ADDICTION IN THE WORKPLACE

An Employer's Guide

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The nature of addiction

INTRODUCTION

Addiction — the mere mention of the word conjures an instant reaction in most people, one that is often negative and poorly informed.

The impact of substance abuse and dependency on Canadian society cannot be understated. The personal toll that it exacts on individuals who suffer from it is high, as it is for their families and friends. As we will see, the costs are also significant for Canadian employers who must cope with a wide range of complicated health, legal and ethical considerations when addressing addiction in the workplace.

"At times, in the popular media, we are left with the impression most people with severe addictions are on the street, unemployed and homeless — but the reality is the majority of people who are addicted are employed and continue to work," says Dr. Charl Els, a psychiatrist and addiction expert at the University of Alberta. "While seven out of 10 people who are addicted continue to be employed, less than 10% of those persons are actually identified as having addictions. When it comes to recognizing addictions in the workplace, we are only seeing the tip of the iceberg. This is a much bigger problem than what we would sometimes like to think."

For employers, addiction is more than a wellness matter, Dr. Els emphasizes. "Employers need to look at addiction as an occupational health and safety issue. We do know that substance use in the workplace is prevalent, and this greatly erodes the creation of a safe workplace for all. It leads to increased rates of accidents and injuries, and the toll of human suffering is one we cannot begin to express in financial terms."

WHAT IS ADDICTION?

Addiction is widely recognized as a disease of the brain resulting from the confluence and interplay of complex biochemical, cellular and molecular processes that are influenced by various genetic, psychological, social, spiritual and environmental factors. Addiction reflects pervasive changes in the user's brain, both on structural and functional levels, and comes to expression with the ongoing use, despite harm, of one or more substances. While understanding the neurobiological processes underlying addiction are beyond the scope of this booklet, it is important to note that addiction is not a voluntary condition, nor is it caused by low socio-economic status, moral failure or by "bad decisions." For clarity, it is worth noting that the word "addiction" is commonly used in our everyday language and has become associated with a broad range of compulsive behaviours (the words workaholic, chocoholic and shopaholic are familiar to most). Although meaningful and colourful, it is this lack of precision that has rendered the word inadequate in the field of medicine.

The Centre for Addiction and Mental Health (CAMH), a world-leader in addiction and mental health research, uses the term "dependence" to describe what is commonly referred to as addiction. Put simply, people use substances, such as drugs and alcohol, to stimulate the brain so they feel good (or, in the case of prescription drugs, to relieve pain). Using an addictive substance results in a surge of dopamine, a chemical in the brain that is associated with feelings of reward, pleasure and motivation (the "feel-good" part of drug use), to which the brain responds both by building tolerance to it and by decreasing how much of it is available. This vicious cycle results in the depressed feelings experienced without the drug, the subsequent craving for it and the need for ever-increasing amounts of it to overcome tolerance.

The same processes may be at work when people become addicted to pornography, sex, gambling and the Internet. For the purposes of this booklet, we will focus on substance dependency, given its relatively high prevalence and associated costs, though all types of addiction can negatively impact the workplace.

There are two classifications for dependence: **Physical dependence** takes place when an individual's body is so used to the presence of a specific substance that it develops a tolerance to it, and therefore requires increasingly higher amounts to achieve a desired effect. When use of the substance is halted, the physically dependent person will experience symptoms of withdrawal. Physical dependence alone does not constitute addiction, although it is often a part of it.

Psychological dependence involves the reliance on a drug or behaviour to cope with daily living — to feel normal, to fit in socially and/or to function in various settings. Importantly, this aspect of dependency also involves a chronic compulsion to engage in certain behaviours despite the potential for negative consequences (e.g., to personal physical and mental health, employment fallout or familial issues).

SIGNS OF ABUSE AND ADDICTION

No single physiological or behavioural indicator can serve as proof of an employee's dependency or abuse problem. Rather, experts suggest managers monitor employees for noticeable changes in behaviour, attitude and appearance. Physical signs can, however, include the obvious (e.g., odours on breath and clothes, changes in speech patterns, bloodshot eyes, constant sweating, marked hyperactivity or fatigue) and the less obvious (e.g., experiencing chills, the presence of small blood spots or bruises or changes in eating habits). Emotional signs can include increased aggression and anxiety, paranoia and depression, while behavioural symptoms often include increased absences and lateness, lower productivity and excessive errors made on the job.

According to the U.S. Department of Labor, signs that an employee's substance use may be creating hazards in the work environment include being involved in on-the-job accidents, repeatedly making mistakes and displaying a lack of attention to detail, taking unnecessary risks and providing unrealistic excuses for poor performance.

HOW COMMON IS ADDICTION, AND HOW MUCH DOES IT COST CANADIANS?

No matter how you slice them, addiction statistics provide a sobering perspective on the scope of the problem in Canada.

According to CAMH statistics, roughly one in seven Canadians aged 15 or older experience alcohol-related problems, while one in 20 have concerns related to cannabis use. Data culled from the *Canadian Community Health Survey: Mental Health and Well-being* (2002), as reported by Statistics Canada, suggest that 2.6% of Canadians were dependent on alcohol, with slightly less than 1% dependent on illegal drugs. Men are two to three times more likely to be dependent, and among all age groups the majority of alcohol and drug abusers are of working age. According to the Canadian Tobacco Use Monitoring Survey, 18% of Canadians aged 15 years and older, or about 4.9 million people, are current smokers.

Substance abuse is estimated to cost Canadians almost $40 billion annually in healthcare costs, loss of productivity from premature death and disability and costs related to law enforcement. Tobacco is responsible for more than 40% of the overall financial burden, followed by alcohol (37%) and illegal drugs (21%).

WHAT IS THE DIFFERENCE BETWEEN SUBSTANCE DEPENDENCE AND SUBSTANCE ABUSE?

The Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR), published by the American Psychiatric Association to define the diagnostic criteria of mental disorders for mental health professionals, clearly differentiates substance dependence from substance abuse:

Substance abuse is defined as a pattern of substance use leading to harmful consequences, including failure to fulfill familial or professional obligations, use in potentially hazardous or safety-sensitive situations and experience of recurrent legal problems.

Substance dependence involves the same phenomena as abuse, but the individual has also experienced increasing tolerance to the effects of the substance and/or withdrawal symptoms when use is stopped, as well as increasing use in the face of both a desire to stop and recognition of harmful consequences related to use.

THE STAGES OF ADDICTION

Health Canada has identified a continuum of risk for the potential consequences of drug use/abuse. It is important to note that an individual can find themselves at a different point on the spectrum for different kinds of drugs. For example, someone may take their medication as prescribed while using another drug that involves negative consequences.

Experimental Use — Driven by curiosity; use not necessarily repeated.
Social/Occasional Use — Usage in an amount/frequency that isn't harmful (e.g., social drinking).
Medication as Directed — Under medical supervision that reduces the risk of harm.
Harmful Use — Usage results in negative consequences (e.g., health issues, legal problems).
Dependence — The user becomes psychologically and/or physically dependent on a drug.

CHAPTER 2:

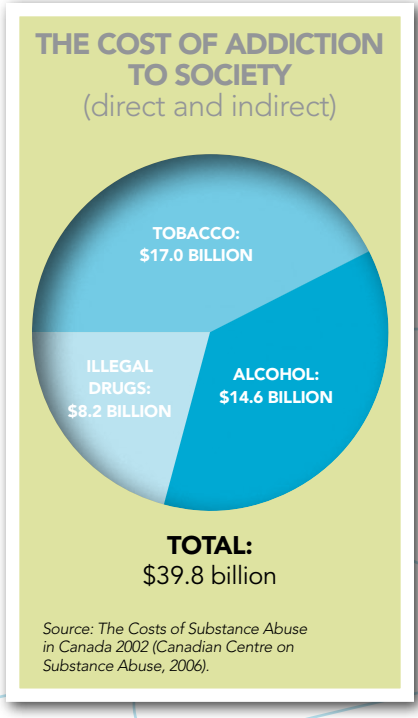
Addiction in the workplace

Substance dependency is a phenomenon that knows no bounds of race, class, gender or profession.

