**WorkforceGPS**

**Transcript of Webinar**

**NIOSH Responds to the Opioid Overdose Crisis and an Update on Workplace Supported Recovery**

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LAURA CASERTANO: With that, I'm going to get myself right out of the way. Again, I want to welcome everyone to today's webinar. And I'm going to turn things over to your moderator today, Robert Kight. He's a division chief with the office of Workforce Investment Employment and Training Administration. Robert, take it away.

ROBERT KIGHT: Thanks, Laura. And good afternoon to everyone, and thank you for joining us. We're so happy to have you with us. As previously stated, I'm Robert Kight. I'm the division chief for Adult Services and – (inaudible) – ETA's Office of Workforce Investments. We are excited to have with us today Dr. Casey Chosewood and Jamie Osborne from the National Institute for Occupational Safety and Health -- and we will refer to it as NIOSH -- who will offer real-time insight on the impact of the opioid crisis on our public workforce system.

ETA believes that the information presented by the NIOSH team provides a great opportunity to enhance the One Workforce vision through sharing the timely and important information with the larger workforce community. We have also invited our DOL's grantees, who have received funding to support and serve communities impacted by the opioid epidemic, to hear the enlightening information.

DOL's primary grant to address the workforce impact of the crisis is the National Health Emergency Dislocated Worker Grant. You often hear us refer to them as DWGs. DWGs are triggered by federal emergency and disaster declaration, such as a terror event or natural disaster. In this case, HHS's declaration of the opioid crisis as a public health emergency trigged its development.

This development of the NHE DWG. As of November 12th, 2020, 20 states and the Cherokee nation have received over $120 million in funding from the National Disaster Relief Funding for opioid-related grants. As we focus on today, the objective for today's webinar includes -- we want to ensure and help the public workforce system gain a better understanding of the opioid crisis across the U.S.

We also want to us to enhance understanding of the opioid crisis among U.S. workers. The NIOSH framework to address the opioid misuse, I think, will be very helpful as well. And the COVID, we want to look at the impact of the COVID-19 pandemic and the opioid overdose epidemic. And finally, we want to look at workplace supported recovery.

Today's speakers, as I mentioned, are Dr. Casey Chosewood, director of the NIOSH Office for Total Worker Health and Safety, and Jamie C. Osborne, public health analyst with the Office for Policy, Planning, and Evaluation. They will complete their presentation and will leave time for questions and answers at the end. So please type any questions you might have in the chat box, and we will do our very best to address them at the end of the presentation. So with that, I'd turn it over to Dr. Chosewood.

DR. CHOSEWOOD: Thank you very much, Robert. We, Jamie and I, both appreciate your kind invitation. We look forward to speaking to your group today. I will just start by saying that it's quite a pleasure for us to be with you and also to say thank you to all of you and your colleagues at the Department of Labor, as well as all the grantees who are doing such vitally important work in this space.

As you can see, Jamie and I are from NIOSH. You probably all know that NIOSH is part of Centers for Disease Control and Prevention. And I would be amiss if I didn't start out this presentation, as I do with all of my presentations, without a mention of COVID-19. The nation's workers were already facing high levels of stress and mental health challenges and certainly the opioid overdose crisis even before this new pandemic began. And the new demands of the pandemic are certainly not just additive onto all these other things.

But unfortunately, many of these things feed on each other. And as we look at understanding the opioid crisis in the U.S., I really think it's especially true, now more than ever, that we think about ways we can support our workers through the midst of this crisis. We know that supervisory and organizational supports are critical, especially as workers are more isolated. They may lack the peer support, they have competing home demands, and they must provide caregiving and homeschooling to manage the day-to-day necessities of this emergency.

And like many of you, certainly myself included, fatigue is setting in. Not only do I have Zoom fatigue and Adobe Connect and Skype Fatigue, but the fatigue just to -- that's interrupting my day-to-day activities, my love of travel, my ability to get out and meet and socialize with the people I care about.

There's a long list of worries that all of us are involved with: worry about our personal safety, the rude juxtaposition of home and work life that has not been seen before. Many folks have lost jobs. And as we get into understanding the opioid crisis, we can see how job loss itself is a significant risk factor for opioid use disorder. The pandemic has also increased our worry over finances, both our own and our employers.

So I say all these introductory remarks to say that your work in the support of workers is now more vital than ever. And again, let me thank each of you for what you are doing to move us in the right direction. So as it relates to the opioid overdose crisis and work, what is it about work, or maybe even the lack of it as I mentioned, that is contributing to the nation's opioid epidemic? Why are some workers at higher risk than other workers, and how can we use the platform of work itself to better intervene for these folks?

