Human Solutions Humaines

Hidden Hazards

The Business Response to Addictions in the Workplace

Human Solutions™ Report | **2009**

Human Solutions Humaines

Winter 2009

Human Solutions™ is pleased to present this year's annual report ***Hidden Hazards: The Business Response to Addictions in the Workplace***. Dr. Mark Attridge, researched and wrote this report with additional contributions by Dr. Scott Wallace. **The report tackles some of the myths and long-held beliefs about addictions and their impact on workplaces across Canada**. We distill the key findings concerning addictions and present these in a manner that can lead to a clear understanding of the issues for HR/Benefits practitioners and other business leaders interested in contributing to building a healthy and safe workplace. In the tradition of previous reports, **we review numerous empirical studies with an emphasis on Canadian data when available**.

We offer this report to our customers and other key stakeholders in an effort to bring the most current and empirically validated perspectives to this very important issue. **Our hope is that this report will assist you by summarizing key elements on addictions which may prompt you to take action such as creating or updating a substance use policy, initiating an awareness campaign at all levels of your organization, or providing information about available support services.**

As a valued customer whose opinions are important to us, your feedback is welcome. Please feel free to provide me or your Account Manager with any ideas that you think would be worthy of future consideration so that we can help you meet your needs.

Regards,

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A 'hidden hazard' is a condition whose characteristics interact with processes in society in such a way as to allow the hazard to be ignored or de-emphasized over time.

– Canadian Centre on Substance Abuse[1]

Introduction

Addictions are the dark secret of the workplace. Although unlikely to be openly discussed or admitted to, roughly one in every four employees, or their family members, are deeply affected by physical and psychological attachments to using certain substances (e.g. tobacco, alcohol, illicit drugs, prescription medications) or to engage in compulsive behaviours (e.g. gambling, sex, eating, computer use, excessive preoccupation with work). New scientific evidence from Canada and other countries clearly documents the damage done by addictions to the user, to society and to the workplace.

Numerous reports reveal an alarming increase in the number of people who suffer from addictions. These problems are developing into a real hazard that can no longer be ignored or marginalized, as occurs with many employers. The cost is simply too great and the journey to recovery too long.

There are many reasons why people engage in addictive behaviours. Health Canada cites curiosity, pleasure, celebration, tension relief, pain management, social pressures, emotional pressures, and medical reasons, as examples.[2] Ultimately, addictions are destructive activities that continue despite the problems that they create.

The following pages present a business-focused review of the key points from the research literature on addictions in the workplace. Notably, most people with addictions are of working age and are employed full-time. Employees with undiagnosed or under-treated addictions often struggle with work productivity, absenteeism, and poor health. Further, due to the chronic and cyclical nature of addictions, afflicted employees may move in and out of the workforce during periods of recovery and relapse (for a complete report summary see **Table 1**).

The information in this report is grouped into four main sections:

1. **The Problem:** The nature of addictions and their prevalence in society.
2. **The Crisis:** The impact of addictions on society, the individual and the workplace.
3. **The Solution:** The treatments for addictions and their effectiveness.
4. **The Future:** How employers can respond with policies, prevention and programs.

The research strongly supports the **need for employers to recognize addictions** and take appropriate action to minimize their impact.

TABLE 1: KEY FINDINGS FROM THE REPORT*

Section I: The Problem

The Nature of Addictions

- The past-year rate of addictions is high in Canada, with about 20% of adults abusing alcohol, 19% smoking tobacco, 15% misusing prescription medications, 14% ingesting marijuana, 5% gambling, 2% using other illicit drugs, and 5% having other kinds of addictions related to sex, food, internet use, and workaholism.
- The majority of people who abuse alcohol and drugs are of working age and are actively employed in the workforce. Alcohol and drug use tends to be higher among smaller size employers.
- Certain industries have higher rates of alcohol and drug use among their employees. These include construction and extraction; transportation; installation, maintenance and repair; arts, entertainment and recreation; accommodations and food services; and retail service occupations.

Section II: The Crisis

The Impact of Addictions

- Addictions can cause a multitude of problems at work (absenteeism, performance problems, safety incidents) and in the individual's personal life (strained personal relationships, family breakdown, health problems). Substance abuse can lead to poor customer relations, absenteeism, diminished work quality and performance, on-the-job accidents and disability claims, workgroup morale issues, turnover, and higher health care services use and costs.
- The annual economic costs of substance abuse include billions in terms of lost work productivity, health care services use, law enforcement and other areas. In one decade, estimates of these costs quadrupled (from 8.9 to 39.8 billion). The total represents a cost of $1,267 to every man, woman and child in Canada.
- Overall, work productivity losses constitute the majority of the societal costs for tobacco, alcohol and illicit drugs.

Section III: The Solution

The Treatment of Addictions

- A range of approaches to alcohol and drug addiction treatment exists, including self-help and support groups, counselling, residential programs, and medications. Many treatments offer a mix of these approaches.
- Employee Assistance Programs have potential to be an effective resource to help companies address substance abuse and addictions issues. When the program is designed properly and delivered effectively, the EAP can assist with prevention, intervention and rehabilitation of addictions. EAPs can also assist with policy development, training and orientation on policies, guidance to supervisors and union stewardship on constructive action steps, and support for individual employees.
- There is a considerable body of evidence showing that treatment for alcohol and drug problems is both clinically effective and cost effective.

Section IV: The Future

The Employer Response to Addictions

- Effective policies should encourage early detection, facilitate early intervention, and, when appropriate, provide support for the employee to address the problem and offer practical assistance with returning to work after treatment.
- Employers should create a substance use policy immediately. Any effort towards policy development sends a message to employees that the company is committed to dealing with substance abuse and addictions in the workplace, and that addictions-related problems will not be tolerated.
- Employers should clearly explain the policy to all supervisors, union members and stewards, employees, new hires, and applicants.

* The source of these findings can be found in the corresponding section of the report.

The majority of people who abuse alcohol and drugs are of working age and actively employed…and if they don't use drugs or alcohol, many employees have to deal with the negative influence of family members who have an addiction.

SECTION 1: THE PROBLEM

The Nature of Addictions

1.1 What Is Addiction?

1.1.1 Definition And Terms

Addiction is a term that is used in many contexts. According to the *Canadian Centre for Addiction and Mental Health*[3] another word for addiction is "dependence" of which there are two types: *physical* dependence and *psychological* dependence.

Physical dependence occurs when a person's body has become so used to a substance that the person needs more and more of the substance to feel the same effects. Further, when the substance is removed, the person experiences symptoms of withdrawal.

Psychological dependence occurs when a person relies on a substance (or behaviour) for daily functioning, just to 'feel normal.' In this context, addiction describes a recurring compulsion to engage in behaviours despite harmful consequences to health, mental state, work, or social life.

This report uses the term 'addiction' to include substance use addictions (e.g. alcohol, tobacco) and those that arise primarily from psychological dependence (gambling, sex, pornography, computers, work, exercise, etc.). This stance is chosen because:

1. Individuals engaging in these activities do so despite harmful consequences to health, mental state, work or social life.
2. Abatement of these activities can cause symptoms characteristic of withdrawal. And,
3. Effective treatments are available that borrow heavily from the more traditional medical concepts of addiction.

Since the majority of addictions research stems from traditional viewpoints, and this report is primarily research-based, the major focus of each section will be on substance-use addictions.

1.1.2 Stages Of Addiction

Within the realm of substance use addictions (e.g. alcohol, illicit drugs) there are generally agreed upon levels or stages of use. However, not every person who uses substances progresses through all five of these stages, not all substance use is a problem, and not all problem substance use is an addiction (see **Table 2**).

1.1.3 Why The Addiction?

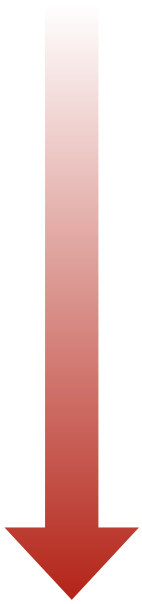
No one starts out trying to become addicted. It is a gradual process that involves many different and interdependent causal factors. Initially, substance use or activity can cause feelings of pleasure or tension relief. What often follows is a need to use more of the substance, or engage in more of the behaviour, to get that same feeling. Over time, this process of needing more to obtain the same effect can escalate until it leads to loss of control and inability to effectively cope with life problems and personal issues.

For severe addictions, painful physical and psychological experiences can follow after the substance use or behaviour is stopped. Thus, after a while, the addict is motivated to continue their addictive behaviour in order to both avoid withdrawal as well as to become 'high'. This approach-avoidance dynamic (avoiding withdrawal and chasing pleasure) combined with biological dependence (characteristic of some addictions) leads to the addiction becoming a chronic condition that haunts the user for years—often for a lifetime in many cases.[4]

1.2 How Prevalent Are Addictions?

Many surveys have been conducted in Canada and other countries that ask people how often they use various substances and engage in various kinds of addictive behaviours. Key findings from the most recent of these studies are presented in **Table 3.**

TABLE 2: CONTINUUM OF SUBSTANCE USE[2]



EXPERIMENTAL USE	Occurs in the beginning; use limited to just a few exposures; motivated by curiosity.
RECREATIONAL OR SOCIAL USE	Used to enhance a social occasion; use is irregular and infrequent; use usually occurs with other people.
SITUATIONAL USE	Use occurs as a regular pattern; use is associated with a particular situation; some loss of control over use but no negative consequences yet.
HARMFUL USE	'Binge' use of a large amount of the substance in short periods of time; or continuous use of the substance over a longer period of time; negative consequences from use.
DEPENDENCE OR ABUSE	Physical dependence with tolerance and withdrawal; psychological dependence with feeling that the substance is needed in particular situations or to function effectively; negative consequences from use.

1.2.1 Use Of Nicotine And Smoking

About one in every five Canadians smoke or use tobacco (a significant decline since 1999 when the prevalence rate was one in every four).[5] The challenge for smokers is that the vast majority want to quit but nicotine addiction is severe and persistent. Unaided attempts to quit are typically successful for only 5% of those trying to stop. The use of formal treatment tools, such as a combination of talk therapy (counselling) and nicotine replacement therapies (patches, medication) can raise the quit rate to between 12 and 25%. However, long term quit rates (over one year) are still very low and relapse is the most common outcome.[6]

1.2.2 Use Of Alcohol

In Canada, more people drink alcohol now than ten years ago (79% of the population in 2004 versus 72% in 1994).[7] Of the nearly eight out of every ten Canadians who drink alcohol, most do not have a problem with their use. However, among those who were drinkers in the past year, 26% reported heavy drinking events at least once a month (five or more drinks on a single occasion for men and four or more drinks on a single occasion for women) and 6.2% report heavy drinking at least once a week.[8]

1.2.3 Use Of Illicit Drugs

Drugs that are manufactured or obtained illegally are used by a growing segment of Canadian society.[9]

Marijuana. After alcohol and tobacco, marijuana (cannabis) is by far the most widely used of all drugs in Canada, and in most other countries as well. Although it is basically a hallucinogen, when marijuana is consumed it produces depressant effects and long-term use can cause both physical and psychological dependence.

