Supporting recovery through Return to Work

Approaches for workers with mental illness and substance use issues in British Columbia's construction industry

SEPTEMBER 2020

DEVELOPED IN PARTNERSHIP WITH THE CONSTRUCTION INDUSTRY REHABILITATION PLAN

A note from the Medical Health Officer

When the Provincial Health Officer declared the overdose crisis a public health emergency in 2016, many did not think that the crisis had or would affect them personally. Findings from the 2017 Fraser Health Chief Medical Health Officer's Report entitled *The Hidden Epidemic* show otherwise. Contrary to popular misconceptions, most overdose deaths are occurring in private residences primarily among men 19-59 years of age. Of those employed at the time of overdose death, the majority work in the trades and transport sectors, which includes construction.

The intent of this report is to contribute to conversations with construction industry partners on how workers with mental illness and substance use issues can be supported with recovery, thereby decreasing overdose risk and overdose death. Consultations with construction employers, unions, associations, and programs involved in worker mental health and substance use treatment have identified return to work as a critical area for further investigation and where interventions could be targeted.

Significant strides have been made in improving access to life-saving overdose reversing medications like naloxone, access to mental health and substance use services, and reducing the harms of a contaminated illegal drug supply with harm reduction measures. We must continue to work to develop a robust system that supports those with mental illness and substance use issues, particularly for those using substances that are "hidden" from view. This requires a coordinated community response with partners outside of our usual health system circles involving innovative approaches to reach people with mental illness and substance use issues where they are situated.

2020 has been a challenging year. Alongside responding to a global pandemic, the number of overdose deaths in BC is now at record highs. The role of workplaces in protecting health and promoting wellness has been further highlighted this year. Workplaces have gone to great lengths to protect their workers from COVID-19. Similarly, by reviewing their return to work practices, workplaces have the potential to further prevent overdose death in those most at-risk and promote mental wellbeing.

This report would not have been possible without the steadfast support from Vicky Waldron and the Construction Industry Rehabilitation Plan. Thank you also to Judith A. Hutson from Hutson and Company and Amy Vilis for their coordination and synthesis of this report.
Sincerely,

Dr. Aamir Bharmal
Medical Health Officer, Fraser Health Authority

Glossary of abbreviations / terms

ACRONYM	DEFINITION
CannAmm	Occupational and Employment Drug Testing Organization
CIRP	Construction Industry Rehabilitation Plan
CLAC	Christian Labour Association of Canada
COAA	Construction Owners Association of Alberta
Concurrent disorder	Conditions in which a person experiences both mental illness and a substance use disorder
EAP or EFAP	Employee Assistance Program or Employee and Family Assistance Program
HR	Human Resources
H&S	Health and Safety
IME	Independent medical evaluation
MD	Medical Doctor
Mental illness	Mental illnesses are characterized by changes in thinking, mood, or behaviour associated with significant distress and impaired functioning. Mental illness can take many forms. Examples include: mood disorders, schizophrenia, anxiety disorders, personality disorders, eating disorders, problem gambling, or substance dependency.
MRO	Medical review officer
OAT	Opioid Agonist Treatment provides a prescribed medicine such as methadone or buprenorphine-naloxone (Suboxone®), in a supervised clinical setting to treat people who have a opioid use disorder.
RTW	Return to Work
SAP/SAE	Substance abuse professional/substance abuse expert
Safety-sensitive	Organizations or positions where impaired worker performance could result in a significant incident affecting the health and safety of the individual, other workers, customers or the public, or could cause property damage
Substance use disorder	When a person's use of alcohol or another substance leads to health issues, or problems at work, school, or home. As substance use disorder is a medical diagnosis, the term "substance use issue" is used in the context of situations where workplaces note substance use concerns.
THC	Tetrahydrocannabinol, the primary psychoactive cannabinoid in cannabis
'Zero-tolerance' policy	A policy of strict enforcement of regulations and bans for every person who breaks a rule regardless of circumstances

Executive summary

Introduction

Since 2016, British Columbia (BC) has been responding to an unprecedented overdose crisis relating to contamination of the illegal drug supply with fentanyl and other opioid analogues. In the Fraser Health region, **70% of these overdose deaths have occurred in private residences and 85% of those are men.** Many dying from overdose also suffer from mental health issues and many use substances to cope with life stresses. Those working in construction are disproportionately represented in overdose deaths. A BC Coroners review of those who died from an overdose in 2016 and 2017 found that of those employed, **55% were working in the trades and transport sectors.**

From consultations with stakeholders in construction, Return to Work (RTW) was identified as a key component of long-term recovery and a period identified as high potential for decreasing overdose risk, giving workers an opportunity to reintegrate into their workplace after a period of intensive recovery engagement.[1,2,3]

Context of the project

A review of current practices around RTW in the construction industry was carried out as part of this project, particularly for workers with mental health and/or substance use issues. This included an assessment of barriers and enablers of participating in RTW.

This review is intended to inform further dialogue with the BC construction industry around overdose risks among construction workers while also informing broader overdose prevention and response efforts within Fraser Health and the province.

Approach and methodology

The project incorporated a blend of key informant interviews with a comprehensive literature review of relevant publications and industry reports.

Over 60 key informants participated in the project (see Appendix for more details). For the unionized sector, key informants from Alberta and Ontario Chapters of Building Trades were also interviewed to understand practices in jurisdictions outside of BC.

An extensive literature review was conducted to determine current RTW practices in the construction industry in BC and to identify promising practices for RTW to support workers with mental health and substance use issues.

Key findings:
Environmental scan

Prevalence

Men working in the construction industry are over-represented in overdoses and overdose deaths in BC. Possible contributing factors include a "work hard, play hard" culture, a high proportion of males among the workforce, some lower barrier employment opportunities, and chronic pain secondary to musculo-skeletal injury which leads to substances being used to manage both physical and emotional pain.

Lack of Awareness of Treatment Services

Industry-wide knowledge of the available treatment services for workers with mental illness and/or substance use disorders appears to be limited. Industry key informants disclosed that the majority of workers within the industry are unaware of the treatment services, the cost of the services, how to access the services, wage indemnity, confidentiality of the services, scope of the services, and the fact that workers can continue to work while receiving treatment.

Stigma

Stigma and shame are barriers faced by workers with mental illness, substance use disorders, and concurrent disorders. Substance use and mental illness may be understood as moral failings rather than chronic health challenges. This stigma may be particularly prevalent within construction workplace settings, especially if shrouded by an out-dated understanding of mental health and addiction, and resulting concerns may be silenced. Based on the feedback from key informants, many workers fear profound repercussions if they disclose these types of health challenges to a peer or supervisor, including job loss, workplace harassment, bullying, social stigmatization and isolation.

Significant Negative Financial Impact

Key informants described how workers taking time off work are negatively financially impacted and that there are impacts on the worker's wellbeing and mental health. Financial concerns drive the majority of early discharges from treatment, both inpatient and outpatient treatment, and available wage indemnity provides a fraction of typical income (estimated at between 70% of income to full wage replacement). Consequently, many workers prefer to engage with treatment services while maintaining employment, using sick or personal time to access services for as long as their allocation allows. Treatment programs with extended hours, particularly those with evening programming that includes counselling - whilst unfortunately limited - are very popular.

Lack of Structured Return to Work Programs

There appears to be limited industry experience in the implementation and management of structured RTW programs for workers with a known substance use disorder and/or mental health issue. Without formal procedural guidelines, both workers and employers are left to manage this complex transition *ad hoc*, typically producing suboptimal results and causing additional stress and confusion. All informants, including workers, managers, and employers stand to benefit when the RTW process is clearly outlined and overseen by a mutually agreed-upon RTW work agreement. At present, the vast majority of workers return to their workplaces and dispatch offices without a formalized transition process, and workplace accommodations are neither recommended nor implemented. Structured RTW programs with clear policies and procedures offer both workers and employers a transparent protocol for the management of the RTW transition. A clear, detailed, and well-communicated organizational workplace mental health and addiction recovery policy supports the RTW process. Key elements of a structured RTW program include defined workplace accommodations, a formal RTW agreement, and a qualified RTW coordinator.

Lack of Specialized Training for Managerial Staff

There is limited education provided to staff members in leadership positions about mental illness or substance use issues, despite the high prevalence of these health challenges among workers in the construction industry. For many workplaces, existing attitudes of stigma may be partially ameliorated by providing education to leaders (union and employers that addresses preconceived ideas regarding mental illness and substance use that promotes holistic health, including mental, physical, spiritual, and psychological components, among workers). The majority of engaged informants identified opportunities to enhance educational support in this area and all welcomed additional guidance and education for staff members in leadership roles aimed at addressing these knowledge gaps.

Unions Unaware When Many Workers in Treatment

Many workers pursue treatment for mental illness and/or a substance use issue without taking time off work. Many workers do not disclose their reason for taking unpaid sick leave, opting to use this time to engage with treatment services rather than applying for wage indemnity. As such, many unions are not aware that their members are receiving treatment for these chronic health challenges. As a result, unions are often not involved in the RTW process for these workers and are not given the opportunity to provide support to workers during this period of transition. These unions may dispatch workers to job sites or locations that are inappropriate given their health circumstances, but without the essential knowledge that a worker is in treatment, they have no reason to amend job assignments.

Provincial Differences

Preliminary discussions with unionized construction counterparts in BC, Alberta, and Ontario suggest there may be widely varying approaches to the management and treatment of mental illness and/or a substance use disorder among workers. According to informant engagement across the country focused on approaches within the unionized construction sector, the Alberta industry is quite focused on testing, including pre-access testing, and the Ontario industry's treatment approach is largely in line with a 12-step, abstinence-based model of care.

Key findings:
Promising practices

Promising practices for mental health and substance use conditions and RTW were identified through a review of workplace best practice guidelines. The practices were assessed while considering the principles of minimizing harm, promoting gradual re-entry into the workforce, minimizing stigma and discrimination, and incorporating a biopsychosocial model. These practices are described below under the following theme areas:

1 Workplace Policies and Culture

2 Mental Health Expertise and Connections

3 Return to Work Enhancements

Workplace Policies and Culture

Mental health and substance use issues are chronic health challenges. Recognition of this and the incorporation of destigmatizing language within agreements can help promote a culture of physical and mental health safety. In addition to agreements, education in the work-place about the biological basis of mental illness and substance use issues can challenge prejudices that they are due to moral failings.
Similar to a policy for when a worker is physically injured, a clear organizational policy for mental health and sub-stance use, which outlines the RTW process, can help with creating a common and coordinated approach when these issues arise. Policies that incorporate a non-punitive approach can support workers disclosing a problem and reaching out for help. This results in workplaces responding proactively to substance use issues rather than reactively when a workplace incident occurs.

Mental Health Expertise and Connections

Training for those in leadership and management roles can help with the ability to identify signs and symptoms of mental health and/or substance use issues. Tools can be used to engage in non-judgmental conversations with workers, and knowing what resources are available to help with longer term substance use and/or mental health issues are ways education can better equip workplaces to respond to these situations.

Additionally, workplaces can champion a peer support network which can empower co workers to reach out to one another in order to get support.

Return to Work Enhancements

RTW can be improved through:

- reviewing current RTW policy,
- enhancing the policy, and
- creating a supportive workplace culture with a commitment to supporting worker recovery.

RTW policies which include a formalized agreement between worker and employer can ensure both parties are on the same page. This agreement includes duration, expectations, and recommended workplace accommodation. Formal RTW programming involves dedicated coordinators familiar with mental health and substance use, and should be reflective of the workers' values. There should be open communication among all involved with the workers' care; including health care providers, mental health professionals, the union, employer and the worker's family. This can improve engagement in the treatment plan, as well as engagement in supports provided after the initial treatment is completed.

The RTW process can be improved through regular communication and meetings, particularly ensuring that the manager, disability management specialist, mental health worker, and/or union representative (when applicable) are apprised of the progress made. Given that some workers may be placed on prescription medications as part of their treatment, communication with the treating physician regarding how their medication prescription will affect the worker's performance and safety on the job should also be considered.

