



**HARM REDUCTION, STIGMA AND THE PROBLEM OF LOW COMPASSION
SATISFACTION: TENSIONS ON THE FRONT-LINES OF CANADA'S OPIOID CRISIS**

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ABSTRACT

Background and Objective

Canada is in the midst of an opioid crisis. Given the sheer magnitude of the crisis and escalating death toll, the mobilization of harm reduction interventions is an important priority. Currently, little is known about the role played by stigmatization, particularly in terms of how this may impact the endorsement and uptake of harm reduction strategies and initiatives among frontline providers.

Materials and Methods

Opening Minds, the anti-stigma initiative of the Mental Health Commission of Canada, undertook a one-and-a-half-year research project to understand the qualities, characteristics, sources, consequences, and solutions to the problem of stigmatization on the front-lines of the opioid crisis. A qualitative key informant design was selected. Participants included various first responder and health provider groups, people with lived experience of opioid or other drug use, and people in key policy or programming roles. Eight focus groups were held across Canada, and 15 one-on-one key informant interviews were completed.

Results

Analysis of focus group and key informant interviews revealed three main ways in which stigma shows up on the front lines of the opioid crisis among providers. These themes coalesced around a central main problem, that of low compassion satisfaction. Suggestions for how these concerns can be addressed were also identified.

Conclusion

The findings from this research revealed several key ways that stigma shows up in the experiences and perceptions of frontline providers and provide several promising avenues for combating stigmatization related to opioid use and harm reduction. An important avenue for future research is to develop and elaborate on the theoretical connections between the concepts of stigmatization and compassion satisfaction as a way to better understand the problem of stigmatization in helping environments.

Canada is in the midst of an opioid crisis. Overall, the crisis has resulted in over 10,300 deaths between January 2016 and September 2018, 93% of which have been accidental.¹ The crisis affects Canadians from all walks of life. In general, communities with populations between 50,000 and 99,999 are being the hardest hit, with data further indicating that the highest number of deaths on a per capita basis are occurring in Western Canada – specifically British Columbia, Alberta, Yukon, and Northwest Territories – although certain metropolitan areas in Ontario and Eastern Canada also show particularly high rates of opioid-related hospitalizations, such as London, Peterborough, Thunder Bay, and Saint John.² There are also some demographic differences, with the majority of deaths occurring among adult males between the ages of 30 and 59, although demographic differences do vary considerably by region and other demographic factors.¹

The emergence of fentanyl and its analogs and their infiltration into the non-prescription drug supply is central to the crisis, accounting for approximately 75% of accidental opioid-related deaths in Canada in the last few years.¹ Importantly, a similar proportion of deaths have also been found to involve multiple substances, including one or more opioids as well as non-opioid substances such as alcohol, benzodiazepines, methamphetamine, or cocaine.¹

As communities, first responder organizations, health authorities and governments attempt to respond, multi-pillared strategies are often adopted, highlighting a balance of attention to prevention, harm reduction, treatment, and enforcement.³⁻⁵ Given the sheer magnitude of the crisis and escalating death toll, the mobilization of harm reduction interventions is often viewed as a particularly immediate priority (e.g.,⁶). Harm reduction is considered a pragmatic public health approach that aims to reduce the harms associated with risky health behaviours.^{7,8} In the case of drug use, its primary emphasis tends to be the prevention of death and disability without requiring that substance use be discontinued. At its core, harm reduction supports any steps in the right direction, takes a value-neutral position on the question of drug use, and is complementary to prevention and treatment strategies.⁷⁻¹⁰ Although still growing and lacking somewhat in high-quality randomized trials, the evidence to date is sound and

suggestive of positive efficacy – particularly for its ability to save lives, reduce HIV and HCV infection risk, increase access to health and social services, and provide a pathway to recovery.⁷⁻¹⁶

With respect to Canada's current crisis, common harm reduction discussions include the provision of venues for safe consumption; ensuring the widespread availability of emergency relief to the public (e.g., naloxone), as well as training first responders and other frontline workers to administer emergency relief in the event of overdose or poisoning; the distribution of sterilized supplies (e.g., needles); and public education and messaging on the risks of opioid-related poisoning or overdose, including the dangers of using alone.^{5,6,8,17} Greater access and availability of medication maintenance therapies are also often emphasized as an important aspect of harm reduction, even though it is perhaps more accurate to understand this as a treatment modality, given the evidence base indicating its efficacy in this regard.^{7-11,13,16}

