

# ***Chronic Musculoskeletal Pain and Opioid Misuse***

**Presented by: Mr. Carmine Tiano**

**February 8, 2024**



# PBCTCO

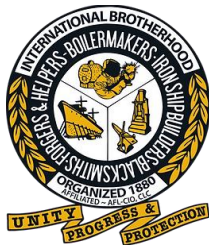
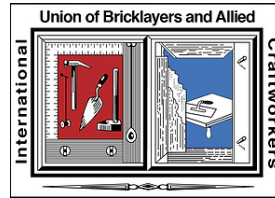
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- The Provincial Building and Construction Trades Council of Ontario (PBCTCO) was established in 1957 to be the collective voice of construction workers at the provincial level.
- Bringing together 16 affiliated construction trades, consisting of around 200,000 members.
- <https://www.ontariobuildingtrades.com/>

# BUILDING TRADE AFFILIATES

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# CONSTRUCTION TRADES

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- There are approximately 30 construction trades with laborers, carpenters, electricians, painters, plumbers, pipefitters, operating engineers, boilermakers making up the highest percentage of the workforce.
- Within trades there are sub-specialities.

# Construction Background



Workplace accidents and occupational disease affect construction workers at an alarmingly high rate.



The construction industry is totally different from industrial or service sector workplaces.



A typical construction project will only employ people until the structure is completed; then the employer moves on to another project.



The typical construction worker works from a hiring hall and will remain with the employer for only a few months.



Little continuity in the workplace nor is it likely that a worker will remain employed by the same company for a prolonged time.

# Construction Background



The trades employed on a construction project also differ considerably from one to the other.



The conditions of employment for a carpenter are far different than those of an ironworker or an electrician.



Each of the trades has its own unique task and thus unique needs and external/internal procedures to deal with workplace issues.



In addition to trade differences, individual construction locals are by and large autonomous entities.



This means that local unions within the same trade may have different procedures to deal with workplace issues.



For example, two Bricklayer locals, although representing workers in the same trade, will likely not share the same internal policies.

# Opioids and the Construction Community

In the recent report, [Changing Circumstances Surrounding Opioid-Related Deaths in Ontario during the COVID-19 Pandemic](#), of the nearly 2,500 opioid-related deaths reported in Ontario, 30% were employed in the construction industry.





# Opioids and the Construction Industry

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Industry (using the North American Industry Classification System)	Pre-Pandemic Cohort N=192	Pandemic Cohort N=264	P-Value
Construction	57 (29.7%)	78 (29.5%)	0.97
Retail trade	7 (3.6%)	15 (5.7%)	0.32
Transportation and warehousing	8 (4.2%)	15 (5.7%)	0.47
Health care and social assistance	9 (4.7%)	14 (5.3%)	0.77
Accommodation and food services	12 (6.3%)	12 (4.5%)	0.42
Manufacturing	10 (5.2%)	12 (4.5%)	0.74
Other services*	46 (24.0%)	61 (23.1%)	0.83
Other Trades**	11 (5.7%)	15 (5.7%)	0.98
Unknown	32 (16.7%)	42 (15.9%)	0.83



# Men in Trades are Disproportionately Impacted

- Since 2016, around  $\frac{3}{4}$  of opioid-related deaths were men.
- Men in trades are overly represented.
- Of people who were employed at the time of death, **30-50% were employed in trades.**





# Hard, Physical Labour Takes a Toll

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- Hard physical labour takes a toll on the body.
- It increases the risk of injury and can result in pain.
- When taken properly, pain medication like prescription opioids, can help manage pain.
- Some workers take higher doses of opioids or seek illegal opioids to keep working through pain which creates a **higher risk for addiction & harms.**





# Work Hard, Play Hard

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Many trades workplaces have a “work hard, play hard” culture, especially outside of work.



Men are more likely to use substances to cope with stress or mental health issues.



Men are less likely to reach out for help because there is a pressure to be “strong.”



# Five Drivers of Drug Dependency

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The DeNovo Treatment Centre (<https://denovo.ca/>) conducted a study in 2021 called the “5 Drivers of Substance Addiction/Suicide”.

Which lists the five key causes leading people to substance dependency and/or to suicide.

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|--|--------|
| <b>1. Work Habits &amp; Schedule</b>       | 44-49% |
| <b>2. Personal Relations</b>               | 45-47% |
| <b>3. Stress, Anxiety &amp; Depression</b> | 40-41% |
| <b>4. Finances</b>                         | 35-44% |
| <b>5. Discrimination &amp; Abuse</b>       | 24-26% |



# Five Drivers of Drug Dependency

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## 1. **Work Habits and Schedule (44-49%)**

- Physical pain due to the kind of work involved.
- Long working hours.
- Not eating properly or following a healthy lifestyle.
- Working in shifts which can cause irregular sleeping patterns and/or trouble falling asleep, feeling tired and low on energy.

## 2. **Personal Relations (45-47%)**

- Staying away from home and/or family for extended periods of time.
- Living on the go, travelling a lot, staying in hotels and not being able to spend enough time at home.
- Inability to maintain relationships.
- Feeling isolated and cut off from family and friends. Not having anyone to talk to. Feeling of being alone or lonely.