Workplaces can support recovery by recognizing the chronic nature of mental health and substance use challenges and how they are prone to relapse. As such, workplace accommodations can often extend past the period of initial treatment and aftercare supports may be needed. These accommodations can include opportunities to attend appointments, alternative work schedules, reassigning to positions that are not safety-sensitive, limiting work assignments that isolate workers geographically, and other opportunities to promote early recovery and prevent relapse.

Conclusion

The overdose crisis is having a substantial impact on men working in the construction industry and the workplace plays an important role in health promotion and wellness. This report seeks to inform further conversations around mental health and substance use disorders in construction by presenting a careful review of the barriers and enablers to participating in RTW programs.

The RTW process was identified as an area of interest for construction partners because it involves those who may have a mental health and/or substance use issue and are trying to reintegrate back into the workplace. This report highlights findings from key informant interviews and promising practices that can form the basis for further conversations to support the construction industry in this area.

Table of Contents

Introduction

Since 2016, British Columbia (BC) has been responding to an unprecedented overdose crisis relating to contamination of the illegal drug supply with fentanyl and other opioid analogues. In the Fraser Health region, 70% of these overdose deaths have occurred in private residences and 85% of those dying are men. **Many dying from overdose also suffer from mental health issues and many use substances to cope with stress.** To understand more about the characteristics of men overdosing in private residences, as well as to identify factors contributing to overdose survival, Fraser Health undertook a chart review in 2017 of all men who overdosed in a private residence, survived, and were subsequently admitted into hospital.

In Fraser Health's assessment of employment status and income source from the chart review, **men working in trades, particularly construction, were found to be disproportionately represented.** When employment industry was documented, trades and transport were the most common industry where men currently or had most recently worked.

A more recent review by the BC Coroners Service shows a similar trend. In their review of overdose deaths in 2016 and 2017, those who died from overdose were often un- or underemployed, with 44% employed at time of death. However, of those employed, 55% worked within the trades and transport sector. Comparing this to 2016 Census results, 15% of the population was employed in this sector.[4]

Given the disproportionate impact of overdose for those employed within the construction industry, Fraser Health engaged with construction associations, unions, employers, training schools, and colleges to identify factors that may increase the risk of overdose and to identify high-level actions relating to reducing the risk of overdose death. From these consultations, it was noted that there are both demographic and industry-specific factors that contribute to high overdose risk. For example, men comprise the majority of the construction workforce, and are generally less likely to seek mental health treatment when compared with women. Construction workers may be more susceptible to addiction secondary to chronic pain from injuries sustained on the job.[4,5] Many construction workers are well compensated for their work, and a culture of *'work hard, play hard'* may increase susceptibility to compromised mental health and patterns of substance use.[6] In fact, alcohol and other substances have been widely acknowledged to be a dominant part of the industry culture for many years.[7] Much construction work is transient in nature, and many individuals may work as day- or short-term labourers and may feel disconnected from their colleagues or peers.[8] Current research also points to a work culture of stigma and silencing where mental health and substance use disorders are concerned, and workers are described as widely reluctant to seek help for fear of discrimination or workplace bullying.[9,10]

No simple solution exists for treating mental illness, substance use disorders, or concurrent disorders (when mental illness is present alongside a substance use issue), but there are concrete steps that employers and unions can take to foster the well-being of construction workers. From consultations with construction stakeholders, Return to Work (RTW) was identified as a key component of long-term recovery, giving a worker an opportunity to reintegrate into their workplace after a period of intensive recovery engagement.[1,2] This project involved three components: i) an environ-mental scan of RTW practices, with a focus on BC and with consideration of similar and relevant practices in both Alberta and Ontario; ii) an assessment of barriers and enablers to RTW; and iii) an assessment of promising practices to support RTW.

FIGURE 1:

A Confluence of Risk Factors which Increase Overdose Risk in Construction

Environmental scan

Approach and Methodology

The environmental scan involved semi-structured key informant interviews with construction industry experts, including those who work within the industry and support the industry. During these interviews, current RTW practices for construction workers with a mental health and/or substance use issue were assessed. In many cases, interview participants recommended other key informants, widening the scope of the engagement even further. Appendix 1 provides summary of the key informants, listed by organization.

Results

The environmental scan covered the following four themes:

1 **Awareness of mental health and substance use in the construction industry**

2 **The process for identifying substance use issues on the worksite**

3 **Awareness of treatment services and process**

4 **RTW policies, practices, and processes**

Awareness of mental health and substance use in the construction industry

All informants acknowledged that mental health and substance use are prevalent issues within BC's construction industry, and that they are not novel. Although there wasn't universal agreement among informants regarding the size of the issue (in one case, an informant estimated up to 30% of workers are affected), **all informants agreed that mental health and substance use issues were significant areas of concern in the construction industry.** The types of substances being used include alcohol, and both "soft" and "hard" drugs. Many informants identified alcohol as the most widely used substance. Repeatedly, the phrase "functioning alcoholics" was used to acknowledge and describe the prevalence of alcohol use within the industry.

Perceptions of Prevalence by Trade or Age

Interestingly, there appeared to be a widespread perception that workers were more likely to be affected by mental health and substance use issues based on the work they engaged in. For example, workers engaged in physically demanding work such as dry-wall jobs, concrete formers, framers, and temporary jobs were perceived to be those most susceptible. Others engaged in certified trades work such as electricians, plumbers, and mechanical work were perceived to be less prone to the mental health and substance use issues.
Age was also perceived as a factor of who was most likely to be affected by mental health and substance use issues. Recreational drug use was identified as a concern, with some informants perceiving trends in substance use, linking alcohol use to older workers, and other substances (including cocaine, amphetamines, opioids, and cannabis) to younger workers. Other informants noted that all age groups are equally exposed to substance use regardless of what type of substance is being used. Many acknowledged there was a link between mental health and substance use issues with only a small number of informants identifying mental health issues as a sole concern.
There appeared to be a difference between the responses of unionized and non-unionized informants when potential causes of substance use issues were queried. Unionized informants appeared to be more likely to make connections between substance use issues and mental health issues. In contrast, non-unionized informants were more likely to make connections between substance use issues and personal health, financial problems, and family disagreements, and less likely to see substance use issues as linked to mental health issues.

Perceived Impact of Mental Health and Substance Use in the Construction Industry

The perceived impacts of substance use among workers were primarily focused on workplace safety and, to a lesser extent, concerns about on-site overdose. Inform-ants reported that many jobs within the industry involve work that is dangerous and technical in nature. This led to concerns that the cognitive impacts of substance use, including reduced sleep quality and the impacts of 'hangovers', negatively impact the abilities of workers to perform their jobs safely. Other informants noted other impacts of mental health and substance use in the industry, including a decrease in profit, difficulty finding workers that show up for work, getting the work completed on time and on budget, as well as low morale among workers.

Primary Issues Contributing to Absenteeism

The informants generally agreed that mental health and substance use issues can lead to absenteeism.
It was reported that absenteeism was generally caused by: personal problems including one's own health (in one report this affected 15-20% of workers); family/children's health; spousal disagreements; personal financial issues such as lack of money to pay for transportation to the worksite; stress coupled with workplace injuries; and use of recreational drugs.

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Only one informant mentioned mental health as a key contributor to worker absenteeism, estimating that mental health issues contribute to 10% of workers not showing up for work.
The major causes of personal problems and exacerbation of mental health issues were believed to be due to alcohol consumption, a high cost of living, and other life stressors that workers have to deal with.

Overdose Incidents

According to the key informants, a few BC construction companies have had an overdose death occur on a job site. Informants were more aware of situations where workers had died from an overdose while "off-site".
To deal with the problem of overdoses on a worksite, some companies have naloxone kits on-site and have their personnel undergo training conducted by regional health authorities (e.g., Fraser Health Authority) or other entities (e.g., St. John's Ambulance).

Process for identifying substance use issues on the worksite

Identification of Substance Use Issues

Key informants were asked how they identify and investigate potential substance use at work. Five common situations emerged:

- Self-disclosure by the worker
- Observation (reasonable cause)
- Non-compliance (poor work performance)
- Failed testing (near-miss/post-incident occurrence)
- Absenteeism

Once a worker's substance use is identified at work, the employer may offer "firm" or "soft" referrals to engage in some form of substance use treatment. "Firm" referrals refer to the process of engaging the workers in formal workplace processes for substance use treatment. "Soft" referrals are the informal processes that may exist within an organization for engaging a worker with treatment. For example, with a "soft" referral, a supervisor may encourage the worker seek treatment without an associated written referral or incident record. Once a worker has been identified as having a substance use issue, generally four outcomes are reported: i) "firm" referral made, ii) "soft" referral occurs, iii) worker quits, or, iv) worker is terminated.

The reasons for providing a "firm" or "soft" referral for substance use treatment vary. For example, one informant suggested that the employer only makes a "firm" referral when there is a perceived "serious health risk", particularly in situations where the worker is older and is perceived to have a higher likelihood of chronic or other health conditions that could be affected by the substance use. Another informant mentioned that "firm" referrals are used over "soft" referrals when there are repeated performance issues on the job and/or worker safety may be at risk. In other cases where a decision has yet to be made by the employer, the worker may resign from the organization. In rare cases, the worker may be terminated from work due to identified substance use at work.

Investigation of a Substance Use Issue

An investigation is launched once there is a reason to suspect a substance use issue. A few organizations indicated they have reasonable cause checklists/decision trees to assist supervisors and management with identifying the warning signs of impairment. Investigations frequently involve Human Resource (HR) and Health and Safety (H&S) departments, a Substance Abuse Professional (SAP)/Substance Abuse Expert (SAE),

and/or medical professionals. These assessments are most frequently conducted based on reasonable cause or post-incident situations. In some cases, immediate on-site drug testing is conducted.

Role of Drug Testing

Some of the informants indicated that drug or alcohol screening or testing procedures were not a part of their organizations' policies. Furthermore, these informants added that testing opened their organization to considerable legal risk, particularly when testing did not have a demonstrated relationship to job safety or performance. For this reason, they avoided including it in their company policies. The inclusion of drug and alcohol testing procedures in substance use policies appeared to be related to organization size. Larger organizations (those with more than 500 workers) were more likely than smaller organizations (those with 100 or fewer workers) to list drug and alcohol testing procedures in their substance use policies.

A number of organizations tested workers for reasonable cause, post-incident, or near-miss incidents. Somewhat fewer organizations indicated they also conducted pre-employment and "random testing". Almost all organizations who used testing as a method of identifying sub-stance use indicated that worker refusal to get tested was treated as though the worker had tested positive for a substance.

It is important to note here that there appeared to be overuse and/or confusion amongst informants around the terms "random testing" and "unannounced testing". During this project, most informants used the terms interchangeably, often due presumably to the confusion around their meanings.

Across the wider construction industry in Canada, "random testing'" is understood to mean that an employer can randomly test workers in the absence of "reasonable cause", "post-incident" or "near-miss incidents". For this reason, the preferred term in RTW practices, and for the purposes of this report, is "unannounced testing". "Unannounced testing" is different from "random testing" as it occurs in the presence of reasonable cause, post-incident or near-miss incidents. This lack of consistent use for terms related to drug testing was noted by an informant to impact how drug and alcohol related policies and best practices are applied, particularly in situations where there are legal ramifications.

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Awareness of treatment services and process

Employer Awareness of Treatment Services

All informants were asked about industry-wide awareness of treatment services. Employer awareness of treatment programs was largely dependent on the arrangements within their respective company. In some companies, only HR or H&S Departments tend to be aware of substance use incidents on-site and manage them accordingly. Depending on the size of the organization, and whether it is unionized or non-unionized, the organization may engage an outside 3rd party organization for treatment such as Employee and Family Assistance Program (EFAP), the Construction Industry Rehabilitation Plan (CIRP), or CannAmm. The 3rd party organization may involve a SAP or SAE who will direct the worker's treatment. The degree of involvement of a 3rd party organization is usually determined on a company-by-company or a case-by-case basis. All informants indicated that there is some form of support for workers accessing treatment. The majority of organizations interviewed referred workers to extended health benefit insurance, EAP and EFAP. Among organizations that did not offer these types of services, alternatives included instructing workers to talk with their personal physicians or informing them of another community resource. Key informants indicated the costs to offer full spectrum supports (medical professionals, monitoring, aftercare programs, etc.) were high and that smaller companies often relied upon community or other free/low-cost services. In about half of the cases interviewed, key informants indicated that employers are aware that their workers are receiving treatment for mental health and/or substance use issues. The majority of workers who seek treatment take medical leave off work; however, the type of medical reason may not be specified if the worker does not disclose the reason to the company. More often than not, union representatives are not aware of union members pursuing treatment. This is particularly salient in circumstances in which workers do not choose to apply for wage indemnity during the time that they are away from work for treatment.