Let's take a closer look at this opioid crisis. Drug overdose stats in the United States, especially from opioids, remains high. That's been true now for more than a generation. From 1999 to 2018, about three quarters of a million people died from a drug overdose. And in the last 20 years, about 446,00 Americans lost their lives to opioid overdoses, either from prescription opioids, especially earlier on in the crisis, or illicit opioids.

Now, to give you some perspective, that number is greater than the number of lives lost to HIV in a time period half as long. So that gives you some idea of the critical nature and the magnitude of this overdose crisis. And certainly true in 2019, about 70 percent of the more than 67,000 drug overdose deaths in 2018, and in 2019 as I mentioned, involved an opioid. So opioids are definitely a centerpiece to this drug death crisis.

We did start to see some earlier improvements in overdoses as it relates to opioid overdoses. In 2018 late and 2019, we saw a bending of the opioid curve. Unfortunately, the COVID pandemic has reversed many of those gains, and Jamie will give you a little bit more insight into this kind of -- this really horrible interaction between opioid overdose deaths and COVID-19.

This is certainly a crisis affecting working-age people. About 95 percent of those who suffer overdose deaths are between ages 15 and 64 years. And 63 percent of self-reported illicit opioid users were employed full- or part-time at the time of their drug use. The pace, the evolution of the crisis, is also concerning.

Overdose deaths at work from the non-medical use of drugs or alcohol increased by at least 25 percent every year between 2013 and 2017. This reflects access to more dangerous drugs, especially with the arrival of illicitly manufactured fentanyl in the workplace. And that's led to workplace overdose deaths. In fact, in some states, the leading cause of workplace death is not flips, trips, and falls; it's not motor vehicle accidents. It's drug overdose death. And that was certainly the case in a couple of years in the state of Massachusetts.

It's probably no surprise to many of you that folks with substance use disorders have work attendance and performance issues. The average worker will have about 10 days of absence a year. Anyone with a substance use disorder will have about 15 days of absence per year. But someone with an opioid or a pain medication use disorder will have about 29 days of absence per year, or about three times the number of average days away from work.

While overdose at work -- overdose deaths at work occur in all industries, they are certainly more common in some industries than others. Using Department of Labor's BLS data, NIOSH looked at the years 2011 to 2016 and found that 43 percent of drug overdose deaths at work occurred in only three industries: transportation and warehousing, construction, and the health care and social assistance sectors.

As I mentioned, in Massachusetts, they reported 54 unintentional drug overdose deaths at work between 2016 and 2017, making unintentional overdoses the leading cause of injury death at work in the state, more than falls, more than motor vehicle crashes. And very hard -- or it's very unfortunate that very small businesses are especially hard hit. One-third of workplace overdose deaths occurred in workplaces with less than 10 employees.

Well, let's take a closer look at the links between opioids and work. What is the interaction between these two issues? If you ask employers, here is what they will tell us: Three quarters of them say that their workplace has been directly impacted by opioids. That's three in four workplaces across the nation. But less that one in five feel extremely well prepared to deal with the issue. About a third report an overdose and arrest, a near miss, or an injury due to opioid use in their own workplace. Only four in ten would return an employee to work after he or she receives treatment for misusing prescription drugs.

Now, this is a big challenge for all of us on the phone because that represents a huge gap between the standard of care, the appropriate level of intervention to help someone get better from a substance use disorder, and their connection to the ability to return to work. We know that employment itself is something that helps people sustain recovery. And the fact that we have quite a large number of employers not interested in returning workers to work despite treatment is concerning.

Here's another worry. As a physician, this bullet perhaps is the most painful of all: Despite effective treatment, only one in five persons suffering from an opioid use disorder receive the gold standard of care, which is medication-based treatment. Why is this? Despite coverage parity, despite some people having certain benefits at work, many people do not have good access to treatments services.

There's a tremendous amount of stigma that is still at play in limiting access to care, and many, many work places and populations face barriers to seeking the care they need. There's a significant shortage of qualified health care professionals in the substance use disorder treatment space as well.

Also, only about half of employers are very confident they have the appropriate HR policies and resources to deal with this. This list represents tremendous opportunity for all of us on this phone to develop better interventions, approaches, and policies. This is a study from the National Safety Council, and it echoes some of those previous concerns. About two-thirds of employers in this study reported concerns about drug misuse. This number increased especially among those employers in the industrial sector. And I think that's generally true when you talk to employers in any safety-sensitive work.

About half of employers reported experiencing absenteeism or impairment among workers, and that confirms much of what we were seeing on the previous slide. Less than half of U.S. employers are very confident that their workplace has the proper policies to deal with these issues.

