THE OPIOID CRISIS AND CONNECTICUT'S WORKFORCE

This white paper is the culmination of over a year's worth of work by a group of professionals committed to saving the lives and livelihoods of workers and families impacted by the tragedy of opioids and other substance abuse.

Updating Your Approach to Employees Suffering from Addiction Can Preserve Your Greatest Resource

FOREWORD

By David Messenger

As a person in recovery, it can be a very daunting task to re-enter the workforce. The stigma that surrounds addiction can be very negative and sometimes will prevent a person in recovery from even wanting to go through the hiring process. This document gives several recommendations regarding the tools that are needed by employers to properly navigate the complex world of workers dealing with addiction as well as those who are in recovery.

My personal experience within the workforce while in active addiction was one of shame and constant fear of being caught. I knew that if my employer found out that I was a drug-user, it would likely cost me my job. This is what ultimately led me to leave the workforce entirely for almost ten years. Once I left my job, my addiction spiraled completely out of control. This would lead me into treatment.

When I first left treatment I wanted to go back to work as soon as possible. I would eventually land a job with my current employer. To say that my experience was pleasantly surprising would be a great understatement. I was completely honest about both my past struggles with addiction and my plans moving forward. My new employer was absolutely in my corner and supportive beyond what I ever could have imagined. They took a very progressive stance when it came to my addiction. They treated me as a valued employee and never looked at me as a problem. This stance has led me to thrive at work. Based on this positive work experience, I will forever look upon this employer with the utmost respect and loyalty.

Addiction in the workplace is a topic that many have not wanted to examine in the past. This document not only addresses this extremely important topic but also provides recommendations for dealing with addicted workers in a way that benefits the employee as well as the bottom line. The costs to employers, workers, and families affected by addiction are staggering. If we are to end this debilitating crisis in workplaces and elsewhere, the days of just looking the other way have to end. As a person in recovery, this is a very exciting time. A document like this gives me hope.

At the end of the day, sometimes hope is all that someone needs.

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EXECUTIVE SUMMARY

***Thomas St. Louis**, MSPH; Occupational Health Program Supervisor, Connecticut Department of Public Health*

An estimated 21.7 million adults sought substance abuse treatment in 2015, according to the National Survey on Drug Use and Health. Many of those adults were workers struggling to maintain their employment status and livelihoods as a functional part of the workforce. Data from the National Safety Council reveal that, while 70% of employers report being impacted by prescription drug misuse, and just as many feel strongly about helping their employees return to work after substance abuse treatment, approximately 80% of employers lack a comprehensive drug-free workplace policy, and a similar percentage lack training on identifying substance abuse in their workplaces.

Substance use/abuse in the workplace costs Connecticut employers millions of dollars per year in lost productivity and days away from work, increased healthcare costs, human resources activities, and other resource expenditures. In addition, helping an employee or coworker maintain their work status in the face of substance abuse can increase workplace stress and severely impact morale. On March 1, 2017, the Connecticut Department of Public Health convened a symposium, *The Opioid Crisis and Connecticut's Workforce*, to educate employers about the development of opioid and other substance abuse issues, the current state of the opioid crisis in Connecticut, and treatment options and strategies for workers struggling with addiction. A second symposium, intended to build on the topics discussed at the previous meeting, was held on October 4, 2017. This discussion focused on the roles of employers, employees, insurers, and healthcare providers in the recognition, treatment, and recovery of workers suffering from addiction. More specifically, the Connecticut Department of Public Health sought to assist symposium attendees with developing a new set of best-practices for identifying workers engaged in or at risk for substance abuse, encouraging workers who need counseling or treatment to seek it, and providing the resources and support necessary to help employees overcome their illness and return to the vital role they play in the workplace.

This white paper is the culmination of over a year's worth of work by a group of professionals representing public and private employers, worker unions and their constituents, physical and mental healthcare providers, legal services, insurers, academic researchers, and state agencies. Though their professional credentials and scope of daily work is highly diverse, these dedicated professionals have a common interest in saving the lives and livelihoods of the workers and families in our state who are impacted by the tragedy of opioids and substance abuse.

HISTORICAL PERSPECTIVES ON SUBSTANCE ABUSE AND EMPLOYMENT

The Rise of Opiate Use and Abuse

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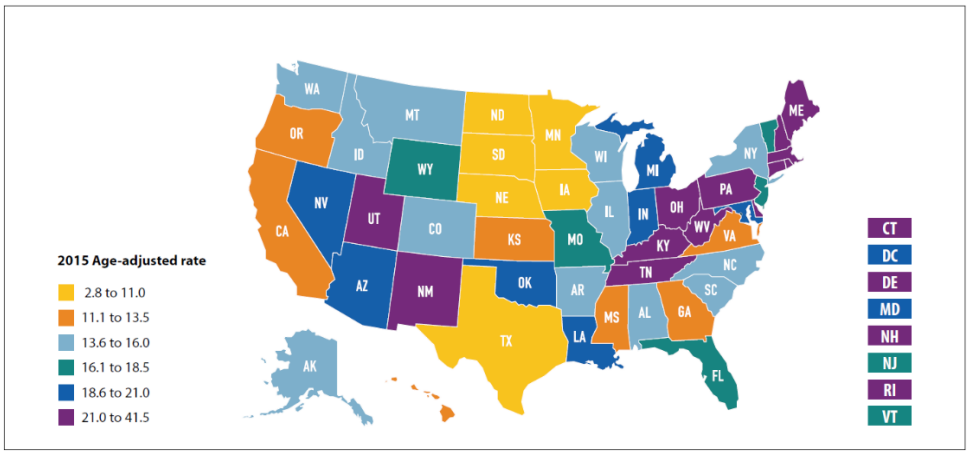
According to the Connecticut State Department of Public Health, Connecticut residents are more likely to die from an unintentional drug overdose than a motor vehicle accident, and the majority of these overdose deaths involve prescription opioids.[1] The national impact of overdose deaths in 2015 can be seen in the diagram below, with Connecticut falling into the highest tier of 21.0 to 41.5 per 100,000 population (Figure 1).[2]

Figure 1: Age-adjusted rates of drug overdose deaths by state — United States, 2015



Source: National Vital Statistics System, Mortality File, CDC WONDER.

Nationally, the majority of drug overdose deaths – 66% according to the CDC – involve an opioid.[3] Opioids in this context include not only illegal drugs such as heroin and illicit forms of fentanyl, but also prescription opioids such as OxyContin©, Opana ER©, Duragesic©, and others. The number of overdose deaths was five-times higher in 2016 than in 1999, as the sale of prescription opioids to pharmacies, hospitals and other licensed entities quadrupled.[3] In fact, 600,000 people died from overdose during this 16-year period. The impact of these deaths led Princeton economist Alan Krueger to conclude that the increase in prescriptions has resulted in a 20% decline in labor force participation by men during that same 16-year period (Figure 2).[4] When surveyed, 43.5% of prime-aged men (aged 25 to 54 years) *not in the workforce* reported having taken "pain medication yesterday" compared to 20.2% of prime-aged men in the workforce and 18.9% of unemployed men in this age group.

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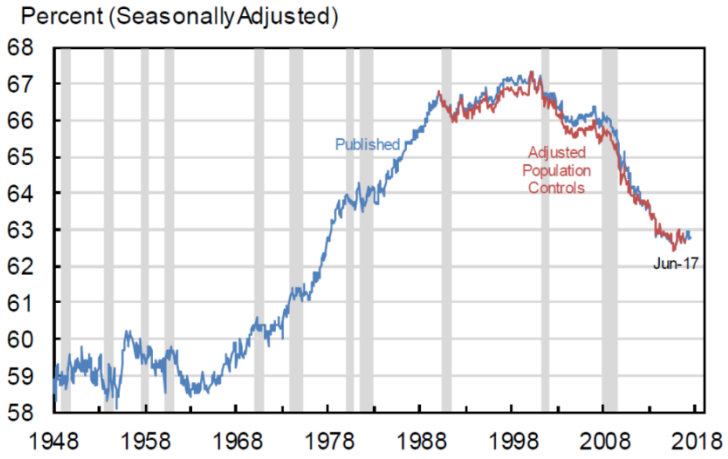
[1] http://portal.ct.gov/DPH/Health-Education-Management--Surviellance/The-Office-of-Injury-Prevention/Opioids-and-Prescription-Drug-Overdose-Prevention-Program

[2] Annual surveillance report of drug-related risks and outcomes, https://www.cdc.gov/drugoverdose/pdf/pubs/2017cdc-drug-surveillance-report.pdf

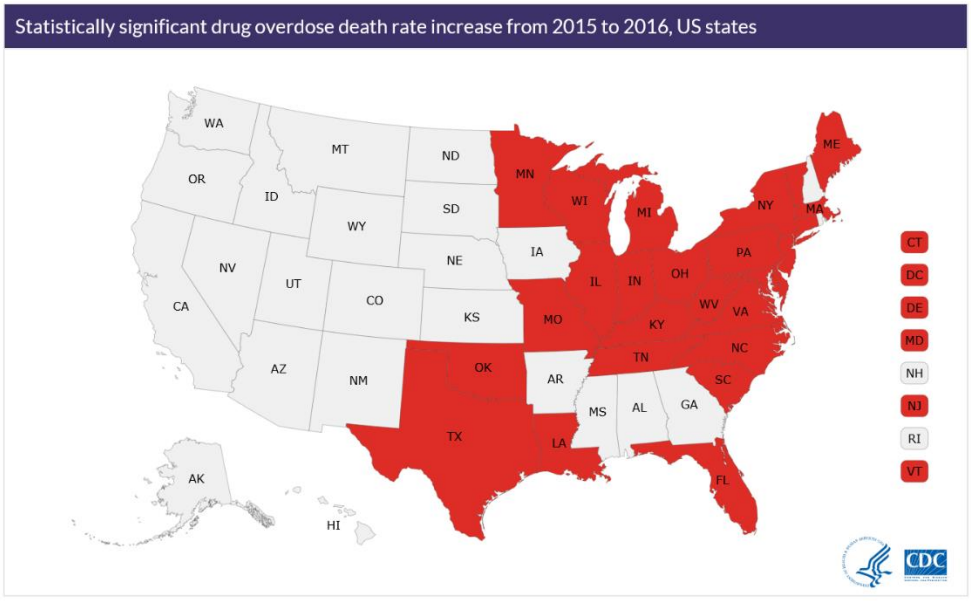
[3] https://www.cdc.gov/drugoverdose/epidemic/index.html

[4] https://www.brookings.edu/bpea-articles/where-have-all-the-workers-gone-an-inquiry-into-the-decline-of-the-u-s-labor-force-participation-rate/

Figure 2: Labor Force Participation Rate, United States, 1948-2018



Although opioid prescribing has declined at a rate of 4.9% annually from 2012 through 2016, prescribers still wrote 66.5 opioid prescriptions for every 100 individuals in the US in 2016. This decline has not necessarily equated to a decline in opioid-related overdose deaths. In fact, 26 states[5] – including Connecticut – saw a significant increase in drug-related deaths from 2015 to 2016:



Although various efforts are underway to limit the prescribing of opioids, it is important for policy makers to recognize that while these efforts are critical to solving the opioid crisis, they are not the absolute answer. As long as illicit drugs like heroin and illegal access to fentanyl are available, tightening the supply of prescription drugs may only drive addicts to use these street drugs. Any effort to curtail access must also be balanced with rehabilitation programs.