Approximately 45% of Canadians report using marijuana at least once in their lifetime and 14% report use during the previous 12 months. Males are more likely than females to have used marijuana in their lifetime (50% vs 39%) and during the past year (18% vs 10%). About two-thirds of marijuana users report that marijuana is the only illicit drug they use.[7,8]

Other Illicit Drugs. In addition to marijuana, many other variants of illicit drugs are available. Excluding marijuana, the illicit drugs most commonly used are hallucinogens (11.4%), cocaine (10.6%), speed (6.4%) and ecstasy (4.1%).[7,8]

Methamphetamine (crystal meth) is arguably one of the most damaging drugs, and its use is increasing.[10] Methamphetamine use in Canada is estimated to be higher than that of cocaine and heroin combined. Part of the surge in popularity of crystal meth is its quick effects (enhanced energy, euphoria and sexual performance) and its ability to be created cheaply and locally, often in a home. However, crystal meth use is difficult to control and tolerance builds quickly.

1.3 Alcohol And Illicit Drug Use Among Employed Persons

The majority of people who abuse alcohol and drugs are of working age and are actively employed in the workforce. While it is true that the *rate* of substance use is highest among unemployed persons, the *total number* of full-time employees with a substance use disorder is higher than the total number of unemployed persons with a substance use disorder (because full-time employees constitute about 2/3 of the population). For example, in the United States, over two-thirds of substance-abusing or substance-dependent people

TABLE 3: LIFETIME PREVALENCE OF ADDICTIONS

	EFFECTS	PREVALENCE
ALCOHOL[2,7,8,9]		
Alcohol is a common term for ethanol, a compound produced when glucose is fermented by yeast. Alcohol is a depressant and drinking alcohol has the effect of slowing down the activity of the central nervous system.	Initially, the drinker is happy and more talkative followed by excited, erratic behaviour, impaired thinking and slowed reactions. Further intoxication results in confusion, loss of control over speech and motor coordination. Alcohol is linked to over 70 kinds of health problems and injury or death from alcohol poisoning or accidents can occur.	Over 90% of all Canadians have ever consumed alcohol in their lifetime and 79% have consumed alcohol in the past year. Between 18% and 20% of all Canadians are considered heavy drinkers or those who have "at-risk" use patterns for drinking alcohol. The use of alcohol in society is increasing over time.
NICOTINE/SMOKING[5]		
Nicotine is the chemical agent found in tobacco. It is consumed in a variety of forms, most commonly smoked in cigarettes or pipes or ingested through mouth tissue from smokeless tobacco.	Acute effects of nicotine dissipate in a few minutes, making it necessary to smoke frequently to maintain the drug's effects and prevent withdrawal. Long-term use is linked to diseases and health conditions and results in premature death. Damaging effects to non-smokers can occur from second-hand smoke.	About 19% of all Canadians have used nicotine in the past year. Among these active smokers, about 80% use daily and smoke an average of 16 cigarettes per day. The use of nicotine in society is decreasing over time.
MARIJUANA (CANNABIS)[2,7,8,9]		
Marijuana is a mind-altering plant whose psychoactive ingredient is THC. Although basically a hallucinogen, when marijuana is smoked it produces depressant effects.	Use impairs short-term memory, alters sense of time, and reduces ability to engage in activities requiring concentration and coordination. Negative health effects on fertility and heart and lung functioning. Has some limited medical uses (e.g. pain management).	About 45% of all Canadians have ever used marijuana in their lifetime (past year use is 14%). The use of marijuana in society is increasing over time.
OTHER ILLICIT DRUGS[2,7,8,9,10]		
Stimulants include hallucinogens (LSD, PCP, ecstasy), cocaine/crack, and amphetamines (speed, crystal meth). Depressants include heroin and opium. Inhalants (solvents, glue, paint thinners, aerosols, fuels) and steroids are also included.	Physical changes can result including heart rate and blood pressure, higher body temperature, sleeplessness, dry mouth, loss of appetite and tremors. Life-threatening infections can result from unsterile injection equipment or self-prepared solutions that are contaminated.	About 17% of all Canadians have ever used illicit drugs (other than marijuana) in their lifetime. However, current use is much lower, at less than 2% who have used such drugs in the past year. The use of illicit drugs in society is increasing over time.
GAMBLING[11,12,13,14]		
Gambling is offering up money or a substance of value in a game of chance for a return that is less than certain. Some forms include casino gambling, horse racing, scratch-and-win tickets, lotteries, slots, video lottery terminals and card games for money.	Repeated gambling can affect work performance, finances, and well-being. Pathological Gambling, also known as Compulsive Gambling involves preoccupation with gambling, lying to others about gambling behaviour and finances, and possibly engaging in illegal activities to finance the gambling. Suicidal thoughts and action may develop.	About 75% of all Canadians have ever engaged in some form of gambling. Of all adults, problem gamblers comprise about 5% and pathological gamblers about 2%. The number of people in society with gambling problems is increasing over time.

TABLE 3: (CONTINUED)

SEX[15,16,17]	EFFECTS	PREVALENCE
Sex addiction is a compulsive disorder such that the person has an unusually intense sex drive or an obsession with sex. Sex and related thoughts dominate thinking. The person engages in persistent and escalating patterns of sexual behaviour acted out despite increasing negative consequences to self and others.	A sex addict gains little satisfaction from sexual activity and forms no emotional bond with his or her sex partners. Sex addicts often rationalize and justify their behaviour and blame others for problems. Self-denial is very strong.	Between 3% and 6% of all adults currently have a sex addiction or a sex compulsion. The number of people in society with sex addiction problems is increasing over time.
FOOD AND EATING[18,19,20]		
Food addiction is a disorder involving a preoccupation with food. It involves the use of food against the individual's better judgment resulting in loss of control or the restriction of food and preoccupation with body weight and image. Types of food addiction include compulsive overeating (binge eating disorder or BED), bulimia and anorexia.	Food is used to cope with life stressors and psychological issues. Cravings lead to eating and periods of increased energy, activity and satisfaction. This is followed by less energy and irritability. 'Yo-Yo dieting' is common. Bulimics rapidly eat and then remove food (e.g. by vomiting or laxatives). Anorexics starve themselves and may use amphetamines to lose weight. Both are prone to over-exercise. Food disorders cause many health problems.	About 5% of women and 0.3% of men currently have food addictions or eating disorders. The population prevalence rate for BED is 2–5% of both sexes; the rate for bulimia is 1–4% of women; and the rate for anorexia is 0.5–4% of women. The number of people in society with food use problems is increasing over time.
INTERNET[21,22,23,24]		
Internet addiction is characterized by excessive or poorly controlled preoccupations, urges or behaviours regarding computer use that lead to impairment and distress.	A mild to severe condition with urges to engage in ritualistic thoughts and behaviour related to Internet use (web surfing, e-mail, pornography, playing computer games, online gambling). Can result in loss of sleep, anxiety when not online, isolation from family and peer groups, loss of work, and periods of depression.	Data suggests that at least 1% of adults are addicted to using the Internet. The number of people in society with Internet addiction problems is increasing over time.
WORKAHOLISM[25,26,27,28]		
Workaholism is a compulsion or the uncontrollable need to work incessantly. The workaholic also persistently and frequently thinks about work, even when not working. Thus, workaholics are 'obsessed' with their work to the detriment of other aspects of their lives.	Work addiction is associated with working many long hours, initial high level of work performance but eventual job burnout, poor social relations and a range of negative psychological and physical health consequences, some of which include stress, headaches, cardiovascular risk, and family and marital distress.	The number of people with work addiction is presently unknown, but estimated at 1% or more of all adults. The number of people in society with work addiction problems is increasing over time.

Alcohol and drug use is more prevalent in certain industries—particularly those characterized by demanding working conditions, low supervision, low to moderate pay, and high staff turnover.

are employed.[29] About 1 in every 8 employees (15%), report using or being impaired by alcohol while at work at least once in the past year and almost 1 in 10 (8.9%) of full-time employed adults are classified as heavy alcohol users who drink at above risk levels on a regular basis.[30] Concerning drugs, other surveys find that 4–8% of full-time employees report using illicit drugs in the past month.[31,32,33] In addition, non substance-abusing employees may still have to deal with the negative influence of their family members who are addicted.

Younger employees are more likely than older employees to binge drink and to use illicit drugs.[8] Among the employed, males and those with less education and less income tend to have higher rates of alcohol and drug abuse. In contrast, white-collar managers and professionals have the lowest rates of alcohol and illicit drug abuse—although they do have high rates of abuse of prescription medications. Some common signs that may suggest a possible substance abuse problem are presented in **Table 4**.

Certain industries have higher rates of alcohol and drug use among their employees.[32] These include construction and extraction (e.g. mine workers); transportation (e.g. truckers); installation, maintenance and repair (e.g. blue collar trade); arts, entertainment and recreation (e.g. musicians); accommodations and food services (e.g. hotel staff and restaurant waiters); and retail service occupations (e.g. clerks and sales staff). Such occupations tend to feature demanding working conditions, low supervision, low to moderate pay, and high staff turnover.

Alcohol and drug use is higher at smaller size organizations. National data shows that at organizations with less than 100 employees, 8.2% of all employees had abused alcohol or drugs; 6.7% of all employees at organizations with less than 500 employees have abused alcohol or drugs, and at organizations with more than 500 employees, 5.7% have abused alcohol or drugs.[33]

1.4 Prescription Medications

It is extremely difficult to assess the levels of abuse of prescription and nonprescription medications but reports indicate that more people may abuse prescription and nonprescription medications than cocaine, hallucinogens, inhalants, and heroin combined.[34, 35] One reason the risk for abuse is so high is the legal and socially accepted status of medications, particularly when their use is recommended (i.e. prescribed) by a physician.[36]

1.5 Addiction Combined With Mental Health Disorders

Some substance users have co-occurring mental health disorders and poly-substance abuse (multiple substances). A survey of over 37,000 Canadians found 7.4% with a mental health disorder, 2.1% with a substance abuse disorder, and 0.9% with both a mental health disorder and a substance abuse disorder.[37] Thus, among those with a substance abuse problem, almost one-third (30%) also had a mental health disorder.