One area where little is currently known is that of the role of stigmatization, particularly in terms of how this might impact the uptake of various harm reduction strategies among users, as well as the endorsement of harm reduction initiatives among frontline providers. To this end, *Opening Minds*, the anti-stigma initiative of the Mental Health Commission of Canada, undertook a research project in partnership with funding from Health Canada to understand and explain the qualities, characteristics, sources, consequences, and solutions to the problem of stigmatization on the front-lines of the opioid crisis. Within this broader objective, perspectives on the successes and challenges of harm reduction were of interest. As such, this paper reports on findings from this larger study specifically related to the topic of harm reduction. A narrative summary of opioid stigma and its management, undertaken as part of this project, was also recently published.¹⁸

The theoretical framework we used to orient our understanding of stigmatization is that described by Link and Phelan,¹⁹ which views stigmatization as a complex social phenomenon involving processes of labeling, separation, stereotyping, devaluation, and exclusion, and which sees prejudice and discrimination as endpoints of stigmatization processes that involves both individual level and structural components. Within

this theoretical understanding, power is both central and necessary, allowing these processes to unfold.¹⁹

METHODS

Ethics approval for the study was received from both the University of Calgary Conjoint Health Research Ethics Board and the Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board. The study used a qualitative key informant methodology.²⁰ Key informants, because of their personal knowledge, experience, or position within a society or in relation to a particular phenomenon, are able to provide more information and a deeper insight into what is going on around them. This method was identified as being well-suited to the aims of the current study.²⁰

Our main key informant groups were frontline healthcare staff, police services, paramedics, fire services, other frontline service providers (such as outreach workers, for example), people involved in policy development and/or service delivery decisions at various community and government levels, as well as people with lived experience of opioid or other drug use problems. Because we were interested in experiences and perspectives regarding stigmatization and harm reduction across multiple domains – as well as to better understand how stigma might show up in terms of access, usage, and endorsement of various harm reduction practices and protocols – we felt it was important to include the perspectives of both providers as well as people with lived experience of opioid or other drug use.

Key informants were identified through a combination of purposive (i.e., by region and first responder type) and convenience (i.e., availability and willingness to participate) sampling. Data collection methods included focus groups and one-on-one key informant interviews. Focus groups sites were selected to ensure: (a) representation from each of Canada's five main regions; (b) a selection of some sites where opioid-related deaths or hospitalizations have been identified as being particularly high and some where the crisis was not yet being as strongly felt; and (c) that we were able to gather information from a number of different key informant perspectives (e.g., frontline health professionals, police services and fire services) to

ensure appropriate rigour in data triangulation.²¹ Site selection also aimed to reflect higher and lower levels of population density as well as reasonable geographic diversity. Focus groups were held in Vancouver and the lower mainland area (British Columbia region), Winnipeg (Prairies region), Calgary (Prairies region), Toronto (Ontario region), Quebec City (Quebec region), St. John's (Atlantic region).

All focus groups were conducted in person. Respondents for one-on-one key informant interviews were identified via snowball sampling, mainly through contacts from focus group sites, and were selected based on the identification of additional information needs arising from the focus group data or themes identified in the focus group data that had not yet achieved saturation. With the exception of two key informant interviews that were completed in person, all interviews were completed by telephone.

An unstructured interview protocol was used, with introductions and prompts for four main topics of discussion – key issues with drug use and opioid poisoning in the community, how opioid use is different or not different from other kinds of drug use problems, what stigma looks like and how it gets in the way of helping people with opioid use problems, and the identification of learning needs and promising practices for tackling the main barriers and challenges related to stigmatization. All focus groups and interviews were tape recorded with participants' permission and transcribed by a third party.

