Accommodating Mental Illness and Addictions at Work
Balancing Safety, Human Rights, Performance and Best Medical Care

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Overview

A growing epidemic surfacing in the North American workplace is becoming overwhelmingly costly in terms of disability, health care and human suffering. Undiagnosed emotional problems often described as "stress", psychiatric disorders and addictive disorders result in attendance, behavioural and safety problems in the workplace that often result in discipline and labour relations conflict. This paper describes an approach, from the perspective of an occupational mental health and addictions consultant that will often result in effective resolution to labour relation disputes arising from these common problems. I will review some of the more common conditions, outlining the essential steps between the appearance of a problem at work through diagnostic assessment and treatment to safe, sustainable return to work. This approach, while balancing the rights, needs and liabilities of the various parties, should result in a win – win outcome: the employee will receive the best chance of achieving improved health and continued employment while the employer may expect improved workplace safety and worker performance. Under this approach, using a motivational technique called contingency management, the employer bears the responsibility of maintaining a safe workplace while accommodating the worker with the medical condition while the employee remains responsible for adhering to a comprehensive treatment plan based upon their specific diagnoses and identified problems. The Judge, Arbitration Panel or Human Rights Tribunal will often be in a position to ensure that the necessary elements are in place that will not only resolve a dispute but will also result in what is sometimes an otherwise unattainable outcome: saved lives and healed families.

How Big is the Problem?

Researchers have identified mental health claims as the most rapidly growing category of disability claims in Canada (Wilson, Joffe, Wilkerson – 2002). In 2003 Statistics Canada reported in 2003 that 20% of employed Canadians experience a stress related illness every year. One in ten working Canadians has a diagnosable mental illness (Dewa, Chau, Dermer - 2009). Ten percent of American workers will experience a substance use disorder (NIDA – 2009). People with other mental health disorders are more than twice as likely to suffer from a substance use disorder (Vaccarino, Rotzinger, WHO-CAMH 2004). Substance use disorders are known to mimic most psychiatric diagnoses (depression, anxiety, stress-related conditions, bipolar disorder, psychosis).

Determinants of Workplace Mental Health
It is important to distinguish between the achievement of optimal health and the treatment of (and workplace accommodation of) medical or mental disorders. This presentation is focused almost entirely on the effective management of employed people who already have a condition severe enough to interfere with their attendance, performance, behaviour or safety at work. On the other hand the most cost-effective approach to this problem in the future, just as it must be in medical care in general, will be to focus on those factors proven to improve happiness, health and function.

In order to remain psychologically and medically healthy human beings have essential needs, including safety, security, belonging, social justice, self-worth, self-esteem, self efficacy, accomplishment and autonomy (Psychological health and safety in the workplace — Prevention, promotion, and Guidance to Staged Implementation – Nat. Standards of Canada – 2013).

Researchers have gathered the evidence to clearly identify a group of factors or determinants that definitely affect the mental health of people in their working environment. These include:

1. Supportive workplace: employer values cares about, recognizes and rewards employees
2. Workplace culture of trust, honesty, fairness, civility and respect
3. Clear, consistent leadership
4. **"**psychological job fit**"**— employee competencies match their jobs
5. Opportunities for employee growth and development
6. Involvement and Influence: employees are informed of plans, included in the process
7. Workload Management: employees have some control over workload— reasonable chance of successfully completing expected roles
8. Recognition of importance of work-life balance
9. Workplace is psychologically safe: from harassment, threats

(Source: J. Samra, http://www.guardingmindsatwork.ca)

In January, 2013, a **National Standard for Workplace Mental Health in Canada** was released. This document outlines a voluntary detailed step-by-step process by which employers of all sizes might develop, implement and sustain their own comprehensive program of prevention of mental health problems and promotion of optimal workplace mental health.

Common Mental Disorders that Impact the Workplace
These include:

- Anxiety disorders, such as generalized anxiety disorder, panic disorder, phobias, obsessive compulsive disorders, acute stress disorder and chronic post traumatic stress disorder
- Mood disorders, such as major depressive disorder, bipolar disorder
- Thought disorders, such as psychotic disorders

- Complex pain disorders
- Sleep disorders
- Addictive disorders – including substance use disorders, gambling disorder.

