RESOLVING ADDICTIONS AT WORK

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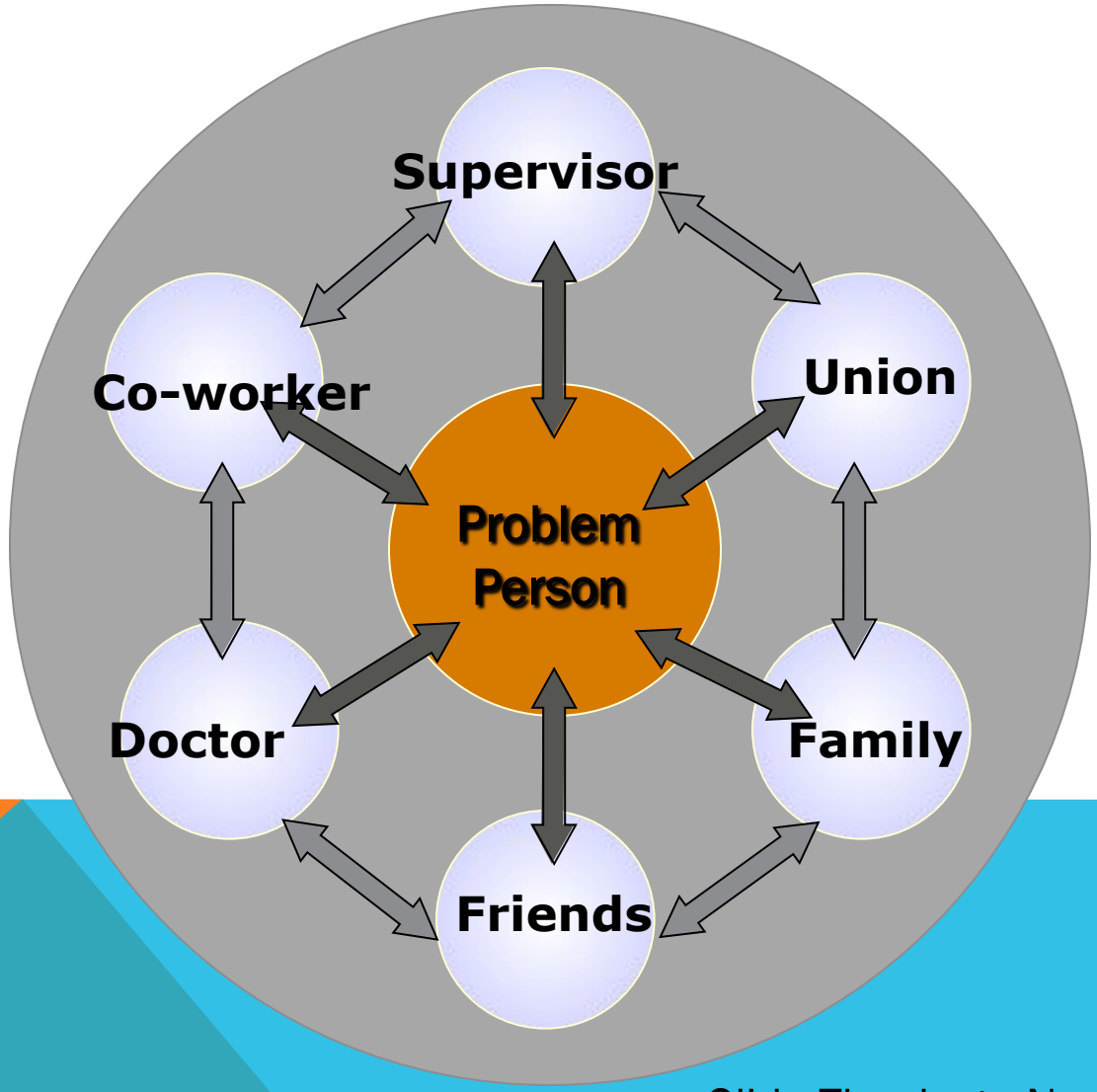
THIS SESSION

- Substance Use and Work: basics
- 4 Cases
- Key components best workplace programs

THE EMPLOYEE WITH ADDICTION

Slide Thanks to Neal Berger - Cedars

THE ENABLING SYSTEM



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ALCOHOLIC FAMILY = ALCOHOLIC WORKPLACE

