comparable with hospital healthcare staff during COVID-19, harm reduction professionals still experienced notably higher levels of burnout and secondary traumatic stress (7).

Trauma-related stress, grief, and burnout can cause emotional distress, fatigue, illness, poor sleep quality and an increased risk of developing PTSD among professionals (15-16).

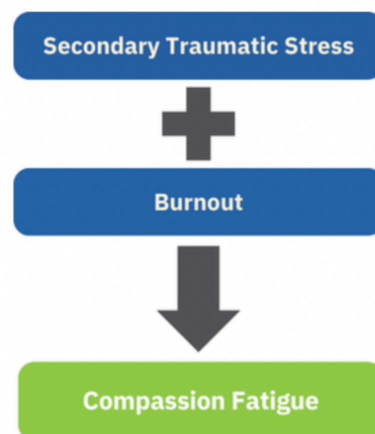
UNIQUE CONTRIBUTORS TO TRAUMA-RELATED STRESS AND BURNOUT FOR PEERS

Peer workers are leaders in the harm reduction movement and are critical in delivering substance use care and harm reduction programming–they help increase program accessibility and acceptability, create safety, educate, facilitate counselling, and build trust and connections (9, 20).

The impacts of trauma-related stress may differ among groups within the substance use workforce. For example, peer workers may have additional considerations compared to their counterparts because of their lived experience and links within communities who use substances (4, 9).

DEFINING KEY TERMS

- ***Trauma-Related Stress***: the by-product of working with individuals who have traumatic experiences (10). This term includes other concepts, like secondary traumatic stress and compassion fatigue (10,15).
- ***Burnout***: a state of gradual mental and physical exhaustion stemming from chronic stress in the workplace (10, 15).
- ***Secondary Traumatic Stress***: a stress reaction following exposure to an individual's trauma (17).
- ***Compassion Fatigue:*** a term used to describe a negative response in professionals that affects their capacity to empathize and can lead to physical or psychological distress. It is developed through prolonged exposure to individuals' trauma and generally consists of two components: secondary traumatic stress and burnout (10, 17-18).
- ***Compassion Satisfaction***: a term used to refer to the generative aspects of working in substance use settings (17). Compassion fatigue, secondary traumatic stress, and burnout are major contributors to low compassion satisfaction among the substance-use workforce (16, 19).



Adapted from Cocker & Joss (2016)

External factors can tie into experiences with trauma-related stress, grief, and burnout (9, 20). Examples of factors include job precarity, and moral distress. In some cases, job precarity is a key stressor and is characterized by nonstandard working arrangements, unpaid labour, and workers rights being impacted. (20-24).

CONSIDERATIONS FOR ALL WORKERS

Other examples of stressors can also include:

- increased job demands and other changes to workload (i.e. making it harder to separate work and home lives);
- top-down organizational cultures resulting in little control and flexibility over workplace environments;
- lack of managerial support and no sense of community among staff;
- low job satisfaction and little recognition;
- higher costs of living;
- insufficient rest between shifts;
- lack of preparedness to treat substance use disorders amidst a deeply inequitable society; and
- lack of adequate training around complex substance use health needs and navigating systemic inequities (12, 16, 19, 25-26).

IMPLICATIONS FOR SERVICE DELIVERY

The connections between trauma-related stress, burnout, and stigma have negative implications for substance use care delivery. Research demonstrates that stress and burnout manifest as emotional distancing, apathy, anger and irritability, reduced ability to express sympathy and empathy, decreased compassion satisfaction, increased absenteeism, impaired decision-making ability, poor morale, lower productivity, and potentially lower quality of care in the workplace, which leads to higher costs for employers (10, 15-16, 27). Stress and burnout also contribute to high staff turnover (7).

Given the complexity of this work, including the ongoing losses due to the drug posioning crisis and the potential impacts on staff, substance use organizations require comprehensive supports. As such, it is imperative that there are tools and interventions in place that can provide care to workers.

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