It is very important to note that addictive disorders, especially the various substance use disorders, are able to mimic all of the symptoms of the disorders preceding them on this list.

"Stress"

Confusion over this term is a perennial problem for disability management professionals. In 1936 Hans Selye defined stress as the "non-specific response of the body to any demand for change" (Selye, H. Stress and Disease *Science*, Oct. 1955). Stress is not a bad thing. It is essential to health and results in healing, growth, improvement and survival from a wide variety of pathogens and other threats to life. People complaining of chronic stress are often simply being given the message in the form of unpleasant negative emotional symptoms to make some changes in how they are living their lives. Although chronic, unrelieved stress can and often does play an etiological role in the development of many medical and psychiatric disorders, "stress" is usually not the correct diagnosis. There are two types of psychiatric disorder involving significant stress – severe enough to cause demonstrable alteration in neurobiology of the brain; a) acute stress disorder, usually a self-limited phenomenon, and; b) post-traumatic stress disorder. Although relatively uncommon, both of these conditions are serious, causing severe distress and requiring some form of treatment. When a worker is so unwell that he or she cannot attend work it is possible, but somewhat unlikely that the accurate diagnosis for the problem would be an acute or chronic stress disorder. Usually, however when an employee produces a brief note, often written by the family doctor on a prescription blank, giving "stress" as the medical explanation for absence, that is not the real diagnosis and the solution lies in something other than stress leave. It could be an undiagnosed psychiatric disorder such as anxiety or depression or a substance use disorder or sometimes there is a workplace in which there is lack of support, conflict or impending disciplinary problem – i.e. a labour relations problem.

Addiction

Of the ten percent of the adult population suffering from substance use disorders, it has been estimated that over 70% of those people are currently attending work (NIDA Drug Facts 2008). Most people with substance use disorders are indistinguishable from their peers most of the time. Bradshaw (http://www.johnbradshaw.com) defined addiction as "a pathological relationship with a mood altering activity with life-damaging consequences". The American Society of Addiction Medicine describes addiction as:

> **"A primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is**

reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death."

http://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2011/12/15/the-definition-of-addiction

DSM 5 (American Psychiatric Association – 2013) has recently refined the diagnostic criteria for substance use and addictive disorders. Along the continuum of substance use, extending from complete abstinence, through occasional or recreational use of potentially addictive, mood-altering substances through to end-stage addiction, the terms substance abuse and substance dependence have been merged into the umbrella diagnosis of 'substance use disorder'. In people receiving prescription drugs capable in causing neuroadaptation with sustained use, signaled by the symptoms of increased tolerance for the drug and withdrawal upon cessation of the drug, these symptoms or indicators have been removed as diagnostic criteria. Craving has been included as a diagnostic indicator and prior legal problems related to substances has been removed as a diagnostic criterion.

From the perspective of a healthcare professional specializing in Addiction Medicine, the key to understanding addiction lies in appreciating that the addicted person is, whether through nature or nurture, unable to adequately comfort himself or herself in times of emotional distress. For that reason the mood altering substance or behaviour becomes more and more important in providing relief, reward or pleasure that would otherwise be denied. Of course the problem is that in addiction the very substance or behaviour providing the sought after escape or comfort begins to cause escalating problems and even more emotional discomfort. Two other factors combine to create the perfect storm: increasing impairment in effective behavioural control over the additive behaviour once it has begun is combined with unconscious defense mechanisms, such as denial, rationalization and intellectualization, the addict becomes incapable of appreciating the magnitude of accumulating negative consequences.

The reason for my pointing out these unique emotional and behavioural features characteristic of persons with addictions is to emphasize the importance of active and firm intervention followed by careful, comprehensive long-term treatment. If we simply prevent the addict from using their addictive substances or behaviours we may have at least temporarily solved one of their problems while entirely neglecting the bigger issue: how to achieve emotional comfort. Treatment of addiction must be staged, customized for the needs of the patient and it must be long-term just as with any other chronic, recurring disorder.