Now let's take a quick look at the data. This is using -- and this is perhaps one of the earliest CDC publications that focused on the connection between the opioid overdose crisis and specific industries and occupations. And it looks at more than 57,800 drug overdose deaths in 26 job groups between the years 2007 and 2012. And it used the metric of proportional mortality ratios. Now, that's a fancy word -- set of words, but basically, it's a tool that we use to compare deaths in one occupation versus the deaths in all occupations.

So how does the death rate, for instance, compare in construction versus the average in all workplaces, in all industry sectors? This study revealed that overdose deaths were highest for six occupational groups. Construction had the highest, followed by extraction. When you hear "extraction," I want you to think of oil, gas exploration, mining. Those tend to be the most common extraction jobs in our country.

Third on the list was food preparation and serving, followed by health care practitioners and technical occupations, followed by health care support workers, and finally, personal care and service providers. And you can see that the type of drug that was at play at a majority of overdoses within these different populations varied as well and largely had something to do with access to those drugs at the time of death. The mortalities were also significantly elevated for those people who were in unpaid work or who were unemployed.

This data examines the question, which drugs are involved and which are the deadliest? This is 2011 to 2016 data, and in fact, unfortunately, we have the problem of lagging data in a lot of our decision-making. State-based reporting oftentimes is a bit slow coming in to the national level. And there are no national-level toxicology surveillance systems, so we rely on state reporting to get a lot of this information, and that leads to gaps in reporting. There's also confusion, oftentimes, over death record reviews and death statements.

So from 2011 to 2016, the rate of drug overdose deaths involving heroin more than tripled. The rate of drug -- death involving fentanyl, the very, very powerful opioid, doubled each year between 2013 and 2016. And drugs most frequently mentioned varied by the intent of the drug overdose death. Was it an unintentional, or was it a suicide by drug overdose?

In 2016, the drugs most frequently mentioned in unintentional drug overdose deaths were fentanyl, heroin, and cocaine, while the drugs most frequently mentioned in suicide were pills like oxycodone, a powerful opioid; or Benadryl, a sedating antihistamine; hydrocodone, another opioid; and alprazolam, which is also known as Xanax, a drug in the Valium family; or benzodiazepine, oftentimes used for anxiety or sleep.

This is the latest release from CDC, and it was -- it just came out in late 2020 looking at data from 2019. And there's several takeaways here: First of all, there's in the percent of overdose deaths of -- involving opioids, and that number has risen from 65 to 70 percent of death up to 80 percent of death. More specifically, three of four deaths involving overdoses of drugs involve illicitly manufactured fentanyl. This is a terribly dangerous, imported opioid of quite concern to all of us.

Again, it's painful to see this fact on the infographic here. Three in five of the people who die from a drug overdose had an identified opportunity for linkage to care or, for some, life-saving intervention or action. They might've presented to a medical facility; they might've called into a hotline; they might've requested information or sought some sort of treatment or information about substance use disorder.

So in truth, many folks who are at risk for overdose death are interfacing with our health care systems, our public safety systems, our legal systems. So there are missed opportunities as we, as a society, are failing to take to be able to intervene here. Let's talk a little bit now about interventions.

As Robert mentioned, I'm the director of NIOSH's Office for Total Worker Health. Our work around opioids uses the Total Worker Health approach, and we've been evolving this concept over the past decade. Total Worker Health is NIOSH's research-to-practice effort with a goal of, first, keeping workers safe, but then secondly, helping them prevent harmful activities or worries or conditions that might impact them both on and off the job, with the goal at the end of the day of increasing the wellbeing of workers.

Why does this approach matter so much for opioid use and misuse? Well, clearly, opioid use is not an isolated issue that just occurs at home or just occurs at work. People don't turn off a substance use disorder when they come to work or when they go home from work. Prevention and intervention require integrated solutions if we're going to be most successful.

And lastly, coordinated or systems approaches not only increase our ability to succeed they help us return folks to work. It's the most efficient way for us to bend the overdose curve. And it takes into account the important role that workplaces, homes, communities, the medical system -- all of those things work together to find the best solution.

Robert mentioned our framework to address opioid misuse, and it basically is both a way to identify those workplace conditions that decrease people's resiliency to avoiding opioid misuse -- determining risk factors for opioid misuse. We're also very much involved in protecting those workers who may come into contact with opioids as part of their job. So I want you to think about first responders and emergency room workers who might have exposure to drugs based on the circumstances of their work.

And then lastly, because we are a lab-based research agency, we want to develop better methods for real-time detection of drugs in the field, especially for those workers who might be potentially exposed, and find appropriate ways to decontaminate work spaces or public spaces where drugs may have been used. This is especially concerning as we talk about some of the more dangerous and highly concentrated opioids.

Let's talk a little bit about NIOSH's ongoing work to address the crisis. This is a great summary slide of our current work. It covers our research activities, our surveillance activities. A number of health hazard evaluations that we've done in certain workplaces describes some of the grant activities that we do and our work with partners. I will invite you to our website to view all of the ongoing effort that we have underway. The fastest way to find all our resources is just to Google NIOSH opioids.