[5] https://www.cdc.gov/drugoverdose/data/statedeaths.html

Gaps in Pain Management Practice

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A number of significant gaps between medical evidence and observations regarding treatment of pain, mental health, and Substance Use Disorders (SUDs) exist that have contributed to the opioid epidemic. These involve all stakeholder areas, but some of the most significant include:

Medical Evidence: While Opioid Pain Relievers (OPRs) can provide short term treatment for acute, moderate to severe pain (e.g. acute injuries like fractures, post-surgical pain, etc.) and can play an important role in managing cancer-related pain, there is limited evidence of OPR efficacy for conditions like non-specific back pain and other non-cancer pain conditions. Studies have found equal efficacy of non-steroidal anti-inflammatory agents (NSAIDs) like naproxen to treat acute back pain vs. OPRs.[6] A study of work-related low back pain noted that only a minority of patients treated long-term with OPRs experience significant improvement in pain or function.[7] A literature review concluded that in addition to the lack of significant efficacy of OPR to treat back pain, perhaps 50% of patients cease OPR due to side effects.[8] Risk of opioid overdose and death increases with higher dose, especially beyond a daily dose of 50 morphine milligram equivalents (MME, an estimate to account for different relative potencies of various opioids), as well as other factors including medical comorbidities (e.g. sleep apnea, respiratory or neurologic diseases, etc.) and the use of sedative and hypnotic medications (including benzodiazepines), gabapentin or alcohol.[9,10,11,12]

Patient Gaps: While many patients express preference for non-medication treatment for physical pain, 22% prefer to take prescribed pain medications[13] despite literature evidence that non-medication options such as exercise are more effective to treat conditions like back pain with less risk. Of concern, 22% perceive OPRs to be very safe and 55% somewhat safe in contrast to evidence of side effects and risks including misuse, addiction and overdose. Many at-risk patients do not seek care, including an estimated 35% of individuals with mental health disorders. Reasons include social concerns, not

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[6] Friedman BW, Dym AA, Davitt M, et al. 2015. Naproxen With Cyclobenzaprine, Oxycodone/Acetaminophen, or Placebo for Treating Acute Low Back Pain: A Randomized Clinical Trial. JAMA;314(15):1572-80.

[7] Franklin GM, et al. 2009. Opioid use for chronic low back pain: A prospective, population-based study among injured workers in Washington State, 2002–2005. Clin J Pain 25:743–751.

[8] Abdel Shaheed C et al. 2016. Efficacy, tolerability, and dose-dependent effects of opioid analgesics for low back pain: A systematic review and meta-analysis, JAMA Internal Medicine; 176(7):958–68.

[9] Bohnert ASB, et al. 2011. Association between opioid prescribing patterns and opioid overdose-related deaths. JAMA 305:1315–1321.

[10] Dunn KM, et al. 2010. Opioid prescriptions for chronic pain and overdose: A cohort study. Ann Intern Med 152:85–92.

[11] Gomes T, Juurlink DN, Antoniou T, et al. 2017. Gabapentin, opioids, and the risk of opioid-related death: A population-based nested case–control study. PLoS Med; 14(10): e1002396.

[12] Jones CM and McAninch JK. 2015. Emergency Department Visits and Overdose Deaths From Combined Use of Opioids and Benzodiazepines. Am J Prev Med; 49(4):493-501.

[13] Gallup Americans Prefer Drug-Free Pain Management Over Opioids, 2017

wanting others to find out, job concerns, and others.[14] Additional barriers precluding treatment of mental health and SUDs include inability to access or afford care, fear, shame, discrimination, and a lack of screening and interventions in health care and the workplace.[15]

Opioid Prescribing Gaps: Despite the lack of evidence of efficacy of OPRs to treat back pain, and guideline recommendations to limit use, observational studies noted an increase in OPR prescriptions for back pain over a ten year period.[16] Similar trends have been observed with unsupported treatment of chronic back pain including OPR prescribing, injections and surgery in chronic settings.[17] Increased risk of long-term use of OPR has been observed in OPR naïve patients even with short-term prescriptions. For example, 6% of patients who received one day of OPR continued using OPR long-term; of those 13.5% continued $\geq$ 8 days and 29.9% continued $\geq$ 31 days.[18] Approximately 6% of patients remain on OPR long-term after minor elective surgery.[19] A review of post-operative OPR prescribing estimated that 60-90% of patients do not use all of their prescribed pills, with high rates of unsecured pills and failure to properly dispose of unused OPRs.[20] Another recently identified prescribing gap highlighted the observation that 28.5% of outpatient visits where opioids were prescribed did not include a diagnosis of a condition causing pain.[21] Patients with mental health issues and SUDs are at increased risk for OPR overdose, yet these patients are more likely to receive OPR and be prescribed high dose OPRs and sedatives.[22,23] Of great concern, over 90% of patients continue to receive OPR after non-fatal overdose.[24]

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[14] Hendiksson M. 2016. Words matter. Substance Abuse and Mental Health Services Administration. 16 May 2016. Accessed at http://blog.samhsa.gov/2016/05/16/words-matter/#.V-1NNPkrLbh on 16 February 2017

[15] Crowley R, Kirschner N, Dunn A, et al.2017. Health and Public Policy to Facilitate Effective Prevention and Treatment of Substance Use Disorders Involving Illicit and Prescription Drugs: An American College of Physicians Position Paper. Ann Intern Med.;166:733-736. doi:10.7326/M16-2953.

[16] Mafi JN, McCarthy EP, Davis RB, et al. Worsening trends in the management and treatment of back pain. JAMA Intern Med. 2013 Sep 23;173(17):1573-81. doi: 10.1001/jamainternmed.2013.8992

[17] Deyo RA, Mirza SK, Turner JA,et al. 2009. Overtreating chronic back pain: time to back off? J Am Board Fam Med.;22(1):62-8. doi: 10.3122/jabfm.2009.01.080102

[18] Shah A, Hayes CJ, Martin BC. 2017. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR 66(10): 265-69.

[19] Brummett CM, Waljee JF, Goesling J. et al. 2017. New Persistent Opioid Use After Minor and Major Surgical Procedures in US Adults. JAMA Surg;152(6):e170504. doi:10.1001/jamasurg.2017.0504

[20] Bicket MC, Long JJ, Pronovost PJ, et al. 2017. Prescription Opioid Analgesics Commonly Unused After Surgery A Systematic Review. JAMA Surg. doi:10.1001/jamasurg.2017.0831

[21] Sherry TB, Sabety A, and Maestas N. 2018. Documented Pain Diagnoses in Adults Prescribed Opioids: Results From the National Ambulatory Medical Care Survey, 2006–2015. Ann Intern Med; DOI: 10.7326/M18-0644.

[22] Morasco B, Duckart JP, Carr TP, et al. 2010. Clinical Characteristics of Veterans Prescribed High Doses of Opioid Medications for Chronic Non-Cancer Pain. Pain; 151(3): 625–632. doi:10.1016/j.pain.2010.08.002

[23] Seal KH, Shi Y, Cohen G, et al. 2012. Association of mental health disorders with prescription opioids and high-risk opioid use in US veterans of Iraq and Afghanistan. JAMA; 307(9): 940–7. doi:10.1001/jama.2012.234. Erratum in: JAMA. 2012 Jun 20;307(23):2489. PubMed PMID: 22396516.

[24] Larochelle M, Liebschutz J, Zhang F, et al. 2016. Opioid prescribing after nonfatal overdose and association with repeated overdose. Ann Intern Med 28 Dec 2016, doi:10.7326/M15-0038.

Pain, Mental Health and Substance Abuse Treatment Gaps: Treatment of pain often lacks evidence based support, does not fully involve patients in shared decision making, or track outcomes.[25] In 2014, more than 21 million Americans were in need of treatment for alcohol (15.7 million) or illicit drugs including opioids (7.7 million), but only 10-18% received care.[26,27] More than 40% of patients with SUDs have mental health conditions, but only 48% receive treatment for either condition. Medication assisted treatment (MAT) including methadone, buprenorphine-naloxone, and naltrexone has potential for misuse, overdose and diversion. However, MAT increases retention in substance abuse treatment; decreases criminal behavior, infectious diseases and transmission associated with shared needles; and helps return affected individuals to healthy and functional lives.[28] Relapse occurs in many chronic diseases, including SUDs, and relapse rates for SUDs are similar to conditions like diabetes or asthma.[29] However, relapse in substance abuse may not be treated with parity compared to these other medical conditions. Naloxone use has been demonstrated to decrease opioid overdose deaths. Barriers to use of Naloxone need to be overcome as well.[30]

Pharmaceutical Industry Gaps: Aggressive promotion, direct marketing to patients and misleading information to prescribers overstating benefits and downplaying safety issues were some of the key pharmaceutical industry drivers associated with escalating OPR prescribing.[31]

Employer Gaps: According to the National Safety Council, although 70% of employers feel that prescription drugs have impacted them, 76% do not offer training to identify misuse, 81% lack a comprehensive drug free workplace policy, and 41% who perform drug tests do not include synthetic opioids (and thus may miss a significant number of positive specimens).[32] A number of employers lack sufficient insurance benefits to cover non-opioid therapies leading to overuse of OPRs and others may lack sufficient coverage for mental health and/or substance abuse treatment.[33]

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[25] https://integration.samhsa.gov/clinical-practice/shared-decision-making

[26] Center for Behavioral Health Statistics and Quality. 2016. Results from the 2015 National Survey on Drug Use and Health: Detailed tables. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[27] Han B, Hedden SL, Lipari R, et al. 2015. Receipt of services for behavioral health problems: results from the 2014 National Survey on Drug Use and Health. NSDUH Data Review. Substance Abuse and Mental Health Services Administration. Accessed at www.samhsa.gov/data/sites/default/files/NSDUH-DR-FRR3 -2014/NSDUH-DR-FRR3-2014/NSDUH-DR-FRR3-2014.pdf on 16 February 2017.

[28] U.S. Department of Health and Human Services (HHS). 2016. Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health, Executive Summary. Washington, DC: HHS, November 2016.

[29] McLellan AT, Lewis DC, O'Brien CP, et al. 2000. Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. JAMA, 284(13), 1689-1695.