Worker Awareness of Treatment Services

A lack of awareness about available treatment amongst workers, including the potential for available funds and support, emerged as a significant theme of the environmental scan. The majority of informants indicated most construction workers are unaware of the treatment supports available. In some instances, treatment options are presented as part of the orientation program following hiring; however, no follow-up information is provided.

Treatment Services and Process

The practices for navigating substance use treatment are inconsistent among construction companies in BC. Many companies in the BC construction industry base their own practices on either Construction Owners Association of Alberta (COAA),[12] also known as the 'Canadian model', the Construction Labour Relations Association Policy,[13] also known as the 'BC model,' and to a lesser extent, the Christian Labour Association of Canada (CLAC). Other organizations may opt to use third party service providers either in addition to these models or as an alternative. Third party providers such as CIRP or CannAmm are used for identification and/or treatment of workers with substance use and/or mental health issues. These third party organizations have developed and offer a broad range of services, guidance, and biological tests for managing mental health and/or substance use issues on the job.

CIRP Services and Processes

CIRP is a non-profit, joint union/management-sponsored alcohol and drug treatment program that provides mental health and substance services to the BC and Yukon Territory unionized construction industry. CIRP's services are available to members and their families of the BC and Yukon Territory unionized construction industry, and these workers access CIRP's services free of charge. However, not all construction unions in BC participate in CIRP. CIRP's care has evolved from an abstinence-based model of care to a biopsychosocial model situated within a harm reduction and recovery-oriented systems of care framework.

Treatment and rehabilitation services are provided as outlined in the Construction Industry of BC Substance Abuse Testing and Treatment Program Policy,[13] which was developed jointly by the Construction Labour Relations Association of BC and the Bargaining Council of BC Building Trades Union.

Currently, CIRP offers the following services:

- 12-month treatment plans designed around the workers' needs
- In-house individual counselling and case management
- Referrals to relevant day programs
- Rapid access residential treatment
- Groups
- Telehealth services

Workers can access CIRP's treatment services by:

- Self-referring into the plan independent of their employer (20-30% of all cases);
- "Soft referrals" into the program by an employer or union through a non-formalized process (30% of all cases); and
- "Firm referrals" by an employer or supervisor (30-40% of all cases).

CannAmm Services and Processes

CannAmm is a private, for-profit company that offers a variety of services to the construction and other industries in Canada. Their services, which are designed to serve the needs of employers, include:

- "Drug and Alcohol Testing, Functional Fitness Evaluations, Occupational Health Testing, Training Programs, Return-to-Duty Services";[14]
- Occupational Testing including "Medical Fitness Testing, Functional Fitness Evaluations, Hearing Testing, Respiratory Testing, Workplace Hazardous Exposure Monitoring";[15]
- Information sessions to employers and workers.[16]

CannAmm receives a "Conditions for Continued Employment" form from an employer following a worker's failed biological test and/or self-disclosure of substance use. CannAmm will assign a SAP to the worker to conduct an assessment to determine if they present with substance use dependency or with substance misuse. Based on the results of the assessment, the SAP prepares a report recommending counselling, outpatient treatment, or long-term residential treatment.

Treatment Process within the Unionized Sector

In BC, treatment for unionized construction workers is generally outlined in two documents, the joint BCBT-CLRA policy[13] ('BC model') and the Construction Owners Association of Alberta 'Canadian Model.'[12] Both policies include details regarding: 1) substance use testing protocols and specimen analysis, 2) agreement to provide treatment services to workers, as well as 3) information about RTW testing. According to the terms of these policies, workers who meet their union's eligibility criteria (typically defined as being a member in good standing who has worked a specific number of days) are eligible to access substance use and/or mental health treatment services. There are both similarities and key differences between the two policies. Both offer access to EAPs, although these EAPs vary in terms of services offered. Beyond the EAPs, the 'Canadian model' directs workers to access external services from SAE at the worker's own cost, whilst the BC Model provides 'internal' services in the form of CIRP at no cost to the worker. Generally, all unions provide wage indemnity (a form of sick pay), which is available to all workers regardless of which policy is implemented within organizations. In most cases, this wage indemnity is not a full wage replacement.

In the majority of these unionized cases, varying degrees of financial support during treatment exists, often in the form of bursaries, insurance salary paid during medical leave, and/or EAP. In a few cases the workers continue receiving their full income during the time they are receiving treatment. In the majority of cases, their income is either diminished or they are not paid at all during the time of the treatment. There are disability payments available if/when a worker is deemed eligible.

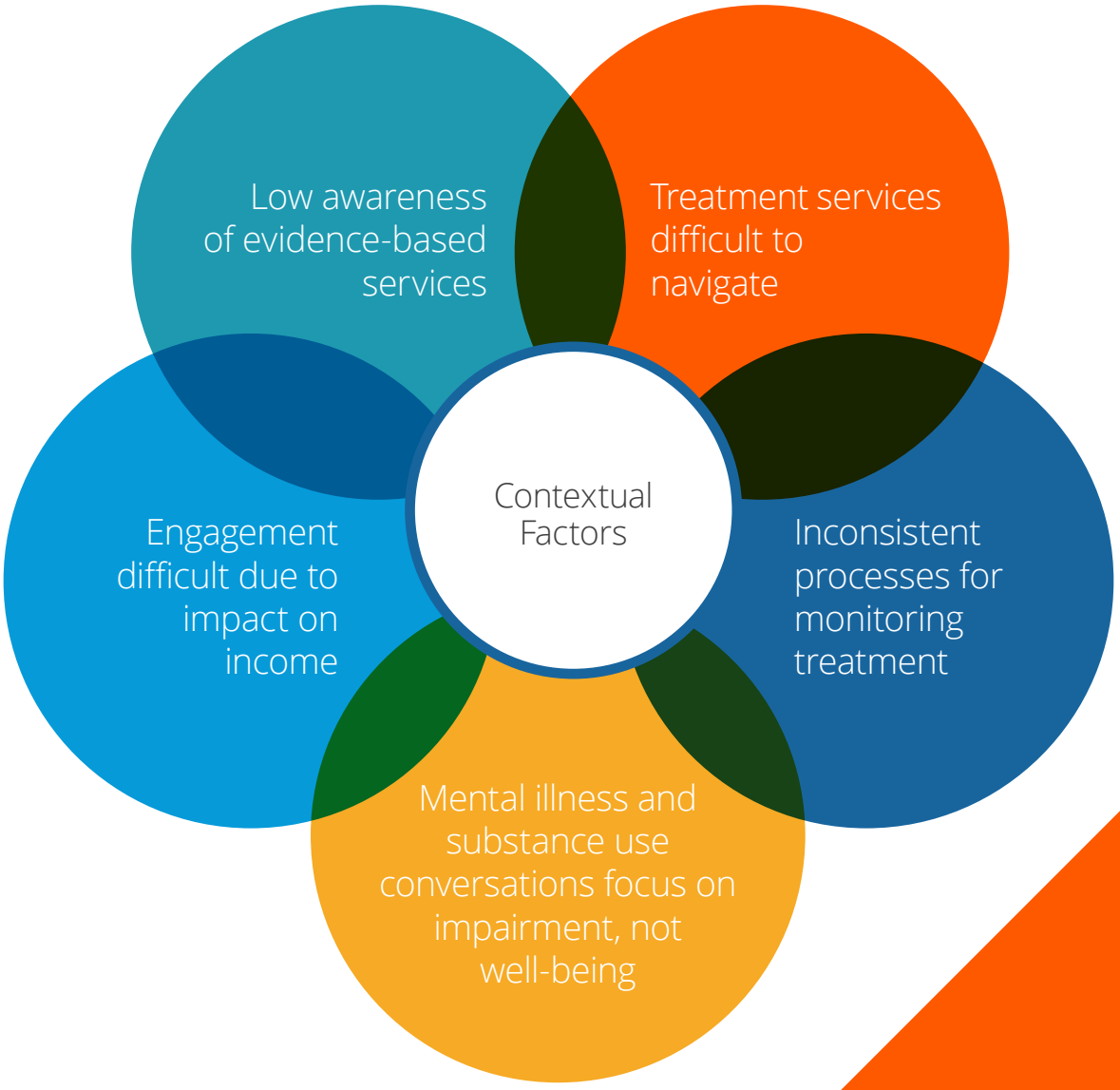
Monitoring During Treatment

During treatment, the workers may stay in contact with their employers, represented by either their supervisor or HR department, worksite safety personnel, union representative, SAP/SAE, MRO, or a CIRP/CannAmm representative. A number of key informants mentioned that their organizations take a more "hands off" approach, whereby unions or professional associations take the lead in monitoring treatment and determining a worker's readiness to RTW. Within the 'BC Model'[13], while a worker is in residential or inpatient treatment, their CIRP counsellor will continue to maintain contact with them throughout their stay and will collaborate with them on a plan for discharge when the time comes. However, in the case of some smaller organizations and the 'Canadian Model',[12] no monitoring is completed during a worker's recovery and RTW preparedness is a clearance letter from a physician.

Within the 'BC model',[13] in most cases where the worker was referred by the organization to an external assessment with an SAP/SAE or to a recovery facility, they have an internal organizational representative who acts as the liaison with the external recovery program provider. These representatives are only informed about whether the worker was successful or not in the program, and what RTW recommendations (restrictions/modifications) will be required. At this time, the organization is informed about the schedule for follow-up testing and is responsible for conducting these tests. For some organizations, conducting and organizing of testing may be handled by an external third party organization.

FIGURE 2:

Contextual Factors Impacting Success with Mental Health and Substance Use Service Engagement



Return to Work policies, practices and processes

Though employers have an obligation to provide workplace accommodation according to the needs of the worker, employers are not required to create jobs that do not exist or offer preferential treatment to workers in recovery.[17] Legally the responsibilities associated with workplace accommodation are described as tripartite:[18]

The union has a duty to accommodate, within the bounds of the rights of the agreement.

The employer has a duty to offer reasonable accommodation based on medical information to the extent that the accommodation does not cause the employer undue hardship.

The worker has a duty to participate in the negotiation of accommodations and to accept reasonable accommodations.

The majority of the construction companies' informants note that in most cases the workers come back to work after receiving formal or informal treatment. Furthermore, workers tend to return to perform the same duties they had been performing prior to receiving treatment. When asked if the informants had concerns about workers returning to safety-sensitive positions, they indicated that all trades positions are considered safety-sensitive and if the worker received a medical clearance, they were able to return to work. Many informants agreed that RTW can be problematic for them since they cannot guarantee that the worker is suitable for returning to the job without further testing or guidance from a Medical Review Officer (MRO). One informant noted they did not have any concerns when it came to RTW; however, they also noted that they would adopt mandatory testing if there were no legal implications. The latter suggests that some companies are inclined to have their workers tested regularly on a mandatory basis.

Union involvement in Return to Work

When union representatives are aware that one of their members is seeking treatment, many informants confirmed that they followed up with members post-treatment, but that the focus of this communication was typically on their member's overall wellbeing, and not on their readiness to RTW. Furthermore, most interviewed union representatives reported that they have had very little or no involvement at all in any type of structured RTW process for their members. It appears that many union members who seek treatment either do so without the knowledge or involvement of their current employer, or do not have a formal position to which to return, which may make following through on a structured RTW plan more challenging.

