

**PEER ADVOCACY FOR
CONSTRUCTION WORKERS
STRUGGLING WITH SUBSTANCE USE
AND MENTAL HEALTH**



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Introduction

Construction work is physically demanding and can lead to injury more often than other types of work. To get them back to work quickly, health care professionals have prescribed opioids to construction workers.¹ The longer and the higher the dose of the initial prescription dramatically increases the risk of addiction, opioid use disorder, and overdose. The construction industry is a vital part of the US economy—what happens in the building trades has social and economic implications for our communities.

Opioids are impacting construction workers at alarming rates. NIOSH's 2018 study of overdose deaths by occupation found construction workers to have the highest risk and that opioids were the leading cause of overdose.² In 2017, a study conducted by the Cleveland Plain Dealer newspaper that analyzed death certificates in the state of Ohio observed that construction workers experienced seven times more fatal opioid overdoses than the average worker for all industries.³ A Massachusetts study underway at the same time showed similar results.⁴ Several feature articles have been written documenting both the toll of the epidemic on the sector and responses from contractors and unions.⁵⁻⁷

In response to the crisis, the North America's Building Trades Unions (NABTU) formed an Opioids Taskforce comprising unions, employers, and employer associations. The task force adopted a public health model to generate an action agenda of primary, secondary, and tertiary prevention activities. For example, because we know that injuries can lead to prescription, the task force identified preventing workplace injuries that cause pain as a primary prevention intervention. In secondary prevention, a key goal is to empower construction workers with awareness and tools to promote non-opioid pain treatment. For tertiary prevention, the taskforce explored what can be done to help workers who already have a substance use disorder, including expanded access to treatment and ongoing recovery support. Several unions already had robust member assistance programs prior to the opioid crisis. Many of these programs were led by "peers" – construction workers in recovery who could serve as mentors for their brothers and sisters in the trades as they went through treatment and recovery.

Peer advocacy for individuals struggling with substance use or mental health is not a new approach.⁸⁻¹¹ Mutual aid modalities of peer support, typically provided in the context of 12-step groups, such as Alcoholics Anonymous, are commonly used by construction workers in recovery.¹² There has also been a growth of a peer workforce in behavioral health. Organizations such as Labor Assistance Professionals that train, mentor and certify peers in the labor movement to provide assistance to those seeking help. (www.laborassistanceprofessionals.com) Many construction unions' member assistance programs are staffed by individuals who have LAP-C certification. There are also professional training standards for peers established by the federal Substance Abuse and Mental Health Services Administration.¹³ Several construction unions have led initiatives to develop in-house member assistance programs that link workers with workers, e.g. bricklayers with bricklayers – to navigate the challenges of long-term recovery.

This paper presents the findings from focused telephone interviews with members of the NABTU Opioids Taskforce to uncover what is currently being done to curb the opioid problem in construction through peer advocacy networks and similar actions. To our knowledge, this is the first qualitative evaluation of peer advocacy programs in the construction industry. The report discusses key gaps in knowledge and provides questions that could inform a future large-scale evaluation of these important strategies.

Methods

Our goal was to understand unions' responses to the opioid epidemic and assess the characteristics of peer advocacy programs in our building trades networks via structured interviews. Dr. Cora Roelofs, our consultant who is a researcher at the University of Massachusetts with expertise in construction safety and health, qualitative methods, and opioids developed an interview instrument based on survey-style questions provided by CPWR. Questions were designed to encourage open dialogue between subject and interviewer with multiple follow-up questions for each area. The instrument included inquiries about the unions' reactions to the opioid crisis and specific interventions, particularly peer advocacy. (see Appendix A for the instrument).

Members of the NABTU Opioid Task Force were invited to participate. Each of the 14 NABTU unions has a representative on the task force and these individuals were the best source of information about local and international union response to the opioid crisis. Some international unions were not represented in the project because the individuals declined or did not respond to efforts to be interviewed, and in some cases, individuals who participated did so by stating that they could only speak for what happens at the local union level (see Appendix B for a list of interviewees).