Transcribed discussions from focus groups and interviews were organized by topic to facilitate the coding and analysis process. Data were analyzed using a thematic approach, using steps outlined by Braun and Clarke,²² and include: (1) data familiarization/immersion; (2) Initial code generation; (3) Interpretative analysis of collated codes into main themes and subthemes; (4) Reviewing of themes in relation to coded extracts and generation of a thematic map; (5) Refining and defining themes and potential subthemes to further unify the emerging story of the data; and (6) Reporting the results of the analysis in a way that demonstrates the merit and validity of the analysis by using appropriate extract examples that relate to the themes, the research question(s), and the existing literature. Transcribed discussions from focus

groups and interviews were organized by question to facilitate the coding and analysis process.²² Analysis was facilitated with the use of the qualitative software MAXQDA (version 18.0.7).²³ All coding and analyses were conducted independently by the first and last author.

The results presented below pertain to findings related to stigmatization and harm reduction among first responders and health and social care providers

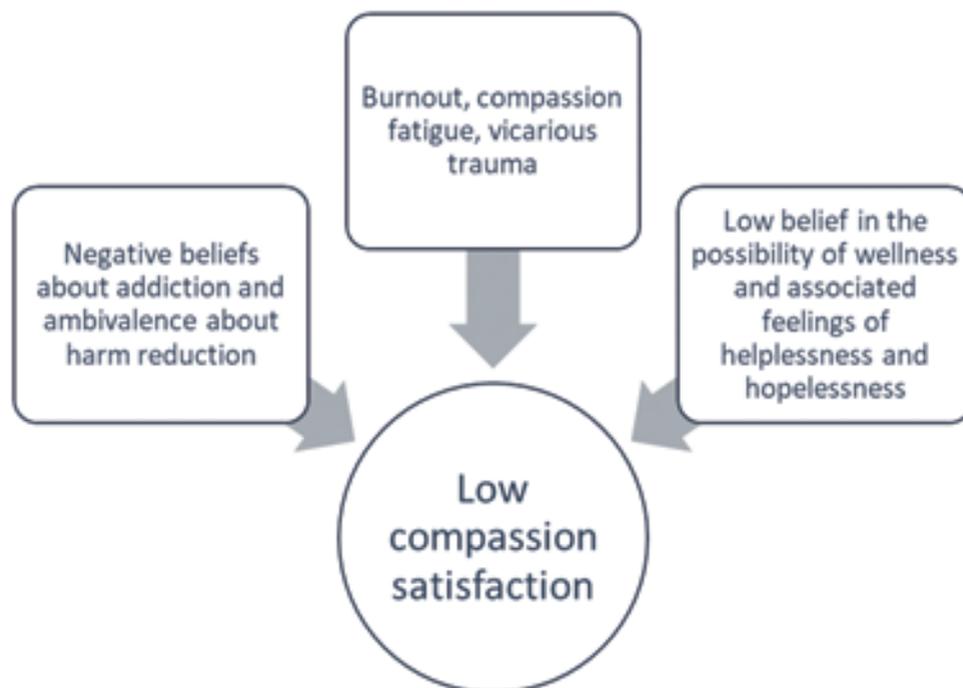
in the context of the opioid crisis. Findings pertaining to the stigmatization of people with lived experience of opioid or other drug use in the context of harm reduction are not included in this analysis. Any extracts used in reporting the results have had personal identifiers removed in order to retain the promise of participant anonymity. Excerpts are indicated simply as either ‘key informant interview’ participant or ‘focus group participant.’

TABLE 1 Details of Focus Group and Key Informant Interviews

Date	Location	# of participants	Participant type	Details
Jan 15	Winnipeg	10	FR	EMS, police, healthcare, public health, shelter/outreach
Jan 15	Winnipeg	5	PWLE	All male, currently in treatment
Feb 1	St. John’s	6	FR	Fire, police, healthcare, shelter
Feb 15	Calgary	10	FR	EMS, police, healthcare, shelter/outreach
Feb 22	Toronto	4	FR	Fire, EMS, police
Feb 23	Quebec City	6	FR	Police, healthcare (conducted in French)
March 5	BC Lower Mainland	6	FR/PWLE	Shelter/outreach, EMS, police, healthcare, peer support/advocacy
March 5	BC Lower Mainland	18	PWLE	Self-advocacy group; focus group conducted during group’s regular meeting time
Jan 15- July 12	Throughout Canada	15	various	PWLE, stigma reduction, mobile response/FR support, policy, training/programming, rural communities, advocacy, recovery, Indigenous perspectives

PWLE = people with lived experience; FR = first responder.