Structured Return to Work Practices

For workers who have sought treatment for a mental health and/or substance use issue, there are few structured RTW practices. Whereas the process for RTW for those with a physical injury is well defined involving communication with WorkSafe BC,[19] very few interviewed employers have managed an RTW program for a worker who has taken time off from work to engage in treatment for either substance use or mental health, and very few have structured RTW practices to manage this unique cohort of workers. Many of the reasons that were put forward for this include:

- Many workers who need treatment do not seek treatment and rather prefer to continue to work.
- Some workers may seek treatment without advising their employer or union of the specific nature of the illness that necessitates time off.
- It is common for workers to pursue treatment, particularly inpatient residential treatment, during seasonal periods when construction work is slow. As a result, there is no job site to formally return to, which may make following through on a structured RTW plan more challenging.
- Some workers who do seek treatment access services in the evenings and/or via video chat, which allows them to continue working without taking a formal leave of absence.
- For those workers who are able to access a set number of counselling sessions prior to returning to a job site or union, there is typically no structured RTW program. The majority of employers simply require documentation of counselling attendance, without details of progress or treatment specifics, before the worker can return.
- Workers may choose not to return to that job site in the event that an issue has been suspected or identified. In the circumstance where a worker sought treatment, a structured RTW plan would generally not be required to return to that specific job site.
- Some workers do not 'own' a particular position on a job site, but are instead dispatched by the union according to skill set, seniority, and job board placement, and as such, a formal RTW program after time off does not necessarily apply. The dispatch procedure is based, for the most part, on a worker's independent indication that they are ready and available to be dispatched for work. At present, there exists no formal assessment for "readiness to dispatch". This is a potential risk, especially if the worker is not ready to RTW.

Among the interviewed informants, there were a small number who had experience supporting an RTW program for a worker with a known mental health and/or

substance use issue. The majority of these RTW programs were for unionized workers, and the minority of these plans were for non-unionized workers who had a long-term relationship with a particular construction company. As described above when discussing navigating treatment supports for workers, organizations may also engage an outside third party organization and SAP/SAE professionals to oversee the RTW process. The CIRP and CannAmm RTW process is outlined below:

"For those workers who do not notify their employer or union out of fear of discrimination or stigma, their treatment and recovery remains private. Unfortunately, employers and unions who are unaware about their worker's chronic health challenges are ill-equipped to provide relapse monitoring or workplace accommodation to support ongoing recovery."

CIRP's Process

- RTW: Counsellors will help the worker evaluate their recovery process and provide guidance on the RTW process including the support structures that might be required
- RTW assessments: The majority of employers do not require a RTW assessment due to reasons such as being assigned to a different job. When needed, however, the counsellor can provide confirmation of program attendance to the employer, with the permission of the worker. CIRP has developed an assessment tool to evaluate a worker's adaptive coping responses to stress and other issues that underlie substance use. Additionally assessments are conducted by MRO physicians and can include the history of treatment provided by CIRP counsellors.
- Workplace accommodations: These include suggestions that workers not return to isolated camps, have time off for counselling or physician appointments, or are temporarily re-assigned, depending on abilities. The treating counsellor, physician, or specialist can make these accommodation suggestions.
- Communication with worker's employer and/or union: Some workers decide to take on treatment outside of working hours and not communicate this to their employer or union. Communication only happens when their employer's mandate workers to take treatment or when they voluntarily choose to communicate with their employer/union. In 2017, 73% of CIRP's discharges involved clients with whom the program eventually lost contact. This suggests that a large proportion of these workers continue to work without receiving comprehensive mental health or substance use treatment.

CannAmm's Process[13]

- A post-treatment substance use test is conducted to evaluate the worker's readiness for RTW. A post-treatment assessment is recommended by the SAP if the worker has recommendations to complete one before RTW.
- The SAP prepares a second report commenting on the worker's readiness for RTW. A RTW plan is drawn that may include further counselling and random testing.
- A return-to-duty test is conducted. A suggested follow-up testing schedule is prepared and sent to the employer based on SAP recommendations.
- The RTW plan will be supplied to the employer for which an employer may create an RTW agreement with the worker.

Opioid Replacement Therapy

Opioid Replacement Therapy, also known as Opioid Agonist Treatment (OAT), is a key part of the provincial best practice guidelines for treatment of substance use issues, particularly for opioid use disorder.[20] The majority of informants were unfamiliar with OAT. Some of the informants explained their lack of knowledge with the fact that they usually do not deal with mental health and substance use issues and refer these directly to the MRO or HR department. Only one informant mentioned they were familiar with OAT and that their MRO asserted that the workers' RTW is not affected as long as proper dosage is adhered to.

Communication With Worker's Employer and/or Union

Fears concerning discrimination, stigma, or job loss prevent many workers from informing their employers or unions about their participation in treatment. Only those workers who are mandated to attend treatment or voluntarily agree to share their information have their participation and engagement with treatment communicated to their employer and/or union. Workers may adopt varying strategies to keep their treatment private from employers. For example, although some workers may have engaged with treatment as a result of a "firm" referral from their employer and their participation is mandatory in order to RTW or avoid termination, many workers will self-refer independently as a pre-emptive measure. Workers may also attend outpatient treatment outside of work hours or may take sick time or personal leave to attend treatment without notifying their employer or union of the nature of their health challenges.

For those workers who do not notify their employer or union out of fear of discrimination or stigma, their treatment and recovery remains private. Unfortunately, employers and unions who are unaware of their worker's chronic health challenges are ill-equipped to provide relapse monitoring or workplace accommodation to support ongoing recovery. This is further complicated by the nature of work in the construction industry, where workers may move frequently between job sites and signs or symptoms of relapse may go unnoticed for extended periods of time.

Workers who self-refer to treatment are free to terminate treatment at any time and may continue working despite worsening symptoms of mental illness and/or substance use issues and it is likely that a large proportion of these workers continue to work without receiving comprehensive mental health or substance use treatment.

Confidentiality

All informants indicated that confidentiality surrounding a worker's substance use is often maintained through HR processes and other organizational policies. It was explained that information is only shared as legally appropriate and with the permission of the individuals involved. Organizations use a variety of methods to ensure confidentiality. These include privacy/confidentiality training for personnel, restricting the number of people who have access to sensitive information, and ensuring those with access have signed disclosure agreements. Organizations that stated they used an MRO, SAP/SAE, physician or equivalent frequently indicated that only these individuals have access to confidential information.

Accommodations/Modified Duties

Although informants indicated that personalized RTW plans do exist, the informants found it hard to describe what a personalization of a RTW for a substance use issue entails. Only in one case could a key informant confidently state that if the worker had a formal substance use disability they would be assigned to an administrative job, work fewer hours, and/or be monitored. A few informants concluded that accommodations were solely for workers with physical limitations and not for substance use issues. This also reflects WorkSafe BC documentation for RTW geared for workers, employers, and physicians.[21,22] It was also suggested that workers could request and be granted the opportunity to be dispatched to a different worksite. For those individuals who continue to work while attending counselling, organizations could provide time off for appointments.

Return to Work Documentation

For those informants who described more structured RTW being in place, all of these informants indicated that RTW documentation is usually prepared by a medical doctor or an MRO. These include a clearance letter, a form certifying what the worker can and cannot do, and for how long, and recommendations for RTW. In some cases, a negative substance use test is also required before the worker can RTW. All but one informant noted that there were no requirements that the construction companies had to fulfill as part of the RTW. The one informant describing the presence of requirements for companies mentioned that CannAmm's requirements are followed for RTW. These requirements include a return to duty assessment, functional fitness evaluation, occupational health test, and training for employers regarding the RTW process.[14,15] A key challenge noted by many informants was that

a physician who was not directly involved with the worker's treatment often completed the documentation provided in order to support an RTW. As a result, this documentation was routinely described as thin on detail and, more often than not, did not provide any information about potential workplace accommodations and/or measures that could be initiated in order to support the worker's RTW. Another concern was the quality of documentation when workers without designated family physicians are forced to go to a walk-in clinic for this assessment, where a physician without an established therapeutic relationship with the worker completed these forms.

Return to Work Agreement and Terms

Where a formal RTW engagement process existed, informants indicated that workers were required to enter into an RTW agreement. Very few informants had experience in the drafting or implementation of this agreement. The person responsible for writing these agreements and what the recommendations from the agreement were based on varied among informants. For example, one informant noted that they have a RTW agreement for workplace injuries, while another indicated that their RTW agreement was aligned with either the recommendations from CIRP, CannAmm, SAP/SAE, or the MRO. Another informant indicated their HR department was responsible for RTW and another noted that their company follows Construction Owners Association of Alberta (COAA) guidelines.[12]

Overall, there was strong support for using an RTW agreement to support a worker's successful RTW; however, the terms of an RTW agreement varied in approach between organizations. There was agreement amongst all informants that the RTW process must be gradual. Some informants note that the gradual transition could involve fewer working hours and monitoring of progress with or without substance use testing. Other informants noted that the transition should be based primarily on medical advice with or without substance use testing.

Few workers, according to the informants, require a personalized RTW for substance use. This contrasts with physical injuries where RTW terms are personalized more frequently. When RTW terms are personalized for substance use, one informant described how the length of the RTW program is adjusted based on whether the worker was a "light" or a "heavy" user of substances.

Organizational Capacity to Support a Successful Return to Work and Healthy Workplace

Informants were asked about their organization's capacity to support RTW and what current practices were in place that addressed mental health and sub-stance use, including:

- Information about substance use disorders, mental health, and/or concurrent disorders.
- Training and education for individuals in leadership roles aimed at improving their management of said health issues.

Construction company informants were asked if they provided any information concerning mental health and/or substance use issues to their workers, and if not, if they would be interested in sharing this type of information in the future. The vast majority of the construction companies provide an overview of the workplace's expectations around substance use at worker orientation. The focus of these presentations is typically to inform workers that on-site impairment is not tolerated and that there is a testing policy in place. Many interviewees felt that while this information was summarily presented, many of the workers were not engaged during these presentations. Half of the construction company informants reported that they provide some additional information to their workers regarding these chronic health challenges, but that there were opportunities to improve both the content and the frequency of these presentations. Of note, this existing information appears to be focused on substance use issues, with little or no mental health content. All construction company informants who do not currently provide information about substance use or mental health were supportive of amending and improving their current practices.

Relapse rate

The majority of the informants acknowledge that relapses happen, however the informants did not agree on how often they occur, with responses ranging from 5% to 15% to an unknown value. One informant noted that relapses tend to happen with "hard" drugs and alcohol.
The majority of the informants indicated that someone in their company has some training to detect relapse; however, the practice for relapse detection varies.

For example, one company uses a substance abuse checklist and offers training for managers; another trains HR personnel and some supervisors; another trains their foremen to notice cases of substance use; and another company trains all of its personnel to detect signs and symptoms of substance use. In companies where training is not available, they may "watch or sniff" the workers or do nothing.

Summary of current industry approach to substance use and/or mental health and Return to Work practices

The construction companies' approaches to mental health and substance use issues are varied. Many companies acknowledge the problem exists and some pursue a "zero-tolerance" policy. Some companies have a plan in place to deal with an overdose (e.g., naloxone kits and training), but many do not. All companies approach the issue of mental health and substance use issues from the perspective of maintaining workplace safety. A few companies also voiced concerns about the impacts of mental health and substance use on worker absenteeism.

The majority of construction companies manage worker substance use and/or mental health issues by sending a worker to enter a treatment program (a "firm" referral), having them leave the company, or encouraging them to stop using substances independently without any requirement for treatment (a "soft" referral).

There are two main approaches to RTW. One is to receive and accommodate the workers after treatment and to make sure they fit back into their previous job. The other approach is to re-assign workers to a different job on a temporary or permanent basis. When workers suspect the latter could happen, they may be reluctant to participate as they may feel uncomfortable with the potential for rumours on site about why the change occurred or that they will need to inform their employer that they are accessing treatment.
The RTW process is also determined by how information and education on mental health and substance use issues are shared among management and workers at construction companies in BC. When the organization's management team is trained and/or information is shared with them with regards to substance use, information and training is usually focused on detecting and recognizing substance use among workers. When workers are offered training about substance use and/or mental health issues, training primarily focuses on the negative consequences to the workers should they be caught using substances. Less frequently, training and information sharing focuses on the resources available to help a worker should they require help with their substance use. Based on information from key informants, mental health training is virtually non-existent in the construction companies in BC with only one informant noting that training was offered.