Interviews were recorded and transcribed. After transcription, transcripts were edited to include only information pertaining to peer support. These transcript pages were read by the researchers to determine themes. Researchers then met to share themes and agree on a set of master themes. The transcripts were then coded based on the master theme list.

Results

Sixteen individuals representing 13 unions or trades councils participated in interviews. The following is a summary of the themes expressed in the key informant interviews which pertained to peer advocacy programs. Themes included the following: Explanation of Peer Advocacy; Who Should Be a Peer; Barriers (Insurance, Buy-in, Stigma, Trust); Connecting Members; Employee Assistance Programs; Planning, Program Design; and Recovery.

Explanation of Peer Advocacy

Key informants described peer advocacy as a very wide set of services, or a specific narrow set of services, depending on the union. For most unions, peer advocacy refers to programs that utilize trained members ("peers") to assist other members in accessing services for substance use disorders (SUDs) or mental health disorders and to support members after they have returned to work following treatment. Peers are paid by the union or benefit fund and work for a "Member Assistance Program" or "Employee Assistance Program (EAP)", or they are volunteers who work full-time in their trade. They most often have received some training and some have received certifications in providing peer support.

Several interviewees stated that peers must be in recovery for a substance use disorder to be selected, but that it is not the rule. What defines them as a "peer" is that they are a fellow union member in the trades. There was nearly universal agreement on what peers' responsibilities were. Several interviewees said that peers are considered to be "first responders" or "first aid" for mental health and SUDs. Nearly all interviewees stated that peers were in place to refer members to services. It was iterated that peers do not have licenses and cannot offer clinical advice, but they can point people to services and share their own experiences with navigating the system and recovery.

Respondents reported that peers should be easily identifiable in the worksite and union hall. This can be achieved by the peer being comfortable telling others about recovery and making it clear that the peer is willing to be a guide for anyone seeking help or treatment.

First of all, the peers are not licensed clinicians. They are not at a higher next level of care. They are doing basic first aid with people who are struggling. One of the things we teach is the three R's: recognize, react, and recommend. We've all seen people struggle on jobsites. But it's what you do with it. You can recognize someone who comes in hungover, that is struggling with alcohol or drugs. You can recognize someone who is out of sorts and have something on their mind other than the job at hand and you can react to it.

Several interviewees mentioned that in addition to being available in the workplace, peers organize and lead support groups at the union halls on a regular scheduled night. One interviewee stated that this meeting was considered a “building trades support meeting” and was focused on mental health and other issues, in addition to alcohol or SUD. Another interviewee explained that the union’s intention was not to duplicate AA or NA, but to offer a meeting that could encompass many issues and be supportive of both members and family members struggling with a mental health disorder, SUD, or an affected loved one.

Explanation of who should be a peer

Interviewees identified that people who are in recovery are the most obvious choice to be a peer, but that it is not a requirement for volunteer peers. One interviewee stated that volunteers without SUD often have close family or friends with mental health disorders or SUD and are motivated to become a peer because of their experience. Several respondents stated that communication skills, empathy and being perceived as being trustworthy are the most important peer attributes.

People that are in recovery—that embrace long-term recovery—want to give back. They are naturals to become peers. A few of the peers were in recovery and want to give back. We've had some other people who have had some family history that want to give back and makes things better. And we've had others who have heard about the program and said “hey I want to help” By no means does it mean you have to be in recovery or have behavioral health issues.

Several interviewees stated that a supervisor or foreman is not appropriate for this role. They explained that members would not speak openly with someone who has power over their employment.

I get how union business managers, while trying to help solve the addiction problem, address it like other problems: “lets get all of our supers, foremen and stewards in a room and teach them what to look for and ask those members if they need help”. The last person someone struggling with SUD is going to be honest with is someone who has some power over their job. Same goes for a business agent or JATC training instructor.

Barriers

Most interviewees mentioned barriers to implementing programs that pertain to substance use, including peer advocacy. The theme of barriers was introduced in the following contexts: insurance, buy-in, stigma, and trust.

