by **Joe Vanden Plas**

# Crisis Mode

## Opioid abuse is a public health emergency; employers can help mitigate its impact.

When a certain type of drug addiction is causing more than 100 deaths per day, and with untold more families worried about addicted family members, stronger treatment networks and support services are urgently needed. Opioid abuse is just that type of scourge, and it should be a chief concern of employers.

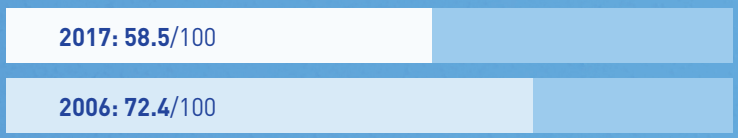
For health care professionals, the challenge is to improve the way opioids are prescribed in primary care settings because the widespread need for chronic pain treatment is very real. Unfortunately, so is the potential for misuse, abuse, and overdose from these potent drugs, and primary care providers have expressed concern about insufficient training in prescribing opioids.

"If peers at work notice something, then express concern to the person before going to HR or to your supervisor to see if you can support them in anyway. Try to be transparent."

—Shelly Dutch, founding director, Connections Counseling

### Dispensing Decline

Prescriptions of all opioids per 100 persons has declined as the American medical community exercises more caution.




Source: CDC 2018 Annual Surveillance Report of Drug-related Risks and Outcomes

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More than 11.5 million Americans ages 12 or older reported misusing prescription opioids in 2016, and the 17,087 deaths from prescription opioids reported that year represented a new annual record high among prescription opioids, according to the Centers for Disease Control and Prevention. Overall, 42,249 opioid overdose deaths were reported in 2016, and preliminary CDC data for 2017 indicate that more than 49,000 died from opioid related overdoses last year.

In a rare bipartisan vote of 396–14, the House of Representatives passed a comprehensive bill to address what is commonly referred to as the "opioid crisis." The law, a compilation of 58 different bills, expands access to treatment and recovery services, allows Medicaid to pay for treatment in certain inpatient facilities that treat mental illness, and identifies alternatives to opioids for pain management and treatment. It also contains provisions for intercepting illegal opioids at mail facilities and to address the use of illicitly manufactured fentanyl, which is driving increases in overdose deaths.

At the time of passage in June, the goal was for the U.S. Senate to act on the measure and send it to President Trump's desk by year's end. In the House, the measure was passed with the full knowledge that more legislation would be needed for what is an ever-changing situation, as even some supporters state the law represents only incremental change.

How widespread is the problem? According to the CDC's 2018 surveillance report, a total of 56.9 million people, or 17.4 percent of the U.S. population, filled at least one prescription for an opioid last year. To nobody's surprise, the highest percent (26.8) of person-level prescribing occurred among people ages 65 and older, but those ages 55–64 (26.3 percent) and 45–54 (23.1 percent) show that working age people are potential victims, as well.

There is evidence that the medical community in Wisconsin is being more careful, as the state recently announced a 32 percent decrease in opioid prescriptions dispensed since January 2015. However, given the ease at which people can become addicted to opiates — within seven days in some cases — it's no time to be complacent. "In my view, employers should be taking a very active role in dealing with this crisis," says Madison attorney Stephen DiTullio. "I read statistics that more than 70 percent of employers in the U.S. are reporting that they are having some impact of some type due to prescription drug misuse, and a lot of that is opioid. From that standpoint, it's an issue that's probably going to touch just about every business out there."

We spoke to a number of area professionals who offered advice to employers about how to help addicted employees. Our expert group includes DiTullio, as well as Shelly Dutch, founding director, and Kim Hurd, mentor coordinator and recovery coach trainer, both of Connections Counseling in Madison, and Dr. Todd Kammerzelt, an addiction psychiatry specialist affiliated with University of Wisconsin Hospitals and Clinics and the Veteran's Administration Medical Center and a consultant with The Manor, a residential treatment facility in Kettle Moraine. They offered six tips for identifying and helping employees cope with an opioid addiction.

## TIP 1: PUT IT IN WRITING

As part of investing in management education on this topic, Dutch recommends starting with a clear written policy for the business so there are no surprises and people know what to expect when an opiate addiction comes to light. Writing such a policy — in consultation with an attorney — is more of a human resources function, and it should be part of any corporate Employee Assistance Plan, but your legal representation should be well versed in employment law because workplace policies must be compliant with the Americans with Disabilities Act and other employment laws.

