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Alcoholism in Industry: A Position Paper

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This paper considers logical grounds for Industrial Alcoholism Programs and concludes that ethical arguments based on the needs of the employee in society could be more substantive than cost-benefit propositions put forward to support programs. The troubled employee diagnostic system, the problems of early identification and the legitimacy of a management role in these programs are analysed, and it is concluded that medical and psychological involvement are required for an effective referral system. The paper then argues that broadbrush programs will be more appropriate in medium and small sized companies and that such employee assistance programs are more likely to be effective than single purpose alcoholism programs. Finally the paper concludes that early identification could be assisted by the development of computer health assessment programs that analyse lifestyle and behavioural information to indicate potential problem areas such as stress, cardiac concern, potential problem drinking and other useful indicators. Such a system would be a useful addition to current procedures, be cost-effective, legitimate and would result in increased referrals to treatment. Increasing the effectiveness of early identification could mean that more problem drinkers as distinct from alcoholics will be referred for treatment and this implies that controlled drinking should be examined as a preferred treatment target to total abstinence.

Alcoholism in industry is of rising concern to many people in this country. This paper analyses the programs and examines some of the concepts on which they are built. The intention is to clarify the logic so that programs may be effective and acceptable to both the treatment services and the industries in which referral systems are located.

Alcoholism programs are argued for on three grounds in a paper by Barry (1976). These grounds are:

1) that the cost of replacement of an employee is higher than the cost of treatment,
2) that the alcoholic as an employee has above-average intellectual capacity, and
3) that the employer has no assurance that he will not be replacing the alcoholic with another alcoholic employee.

The second argument is of course, an elitist argument as the level of intelligence would hardly be expected to influence clinical judgement of a person in need. No evidence on the level of intelligence is offered by Barry, but Gregson and Taylor (1977) have shown that patient scores on a Patterned Cognitive Impairment Test are significantly higher for the people who successfully complete a treatment program than for those who did not complete the program. A reasonable extrapolation from this data might be to assume that people who have no drink problems are equal, or perhaps slightly higher in cognitive performance to those who have an alcoholic problem. The argument is essentially unimportant, as there are few logical reasons for administering such tests to potential patients.

The cost of replacement and the probability of hiring another alcoholic are essentially the same question and the first of Barry's arguments of the replacement of one alcoholic by another unrecognised alcoholic, involves an assumption that a personnel officer examining the references and job record of an applicant, will be unable to hold the incidence of hiring unrecognised alcoholics to at least the current level of alcoholism within the organisation. Replacement costs of employees are very high, being well over $1,000 for a manual production worker and over $6,000 for a salesman re-

quiring a little training. It is generally argued, though it is not clear on what grounds, that alcoholics are working at 75-80% of their production capacity. On these assumptions, assuming a $10,000 salary, 50% overhead and 80% efficiency, the profit foregone by an organisation would be $3,000. At this kind of level, we might like to take $2,000 as the direct costs of replacing an alcoholic employee. If an organisation fired 10 alcoholics and picked up one additional alcoholic within the replacement group, they would have at least an extra $7,000 of profit without taking into account any treatment costs. Further, these numbers do not take into account the problem of effectiveness of treatments which seem to range in the journals from 30-70%.

The real thrust of the cost argument ought not to be that companies should invest in an industrial alcoholic program for reasons of profit. Such arguments are built on a simple minded and potentially insulting analysis which implies that no personnel policy is initiated that does not show a direct and immediate dollar profit to the organisation. Simpler arguments emanating from simple human values, could be a sounder and more acceptable approach to many directors.

The economic benefits of alcoholic programs are by no means clearly stated in the literature and indeed, some current programs are under attack. Kane (1975) argued the economic benefits accruing to the New York Police Force of their program but his paper ends the following way.

> "These programs may be set back by an economic recession in the next few years. Corporations that are in the process of cutting back production and personnel will most assuredly decide that these programs are costly and unnecessary."
>
> (Kane, 1975, p 384).