Before I turn this over to Jamie, I'm going to give just a few updates and a few examples of some of our resources. One of our most popularly visited websites, with more than 10,000 hits a month, is our first responder tool-kit. As I mentioned, first responders are often on the front lines after calls for help where illicit drugs may have been present or used in an overdose. In September of 2019, we released a new virtual tool-kit that provides resources to help keep these workers safe when arriving on the scenes where illicit drugs have been used.

This is, again, especially important for fentanyl and other very powerful fentanyl analogs. To help understand the risks and better prepare responders, the tool-kit includes training videos, infographics, and postcards with our recommendations on how first responders can better protect themselves.

One of our earliest resources featured information guidance and recommendations around the use of the rescue drug naloxone. Also known as NARCAN, it's a non-addictive, life-saving drug that can reverse the immediate effects of an opioid overdose when administered in time. And it has been used in thousands and thousands of rescues to save thousands and thousands of people's lives.

The goal of this document is to take away the fear of intervening, including in workplaces, and to increase the number of workplaces where there is access to naloxone. We've been told about lots of incidents where workplaces have faced overdoses in their parking lots, in their restrooms, in the parks, in the neighborhood, in the libraries, in the coffee shops. So this is an important intervention where workplaces can play a critical role.

The naloxone program that we developed has a list of considerations for workplaces interested in implementing a naloxone rescue program. We also provide all the guidelines that you might need to develop a -- both a naloxone program as well as the policies and the procedures to help train workers in the administration of naloxone. There's very little downside to implementing such a program. And if you can influence your own workspace or those employers where you have contact to implementing a naloxone use program, we absolutely believe that it saves lives.

An accompanying infographic looks at using naloxone to reverse opioid overdoses and really gives a step-by-step guide. So this is a quick look at the resources ready for sharing, and we're really happy that we've been able to roll this out. We've also developed employer-based resources around the issue of medication-assisted treatment. As I mentioned, this is the definitive treatment for substance use disorder. And MAT, or medication-assisted or medication-based treatment is considered the gold standard.

We view substance use disorder as a chronic disease, not a moral failing. It's treatable; it's manageable; people can get better. And MAT we know contributes to more stable, long-term employability options for workers as well. And return-to-work strategies are critical if people are going to maintain recovery over a long period of time.

Our solution also focuses on just beyond the medication to talk about a supportive workplace culture and primary prevention of opioid use, keeping workers safe from injury in the first place so they don't run the risk of developing a painful injury, improving working conditions so that people don't report to work every day with daily pain. Keeping workers safe to avoid that first use of opioids is a critical piece of the puzzle here.

I'm going to take a pause now and ask Jamie to come on board and talk to you a little bit about the most urgent -- any urgent aspects of the opioid crisis -- and that is its relationship to the COVID-19 pandemic. I'll talk to you again when we get to our Q&A portion of today's webinar. Jamie, I'll turn it over to you.

JAMIE OSBORNE: All right Thanks so much, Dr. Chosewood. Can I just get a sound check? Can everyone hear me all right?

MS. CASERTANO: We hear you.

DR. CASEY CHOSEWOOD: Yes. Loud and clear.

MS. OSBORNE: Okay. Perfect. Thank you so much. So I'd like to start by mentioning that we actually published a NIOSH science blog back in September on the same topic. And it covers a lot of the implications and challenges that I'm going to share with you today. So if you want to check that out, I'm actually going to drop a link in the chat right there. Let's see if I can advance the slides. All right. We're good to go.

So before the pandemic took hold, the United States was already facing another public health crisis: alarming rates of opioid overdose deaths. The co-occurring COVID-19 pandemic and the opioid overdose epidemic have created what some have called "the perfect storm" for folks who are substance dependent. And that figure on the slide is actually dated at this point. The AMA has updated that figure. More than 40 states have now reported increases in opioid-related mortality.

And the SAMHSA Disaster Distress Helpline has seen an exponential increase in calls compared to the same period last year, over 900 percent. So the additive impacts of COVID-19 and the opioid crisis increase the likelihood of illness and death among workers struggling with opioid use disorder, or what I'm going to start referring to as OUD.

Individuals with OUD are more likely to lack health knowledge and access to harm reduction services. They may lack reliable internet service to access information about the pandemic, and they may have difficulty accessing provisions needed for sheltering in place for an extended period of time. Additionally, opioids negatively impact lung and heart health, which, coupled with a higher prevalence of underlying medical conditions and tobacco use, may put people with OUD at higher risk for severe illness from COVID-19.