No one is immune to this condition. It is a silent epidemic few individuals or organizations are willing to address openly, clouded as the issue is by social stigma and widespread ignorance of its causes and of solutions that can address the problem, both at home and in the workplace. It can also be an easy problem to ignore given the high visibility and familiarity associated with other conditions (e.g., certain chronic diseases) that affect productivity and health.

"Employers as a whole in Canada don't really have a grasp on the scope of the addiction situation," says Gerry Smith, vice president of organizational health at Shepell·fgi. "It's a problem that goes largely undetected, even though support is widely available. Many organizations in Canada have access to some form of employee assistance program as well as some form of occupational health policies and programs — the difficulty we're seeing is a lack of screening for addiction and subsequently getting people directed to the help they need."

The reasons for this phenomenon are complex, according to Dr. Greg Banwell, senior vice president, professional services for Human Solutions. "Most employers are really underprepared to proactively handle the issue of addiction," he says. "It's not so much because of a lack of understanding of the key concepts and issues as it is about 'how do we handle this?' Employers expect managers and supervisors to recognize the problem and take action, but they may be reluctant to bring a problem forward to keep the team together, or to avoid appearing as if they aren't treating people fairly. And we also know employees with addictions are often reluctant to seek help."



HOW DOES ADDICTION AFFECT BUSINESSES?

Addiction and substance abuse have a profound, negative effect on the Canadian economy, to the tune of almost $40 billion each year in health costs, lost productivity and other societal burdens. This figure represents a quadrupling of costs over only 10 years, between 1992 and 2002. Compare it with the annual direct and indirect costs associated with heart disease ($22 billion), musculoskeletal diseases such as arthritis and osteoporosis ($16.4 billion), cancer ($14.2 billion), diabetes ($9 billion) and injuries ($8.7 billion), and substance abuse and dependency emerge as leading economic and health concerns for Canadians.

Clearly, addiction is an issue that employers ignore to their peril. In Canada, as in many Western nations, tobacco and alcohol have the dubious distinction of heading up the list of substances widely used and abused by the population, followed by illicit drugs and misused prescription drugs. At best, use and abuse of these substances lead to increased absenteeism, presenteeism and reduced productivity, while at worst they contribute to unsafe work environments that can involve accidents, injury and death.

Importantly, substance abuse and dependency can affect all employees in the workplace, and not just those directly afflicted with an addiction. Higher turnover rates, lower staff morale, dangerous behaviour, theft to fund addictions and increased costs associated with employees who collude to, or feel compelled to, cover for an addicted employee are all factors associated with the intangible costs of addiction.

CANADIAN PRODUCTIVITY LOSSES FROM TOBACCO, ALCOHOL AND ILLEGAL DRUGS*

	TOBACCO	ALCOHOL	DRUGS
Long-term disability	$10.5 billion	$6.2 billion	$4.4 billion
Short-term disability (days in bed)	$24.4 million	$15.9 million	$21.8 million
Short-term disability (days with reduced activity)	$36.2 million	$23.6 million	Data not available
Premature mortality (e.g., fatal accidents)	$1.9 billion	$923 million	$248.5 million
TOTAL	$12.5 billion	$7.1 billion	$4.7 billion

Source: The Costs of Substance Abuse in Canada 2002 *(Canadian Centre on Substance Abuse, 2006).*
**Numbers rounded.*

THE DEMOGRAPHICS OF ADDICTION

While no particular industry or social group is innately prone to the development of substance dependencies, broad themes nonetheless emerge across the many studies and surveys that have looked at the issue of abuse and dependency among workers.

The report *Worker Substance Use and Workplace Policies and Programs*, published by the U.S. Substance Abuse and Mental Health Services Administration, found that the highest rates of illicit drug use are found in the food services, construction, transportation, installation, maintenance and arts and entertainment industries. Common across all of these industries are low supervision, lower remuneration and high staff turnover, as well as demanding work environments. Males, particularly those with little education who work within a lower income strata, are more likely to abuse drugs and alcohol. Younger workers are also more likely than older employees to abuse drugs. Employees working in public administration, education, utilities, community/social services and protective services had the lowest prevalence of drug use.

ABUSE & DEPENDENCY AS OCCUPATIONAL HEALTH & SAFETY ISSUES

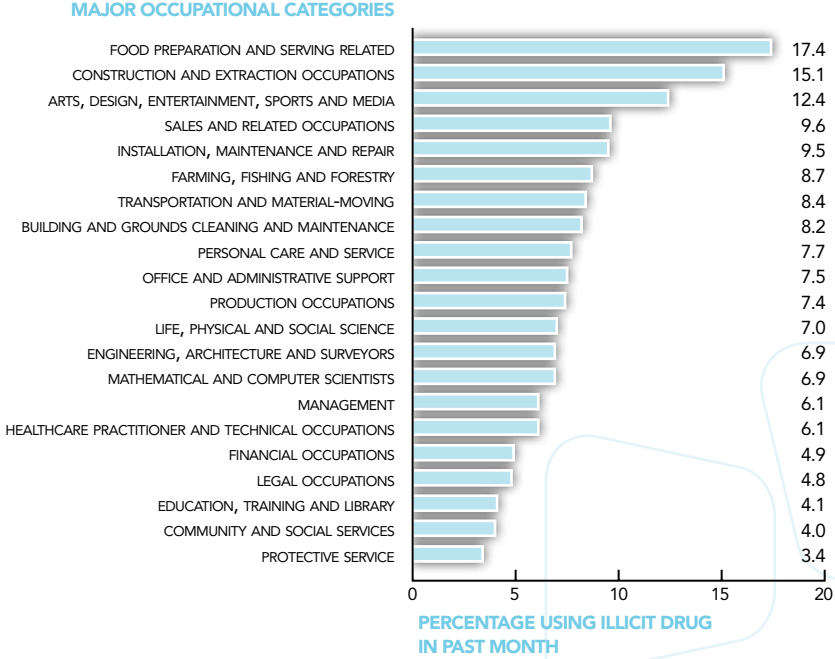
Beyond accidents, injuries, lost productivity and other major costs, substance use and abuse in the workplace can lead to:

- Reduced individual efficiency, poor decision-making and difficulty performing tasks
- Lateness, fatigue and sleeping on the job
- Lower workplace morale for all workers and increased friction with co-workers and supervisors
- Theft to support dependency, selling of or procuring drugs in the workplace
- Higher staff turnover, training challenges and disciplinary procedures
- Costs associated with drug testing, higher EAP usage and health benefits

Some key job-related factors that contribute to abusing substances in the workplace include:

- Low visibility/supervision of work behaviours
- High degree of mobility during work hours
- Lack of formal policies governing drug use
- Sense of approval in specific sectors (e.g., entertainment industry)
- High stress levels
- Repetitious job functions
- Fatigue

PAST MONTH ILLICIT DRUG USE AMONG FULL-TIME WORKERS AGED 18 TO 64, BY MAJOR OCCUPATIONAL CATEGORIES: 2002–2004 COMBINED



Adapted from: Worker Substance Use and Workplace Policies and Programs, *Substance Abuse and Mental Health Services Administration, 2007.*

CHAPTER 3:

Overcoming addiction

Addiction is a particularly complicated medical disorder, with many varied contributors. No single approach is considered appropriate for all addicted persons. Help with overcoming substance-related issues needs to be an individualized process. It is a complex and challenging task, requiring the support of the employer and the employee.

"Treating substance dependency is at least as difficult as treating other types of addiction, such as those to food and sex, and as difficult as overcoming obesity given the physiological changes that take place with both diseases," explains Dr. Greg Banwell. "It is a serious mental health issue — for the dependent person, it's very difficult to overcome the neurological changes that have taken place."

