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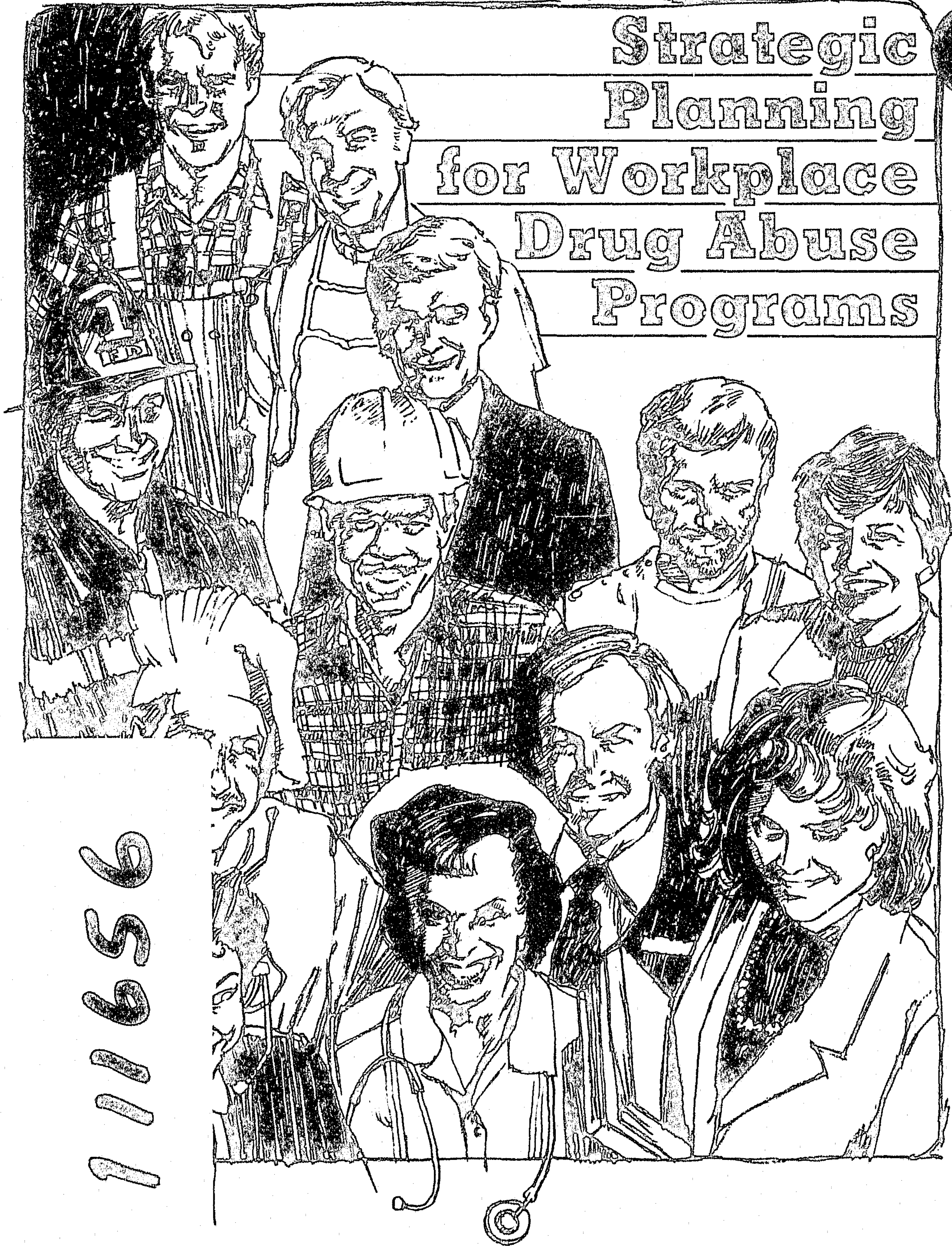
Strategic Planning for Workplace Drug Abuse Programs



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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

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Strategic Planning for Workplace Drug Abuse Programs

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U.S. Department of Justice
National Institute of Justice

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by
Thomas E. Backer, Ph.D.
for the
National Institute on Drug Abuse

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Foreword

Drug use impinges on all aspects of American life—it threatens the home, the schools, the community, and certainly the workplace. The American economy suffers billions of dollars in losses attributable to drug abuse each year.

How widespread is the problem? The highest drug-using segment of the American population is the young working adult. According to a national survey in 1985 by the National Institute on Drug Abuse (NIDA), 29 percent, or nearly a third of employed Americans 20 to 40 years old used an illicit drug at least once within the year prior to the survey, while 19 percent, or almost 1 in 5, reported use within the preceding month.

Employers cannot afford to ignore a problem that affects such a large proportion of the workforce. Management has a responsibility to provide a healthy and safe workplace for all employees, to ensure the best product or service achievable, and to protect shareholders from losses due to alcohol and drug abuse.

How can the problem be stopped? Employers must first realize that the worksite is an appropriate setting for dealing with substance abuse. NIDA has been working to help many employers develop comprehensive workplace programs that stress the development of drug abuse policies, the appropriate use of drug testing, and the design and development of employee assistance programs to help substance abusing employees.

Now, *Strategic Planning for Workplace Drug Abuse Programs* provides a written guide to help employers through the complex process of planning and organizing anti-drug abuse programs. If these programs are to succeed, the book points out, top managers must commit themselves to the program and provide the needed personnel and financial resources to develop and implement an appropriate plan.

I hope that businesses all over the country will pick up the pace and continue the fight against drug abuse in America. I have no doubt that these efforts will save countless careers, reputations, and help to preserve happiness in many American families. This book can help company leaders understand the complexity of this issue and will enable them to make informed decisions.

Charles R. Schuster, Ph.D.
Director
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I
The Challenge

What Employers Already Know

The great American actress Helen Hayes once said: "It's what you learn after you know it all that really counts." Today's employers already know a lot about drug abuse and the challenge it presents to their organizations and to society. Most employers know that:

- A significant number of U.S. workers use drugs
- Drug abuse endangers the health and safety of these workers, their coworkers, and often the public as well
- Workplace drug abuse affects productivity and profits
- Drug abuse also affects workers' personal lives, families, and the community
- Many solutions are now being offered for the problem of workplace drug abuse, from testing programs through management training to comprehensive employee assistance programs
- These solutions vary in their cost and effectiveness

The mass media, the Federal Government, employer groups, and management consultants are among those who have done much during the last 2 years to help employers learn about workplace drug abuse. Most employers now know there is a problem and a need to respond; however, many employers need to be more aware of the extent of the problem and what can be done to mitigate the situation.

Given the unique circumstances of each workplace and the distinctive character of its workforce and community, employers need to know how to respond and how to plan and implement an effective program.

The solutions presented to employers are often contradictory, and evidence about their effectiveness is sometimes vague or nonexistent. Some solutions, such as drug testing, involve both highly technical standards for implementation and potential legal challenges. There is general agreement among the experts that such solutions work best when set in context with other program components in a comprehensive response to workplace drug abuse.

All solutions have to be evaluated carefully to determine their potential for any enduring impact. Chemical dependency treatment programs vary widely in quality, and even the best programs can be compromised unless good aftercare also is provided (see discussion of the problem of recidivism in chapter V). Management training by consultants or audiovisual materials can be little more than band-aid solutions unless chosen precisely to fit an overall workplace program. Like it or not, employers have to realize that there are no quick fixes to the problem of drug abuse in the workplace.

Some observers contend that the issue of drugs in the workplace has been exaggerated and distorted by the media and other influential voices. For example, in the March 1987 issue of *Training*, five leading experts in the training and development field challenged the use of random drug testing. One expert even claimed that eradicating drugs and alcohol in the workplace would make little difference in industry's overall productivity. Yet other experts, including those at the National Institute on Drug Abuse (NIDA), assert that drug testing has a useful role in many workplace programs. Understandably, employers are often bewildered about which experts to believe and what actions they ought to take.

Integrating a new or enhanced drug abuse program with an employer's already-existing efforts to combat substance abuse may be difficult. Drug and alcohol abuse is hardly the *only* challenge employers have to meet. Employers struggle with illiteracy in their workforces and help workers cope with many health risks such as smoking and an ever-growing roster of other challenges to productivity, profits, and worker well-being. Thus, whatever is done about drug abuse, the effort must fit into an extremely complex configuration and often must compete for resources.

Although alcohol problems have been a major concern to industry for the last 20 years or more, until the 1970s drug use other than alcohol elicited a much lower level of attention. Even as managers in workplaces began to observe the effects of the "epidemic" of drug abuse in the

OVERVIEW I
KEY ISSUES—
DRUG ABUSE IN THE WORKPLACE

Over 500 books, articles, and research reports in the literature of business, drug abuse, and health care, as well as pieces in the popular press, were reviewed for this document. The 14 key issues in this review are summarized here.

1. Drug testing
2. Organizational policy on drug abuse
3. Supervisory training regarding drug abuse
4. Health care cost containment as it relates to worker drug abuse (both cost of drug abuse treatment and cost of other health care services necessitated by drug abuse)
5. Insurance coverage for drug treatment services (special focus: outpatient and long-term followup services aimed at reducing recidivism)
6. Workplace security (drug trafficking or possession of illegal drugs in the workplace)
7. Safety of workers and the public
8. Impact of drug abuse on worker motivation, decisionmaking, and creativity (thereby affecting product/service quality and productivity)
9. Availability of accurate and timely information on workplace drug abuse, and availability of needed training and consulting services
10. Workplace drug abuse programs as "management fad," and as a "band-aid" solution to serious, ongoing problems
11. Strategic planning for effective workplace drug abuse programs (special focus: promoting long-term success)
12. Integration of workplace drug abuse programs with other health care/human service issues
13. Legal liability of employers (both with respect to drug testing and other issues for those who *do* have programs, and with respect to industrial accidents and other issues for employers who don't have programs)
14. Program effectiveness (of both workplace drug abuse programs themselves and the community treatment programs they refer workers to)

late sixties and early seventies, little in the way of systematic planning and action was undertaken. Employers were slow to respond because they did not realize how widespread the problem was and had few ideas about how to combat it. Managers were not sure how to recognize the signs of drug abuse, and were often afraid to confront workers who appeared to be high. As many young people who grew up in the drug-tolerant 1960s came into the laborforce, prevailing attitudes about drug use changed. Employers found that taking action was not easy and feared the bad publicity and possible legal complications that could come from a crackdown.

By the mid-1980s, this situation had changed dramatically. Policies regarding drug use had become common in workplaces of all sizes. Employee Assistance Programs (EAPs), the principal vehicle for intervening with substance abusers in the workplace, had begun to pay even more attention than before to some of the specific problems of drug abuse.

There is now little need to get employers' attention about drugs in the workplace. The problem is clear and it is serious, whether expressed in human or economic terms. Moreover, the problem will not go away without active interventions. The question is, *what* interventions and *how* to effectively implement them?

Meeting the Challenge: Three Commitments

This publication is designed to guide employers interested in developing or enhancing a workplace drug abuse program. It assumes that the employers, in conjunction with workers at all levels and with relevant outside experts or resource organizations, can and should take primary responsibility for developing an effective program. A workplace drug abuse program is not a commodity to be bought and plugged in like a new copying machine. To be effective, such a program needs to be treated as what it is: a major organizational change.

Meeting the challenge of workplace drug abuse necessitates three commitments by employers:

1. *Leadership commitment*—open, enthusiastic support from top management in the company for a workplace drug abuse program, typically expressed in a written policy about drugs in the workplace and the nature of employer responses

2. *Resources commitment*—the ability to assemble needed personnel and financial resources within the organization, and the required community resources for service delivery, that will make a program work

3. *Strategic planning commitment*—a well-designed strategic plan that develops the workplace drug abuse program effectively and places it properly within the organization is essential for undertaking the significant organizational change most programs require.

This publication is organized around the strategic planning process as currently used in major organizations all over the world. Integrated in the process are methods for enhancing leadership and resources.

Ways To Use This Publication

Three major uses are anticipated for the material that follows:

1. *Evaluation* of an existing program, to determine whether it addresses the special problems that workplace drug abuse represents, for example, that most drugs in the workplace are illegal; that misuse of prescription drugs can impair job performance; that some drugs like cocaine in "crack" form are more intensely and rapidly addictive than alcohol. Many workplace programs may already be doing much that is suggested here; however, a review using the strategic planning structure might identify areas for possible improvement.

2. *Enhancement* of an existing workplace program to provide more focused, effective attention to worker drug abuse (typically, this means enhancing an Employee Assistance Program that already includes services to workers with drug abuse problems, but redefining policy about drug abuse; adding new services; increasing insurance coverage; providing supervisory training, employee prevention and education activities; etc.).

3. *Extension* of an employer into providing substance abuse and related services for workers, using the current flurry of interest about drug abuse as a stimulus for involvement—this may be especially likely with small companies that have not recognized they might have workers with problems, or felt they could not afford their own employee assistance program (the overview on small companies identifies some helpful strategies).

For many employers, the high level of visibility and attention to drug abuse represents an opportunity for an "organizational passage," to use writer Gail Sheehy's term, a chance to move to a new level of maturity in effectively handling human resources. And as mentioned, these responses take place in a highly complicated environment involving health care benefits (and containing health care costs), health promotion activities, an employer's entire human resources development strategy, and the employer's position on social responsibility.

Workplace Drug Abuse: The Special Context

Part of the complexity employers must deal with in developing or enhancing a workplace drug abuse program is the special nature of drugs of abuse:

1. Use of drugs, except for prescribed medical purposes, is *illegal*. Employees using drugs are subject to arrest and imprisonment. Moreover, drug-using workers often buy their drugs in the workplace, introducing further illegal activity and the criminals who engage in drug sales. This can create problems of safety and security, and can increase the likelihood of other criminal behavior in the workplace (e.g., stealing from an employer in order to buy drugs). In worst-case scenarios, the whole social structure of the workplace can be jeopardized, e.g., a medical director fighting drugs on the job site who gets death threats, workers who are assaulted and robbed by other drug-addicted employees who "need a fix."

2. The *shield of medical necessity* often obstructs identifying and assisting workers with drug abuse problems. Prescription drugs are widely abused, but workers may be able to hide behind the claim "my doctor told me to take these pills."

3. The *toxicity* of some drugs (e.g., cocaine, especially in crack form, and many "designer drugs") is much greater than that of alcohol in the doses generally taken, and can lead to much more rapid and severe physical and psychological consequences. Drug abuse specialists note that it often takes 20 years for severe physical side effects to emerge from abuse of alcohol, as compared with 6 to 12 months for crack cocaine. Deaths from alcohol overdoses, while not unheard of, are rare (though deaths from long-term complications of alcoholism are, of course, very high).

4. Drugs such as cocaine often present a *detection* difficulty. Excessive use of alcohol

OVERVIEW II: THE PROBLEM AND IMPACT OF WORKPLACE DRUG ABUSE

This overview summarizes statistics and interpretations that have been widely quoted in the business and popular press over the last 2 years. Most of the data comes from the Research Triangle Institute's 1984 report for the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) on costs to society of substance abuse and mental illness. Other sources are cited in the bibliography.

Extent of the Problem

Experts estimate that between 10 percent and 23 percent of all U.S. workers use dangerous drugs on the job. Others may be under the influence when they arrive at work, or use drugs so extensively outside the workplace that their health and judgment are permanently impaired. As many as 65 percent of the young people now coming into the American workforce have used illegal drugs, reflecting recent changes in our society's attitude toward recreational drug use. The post-World War II "baby boomers," whose 1960's experiences with drugs strongly shaped these changing attitudes, are now in their 40s and moving into positions of key executive responsibility. Thus, they are in position to encourage or tolerate drug use, or conversely, to make decisions opposing drugs. In sum, the problem of workers who abuse drugs is not likely to go away or even abate significantly in any spontaneous way.

Impact on Employers

Drug abuse cost the U.S. economy $60 billion in 1983, or nearly 30 percent more than the $47 billion estimated for 1980. Lost productivity, absenteeism and turnover costs, increased health benefit utilization, accidents, and losses stemming from impaired judgment and creativity are among the drug-related difficulties included in this estimate. Because poor decisions or noncreative work by executives are often assumed to be unconnected with drug use, this part of the problem may be seriously underestimated. To give just one example, in 1985, a major airline's computer operator, high on marijuana, failed to load a crucial tape into the computer reservation system. The system was out of service for 8 hours at a loss to the company of $19 million.

A study conducted by Bruce Wilkinson of Workplace Consultants, Inc., though restricted to a small sample of employers, gives a vivid profile of a typical drug-abusing worker:

- Late three times more often than nonabusing employees
- Requested early dismissal or time off during work 2.2 times more often than nonabusing coworkers
- Had 2.5 times as many absences of 8 days or more
- Used three times the normal level of sick benefits
- Was five times more likely to file a workers compensation claim
- Was involved in accidents 3.6 times more often than other employees

The figure on accidents is especially disturbing because it includes workers with responsibility for public safety as well as for themselves and fellow workers. In 1979, for instance, a Conrail employee, high on marijuana, was at the controls of a locomotive when he missed a stop signal and crashed into the rear of another train; two people were killed. The National Transportation Safety Board attributed a fatal 1983 air cargo plane crash to illegal drug use. In Los Angeles, a succession of 1986 Rapid Transit District bus accidents in which dozens were injured was partially attributed to drug use by drivers. While data are still largely anecdotal, it seems likely that many industrial injuries are caused at least in part by drug abuse.

The effect of drug abuse on health benefits is not fully realized. This story began in the 1950s, when health coverage became an expected fringe benefit for workers. Coverage for alcohol and drug abuse treatment is now provided by more than 60 percent of all workplace-based insurance policies. State legislatures are beginning to raise legal minimums of such coverage, in response to mounting awareness of the burden on individuals and society from untreated substance abuse. As

a result, we are just beginning to see the tidal wave of costs to employers for treatment of drug-addicted employees through mandated insurance. Moreover, the costs of direct treatment are only one aspect. Other costs arise from injuries occurring under the influence (to self or others); early retirement or workers compensation settlements for workers whose health is permanently impaired by drug abuse; insurance and death benefits for those who die from the effects of addiction; and other diseases brought on by drug abuse, ranging from heart attacks to AIDS (in the case of intravenous (IV) drug users who share needles).

As the focus of health care in our society shifts more and more to cost containment, employers will inevitably look for ways to prevent and curb worker drug abuse. Effective cost containment requires it.

Impact on Workers

Drug abuse produces a wide range of consequences for users and their families. Along with the major effects of loss of life or job, serious illness, or family disruption, are many more subtle impacts. Drug abuse tends to cut workers off from the ordinary stimulation and satisfaction of their jobs (in fact, it is speculated that a major reason assembly line and other lower level workers use drugs is *because* it cuts them off from the tedium of their daily activities). This not only interferes with job satisfaction, but removes a major motivator that can help promote effective career development. Workers also may be isolated from all but other drug users in their work setting. Associating with drug dealers may even be physically dangerous.

Drug addicts are known to neglect their nutrition, sleep needs, and other aspects of physical health, rendering them more vulnerable to disease and illness. The cost of their drug habit may lead to bankruptcy or criminal activity—some drug addicts wind up homeless after years of earning high incomes. Marriages are shattered and children suffer. Drug abuse by any individual may involve a child, spouse, or other family member in drug use as well.