Health Canada notes the following five areas of mental health that tend to co-occur with substance abuse: mood (depression) and anxiety disorders, severe and persistent mental disorders (schizophrenia), personality disorders, eating disorders, and other mental health disorders (including problems of intimacy and sexual expression).[38]

1.6 Addictions Are Ignored Or Hidden

Like mental health disorders, addictions often go unrecognized and untreated in the general health care system.[39] When people with addictions seek medical care for routine or acute physical health reasons, the status of their addiction is largely ignored. Less than half of all medical care patients are screened for alcohol consumption, even though validated and inexpensive brief screening tools are available.[40] Additionally, even if questioned directly, some withhold information about their true level of substance use because of denial or shame. The result is that patients continue to be treated for alcohol- and drug-related health conditions without getting treated for the underlying problem of substance abuse. For example, a Statistics Canada national survey found that two-thirds of those meeting clinical criteria for having a mental health disorder or a substance use disorder had no contact with a health professional during the prior year.[41] These statistics show that the extent of the problem is massive (especially for alcohol) and yet corrective action in day-to-day health care delivery practice is just beginning to be developed.[42]

TABLE 4: COMMON SIGNS OF SUBSTANCE ABUSE[43,44,45,46]

Each of these symptoms can be related to substance abuse. None of these signs is necessarily indicative of a substance use problem and can reflect any of a number of other problems. One key to look for is change—change in personality, change in behaviour, etc.

Physical Indicators

- Sweating, tremors, jitters, constant scratching of skin
- Complaints of headaches
- Odour of alcohol on breath
- Faint skin odour, either sweet or acrid
- Deterioration in appearance and/or personal hygiene
- Small blood spots or bruises on skin
- Bloodshot or watery eyes, runny or irritated nose
- Easily fatigued or constantly fatigued
- Hyper-excitability, hyperactivity, constant toe-or heel-tapping
- Changes in appearance (e.g. sudden gain/loss of weight)
- Changes in eating habits
- Dizzy spells, stumbling, shaky hands
- Consistent run down condition
- Speech pattern changes, slurred speech, faster speech, slower speech
- Blackouts and forgetfulness

Behavioural and Work Performance Indicators

- Taking extended breaks
- Excessive absenteeism or tardiness
- Moving to a position with less supervision
- Arriving late for work; leaving early
- Excessive number of incidents/mistakes
- Low productivity, low quality work, missed deadlines
- Sudden deterioration of friendships and relationships
- Explosive disagreements over small matters
- Frequent hangover symptoms
- Financial problems or frequent borrowing of money
- Lying and/or providing implausible excuses for actions
- Inappropriate behaviour at work

Personality Indicators

- Poor morale, "I don't care attitude"
- Mood swings (e.g. passive and withdrawn one minute and angry or hostile the next)

KEY MESSAGES

- The majority of people who abuse alcohol and drugs are of working age and are actively employed in the workforce.
- Certain industries have higher rates of alcohol and drug use among their employees. These include construction and extraction; transportation; installation, maintenance and repair; arts, entertainment and recreation; accommodations and food services; and retail service occupations.
- Alcohol and drug use tends to be higher among smaller size organizations.
- A greater number of younger employees are more likely than older employees to binge drink and to use illicit drugs.
- Substance use can be classified along a continuum of severity ranging from experimental use to dependence or addiction.
- Alcohol is a widely abused substance, with 20% of Canadians with use above risk levels in the past year. Other addictions of significant prevalence include tobacco, marijuana, illicit drugs, and prescription medications.
- Other addictions, not involving substances, include gambling, pornography and sex, food, Internet use, and workaholism.
- Certain groups of the population are more at risk for having alcohol and drug use problems, including youth, elders, women and the employed. Men are more prone to have gambling and sex addictions; women are more likely to have eating disorders.
- Having multiple kinds of addictions, co-occurring disorders (an addiction and a mental health disorder), and co-morbidity of addiction with physical health conditions, is common and can create a variety of complications (e.g. with treatment).
- The lack of action by health professionals to detect and treat substance abuse and co-occurring mental health disorders is perhaps the single biggest hurdle facing addictions today.

No sector of Canadian society is untouched by the harms that can result from the problematic use of alcohol and other drugs and substances. Individuals, families and communities may all bear negative health, safety and economic consequences.[7]

SECTION 2: THE CRISIS

The Impact of Addictions

Addictions can create a web of interrelated problems for users and others in their lives. The empirical research literature in this area is largely limited to alcohol, tobacco, illicit drugs and to a lesser extent, gambling. The damage caused by other addictions is mostly anecdotal clinical evidence and, therefore, not the subject of this section.

2.1 Impact Of Addictions: Society

There are many consequences of substance abuse at the societal level. In 1992, the economic costs of tobacco, alcohol and illicit drugs to Canadian society was estimated at $8.9 billion.[47] A decade later, this estimate quadrupled to $39.8 billion (this cost represents $1,267 to every man, woman and child in Canada).[48] This estimate is based on costs from several categories, including the burden on services such as health care and law enforcement and the loss of productivity in the workplace or costs resulting from disability and premature death. Based on estimates from the 1990s employing generally comparable methodologies, the societal costs for alcohol abuse, drug abuse and smoking are comparable to other serious health conditions such as heart disease, mental illness, Alzheimer's disease, obesity, diabetes, cancer, and stroke.[49]

2.1.1 Injury And Death

Societal consequences are not only measured in dollars. Some addictions can result in injury and death for the user and through the behaviour of the drug user, injury and death to others as well. A recent World Health Organization (WHO) report determined that globally, alcohol causes 3.2% of all deaths.[50] Of the total number of alcohol-attributable deaths worldwide, 32% were from unintentional injuries, and 14% were from intentional injuries. In Canada, the most recent national statistics reveal over 3,000 deaths due to alcohol each year and over 500 deaths due to illicit drugs.[51]

Death From Driving Drunk or Using Drugs. The number of people charged with impaired driving offences has fallen dramatically in Canada from approximately 128,000 in 1987 to approximately 70,000 in 2001 and to under 50,000 in 2003/2004.[42,51] Similarly, the incidence of fatally injured drivers who tested positive for the presence of alcohol has declined from 53% in 1987 to 38% in 2001.

In addition to alcohol, the presence of drugs in toxicological samples of fatally injured drivers varies from 20–26% (marijuana, benzodiazepines and cocaine are the substances most frequently detected).[52]

Death From Alcohol Overdose. Although far less common than vehicle-related deaths due to alcohol use, deaths from alcohol overdoses do happen. In the US, about 50,000 reported cases of medical injury from alcohol poisoning occur each year and about once a week someone dies from alcohol poisoning—thus, about 50 people each year.[53] Also, the consumption of even small quantities of non-beverage types of alcohol, such as methanol or rubbing alcohol, can be fatal.[54] In most cases though, drinking too much alcohol will produce nausea and vomiting, and thus most people stop drinking before consuming enough to result in toxicity and death.

In one decade, estimates of the economic costs of substance use to health care, law enforcement, and workplace productivity in Canada **have quadrupled** (from 8.9 to 39.8 billion).[48]

Death From Drug Overdose. While drug-related deaths have been stable in Canada, data from the US indicates that deaths from accidental drug overdoses have increased dramatically in recent years, and prescription opioid pain-killers account for more than a third of these deaths.[55] The largest increase in these accidental drug poisonings is among men and women of working age (ages 20 to 64).

Death From Suicide Related to Alcohol or Drug Use. About 1 in 25 Canadians will attempt suicide in their lifetime.[56] Alcohol consumption and illicit drug use have been identified as important risk factors for suicide, especially when combined with mental health conditions.[57]

2.2 Impact Of Addictions: Individual

2.2.1 Consequences Of Alcohol Use

Alcohol abuse has health risks for more than 70 conditions that often eventually entail hospitalization.[58] WHO ranked alcohol misuse as one of the top five contributors to disease and injury worldwide.[59] The major areas of alcohol-related damage in the body include liver function, cardiovascular diseases, and some cancers.[54]

Alcohol and Accident Injury Risk. Alcohol can slow reaction time, impair control of body movements and attention, and (particularly in young men) lead to increased risk-taking and impulsivity. All of these factors significantly increase the risk for a serious or fatal injury. In Canada, a recent WHO study of visits to emergency rooms found that 1 in every 16 visits to the ER were related to alcohol use.[50] Alcohol intoxication also affects how well one can heal and recover from injuries. For example, drunk drivers are more likely to be seriously or fatally injured in comparison to sober drivers, and drinkers in accidents with central nervous system injuries are more than twice as likely to die sooner from those injuries than are sober people. Motorcyclists with head injuries are about twice as likely to die from those injuries if they are intoxicated than if they are sober.[58]

Alcohol and Harms to Self and Others. National surveys of Canadians show that close to 1 in 4 drinkers report that their drinking has caused harm to themselves and to others at some time in their lives.[7] Further, approximately 1 in 3 Canadians report having been harmed at least once in the past year because of someone else's drinking.[7]

Fetal Alcohol Spectrum Disorder (FASD). Alcohol use during pregnancy is one of the leading causes of preventable birth defects and developmental problems in children. In Canada, at least one child is born with FASD each day. Although data about level of alcohol consumption during pregnancy are scarce, it is possible to estimate that approximately 1 in 7 Canadian women drink during pregnancy, albeit infrequently. The FASD-related costs have been estimated to be more than a million dollars per individual for extra health care, education and social service, over their lifetime.[42]

A wide variety of work problems stem from substance abuse, including damaged customer relations, absenteeism, poor work quality, diminished performance, more accidents, workgroup morale issues, supervisor strain, and increased health services use.[60]

2.2.2 Consequences From Marijuana Use

About 1 in 20 Canadians report a marijuana-related concern as measured by the *Alcohol, Smoking and Substance Involvement Screening Test.*[8] Among past-year marijuana users, about one-third report failing to control or limit their use and also report a strong desire to use. In addition, about 16% of users report that friends or relatives expressed concern about the respondent's marijuana use, 7% report failed expectations, and 5% report experiencing health, social or legal problems due to marijuana use.

2.2.3 Consequences From Other Drugs

The most commonly reported drug-related harm involves physical health, reported by 30% of lifetime and 24% of past-year users of drugs.[8] The next most common kinds of negative consequences include harm to friendships and social life (22% and 16% lifetime and past-year, respectively), harm to home and marriage (19% and 14%), harm to work (19% and 14%), and financial harms (20% and 19%).