Several decades of research have resulted in the development of a variety of broad approaches to treating addiction, each of which is tailored to meet individual requirements. So far, researchers and health practitioners have not identified a proven method for matching specific interventions to particular individuals.

There are misconceptions of what constitutes effective treatment for the disease. The media is full of examples of celebrities being whisked away to treatment facilities and re-emerging, "cured," a mere 28 days later. This portrayal contributes to the unrealistic perception that chronic disease treatment is a one-time event centred around detoxification (National Council on Alcoholism and Drug Dependence, 2006). Rather, like any other chronic disease, relapse is common and treatment requires a longitudinal approach that reflects the chronic, relapsing nature of the disease. Detoxification is simply the first step in getting someone ready to benefit from psychosocial and other addiction treatments.

The severity of an individual's addiction, the nature of the substance(s) to which they have become dependent, the degree to which they are willing and able to participate in treatment, the presence and nature of any related mental health issues and the therapeutic resources available are all factors that will impact which approach is pursued, for how long and under which circumstances. Treatment programs typically involve a combination of modalities based on these criteria, the sum total of which is designed with one simple goal in mind: to help the person with a dependency issue regain control of his or her life.

RELATED MENTAL HEALTH CHALLENGES

Researchers and health practitioners have identified a clear relationship between addiction and mental health disorders — concurrent mental illness has been identified in as many as 30% to 50% of people who report a substance use problem. Put simply, an individual with a substance

CONCURRENT DISORDERS

Some common combinations seen in concurrent disorders:

Anxiety disorder + problem drinking

Schizophrenia + marijuana dependence

Borderline personality disorder + heroin dependence

Depression + sleeping pill dependence

—About 50% of persons with mental illness are also tobacco smokers, and about 70%–90% of persons with addiction to alcohol, are also smokers.

—53% of people with a substance use disorder other than alcohol will experience a mental health disorder, as will 37% of those with an alcohol disorder — respectively four times and two times the rate of the population without a substance use disorder.

—It's a two-way street: The DSM IV-TR recognizes these substance-induced mental disorders: delirium, persisting dementia, amnestic (contributing to amnesia), psychotic, mood, anxiety, sexual dysfunction and substance-induced sleep disorder.

dependency issue is at increased risk for having a mental health disorder, and vice versa, creating what is referred to as a concurrent disorder. Both sides of this health equation must be treated to effectively help people who suffer from these conditions.

According to a CAMH report, anxiety and mood disorders in combination with substance dependence are the most common concurrent disorders. "Addiction alone is one issue, but research suggests that as many as half of people with addiction may have a co-occurring mental illness," says Dr. Charl Els. "The most common reason for relapse to drug use is untreated mental illness. And the most common cause of relapse to mental illness is untreated drug use problems. We are only starting to wake up to this phenomenon. When we talk about addiction in the workplace, we cannot artificially separate these conditions any longer. Integrated treatment models are required to address both mental illness and addiction at the same time."

Because it is a chronic disease, achieving control over dependency often requires a significant investment of time — there are no quick fixes that reverse the profound physiological, neurological and psychological effects drugs can have on the brain and behaviour. Once achieved, maintaining control then requires frequent monitoring and adjustment to the treatment regimen, a process that very often involves relapses and subsequent readjustments to the program. For some types of dependency, recovery is a lifelong process.

Substance abuse and dependence treatment can be accessed in a variety of settings — on an inpatient (or residential), outpatient or partial hospitalization basis, using both behavioural and pharmacological approaches, at the same time. Most programs also offer access to 12-step groups (e.g, AA, NA, CA, etc.).

Treatment retention is one of the most important factors predicting success, and staying in treatment for a sufficient period of time is associated with better outcomes than short-term treatment. This does not mean that individuals have to remain off work for the total period of time, but many can return to work and continue with outpatient treatment after completing residential treatment.

Many factors impact whether or not an addicted person remains in their prescribed treatment program. Strong personal motivators that help prevent dropouts include keen support from family, friends and co-workers, as well as pressure by

SELECTED KEY PRINCIPLES OF EFFECTIVE ADDICTION TREATMENT

1. No single treatment is appropriate for every person or type of addiction.
2. Treatment needs to be accessible and available when needed — the earlier addictions are treated, the better the outcomes.
3. Treatment must address more than just the substance dependency and must focus on associated medical, psychological, social, occupational and legal issues. Sensitivity must be given to age, gender, ethnic and cultural considerations.
4. Remaining in treatment for an appropriate amount of time — determined by individual needs — is critical to success.
5. Treatment plans require continual assessment and adjustment to meet the changing needs of the person facing dependency issues over time.
6. Integrated, concurrent treatment for mental illness and dependency is necessary when applicable.
7. Treatment does not have to be voluntary to be effective.
8. Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse.
9. Individuals in treatment must be monitored for relapses.

Adapted from: Principles of drug addiction treatment: A research-based guide, *NIDA, revised 2009.*

employers, courts and/or the family to seek treatment. Programs that are designed with input from the addicted person and that outline clear objectives also tend to be more successful, according to the National Institute on Drug Abuse (NIDA).

The good news, according to a NIDA review of available evidence looking at the success of various treatment paradigms, is that the majority of individuals who enter and remain in a treatment program that suits their unique needs actually stop using drugs and see clear social, professional and psychological benefits. Treating addiction, they conclude, is also cost effective, with a return on investment ranging from $4 to $12 for every dollar spent on treatment.

WHAT ARE THE OPTIONS FOR ADDRESSING ADDICTIONS?

Self-change

Many people with abuse and dependence erroneously believe they are in control of their substance use and that they are able to stop whenever they wish. In reality, few individuals are able to stop, and extremely few who have had an addiction problem with alcohol or other drugs successfully continue to use these (or any addictive drug) in moderation. To supplement formal addiction treatment, many resources are available in the form of books and web sites that can help with self-change efforts. In the case of tobacco addiction, over-the-counter products can bolster self-help attempts.

Although many people who suffer from substance-related disorders choose to rely on self-change and not access treatment, the emphasis should always fall on offering the least restrictive level of care that is safe and effective. People should generally not be encouraged to rely on self-change, as there are effective and safe treatment options available.

Self-help groups

Most people are familiar with the peer group support format employed by Alcoholics Anonymous and similar organizations. Such programs are not religious in nature, but rather termed "spiritual." They are widely available across Canada for a variety of addictions. Their goals range from focusing on the reduction in use of a certain substance (or the reduction of harmful behaviours) to outright abstinence, and all are modelled on the principle that peer support and social reinforcement promotes drug-free living. People suffering from addictions are advised to access such groups, but also not at the exclusion of evidence-based interventions and approaches.

TREATMENT APPROACHES

Some essential principles of addiction treatment programs include the following:

Detoxification/Withdrawal management

The process of clearing the body of drugs is often the first stage of treatment for many addictions, whether that treatment is administered on an in- or out-patient basis. Ameliorating the sometimes life-threatening physiological effects of withdrawal using pharmacotherapy and other approaches is the key goal of detoxification. So is beginning to address any concurrent psychological or physiological issues related to the addiction, as physical detoxification in and of itself does not contribute to the long-term behavioural changes that are key to successful recovery efforts. Unless detoxification is followed by other treatment, it is of little value in improving long-term outcomes

Individual and group counselling

Many psychotherapeutic treatment options are offered in either individual and/or group psychological counselling settings. One such modality emphasizes short-term behavioural goals and the development of coping strategies for the long-term avoidance of substances. Programs that employ cognitive behavioural therapy — a psychotherapeutic intervention that teaches people methods to avoid situations that place them at risk for relapse and to cope with the urges to use drugs — are common. Group counselling adds peer support and shared learning to the process. Another modality, which is proven to improve outcomes, is called motivational enhancement therapy.