Jurisdictional scan of Return to Work practices

Approach and Methodology:

A jurisdictional scan of RTW practices was conducted for predominantly unionized organizations and associations, specifically Building Trades chapters, in both Alberta and Ontario through semi-structured key informant interviews.

Findings:

Alberta – Overview of Return to Work Current State

Informants in Alberta identified a strong industry emphasis on biological testing, particularly pre-access testing. It was reported that many construction workers in Alberta have discovered several ways of bypassing this barrier, including the use of alternate substances that metabolize more quickly from the bloodstream, and the smuggling and exchange of clean urine. In Alberta, the most widely used publication concerning substance use in the workplace is the Construction Owners Association of Alberta "Canadian Model".[12] This best practice document was recently updated in 2018.

In April of 2016, Alberta Health Services and the Alberta Addiction and Mental Health Research Partnership Program jointly released a summary report entitled Addiction and Mental Health in *Alberta's Construction Industry.*[23] This research indicates that in the 12 months prior to the survey, a much higher percentage of construction workers (16%) used illicit substances, when compared to the province's average (7%). The report endorses the promotion and expansion of existing EFAPs.

Ontario – Overview of Return to Work Current State

Although the province of Ontario does not have a mutually-agreed upon joint policy that extends universally across its unionized construction industry, several dozen unions jointly support De Novo,[24] an alcohol and drug treatment service provider that serves workers, employers, and their families. De Novo operates a residential treatment facility for male workers and refers female workers to a partner agency in the Toronto area. De Novo is accredited by the Canadian Centre for Accreditation, and their phone line is staffed 24 hours/day, 365 days/per year. Their residential treatment program is 35 days in length and operates within the guiding principle of the 12-step, abstinence-based approach to recovery. Individuals must be free from all substances for 72 hours prior to their admission to De Novo's treatment facility.

"De Novo's programming places significant emphasis on the impact of family and social support to long-term recovery."

De Novo's programming places significant emphasis on the impact of family and social support to long-term recovery. 'Graduated' workers are encouraged to maintain connection with each other, and De Novo hosts annual celebrations that bring together graduates of past years. De Novo encourages workers to engage with 12-step meetings after graduation and offers a one-week long "Recovery Enhancement Program" of increasing supports for those individuals who may be struggling in their recovery post-graduation. All of De Novo's services are free to access by eligible workers, supervisors, and administrative and managerial staff members.

According to interviewed informants, drug testing in the province of Ontario is not permitted unless there is an RTW agreement in place detailing the exact nature and frequency of this testing.

Barriers and Enablers: Seeking Treatment and Return to Work

Approach and Methodology

Key informants were asked specifically about barriers and enablers to workers seeking treatment and RTW. When facing the decision of whether to pursue treatment for mental illness, substance use disorder, or concurrent disorders, workers must carefully consider the benefits and risks. Disclosure of significant health challenges of this nature has the potential for high risk of judgment, stigma, or loss of social connection. This section outlines the barriers and enablers for workers who are considering treatment, are taking steps to pursue treatment, and are returning to work after treatment.

FIGURE 3:

Barriers and Enablers to Return to Work for those with Mental Illness and Substance Use Issues

Barriers

The current review found that six predominant themes emerged as significant barriers for those contemplating, pursuing or returning to work from treatment.

Negative Impact on Income

The wide majority of interviewed clients and clinicians consistently identified financial concerns as a significant barrier to treatment engagement, both initially and over the long-term. These financial concerns influenced whether or not the worker would engage in initiating treatment and whether or not a worker could/would stay in treatment.

Within the construction sector, 'wage indemnity' is a form of short-term disability coverage that some workers can access when they experience short-term or acute illness. Wage indemnity can potentially be used to cover treatment costs for workers considering mental health and/or substance use treatment. However, many workers, supervisors, and managers are unaware that wage indemnity coverage can be applied to mental health and substance use issues. As a result of this lack of awareness, treatment may not be considered or initiated for these issues. Even when workers have wage indemnity as part of the conditions of their employment, it was reported that across the industry, current wage indemnity coverage is insufficient to replace a worker's normal or "full" income. For most workers, even this reduced income creates a significant financial barrier, and for some this barrier becomes insurmountable particularly in households where the worker is the primary or sole income earner.

Additionally, concerns and stresses related to maintaining income present major challenges to the workers engaged in treatment. For workers who are considering treatment, many state they would prefer to maintain employment and attend treatment in the evenings and during weekends wherever possible in order to minimize the economic impact of treatment engagement. Similarly, when some workers pursue treatment, they tend to do so in seasonal periods of slower work. Once work becomes available again, it can draw workers away from sustained engagement with treatment. Many clients discontinue treatment early and often against professional advice, in order to return to full-time work and restore their household income. CIRP estimates two-thirds of their 12-month clients will discontinue services at the three-month mark with "lack of income" cited as the primary reason for doing so.

"For workers who are considering treatment, many state they would prefer to maintain employment and attend treatment in the evenings and during weekends wherever possible in order to minimize the economic impact of treatment engagement."

Lack of Awareness of Treatment Services

The vast majority of those interviewed consistently identified a widespread lack of awareness about treatment offerings throughout and across all organizational levels. This lack of awareness includes knowledge gaps concerning the existence and scope of treatment services, and about how the treatment model that guides the organization and delivery of these services, and how workers and their supervisors can connect with treatment providers.

It is likely that for many construction workers in BC whether unionized or not, the topics of mental health and substance use issues are largely unexplored in the context of the workplace. Without deliberate initiatives to provide information about the nature of these health challenges and the available supports for those workers who may need assistance in treatment, most workers will continue to be unaware of the assistance to which they are entitled through organizational policies.

Shame, Stigma, and Social Isolation

Shame and stigma consistently emerged as major barriers to treatment engagement and subsequent successful RTW initiatives. Various informants indicated that stigma of mental health and substance use issues are notable within the construction industry and that, on the whole, the industry is silent on these issues. For many workers, this culture of stigma-induced silence provokes intense feelings of shame, which is further compounded by a widespread lack of workplace conversations or initiatives that speak to mental health promotion or substance use treatment. As a result, workers tend to be unlikely to disclose mental health and substance use issues to a supervisor or manager for fear that it puts them at risk for discriminatory workplace treatment. Further compounding this fear of disclosure is that many construction workers earn a relatively high income while often functioning as the sole or primary income earner in their households. As such, many workers may hide their health issues rather than risk unemployment.

With respect to shame and stigma relating to RTW, for workers who retain employment and are engaged in RTW agreements after treatment, many report strong fears surrounding the transition, particularly where it concerns their relationships with their co-workers and peers. Important opportunities for social connection often occur in settings of social substance use (e.g., drinking), and workers in the early stages of their treatment journey may need to recuse themselves from these activities, which increase their risk of social exclusion and loneliness. Many workers also fear discrimination from peers who may take issue with workplace accommodations that are provided to workers who RTW after treatment.

Confidentiality

Fears concerning the impacts of unauthorized disclosure are widespread, with many workers reporting concerns about the perceived lack of confidentiality protection as a major barrier to treatment engagement. Workers expressed concerns regarding the impact of unauthorized disclosure on the potential for discriminatory job loss or unfair challenges in finding future employment. This potential for unauthorized disclosure prevents many workers from coming forward and asking for help. Currently, many workers, as well as their managers

and supervisors, are unaware of their rights to confidentiality and information protection. For many workers, the knowledge and assurance that treatment engagement is possible under strictly confidential terms may be sufficient to assuage concerns over discrimination and open the door to treatment engagement by workers on their own terms.

Lack of a Clear Process

Currently, the industry landscape of RTW following treatment for mental illness and/or substance use issues is largely without formal policies or procedures to manage the transition from treatment to the workplace. Without clearly defined RTW processes that include assessment, communication of relevant workplace accommodations, and an overarching RTW agreement, the transition from treatment to work is likely to be challenging for both worker and managerial staff members and in turn creates further barriers to treatment. This can result in impacts on a timely and successful reintegration of a worker to the job site. Consequently, workers may be vulnerable to higher levels to stress due to their early recovery and may feel uncomfortable declining work that is inconsistent with their treatment plan, such as work away at camps. Without RTW policies or procedures, managerial staff may not have the direction they need to provide and inform their workers of the supports that they can implement. As a result, ongoing worker recovery may be compromised.

"Many workers who are currently in treatment report that it is because of this widespread social use of alcohol and other drugs that they fear returning to work, stating that it carries a substantial risk of relapse."

Fears about the Workplace Triggering a Relapse

All informants reported an industry culture of "work hard, play hard". This culture often involves the social use of substances, both illicit and legal. Many workers who are currently in treatment report that it is because of this widespread social use of alcohol and other drugs that they fear returning to work, stating that it carries a substantial risk of relapse. This particular barrier presents a major challenge to workers in the planning stages of RTW, especially since, as previously noted, fears of social isolation and/or stigmatizing behaviour from colleagues may already be present. It is important to note that these fears do not exclusively apply to workers with substance use issues – workers with mental health challenges reported that they also find the workplace to be a triggering or problematic environment. In addition to concerns about workplace attitudes regarding recovery and treatment of mental health and/or a substance use issue, many workers and clinicians identify the isolation of many remote workplaces as a barrier to sustained success in recovery.

For many, working in geographically isolated work camps and job sites separates them from both their social support networks as well as clinical support services. This was identified as a significant barrier to treatment success and a healthy RTW, particularly for those individuals in the early stages of recovery when the risk of relapse is high.

Enablers

Key informants were asked to identify factors that enable and promote successful treatment engagement and a healthy RTW. Enablers are those factors that increase the probability and success of treatment initiation, sustained treatment engagement, and long-term recovery.

Individual and Organizational Awareness of Treatment Services

Workers who are periodically provided with information about the location, format, and scope of available services, as well as the knowledge that these services do not require a co-pay or fee, are deemed much more likely to reach out for help in times of need. Additionally, workers whose direct supervisors and/or managers have comprehensive knowledge of the availability of treatment services are well-positioned to provide workers with timely and accurate information when the need arises. Ideally, this information is disseminated in a manner that allows workers the opportunity to further research the availability of treatment offerings in private, without necessitating disclosure to a supervisory staff member. Several current workers who are undergoing treatment have identified word-of-mouth as a particularly important form of knowledge dissemination among staff members, both because coworkers are sharing the information with them and because it doesn't involve having to approach an employer to get this information.

Financial Support and Job Security

Income replacement that gives workers the opportunity to focus on their recovery and allay concerns about significant income loss was identified as another enabler. Comprehensive wage replacement allows workers to focus their energy and attention on their health while protecting their households from precipitous income decline. Workers without this income replacement are much more likely to terminate treatment engagement early as income loss mounts, preventing many from progressing beyond the initial 'stabilization' phase of treatment, to the more complex and time consuming

'trauma processing' phase of treatment where underlying issues are addressed.

This enabler also includes assurance that, wherever possible, workers are able to return to their previous position or role after a period of treatment. This assurance signals to workers that they are valued by the union and/or workplace, and that taking time off of work to engage in intensive treatment does not necessarily equate to complete job loss.

Ability to Continue Working while Pursuing Treatment

While many workers may be under the impression that intensive inpatient residential treatment is the only treatment modality available, there are other ways in which workers can engage with treatment services. Importantly, this includes one-on-one and group counselling that may be undertaken while individuals continue to work, without necessitating time off. When these types of services are offered, many workers will continue working while simultaneously engaging with treatment services in the evenings and weekend hours. This type of service framework has numerous benefits, allowing workers to maintain their income levels, protect the structure and routine of daily life, maintain confidential access to services where preferred, and take a gradual approach to treatment engagement.