2.3 Impact Of Addictions: Workplace

Having an addiction not only affects the individual's life in personal ways, it can also cause problems on the job and for others with whom they work. Dozens of studies have documented a wide variety of work problems that stem from substance abuse, including damaged customer relations, absenteeism, poor work quality, diminished performance, on-the-job accidents, workgroup morale issues, supervisory strain and turnover, safety risks, family issues affecting work performance, and increased health care utilization.[60]

The Alberta Alcohol and Drug Abuse Commission conducted a study to estimate the costs of alcohol abuse, drug abuse and problem gambling in the workplace. The study used employees' own reports of missed time and lost productivity to develop an estimate of how much alcohol and drug use, and gambling, costs the Alberta economy. The results found that **employees missed almost four million hours from work — the equivalent of $74 million**. Over two-thirds of this loss was a result of the use of alcohol ($51 million), followed by illicit drugs ($16 million), and gambling ($7 million).[14]

Work Performance and Productivity Losses. Overall, work productivity losses constitute the majority of the social costs for tobacco, alcohol and illicit drugs (see **Figure 1**). Of the total $24.3 billion figure for lost productivity, tobacco accounted for $12.5 billion (52%), alcohol for $7.1 billion (29%) and illicit drugs for $4.7 billion (19%).[48]

Absenteeism. It is estimated that alcohol use among employees causes 3–5% of all absences from work in the UK each year.[61] Employees in a US study had substance-related work performance deficits such that they lost an average of 0.64 lost work days (absence) and 1.47 days with work cut-back (lost productivity) during the past month.[62] This level of work impairment on a monthly basis translates to over 10 full workdays, annually.

Workgroup Morale. Employees with an addiction have an impact on their workgroups. Commonly reported problems include: low morale, poor communication, and resentment from other employees who have to 'carry' that person's workload because of their drinking.[63]

Turnover. Employees who are substance users have high rates of job turnover. Data from the US reveals that illicit drug users are more than twice as likely as those who are not (12.3% vs 5.1%) to have changed employers three or more times in the past year.[64]

Safety. Substance use by employees threatens the safety of the work environment. Drinking even small amounts of alcohol before or while carrying out work that is 'safety sensitive' increases the risk of an accident. People who abuse drugs or alcohol are more than three times more likely to be involved in a workplace accident, resulting in increased workers' compensation and disability claims.[65] More than a third of all industrial injuries and fatalities are linked to alcohol use.[66]

Family Contamination. The alcohol and drug problems of the family members of employees can negatively impact the work performance of those employees.[67] Studies of AA group participants have found that approximately half of working family members of alcoholics report that their own ability to function at work and at home was negatively impacted by their family member's drinking.[68]

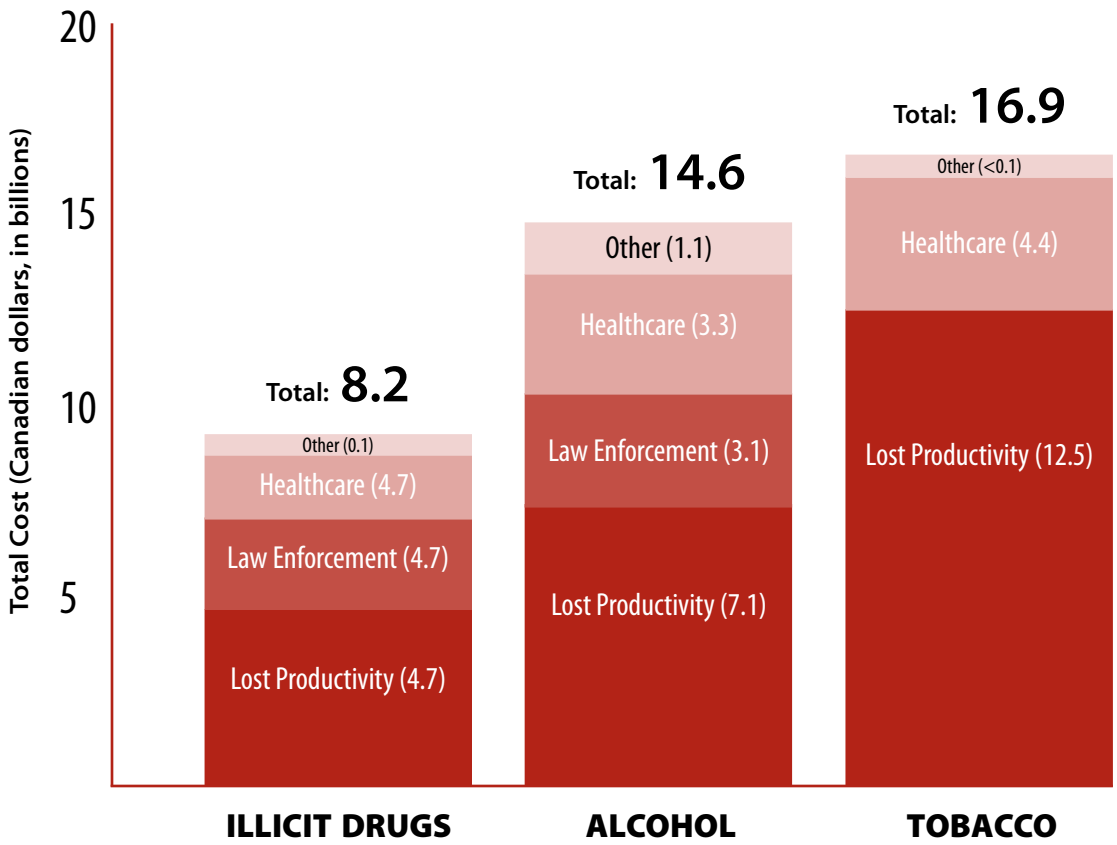
Health Care Utilization. Employees with substance abuse problems tend to have higher health care costs than employees without such problems, even when controlling for costs of substance abuse treatment (if it is even used). This increase is substantial, with use of medical health care benefits at from 1.5 to 2.0 times higher than that of non-abusers.[69] The usage profile is even greater among people with co-occurring substance use disorders and mental health conditions (e.g. depression). In part, this is due to the afflicted employee waiting until they are at an acute stage of health care need before seeking appropriate health care.[70] Reviews of longitudinal data found the rate of hospital admissions for patients with co-occurring alcohol/drug abuse and addictions had more than doubled between 1994 and 2002.[71]

2.4 Attitudes About Harm

It is of interest to examine how much of the impact of addictions is recognized by the public and by employers. The results of several studies of both users and non-users are illuminating in this regard.

Perceived Problems for the Substance User. A national *Canadian Addiction Survey* examined attitudes of the public on alcohol and drug issues.[72] In terms of perceived *harms to self* caused by drug use on a regular basis (i.e. problems for the person taking the drug) the highest proportion of Canadians that were surveyed felt that cocaine was a great risk (95%); this was followed by heroin (95%), solvents (92%), hallucinogens (91%), cigarettes (82%), ecstasy (82%), steroids (81%), methamphetamine (79%), marijuana (66%), and alcohol (59%). Regarding *harms to others* (i.e. people other than the drug user) the highest proportion of Canadians (83% of those surveyed) felt that heroin and cocaine were a great risk, followed by hallucinogens (79%), solvents (70%), ecstasy (67%), cigarettes (64%), methamphetamine (63%), alcohol (56%), marijuana (48%) and steroids (46%). Even though alcohol is by far the most widely used drug in Canada, it has low levels of perceived harm.

FIGURE 1: COSTS OF SUBSTANCE ABUSE TO CANADIAN SOCIETY[48]



Perceived Problems for Society. The majority of Canadians perceive substance abuse to be a serious problem.[72] Of those surveyed, 89% rated illicit drugs as *somewhat serious* or *very serious*; alcohol (83%); drugs that are injected (73%); prescription drugs (68%); over-the-counter drugs (60%); and solvents (50%). In all of these cases, women were more likely than men to perceive the problems caused by these substances as being serious.

Alcohol Impact is Under-Recognized. These survey findings present a puzzling pattern of findings. As noted in previous parts of this report, alcohol use negatively affects many more Canadians than illicit drug use (directly or indirectly). Yet alcohol does not receive proportionately higher levels of concern about the harms it causes to society compared to other kinds of drugs. Alcohol was rated as being either a somewhat or very serious problem to society by more than 8 in 10 people (which is quite high in an absolute sense), but on the same survey illicit drug use was rated as being a problem by almost 9 in 10 people (see above paragraph). Given that there are ten to twenty times the number of people in society who have alcohol abuse disorders in the past year than there are people who have illicit drug abuse disorders, this focus—or relative parity for—illicit drugs seems misplaced and at odds with the facts. Indeed, one recent report indicated that the total direct social costs associated with alcohol are more than double those for all illicit drugs combined.[1]

Thus, the perception by Canadian citizens of the relative level of impact on society for alcohol and for drugs is not aligned with their actual cost and consequences. The public thinks that illicit drugs are the biggest problem, but in reality it is alcohol that is the primary problem. There is also an even more extreme skew evident in law enforcement in that most of the police and criminal justice activity in Canada is focused on marijuana, when it is much less of a problem to society (in terms of actual costs and perceived harm ratings) than alcohol or even other illicit drugs.[9]

KEY MESSAGES

- The annual economic costs of substance abuse include billions in terms of lost work productivity, health care services use, law enforcement and other areas. Between 1992 and 2002, the estimates of these costs quadrupled (from $8.9 to $39.8 billion). This represents $1,267 for every man, woman and child in Canada (based on 2002 data).
- Addictions can cause a multitude of problems at work (absenteeism, performance problems, safety incidents) and in the individual's personal life (strained personal relationships, family breakdown, health problems). Substance abuse can lead to poor customer relations, absenteeism, diminished work quality and performance, on-the-job accidents and disability claims, workgroup morale issues, turnover, and higher health care services use and costs.
- Overall, work productivity losses constitute the majority of social costs for tobacco, alcohol and illicit drugs.
- It is estimated that alcohol use among employees causes between three and five percent of all absences from work each year. The colleagues of the addicted employee also experience impacts such as lowered morale, poor communication, and resentment among other employees who have to 'carry' colleagues whose work declines because of their drinking.
- The public thinks that illicit drugs are the worst problem, but when prevalence rates, total actual costs and range of consequences are considered, it is alcohol that is the primary problem. The public and employers need to face up to the facts and address the perils of alcohol abuse and addiction with the priority it deserves.