Short- and long-term residential treatment and counselling

An individual who cannot be managed in the community (as an outpatient) is often referred to residential programs, for which stays can vary from days to several months in length, with extended residential services added on in some settings. These programs are typically aimed at more severe cases of addiction and related mental illness. Treatment in these settings is most likely more intensive, and employs a combination of individual and group counselling techniques, 12-step work, pharmacological support and close supervision. Day programs are also available that allow individuals in treatment to return home at night or to work for part of each day. Relapse risk

management and attention to recovery environments after discharge play a huge role in addiction treatment as well.

Pharmacological support

Certain medications and drugs can act as maintenance therapies for specific addictions to reduce harm and to control side effects. The best scientific evidence for addiction treatment medication is for opioid addiction (e.g., heroin, oxycodone, Percocet, morphine and others), alcohol addiction and tobacco addiction. Nicotine replacement therapy (NRT), bupropion and varenicline can increase abstinence rates in those quitting smoking. According to *Treating Tobacco Use and Dependence: 2008 Update*, "Numerous effective medications are available for tobacco dependence." The publication cites the 2008 U.S. clinical practice guidelines, which suggest that "clinicians should encourage their use by all patients attempting to quit smoking — except when medically contraindicated or with specific populations for which there is insufficient evidence of effectiveness." Other medications are available for those addicted to alcohol, including naltrexone, disulfiram and acamprosate. For opioid addiction there is methadone, Suboxone or naltrexone. Pharmacological interventions that help with concurrent mental illnesses related to the addiction, such as the use of antidepressants, are also used to treat individuals with abuse and dependence disorders.

Employee benefits and assistance programs

See Chapter 8: Developing substance abuse policies.

HARM REDUCTION

The harm reduction approach to addiction management is not without controversy, particularly in North America, where treatment has more commonly been viewed from a disease management perspective. Harm-reduction focuses on prioritizing and addressing the negative consequences of substance use and abuse (disease, death, crime, personal suffering), rather than focusing on the user's participation in treatment and/or stopping use. Enabling informed decision-making by substance users underscore this approach, according to the Canadian Centre on Substance Abuse, as does providing them with the means to reduce harm by making safer choices. The use of methadone as a replacement for heroin is a common example of a harm reduction technique, as is the provision of clean needles to intravenous drug users.

STAGES OF CHANGE

The Stages of Change model was first proposed in the late 1980s to describe the step-wise manner in which smokers managed to successfully overcome their addiction. Note that change is not one concrete set of actions, but rather a series of behavioural modifications; those with substance dependency issues often move back and forth along this continuum until they finally achieve control. The model has been successfully applied to many models of problem behaviour and addiction, including alcohol, and many abuse and dependency treatment programs are designed to provide step-wise care targeted towards each phase:

PRECONTEMPLATION: The individual is not thinking about quitting or thinks it is impossible and not worth trying.

CONTEMPLATION: The individual seriously considers quitting, but often weighs what they see as the pros and cons (e.g., smokers may be reluctant to quit if they associate smoking with another activity they enjoy).

PREPARATION: Goals to quit within a given time have been set, often involving a "cutting down" of substance use or certain behaviours.

ACTION: The point at which the individual takes steps towards making a change or seeking help, and the early stages following the initiation of treatment.

MAINTENANCE: The ongoing reinforcement, monitoring and adjustment of treatment.

RELAPSE: Problem behaviour or substance use has resumed. Like most chronic diseases that involve both physiological and behavioural aspects, addiction is prone to relapse. Relapses should not be viewed as failures, but rather as indications that treatment approach/plan modifications are necessary.

CHAPTER 4:

Common addictions: NICOTINE

It's a testament to the power of addiction.

Smoking remains the top preventable cause of death and disease in Canada and around the world in spite of mountains of research over the past several decades that have revealed the side effects of first- and second-hand smoke on the human body.

Exposure to cigarette smoke and its more than 4000 chemicals — of which there are at least 172 toxic substances, 33 hazardous air pollutants, 47 chemicals restricted as hazardous waste and 67 known human or animal carcinogens — has been implicated in 85% of lung cancers, as well as the development of several other forms of cancer, respiratory diseases and cardiovascular disease.

While the use of nicotine continues to decline in Canada, 18% of Canadians aged 15 years and over reported smoking last year. Direct and indirect costs of smoking outpace those of alcohol and illegal drugs, and are particularly costly to employers. Health Canada says that almost 40,000 Canadians die each year from the effects of tobacco smoke — or, put another way, 16% of all deaths are the result of smoking *(The Costs of Substance Abuse in Canada 2002, Rehm et al.,* 2006).

"Smoking is still erroneously perceived as a choice or an adult decision," explains Dr. Charl Els. "It's only been since the 1980s that have we have had access to more effective, novel medical approaches to safely and effectively treat this disease. We now know it's a treatable chronic condition, like most other chronic diseases, and that treatments are effective, safe and cost effective. Employers are only now beginning to catch up to where the science has gone."

COST BURDEN PER SMOKER/ANNUM IN CANADA

Increased absenteeism	**$323.00**
Decreased productivity	**$3,053.00**
Increased life insurance costs	**$0.00**
Smoking facilities costs	**$20.00**
Total	**$3,396.00**

Sources: 2003 Canadian Tobacco Use Monitoring Survey; Smoking and the Bottom Line: Updating the Costs of Smoking in the Workplace; The Costs of Substance Abuse in Canada 2002; Tobacco Addiction: What do we know, and where do we go?

WHY IS IT SO HARD FOR PEOPLE TO QUIT SMOKING?

What makes tobacco so addictive? As drugs go, nicotine itself is a highly addictive compound not unlike cocaine and heroin in terms of its effect on dopamine levels in the brain. But the cigarette itself, according to Dr. Els, is a marvel of modern engineering, featuring no fewer than 150 design elements (such as the addition of ammonia) that allow the nicotine, when smoked, to be "free-based," meaning it gets to and acts upon the brain much faster than delivery through, for example, the skin or via chewing tobacco. In short, the cigarette makes nicotine as effective and addictive as it can be — a cigarette is "addictive by design," a highly engineered drug delivery device. Multiply this effect several times each day: according to NIDA, the typical smoker takes about 10 "puffs" on a cigarette over five minutes, meaning a person smoking 25 cigarettes per day receives 250 hits of nicotine per day, and some 100,000 doses per year. "From this perspective, nicotine inhaled through a cigarette is considered one the most addictive compounds on the face of the planet — as addictive as injected heroin, smoked crystal meth or crack cocaine," notes Dr. Els.

Smokers often make multiple attempts to quit before they are ultimately successful, with higher rates of relapse within the first few weeks and months following an attempt.

WHAT HELP IS AVAILABLE TO PEOPLE WHO WANT TO QUIT?

Smoking cessation should always begin with a trip to the doctor, who will be able help determine the best treatment and counselling options. Treating smokers can involve behavioural approaches (i.e., counselling) and pharmacological interventions, or a combination of the two, according to clinical practice guidelines developed by the U.S. Department of Health and Human Services. Research suggests that combination approaches effectively lead to higher cessation outcomes.

Pharmacological options in Canada currently include nicotine replacement therapies (NRT), bupropion hydrochloride (Zyban) and varenicline tartrate (Champix), the latter being the first in a new class of medications specifically designed to reduce cravings for nicotine, and the former an antidepressant that was discovered to reduce the urge to smoke. While both are effective, varenicline has been shown in clinical trials to triple success rates of quitting smoking. The oldest pharmacological options are nicotine replacement therapies (NRT), which are designed to administer nicotine to reduce the severity of withdrawal symptoms. Four over-the-counter varieties of NRT are available — the patch, gum, an inhaler and a lozenge. NRT, bupropion and varenicline can increase abstinence rates in those quitting smoking.