Drug addiction is likely to create a crisis in the life of the worker and his/her family for which no one is prepared. Because denial is a common pattern in addiction, serious damage can be done before drug-dependent persons, or anyone else close to them, recognize the need for professional help. With such fast-addicting drugs as crack, great damage can be done in a short time.

Impact on the Community

Drug abuse in the workplace affects the community in numerous ways. Higher prices for consumer goods and services result from the increased costs of health insurance, lost productivity, and other factors associated with reduced job performance. Another impact on the community is safety. In many industries, the decisions and actions of some individuals can exert an enormous influence on the safety, health, and well-being of quite large numbers of people.

Employers are in a good position to influence community attitudes and norms concerning substance abuse. For example, a clearly articulated policy about the use of alcohol and drugs in the workplace can let the community know that employer ABC will not tolerate substance abuse and that any employee with a drug or alcohol problem is required to enroll in an Employee Assistance Program. On the other hand, XYZ may be a company where drugs are tolerated, probably by inaction rather than intention, and that message can be harmful to the community, particularly for what it says to teenagers about the world of work. Teenagers and young adults eager to enter the job market are especially vulnerable to the messages conveyed by employers.

Employers who understand the realities of drug abuse and who have developed plans and programs for confronting those realities can be powerful motivators—not only for young people eager to get on with their careers, but also for employees who are abusers or addicts and who can be induced to "get clean" or face the possible consequence of loss of job. Workers who may be resistant to other interventions are often motivated to change their lifestyles dramatically when the threat of losing a job becomes real. The income, status, and meaning associated with a job—even a relatively low-income job—are important and compelling reasons for most employees to conduct themselves in concord with their employer's stated policies and expectations regarding job performance.

on the job leads to drunken behavior, which is usually hard to conceal, but workers on drugs like cocaine often can maintain an appearance of normality even while using heavily. As with alcohol, detection is made much more difficult by the worker's active efforts to conceal and deny his/her problem—and by the frequent complicity of coworkers in shielding the person with the problem. Drugs such as marijuana may exert subtle, but significant, effects on perceptual-motor performance. Workers high on cocaine may seem energized and creative, but when evaluated more carefully their ideas are often thin and judgments weak. By the time supervisors recognize these more subtle signs, great damage may already have been done.

5. The *traditional orientation of EAPs to alcoholism* is still a problem in some workplaces, because many employee assistance efforts were started by recovering alcoholics and most of their services are oriented in this direction. Most programs today only serve drug-abusing workers because multiple addiction has become so common. Some EAP staff have yet to receive specific professional training in drug abuse, and this may limit their effectiveness. Similarly, some supervisors may not identify performance problems as due to drug abuse, where the signs and symptoms can be somewhat different from alcohol abuse.

The challenge of building an effective workplace drug abuse program faces all employers in the United States today, from tiny entrepreneurial businesses with 20 employees to Fortune 500 companies considering extensive reworking of longstanding and successful EAPs.

Numerous new developments point to the need for evaluation, enhancement, and extension. Changes have occurred in awareness, in perception of employer responsibility to do something, in the technology for detection and treatment, in insurance coverage, in health care costs and containment, and in legal challenges.

All workplaces need to "look to the leaders" for inspiration in developing programs that work. This means examining programs such as the model programs presented in chapter VI. It means making use of resources developed by professional and trade associations such as the Association of Labor-Management Administrators and Consultants on Alcohol (ALMACA), the Conference Board, or the U.S. Chamber of Commerce's National Chamber Foundation. And it means looking at the Federal Government's leadership, both through the Anti-Drug Abuse Act of 1986 and the Executive Order calling for a drug-free Federal workplace. Finally, it means looking at the growing literature on this subject. In the research program the writer is directing, over 500 literature items have been identified already, and many of them are from business or health-related periodicals from 1986 and 1987. Consultants and EAP firms contribute as well, in both providing services and offering examples of good program development.

The essence of good strategic planning for any employer, large or small, in utilizing all these resources, is to determine how particular program models, activities, or services fit with the defined needs of the organization. Programs that succeed over the long run are well-designed to fit the particular circumstances of the given employer. This publication is dedicated to providing this combination of leadership, information, and the capacity to custom-tailor an effective program.

Employers in the 1980s are viewed as having major responsibility for shaping the environment and social conditions. The notion of private enterprise in isolation has been replaced by the concept of "corporate responsibility," an inevitable byproduct of the increasing interdependence of all areas of society and the increasing influence of the workplace. As U.S. Chamber of Commerce President Dr. Richard Lesher put it,

> It is imperative that business people take the lead in the campaign against drug abuse in our society . . . Business people wield significant power and influence in their communities. They are looked to for leadership in setting standards of personal behavior and particularly in public affairs.

Employers have the resources, the leverage with workers, and the responsibility (as seen by the community at large) for "doing something about drug abuse." This seems to be highly convergent with employers' self-interest in enhancing the quality and productivity of their workforces and minimizing accidents, poor decisions, and unnecessary expenditures on health benefits and other matters affected by drug abuse.

OVERVIEW III: GUIDELINES FOR SMALL ORGANIZATIONS

Some 58 percent of all Americans work for organizations with fewer than 500 employees, and many of the 40 million new jobs created in the last 10 years are in companies with fewer than 200 employees. Thus, the majority of workers in the United States today are employed in settings that may lack the resources to develop a major workplace drug abuse program. Insurance coverage in small organizations may be a problem, as well as financial and staff resources for program development. Most EAP experts stipulate 200 employees as the minimum size for an in-house effort.

Increasingly, small businesses are developing something like EAPs. Senior managers, perhaps in coordination with a human resources professional (typically a personnel director), often provide the impetus behind such programs, which utilize a variety of community-based resources to compensate for the lack of in-house programs. While many of America's new companies lack the perspective on human resources of the Fortune 500 (and the financial resources to implement that perspective), they are usually run by well-educated people who live day-to-day in the work setting and are likely to be concerned with quality-of-worklife for their employees.

While the guidelines and methods set forth in this publication may have to be modified substantially to meet the needs of small business, the three basic commitments remain the same: top management support, resources, and strategic planning.

Small employers might consider the following strategies in developing and implementing a drug abuse program:

- Band together with other small employers in the same geographic area (or the same type of business) and develop a consortium program (see chapter III for a definition, and chapter VI, model 2, the Entertainment Industry Referral and Assistance Center, for an example of this type of program).

- Encourage a local business or industry association to provide educational seminars on workplace drug abuse and to serve as a coordinating point for information and program development (perhaps also as the organizing unit for a consortium)

- Subcontract services from an existing program in a nearby large concern (see chapter VI, model 6, City and County of Ventura, for a model program).

- Join with other local employers to retain a consultant specializing in program development for a group consultation (perhaps leading to generation of several individual company programs or a consortium).

- Contract with a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO) that provides drug abuse treatment services.

- Contract with a local mental health or substance abuse professional in private practice for employee assistance services (some EAP experts consider this approach unwise, however, unless the professional has an adequate background in substance abuse problems in the workplace).

- Arrange for volunteer support for a program through local self-help groups, or perhaps through an employee who is recovering.

- Arrange for ongoing educational seminars and awareness programs through local chemical dependency treatment facilities, which usually will provide such services gratis because of potential referrals for treatment.

- Enhance insurance coverage to include drug abuse treatment in workers' insurance packages.

- Conduct a site visit to other small employers who have developed effective workplace drug abuse programs to determine how such programs can be developed despite limited resources. (This could be done as a group field trip through a local business and industry association.)

II

The Response

Current Workplace Programs: Successes and Shortcomings

Effective strategy is essential for an outstanding company. Strategy is the single most important differentiating factor between successful and unsuccessful businesses, and between corporate leaders and followers. An effective strategic plan, coupled with management commitment and deployment of adequate resources to implement the plan, is the single most important ingredient for a successful workplace drug abuse effort.

Employers have gained a great deal of knowledge about the challenge of workplace drug abuse, and now a lot is happening that can help employers determine the nature and extent of their response to this challenge. Interest in this topic has been intense since mid-1986. Many public and private organizations have reexamined and restructured their activities to assist workers with drug abuse problems. Corporate policies have been initiated or rewritten; management training has been provided; consultants or outside EAP contractors have been hired; in-house EAP staff have been trained in specific aspects of drug abuse. Drug testing has become a growth industry, with estimates of its current size ranging from $100 million to $300 million a year.

Many conferences, continuing education seminars, and special events by business and industry organizations have been conducted on drug abuse, and in particular on issues surrounding drug testing. Coverage in business periodicals and business-oriented television and radio shows has proliferated.

Even workplaces that do not have a "new program to fight drug abuse" have often assigned a human resources or medical department staff person to "look into the problem" or started a committee or task force.

The resulting situation is reminiscent of the ancient Chinese language symbol for crisis—it contains elements of both danger and opportunity. The opportunity comes from the energy and motivation to consider new programs and practices, some of which can be genuine improvements in how workplaces deal with drugs. The danger is that this same energy comes in an atmosphere of urgency to act immediately, sometimes almost a panic response of "we've got to do something—anything!—about drugs!"

Responses generated under such conditions are likely to fail for two reasons. They tend to be hastily conceived and sloppily executed, without regard for the known necessities for successfully implementing major organizational changes (and it must be understood from the outset that an effective workplace drug abuse program *is a major organizational change*). The other reason for failure is that individuals and organizations all too often deliberately look for a quick-fix, magic-pill solution, such as jumping on the drug-testing bandwagon or hiring a consultant to conduct management training sessions. These interventions typically are inexpensive ways of seeming to respond to the problem without really doing so.

While some of the new drug-testing organizations and consultants can indeed be part of an effective response to workplace drug abuse problems, there are no quick fixes. Careful planning and deliberate action are required to create programs and install them properly despite the urgency of the problem.

Fifty years of management research demonstrates rather convincingly that major organizational changes are unlikely to succeed unless they are well-planned and follow certain basic principles about the psychological and structural realities of people and organizations. The more urgent the problem, the more attention focused on it, the greater the temptation to apply a quickly conceived, "band-aid" solution. This kind of solution simply won't work.

How do employers today find successful drug abuse programs? First, they look for programs that fit the best of what we know about how to effect organizational change. Most of this publication addresses this concern through one particular method, strategic planning.

Second, employers look at what has already been done. This means examining their own activities, especially Employee Assistance Programs. It means looking at workplace drug abuse programs in the full organizational context—typically, units labeled "health benefits," "occupational safety and health," "prevention and wellness," "human resource development," and "security" are the most relevant.

It also means looking at the history of drug

abuse responses in America, including those from employers, to see what we can learn from past experience. Recent events certainly do not comprise all of "America's drug crisis." Cocaine was the subject of national concern in the late 19th century when a dash of it was added to Coca Cola, until public outcry sent it into the dark recesses of society for decades. In 1970, several large companies sponsored the First Symposium on Drug Abuse in Industry to consider issues of policy, screening, and so forth. The first major workplace-based antidrug program was started by the U.S. military in 1978. So we actually have quite an experience base to build on.

Thoughtful employers are now reappraising both the historical and the current climate of concern to determine what kinds of solutions might work best. What role can drug testing play? How can security issues best be negotiated? And what sorts of interventions can help to both treat drug abuse and prevent it? Out of such considerations can come creative, potentially successful responses to the problems employers face in the drug abuse area.

Foundations for Effective Response

Employers need not start at ground zero in developing or enhancing a drug abuse program. Taken together, the existing resources listed here constitute a foundation for effective response by both public and private employers:

- First and foremost, the Employee Assistance Programs in approximately 10,000 American workplaces and the body of knowledge and practice that has built up around them

- 50 years of research on organizational change and a large body of experience in American work organizations, with strategic planning as a method for coping effectively with change

- Current knowledge and practice in related areas such as human resource development, health care cost containment, health promotion, and creative use of employee benefits

- The larger changes in attitudes occurring in our society as exemplified by public persons such as First Lady Betty Ford "coming out of the closet" with chemical dependency problems and many other public figures in all realms giving the message (especially to young people) that it simply isn't "all right to do drugs" (as seen in First Lady Nancy Reagan's "Just Say No" program)

- Growth of the chemical dependency treatment industry and the increasing number of facilities available

- Leadership by the Federal Government, organizations such as ALMACA, and major employers in developing and implementing model programs

- Research on treatment, prevention, and methods for identifying and working with chemical dependency in the workplace—a developing new technology for effective response

All these basic resources are alluded to later in this publication, but two of them—EAPs and strategies for organizational change—seem worthy of further comment here.

Employee Assistance Programs

EAPs have become increasingly visible in American workplaces during the last few years. Although the estimate of 10,000 current programs is difficult to verify, many large and medium-sized workplaces undoubtedly have EAPs. These service programs, typically offered as employee benefits at no cost to the worker, help troubled employees deal with problems ranging from alcohol and drug abuse to marital and family problems, financial difficulties, and preretirement planning. EAPs represent an increased understanding by employers of the impact that unresolved personal problems of workers can have on organizational performance.

EAPs grew out of occupational alcoholism programs first established in American industry in the 1940s. Today's more comprehensive programs began in the 1970s, when changing corporate and social values began to press for greater intervention at the workplace to help troubled employees and their families. EAPs exist today in virtually every type of work organization: private industry, the U.S. Government, and educational institutions. Unions as well as management have shown positive attitudes toward EAPs and their potential for enhancing both employee well-being and organizational performance. In fact, EAPs are often seen as one of the latest steps in America's 100-year-long search for methods to improve worker performance as a way to meet organizational goals.

Typical EAPs are relatively small-scale programs staffed by a handful of professional persons with appropriate support staff. They provide confidential counseling and referral services to employees and their families. Some programs are operated internally, while others are conducted by outside consultants or consulting firms; most

provide only crisis intervention and referral services, plus some educational interventions, while a few are full-service programs and may include treatment. Some EAPs are operated by unions and others by consortia of employers in a given geographic area or type of industry.

Many EAPs offer some sort of service to persons with drug abuse problems, though the nature and extent of these services have not been documented. The National Institute on Drug Abuse has funded a major research study of drug treatment and EAPs that will provide new information on this topic (see appendix E).

Organizational Change

The main purpose of this publication is to provide guidelines for strategic planning by employers wishing to develop a workplace drug abuse program or to significantly enhance an existing effort. The principles of strategic planning presented here should be familiar to many readers, since they are used by many Fortune 500 companies as well as other public and private organizations.

The following principles are based on assumptions about organizational change that have been well-documented in academic literature and management research and publicized in such well-known books as Peters and Waterman's *In Search of Excellence*, Rosabeth Moss Kanter's *The Change Masters*, and Peter Drucker's *Innovation and Entrepreneurship.*

- Effective change begins with setting goals for the change program, expressed in measurable terms and set into a formal organizational policy.

- Planning to implement these goals needs to be a systematic rather than a haphazard or informal process, with adequate documentation of the steps by which the goals will be achieved (this is called the strategic plan).

- Effective change in worker behavior, especially in an area as sensitive as use of drugs, requires certain corresponding changes in organizational culture; the culture must, to some extent, have been supporting and reinforcing the behaviors that are no longer desired, which adds to the complexity of change.

- To be successfully implemented, a change program must be developed through active participation in the planning process by all those in the organization who will have to live with the results of the change—i.e., representatives of workers at all levels in the organization.

- Once successful, a change program must be evaluated and improved to maintain its vitality and viability over time.

- A change program must be integrated effectively with the existing successful organizational components, being careful to remember, when contemplating changes, that old workplace maxim, "If it ain't broke, don't fix it."

Making the Three Commitments

This brings us back to the three commitments from management—leadership, resources, and strategic planning—needed for an effective workplace drug abuse program. Part of the value of strategic planning is that the other two commitments can be viewed from an integrated perspective.

In *The Change Masters*, Rosabeth Moss Kanter emphasized the importance of integrative approaches to problem-solving as a key to effective innovation. Any problem requiring change must be seen in its larger context, she said, thus opening the door for challenges to conventional wisdom and to solutions that draw upon natural synergy and combined efforts of many people.

Certainly this advice applies in the drug abuse area. As will be seen in chapter V, employers face a bewildering number of complexities and challenges with respect to drug abuse in the workplace. While we know that drug abuse programs are an aspect of overall organizational efforts to maximize human resources (which is in turn a key focus of all the "excellence in management" books), these efforts to change the workplace and workers in it are far from the ordinary human resource development program.

Drug abuse, it is said, is a disease of denial. Breaking through the denial isn't easy, and many change efforts may be resisted for this reason alone. Whole organizations can deny that problems exist, despite overwhelming evidence to the contrary. An organizational pattern of denial can resemble the family dynamic in which parents are unable to accept the reality that their child has a drug problem. This kind of blindness and denial can have sad and dangerous consequences.

One stage in the denial response appears on the surface to be a healthy recognition of the problem, but the reaction, in effect, continues the denial by saying, "I know there was a problem but now I've solved it." Much of the motivation for quick-fix solutions to drug abuse problems in the workplace and elsewhere derives from this common avoidance pattern. Management should know about this psychological reality and be on guard when it is manifested.

Any change effort concerning drug use is complicated by the fact that most drug use in

the workplace is illegal. Change strategies must also contend with the reality of the many social reinforcers that condone drug and alcohol use, on or off the job. A problem-solving approach, to succeed, must be flexible and able to adjust to rapid changes in drug use patterns and to social perceptions about using drugs and alcohol. Management that is cognizant of the dramatic changes that occur in the drug abuse area will devise strategies to cope with these inevitable changes, such as recent developments in legal cases involving drug testing; changing medical technology and health insurance provisions; and the emergence of laboratory-created "designer drugs," just to name a few. Thus, tomorrow's drug crisis will look only somewhat like today's, and the effective program will anticipate these major trends in its design.

Effective drug abuse programs produce other positive changes in the workplace. An integrative, human response to the problems of drug abuse can help an employer's image both inside and outside. Organizational morale can be greatly boosted, and a more positive community image created. Dealing with the disease of denial and the performance decrements involved in drug abuse can promote greater innovativeness in other areas. Rosabeth Moss Kanter says that "open communication is fundamental to innovation." How can there possibly be open communication in an organization that is unwilling to talk about and take action on problems of workplace drug abuse? Moreover, as has been firmly established in studies of the creative process, drug abuse depletes creative, innovative responses. "Drugs don't make you more creative; they just make you think you're creative." The greater an organization's problems with drug abuse, the more likely it is that creative decisionmaking and innovation declines.

III

Planning for a Workplace Drug Abuse Program

This chapter presents the elements of a strategic planning process for developing a drug abuse program in any public or private workplace. Chapter IV then describes each of the 10 major planning steps in more detail. Commitments of leadership and resources are assumed to have been made by the time planning begins, although deployment of what these commitments provide is an essential part of strategic planning. Indeed, a major organizational change like a workplace drug abuse program requires regular reexamination and revitalization of the commitments of leadership and resources, as the section on conceptual foresight makes clear.

Adapting This Model to Review Existing Programs

When used for evaluating or enhancing an existing workplace drug abuse program, the strategic planning model presented here becomes a list of review questions: Have job performance standards been developed in a useful way for dealing with drug abuse problems? Are they up to date? Are organizational patterns of drug abuse changing? (Many workplaces find that patterns have changed substantially just since 1980.) Based on changing patterns of abuse, what corresponding changes in community resources might be helpful? And how should the strategic plan be modified in light of these considerations?