Return to Work Agreements

The drafting, acceptance, and implementation of a clear RTW agreement was identified as a major enabler to a successful RTW transition. The agreement should be drafted in collaboration, including the input of the individual worker, then agreed to by all participating parties. Most importantly, this agreement should detail the implementation of any mutually agreed upon work-place accommodations and provide for opportunities for periodic re-assessment as the transition unfolds.

Vocal Support from Supervisors, Managers, and Unions/Association Leaders

A significant enabler to the development and maintenance of a healthy workplace is vocal support from individuals in roles of leadership. This support is particularly salient where individuals may be contending with mental illness and/or a substance use issues, which traditionally carry significant burdens of stigma and shame. Workers who receive genuine encouragement from their managerial and/or supervisory staff and union representatives are much more likely to come forward in times of need or when concerned about the possibility of relapse or decompensating.

This support is particularly valuable in the early days of a worker's RTW, when fears concerning discrimination or feelings of shame and guilt may be especially pronounced.

Family and Peer Support

Workers with the active and vocal support of their family, friends, and/or peers are also much more likely to be successful in their long-term recovery efforts. Many treatment service providers prioritize the engagement of spouses and family members in the treatment process of an individual, recognizing that the management of any chronic health challenge is optimized when the members of an individual's support system are informed, engaged, and supported.

Peer support services have also been identified as an important enabler to successful long-term recovery. Workplace-specific peer networks are particularly valuable, especially when it comes to the building of healthy, meaningful social connection with others who understand the unique context, challenges, and culture of a specific industry.

Promising practices for mental health and substance use issues and return to work

Approach and Methodology:

Promising practices were identified through a literature review with a specific focus on construction workers as a unique population of health care users. Promising practices were identified from both a clinical and operational perspective. Operational practices were evaluated from the lens of identifying those relating to RTW recommendations in construction.

Data and information incorporated into the operational promising practices were sourced from the following:

- Health authority publications
- National and international (US, Australia) best practice guidelines
- National and international (US) health survey data
- Industry-specific technical reports and workplace policies
- Publications from academic journals, including peer-reviewed publications in clinical pharmacology, occupational medicine, psychiatry, addictions medicine, and physical rehabilitation medicine
- Existing treatment program operational guidelines
- International (Australia, UK) RTW recommendations
- National labour standards and human rights legislation
- Relevant union publications from other unionized industries

Clinical promising practices were evaluated from the lens of identifying those relating to concurrent disorders and which incorporated RTW as a component of recovery. Clinical promising practices were reviewed with a number of clinical experts.

Data and information incorporated into the clinical promising practices were sourced from the following:

- National, provincial (BC, Nova Scotia, Saskatchewan, Alberta) and international (US, UK, Australia) best practice standards
- International (US) health survey data
- Provincial (BC) Ministry of Health publications
- Industry-specific technical reports and policy recommendations
- International (Australia) medical presentations
- Health authority publications
- Relevant media and news publications
- International standards for treatment (United Nations, World Health Organization)
- Publications from relevant unionized industries, including nursing and other health care workers, railway workers, pipeline workers, oil and gas workers, and forestry workers
- Publications from academic journals, including peer-reviewed publications in addictions medicine/ science, withdrawal management, clinical pharmacology, occupational medicine, and psychiatry
- Input from interview with De Novo Treatment Centre (Ontario)

Findings:

Effective RTW programs have the potential to greatly benefit both employers and workers. RTW programming allows workers to feel supported during their recovery, increasing chances of long-term stability, and can lead to increased feelings of self-worth, better economic stability, and increased social support.[21,22] Employers and unions who recognize the vital need for high-quality RTW programming are rewarded with improved worker retention, increased workplace safety, improved worker performance, reduced absenteeism, and improved staff physical and mental well-being.[25]

The economic impacts of these results can be significant,[26] and there are notable cost-saving opportunities when adopting practices and policies that address supportive RTW programming. The construction industry has the opportunity to make meaningful changes that address stigma and discrimination, empowering its workers to address mental health and substance-related health challenges, while providing workplace stability and supports that improve their business's bottom line. This is a belief also held by The BC Construction Safety Alliance; it recognizes these two-way benefits, reminding affiliated employers to "invest in workers, and they will invest in you".[27]

This section outlines promising practices related to mental health and substance use issues and RTW. It is intended to help guide action by providing information about current recommended practices with a focus on support for workers in construction.

The RTW practices for workers with a substance use and/or mental illness are described in three key sections: **Workplace Policies and Culture**, **Mental Health Expertise and Connections**, and **Return to Work Enhancements**, and are based on the following principles:

1

Biopsychosocial Model:
Treatment, including RTW planning, should address the biopsychosocial determinants of health, taking into account the unique context of each individual.[28] The biopsychosocial model notes that to understand a person's health, it cannot be simply understood through biological factors, but that social and psychological factors need to be considered as well. For both mental illness and substance use, biological factors interact with psychological factors (such as thoughts, coping skills, and beliefs) and social factors like work issues, family circumstances, and peer groups. Recognizing that working adults spend much of their time at work, work and employment have an important role in shaping health.

2

Harm Reduction:
Harm reduction is an important pillar in the management of a substance use issue and fits into the spectrum of interventions for treating substance use issues. Harm reduction is person-centered and focused on reducing the negative consequences associated with drug use. This may include safer substance use or reduced use.[29] Reasonable accommodations of harm reduction practices among workers should be encouraged where possible,[30] though this may present some challenges in the context of many job sites.

3

Minimize Stigma and Discrimination: Stigma and discrimination are major barriers and stressors faced by those in need of assistance for both mental illness and/or substance use issues.[31]

4

Gradual Re-Entry: A gradual re-entry into the workforce has been identified as a key component of recovery, and successful reintegration increases the probability of long-term health and wellness.[32,33,34]

Section 1:
Workplace policies and culture

Developing psychologically safe workplaces that support those with mental health and substance use challenges must start at the operational and leadership level through clearly outlined workplace expectations and processes. The following is an overview of operational promising practices based on published academic research and international guidelines.

Acknowledgment that substance use issues and mental illness are chronic diseases

De-stigmatizing language within agreements contributes to a wider industry consideration of both illnesses as health challenges, rather than moral failings. Agreements can include specific language acknowledging that sub-stance use and mental illness are chronic diseases that may necessitate treatment.[12,35,36]

Positive culture of physical and mental safety and reducing stigma

Institution of workplace measures to actively promote a positive culture of physical and mental safety, including concrete efforts to reduce stigma and discrimination. A culture of fear and silence surrounding mental illness or substance use issues is costly to employers.[37] Workplaces can address stereotypes about mental illness and addiction by addressing gaps in their workers knowledge.

Confidentiality

Barriers such as guilt and shame, or fear of discrimination may prevent workers from coming forward and seeking treatment, and clear policies that protect confidentiality are important. Moreover, beyond the creation of organizational policies, creating a culture of confidentiality and accountability is likely to send a message that workers are an important and valuable part of the organization. Proactive efforts to inform workers of the protection of their confidentiality, if ever a disclosure is made, is likely to increase worker help-seeking and access to available services.

Workplaces that actively support mental health promotion see concrete benefits, including increased productivity, greater attendance, improved worker engagement, and higher staff retention.[1,31,32,34] Efforts to support mental health should also include reducing work-related risk factors for development of mental health issues.[38]

Mental health and substance use policy

If not already in place, the development and implementation of a clear, detailed, and well-communicated organizational workplace mental health and substance use policy that supports the RTW process can ensure a shared understanding and approach to these issues and help in supporting the implementation of an effective RTW program.[2,39]

Adoption of a non-punitive approach within workplace policies and procedures can support an organization's workforce, particularly when workers voluntarily disclose mental illness, a substance use issue requiring treatment, or self-refer to treatment.[12,40] A non-punitive approach can also support a workforce when responding to the initial disclosure or discovery of a substance use issue.[9,13] Stigma and fear prevent disclosure, keeping mental illness and addiction hidden, concerns silenced, and thus endanger the safety of all staff. Punitive systems create barriers to reporting, and the abrupt loss of a job upon disclosure is likely to worsen a health crisis. Workers whose illnesses are "discovered" on one job site and who lose that job due to zero-tolerance policies may move to another job site and resume working without being offered treatment or support. This is particularly applicable to the construction industry, where workers can avoid one job site for future projects if a substance use issue or mental illness has been suspected.

Section 2:
Mental health expertise and connections

Ensuring mental health and substance use issues can be addressed through the workplace.

Training and Support for Mental Health and Substance Use Education

Research shows that specialized training and support for union representatives and employers, particularly those workers in supervisory roles, can be effective in addressing knowledge gaps and fixed beliefs about mental illness or substance use issues. These measures are instrumental in the development and maintenance of a workplace culture that supports worker health.

Specialized training for individuals in leadership and management roles should encompass the following:

- Identification of symptoms and signs of worsening mental health and/or substance use challenges[2,41]
- Tools to engage in productive, non-judgmental conversations with workers that promotes open communication and honesty[31]
- Efforts to encourage individuals in leadership roles to reach out to workers in order to provide ongoing support and signal to workers that they are valued member of the organization

Leaders are well-positioned to recognize atypical behaviour and take action, and their response often determines whether a situation improves or worsens.[1] This may include training on how to identify signs of decompensating health, as well as tools for engaging in productive and non-judgmental conversations with workers which can thereby encourage early, voluntary disclosure of a mental health or substance use issue.[21,22,23]

Access to mental health experts

Fulfilling professional obligations to workers with mental health and/or substance use issues can be a challenging issue for many organizations. Developing connections between workplace leaders and employers to mental health professionals can help organizations better respond to their workers when approached about mental health and/or substance use issues. Mental health experts can provide supports such as coaching, education and advice on organizational responses to a worker's disclosure, as well as support with developing pre-emptive policies and workplace practices.

Peer support services

It is likely that most workplaces have more than one staff member coping with mental illness and/or a substance use issue, and in-house peer support interventions have been shown to be highly effective in promoting recovery.[42] Peer support can decrease isolation, reduce the impact of day-to-day stressors, increase sharing of health and self-management information, and provide workers with positive role modeling.[1,43]

Section 3:
Return to Work enhancements

The promising practices of RTW are organized into three key areas:

1 Policies and Culture

2 Return to Work Process

3 Supporting Recovery

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1 Return to Work Policies and Culture

Employment provides many individuals in recovery with stability, improved self-esteem, self-sufficiency, and a sense of community. By implementing policies that enable workers to RTW in a supportive and structured manner, employers help workers constructively address their health challenges by focusing on maintenance of long-term recovery. Simultaneously, open communication and unambiguous documentation helps to set clear expectations to protect the safety of the workplace.

Return to Work is seen as a key component of recovery

This includes asking workers about their RTW expectations early and helping workers set realistic and health-promoting goals from the outset of care. It is vital to recognize that employment is an important determinant of health, and that workers who undertake a gradual and early RTW enjoy a more complete recovery and have fewer long-term complications.[21-23, 33]

Where appropriate, support treatment of underlying physical injury

"Construction workers with a history of opioid or other substance use may have an underlying physical injury that requires treatment."

Construction workers with a history of opioid or other substance use may have an underlying physical injury that requires treatment. There is a high rate of persistent musculoskeletal injuries among construction industry professionals,[5] and engagement with non-pharmaceutical pain management therapies will likely help address some of the root causes of a worker's substance use issue.

Formal Return to Work agreement

RTW should include a formalized agreement between the worker and the employer.[19,44,45,46] This agreement is a formal, written record of the agreements made between the worker and the workplace or union, and should specify the following:

- Duration of the agreement.
- Recommended workplace accommodations.[2,3,19,26,31,35] For some workers, this may include specific tasks, and for others, this may include restrictions on certain shifts, working overtime, and/or the amount of time spent in remote job sites away from support networks. It could include time off for treatment, meetings, or appointments, or the provision of an alternative work schedule, location, or duties.[19]
- Detailed timeline of predicted progression with stated goals.
- Agreement of the worker to participate in relapse prevention and/or other therapy as recommended by their clinician(s).
- Commitment to abstain from substances, including pharmaceuticals, unless prescribed by a physician knowledgeable about the worker's history of substance use.
- Frequency and type of any biological testing that may be collected by the employer.
- Consequences in the case of a positive biological test or relapse.