DiTullio, an attorney with the DeWitt Ross and Stevens firm, has worked on many employee handbooks and policies, and every handbook he's done over the past 20-plus years has had some type of

a drug-free workplace policy, including a drug and alcohol testing policy. Due to the more recent opioid epidemic, DiTullio says those policies must be updated.

In the past, it was fairly common to focus these policies on illegal drugs, so employees were tested for cocaine, PCP (phencyclidine), amphetamines, and other illegal drugs. If somebody was under the influence of alcohol during the work day, and if there was a reasonable cause to test them, they could get tested for alcohol, as well. However, until recently, most corporate drug policies had not addressed prescription drug use and misuse.

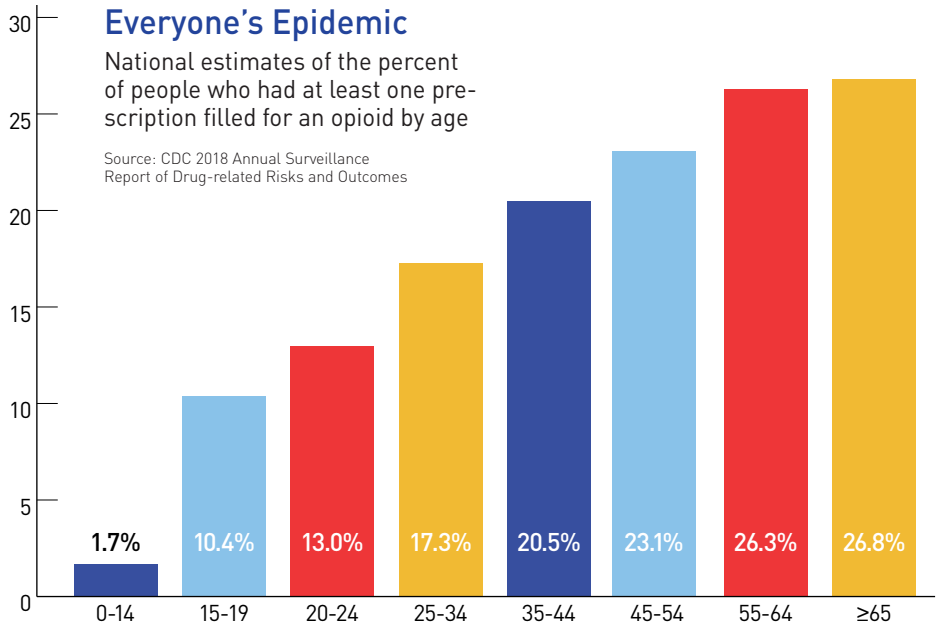
"Those policies need to be taken off the shelf and evaluated because it's a different world now, and this is such an epidemic that it's really important to get into the issue of prescription misuse," DiTullio states.

In his view, the refresh would start with the same types of things — that you have a drug-free and alcohol-free workplace. In regard to drugs, policies should state that employees can't use, possess, or sell illegal drugs or intoxicants, and they should specify the drugs they are testing for. While that part stays the same, DiTullio says today's policies also need a statement that says prescription and over-the-counter drugs are not prohibited as long as they are taken in standard dosage or according to a doctor's prescribed use.

"That's where we start to get into ADA issues and also, frankly, state law," DiTullio states. "The Wisconsin Fair Employment Act would probably view it the same way because there are people that are on prescription medications, including opioids for pain, and they are using them properly, they get done using them, and they don't use them again. That type of drug does stay in your system for a period of time, so if they got drug tested, maybe they have a very reasonable explanation. Certainly, if they are taking the drug pursuant to a physician's prescription, there is no issue there and there shouldn't be.

"If there is something they must continue to use during a period of time while the person is working, you would have to take a look at whether there has to be some kind of reasonable accommodation," he adds. "That should be mentioned in the policy."

However, employers also can and should include that if employees are taking either prescribed or over-the-counter medications, the employee ultimately is the one responsible for consulting with a physician and/or pharmacist. This is included to ensure the medication doesn't interfere with the safe performance of a job, which is particularly critical when workers operate heavy equipment in a manufacturing setting, or if they operate a vehicle, a truck, or a forklift.

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>
> — Stephen DiTullio, attorney, DeWitt Ross & Stevens

"Your policy should basically say, 'Employees, make sure that you have discussed this with your physician and/or pharmacist, and if there are impacts on what you can and cannot do, you've got to let us know because then the employer has to figure out whether or not this is something that can be reasonably accommodated," DiTullio advises. "Then you must go on and basically say if the use of the medication, and again we're talking about prescribed or over-the-counter, could compromise some type of responsibility the employee has, you have to figure out if it's best for them to be on a leave or use their vacation."