Barriers: Insurance

Several interviewees mentioned that insurance benefits and the way in which benefits are structured can determine if a member receives an appropriate level of care. One respondent stated that the mental health parity guaranteed by federal law does not ensure an appropriate level of care. One respondent pointed out that because SUD and mental health disorder treatment often means the individual is unable to work while being treated, an individual can lose health benefits. The example given was that there are members who are able to enroll in a treatment program, but when the level of care requires residential treatment and the union member is unable to work he or she can “lose hours,” which means not working enough to keep benefits administered by their multi-employer fund, including health care. These members are then forced to leave treatment if unable to pay out of pocket. One interviewee suggested a solution to that issue.

I would love to have some sort of gap fund. Insurance is generally there to try and not pay. Even mental health parity feels like a wink and a nod. [The gap fund would] make sure a member doesn't get booted out because they ran out of hours. People don't go to treatment on a winning streak—we all know that, but they are going in with the least amount of support and resources they've had in their life. We want a system that will hold them for an appropriate amount of time. [We're] always fighting—always a battle. We want to develop some sort of fund to fill those gaps. I think something like that would be tremendously useful.

Barriers: Buy-in

Several interviewees suggested that is not possible to implement peer advocacy program without buy-in from all levels within a union or contractors' association. Several respondents mentioned that buy-in for members can occur through education, stigma reduction and trust (to be discussed below). Other respondents felt that getting an organizations' decision makers to buy in to programming for peer advocacy is the first step in organizing a program.

I didn't have that much of a barrier because I had support from our leaders. That's where this comes from, it comes from the top. I can probably go to any unions, any org, any local, and you'll have two things. You have the administration that embraces program and the ones that need to be educated on the program. It's that simple. If you have buy-in from the top you can make anything work. If the top admin doesn't believe in it, it's not going to work because you won't have the resources and the ability to build it—whether it is comes from a bottom up or top down program.

One interviewee suggested that making a personal plea is one way to get individuals to buy in to peer advocacy.

You know me, I speak from the heart. It has affected a lot of people I know, and myself. But I don't approach them from the heart. I approach them from the possible. I say, "it's important to understand that these things are now affecting their own kids' lives and families." Now their ears are open a bit more to say, "how do I get involved, what do I do?" So I think we have more of an audience at the contractor level.

It was also suggested that in order to get decision-maker buy-in it is imperative to show that investing in programs will positively impact the contractor's bottom line because most people can be persuaded by one of these two strategies (the personal plea and pocketbook approaches).

So we took an approach with contractor associations—talking about what these issues look like on a human basis and what issues look like on the pocketbook. What will it cost if you don't do this? We we're able to show that for every dollar you invest you get 4 [dollars] back.

Barriers: Stigma

The idea that continued stigma reduction must take place was ubiquitous among those interviewed. Interviewees used the term stigma to refer to an induced shame, humiliation or label of disgrace that can be associated with having a mental health problem, SUD, or suicidal ideation. They said it is a barrier to getting help, asking for help, or to successful recovery. There was agreement among interviewees that unions can better assist members with SUD if those individuals do not feel stigmatized for needing help.

That's why peer support is so important. That's why talking about it at a local and national level, doing our part to try and kill the stigma behind mental health and SUD and suicide prevention. Addiction dies a little bit when we shine some light on it, when we exercise a little humility and faith in sharing our own struggles, we chip away at stigma. All of that is going to be building blocks that can help our members stay sober during some of the most vulnerable time, early recovery and first few months up to that first year.

One interviewee used the metaphor of stigma creating a wall between the person and the ability to get or ask for help.

So when we've built that wall, and we haven't taken one brick out of it and then you're expecting employees to come to you for help—it's just not going to happen overnight. We need to build an education program for contractors and association groups to understand how to break the wall down.