A significant program review or enhancement, of course, can be almost as much of an organizational change as starting a program from scratch, so strategic planning principles should also be used in designing and carrying out such a plan. Thus the model given here can be a framework for these activities as well.

Establishment of Job Performance Standards

Impaired job performance is the most immediate justification for intervention with a suspected drug abuse problem. Supervisory referral to an EAP under such circumstances can include "constructive confrontation" in which the employee's possible need for help is presented candidly and the leverage of "keeping your job" is used to motivate a response.

Education and prevention activities, important components of many workplace programs, do not depend on observed performance problems. They are intended to prevent performance from deteriorating in the first place. Moreover, standard methods of supervision and job performance evaluation, even if satisfactory for other purposes, may not be sufficient for early detection of drug abuse problems. Supervisors may need to learn how to detect and understand subtle signs of deteriorating performance associated with drug use (e.g., impaired judgment, memory lapses, etc.). But these more subtle judgments, too, have to be made against some baseline.

Organizations need specific standards of performance for each job to provide an objective basis for documenting inadequate or deteriorating job performance. A work organization has a vital interest in the negative impact of employee drug abuse on job performance since such abuse can increase costs due to absenteeism, turnover, lowered productivity, etc.

Basing any action on job performance avoids unwarranted intrusion into employees' private lives. Moreover, if the threat of disciplinary action or dismissal is used to get a worker into a drug abuse treatment program, ineffective job performance must be absolutely documented, particularly given recent legal decisions that allow workers to bring actions against employers who discipline or dismiss without cause.

Many small or recently established work organizations may find a legitimate problem in developing job performance standards. Often small organizations lack the kind of system and documentation that large companies or government agencies do; the organized bureaucracy of human resources development hasn't reached them. They may need to invest time and money in building such job performance standards for each class of worker, but there are many good business reasons for developing them. Trade associations, business and professional societies, and consultants may all be helpful in providing the expertise needed for developing these standards.

Needs Assessment

Organizations differ widely in the pattern and type of drug abuse occurring in the workplace. Some of these variations relate to the community in which the company exists, the demographics (e.g., age range) of its workers, or other factors such as salary levels (high disposable income makes some patterns of drug abuse easier). Being able to discriminate between patterns or varying levels of drug use or addiction, and to discriminate between abuse of prescription drugs and illegal street drugs also are important.

The types of drugs presenting a problem will affect the focus of a program in that different drugs require different counseling and treatment approaches; e.g., a significant incidence of cocaine abuse may necessitate arranging for special treatment services. Similarly, the extent of drug abuse will determine the size of the potential caseload.

Several possible approaches can be used to estimate the nature and extent of drug abuse within a work organization:

- National or regional studies of occupational drug abuse, especially those specific to the organization's area of work, can provide rough approximations that may be useful as an economical starting point.

- Statistics gathered by local substance abuse agencies (or health or law enforcement agencies) to depict the extent and the consequences of workplace drug abuse may be useful.

- Statistics gathered by local treatment facilities or by local chapters of ALMACA, National Council on Alcoholism chapters, or other service-oriented associations may be relevant.

- Statistics provided by local or regional business and industry or trade associations may pertain. (Some national organizations of this sort can also provide statistical profiles.) Local medical societies with an impaired physicians program may have statistics to offer a hospital planning a drug abuse program for its own staff, just to give one example. Local hospitals may also provide statistics on drug- and alcohol-related emergency room cases.

- Original data may be collected in the workplace by organizational staff (typically EAP personnel, human resources staff, or a special committee or task force of workers). Anonymous questionnaires and interviews are essential to promote accuracy of reporting. In addition, human resources or medical department records can be analyzed for both direct and indirect statistics (number of persons hospitalized for drug abuse problems, absenteeism, turnover records, etc.).

- Original data may be gathered by outside consultants. Royer Cook International, a Washington, DC-based research and consulting firm, is one of several organizations currently developing instruments for gathering data about drug abuse incidence in the workplace. In addition, software is now being developed for EAPs to create their own ongoing databases about incidence, consequences, treatment modalities and effectiveness, and other data useful to drug abuse programs.

Evaluation of Current Resources and Responses

The nature and scope of any drug abuse program will depend, to a large extent, on the types of resources available within the company and in the local community. Accordingly, it is important to evaluate these resources and design the program around them (or so that critical missing resources can be identified and located).

Organizational resources include the following:

- Available staff and budget commitments in human resources, medical, security, safety, and health benefits departments, including attitudes of staff in these departments toward drug abuse

- An existing employee assistance program and its activities

- Existing health insurance benefits for drug abuse treatment. A recent survey reported by the Clearinghouse for Business Coalitions on Health Actions stated that 68 percent of companies with more than 5,000 employees provide some sort of insurance coverage for drug abuse, while only 51 percent of companies with fewer than 100 employees do so (while many States now make coverage of drug abuse treatment by health insurers mandatory, companies with fewer than 25 employees are often exempt). A secondary part of this analysis is to find out what kind of coverage is provided: Can outpatient services be paid for? Can inpatient services be funded more than once?

- An existing physical facility to house the program that provides basic needs for privacy, security for records storage, etc.

- Existing self-identified recovering drug abusers who could be encouraged to provide support and volunteer services to the new program

Community resources that can be surveyed include:

- Inpatient chemical dependency programs (either free-standing or associated with hospitals or university medical centers)
- Outpatient treatment facilities
- Halfway houses and other residential treatment programs
- Methadone maintenance programs for heroin abusers
- Volunteer and self-help organizations (especially AA and other 12-step programs)
- City or county funded drug abuse prevention and education centers
- Consultants and consulting firms offering supervisory training, education and prevention programs, and other services
- Related resources, such as a stress management program available through the local community mental health center

These resources can be identified through several entities: local chambers of commerce or business and industry associations; local treatment facilities; alcohol or drug abuse city/county coordinating agencies; local chapters of ALMACA or other drug abuse-oriented groups; or knowledgable persons already employed in the given workplace.

For any and all treatment resources, a workplace representative should visit or telephone to verify what services are available and how they can be accessed. Ideally, such information-gathering should be guided by a standard form or interview schedule. These data can be the beginning of the resource inventory needed by any workplace drug abuse program for effective operation. This resource identification and inventory is analogous to the process by which companies develop specifications in preparing to seek bids for goods or services to be purchased, and conduct reference checks on quality, reliability, and other measures of satisfactory performance.

Strategic Planning Model

Once job performance standards have been developed and an initial needs assessment has been conducted to determine the extent of the problem and current resources evaluated, the organization can decide whether a drug abuse program is needed, and if so, then construct a plan to make it happen. These first three steps may be the conjoint activity of a special task force or committee within the organization, which ideally includes representatives of workers at all levels and relevant unions if any are involved. The steps just outlined are considered preliminary to the development of the strategic plan itself because the organization may decide not to implement a program if, for example, the specific problems of drug abuse turn out to be much less than predicted, or if an appropriate response could be simply incorporated into present service offerings.

The next step is to develop a strategic plan for the workplace drug abuse program. The following 10-step model for developing such a plan is based upon principles of strategic planning used widely in private industry, especially among Fortune 500 companies. For those interested in reading more about the basic concepts of strategic planning, some basic reference works are listed in the bibliography.

Typically a strategic planning approach begins with commitment from the organization's top management to an enhanced workplace drug abuse program. Appointment of an individual or committee to develop a written strategic plan based on this model comes next. Usually the plan will be developed by staff, although in some cases an outside consultant might be retained for this purpose. Management may assign a deadline for delivery of the written plan and provide some general guidelines about its later implementation.

The strategic planning process may require weeks or several months of activity to develop a set of organizational goals and proposed activities in each of the strategic plan's 10 content areas. The final plan may be anywhere from several pages in length to an extensive report. It covers issues such as whether all worksites and employees will be included in the proposed program (a policy issue); whether preemployment drug testing or testing for cause will be conducted; and how the drug abuse program will be integrated with the organization's existing programs and policies. In general, a fair amount of detail without exhaustive background material will provide the most useful guidance for creating a program. For example, the strategic plan may outline the main components of organizational drug policy without developing a full text. It may set goals and general procedures for supervisory training without detailing training content.

Those involved in the planning process can get much valuable input from workers and supervisors, including information about current addiction problems and other matters, as long as

OVERVIEW IV
STRATEGIC PLANNING MODEL FOR WORKPLACE DRUG ABUSE PROGRAMS

1. Setting organizational drug policy
2. Developing a written program design covering all aspects of operations, staffing, and financing in eight program areas
3. Supervisory training on drug abuse
4. Identification (including drug testing) and outreach program components
5. Workplace security components
6. Assessment and referral program components
7. Counseling and treatment program components
8. Followup program components
9. Recordkeeping and evaluation program components
10. Prevention and employee/family education program components

it is apparent that confidentiality will be maintained. Another valuable resource is other employers in the local community who may be willing to share what they have accomplished in their own programs—how they are set up, their goals, how they operate, and degree of client satisfaction. Other issues may also be addressed in these interactions such as the quality of certain treatment facilities and how to convince top management that a program is needed.

Once the report has been written, a critical step is having it reviewed while still in draft form by relevant supervisory staff in the organization and perhaps by some outsiders as well. For instance, review by a union official might be essential for later support in the event that management, for whatever reason, did not include union representation on the planning committee.

Review by a consultant or professional in the drug abuse field might also be of value. The report should definitely be reviewed by representatives of all levels of workers in the organization, to determine whether the general goals and procedures in the strategic plan are fair, technically correct, and feasible.

During all phases of development, the report must be reviewed by the organization's legal counsel, and if possible, by an outside legal expert with special knowledge in litigation and liability issues regarding workplace drug abuse. Legal challenges to workplace drug abuse policies and programs are proliferating, according to articles in newspapers and law publications. As reported in case summaries in the newsletter *Drugs in the Workplace*, arbitrators and courts generally find for the employer where a well developed and well communicated policy exists, another reason for management to develop a strategic planning group. The area most under contention is drug testing (see section on drug testing in chapter IV), but virtually every aspect of a workplace drug abuse program should be subjected to careful legal review in order to limit organizational liability. Moreover, there should be a process for ongoing review as the program develops.

Finally, the plan is presented to top management for approval and implementation of the program (covered in the next chapter). When the plan for the drug abuse program is announced to workers, the help of those who participated in its development should be acknowledged. Mentioning individuals by name will build credibility for the program by letting workers know how much professional advice came from their own ranks.

Conceptual Foresight

A good strategic plan has built-in components for conceptual foresight—anticipating possible deficiencies or problems in implementation, and planning in advance for their resolution. Many otherwise good programs fail because their designers did not anticipate anything going wrong, as if they had never heard of Murphy's Law; by the time the problems are evident, it may be too late!

Five questions about conceptual foresight that seem especially important for developers of workplace drug abuse programs are:

1. Are there any deficiencies in available leadership resources? Does the plan have the approval of the president, chief executive officer, or chair of the board? For example, are one or more top managers giving enthusiastic lip service to the program but expressing private doubts or hesitations? (On occasion this may even happen for a uniquely embarrassing—and most dangerous—reason: the executive is him or herself a drug abuser! How to deal with such a delicate matter must be thought out in advance, or the program is likely to fail no matter how well designed otherwise.)

2. Are there any deficiencies in available personnel or financial resources? Do key personnel have the skills, knowledge, and experience needed to implement a full-scale EAP plan? For example, despite excellent commitment of finances, could a downturn in company revenues or profits create a funding crisis? What would happen if certain key personnel left the organization? Does the local community have the treatment resources needed to make the program work?

3. Might there be a problem of overresponse—developing a program more intense than the organization's drug abuse problems really justify? An overly intense program, especially one that requires numerous experts, in-house or external consultants, or that involves sensitive areas like testing for drug use, may lose credibility quickly.

4. Might there be a problem of overexpectation—the program is being "sold," or at least being viewed (by management, by workers, or by the community at large) as leading to direct and immediate "cure" of all drug abuse problems, or even all problems of productivity and performance in the workplace? When this unrealistic dream does not come true, the good the program otherwise does may be ignored, and credibility can be permanently compromised.

5. Might there be a problem of overextension—a program that is intended to meet a real need, but sets more ambitious goals than it can realistically accomplish? Again, quick loss of credibility can happen in such a case.

With all these potential problem areas, the key ingredient is advance planning. We start with the assumption that the problem can and will happen, but that we can limit or even avoid negative consequences with clever strategic planning.

Interfacing With Other Organizational Programs

Drug abuse is a hard problem to grapple with because it relates to so much else in the workplace. For this reason, and because many organizations already have begun interventions that may help reduce the problems of drug abuse, it is imperative that the designers of a workplace drug abuse program determine early on how this will interface with other organizational components.

The clearest example of such a component, of course, is an Employee Assistance Program. The EAP already has set up mechanisms for counseling, education and prevention, maintenance of confidential files, and other devices that are of enormous value for a budding drug abuse program. Thus the force of the strategic plan should be to embrace the EAP, not to ignore or sidestep it.

Workplace drug abuse programs also need to interface with the human resources or personnel departments of an organization. Many of the program's activities will in fact be administered through human resources.

Health care and other benefits programs offer a natural tie-in for the drug abuse program. In many cases, the single most important determining factor in a worker's getting the needed professional services is whether it will be covered by health insurance.

It already has been emphasized that the goal of any workplace drug abuse program is to help workers with problems get help (as well as preventing drug abuse in the first place, education, etc.) and today companies vary enormously in the benefits they offer. An increasing number of organizations, including many of the larger Fortune 500 corporations and the larger public agencies, have workplace health promotion and wellness programs. These emphasize exercise, stress management, weight loss, and other factors that need to be integrated with an organization's drug abuse program. Sometimes the nature of these interrelationships is fairly complex. For example, many issues of confidentiality may have to be worked out to permit a consultation about a given worker between the staffs of the drug abuse program and the company-run weight loss program, even though drug addiction from diet pills is a major problem. Similarly, inclusion of stress management training for ex-drug abusers may be a significant part of the rehabilitation process.

Company medical and security departments also need to be involved in the development of a drug abuse program. Both these departments can be excellent referral pathways. The credibility and potential for referrals stemming from interest in the program by the company medical director or security head may be quite substantial.

Integration also should be achieved with existing community treatment and rehabilitation resources. These facilities, including self-help groups, can be of tremendous value both in initially detecting and treating drug abuse and in maintaining workers drug-free after they've been through an intervention.

IV

Implementing a Drug Abuse Program

Every organization using the 10-stage Strategic Planning Model presented in chapter III will implement it differently. The 10 components are defined more fully here, with lists of issues and implementation steps given, as well as some examples. More information is available through publications listed in the bibliography and the resources listed in appendix E.

The Overall Context

Like any other organizational change, a new (or enhanced) workplace drug abuse program gets implemented in a complex, sometimes contradictory context. Some of the contextual factors that need to be considered include the following:

- Integration of efforts to deal with drug abuse problems into an existing (or developing) Employee Assistance Program that also attends to alcoholism, and quite likely a variety of other workplace and personal employee issues

- Integration of the program with the organization's efforts in human resource development, health promotion, etc.

- Integration with existing job performance standards, health benefit coverage, labor-management agreements, employee disciplinary policies, workplace security policies, etc.

- Attention of the program to other factors that might affect drug abuse (especially self-medication for stress), such as financial difficulties of the organization

- Attention of the program to factors common to the industry of which the given workplace is a part (e.g., working conditions that appear to produce greater likelihood of substance abuse in industries such as entertainment, professional athletics, banking and finance, etc.)

- Attention of the program to local community attitudes and activities with respect to drug abuse (for instance, does the workplace exist in a community known to have serious drug abuse problems or an unusually effective/ineffective treatment system?)

In fact, all the special issues cited in chapter V constitute contextual issues to which program planners must respond, either by deciding they are not relevant (or at least not addressable), or by determining how to respond to them. And the contextual factors work both ways. For instance, a company working to establish a drug abuse program might also consider how this activity could "pull along with it" efforts to provide stress management training for employees (to reduce self-medication for stress and for other purposes).

Program Administration and Staffing

Staffs for workplace programs tend to be small, even when very large organizations are being served. The typical program in a medium- to large-sized organization will consist of a program director plus an administrative assistant and one or two counselors at the most (however, these full-time staff are often supplemented by part-time human service professionals working on a contract basis, especially if the program is providing clinical services to a large number of employees).

Outside Consultants

For those employers choosing to operate a program through an outside consultant, all the standard organizational guidelines about identifying, evaluating, and choosing a consultant apply. Consultants and consulting firms in the employee assistance/drug abuse field abound these days, and both outstanding practitioners and dubious choices are available. A few of the questions that may arise when selecting a consultant include the following:

- What is the consultant's track record in working with troubled employees?

- What track record does the consultant have with organizations in the employer's community or industry?

OVERVIEW V: PROGRAM MODELS

Seven of the program models most frequently seen today in both public and private workplaces are:

- *Education-only*: Some organizations may wish to begin their efforts to combat drugs in the workplace with educational programs for workers, supervisors, and executives. These can offer helpful guidance on how to recognize problems of abuse, what community resources are available, etc. To be effective, this kind of program requires a director with the training and skills to know what educational materials to use and how to present them. However, in most instances education alone will not solve a company's drug abuse problem if one exists; this should be considered a first step toward developing and implementing a comprehensive program.

- *Referral-only program*: Programs of this type combine inperson and/or telephone referral to community resources (self-help programs, chemical dependency facilities, etc.). Sometimes a modest amount of crisis intervention counseling may be provided as well, since it may be necessary to intervene with an emotionally distressed drug abuser or family member in order to learn enough to make an appropriate referral. In some communities, even crisis intervention services may be available from an outside agency, so that the inside person has only to give a telephone number to the worker seeking assistance. The program does not provide financial or case management support for services, however.

- *Workplace-run program with outside treatment resources*: In this model, referral and crisis intervention resources are combined with some level of direct service provision supported by the employer, whether through direct payment or insurance. The program coordinator and staff (if any) are employees.

- *Consultant-run program with outside treatment resources*: In this model, referral, crisis intervention, and short-term treatment resources are coordinated and offered by an outside consultant retained by the employer for this specific purpose. In most larger cities, consulting firms are now readily available, and some are set up to provide national or regional services for multisite workplaces as well. Again, major treatment services are provided by outside facilities.

- *In-house program*: Only a few workplaces do it all, i.e., provide initial services and a range of treatment programs operated by the work organization. Some Federal Government agencies operate on this model (e.g., the military services); so do a very few companies and an occasional union. However, the complexities of maintaining a full-service facility and hiring appropriate professional staff are such that even most large, multinational corporations do not find it cost-effective to do so.

- *Consortium program*: In this model, a group of work organizations (or sometimes employers and unions combined) jointly develop and fund a program. Typically, the workplaces are within a defined geographic area, and often they are within the same or related industries as well. This approach is used frequently by organizations too small to have their own independent programs, and it may be facilitated by a local chamber of commerce, business and industry association, or other group. An early example was the Downtown Drug Center in New York City, which was jointly sponsored by AT&T, the American Stock Exchange, Chemical Bank of New York, and Merrill Lynch. Another example is the Entertainment Industry Referral and Assistance Center, presented in chapter VI (see overview II for more details on this model).