[30] Crowley R, Kirschner N, Dunn A, et al.2017. *Ibid.*

[31] Van Zee A. 2009. The Promotion and Marketing of OxyContin: Commercial Triumph, Public Health Tragedy. American Journal of Public Health. Vol 99, No. 2: 221

[32] Hersman D. 2017. How the Prescription Drug Crisis is Impacting American Employers. National Safety Council.

[33] https://www.cdcfoundation.org/businesspulse/opioid-overdose-epidemic-infographic

Costs of Addiction to Employers

***Brian Downs**, MBA; Vice President, Quality & Provider Relations, Workers' Compensation Trust*

The recent opioid crisis in the United States has been indiscriminate in its path of destruction. It has cut across all economic geographies, social strata, and industries. Its devastation is revealed in social costs, personal struggles and loss, disrupted and broken families, lost productivity and increased crime.[34] With such far-reaching impacts, it is not difficult to imagine the cascading impact it continues to have on U.S. employers.

The American Society of Addiction Medicine has estimated that opioid abuse cost employers approximately $10 billion in absenteeism and presenteeism alone.[35] The term presenteeism, which is often difficult to measure, generally refers to employees who are coming to work despite having a sickness that justifies an absence and, as a consequence, performing suboptimal work. Employees taking opioid medications might struggle with presenteeism because the medications can produce drowsiness and mental confusion, impairing attention, focus, creativity and reliability. This can have a significant impact on both quality of work and safety.

A national survey on drug use and health conducted in 2015 by the Substance Abuse and Mental Health Services Administration revealed that 75% of adults ages 18 to 64 with substance misuse disorders are active in the workforce.[36] If that statistic alone is not alarming enough for employers, a recent study found that there has been a steady decline in the U.S. labor force since 2007 especially among prime age working males. The study found that nearly half of this demographic group were not actively in the workforce as a result of taking ongoing long-term opioid pain medication.[37]

The facts are clear, the problems are real, and yet many employers still struggle with understanding the potential present and future impact on their organizations and those they employ who may be struggling with this insidious disease of addiction. Most employers understand how detrimental illegal drugs can be in the workplace, but few recognize the toll of the prescription opioid painkiller epidemic. Listed below are several significant ramifications that could directly impact the safety and financial security of employers who find themselves unknowingly confronted with this hidden epidemic within their workforce.

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[34] Substance Abuse and Mental Health Services Administration. Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, Maryland: Substance Abuse and Mental Health Services Administration, 2013.

[35] J. Fudin, (2015). "The Economics of Opioids: Abuse, REMs and Treatment benefits." Retrieved February 19, 2018 - www.ajmc.com/journals/supplement/2015/ace0029_aug_painrems?ace0029_aug15painrems_fudin.

[36] Center for Behavioral Health Statistics and Quality (CBHSQ), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS), and by RTI International, Research Triangle Park, North Carolina. Retrieved February 19, 2018 - www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf

[37] 4) A. Krueger, (2017). "Where Have All the Workers Gone? An Inquiry into the Decline of the U.S. Labor Force Participation Rate. "Retrieved February 19, 2018 -www.brookings.edu/content/uploads/2017/09/1_krueger.pdf

1) Opioid painkillers compromise employee safety. Even after an employee returns to work, they could still feel the effects of prescription painkillers. Although an employee may take a legitimately prescribed amount of painkillers, they may be too impaired to operate equipment, drive, or perform other job duties.[38]

2) Workers prescribed opioids have significantly higher workers' compensation claims. Workers prescribed even one opioid have four-times more expensive claim costs than workers with similar claims who weren't prescribed opioids.[39]

3) Using opioid painkillers increases the likelihood of long-term disability claims. Studies have shown that receiving more than a one-week supply of opioids soon after an injury doubles a worker's risk of disability one year later.[40]

4) Workers with substance abuse disorders miss nearly 50% more days than their peers, and up to six weeks of work annually.[41]

So what should employers do? A good starting point would be to develop an action plan to gain a better understanding of the impact of opioid use within their employee population. This initial step helps determine the focus and breadth of a communications campaign in identifying the resources and programs needed to assist in prevention and treatment efforts. Employers should look at whether certain data points such as workers' compensation injury rates, particular demographics, or employee occupational groupings where higher than typical use of opioid medications are identified. Employers in industries such as construction, entertainment, recreation and food service should be particularly aware that those employed in these industries have twice the national average number of substance abuse disorders.[42]

All employers must recognize that the opioid epidemic is here and that no industry, level of education, professional credential or pay grade is immune to it. Moreover, those responsible for monitoring this epidemic agree that it is not going away anytime soon. Odds are that people struggling with opioid dependence or addiction are silently struggling on the job. As employers, the time is now to offer assistance to those who are struggling, and provide company-wide education and risk reduction efforts to protect the health and well-being of their employees as well as protect the financial well-being of the organization itself in addressing this issue head on and in a proactive manner.

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[38] White JA, Tao X, Tairefa M, Tower J, Bernacki E, _eE_ect of Opioid Use on Workers' Compensation Claim Cost in the State of Michigan (August 2012) Journal of Occupational Environmental Medicine Vol. 54, Issue 8.

[39] *Ibid.*

[40] Franklin, G., Stover, B., Turner, J., Fulton-Kehoe, D., & Wickizer, T. (2008). Disability Risk Identification Study Cohort. Early opioid prescription and subsequent disability among workers with back injuries: the Disability Risk Identification Study Cohort. Spine, 199-204.

[41] National Safety Council. "Drugs At Work- What Employers Need to Know." Retrieved February 19, 2018 - www.nsc.org/learn/NSC-Initiatives/Pages/prescription-painkillers-for-employers.aspx.

[42] U.S. Department of Health and Human Services. Results from the 2007 National Survey on Drug Use and Health: national findings. Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies; 2008. NSDUH Series H-34, DHHS Publication No. SMA 08-4343.

Drug-free Workplace and "Zero-tolerance" Policies: Challenges and Barriers in the Opioid Age

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The concepts of the drug-free workplace and zero-tolerance policy have roots in the military and federal government.[43] During the Vietnam War, a high percentage of returning service members used or were addicted to illegal drugs, including heroin. The military drug-tested these soldiers and referred those with positive drug tests for treatment. Service members tended not to face punitive action because the goals were treatment, rehabilitation, and retention. However with this approach, illegal drug use among service members remained high, ranging from 27-38% in some units.

On May 26, 1981, an aircraft crashed aboard the USS Nimitz, an American aircraft carrier and one of the largest war ships in the world. The accident killed 14 service members and injured 48, resulting in an estimated cost of $150 million. Illegal drug use by service members was found to have been a contributing factor to the disaster and began to be viewed as a discipline problem rather than an addiction problem. Afterwards, the Department of Defense instituted a zero-tolerance policy and authorized punitive actions including court martial and discharge to be used against service members who failed drug tests.

The military's new zero tolerance policy occurred within the larger political context of the launch of the new Presidential "War on Drugs"[44], where drugs were criminalized and punitive measures against drug users were emphasized, with drug users frequently incarcerated. By 1985, illegal drug use among service members had dropped to 8.9%.[45] In 1986, the Reagan Administration expanded the drug-free workplace and zero-tolerance policy to the entire federal government civilian workforce through Executive Order 12564.[46] As justifications for the policy, the Administration cited the billions of dollars of lost productivity in the American workplace caused by illegal drug use as well as the risks federal employees who used illegal drugs posed "to national security, the public safety, and the effective enforcement of the law." Ultimately, it was their intent that this drug-free workplace concept and zero-tolerance policy for the federal government, the largest employer in the nation, would serve as a model drug policy for all U.S. employers.

In 1988, Congress expanded the drug-free workplace concept and zero-tolerance policy into the private sector by passing the Drug-Free Workplace Act, requiring companies who wanted to contract with the federal government to establish a drug-free workplace policy and make "good faith" efforts to maintain a drug-free work place.[47] The Act, still in effect today, requires employers to penalize their employees

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[43] United States Department of Defense, Military Drug Program Historical Timeline http://prhome.defense.gov/Portals/52/Documents/RFM/Readiness/DDRP/docs/72208/DoD%20Drug%20Policy%20History.pdf – accessed 12/23/17

[44] Dufton, Emily (March 26, 2012). "The War on Drugs: How President Nixon Tied Addiction to Crime". *The Atlantic*.

[45] United States Department of Defense, *ibid.*

[46] Federal Register, Executive Order 12564 (1986) - Drug-Free Federal Workplace, https://www.archives.gov/federal-register/codification/executive-order/12564.html – accessed 1/8/18

[47] The Drug-Free Workplace Act of 1988 (41 U.S.C. 81) http://uscode.house.gov/view.xhtml?req=(title:41%20chapter:81%20edition:prelim)%20] – accessed 12/20/17

for drug abuse violations and notify employees of the penalties they will receive.[48] For employers who do not meet the government's drug-free workplace standards, the Act permits harsh consequences including suspension of payments on a contract, termination of the contract and debarment, meaning the employer would be ineligible to contract with a federal agency for up to 5 years.[49] It was under the blanket of this directive that companies in the private sector followed suit and voluntarily established drug-free workplaces with zero-tolerance policies, often in conjunction with drug testing programs. Current policies established by private sector companies often reflect the zero-tolerance and punishment-oriented policies established by the military and federal government.

Viewed from the perspective of drug use and addiction as a personal choice to engage in illegal acts rather than a disease, traditional drug-free workplace and zero-tolerance drug policies can act as significant barriers to employees coming forward to get help with overcoming addiction. As an example, imagine a high-performing employee who has a 20-year tenure with a company who experiences a back injury, is prescribed opioids for pain by their doctor, and subsequently develops an opioid addiction disorder. Consider what this employee will think as they read a drug-free workplace policy. More importantly, consider what someone with a substance abuse issue is most likely to do after they read a policy. When employees see the usual language of a traditional workplace drug policy, they often see phrases like "zero-tolerance," and "will lead to discipline or termination". In these cases, employees struggling with substance abuse may not take the risk of coming forward to seek help for fear of losing their job or professional status.[50]

Companies often use the term zero-tolerance in conjunction with undesirable behavior or criminal, violent activity such as sexual harassment, racial discrimination, and workplace violence. To an employee struggling with addiction, it may seem as if the employer and coworkers will view them as a criminal rather than a valued employee with a chronic condition. As such, they may not come forward for fear of stigmatization.[51]

An additional incentive for employers to reassess drug policies which are zero-tolerance oriented is the fact that these drug policies might be legally challenged in the future.[52] The legalization of medical marijuana has taken place in several states, including Connecticut, and most states provide protections for employees who use medical marijuana outside the workplace. Moving forward, employers will need to navigate and course-correct in a rapidly changing legal landscape.

