COM-CAP
Community Opioid / Overdose Capacity Building

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RAPID REVIEW

Organizational Supports for Workers Responding to Overdose

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Key Findings

- Repeated exposure to increasing overdoses and overdose-related loss can be stressful, demanding, and traumatic for workers responding to overdose during the drug poisoning crisis.
- There is little research and evaluation on available approaches used to support workers with overdose and substance-use related grief, stress, trauma, and burnout in the current context. Facilitating access to support services, enabling peer-based supports, opportunities for training and skill development, and strengthening supportive management that better serves employees are common approaches that currently exist or are recommended.
- Our analysis identified key areas for future research and practices for supports that address the emotional toll of workers responding to overdose. These include addressing inequities, workers' perspectives, and factors at multiple levels that shape workers' well-being. Assessing these supports to make sure they are effective for different workers, settings, and contexts, and do not produce further stress or other unintended harms is critical.

Scope

- Our rapid reviews addresses the following question: What current organizational supports are cited in the published and grey literature for workers responding to overdoses in the community?
- We defined workers as any individuals responding to substance use-related harms. This includes individuals who are paid by an organization and those who are unpaid for overdose response in the community. Our search primarily focussed on community health workers, workers with living and lived experience of substance use, and health or social service providers.
- As part of this review, we aimed to explore a broad range of potential organizational supports to protect and promote the safety, health, and well-being of workers. This includes training, compensation and benefits, policies, amongst others. Individual-level personal habits and self-care activities were not in scope.
- While many sectors are impacted by the ongoing drug poisoning crisis, the scope of our review is the substance use, mental health, harm reduction, sexually transmitted and blood-borne infection, housing, and healthcare sector.

Background

Workers providing direct services to people who use drugs and responding to overdose play an essential role amid a worsening drug poisoning crisis during the COVID-19 pandemic.[1] Exposure to increasing overdoses and overdose-related loss can be stressful, demanding, and traumatic.[2] Not surprisingly, evidence points to the experience of stress, grief, trauma, and burnout among harm reduction workers and other first responders in the context of the drug poisoning crisis.[3-8] Prolonged exposure to work-related traumatic events may in turn increase risk of mental health concerns and other adverse health and social outcomes among workers.[9]

More recent research has highlighted the inequitable occupational status of working in harm reduction such as feeling under-valued and lack of stable funding, job security and stability, fair compensation and lack of unionized positions.[10-13,5,6,12,14] All of these factors can intensify the already stressful environment of direct service work.[11] Despite this, many individuals working in harm reduction, including those who have drug use experience, lack access to organizational support for work-related issues including dealing with grief, trauma, and burnout that are available to other professionals responding to overdoses.

It is important to acknowledge that many individuals working in harm reduction also have personal connections to the local community. Many individuals working in harm reduction have living or lived experience of substance use and have lost close friends, colleagues, or family members to overdose. The interface between professional and personal lives can present additional complexities and the need for different levels of support.

Further, it is important to consider the organizational supports for employing and retaining workers with living and lived experience of substance use. This workface has valuable knowledge about the needs and practices of people who use drugs, are often the most effective public health messengers for reaching other people who use drugs, and serve as role models for others.[15] For these reasons and others, the loss and burnout of this critical workforce will have negative consequences for harm reduction service delivery and overdose prevention.

While there is growing attention on the need to address the emotional toll of workers responding to the drug poisoning crisis, it remains unclear what current approaches communities and organizations have used to support workers with their grief, trauma, and burnout.[16] Such an understanding is needed to inform the development and implementation of supports to mitigate harms and strengthen essential overdose response work.

The aim of this rapid review is to identify existing and recommended practices that are used to support workers with substance use-related grief, trauma, stress, and burnout. This information can support organizations and decision-makers to develop and implement practices that better protect and promote the well-being of workers responding to overdose.

Methods

We conducted a rapid review of the peer-reviewed and grey literature on organizational supports for workers responding to substance use-related harms. In considering feasibility and the need to be responsive, we chose a rapid review method to address our research question. A rapid review is a form of knowledge synthesis where certain steps are left out in order to be timely (e.g., no duplicate screening, no quality appraisal).[17]

On August 8th, 2021, Public Health Ontario (PHO) Library Services searched the following four electronic databases: MEDLINE, Embase, PsycINFO, and CINAHL. Searches were limited to English language articles published since 2011 (See Appendix A). We also conducted a supplemental search in MEDLINE on September 3, 2021 that broadly focused on first responders involved in overdose response. To identify relevant grey literature, we searched Google using similar terms and reviewed the first 100 search results of each search string.

The most pertinent and relevant articles were identified in MEDLINE. Therefore, we only searched MEDLINE for organizational supports for first responders. Our search terms for first responders included firefighters, law enforcement, paramedics, and emergency department and critical care doctors or nurses.

Peer-reviewed and grey literature records were included if they examined existing or recommended organizational supports for workers responding to substance use-related harms. We excluded the following types of records:

- records that did not focus on workers in hospital or community substance use, harm reduction, mental health, sexually transmitted and blood-borne infections, housing, or health care;
- those that only looked at risk factors related to worker experiences of grief, trauma, and burnout;
- supports that did not target grief, trauma, or burnout as the primary focus; and
- newsletters, commentaries, and editorials that did not provide sufficient detail or examples of supports.

Two PHO staff divided title and abstract screening, full-text reviews, and extracting relevant information from records. A secondary reviewer finalized decisions on the list of included full texts.