Barriers: Trust

Trust as a general barrier came up for many interviewees. Trust was described as an issue related to trusting peer advocates, the services to which they referred, the EAP or treatment facility, the union to have the best interest of members in mind when making decisions, and that one's job was not at risk if a member were to ask for help or go to treatment. Several interviewees agreed that that peers should be perceived as trust-worthy by members and that this is accomplished by ensuring that peers advocates are not in a position of authority over members. It was stated that peers need to be worker-colleagues, rather than a foreman or business manager. One interviewee attributed program underutilization to using peer advocates in authority positions. Several respondents suggested that preserving members' privacy is a key component to program utilization.

As with any organization you have the administration and union officials and people feel if they go to a problem with a union official they will be ostracized and it will hurt your working status. Whereas, if you have members that have spent more time with each other out in the field on job sites talking and promoting good health practices, we're finding that members are more apt to ask for help, knowing that it is a confidential-based program and that we can point them in the right direction to get the professional services they need.

Several interviewees stated that members need to know that their employment is not at risk if they ask for help—that they will not be blacklisted by a contractor, or that they will not be considered to be a problem employee. One interviewee suggested that a “no wrong door policy” is one way to address this issue.

That's what I call an 'open-door policy/no wrong door policy', which I'm building for the contractors association right now. It means that an employee should be able to knock on a door and have a conversation about mental health or SUD with no judgement. Then you should know what to do with that person—know how to get them help and accommodate them when they get back to work.

Respondents felt that, ultimately, peers need to be trusted individuals and without trust, programs will not be utilized by those members who need help or resources.

Connecting members

Several interviewees reported that connecting struggling members to other members in recovery is a facet of peer advocacy that gives members hope in an creating a future that includes recovery and abstinence from substances. Several respondents described peer advocacy programs where peers facilitate support groups. These can be open to the members, spouses, and dependents and the purpose of meetings can run the gamut from SUD and mental health support for those directly in need of services, or education about these issues for a friend or family member. Most importantly, it was pointed out that when support group meetings are integrated with peer advocacy, it gives individuals hope because they see others who are living in recovery.

Now our peer advocates have a conversation with them— they have an identity— “Joe’s a brick layer,” and they can connect. So, there is comradery built in. The real nuts and bolts of this program is the parking lot—after the meeting. You can see people who had no hope, and after the meeting you are seeing people smile and engage and see them start to realize there is hope.

While the support group format was utilized by several unions, one interviewee mentioned that the stand down model is one way that peer advocacy and individuals asking for help is getting traction in the industry. Similar to the fall prevention stand down, a stand down is where time is taken out of a work day for everyone to focus on SUD prevention and recovery.

We are starting to look at a stand-down plan similar to what’s happening up in Boston which has been impactful. Identifying first job sites for stand down to help and encourage workers to come forward. Info being disseminated through stewards on the jobsites and foremen and the partnerships with employer-industry side have been critical to get it out to workers. The partnerships with prime contractors and construction management firms have been effective helping union reach workers who are on the job sites.

Employee Assistance Programs

Multiple interviewees mentioned that peers need an EAP with robust services to which they can refer individuals. These included counseling or talk therapy, inpatient treatment, outpatient treatment, and support groups. EAPs are services offered by an employer or benefit fund to employees for free. They are often a way for an individual to get short-term help or referred to a professional who is covered by the employees’ insurance plan. A Member Assistance Program (MAP) is similar an EAP, but it is offered by the union rather than the employer. Employers and unions can choose to conduct EAP and MAP services in-house, or they can be contracted out. This can affect how much control the employer or union has over the services offered.

Several respondents stated that referrals for services is best achieved by having an EAP in place and EAP’s services need to be audited from time to time to ensure evidence-based practices are being employed. Several interviewees showed skepticism in the EAP’s ability to offer appropriate levels of care if they are not held accountable by an outside agent.

We don’t think that some of our big EAPS are offering correct advice [regarding] not only level of care, but how long and which treatment they should go to.

One respondent stated that when an EAP is well-run, it can be the difference between getting a member help in a timely manner versus missing a critical window.

We can get them to a licensed clinician in a matter of hours and not days weeks or months. We’ve retained a licensed clinician on staff that is available to us 24/7 so they can get help when they need it and how they need it.