In developing new drug policies, employers may want to consider the unique features of the opioid epidemic in contrast to past drug epidemics. Rather than addiction to illegal drugs, individuals with

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[48] Drug-Free Workplace Act of 1988, 41 U.S.C.§ 8102(a)(1)(B)(iv)
[49] Drug-Free Workplace Act of 1988, 41 U.S.C. §8102 (b)(3)
[50] A Painful Epidemic, Julie Cook Ramirez, June 5, 2017
http://www.hreonline.com/HRE/view/story.jhtml?id=534362500 – accessed 12/6/17
[51] Prescription Drug Monitoring Programs: Critical Elements of State Legislation, Shatterproof, March 2016
[52] "Viewpoint: Zero-Tolerance Policies May Need to Be Trashed," Sue Stott, Esq. and Lauren Kulpa, Esq. Apr 25, 2016

opioid addictions are often addicted to legal painkillers that have been prescribed by a physician, often after workplace injuries, a surgery, or a chronic medical condition. Moreover, 60% of people with a prescription opioid addiction disorder are employed.[53] In applying traditional zero-tolerance policies, employers may not only lose good, loyal frontline employees, they may also lose management employees and even executives.[54]

While reassessing their drug policies, employers may want to consider developing policy and language that encourages employees to come forward for help when they are experiencing issues with addiction rather than keeping the issue of employee addiction underground. Traditional drug policies that are punitive in nature reflect an old understanding of addiction as a moral failing rather than a disease. This traditional point of view may act as a barrier to employees seeking help with their addiction from their employer. Drug policies that reflect a current, science-based understanding of addiction as a disease and which communicate empathy and compassion can act as encouragement to employees with substance use disorders to come forward for help.

Policies include not only the employer's written policy but what employees perceive through company culture, leadership messaging and how the employer engages with addicted employees. An inquiry as simple as: "Is work going ok? You seem a little fatigued. Is there anything I can do to help?" from a supervisor or a Human Resources representative to a struggling employee can make the difference between an employee coming forward or keeping their disease hidden.[55] Employers themselves say policy changes are compassionate, but they admit they are also motivated by productivity and profit.[56] There are costs, risks and liabilities of keeping the issue of addicted employees underground in the workplace including reduced productivity, increased absenteeism, risk of injury to themselves and others, as well as increased workers' compensation, disability, medical, and legal costs associated with employee overdoses and deaths.

Many large employers, such as Google, Gap, Inc., and CVS Health have moved away from zero-tolerance language in their workplace substance use policies, and frame their policies in the broader context of the safety of their employees, contractors, vendors, and customers.[57-59] If employers are to retain a healthy and stable workforce, they must consider developing new drug policies that engage addicted employees and embrace the current, science-based understanding of addiction as a disease.

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[53] A Substance Use Cost Calculator For Employers Methodology, Eric Goplerud, Vice President Public Health Department NORC at the University of Chicago

[54] A Painful Epidemic, Julie Cook Ramirez, June 5, 2017

[55] Combatting the Prescription Drug Crisis, Dori Meinert 10/13/17

[56] Employers Shift Focus to Treatment for Workers Struggling with Addiction, Amy Coveno, 12/7/17

[57] Google, Inc., 2017 Code of Conduct, https://abc.xyz/investor/other/google-code-of-conduct.html - accessed 1/8/18

[58] Gap, Inc. 2016 Code of Conduct, http://www.gapinc.com/content/dam/gapincsite/documents/COBC/COBC_english.pdf - accessed 1/8/18

[59] CVS Health, 2017 Code of Conduct, https://cvshealth.com/sites/default/files/cvs-health-code-of-conduct.pdf - accessed 1/8/18

A NEW APPROACH TO ADDICTION IN THE WORKPLACE: 5 Key Principles for Employers

As is clear in the information presented above, substance use and abuse is increasing at a drastic rate in the US; much of this increase has been and continues to be fueled by the prescribing and use/misuse of prescription opioid medications. It is also clear that the potential effects on the health and stability of the workforce could be significant. Employers' past and current use of punitive measures as a method for preventing substance abuse by employees and contractors, such as "drug-free workplace" and "zero-tolerance" policies, can ultimately exacerbate worker addiction issues by villainizing this disease state and encouraging the drug-addicted worker to keep their condition hidden rather than seeking much needed help. Below, we outline five key principles to change the culture in US workplaces as it pertains to addiction, from one of punitive judgment to one of encouragement and support.

1. Early Identification

***Declan Barry**, PhD; Director of Pain Treatment Services, APT Foundation, Yale University School of Medicine*

Abuse of licit (e.g., nicotine) and illicit substances (e.g., cocaine) costs Americans more than $700 billion annually from lost productivity, health care costs, and crime.[60,61] While members of the general public often conceptualize addiction or substance use disorders (SUDs) as an absence of willpower or a personality flaw, these views are not supported by scientific research. Instead, addiction is a chronic, relapsing medical condition that is characterized by compulsive drug-seeking despite negative consequences.[62] Imaging studies of people with SUDs have shown that brain areas central to job performance, such as judgment, learning, decision making, and behavior control, are altered.[63,64] Among the estimated 29 million people with SUDs globally, only 14% have accessed treatment.[65] This is highly problematic, since SUDs often do not resolve without treatment. Prevention efforts targeting SUDs may be primary (e.g., prevent an employee from using illicit substances by providing psychoeducation regarding risk), secondary (e.g., identify an employee with subthreshold substance abuse problems and intervene so that a full-blown SUD does not emerge), or tertiary (e.g., assist an employee in treatment for SUD to not relapse). In this section, we focus on opioid use disorder given that the US is currently in the midst of an opioid epidemic.

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[60] National Drug Intelligence Center. The Economic Impact of Illicit Drug Use on American Society. Washington DC: United States Department of Justice. 2011.

[61] Rehm J, Mathers C, Popova S, Thavorncharoensap M, Teerawattananon Y, Patra J. Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. The Lancet. 2009;373(9682):2223-2233

[62] McLellan AT, Lewis DC, O'Brien CP, Kleber HD. Drug dependence, a chronic medical illness. JAMA. 2000; 284(13):1689-1695

[63] Fowler JS, Volkow ND, Kassed CA, Chang L. Imaging the addicted human brain. Science & practice perspectives. 2007; 3(2):4-16.

[64] Volkow ND, Fowler JS, Wang G-J. The addicted human brain: insights from imaging studies. The Journal of clinical investigation. 2003; 111(10):1444-1451

[65] United Nations Office on Drugs and Crime. World Drug Report 2016 (United Nations publication, Sales No. E.16.XI.7). Accessed on October 16, 2017 at: http://www.unodc.org/doc/wdr2016/WORLD_DRUG_REPORT_2016_web.pdf.

Many adults who use illicit substances are employed.[66] Employees who use substances are more likely than those who do not to be absent or late for work, be less productive, change jobs frequently, be involved in a workplace accident, and file for workers' compensation. Many employers in the U.S. have implemented drug-free workplaces (e.g., federal government), resulting in decreased rates of absenteeism, work accidents, and turnover.[67] Additionally, employers with drug-free workplace policies may qualify for decreased workers' compensation and other incentives.[68] However, linking employees with SUDs to appropriate treatment is a less stigmatizing alternative, which may ultimately benefit employees, employers, and society.

Common strategies for early detection of SUDs include: a) drug testing, where specimens are collected via urine, saliva, hair, or sweat and tested for commonly used drugs such as opioids, cannabis, or amphetamines (in the case of alcohol, breathalyzer tests are more commonly used), and b) screening or survey instruments. Traditionally, workplaces in the U.S. have relied on drug testing to detect substance use. However, the Substance Abuse and Mental Health Services Administration (SAMHSA) recently established the Preventing Prescription Abuse in the Workplace (PAW) program to develop occupation-specific screening instruments and to provide workplaces assistance to reduce nonmedical opioid use. Screening instruments with demonstrated reliability and validity include the 10-item Alcohol Use Disorders Identification Test (AUDIT)[69]; the 8-item Alcohol, Smoking and Substance Involvement Screening Test (ASSIST); and the 8-item NIDA Modified ASSIST (NM ASSIST).[70] Since most people with SUDs do not seek specialty treatment but may use primary care services, many primary care clinics have implemented universal addiction screening. Given the large number of people in the U.S. who have been prescribed opioids for the management of chronic pain, a 5-item screening instrument with established psychometric properties called the Opioid Risk Tool (ORT)[71] is often used by medical providers prior to initiating treatment to identify patients at risk for nonmedical or prescription opioid use or opioid use disorder.

In recent years, a public health approach called SBIRT (Screen, Brief Intervention, Refer to Treatment) has been successfully applied in primary care, emergency departments, and other healthcare settings to

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[66] Substance Abuse and Mental Health Services Administration. Results from the 2015 national survey on drug use and health: Detailed tables. https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.pdf. Published September 8, 2016. Accessed February 17, 2018.

[67] Substance Abuse and Mental Health Services Administration. Making Your Workplace Drug-Free: A Kit for Employers. http://store.samhsa.gov/product/Making-Your-Workplace-Drug-Free/SMA07-4230. Published January 1, 2007. Accessed February 17, 2018.

[68] Substance Abuse and Mental Health Services Administration. 14 Short Employer Cost Savings Brief. http://store.samhsa.gov/product/Making-Your-Workplace-Drug-Free/SMA07-4230. Published January 1, 2007. Accessed February 17, 2018.

[69] Saunders JB, Aasland OG, Babor TF, De la Fuente JR, Grant M. Development of the alcohol use disorders identification test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption-II. Addiction. 1993; 88(6):791-804.

[70] WHO ASSIST Working Group. The alcohol, smoking and substance involvement screening test (ASSIST): development, reliability and feasibility. Addiction. 2002; 97(9):1183-1194.

[71] Webster LR, Webster RM. Predicting aberrant behaviors in opioid-treated patients: preliminary validation of the Opioid Risk Tool. Pain Med. 2005; 6(6):432-442.

identify and intervene with individuals who have risky levels of substance use or SUDs. Early detection and intervention can avert the considerable health, psychiatric, and safety problems that frequently accompany addiction.[72] The U.S. Preventive Services Task Force graded SBIRT for alcohol use (one of the most common clinical targets of this approach) a 'B' (the same rating it awarded influenza vaccination).[73] Using a SBIRT approach, tools like the AUDIT and ORT can be used to assess level of risk and determine the appropriate level of intervention. Augmenting problem awareness and increasing intrinsic motivation toward behavior change often comprise the foci of the brief intervention, while individuals requiring more treatment can be referred to specialty care. Evidence-based interventions for opioid use disorder called medication-assisted treatment (MAT) combine psychosocial interventions with FDA-approved medications such as methadone (opioid agonist), buprenorphine (partial opioid agonist) or injectable naltrexone (opioid antagonist), and form a crucial public health strategy in confronting the opioid epidemic.[74-77]

2. Instant Support

***Melissa Monroe**, LPC; Clinical Director, Rushford*

There are many faces of addiction as it does not discriminate. Addiction, once thought of as an inner-city problem, is a national crisis that impacts every demographic, gender, race, and socioeconomic class. There is no community that is immune to the effects of addiction. In this growing opioid crisis we are starting to also see our working professionals and employers being more directly impacted. Employers who are willing to acknowledge and address the opioid epidemic and other substance use disorders are more likely to retain their employees, increase productivity, and be recognized for having a positive company culture.