Either these programs are cost effective in which case they will not be cut back or they are a cost to the organisation in which case if they were justified solely on economic grounds, then cutbacks could be expected. The point on costing alcoholic programs is that though the directors of substantial companies may not always be the most articulate of people, they can clearly calculate value. Programs for referral and treatment are better argued on social grounds, than simple minded inaccurate costing.

The Troubled Employee Diagnosis System

The most common concept put forward for the diagnosis of an alcoholic in the work situation summarised is the troubled employee syndrome. This position argues that alcoholics are indicated by performance decrements in quality of work, interpersonal relations, reduced output, absence and other fluctuations from normal employee behaviour. For example, Barry (1976) claimed that the alcoholic employee will be absent 16 times more frequently than the non-alcoholic employee. This is a remarkable assertion and if it were true, would indicate that management needed as much reformation as the alcoholic employee. More probable figures are given by Pell and D'Alonzo (1970) in their study at a Du Pont Plant which showed that alcoholics had a frequency rate for absence, running at 3.6% of work time versus 1.6% for controls.

However, when one examines the distribution of absence in this study, 8 out of 10 alcoholics, and 9 out of 10 non-alcoholics have two or less reported absences. Taking a convenient, if high 10% incidence of alcoholism in any group of employees, using absence as an indication of alcoholism, we would classify 9 non-alcoholics as alcoholic, in order to correctly classify two alcoholics —this level of misclassification is misleading.

A second problem with the use of absence ratios to indicate alcoholism, is that they are more culturally determined rather than set by the level of alcoholism within the country. Australian mining awards allow 3.6% of work time as payable sick leave entitlement—some larger companies which are well managed, run at an actual level of absence of 4.2%. New Zealand absence rates would probably run up to three times higher than these figures. Using the American figures, would indicate that half of the Australian labour force was alcoholic which would be an absurd proposition. From this, it may be argued that it is the quality of supervision and cultural differences which

determine the level of absence, not alcoholism.

Absence is clearly an ambiguous indicator of alcoholism in the work place. One suspects that low productivity and tardiness would be equally difficult to attribute in the majority of cases to alcoholism. If this is the case, the troubled employee syndrome could require very careful evaluation. With a progressive problem such as alcoholism, the establishment of programs that only initiate treatment when the level of work performance has reached a situation that legally permits the employer to dismiss an employee, is illogical because by the time the situation has become this critical, the employee should already have been referred through to the helping professions.

Diagnosis and Treatment

Troubled employees may be a good source of referrals but research investigating the actual sources of patients for alcoholism treatment programs, indicates this is by no means the only source. Heyman (1976) found that only 29% of her sample were in the treatment program because of impaired job performance. Over half of the patients were not influenced to seek treatment by events connected to the workplace. Anderson (1978) however, reports that 60% of the group she studied had unsatisfactory employment records. The incidence of impaired job performance leading to treatment thus ranges between 29% and 60%. This indicates that many people with satisfactory job performance are involved in alcoholism treatment programs.

Logically, it seems unsatisfactory that alcoholism presented as a progressive disease, utilises a diagnostic system that requires publicly manifested decrements in job performance before intervention is initiated. Further, social bias is inherent in this model because of the difficulty of establishing performance decrements of the magnitude required for legalistic intervention in jobs such as accountancy, sales management and indeed, the overall direction of a company

Trice and Roman (1972) discuss the precipitation of a crisis situation in which the alcoholic comes to recognise his problem. In general, it seems that under the troubled employee model, this crisis precipitation is the point for which supervisors in the work place need training. Stolz (1975) writes that a supervisor is to be alert, aware of hangovers, hand tremors, red eyes, breath, irritability and other potential symptoms. He then goes on to write that the supervisors are not to be trained to become amateur diagnosticians—this is ambiguous. If they are not to be diagnosticians, then why train them in diagnostic evaluation? It is clearly a supervisor's role to contribute to the profitable running of an organisation and not to become a paramedical assistant to the medical centre. It is only in the area of clear decrements of performance in the work situation, that the question of cause of this loss of performance can be asked of an employee and this is not an optimal intervention time to achieve behavioural change—it should be earlier. Later, this paper will define a system that will speed identification—the immediate issue revolves around who should diagnose alcoholism problems under a troubled employee model.