Planning

Several respondents talked about the importance of planning, goal setting, and flexibility as facets of a successful peer advocacy program. One interviewee described the process of organizing the educational program that supports peer advocates. It was mentioned that peer advocacy programs must fit the needs of the members. This can be done by surveying members, but it is also possible to work with the EAP and see what diagnoses are most common. A peer advocacy program can then be tailored to meet these needs.

We started the peer advocacy program, and it took a long time to get the training and education perfect. We did a lot of surveys. Who is the customer? What does it look like? What are the needs?

One interviewee described how setting goals for establishing a peer program allows for unions to track success and stay focused. When reading these goals the interviewee learned that they were ahead of schedule.

I pulled up our five-year plan. For 2019, we were supposed to build online training and then start peer training—which we have done. In 2020-22, build the peer network and develop the 3 -day peer program—which we have done.

Several respondents described a desire for a peer advocacy road map to be established for the trades. Some interviewees advised against this, saying that a cookie-cutter approach will not work and that these programs will not be successful or sustainable.

My wish list for the building trades is to establish a building trades-wide peer recovery program or even a road map for how to set up a local program. I think sometimes people really want to initiate things, but they just don't know how to do it. I find the easier we make it for them to implement [a program], the more likely they are to do it. I believe with something like this we can figure out what that looks like without recreating the wheel, and not stepping on the Labor Assistance Professional's toes. Just a very easy A-B-C/1-2-3 peer program roadmap: Where does someone even start if they are in recovery and they want to help people. What should they do?

One interviewee discussed struggling to establish a national union peer advocacy program because health insurance is administered through many local joint labor management funds across the country. These funds determine the types of benefits available, and the benefits vary. This is one of the reasons a cookie-cutter plan, or a single national approach, may not work.

Peer Advocacy Program Design

There was not consensus on peer advocacy program design among interviewees. One respondent described program design as being slow and iterative. Creating a peer advocacy program may have an obvious formula at first glance, but once in place, the issue of referrals becomes integral to a successful program. This interviewee suggested that having trusted providers who practice evidence-based treatment can only be accomplished by checking each provider one by one.

[We have] hired experts for analyzing treatment centers nationally. We can find and build a preferred provider list so we can offer a negotiated, discounted rate for local unions at what we consider to be the best treatment centers in the country. We are in the process of [reaching out], Local by local, EAP by EAP, health plan by health plan, to include those treatment centers for consideration when members need drug and alcohol/SUD treatment.

One respondent described a process to meet members' needs and be able to adapt when these needs change. This interviewee suggested adding educational modules to the peer advocacy training to expand their competency in assisting members.

The program wasn't addressing what happens when someone gets back from treatment. So, our peer advocate training started to build around relapse prevention and educating people about the disease model, and about breaking down stigma in the workplace. We ended up adding another 16 hours to the training on other topics around the support system, so when the person comes back to workplace, [peers know] how to engage that person with support. And how to keep them connected to their treatment programs—that was the piece that really excited me about the program.

Respondents described as many designs as there were programs. One respondent stated that they were building a team of experts to disseminate the peer training program as opposed to using a train-the-trainer model.

We are not wild about train-the-trainer, I've seen that in other unions, but I think we can do better by building teams of mental health professionals and Subject Matter Experts. We are going to build those teams and send those out to respond to local unions. We are in the process of building the second team. We will have a couple suicide prevention people, experts on confidentiality, ethics, all of the different things we might be teaching, community support process, and mental illness. We are in that process so we can get more local unions involved with this training.

Some peer advocates have started peer support meetings that are held at the union hall. These can take different forms, but are often designed to supplement to AA and NA, meaning that they are not SUD-only meetings. Meetings can be support-based or educational, depending on the union. Topics range from mental health, SUD to other issues. They can be attended by members or families and dependents. One interviewee pointed out that connecting members to trade-oriented support meetings before they have even left treatment, i.e. having those in treatment attend this meeting can be a positive way to jump start aftercare.