Public opinion does not match the realities of alcohol and drug use—the public thinks that illicit drugs are the biggest problem, but in reality **alcohol is the primary problem.**

What would the reaction be if other chronic health conditions, such as cancer or diabetes, were so poorly attended to by health professionals that two of every three people with the problem never saw a doctor about the problem? This is the situation now with addictions.

SECTION 3: THE SOLUTION

The Treatment of Addictions

An individual with an addiction faces a road to abstinence that is fraught with many detours and U-turns. This section of the report presents key findings from research reviews on the different types of treatment interventions available and the typical outcomes from these treatments.

As most of the research attention has been directed toward alcohol and drugs (one review found over 23,000 studies on alcohol problems alone in the last 50 years), these two kinds of addictions are addressed in the most detail.[73] Treatments for addictions involving tobacco, prescription medications, gambling, sexual behaviour, eating disorders, and Internet use, all tend to borrow key elements and practices from the approaches developed for alcohol and drugs and tend to have similar levels of effectiveness and limitations. Given this overlap, the treatments for these other addictions are not specifically reviewed in this report.

3.1 Conceptual Approaches

Historically, three conceptual approaches have been used to explain the cause and course of addictive behaviour: moral problem, medical disease, and behavioural disorder.[74]

The Moral Model. The oldest approach to understanding addictions is that it is a moral failing. Essentially, those who choose good behaviour are to be praised, and those who choose bad behaviour are to be punished.

The moral model is now largely discredited among most professionals in the addictions field. One reason has been the negative results that flow from a model that stigmatizes and shames people with addictions, which keeps many away from realizing the benefits of treatment. Other evidence that this approach is flawed comes from failed societal efforts at making alcohol illegal in the 1920s and early '30s during prohibition.

The Disease Model. The disease model considers addiction to be caused by genetic and biological factors. Although environmental and interpersonal factors are important, this model recognizes the genetic predisposition in alcoholism, particularly in the more severe forms of the disease. The heritability of alcoholism is considered to be 40–60%,[75] thus, alcoholism is familial in that the risk for it can be inherited from parents and grandparents in one's family.

While still popular, a number of shortcomings have emerged with the disease model. For example, the specific aspects of genetic determinants for alcoholism and other drug addictions remain to be determined. In addition, although pharmacological methods are increasingly available to treat addictions most of them are successful only when combined with behavioural and cognitive counselling. Furthermore, by defining addiction as an incurable and progressive disease, the ability for people to change their addictive patterns or to decide to give up alcohol or drug use on their own without treatment is difficult to explain. And finally, it should be noted that heritability may be behavioural, in other words growing up in an environment where alcohol is prevalent increases the likelihood of similar behaviour being practiced by the next generation.

The Behavioural Model. Based on behavioural and social cognitive theories, the behavioural model assumes that addictive behaviour has multiple determinants and that people vary in their risk for developing an addiction depending on their unique history. The model places greatest emphasis on understanding the rewards of engaging in addictive behaviours, of which there are two basic kinds: positive reinforcement (e.g. feeling good while being 'high') and negative reinforcement (e.g. the temporary perceptions of removing one's problems while using drugs). The goal of treatment from the behavioural approach is to understand how these processes were learned and how they can be changed with the appropriate intervention.

With the behavioural model, 'choice' is in the hands of the individual. The model acknowledges that most addictive behaviours involve problems of self-management and thus the individual must ultimately take responsibility for changing their own behaviour.

3.2 Types Of Treatment And Effectiveness

Addictions treatment can occur in a variety of settings, in many different forms, and for different lengths of time. The specific kind, or combination, of treatment(s) that is most appropriate varies depending on the kind of addiction and the characteristics of the person. Other issues may need to be addressed since many addicts suffer from co-occurring mental health, occupational, and physical health problems. Even if there are few co-morbid or associated problems, the severity of addiction itself ranges widely among people.

Measures of the effectiveness of alcohol and drug treatment typically include changes in the level of substance use, as well as changes in health status, family functioning, employability and work performance. Over the last three decades, scholars have examined hundreds of outcome studies and have produced a number of comprehensive literature reviews of the effectiveness of alcohol and drug abuse treatment.[76,77] Other similar reviews and meta-analyses are presented in extensive government-sponsored reports.[73,78,79,80,81,82,83]

The consistent conclusion from these reviews is that treatments for alcohol and drug addictions are only somewhat successful at completely stopping substance use (abstinence or sobriety), but treatment can successfully lead to *moderation* in the level and frequency of use and thus deliver 'quality of life' improvement.

3.2.1 Self-Help

Almost three-fourths of those with a drinking problem try to recover from problem drinking by self-help methods.[78] Many of these individuals are prompted to change by family and friends or by self-appraisal of their problem drinking. A review of 38 natural recovery (i.e. "self help") studies examined reasons why drinkers attempted to reduce or stop drinking on their own. The most common reasons were to improve health, lessen negative personal effects, and reduce financial problems associated with drinking. [84]

Effectiveness. Nearly all addicted individuals believe in the beginning that they can stop using alcohol or drugs on their own. However, most of these self-directed attempts to stop using are ultimately not successful. Research has shown that long-term alcohol and drug use results in significant changes in brain function that persist long after the person stops using alcohol or drugs. These chemical-induced changes in brain function have many behavioural consequences, such as the compulsion to use drugs despite adverse results. In cases where recovery from drinking was achieved by self-help methods, success is facilitated by having social support from spouse and others and developing personal activities and interests incompatible with drinking.[84]

3.2.2 Peer-Based Group Support

Part of many self-help efforts to stop substance abuse involves replacing one's social network. This is why many addicted individuals turn to peer-based groups comprised of others who are in recovery from substance abuse. Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are examples of these peer-based groups and they are available in communities all across Canada, around the globe, and even on the Internet.

Research suggests that starting AA involvement early in the treatment process increases positive outcomes.[85] Most substance abusers, however, initially resist attending these groups. This resistance may be due to fear of being recognized or due to misinformation (e.g. that you must identify yourself as an addict in order to participate).[86]

Peer-based group support programs are particularly supportive for those who are poor (the programs are free), isolated, lonely, or who come from a heavy-drinking social background. One review on AA programs found that those who are most likely to participate in AA successfully had the following personal characteristics:

- Social supports to stop drinking.
- More likely to have experienced loss of control over drinking.
- More anxious about drinking.
- Obsessively involved with drinking.
- Believed alcohol improved mental functioning.[87]

Effectiveness. Reviews of peer-based group support methods with a clear structure and well-defined interventions have modest favorable effects on reducing alcohol use and related problems.[83] For example, in the US in 2006 and 2007, survey data found that 46% of self-help group participants for alcohol use were able to stop drinking, 33% of those in groups for illicit drug use were able to stop using, and 53% of participants in groups for using both alcohol and drug use were able to quit using.[88]

The evidence is mixed for supporting the effectiveness of peer-based group support treatments when provided as singular interventions. For example, most of the people who enter residential treatment programs for help with serious addiction problems (see section 3.2.6) have a history of prior participation in AA or similar programs.[89] This data indicates a failure of AA to prevent the need for further treatment among serious drinkers. Perhaps this is why it is common for addicted or problem drinkers to use peer-based support programs in conjunction with other counselling and/or medication treatments.

3.2.3 Employee Assistance Programs

Employee Assistance Programs (EAPs) can play a key role in identifying addictions early and improving outcomes. EAPs typically provide screening, assessments, and short-

term counselling as part of their services offered to client organizations.[90] They may also help monitor treatment adherence and progress for employees referred to addictions counselling programs. It should be noted, however, that while many EAPs are effective in supporting the efforts of an addictions-free workplace, all EAPs are not created equal—the quality of EAPs is neither uniform nor consistently high.[91] This makes selection of the right EAP a critical step for any workplace that is committed to dealing with issues of addictions.

EAPs stem from a grassroots movement that was influenced by the founding of Alcoholic Anonymous in the 1930s. Indeed, many of the first EAP counsellors were recovering alcoholics themselves, with a personal interest in helping employees and their families cope with the addiction, while simultaneously encouraging the employer to support rehabilitative efforts rather than termination. Today, many EAPs have professional status and are comprised of a variety of formally-trained and industry-certified practitioners who are prepared to assist with a myriad of employee and workplace issues, yet addictions counselling and referrals still comprise a small but important portion of EAP caseloads.

An effective EAP will not offer quick fix solutions for employers committed to dealing with addictions issues. Instead, the EAP will encourage policy development, education (e.g. training and orientation on these policies), identification and referral, and rehabilitation (e.g. counselling) in conjunction with support for progressive actions for unacceptable work performance. The effective EAP will also consult with supervisors, union stewards, and human resources.

Finally, a high quality EAP will provide systematic follow-up monitoring of an employee's treatment efforts and recovery, helping to ensure that the employee adheres to the dictates of their care, and helping prevent employees from falling into destructive patterns of behaviour and 'triggers' that prompted the cravings for alcohol and other substances in the first place.[92]

EAPs are typically accessed through self-referral (e.g. the employee acknowledges a substance use problem and contacts the EAP for assistance). Sometimes an employee will access the EAP because a family member, friend, coworker, supervisor, or union steward recommends the program (commonly known as an 'assisted referral'). There are those instances, however where in spite of supervisor or union support and encouragement, an employee continues to perform poorly at work and refuses any suggestion for help. In this latter case, a 'formal referral' may be recommended on behalf of the organization. Formal referrals commit the employee to attend treatment and allow the EAP to be involved in monitoring that treatment and its associated follow-up activities. These types of referrals need to be made with great care and attention as they can become complex (e.g. certain kinds of information regarding involvement in treatment programs needs to be released back to the employer while at the same time preserving employee confidentiality). For this reason, a working dialogue between the EAP provider and HR personnel is essential.

Nearly all addicted individuals believe they can stop their compulsive behaviour on their own. However, **research shows that most self-directed attempts to change addictive behaviour, without other types of interventions, are unsuccessful.**

Regardless of the type of referral (self-initiated, assisted, or formal) it is never mandatory that an employee accept the referral, but it is mandatory that the employee maintain acceptable levels of performance. In all instances, confidentiality of personal information is always maintained, and the onus is on the employer and supervisors to maintain this confidentiality and never release information without written consent from the employee.