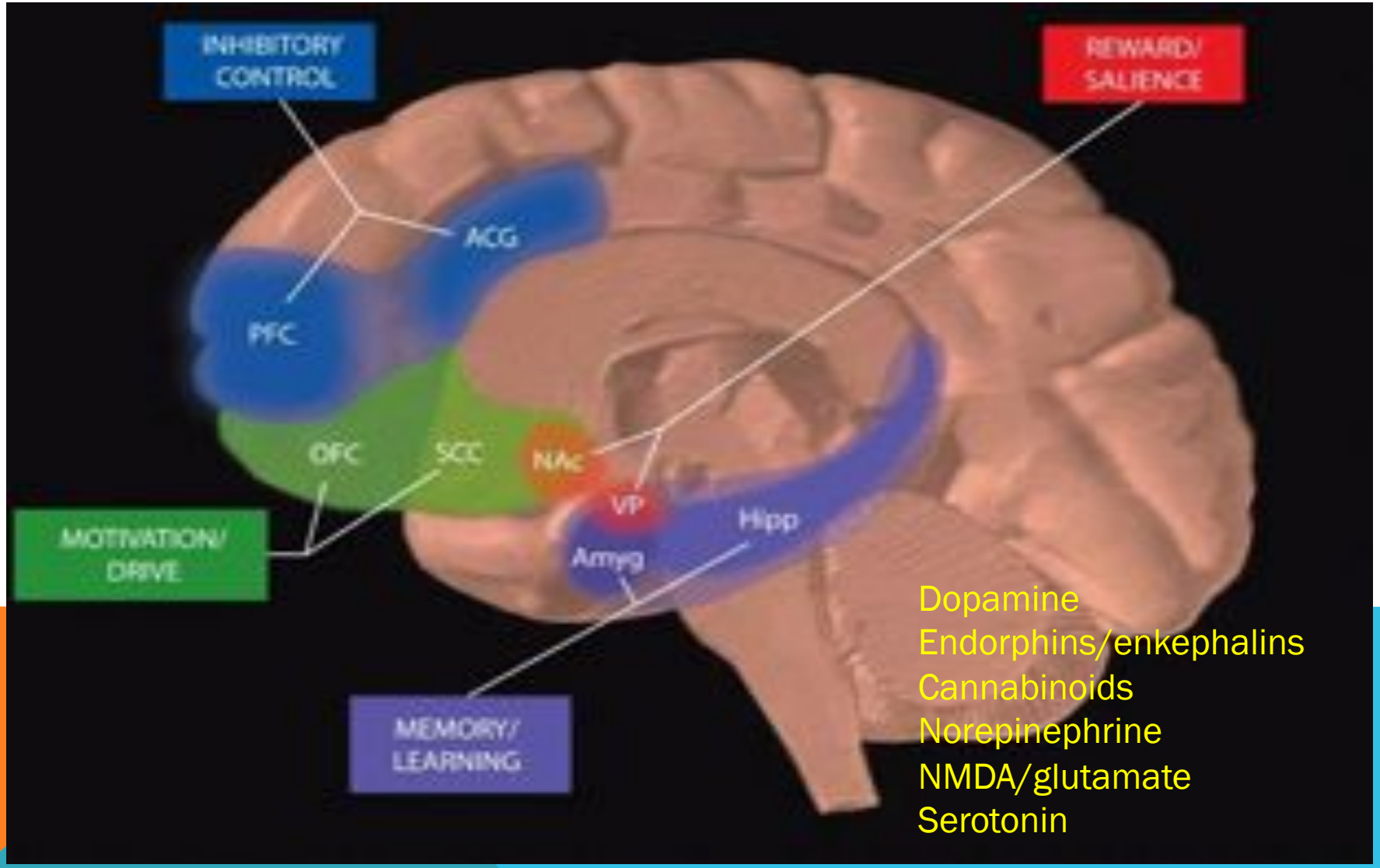
- Families “adjust” to crisis in a predictable way.
- The adjustments made by the system will produce health or harm. When the crisis is addiction, the adjustment will harm the entire system and all of the members.
- The HARM (risk) is foreseeable.
- Intervention is required to restore health.
- Organizations and communities are systems that function like families.