FIG. 1 How stigma shows up among providers on the front lines of the opioid crisis



RESULTS

A total of eight focus groups were conducted between January and March 2018, six with first responder groups and two with people with lived experience of opioid or other drug use problems (see Table 1). In addition, 15 key informant interviews were completed between January and July 2018, at which point saturation was reached (Table 1). Results of the analysis are presented in two main sections – findings explicating the process of stigmatization specific to providers (Figure 1), and findings outlining proposed solutions (Figure 2).

The Problem of Low Compassion Satisfaction – The Uniting Theme

Low compassion satisfaction emerged as the central problem to the question of ‘how stigma shows up’ on the front lines of the opioid crisis among providers (Figure 1). It was described using terms such as frustration and/or apathy, descriptions of emotional and clinical distancing from clients, and experiences of providing lower overall quality care and response. The following comments illustrate:

I’d say for sure there’s a sense of apathy for all of us. And for sure, there’s less of a sense of urgency to get that patient treated. We’ll treat them but we’re not going to rush in and go kneeling in needles and killing ourselves to treat them. (focus group participant)

I can say in the last three years since the crisis has started, I had found myself and I’ll admit to going, “Why? Why this time?” Because I’ve seen this individual three times this week. So again, it’s that ability to check in. I think the mental health of not only the patient but of the practitioner coincides almost exactly. The apathy just erodes confidence and you get sucked dry. (focus group participant)

For a staff member to feel like, “Maybe we just shouldn’t do it this time.” Obviously, that’s not something that people would actually do in practicality but emotionally, that’s a place that this crisis can take you to. (focus group participant)

[Frontline workers] don’t have enough compassion satisfaction in their work. The

more compassion satisfaction you have, the less likely you are to engage in distancing or other behaviours. (key informant interview)

Importantly, these experiences were described as being informed by and coalescing around, three main themes or problems, which emerged as the main drivers of stigmatization in relation to harm reduction and the opioid crisis for providers. They are:

- Negative beliefs about people with opioid and other drug use problems and ambivalence about harm reduction.
- Low belief in the possibility of wellness and associated feelings of helplessness and hopelessness.
- Practitioner burnout, compassion fatigue, and vicarious trauma.

Each of these themes is described in more detail below.

Negative Beliefs about Addiction and Ambivalent Views about Harm Reduction

Respondents widely agreed that harm reduction measures were both important and effective in helping to keep people alive and to reduce other harms associated with opioid and other drug use. However, many respondents also expressed a high degree of ambivalence about harm reduction techniques and practices – speaking, for example, about emergency relief measures like naloxone being a ‘double-edged sword,’ and expressing the view that harm reduction practices further enabled addiction and/or encouraged risk behaviours. Resistance to harm reduction was also expressed among some respondents because its purpose is not treatment-based – i.e., because it does not directly address the underlying causes of addiction. As the following comments show:

We have to be truthful about all of the aspects of the story, right? [Harm reduction] is feeding the addiction. These things don't do anything to treat the addiction. (focus group participant)

So, the big push has been for Narcan, naloxone. The survivability is better I guess and that's a win, right? People aren't dying as often. However, it's had a spinoff of actually making the usage more

common....they're more willing to take the chances with higher doses or different products that they know are purer because they know their friend has the Narcan kit or they know they can get Narcan from the drop-in or they know that EMS will be called or police or fire. ... So, the behaviour becomes riskier. (focus group participant).

There's huge stigma regarding methadone and other medication treatment...they see it that you are using a crutch – substituting one drug for another....like you are not 'doing the work'. (key informant interview)

Importantly, ambivalence about the value of harm reduction was and often expressed in a broader context of beliefs about addiction and people with addictions, particularly in terms of beliefs around personal responsibility and deservingness of care. The following comments illustrate:

We still see addiction as being a choice or just this bad thing and...why should I be paying for your lifestyle choices that you're making?....But the reality is that every day people are in hospitals getting treated for lifestyle related - right, people are - you know we don't shame people who have diabetes because you ate too much ice cream or too much sugar. We don't shame people who have cancer because of smoking. We just treat them. (key informant interview)

We're not treating addiction the same way we would treat cancer or that you have an illness. We're treating it as you have a failing. (focus group participant)