These individuals are often stigmatized and under-observed in health care settings and may experience even greater barriers to receiving care, especially when hospitals and clinics are pushed to capacity with COVID-19 cases. Closures of businesses and social distancing measures aimed at reducing the spread of COVID-19 may inadvertently increase harms related to OUD. Closures of treatment clinics and other disruptions to harm reduction programs may lead to increased sharing of injecting and non-injection equipment, increasing the risk of COVID-19 and other transmissible diseases like HIV.

Pandemic measures have created a scarcity of health care resources, including access to medication-assisted treatment, which may lead to discontinued treatment among those that are seeking recovery. Economic disruptions like job loss and social disruptions like border crossing restrictions may reduce access to the usual drug supply and lead to more harmful drug use patterns and greater exposure to more dangerous drugs.

Social distancing, a key measure in preventing the spread of COVID-19, may lead to isolation and potentially conceal a third of opioid misuse and mental health issues. People with OUD have disproportionately higher rates of psychological trauma and mental health conditions, the effects of which may be exacerbated by the isolation and exposure to a large-scale disaster, presenting an increased risk from opioid overdose.

A trade-off really exists in the choice to practice social distancing, which reduces the risk of COVID-19 exposure, but increases the risk of overdosing alone and decreases the opportunity for rescue through bystander administration of life-saving naloxone. Once the COVID-19 pandemics ends, whenever that may be and whatever that will look like, the challenges and implications for workers with substance use disorders will remain.

Workplaces represent a critical point of contact for Americans struggling with or recovering from a substance use disorder, and employment is a vital source of recovery capital. More than ever, workplace supported recovery can play a significant role in helping American workers lead healthy and productive lives.

So what is workplace supported recovery? Workplace supported recovery is an integrated set of evidence-based interventions and policies that eliminate workplace hazards that promote the development or perpetuation of substance use disorders and undermine recovery. They create workplace supports, preventing the development or perpetuation of substance use disorders and facilitate recovery.

They help employees maintain or regain employment during recovery and promote overall growth and wellbeing among employees, work organizations, families, and communities. This is all consistent with NIOSH's broad perspective on Total Worker Health, as Casey mentioned, which advocates for protection from work-related hazards and risks while also embracing prevention efforts both on and off the job to improve the overall wellbeing of workers.

So what does the recovery-supportive workplace look like? A recovery-supportive workplace aims to prevent exposure to workplace factors that could cause or perpetuate a substance use disorder while lowering the barriers to receiving care, seeking care, and maintaining recovery. This is accomplished in part by educating its management team and workers on issues surrounding substance use disorders to reduce the stigma that's really common around this challenge.

A recovery-supportive workplace understands the nature of substance use disorders and recovery as well as the factors that support the initiation of treatment and the maintenance of recovery. A recovery-supportive workplace encourages employees to seek treatment and initiate recovery early in their disorder. They provide access to evidence-based supportive resources for treatment and recovery, and it educates its management and workforces to make sure that they really understand the true nature of what substance use disorders are and what recovery can look like.

A workplace supported recovery program involves the implementation of comprehensive, evidence-based policies and programs aimed at reducing those risk factors associated with substance misuse. And that can look like preventing injuries at work that may lead to a prescription for opioids.

A program would also lower the barriers for seeking care, so making sure that you have comprehensive employee-assistance programs, for example. And really, it's assisting workers in recovery and employment goals, all while actively ensuring worker privacy and confidentiality. So a comprehensive program would focus preventing work-related injuries, as I mentioned, that could lead to the initiation of substance misuse while also decreasing difficult working conditions or work demands that might lead to daily or recurrent pain.

They promote the use of alternatives to opioids for pain relief when there is a workplace-related injury or illness with the goal of preventing the initiation of substance misuse. They provide information and access to care for a substance use disorder when it is needed, including access to MATs, medication-assisted treatment or medication-based treatment, along with individual counseling. They develop return-to-work plans and support second-chance employment.

They provide workplace accommodations and other return-to-work assistance. And they provide peer support and peer coaching to bolster those social supports available to workers in recovery. And I also have identified several areas of consideration for employers wishing to cultivate a recovery-supportive workplace. In the interest of time, I won't go over each of these today, but we do have more information on our webpage, which is linked on that handout that you'll see in the downloads.

I do want to talk a bit more about stigma, which has been really a recurring theme in our exploration of substance use disorders and recovery. So stigma can lead to prejudice, discrimination, social exclusion, and limited opportunities to participate fully in employment and other life roles. Stigma is not just experienced by individuals struggling with substance use or those seeking or undergoing treatment; it's also experienced by individuals who have already recovered from a substance use disorder.