Effectiveness. The body of evidence supporting the role of EAPs in an addiction-free workplace is very favourable. While different EAPs offer different capabilities in areas of education, prevention, short-term counselling, policy development, and treatment follow-up, the sum total effect of all of these activities can contribute positively towards prevention, intervention, and improving return-to-work outcomes.[93,94]

3.2.4 Brief Interventions In Primary Care

Designed for people with early-stage forms of alcohol and drug problems, the focus of brief intervention (often defined as an intervention of no more than four sessions) is on taking the opportunity for direct and private contact between physician and patient to explain the medical consequences of continued substance abuse, to discuss health improvements possible with abstinence or reduced use, and to explore

other life events contributing to the patient's substance use. Physicians can also make referrals to addiction counselling and/or prescribe medications to assist with reducing the cravings and biochemical aspects of alcohol or drug use.[95]

Effectiveness. There have been dozens of high-quality studies on the effectiveness of brief interventions in primary care settings.[96] This body of evidence indicates that brief interventions often do result in small reductions in drinking and other related outcomes among hazardous drinkers (those with less severe issues than those who are alcohol dependent or addicted). For example, one review examined the results from multiple studies with over 7,000 program participants who were randomly assigned to groups that received either a brief intervention or a control condition with only initial and follow-up assessments.[97] After follow-up of a year or more, the participants who received the brief intervention drank less alcohol than participants in the control group, but not that much less—only about four drinks less per week. When the typical study participant had consumed about 30 drinks a week at baseline, four less drinks per week may be a scientifically significant difference but hardly represents a major change in overall drinking lifestyle.

The real value of brief interventions comes when the patient takes the advice of the doctor to start treatment and get more specialized counselling for their addiction and when the patient benefits from adding medication treatment for the substance abuse (if appropriate).

3.2.5 Psychological Counselling

Psychological counselling for addiction focuses directly on helping an individual to reduce or stop his or her alcohol or drug use or addictive behaviours (such as with gambling or sex addiction). It also addresses related areas of impaired functioning, such as employment status, illegal activity, family and interpersonal relations as well as the features of the individual's recovery program. Though the emphasis is primarily on short-term behavioural goals, individualized drug counselling helps the individual to develop coping strategies and practical tools for abstaining from drug use and then to maintain abstinence over time. After self-help, counselling is the most widely used form of treatment for addictions—about two-thirds of all people with substance abuse problems receive some kind of outpatient counselling treatment.[98]

Cognitive Behavioural Treatment (CBT). The aim of CBT is to teach individuals, by role-play and rehearsal, to recognize and cope with high-risk situations for relapse, and to recognize and cope with cravings. In CBT, individuals address issues of motivation, build skills to resist substance abuse, replace substance-abusing activities with constructive and rewarding activities, and improve problem-solving abilities. Behavioural therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community. This kind of outpatient treatment may consist of attending individual or group counselling sessions for an hour or two each week, or it may involve longer, more intensive blocks of treatment during the day, evening, or weekend.[78,79]

Effectiveness of Counselling Treatment. Individual-based addictions counselling treatment approaches have robust research support for their effectiveness. This kind of treatment is effective for behaviourally-based kinds of addictions with compulsive control features (gambling, sex, eating disorders, Internet, etc.). Cognitive behavioural therapy, in particular, is considered the most successful kind of individual counselling treatment for alcohol and drug addictions, especially in the prevention of relapse.[76,77,78,79,80,81,82,83]

3.2.6 Inpatient (Residential) Treatment

Residential programs require the person to stay at the treatment facility for a period of time. This kind of treatment provides around-the-clock supervision, group and individual therapy, education, meals, and housing accommodations.[79]

Inpatient, or residential setting, kinds of treatment are necessary when substance use has progressed from problematic use to abuse and dependence. Compared with individuals in other forms of treatment, the typical residential patient has more severe problems, with more co-occurring mental health problems and, possibly, more experience with criminal activities.[99]

Day treatment is a counselling service offered several hours per day, several days (or nights) per week for several weeks. Day treatment is an alternative to residential treatment since the client returns home every day after treatment.

Detoxification (detox). The initial step for many substance abusers before entering residential inpatient treatment is a short stay in chemical detoxification services.[78] Detox is a medical service designed to safely manage the acute physical symptoms of withdrawal associated with stopping drug use. The immediate aims are to alleviate the physical symptoms of withdrawal, to achieve at least a temporary state of abstinence from the substance(s) and to treat any co-morbid physical or psychiatric conditions.

Individual-based addictions counselling treatment approaches have robust research support for their effectiveness—particularly in preventing relapse.

Effectiveness. Studies show that inpatient treatment of drug dependence has consistently been shown to be effective at reducing drug use.[78,79,100] For example, it is estimated that inpatient treatment reduces illicit drug use by 40–60% and significantly decreases criminal activity during and after treatment. Inpatient treatment can also improve the prospects for employment, with gains of up to 40% after treatment.[101]

3.2.7 Pharmacological Treatment (Medication)

Many people with more serious levels of substance abuse can benefit from careful use of controlled doses of certain medications or drugs. The goal of these treatments, sometimes called 'maintenance' or 'replacement' therapies, is to eliminate or reduce use of a particular substance or to reduce harm from its administration (e.g. injecting).

Effectiveness. Medications can also reduce longer-term overall health costs of problem drinkers. Methadone treatment among narcotic addicts has been shown to decrease drug use and decrease associated criminal behaviour. Treatment with prescription anti-depressants and anti-anxiety drugs also has been found to relieve the symptoms of depression and anxiety in alcoholics, but does not show any positive effects on reducing alcohol use or dependence.[83] But through reducing co-morbid mental health conditions, the alcoholic or drug addict may be better able to engage in treatment specific to substance abuse.

Summary of Treatment Effectiveness. A large research literature shows that treatment tends to reduce alcohol and drug use, although there is wide variability in results by individuals, type of addiction, and type of treatment. Individual treatment outcomes depend on the extent and nature of the individual's problems, the appropriateness of the treatment components and related services used to address those problems, and the degree of active and sustained engagement of the individual in the treatment process. It must also be noted that treatments of all kinds are only effective if delivered in accordance with the procedures of their current best practices and if carried out by competent trained practitioners. While treatment has been shown to reduce drug use significantly, most people do not actually completely quit using alcohol or drugs, but rather they reduce the quantity or frequency of substance use and related activities. However, despite the fact that many people do not get completely 'cured' in terms of lifelong sobriety or quitting drugs, there are still appreciable benefits from most kinds of treatment for alcohol and drugs.

3.2.8 Harm Reduction As An Alternative To Treatment

The "harm reduction" movement has evolved as an alternative approach to address the many issues of limited access to care and the long-term course of treatment. Harm reduction is a public health philosophy that makes the reduction of potential harm from substance use a higher priority than participation in treatment[78,83,102]. Harm reduction supports policies and practices aimed at addressing risky substance use behaviours without requiring abstinence. Harm reduction seeks to ensure individuals are fully informed of their options concerning substance abuse and are provided the means to make safer choices while recognizing that it is impossible to keep people from engaging in certain risky behaviours and also valuing individual autonomy and responsibility.

Such policies and practices have the goals of preventing and reducing harm to users. Thus, success of these kinds of programs is reflected more by reductions in the rates of death, disease, crime, and individual suffering than in changes in the consumption patterns for addictive substances or behaviours. Canada has been a world leader in experimenting with innovative harm reduction programs relating to substance abuse, particularly in British Columbia.[103,104]

3.3 Treatment Issues

Return On Investment. The relative size of economic benefits of treatment are so large that even in a typical short-run analysis of a year or two, it is possible to find a positive cost-benefit ratio in which the financial value derived from the treatment exceeds the cost of delivering the treatment. For example, in one review of 18 cost–benefit addiction treatment studies, the dollar value of the benefits far exceed the costs, even when only a limited number of benefit components were accounted for in the analysis.[105] The US government has concluded that for every $1 invested in addiction treatment programs the yield is a return of between $4 and $12 in reduced drug-related crime, criminal justice costs, theft losses and health care costs.[78] The government in England has also concluded that treatment for alcohol problems is cost-effective, such that the financial benefits to society are five-fold greater than the costs of treatment.[83]

Relapse. Relapse (returning to the use of alcohol or drugs after a period of abstinence or non-use) is common and presents a formidable challenge to treating addictions. Longitudinal follow-up studies routinely find that up to two thirds of those in treatment programs relapse within as little as six months after completing their treatment.[106,107] Because relapse during and after treatment is so common, it is now recognized by most clinicians that strategies used to *initiate* change are different from those used to *maintain* change.

Denial. When initially confronted about their drug problem, many addicts resist formal evaluation and treatment. Even with publicly identified risk factors and a pattern of altered behaviours, most addicts deny that they have a problem. Indeed, addicts and those who love them are often the last to accept the severity of situation, as they often are engrossed in denial and the need to prove they are still in control. Denial not only prolongs suffering for the addict by preventing or postponing needed care, but it also increases the risk of impacting others at home and work.

For every $1 invested in addiction treatment programs the yield is a return of between $4 and $12 in reduced drug-related crime, criminal justice costs, theft losses and health care costs.[78] Other studies have concluded that treatment for alcohol problems is cost-effective, such that **the financial benefits to society are five-fold greater than the costs of treatment.**[83]

Access. Because addicts may be uncertain about the need to enter treatment, it is crucial to take advantage of opportunities when they are ready to seek treatment. However, the chance to get into treatment can be lost if treatment resources are not immediately available and easy to access. This is where practical support from family, medical staff or the EAP counsellor can really make a difference.

Women and Treatment. Recent studies suggest that there are important differences between the sexes in terms of effective methods of treatment for addictions.[108] Once they have a substance use problem, women are more likely than men to face multiple barriers to accessing substance abuse treatment and are less likely to seek treatment at all. Women also tend to seek care in mental health or primary care settings rather than in specialized addiction treatment programs, which may contribute to poorer treatment outcomes. One positive difference is that relapse tends to occur less often for women than men, in part because women are more likely than men to attend supportive aftercare programs.

Recognizing the range of issues indicated by these kinds of sex differences, Health Canada has joined with other organizations in advocating for the further development and testing of women-centered approaches to alcohol and drug treatment and prevention.[109] The limited literature that is available so far suggests, however, that sex-specific alcohol treatment is no more effective than mixed-sex treatments, though certain women may only seek treatment in women-only programs.[110]

KEY MESSAGES

- A range of approaches to alcohol and drug addiction treatments exists, including self-help and support groups, counselling, residential programs, and medications. Most treatments typically offer some mix of these approaches.
- EAPs are an effective resource to help companies address substance abuse and addictions issues. Key components of effective EAPs are prevention, intervention and rehabilitation. EAPs assist employers to focus on employee support and intervention efforts in conjunction with policy development, supervisory training, and work performance-related progressive actions.
- Cognitive Behavioural Therapy (CBT) in combination with peer-support and physician-directed medication (if appropriate) is perhaps the most effective treatment model for more severe alcohol and drug dependence.
- The overall success of addiction treatment varies widely and fails in many cases, with only a third to half of those receiving treatment being able to quit or substantially reduce their problematic use behaviour patterns in future years.
- Treatment effectiveness is limited by many factors, including denial, the false hopes of self-treatment, lack of availability of treatment resources, having multiple addictions and other mental and physical health problems, gender-specific treatment needs for women, and the larger failure of the health care system to even diagnose and treat addictions at all.

