Official Newsletter of Drug Free Workplaces
March 2024 Vol. 20 No. 3

Published by The Council on Alcohol and Drugs
Tel (404) 223-2486 | Fax (866) 786-9811 | www.LiveDrugFree.org

Remember that just because you hit bottom doesn't mean you have to stay there.
– Robert Downey Jr.
www.LiveDrugFree.org

Supervisor Newsletter

Five Steps to Prevent an Opioid Crisis at Work

Workplace overdose deaths have continued to increase over the past five years, and the National Institute on Drug Abuse has reported that opioid drugs are implicated in 64% of overdose deaths across all industries.

Urgent actions are needed to prevent an opioid crisis at work, and to create safer and healthier work environments for all members of the workforce. Here are five steps employers can take to address the problem.

First Step: Substance Abuse Policy

Dealing with the opioid epidemic in the workplace requires multiple steps. The first step is to have a legally sound substance abuse policy.

Some companies choose to have a zero-tolerance substance abuse policy. A zero-tolerance approach to employees testing positive for drugs, however, puts employers at risk because firing a worker who is undergoing treatment or refusing to grant them reasonable leave time—such as for workers who need to visit a methadone clinic daily—could be considered disability discrimination under the ADA. In addition, workers prescribed an opioid painkiller have an underlying medical condition that might also qualify for disability protection. It is vitally important to ensure that the company policy meets all state and federal legal requirements.

Second Step: Drug Testing

Drug testing is the second step in maintaining a comprehensive drug free workplace program designed to prevent substance abuse and overdose. When taking employment action on a positive, confirmed drug test however, supervisors must keep in mind that employees who are experiencing substance abuse addiction are protected under the federal Americans with Disabilities Act (ADA), unless they are currently using drugs illegally.

If a test comes up positive for a prescription painkiller drug for example, supervisors should require employees to provide documentation, such as a letter from their physician, that the medication for treatment is in fact a legitimate prescription.

Third Step: Employee Assistance

An Employee Assistance Program (EAP) is the third step necessary in combating the opioid epidemic

through a drug free workplace program. EAPs provide workers with assessments, short-term counseling, referrals, and follow-up services to address personal or emotional problems that are interfering with job performance, including opioid use disorders. EAPs are associated with increased employee well-being, morale, and productivity, as well as reductions in absenteeism among employees. They have been shown to be appealing to employees seeking assistance with a substance use disorder and a potential vehicle for positive life changes, including improved attitudes about work and interpersonal relationships with colleagues. Several studies have found that participation in employee assistance programs was associated with decreases in unhealthy behaviors, including binge and heavy drinking.

Fourth Step: Employee Education

Educated and empowered employees are the first line of defense in preventing opioid overdoses at work. Workers should be made aware of the scope and severity of the opioid crisis, the relationship between workplace injuries and opioid use disorder, and actions that can be taken to prevent and respond to opioid use and misuse.

Employee education on the opioid crisis focused on overdose recognition and reversal with intranasal naloxone has also been successful in increasing knowledge related to overdose prevention.

Providing information to injured workers on how to talk to providers about pain management, how to avoid misuse of opioids, and alternative pain treatments is a key secondary prevention intervention.

Fifth Step: Supervisor Training

Supervisors should be trained on how to:

1. Identify strategies to improve workplace hazards that might result in opioid use.
2. Improve organizational systems to help injured workers avoid use of opioids.
3. Enforce the substance abuse policy and policies related to treatment/recovery and return-to-work.
4. Understand the reasons for prescription pain reliever misuse.

Training supervisors on how to reduce exposure to hazards by evaluating risk factors and taking corrective action is critically important. Hazard evaluation includes analyzing data sources such as logs maintained for occupational injury reporting and workers' compensation records.

Implementing the five steps listed here will help employers move from a reactive to proactive approach.

Official Newsletter of Drug Free Workplaces
March 2024 Vol. 25 No. 3

Published by The Council on Alcohol and Drugs
Tel (404) 223-2486 | Fax (866) 786-9811 | www.LiveDrugFree.org

Remember that just because you hit bottom doesn't mean you have to stay there.
– Robert Downey Jr.
www.LiveDrugFree.org

DrugFree@WorkPlace

Counterfeit Pills

Counterfeit pills like Percocet, Xanax, Adderall, and even Advil and Tylenol have become a prolific and deadly problem in America. These fake medications are often tainted with the synthetic drug fentanyl, or in some cases are entirely fentanyl.

The U.S. Drug Enforcement Administration (DEA) seized more than 75 million fake pills and almost 12,000 lbs. of fentanyl powder in 2023. That's equivalent to more than 397 million lethal doses of fentanyl.

DEA laboratory testing reveals that seven out of every ten pills seized by law enforcement contain a lethal dose of fentanyl.

According to the DEA Fake Pills Fact Sheet; One Pill Can Kill:

- Criminal drug networks are mass-producing fake pills and falsely marketing them as legitimate prescription pills to deceive the American public.
- Fake pills are easy to purchase, widely available, often contain fentanyl or methamphetamine, and can be deadly.
- Fake prescription pills are easily accessible and often sold on social media and e-commerce platforms, making them available to anyone with a smartphone.
- Many fake pills are made to look like prescription opioids such as oxycodone (Oxycontin®, Percocet®), hydrocodone (Vicodin®), and alprazolam (Xanax®); or stimulants like amphetamines (Adderall®).

The Centers for Disease Control and Prevention reports that more than 185 people in the U.S. die every day of opioid overdoses, most involving fentanyl. Many of these overdose deaths are from ingesting a counterfeit pill.