Visible educational materials and consistent discussions of the actual nature of substance use disorders, treatment, and recovery may help reduce stigma and encourage entry into treatment and recovery. A key talking point for employers wishing to cultivate a supportive workplace is that substance use disorder is not a moral failing and that recovery is possible. We've developed some workplace recommendations adapted from the center on addiction aimed at reducing stigma around substance use disorders.

In addition to consistently affirming that substance use disorders are not a moral failing and that recovery is possible, workplaces can provide training to overcome misunderstanding and biases against individuals with substance use disorder. They can adopt health-promoting policies to raise awareness and support workers and their families. They can eliminate potentially stigmatizing terms from workplace language. And they can ensure that all policies are informed by science and supported by data.

So we're excited to announce that phase one of our NIOSH webpage on workplace supported recovery is live. And it covers a lot of the information that I've shared with you today. We are working on phase two of the webpage as well as additional resources, a journal article, a workplace solutions document, so definitely stay tuned for all of that on our website.

And that brings us to the end of our presentation. We don't often have such a unique opportunity like we do today to be able to talk with such a large and diverse group of stakeholders, so we definitely welcome any questions. But equally so, we're really eager to hear any feedback you might have about what we're working on, what needs you may have that we haven't addressed, what kinds of obstacles or barriers you may be experiencing.

We'd really love to hear it all, whether it's in the chat box or if you want to send either of us an e-mail later on today or later in the week. We would really love to hear what's on your mind. So I will open it up now for some discussion, and thank you so much for your time today.

MR. KIGHT: Okay. Thank you, Jamie and Casey. Thank you for the -- sharing this information with you -- with all of us today. As you know, Charlotte, one of my colleagues, and I had an opportunity to sit in on a couple of your presentations – (inaudible) – maybe a month or so ago, and we found this information so interesting.

And we thought that, particularly, our grantees could benefit from this information because the workforce system is trading in new territories here as well as -- I neglected to say that I also reached out to several of my colleagues over at the Department of Transportation as well as the U.S. Agriculture -- Department of Agriculture and invited them to participate as well.

And so with that, I see that we have several questions in the chat box. I don't know if you can see them, Jamie, but if you want -- if you can't see them, I will read them out to you. One was, "Casey, can anyone buy" -- is it naloxone or --

DR. CHOSEWOOD: Yes. Yes.

MR. KIGHT: -- "or is it only available by prescription?"

DR. CHOSEWOOD: Thanks, Robert. That's a great question. And it is pronounced "naloxone," but that's a mouthful there. The -- so the data that we have on this is quite encouraging. We did a scan of all 50 states in 2017, and this is referenced in our guidance document around naloxone, so I would invite people to take a look at the full document itself.

But the quick answer to this question, as of 2017 when we finalized this document, 43 of the 50 U.S. states had naloxone available without a prescription. There were a few holdout states that did not yet have that. But we understand that many of them now have passed state laws to allow for the over-the-counter purchase of naloxone.

We and -- I think someone in the chat mentioned this -- and we're also aware that a lot of local jurisdictions, state health departments, local health departments, community recovery and resources are providing free naloxone as well as instructions on how to use it for community members. So it is increasingly available, most oftentimes without a prescription.

Thirty-four of the states in 2017 had civil and criminal liability protections against people who would use naloxone. And also good Samaritan laws in almost all jurisdictions protect folks who intervene in the midst of an overdose as well. So that's good news on that front. And while we can --

MR. KIGHT: Okay. Thank you.

DR. CHOSEWOOD: We can see the questions now. Should we just – (inaudible) – down the list here?

MR. KIGHT: Okay. Great. Yes. Great. Great.

DR. CHOSEWOOD: Great. And Jamie, I am -- it looks like you are ready to go on question two and -- or I will do question two and three, and then it looks like we'll put a link in the handout as well. So let me go ahead and give you guys question two. The question is, "Will you be sharing examples of companies that have successful return-to-work programs in place?"

And you are exactly right. There are some companies that are doing just stellar work in this area. And one of the ones that we're really impressed with is Dartmouth Hitchcock Medical Center. Fortunately, they are one of our partners, and we featured them in one of our newsletters recently.

And we will get a link to their ECHO program at Dartmouth Hitchcock and share that with you as well. There are other examples that we will be placing on our website and in the resources that are on our workplace supported recovery pages that do reference other organizations that are doing great work in this [inaudible]. So it's a great question.

The next question asks, "Is NIOSH going to be working with SHRM, or the Society for Human Resources Managers [sic]?" And we are happy that SHRM is a NIOSH partner. In fact, we've done a number of press interviews with SHRM, and we're working a lot around policy development that will help inform the work of human resources and benefit managers already.

If you Google SHRM and NIOSH, you will find a couple of interviews that we've done in their publication that actually do a good job of outlining the relationship between NIOSH and SHRM. Jamie, I'll let you take question number four.