- *Mixed model program*: Large, multisite work organizations have recently begun deploying this approach to dealing with worker/family needs that may vary greatly from site to site. Economic as well as service issues may be involved, as an employer can realize significant cost savings by using outside consultants for some work sites and an in-house program for others. For example, a corporation may coordinate an overall program through an in-house coordinator based in the corporate offices, with a blend of outside consultants on contract for some remote sites and a telephone hotline for referrals (often through the corporate headquarters program) at others, especially small sites with only a hundred or so workers. Management training, program development, administration, and policy are all handled by the corporate-office in-house program in most of these arrangements. The Union Carbide EAP has been moving toward such a model recently, and Toyota Motor Sales USA, currently in transition, is considering the Mixed Model Program as one of its options (see chapter VI).

- What is the specific track record in drug abuse? Some EAP consultants come from a mental health or alcoholism services background and may know little about drugs such as cocaine.

- What level of detail about operations and success rates is the consultant prepared to share in advance? An almost sure sign of a poor choice is the consultant who is unable to talk about the specifics of program design or who will say nothing about success rates with other clients.

- What do other satisfied clients of the consultant have to say? Another easy sign of a dubious consultant is unwillingness to provide referrals to other clients.

- What will the services cost, and specifically, what is provided for the costs incurred?

Staffing

In the past, many treatment program and worksite effort staffs, including a number of program heads, were recovering substance abusers. As the chemical dependency field expanded, this situation changed somewhat, and fewer staff now have this background. At present, many major universities offer training programs for employee assistance counseling, and an increasing number of professionals are selecting this field as their first career choice.

Moreover, certification programs now are emerging for personnel in the employee assistance field. ALMACA has begun a national program, and the American Medical Society on Alcoholism and Other Drug Dependencies has one for physicians. Each State has its own certification standards and boards, and there is a National Commission for the Accreditation of Alcoholism and Drug Abuse Certifying Boards. Other organizations supportive of sound certification standards include the National Association of Alcoholism and Drug Abuse Counselors and the Certification Reciprocity Consortium, based in Oak Park, IL that works to facilitate transfer of certification when counselors relocate in other States. Certain States, California for example, are also experimenting with legislation requiring certification of EAP operations and personnel.

The recovering person has a unique perspective and often can see beyond the denial, other defense mechanisms, and manipulative behavior of an addict that may be difficult for a nonrecovering person to detect. At the same time, knowledge about treatment methods, program administration, and substances of abuse that an individual has no personal experience with does not come automatically to recovering people. These result from professional training and may be important to program success. Mental health background and training are also important, especially for dealing with the more serious individual or family psychopathology that may be part of the addiction experience.

Placement of Program in Organizational Structure

The administrative placement of a program relates not only to management of organizational operations, but to program effectiveness as well. In general, effectiveness is heightened if the program is regarded as a professional service made available to employees (this is one reason so many programs are contracted to outside consultants).

Administrative accountability should be restricted to aspects external to the actual provision of services, e.g., operating expenses and information on outcomes should be reported. Coordination with other departments on such matters as health insurance coverage is also necessary. At the same time, a considerable independence helps to promote the confidentiality of the program. In particular, the program must be free of any specific identification with a security department, since this would compromise the treatment approach (more on this below).

The most common placement is within an existing Employee Assistance Program. Other choices are the workplace's human resources department, medical department, or special placement in the office of the CEO. Except under unusual circumstances, placement within company security or safety departments would be inadvisable because of the regulatory purposes these units serve.

Organizational Policy

A written policy statement should be prepared and distributed to all workers, stating the organization's philosophy and practice with regard to employees who abuse drugs. As such, it provides guidelines to management and supervisory personnel for handling employees suspected of abusing drugs. In addition, it can be used to inform all employees about the organization's position on drug abuse and provisions for assistance for those employees with drug abuse problems.

It may be valuable to read other workplaces' policy statements and to consult with those responsible for creating policy guidelines to determine why certain issues were covered, how the policy was reviewed and revised in draft form before finalization, etc. Some sample policy statements are provided in appendix B.

Content

Issues that need to be addressed in the policy statement include the following:

- The organization's overall position on drug abuse (e.g., drug abuse is a medical problem, but it is unacceptable in the workplace)
- The organization's position on consequences for employees using, selling, or possessing drugs in the workplace (discipline, termination, due process, etc.)
- The organization's position on job performance as it relates to drug abuse
- The organization's position on safety of the public and coworkers as related to drug abuse
- The organization's position on the treatment and rehabilitation services available to employees who have drug problems
- The responsibility of the employee to seek treatment
- The need for strict confidentiality for employees who are in treatment and procedures for dealing with any violation of confidentiality
- The organization's position on drug testing

Review of Policy

A policy statement should be drafted by management, union representatives, and workers representing all levels of the company. Active cooperation with any labor unions involved is essential since the policy almost surely will touch on issues governed by union contracts. Human resources, health benefits, security and other involved departments must be allowed to review the policy in terms of its impact on their operations. Staff involved in long-range planning for human resources of the organization need to appraise the policy for its impact on the workplace as a whole. A review by appropriate legal experts is necessary because policies related to drug testing, rehabilitation, and so forth are the subject of increasing litigation.

If an EAP exists in the organization, it is especially important that EAP staff be involved in drafting and reviewing the drug policy statement even if the EAP will not be solely responsible for implementing it. EAP activities will be critical to the success of any drug policy, for treatment and rehabilitation, and for prevention and education purposes.

Communication of Policy

A written policy statement, made available to all employees, can serve as an effective introduction to a drug abuse program. Organizations often overlook the communication value of a newly completed policy, for instance a special memo from the CEO announcing it, or even an all-hands meeting of workers to discuss how the policy will be implemented. In some cases, formulation of a written policy may toughen or make more specific a stance the organization has long taken. For example, in 1984 Kimberly-Clark reiterated its long-standing policy on substance abuse by issuing a written statement about the sale, distribution, or use of alcohol or other mood-altering substances on company property. The statement clarified the company's intent to promote a drug-free work environment to protect the health and safety of all its workers. Sometimes the policy statement may be used to give a 30- or 60-day advance warning that new procedures will be instituted, such as testing, suspension, or firing under certain circumstances.

When a policy statement has been completed, consideration should be given to various methods of communicating it within the general employee population. The program can be publicized through an organization-wide memo, supplemented by pay envelope stuffers or even mailings to employees' homes. Information posted on bulletin boards or placed in the workplace's newsletter can also help. An initial orientation session at which workers gather with top management can serve an important function. Ultimately, however, the most effective publicity may come from word-of-mouth among employees, once the program has established a solid reputation.

The content of program publicity can include a statement of the organization's policy on drug abuse, a description of the services offered under the program, and information on how to contact program staff. Confidentiality should be stressed.

Program Plan

A specific written plan for the operation, staffing, financing, and evaluation of the drug abuse program is essential for effective operations. Although such a plan may be brief, it needs to specify how the program will operate, the reporting structure within the organization, provisions for regular review of policy/procedures and outcomes, and mechanisms for program improvement over time. The plan should include details about each of the eight program areas (steps 3-10) in the Strategic Planning

Model (see p. 15). Reviewing the plan with other local employers who have recently installed drug abuse programs may also be quite valuable.

Management and Supervisory Training

Training for front-line supervisors and senior managers in a workplace may be needed in a number of areas. Most newly developed programs benefit from a training needs assessment done as soon as possible after the program design has been approved. Training may be necessary to prepare managers in some of the following competencies:

1. The physiological and psychological aspects of addiction and specifics about major drugs such as marijuana and cocaine

2. How to detect, and detect early on, deteriorating performance that may be related to drug use (while it is not the purpose of any drug abuse program to make supervisors into drug detectives, some knowledge of the warning signs of drug abuse—both physical and psychological symptoms—may alert supervisors to employees needing closer watching at the performance level)

3. The special issues surrounding drug abuse in the workplace—testing, drug trafficking, etc.

4. Prevention and education strategies and how to implement them

5. How the drug abuse program relates to other EAP activities, insurance coverage, health care cost containment, and other issues in the human resources area

Education may take several forms, including seminars, films or videotapes, lectures, or printed materials. Appendix E lists some potential training resources. The education sessions may be conducted by the program coordinator, outside consultants, or other personnel closely associated with the program.

Special Training for Managers

Middle and upper management personnel also may need training in how to convey the concepts of the program to their supervisors. Their training sessions can include orientation to the use of drug abuse programs in other workplaces, statistics on evaluation, and the provisions being made by their own organization for evaluative activity. Knowing what is happening nationally in the drug abuse arena and what is best practice in a given industry can help managers assume leadership positions in their own workplace. Finally, managers can receive awareness training about drug abuse in their own ranks, which may help some of them to self-refer for program services and others to identify executive performance problems that can lead to management referrals.

Special Training for Supervisors

Supervisors, because of their central role in the referral process, benefit from special training in addition to general education on drug abuse and program goals. That is also true for union representatives who may be involved in the referral process. Training should focus on the functions of the supervisor in the referral process: observing and documenting unsatisfactory job performance, notifying employees when their job performance is unacceptable (e.g., using constructive confrontation), referring an employee to the program or encouraging employees already receiving EAP services. Care should also be taken to teach supervisors what they should not do: they are not drug abuse professionals and should not try to either diagnose or treat possible drug problems among their workers.

Three training approaches are provided in appendix C.

Identification and Outreach

Identification: Getting the Referrals

Workers are referred to drug abuse programs in four principal ways:

- Self-referral

- Supervisory referral (including both voluntary referrals and those involving constructive confrontation or disciplinary action; it may also include referrals made by medical or human resources department staff as well as the worker's direct supervisor)

- Drug testing referral (described more fully below)

- Family referral (a family member, today even a minor child, may confront the worker with a suspected drug abuse problem and encourage treatment)

When the referral is to some extent nonvoluntary, both those making the referral and the program personnel receiving the individual must

be prepared for hostility and suspiciousness about the drug abuse program. Even with voluntary referrals, the denial process may still be strong enough to prevent a clear statement about the nature and extent of drug abuse. This increases the importance of initial assessment services (see below).

While detection of impaired job performance is the single most frequent reason for a supervisor to make a referral, early detection often is possible through observation of unusual behavior (e.g., obviously acting high on the job or in social situations). The role of the supervisor is not to judge whether a problem exists, but only to refer the person to a trained professional for that determination.

Once the employee has been connected with the program, the relationship between the worker's supervisor and the program becomes sensitive. If the referral was initiated by the supervisor, the program is usually required to report progress, but this may be a simple statement that the worker has kept appointments, or that satisfactory progress is being made. In some instances, direct consultation with the supervisor may be helpful, assuming that the worker gives permission for it.

Employee self-referrals are likely to increase as the program gains credibility and employees develop confidence in it. Self-referrals can be encouraged by guaranteeing confidentiality to those who contact the program and by providing a special office and/or telephone number where employees can reach a program staff member. Accepting anonymous telephone contacts also increases self-referrals, since they allow reluctant employees to gradually gain confidence in the program.

When the workforce is represented by labor unions, it may be possible to integrate procedures for identification and referral into a joint agreement. Many union contracts are now being written so that employees who decline referral to an employee assistance program after well-documented evidence of performance problems may be dismissed without union protest.

Drug Testing

A business is encouraged to develop a comprehensive policy that fully addresses the issue of drug abuse in the workplace, including a policy statement on drug use and abuse in the workplace; an employee assistance program that provides assessment, short-term counseling, and referrals to appropriate rehabilitation; a supervisory training program; an employee drug prevention and education program; and drug testing. Drug testing is one of the many tools available that can be used to reduce drug abuse in the workplace. Companies may use drug testing to send a strong message to applicants, employees, and supervisors alike, that drug use in the workplace will not be tolerated. The work atmosphere created by this message may actually encourage non-drug using employees to remain drug-free and encourage occasional users to stop. Drug testing in this capacity may actually achieve a deterrent effect. A drug-free message is further emphasized if employees with drug problems are offered a helping hand through the employee assistance program, and applicants who test positive are given information for referral to local treatment programs and told that they may be considered again for employment after a period of time as set out in the company policy. In this publication, we discuss drug testing as one component of a workplace drug abuse program, used to facilitate referral for treatment.

Placing drug testing first on the list of issues emerging from the literature review conducted for this publication was not accidental. Clearly, testing is the issue most on employers' minds today. Five 1986 surveys—by the American Management Association (AMA), the Employment Management Association (EMA), the College Placement Council, and the Placement Offices of Northwestern and Michigan State Universities—confirm that an increasing number of employers are using some sort of testing program, and more plan to do so in the future. About one-third of larger American workplaces now have a testing program. The majority of these programs are for preemployment screening, although testing workers on the job for certain reasons (e.g., after an accident) is also becoming more frequent.

A particularly important finding of this study is that among companies engaged in testing, the number of rehabilitative employee referrals triples if a training/education initiative is also present, strongly reinforcing the notion that the best programs are those that combine testing with other activities. Moreover, "smart supervisors" trained to know how to spot possible impairment and intervene are seen as the most important single aspect of a successful workplace program. Two-thirds of the respondents see assistance and rehabilitation as the appropriate response for an employee who tests positive.

The AMA study also found that employers who consider, then reject, testing are most often concerned with invasion of privacy, questionable accuracy of testing, and negative impact on employee morale. They are also concerned with possible legal challenges. Written policies for drug testing are common, with 40 percent of those responding indicating their policy was written in 1986, and only 3 percent pre-1986. The most common reason stated for a testing program was "workplace safety."

The EMA reported that 29.1 percent of the 492 organizations responding to their 1986

survey had preemployment alcohol/drug testing programs, and 20.9 percent had programs to test employees. Before 1984, only 3 percent of the participating employers had tested either group.

The College Placement Council's survey of 497 employers found 28.2 percent who reported that drug screening procedures, usually including urinalysis, were required of potential employees.

The 1986 Michigan State Recruiting Trends report on data from 761 private and public sector employers showed that 20 percent screened new college graduates, and 95 percent said they would reject an applicant who showed evidence of drug use.

The Northwestern University report found 33 percent of 230 employers surveyed using drug tests. Two-thirds of that group tested only new employees; 76 percent retested the applicant if the first drug test was positive. Although 12 percent of the employers did not notify job applicants they were being tested for drugs, 68 percent said they communicated their testing policy to the applicant in writing.

In an as-yet unpublished study (revealed in a December 22, 1986 press release), the National Federation of Independent Business polled their membership on the subject of drug testing. Nearly two-thirds (65 percent) of the 78,294 small-business respondents agreed that employers should be allowed to require employees to submit to drug tests. Twenty-four percent disagreed, and 11 percent were undecided on this issue.

Briefly, drug testing typically involves the analysis of a sample of urine to determine whether the person has recently used drugs. A number of testing procedures are currently used, some of which are extremely accurate. However, all viable programs involve retesting any sample shown positive, usually with a different type of test. A legal procedure called a chain of custody is used to protect the integrity of the sample by documenting each and every person who handles the specimen from its origin through all phases of testing. Urine testing shows whether a person has used drugs in the recent past, but does not prove intoxication or impaired performance (a worker could test positive from drug use away from the workplace, with no evident impairment of job performance).

The subject of testing has become too complex to address it completely here. An informative publication by Dr. J. Michael Walsh of the National Institute on Drug Abuse, *Q&A: Employee Drug Screening—Detection of Drug Use by Urinalysis*, is one of the best authorities for those who want to know more about testing. More resources are cited in the bibliography to help employers understand the issues surrounding testing.

Drug testing is done for six main reasons:

- Preemployment screening of job applicants
- Testing "for cause" persons who appear to be high on drugs or involved in an incident—such as an accident—that might have been caused by drug use
- Testing workers whose jobs involve safety of coworkers or the public (e.g., bus drivers, heavy equipment operators)
- Testing in connection with return-to-service physical exams, as followup after treatment, or at time of promotion into sensitive positions
- Random testing to identify drug users and to discourage future use by workers who fear discovery on a subsequent test
- Universal testing of all workers in a given workplace

Whatever the reasons or justifications for instituting random or universal testing of all employers, they arouse the most controversy of all the issues related to drug tests in the workplace.

Instructive guidelines to help employers decide about testing have been suggested by David Evans, a Lawrenceville, NJ attorney who has practical knowledge of current legal issues. In his article in the ALMACAN (see bibliography), he discusses briefly several considerations in formulating a policy on drug tests:

- *Document the need for a testing program.* Is it necessary for enforcing work performance standards, detecting illegal drug possession, preemployment appraisal, EAP monitoring, or determining cause of on-site incidents?
- *Develop a testing policy.* In conjunction with unions, management, personnel, occupational health and safety, affirmative action, risk management, security, legal department, and the EAP, develop a testing policy dealing with the following issues:
  - Need for the policy
  - Use of drugs or alcohol on company premises and on or off duty
  - Need for company-wide awareness of work performance standards
  - Possible consequences of positive test results as they relate to discharge, discipline, or other sanctions
  - Policy on rehabilitation opportunities if an employee tests positive
  - Need for compliance with State and Federal discrimination laws

- Procedures for referral to the EAP
- Responsibility of employees to seek treatment
- Confidentiality of test results and treatment
- Circumstances in which testing will be required
- Consequences of refusal to take required drug tests
- Company procedures for fair and dignified testing procedures
- Due process procedures for employees who test positive
- Procedures for confirmation of positive tests

It may also be helpful for the policy statement to deal with the types of drugs the tests will cover.

- *Implement the policy.* All supervisors, employees, and job applicants should be informed in writing of the details of the policy. Training should be provided on job performance standards and operation of the testing program and its relationship to services (e.g., those offered through the company EAP). Modifications in collective bargaining agreements also may be needed to successfully implement a testing policy. A procedures manual should be developed for testing, including chain of custody. Finally, the program should be evaluated periodically by an outside consultant, with the collaboration of a program improvement committee composed of workers at all relevant levels and the organization's legal counsel.

Legal consultation is especially important because employers have to contend with an increasing number of issues related to testing (the surveys mentioned above all reported that employers with testing programs are being sued). Among the key issues are invasion of privacy, wrongful discharge, defamation, intentional infliction of emotional distress, employer negligence, assault and battery, false imprisonment, and discrimination against minorities or persons with disabilities.

Employers considering a drug testing program may want to visit a nearby workplace that has already made a similar effort, to learn not only about program design but about implementation problems and any real or threatened legal challenges. Also, model programs and policies are starting to be documented in the literature (see bibliography). Two model programs are mentioned briefly here.

In September 1986, President Reagan issued an Executive Order entitled "Drug Free Federal Workplace." It established a policy against the use of illegal drugs by Federal employees, whether on-duty or off-duty. All Executive agencies must develop drug policies, have in place Employee Assistance Programs, provide supervisory training, offer rehabilitation services, and provide procedures for identifying positions to be tested under the program. The Executive Order includes guidelines for drug testing, sanctions against Federal workers who test positive, and protection of workers' privacy and other rights. The DHHS is setting model policies and procedures for all Federal agencies.