We used two conceptual frameworks and approaches related to worker safety, health, and wellbeing to help guide how we sorted and analyzed the information from each record. Sorenson and colleagues proposed a framework that considers the influence of multiple levels and pathways that affect worker safety, health, and well-being including the:

- the socio-political-economic environment;
- employment and labour patterns;
- enterprise or organization; and
- worker.[18]

The Total Workers Health approach is consistent with the framework by Sorenson and colleagues, which recognizes that integrated strategies that address workplace practices are critical to modifying the complex and linked factors that influence worker safety, health, and well-being.[19]Using both frameworks allowed for a more comprehensive analysis. We used the first framework to guide our overall thinking of

overdose response work, and supplemented it with the details provided by the Total Workers Health to better facilitate the mapping of supports.We summarized the results by grouping common supports into the 10 categories of broad issues relevant to advance worker well-being using the Total Worker Health approach.[19]

The categories of the Total Worker Health approach included:

- prevention and control of hazards and exposures
- built environment supports
- community supports
- compensation and benefits
- healthy leadership
- organization of work
- policies
- technology
- work arrangements
- workforce demographics

In considering feasibility and the need to be responsive, we did not appraise the quality of included records from the peer-reviewed and grey literature. People with living and lived expertise of substance use, researchers, and people with expertise in mental health, drug strategies, and harm reduction were involved in reviewing the original proposal and following drafts.

Results

The library search of electronic databases identified 1639 articles, of which 8 were selected for full-text screening. Of the 8 full-text articles identified, 1 met our eligibility criteria. An additional 9 records were identified through our search on Google. Most excluded records did not provide sufficient detail on examples of supports that addressed grief, burnout, or trauma as the primary outcome and focus.

The 10 records mostly focused on support delivered in the United States and Canada, with two documents from elsewhere.[20,21] Records included were qualitative studies, reviews, or relevant reports and guidance documents produced the AIDS Bereavement and Resiliency Program of Ontario (n=2), Ankors (n=1), Health Resources in Action, Inc. (n=1), the MAP Centre for Urban Health Solutions (n=1), and Mainline (n=1) There were a range of workers considered in supports including harm reduction workers, staff at supportive housing agencies, substance use providers, and individuals working in the HIV/AIDS sector; only one explicitly discussed supports to workers not formally employed in overdose response work who had received naloxone training.[22]

We grouped supports based on themes related to the categories of the Total Worker Health framework.[19] We found supports that related to 6 of 10 TWH categories, while none related to work arrangements, technology, prevention and control, or built environment. Below, we summarize the most common types of support identified within these categories (Table 1). Of note, records often described multiple strategies to support workers, teams, and organizations dealing with grief and loss.[23] Two records were also led by the same organization, but one focused on a specific pilot project.[23,24]

There were a number of key elements that cut across the different supports. Many workers indicated that supports be formalized, readily accessible (e.g., affordable), adequately resourced, and of high-quality (e.g., knowledgeable, appropriately trained/skilled).[25,26,21,24,27] Some workers noted that supports were not always available or poorly executed.[21] Taking a holistic approach to develop and offer a range of supports was also suggested to better meet the diverse understandings, experiences, and needs for grief support among workers.[23,24,26]

Table 1. A summary of existing or recommended supports for workers

Total Worker Health Categories	Types of supports	Number of records
Compensation and benefits	Facilitating access and referral to support services and resources	9
	Providing opportunities for training and skill development	7
	Providing paid and unpaid time off	5
	Providing health benefits	4
	Offering Employee Assistance Programs	3
	Offering adequate wages	2
Organization of work	Enabling peer-based support	8

Total Worker Health Categories	Types of supports	Number of records
	Providing opportunities to debrief	6
	Addressing staff scheduling	4
	Providing team-building days and self-care	4
	Closing overdose prevention and response program briefly following an overdose event	1
	Changing work and workload	1
	Recognizing staff	1
Healthy leadership	Strengthening management support	7
	Providing clinical supervisors and external support roles	6
	Fostering collaborative and participatory environments	4
Organizational policies	Developing an organizational approach to grief and loss, including policies and procedures	2
Community support	Coordinating and collaborating with other organizations	3
	Facilitating access to or developing centralized support structures to expand capacity	2
	Addressing systematic inequities	1
Workforce demographics	Increasing the number of Indigenous workers in the substance use sector	1
	Building the cultural competence and cultural safety skills among the non-Indigenous workforce in the substance use sector	1

Compensation and Benefits

Supports related to compensation and benefits fall into five categories: 1) facilitating access and referral to support services and resources (n=9); 2) providing opportunities for training and skill development (n=7); 3) providing paid and unpaid time off (n=5); 4) providing health benefits (n=4); and 5) offering employee assistance programs (n=3). Only two records recommended adequate pay for harm reduction workers including specific navigation support for people receiving social assistance.[27,28]

FACILIATING ACCESS AND REFERRAL TO SUPPORT SERVICES AND RESOURCES

Nine records highlighted the importance of offering access to a range of community-based services and resources that promote well-being such as counselling, workshops, acupuncture, housing services, and Indigenous healing circles and Indigenous Elders.[20,21,23-29,27,28,25] Suggestions for access included both as integrated within workplaces and during work or referral pathways to external support services that are convenient, affordable, of high quality, and culturally appropriate.[27,29,25,24-26,21] In considering the privacy of staff, one record recommended support be provided externally to better foster an environment where people with living and lived experience of substance use can openly share challenges.[20] Fewer records described facilitating access to services and disseminating information on resources.[23,28] When described, it was suggested that organizations work with other community services to provide grief and loss supports, create a role for a person with living and lived experience to support navigating access to external support services, or use an intranet or bulletin-board to share information about available grief and loss resources.[23,28]

PROVIDING OPPORTUNITIES FOR TRAINING AND SKILL DEVELOPMENT

Seven records suggested providing, expanding, or enhancing access to training opportunities for workers in substance use, public health, harm reduction and housing sector.[20-25,28,21,25,22,25,20,25,28,24] Training topics frequently included: grief and loss support; mental health symptoms, coping skills and strategies; trauma; and compassion fatigue.[23-25,20,21,28,22,23] When described, training modalities included facilitated discussions, worksheets, presentations, and exercises.[23,24] Trainings were described as workshops that occurred over lunch (e.g., 'lunch and learn'), a full day, multiple days, or semi-annual and annual follow-up trainings.[23,24,22] One record described access to well-established external and internal training opportunities, and highlighted the need for workplace trainings that are designed for individuals without lived experience to be tailored to the lives of workers with living and lived experience of substance use.[28]