Slide Thanks to Neal Berger - Cedars

ADDICTION

- “A pathological relationship with a mood altering activity with life-damaging consequences”*BRADSHAW*
- Activities or substances that stimulate reward circuitry cause brain changes, some of them permanent

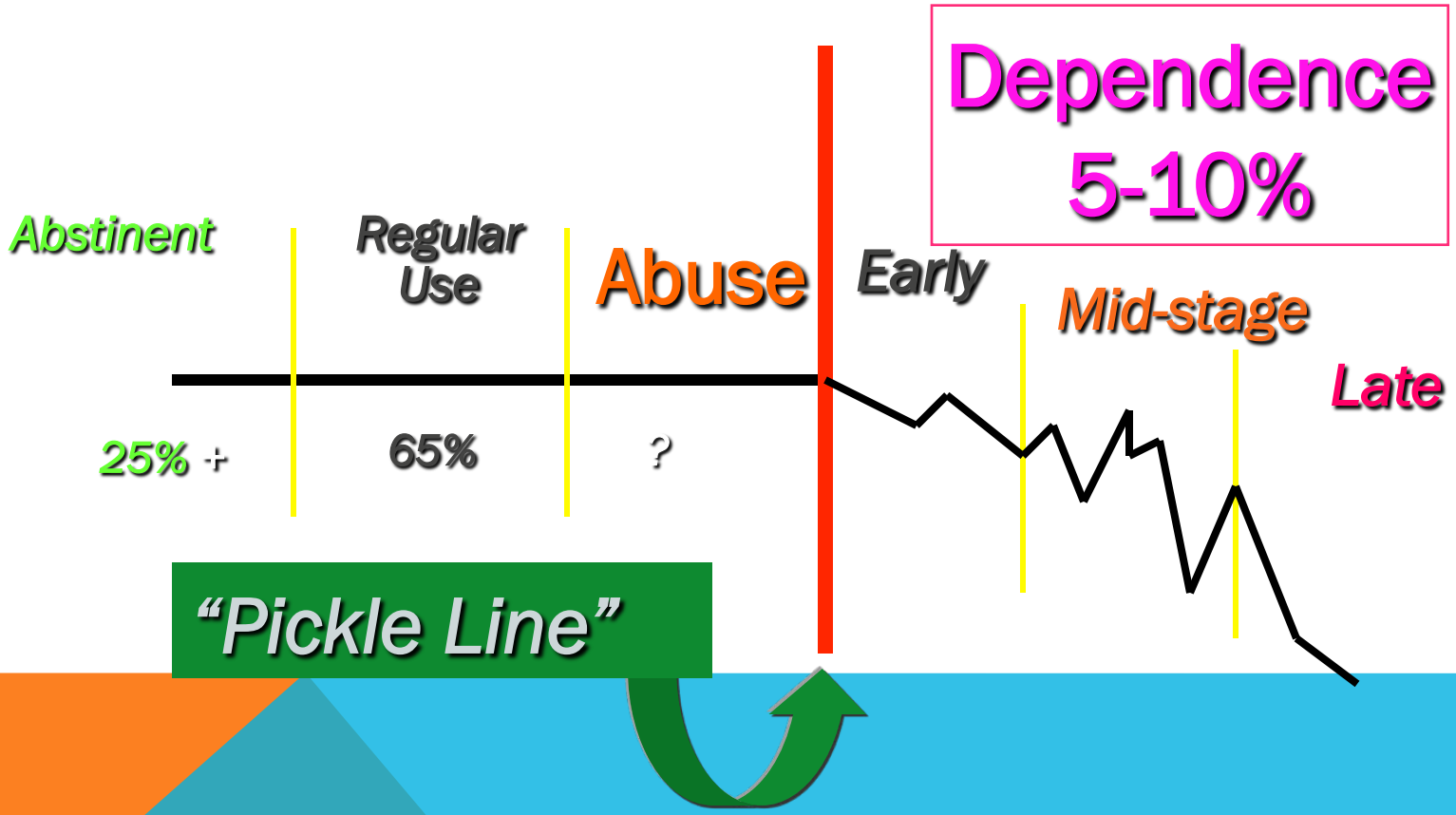
BRAIN CIRCUITS INVOLVED IN ADDICTION



HOW ARE ADDICTS DIFFERENT?