Although legal challenges have already been raised (e.g., by the National Treasury Employees Union) to this Executive Order, it may provide a useful set of benchmarks for construction of a drug testing program and policy in other workplaces. The Department of Justice, which has handled the legal defense of the President's program on drug testing, has withstood every Federal Appeals Court challenge. In five circuits, these courts have held constitutional the testing of public employees without individualized suspicion. Reasonable suspicion as a cause for testing has been upheld by Federal Appeal Courts for such job classifications as employees who carry firearms, those who have access to classified information, law enforcement employees, bus drivers, prison guards, race jockeys, and military personnel.

A second model program comes from the private sector. Created in August 1985 by the Lockheed-California Company, it includes a separate policy and procedure document in looseleaf notebook form. A comprehensive planning committee, including the company's medical director and EAP director, developed this program and the manual undergirding it. The manual begins with a memo from the Company's CEO, outlining Lockheed's overall philosophy regarding drugs and the reasons for initiating this preemployment screening program. Then detailed procedures are laid out for the screening effort, along with background information about testing methods and chain-of-custody procedures.

Outreach

Outreach programs can take advantage of the workplace's entire communication structure. Pay envelope flyers, bulletin board notices, "brownbag" lunch lectures, speeches at organizationwide gatherings, notices or articles in a company newsletter, and many other devices have been used. In some cases, a work organization's audiovisual department has put together a tape-slide show or videotape presenting the program. In others, workers recovering from drug addic-

tion problems are recruited to talk to their fellow workers.

Considerable ingenuity can be used in these outreach approaches. For example, it has been found consistently that brown-bag lunch seminars with titles like "How To Tell If Your Kid Is On Drugs" draw large audiences—always including some workers who are there to learn something about their own drug problem, not their child's. These outreach programs can usually be designed to help build the overall program's credibility with workers.

Security

A workplace's security operations become involved with worker drug abuse in some of the following ways:

- Stopping the sale of drugs in the workplace
- Detecting the presence of illegal drugs in the workplace
- Dealing with workers who are high on the job and whose performance is impaired
- Dealing with drug-related behavior, e.g., stealing from other workers to buy drugs
- Dealing with issues related to confidentiality of information or products of the workplace (e.g., for aerospace companies doing business with the military).

Increasingly, organizations are using their own security forces and consultants from the outside, including drug-sniffing dogs and high technology, in their efforts to deal with drugs in the workplace. In some cases, collaboration with local, State, or Federal law-enforcement agencies may also be desirable. John Posey, Security Administrator at Boise-Cascade, advises that a careful preliminary investigation should be done before bringing in outside law enforcement, and that some local agencies are simply not equipped to handle a sophisticated undercover investigation (at the same time, large agencies may not want to get involved in what they see as small-scale drug operations in a workplace).

Drug testing programs sometimes may interconnect with security efforts, as in required testing for workers who are brought under suspicion by inside or outside investigations. The entire workplace drug abuse program or EAP must be coordinated carefully with security operations. While it is essential that independence of the two operations be maintained (any treatment/prevention effort will instantly lose all credibility if it is seen as having an investigative or enforcement function), many levels of cooperation and information-sharing may be possible. For example, security personnel may see evidence of drug abuse that can be handled discreetly by helping workers come into treatment.

Assessment and Referral to Treatment

Assessment

When a worker enters the drug abuse program, an initial assessment is conducted to determine what services may be needed. Most professionals find it helpful to use a structured interview form, including questions about life history, previous treatment, drug history, self-appraisal of performance impairment, and other issues (consulting and service organizations such as Royer Cook International in Washington, DC are developing assessment instruments specifically for this purpose). Careful recordkeeping can facilitate better service down the line, especially if the program will be involved in providing followup assistance or initial counseling. Decisions might need to be made without this process, however, in a crisis, e.g., if a potential overdose, suicide, or major medical problem requires immediate commitment to a chemical dependency facility or hospital.

In the initial assessment interview, the most effort needs to be made to stress confidentiality procedures and to help the worker understand the philosophy and services of the program. Especially for self-referrals, the persons may simply not come back unless their first experience is positive.

Referral to Treatment

The next step is to develop a service plan that will meet the needs identified in the assessment. The services most likely to be rendered in the workplace are crisis intervention counseling, or short-term counseling for problems that can be resolved in one to five sessions. For example, a worker who is having trouble withdrawing from sleeping pills after a traumatic divorce needs service, but may be able to resolve the problem through a few sessions with an in-house counselor.

The service plan often involves referral to an outside treatment facility as well. This step requires the drug abuse program worker to be sensitive to the special needs and circumstances of the drug-abusing employee and fully aware of the resources available in the community. Even in relatively low-population areas, drug abuse treatment facilities are springing up. Many large hospitals now have chemical dependency units, in addition to the free-standing programs that offer detoxification, counseling and short-term

psychotherapy, and long-term rehabilitation services.

Typically, the best way to become familiar with community resources is to arrange site visits. When setting up a drug abuse program, such site visits will require a regular commitment of time during the program's first 3 months of operations, and should be budgeted accordingly. Whenever evaluating a facility, questions such as the following should be asked:

- Who provides diagnosis, treatment, and supervision and what are their professional qualifications?

- What drugs of abuse and types of drug users (e.g., psychopathology, depression, anxiety, antisocial personality) does the facility claim competence in dealing with?

- What treatment model does it use, and what specific treatment is provided?

- To what extent are self-help groups and the AA model a part of the treatment philosophy?

- What is the facility's reputation in the community?

- To what extent does it serve employers well?

- What kinds of accreditation does it have?

- What is its fee structure and to what extent can this be adjusted for special needs?

- How does the facility stack up during an unannounced visit, as opposed to taking a guided tour?

- What special populations does the facility cater to?

- How long does the program last, and is any aftercare or followup provided?

One of the most valuable tools any program coordinator will generate is a notebook or file of local treatment facilities and the answers to such questions about each of them. Program staff needs to be quite familiar with these programs to identify the one that is right for a given worker. Knowing, for example, that a particular facility would be appropriate for a lower level production worker but not for a senior executive can help avoid inappropriate referrals. Are there special circumstances, e.g., does the worker have small children who need care? What type of insurance coverage is available? Often, insurance provides only for inpatient care, even though the person may need extended outpatient care; in that case, a negotiation process may be needed to determine what the workplace can provide and what the person can afford to pay out of pocket.

In addition to treatment facilities, community resources such as AA and its sister programs, family support groups, drug education projects in the schools, services available through local mental health centers or hospitals for employee education, training media that may be available through local schools or television stations, and many other local services will help in building a complete treatment and rehabilitation program.

Followup

Even the most successful substance abuse treatment programs have high recidivism rates. Drug dependence/abuse is a chronic relapsing and recurring illness that historically continues for years. Long-term treatment and/or followup is the rule rather than the exception. This has important implications for both the workplace program and the treatment services that take its referrals. Followup components of the workplace program include:

- Use of case management approaches to monitor and evaluate the help the worker is receiving from a treatment program. For example, what kinds of counseling and group support does the program offer and how do these fit with the individual worker's situation?

- Appraisal of the work environment to which the worker returns after treatment. At present, many employers are reevaluating the workplace in terms of reducing job stress and improving overall work conditions as a means of preventing rehabilitated workers from returning to drug use—and more importantly, helping to prevent drug abuse in the first place. Program operators may need to assess levels of job stress and consult with supervisors or top management to effect changes in the work environment.

- Development of followup support services, e.g., Alcoholics Anonymous or other self-help group meetings based at the worksite

- Review of organizational insurance coverage to determine whether appropriate followup services are eligible for coverage. For example, many policies do not provide for outpatient services, even when this may be the most appropriate mechanism for treatment (and much more cost-effective than repeated hospitalization)

- Review of treatment facilities to see which ones attend to the recidivism problem most creatively. For example, in 1987, one facility began offering a "guarantee" of additional treatment for those who were rehabilitated but returned to using within a certain period after leaving their program.

Recordkeeping and Evaluation

Recordkeeping

As with any worker service program, an information system must be set up to permit good referrals to appropriate community resources, with a parallel recordkeeping system for services provided. Increasingly, in large programs these systems are being computerized. For example, the Lockheed California Company maintains all program data on computer, with monthly reports printed out. Comparisons of costs and outcomes by month or year are simple to prepare with such a system.

Data on costs, number of contacts, source of referrals, case dispositions, and impact of interventions on employee absenteeism, sick leave insurance claims, and disciplinary actions will prove useful in evaluative efforts. Information on employee background, source of referral, and stated purpose of contact can be made during initial interviews. Other information on case disposition and job performance during and after contact can be routinely entered in case records; personnel records of the organization may be consulted to gather information on job performance evaluations.

All case records must be kept absolutely confidential and located in a place where only a program coordinator or counselor has access to them. When data from case records are used for evaluation purposes, they should be presented in the aggregate with no chance for individual clients to be linked to specific information.

Evaluation

Program evaluation is an integral part of a drug abuse program, both in terms of administrative accountability and successful program operation. Evaluation of program outcomes can yield information on the effectiveness of a program and point out its particular strengths and weaknesses. However, depending upon the complexity of the evaluation, it may be necessary to have staff especially trained in conducting such studies to work with program staff in the evaluation. Special skills may be needed to design an appropriate study methodology and to systematically collect the date and complete the analyses. Program staff frequently lack training in conducting complex evaluations.

Program evaluation serves two major purposes: first, to provide information on the types of drug abuse problems among the employee population, which may then guide program development; and second, to provide feedback for program improvement to staff and management. Of course, the larger purpose of feedback to management is to ensure continuance of the program. As is being discovered throughout the employee assistance field, only those programs that can demonstrate reduced costs and increased organizational productivity are likely to survive.

One useful evaluation approach is to compare various measures of employee job performance before program contact and after. A sustained evaluation process, perhaps on a quite regular basis at first, can help in program development. Regular review, perhaps annually, by an outside drug abuse consultant or by an in-house advisory body may also be useful.

Prevention and Employee/Family Education

Prevention

The ultimate solution to drug abuse is preventing its occurrence. Increasingly, professionals, politicians, and the general public are coming to this wisdom about most human problems. As with many other problem areas (e.g., smoking and the diseases it causes), the key to effective prevention is to change people's attitudes and beliefs so they can change their behavior. The workplace surely is one of the best environments for undertaking prevention activities. People spend more of their waking lives at work than any other single environment, and pay at least some attention to their employers because they supply the paycheck!

Most early prevention programs were oriented to giving facts about drug abuse. Many concentrated on scare tactics ("do drugs and you'll die"). Such efforts are largely ineffective. Workplace drug abuse programs must concentrate their prevention efforts in other areas: identifying non-drug-using coworkers who can serve as role models, providing incentives for participation in various antidrug activities, and generally encouraging an atmosphere in which drug use is not tolerated.

Prevention also may mean encouraging special efforts to reduce stress in the workplace or in workers' personal lives, or providing training in stress management techniques. These interventions prevent drug abuse by reducing the motivation to use drugs as self-medication for stress. Tie-ins between a workplace health promotion program and a drug abuse program also can be helpful in this regard.

Ultimately, a prevention program is in the business of changing not only individual worker

behavior, attitudes, and beliefs, but also changing the organizational culture as a whole. As long as the set of common values, attitudes, and assumptions about life in the workplace encourage or tolerate drug use, it will continue. While the complexities of corporate culture are such that they cannot be considered further here, suffice it to say that a long-range goal of any workplace drug abuse program is to create a social environment at work where drug use simply isn't allowed, by common consent of all who work there.

Employee/Family Education

Providing information about the physiology and psychology of drug abuse, and about methods for treatment and rehabilitation, can be a valuable adjunct to a prevention program. For example, people sometimes get addicted to prescription drugs because they genuinely believe they can't become dependent on something their doctor prescribes for them. Or they do not realize the powerful synergistic effect of alcohol combined with tranquilizers or other drugs. Or they still believe certain myths that stubbornly refuse to die, such as those about casual drug use being completely safe.

Educational programs need not stop with workers. Educational seminars for spouses and children of workers can be just as valuable, both in transmitting needed information and in helping to create an overall less drug-tolerant atmosphere for the worker who may be tempted.

V

Special Issues

Workplace drug abuse programs are developed and operated in the context of many complicated, often conflicting issues related to the characteristics of addiction and its consequences, aspects of the workplace with respect to its human resources, and the nature of drug treatment, especially with regard to certain groups of workers.

In this chapter, a number of these special issues are briefly discussed. Some are included because they represent the cutting edge—new topics with many gaps in information and good practice, such as AIDS and IV drug users. Others are included because they have been historically under-represented in drug abuse treatment efforts, such as prevention and self-medication for stress. Still others are discussed because they seem to represent directions of great future importance for the growth and long-term success of workplace drug abuse programs—in particular, health care cost containment, which most observers predict will enormously influence the attitudes of employers toward drug abuse programs (i.e., if drug abuse prevention and treatment can be shown to effectively contain costs of employee health benefits, they will be supported by employers).

Most experts on strategic planning agree that an important part of good planning is conceptual foresight, that is, predicting where within the organizational change problems or challenges are most likely to arise and then planning in advance how to deal with them. The following list of special issues is presented with the suggestion that employers, in their planning process, deliberately focus on each one. Even if the employer decides not to deal with a given issue, the overall strategic plan will be stronger for that decision.

Each issue that follows is discussed briefly because of space limitations; interested readers may consult the bibliography and appendix E for more information on these topics. Many of these issues are addressed in the chapter on implementation, and other suggestions for employers can be found in the chapter on model programs. A few questions for employers' consideration in program design follow each special issue. These are intended only as a starting point for discussion of how an individual program might be better designed.

Characteristics of Drugs and Addiction

Cocaine

Cocaine has received the greatest amount of attention in the recent furor over drugs, and for good reason. It is now one of the most popular drugs of abuse, and especially in its newest form, "crack," it is extremely addictive—possibly the most addictive substance now widely used. Cocaine is an increasingly popular drug to use at work, partly because it is easy to conceal, partly because it is still considered glamorous ("part of the yuppie dream of success"), and partly because the intense high it generates can give users the false feeling that they can do their jobs better and faster. Indeed, the physiological effects of cocaine initially accelerate concentration and intensify feelings of well-being; the problem is the rapid development of tolerance and the damaging effects of the drug as it is taken in increasing doses as the user desperately strives to recapture that initial high.

Occasional use can cause a stuffy or runny nose, while chronic snorting can ulcerate the mucous membrane of the nose. Injecting cocaine with unsterile equipment can cause hepatitis or other infections; shared needles can transmit the human immunodeficiency virus (HIV) that causes Acquired Immune Deficiency Syndrome (AIDS). Furthermore, because preparation of freebase involves the use of volatile solvents, deaths and serious injuries from fire or explosion can occur. Though few people realize it, overdose deaths can occur when the drug is injected, smoked, or even snorted. Deaths are a result of multiple seizures followed by respiratory and cardiac arrest.

Employer questions: Is there reason to believe your workplace includes a significant number of cocaine abusers? How will your program custom-tailor services to meet the needs of this special population? Do your program's personnel have an adequate understanding of the nature of cocaine addiction and how to deal with it?

Heroin

In the minds of many middle-class people, heroin is used only by inner-city hard-core drug

OVERVIEW VI: SPECIAL ISSUES ON WORKPLACE DRUG ABUSE

Characteristics of Drugs and Addiction

- Cocaine
- Heroin
- Marijuana
- Designer Drugs
- Self–Medication for Stress
- Multiple Addiction
- Post–Drug Use Syndrome
- AIDS and IV Drug Users

Human Resources Context

- Health Care Cost Containment
- Insurance Coverage
- Union Cooperation

Treatment and Special Populations

- Prevention
- Recidivism
- Quality of Treatment
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abusers. They would be surprised to find how many professionals and executives (as well as blue–collar workers) who certainly don't think of themselves as typical "junkies" regularly use this drug. Heroin abuse is frequently found in conjunction with cocaine, most often as a self–medication for some of the consequences of frequent cocaine abuse.

The physical dangers of heroin use depend on the specific opiate used, its source, the dose, and the way it is used. Most of the dangers are caused by using too much of a drug, the use of unsterile needles, contamination of the drug itself, or combining the drug with other substances. Over time, opiate users may develop infections of the heart lining and valves, skin abscesses, and congested lungs. Infections from unsterile solutions, syringes, and needles can cause illnesses such as liver disease, tetanus, serum hepatitis, and AIDS.

Employer questions: Are your supervisors—and indeed your EAP personnel—aware of the potential for heroin abuse among your work force? Do our program's personnel have a good understanding of locally available programs for treating heroin dependency?

Marijuana

The drug of choice for a whole generation, the purported health consequences and performance impairment effects of marijuana have been debated widely in the scientific and medical community in recent years. What cannot be debated is that a huge number of Americans, perhaps 50–60 million, have tried marijuana at least once, and an estimated 22 million use it at least once a month. Evidence is accumulating from laboratory studies and investigations of industrial accidents that marijuana does impair certain kinds of work performance; its effects on heavy users last a considerable time after ingestion.

Employer questions: What is the attitude of your workforce toward marijuana? What special education efforts might need to be developed to convince workers that heavy or habitual marijuana use is a significant problem, including a possible threat to their safety?

Designer Drugs

Gene Haislip, deputy assistant administrator of the U.S. Drug Enforcement Agency, calls designer drugs "the drug version of Chernobyl—the kind of problem, unimaginable 20 years ago, that's a direct response to the increasingly high–tech, scientific orientation of our society." These are synthetic versions of controlled drugs, created in underground labs by chemists. Often they are even legal, at first, because their chemical structure is slightly different from the illegal drugs they mimic. Often they are 50 to 100 times more powerful than their natural counterparts, making them intensely addictive and easy to overdose.

Employer questions: Are your program staff adequately knowledgable about designer drugs? Are there any conditions in your workplace (e.g., access to appropriate chemical equipment for manufacture) that increase the likelihood of such drugs appearing there?

Self–Medication for Stress

In most of the recent media attention to drug abuse, the emphasis has been on psychoactive substances used, as the expression goes, recreationally, for the pleasurable feelings these substances release. Users claim they feel more

creative, witty, charming, and in control, especially when the drug is cocaine. Much less attention has been given to another major reason people abuse drugs: because their work (and perhaps personal lives as well) are extremely stressful, and significant drug use is actually an effort to self-medicate for stress. Often their physicians are in complicity in this procedure, prescribing tranquilizers and other drugs for stress without exploring alternatives. Employers who place high expectations on their employees but give them little support are likely to raise stress levels in workers both on and off the job. Employees who become dependent on prescribed medications to help them through especially stressful periods are likely to continue using the drugs even when the stressing conditions are ameliorated or ended. At that point, drug dependency becomes addiction unless there is some kind of intervention.

In a recent survey of employers, James Schreier of Marquette University found that management is just beginning to look at the quality of life in the workplace and its impact on drug abuse. In seminars and conferences on the subject, employer representatives are starting to report on how workload, ineffective supervision, and rapid technological change may contribute to stress, with the response being increased drug abuse. At Wells Fargo Bank, EAP Director Bryan Lawton has conducted stress management training for over 2,000 employees, in an active prevention campaign aimed at reducing the likelihood of substance abuse.