A systematic, structured, and coordinated RTW initiative improves the RTW outcome.[26] Practices should be specific, goal-oriented, engage the worker in the RTW process, and maintain a focus on work function and long-term outcomes. The process should be consistent, transparent, and confidential.

Flexible and collaborative Return to Work programming

While agreements need to be made systematically and in a structured way, RTW programming needs to be flexible and collaborative where it considers individual circumstances and context. Personalized support is a vital component of the RTW process.[31] RTW supports can be personalized by directing focus on worker values, views, and needs. This can be facilitated by ongoing communication between workers, health care professionals, and employers.[31] Collaboration should include the union, employer, worker, worker's family, health care providers, and other mental health professionals, where applicable.

Clear disability benefits and claims processes

Agreements should ensure that relevant disability and/or benefit claims processes, are clear and don't contribute further to existing stress already experienced by the worker.[48,49,50] Navigating the system should also not add to a worker's existing stress.

Commitment to Return to Work after treatment

Taking all feasible steps to guarantee re-hiring or reassignment of workers upon successful completion of initial treatment can decrease barriers to help-seeking for mental health and substance use issues. This encourages early, voluntary disclosure before a workplace accident occurs, and provides workers with employment security and incentivizes treatment participation and completion. If employers show loyalty to their workers, that loyalty is typically returned, which increases staff retention over the long-term.[27,51]

Qualified Return to Work Coordinator/Disability Manager
Workers with access to RTW coordinators or disability managers with whom they have a trusting relationship are much more likely to come forward and request assistance in times of possible relapse or decompensation.[52,530] Employers and workers benefit from high-quality recovery support, and the presence of this type of specialized staff encourages early disclosure and promotes a healthy, communicative relationship.[10] This role should ideally be held by someone with either demonstrated experience in supporting people with mental illness, substance use issues, and/or concurrent disorders. Importantly, the role of the RTW coordinator is not tied to a specific discipline and can be assigned to all different professional designations across the industry.[26]

"Workers with access to RTW coordinators or disability managers with whom they have a trusting relationship are much more likely to come forward and request assistance in times of possible relapse or decompensation."

2 Return to Work Process

Regular meeting
Workers should meet regularly with the manager, dis-ability management specialist, mental health worker, and/or union representative. Where possible, in-person meetings are best, but telephone or video conferencing is acceptable where geographic or temporal constraints apply.

Workplace accommodations
Workplace accommodations should be reviewed periodically, particularly in the early stages of a worker's return to the workplace.[19] Regular re-assessment of the implementation and effectiveness of workplace accommodations allows for necessary adjustments and review of a worker's progress. There has been demonstrated success in managing RTW where an occupational therapist and/or mental health worker is responsible for liaising with workers and employers to ensure consistent implementation and appropriateness of workplace accommodations.[54]
Additionally, regular check-ins allow for worker monitoring to identify early signs of decompensation or relapse and provide assistance as needed.

Communication with healthcare provider about workplace demand and prescribed medications
Coordination and communication with healthcare providers about workplace demands is likely to yield beneficial results for both the worker and the organization by reducing disability duration.[47,55] However, this type of collaborative communication can only proceed with full and informed consent. It is particularly important to include physicians in the collaborative care process, in instances where workers have been prescribed opioid agonist treatment (OAT) (also known as opioid replacement therapy) for treatment of opioid addiction. OAT is the gold standard treatment for opioid use disorder.[20] Buprenorphine/naloxone and methadone are examples of OAT.

Safety-Sensitive Positions and Prescribed Medications
The RTW process must include consideration of any job or position that is deemed safety-sensitive. A safety sensitive job is one which "could result in direct and significant risk of injury to the worker, others or the environment".[45] Workers in safety-sensitive positions may benefit from temporary re-assignment or additional monitoring measures. Recommendations for such accommodations may require ongoing communication with both the worker and the treating clinician(s).
As part of their ongoing treatment, a treating physician may prescribe medications to some workers which

prevent substance use withdrawal. Many governing bodies have approved the use of these medications while working in positions requiring the use of machinery, though typically under close physician supervision and with regular assessment and medical review, and after a period of dose stabilization.[56,57,58]

According to the RTW terms mandated by both Interior Health Authority and Fraser Health Authority, workers in recovery are expected to consult with their physician or pharmacist to explore the possibility of any potential negative impacts on job performance or safety of prescribed medication. Similarly, for many individuals, the RTW agreement will include an explicit commitment to avoid the use of all potentially addictive compounds unless prescribed by a physician who is knowledgeable about the worker's history of substance dependence.[46]

3 Supporting Recovery

Ongoing communication

Workers should maintain communication with employers and unions throughout recovery and reach out when additional supports are needed.[26,59] Emphasis should be placed on the building of strong relationships between supervisors and staff that encourages open communication.[26,52] Examples of this include staying in touch with workers who are off work, and actively letting them know that they are supported and will be welcomed if and when they RTW. Social support during recovery has been shown to have positive effects when building a line of defence against addiction or relapse.[42,43,60]

Aftercare Supports and Relapse Prevention

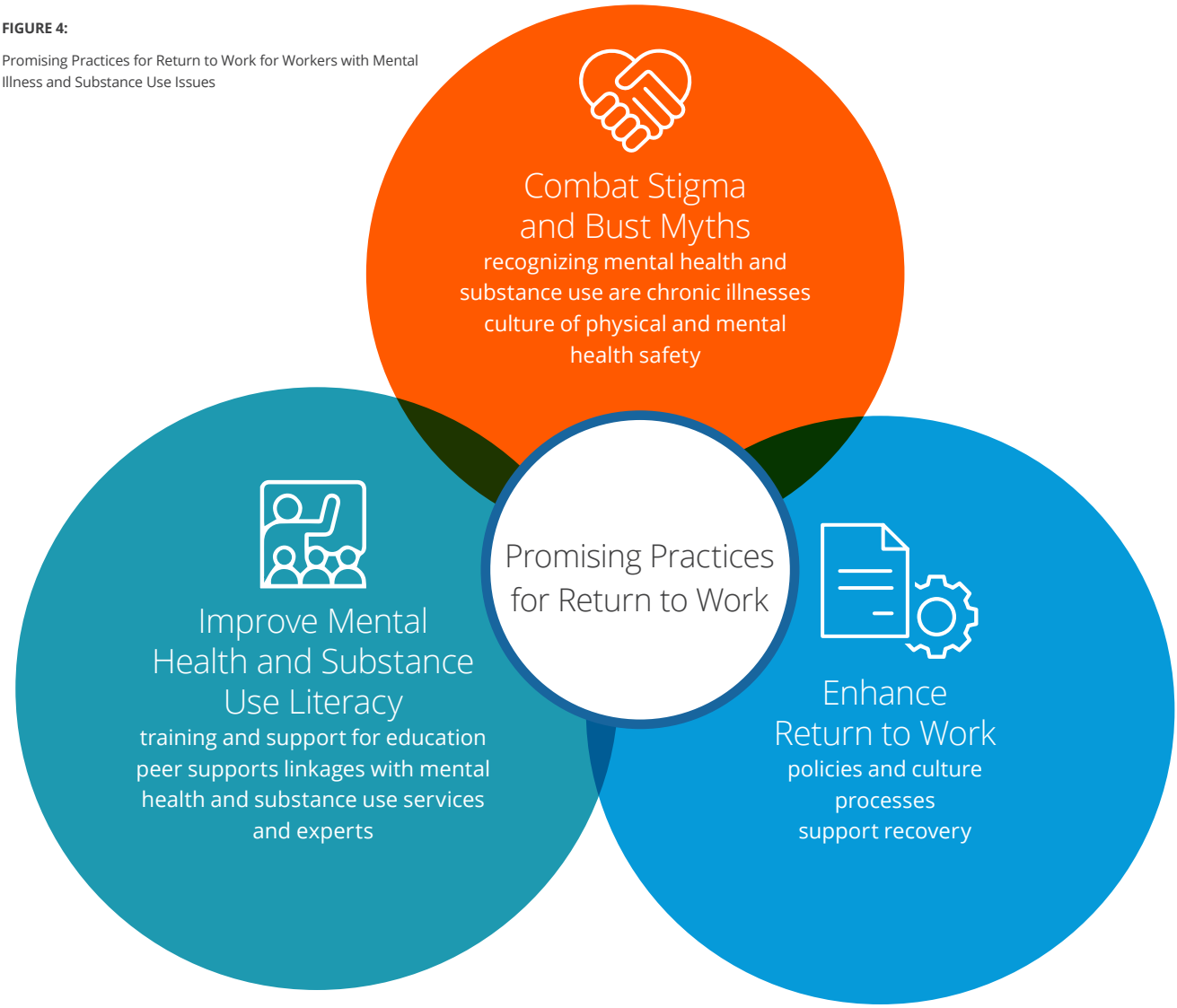
For many individuals with substance use issues, the risk of relapse persists for many years, and in some may never go away. As such, therapeutic services need to be available over the long term so that monitoring and support after initial treatment can be accessed.[44,61] As per best practice guidelines, the success of long-term recovery is improved when the treatment continuum for substance use issues includes the recovery period following discharge from the primary treatment program(s).[61] After completion of primary treatment (e.g., residential or outpatient treatment), workers should participate in ongoing aftercare programs. Aftercare programming should be ideally designed in collaboration with their clinician(s).[61]

Aftercare services may include community-based counselling, peer support, ongoing medical care, strategies for relapse prevention, and/or unannounced testing. The structure and frequency of this type of aftercare should be tailored to the individual's needs. The length of treatment varies based on an individual's needs and individual progress, therefore no predetermined or 'blanket' length of treatment should be universally applied.[61]

Workplace accommodations can support these aftercare plans. For example, accommodations where workers can attend counselling appointments and other aftercare programs can help workers maximize their chances of long-term recovery and stability.[44] Other workplace accommodations to support long-term recovery may include alternative work schedules (which may or may not include altered or reduced work hours), locations, or duties,[17] including re-assignment to positions that are not safety-sensitive. Workers may also benefit from work assignments that do not isolate them geographically from their support networks, particularly during early recovery.

FIGURE 4:

Promising Practices for Return to Work for Workers with Mental Illness and Substance Use Issues



Key findings

This section summarizes the key findings of this report, specifically the environmental scan and promising practices.

Key findings:
Environmental scan

Prevalence

Men working in the construction industry are over-represented in overdoses, and overdose deaths in BC. Possible contributing factors include a “work hard, play hard” culture, a high proportion of males among the workforce, and chronic pain secondary to musculoskeletal injury which leads to substances being used to manage both physical and emotional pain.

Lack of Awareness of Treatment Services

Industry-wide knowledge of the available treatment services for workers with mental illness and/or substance use issues appears to be limited. Industry key informants disclosed that the majority of workers within the industry are unaware of the treatment services, the cost of the services, how to access the services, wage indemnity, confidentiality of the services, scope of the services, and that workers can continue to work while receiving treatment.

Stigma

Stigma and shame are barriers faced by workers with mental illness, substance use issues, and concurrent disorders. Often substance use and mental illness are understood as moral failings rather than chronic health challenges. This stigma may be particularly prevalent within construction workplace settings, especially when shrouded by an outdated understanding of mental health and substance use issues that results in concerns being silenced. Based on the feedback from key informants, many workers fear profound repercussions if they disclose these types of health challenges to a peer or supervisor, including job loss, workplace harassment, bullying, social stigmatization and isolation.

Significant Negative Financial Impact

Key informants described how workers taking time off work are negatively financially impacted and that there are impacts on the worker's wellbeing and mental health. Financial concerns drive the majority of early discharges from treatment, both inpatient and outpatient treatment, and available wage indemnity provides a fraction of typical income (estimated at between 70% of income to full wage replacement). Consequently, many workers prefer to engage with treatment services while maintaining employment, using sick or personal time to access services for as long as their allocation allows. Treatment programs with extended hours, particularly those with evening programming that includes counselling, whilst unfortunately limited, are very popular.

