IDENTIFICATION AND REHABILITATION
OF THE PROBLEM DRINKER

ALCOHOLISM IN INDUSTRY --
PROPOSED SOLUTIONS

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Alcoholism is a widespread yet highly misunderstood disease. We are familiar with the symbols associated with other important health problems: the cross of the National Lung Association, the sword of the American Cancer Society, and the heart and torch of the American Heart Association. Alcoholism, unfortunately, has too often been symbolized by the skid row drunk. If concepts of alcoholism are influenced by this distorted view, then it impedes our efforts in prevention, treatment and rehabilitation. Only 3% fit this picture--97% are working.

Growing concern over alcoholism has resulted in various methods designed to control this disease. The methods were basically aimed at control of the use of alcohol, and could be classified as: 1) prohibiting the manufacture, distribution or consumption of alcoholic beverages, 2) indoctrinating people in the consequences of excessive drinking, 3) controling the manufacture, distribution and sale of alcoholic beverages, and 4) substituting "counter attractions", such as recreational facilities in isolated communities where drinking seemed to be the only release from boredom. Laudable as the aims of these efforts may have been, they have not been successful.

Failure comes not only through the wrong approach but also because there are serious obstacles to treatment. Here are some examples: 1) Most alcoholic employees are hidden and protected. The family or the immediate supervisor often may try to deal with the problem in their own way. 2) The alcoholic employee denies drinking heavily and has little motivation to seek help. 3) The alcoholic employee cannot be forced to seek help. 4) There has been a lack of consensus about the cause of this disease. So, although the medical profession recognizes there are different types of alcoholism, treatment has developed in a haphazard, empirical fashion. 5) There has been professional apathy toward treating alcoholics. This starts at the medical and nursing school level where, even now, courses in this illness are grossly inadequate. 6) Alcoholism has been recognized as a disease only recently. 7) Hospital facilities are inadequate to care for

and rehabilitate the acutely ill alcoholic. 8) Law enforcement agencies and businesses alike have generally taken a punitive attitude toward the alcoholic. 9) Alcoholism is generally not covered under insurance plans.

Fortunately, we now are better able to understand and treat this disease. There are now many good programs in industry and the medical profession has begun to show greater interest. For instance, the American College of Physicians recently made a special effort to alert its members to its obligations in understanding and treating alcoholism. The American Occupational Medical Association and the American Academy of Occupational Medicine have programs to help combat this disease. The American Medical Association has published an excellent manual on alcoholism. Many hospitals are developing specialized facilities and programs specifically for alcoholics. Excellent inpatient treatment centers are available in most areas of the country. These treatment centers are branching out into outpatient long-term followup care as a further method of treatment.

Great concern has been expressed at all levels of government. The National Institute on Alcohol Abuse and Alcoholism has been established in the Department of Health, Education and Welfare. One branch is solely concerned with the problem of alcoholics in industry. State and local governments are developing programs of education and facilities for rehabilitation of the alcoholic.

Business management is more aware of the problems of alcoholism, its costs, and the variety of solutions. For instance, the National Industrial Conference Board has published a monograph, "Company Controls for Drinking Problems", for all its members. Almost every management journal has carried articles about alcoholism. The press, radio and television have brought the consequences of alcoholism and the techniques of rehabilitation to the public. Unions, too, are more interested in this illness and in the fate of employees suffering from it. This interest has led to union-sponsored educational and rehabilitation programs and negotiations of insurance benefits for alcoholic employees.

The work of Alcoholics Anonymous is legendary. This incredibly successful organization was founded in 1935 by two alcoholics - a physician and a stock broker - and has now grown to an estimated 600,000 members. By their conspicuous success, they have contributed to the recent change in public opinion about this disease. In short, industry, the occupational physician and nurse are now feeling many internal and external pressures to develop new and better programs for alcoholism.

A program for the control of alcoholism in industry does not need to be expensive or extensive. The program can easily be tailored to the number of employees, the budget and available facilities. There are some factors which are common to all successful programs in industry:

1) Recognition of alcoholism as an illness -- its inclusion in disability and insurance plans.
2) The understanding and support of all levels of management of the company's position.
3) A written statement of policy.
4) Union support
5) Education of all employees and their families.
6) Education of all levels of management in the techniques of recognition, referral and rehabilitation
7) Establishment of referral sources either in the company or community.
8) Adequate long-term followup.
9) Research in various aspects of alcoholism.
10) Education of physicians and nurses in the problems of alcoholism and rehabilitation.

The program design will be determined by the budget and facilities available. Most large firms have a medical department. For them it is recommended that the alcoholism program be a medical department responsibility. The occupational physician or nurse must become familiar with the techniques of handling these employees. A counselor, who could be a member of Alcoholics Anonymous, a psychologist, or a trained social worker, may also be a part of the Medical Department team. This counselor would work directly with the employee and family. Adequate arrangements must be made with community resources for hospital and outpatient care and treatment. Continuous communication with the employee's department is essential. It is only through the constructive coercion of both departments that most employees will successfully complete a rehabilitation program.