- Neurobiology is altered
- Inability to adequately self-soothe
- Difference may be congenital (high genetic risk) or acquired (post-trauma, psych. comorbidity, heavy long-term use)
- Lack key coping skills (missing puzzle pieces)

ALCOHOL & OTHER DRUG USE (DSM –IV-TR)



ABUSE OR ADDICTION (DSM-IV)

Drug (alcohol) abuse (not considered disability)

- Hazardous or harmful use with potentially negative consequences—dumb drinking and drugging

Drug (alcohol) dependence (3 C's)

- Loss of control
- Negative consequences
- Compulsive use
- Tolerance and withdrawal

SUBSTANCE USE DISORDERS/ ADDICTIONS DSM 5 (2013)

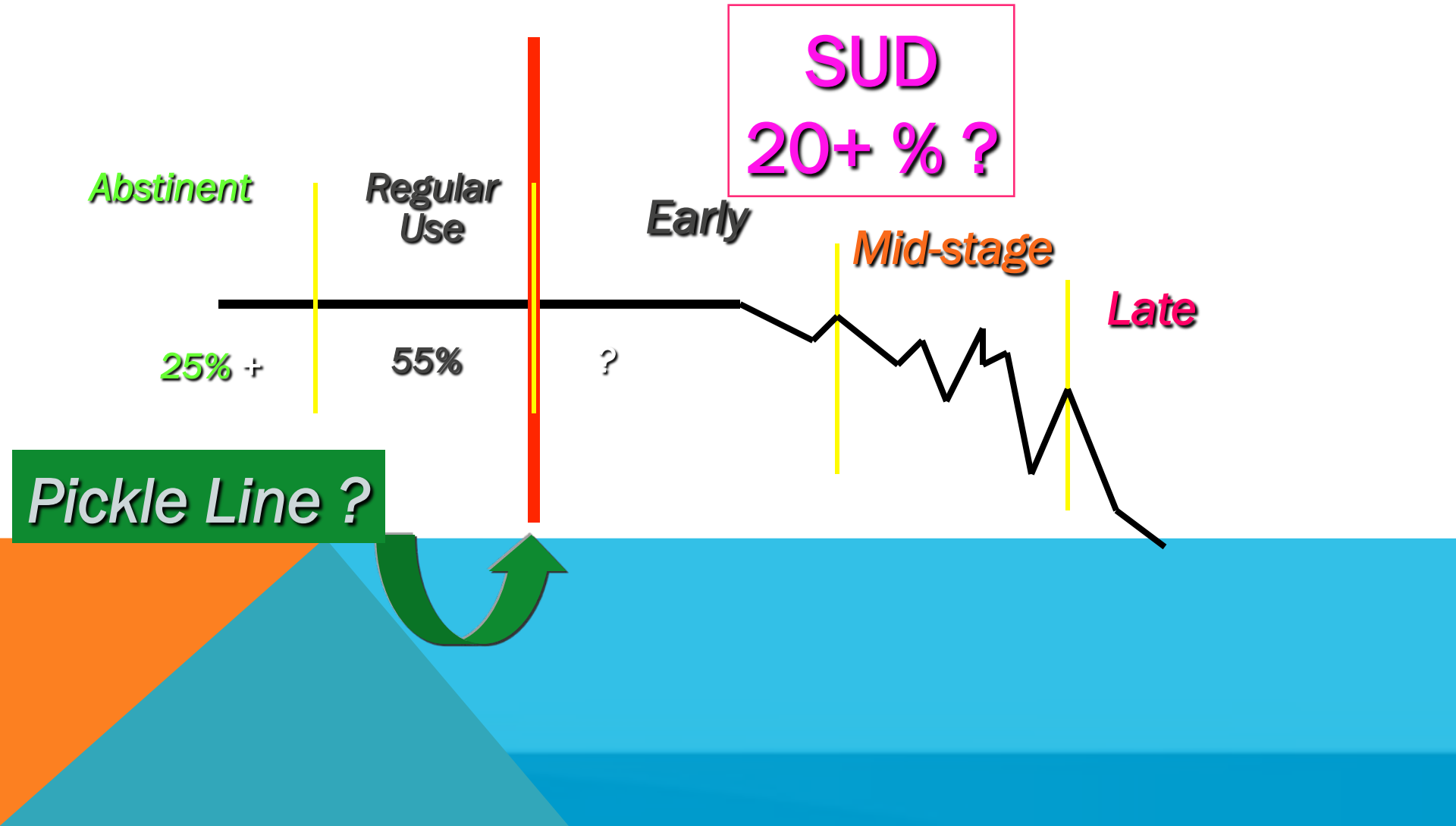
Abuse + Dependence blended = substance use disorder

