Special Feature:

Perspectives on the Opioid Crisis and the Workforce

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John S. Gaal, Ed.D., director of training and workforce development for the St. Louis–Kansas City Carpenters Regional Council, has spent the last two years researching the opioid crisis while he has seen its impact on the construction industry. Gaal offers his own perspective on the matter and interviews four experts who recently participated in International Foundation panel discussions on opioids to get their views on how the opioid crisis started and efforts to treat and prevent the spread of opioid use disorder (OUD).

John S. Gaal: As I’ve researched the problem, I’ve received input from a multitude of sources on the opioids/heroin-related crises. A recently released report from the state of Missouri showed that nearly $13 billion per year (approximately $35 million per day) is spent on economic issues related to opioid use disorder (OUD) (HIDI, 2018) in Missouri. Shockingly, Wyman (2017) asserts that opioids claimed 64,000 lives in the United States during 2016 alone (or, in other words, approximately 170 people per day)—more than car accidents or guns. Since many International Foundation members are involved with the construction industry, it should be of interest that construction workers are among the most vulnerable to opioid abuse, behind only food service industry workers (March, 2017). Finally, when it comes to a cyclical industry that tends to place enormous pressures on a craftperson’s long-term ability to perform, Dasgupta, Beletsky and Ciccarone (2017) posit, “the [opioid] crisis is fundamentally fueled by economic and social upheaval. . . . Overreliance on opioid medications is emblematic of a health care system that incentivizes quick, simplistic answers to complex physical and mental health needs.” J. D. Vance, the author of Hillbilly Elegy, refers to these phenomena as diseases of despair (Campbell, 2017).

Mental Health, Chronic Pain and the Opioid Crisis

Gaal: The opioids/heroin crisis has negatively impacted people across all spectrums within our communities. How are the issues of chronic pain, depression and mental health interconnected, and how has the medical profession’s response led to today’s state of affairs?

Joseph Ricciuti: The opioid and heroin epidemic has become a national crisis in both Canada and the U.S., but it didn’t happen in isolation. Two other health care issues were quietly percolating behind the scenes—mental health and chronic pain—and they fueled the demand for opioids, which created the crisis we have today.

The prevalence of mental health issues has dramatically increased over the last 50 years and more than doubled in the last 20 years. The World Health Organization projects that mental health will become the second-leading cause of disability next to heart disease by 2020. Mental illness also has an exponential effect on health care costs, performance issues and occupational
injuries. Approximately seven out of ten people with depression are in the workforce, and depression is a chronic disorder that is clinically linked to a number of other physical disorders. Because of stigma, most don’t get professional help. One in three people with depression struggles with a substance addiction.

Chronic pain, which can be caused by injuries, illnesses and complications from surgery, has also been on the rise, and 50 million Americans now live with chronic pain at any given time. Being saddled with chronic pain stymies the ability to work, exercise or enjoy life.

The relationship between mental illness and chronic pain is complex and comorbid. They can exist as a dual condition, and disorders such as depression and anxiety can be present both before and after the onset of pain.

Pain causes sleep disturbances and, when chronic, can trigger symptoms of depression. It is crippling and emotionally draining, and the need to relieve its effects are often urgent and desperate. The neurology that underlies chronic pain conditions and major depression are very similar. Some researchers tend to view the relationship between chronic pain and mental health as an interaction between biological, psychological and social influences.

When mental health issues and chronic pain include a pharmacology treatment plan, there is a risk of drug dependency and/or an adverse drug reaction, which creates a volatile environment for abuse and illegal use. When medications such as opioids (like oxycodone) or benzodiazepines (like Xanax®) are properly prescribed and used, the chance for addiction is relatively low, although it can still occur. Reliance and an oversupply of legally prescribed opioids and a black market present a toxic recipe to satisfy wants and needs. The risk is harmful addiction and a death warrant by overdose.

There is plenty of blame to go around. Clearly the heavy-handed marketing and promotional strategies of the pharmaceutical companies have influenced doctors to overprescribe in the name of making a profit. But just as guilty are organizations that fail to promote psychological health and safety in the workplace.

Research has shown that the work environment and chronic job stress are risk factors for mental and physical injuries and can contribute to substance use and abuse. These issues can’t be ignored, and they underscore the need to improve awareness and training to secure the mental health and safety of working populations. It starts with leadership and the will to prevent the sources causing opioid and heroin addiction from happening in the first place.

The Impact of OUD

**Gaal:** What is OUD, and what impact has it had on families and the workforce? What are some effective evidence-based prevention and treatment methods for battling OUD?

**Jenny Armbruster:** It’s becoming increasingly difficult to get through the day without hearing at least one horrible piece of news about the country’s opioid epidemic. We have reached a point where virtually everyone knows someone whose life has been affected—or taken—by this awful and seemingly intractable problem.

OUD is a brain disease. Using an opioid, such as a pain-killer or heroin, creates changes in the brain over time. It also takes time for these changes to heal once a person finds recovery and stops using. The fact that it is a brain disease means that someone does not choose to become addicted. Substance use disorder has no boundaries and can happen to anyone. Stopping is not just about willpower.