Addiction is defined as a disease by most medical associations, including the American Medical Association and the American Society of Addiction Medicine. Like diabetes, cancer and heart disease, addiction is caused by a combination of behavioral, environmental and biological factors. Genetic risk factors account for about half of the likelihood that an individual will develop addiction.[78] Even though addiction is recognized as a chronic disease, there is still a significant negative stigma attached to those

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[72] Babor TF, McRee BG, Kassebaum PA, Grimaldi PL, Ahmed K, Bray J. Screening, Brief Intervention, and Referral to Treatment (SBIRT) toward a public health approach to the management of substance abuse. Subst Abus. 2007; 28(3):7-30.

[73] Force USPST. Final Recommendation Statement: Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care. May 2013. https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care. Accessed on February 19, 2018.

[74] Kolodny A, Courtwright DT, Hwang CS, et al. The prescription opioid and heroin crisis: a public health approach to an epidemic of addiction. Annu. Rev. Public Health. 2015; 36:559-574.

[75] Volkow ND, Frieden TR, Hyde PS, Cha SS. Medication-assisted therapies—tackling the opioid-overdose epidemic. N. Engl. J. Med. 2014; 370(22):2063-2066.

[76] Murthy VH. Ending the opioid epidemic—A call to action. N. Engl. J. Med. 2016; DOI: 10.1056/NEJMp1612578.

[77] Crowley R, Kirschner N, Dunn AS, Bornstein SS. Health and public policy to facilitate effective prevention and treatment of substance use disorders involving illicit and prescription drugs: an American College of Physicians position paper Ann. Intern. Med. 2017; doi:10.7326/M16-2953.

[78] Columbia. (2012) Addiction Medicine: Closing the gap between science and practice. Center on Addiction.

who are impacted by this disease, which can be a cause of discrimination in the workplace. A person who experiences stigma based on their health issues can be seen as "less than" or incapable of completing their work duties. Those who feel impacted by stigma are less likely to seek treatment. Therefore, an employee who is suffering from addiction may find it more challenging to approach their employer about what they are going through based on a history of stigmatization.

Organizational involvement is critical to help our communities address the opioid crisis. Employers need to ensure that they are treating substance abuse as a disease and discouraging stereotype terms such as "addicts, druggies" in the workplace. Employers should consider working closely with Employee Assistance Programs (EAPs) or their own Human Resources departments for additional guidance in supporting employees who are asking for assistance in finding treatment. If applicable, all managers should be trained to know how to address staff with potential addiction abuse or misuse. Employers may even consider having visible educational materials on mental health and substance abuse in the workplace either in their Human Resources offices, as part of an employee handbook, or visible in a communal area (such as a break room).

The more open an employer is about accepting addiction as a disease, the more likely an employee will feel more comfortable seeking help. There are also opportunities to work with local treatment agencies to have a forum on these topics and demonstrate openness and willingness to help an employee or even employee's loved ones with a substance use disorder. Training supervisors and managers to spot the first signs of drug misuse and scheduling routine check-ups with employees will help enhance rapport and staff engagement. Enacting strong company drug policies that are clear, specific and allow for an open door policy (unlike punitive "zero-tolerance" policies) and ensuring employee confidentiality may also help increase the likelihood that employees will feel supported and that they will not be discriminated against for their addiction.

There are many ways in which employers can create a drug-free work environment that is not strictly punitive. Employers can educate themselves and employees on not only identifying the signs and symptoms of alcohol and drug use; but also, the necessary steps to take when one suspects that a coworker may need help. Through education and clear drug-free workplace policies, employers can aim to increase awareness and clarify expectations.[79] Lastly, employers should exercise best practices around managing and treating employees with empathy. Treatment for addiction, facilitated within or by the workplace, has been shown to be successful in increasing employees' legal, mental, and social functioning, as well as decreasing absenteeism rates, workplace conflict, and productivity problems upon return from treatment. Addiction is a chronic and relapsing disease, but individuals can achieve long term sobriety, allowing them to live a healthy, meaningful and productive life. Employers can help break the stigma of addiction and provide education and support to their employees who need help, and in doing so, employers can save lives.

[79] Kelly. (2017) Working on Addiction in the Workplace. Harvard Health Publishing, Harvard Medical School.

3. Employer Flexibility

***Tom Matthews**, MA, CEAP, CPP; Director, Solutions EAP and **Marlene Kurban**; Kurban Consulting*

While some employees with a substance use disorder may need to take a leave of absence for detoxification and treatment, many treatment programs are designed to let individuals continue working. For employees in recovery, the job is often a lifeline providing not only a paycheck but daily structure, a sense of purpose and identity, stability, and social support. The employer's intervention may have even been the catalyst for the employee to get help.

Keeping valued employees on the job has benefits for employers as well. First, it makes good business sense. The costs of recruiting and training a new employee can be significant, and there are no guarantees that a new hire will be a better choice. Second, employees who feel valued and appreciated by their leaders are likely to be more engaged, loyal, and willing to go the extra mile for the organization. Third, employers who demonstrate compassion and concern for employees' well-being generate good will internally and externally. An organization that has a reputation for caring about its employees has a competitive edge when it comes to employee recruitment and retention.

However, one of the challenges employees may face, especially while in treatment or early recovery, is balancing the demands and responsibilities of work with self-care. For example, employees may request flexibility in their work schedule to attend medical appointments, or treatment or support groups. There may be a temporary need for light duty, non-hazardous work, or other modifications. Employers can address these needs as they would with employees who have other health-related conditions and in accordance with their personnel policies and collective bargaining agreements, if applicable. In addition, if the employer has an Employee Assistance Program (EAP), they can consult with their EAP for guidance. The EAP can help manage referrals and monitor the individual's progress.

It is important to note that an employer's actions regarding employees who are recovering from a substance use disorder may also be subject to state and federal laws and regulations, including the Family and Medical Leave Act (FMLA)[80] and the Americans with Disabilities Act (ADA)[81]. In addition, employees in certain safety-sensitive positions are subject to the rules of the U.S. Department of Transportation, which has its own return-to-duty process and procedures that the employer and employee must follow.

The **Job Accommodation Network (JAN)**, a service provided by the U.S. Department of Labor's Office of Disability Employment Policy, provides free, expert, confidential guidance to employers regarding workplace accommodations and disability employment issues, including drug addiction.[82] Employers of all sizes, including government agencies, can contact JAN for assistance by telephone or via electronic communication.

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[80] Family and Medical Leave Act (1993); 29 U.S.C. § 2601.
[81] Americans with Disabilities Act (1990); 42 U.S.C. § 12101.
[82] Job Accommodation Network. (2013) Accommodation and Compliance Series: Employees with Drug Addiction. Retrieved from https://askjan.org/media/drugadd.html

JAN provides a list of questions on limitations and possible accommodations for employers to consider:

1. What limitations is the employee with drug addiction experiencing?

2. How do these limitations affect the employee and the employee's job performance?

3. What specific job tasks are problematic as a result of these limitations?

4. What accommodations are available to reduce or eliminate these problems? Are all possible resources being used to determine possible accommodations?

5. Has the employee with drug addiction been consulted regarding possible accommodations?

6. Once accommodations are in place, would it be useful to meet with the employee with drug addiction to evaluate the effectiveness of the accommodations and to determine whether additional accommodations are needed?

7. Do supervisory personnel and employees need training regarding drug addiction?

Depending on the employee's needs and the employer's policies, possible solutions may include the use of paid or unpaid leave for treatment, counseling and attendance at support meetings, a modified daily schedule, temporary reassignment to a less stressful job, flexible use of leave time, or the ability to work from home. Making reasonable accommodations does not prevent an employer from addressing poor job performance, as some employers fear. Employers can hold employees with a substance use disorder to the same performance standards that apply to other employees.

4. Regular Review

***Andrea Becker-Abbott**, CADC, SAP, LAP and **Gerard Marcil**, LADC, LAP-C, CEAP, Managing Partners of CCW-EAP & Connecticut Counseling & Wellness*

Addiction is a disability that requires simple, but consistent accommodations. Due to the chronic nature of addiction, and the necessity of external motivation during the early stages of recovery, regular review of an employee's recovery progress by his or her supervisor(s) should be conducted in an atmosphere of positive reinforcement. Employer and peer-based supports are established through careful planning. Volunteers are obtained to assist the employee with successful workplace re-entry. Effective methods for soliciting workplace volunteers may include promotional emails, flyers, written invitation, or supervisor referral.

The primary task of the recovery accommodation review is to support and encourage the employee's adherence to his or her Recovery Accommodation Plan (RAP). Feedback regarding the employee's recovery progress excludes references to overall job performance, and should not be construed as a stressful job performance review. Regular review is not to be regarded as an afterthought. The RAP process commences upon an employee entering treatment for a Substance Use Disorder. The returning employee may be encouraged to sign a release of information. Doing so will enable those involved in his or her RAP to verify the employee's compliance with treatment recommendations.

1. A Recovery Accommodation Plan is initiated when an employee enters treatment, discloses an interest in recovery support services, or when a supervisor is informed of an employee's early recovery status.

2. The RAP begins by educating the recovery team with information concerning addiction and the recovery process. This education will include recovery-sensitive language (suitable vs. offensive terminology), the stages of change model, and motivational interviewing skills. Additionally, specialized training with respect to reasonable suspicion will provide team members with the necessary skills to identify and address relapse warning signals. Objective and consistent identifiers are documented, and the RAP is amended as is indicated.

3. Once the basic plan is established, an individualized RAP is documented. It is recommended that the RAP meeting occurs before the employee returns to duty. This meeting takes into consideration clinical recommendations to personalize a return to work RAP. Both the employee and recovery support team review and sign the RAP agreement. The employee should be informed that he or she is expected to follow any accommodations that have been agreed upon. Strict adherence to the RAP protocol will enable all involved parties to measure the effectiveness of the plan.

4. Drug screening is a well-established deterrent to relapse.[83] Independent of customary drug screening protocol, the employee agrees to additional screening upon request. Compliance with this provision of the plan is explicitly communicated to the employee and is indicated explicitly in the RAP.

5. The employee is provided with a list of available peer and community supports and is encouraged to participate in related self-help support groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Al-Anon, and similar resources.