Our treatment providers, working in collaboration with me and my group, bring our members who are in treatment facilities to the group meeting. Now we have all the people that are in treatment come to an outside meeting. When they get there, they might be a little uncomfortable at first, but our peers are there and they introduced to the peer advocates at that meeting.

Recovery

According to interviewees, a central reason that peer advocacy was established was to prevent relapses by connecting members who have finished treatment to others in recovery. Peer advocacy programs recognize that relapse can be part of recovery, that unions can act to reduce relapse triggers, that 12-step meetings can be helpful, and that peers can support members in recovery. One respondent mentioned that, although his union has put time and effort into making sure members have access to evidence-based treatment, his members were relapsing at an alarming rate when they get back to job sites. He responded to this by making changes to the peer advocacy program so that the peer advocates' education includes recovery and support on the job, in addition to training for the "first aid" model previously referenced. This respondent worried that the impacts of great treatment can be quickly exhausted by not having supports in place when the person returns to work and needs help navigating the pressures of living and working around triggers.

We really haven't thought out that support piece at all. And that's where we go back and say, we have three of the things right, but the last one's not working and it's breaking the whole system. That's when we start to see relapse and redundancy, and we see payers fed up with how many times people are going back to treatment. So, we haven't really fixed the problem yet if we haven't fixed that support piece.

This same respondent suggested that peer advocacy can aid recovery in general and especially when one returns to work after an inpatient treatment. The first year is an especially trying time for those in recovery, and having active peers can be one way to combat relapse and foster active recovery during this difficult period.

Several respondents pointed out other ways in which unions have inadvertently promoted a drinking culture. This may happen on the job, but one union suggested that annual conferences are a time when drinking can be promoted. One solution is to not have a bar or free drink tickets at the annual conference and offer AA/NA meetings for members in the evenings during the conference.

After a conference we often have a 5-6 happy hour: "here's 2 tickets to an open bar." We all know those can be passed around. We scratch our heads, what are we doing here? From time to time there's the guy where one beer turns to 15 beers and we are partly to blame. Maybe we have to look in the mirror because we are putting someone in a situation that's too tough for them. Going forward, for any conferences we have we'll be sure to set aside a room or location where participants can have the option of attending an AA or NA meeting.

Discussion

Seven of the 16 interviewees represented unions or trades councils that have a peer advocacy program and were able to provide information about the processes of designing, starting, or running a peer advocacy program. Interviewees' experience with peer advocacy was varied. Some interviewees had started peer advocacy programs or run these programs for the union, while others had proximal knowledge about the peer advocacy program or had spoken with individuals running peer advocacy programs for the union prior to the interview.

There are several unique characteristics of peer advocacy programs in the trades. First, nearly all peer advocacy programs in the trades are staffed, at least in part, by unpaid volunteers. These volunteers are members of the union who are known on worksites and in the union halls to be peer advocates. Furthermore, peer advocacy in the trades does not focus on only one type of disease or disorder. Peers may have a SUD or mental health disorder; however, this was not a requirement to be a peer volunteer for most programs. For these programs, peers are peer-workers first.

While programs varied in their focus and reach, most programs centered on referrals and support for members entering and leaving treatment. Most had training programs for peer advocates, although the approach to training varied with some relying on SUD and mental health professionals while others were training peers based on their own program experience. Both the training programs and the peer advocacy programs were described as needing flexibility and adaptability to help the programs navigate the diverse needs of the members. Some program administrators utilized surveys and program evaluation to determine new directions and needs. Program success was dependent on union, contractor and member buy-in and trustworthiness of the peer advocates. Job and insurance protection were also deemed an important, if sometimes elusive, goal of the programs. The strength, effectiveness, responsiveness, and integrity of the EAP was also deemed an important factor in program success. Other barriers to success included negative attitudes towards treatment and people who are struggling, however the programs often incorporated education programs and conversations to reduce stigma and build support for their programs.