Employer questions: What evidence do you have of overall stress levels among workers? Does the organization have a stress management program, and how might this be interfaced with the drug abuse program? What changes in work environment might be made to ameliorate stress and thus reduce temptation to abuse drugs?

Multiple Addiction

In many drug treatment programs today, the person addicted to only one substance has become almost a thing of the past. Abuse of combinations of two, three, even four different substances are becoming more and more common. Multiple addictions are hard to treat, the prospects for overdose or severe physical side effects are great, and recidivism rates are high.

Employer questions: What evidence exists about multiple addiction in your workforce? Are your program's staff adequately knowledgable about how to assess and deal with this population? Does your supervisory or worker education program include information about the dangers of mixing chemicals?

Post-Drug Use Syndrome

As the number of high-dosage drug abusers increases, medical researchers are becoming concerned about the increasing incidence and effects of post-drug use syndrome, a set of signs and symptoms that includes disruptions of brain function and effects on the body's immune system long after the drugs have been administered. Physical illness, brain damage, and impaired judgment and physical performance can appear days, weeks, or months after cessation of heavy drug use. This raises questions about whether employers may indeed have a right to know about past drug abuse of prospective employees. Employers must also know about long-term rehabilitation issues for exabusers currently in their workforces. Medical science is only starting to understand the long-term effects of chronic drug abuse; clearly, the body takes a long time to return to normal, if it ever does, after the significant impact of heavy drug use.

Employer questions: Does your workplace include jobs that would be significantly impacted by post-drug use syndrome (e.g., those involving safety issues and/or requiring precise intellectual and physical control)? Does it have an onsite self-help group to support employees who have undergone treatment for heavy drug use?

AIDS and IV Drug Users

According to statistics from the Centers for Disease Control, Public Health Services, 25 percent of existing AIDS cases in the United States are intravenous drug abusers, a statistic that will inevitably increase since needle-sharing is a prime mechanism for the transmission of AIDS. Public health officials and epidemiologists are projecting a sharp increase in AIDS cases, and a disproportionate number of cases will result from the behaviors of drug abusers. Many environmental and cultural factors make it particularly difficult to affect behavioral changes in drug addicts—even, it appears, in the face of an epidemic of a disease as fatal as AIDS. Unless the behavior of IV drug users changes radically, epidemiologist predict that not only will the lives of addicts who share needles be in jeopardy, but the lives of their sex partners as well. Companies developing policies on IV drug abuse must also consider AIDS education and prevention. A few companies, e.g., Levi Strauss and the Bank of America, are beginning to develop such policies and programs.

Employer questions: How might your policy on AIDS in the workplace be integrated with drug abuse policy? Are your program staff adequately knowledgable about AIDS and IV drug use?

Human Resources Context

Health Care Cost Containment

Of primary interest in all workplaces today are the rising costs of health benefits for workers. Since the 1950s, it has become increasingly common practice, now almost universal, for employers to pay many of the health care costs for workers and their families. Most frequently this has been done by purchasing health insurance. With the great rise in health care costs in the 1970s and 1980s, employers have faced greatly increased expenses in this domain. In a recent year, General Motors spent more on health benefits for its workers than on steel to build its cars. Now, health care cost containment is a major concern for all employers, and this affects drug abuse in two ways. First, employers are wary of long-term, expensive drug treatment programs, and health insurance coverage for drug abuse is often limited. Second, effective treatment of drug abuse often can reduce utilization of other health care benefits (as well as increasing worker productivity), effecting an overall cost savings to the employer.

Employers questions: What does a review of your current health insurance policies show regarding drug abuse? How might this coverage be improved? What cost-containment measures are you currently taking that could be integrated with your drug abuse program? Does your EAP refer employees to its own treatment program, or to local outpatient treatment programs as an appropriate option for cost containment?

Insurance Coverage

Adequate insurance coverage for inpatient and outpatient services is one of the most important components of any workplace drug abuse program. Often EAP and employee benefits personnel need to work together with top management to review insurance coverage. Such review can result in an employer adding coverage for its workers (assuming that the increased costs will be offset by savings in productivity and in reduction of other health care costs). In some cases the employer can advocate with the insurance company or its case management consultant for coverage of longer term (but lower cost) outpatient services, which may be critical to reducing the recidivism problem.

Employer questions: What is the quality of communication between EAP personnel and health benefits personnel? What provisions for outpatient services, counseling for family members of a drug-abusing person, and other nontraditional coverage exist in the current insurance portfolio? Is the current insurance package adequately meeting the needs of the workplace's persons with drug abuse problems?

Union Cooperation

Support from labor, especially in unionized workplaces, is critical for a successful drug abuse program. Workers must have input to the design of a program, and labor union requirements for due process and treatment of impaired workers have to be addressed. In particular, issues such as nonvoluntary referral to a program, confidentiality, and adequacy of health care coverage for workers with drug abuse problems are of great interest to unions. The key to promoting collaboration between labor and management is the development of a mutually beneficial and effective program.

Employer questions: Based on past experience, what issues are most likely to concern labor in your workplace with respect to drug abuse? How can labor be appropriately involved in design and execution of the program? If there is no labor union, what other mechanisms for labor involvement are possible?

Treatment and Special Populations

Prevention

The ultimate key to success for reducing drugs in the workplace, and reducing the overall impact of drugs on society, is prevention. The Just Say No program, widely publicized through the advocacy of First Lady Nancy Reagan, is an excellent example of how a program to change attitudes and behaviors can be replicated on a large scale. Just Say No is a grassroots approach aimed at young people to help them avoid the temptation to smoke, drink, or use drugs by adopting the attitude that drugs are a downer and it is quite all right not to use them. Research studies have shown that training in assertiveness and social and communication skills have helped young people resist peer pressures to smoke. Encouraging young people to use graceful but firm responses, asserting their right to say no to drugs, drinking, or smoking, makes an effective prevention program. Similar efforts to reshape attitudes, beliefs, and behavior related to drug-using lifestyles can be developed for the workplace, using a variety of motivational messages, images, and approaches.

Employer questions: In what other prevention areas has the workplace been successful (e.g., reducing accidents, helping people to stop smoking, etc.)? How can that experience be useful for the drug abuse program? What other current

prevention activities can be integrated with the drug abuse program (e.g., a company health promotion program)?

Recidivism

Most treatment programs have a high rate of relapse, estimated to be 60 percent or more in some instances, especially where drugs such as cocaine or heroin are concerned. The nature of chemical dependency is such that many drug abusers need more than one period of intensive treatment. Moreover, even a good inpatient or outpatient treatment program may be ineffective unless there is provision for long-term aftercare (e.g., regular counseling sessions with a professional, encouragement to participate in self-help groups such as Narcotics Anonymous, etc.). And if workers are thrust back into the same stressful job conditions that contributed to their drug problems to begin with, it should not be a surprise if they return to using. Thus, employers need to have realistic expectations about the number of workers who will be successfully rehabilitated.

Employer questions: How can workplace characteristics or the nature of individual jobs be modified to assist the rehabilitating addict in staying clean and sober? How do chemical dependency facilities in your geographic area handle relapsed clients?

Quality of Treatment Programs

The quality of the local treatment programs should be assessed periodically to determine how well they provide detoxification, counseling, and rehabilitation services for workers with drug abuse problems. Some guidelines for determining the excellence of treatment facilities are given in chapter IV.

Employer questions: What experiences have other local employers had with specific treatment programs? What resources (e.g., single State agency, local city or county drug abuse agencies, local chapters of self-help groups) are available to help assess the quality of treatment programs?

Special Programs for Executives

Abuse of cocaine and other drugs is increasingly common among executives in workplaces. Treatment for executives differs significantly from treatment for lower level workers: for one thing, it is often easier for an executive to conceal patterns of abuse behind closed doors (with the often unwitting complicity of secretaries and assistants). Also, executives are more likely to have the disposable income needed for heavy drug habits. They may require a special treatment program, one that provides both a setting commensurate with their lifestyle and attitudes and, in some cases, the possibility of continuing to work, since their talents and skills may be difficult to replace.

Employer questions: What informal evidence exists about drug abuse in the executive ranks of your workplace, and what steps need to be taken to avoid the drug abuse program being damaged by high-level resistance? How can executive job roles be modified to reduce risk of drug abuse or to make recovery more effective for those who are already addicts? Are policies equally enforced for executives and other levels of workers in the organization?

Special Programs for Women

Women's patterns of abuse are significantly different from men's in many cases. According to recent estimates, women use 80 percent of all amphetamines consumed in the United States and 72 percent of all tranquilizers. In short, with all other factors held constant, women may be more likely to abuse legal drugs. As women move up the corporate ladder, they are also more likely to become drug abusers through self-medication for stress, just as their incidence of heart attacks, ulcers, and other stress-related disorders go up. These special circumstances require special treatment programs.

Employer questions: How can women, including women executives, in the organization be included in the planning process for a workplace drug abuse program? What anecdotal evidence exists about drug-related problems of women workers in your organization? What special needs for family support must be met while head-of-household women are in treatment?

Special Programs for Minorities

Blacks, Hispanics, and other minority groups may have quite different cultural values about substance abuse. Both prevention and treatment programs may need to be modified—in content and language—to fit these cultural values. Workplaces with large minority components may need a specially tailored program, created and perhaps offered by representatives of the minority group in question, including possible in-house counseling or followup by persons of the same minority group.

Employer questions: What is the minority composition of your workforce, and how does this relate to your drug abuse services? Who in the organization and in the local community might offer useful consultation about design of a

program to meet the special needs of a given minority population?

Special Industry Conditions

It is commonly asserted, although this is not backed by scientific evidence, that drug abuse is probably more extensive in areas of work such as the entertainment industry, banking and financial services, high technology, professional athletics, and advertising. If so, the reason may be a set of special conditions that these industries happen to share—high income, high stress levels, high degree of uncertainty about work success or failure, rapidly changing work conditions, and tolerance for drug abuse, especially in the upper echelons of success. These conditions appear to contribute to unusually intense involvement with drugs, rather than anything inherent in the work or the industry per se. To the extent that such conditions influence drug abuse patterns, it is important for program designers to be aware of these influences and to create programs that take account of them.

Employer questions: To what extent does your workplace manifest the special conditions just mentioned? What is being done (independently of efforts specific to drug abuse) to deal with the problems these conditions may produce?

VI

Model Programs

This chapter presents brief descriptions of seven Employee Assistance Programs. Each program summary highlights treatment, education, and prevention services for drug abusers, including case examples where possible. The programs included are not meant to be a representative sample; indeed, where drug abuse services are concerned, no body of research data yet exists from which we can conclude what *is* representative (the National Study of Workplace Drug Abuse Programs, described in appendix E, is currently developing such a database).

The seven programs represent four different types of EAPs:

- Workplace-run program (Lockheed, Wells Fargo Bank)
- Consultant-run (Toyota)
- Consortium (EIRAC)
- Combined company / consultant - operated (Union Carbide, Carpenter Technology)

In addition, several special issues are highlighted by these programs:

- Introduction of a Benefits Certification Program into EAP operation (Ventura)
- Introduction of Preferred Provider Organization approaches into EAP operation (Ventura, Wells Fargo)
- Programs in transition—changing EAP vendors and considering a drug-testing policy (Toyota)
- Moving from company-operated to a combination of company and consultant operation (Union Carbide)

The main aim of these program summaries is to stimulate thinking about how drug treatment, education, and prevention services can be most effectively and creatively integrated into an EAP's operation, and how drug abuse programs can cope with issues such as cost containment.

Each description overviews the main aims and service offerings of the EAP, along with a capsule description of the organization or environment in which it is housed. Services specific to drug abusers are then described, followed by contact information for those readers who may desire more background on these programs.

Wells Fargo Bank and Company

The Wells Fargo EAP is now more than 11 years old and serves more than 1,200 employees and family members each year. Although drug problems account for only a small percentage of EAP visits, the proportion is likely to grow in the years ahead. The program is run in-house as a department of the company, with a staff of six counselors, all based in the San Francisco corporate headquarters. The program is headed by a licensed psychologist.

Wells Fargo's "Employee Assistance Services Department" is a clearly-identified part of its human resources policy, described in the company's employee handbook and supervisory training handbook. Employee assistance services are available through both in-house counselors and referral to outside treatment services in the following areas: emotional stress, marital and family difficulties, alcohol and drug abuse, child abuse, child care, financial, medical, legal, and vocational. In addition, the program provides health promotion services and referrals.

Wells Fargo's program takes a proactive approach with a coordinated strategy of prevention programming, early identification, and community treatment for all kinds of personal problems, and changes in the design of health-care benefits as needed to meet evolving employee needs. The EAP's overall aim is to reduce the personal and financial loss caused by personal problems that affect productivity, health-benefit usage, and employee morale.

While voluntary use of the program is encouraged, supervisory referrals are also an important part of the EAP's operation. Supervisors and personnel officers are trained to recognize potential problems and to consult with EAP staff about them. In many cases, such consultations lead to referrals. The company takes the position that its internally administered program has an advantage in that staff are intimately familiar with the nature of Wells Fargo's business, and with its management philosophy, grievance procedures, etc. Moreover, employee assistance

staff, being insiders, are more likely to directly address job performance issues. A proactive stance on problems such as alcohol and drug abuse is also needed because substance-abusing workers affect their coworkers as well, reducing productivity of the work team, and perhaps generating safety problems as well.

Wells Fargo does not at present have a drug testing program, although a recent statement "reserved the right to do so if the situation warrants." Geographic dispersal of the workforce, difficulties in testing quality control, and legal challenges to use of testing are among the reasons cited for the decision not to pursue a testing program at this time.

In 1983, Wells Fargo broadened its substance abuse benefit plan to include HMO participants, as well as those in the company's self-funded plan. The EAP was given preadmission approval for residential treatment and for a second outpatient treatment plan. Other aspects of the Wells Fargo program related to substance abuse include the following:

- Preferred Provider Organization contracts for reduced substance abuse treatment cost
- Aftercare tracking and monitoring of employees and/or significant others treatment for substance abuse
- A review process to identify and assess potential substance abuse risk in company drivers
- Stress management training provided to more than 2,000 employees as part of a prevention program. Substance abuse concerns are highlighted in this training, and a substance abuse questionnaire is included to encourage early self-identification
- Ongoing articles on substance abuse in the Wells Fargo newsletter, and training for supervisors in recognizing substance abuse problems

For further information, contact:

Bryan Lawton, Ph.D.
Vice-President and Director
Employee Assistance Services
Wells Fargo Bank
343 Sansome Street
San Francisco, CA 94163
415/395-3033

Entertainment Industry Referral and Assistance Center

The Entertainment Industry Referral and Assistance Center (EIRAC), founded in 1984, is an umbrella Employee Assistance Program serving the entire film and television industry in Southern California. EIRAC currently offers referral, crisis intervention, and management education services for entertainment companies, their workers, and family members, centering on alcohol and drug abuse problems. EIRAC is staffed by a full-time director, a social worker experienced in the field of substance abuse, and two professionals. A 24-hour hotline handles calls for assistance or information about the program. The Center's offices are in a private office building in Burbank, CA within easy commuting distance of most of the entertainment companies it serves.

EIRAC is designed to supplement EAPs already operating in many of the major film studios and the three television networks. For companies with existing EAPs, the Center provides a means for keeping current and for communicating with other programs and professionals working within the industry. Workers and their family members who might be hesitant to make their first program contact within the company that employs them can instead use EIRAC's confidential service. The Center is available for companies that do not have EAPs, offering services such as counseling on a time-limited basis, primarily for crisis intervention and appropriate referral.

From its beginnings, the Center has operated under two key assumptions about substance abuse and the entertainment industry. First, problems of substance abuse in the entertainment industry are shaped by a number of conditions peculiar to the profession, including its high public visibility and intensely high-stress working conditions. An EAP's services and the treatment program it refers to must be cognizant of these special circumstances. Second, there is a substantial casual labor force in the industry, moving from one workplace to another on an irregular but frequent basis, thus making it difficult for in-house programs to be fully effective. As an umbrella program, EIRAC is able to counteract, to some extent, this phenomenon and to provide some services for companies too small to have an EAP.

Drug abuse is a major problem for workers seen by EIRAC staff. The most common situation is multiple drug use, usually combining alcohol with cocaine and perhaps with heroin as well. The Center also sees a significant number of long-term heroin addicts, and long-term care is provided for them as well as for polydrug abusers.

Each worker is interviewed comprehensively by an EIRAC staff member to determine the nature of his/her chemical dependency problems and to formulate a comprehensive treatment plan. All treatment facilities that the EIRAC staff uses for referrals have been visited. A

hallmark of the program is fitting the treatment facility to the particular lifestyle and preferences of the individual, to maximize the chances for success. An example is the hypothetical case of a $200,000-a-year executive with a severe cocaine addiction, who insists upon continuing to work and whose company also wants to keep him on the job. This would present a special placement problem that many treatment programs simply could not accommodate. EIRAC staff attempts to know and select programs with the best possible fit and to negotiate special arrangements as necessary. Often these special arrangements relate to insurance coverage and the amount of treatment needed. Because EIRAC refers a substantial number of cases to local facilities, some leverage on treatment rates is possible.

EIRAC staff recognizes other complications of being a drug abuser in the entertainment industry: the tolerance and even positive support for use that exists in some quarters; the enormous pressures (including the boredom that may tempt a highly paid person, who doesn't work for several months at a time, to turn to drugs); the likelihood of recidivism if the person returns to the work environment that contributed to abuse in the first place. In selecting treatment and rehabilitation programs, the staff is aware that people in the entertainment industry view themselves as a special breed, and this recognition of the psychological reality of this self-identity on the part of treatment professionals increases the likelihood that treatment will work. Even self-help groups like Alcoholics Anonymous and Cocaine Anonymous have chapters that specialize in entertainment folk. Some of these groups hold meetings right on the film studio lots.

Two case examples of program clients follow:

- Male, age 37, sound technician in films: a polydrug-abuser (phenobarbitol, librium, valium, marijuana, and alcohol), who came to EIRAC requesting outpatient services. He clearly needed inpatient treatment for withdrawal from phenobarbitol and valium; after considerable counseling with the man and his wife, he agreed to enter a local private facility. A very difficult withdrawal period was followed by a thus-far successful rehabilitation. Followup services include ongoing counseling at EIRAC and participation in Narcotics Anonymous.

- Male, age 34, polydrug-abuser (cocaine and alcohol), who had been in and out of a number of treatment programs and in a self-help 12-step program, none of which seemed to work. After initial assessment at EIRAC, a decision was made to put him into a hospital facility for a 2-week detoxification program and then into a highly structured outpatient program, where he has now been for more than a year.

In both these cases, the ability to custom-tailor treatment through flexible benefits and EIRAC's great familiarity with local treatment options were critical to success.

For further information, contact:

Ms. Dae Sullendar Medman
Director, EIRAC
1918 W. Magnolia Boulevard
Burbank, CA 91506
818/848-9997

Union Carbide

Through its Employee Assistance Program, Union Carbide offers employees and their families help in dealing with a broad range of personal difficulties. Among the problems most frequently addressed are marital and parenting concerns, emotional stress, and alcohol and drug abuse problems.