First the addicted person might require detoxification, sometimes an alarming and even dangerous period of treatment, while their brain recovers from the effects of the substance. They might temporarily benefit from a carefully prescribed medication to reduce craving, lessen to rebound effects of withdrawal or reduce the risk of early relapse. Next they need to learn and practice new behaviours, refusal skills and alternative non-chemical coping strategies. This will often occur in the setting of an intensive multidisciplinary treatment program – either inpatient or outpatient. They often need help to identify important skills they lack – such as ways to identify and handle negative emotions, conflict resolution skills, assertiveness, healthier eating, sleep hygiene, maintenance of good interpersonal boundaries, athletic and exercise activities. Finally, and perhaps of most importance, the addicted person must rejoin the human race, becoming part of family, society, peer support groups and the workplace. Some of the most important long-term outcome data on large populations of recovering alcoholics has demonstrated that the most reliable single predictor of stable, abstinent long-term remission is involvement in an addictions recovery mutual support group program such as Alcoholics Anonymous (G. Vaillant – Natural History of Alcoholism revisited – 1995). Woven through many or most effective programs for the management of addictive disorders are spiritual elements of prayer, meditation combined with principled behaviours – "If you want to feel good – you gotta do good"

Hitting Bottom – The Cost/Benefit Analysis

What does it take to arrive at that magic moment when the addict (or the overweight executive with mild chest discomfort on exertion or the obese person with type 2 diabetes) admits he or she is in trouble and reaches out to begin the recovery process? All of us continue doing the things we do based upon our ongoing cost-benefit analysis of the situation. As long as our tally tells us the benefits of our behaviours (no matter how much nagging we are getting from concerned others) outweigh the perceived consequences, we will continue doing what we've been doing. Although more prominent in addictions, but certainly not unique to addicts, those sneaky defense mechanisms we use to justify our misbehavior, are, by definition, unconscious: we are unable to accurately appreciate the magnitude of the negative consequences. Only when the denying, rationalizing, intellectualizing addict (obese person, impending heart attack victim) experiences that temporary window of clarity, most often in the form of a painful negative consequence, will he or she take the necessary steps to get help. Enabling (killing them with kindness) is a term embraced by the addiction community referring to acts of well-meaning friends, family, employers and helping agencies that relieve the unpleasant effects of those negative consequences. For some people a single blackout, a drinking driving offence or social embarrassment while intoxicated is enough to trigger the change. Although some never get the message and die of their progressive disease, there are some who only got clean and sober after the warnings, discipline and last chances were over and they experienced termination. Enabling can take many forms – concealment, endless warnings, misdiagnoses, inaccurate medical

diagnoses on insurance claims or switching the active alcoholic worker from a safety sensitive position to a desk job rather than insisting upon proper treatment of the disease.

Signs of Problems at Work
Whether the problem is due to unresolved stress, depression, anxiety disorder, chronic pain or many gradually worsening medical conditions, there are signs and symptoms that a vigilant manager should notice.

- Deterioration in attendance, perhaps with a characteristic pattern
- Sudden change in personal appearance
- Uncharacteristic behaviours
- Increasing interpersonal conflict
- Possible impairment: unsteady gait, slurring, poor coordination, slowed response
- Repeat disability claims

These should result in a private and respectful conversation between the manager and employee.

When to Ask for an IME
Privacy and confidentiality statutes limit the type of information the employer may demand and that regulated health professionals may provide. Although the employer must be able to determine whether or not workers are fit to safely perform their jobs, they are not permitted to demand diagnostic or treatment details. For this reason employers must rely on communications on behalf of the employee/patient from attending physicians. The medical information must be sufficient for both the disability insurer and employer so that important decisions may be made, with respect to:

- Fitness to work
- General nature of the disability
- Predicted duration of disability
- Whether treatment has been prescribed and is being adhered to
- Recommendations with respect to workplace restrictions and accommodations
- Special recommendations, such as the need and specifics of medical monitoring
- Prognosis

When there is insufficient information or when the medical explanation seems inadequate to explain the situation, the employer or insurer might, occasionally, request the opinion of an independent medical evaluator or medical specialist.