The final thing that must be added is a clear statement that the illegal or unauthorized use of prescription drugs or over-the-counter drugs is prohibited because that is something on which an employer can take disciplinary action. This is at the core of the opioid epidemic — that if somebody is continuing to use these medications in a way that was not prescribed, that is a policy violation and grounds for termination. "There is nothing wrong with saying that," DiTullio states. "That's different than the ADA accommodation issue."

Of course, employers that want to salvage the relationship and help employees overcome an opiate addiction must have related provisions in their written policy. Not every employer does this, but many do, DiTullio notes, and those that do typically have a statement that encourages addicted employees to be proactive in seeking help. It should say something along these lines: If you have a drug or alcohol issue, let us know so we can make sure that you are connected with your own resources if you need time off.

"It's probably going to be unpaid other than maybe some accrued vacation or PTO," says DiTullio, "but we as a company are not going to discipline you for being proactive in bringing it to our attention."

At the same time, there should be an expectation in the policy that the employee must complete rehabilitation or counseling, or continue counseling if it's an ongoing thing, as it often is with drug addiction.

DiTullio highly recommends the adop-

tion of employee assistance programs, and says the provisions encouraging proactivity should be mentioned in EAPs, as well.

In addition to identifying what employees will be tested for, a standard part of the written policy is to outline circumstances under which employees will be tested, the testing procedures, and testing facilities used. According to Dutch, there are screening processes that can be incorporated into the work place, including two that are opioid-related — SBIRT (Screening, Brief Intervention, and Referral to Treatment) and ORT (Opioid Risk Tool) — and present a series of questions to ask employees and discern whether they meet certain criteria.

## TIP 2: KNOW THE SIGNS

The reason Shelly Dutch founded Connections Counseling was her own recovery from addiction. She wanted to help others deal with the isolation, shame, and fear that goes along with it, and she's well versed in the physical, psychological, and behavioral signs that accompany it.

The physical signs can manifest themselves somewhat differently and in two phases; the first phase is when someone is using and the second is a withdrawal phase. Physical symptoms would be drowsiness or nodding off at work, the lack of alertness, episodes of confusion or poor judgment, and constant itching because opioid users often get lesions on their face. Employers also might see needle marks and notice mood swings. "Pupils tend to be smaller or pinpoint, as opposed to large and dilated," she notes. Withdrawal symptoms such as profuse sweating, exhaustion, and headaches and stomach aches, also become evident.

"Along with the physical signs would obviously be some psychological signs," Dutch adds, "such as possibly a changing personality or attitude, where somebody might have been a team player, and all of the sudden they are negative or have difficulty focusing or they may have angry outbursts, become more irritable or agitated than normal. It's the same thing around motivation — a little more lethargic, so they are less motivated and occasionally paranoid or anxious."

Finally, there are behavioral symptoms, including obvious ones such as spotty attendance and poor work performance, and financial warning signs where employees sneak into people's offices and steal money or prescription bottles, ask for an advance in payment, or frequently borrow money from coworkers. Suspi-



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cious behavior in the workplace — more isolation instead of collaboration — is an additional sign, as are neglecting responsibilities and increasing reprimands. Outside the office, there might be occasional legal jams, and there often is a mental health issue connected with the addiction.

"Those are some of the common signs," Dutch notes. "It may even surface in relationship problems at home. Sometimes, peers at work hear about that, and then most common along those lines would be dishonesty and rationalizing."

When colleagues start to notice excuse making or someone losing interest in things that once generated professional passion, it should not be swept under the rug. "I really stress communication and having an open dialogue in the workplace," Dutch states. "If peers at work notice something, then express concern to the person before going to HR or to your supervisor to see if you can support them in anyway. Try to be transparent."

## TIP 3: SCHOOL YOUR SUPERVISORS

Investing in management training is important for several reasons, including knowing what to look for, identifying available resources, and the internal imperative of knowing company policies. "We shouldn't assume they have this expertise, so doing some training is really important," states Dutch, who recommends having a recovery coach on board. "Those can be very low financial costs for a business because while they are certified, they are not master's level professionals."