Counselling is an important component of a quit program, whether it is delivered in a group setting or on an individual basis, and can help soon-to-be ex-smokers with strategies to manage cravings and avoid the triggers and high-risk situations that cause relapse.

Source: Tobacco Addiction: What do we know, and where do we go? (white paper)

WHAT CAN EMPLOYERS DO TO HELP THEIR EMPLOYEES QUIT SMOKING? WHY SHOULD THEY?

Most workplaces prohibit the use of alcohol and illicit drugs, and many have policies in place that limit where and when smoking can take place — but nicotine addiction is often looked upon as a lifestyle choice, and not a serious, life-threatening chronic disease. Recognizing it as such and including it among addictions covered by a substance abuse policy is a critical step towards helping employees.

Long-term health risks and associated costs aside, smoking represents a slow draw on the bottom line for many organizations on a daily basis. The Conference Board of Canada estimates that absences related to smoking cost employers $323 per year per smoking employee, and that each smoker costs his/her employer an additional $3,053 annually from lost time and productivity during "smoke breaks" (the majority of which are taken outside of traditional or authorized break times). Smoking also impacts costs in terms of increased health benefits usage, absenteeism due to related illness and facilities costs to accommodate smokers (e.g., providing and maintaining outdoor ashtrays).

Engaging employees to quit smoking through a comprehensive workplace program — involving EAP resources, counselling, education and other workplace wellness initiatives while covering the costs associated with NRT and pharmacotherapy — has been shown to be one of the most cost-effective investments in health an employer can make.

"Employers should recognize that, by treating tobacco addiction among employees, they can positively impact their bottom line," Dr. Els concludes. "There are models available whereby employees can be helped — there is no quick fix and, yes, there are short-term economic implications, but in the long term, there is a strong business case to identify and treat this disease."

CHAPTER 5:

Common addictions: ALCOHOL

When it comes to bending the elbow, more Canadians are drinking than ever before — 79% of the population in 2004 reported consuming alcohol, 6% of whom drink heavily (five or more drinks for men at one sitting; four or more for women) at least once each week (Canadian Addiction Survey).

When the Alberta Alcohol and Drug Abuse Commission looked at alcohol use in the workplace, they found that travelling for work, putting in long hours and overtime, working at remote job sites and being entertained by business contacts were all associated with higher usage rates. Job stress and the degree to which individuals were satisfied with their position were not associated with drinking. The survey also found that utilities, forestry/mining and public administration workers generally used alcohol more than those employed in any other sector, while at-work use was more prevalent among financial, insurance, real estate and other service sectors.

Although the percentages may seem insignificant, they actually tell a sobering tale about the potential scope of alcohol abuse. Though only 1% of Albertan workers reported having problems at work because of alcohol, 11% said they drank while at work — which translates into more than 180,000 workers in that province alone.

WHAT ARE THE COSTS ATTRIBUTED TO ALCOHOL ABUSE?

Despite these figures, public perceptions about the costs and harms associated with alcohol abuse remain out of line with reality — even though the direct costs attributed to alcohol are double those of all illicit drugs combined, Canadians think that illegal drugs are the larger problem (*Comparing the Perceived Seriousness and Actual Costs of Substance Abuse in Canada*).

ALCOHOL USE IN CANADA BY THE NUMBERS

4,258 — The number of deaths attributed to alcohol in Canada in 2002

1,550,554 — The number of acute care hospital stays (in days) due to alcohol in 2002

25.5% — Proportion of Canadians who say they drink heavily at least once each month

17% — Proportion of drinkers considered to be at high risk for harm

Sources: Canadian Addiction Survey; Canadian Addiction Report; Cost of Substance Abuse in Canada

A U.S. survey (*J Stud Alcohol.* 2006) that specifically looked at drinking in the workplace estimated that 15% of the workforce is affected by alcohol use and impairment on the job — almost 2% of respondents reported drinking before work, while 7% said they drink during the work day and 9% admitted to working with a hangover.

Of the almost $15 billion in direct and indirect costs to Canadians, $7.1 billion is attributable to lost productivity, $6.2 billion of which is due to long-term disability costs. The difference is made up of costs associated with premature mortality and short-term disability as measured by days in bed and days with reduced activity (*Cost of Substance Abuse in Canada).* According to the Substance Abuse and Mental Health Services Administration, healthcare costs for employees who abuse alcohol are double those for other employees, and individuals who use alcohol at work or drink heavily during off hours are more likely to take longer breaks, leave early, sleep on the job and experience high job turnover. Alcohol abusers are also three times more likely to be involved in a workplace accident.

WHAT ARE THE HEALTH EFFECTS OF ALCOHOL ABUSE?

Alcohol is a depressant that slows activity in the nervous system; at lower doses it produces relaxation and lowered inhibitions, while at high doses it impairs cognition, memory and physical coordination. While moderate use of alcohol may have some health benefits and social currency, heavy consumption is known to damage organs such as the heart, lungs and kidneys, and can cause cirrhosis of the liver, diabetes, cardiovascular disease, psychiatric conditions and even cancer. Drinking during pregnancy can cause fetal alcohol syndrome and other disorders in the fetus.

Concurrent mental illness and abuse of illicit drugs are common among those who misuse alcohol, as is smoking for upwards of 90% of individuals with an alcohol addiction.

HOW ARE ALCOHOL ABUSE AND DEPENDENCY TREATED?

Participation in self-help peer groups, such as Alcoholics Anonymous, has been shown to be moderately successful, helping almost 50% of participants to stop drinking. More commonly, a combination of group and individual counselling, including cognitive behaviour therapy and pharmacotherapy are employed. Drugs available for the treatment of alcohol dependency in Canada include disulfiram (Antabuse), a drinking deterrent, and naltrexone (ReVia), which may reduce alcohol consumption and prevent relapse.

CHAPTER 6:

Common addictions: ILLICIT DRUGS and PRESCRIPTION MEDICATIONS

ILLICIT DRUGS

According to the *2007 National Survey on Drug Use and Health,* published by the U.S. Department of Health and Human Services, most drug users are employed.

Of the estimated 17.4 million illicit drug users 18 years of age or older in the U.S., fully three quarters are full- or part-time members of the workforce. Other, recent U.S. data (*Journal of Applied Psychology,* 2006) found that 3% of employed adults used illegal drugs in their place of employment during work hours, more than half of whom did so at least once per week. Almost 100% of these workers reported at least some impairment arising from use of the drugs.

The Canadian Addiction Survey (2004) reports that the most commonly used illicit drug in Canada is cannabis (marijuana, hashish). Almost half of Canadians have used cannabis in their lifetime, and 14% in the year preceding the survey. Most forms of cannabis are inhaled, and use of the drug causes depressant effects, impaired perception and coordination, as well as troubles with problem solving, learning and memory. Harms associated with the drug include failure to control use (4.8% of users), strong urges to use (4.5%) and concerns about use from friends (2%). Males, and younger people in general, are more likely to use cannabis. Overall, use of this drug is increasing over time, and so are the problems associated with it.

Hallucinogens (such as LSD, PCP, ecstasy) are the next common category of illicit drug used by 11% of Canadians in their lifetime. Cocaine (10.6%) and amphetamines (6.4%) round out the top four. Less than 1% of the

ILLICIT AND PRESCRIPTION DRUGS BY THE NUMBERS

1,695 — Number of deaths attributed to illegal drugs in Canada, 2002

11% — Proportion of admissions to substance abuse treatment programs in Ontario in 1999–2000 for abuse of prescription drugs

1 in 10 — Number of Americans who admit having misused a sedative

$1.70 — The cost of one 60 mg tablet of a brand-name slow-release morphine tablet

$35 — The value of that tablet on the street

Sources: CSSA Prescription Drug Abuse FAQs; Cost of Substance Abuse in Canada

population report using inhalants, heroin, steroids or intravenous drugs during the past year. Reported harms related to abusing these substances include damage to physical health (24% of past-year users), to friendships and social life (16% of past-year users) and to marriage and work (roughly 14% each for past-year users) (*Canadian Addiction Survey*, 2004).