Rather than involving supervisors in pseudo-diagnostic training, it would be appropriate to initiate a personnel policy that was implemented when performance decrements are critical, 'when an employee is being considered for dismissal he should be offered the opportunity to discuss factors that may influence his work with company medical staff'. Such medical staff may, within professional ethical constraints, request management to delay dismissal procedures while treatment is attempted. This type of procedure simplifies the involvement of counsellors working for alcoholism boards, to the setting-up of appropriate personnel policies that lead to adequate medical intervention when the employee is seriously troubled and to the modification of certain deleterious work/community attitudes toward alcoholism. They should not be involved in the setting of performance criteria in the work situation.

Thus, the emphasis for professional involvement returns to the medical area rather than the personnel function. This simplification of the referral model reduces the real

problem of confidentiality as it removes the need for personnel file records containing reference to the medical condition of alcoholism. Supervisory training in alcoholism should simply be awareness training of the human problems surrounding the alcoholic and the need to facilitate referral to medical practitioners. Kane reported of damaging publicity happening to a New York Police Program. Even more serious, is that employees themselves become resentful of publicity being generated by personnel departments who seek to gain favourable public recognition of their 'innovative' role in alcoholism programs. Kane also reports that some employees believe that this publicity is a management ploy, to destroy the public image of the non-alcoholic policeman. In general, it seems eminently sensible to maintain a low profile in any company-based alcoholism program.

The medical program approach reduces publicity problems that conscientious companies which have developed alcoholism programs, have in the past been faced with on being reported in the inimitable journalistic style of the Sunday papers.

Employee Assistance Programs

Under the troubled employee diagnostic model, coercion is used to precipitate a crisis, that leads on to an acceptance by the employee of his need for treatment. The whole general psychological literature on conflict, suggests that the use of threats to resolve conflict, results in a compliance which produces side effects that are inconsistent with the solution desired for the problem before the threat was issued. Threats reduce cooperation and friendliness. Further, threats issued in the presence of an audience lead to increased retaliation by the threatened party. Finally, compliance produced by a threat is a function of its feasibility and its magnitude. Threatening a highly successful salesman, is hardly likely to be effective even though his full potential in the job is not being achieved due to alcoholic problems—he knows his market value. In certain industries such as mining where alcoholism is a clearly perceived menace to the welfare of the work-group, the use of threats is legitimised and seen to be part of what Livingston (1977) would call rules of the road. These rules of the road are realistic normative codes of behaviour which we use to monitor/control social behaviour.

An alternative to the threat is the promise which increases the probability of reaching a favourable outcome. The effect of a promise is a function of the credibility of the person making it, and his perceived trustworthiness—thus, compliance is a function of the credibility of the promise. Using credible promises that conform to the value of both parties is positive in its effect and is generally a better way to proceed.

The literature on the effect of stress, is also significant in relation to the use of coercion to precipitate a crisis. In situations of stressful conflict, people tend to offer the most predominant response to a question, rather than the calculated, assessed and effective response. In times of high unemployment, dismissal threats are serious and the information gained under duress may not be as helpful as information gained in a typical medical interview.

In addition, the implications of having witnesses present, tend to make the behaviour more aggressive and less effective. One suspects that the confrontation situation where it occurs outside the medical sphere, is not perceived to be legitimate by the employee as in the Australasian work ethic it may well be that in the majority of jobs, people would believe that management has not the right to enquire about alcohol consumption outside of working hours. It is not management's basic role in our society despite what social welfare, personnel and union officials may tell us. This does not mean that management has no concern but perceives itself as having no legitimised authority to operate in these areas.

Broadbrush Health Programs in Industry

Although the majority of papers argue for the need for coercive referral, there is by no means complete agreement on this matter. Morehouse (1978) states that contrary to popular belief, many alcoholics are grateful for referral. The INSIGHT Program

of the Utah Copper Division, of Kennecott Copper Corporation (Jones, 1977) offers a broadbrush employee assistance program in such areas as alcoholism, drug abuse, family problems, debt and legal problems. In this type of program, employee involvement is never mandatory and is self-determined. It is assumed that by resolving personal problems, an organisation achieves increased loyalty and a reputation for genuine care.