Part of this education is to help everyone recognize that addiction is a chronic illness, not a choice or a moral failing or a shortcoming in someone's personality. Removing the shame that can be toxic and prevent people from coming forward can go a long way to allowing them to forgive themselves, to work with professionals to begin their recovery, and convince them that they deserve treatment. "Education is the first step to say this is an illness," says Dr. Todd Kammerzelt. "Nobody at the outset wakes up and say they want to be a heroin addict or a dependent on prescription opiates."

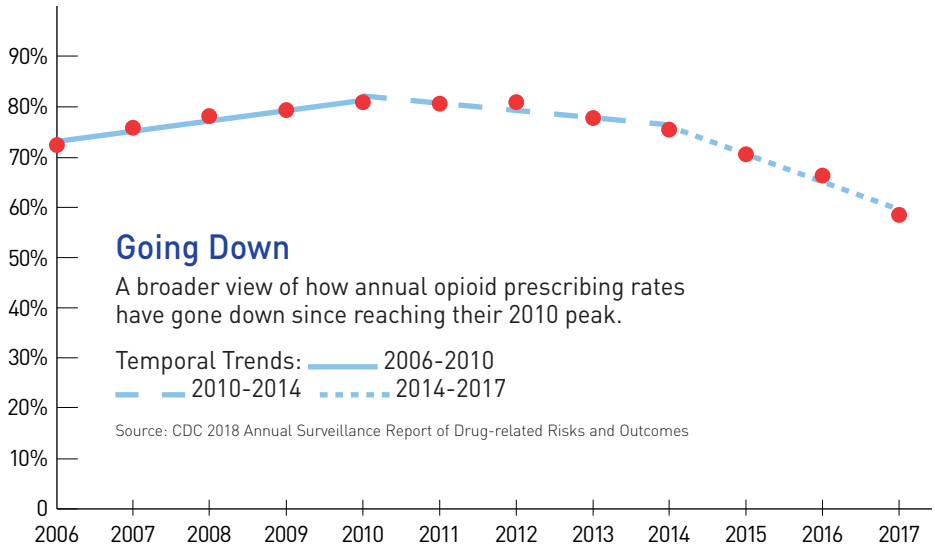
As a chronic illness, Kammerzelt adds that there's a different recovery expectation. "You're not going to go away for a month and come back and everything is going to be solved," he notes. "Addiction is not like an ear infection where you can wait for a week or two or take an antibiotic and have it cleared up, and then it's gone. Addiction is a chronic condition that is amenable to treatment but isn't cured."

DiTullio would like to see larger employers share some of their best practices with small employers. In his experience, larger employers with larger resources tend to be ahead of the game on such matters, and he would like to see more information sharing through public forums. "This is a problem for everybody, every company out there. It's just a social problem. Maybe this is just a little bit pie-in-the sky thinking, but there is a lot of good work being done out there by large employers — not exclusively because some midsize and small employers are on top of this, as well — but sharing that information between businesses because this is not a competitive advantage issue."

## TIP 4: MONITOR MEDICATIONS

Medication-assisted therapy is critical for opiate addicts, and while employers certainly don't prescribe drug therapies, it helps to know what medications are being used to help people overcome their addiction and prevent overdoses. Kammerzelt notes there are three FDA-approved medications that are the mainstay of treatment for opioid addiction or opiate use disorder.

Buprenorphine (brand name Subox-



one) is probably the most commonly prescribed therapy in an outpatient setting, and it comes in films, tablets, an implant

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> — Dr. Todd Kammerzelt, addiction psychiatry specialist, University of Wisconsin Hospitals and Clinics, Veteran's Administration Medical Center, The Manor

that is replaced every six months, and the Food and Drug Administration recently approved a once-a-month subcutaneous injection. Classified by the federal Drug Enforcement Agency as a Schedule III controlled substance, it can be prescribed from a physician's office.

Buprenorphine is meant to reduce cravings or urges to use, and it also prevents withdrawal. "Nobody chooses to develop an addiction or have that disease, but once it's firmly in place, breaking that cycle is really hard and it's really hard because of physical withdrawal symptoms and cravings or urges to use," Kammerzelt notes. "The buprenorphine helps on those."

Another drug therapy is methadone, which is a Schedule II and can only be prescribed from a methadone clinic when it's used to treat opioid dependence. Methadone has been around for decades — it was the first medication used to treat opioid dependence — but it's somewhat limited in its availability because it is an opioid and there is a good deal of regulation around methadone dispensing. "They [methadone clinics] obviously can't reach large numbers of people," Kammerzelt notes. "They are usually in medium to larger-sized urban areas, so the advantage Suboxone [buprenorphine] has is that it can be more widely available and prescribed out of doctor's offices, whereas methadone, when it's used to treat addiction, is restricted to the methadone clinics."