MS. OSBORNE: Yeah. So question number four is, "Do you have a link to NIOSH's Total Worker Health tool-kit for employers?" So if you look at the file share box at the bottom of the screen here, you'll actually see that we have an opioids one-pager, and that has a lot of links to all of our resources: Total Worker Health, our naloxone documents, our MAT documents, our workplace supported recovery webpage, a lot of our NIOSH science blogs. So definitely download those and check those links out because there should be everything that we've discussed today in that document.

DR. CHOSEWOOD: Great. Thank you for that. The next question is an important one: "How do we reach employers with this information so they can prevent accidents in overdoses?" That's an exceptional question, and NIOSH is always looking for additional avenues to get our message out.

As you guys know, we are really -- within the Centers for Disease Control, NIOSH is really closely aligned with our sister agency in the Department of Labor, and that's OSHA. We're not regulatory -- unlike OSHA, we're not regulatory, but we work closely with them. In fact, many of OSHA's regulations are as a result of the research and the surveillance and other policy development activities that arise from NIOSH. So -- and many folks see us as the research arm, or one of the research arms that informs much of OSHA's regulatory work.

So we're closely connected to employers, employer organizations, labor groups, unions, advocacy groups, chambers of commerce, health departments and their occupational help subsections, but we're always looking for new ways to get our message out. Two of the most powerful engines that we have at NIOSH are our eNews, our Total Worker Health in Action eNews, and our NIOSH eNews. And those are our large distribution platforms that we use to get the information out.

Robert, did you have something you wanted to share here?

MR. KIGHT: Yes. I also wanted to encourage our workforce services staff to think about your business services as you're out talking to employers. The workforce system can play a tremendous role as a facilitator to help employers connect with these resources, whereas we might be aware of them because we're on the inside. Many employers are perhaps struggling with this situation and have no idea of what these available resources to them. So we strongly encourage you to become the facilitator and share this information with employers as well.

DR. CHOSEWOOD: Great. Thank you for that. If you folks would like the most direct link to our regular resources on this topic, we would invite you to sign up for the Total Worker Health in Action eNews. And you can just Google Total Worker Health or NIOSH Total Worker Health, and that Google will lead you to our homepage for Total Worker Health. You'll be able to sign up for our eNews and all of our alerts and all of our publication releases using that linkage.

In addition to that, as Jamie mentioned, we have a suite of new resources on the way. And I think you'll find these really valuable. Our new resources are going to delve more deeply into the concept of workplace supported recovery. And I know that's a special area of interest for the people on the call today.

In addition, we plan new resources around the issue of impairment and work and even more -- expanding our current resources around the issue of cannabis and work. Now there's a host of states, more -- almost more than two-thirds of states have either some legal use of cannabis, whether it be for non-medical or for medical use, and that number's only growing. So there is additional call for guidance among our nation's employers around the issue of cannabis impairment and it's overlap with work.

Our next question is an interesting one, and as a physician, it's a question that I take very much to heart. So the question is, "Are there options for people who have to continue taking prescription medications due to illness and injuries that will never be healed or corrected?" And this really -- this question gets to the heart of the issue of managing chronic pain.

Unfortunately, there are a number of painful chronic conditions: cancer pain, joint pain, unfortunately all sorts of medical conditions that lead to pain day in and day out. And the issue there is oftentimes, non-opioid pain relievers, or over-the-counter pain relievers are not adequate. So what is the answer here, and how do you help those people without increasing their risk for opioid use disorder?

It's a very important consideration because most people believe and most people say a huge portion of the nation's opioid use disorder crisis is related to the heavy, heavy use of prescription opioids. In other words, it isn't like marijuana was the gateway drug to heroin. Unfortunately, the gateway drug to heroin was a prescription opioid that maybe someone got legitimately, or a prescription opioid from a friend, or a grandmother's medicine cabinet.

And that introduction to opioids led to a use disorder that then led to other pill use or heroin use, street opioids, if you will. And that cycle was seen time and time again and is likely, to some degree, still at play. One of the earliest products that CDC developed was a new set of prescription guidelines related to opioid prescribing.

And now in the country, we've seen a dramatic improvement and certainly far, far less use of prescription opioids. These guidelines recommend trying to find alternatives for pain control than opioids. Are there medications and other therapies and treatments, including alternative treatments and therapies like acupuncture or massage or physical therapy, for example, that diminish the need for opioids?

For that small subset of people who still need opioid pain control, having very clear prescribing guidelines, agreements with patients about how and when medications will be refilled and when doses will be changed, and having good accountability on both sides of prescriber and patient. There are also now national databases that are managed through states and overseen by the DEA that control the overprescribing of opioids among physicians and other prescribers. So this is an important concern, and I'm happy you raised that question.