Most New Zealand organisations are not centralised or are far too small to sustain a cost-effective single purpose alcohol problem. A reputedly successful industry program at the Metropolitan Life in the USA produced only 16 cases per 1,000 employees referred each year. (Cunninck, 1977). In New Zealand for example, 500 employees may be regarded as a substantial business. A 5% initial referral rate would constitute one referral every two weeks but even this rate of referral, is not sufficient to develop and maintain effective internal company expertise. Although the total referral rate from single purpose alcoholism programs may be more than from a broadbrush program the incidence of total referrals over all the problems covered will be more likely to be sufficient to keep the program alive and increase the long term effectiveness of industrial programs.

One of the key problems in this whole area of alcoholism industry programs, is that the successful programs seem on observation to be successful, less because of the nature of the program and more because of the charismatic leadership of the individuals initiating the program within an organisation. When this leadership is removed, the program gradually ceases to function. A broadbrush program would have a greater chance of survival due to the greater number of employees who are likely to be using this system and because of wider benefits occurring to the host organisation. The success of treatments in areas such as budgetary control, are far more certain and more easily acknowledged by those who seek help. Consequently, the positive attributes of the program will engender a public reputation which will flow onto other less acceptable parts of the program.

Early Identification

An additional tool that could be used to promote referrals would be a computer based health assessment program with a scale that deals with the probability of problem drinking. Work such as that done by Campbell (1979) could be validated and extended to cover stress, obesity, fitness, cardiac problems, as well as alcoholism. Such computer based assessment program has a fundamental advantage—it can be applied earlier to the problem, than the troubled employee model and it can be a simple transfer of information between the patient and the medical practitioner, in a role that is entirely legitimate within our society. That the necessary indicators can be generated in respect to alcoholism, is clear from the review developed by Millar, (1976). These scales could be programmed to produce indicators for a medical officer to initiate discussions in problem areas. The practitioners can be used to validate these scales by feeding back criterion information which can correct the mathematical diagnostic models every thousand or so cases.

The alcoholism scales should not be based in personality measurement but should concentrate on the actual extent and pattern of reported alcohol use and the consequent behavioural problems that are related to excessive consumption. This could be called lifestyle or personal history data. Adding physiological measurements to the system, would clearly improve diagnosis (Ringer et al, 1977). The system could be constructed so that data capture involves only the use of paramedical staff but the interpretation and consultation arising from the data is ideally performed by medically qualified personnel who should be made fully aware of the range of treatment options by industrial alcoholism advisors.

In companies, the system could be presented by medical officers or visiting health specialists as part of a general purpose preventative health assessment program. Employees could voluntarily pass through the system which would provide data for medical staff. Where alcoholism possibilities were indicated, the medical staff would initiate further diagnostic tests or discus-

sions. It is important that the interface for the system is a direct link between the individual and a medical officer, reducing the need for company involvement other than providing access to the employees.

A general health, diagnostic package of this kind, would supplement and provide a major new source of referrals to treatment facilities. It is not a substitute for either the current broadbrush or specific alcoholism programs. It will however, add to the efficiency of industrial programs and increase the probability of early identification of problem drinkers. It must be stressed that this is not a matter of further research, merely an application and development of currently viable technology and ought to be pursued for the Alcoholism Liquor Advisory Council.

An effective industry referral program like that just described, will identify problem drinkers earlier and increase the number of people who are not true alcoholics who enter treatment. It could be inappropriate to use the same treatments given to the referred chronic alcoholic under current programs. Further, any executive sponsoring an industry program, would be concerned with the nature of treatment programs. The literature distinguishes two general treatment targets, total abstinence and controlled drinking. Current practice in New Zealand favours the former and where there are physiological disabilities or symptoms derived from excessive alcohol consumption, abstinence is a clearly acceptable goal.