(11 diagnostic criteria from which to choose)

Pathological gambling = gambling disorder

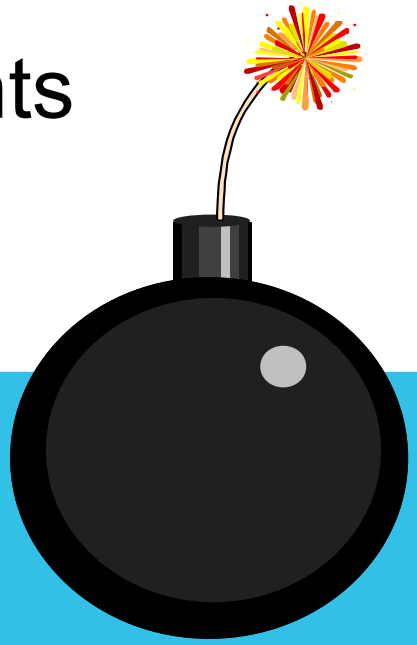
Physiologic dependence criteria (tolerance/withdrawal) don't count if on prescribed physical dependence-producing drugs

ALCOHOL & OTHER DRUG USE (DSM 5)



WARNING FLAGS AT WORK

- Change in attendance pattern
- Change in appearance, behaviour
- Increasing interpersonal conflict
- Change in performance
- Incidents, near misses, accidents
- Apparent impairment
- Repeat disability claims



JOHN 41 YR OLD TECHNICIAN

JOHN: WORK HISTORY

12 year employee: steady, reliable until 18 months ago

Began to miss time, performance erratic

Conflict with his manager

Making paranoid accusations

WENDY – 34 YEAR OLD TECHNICIAN

WENDY

Was excellent employee until 2 years ago

Unexplained absences from work with vague, undocumented medical time off

Moody, occasionally rude – complaints from clients

Rumours of drug use

HANK 44 YEAR OLD LOGGER

HANK

- Skidder operator, known as “weekend warrior” often returned to camp shaky
- Back injury 7 years ago (WCB)
- Recently off work for 3 months due to reinjury/back pain
- Insurer concerned that safe RTW unlikely, taking so many pain pills
- Family doc (reluctantly) provided authorization for “medical” marijuana

JOE 32 LABOURER

JOE

- Joe, a mediocre employee but worsening over past 18 months
- Increasing absenteeism, deterioration of work quality
- Recent impaired conviction: now can't operate company vehicle
- In meeting with employer/union Joe "self-disclosed" he had alcohol problem
- Widely known that he smokes marijuana

ALCOHOLISM: THE MEDICAL IMPOSTER

- **High blood pressure**
- **Enlarged heart**
- **Ulcers and reflux (serious heartburn)**
- **Accidental injuries**
- **Sleep disorders, sleep apnea**
- **Anxiety, panic, social phobia**
- **Depression, bipolar disorder, stress/burnout**
- **Seizures**
- **Type 2 diabetes**
- **Easy bruising and bleeding**
- **Dental (periodontal) disease**
- **Sexual dysfunction**
- **Dementia, delirium**

OTHER DRUG-RELATED CONDITIONS

- Depression caused by depressant drugs: sedatives, marijuana, stimulants
- Psychosis caused by stimulants: cocaine, methamphetamine, caffeine
- Anxiety/panic caused by sedatives
- Pain caused, made worse by pain killers
- All drugs of abuse can cause: sleep disturbances, sexual dysfunction, memory loss, confusion, incoordination