If your organization does not already have a policy concerning substance abuse and addictions, when is the best time to start planning one? Today.

SECTION 4: THE FUTURE

The Employer Response to Addiction

The themes covered in this section include what employers can and should do regarding the organization culture, establishing policy, prevention efforts, drug-testing, and worksite programs. There are also major new summary reports that offer resources on workplace addictions.

4.1 What Employers Can Do

Research and clinical experience consistently points to how difficult it is to effectively manage and treat an addiction once it has reached the dependence stage. It often entails repeated experiences with treatment and recovery over many years. Employers should therefore recognize that many addictions pose the same kinds of challenges to employees and their families as other chronic serious medical disorders, such as diabetes and cancer. However, unlike many health challenges which employers and individuals may have little ability to influence, there is a clear role that employers, and employees, have in the prevention and treatment of an addiction.

Employers who want to drastically reduce the costs to their business from addictions have a clear mandate to fulfill (whether those costs are in terms of increased absenteeism, reduced productivity, increased safety violations and incidents, or increased health claims): Create a comprehensive policy concerning substance abuse and addictions, educate managers and supervisors to enforce that policy, educate employees (current and prospective) about that policy, assist with referrals for treatment, and provide access to suitable treatments.

4.1.1 Policy Development

Employers can create formal policies on employee alcohol and drug use, gambling and other addictive behaviours.[111] Such policies should encourage early detection, facilitate early intervention, and, when appropriate, provide support for the employee to address the problem and offer practical assistance with returning to work after treatment. Having a clear and fair policy on substance use creates and reinforces the expectation that employees should arrive fit for work and remain so throughout the workday. Spelling out exactly what the employer requires of employees allows employees to ensure that their behaviour at work follows the policy, and it also prepares them for the consequences of violating that policy. Finally, applying the policy consistently across all levels of the organization, without exceptions, sends a message that the policy is fair and applicable to all.

The number of employers that have addiction policies is increasing. For example, a survey of employers in Alberta found that in year 2002 the majority had specific alcohol (61%) or drug policies (60%) and about 1 in 10 had gambling policies (11%).[14] This is approximately double the number of employers with policies compared to a decade earlier. This suggests that more employers have become aware of alcohol

Employers who want to drastically reduce the costs to their business of addictions have a clear mandate to fulfill:

create, communicate, and support a policy to convey that substance abuse is never permitted.

and drug issues and have taken positive steps to address these concerns at the policy level.

There is no one substance abuse/addictions policy that is right for all employers. However, the following key elements provide a framework that can guide policy development for any organization of any size, in any industry.

Set the Ground Rules. Start creating a policy immediately. Any effort towards policy development sends a message to employees that the organization is committed to dealing with substance abuse and addictions in the workplace, and that the addictive behaviour will not be tolerated.

Create the Policy Statement. Outline where the organization stands on substance abuse and other addictions, what is expected from employees and the consequences if the policy is violated. The exact wording used will depend on the industry, number of employees, values, and culture. Consider everyone who will be affected by the policy and involve key representatives of various employee groups in its development (managers, supervisors, employees, stewards, new hires, work-at-home arrangements, etc.).

A substance use/addictions policy should:

- Let employees and applicants know that substance use on the job, or that affects work performance, is never permitted.
- Explain the reasons for the policy (e.g. workplace safety, product quality, public liability).
- Specify consequences for policy violations.
- Describe the responsibilities of the employer to enforce the policy and assist with referrals.
- Describe the responsibilities of an employee with a substance abuse problem to seek and complete treatment.
- Remind employees that participation in treatment is confidential but it will not protect employees from progressive action for continued unacceptable job performance or policy violations.

Note: Consult with an HR specialist when creating a substance abuse policy to ensure that federal and provincial regulations are adhered to, and that any industry-specific actions or exceptions are noted.

Train and Educate. Train managers and supervisors on the policy and how to identify substance abuse and addiction problems, how to enforce the policy, and how to refer employees to the resources that are available to assist them (e.g. the EAP) so that any problems that may be affecting work performance can be addressed. Ensure that managers, supervisors and stewards are well trained in how to observe and document unsatisfactory work performance or behaviour, talk to employees about work problems and what do about them, explain the policy to their employees, and know when to take action. Remind supervisors that their role is not to diagnose substance abuse problems or treat them but to know what to look for and know what to do.

Inform Everyone. Make sure all employees, new hires and applicants know the policy and are aware of your ongoing commitment to an addictions-free workplace. For example, have each employee acknowledge in writing that he or she has read and understood the policy.

4.1.2 Make Ground Rules Clear

Employers have enormous power to protect their businesses from the negative impact of addictions, and to support employees to obtain the help they need to overcome addictions.

The most important action the employer can take is to ensure that a comprehensive substance use policy, and support services, are in place (the specifics of which have been outlined in the previous section).

However, policy development is only a first step. Employers have a great deal of latitude in how policies are disseminated (e.g. training, orientation) and how they are operationalized or put into action. The most effective route is to train supervisors and stewards to intervene when work performance suffers and/or there is suspicion of substance abuse.

Employer inaction accomplishes nothing more than supporting minimization of an addictions problem (denial) and preventing that employee from striving for and maintaining their recovery. An employee with an addiction problem needs to know the 'ground rules' and consequences. **There are no exceptions.**

It is also paramount that employers set clear performance expectations and consequences for individuals with a substance use problem, or who are in recovery for that problem. If an employee with an addiction does not know the relevant workplace policy, or is not held to reasonable performance standards, and/or does not experience consequences for failing to meet these standards, that employee will almost certainly not strive for recovery.

4.2 Policy Implications

4.2.1 Legal Issues For Employers

From an employment law perspective, substance abuse is recognized as a disability in Canada.[79] Since addiction is regarded as a disability within the meaning of the Canadian Human Rights Act, employers must seek to accommodate employees in order to help them keep their job.[112]

An employer must be attentive to the behaviour of employees, since it has a duty to provide support even if an employee will not admit openly that the problem exists. An employer with reason to believe that an employee has an addictions problem is therefore obliged to let the employee know they have a problem and offer them an opportunity to correct it, before taking progressive action. An employer may dismiss an employee who is frequently absent because of this kind of problem only if the employee has had sufficient time to take responsibility for it, but shows little likelihood of improvement.

4.2.2 Stigma

Many addicts are demoralized by feelings of self-blame, shame, and guilt. These negative feelings often create a mindset that makes the person unwilling or unable to seek help or treatment. For example, when seeking help the addicted employee must overcome a number of risks and barriers, including stigmatization, fear of losing their jobs and strained relationships with family members and coworkers. Returning to work after treatment has ended and recovery has begun also brings many of the same challenges. A key aspect of respectful attitude is to maintain the employees' confidentiality in the process. Employers may not know who among their workforce is in recovery, but if they do, they must recognize and appreciate the delicate balance between wanting to help and maintaining the employee's legal rights, needs, and desires for privacy.[33]

4.3 Prevention

The *Canadian Network of Substance Abuse and Allied Professionals* (CNSAAP) considers addiction prevention as "interventions that seek to delay the age of first use or reduce/prevent harmful use after it has occurred".[113] Both of these prevention goals can best be achieved with a comprehensive approach. Organizational health research has identified risk factors and protective factors for substance abuse in the workplace and these factors function at three levels: the organization, the workgroup, and the individual.[63]

The cornerstone of prevention is to educate all employees about the nature of addictions. Providing employees with an education and awareness program allows them to identify problems in the workplace or to identify their own problems and seek help before there are serious consequences on the job. Such tactics can help to reduce the risks of exposure to substance use by coworkers and to reduce the tolerance among coworkers for abuse-related behaviour that affects work. Most employers provide some form of regular education and awareness to all employees and thus address the individual level of risk.

Drug or alcohol dependence is regarded as a disability within the meaning of the Canadian Human Rights Act. Employers must take reasonable steps to accommodate these employees in order to help them keep their job.[112]

In contrast, fewer employers do prevention at the workgroup or organizational levels. Perhaps this is because it is more difficult to change group dynamics and shape the larger work culture concerning attitudes and behaviour toward addictions (other than through workplace policy). Nonetheless, it is important to try to change subgroups of employees that may have developed an accepting attitude toward substance use and to not allow supervisors and other employees to cover-up, ignore or otherwise enable employees who are abusing alcohol or drugs. Positive ways to accomplish this can be to improve the teamwork of groups of employees in order to build stronger group norms and peer support opportunities.

At the organizational level it is critical to implement policies and employer-sponsored benefits for employees that can identify problems and also offer practical and immediate support for employees with addiction issues. Employers may wish to assess and improve the characteristics of some working conditions that are associated with increased risk for alcohol and drug use. According to the *Canadian Centre for*

TABLE 5: RESOURCE ORGANIZATIONS

CANADA

AADAC (Alberta Alcohol and Drug Abuse Commission): www.aadac.com

Alberta Gaming Research Institute at University of Alberta: www.abgaminginstitute.ualberta.ca

BC Mental Health & Addiction Services: www. bcmhas.ca

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

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

Canadian Harm Reduction Network: www.canadianharmreduction.com

Centre for Addiction and Mental Health (CAMH) at University of Toronto: www.camh.net

Employee Assistance Society of North America (EASNA): www.easna.org

Global Business and Economic Roundtable on Addiction and Mental Health: www.mentalhealthroundtable.ca

Health Canada: www.hc-sc.gc.ca/hecs-sesc/cds

Here to Help (B.C. Partners for Mental Health and Addictions Information / Kaiser Foundation): www.heretohelp.bc.ca

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

UNITED STATES

Center of Alcohol Studies, Rutgers University: www.alcoholstudies.rutgers.edu

Ensuring Solutions to Alcohol Problems, George Washington University Medical Center: www.ensuringsolutions.org

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

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

National Registry of Evidence-Based Programs and Practices (NREPP): www.nrepp.samhsa.gov

Society for the Advancement of Sexual Health (SASH): www.sash.net

Occupational Health and Safety (CCOHS), there are a number of workplace conditions that are suspected of contributing to incidents of substance abuse.[114] For example, jobs involving higher than normal levels of stress, low job satisfaction, boredom, isolation, or those in which long hours are common can help make addiction problems more likely.