Overall, providing training opportunities was seen as an important way to raise awareness and improve self-confidence and capacity for workers to support themselves and others.[21,20,28] One review noted that having substance use service providers learn about specific therapies can be associated with lower levels of burnout and a greater sense of control over their work.[26] Post training surveys with workers from supportive housing agencies found that grief and loss training allowed for connection to coworkers and validation of their experiences.[24]

PROVIDING PAID AND UNPAID TIME OFF

Five records outlined policies or suggestions related to time off from work.[21,23,24,26,27] All four described paid time off either for sickness, vacation, bereavement, mental health, and caregiving. Of these, two records included practices related to unpaid and discretionary time off, and one recommended allowing leave for cultural obligations.[23,24,21] One review found that taking paid time off can help reduce burnout.[26]

PROVIDING HEALTHCARE BENEFITS

Lack of universal access to benefit coverage was a challenge for workers in the harm reduction sector including those with living and lived experience of substance use.[27] Four records described access to healthcare benefits. Generally, this involved access to extended health benefits, which includes benefit packages that cover counselling.[27,23-25] There was insufficient detail on the amounts and limits in health benefit packages.

OFFERING EMPLOYEE ASSISTANCE PROGRAMS

We identified three records the highlighted access to Employee Assistance Programs.[23-25] While a few records noted providing access to Employee Assistance Programs, workers highlighted concerns around the short-term temporary model of support and the counsellors' lack of knowledge on the drug poisoning crisis, overdose-related losses, culturally competence and overall not being helpful.[27,21,24]

Organization of Work

Supports that focussed on the organization of work fall into five categories: 1) enabling peer-based support (n=8); 2) providing opportunities to debrief (n=6); 3) addressing staff scheduling (n=4); and 4) offering team-building days and self-care (n=4). Less frequent strategies included the short closure of overdose prevention and response programs following an overdose event, changes to or distribution of the workload, and staff recognition.[29,23,28]

ENABLING PEER-BASED SUPPORT

Eight records emphasized the important connection and support received from coworkers in comparison to managers in formally employed positions.[20,21,23-28,24] Peer support was described as one-on-one informal support, mentorships, structured mutual networks (e.g., Frontline Workers Support Network), or support groups.[23,27,20,25,21,27,23-26] One record described the development of a Peer Support role by someone with living and lived experience of substance use to listen and debrief with workers who have shared experiences.[28]

Professionals working in substance use described connections to coworkers facilitated debriefing, and discussions on strategies to deal with burnout.[21,26] While seen as a an important source of support, records noted challenges with the lack of resources supporting worker-led support networks and not wanting to further burden coworkers dealing with their own grief.[21,27] Recommendations were thus made to enable peer-based supports by dedicating sufficient resources.[24,27]

PROVIDING OPPORTUNITIES TO DEBRIEF

Another common grief and loss support cited in included records was providing opportunities to debrief.[20,23-25,27,29] The purpose of debriefing was often to create space for workers to discuss, process, and learn how to deal with experiences of grief, loss, and work-related stress.[24,20] Characteristics of debriefing practices varied across records. Debriefs included both group and individual sessions, with suggestions that both options be offered to meet worker preferences.[20,24,27,29] Typically, debrief sessions were suggested immediately following a loss or monthly, and ranged from 5 minutes to half or full-day retreats for healing.[23,24,20,29] A number of individuals were involved in leading debriefs: managers, human resources staff, psychologists, and external counsellors.[29,20,25]

One record described a pilot project that implemented two two-hour impact debriefing circles and training for managers and workers of supportive housing agencies.[24] The debriefing circles provided a workers an opportunity to identify and share experiences and impacts of losses with others; and learn practices and tools related to emotional self-awareness, resiliency, and responding to multiple losses. Feedback from direct service workers on debriefing circles indicates that workers felt it was an effective way for workers to process the impacts of grief and loss; however, some workers noted challenges on returning to work after sharing their experiences.[24] Other records cited resource challenges to create supportive debriefing practice.[27]

ADDRESSING STAFF SCHEDULING

Another strategy was to address staff scheduling in order to present options for workers to take some time off work. This included having staff available from back-ups, replacements, shifts or rotations.[23,24,29] To facilitate such arrangements, one record suggested that a back-up and buddy system be put into place at work.[23] Flexible scheduling arrangements were also suggested, with one review highlighting a holistic approach to address burnout among Indigenous substance use service providers such as having flexible work arrangements.[23,24,26] Building on this, one record described the need for more flexibility with scheduling to allow for Indigenous workers to engage with community members.[21]

OFFERING TEAM BUILDING DAYS AND SELF CARE

Four records outlined opportunities to allow workers to de-stress such as 'teambuilding days' with activities or 'wellness initiatives'.[29,23,28,25] Of these, one record also discussed integrating self-care strategies and activities as part of job duties and responsibilities.[23]

Healthy Leadership

Supports related to healthy leadership fall into three categories: 1) strengthening management support (n=7); 2) providing clinical supervisors and external support roles (n=6); and 3) fostering a collaborative and participatory environment (n=4).

STRENGTHENING MANAGEMENT SUPPORT

Workers cited that management lacked resources and knowledge to effectively deal with the impacts of grief and loss.[24,27] Thus to foster supportive organizational cultures, seven records described strengthening support from management.[20,22-26,29] Most often strategies focussed on facilitating regular check-ins and debriefs, communication, and offering and connecting workers to appropriate support services and resources.[20,24,29]

Records also highlighted helpful management characteristics from the perspective of workers with living and lived experience of substance use and others from the supportive housing sector.[20,24] Generally, workers valued managers that were: knowledgeable and experienced;[20,24] empathetic and validated experiences; had an open-door policy; available when needed including after hours; and willing to talk about support needs.[20,24,29] Workers at supportive housing agencies noted that it was not helpful when managers sent staff home, did not acknowledge loss, provided unsolicited advice, made assumptions about staff's ability to deal with grief and loss, or directed them to Employee Assistance Programs.[24] One review of interventions to manage the impact of burnout among substance use service providers found that workplaces where service providers can speak to their supervisors openly and voice concerns can reduce job frustration and can decrease burnout.[26]