The diverse characteristics of peer programs could be a strength of the building trades approach to peer advocacy as both experience and innovation could be drawn upon by those starting new programs or wanting to strengthen the ones they are operating. A systematic study of program effectiveness could deepen our understanding of the relationship between program strategy or component and outcomes. Such a study could investigate what facets of a program make for high utilization, low relapse/high resilience, and help facilitate long-term recovery.

Inputs to study include, but are not limited to: type of education required for peers; types of certifications required for peers; recovery requirements for peers; whether a peer is paid or is a volunteer; whether peers run support groups; whether peers have the disorder for which they are helping others; EAPs vs. MAPs; how and whether the EAP and other resources get audited; the method by which peer advocacy advertised to members; and confidentiality. Intermediate outcomes include but are not limited to: peer advocacy utilization; peer-led-support-group utilization; EAP utilization; inpatient and outpatient utilization; and other related-services utilization. Long-term outcomes include but are not limited to: change in SUD rates and relapse rates, and per-capita time abstaining and time in active recovery. While interviewees disagreed on whether a “model” peer advocacy program should be a goal for the trades, all agreed that programs can be strengthened by learning from others’ experiences and expanded resources – both of which could be facilitated by inter-program cooperation and learning.

In addition to more formal evaluation of the effectiveness of peer programs, recommendations that emerged from this interview project included:

- Robust and on-going in-service training for staff and volunteers
- Program evaluation for improvement
- Outward facing events to build support for the programs
- Peer-to-Peer advocate interchange opportunities
- Models for job and insurance protection for workers in treatment
- Best practices in auditing EAPs/expectations in EAP programs
- Strategies for building recovery-friendly union culture

Conclusion

The trades have been greatly affected by opioid use disorder and related SUDs. NABTU Opioid Task Force Members' unions have responded to this crisis by initiating or expanding peer advocacy programs of diverse design. CPWR conducted a qualitative study by performing key-informant interviews with task force members with knowledge of their union's peer advocacy programs. Based on the interviews CPWR recommends conducting a program effectiveness study to better understand how to achieve desired outcomes, which include lowered SUD rates and relapse rates, and increased time in abstinence and active recovery.

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Appendix

A. Interview Instrument

Interview-style questions:

1. How do you think substance use, mental health and suicide are impacting your members?
2. How has your International Union taken action on issues related to substance use, mental health and/or suicide for your members?
PROMPTS
 - a. What programs do you have in place?
 - b. What statements or policies have been made, including articles in the media/press?
 - c. What resources are available to members?
 - d. How would you describe any Member Assistance or Employee Assistance Programs sponsored by the International?
3. How have your union and union benefits funds supported workers seeking to access treatment for substance use disorders and mental health?
 - a. How have these benefit programs changed in recent years?
4. What programs do you have to support workers in recovery in returning to work (and staying in recovery)?
 - a. How have you worked with employers around these issues?
5. What are some examples of how your International's local unions have responded to the needs of their members with regard to substance use, mental health and/or suicide?
6. How do these issues get addressed in union-sponsored member training or educational programs?
7. In what ways do union personnel address these issues as part of their responsibilities?
8. What challenges does the union face in serving the needs of your members related to substance use, mental health and/or suicide?
PROMPTS:
 - a. How have you addressed the barrier of stigma – the shame and disgrace of even talking about these issues?
 - b. What have been the challenges of finding resources to support these programs and how have they been overcome?
9. In what ways have your approach and programs been successful?
PROMPT:
 - a. What kinds of partnerships and connections have been made around these issues?
10. What plans or goals does your international have for addressing these issues?

11. New data and reports indicate that many workers who run into trouble with opioids, started with a prescription as a result of a work-related injury. In what ways does your union address this issue?

PROMPTS

- a. How have your union's H&S programs taken on the issue of pain management/opioids?
- b. In what ways does any union-sponsored managed care, benefits fund, comp management or other insurance programs address injury prevention?
- c. In what ways does any union-sponsored managed care, benefits fund, comp management or other insurance programs address opioid prescriptions/alternative pain management?