4.4 Screening And Drug Testing

One way that employers approach prevention of employee alcohol and drug use is by conducting workplace testing to chemically identify substance use among employees. Also, it is becoming common practice to seek a substance use assessment to clarify the existence of abuse/dependence. This involves psychological assessment which provides a diagnosis and a treatment direction.

Drug testing by employers is far less common in Canada than in the United States. A study in Alberta found that less than 10% of employers in 2002 had testing programs for alcohol and drugs and that only about one-third of the employers using this testing considered it effective in dealing with alcohol or drug use problems in their workplace.[14]

Canadian organizations using drug testing tend to be in safety sensitive industries, such as forestry/mining, oil/gas, transportation and construction. The most common work conditions involving the use of drug testing programs includes testing after accidents, testing on referral by a supervisor who noticed performance problems, testing after a near miss of an on-the-job accident situation or general pre-employment testing.[79]

In Canada, when an employee returns to work after treatment for alcohol or drug use, an employer is generally entitled to test whether the employee is abstaining from drugs or alcohol and to ensure that the employee is able to work safely. Since alcohol and drug testing violates the dignity, physical integrity and privacy of the individual, employers are restricted to conducting only the tests necessary to ensure sobriety, without unduly infringing the employee's privacy. However it is done, alcohol and drug screening is a sensitive issue. Canadian case law on this issue is not well developed and there appears to be insufficient experience to direct employers one way or another as to whether testing is legally acceptable as a component of a drug and alcohol policy.[112]

TABLE 6: RESOURCE REPORTS

Depression and Work Function: Bridging the Gap between Mental Health Care and the Workplace. Depression in the Workplace Collaborative. http://www.carmha.ca/publications/index.cfm

Don't Mix It: A Guide for Employers on Alcohol at Work. Health and Safety Executive. http://www.hse.gov.uk/pubns/indg240.pdf

Employer Cost Savings Briefs on Substance Abuse. National Institutes of Drug Abuse. http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=17943

Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction. British Columbia Ministry of Health Services. http://www.health.gov.bc.ca/library/publications/year/2004/framework_for_substance_use_and_addiction.pdf

It's Our Business: Alcohol, Drugs and Gambling in the Workplace. Alberta Alcohol and Drug Abuse Commission. http://www.aadac.com

Keeping Good Company: An Employer's Guide to Understanding and Avoiding Alcohol Liability. Mothers Against Drunk Driving and the Canadian Centre on Substance Abuse. http://www.madd.ca/english/research/liability_employer.pdf

Quick Facts: Mental Illness & Addictions in Canada. Mood Disorders Society of Canada. http://www.mooddisorderscanada.ca/page/quick-facts

Smoking Cessation in the Workplace: A Guide to Helping Your Employees Quit Smoking. Health Canada. http://gosmokefree.gc.ca

Toward a Culture of Moderation: Reducing Alcohol-Related Harm in Canada. The National Alcohol Strategy Working Group. http://www.nationalframework-cadrenational.ca/uploads/files/FINAL_NAS_EN_April3_07.pdf

Workplace Screening and Brief Intervention: What Employers Can and Should Do About Excessive Alcohol Use. Ensuring Solutions. http://www.ensuringsolutions.org/usr_doc/Workplace_SBI_Report_Final.pdf

You Are the Key: 10 Steps for Employers to a Drug-Free Workplace. Sunshine Coast Health Centre. http://www.sunshinecoasthealthcentre.ca/key-guide.pdf

4.5 Employer-Sponsored Benefits

There are several kinds of programs that employers can provide for employees and their family members that support addictions. These include employee benefits, offering worksite wellness and screenings, offering employee and family assistance programs, and offering return-to-work and job accommodation services.

Employee Benefits. A key organizational level prevention strategy is for employers to invest more in benefits that offer substance abuse and mental health treatment. Effective health and disability benefit policies should cover screening, treatment and coordination of mental health and substance use care as well as pay for peer support and illness self-management programs in the community. Literature reviews have found that results from organizations that have done this have later benefitted financially as well as encouraging a more resilient and productive workforce.[40,115,116]

Worksite Wellness and Health Screenings. Employers should integrate substance abuse and mental health education into other workplace health and wellness programs.[117] One example is to incorporate brief screening survey tools into health risk appraisals (HRAs) and other worksite wellness events and actively promote these screenings and risk appraisals. Some employers offer incentives or motivational campaigns to drive up the number of employees participating in wellness offerings. Case study examples and intervention tools to do this kind programming are profiled on a website resource for employers called the *National Registry for Evidence-based Prevention Programs* (see **Table 5**). Although recommended, sadly, only about 1 in 8 Canadian employers (16%) offered screenings for mental health and addictions to their employees in 2007.[118]

Employee Assistance Programs (EAPs). Employee Assistance Programs can provide confidential services to employees with substance use disorders and associated mental health disorders and can be involved in providing screening, referring employees for treatment, and offering follow-up care and support during recovery.[118] Thus by offering access to an EAP, an employer can be more successful in reducing harm from the misuse of alcohol and other drugs by having a dedicated resource to support the organization's policy on alcohol and drug use. A 2006 survey found that half of Canadian employees had access to an EAP and 11% of those with an EAP resource available had used it.[119] EAPs are less common among smaller size employers than moderate or large employers.

Return-to-Work Programs and Job Accommodation. Employers and unions in Canada are required to make every reasonable effort, short of undue hardship, to accommodate disabled (injured or ill) employees.[120] Duty to Accommodate is a legal concept that has evolved out of case law, human rights and labour standards legislation.[121] Implementing a Return-To-Work program will meet the employer's duty to accommodate obligations and facilitate the return of disabled employees to safe, meaningful, and productive work environments.

Return-To-Work programs are based on the philosophy that many employees can safely perform progressively more demanding levels of productive work while participating in the process of recovery. These kinds of programs must be collaborative and sensitive to the particular challenges in preparing the employee to return to work after treatment for addictions in order to avoid a relapse.

In 2007, 60% of Canadian employers had a Return-To-Work program in place.[119] Research on the success of programs for the reintegration of employees back to work after treatment for substance abuse[122] and for workplace-based return-to-work interventions in general[124] has found positive impacts on reducing the duration and the costs of work disability.

4.6 Resources

Table 5 provides a list of some of the leading organizations from Canada and the United States that offer workplace addiction information and resources.

There are now many sources of highly credible reports on addictions and what can be done to improve the situation. Some of these reports are listed in **Table 6**. These particular resources were selected because they are the most recent and the most authoritative reports that are written for business readers. All of these reports are available at no cost online from the website listed for each report. Please note that most of the featured reports are supported by organizations that are devoted to promoting addictions and workplace mental health and thus many other resources are also available at their websites.

KEY MESSAGES

- There is no one substance abuse/addictions policy that is right for all employers, but policies should encourage early detection, facilitate early intervention, and, when appropriate, provide support for the employee to address the problem and offer practical assistance with returning to work after treatment.
- Start creating a substance use policy immediately. Any effort towards policy development sends a message to employees that the organization is committed to dealing with substance abuse and addictions in the workplace, and that problems from their use will not be tolerated.
- Regardless of specifics, the policy should: (1) let employees and applicants know that substance use on the job, or that affects performance, is never permitted, (2) explain the reasons for the policy (e.g. workplace safety, product quality, public liability), (3) specify consequences for policy violations; describe the responsibilities of the employer to enforce the policy and assist with referrals, (4) describe the responsibilities of an employee with a substance abuse problem to seek and complete treatment, and (5) remind employees that participation in treatment is confidential but it will not protect employees from progressive action for continued unacceptable job performance or policy violations.
- Clearly explain the policy to all employees, new hires, and applicants. This may entail having each employee acknowledge in writing that he or she has read and understood the policy.
- Train managers and supervisors on the policy and how to identify substance abuse and addiction problems, how to enforce the policy, and how to refer employees to the resources that are available to assist them (e.g. the EAP) so that any problems that may be affecting work performance can be addressed.
- Screening and drug testing can be used in select circumstances as a preventive tool to both discourage use, to identify those already using substances, and to monitor the course of recovery after treatment.
- Employers can provide certain kinds of benefits and programs to assist employees with addictions. Providing insurance coverage for treatment is important, as well as integrating substance abuse and mental health screenings into wellness initiatives, offering an EAP, and using Return-To-Work programs.

Substance abuse is a problem that must be addressed on all fronts. As a social phenomenon it is probably unsurpassed in its complexity and deep-rootedness in Canadian life.
–Health Canada[48]

Final Statement

With effective treatment those with an addiction can become non-users or control and modify their behaviour enough to return to good health, good family relations, and good work performance. It is important, though, to realize the many challenges that individuals with an addiction face in trying to stop the addiction and maintain this change. Successful treatment can be a long-term process involving, perhaps, multiple types of interventions and repeated attempts to recover. This is particularly true for alcohol and drug addictions.

Workplaces that do not take a proactive and preventive stance concerning addictions can expect to encounter safety incidents, performance problems, productivity losses, and more. The corollary is that workplaces that *do* take a proactive and preventive stance concerning addictions can improve the safety of their work environment and the productivity of employees. Along these lines, the proactive employer can establish or update substance abuse and addictions policy, implement awareness campaigns for all employees, managers and stewards at all levels of the organization, provide training in how to implement the policy, and provide support for employees seeking treatment services.

Addictions are not easy or comfortable to acknowledge and deal with and it is not only the individual who can be in denial of an addiction, but the organization that he or she works in as well. However, clinical research shows that most addictions, left unchallenged, have a deteriorating and deepening course. Once the issue is understood and brought into the light, employers can take action to respond to addictions in positive and proactive ways.

After taking in all of the evidence and experiences of other organizations, it is time for more employers to take a stand and recognize that addictions are sabotaging the lives of many of their employees, creating undue burden on supervisors and coworkers, and significantly reducing workplace productivity. An organization culture and work environment that is knowledgeable about addictions can make a difference in preventing addictive behaviours and assisting those already on the journey to overcoming addiction. For the health of employees and for the health of the workplace, addictions should be recognized and regarded with the seriousness they deserve.

No one starts out planning to become addicted and no employer wants to contribute to this process by ignoring the problem.

When left alone, **most addictions have a deteriorating and deepening course unless the problem is directly addressed**. Once the problem is understood, **employers can take action to respond in positive and proactive ways.**

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