PROVIDING CLINICAL SUPERVISORS AND EXTERNAL SUPPORT ROLES

Six records suggested providing clinical supervision to support harm reduction workers, Indigenous alcohol and other drug workers, and mental health and substance use providers.[21,24-27,29] The role of clinical supervisors was diverse including leading debriefs and providing counselling and grief support.[25] One review of interventions to manage the impact of burnout among substance use service providers noted that clinical supervision was negatively associated with emotional exhaustion and can increase workers' commitment.[26] Another record described the need for clinical supervision to be offered by someone who has is not responsible for performance reviews and has appropriate training and knowledge.[27]

FORSTERING A COLLABORATIVE AND PARTICIPATORY ENVIRONMENT

Four records suggested integrating and involving workers in the development of organizational policies and procedures, specifically related to grief, loss, and setting boundaries.[20,21,23,29]

Organizational Policies

We identified two records that emphasized organizational policies and approaches to support workers with grief, loss, and burnout, and both were from the same organization.[23,24] This included integrating grief practices into the orientation process for all workers, which involved asking how they would like to be informed on the death of a client, as well as the inclusion of grief as part of an organizational wellness and resiliency plan that promotes worker well-being, with specific grief and loss policies and procedures.[23,24]

Community Supports

Three records emphasized that coordination and collaboration with other agencies would help support them in better addressing grief, loss, and burnout.[21,23,24] Other records described the availability of a centralized structures and resources to support workers with grief and loss.[24,25] Examples of such strategies included: a Provincial Mobile Response Team; Provincial Workplace Health Call Centre; Community Crisis Intervention Team; and centralized staff that are available to provide training, debriefing, coaching, and other support to workers at supportive housing agencies and community health centres.[25,24] Only one record described redressing systemic inequalities.[21]

Discussion

This rapid review summarizes the current literature about organizational supports for workers responding to substance use-related harms. A total of 10 records met our eligibility criteria. The most common types of supports that were offered or recommended were facilitating access and referrals to support services and resources, enabling peer-based supports, providing opportunities for training and skill development, and strengthening supportive management. We identified no records that evaluated supports and reported outcomes related to burnout among workers responding to overdose. Being formalized, appropriately resourced, readily accessible, and of high quality were key elements across supports. By synthesizing the small amount of literature available on supports, we identified key gaps that warrant further exploration for research and practice.

First, the small number of records included reveals the lack of research and evaluation focusing on supporting workers in overdose response with grief, loss, trauma, and burnout. Thus, there is a gap in knowledge on what supports are most effective for workers responding to an overdose, the factors that influence effectiveness for different workers, settings, and contexts, and the unintentional consequences of supports increasing stress or other factors that contribute to burnout. For example, records that integrated the worker perspectives noted that supports cited in this rapid review can be poorly executed, not always helpful or even harmful.[21,24,27] Given limited and inconclusive results of debriefing following traumatic events in clinical settings, it is also important that implementation factors such as the aim/focus, having the right facilitator, and timing of debriefing are taken into to consideration to achieve intended outcomes and to be helpful to workers.[30,23] Further examination of supports is required to understand the unintended consequences and determine the efficacy of supports for the current context and lived realities of different types of workers responding to overdose including those with living and lived experience of substance use, formally and not formally employed.

We included a grey literature review of interventions to reduce burnout among substance use service providers (e.g., social worker, healthcare professional, harm reduction worker), which highlighted that positive clinical supervision, supportive management, and education on specific therapies can lower levels of burnout.[26] There is a large body of research on several supports included in this rapid review from other disciplines; however results tend to be mixed, and the quality, generalizability, and focus of the studies are limited.[31] A systematic review of interventions to reduce compassion fatigue among healthcare, emergency, and community service providers found that supports involving teaching or improving resilience were the most promising.[31] Meanwhile approaches such as grief rituals to acknowledge clients, mindfulness education, and connecting with coworkers were shown to be ineffective.[31] A meta-analysis of interventions addressing job burnout in mental health providers found that person-directed interventions were more effective at reducing emotional exhaustion, and that job training/education was the most effective type of organizational intervention.[32] Ongoing collaboration with workers, including people with living and lived experience of substance use, may increase understanding of what does and does not work when organizations plan to support the needs of workers, particularly in the context of drug poisoning crisis.

Another gap was that our search did not identify many records addressed inequities in the design or delivery of supports. Three records explicitly discussed the need for Indigenous ways of working or culturally safe approaches for Indigenous workers experiencing grief and loss.[21,23,26] Fewer described the emotional toll of stigma and racism in the workplace, and only one highlighted approaches to reduce the inequitable access to organizational and mental health supports among workers with living and lived experiences of drug use.[28,21] Also lacking were supports for workers not formally employed in overdose response, including people with living and lived experience working in community setting.[3] Trauma brought on by overdose events may reinforce the multiple factors that exacerbate the harm and poor

health and social outcomes experienced by people with living and lived experience of substance use (e.g., racism, colonialism, housing instability, poverty, and drug policies).[33] Equitable access to supports should be a priority for all workers, included those employed full-time, part-time or on contract, and for those not formally employed but engaging in overdose response.[33] Additionally, there is need for organizations employing harm reduction workers to collaborate with workers to fund and develop sustainable professional development programs to facilitate entrance into other roles and sectors.