Awareness of the dangers of misusing opioids has increased, but people continue to die. A record-high number of Americans died from fatal overdoses in 2016, with more lives lost to drug overdoses in 2016 than in the entirety of the Vietnam War. The total for 2017 will be higher, and no end is in sight.

Loss of life is the greatest but not the only devastating impact of the opioid epidemic. This crisis has also contributed to a smaller workforce, because OUD is most prevalent in 18- to 30-year-olds, who represent the emerging workforce. This creates a smaller pool of eligible candidates that will apply or be able to pass initial drug screenings. A 2016 survey of men aged 25-54 who were not in the labor force, which is defined as not employed or looking for work, found that 47% had taken a pain medication on the previous day. Misuse of opioids by working individuals impacts job performance and increases employer costs. The American Society of Addiction Medicine has estimated that opioid abuse costs employers approximately $10 billion in absenteeism and presenteeism losses alone.

Prevention of substance use disorders must begin early with consistent education to young people. Parents and oth-
ers also must receive messaging and education about the dangers of opioids and the connection between prescription painkillers and opioids; two-thirds of people who use heroin began by misusing prescription painkillers. Community interventions also are necessary to promote the safe use, storage and disposal of prescription medications. Physicians should be having conversations with patients about the dangers of misuse and should prescribe low amounts of opioid medications only as needed.

To reduce the harms of opioid use and decrease the risks of overdose deaths, it is important for overdose education and naloxone distribution to be widely available. Naloxone (Narcan®) is the antidote medication that will reverse the impact of the overdose and revive an individual.

The current best practice for treatment of OUD includes the use of medication-assisted treatment (MAT) and traditional treatment modalities such as counseling and social supports. MAT includes the use of methadone, buprenorphine (Suboxone®) and naltrexone (Vivitrol®).

A Hands-On Canadian Perspective

**Gaal:** How has the opioids/heroin crisis impacted the community your union serves? In addition, please briefly explain the innovative measures your union has undertaken to help members overcome OUD.

**Paul Finch:** BCGEU is situated at the epicenter of the opioid crisis in Canada. The densely populated metro-Vancouver area in particular has been the epicenter for overdose deaths, a thousand of which in 2017 were linked to the powerful and cheap opioid fentanyl, a synthetic form of heroin that can be up to 100 times more powerful.

With over 74,000 members in the public and private spheres, BCGEU members come in contact with the fentanyl crisis in many ways. Some members are employed in a network of shelters across the lower mainland and are often equipped and trained with naloxone kits for rapid overdose response. These workers administer critical life-saving aid, sometimes up to a dozen times a day.

Other members come into direct and indirect contact working as social workers, librarians, trades instructors, sheriffs and corrections officers, and a host of other professions and trades.

BCGEU recognized early on that employers were not providing the occupational health and safety (OHS) training, materials or psychological support that was required to cope with the scale of the crisis.

One of our first actions was to canvass our membership to explore and examine the scope of the crisis. The union invited members to share their stories with us directly and also with the general public, on our campaign website—https://fentanyl.bcgeu.ca—and we invited them to register to receive e-mail and information updates.

BCGEU put together comprehensive OHS training including discussions of posttraumatic stress disorder (PTSD), trauma and harm reduction. We then hosted a series of public forums that were shared online, and we did a series of site visits to speak directly with impacted members and put on targeted OHS training for frontline workers and members.

Some of our response has been public facing—not only trying to build political awareness that BCGEU members are often the “hidden” first responders but also lobbying government to provide funding for better equipment and training for those on the front line.

A Hands-On U.S. Perspective

**Gaal:** As a labor leader in the construction industry, how have you seen the opioids/heroin crisis affect the community in which you live? And what measures has your union taken to increase access to proven prevention and treatment methods for your members?

**Don Willey:** As the business manager of LiUNA Local 110 (approximately 3,200 members), I have a very personal perspective on this epidemic and a practical business outlook. On March 29, 2016, after seven days in the ICU, I took my son, Matthew, off his respirator to let him pass on. Matthew struggled with OUD for 15 years and put his family through hell in the process. The point is OUD not only destroys opioid users, but it often destroys the families caring for them. An employee may be a caregiver dealing with a loved one struggling with OUD, and on many days will experience a concept known as presenteeism. So employers can’t isolate the effects of this problem with a drug-testing program alone.

We need to directly deal with the stigma of this disease, like we have with AIDS, breast cancer, diabetes and other...
diseases. As the latest campaign slogan from NCADA says, we need to “Talk About It” openly with our kids, family, friends and strangers.

The employee benefits fund for Local 110 members, the St. Louis Laborers’ Welfare Fund (SLLWF), has added mental health and addiction vendors to the annual members health fair and wellness program to build awareness. When treating members, these vendors use intensive outpatient MAT therapy along with counseling and social support. The goal of the SLLWF addiction treatment program is to keep members employed while in treatment, thus eliminating the stress and stigma that come with unemployment. The SLLWF waives the deductible if the six-month program is successfully completed. Families are often emotionally and financially spent, and a deductible can be a huge barrier to treatment. Allowances for relapses are also built in to treatment. These programs are promoted through print and social media.