Prevent Overdose Deaths

Signs of a fentanyl overdose are: tiny, pinpoint pupils, lethargy or sleepiness all the way to coma, and respiratory depression in which people breathe slower and shallower until they stop breathing and die. If a person becomes unconscious from an overdose, they can't protect their airway, the airway collapses and obstructs breathing. This often sounds like the person is snoring.

If someone has overdosed, the best antidote is naloxone, known as Narcan. Narcan is usually administered intravenously or through the nose. But Narcan must be administered quickly in order to work. If the person has stopped breathing and no longer has a pulse, Narcan won't work.

Narcan was approved for sale over the counter in March of 2023. It can be purchased online at Narcan.com. The manufacturer of Narcan describes how to use the drug with the phrase: LAY, SPRAY, STAY. The first step is to lay the person on their back and tilt his or her head up. Then insert the Narcan device into either nostril and press the plunger firmly. Next, call 911 (if not already called) and continue to administer doses as needed and wait with the person until help arrives.

Narcan is a safe medication, but it can put a person into withdrawal. However, withdrawal is better than death. Some people have expressed concern that giving Narcan to someone who is addicted to opioids would be like giving them permission to continue using. But people who have overdosed will not be able to give naloxone to themselves. Having Narcan available will not encourage a person with opioid use disorder to keep using. Whether Narcan is available or not, that individual is going to keep abusing opioids until he or she gets treatment.

The following suicide prevention information, while provided by the Georgia Department of Behavioral Health and Developmental Disabilities, will also be helpful to those in states other than Georgia. All online resources listed are available to users nationwide.

March not only marks the beginning of Spring, but it is also the month when advocates, researchers, and medical practitioners raise awareness about traumatic brain injury (TBI), which is sustained by 1.4 million people each year. We in the field of suicide prevention do a lot of work to raise general awareness about suicide during the month of September, but there are many contributing factors that lead to increased suicide risk that overlap with various other mental health and medical conditions.

Because of the stigma that surrounds the topic of suicide, it is often considered an amoral or criminal act, right down to the language we use to describe it when we say that someone committed suicide. But thoughts of suicide have been directly associated with various health conditions, such as TBI.

In fact, clinical studies posited that patients who have experienced a mild TBI double their risk of suicide compared with individuals without mild TBI. Moreover, patients with mild TBI also appear to have a higher risk of suicide attempts as well as ideations of suicide. Those are staggering statistical increases for individuals who suffer this type of brain trauma, which helps to pull our ideas about suicide out from the murky waters of moral judgment so that we can also examine the physiological conditions that increase suicide risk. But it is also important to note that the increased risk of suicide for people who have experienced a mild to severe TBI extends beyond the effects of physical trauma to the brain. Experiencing a TBI can also lead to life changes that can increase suicide risk such as job loss and no longer being able to participate in normal activities, which can lead to financial hardship and isolation. For instance, a professional or student athlete would likely no longer be able to participate in their sport after experiencing a TBI, which could lead to a loss of financial support, scholarship, and important sense of identity.

The CDC has also compiled a comprehensive list of demographics who are at a heightened risk of experiencing a TBI, which include racial and ethnic minorities, service members and veterans, people who experience homelessness, people who are in correctional and detention facilities, survivors of intimate partner violence, and people living in rural areas—all of which are already groups of individuals at increased risk for suicide[1]. The particular risk of TBI for service members has been highlighted by the U.S. Military's Defense Suicide Prevention Office for good reason. They mention in their brief that a history of moderate to severe TBI is associated with an increased risk for suicide by firearm and list limiting access to lethal means as an important strategy for prevention among veteran and service people who have experienced TBI. In a study that examined vital statistics data from 2008 to 2017, it was estimated that "...firearm suicide accounted for nearly half (48.3%) of the increase in the absolute incidence of TBI-related death when combining all injury categories showing absolute increases" (Miller et al. 2020). Looking at those numbers, it is not surprising that the Defense Suicide Prevention Office suggests limiting access to lethal means as a key strategy.

One pioneer in researching TBI is Boston University's Chronic Traumatic Encephalopathy (CTE) Center. Their goal is to grow our understanding of chronic traumatic encephalopathy and other long-term consequences of repetitive brain trauma in athletes, military personnel, first responders, victims of physical violence, and others affected by head trauma through various forms of advanced research. This kind of research and its discoveries can greatly advance our screening protocols, allowing us to provide the necessary support and intervention strategies needed to help keep these at-risk individuals safe.

These efforts in medical research into TBI can greatly reduce suicide risk, but the onus is also on us as a society to change our lens and move away from stigmatizing language like "committed suicide." In its place we use the term "died by suicide" to help detach the empirical truth of suicide from the socially stigmatized place it has historically held in our culture. This shift in language not only helps guide us towards a public health approach to its prevention, but it also begins to break down one of the biggest barriers for individuals experiencing thoughts of suicide to ask for help, which is the shame that results from cultural stigma.

To learn more about TBI and suicide risk, visit the following links:

- DSPO: What You Should Know About TBI & Suicide Prevention
- Understanding Health Disparities in TBI & Concussion

Sources:

1. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2023, October 19). *Health Disparities and TBI*. www.cdc.gov. Retrieved January 24, 2024, from https://www.cdc.gov/traumaticbraininjury/health-disparities-tbi.html
2. Gabrielle F. Miller, Scott R. Kegler, Deborah M. Stone, "Traumatic Brain Injury–Related Deaths From Firearm Suicide: United States, 2008–2017", American Journal of Public Health 110, no. 6 (June 1, 2020): pp. 897-899.

To learn more about suicide prevention, visit the DBHDD website at: https://dbhdd.georgia.gov/suicide-prevention.

Or contact the Suicide Prevention Director, Rachael Holloman, at: rachael.holloman@dbhdd.ga.gov.