A third drug therapy is naltrexone, which is sold under brand names such as ReVia and Vivitrol. Naltrexone is not a controlled substance in the DEA classification, and it works as an opioid blocker, so it does not allow people to get high or have the reinforcing effects of opioids if someone were to have a relapse. According to Kammerzelt, it's best given as a once-per-month injection. It also comes in pill form, but the data hasn't been as supportive in terms of treatment of opioid abuse disorder when taken by mouth.

"Naltrexone is really attractive in a lot of people's minds because it's not an opioid, whereas buprenorphine and methadone are both opioids," Kammerzelt says. "However, when people stop naltrexone, their risk of overdose goes up dramatically because they have no tolerance for an opiate, and if they do relapse, they are at higher risk for death. You have to be active in recovery."

As for medical insurance coverage, mental health and substance abuse treatment is one of the 10 essential health benefits that is covered under the Affordable Care Act, but Kammerzelt says the degree to which each medication or formulation

of the medication are covered can vary in different health plans.

### TIP 5: MIX WITH MENTORS

Employers can help the recovery process by pointing addicted employees toward mentoring programs. Having a mentor who has been in the shoes of an addict can make all the difference in not only keeping an addict on the recovery track, but also giving them the assurance that recovery is possible in the first place.

> "We assign mentors to individual clients just to help them navigate, connect to the recovery community, inspire hope, give them tools and things that have worked for them."
>
> — Kim Hurd, mentor coordinator, recovery coach trainer, Connections Counseling

Kim Hurd, who is recovering from an opioid addiction, fills several roles with Connections Counseling, including mentor coordinator and recovery coach trainer. If a client has anywhere from six months to a year of sobriety and is doing well in recovery, their therapist can refer them to a mentorship program. If they agree to become a mentor, they help new clients that enter the recovery program. Mentors also host sober (including alcohol sobriety) yet fun gatherings for those who wonder whether recovery is an enjoyment-deprived experience, and they also mentor in groups for added support.

The operational theory is that addiction is a disease of isolation, and an addict alone is an addict in bad company. "We assign mentors to individual clients just to help them navigate, connect to the recovery community, inspire hope, give them tools and things that have worked for them," Hurd explains. "They also give them added support, whether that's texting, talking on the phone, meeting for coffee, getting them connected to the recovery community, and maybe helping them find a sponsor or different outside recovery groups, not only 12-step meetings but also smart recovery or to celebrate recovery."

### TIP 6: CONFIRM CONFIDENTIALITY

Ensuring your employees of confidentiality is an absolute must. They have to know their privacy will be maintained when they take the proactive step of contacting an HR manager or EAP coordinator or upper management. Without this assurance, addicts are far less likely to come forward.

DiTullio recommends publicizing and leveraging your employee assistance plan. He estimates that 99 percent of employers have EAPs as an employee benefit, but a lot of employees never use them. "It can really help the employee and employer by addressing the issues more proactively than when things get really bad," he states. "That type of employee education is really important."

### WE'RE ALL IN

Another important consideration is that opiate and other addictions rarely discriminate; they affect everyone from rank-and-file workers to management employees. "Addiction affects people across education levels, across socio-economic status, religious belief, political affiliation. It doesn't spare anyone," Kammerzelt states. "We are all susceptible to it, and some people have greater risk factors than others and we can identify some of those, but it doesn't mean in the absence of risk factors that a person still can't develop addiction." IB

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## Resourceful Recovery

When it comes time to get help with substance abuse, knowing your resources is critical. Here is an addiction resource list that can really make a difference for employers and their workforce.

**12-step programs**
www.aamadisonwi.org

**Connections Counseling**
www.connectionscounseling.com
5005 University Ave., Suite 100, Madison, 53705
Phone: (608) 233-2100, extension 0

**Journey Mental Health, Madison**
www.journeymhc.org
Phone: (608) 280-2720

**National Association of Mental Illness, Dane County**
Madison area: www.namidanecounty.org
National site: www.nami.org
National helpline: (800) 950-6264

**National Institute on Drug Abuse**
www.drugabuse.gov

**Substance Abuse & Mental Health Services Administration**
Free national helpline:
(800) 662-4357

**The Manor**
www.discoverthemanor.com
Phone: (414) 930-1930