Finally, a critical discussion is needed on the focus of supports. We found that most supports tend to focus on individual-level knowledge and skills to identify and cope with stressors, grief, and loss, leadership interactions, individuals accessing supports, or support from coworkers. While important, focussing on individual-level supports pays insufficient attention to the organizational cultures, community availability of services, and the broader social, political, environment that workers are embedded in.[18,19] When supports were described at the organizational-level, addressing factors such as fair wage, access to benefits, paid sick days, work hours, amongst other structural factors that affect workers' experiences and their ability to deal with grief, stress, trauma, and burnout were less common. Indeed, it is likely that we missed organizational supports that address these factors but may not be directly targeting burnout as the primary focus. Nevertheless, efforts that address the emotional toll on workers responding to overdose should consider the interplay of factors at multiple levels that shape a worker's experiences. Doing so can also help with the sustainability of support practices.[28]

Limitations

This rapid review included studies from different settings and sectors, which highlighted a range of supports; however, this poses challenges to the applicability of results given the systematic differences in resources available to certain sectors. Our scope did not include reviewing the sources that contribute to workplace-stress, burnout and trauma or factors that help mitigate them, which are important to consider when planning for supports. As such, there may be key strategies and interventions that broadly address workplace-stress, burnout, and trauma that could be helpful for this population of workers. For the purpose of this rapid review, our search and screening focussed on the context of overdose and workers responding to substance use-related harms and overdoses; however, there is a need to draw from what is known more broadly in the literature on workplace mental health and collaborate with workers responding to overdose to identify and use strategies that may be appropriate in this context and setting. Our search and eligibility criteria focussed on supports that directly target either burnout, trauma, stress, or grief as a primary focus related to working with people who use drugs. In doing so, we also missed supports and strategies that aim to improve conditions that influence workers' experiences of grief, burnout, and trauma. Due to the time constraints, we did not review references of included records, assess the quality of the included records, and involve more than one reviewer in the title and abstract screening and data extraction process. An additional reviewer was involved in final decisions on full-text inclusion.

Conclusion

Our rapid review describes current existing and recommended organizational supports for workers across diverse sectors responding to the drug poisoning crisis. The ten records included in this rapid review provide examples of strategies that can be used to support workers' well-being and address grief, stress, trauma, and burnout. Being formalized, appropriately resourced, readily accessible, and of high quality were key elements across support strategies.

By synthesizing the small amount of literature available on supports, we identified key areas that warrant further exploration for research and practice.

These include:

- Addressing inequities in supports, particularly as it relates to the equitable access to supports across diverse types of workers, including culturally safe and appropriate supports to deal with trauma, grief, loss, and burnout;
- Understanding the factors that influence the effectiveness of support strategies for different workers, settings, and contexts and the unintended consequences.
- While individual-level supports are important, more attention is required on the organizational cultures, community-level availability of services, and the broader social, political, environment that shape workers' experiences and overdose response.[31,18,19]

This review can help inform discussions among decision-makers, organizations, workers, people who use drugs, and other service providers planning supports to protect and promote the wellbeing of workers at the forefront of multiple ongoing public health crises.

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Appendix A

Table 1a. Search strategy for Ovid MEDLINE(R) ALL <1946 to August 06, 2021>

#	Searches	Results
1	Drug Overdose/dt, pc or Emergency Shelter/ or Harm Reduction/ or Naloxone/dt or Needle Exchange Programs/ or Opiate Overdose/dt, pc or Substance Abuse Treatment Centers/ or (((((("needle exchange" or "syringe distribut*") adj2 program*) or ((drug or opioid or safe or safer or supervised or substance) adj3 (consumption or inhalation or inhaling or injecting or injection or smoking or low-threshold* or experiential or "living experience" or "lived experience")) or "overdose prevention" or "overdose response") adj2 (center* or centre* or facility or facilities or room* or service* or site* or space*)) or homeless* or shelter? or "addiction service?" or detox*).ti,kw,kf. or (SIF or SIS or DCR or MSIC or DCF).ti,kw.	32832
2	Community Health Workers/ or Health Personnel/ or Patient Care Team/ or Peer Group/ or Workforce/ or (counsel?o?r or ((client or community or frontline or peer) adj2 (educator* or representative* or service? or support?)) or employee* or staff or worker* or workforce or personnel or "peer witness*" or team*).ti,kw,kf.	350875
3	1 and 2	1173
4	((((((("needle exchange" or "syringe distribut*") adj2 program*) or ((drug or opioid or safe or safer or supervised or substance) adj3 (consumption or inhalation or inhaling or injecting or injection or smoking or safe* or low-threshold or experiential or "living experience" or "lived experience")) or "overdose prevention") adj2 (center* or centre* or facility or facilities or room* or service* or site* or space*)) or homeless* or shelter? or "addiction service?" or detox*) and (counsel?o?r or ((client or community or frontline or peer) adj2 (educator* or representative* or service? or support?)) or employee* or staff or worker* or workforce or personnel or "peer witness*" or "team member*")).ab.	2974
5	3 or 4	3931
6	Alert Fatigue, Health Personnel/ or Burnout, Professional/ or Burnout, Psychological/ or Caregiver Burden/ or Compassion Fatigue/ or Mental Fatigue/ or Occupational Stress/ or Psychological Trauma/ or Stress Disorders, Post-Traumatic/ or Stress Disorders, Traumatic, Acute/ or Stress Disorders, Traumatic/ or Stress, Psychological/ or Mental Health/ or Resilience, Psychological/ or (((psychol* or psychosocial* or mental*) adj5 (health* or safe* or well* or ill* or resilien* or injur* or distress* or harm* or trauma* or hazard* or risk*)) or stress or PTSD or fatigue or burnout).ti,kw,kf. or (((alert or compassion or mental*) adj2 fatigue) or burnout or burn-out or "burned out" or ((acute or mental or occupational or work* or psychological) adj2 (stress or trauma)) or ((psychol* or psychosocial* or mental*) adj5 (health* or safe* or well* or ill* or resilien* or injur* or distress* or harm* or trauma* or hazard* or risk*))).ab.	756114

