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Standing Committee on Health: Canada's Health Workforce Brief

Introduction

The Canadian Centre on Substance Use and Addiction (CCSA) welcomes the opportunity to provide a brief to the Standing Committee on Canada's Health Workforce. CCSA is the only national organization with a legislated mandate to reduce the harms of alcohol and other drugs on people in Canada. Created by an Act of Parliament almost 35 years ago, CCSA provides national leadership by harnessing the power of research and providing evidence-informed guidance to decision-makers, by curating knowledge and by bringing together diverse perspectives to galvanize individual and collective efforts.

The capacity and success of the healthcare system depend on the health of the healthcare professionals that provide the care. Understanding Canada's health workforce requires understanding the circumstances unique to mental health and substance use health (MHSUH) service providers as they address dual health emergencies: COVID-19 and drug toxicity. Harm reduction workers, a subset of MHSUH service providers, are facing additional and compounding challenges that require urgent attention. Particularly at a time when greater investments are being made in this area across the country. As such we have divided this brief in two sections, starting with the broader MHSUH workforce and ending with the harm reduction workforce.

COVID-19 and Canada's MHSUH Workforce

There were immediate impacts of the COVID-19 pandemic on the MHSUH workforce. The workforce experienced higher rates of mental health symptoms, increased substance use, and a reduction and disruption in service delivery and in-person capacity. For example, there was an 11 per cent increase among this workforce in cannabis use, a 10 per cent increase in alcohol use and an 11 per cent increase in suicidal ideation than prior to the pandemic (see Appendix 1) (Leslie et al, re-submitted).

In addition to the impact of the dual health emergencies, the MHSUH workforce also faces a number of existing challenges that include stigma, inequalities (Gender, wage etc.), and funding gaps, as well as burnout, stress and trauma from the current drug toxicity crisis (Leslie et al, re-submitted). Through key informant interviews, it was found that MHSUH workers were being called to support their colleagues and other healthcare providers in other sectors with burnout, adding to already high stress levels and low morale. Additionally, reduced capacity of providers to deliver care was found,

with capacity decreasing most for providers who are women (44.6% for women versus 34.3% for men).

Another running theme heard in these interviews and supported by literature reviews is the gaps in MHSUH data, particularly in the community. Currently, psychotherapists, counselling therapists, addiction counsellors, and peer support workers are not included in the Canadian Institute for Health Information (CIHI) data. This makes it difficult to respond to MHSUH challenges and gaps in this particular workforce as there is inadequate information to monitor, understand and respond to changes and trends when it comes to MH and SU treatment and when assessing the gap between supply and demand.

Despite these challenges, the MHSUH workforce has been quick to modify its service provisions to better respond to the needs of the population during the pandemic. This includes rapid implementation of virtual care, task shifting from specialized to less specialized, and temporary exemptions for prescriptions of controlled substances.

Call to Action:

A gender and equity lens is needed to fully understand the issues impacting the MHSUH workforce. Understanding the unique issues faced by gender is critical in responding to alleviate gender-specific impacts on the workforce. Additionally, there needs to be further recognition within policy of the MHSUH workforce in providing care for other healthcare providers. The sector as a whole, and some professional groups within it, needs regulation to recognize the professionalism and hard work provided by these workers. Lastly, big picture planning is needed to help us with emerging trends in this workforce. This means that data collection and closing of gaps within the data collection is required across the private and public sectors (Leslie et al, re-submitted) and in the regulated and unregulated professional groups. This is crucial if we are to have a complete picture of the MHSUH workforce, its unique issues and its overall gaps.

Substance Use in Canada Report Findings: Harm Reduction Professionals:

Harm reduction professionals provide needed services and meet people who use drugs where they are at. However, their efforts are hampered by limited resources and support, stigma, as well as the fact that services are provided by regulated and unregulated workers, such as addiction counsellors and volunteers. Additionally, they experience the mounting loss of family, friends and members of their communities. Thus, COVID-19 has made an already challenging situation even more difficult.

The Public Health Agency of Canada (2022) reported a 95% increase in apparent opioid toxicity deaths from April 2020 to March 2021 relative to the same period prior to the pandemic. This has been tied to increased drug toxicity, increased isolation, stress and anxiety and limited availability or access to services. With the drug toxicity crisis and the COVID-19 pandemic, harm reduction health professionals have had to tackle a dual public health emergency.

In our *Substance Use in Canada Report*, CCSA conducted a study to understand the impacts of the drug toxicity crisis on harm reduction service providers in Canada (Cycle One; 2019) and the compounding effects of this toxicity emergency and COVID-19 (Cycle Two; 2021). Each cycle included an online survey to quantify levels of grief, trauma, burnout and self-care. Analyses

examined how experiences differed across gender identities, by professional regulatory status, and amongst those who had lived or living experience with substance use. This study ensured that harm reduction professionals had the opportunity to provide meaningful input throughout.

Despite high levels of job satisfaction, this study found high levels of burnout and secondary traumatic stress among harm reduction professionals as compared to benchmarks set in literature among nurses working in a variety of settings and professional caregivers for survivors of trauma. Even when examining the experiences of hospital healthcare workers during COVID-19, burnout and secondary traumatic stress was markedly higher in our study with harm reduction professionals.