6. The RAP team meets at regular intervals, which at first are daily, then weekly, and eventually monthly. The plan can be reviewed and adjusted as is deemed necessary.

7. Unless the employee requires an extension, he or she is permitted to transition to a pe er-based support plan after six months of abstinence.

[83] Carpenter CS. (2007) Workplace drug testing and worker drug use. Health Services Research 42(2):795-810.

The employer may note that addiction is a disease, and treatment, followed by a prompt return to work, is cost-effective in comparison to the prospect of replacing the employee. Addiction is a disability which, in the absence of a reliable and effective RAP protocol, may result in a significant loss of productivity. According to Dr. James Quayle, the Medical Director of more than 60,000 employees at Kimberly-Clark over a 20-year period, recovering employees typically return to work and perform significantly better than their non-recovery counterparts.[84] The effectiveness of regular review is optimized when the RAP is executed correctly, monitored closely and becomes an established component of company policy.

5. Enlisting Success

***Kyle Zimmer**, LAP-C; Health & Safety/Member Assistance Director, International Union of Operating Engineers, Local 478 and **Jody DeCarolis**; Site Safety Manager, Dimeo Construction*

The International Union of Operating Engineers (IUOE) Local 478 Members Assistance Program (MAP) is an innovative tool to assist in tackling the current opioid crisis and help members who are struggling with lifestyle issues.[85] The MAP trains staff, union members and contractors as peer counselors to help members and their families who are in need of assistance. The objective of the MAP is to get members back to work, after completing treatment programs or other recovery options and devising a plan to follow up with them on a frequent basis. IUOE Local 478 has nearly 250 signatory contractors, many of which have taken an interest in MAP and have looked into further training to instill the program on their job sites. Many employees are trained with the skills to notice if there is something not right in a person

[84] https://www.hazelden.org/web/public/ade40405.page
[85] https://local478.org/training_and_licensing/community_outreach/page.php

that they work with on a daily basis, and know the proper ways to approach them, or to get them help. Many times, other members don't have to approach the struggling member, as the environment created at Local 478 is a stigma-free environment that encourages members to feel comfortable seeking help. MAP is discussed frequently at monthly union meetings, and also at other events. It is a key component to safety in many situations, because if a member on a job is using substances, or going through something at home that is emotionally impacting them, their job can be compromised. This can put them personally, and those around them, at risk.

When substance abuse is involved, the biggest priority is to get the member healthy and in recovery. The second biggest priority is to get them back to work. Local 478's Operating Engineers are trained at a state-of-the-art training school, and they go through many years of training to become experts. The contractors recognize the expense and time that goes into each of these Operators and they do not want to lose these highly-skilled workers. When the MAP program is properly implemented, it is not uncommon to get members back to work with the company they left when they entered the path of recovery.

Another priority of Local 478 is follow-up. The union reaches out to the member and recommends avenues to take on their journey of recovery. As of last year, the union started hosting a group that covers substance abuse education and allows for a check-in and personal stories. The group has become an outlet for many people in recovery. It has been very successful and has grown since its inception. The union recognizes that recovery is not easy and that sometimes its members will have to enter treatment a few times before they make a change. As long as the worker in recovery is honest and remains willing to work with the union, Local 478 will continue fighting the battle of addiction alongside their members.

One of the contractors working with Local 478, Dimeo Construction, has successfully implemented MAP into their everyday work routine. Dimeo embraces the program, and their management has led by example, by taking the lead when they notice someone on the job site is having a difficult day. Dimeo is completely invested in MAP, and in turn so are their employees.

After members enter recovery, many of them decide to become key peer-to-peer counselors. There is no better person to speak with when entering the journey of recovery, than someone who has walked that path themselves. MAP has proven to be a great success with participation from union leaders, union staff and members. MAP has helped many people and their families get help, get back to work and live a healthy lifestyle.

PRINCIPLES-TO-PRACTICE

***Adam Seidner**, MD, MPH; Chief Medical Officer, The Hartford and **Michael Erdil**, MD, FACOEM; Asst. Clinical Professor, University of Connecticut Health Center*

Employee Support and Retention

Employers should know that there are many contributors to the growing opioid epidemic in the US, including overprescribing, availability of prescribed and illicit opioids, gaps in patient expectations and perceptions of risk, fractionation of care, problematic insurance benefit systems, lack of effective management of chronic pain and mental health, social and economic inequalities, misleading information and aggressive pharmaceutical marketing and other problems. For example:

Prescribing Observations: In 2015, it is estimated that 37.8% of the U.S. adult population received a prescription for an opioid pain reliever (OPR).[86] This is approximately 640 morphine milligram equivalents (MME) per capita, or the per person equivalent of hydrocodone 5 mg, four times per day for more than one month.[87]

Misuse and Addiction: For individuals prescribed OPRs, 12.5% reported misusing their OPR and 16.7% reported having an opioid use disorder (OUD).[88] Overall, an estimated 11.5 million Americans misused OPR and 1.9 million Americans had an OUD in 2015.[89] OUD estimates increased to 2.1 million Americans in 2016.[90] As many as 600,000 Americans have a substance abuse disorder (SUD) involving heroin.[91] Almost half of patients treated for OUD began using opioids after receipt of a physician prescription[92] and 80% of heroin users report using OPR before transitioning to heroin.[93] There were 520,000 hospitalizations for OUD in 2012 with an estimated cost of $15 billion.[94] Each day, more than 1,000 people are treated in emergency rooms for misusing prescription opioids.[95]

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[86] Han B et al., 2017. Prescription opioid use, misuse, and use disorders in US adults: 2015 National Survey on Drug Use and Health, Ann Intern Med,[published online ahead of print August 1, 2017]. doi:10.7326/M17-0865.

[87] Guy GP, Zhang K, Bohm MK, et al. 2017. Vital Signs: Changes in Opioid Prescribing in the United States, 2006–2015 MMWR 66(26) 07/07/17

[88] Shah A, Hayes CJ, Martin BC. 2017. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR 66(10) 03/17/17

[89] Han B et al., 2017. *Ibid.*

[90] https://www.hhs.gov/opioids/sites/default/files/2018-01/opioids-infographic.pdf

[91] O'Donnell JK, Gladden RM, Seth P. 2017. Trends in Deaths Involving Heroin and Synthetic Opioids Excluding Methadone, and Law Enforcement Drug Product Reports, by Census Region — United States, 2006–2015. MMWR 66(34) 09/01/17

[92] Cicero TJ, Ellis MS, Kasper ZA. 2017. Psychoactive substance use prior to the development of iatrogenic opioid abuse: a descriptive analysis of treatment-seeking opioid abusers. Addict Behav.;65:242-244

[93] Compton WM, Jones CM, Baldwin GT. 2016. Relationship between nonmedical prescription-opioid use and heroin use. N Engl J Med.;374(2):154-163.

[94] Ronan MV, Herzig SJ. 2016. Hospitalizations related to opioid abuse/dependence and associated serious infections increased sharply, 2002-2012. Health Aff.;35:832-837.

[95] https://www.cdc.gov/drugoverdose/data/overdose.html

Overdose Deaths: Approximately 33,000 Americans died from opioids in 2015, including almost 13,000 from illicit heroin and fentanyl.[96] The updated estimate for prescribed and illicit opioid deaths in 2016 was 42,249 deaths (116 per day), including 47 deaths each day resulting from prescribed OPRs.[97,98] The nature and rates of opioid deaths in all states are highly variable and constantly changing, and many opioid overdose deaths involve multiple opioids.[99] Thus, of the 42,249 opioid deaths in 2016, 17,087 involved prescribed opioids, 15,469 involved heroin and 19,413 involved synthetic opioids such as fentanyl. Opioid overdose deaths are contributing to a decline in overall life expectancy after years of increased longevity for each generation.[100]

Overall Costs: Estimated costs of nonmedical use of OPR in 2011 was $53.4 billion, including $42 billion (79%) due to lost productivity, $8.2 billion (15%) to criminal justice, $2.2 billion (4%) to treatment of drug abuse, and $944 million to medical complications (2%).[101] A 2013 estimate for the total cost of opioid misuse and dependence was $78.5 billion including $28.9 billion for health care and substance abuse treatment.[102]

Workers' Compensation Costs and Facts: Opioids contribute to delayed recovery from low back pain, increased medical costs, disability and overall costs.[103-105] In 2011, opioids accounted for an estimated 25% of workers' compensation prescription drug costs.[106] In Utah, 36% of individuals with opioid overdose deaths were employed within two months of death, and 57% had a history of work injury.[107] In Washington state, of the individuals receiving workers' compensation benefits who experienced overdose deaths, 60% were probably related to prescribed opioids.[108]

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[96] Rudd RA, Seth P, David F, Scholl L. 2016. Increases in drug and opioid-involved overdose deaths—United States, 2010–2015. MMWR 65(50,51) 12/30/16:1445–52. https://doi.org/10.15585/mmwr. mm655051e1

[97] https://www.cdc.gov/drugoverdose/data/overdose.html

[98] https://www.hhs.gov/opioids/sites/default/files/2018-01/opioids-infographic.pdf

[99] https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state

[100] Dowell D, Aria E, Kochanek K, et al. 2017. Contribution of Opioid-Involved Poisoning to the Change in Life Expectancy in the United States, 2000-2015. JAMA; Volume 318, Number 11 1065

[101] Hansen RN, Oster G, Edelsberg J, Woody GE, et al. 2011. Economic costs of nonmedical use of prescription opioids. Clin J Pain.;27:194–202.

[102] Florence CS, Zhou C, Luo F, et al. 2016. The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013 Medical Care _ Volume 54, Number 10

[103] Franklin GM, Stover BD, Turner JA, et al. 2008. Early opioid prescription and subsequent disability among workers with back injuries: the Disability Risk Identification Study Cohort. Spine;33:199-204.

[104] Tao XG, Lavin RA, Yuspeh L, et al. 2015. The association of the use of opioid and psychotropic medications with workers' compensation claim costs and lost work time. J Occup Environ Med.;57:196-201.

[105] Volinn E, Fargo JD, Fine PG. 2009. Opioid therapy for nonspecific low back pain and the outcome of chronic work loss. Pain.;142:194-201.

[106] https://www.cdcfoundation.org/businesspulse/opioid-overdose-epidemic

[107] Cheng M, Sauer B, Johnson E, et al. 2013. Comparison of opioid related deaths by work related injury. Amer Journal of Indust Med 56:308-316.

[108] Franklin GM, Mai J, Wickizer T, et al. 2005. Opioid dosing trends and mortality in Washington state workers' compensation, 1996-2002. Amer Journal of Indust Med 48:91-99.