#	Searches	Results
7	Posttraumatic Growth, Psychological/ or Counseling/ or Directive Counseling/ or Motivational Interviewing/ or Mental Health Services/ or ((counsel?ing or counsel?or* or therapy or "psychological support") adj5 (organi#ation* or institution* or workplace or internal or external or in-house or inhouse or in-person or inperson or onsite or on-site or ongoing or provid* or paid or inclus* or community-based or "harm reduction informed")).ab,ti,kw,kf.	130847
8	"psychological first aid".ab,ti,kw,kf.	231
9	(((destress or multifaith or prayer or quiet or recharge or wellness) adj2 (room? or space?)) or debrief* or acupuncture or massage* or "complementary therap*" or "prayer circle*" or ("indigenous-led " adj2 circle*) or ((group or shared or staff or team) adj2 meal?)).ab,ti,kw,kf.	43912
10	7 or 8 or 9	174334
11	"Compensation and Redress"/ or (((adequate or living or decent or livable) adj2 (compensation or remuneration or pay or wages)) or (benefit adj2 (coverage or health or medical or dental or childcare or "child care")) or "sick days" or "sick time" or "time off" or "vacation days" or "holiday days" or (paid adj2 ("days off" or "time off" or holiday* or leave or vacation*)) or ((permanent or full-time) adj2 (job* or position* or staff or work*))).ab,ti,kw,kf.	17139
12	Needs Assessment/og or Capacity Building/og or Community Health Planning/og or ("capacity building" or "needs assessment" or "employee engagement").ti,kw.	9738
13	Work Schedule Tolerance/ or Work-Life Balance/ or Workload/ or (schedul* or ((case or client or work) adj (load* or number*)) or workload* or (work adj2 balance) or (setting adj1 boundar*)).ab,ti,kw,kf.	214952
14	Inservice Training/ or Staff Development/ or ((organi#ation* or employer or supervisor* or manager* or external or institution* or workplace or internal or external or in-house or inhouse or in-person or inperson or onsite or on-site or paid or ongoing) adj5 (educat* or support or training)).ab,ti,kw,kf.	84981
15	Occupational Health Services/ or Occupational Health/ or (occupational adj2 (health or safety) adj3 (program* or service*)).ab,ti,kw,kf.	45776
16	((organi#ation* or external or institution* or workplace or internal) adj12 ((emotional or organi#ational or financial or structural or housing or instrumental or educational or cultural or spiritual) adj2 support)).ab,ti,kw,kf.	2791
17	11 or 12 or 13 or 14 or 15 or 16	362605
18	6 or 10 or 17	1224064
19	5 and 18	1308

Table 2a. Search strategy for Ovid MEDLINE(R) ALL <1946 to September 01, 2021>

#	Searches	Results
1	health personnel/ or community health workers/ or emergency medical dispatcher/ or nurses, community health/ or nurses, public health/ or physicians, family/ or physicians, primary care/ or social workers/ or emergency responders/ or emergency medical technicians/ or firefighters/ or police/	92634
2	(((emergency or first) adj2 responder*) or ((doctor* or nurse* or physician*) adj2 ("critical care" or ICU or ER or "A&E" or "accident and emergency" or (emergency adj2 (department* or room*)) or "urgent care")) or "911 operator" or (("911" or emergency) adj2 dispatcher*) or firefighter* or firem#n* or firewom#n* or "fire fighter*" or "police officer*" or police* or ("law enforcement" adj2 (officer* or personnel)) or (ambulance* adj2 (attendant* or driver*)) or paramedic*).ti,kw,kf.	13275
3	(((emergency or first) adj2 responder*) or ((doctor* or nurse* or physician*) adj2 ("critical care" or ICU or ER or "A&E" or "accident and emergency" or (emergency adj2 (department* or room*)) or "urgent care")) or "911 operator" or (("911" or emergency) adj2 dispatcher*) or firefighter* or firem#n* or firewom#n* or "fire fighter*" or "police officer*" or police* or ("law enforcement" adj2 (officer* or personnel)) or (ambulance* adj2 (attendant* or driver*)) or paramedic*).ab. not medline.st.	5179
4	1 or 2 or 3	104459
5	Alert Fatigue, Health Personnel/ or Burnout, Professional/ or Burnout, Psychological/ or Caregiver Burden/ or Compassion Fatigue/ or Mental Fatigue/ or Occupational Stress/ or Psychological Trauma/ or Stress Disorders, Post-Traumatic/ or Stress Disorders, Traumatic, Acute/ or Stress Disorders, Traumatic/ or Stress, Psychological/ or Mental Health/ or Resilience, Psychological/ or (((psychol* or psychosocial* or mental*) adj5 (health* or safe* or well* or ill* or resilien* or injur* or distress* or harm* or trauma* or hazard* or risk*)) or stress or PTSD or fatigue or burnout).ti,kw,kf. or (((alert or compassion or mental*) adj2 fatigue) or burnout or burn-out or "burned out" or ((acute or mental or occupational or work* or psychological) adj2 (stress or trauma)) or ((psychol* or psychosocial* or mental*) adj5 (health* or safe* or well* or ill* or resilien* or injur* or distress* or harm* or trauma* or hazard* or risk*))).ab.	762007
6	Alert Fatigue, Health Personnel/pc or Burnout, Professional/pc or Burnout, Psychological/pc or Compassion Fatigue/pc or Occupational Stress/pc or Psychological Trauma/pc or Stress Disorders, Post-Traumatic/pc or Stress Disorders, Traumatic, Acute/pc or Stress Disorders, Traumatic/pc or Stress, Psychological/pc or Needs Assessment/og or Capacity Building/og or Community Health Planning/og or ("capacity building" or "needs assessment" or "employee engagement").ti,kw.	23969
7	((organi#ation* or external or institution* or workplace or internal) adj12 ((emotional or organi#ational or financial or structural or housing or instrumental or educational or cultural or spiritual) adj2 support)).ab,ti,kw,kf.	2825