The Occupational Diagnostic Evaluation for Mental Disorders/Addiction
This examination must be performed by a medical professional or team with

recognized expertise (addiction, pain, psychiatric disorders, medical problems) with no prior, present or future therapeutic relationship with the examined person

Specific questions to be answered:

- Is this person fit to safely perform their job
- Is there a medical/psychiatric/addictive disorder requiring accommodation?
- Is the problematic attendance or behaviour related to the disorder?
- Has appropriate diagnosis and treatment been provided to the employee?
- Has the examinee made reasonable attempts to adhered to recommended treatment?
- Please provide diagnostic summary, treatment recommendations to the appropriate case management/treatment personnel
- Are there recommended accommodations and restrictions for safe, sustainable return to work?
- What is the predicted duration of complete/partial disability?
- Prognosis?

Components of Comprehensive Biopsychosocial Evaluation

- Informed voluntary consent
- Thorough chronological medical history
- Psychiatric history
- Psychosocial history
- Pain history
- Medication review – including electronic records if available
- Physical examination
- Appropriate laboratory investigations: including general blood tests, urine tests for common substances, other medical investigations based upon results of history and physical exam
- Self administered questionnaires) cognitive, depression, anxiety, gambling, pain, alcohol and other substance use)
- Review of collateral documentation: medical, workplace
- Collateral interviews: workplace representative, medical practioners, other treatment personnel, family, support group person
- Diagnostic formulation
- Staged Treatment Plan
- Longer term medical monitoring recommendations
    - Return to work recommendations including accommodations and restrictions – specific workplace situations to be avoided (e.g. exposure to drugs/alcohol)

Treatment of Addictions (with and without psychiatric/pain comorbidity)
When psychiatric symptoms (depression, anxiety, panic, psychosis) or chronic pain with chronic opioid treatment are present with active substance use disorder:

1. It is impossible to treat the psychiatric or the pain disorder until the

substance use disorder has been stabilized and is being treated

2. Both addictions and psychiatric diagnoses are “primary” conditions – it is a mistake to assume that treating one as the “underlying” problem and expect the other to go away – both conditions must be treated concurrently
3. Active addiction is accompanied by many psychiatric symptoms, due to the substance use disorder. These symptoms will gradually subside with stable remission of the addiction
4. Treatment must be staged:
    a. Detoxification/stabilization, sometimes requiring active medical, psychiatric, pharmacologic care
    b. Early intensive treatment either inpatient or outpatient depending upon severity and stability of patient. To develop
        i. Psychoeducation about the nature of the disorder(s)
        ii. Refusal skills
        iii. Self-examination to determine absent coping skills (missing pieces of the puzzle)
        iv. Introduction and early practice of non-chemical coping skills
        v. Psychotherapeutic and/or pharmacologic treatment of serious comorbidity or emotional trauma
        vi. Introduction to community based recovery resources: counselling, mutual support group programs
    c. Post-Treatment or “aftercare” is by far the most important component of treatment and it includes:
        i. Active involvement in mutual support group program
        ii. Accountability to family, sponsor, workplace, medical monitor
        iii. Medical/medication management of all diagnoses
        iv. Regular aerobic exercise
        v. Nutritional program
        vi. Sleep hygiene
        vii. Return to work process
        viii. Daily spiritual activity (e.g. meditation, prayer, acts of kindness/volunteer work etc.)

During the first two years of early recovery, persons with a history of substance use disorder, especially those who had been troubled by symptoms of mood disorder, anxiety, mood swings, personality disorder and pain during active addiction, will oscillate wildly as they slowly learn to apply their new skills to cope with life’s discomforts. Unfortunately during this period they sometimes receive incorrect diagnoses and treatments for conditions such as bipolar II disorder or attention deficit disorder, but if they are given support and encouragement, especially from those ahead of them on the journey of recovery, these troubling symptoms will usually gradually settle and disappear.