I think that one of the big stereotypes, one of the biggest problems we have it's that...in the eyes of society, [people with drug use problem], they're not worth much. Some might even say, 'one less drug addict is one less financial drain on society.' (focus group participant)

These attitudes and beliefs emerged as central to the problem of stigma in that they were described as enabling and supportive of negative, punitive and/or judgmental helping behaviours towards people who used opioids or other drugs. The following comments illustrate:

Just this week we had someone in who had an opioid addiction, and she had chosen to smoke weed instead of opioids. So, the staff came and said, 'She's out in the parking lot smoking weed every single day.' And I went 'Excellent because she's not shooting up.' And they're like 'That's just wrong. She shouldn't be doing...' So, the stigma is very much a lack of understanding. (focus group participant)

If I went back and told the staff 'Okay, we're going to give clean [sic] needles to people now that come in', they would just lose their mind, like 'We're doing what?' We're so not there yet... I have to fight to have a naloxone kit at [organization], because that's a needle and that could encourage drug use. (focus group participant)

"In emerg . . . [if] an IV-drug user is there with their cellulitis, or some older gentleman is there with cellulitis, maybe because he's a diabetic, and you got one space; I can tell you who's going to get it, right? — even if that IV-drug user's cellulitis is much worse — because that's a druggie. He did it to himself." (focus group participant)

Low Belief in the Possibility of Wellness and Associated Feelings of Helplessness and Hopelessness

Another key tension point relating to stigma and harm reduction pertained to how frontline providers experienced their roles as 'helpers' or 'healers' in the context of harm reduction. Specifically, they expressed frustration about many aspects of harm reduction work, including a feeling that they were not really helping individuals beyond keeping them alive – and that given the sheer magnitude of the current crisis, saving lives often did not generate much sense of helping satisfaction. Central to their experiences was a sense of 'not making a difference', especially in regard to not being able to help move people towards recovery, and in attending to high recidivism clients:

The staff perspective is really, really hard because they can go to someone who's overdosed once and provide intervention and be okay with that and feel like they've done something successfully.

But when they see that same individual maybe 10 or 20 times...it feels like this hopeless kind of journey because we're not addressing the root causes of why that person is an addict, to begin with. We're really just giving it temporary intervention. (focus group participant)

Harm reduction work can feel demoralizing – [it] feels like we are helping them stay in addiction, just keeping someone alive. It's hard to have expectations that we are really healing. (key informant interview)

This endless cycle of overdosing and returning and overdosing and the inability to get people further down on the path towards recovery... [is] one of the reasons why our team was formed. Because paramedics are leaving the job in droves. (focus group participant)

Importantly, providers' experiences in this regard were also connected to system-level inadequacies. Respondents recognized that their frustrations and feelings of helplessness were also connected to problems with adequate availability and accessibility of services for people with opioid and other drug use problems:

[Addiction and mental health treatment] is seen as not as important, there's no status attached to it unlike if you're working in cardiology or orthopedic surgery. So that's why one of the reasons working conditions are so difficult I think is because they're working with that population. (focus group participant)

The indifference is because the way the system goes... You become indifferent when you say, 'because what's going to change from the last time? Nothing, right?' (focus group participant)

PRACTITIONER BURNOUT, COMPASSION FATIGUE, AND VICARIOUS TRAUMA

The third major theme and contributor to low compassion satisfaction that emerged in focus groups and interviews was that of vicarious trauma, compassion fatigue, and burnout from working on the front-lines of the crisis. The stresses and challenges associated with helping high recidivism clients, witnessing multiple

numbers of poisonings and poisoning-related fatalities, and struggling with ongoing system inadequacies such as lack of resources, understaffing, and inadequate access to treatment and care for users, were the most commonly described factors.