JOHN - INTERVENTION

- In meeting w supervisor, confronted with attendance, performance, behaviour
- Asked if he needed help, offered EFAP
- Nothing changed
- Formal meeting, advised of possible discipline
- No info from MD
- Sent to Occ Health
- Occ health determined probable addiction
- Referred for Addiction Medicine Evaluation

WENDY

- 2 supervisor interviews, no change,
- Heading down disciplinary path
- Agreed to go to EFAP
- EFAP identified severe addiction, recommended Addiction IME

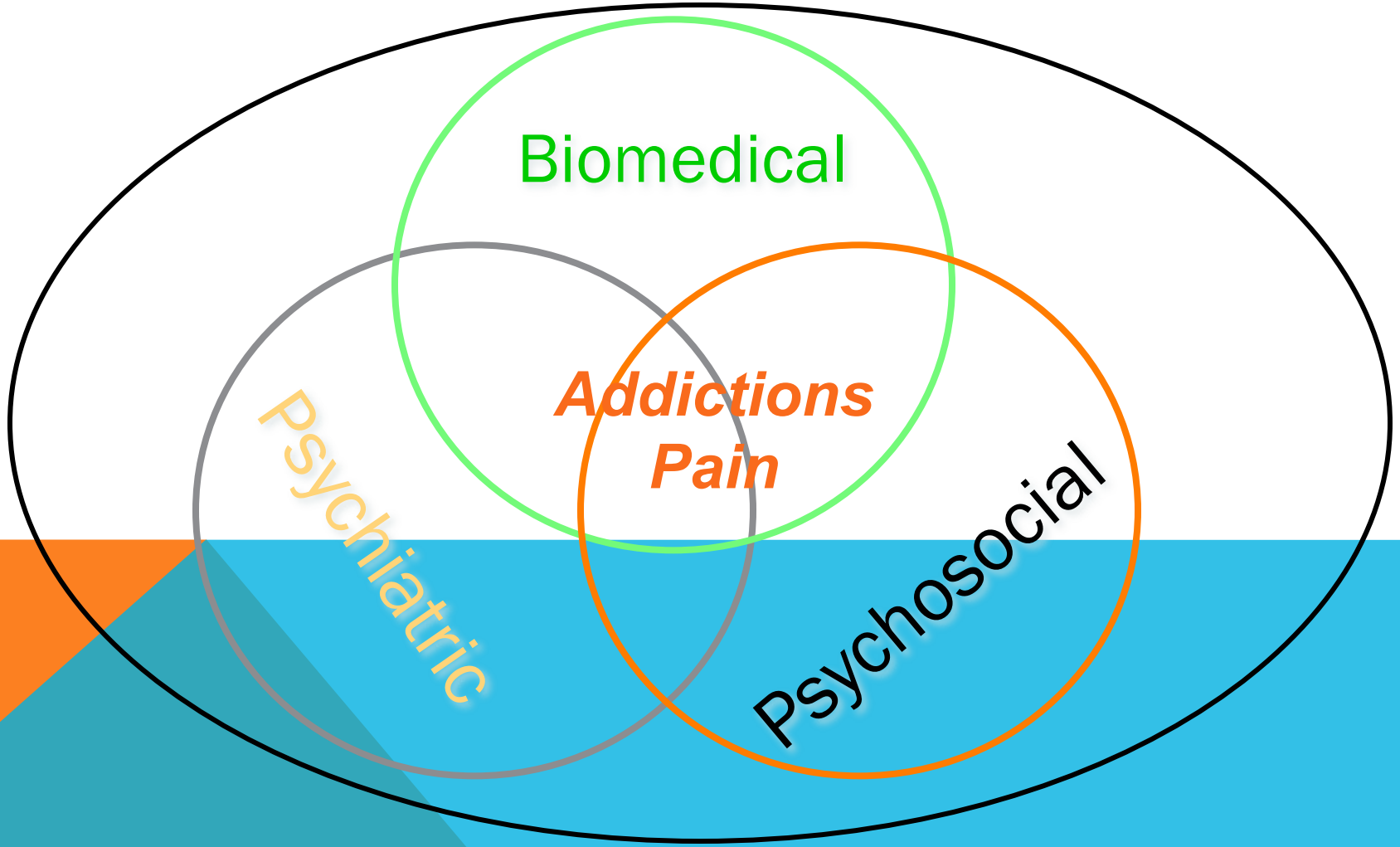
WHEN TO ASK FOR IME

1. When medical information/explanation is insufficient to account for ongoing problem of attendance, performance or safety
2. If safety issue and ER has not been provided sufficient medical assurance that EE may safely RTW
3. If ER is expected to make major accommodation
4. When there is uncertainty about diagnosis and required treatment

WHAT INFORMATION DOES ER NEED?