The company began an alcoholism program in the late 1950s and developed a formal policy on alcohol abuse treatment in the early 1960s. The current, broader employee assistance emphasis began in the 1970s, with a corporate EAP set in place by 1982. The program is currently in transition, with selection now underway for a contract vendor to handle the headquarters EAP, which now includes direct-service assessment, short-term counseling and referral, and supervisory training, as well as service referral through a national databank of community services for employees at company sites without local EAPs.

In addition, the company has mandated that any local Union Carbide site that initiates a drug-testing program for current employees must also have a locally based EAP. A number of local sites have initiated preemployment screening and some also conduct drug testing for suspected impairment, post-accident/incident, and for safety-critical jobs. The company provides all the support services and structures for setting up local drug-testing programs, including a contractual relationship with a testing laboratory, instructions on chain of custody, training for supervisors and managers, etc.

Currently, 20 EAP vendors work at various sites throughout the country, with an additional 10,000 employees covered through the corporate EAP's databank. The goal is to get down to three or four contractors, with one handling the majority of the company's employee population.

Union Carbide's EAP staff conducts some short-term counseling, but primarily offers assessment and referral services. Drug abuse cases may be referred to either inpatient or outpatient

facilities as the occasion dictates. EAP staff also provides confidential followup monitoring of employees referred by management to the program as a result of job performance difficulties.

EAP staff conducts management training programs at a number of plant sites throughout the nation. During these sessions, program participants receive heavy emphasis on developing the skills necessary to define and understand the dynamics of job performance. They are also trained to identify and understand the nature of personal problems employees are likely to experience, and how those problems can have an adverse effect on an individual's work effectiveness.

Substance abuse and the impact of codependency also receive special emphasis during Union Carbide's management training sessions. Participants learn to use job performance criteria to assist them in the early identification of substance abuse problems. They also learn about the progressive stages of substance abuse and how each may be reflected in an individual's job performance.

Union Carbide's EAP serves over 1,000 workers a year within the United States. Approximately 20 percent of these cases involve counseling for drug or alcohol problems.

The corporation maintains a significant management commitment to employee awareness and education efforts, though programs offered vary by location. The corporate headquarters staff has sponsored successful brown-bag lunch seminar programs, which feature outside experts discussing such topics as parenting, teenage drug abuse and suicide, as well as how to deal with family members who have alcohol, cocaine, or other drug abuse problems.

Additional EAP visibility and effectiveness are maintained through periodic visits by staff members to individual Union Carbide manufacturing and office facilities, where site managers have the opportunity to learn more about the program and to begin developing site-specific capabilities to assist their employees.

For further information contact:

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Manager, Corporate EAP
Union Carbide, D-3
Danburg, CT 06817
203/794-5606

Lockheed-California Company

Lockheed-California Company is an aerospace and defense contractor headquartered in Burbank, California, and employing over 17,000 personnel. The company started an Occupational Alcoholism Program in 1952, which was converted in 1981 into a formal, internal broad-brush Employee Assistance Program. The EAP is available to employees and their families with personal problems, e.g., legal, marital, financial, drug/alcohol, family and child. Referrals can be made by the individual employee, management, medical department, or the union.

The Lockheed EAP is staffed by an administrator, one counselor, and one administrative assistant. The EAP provides a range of crisis intervention, assessment and referral, and management training services. Treatment services to which employees are referred are covered by the Lockheed Group Insurance Program, or by an employee-selected HMO. In addition, the EAP has a separate supplemental fund for substance abuse treatment. Carefully-designed collaborative procedures have been worked out with the several unions representing Lockheed employees.

The EAP is unusual in that several cost-benefit studies have been conducted of services rendered by the program. A computerized management information system is used to maintain program data, including evaluation data. A cost-benefit analysis of the years 1980-83 showed that the company saved $1.6 million (absenteeism, health benefits utilization, etc.) on the employees who had been enrolled in the EAP during that time.

Program data show that the number of drug abuse cases have been increasing substantially each year since 1982 (8 percent of the total) to 1985 (22 percent). Lockheed speculates that the growth of drug cases is due to the availability of illicit drugs in the last few years; specifically, a significant increase in cocaine cases has been noted. Most of the increase is from self-referrals with drugs as the primary addiction, although alcohol cases continue to outnumber the drug cases.

Both inpatient and outpatient referral facilities are used by Lockheed for drug cases. Employees who enter treatment are monitored by the EAP for 1 year thereafter, meeting on a regular basis with an EAP counselor to discuss their sobriety, work, family situation, and their general well-being. Participation in self-help groups such as Alcoholic Anonymous or Cocaine Anonymous is encouraged, and in some cases is mandated.

In August 1985, Lockheed initiated a preemployment drug screening program, which was communicated to management and workers as "the backbone of our drug abuse prevention effort." The program involves testing every applicant for a Lockheed job for six categories of illicit drugs. This program is described in detail elsewhere in this publication.

A recent case example follows:

- Male, 23, an Area Dispatcher with 4 years seniority, entered the Employee Assistance program as a self-referral seeking help for a drug abuse problem. Primary drugs of choice

were PCP and cocaine, presenting a history of 10 years of abuse. He was referred to an inpatient treatment program and completed it with a minimal degree of success. After several relapses coupled with continued outpatient treatment, the employee finally found his path to full recovery almost 3 years after the initial self-referral. He is now considered by his manager to be one of the best employees in his area and has been promoted several times.

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Toyota Motor Sales USA, Inc.

Toyota Motor Sales USA is the national organization supporting sales of Toyota automobiles in the United States. Headquartered in Torrance, California, the company employs more than 3,000 persons in 12 locations throughout the country. After an extensive analysis of the then-new subject of Employee Assistance Programs in 1981, Toyota initiated its own EAP in 1982.

Toyota's Associate Assistance Program (Toyota employees are called associates) is coordinated by a Manager of Training and Associate Relations. It is presently operated through a contract with an outside EAP consulting firm, which has EAP contracts with a number of Southern California public and private organizations.

The EAP provides crisis intervention and treatment services to all Toyota associates in a broad-brush program, including alcohol and drug abuse problems, marital or financial difficulties, and interpersonal problems on or off the job. Both associates and their immediate family members are eligible for service, and the program is designed to interface with Toyota's multioption insurance program. It was decided from the start to offer more than just crisis and referral services; a major feature of the program is the provision of up to five counseling visits with an EAP counselor, a sufficient therapeutic resource to deal with a number of presenting problems. Referral is made to inpatient or outpatient treatment facilities, or to individual counselors/therapists, for any needs that exceed these limits.

A 24-hour collect hotline for the program is based in Los Angeles. Toyota employees outside the area are referred to locally based counselors.

Toyota's program is currently in transition. Management is considering adding a drug-testing program (its dimensions and coverage yet to be determined). Undertaking this major move has brought to the surface many other issues about the structure and operation of Toyota's entire employee assistance effort, e.g., (1) whether the program should continue to contract with its current vendor, change vendors, or change the type of contractual service provided through a vendor; and (2) how to evaluate the accomplishments of the program in its initial years of operation. Using the occasion of planning a drug-testing program to review and evaluate the overall program is a strategy that many other companies with EAPs might use.

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City and County of Ventura, California

The County of Ventura Employee Assistance Program, which also serves the City of Ventura, California, is based in one of the fastest-growing urban areas in the United States. The EAP was started in 1984 and provides services to all city and county employees (almost 7,000 workers in all) and their family members. Crisis intervention, diagnosis and referral, supervisory consultations, and wellness/education services are all part of the EAP's activities.

The program is headed by a social worker Program Coordinator, and currently has a full-time staff of two. Clinical services are also provided by independent contractors working on an as-needed basis. In addition, the program uses the services of interns provided by local university EAP training programs. Initial services are provided free of charge to the employee, with ongoing counseling or hospitalization covered in large part by city/county insurance plans, with the EAP serving as gatekeeper.

The EAP is quartered in a private office building adjacent to the county office facilities. Recently, a countywide survey of service providers (both individuals and institutions) in the mental health and substance abuse areas was undertaken to provide up-to-date information about services, price structures, etc. A Social Service Resources Manual is being prepared to record the results of this survey.

Seminars, pamphlets, group supervisory training, and individual consultations for mana-

gers dealing with problem employees are also part of the EAP's education and prevention services. The EAP defines itself as a broad-brush program, covering mental health, substance abuse, domestic violence, child care, financial difficulties, and related topics that may affect employee performance. The EAP presently is developing a comprehensive program evaluation plan to document the cost-benefit of its services.

A unusual feature of the Ventura EAP, believed to be one of the first of its type in the country, is a *Benefits Certification Program.* Ongoing counseling and inpatient hospitalization services are covered by this program, which reviews the need for care to determine the worker's eligibility for increased insurance benefits. Anyone covered under the city/county's self-funded medical plans is eligible for EAP review for possible higher coverage (moving from 50 percent to 80 percent or 100 percent depending upon the worker's particular type of plan—the 100-percent coverage is for a preferred provider plan of the county). Employees who wish to participate in this plan have their service provider fill out a Benefits Certification Form, which is then reviewed by an impartial panel of consultants. Those workers who feel that increased coverage has been improperly denied may appeal. This program provides a measure of quality control for services to workers that few other EAPs currently have and also helps in health care cost containment. In addition, the Benefits Certification Program has helped gain considerable visibility for the EAP in the local health care community, which can improve the EAP's access to and favorable pricing structures from local treatment facilities.

In its most recent reporting period, 5 percent of the workers seen by the EAP reported chemical dependency as their primary reason for seeking assistance. According to the program director, the concealment factor was very high before the program began, with a considerable amount of alcoholism among county executives.

A recent case example follows:

- Male, heroin addict, a long-term employee of a service department. Some of this individual's job duties involved operating heavy equipment, and the EAP coordinator recommended an immediate change in work duties pending success in rehabilitation. The worker was stabilized on methadone, and a long-term treatment program was begun. Interestingly enough, supervisory support was determined to be high, and the supervisor and his family later turned out to have drug abuse problems as well. Frequently, a referral chain of this sort seems to operate: some activity of the EAP will bring staff into contact with a segment of city or county government where its activities had previously been quite low.

The Ventura EAP's work in handling drug abuse cases thus far has been fairly limited. The model is presented here for two reasons: first, its Benefits Certification Program is a highly creative idea that will no doubt be copied extensively elsewhere in the country (the EAP coordinator has already received many requests for further information). Second, the Ventura EAP was started in an environment not very favorable to the kinds of services it offered: both management and union were hostile to the program, and there were various conflicting interests (concealment had been a problem because of a high rate of alcoholism among executive-level staff).

The EAP has chosen to respond to this hostile environment by a very careful, deliberately long-term effort to win the confidence and enthusiasm of staff at all levels. Training sessions and supervisory consultations help to reduce misinformation about the program and slowly raise consciousness about the purpose of the program. Staff have been willing to meet potential consumers of program services "where they are"—at first dealing mostly with the "worried well" who have stress management problems and the like, and using these initial successful activities to enhance the reputation of the program. The EAP coordinator attempts to attend as many regular department meetings of both city and county as he can, as a way of being visible and knowing what is going on. Formal training sessions are being initiated only after this familiarity has been established.

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Carpenter Technology Corporation

Carpenter Technology, based in Reading, PA is the largest domestic producer of specialty steel, with more than 4,500 employees in 27 locations across the United States. Carpenter has a comprehensive EAP, which now includes a drug-testing program that was initiated in June 1986. The Carpenter EAP has been in operation since 1974.

The program combines an in-house EAP, based at the Reading corporate headquarters, with EAP contract vendors at the company's locations in Bridgeport, CT; Orangeburg, SC; and El Cajon, CA. The company's other 24 locations are serviced through the corporate headquarters program, and the vendors are selected and admin-

istered through the corporate EAP coordinator.

The Carpenter EAP is a broad-brush program that provides assessment and referral services, with appropriate community agencies as the end-point of the referral process. Five counseling sessions may be conducted directly by the corporate EAP or its vendors. Any subsequent treatment is provided through community referral, with services reimbursed by the company's insurance program.

The drug-testing program was initiated partly because Carpenter had noted a recent 14-percent increase in the number of alcohol- or drug-related referrals to the EAP as well as an increase in alcohol or drug-related fitness for duty incidents, and partly because employees and supervisors expressed a feeling that steps should be taken to ensure a safer, drug-free work environment. A companywide alcohol and drug policy was developed and provided to every employee in the form of a short, printed article outlining the issue and stating the company's intention to provide help to any employee with a substance abuse problem.

Under this program, all job applicants must be tested prior to an employment offer being made (a confirming test of all positives, using an alternative testing method, is performed automatically). Thereafter, any employee who is referred for treatment is given a written statement of the conditions of continued employment, which stipulates that if the employee, after treatment, fails a second test, he or she is subject to disciplinary action up to and including discharge. Employees who refuse to undertake screening or treatment are subject to immediate suspension with intent to discharge.

Orientation sessions for supervisors provide clearcut guidelines regarding the specific behaviors that would qualify employees as "unfit for work." The steps involved in making that judgment and handling the details of the procedure are carefully communicated to all supervisors. Substance abuse is just one possible cause of "unfitness"; other causes include preoccupation with financial problems, lack of sleep, etc.

The Carpenter drug-testing program is in place in 2 of the company's locations and will be in force at all 27 company locations within a year.

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NOTE: This Bibliography contains only recent publications. For earlier literature citation also see Stephens and Prentice (1978) and Vicary and Resnik (1982).

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Walsh, J.M., and Hawks, R.L. *Q&A: Employee Drug Screening: Detection of Drug Use by Urinalysis.* Rockville, MD: National institute on Drug Abuse, 1986.

Weber, E.M. Should drug testing in the workplace be mandatory? (Counterpoint). *The U.S. Journal,* February 16, 1986.

Weinstein, H. Teamster drug program runs into troubles. *Los Angeles Times,* October 21, 1986.

Weinstein, H. Drug tests: Privacy vs. job rights. *Los Angeles Times,* October 26, 1986.

Weinstien, H. Drug test shows positive—now what? *Los Angeles Times,* October 29, 1986.

Williams, L. Reagan drug testing plan to start despite court rulings opposing it. *New York Times,* November 29, 1986. pp. 1(N) and 1(L).

References on Programs for Small Organizations

How a smaller employer should set up an Employee Assistance Program. *Drugs in the Workplace,* April 1987, 6–8.

References on Strategic Planning

Byars, L.L. *Strategic Management: Planning and Implementation.* New York: Harper & Row, 1984.

Gardner, J.R.; Rachlin, R., and Sweeny, H.W.A., eds. *Handbook of Strategic Planning.* New York: Wiley, 1986.

Higgins, J.M. *Organizational Policy and Strategic Management: Text and Cases.* Chicago: Dryden, 1983.

Holer, C.W., and Schendel, D. *Strategy Formulation: Analytic Concepts.* St. Paul, MN: West, 1978.

Yavitz, B., and Newman, W.H. *Strategy in Action: The Execution, Politics and Payoff of Business Planning.* New York: Free Press, 1982.

Appendices

A

Selected Annotated References

For those interested in a short course on workplace drug abuse programs, some key references follow that may be consulted to expand on the coverage given in this publication. Each reference (also cited in the bibliography) includes a brief annotation as to its contents.

Addiction Research Foundation. *Drugs and Drug Abuse: A Reference Text*. Toronto: the Foundation, 1985.

A useful guidebook, for both professional and layperson, regarding the nature of drugs and the addiction process. Includes much technical information that may be of value in understanding a specific drug and its actions.

American Management Association. *Drug Abuse: The Workplace Issues*. New York: the Association, 1987

This report provides comprehensive results of an AMA employer survey on drug testing—policies, procedures, legal issues and program development/implementation. An approach to combatting drugs in the workplace is discussed, which emphasizes "smart supervisors" and a comprehensive program as well as a drug-testing effort. Sample company policies are given in an appendix.

Axel. H. *Corporate Strategies for Controlling Substance Abuse*. New York: Conference Board, 1986.

An overview of corporate viewpoints about drug testing, expenses associated with rehabilitation, and so forth. A number of visible EAP coordinators and researchers are among the principal authors.

Battling the enemy within. *Time*, March 17, 1986, pp. 52–61.

A useful introduction to the problems public and private work organizations are currently having with drugs in the United States. Includes examples of successful workplace drug abuse programs, some background on drug testing, and coverage of security issues.

DeBernardo, M. *Drug Abuse in the Workplace: An Employer's Guide for Prevention.* Washington, DC: U.S. Chamber of Commerce, 1987.

Offers an overview of issues employers are likely to face in considering developing and implementing a drug abuse program. An emphasis is placed on *prevention*, and on how other components such as drug testing can contribute to prevention activities. Physical effects of drugs, comparison of drugs with alcohol, and the effects of various dangerous drugs are among the other topics discussed.

The enemy within. *Time*, September 15, 1986, pp. 58–73.

An excellent overview of the problems of drug abuse currently faced by American society, including some of the recent history of political and media attention to this crisis, and a wry examination of history showing that we've seen this crisis before.

Gardner, J.R.; Rachlin, R; and Sweeny, H.W.A., eds. *Handbook of Strategic Planning.* New York: Wiley, 1986.

The best and most comprehensive textbook on the science and practice of strategic planning as it is conducted in American private sector business.

Hawks, R.L., and Chiang, N. *Urine Testing for Drugs of Abuse.* Rockville, MD: National Institute on Drug Abuse, 1986.

A collection of scientific papers, some of them rather technical, that provides the best and most up-to-date treatment of the issues involved in drug screening.

Klarreich, S.H.; Francek, J.L.; and Moore, C.E., eds. *The Human Resources Management Handbook: Employee Assistance Programs.* New York: Praeger, 1985.

One of the most comprehensive and up-to-date overviews of the development and implementation of EAPs, including chapter authors who are leaders in this growing field.

Vicary, J.R., and Resnik, H. *Preventing Drug Abuse in the Workplace*. Rockville, Md: National Institute on Drug Abuse, 1982.

Including an excellent bibliography, an excellent early overview of workplace drug abuse programs written before many of the current developments such as drug testing. Contains an extended discussion of programs to prevent drug abuse in workplaces and how these relate to health promotion and related efforts employers can make.

Walsh, J.M., and Gust, S.W. *Consensus Summary: Interdisciplinary Approaches to the Problems of Drug Abuse in the Workplace*. Rockville, MD: National Institute on Drug Abuse, 1986.

A brief document summarizing a March 1986 national conference of drug abuse experts, employers, attorneys, and others concerned with the problems of workplace drug abuse. Includes an overview statement about drug testing and its appropriate place in employment and human resources practices.

Walsh, J.M., and Hawks, R.L. *Q&A: Employee Drug Screening: Detection of Drug Use by Urinalysis*. Rockville, MD: National Institute on Drug Abuse, 1986.

Summary of major issues employers would have concern about in the drug-screening area, presented in a question-and-answer format.

B

Sample Policy Statements

Clear and concise organizational policy regarding drugs in the workplace is an important component of any effective workplace drug abuse program. Most of the policy statements following are from medium-sized to large organizations having Employee Assistance Programs, so that the policy also is intended to cover EAP operations.

Policy of a Large Petrochemical Company

The company believes that alcohol or drug abuse is an illness requiring medical treatment. It will therefore (a) encourage affected individuals to seek medical help voluntarily at an early stage; (b) assist supervisors in dealing with associated problems related to work performance; (c) discourage supervisors, fellow employees, and possibly family members from "covering up" for the affected individual.