SLLWF is looking into how to get health care providers to comply with the American Medical Association opioid-dispensing recommendations. This will cause a backlash from some members because they believe that opioids are the quickest way to get back to work pain-free. Not all doctors are trained to talk about the family genetics of addiction and mental illness or the social triggers that might lead to abusing prescribed opioids.

SLLWF also is looking into covering the prescription cost of Narcan. Meanwhile, NCADA has trained the staff at the Laborers Training Center in High Hill, Missouri, along with regional Laborers union representatives, on the use of Narcan. It is available on site at the union halls and training school, and soon Local 110 business representatives will carry it in their vehicles.

Nicole Browning of NCADA, Dr. Gaal and I also gave a talk on OUD and Narcan training at a recent Associated General Contractors of St. Louis annual safety banquet. The goal was to educate the three-dozen-plus contractors and 500 tradesworkers. It’s our hope that contractors will soon add Narcan to their first aid equipment on the jobsites.

In an example of outside-of-the-box thinking, a group of community stakeholders is having roundtable discussions with Washington University medical staff and key personnel at UnitedHealthcare, which is the insurer for other area Laborers health funds. Two of the many topics discussed were best practices for MAT and exploring the possibility of using a well-regulated recovery house model with measured outcomes as an alternative or supplement to inpatient care. I believe that recovered addicts (with clinical training) helping people struggling with OUD to obtain sobriety could be a win-win for all parties involved in this fight.

Closing Thoughts From Gaal

Look Before You Leap

Unfortunately, in this fast-paced age of instant gratification, it seems that more and more people are seeking a magic pill to cure their pain-related ills and, as noted above, this attitude plays a role in what got us into this predicament. Interestingly, Kaplan (2018) reports that a recent study found that “in the first randomized clinical trial to make a head-to-head comparison between opioids and other kinds of pain medications, patients who took opioids fared no better over the long term than patients who used safer alternatives” (i.e., Tylenol®, ibuprofen and lidocaine). However, when it comes to OUD recovery, the one thing that seems to be clear is that no silver bullet exists to overcome the opioids/heroin crisis.

What works for one person may not work for another due to a variety of factors (i.e., personal support system, genetic makeup, etc.). Therefore, the health care system must remain open-minded to different (empirical) approaches to pain management beyond that of merely prescribing drugs. To this end, a recent proclamation from the American College of Physicians (ACP) recommends that doctors consider non-drug therapies (e.g., heat, massage, acupuncture, spinal manipulation) for patients with acute (lasting less than four weeks) and subacute (lasting four to 12 weeks) lower back pain (2017).

When it comes to (residential) recovery, Whalen (2018) warns, “The rehab field is highly fragmented with thousands of small providers offering treatment that isn’t grounded in science.” To this end, “parents and family members desperate to keep their loved ones from overdosing find themselves shelling out again and again through rounds of recovery and relapse.” Please note that “relapses are common in most chronic diseases.”

Carrot or Stick

President Trump recently rolled out a new plan to tackle the opioid crisis, including the death penalty for high-intensity drug dealers. Nonetheless, Merica, Gray and Drash (2018) state, “Trump’s talk of stricter penalties for...
drug crimes has worried some treatment advocates, who said there is no way the United States can punish its way out of the opioid crisis.”

One means of addressing the so-called worker short-age would be to revisit substance abuse testing rules in the current workplace. Sperance and Sudo (2017) note, “Many construction sites have zero-tolerance policies so, when a test comes back positive, it often means termination—not finding the worker help.” However, Fraser and Perez (2018) claim that when OUD patients couple MAT with psychosocial treatment (i.e., counseling, self-help groups, mindfulness training, cognitive behavioral therapy, etc.) the treatment is more effective, and those who complete it are more likely to achieve opioid abstinence. While jobsite safety remains an important factor, Riley II (2018) insists that people with OUD who follow a prescribed MAT plan can once again become productive members of society.

**Mining for Good vs. Gold**

In the interests of their members’ well-being, since several construction-related unions administer their own health and welfare plans, it may behoove them to take a pro-active role by mining their insurance data to detect potential problems (Mueller, 2017). Accordingly, Mueller claims one Midwest union saw opiate-positive drug tests (without a valid prescription) nearly double between 2014 and 2016. Among other actions, this union now refers members who test positive to counseling that must be completed before returning to work, limits the number of pain medications participants can have following an injury or surgery, and limits the member to one pharmacy for (opioids-related) plan coverage.

**Act Now**

Have you considered adding Narcan to the first aid kits in your office and on the jobsite? If not, why not? McLellan (2018) asserts naloxone reverses the deadly effects of opioid overdoses. It was never intended as a long-term treatment solution, but it saves lives.

Finally, Strait (2017) declares that preventive measures, like Mental Health First Aid, an eight-hour certification course, can help supervisors and peers identify employees who may require counseling before they turn to masking their problems with addictive substances and/or act in harmful/destructive ways. Please contact www.afsp.org for more details.

**References**