- Fitness to safely work
- Is there a disability? (that might need accommodation)
- Relationship between incident and disorder?
- Predicted time off
- Is the EE following recommendations?
- Barriers to returning to work? (non-medical?)
- Recommended accommodations/restrictions?
- GRTW plan?
- Is medical monitoring recommended after return to work?

THE IMPORTANCE OF ASSESSMENT



FULL PSYCHOMEDICAL IME

Medical, psychiatric, psychosocial, addictions, pain evaluation (incl. Rx drug review)

Result in itemized diagnoses , stressors and problems due to absent coping skills

Produces a detailed, stepwise treatment plan: that incorporates concurrent treatment for all diagnoses

Abridged “need to know” report to HR

Requires case management to implement

Always includes lab work

Provides basis for monitored relapse prevention agreement

JOHN: IME

- John appeared to have depression and psychotic delusions
- Working out, taking steroids
- Met younger woman, introduced to crack
- Dramatic deterioration in health, personality change

WENDY

Assessment revealed

- Mid-stage alcoholism, onset in adolescence
- History of childhood emotional trauma
- Recurrent depression requiring psychiatric care
- Mom of 2 kids, no childcare
- Wanted to try outpatient Rx

HANK

- IME: longstanding, mid-late alcoholism - Stopped drinking almost entirely 7 years ago when Tylenol #3>Percocet>Oxycontin progression began
- Suffers chronic pain, made worse by the drugs
- Recent daily use of smoked marijuana, uncertain if dependent but definitely impaired
- Level of function poor, mental status poor, feels like isolated victim, blames everyone

JOE IME

- Used/abused wide variety of substances since early teens (daily mj since age 13)
- Prescribed “medical” marijuana for vague pain complaints
- Acts mildly cognitively impaired
- Not really motivated to change (just motivated to get out of trouble)

TREATMENT OF ADDICTIONS

Effective treatment must concurrently address all diagnoses (psychiatric, medical, addictions)

Treatment must be staged: detox then education & refusal skills, then relapse prevention activities

Long-term recovery is about finding sustainable happiness

Without thorough diagnostic assessment, as with other complex and chronic medical disorders, effective treatment planning is hit & miss

What happens after “treatment” much more important than what happens during “treatment”

Spend your resources accordingly

CONTINGENCY MANAGEMENT

Proven to be the most effective single intervention in treatment of addictive disorders

Link benefits with participant compliance with consequences for voluntary non-adherence

Important during periods of insured disability

Essential for safe return to work for employees with a disorder that is likely to interfere with safety

The basis for medical monitoring

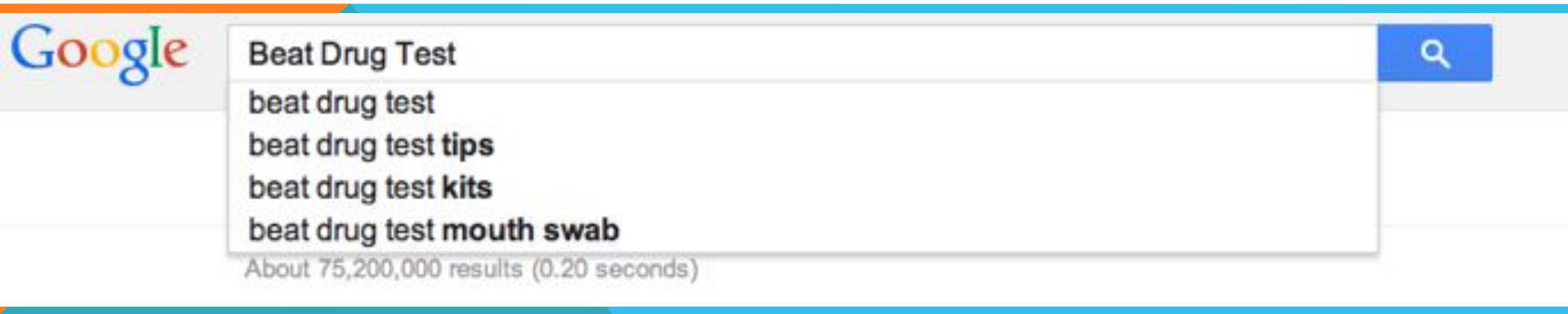
Distributes the responsibilities in accommodation