#	Searches	Results
8	Work Schedule Tolerance/ or Work-Life Balance/ or Workload/ or (schedul* or ((case or client or work) adj (load* or number*)) or workload* or (work adj2 balance) or (setting adj1 boundar*)).ti,kw,kf. or ((schedul* or ((case or client or work) adj (load* or number*)) or workload* or (work adj2 balance) or (setting adj1 boundar*)).ab. not medline.st.)	72157
9	Inservice Training/ or Staff Development/ or ((organi#ation* or employer or supervisor* or manager* or external or institution* or workplace or internal or external or in-house or inhouse or in-person or inperson or onsite or on-site or paid or ongoing) adj5 (educat* or support or training)).ab,ti,kw,kf.	85505
10	Occupational Health Services/ or Occupational Health/ or (occupational adj2 (health or safety) adj3 (program* or service*)).ti,kw,kf. or ((occupational adj2 (health or safety) adj3 (program* or service*)).ab. not medline.st.)	45288
11	6 or 7 or 8 or 9 or 10	218390
12	5 and 11	34134
13	"psychological first aid".ab,ti,kw,kf.	233
14	(((destress or multifaith or prayer or quiet or recharge or wellness) adj2 (room? or space?)) or debrief* or acupuncture or massage* or "complementary therap*" or "prayer circle*" or ("indigenous-led " adj2 circle*) or ((group or shared or staff or team) adj2 meal?)).ab,ti,kw,kf.	44149
15	Posttraumatic Growth, Psychological/ or Counseling/ or Directive Counseling/ or Motivational Interviewing/ or Mental Health Services/ or ((counsel?ing or counsel?or* or therapy or "psychological support") adj5 (organi#ation* or institution* or workplace or internal or external or in-house or inhouse or in-person or inperson or onsite or on-site or ongoing or provid* or paid or inclus* or community-based or "harm reduction informed")).ti,kw,kf. or (((counsel?ing or counsel?or* or therapy or "psychological support") adj5 (organi#ation* or institution* or workplace or internal or external or in-house or inhouse or in-person or inperson or onsite or on-site or ongoing or provid* or paid or inclus* or community-based or "harm reduction informed")).ab. not medline.st.)	89996
16	13 or 14 or 15	133995
17	12 or 16	165946

Appendix B

Table 1b. A summary of the included records

Reference	Type of workers	Relevant sector	A summary of existing or recommended practices	Design and implementation considerations
Rigoni et al., 2020[20]	Harm reduction workers with living and lived experience	Harm reduction	**Recommendations:** • Offer debriefing sessions or other types of mental health support • Offer mental health support from an external provider • Mentorship from other workers with lived experience • Training opportunities related to burnout prevention, stress management, and mental health symptoms • Clear communication from management about work policies • Involving staff in making work policies	**Debriefs:** Provide options for both group or individual debriefs. Debrief at least once a month.

Reference	Type of workers	Relevant sector	A summary of existing or recommended practices	Design and implementation considerations
Roche et al., 2013[21]	Indigenous 'alcohol and other drugs' (AOD) workers	Substance use	**Recommendations:** • Increase the number of Indigenous AOD workers to reduce job demands and stress • Build the substance use-related skills and knowledge of Indigenous workers in health and human services • Expand capacity of Indigenous communities to address issues in community and systemic inequities • Build mutual networks for workers for support • Offer mentoring opportunities • Provide access to culturally sensitive counselling and support services • Provide training opportunities on boundary-setting, skills and strategies in self-care, • Facilitate workers' input into organizational policies and process • Offer clinical supervision • Be more flexible with staff scheduling (e.g., allowing workers to engage with clients on their terms) • Coordinate with other services • Provide adequate leave provisions to participate in cultural obligations	Workforce capacity-building initiatives needed at multiple levels Adequate funding needed to implement strategies

Reference	Type of workers	Relevant sector	A summary of existing or recommended practices	Design and implementation considerations
Anguilar-Amaya et al., 2019[22]	"Lay" employees	Public health	**Existing practice:** • Management to meet with the lay employees to debrief • Offer annual naloxone training with a 6-month follow-up refresher course • Provide information on secondary trauma and coping mechanisms	
Perreault et al., 2011[23]	Managers, HIV/AIDS service providers	HIV/AIDs services	**Recommendations:** • For supportive management: be open, have frequent communication, offer immediate contact, acknowledge and address the loss directly, provide specific practical support, encourage discussion if they want, and explore options • Offer team retreats • Provide temporary adjustments to the workload, back-ups, and replacements • Offer time off such as sick leave, leave without pay, flex time, bereavement leave • Develop and adopt comprehensive grief and loss organizational policies and procedures including agency resiliency plan, systems for integrating grief awareness into the orientation process, etc. • Develop mechanisms to inform staff of death and to share information and resources about grief and loss (e.g., an Intranet, resources bulletin board)	No 'one size fits all' model to grief; a range of options should be available as grief and coping is different for everyone. Assumptions should not be made about the type of support needed. Integrate practice across all level of organizational structures. Training: 'lunch and learn' workshops or information sessions. Group support: Both formal and informal support. Debriefs: Most useful within a week of death. 1-1.5 hour session for staff and management. Supports offered internally should be on work time.

Reference	Type of workers	Relevant sector	A summary of existing or recommended practices	Design and implementation considerations
			• Offer referrals to appropriate internal and external community resources including counselling • Offer rituals, funerals, and memorials • Provide group debriefing sessions after a death or after a traumatic event • Offer Employee Assistance Programs • Offer counselling as part of health coverage • Involve staff in discussion on ways to deal with grief, loss, or compassion fatigue around the workplace • Enable buddy system to support and check-in • Offer professional development for staff • Offer workplace training and workshop opportunities related to compassion fatigue, resiliency, grief, loss, and trauma for staff, management, boards • Work with other agencies to develop and coordinate strategies	

Reference	Type of workers	Relevant sector	A summary of existing or recommended practices	Design and implementation considerations
Perreault et al., 2018[24]	Managers, staff, and workers with living and lived experience	Supportive housing	**Pilot project with 8 participating organizations:** • Two impact debriefing circles: First debriefing focussed on completing the questionnaire, providing space to identify and discuss work-related losses and impacts, and offering a framework for understanding resiliency and multiple losses. Second debriefing focussed on reviewing and using the impact debriefing guide • Questionnaires about existing workers support, gaps in support, and potential skill building needs • Training for managers and workers: Managers training focussed on the range of grief/loss supports available, theoretical frameworks for understanding resiliency and multiple losses, multi-level responses at work, and practical steps. Worker trainings had a similar focus in addition to discussing mutual support opportunities and a community-based closure tool **Pilot project recommendations:** • Create a central resource to provide training, debriefing, and coaching on dealing with the impact of grief and loss • Expand access to grief and loss training and support to all housing organizations in Toronto • Build on current pilot by offering grief and loss training, build sector capacity by creating a team within the sector to serve as resources for	Impact debriefing circles: 2-hour sessions, 2 per site. Managers participated based on the discretion of each site. Debriefing circle table for remembering the names of the people who have died. Some workers found it difficult to go back to work right after and wished there was more time for grounding after sharing experiences. Training: 1-day training session, with: warm-up activities (check-ins, grounding exercises), opportunities for mutual learning between attendees, personal reflections through worksheets and discussions, PowerPoint presentation and discussion of frameworks, use of worksheets and group dialogue on possible workplace application of theories/practices, and practical tools for workplace memorials (closure activities). Supportive management: Commonly, workers found it most helpful when their manager checked-in/offered support. They did not find it helpful when managers offered no opportunity to