Lack of Structured Return to Work Programs

There appears to be limited industry experience in the implementation and management of structured RTW programs for workers with a known substance use issue and/or mental health issue. Without formal procedural guidelines, both workers and employers are left to manage this complex transition ad hoc, typically producing suboptimal results and causing additional stress and confusion. All informants, including workers, managers, and employers stand to benefit when the RTW process is clearly outlined and overseen by a mutually agreed-upon RTW agreement. At present, the vast majority of workers return to their workplaces and dispatch offices without a formalized transition process, and workplace accommodations are neither recommended nor implemented.
Structured RTW programs with clear policies and procedures offer both workers and employers a transparent protocol for the management of the RTW transition. Clear, detailed, and well-communicated organizational workplace mental health and addiction recovery policy supports the RTW process. Key elements of a structured RTW program include defined workplace accommodations, a formal RTW agreement, and a qualified RTW coordinator.

Lack of Specialized Training for Managerial Staff

There is limited education provided to staff members in leadership positions about mental illness or substance use issues, despite the high prevalence of these health challenges among workers in the construction industry. For many workplaces, existing attitudes of stigma may be partially ameliorated by providing education to leaders (union and employers) that addresses preconceived ideas regarding mental illness and substance use, and that promotes holistic health among workers that includes mental, physical, spiritual, and psychological components of health. The majority of engaged informants identified opportunities to enhance educational support in this area and all welcomed additional guidance and education for staff members in leadership roles aimed at addressing these knowledge gaps.

Unions Unaware When Workers in Treatment

Many workers pursue treatment for mental illness and/or substance use issues without taking time off work. Many workers also do not disclose their reason for taking unpaid sick leave, opting to use this time to engage with treatment services rather than applying for wage indemnity. As such, many unions are not aware that their members are receiving treatment for these chronic health challenges. As a result, unions are often not involved in the RTW process for these workers and are not given the opportunity to provide support to workers during this period of transition. These unions may dispatch workers to job sites or locations that are inappropriate given their health circumstances, but without the essential knowledge that a worker is in treatment, they have no reason to amend job assignments.

Provincial Differences

The BC, Alberta, and Ontario construction industries have widely varying approaches to the management and treatment of substance use issues and mental illness among workers. According to informant engagement across the country focused on approaches within the unionized construction sector, the Alberta industry is quite focused on testing (including pre-access testing) and the Ontario industry's treatment approach is largely in line with a 12-step and abstinence-based model of care.

Key findings:
Promising practices

Promising practices for mental health and substance use conditions and RTW were identified through a review of workplace best practice guidelines. The practices were assessed while considering the principles of minimizing harm, promoting gradual re-entry into the workforce, minimizing stigma and discrimination, and incorporating a biopsychosocial model. These practices are described below under the following theme areas:

1 Workplace Policies and Culture

2 Mental Health Expertise and Connections

3 Return to Work Enhancements

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1 Workplace Policies and Culture

Mental health and substance use issues are chronic health challenges. Recognition of this and the incorporation of de-stigmatizing language within agreements can help promote a culture of physical and mental health safety. In addition to agreements, education in the workplace about the biological basis of mental illness and substance use issues can challenge prejudices that they are due to moral failings.

Similar to when a worker is physically injured, a clear organizational policy for mental health and substance use, which outlines the RTW process, can help with creating a common and coordinated approach when these issues arise. Policies that incorporate a non-punitive approach can support workers disclosing a problem and reaching out for help. This results in workplaces responding proactively to substance use issues rather than reactively when a workplace incident occurs.

2 Mental Health Expertise and Connections

Specialized training for those in organizational leadership and management roles to i) identify signs and symptoms of a worsening mental health and/or substance use issue, ii) have tools to engage in non-judgemental conversations with workers, and iii) knowledge of which resources are available for crisis response and for longer-term mental health and substance use issues can address knowledge gaps and ensure workplaces are better equipped for responding to these situations. In addition, workplaces can champion peer support services, which can empower workers to reach out to one another and get those struggling the help they need.

3 Return to Work Enhancements

RTW can be improved through enhancements to the RTW policies and culture, reviewing the current RTW process, and through workplace commitments to supporting recovery.

RTW policies that support a formalized agreement between the worker and employer, outlining factors like the duration of the agreement, the expectations of the worker, and the recommended workplace accommodations, can ensure both parties are on the same page. Formal RTW programming involving RTW coordinators familiar with mental health and substance use issues can promote linkage to evidence-based supports. Programming that incorporates workers values, views, and needs that is facilitated by open communication by all those involved in the workers' care, including health care providers, mental health professionals, the union, employer, worker's family, and others can improve coordination and engagement in the treatment plan and supports after initial treatment is completed.

The RTW process can be improved through regular communication and meetings, particularly ensuring that the manager, disability management specialist, mental health worker, and/or union representative (when applicable) are apprised of the progress made. Given that some workers may be placed on prescription medications as part of their treatment, communication with the treating physician regarding how their medication prescription will affect the worker's performance and safety on the job should also be considered.

Workplaces can support recovery by recognizing the chronic nature of mental health and substance use challenges and how they are prone to relapse. As such, workplace accommodations can often extend past the period of initial treatment and aftercare supports may be needed. These accommodations can include attending appointments, alternative work schedules, reassigning to positions that are not safety-sensitive, limiting work assignments that isolate workers geographically, and other opportunities to promote early recovery and prevent relapse.

Limitations

There are some limitations to the findings of this report. First, the construction industry is a large employer in BC made up of many companies each employing a small number of workers. While efforts were made to incorporate the perspectives of smaller companies, many of the key informants for this report are from medium-sized and larger employers. As such, the perspectives of smaller employers do not figure as prominently in the findings. From those smaller employers surveyed, the challenges experienced by them in responding to mental health and substance use issues and RTW appear to be similar to those of larger employers. It is expected that these challenges be may even more acute for smaller employers who may not have dedicated infrastructure or processes to respond to mental health and substance use issues when they arise.

Second, this report did not gather the perspectives of informants who are involved with EAP/EFAP. Recognizing that these programs do provide dedicated support to some companies, this is an area that should be assessed as part of further study.

Third, the jurisdictional scan of practices in Ontario and Alberta are limited to the experiences of some unionized companies via the Alberta and Ontario chapters of the Building Trades. The perspectives of the informants provide a snapshot of some varying approaches to responding to substance use and for RTW but should not be considered representative for the practices of the entire industry in either of the two provinces.

Conclusion

Employment is a key determinant of health. Many adults spend most of their days at work. Therefore, workplaces are important settings for preventing disability and disease and for promoting healthy behaviours. Healthy, safe workplaces are productive workplaces.

Mental health is an indispensable component of a worker's overall health and wellness. Mental illness affects as much as 50% of the general population by the age of 40, but treatment, particularly when initiated early in the disease process, has been shown to be widely successful in improving health outcomes.[62] To date, much of the dialogue concerning health and wellness in the construction industry has been focused on physical wellness, particularly the management of chronic musculoskeletal injuries, leaving mental health largely absent from the conversation.

The overdose crisis has impacted men working in construction substantially. RTW has been identified as a key area for the industry to assess. This report outlines the current RTW practices in the industry through an environmental scan, and demonstrates that there are variations in RTW across the industry. Given developments in the evidence for managing mental health and substance use issues in the workplace, the report describes promising practices that can be incorporated to help support RTW for workers, which can help improve both mental and physical health and safety in workplaces.

Appendix

KEY INFORMANTS

Listed below are the key informants who participated in the project listed by organization. Note that there are some interview participants that were representing more than one organization.

Construction Labour Relations Association of BC (CLRA)

Clyde Scollan, President and CEO
Theresa Hughes, Director, HSE
CLR HSE Employer Group Meeting (12 employer representatives)

BC and Yukon Territory Building and Construction Trades Council (BCBT)

Dave Holmes, President BCBT
Tom Sigurdson, Executive Director
Merrill O'Donnell, Worker's Advocate

Construction Industry Rehabilitation Plan (CIRP) Staff

Vicky Waldron, Executive Director
Jason McBain, Caseload Assistant
Kelsey Atkinson, Concurrent Disorders Counsellor
Nina Sheere, Concurrent Disorders Counsellor
Heather Scott, Concurrent Disorders Counsellor

Construction Industry Rehabilitation Plan (CIRP) Board Members

Dave Holmes, Business Manager-Secretary Treasurer, IUPAT DC38
Clyde Scollan, President, BC Construction Labour Relation Association
Lee Loftus, Business Manager, Heat and Frost Insulators L.118
Brooks Patterson, Vice President, HSE and Loss Control, Norland Pacific Blasting
Darcy Biln, Health and Welfare Manager, IBEW L.213
Nav Malhotra, President, LiUNA 1611
Amber Roberts, HR Manager, Houle Electric
Dan Burroughs, Business Manager, Sheet Metal Workers L. 280

CIRP Clients – Men's Support Group

Participants to remain anonymous
- Facilitated session with a group of men receiving treatment from CIRP

WorkSafe BC – Board of Directors

Lee Loftus, Business Manager, Heat and Frost Insulators, L. 118
Brooks Patterson, Vice President, HSE and Loss Control, Norland Pacific Blasting

WorkSafe BC – Staff

Todd McDonald, Vice President, Claims Services
Dr. Peter Rothfels, Chief Medical Officer
Roberta Sheng-Taylor, Industry and Labour Services – Construction
Judy Reilly, Key Account Performance Consultant, Strategic Enhancements
Luisa Johns, Quality Assurance Supervisor, Health Care Services
Andrea McNeill, former Quality Assurance Supervisor, Health Care Services

BC Construction Safety Alliance

Mike McKenna, Executive Director

Fraser Health

Dr. Nader Sharifi, Lead, Addiction Medicine
Dr. Nickie Mathew, Addictions Psychiatrist
Dr. Paul Sobey, Addictions Physician and President, Canadian Society of Addiction Medicine

Overdose Emergency Response Centre, Ministry of Mental Health and Addictions

Jeff West, Project Manager, Overdose Emergency Response Centre

CLRA Members

Perry Harvey, Occupational Health and Safety Specialist, Mott Electric GP
Tomm Adams, Project Management Lead, Viking Construction
Laura Wydra, Construction Safety Officer, W.S. Nicholls Western Construction Ltd.
Ryan Thomas, Health and Safety Supervisor, Fred Welsh Ltd.
Aaron Olsen, Director of Environmental Health and Safety, Industrial Scaffold Services L.P.
Kim Stanley, Health and Safety Manager, Brymark Installations Group INc.
Dianna Musil, Human Resources and Health and Safety Representative, National Hydronics Group
Charles Finch, Health and Safety Manager, Emil Anderson Construction
Wayne Fettback, Director of Safety and Procurement, Western Pacific Enterprises Ltd.

Alberta/ Ontario Construction Companies/Organizations

Terry Parker, Executive Director, Alberta Building Trades
Carmine Tiano, Director, Occupational Health Services, Provincial Building and Construction Trades Council of Ontario
Marie Lloyd, Executive Director and Registered Psychotherapist, De Novo Treatment Centre, Ontario
Aaron Sinclair, Registered Psychotherapist, De Novo Treatment Centre, Ontario
Randy Robb, Registered Social Service Worker and Psychotherapist, De Novo Treatment Centre, Ontario

British Columbia Construction Companies/Organizations

Bill Strain, President/Owner, Villa Electric
Jim Billey, Safety Manager, Beedie
Kelly Ann Williams, HR Manager, Scott Construction Group
Barry McCarty, Sr. Manager Health and Safety, Ledcor Western Canada
Robert Roy, Director Health and Safety, Universal Group
Manny Kursan, Operations Manager, Pristine Labour
Richard Verbeek, Regional HSE Manager, Western Canadian Buildings – PCL Constructors
Nicole Devost, Supervisor Return to Duty Services, CannAmm
Peter Hull, Substance Abuse Professional, CannAmm

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