Implementing the Five Key Principles for Supportive Substance Abuse Policies

The potential consequences of opioid use in the workplace include the risk and the cost of injury and the loss of productivity. These safety concerns have led to the development of this guidance, and the corresponding policy-development principles to assist in identifying and addressing impairment issues related to the use of opioids and other substances. Although prevention of injuries is important, helping your employees who are struggling with a chemical impairment or a substance use disorder requires a thoughtful and compassionate approach. So the remaining question is: *How should employers revise their thinking about workers suffering from addiction and what are the steps employers can take to begin to develop and/or revise substance abuse and other policies to reflect these principles?*

Under Occupational Safety and Health Administration rules, employers have a federal mandate to address impaired workers who contribute to unsafe work environments.[109,110] The best practice for employers is to begin with a clear written policy regarding chemical use and impairment. We firmly believe that employers who are able to integrate the five key principles outlined in this document as the foundation of their workplace substance abuse policies will be engaging in current best practices to help raise awareness, assist efforts in managing chemical impairment and substance use disorders in their workplaces, and support addicted workers through treatment, recovery, and retention.

Early identification and an employer's approach to an employee with a substance use disorder are critical to successful outcomes. Simply having a Drug-Free Workplace Policy is not enough. Employers can embrace a new paradigm to address substance abuse in the workplace. Treating substance use disorders as a disease represents a fundamental shift from previous approaches.

Ongoing performance problems that do not respond to normal supervisory actions may be signs of addiction or other personal problems and may require further intervention. Examples of common performance problems that may be indicators of underlying substance use or chemical addiction include: poor attendance, tardiness, unexplained absences, coworker or customer complaints, and mistakes or missed deadlines. Workplace policies may rely on the observation of specific individual behaviors indicating chemical influence or impairment. There are guides that outline the steps management should take to properly execute and document situations under a drug and alcohol testing policy.[111] Management should document reasonable suspicion and may pursue drug testing, however organizations should seek legal counsel on how to proceed with positive test results. When a performance problem has been identified, it should be properly documented. The employee can be

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[109] Shaw WS, Robertson MM, Pransky G, McLellan RK. Employee perspectives on the role of supervisors to prevent workplace disability after injuries. J Occup Rehabil. 2003; 13(3):129–42

[110] Shaw WS, Robertson MM, et al. A controlled case study of supervisor training to optimize response to injury in the food processing industry. Work 2006 26. 107-14.

[111] Slavit W, Reagin A, Finch RA. An Employer's Guide to Workplace Substance Abuse: Strategies and Treatment Recommendations. Washington, DC: Center for Prevention and Health Services, National Business Group on Health; 2009

referred for assistance and, in return, the employer should follow up on how the employee is progressing.

Employers should determine what type of assistance will be made available to their employees who are in need of help. Employers should clearly state the company's policy and communicate that they are there to help employees. The employee's decision to seek help is a private one and should not be made public. Privacy policies help protect employee confidentiality.

Employees who appear to be impaired in the workplace should be assessed according to employer policies and made to feel that they are receiving ***Instant Support***. Small business owners, managers, supervisors, and human resource personnel can be helpful by providing information for community hotlines; self-help groups such as Alcoholics Anonymous, Narcotics Anonymous, Al-Anon; community mental health centers; private therapists or counselors; and addiction treatment centers.

If the employee has a primary care physician, he or she may want to follow up with them or the physician prescribing their opioids. When Employee Assistance Program (EAP) services are available, employees should be reassured that their EAP records are separate from personnel records and can be accessed only with a signed release from the employee. EAP professionals are bound by a code of ethics to protect the confidentiality of the employees and family members that they serve.

Employer Flexibility should be an overarching theme of policy statements outlining the company's commitment to addressing employee chemical use and impairment in the workplace. A good policy will support the worker and assist in their recovery and retention as well as outline the company's policies, procedures and programs related to chemical use and impairment in the workplace. The employer can demonstrate their commitment by inviting workers to participate in the development, implementation and improvement of the company's policies and programs.

Policies and procedures related to addressing chemical impairment in the workplace should align with any existing medical practices, wellness program elements, and organizational values. Questions to be asked when developing a workplace policy include: *What is the purpose of the policy and program? Who is covered by the policy? When does the policy apply? What behavior is prohibited? Are employees required to notify supervisors of drug-related convictions? Does the policy include searches? Does the program include drug testing?*

Policies should conform to union contracts where applicable. In addition to legal counsel, other disciplines to be considered in the development of a chemical impairment policy include managers, human resources, a medical review officer (MRO), or other occupational health professional. An effective policy will focus on employee needs and provide ongoing communication and support.

Employers should understand their legal requirements for dealing with chemically impaired employees. Employers who have established policies and procedures may transition from a reactive state to a

proactive state, indicating the workplace has the basics in place and is ready to develop a comprehensive policy and procedure program to implement best practices. Employers may wish to expand their focus to include general wellness programs for their workforce.

Company policies should be regularly reviewed. They may need to be updated because of recent court rulings, new regulations, or changes in the workplace. Employees with chemical impairment should also be reviewed to document their progress. Some general principles to consider include making early and considerate contact with employees who are out of work. The employer should consider making an offer of modified work accommodations to the employee so they can return early and safely to work. Accommodations should include activities suitable to their condition and abilities. A Return-to-Work policy and plan involve more than matching the affected worker's restrictions to a job accommodation. Coworkers and supervisors might be placed into new relationships and routines. Managers and supervisors have been identified as important to the success of a worker returning to work due to their proximity to the worker and their ability to manage the immediate work environment. Managers and supervisors should be trained in work disability prevention and included in return to work planning.

While early contact is a key component to helping a worker suffering from addiction feel supported, ***Regular Review*** and continued contact that keeps an employee feeling connected to the workplace is just as important to successful recovery. If an employee is out of work, contact within the first week is recommended.[112] Regular contact with the employee should be established and the contact times or frequency agreed upon by the employee and employer. Once the employee is released to perform work, ensure that the work activities are consistent with the employee's capabilities and restrictions.

Managers and supervisors can assist the employee with chemical use and impairment issues by asking how they can be helpful to the recovering employee and his or her family. An open dialogue can be helpful from the beginning. If there are times that the employee is experiencing difficulty, speak directly to that employee about how you can assist them. Providing feedback will allow the employee to help identify what kind of help they need and ensure a successful return to work. Return-to-Work policies are an excellent opportunity for the company to show its commitment to their employees and facilitate return to work.

Consider ***Enlisting Success*** in your workplace by developing a bridging program to help prepare the employee to return to the workplace while or after they receive treatment. Partnerships with stakeholders can play a significant role in identifying chemically impaired employees and assist in their return to work process. To the extent employees are comfortable, peer-to-peer counseling networks within your workplace or in combination with others for smaller employers, that match workers in recovery with a peer network of individuals who have overcome similar addictions, can help overcome

[112] Barbieri B, Dal Corso L, Di Sipio AM, De Carlo A, Benevene P. Small opportunities are often the beginning of great enterprises: The role of work engagement in support of people through the recovery process and in preventing relapse in drug and alcohol abuse. Work. 2016 Oct 17; 55(2):373-383

feelings of isolation and promote the realization that addiction is a common disease that affects many other working adults, including coworkers.

In addition, communicating with the worker's healthcare provider(s) and providing them information about his/her work environment can be beneficial.[113] The more these stakeholders understand the worker's job and the workplace's ability to provide accommodation, the better able they are to advise the worker and participate in informed return to work. Permission from the worker is needed for this contact to proceed, and the degree and nature of the contact between the workplace and health care providers can vary depending on individual circumstances. The contact may be in the form of a paper-based information exchange or a telephone conversation about work and job demands. It may even include a workplace visit by a health care provider to view the work activities and converse directly with the employer.

These partnership arrangements may help accelerate the impaired worker's recovery. Sharing evidence-based knowledge with stakeholders can improve workplace quality for all employees. Providing practical assistance to employees, managers, supervisors, physicians, and other health care providers can help support the development and refinement of successful and sustainable policies and procedures dealing with worker addiction, recovery, and return-to-work, ensuring the success of the employer's most valuable asset – the employee.

[113] Phillips JA, Holland MG, Baldwin DD, Meuleveld LG, et al. Marijuana in the workplace: guidance for occupational health professionals and employers: Joint Guidance Statement of the American Association of Occupational Health Nurses and the American College of Occupational and Environmental Medicine. J Occup Environ Med. 2015 Apr; 57(4):459-75

A CALL TO ACTION IN THE WORKPLACE

***Michael Erdil**, MD, FACOEM; Assistant Clinical Professor, University of Connecticut Health Center*

Many of the causes of the opioid epidemic are outside of the immediate domain of employers, including socioeconomic and cultural factors, health care systems design, health disparities, medical evidence and practice, regulatory controls and other considerations. However, employers have a responsibility and opportunity to effect change. These include:

Recognize the significance of the opioid epidemic and the impact on employers and their employees.

Establish a workplace framework to permit action. This includes changing workplace culture (including treatment of pain, mental health and Substance Use Disorders (SUDs), encouraging confidentiality and employee ability to seek care early, addressing barriers to reporting and care (such as stigmas), achieving support throughout the organization, and adopting appropriate policies and procedures that translate to action.

Educate managers and employees to identify mental health and SUDs, understand treatment and pain management options and recognize ways to avoid or reduce risks.

Review benefit structures to improve coverage (evidence-based pain management with demonstrated outcomes, mental health and substance abuse coverage, better partnerships and innovations with health care providers) and achieve better integration among group health insurance, pharmacy benefit managers, workers' compensation, and short and long-term disability.

Become active to prompt action by federal and state legislators, including workers' compensation systems and health care organizations. Promote innovative solutions and research to identify and implement better screening and practice, develop ideal systems design for integrated and multidimensional pain and substance abuse care, and analyze outcomes.