In other industries the responsibility for the alcoholism program has been assigned to departments such as personnel or labor relations. For an industry with no medical facility, this approach is all that is available and a simple solution may be to have a volunteer counselor - perhaps an employee in AA - to arrange for the services of an outside physician or hospital rehabilitation program. Regardless of the type of program selected, it need not be expensive. Its success will depend on meeting the essentials of a good program and the zeal and enthusiasm of the people directing the program.

It is realistic and advantageous for industry to conduct a rehabilitation program. Government, public and union pressures will eventually force industry to do this. However, the same moral, medical and economic arguments that apply to emotional illness apply to alcoholism and drug abuse as well. Alcoholism will be found in any employee population. Industry can only protect itself against the actual and hidden costs by meeting the problem head on.

A brief summary of the Illinois Bell Telephone Company program will illustrate a successful operating plan:

First, there is complete cooperation of all levels of management in a commitment to recognize alcoholism as an illness, to treat it as such under disability and insurance programs and to offer a chance for rehabilitation.

The following written policy statement covering alcohol and other drugs has been well publicized in the company. It is presented here as a workable policy that has stood the test of time. It may be adapted to suit the individual needs of any particular industry.

> "The use of any drug interfering with safe and efficient job function is a matter of company concern and will be dealt with in an appropriate manner.
>
> "Alcohol is also a drug about which there is serious concern. Its excessive use will be considered in the same manner.
>
> "The company recognizes that drug misuse may be a serious medical problem. A rehabilitation program is offered in the Medical Department. Employees cooperating in a clinically supervised rehabilitation program may be eligible for benefits.
>
> "Possession or use of illegally obtained drugs or alcohol on the job or on company premises may be a cause for dismissal."

We feel it is important to treat alcohol and other mind-altering drugs in the same general policy statement.

Education of the employee population is accomplished in several ways. Members of the Medical Staff and nurses talk to many employee groups. Articles appear in the company magazine and newspaper. A pamphlet was mailed to the home of all employees, explaining the policy on alcoholism and offering help in rehabilitation. In addition, a condensation of the book "The Drinking Game and How to Beat it" was sent to the home. Films are shown at company locations and health education material is available in easily accessible locations. Employee education is seen as a continuing part of the health education program.

Managers are educated in three ways. First, medical staff members present the program at various operating staff meetings. Second, a videotape is shown at employee group meetings. Finally, a published guide is available for the supervisor.

This program has been in operation since 1950. Over the years it has grown in size and sophistication but still operates under the same basic concept of case finding by the employing department, constructive coercion and a sincere desire of everyone to help the ill employee.

TABLE 1--HOW REFERRED TO PROGRAM

	Women	Men	Total	%
Employing Dept.	86	277	363	90
Medical Dept.	5	11	16	4
Self	2	21	23	6
Total	93	309	402	

It is obvious to us that we must rely on the employing department as our case finder (Table 1). Not only must we rely on them, we must educate them in the art of case finding. This must be a continuing effort. Management changes. Goals change. We must constantly adapt our efforts to these changes. This can only be done by education - and re-education - of management.

TABLE 2--YEARS OF SERVICE WHEN REFERRED TO PROGRAM

	Women	Men	Total	%
Under 10	19	58	77	19
10 - 19 years	23	99	122	31
20 - 29 years	27	77	104	25
30 - 39 years	23	56	79	20
40 or over	1	19	20	5

TABLE 3--AGE WHEN REFERRED TO PROGRAM

Age	Women	Men	Total	%
Under 25 years	2	7	9	2
25 - 34 years	4	56	60	15
35 - 44 years	30	95	125	31
45 - 54 years	50	106	156	40
55 or over	7	45	52	12

The next two tables again show us an interesting aspect of our patient population. Table 2 shows the years of service. Over 50% of patients had between 10 and 29 years of service. Table 3 shows the range of ages. Here we see that 71% were between 35 and 54 years old. This data carries a message which is loud and clear. We were simply missing alcoholism in its early stages. Knowing the general natural history of the development of this disease, we can safely say that alcoholism had been present for a long time before it resulted in a job crisis of sufficient magnitude to demand correction. The obvious remedy to this is to alert our operating departments to have health evaluations much earlier than was done in the past. Repeat them again and again if necessary. It also made our physicians aware of the subtle nature of early alcoholism and has made them much more alert to the disease and much more efficient diagnosticians. Recently we have noted many younger employees are mixing drugs and alcohol, or are switching to alcohol as the drug of choice.

TABLE 4--MARITAL STATUS OF PATIENTS

	Women	Men	Total	%
Single	19	39	58	14
Married	33	227	260	64
Widowed	10	5	15	4
Separated	6	9	15	4
Divorced	25	29	54	14

The marital status of patients is of academic interest and did not materially change our program (Table 4). However, we have gradually come to the realization that alcoholism is often a family disease affecting both husband and wife. We now thoughtfully look into this possibility. The incidence of divorce or separation was much higher in women. This could indicate a difference in the view of society toward alcoholism in women, or could indicate that the married dependent woman is willing to endure more to save her marriage.