Contingency Management – Medical Monitoring

Substance use disorders that have reached a stage that is late and severe enough to negatively affect the workplace are almost always chronic, progressive and potentially fatal conditions. The early responders or "high bottoms" made the necessary changes or got help long before the problem began to impact their attendance, performance, behaviours or safety at work. Yet there is a recognized group of workers, diagnosed and treated for substance use disorders, often mandated to receive treatment, that routinely achieve rates of recovery (stable, abstinent, long-term remission) of 74 - 90%. (Berge, Seppala, Schipper, *Mayo Clin Proc. July 2009;84(7):625-63).* The fact that these people are physicians (similar results have been achieved with airline pilots) with their self-discipline and goal oriented behaviours might account for part of their remarkable success, however there is likely another explanation. Contingency management is a motivational technique that has been used successfully to initiate, motivate and sustain behavioural change in homeless populations of persons with addictions and mental illnesses, in apprehended drinking drivers given the alternative of diversion, and in drug courts. What is required is a motivator or reward for certain behaviours with naturally occurring consequences in the event of non-adherence with those agreed upon behaviours. It turns out that substance dependent people who are enrolled, even if this participation is mandatory, in a medically monitored relapse prevention program have by far the greatest rates of successful recovery.

Medical Monitoring

It is important not to confuse medical monitoring with simple random drug testing programs used in a variety of safety sensitive industries especially in the US. People with addictions, especially those with psychiatric, medical and pain comorbidity, are complex. Addictions and many serious co-occurring mental health disorders are chronic conditions - meaning these conditions are quite likely to relapse in the future. If employees with these mental health disorders work in safety-sensitive or highly responsible positions, or if they have reached the point that the employer has difficulty accommodating them because of their illness, the only safe way to return them to work is to establish a mechanism to ensure they continue to follow their medical and psychiatric treatment plans. Medical monitoring is an extension of the occupational addictions/psychiatric evaluator's treatment plan. All components of long-term treatment and relapse prevention are included in a relapse prevention agreement, signed by the participant at enrollment. The relapse prevention agreement, a confidential medical document (not to be confused with the return to work agreement between the employer and employee/union), contains details about required medical treatments, psychiatric treatments, counselling, mutual support group activities, communication between all treatment providers, review of all prescribed and non-prescribed medications, randomly scheduled biological testing, and compliance reporting arrangements. Duration of agreements vary depending upon the severity of the disorder and the level of responsibility of the participant, starting at 2 years and extending up to 10 years or in some cases as long as the at-risk participant holds a certain position.

Compliance represents a continuum, from reluctant resistant compliance with minor issues of non-adherence, through missed appointments all the way to concealed full relapse. Reporting to the employer, insurer or regulatory body is on a regular schedule but in the event of critical non compliance, such as a relapse in a safety sensitive worker immediate reporting is essential. Careful medical oversight of the monitoring and biological testing process is an important part of the process in order to assist the oversight body or employer in making the best decisions. High quality medical monitoring is not cheap, and, although it is probably the most important factor to achieve the highest rates of recovery, it is not considered 'treatment' – there can be no therapeutic relationship between monitoring personnel and participant – so it is not usually a medically insured service.

Conclusions – Summary

Addictions, often complicated by mental health problems and pain disorders, are remarkably common, affecting over 10% of the workforce. These chronic, progressive and potentially fatal conditions are remarkably responsive to treatment, provided the treatment is based upon a thorough and accurate diagnostic process and the treatment plan is followed for enough time to achieve stable sustainable remission. Although addictions and associated mental health conditions do not come to the attention of the employer until they have become serious problems, workplace intervention and contingency based treatment results in extremely high rates of safe, stable and sustainable return to work – as well as return to health and happiness for the sufferer. Employers, unions and those assigned Solomon-like duties of resolving disciplinary issues between these parties may play a vital role in early identification, intervention, proper assessment, treatment, relapse prevention and return to work for these employees.