12. What else would you like to share about this topic?

Survey-Style Questions:

1. Awareness and efforts to destigmatize substance use disorders.
 - a. Do you have educational programs that address substance use disorders? In place/ in development/ none
 - b. Do you have educational programs that address mental health? In place/ in development/ none
 - c. Do you have educational programs that address suicide? In place/ in development/ none
 - d. Do you have educational programs that address the stigma related to any of the above? In place/ in development/ none
 - e. Does your international union have counselors or peer educators for any of these? In place/ in development/ none
 - f. Do your members have access to telephone or online support information or hotlines? In place/ in development/ none
2. Work-related injuries and working in pain can contribute to opioid use.
 - a. Does your international have any interventions aimed at reducing prescribed opioid use? In place/ in development/ none
 - b. Does your international have any return to work alternatives/modified duty programs? In place/ in development/ none
 - c. Does your international have income support for workers who have experienced a work-related injury? In place/ in development/ none
 - d. Does your international have pain management or alternative pain management programs? In place/ in development/ none
 - e. Does your international offer its workers assistance negotiating the WC system? In place/ in development/ none
3. Rehabilitation of members with substance use disorders.
 - a. What percentage of members have access to an EAP or MAP?
 - b. What percentage of members have substance disorder treatment covered under health plans?
 - c. What percentage of members with mental health disorders have treatment covered under health plans?
 - d. What percentage of plans cover inpatient, outpatient, and medically assisted treatment for substance use disorders?

- e. What percentage of plans cover inpatient and outpatient treatment for mental health disorders?
- f. Do you have a process for vetting substance use disorder treatment centers? In place/ in development/ none
- g. Is family support or family treatment covered by the EAP/MAP In place/ in development/ none
- h. Do you vet these programs? In place/ in development/ none
- i. Is there income support if someone had to take a medical leave for treatment purposes? In place/ in development/ none
- j. Is there a Pharmacy Benefit Management Program? In place/ in development/ none
- k. Do you work with any 3rd party organizations like Facing Addiction or Labor Assistance In place/ in development/ none

4. Ongoing recovery support

- a. Do you support members with substance use disorders through recovery and maintenance? In place/ in development/ none
- b. Does the international sponsor 12-step or other ongoing recovery support programs nationally? In place/ in development/ none
- c. On a local basis that you've heard about? In place/ in development/ none

5. Final catch-all questions

- a. Do your locals/training centers stock Narcan? In place/ in development/ none
- b. Would you be willing to field a detailed survey to your locals, health funds, and/or training centers? yes/no
- c. Are there any other interventions you would like to share?
- d. What are your biggest needs?
- e. What is not working out there?
- f. Do you have any recommendations about what the Task Force should prioritize?

B. List of Interviewees

Jamie F. Becker, Laborers' Health & Safety Fund of North America

Kevin Byrnes, Ironworkers International Chief of Staff and Jim Dufficy, Ironworker Locals 40, 361 & 417 Members Assistance Program

Chris Carlough, Director of Education, International Association of Sheet Metal, Air, Rail & Transportation Workers, and Randy Krocka, Sheet Metal Occupational Health Institute Trust Inc. (SMOHIT)

Andrew Cortez, Director, Building Futures; Chairperson, Apprenticeship Road Island; RI Building & Construction Trades Council, and Jill Treacy, Health Initiatives Manager, Building Futures

Robin Donovan, Executive Director, International Health Fund, International Union of Bricklayers and Allied Craftworkers.

Deven Johnson, Executive Director OPCMIA International Training Fund

Timothy Keane, Heat and Frost Insulators and Allied Workers

Brendan T Loftus, Local 1 IUEC, LAP-C, Director, Member Assistance/Education Program

Steve Maki, SMS, CHST, CWB & CTC Training Director HAMMER

Michael Richard, Director of Construction and Maintenance, IBEW

Kenneth Seal, IUPAT/IFTI

Kenneth Serviss, CEAP, CAC, QSAP, Executive Director, Allied Trades Assistance Program, Philadelphia Building Trades Council

Kyle F. Zimmer, Jr., Health&Safety Director/Members Assistance Program Director, IUOE Local478



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