MEDICAL MONITORING

- Essential for safe RTW for SS workers with substance dependence (and some mental disorders e.g. bipolar)
- Performed by trained health professional under medical supervision
- Combine behavioural accountability (AA, counselling, meds) and biological testing
- Compliance reporting to employer, insurer, regulator
- Non-compliance (range of seriousness) results in range of consequences

Drug Testing

- Does not prove impairment
- More likely to detect some drugs
- Ineffective without program: we still need responsible supervisors and co-workers
- New test (EtG) – detects alcohol for up to 5 days
- Helps motivate abstinent recovery post-treatment
- Not difficult to beat (Google “beat drug test”)



JOHN

- Sent to low-intensity, longer term treatment (inpatient) psychosis disappeared
- Learned effective coping skills
- With CBT became happier
- Embraced mutual support groups (AA, NA, CA)

JOHN

- Returned to work at 5.5 mo
- Monitored relapse prevention agreement for 2 years
- Now 5 years since intervention – John has been promoted, serves as role model
- Newly married, baby on the way

WENDY

- Highly motivated
- Continued working, engaged in intensive outpatient treatment
- Family doc and psychiatrist carefully managing her depression
- Signed on with monitor to ensure safety and ongoing compliance
- Loves AA, Got a great sponsor

WENDY

- After initial ‘pink cloud’ Wendy had a slip, got very drunk over a weekend at 3 months sober
- Self-identified, tightened up her recovery activities
- Had to dump an abusive boyfriend who sabotaged her recovery
- Now 3 years sober (completed monitoring), continues with AA meetings
- Top notch reliable employee

HANK

- Sent to high quality residential program, weaned from all drugs
- After period of resistance (and worsening pain) he started to recover
- Learned effective skills for handling emotional and physical discomfort
- AA and physical exercise
- 6 months later was ready for GRTW

HANK

- Now laughs about his “medical” mj scam
- 2 year monitoring included his MD, PharmaNet reviews
- Did well in mutual support groups (AA)
- Lost weight, quit smoking, exercises regularly
- When monitoring ended he asked that it be continued
- Attendance now same as peer group

JOE

- Joe attended 6 wks treatment centre
- Following initial treatment signed monitored relapse prevention agreement
- Returned to work

JOE

- During monitoring urine tests all negative
- Workplace noted no change in behaviour or attitude – vague, sloppy, forgetful
- Attended minimal AA/Smart Recovery
- Caught providing substituted cold urine sample
- Sent for longer term treatment

JOE

- Was off work almost a year
- Stayed clean long enough to clear his head
- Gradually embraced AA/NA
- Returned to work with last chance agreement and monitoring
- Now, 3 years later, he's a year clean and sober, working part time
- Became reliable employee

WORKPLACE BEST PRACTICES: KEY COMPONENTS

- Buy-in from the top: LEADERSHIP
- Cooperative consultation with labour, all personnel in developing SUBSTANCE POLICY
- Supervisor/union training – policy content, documenting behaviour, “the difficult conversation”, intervention for safety concerns
- Coordination/education of all players: insurer, union, workforce, management, disability managers, identified service providers
- Indentification of key providers: Tester, evaluators, medical monitors
- Safe RTW process for persons with substance use disorders (monitored relapse prevention agreement signed, return to work agreeement in place
- Consistent “no blink” approach

SUMMARY

- Addictions: common disorders affecting mental health of entire workplace
- They mimic stress, chronic pain, psychiatric problems
- Workplace intervention may result in highest rates of recovery
- Monitoring is the secret to resolution
- Concealment kills people

HEALTHQUEST

OCCUPATIONAL HEALTH & DISABILITY MANAGEMENT SERVICES

Thank You

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