These findings indicate that those working in harm reduction are experiencing a pronounced strain on their emotional well-being. Vulnerability to grief reported, approached levels previously observed among bereaved individuals. Levels of secondary traumatic stress and vulnerability to grief increased in Cycle Two, and respondents indicated that they had become more sensitive to the well-being of their clients during the pandemic (Taha, King and Atif, in press).

The Report's Call to Action

The Call to Action in CCSA's *Substance Use in Canada* report on the experiences of harm reduction service providers sets out a path forward to ensuring the health of our front-line harm reduction professionals. These actions seek to build a bridge between the knowledge gained by the study of the needs and knowledge of the gaps found in scientific literature.

The Call to Action highlights the required actions needed within the broader system to improve the health of health professionals providing harm reduction services under a variety of themes:

- **Access to services**
    - Changing the approach to substance use from a single substance approach to an approach built on the role of social determinants of health, polysubstance use and the interaction with mental and physical health may improve the well-being of those providing support. The harm reduction workforce requires the tools necessary to address the complex nature of their clients' needs through the support of the government at all levels, including increased and sustained funding.
    - The harm reduction workforce also needs access to a full range of effective medical and non-medical treatments and interventions for their clients to respond to the drug toxicity crisis, including support for people who are at risk of overdose. For example, access to training and support for naloxone administration or prescribing opioid agonist therapy such as, methadone. It is imperative that the continuum of care and overall coordination between services be improved to reduce some of the burden placed on harm reduction service providers.
    - Technology has played an important part in meeting capacity challenges within other areas of health, especially during the COVID-19 pandemic. As such, to elevate the capacity of our system to support harm reduction workers, different models of care that address system capacity and technology need to be explored. This includes providing training to frontline workers and their clients on how to use these new technologies.
- **Stigma**:
    - Harm reduction workers continue to face stigma, particularly from other health care providers, which represents an additional burden for these workers. This very likely contributes to the adversity and high stress levels indicated in the *Substance Use in*

Canada report. A driving force must be to support the well-being and health of those who use substances and the harm reduction workers supporting them.

- Policies and regulations
    - A clear theme from the report is that harm reduction services are underfunded and those providing these community services are often underpaid. It is critical that all levels of government create strategies to increase and provide sustainable funding for these services as well as address wage parity issues. Organizations that provide MHSUH services are often not captured within the parity framework or national dialogues pertaining to health care workers in general. Given the increase in MHSUH concerns in our population, and the impact of those providing these services, special attention should be given to this group of health professionals.

Conclusion

The capacity and success of the healthcare system depend on the health of the healthcare professionals that provide the needed care. Providers of MHSUH services are facing unique challenges in the dual public health emergencies and require special consideration when addressing ways to improve the health of our human health resources.

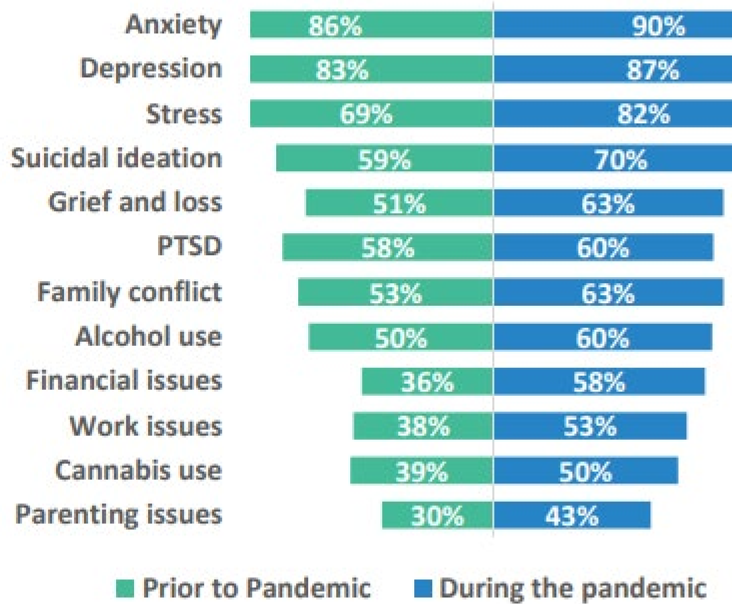
As noted earlier, the harm reduction providers are a subset of that. A comprehensive healthcare system that truly integrates harm reduction services will increase access and better meet the needs of those using substances and those providing harm reduction services. However, sustainable and reliable funding for harm reduction is needed for continuity of services and will remove financial and planning stressors for program directors and staff thereby helping to address the increase in demands in the MH and SUH sectors.

Additionally, continued examination and evaluation of equitable staffing models and policies, as well as addressing structural vulnerabilities to burnout, such as job precarity, supports and economic insecurity will inform efforts to improve well-being.

Lastly, tackling stigma is crucial for the well-being of both MHSUH healthcare providers and people who use drugs.

Appendix 1: MHSUH Workforce Concerns

N=2169 (Leslie et al., re-submitted)



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