# Five Drivers of Drug Dependency

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## 3. Stress, Anxiety and Depression (40-41%)

- Work-related stress.
- Feeling sad, depressed or hopeless.
- Feeling anxious, restless or uneasy. In fact, people with a mental illness are twice as likely to have a substance dependency compared to the general population (Rush et al., 2008).

## 4. Finances (35-44%)

- Financial insecurity.
- Inability to pay bills.
- Uncertainty about the next job and/or obtaining a new job.



# Five Drivers of Drug Dependency

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## 5. Discrimination and Abuse (24-26%)

- Includes bullying by colleagues and/or supervisors.
- On-the-job site physical, verbal or mental abuse.
- Difficulty with fitting in with colleagues.
- Being from a different racial or ethnic background (being non-white). Speaking a different language.
- Discrimination by gender (i.e., being a woman in a male dominated industry) and/or sexual orientation. Sexual harassment.

# Workplace Barriers

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# 1. Stigma & Compensation Landscape:

## Not Supportive

- Many construction workers do not report “wear and tear injuries” due to stigma and fear of employer retaliation.
- Even when “wear and tear” injuries are reported to a compensation provider, they are routinely denied.
- In Ontario, the Workers Safety and Insurance Board (WSIB) continued aggressive approach to adjudication has created challenges when dealing with entitlement issues.
- Too often, gradual onset disablements are denied, even when all, or almost all, medical evidence supports work relatedness.

# 1. Stigma & Compensation Landscape:

## Not Supportive

- Attributing ongoing symptoms to a pre-existing condition has become the main tool to limit benefits for work-related injuries.
- WSIB has regularly denied ongoing entitlement where workers have not recovered from a strain or musculoskeletal injury within the “expected” recovery time.
- Older workers have been especially hard hit. WSIB tells these workers their injuries should have healed and blames any ongoing symptoms on age-related degeneration.
- Result: Workers do not claim for benefits, and they struggle with pain. Which often leads to substance use.

# 1. Stigma & Compensation Landscape:

## Not Supportive

- WSIB Adjudicators do not take the time to interview the injured worker, take the time to understand the tasks performed, or equipment used.
- Often previous claims are ignored or used against the injured worker.
- Loopholes such as timelines to file etc.
- Claims denied based on ignorance of Adjudicator.
- WSIB process is designed to be frustrating, and tedious so workers will not file/drop their claim

## 2. Reluctance of Workers to Report & Seek Treatment

- The social stigma and potential for job loss if opioid use (whether legal or illicit) becomes known to co-workers and supervisors.
- A major issue in the construction sector is the underreporting of injuries.
- The underreporting of injuries further obscures the relationship between workplace physical demands, pain, and opioid use.

## 2. Reluctance of Workers to Report & Seek Treatment

- The fact WSIB routinely denies “wear and tear injuries”, coupled with the under reporting has created **landscape/environment** where we do not know the true burden of musculoskeletal injuries.
- Nature of work often makes scheduling a Doctor’s appointment difficult
- If we do not know the **true burden of musculoskeletal injuries** and associated pain how can employers, unions, and regulatory partners insure adequate prevention and treatment options.

# Moving Towards a Total Worker Health (TWH) Perspective

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TWH is relevant because opioid use can involve both personal risk factors such as age, gender, fitness, occupational identity, and health history.



Workplace factors, such as physical demands, hours of work, job insecurity, and time pressures.



Work-related back injuries, for example are common in the construction industry and frequently lead to opioid prescriptions.

# Moving Towards a Total Worker Health (TWH) Perspective

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TWH is defined as “policies, programs, and practices that integrate protection from work-related safety and health hazards with promotion of injury and illness prevention efforts to advance worker well-being.”



The TWH perspective examines the shared responsibility and opportunity for health and well-being between those who control the conditions at work.

# **Policy and Program Activities Across the Continuum of Care**

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<b>Agent</b>	<b>Problem</b>	<b>Actions</b>
<b>Government</b>	Compensation Landscape Not Supportive	Review the Workplace Safety and Insurance Board (WSIB) entitlement policies. (Gradual onset and chronic mental stress policies)
<b>Government</b>	Few non-pharmacological treatment options available for acute or chronic pain	Provide local/community access to high quality pain management programs applying behavioural principles, interdisciplinary care, and a bio psychosocial framework.
<b>Government</b>	Health and safety working conditions.	Ongoing inspections/enforcement targeting musculoskeletal hazards and workplace hazards.

<b>Agent</b>	<b>Problem</b>	<b>Actions</b>
<b>Government</b>	Musculoskeletal (MSK) injuries approached as a singular, localized issue	Following the biopsychosocial-emotional multimodal research of injury/pain treatment/ management, expand research of biopsychosocial-emotional factors that contribute and/or exacerbate MSK injuries.
<b>Government Employers Union</b>	Limited awareness of job MSK/ biopsychosocial-emotional expectations, exertion, and strain	Provided job operational evaluation of MSK/biopsychosocial-emotional expectations, exertion and strain including but not limited to biomarkers, skills development, functional application skills, communication.
<b>Government Employers Union</b>	Prevailing approach to MSK injury pain is avoidance & is symptom reactive	Provide proactive, restorative programming & resources supporting active wellness; optimal mind/body conditioning & preparedness relative.