Reference	Type of workers	Relevant sector	A summary of existing or recommended practices	Design and implementation considerations
			Impact Debriefings, coordinate monthly debriefing circles for workers and bi-monthly debrief for managers, coordinate monthly peer-based support group **Existing practices for loss in personal lives or work-related loss:** • Provide paid time off (vacation, sick, bereavement) • Offer Employee Assistance Programs • Provide extended benefit coverage • Supervision and manager check-in/support, on-call manager • Set up communication mechanisms with other staff • Debriefing or debriefing with external facilitation • Offer events, space, or symbols for memorials • Enable peer/team-based peer support • Arrange flexible schedule or discretionary time off • Offer informal supports • Referrals to external supports • Provide clinical supervision • Provide training opportunities related to trauma, anti-oppression, grief, and loss **Recommendations:** • Managers noted that their organization would benefit from more grief and loss training/capacity building	debrief, immediate support or did not acknowledge the death. Most workers identified that they get more support from co-workers than managers. Debriefs: Timely debriefing, access to affordable and knowledgeable counselling, and peer support were seen as common supports needed to help cope with the trauma of a clients' death. Workers wanted managers to better respond to grief needs, offer capacity building for peer support, and provide additional training on resilience.

Reference	Type of workers	Relevant sector	A summary of existing or recommended practices	Design and implementation considerations
			• Immediate debriefing and options to leave work for a short time are common immediate support needs amongst workers • Managers identified gaps related to inconsistent practices, knowledge and skill, and organizational structures/process. Manager support, funding/staff, organizational approach, leadership, and peer-based supports were identified as ways to address gaps • Workers identified gaps related to manager skill/knowledge, organizational approach, and agencies working together. Interagency cooperation, better communication about losses, and enabling staff (e.g., activism, peer-based support) were identified as ways to move forward	
Ankors, 2020[25]	Service providers	Primary health, social services, housing, harm reduction, substance use treatment services, pharmacy, other	**Existing practices across health regions:** • Facilitate access to counselling via referrals or internal resources • Provide benefits to cover counselling • Access to centralized supports e.g., Provincial Workplace Health call centre, mobile response team, community crisis intervention team • Provide access to on-site professionals for debriefing, grief support, and counselling • Access to Indigenous Elders and Healing Circles • Provide Employee & Family Assistance Program • Offer wellness days • Supervision	Supports would benefit from being visible, formalized, and readily accessible.

Reference	Type of workers	Relevant sector	A summary of existing or recommended practices	Design and implementation considerations
			• Recommendations based on what service provider said would be helpful: • Access to trauma counselling • Offer formalized clinical sessions • Offer services that are convenient to staff • Provide opportunities for peer-led support groups • Offer formal pathways to supports • Provide educational opportunities, e.g., on grief support	
Rapid Response Service, 2019[26]	Substance use providers	Substance use	• Person-directed interventions more effective than organizational • Have service providers use specific therapies • Clinical supervision negatively associated with emotional exhaustion • Supportive work environments can decrease burnout • Peer-based groups and interaction with co-workers to discuss burnout • Access to professional counselling • Self-care and coping strategies • Holistic approach to burnout including flexible work arrangement for Indigenous service providers	

Reference	Type of workers	Relevant sector	A summary of existing or recommended practices	Design and implementation considerations
Khorasheh et al., 2021[27]	Harm reduction workers including those with living or lived experience	Harm reduction	**Recommendations:** • Adequate pay, benefit coverage, and sick and vacation day for part-time and contract workers • External role with appropriate qualifications to support staff • Dedicate resources for individual and collective grief and loss supports including those at the workplace.	Help navigate the implications of pay and benefits for workers receiving social assistance. Hire trained professional with community-based knowledge of the overdose crisis and skills in addressing complex trauma. Offer community-based services that promote wellbeing at the workplace such as access to counselling, workshops, and acupuncture.
Mamdani et al., 2021[28]	Workers with lived experience	Housing/ shelter, harm reduction	**Recommendations of ROSE intervention model (R: Recognition of Peer Work, O: Organizational Support, S: Skill Development; and E: for Everyone)** • Recognition of worker through providing basic resources and raising awareness of work • Create formal employment contracts • Create a "Peer Supporter" role to provide peer-to-peer debriefing • Create a 'Systems Navigator' role to support other workers with living and lived expertise of substance use in navigating access to external services and supports • Offer teambuilding days to allow time to de-stress • Offer skill development opportunities	Systems Navigator position: assist with access to harm reduction services, healthcare, legal, housing, income, amongst other supports. Teambuilding: fun/celebratory parties twice a year. Training: Training that is tailored to the realities of people with living and lived expertise of substance use including technical and people skills (e.g., peer debriefing skills, self-care).

Reference	Type of workers	Relevant sector	A summary of existing or recommended practices	Design and implementation considerations
Human Resources in Action, 2019[29]	Service providers	Corrections, housing/ shelters, public libraries, substance use services	**Recommendations:** • Offer opportunity to debrief with staff after an overdose • Connect staff to support resources • Offer team-building lunches or half/full-day retreats for healing and discussion • Set up individual clinical supervision in addition to group clinical supervision • Allow staff to access supports and self-care during the workday	Debriefs: Discuss what happened, how the team responded, how people are feeling, additional support that is needed. Debrief can last between 5 minutes to an hour and be led by managers, human resources staff, or an external counselor. Check-in later in the day and then follow-up days/weeks after. Allow the site to close for a short period or provide a quiet space/time away from the site.

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