While there are a number of treatment options that could benefit from further research, there are some recent guidelines that have evidence-based support and the potential to improve outcomes. Employers interacting with insurers, providers and health care systems could benefit from promoting the concept that care systems should implement and track evidence-based care and outcomes. Additionally, substance abuse treatment guidelines should include evidence-based treatment. Some relevant guidelines include the following:

- ✓ Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians [114]
- ✓ CDC Guideline for Prescribing Opioids for Chronic Pain [115]
- ✓ American Society of Addiction Medicine. 2015. National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use [116]
- ✓ Substance Abuse and Mental Health Administration (SAMSHA) Federal Guidelines for Opioid Treatment Programs [117]
- ✓ VA/DoD Clinical Practice Guideline For The Management Of Substance Use Disorders [118]

To assess the efficacy of interventions, outcomes need to be tracked. The decision regarding key indicators to monitor requires an understanding of stakeholder experience and goals. The following data elements may be relevant:

Employers Working with Insurers and Pharmacy Benefit Managers (PBMs) - Frequency of opioid prescribing, opioid duration and dosing, utilization of evidence-based non-opioid pain and behavioral treatments, monitoring with urine drug testing, work loss and modified duty days

Public Health Systems - Prescription Drug Monitoring Program (PDMP) - Use by prescribers, emergency room visits resulting from opioid misuse including overdose (fatal and non-fatal), hospitalizations for Opioid Use Disorders (OUDs), OUD treatment delays, rates of Medication assisted treatment (MAT) for OUDs including retention and relapse rates, opioid overdose and deaths, naloxone distribution

While research agendas are beyond the domain of employers, employers can play a role in advocating for research funding and participating in research studies. There are a number of considerations for research efforts involving employers and workplaces:

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[114] Qaseem A, Wilt TJ, McLean RM, Forciea MA, et al. 2017. Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians. Ann Intern Med.;166:514–530. doi: 10.7326/M16-2367

[115] Dowell D, Haegerich TM, Chou R. 2016. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1

[116] https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf

[117] https://www.store.samhsa.gov/product/Federal-Guidelines-for-Opioid-Treatment-Programs/PEP15-FEDGUIDEOTP

[118] https://www.healthquality.va.gov/guidelines/MH/sud/VADoDSUDCPGRevised22216.pdf

- Effective workplace prevention programs (pain, mental health, substance abuse) and barriers to implementation of evidence-based prevention efforts

- Design and implementation of workplace programs equivalents of Screening, Brief Intervention and Referral to Treatment (SBIRT) programs[119]

- Interventions to decrease stigma in the workplace and promote early reporting by employees with OUD/SUD

- Assessment of the impact of Workers' Compensation Medical Protocols (including pain and opioids) on outcomes of care and further needs (e.g. additional medical protocols, formulary options) and implementation of changes where necessary

- Strategies to improve employer insurance coverage and health care provider utilization of evidence based treatment of pain, mental health and OUD/SUD including safer opioid prescribing, and monitoring (e.g. pain and function outcomes, adverse effects, PDMP, UDT)

- Interventions to overcome workplace barriers to improve stay at work, return to work for patients with pain, mental health and OUD/SUD

- Determining the most effective communication strategies to improve workplace participation in interventions and to understand the scientific basis and rationale for interventions

Connecticut, like many other states, is facing an epidemic of opioid use and abuse. The impact of this epidemic touches individuals, employers, health care systems, governments, public health systems and our society. However, as with many other public health crises throughout history, there are solutions. The answer will require cultural shifts, education, innovation, adoption of evidence-based prevention and treatment, improved care coordination and communication, evaluation of health care reimbursement structures, funding for research, public health systems and interventions as well as data tracking and analysis.

[119] https://www.samhsa.gov/sbirt

EMPLOYER RESOURCES

Connect with JAN at (800) 526-7234 (VOICE) OR (877) 781-9403 (TTY)

If you have a question about workplace accommodations or the Americans with Disabilities Act (ADA) and related legislation, ask us.

The Job Accommodation Network (JAN), a service of the U.S. Department of Labor's Office of Disability Employment Policy (ODEP) is the leading source of expert, confidential guidance on workplace accommodations and provides one-on-one consultation to employers and employees, as well as service providers and others, free of charge. https://www.dol.gov/general/topic/disability/jobaccommodations

SAMHSA: Drug-Free Workplace Toolkit https://www.samhsa.gov/workplace/toolkit

National Safety Council:

The Proactive Role Employers Can Take: Opioids in the Workplace
http://www.nsc.org/RxDrugOverdoseDocuments/proactive-role-employers-can-take-opioids-in-the-workplace.pdf and/or https://www.nsc.org/Portals/0/Documents/NewsDocuments/2017/Media-Briefing-National-Employer-Drug-Survey-Results.pdf

Drugs at Work: What Employers Need to Know
https://www.nsc.org/work-safety/safety-topics/drugs-at-work

Prescription Drug Employer Kit
This includes a number of resources including what to do if you suspect someone has an addiction disorder, updating your drug-free workplace program, structuring benefits, and educational resources for staff and employees. http://www.nsc.org/learn/NSC-Initiatives/Pages/prescription-drug-employer-kit.aspx

U.S. Chamber of Commerce

Contains useful information for employers with links to additional resources including a substance use cost calculator, links to useful information from the National Safety Council.
https://www.uschamber.com/event/the-opioid-epidemic-the-front-lines-the-boardroom

CDC Foundation

There are a number of materials and links to information regarding opioids, overdose information, infographics, evidence-based policies and interventions, support for employees struggling with OUD, external links including a national helpline. https://www.cdcfoundation.org/businesspulse/opioid-overdose-epidemic-resources

Workplace Mental Health

The Partnership for Workplace Mental Health is a program of the American Psychiatric Foundation, a subsidiary of the American Psychiatric Association. The Partnership collaborates with employers to advance effective approaches to mental health and promotes the business case for quality mental

health care. The Partnership's network includes more than 9,000 employers and related stakeholders. For more information see www.workplacementalhealth.org.

The American Psychiatric Association

The American Psychiatric Association is a national medical specialty society whose physician members specialize in the diagnosis, treatment, prevention and research of mental illnesses, including substance use disorders. Visit the APA at www.psychiatry.org. The American Psychiatric Association (APA) https://www.asam.org/docs/default-source/2015-conference-epk/asam-impact_barriers4-02-14.pdf?sfvrsn=4

EMPLOYEE RESOURCES

Substance Abuse and Mental Health Services Administration (SAMHSA)

National Helpline: 1-800-662-HELP (4357) or 1-800-487-4889 (TDD, for hearing impaired)

Behavioral Health Treatment Services (search by address, city, or ZIP Code):
http://findtreatment.samhsa.gov/

Choosing Wisely http://www.choosingwisely.org/ is an initiative of the ABIM Foundation that seeks to promote conversations that reduce unnecessary medical tests, treatments or procedures associated with unnecessary costs and potential patient harm. Several medical organizations and associations have identified tests, treatments or procedures commonly used in their field whose necessity should be questioned. The goal is to prompt patient and provider conversations regarding these interventions.

American Society of Anesthesiologists – Pain Medicine

Don't prescribe opioid analgesics as first-line therapy to treat chronic non-cancer pain.
http://www.choosingwisely.org/clinician-lists/american-society-anesthesiologists-opioid-analgesics-for-chronic-non-cancer-pain/

Medicines to Relieve Chronic Pain

http://www.choosingwisely.org/wp-content/uploads/2018/02/Medicines-To-Relieve-Chronic-Pain-ASA.pdf

Avoid Opioids for Most Long-Term Pain

http://www.choosingwisely.org/wp-content/uploads/2018/03/Avoid-Opioids-For-Long-Term-Pain_8.5x11-Eng.pdf

American Academy of Neurology Treating Migraine Headaches

Using too much pain medicine can lead to a condition called MOH, or medication overuse headache.
http://www.choosingwisely.org/patient-resources/treating-migraine-headaches/

Consumer Reports https://www.consumerreports.org is an independent, nonprofit organization that works side by side with consumers to create a fairer, safer, and healthier marketplace. To help patients understand medical screening and treatment options for select conditions including pain and opioids, and to better ask questions about what tests, treatments and procedures are right for them, Consumer Reports (has developed several patient-friendly health information materials.

The Better Way to Get Back Pain Relief

https://www.consumerreports.org/back-pain/the-better-way-to-get-back-pain-relief/

Should You Take Opioids to Treat Pain?
https://www.consumerreports.org/cro/2012/07/should-you-take-opioids-to-treat-pain/index.htm

5 Surprising Facts on Prescription Painkillers
https://www.consumerreports.org/cro/2014/01/5-surprising-things-you-need-to-know-about-prescription-painkillers/index.htm

Long-Term Opioid Use Can Start After Surgery, New Study Shows
https://www.consumerreports.org/opioids/long-term-opioid-use-can-start-after-surgery-study-says/

If You're Taking Opioid Painkillers, You Need to Have Naloxone on Hand
https://www.consumerreports.org/opioids/long-term-opioid-use-can-start-after-surgery-study-says/

How to Avoid Getting Hooked on Opioids
https://www.consumerreports.org/opioids/how-to-avoid-getting-hooked-on-opioids/

Federal Drug Administration (FDA) Patient Handouts:
A Guide to Safe Use of Pain Medication and How to Dispose of Unused Medications
https://www.fda.gov/Drugs/ResourcesForYou/Consumers

Centers for Disease Control and Prevention
CDC has information for several stakeholders including Helpful Materials for Patients regarding the CDC Guidelines for prescribing opioids for chronic pain, prescription opioid information, preventing misuse and overdose, pregnancy and opioids, infographics.
https://www.cdc.gov/drugoverdose/patients/materials.html

Turn the Tide
The Turn the Tide addresses the U.S. Surgeon General's initiative to address the opioid epidemic. It includes information for clinicians regarding treatment of pain, prescribing opioids, assessing patients, opioid use disorders and overdose risk. Information for patients includes opioid education, managing pain, taking opioids, safe storage and disposal, help lines. https://turnthetiderx.org/for-patients/#about-opioids

SAMSHA Treatment and Recovery
Decisions in Recovery: Treatment for opioid use disorder
https://store.samhsa.gov/shin/content//SMA16-4993/SMA16-4993.pdf

Opioid Overdose Prevention Toolkit (includes information for prescribers, patients and family members, first responders and community members) https://store.samhsa.gov/shin/content//SMA18-4742/SMA18-4742.pdf.

Naloxone Emergency Treatment of Known or Suspected Opioid Overdose

Connecticut Department of Mental Health & Addiction Services - *Opioid Overdose Prevention/Naloxone (Narcan) Initiative.* For more information regarding CT laws, training, naloxone prescribing pharmacists, and other useful links go to http://www.ct.gov/DMHAS/cwp/view.asp?a=2902&q=509650.

Opioid Overdose and Prevention Initiatives

https://portal.ct.gov/DPH/Health-Education-Management--Surveillance/The-Office-of-Injury-Prevention/Opioids-and-Prescription-Drug-Overdose-Prevention-Program

Train Connecticut

Free training course to prepare Emergency Medical Responders to intervene in opioid emergencies
https://www.train.org/connecticut/course/1072448/

Narcan Quick Start Guide - https://www.narcan.com/pdf/NARCAN-Quick-Start-Guide.pdf

Narcan Patient Information - https://www.narcan.com/pdf/NARCAN-Patient-Information.pdf

NIH Opioid Overdose Reversal with Naloxone

https://www.drugabuse.gov/related-topics/opioid-overdose-reversal-naloxone-narcan-evzio

Naloxone for Opioid Overdose: Life-Saving Science

https://www.drugabuse.gov/publications/naloxone-opioid-overdose-life-saving-science/naloxone-opioid-overdose-life-saving-science

Harm Reduction Coalition Guide to Developing and Managing Overdose Prevention and Take-Home Naloxone Projects

http://harmreduction.org/wp-content/uploads/2012/11/od-manual-final-links.pdf

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