PRESCRIPTION MEDICATIONS

The degree to which prescription drugs are abused (used contrary to the manner in which they are prescribed) in Canada remains unclear, but as a nation we are among the global leaders in the consumption of medications — second for benzodiazepine use, fourth for prescription narcotics and in the top 15 nations in terms of stimulant usage — many of which have the potential to be abused (Substance Abuse in Canada).

According to NIDA, non-medical use of prescription medications in the U.S. is most commonly reported for painkillers (opioids such as morphine, oxycodone, codeine), tranquilizers (benzodiazepines such as Valium and Xanax) and stimulants (amphetamine and central nervous system depressants).

A combination of group and individual counselling, including cognitive behaviour therapy, and pharmacotherapy (e.g., methadone, buprenorphine [Suboxone] or naltrexone for opioid addiction) are employed to treat abuse and dependence to illicit and prescription drugs of the opioid class.

CHAPTER 7:

Developing substance use policies

Given the prevalence of substance abuse and dependency among workers and the devastating personal, social and economic effects the disease brings about, what can employers do to ensure they are meeting the needs of their employees while protecting the workplace from related risks?

The answer, experts say, is fairly simple, though perhaps easier said than done: set appropriate policies, continually educate staff about them and constantly monitor for their effect.

"The winning formula for doing your best for addicted employees is to have prepared in advance very clear policies and to have communicated them so that every employee knows what the expectations are concerning substance use," explains Dr. Greg Banwell. "Second, a high level of training is required for all management levels — if not all employees — about the risks of substance use to the company and to the employee's long-term health, their families and their communities."

Once established, employees' understanding of — and trust in — those policies must be cultivated in order for them to work effectively.

"There's absolutely no point in developing policies unless you are going to make the effort to create the circumstances under which they can be learned and accepted," says Gerry Smith. "Employees need to see that the policy can be put into practice, that it is fair and consistently applied and that people who become affected by an addiction issue are treated confidentially and in the same humane manner as if they had any other disability."

WHAT ARE THE KEY ELEMENTS OF AN EFFECTIVE SUBSTANCE USE POLICY?

The overarching goal of any workplace policies concerning addiction should be to prevent conditions that encourage substance use (e.g., sales of tobacco onsite, funding alcohol for social events), prevent exposure of employees to substance use (e.g., secondhand smoke, impaired driving), foster early detection of any substance-related issues (e.g., monitoring accidents), provide help to those employees who require it (through comprehensive EAPs), support their return to work (e.g., reducing hours if necessary) and provide long-term support (to prevent relapse).

According to the Canadian Centre for Occupational Health and Safety, a comprehensive workplace substance use policy should clearly state the need for the policy as well as its objectives, identify who is bound by the policy, define substance use and abuse and enshrine all employees' right to confidentiality.

An effective plan should also:

» Clarify that substance use in the workplace is strictly prohibited;

- Model non-support of the use of any substance, such as:
  - Provision of non-smoking grounds on the workplace;
  - Refusal of partnering with, funding from or advertising of tobacco or alcohol;
  - Refusal to sell tobacco on the worksite;
  - Refusal to provide free alcohol or tobacco during social events; and
  - Carefully monitoring medications that may be available in the workplace.
- Have provisions for employee education about substance use and abuse, and any assistance programs available to them;
- Develop comprehensive employee benefit plans that include support for family members, as this contributes to successful outcomes;
- Ensure that employees, supervisors and management are trained in the identification of impaired behaviour;
- Clearly outline processes for intervening with impaired workers;
- Map out policies regarding alcohol and drug testing and dependency assessment;
- Map out policies regarding employees' obligation to seek and comply with treatment; and
- Transparently define disciplinary actions related to substance use.

As well, human resources and/or legal experts should be consulted during the development of workplace substance use policies to ensure all federal and provincial regulations are followed.

"The key for any policy is to enshrine the notion that drugs and alcohol in the workplace is a safety issue," says Gerry Smith. "A good policy should be supportive, not punitive, in its approach. Our job in the workplace is not to diagnose or judge employees — it's to manage people, and the best way we can do that is to manage performance and behaviour. People need to come to work in such a condition that they are fit to work, and perform their job functions appropriately. Clear poli-

EMPLOYEE AND FAMILY ASSISTANCE PROGRAMS

Employers can bolster employees' ability to cope with substance abuse challenges by offering benefits that provide general wellness information, screen for disease, provide medical and counselling assistance for afflicted workers and their families and assist with employees' efforts to return to work.

Evidence suggests that EAPs can play a significant role in addressing addiction issues for employer and employee alike, and when administered properly improve return-to-work outcomes. Well-designed and implanted programs can offer a holistic suite of solutions to substance use in the workplace, from providing confidential screening and treatment referral services to providing support during recovery.

Good EAP providers focus on sound policy development, employee education and identifying and properly treating problems, while working in line with expectations surrounding workplace performance and behaviour.

RETURN ON INVESTMENT

According to NIDA, various studies have concluded that every $1 invested in addiction treatment programs returns upwards of $12 in reduced healthcare, drug-related crime and law enforcement costs. Other benefits include reduced interpersonal conflict, higher workplace productivity and fewer drug-related accidents, including overdoses and deaths.

cies and expectations can help set the tone and keep everyone on the same page."

The organization should also reflect on any contribution the conditions of employment might have that increase the risk of their employees developing an addiction. This may include pain related to injury or fatigue and disruption related to shift work and frequent travel. It may be key for the organization to mitigate any such risk.

WHAT ARE THE LEGAL AND ETHICAL ISSUES EMPLOYERS NEED TO CONSIDER WHEN DEVELOPING A WORKPLACE SUBSTANCE USE POLICY?

Employers have much to consider when developing and implementing a substance use policy, particularly since Canadian employment law identifies substance dependency as a disability, and since obligations under the Canadian Human Rights Act compel companies to make efforts to help disabled employees keep their job. Such accommodations must be made even when an employee does not openly admit to having a substance problem, which makes identifying behaviours indicative of impaired work all the more critical. Adding to that challenge is knowing when and how to intervene, and to what extent.

"The moment that a diagnosis of dependence takes place, the problem is indeed regarded as a disability," explains Dr. Banwell. "Drug use, while it can be harmful, can be treated as a performance issue. But if an employee is addicted, the course of action will be different — you then have a health benefits issue. What's difficult for employers to know is how far do you go in determining the extent of the problem? Who do you test for substance use, how often and under what circumstances? Who gets access to the employee's information? There are lines that can and cannot be crossed, but they are sometimes poorly defined, even within Canadian case law. Employers often find themselves not knowing what to do."

Some organizations in Canada require employees to undergo chemical tests for substance use or psychological assessments to determine the extent of an individual's abuse of, or dependence on, a particular drug. For the most part, drug testing in this country occurs within a safety-sensitive context, among workers employed in higher risk industries, such as transportation, construction and mining, or for employees who have returned to work following treatment for addiction. No matter what the circumstances, testing and screening are hot-button issues for employers and employees alike, a potentially tangled web of human rights, workplace safety and professional practice/ethical issues.

"When it comes to crafting policies, the goal is to find the pathway that best manages risk, using a standardized and evidence-based approach where possible for assessment and treatment, and an informed point of view in terms of the regulations governing these policies," Dr. Banwell concludes.

Dr. Banwell and Smith offer these additional insights on developing and implementing substance use policies:

- Developing a comprehensive substance use policy is an integrated effort within any organization, not just something conceived of and executed by a human resources department. It should involve senior management, supervisors and employees, as well as legal, HR and communications departments.
- Small- and mid-sized employers who lack expertise in addiction issues and who have fewer in-house resources can benefit from using third parties to craft and implement effective policies. Many employers ignore the problem too long, thinking they cannot afford to pay attention to it — but there is an established return on investment.
- Train managers and supervisors on how identify changes in behaviour and how and when to intervene with an employee. Don't forget that managers, too, can face addiction issues, and so

special policies may need to be crafted to accommodate losing a key employee to treatment.