The next question relates to this: "I know that alcoholism, which we would probably term 'alcohol use disorder' is a little bit less stigmatizing in general. I know that alcohol use disorder is covered under the ADA, but what about drug addiction to illegal drugs? Is this going to change?" Well, because there's been such a national attention to this issue, pain medication use disorders, opioid use disorders are actually considered a disability now.

This is a diagnosis under the formal official Diagnostic and Statistical Manual, or the DSM. And from a disability standpoint, almost all jurisdictions consider pain medication use disorders a certified disability. So that, I think, is important. It also gives employers with the -- of enough size to be under the guidance of the ADA. It gives them the responsibility to follow the law when it comes to accommodating people, to giving people FMLA benefits, to seek care and treatment, and to supporting -- another element of supporting their recovery and their return to work.

The next question is this. It says, "I work directly with clients in treatment to assist in obtaining and maintaining employment. Do you have resources I could use when working with clients directly?" I love this because I think, especially if you're dealing with employers, almost all our resources are developed with the needs of employers in mind, so the naloxone document for sure.

The workplace supported recovery documents are a rich resource that would be very, very valuable for helping workplaces develop a culture with many, many different interventions, policy changes, culture changes, training, awareness-raising, barrier-lowering, stigma-lowering interventions that can be put in place to make a recovery friendly, a recovery supportive workplace.

So definitely look at our workplace supported recovery pages. A quick way is just to Google "NIOSH workplace supported recovery" or "NIOSH opioids" and you will be able to get to that page. We're down to our final few minutes, and it looks like we just have a couple of questions left.

"How would you rebuild trust between a client and the health care system after prescription opioids led to an -- a pain medication or an opioid use disorder?" It's difficult to do. Oftentimes, as I mentioned, the gateway to illicit drug use is through prescription opioids. It might not always be possible to regain this trust; people might need a new health care provider to move them forward in recovery.

I think there -- the good news is that there's a growing number of educated providers who understand the nature of substance use disorder and what we need to do more in training even the best physicians in lowering their own personal bias and stigma about this issue. The treatment landscape is improving. Resources are going in the right direction to move people to having better options for substance use disorder.

Lastly, we have a question. I think we have time for this really quick one: "What would you consider one of the most important strategies to reduce stigma associated with opioid use disorder, and what would that be?" I'll take a stab at that, and then I would just ask Jamie if she has any final comments on this.

To me, the best way to lower stigma is to talk about this issue nonstop. Bring it up in every conversation, have awareness-raising activities, share personal stories that many of you've been sharing on the chat line. Those are powerful ways to make this a non-academic discussion and to make it one that's about people. And that is how we're going to change the hearts and minds of the people that we care about here. Jamie, do you have final thoughts?

MS. OSBORNE: I absolutely agree with you. I really think knowledge is power. And truly understanding the nature of a substance use disorder and the nature of recovery is going to be a huge step in lowering that stigma, just really understanding where people are at. We're working on a journal article right now that kind of delves into the nuances of workplace supported recovery and the nature of recovery.

And I know one of the statistics is that when someone with an opioid use disorder or substance use disorder has been in sustained recovery, which I believe is five years, their chance of relapse is actually the same as anyone in the general population developing a substance use disorder. So just really understanding that recovery is possible and what a substance use disorder is, that it's not a moral failing, that it is a disease, I think, is the best first step.

DR. CHOSEWOOD: Great. Robert, we'll turn it back over to you, and just would like to thank you so much for having us today.

MR. KIGHT: No. I say thank you for both you and Jamie participating in this webinar today and sharing so much information. And thanks to our participants as well. And I agree with you, Casey. Some of you shared some really touching stories, real life, personal experiences that bring home to us that this issue is really real, and it not only impacts people within the workplace who we try to serve but it also impacts many of our family members.

Here at the Department of Labor, ETA, we have an ongoing opioid work group, and that's where we were able to untap this tremendous resource over at NIOSH. And so as we continue our conversation and bring in other speakers, other guests to share information on what's going on out in the real world to address the opioid crisis, we will continue to schedule these kinds of events.

I think, from your participation today and the responses that I've read, you've found this to be very helpful. So again, thank you, and enjoy the rest of your day.

MS. CASERTANO: All right. I just want to thank the presenters. I'm going to ask our participants to leave us some feedback. If you look at the top of your screen, you'll see a feedback window where you can let us know what you thought of today's presentation. Please take a second to let us know what you thought we did right or how we can improve.

Just a reminder, you can find a copy of the PowerPoint as well as the transcript and the recording of today's session on WorkforceGPS in about three business days. And one last reminder to fill out that survey that's going to be e-mailed to everyone immediately following today's session. With that, please enjoy the rest of your day.

(END)