Respondents also recognized that experiences of vicarious trauma, compassion fatigue, and burnout were a major contributor to low levels of compassion satisfaction and emotional and behavioural distancing from clients. They also recognized that these experiences were negatively impacting their own mental health and wellbeing. The following comments illustrate:

One group asked us to come in and do some training on how to help their people be empathetic and then they said to us, “you know I’m an animal control guy and I go home and kick my dog, like what’s with that?” And they don’t understand that it’s trauma, you know and they’re saying, “I’m a good guy, I got kids, why am I going home and yelling at everybody?” and “I’m a good person, why am I doing this?” (focus group participant)

We wind up working in survival mode, all the time. That’s often what’s so hard. (focus group participant)

In the field with the first responders...one of the big concerns is burnout and compassion fatigue. Because they’re getting numb...they’ve just seen so much that I think they don’t even have time to do self-care. (focus group participant)

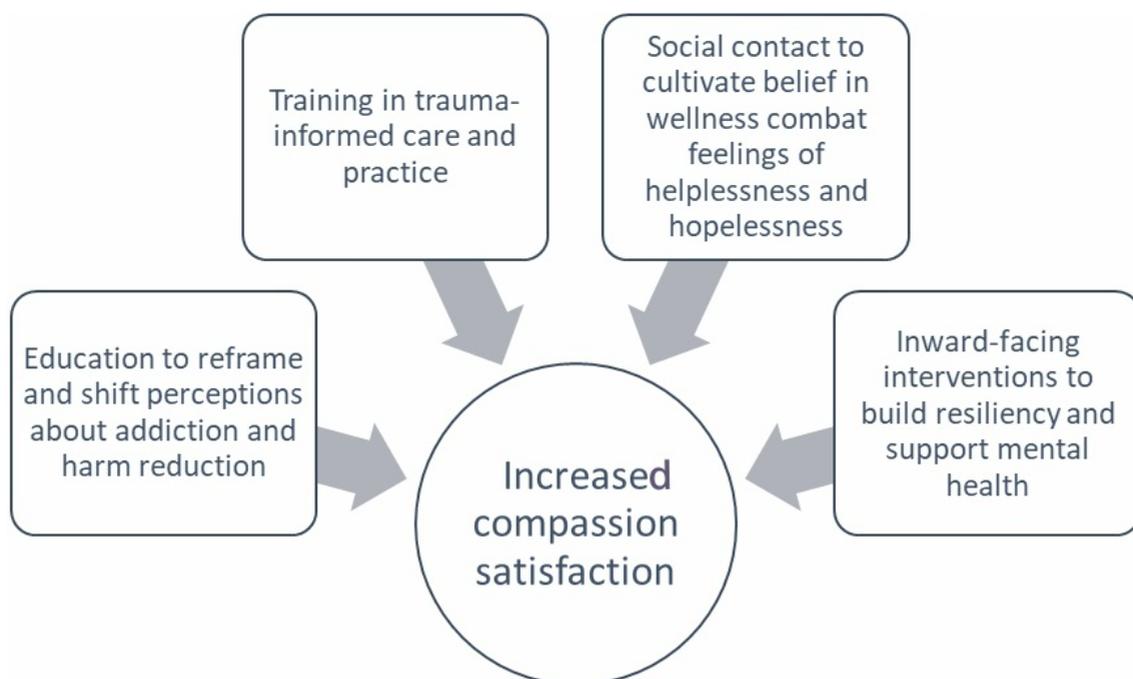
Importantly, these experiences were described with a greater sense of intensity and urgency among respondents living and working in areas of the country where the crisis was particularly acute.

PROPOSED SOLUTIONS

The proposed solutions identified by respondents for reducing stigma tended to be those that target the three main problems described above and support the overall aim of improving providers’ experiences of compassion satisfaction. These solutions are highlighted in Figure 2 and described in more detail below. They include:

- Education to reframe and shift perceptions about addiction and harm reduction
- Training in trauma-informed care and practice
- Social contact to cultivate belief in wellness combat feelings of helplessness and hopelessness
- Inward-facing interventions to build resiliency and support provider mental health.

FIG. 2 Proposed solutions for combatting stigmatization among providers on the front lines of the opioid crisis.



Reframing Harm Reduction and Addiction

First of all, respondents emphasized a need for interventions that provided greater understanding of the theory and evidence surrounding harm reduction practices and principles. This included emphasizing the role of harm reduction within a larger context of wellness, hope and care – and within a framework that emphasizes addiction as a legitimate medical condition. Ultimately, what respondents described was a need for education that would help reframe perceptions of both harm reduction and addiction away from notions of harm reduction as enabling addiction, and views of addiction as a choice and as a moral failing. Social contact and education were both discussed as useful approaches in this regard. Below are some examples of respondents' comments:

I always like to compare....it to something we know, like diabetes for example. It's a chronic illness that someone's going to suffer within their lifetime. There's going to be ups and downs, just like there's going to be in your lapses and intoxications and we need care to help support through that continuum. So, what that might look like, if someone with diabetes, if they go into toxic shock or they end up having a heart attack, we have that acute response to manage those things, but then we also have those sustainable other portions to help them throughout that, which includes different forms of harm reduction. (focus group participant)

The perception of addiction needs to shift, that it is a medical condition, that is it a health concern and medical condition as opposed to a choice or a lifestyle or an aspect of criminality. It is the current approach to the condition that is wrong. (key informant interview)

I also think the connection with people – peers, people with lived experiences – is so important. ...A lot of health care providers don't really know people who are using substances, other than alcohol, they can make assumptions. Connection, bringing people together, is important. (focus group participant)

Use Social Contact to Cultivate a Belief in Wellness and Recovery and to Combat Feelings of Helplessness and Hopelessness

The second theme regarding proposed solutions was to cultivate and foster a greater understanding and belief in the processes of hope, wellness, and recovery from drug use problems and addiction, including an emphasis of the importance of providers' roles in people's experiences. Respondents commonly felt that exposing frontline providers to recovery stories and recovery-based social contact interventions would be a valuable strategy. As the following comments illustrate:

I was feeling down about [the crisis] and there was an article in the [newspaper] at Christmas time about this guy that was apparently like accused of murdering some terrible criminal – he was going to kill himself or something like that. And he found God or whatever. And now he goes and helps addicts [sic] and tells them that, you can turn your life around. And he's now working – he spent 10 days at Christmas down in [city] talking to addicts [sic]. I was like – I had tears running down my face and I was like, 'Okay, this is who I have to think of for the 24th time we've given the same guy a Narcan intervention. Maybe he's going to be this guy that eventually is going to clean himself up [sic] and go and help people. So that helped me for that week. (focus group participant)

For me, working at a place like the [organization] where people are in recovery helps an awful lot with my burnout because I will see people come through on the other side where they're actually trying to get sober, have periods of sobriety. And you see them as completely different people. They are different people when they're not actively using. So that helps me to be able to keep doing what I'm doing in the emerg....I just offer that as a bit of hope is that sometimes people do get better and when they do get better, they're different like amazingly different. (focus group participant)

Part of the plan for this workshop is to involve somebody who is in recovery now, having had addiction... [Organization name], for example, organized a day for the RCMP, ambulance attendants, and bylaw enforcement officers.... And they had a person with lived experience, who is in recovery, solidly in recovery, talk about how the addiction developed for them, and just talking about that journey to recovery, how challenging it was and what difficulties they encountered and how much discrimination played a role in creating obstacles for their recovery. (key informant interview)

Provide Training in Trauma-Informed Care and Practice

Another important priority for combatting stigma was to provide training in trauma-informed practice and care. As illustrated in the following comments, training in trauma-informed practice and care was identified as an important stigma reduction strategy on two fronts – to provide a safer environment in which care and response are provided, as well as a tool or practice that would help first responders in their own work environments deal with vicarious trauma and other stressful experiences:

The question that service providers need to ask themselves is not, ‘how is this person expecting I’m going to be able to help them?’. Instead, they should be asking themselves, ‘how is this person going to expect I’m going to - be hurting them?’ And they need to learn how to interact in a way that really projects explicitly that they’re going to— give that personal choice, and they’re not going to treat them as if they are a label. (key informant interview)

I see it not only for the people who are using drugs but I also see it for the people who are helping those who use...you know instead of saying, “What’s wrong with somebody?” we need to say, “What happened to them?” (focus group participant)

[Program on trauma-informed care] takes into account providers’ own trauma. It reminds them of the way they want to show up, helps them

know how to be more mindful, not just “correct” behaviour, but see their interaction with patients as a relationship. It reminds people to be aware of the histories people carry with them – and reminds providers they don’t want to inflict more harm. It reminds them of their desire to do no harm. (key informant interview)

Provide Inward-Facing Interventions to Build Resiliency and Support Provider Mental Health

The final theme that emerged from our interviews and focus groups was the importance of inward-facing training to help mitigate the risks and experiences of high occupational stress – especially vicarious trauma and burnout. Interventions that focussed on workplace mental health and resiliency were emphasized. Importantly, however, respondents also noted that any such interventions needed to be accompanied by appropriate organizational supports. A sample of comments is provided below:

It’s creating burnout among the frontline workers and we’re struggling with how to deal with our own sort of moral ethical conscience, and obviously, psychological health and safety. That kind of robust understanding’s super, super important...and that’s one of the training gaps What kind of resiliency provisions can we look at for individuals to make that transition and to be able to make it successfully if they choose to continue their career in the frontline? (focus group participant)

They want tools to allow them to help themselves and tools to help each other, so those tools were things like psychological first aid, understanding signs of trauma, that trauma-informed practice or care, and education. A lot of what we’ve been doing now with our education sessions is people going, ‘Oh now I get it, there’s nothing wrong with me, I can get better, I just, you know, I have vicarious trauma,’ so for a lot of them they don’t know what that is. (key informant interview)

Organizations need to recognize that when those soft skills diminish, that’s time for a change

for that person. You need to have supervisors who are hands-on saying, 'Look, you know what, do a great job. Let's take care of you now and kind of get you back somewhere where you can recharge your batteries.' (focus group participant)

SUMMARY AND CONCLUSIONS

The findings from this research revealed several ways in which stigma shows up on the front lines of the opioid crisis among first responders and health and social care providers in the context of harm reduction. Ambivalence about the benefits of harm reduction and negative attitudes about addiction, low belief in the possibility of wellness and associated feelings of feelings of helplessness, and experiences of provider burnout, compassion fatigue and vicarious trauma all emerged as key themes, which coalesced around a more central or core experience – the problem of low compassion satisfaction. Many of these themes, which were described as both feeding off and reinforcing stigmatization of people with opioid and other drug use problems, are consistent with existing research on the stigma of opioid and other drug use.¹⁸ Importantly, however, these findings also extend the literature, particularly in terms of the important connection between the concepts of compassion satisfaction and stigmatization.

The concept of compassion satisfaction is generally understood as professional fulfillment experienced through helping others.²⁴⁻²⁶ It occurs when empathy drives altruistic behaviour on the part of the provider in order to alleviate the suffering of those they are healing.²⁴ Compassion satisfaction also includes the experiences of hope and optimism, with a desire to continue in the caregiving role.²⁴ Indeed, burnout and compassion fatigue are both found to be correlated with low levels of compassion satisfaction, as are distancing behaviours.^{25,26} For example, a recent study on compassion satisfaction in UK emergency departments found that providers with low compassion satisfaction scores were more likely to report being irritable with patients, reducing their standards of care, and have less ability to maintain empathy for their patients.²⁶

This connection to quality of care was also found in our research. In as much as the respondents in our

study spoke of harm reduction work feeling demoralizing and described feelings of frustration, helplessness, and the sense that what they are doing wasn't really helping, they specifically connected these experiences directly to consequences for care – consequences such as social and emotional distancing, disconnection, and apathy. It was in this context that the call for inward-facing training and support for frontline providers was clearly identified, particularly initiatives that would support frontline providers in building resiliency, as well as cultivating, protecting and enhancing compassion and compassion satisfaction. Although more research is required, promising and proposed strategies include the use of social contact approaches to shift perceptions and build compassion, as well as training in trauma and resiliency-informed practice, as identified through this and other related research.^{18,27,28} More training in, and a better understanding of, harm reduction theory and best practice – particularly in terms of how harm reduction can support and can be an integral component of, of hope, wellness and a potential pathway to recovery – also merged as a key learning need. Equally as important, providers on the front-lines of the opioid crisis identified the value of social contact as a key stigma reduction strategy for improving attitudes, along with the need for interventions that would help them see and believe that wellness and recovery are both real and possible. Notably, these findings are consistent with research in best practices for combatting mental illness-related stigma in healthcare environments.^{29,31}

That stigma emerged in this study as first and foremost a problem of low compassion satisfaction is indeed noteworthy. It suggests that existing intervention frameworks that seek to address stigma as a problem of knowledge, attitudes, and behaviours (e.g.,³²) may be missing an important element, and that an important avenue for future research would be to develop and elaborate on the theoretical connections between the concepts of stigmatization and compassion satisfaction as a way to better understanding the problem of stigmatization in helping environments.

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