» Be aware of changing behaviours among staff in the workplace. Get to know their regular patterns of behaviour, and when deviations are noticed, don't wait until it's too late — intervene.

» Demonstrate the success of your policy — without compromising confidentiality, regularly communicate to employees about how many people it has helped successfully return to work.

Dr. Charl Els agrees that employers have much to do when it comes to helping employees face addiction. "There is still an erroneous perception that addiction is a moral issue. Or a choice and not a disease — therefore many people don't seek help," he says. "From a workplace perspective, the sooner we can recognize addiction as a *bona fide* chronic and treatable medical condition, the better job we can all do at identifying those with addictions and matching them with the right treatment. And the sooner we do that, the better we'll do at reducing the negative impact on the workplace itself. That is also where the real cost-savings would be."

THE SPECIAL CASE OF TOBACCO

There are several advantages inherent to addressing tobacco reduction in the workplace setting:

» It provides access to a large number of people who make up a relatively stable population,

» It has the potential for higher participation rates than non-workplace environments,

» It may encourage sustained peer group support and positive peer pressure,

» It provides a particularly good opportunity to target young men (who traditionally do not access medical care and have some of the highest rates of smoking),

» There may be occupational health staff available to implement interventions, and

» The employee is not required to travel.

The models and methods of tobacco cessation interventions will be familiar to those human resource departments that have experience managing employees who use alcohol and/or other drugs. Employers' efforts to offer smoking cessation support are generally valued and appreciated by employees and their families. Seventy percent of people who smoke are interested in quitting, and almost half of all smokers will make a quit attempt in any given year (CTUMS, 2007). Also, quitting smoking provides immediate and sustained health benefits, supporting some of the objectives for workplace wellness initiatives.

THE STIGMA OF ADDICTION

The stigma that goes hand-in-hand with addiction adds yet another obstacle on the road to recovery for individuals afflicted with this illness. All too often, experts agree, the problem is kept in the shadows by people with substance use issues who are unable to seek help, and others (family members, friends, co-workers) who are all too happy to sweep a "dirty little secret" under the rug. Just as often, those who want to seek help for themselves or for others don't know where to turn or lack access to the resources they require to get help.

According to Statistics Canada, data culled in 2003 from the *Canadian Community Health Survey* suggests that over 20% of Canadians who self-identified as having one of five predefined mental disorders (including alcohol and illicit drug dependency) did not report seeking professional help. Most of these individuals sought to deal with the issue themselves (31%) and almost 20% did not seek help because they were afraid to reach out and/or afraid of what other people would think of them.

CHAPTER 8:

Case Studies

SMOKING CESSATION

John enjoyed smoking. It was the one "vice" (as he described it) that he allowed himself, and as a result, he indulged whenever the urge took him. He'd started smoking at a young age, both because it was the thing to do then, and because it actually seemed to help calm him down. Now, that had him up to a pack and a half a day, sometimes two packs a day on weekends. He knew that his friends and co-workers complained of an odour after he returned from stepping outside on breaks, but he didn't think it was that bad. However, John's doctor's opinion that his breathing difficulties were related to his smoking was beginning to weigh heavily on his mind.

Lately, John's supervisor Linda had spoken with him about the amount of time he was spending out on smoke breaks. She had said that not only was he completing less work than his colleagues, but that no one wanted to sit near him because of the smell of tobacco smoke, and that his "repeated coughing" was disruptive to the entire office.

Linda approached John discreetly to discuss the performance concerns that she had. Linda had consulted the human resources department and discovered that their health benefit package covered smoking cessation medications that can improve the odds of successful quitting. Their employer placed a high priority on workplace wellness and considered smoking cessation tools key to helping their employees become and stay healthy.

Linda also consulted her EAP provider and obtained information on their smoking cessation program, and formal referral process for performance management concerns. Linda learned that the program was comprehensive and started with identifying the client's readiness for change and then built motivation at that level. It broadened dissonance between each person's unique pros and cons for smoking, provided educational information, examined the appropriateness of both pharmacologic and counselling interventions, identified subjective triggers and hurdles, such as weight gain, anxiety, other emotional issues and stress, and prepared individuals with relapse prevention support.

When she called her performance review meeting with John, she presented her facts about how his smoking behaviour was interfering in the workplace and with his production. Despite disagreeing, she validated his perspective, yet held firm to her factual statements, and as compassionately as possible, explained to John that these issues needed to be resolved. Surprisingly, John shared that he enjoyed smoking, but was open to considering the idea of quitting, although he hadn't thought it through. Linda provided John with information on the EAP's smoking cessation program, and how it could assist him to explore the issue. John also agreed to revisit his doctor to discuss his breathing difficulties and medication options to help him quit smoking.

ALCOHOL SUSPICION

Carol is a 36-year-old administrative employee who has provided excellent performance in her role onsite at an oil refinery for the last four years. Throughout this period, her human resources manager, Dan, has become increasingly aware that absenteeism is a growing concern for her. Carol has used more than 12 sick days per year for the last two years, and has missed either Fridays or Mondays on average twice per month during the last eight months. He knows that she has had various personal struggles during her employment, however she has always completed her work well, and on time. In recent months however, Dan has noticed that she is beginning to take longer lunches, is frequently gone 45 minutes during the afternoon break, and her personal hygiene has become consistently poor. Last week she missed an important deadline, and when approached by Dan to discuss the matter, Carol responded uncharacteristically with defensiveness and hostility. This morning, when he passed by her in greeting, Dan believed he detected the odour of alcohol and that her speech was slightly slurred.

Dan shared his suspicions with Carol, and asked her to complete an alcohol breathalyzer test with the industrial testing service their company uses. The test was positive for alcohol. Dan contacted his EAP provider for best-practice suggestions for handling alcohol-related performance concerns. As a result, Dan decided to provide Carol with the opportunity to have a Substance Abuse Expert assessment done as the first step to manage this issue so she could receive help, and the company could try to retain a good employee. Dan informed Carol that the assessment would confidentially provide a determination of the existence and level of an alcohol problem, along with the appropriate treatment recommendations to resolve it. Further, the assessment would provide

Dan with direction about whether or not the company had a duty to accommodate Carol if the assessment results identified alcohol dependency, rather than a lesser diagnosis. After his performance meeting explaining the available options to her, Carol agreed to proceed with the assessment.

Carol was able to have the assessment within two days, and the results confirmed alcohol dependence. As a result of this disability, Dan recognized that the company was obliged to provide her with the opportunity to address her problem. Dan held Carol's position while she completed the inpatient treatment program and initiated the first of several ongoing relapse prevention counselling sessions, recommended by the EAP psychologist. After her first counselling appointment, Carol returned to work visibly improved. Dan continued to receive limited confirmations of her compliance with the additional relapse prevention recommendations over the next two years. This enabled him to know that Carol continued to receive the support she required, and that the company's risks associated with impaired performance on this site were being managed.

MEDICATION DEPENDENCE

In her late 30s, Nancy, a nurse in a large teaching hospital in downtown Toronto, works 12-hour shifts in a high-pressure intensive care environment. She deals with patients on a daily basis who have life-threatening illnesses — and the required care, constant focus and high level of dedication required is exhausting.

As a single parent, Nancy is also responsible for providing for her 10-year-old daughter. Working shifts makes it difficult to establish good routines at home, and she depends very much on the goodwill of parents and family to support childcare efforts and to foster as much normal activity as possible for her growing daughter. The laundry, the grocery shopping, paying the bills — it all mounts up. Nancy feels she is never really able to stop, even for a moment.

To make matters even more challenging, she is intent on excelling at her career, and is trying hard to enhance her skill and ability through continuing education. She wants to advance and get into the management side of the nursing profession.