TABLE 5--ESTIMATED MAJOR AREA OF LIFE STRESS*

	Women	Men	Total	%
Self	69	277	346	86
Home	42	60	102	25
Job	12	24	36	9
Other	1	13	14	3

* Some Patients have two or more areas of stress.

Major life stress did not appear to be job-connected in many patients (Table 5). In those cases where it has been proven to be significant we have made every effort to change the job situation if the solution seemed reasonable.

TABLE 6--DIAGNOSIS OF TYPE OF DRINKING

	Women	Men	Total	%
Heavy Drinker	17	66	83	21
Chronic Alcoholic	54	201	255	63
Reactive Drinker	7	16	23	6
Symptomatic Drinker	15	26	41	10

Knowing the type of drinking is very important (Table 6). Heavy drinkers (21%) are not true alcoholics, but drink in a serious, damaging, recreational way. They are able to control their drinking much easier than the other types. Typical chronic alcoholics (63%) are people in whom drinking is compulsive and self destructive. Reactive drinkers (6%) simply react to life situations by drinking. Symptomatic drinkers (10%) are suffering from an underlying emotional illness. Alcoholism is a manifestation of emotional illness. We now know that different techniques of treatment are required. One cannot simply apply the same type of therapy to every patient and expect success! We believe that this is extremely important and may be a factor in the disappointing results of some industrial programs.

TABLE 7--ACCEPTED ALCOHOLICS ANONYMOUS

	Women	Men	Total	%
Yes	39	183	222	55
No	54	126	180	45

Fifty-five percent of patients accepted Alcoholics Anonymous (Table 7). These came almost entirely from the group of chronic alcoholics - 63% of the patients. The chronic alcoholic benefits from this fellowship and the support it gives. These same chronic alcoholic patients benefit greatly from seeing our counselor at regular intervals. This is actually extending the AA philosophy to a one-to-one basis.

TABLE 8---SUCCESS IN REHABILITATION IN 402 REFERRALS

	Women	Men	Total	%
Rehabilitated	52	178	230	57
Improved	20	40	60	15
Accepted Help	17	75	92	23
Not Controlled	4	16	20	5

A recent study of 402 employees for whom we had employment records for five years or more prior to entering the program and five or more years after referral illustrates the success that may be achieved.

The rehabilitation rate is important. "Rehabilitation" means no drinking for one year or more. Fifty-seven percent were in this

category. An additional 15 per cent were improved. These employees were functioning satisfactorily on the job even though they had not totally quit drinking. This makes a total job rehabilitation rate of 72 per cent.

There is more to the story, however, than just rehabilitation. If it is truly successful it should have measurable parameters of benefit to the business. Among the parameters were: 1) job efficiency, 2) sickness disability absence (absence lasting more than seven days), 3) off-the-job accidents, 4) on-the-job accidents. A successful rehabilitation program should produce positive results in all of these areas.

Job efficiency was estimated by the employing department both before and after referral to our program. It is clear the rehabilitated employee is a better employee. (Table 9)

TABLE 9--ESTIMATE OF JOB EFFICIENCY

	5 Years Before		5 Years After	
	Employees	%	Employees	%
Poor	112	28	51	12
Fair	199	50	119	30
Good	91	22	232	58

TABLE 10--NUMBER OF SICKNESS DISABILITY CASES*

	5 Years Before	5 Years After
Women	299	75
Men	433	281
Total	732	356

* (MORE THAN SEVEN DAYS OF REPORTED ILLNESS)

It is well known that alcoholic employees have a greater absence rate. The statistics presented are for absences of eight days or more. No medical records are kept of absences of seven days or less. The disability rate after rehabilitation is approximately the same as for our whole employee population. These statistics simply mean the company has been paying the cost of alcoholism even though it had been called some other illness. By doing so it was literally helping to perpetuate an illness. By recognizing the problem, a marked reduction in cases was accomplished. A conservative estimate of the direct dollar savings to the company

in sickness disability benefits alone is $459,000 during these five years. In addition there were savings in departmentally-paid absence costs, insurance utilization, and all the other hidden costs of alcoholism. (Table 10)

TABLE 11--NUMBER OF ON DUTY ACCIDENTS*

	5 Years Before	5 Years After
Women	4	1
Men	53	10
Total	57	11

* (ANY ACCIDENT REQUIRING MEDICAL TREATMENT)

TABLE 12--NUMBER OF OFF DUTY ACCIDENTS*

	5 Years Before	5 Years After
Women	32	6
Men	43	22
Total	75	28

* (MORE THAN SEVEN DAYS ABSENCE)

It is also well known that alcoholic employees have more off-the-job and on-the-job accidents. The results obtained by rehabilitation clearly has had a dramatic influence on the accident rate. (Tables 11 and 12)

When one considers the advantages to the company as well as to the sick employee, the family and society, the value of a rehabilitation program becomes quite clear.

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