Agent	Problem	Actions
<b>Government Employers Unions</b>	Healthy/ not healthy perspective of pain and injury can be exclusionary and divisive.	Expand perspective of injury/pain to include a graduated assessment of an incident and accessibility to non-opioid based resources balanced by an optimal successive plan.

Agent	Problem	Actions
<b>Government</b>	No musculoskeletal (MSK) strategy.	<p>A successful management of MSK requires a wide range of interventions, mainly at the workplace level. These include:</p> <ol style="list-style-type: none"><li data-bbox="884 264 1806 411">1. Increased Inspection as there is insufficient enforcement of the manual handling and ergonomic hazards in the workplace.</li><li data-bbox="884 425 1806 521">2. Beginning to develop Ontario's first Ergonomic standard and supportive regulations.</li><li data-bbox="884 535 1806 735">3. Employers are over-reliant on training to address MSD issues; instead, they should be using risk assessment to reduce physical exposures.</li><li data-bbox="884 749 1806 949">4. The quality of manual handling training is inconsistent and often poor. Develop consistent and uniform training standards for material handling.</li><li data-bbox="884 963 1806 1120">5. Poor workplace design can increase the need for manual handling, which consequently reduces productivity.</li><li data-bbox="884 1135 1806 1278">6. A poor ergonomic set up of equipment contributes to musculoskeletal injuries and consequently, reduces productivity.</li></ol>

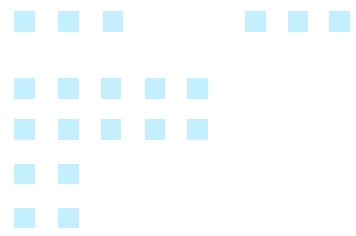
Agent	Problem	Actions
<b>Government</b>	Absence of research on the workplace factors and interventions to prevent OUD.	The prevention office and other funding agencies prioritize work environment and prevention of opioid-related deaths. Specifically, in the construction sector the relationship between workplace hazards and chronic musculoskeletal pain and opioid addictions.
<b>Employer</b>	<p>Workplace Occupational Health &amp; Safety Programs are not holistic.</p> <p>Conventional health promotion practice generally focuses on personal risk factors and individual behavior change.</p>	<p>Move to a Total Worker Health (TWH) model organized around the paradigm of integrating traditional occupational safety and health protections with workplace health promotion.</p> <p>The TWH can be put a broader emphasis on workplace programs for enhancing worker safety, health, and well-being.</p> <p>Training often provided as the only prevention technique, or to meet government requirements.</p>

Agent	Problem	Actions
<b>Employer and Unions</b>	Workers received little education about risks and treatments for all OUD	Expand existing safety, apprenticeship, and workers wellness training programs. This can incorporate information about opioid risks, non-pharmacological pain management alternatives, and how to access confidential care.
<b>Unions</b>	Employee assistance programs (EAP)	Ensure appropriate supports are provided to members for MSK pain, mental health, etc.

Agent	Problem	Actions
<b>Government Employer Unions</b>	Limited incorporation of Trauma Informed Practice in support of MSK injury/pain and Opioid misuse	When MSK injury/pain and opioid misuse is exacerbated by trauma support can be expanded in the in the following ways: <ol style="list-style-type: none"> <li>1) Assessment / Treatment determining vicarious, individual environmental impact.</li> <li>2) Impact related to regulation, coping executive functioning and new learning.</li> <li>3) T.I.Adapted learning &amp; education of workplace supports</li> <li>4) RTW programs w/ “real time” functioning w/ guided support, training, data collection, measurable goals</li> <li>5) Family systems support w/ education regarding MSK injury/pain, opioid misuse, and trauma</li> </ol>
<b>Government Employers Unions</b>	Limited workplace education and practices specific opioid misuse /harm reduction awareness and overdose prevention	Given the growth movement toward harm reduction vs abstinence policy development, awareness and skills training is required to support the worker, reduce the stigmatization, and inform employer of best practices. Including awareness of.

Agent	Problem	Actions
<b>Worker</b>	Lack of reporting/seeking medical attention	<ol style="list-style-type: none"><li>1.) Document your employment history claims often denied due to gaps in work history.</li><li>2.) Record type and duration of equipment used</li><li>3.) Seek medical attention for pain/injuries. Most WSIB claims denied due to lack of medical continuity</li><li>4.) If injured on the job document who witnessed and/or get a statement</li><li>5.) Do not be forced to not file a claim this can result in future denial of new claims for reoccurrences</li></ol>





**Thank you.**

**For a copy of this presentation, please  
contact me at  
[carmine@ontariobuildingtrades.com](mailto:carmine@ontariobuildingtrades.com)**