The evidence on abstinence is not conclusive and if earlier identification were achieved, it may not be the most acceptable initial treatment target. However, Gerard (1962) indicated that only 11 out of 50 total abstinence successes had no adjustment problems in the community. Further, reversion to drinking does not automatically lead to a continuation of previous madadaptive behaviour (Ludwig, 1970) and there is some New Zealand data which suggests that patients from abstinence programs are in the community drinking with no related problems—(Anderson, 1978). This position seems confirmed by Millar and Caddy's (1977) review of the literature. Intuitively, there is less likelihood of disrupting a patient's social lifestyle, when the initial target of treatment is to control drinking. If the referred population changes then the treatment given may need reassessment.

Conclusions

This paper argues that successful industry programs should be of low visibility, so as not to create negative publicity and the programs should be centred on the general medical and social welfare facilities our society provides rather than being perceived of as a function of a paternalistic personnel function. Pseudo commercial reasoning centred on the cost of alcoholism to a company and the use of broad performance indices such as absenteeism have many credibility problems when promoting programs to executives.

The aim must be to achieve early identification through lifestyle and behavioural diagnosis. This would mean that the troubled employee diagnostic model would be a last resort program, rather than the major referral tool of industry programs and that controlled drinking would be the logical treatment target. Broadbrush programs should be promoted as the norm rather than the exception in the industrial alcoholism area due to the size of New Zealand companies.

References

Anderson, M. Treatment in an alcoholism and drug addiction unit. *The New Zealand Medical Journal,* 1978, *88,* 233-237.

Barry, L. M. Industrial alcoholism programs: the problem, the program, the professional. *The Family Co-ordinator,* 1976, *25,* 65-72.

Campbell, D. R. Computers, Health and life expectancy. *Health,* 1979, *31,* 4-5.

Cunnick, W. R. & Marchesini, E. P. The program for alcoholism at Metropolitan Life. In Carl J. Schramm ed., *Alcoholism and its Treatment in Industry,* John Hopkins University Press. London, 1977.

Gerard, D. L., Saenger, G. & Wile, R. The abstinent alcoholic. *Arch. Gen Psychiat,* 1962, *6,* 83-95.

Gregson, R. A. M. & Taylor, G. M. Prediction of relapse in men alcoholics *Journal of Studies in Alcohol,* 1977, *38,* 1749-1760.

Heyman, M. M. Referral to alcoholism programs in industry. *Journal of Studies on Alcohol,* 1976, *37,* 900-907.

Jones, O. Kennecott's INSIGHT program. In Carl J. Schram ed., *Alcoholism and Its Treatment in Industry,* John Hopkins University Press. London, 1977.

Kane, K. W. The corporate responsibility in the area of alcoholism. *Personnel Journal,* 1975, *July,* 380-384.

Livingstone, D. G. Rules of the road: Doing something simple about conflict in an organisation. *Personnel,* 1977, *54,* 23-29.

Ludwig, A. M., Levine, J. & Stark, L. H. *L.S.D. and Alcoholism.* Thomas, Springfield. 1970

Millar, W. R. Alcoholism scales and objective assessment methods: a review. *Psychological Bulletin,* 1976, *33,* 649-674.

Millar, W. R. & Caddy, G. R. Abstinence and controlled drinking in the treatment of problem drinkers. *Journal of Studies in Alcohol,* 1977, *38,* 986-1003.

Morehouse, E. R. Treating the alcoholic on public assistance. *Social Casework,* 1978, *1,* 36-41.

Pell, S. & D'Alonzo, C. A. Sickness absenteeism of alcoholics. *Journal of Occupational Medicine.* 1970, *12,* 198-210.

Ringer, C., Kufner, H. Antons, K., & Feuerlein, W. The N.C.A. criteria for the diagnosis of alcoholism. An empirical evaluation study. *Journal of Studies on Alcohol,* 1977, *38,* 1259-1273.

Stolz, P. A multi-million dollar problem for industry-alcoholism and drug dependence. *Work and People,* 1975, *1,* 19-24.

Trice, H. M., & Roman, P. M. *Spirits and Demons at Work: Alcohol and Other Drugs on the Job.* Cornell Press, Ithaca, 1972.