One day, on the spur of the moment, she is feeling tired and exhausted at the end of the working day, but her mind is active. While no one is watching, she slips a small pill from the narcotics cabinet into her scrubs — after all, no one will notice one small pill missing from such a large batch. Before going to bed that evening, she takes the pill, in the hope that she will get a restful night, which she does.

It's not long before Nancy is making a habit of slipping morphine into her pocket. She's beginning to need the medication to get to sleep. She becomes worried that she'll be caught, and so she replaces the morphine with another over-the-counter medication that looks similar to the small pills she's been stealing.

It does not take long for the hospital to recognize something is wrong. Authorities are informed — a watchful eye is kept on the tracking of the meds, but still Nancy helps herself, because by now she can't stop. An investigation takes place — all staff are interviewed, and still Nancy is using the morphine to help her sleep, function and run her life. She is trapped, but feels unable to get out of the trap of needing to use and simultaneously wanting to quit.

Eventually, Nancy realizes that her employers might call in the police and cause her even more problems — she faces ruin from the loss of her job, perhaps the breakdown of her small family unit and certain expulsion from the college of nurses. So, she turns herself into the hospital, and is surprised to find compassion, care and an offer of supportive help she now needs to deal with her dependence. She knows she will have to face consequences only after her recovery, but that she has been given a chance to get help and salvage her career.

Nancy is now in her mid 40s. Her parents and family are still supportive, and her daughter is now a teenager. Nancy is a teaching nurse in intensive care in the same large teaching hospital in Toronto.

Resources

Al-Anon/Alateen:
www.al-anon.alateen.org

Alcoholics Anonymous Canada:
www.aacanada.com

Alcohol Policy Network (APN):
www.apolnet.ca

Canada Alcohol and Drug Rehab Programs:
www.canadadrugrehab.ca

Canadian Assembly of Narcotics Anonymous:
www.canaacna.org

Canadian Centre on Substance Abuse (CCSA): www.ccsa.ca

Canadian Harm Reduction Network:
www.canadianharmreduction.com

Centre for Addiction and Mental Health (CAMH):
www.camh.net

Drug Free Workplace Kit:
www.drugfreeworkplace.gov/WPWorkit/brochures_factsheets.html

Health Canada Quit for Life:
www.quit4life.com

National Cancer Institute, Fact Sheets:
Tobacco/Smoking Cessation:
www.cancer.gov/cancertopics/factsheet/Tobacco

National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada:
www.nationalframework-cadrenational.ca

National Institute on Alcohol Abuse and Alcoholism (NIAAA):
www.niaaa.nih.gov

National Institute on Drug Abuse (NIDA):
www.nida.nih.gov

Nicotine Anonymous:
www.nicotine-anonymous.org

Human Solutions
Humaines

Human Solutions Canada Inc.™ is a highly respected national organizational health provider, founded in 1979. We are guided by our desire to contribute to the total health, wellness and functioning of our customers' organizations through professional responses to the mental, social, workplace and health needs of their employees. We provide end-to-end assistance, dedicated to nurturing the entire employee life cycle.

Our philosophy is based upon the premise that by delivering the highest standards in service we will advance the development and wellbeing of organizations and their employees. We believe that employee health is a strategic issue that requires buy-in from all levels of the organization. This buy-in creates the opportunity for long-term gains in productivity and sustainable employee health.

Human Solutions assists companies from the ground up, beginning with selecting the right employees, to providing a comprehensive Employee and Family Assistance Program (EFAP) to an integrated Disability Management Program and customized communications that increase employee health awareness, Human Solutions partners with organizations across all industries to build the business case for health and wellness. We are instrumental in helping companies find and retain the best talent and we assist in forming an employee culture that focuses on total wellness and healthy living.

Owned and operated by the same people that founded the company over thirty years ago, Human Solutions prides itself on providing quality organizational health services to thousands of companies across Canada. Our approach to improving the workplace and all those involved allows us to build upon our knowledge and experience to truly maximize the potential of every one of our clients and each and every person that comprise them. We are the "just right" solution, dedicated to providing the professional support to improve the lives of all employees in the workplace.

Pfizer Canada Inc. is the Canadian operation of Pfizer Inc, the world's leading pharmaceutical company. Pfizer discovers, develops, manufactures and markets prescription medicines for humans and animals. Pfizer Inc invests more than US$7 billion annually in R&D to discover and develop innovative life-saving and life-enhancing medicines in a wide range of therapeutic areas, including arthritis, cardiovascular disease, endocrinology, HIV/AIDS, infectious disease, neurological disease, oncology, ophthalmology and smoking cessation. Global headquarters are located in New York City, where the company was founded in 1849. During the Second World War, Pfizer became the first company to mass-produce penicillin, launching Pfizer into the modern pharmaceutical era.

Pfizer Canada is one of the top investors in Canadian R&D, investing more than $130 million in 2006. Canadian headquarters of Pfizer Global Pharmaceuticals is in Kirkland, Quebec. Pfizer Canada also operates distribution facilities in Ontario and western Canada. As one of the top corporate charitable donors in Canada, Pfizer Canada is a proud member of Imagine Canada and its Caring Company program. In 2006, Pfizer Canada's Community Investment Program supported more than 1,000 non-profit organizations and projects across the country with a total investment exceeding $20 million. For more information, visit www.pfizer.ca.

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We also recognize that it takes More than Medication to be truly healthy, and it is our belief that, in addition to offering innovative medicines, we have a commitment to help Canadians live healthier, balanced lives.

This belief is reflected in everything that we do at Pfizer Canada, from our disease awareness efforts to our community partnerships.

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Pfizer Canada: Working together for a healthier world.

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Shepell·fgi is the leading provider of employee health and productivity solutions that address mental, social and physical health issues. Through solutions such as employee assistance programs (EAP), attendance management, disability management, pandemic services and organizational training, we help Canada's employers keep their workplaces healthy. We work closely with our clients to identify the health risks directly affecting their organization and provide strategic and integrated solutions that effectively address or prevent those issues while maximizing return on investment. Our solutions can be broadly placed in the following three categories:

Employee Assistance Programs

Shepell·fgi serves approximately 7,000 organizations, representing eight million employees and their family members. Each day of the year, we receive 4,000–5,000 calls from individuals seeking help from their EAP. Through best practice triage and assessment, followed by care from an extensive network of counsellors, case managers and professional service providers, individuals receive the help they need to remain present and focused at work. Services are offered in person, by phone, online or by self-directed learning and focus on prevention and encourage behaviour change, which are the most sustainable ways to resolve issues and eliminate recurrence. We also support people leaders with the tools and information they need to promote prevention and early intervention for employee health issues in the workplace.

Health Management

Since not every condition can be anticipated and prevented, Shepell·fgi takes an innovative approach to health management by integrating programs and services that provide seamless support along the entire continuum of care from pre- and early absence through intervention and recovery, including successful return to work.

We take a holistic approach to address the reasons people may be off work, and provide solutions to help them return to work. Our Health Management encompasses: Disease Management (includes health risk assessments, health screening and health coaching); Disability Management (integrates absence prevention, best practice case management and successful reintegration and return to work); and Occupational Health (includes hazard prevention, medical surveillance and testing).

Organizational Solutions and Training

Shepell·fgi's experts work closely with organizations to help them understand their unique workplace challenges, the causes of those issues and the solutions that will generate positive change and maintain high-functioning workgroups even during crises or times of significant change. Our organizational solutions include: pandemic planning and antiviral programs, trauma support, mediation, workplace assessments, cross-cultural training and global workforce preparation, support and repatriation.

We also have a Research Group dedicated to educating business leaders on the impact that mental, social and physical health issues have on individuals and their workplaces. Through a variety of research reports, we share a wealth of information and analysis, contributing to Shepell·fgi's position as a thought leader in employee health, wellness and productivity.


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