Medical treatment may be obtained by (a) voluntary referral—an employee who feels that he or she may have an alcohol or other drug problem is encouraged to seek the advice and help of the company medical department, his private physician, or any agency with special interest in this field. When the help of the medical department is sought on a voluntary basis the case will be handled confidentially, as in any other kind of illness; (b) mandatory referral—an employee may be referred by management to the regional health center for medical help because of deteriorating job performance or excessive absenteeism associated with abuse of alcohol or drugs.

Eligibility for benefits. Since problem drinking and misuse of drugs are treatable illnesses, an employee will be eligible for temporary disability benefits while he cooperates in taking any medical treatment prescribed and conscientiously endeavors to regain normal health.

Failure to respond to treatment. Addiction to alcohol or drugs is not, in itself, sufficient grounds for payment of extended disability benefits or retirement under Section 2.2(c) of the retirement plan. Failure to follow prescribed medical treatment or to improve work performance to an acceptable level will be justification for termination of employment on the same basis as any other employee whose work performance is unsatisfactory.

Effect on company rules. It is emphasized that recognizing alcoholism or drug abuse as an illness does not detract from local rules and regulations in respect to intoxication on the job, or having liquor on company property, which should continue to be enforced.

Policy of a Large Public Company.

(An Overview states the company's concern about alcohol and drug abuse as it affects job performance and the work environment, and as it undermines the public's confidence in the company.)

The company will take action against employees who use, distribute, or possess controlled substances on or off the job, and who violate company rules in reference to possession of alcohol on the job.

Employees must report to work in a fit condition for duty. Being under the influence of alcohol or drugs is prohibited.

Alcoholism and drug abuse are recognized as illnesses or "disorders," and the company accepts responsibility for providing channels of help, but it is the employee's responsibility to seek help.

If the employee seeks help prior to discovery, then confidentiality, job security, and promotional opportunities will be protected. But if the employee does not seek help and the problem in some way comes to the attention of the company, then disciplinary action will result.

Employees who use or distribute drugs on the job are subject to discharge, and any drugs confiscated will be turned over to local law enforcement.

If an employee is arrested off the job for drug involvement, the company will consider various circumstances surrounding the arrest before taking action.

If an employee is under treatment with a drug that could alter his or her ability to do the job, the employee could be subject to reassignment.

Each employee is requested to sign the policy statement.

Policy of a Large Chemical Manufacturing Company

In order to assure a safe and efficient work environment, the following policy has been adopted to supplement existing personnel policies, practices, and procedures:

Impairment Prohibited

No employee will report for work or will work impaired by any substance, drug or alcohol, lawful or unlawful, except with management's approval; such approval will be limited to lawful medications and based strictly on an assessment of the employee's ability to perform his/her regular or other assigned duties safely and efficiently. "Impaired" means under the influence of a substance such that the employee's motor senses (i.e., sight, hearing, balance, reaction, reflex) or judgment either are or may be reasonable presumed to affected. Any violation of this policy may result in summary discipline, up to and including discharge.

Possession Prohibited

No employee at any work site will possess any quantity of any substance, drug or alcohol, lawful or unlawful, which in sufficient quantity could result in impaired performance, except for authorized substances. "Work site" means any office, building, or property (including parking lots) owned or operated by the employer, or any other site at which an employee is to perform work for the employer. "Possess" means to have either in or on an employee's person, personal effects, motor vehicle, tools, and areas substantially entrusted to the control of the employee such as desks, files, and lockers. Authorized substances include only (1) lawful over-the-counter drugs (excluding alcohol) in reasonable amounts; and (2) other lawful (prescription) drugs or alcohol, the possession of which management has been advised and approved in advance. Any violation of this policy may result in summary discipline, up to and including discharge.

Substance Screening

For purposes of assuring compliance with the above, both employees and applicants for employment may be subject to substance screening under the circumstances described below. "Substance screening" means testing of blood, urine, breath, saliva, or otherwise as reasonably deemed necessary to determine possession or impairment, and the completion of a substance use questionnaire.

Applicants. Prior to assuming any job, an applicant will be subject to substance screening incident to a preemployment physical. Refusal to submit to such screening will make it impossible to medically classify the applicant, foreclosing any further action on his employment.

Employees. The substance screening of employees will be the determination of a component/unit. Any such screening will be under the circumstances described below. Before the implementation of any such substance screening, classes of employees that will be subject to inclusion will be so notified.

Suspected impairment. When there is reasonable evidence to suspect any employee has reported to work or is working impaired, he or she may be subject to substance screening. Refusal to submit to such screening will be considered an act of insubordination, with attendant disciplinary and employment consequences.

Post accident/incident. Any employee involved in either a job-related accident or job-related incident involving the apparent violation of a safety rule or standard, which did or could have resulted in serious injury or property damage, may be subject to substance screening. Refusal to submit to such screening will be considered an act of insubordination, with attendant disciplinary and employment consequences.

Safety critical jobs. Employees holding safety critical jobs may be subject to substance screening at any time on a random or other nondiscriminatory basis, as a term and condition of holding such jobs. Only those jobs the performance of which requires a high degree of care and caution in execution that even minor impairment would constitute an imminent hazard will classified as "safety critical." Incumbents of such jobs will be so notified. Upon request, employees will be considered for reassignment to a non-safety critical job that may be available providing they are qualified and such reassignment is consistent with applicable personnel policies and/or contractual requirements. Any refusal by an incumbent of a safety critical job to submit to substance screening will be considered an act of insubordination, with attendant disciplinary and employment consequences.

Inspections

For purposes of assuring compliance with the prohibition of possession, employees may be

subject to inspections of the kinds and under the circumstances described below. Any refusal to submit to such an inspection will be treated as an act of insubordination, with attendant disciplinary consequences.

Without cause. An employee's locker, closet, work area, desk files, company motor vehicle, and similar areas are subject to inspection at any time on a random or any other nondiscriminatory basis for purposes of this program. Similarly, an employee's own car, lunch box, and like personal containers are subject to such inspection when brought onto any work site.

Administration

Privacy. The results of any program screening will be considered a medical report disseminated only in strict compliance with the Company Occupational Health/Medicine Information "Confidential Policy."

Handicaps. The program will be administered so as not to interfere with the rights of handicapped applicants and employees, except to the extent any substance abuse handicap would directly interfere with job performance.

C

Sample Management Training Approaches

Training Program for a Consortium EAP

This multifaceted training program is offered to managers and supervisors of the numerous companies served by a consortium-model EAP, which is supported by donations from a number of organizations. It offers the following types of management and supervisory training services:

- Individual consultations with industry leaders (CEOs of major companies, directors of trade associations and unions) on policy issues

- Individual training on awareness and intervention skills for supervisors and managers that EAP staff happen to interface with in connection with other program activities (sometimes managers and supervisors also approach the EAP directly)

- Management training sessions given to groups of supervisors and managers in a given company

- Management seminars provided through professional or trade associations for the entire industry of which the consortium companies are a part, intended to target a wide range of executive-level personnel

- Development of learning materials, such as a Manager's Survival Kit, which consists of case examples, definitions of EAP services, guidelines and checklists for managers' behaviors with respect to alcohol and drug abuse, and selected readings such as the 1985 *Fortune* magazine article on "executive addicts," which emphasized the problems of addiction to cocaine, heroin, and prescription drugs.

The Managers Survival Kit and the consortium EAP's first industry-wide management seminar were developed jointly by the consortium EAP's executive director and members of its professional advisory board. The special evening meeting was held at a local hotel and was cosponsored by a professional/trade association of young managers in the industry of which the consortium companies are a part. The cosponsorship by this organization turned out to be crucial in attracting a large number (more than 150) of participants, and was especially helpful in promoting the attendance of middle managers.

Major topic areas covered during this one-evening seminar included:

- Structure and services of the EAP, and how to access them

- Nature and extent of the substance abuse problem in the industry of which the consortium members are a part

- Special problems of substance abuse experienced by people in the consortium's particular lines of work

- The physiology and psychology of substance abuse

- The special problems of cocaine

- The special problems of multiple addictions

- How to recognize and intervene with a substance abuse problem

- What managers should *not* do (e.g., they should not attempt to "treat" a substance abuse problem)

This format now is being used in followup seminars at individual companies, and future industry-wide seminars also are being planned. These educational approaches are felt to carry more impact than seminars or courses given outside the industry because they can attend to the special problems of this particular industry.

Policy of a Large Computer Company

Through a Los Angeles-based chemical dependency treatment program, this computer company provided its L.A.-based supervisors and managers with a 1-day training program on substance abuse. The major topics covered during this training were as follows:

- The larger picture about alcohol and drugs in the workplace

- Employee Assistance Programs and how they work

- Attitudes and beliefs about substance abuse

- The nature of addiction
- The corrective supervisory interview as it is used at the company
- Assessment, referral, and treatment procedures and how they work

This training session stressed audience participation, ranging from asking questions to presenting real-life case examples and working them through, to role-playing to test behavioral mastery of some essential principles of supervisory interviews. The training method emphasized methods for detecting impaired performance and deterioration of behavior, and documenting impairment to support later supervisory action as needed. Intervention steps, all of them based on performance rather than supervisor's "judgment" that the employee is in fact a substance abuser, are clearly laid out in terms of referral to EAP, disciplinary action, etc.

A number of training materials were distributed during the training session. A film was shown to highlight some of the issues involved in detection and intervention. Materials included fact sheets on alcohol and drug abuse, checklists of supervisory procedures, a questionnaire on attitudes and beliefs about substance abuse, and checklists on clues to impairment. The company's recently adopted substance abuse policy also was distributed and discussed.

This training approach emphasizes both education about the substance abuse problem and active involvement by supervisors and managers in developing intervention skills. Specific details of the company's policy about substance abuse are covered, which is critical for making appropriate interventions. This particular company has a relatively specific substance abuse policy, which greatly aids in making effective interventions. Finally, the training emphasizes the role of the Employee Assistance Program in diagnosis and treatment of potential substance abuse problems; supervisors and managers are encouraged to focus on job performance and to make referrals to the EAP when performance is impaired, without attempting to intervene in any substance abuse problems they may believe exist.

Supervisory Training Offered by an EAP Consulting Firm

This national EAP consulting firm has a number of public and private sector organization clients and offers a substance abuse training program as one of its services. The program focus is on recognizing and dealing with impaired productivity and dysfunctional behavior regardless of specific cause. The training program materials explicitly caution against use of drug testing in isolation by workplaces. Testing, if used, should be part of a comprehensive program based on well-developed policy, well-trained managers and supervisors, and services to assist those workers who have a substance abuse problem.

The short-term goal of the firm's training program is to increase manager and supervisor awareness of alcohol and drug abuse and other problems with symptoms that may be similar to those of drug abusers, and to provide strategies to deal with at-risk employees. The long-term goal is to increase performance and productivity by controlling illicit use and reducing significantly the personal and organizational cost of abusing alcohol and drugs.

The firm's training programs are adapted to each organization's culture and structure, but all contain five main modules:

- Consultation with management to establish substance abuse policy (targets are top executives and personnel in benefits, human resources, training, corporate counsel and security)
- Training for managers and supervisors on alcohol, street drugs, and prescription drugs; multiple addiction; and psychology and physiology of the addiction process
- Training in how to identify troubled employees, principles of observation and performance documenting, and how to set job performance standards against which potential problems can be evaluated; emphasizes that supervisors and managers are not expected to be substance abuse counselors
- Training on how to deal with the employee at risk, including coordination of referrals to the EAP
- Training in how to appraise whether supervisors and managers are properly using behavioral observation methods as part of performance evaluation; methods for evaluating EAP activities and outcomes.

D

State Drug Abuse Authorities

The following lists the drug abuse agencies in each State responsible for drug abuse prevention and treatment services. You may wish to contact your State Drug Abuse Director to learn about workplace drug abuse programs in your State.

Department of Health and Social Services
Office of Alcoholism and Drug Abuse
Pouch H-05-F
Juneau, AK 99811
907/586-6201

Department of Mental Health Community Programs
Division of Mental Illness and Substance Abuse
200 Interstate Park Drive
P.O. Box 3710
Montgomery, AL 36193
205/271-9209

Arkansas Office on Alcohol and Drug Abuse Prevention
1515 West 7th Street
Suite 300
Little Rock, AR 72201
501/371-2603

Arizona Department of Health Services
Office of Community Behavioral Health
701 East Jefferson Street
Suite 400A
Phoenix, AZ 85034
602/255-1152

Department of Alcohol and Drug Abuse
111 Capitol Mall
Suite 450
Sacramento, CA 95814
916/445-0834

Colorado Department of Health
Alcohol and Drug Abuse Division
4210 East 11th Avenue
Denver, CO 80220
303/331-8201

Connecticut Alcohol and Drug Abuse Commission
999 Asylum Avenue
Hartford, CT 06105
203/566-4145

Department of Human Services
Office of Health Planning and Development
1875 Connecticut Avenue. N.W.
Suite 836
Washington, DC 20009
202/673-7481

Bureau of Alcoholism and Drug Abuse
1901 North Dupont Highway
New Castle, DE 19720
302/421-6101

Department of Health and Rehabilitative Services
Alcohol and Drug Abuse Program
1317 Winewood Boulevard
Tallahassee, FL 32301
904/488-0900

Georgia Department of Human Resources
Division of Mental Health and Mental Retardation
Alcohol and Drug Section
878 Peachtree Street, N.E., Suite 318
Atlanta, GA 30309
404/894-6352

Government of Guam
Department of Mental Health and Substance Abuse
P.O. Box 8896
Tamuning, GU 96911
671/477-9704

Department of Health
Mental Health Division
Alcohol and Drug Abuse Branch
1250 Punchbowl Street
P.O. Box 3378
Honolulu, HI 96801
808/548-4280

Iowa Department of Public Health
Division of Substance Abuse and Health Promotion
321 East 12th Street
Lucas State Office Building
Fourth Floor
Des Moines, IA 50319
515/281-3641

Department of Health and Welfare
Bureau of Substance Abuse and Social Services
450 West State
Boise, ID 83720
208/334-5935

Illinois Department of Alcoholism and Substance Abuse
100 West Randolph Street
Suite 5-600
Chicago, IL 60601
312/917-3840

State of Indiana Department of Mental Health
Division of Addiction Services
117 East Washington Street
Indianapolis, IN 46204
317/232-7816

Alcohol and Drug Abuse Services
2700 West 6th Street
Biddle Building
Topeka, KS 66606
913/296-3925

Department for Mental Health/Mental Retardation Services
Division of Substance Abuse
275 East Main Street
Health Services Building
First Floor
Frankfort, KY 40621
502/564-2880

Office of Prevention and Recovery from Alcohol and Drug Abuse
2744-B Wooddale Boulevard
P.O. Box 53129
Baton Rouge, LA 70892
504/922-0730

Massachusetts Divisions of Substance Abuse Services
150 Tremont Street
Boston, MA 02111
617/727-1960

State of Maryland
Addiction Services Administration
201 West Preston Street
Herbert O'Conor Building
Baltimore, MD 21201
301/225-6926

Office of Alcohol and Drug Abuse Prevention
Bureau of Rehabilitation
State House
Station 11
Augusta, ME 04333
207/289-2781

Michigan Department of Public Health
Office of Substance Abuse Services
3500 North Logan Street
P.O. Box 30035
Lansing, MI 48909
517/373-8600

Department of Human Services
Chemical Dependency Program Division
444 Lafayette Road
Space Center Building, Second Floor
Saint Paul, MN 55155
612/296-3991

Missouri Department of Mental Health
Division of Alcohol and Drug Abuse
1915 South Ridge Drive
P.O. Box 687
Jefferson City, MO 65102
314/751-4942

Mississippi Department of Mental Health
Division of Alcohol and Drug Abuse
1500 Woolfolk State Office Building
Jackson, MS 39201
601/359-1297

State of Montana Department of Institutions
Alcohol and Drug Abuse Division
1539 11th Avenue
Helena, MT 59620
406/444-2827

Division of Mental Health/Mental Retardation Services
Alcohol and Drug Abuse Section
325 North Salisbury Street
Albermarle Building, Room 1100
Raleigh, NC 27611
919/733-4670

North Dakota Department of Human Services
Division of Alcoholism and Drug Abuse
State Capitol/Judicial Wing
Bismarck, ND 58505
701/224-2769

Nebraska Department of Public Institutions
Division on Alcoholism and Drug Abuse
801 West Van Dorn Street
P.O. Box 94728
Lincoln, NE 68509
402/471-2851/5583

New Hampshire Office of Alcohol and Drug Abuse Prevention
Hazen Drive
Health and Welfare Building
Concord, NH 03301
603/271-4627

New Jersey Division of Narcotic and Drug Abuse Control
129 East Hanover Street
CN 362
Trenton, NJ 08625
609/292-5760

Behavioral Health Services Division
Substance Abuse Bureau
725 Saint Michaels Drive
P.O. Box 968
Santa Fe, NM 87504
505/827-0117

Department of Human Resources
Bureau of Alcohol and Drug Abuse
505 East King Street
Carson City, NV 89710
702/885-4790

New York Division of Substance Abuse Services
Executive Park South
Box 8200
Albany, NY 12203
518/457-7629

Bureau of Drug Abuse
30 East Broad Street
Room 295A
Columbus, OH 43215
614/466-7893

Oklahoma Department of Mental Health
Alcohol and Drug Programs
4545 North Lincoln Boulevard
Capitol Station
P.O. Box 53277
Oklahoma City, OK 73152
405/521-0044

Office of Alcohol and Drug Abuse Programs
301 Public Service Building
Salem, OR 97310
503/378-2163

Pennsylvania Department of Health
Commonwealth and Forster Avenues
P.O. Box 90
Harrisburg, PA 17108
717/787-9857

Puerto Rico Department of Addiction Control Services
P.O. Box B-Y
Rio Piedras Station
Rio Piedras, PR 00928
809/764-3795

Department of Mental Health/Mental Retardation and Hospitals
Division of Substance Abuse
Substance Abuse Administration Building
Cranston, RI 02920
401/464-2091

South Carolina Commission on Alcohol and Drug Abuse
3700 Forest Drive
Landmark East
Suite 300
Columbia, SC 29204
803/734-9520

South Dakota Division of Alcohol and Drug Abuse
523 East Capitol
Joe Foss Building
Room 125
Pierre, SD 57501
605/773-3123

Tennessee Department of Mental Health/Mental Retardation
Alcohol and Drug Abuse Services
706 Church Street
Fourth Floor
Nashville, TN 37219
615/741-1921

Department of Health Services
Office of the High Commissioner
HICOM Headquarters
Saipan, Mariana Islands, TT 96950
615/741-1921

Texas Commission on Alcohol and Drug Abuse
1705 Guadalupe Street
Austin, TX 78701
512/463-5510

Utah State Division of Alcoholism and Drugs
150 West North Temple
P.O. Box 45500
Salt Lake City, UT 84145
801/538-3939

Virginia Department of Mental Health/Mental Retardation
Office of Substance Abuse Services
109 Governor Street
P.O. Box 1797
Richmond, VA 23214
804/786-3906

Virgin Islands Division of Mental Health, Alcohol and Drug Dependency
P.O. Box 7309
Saint Thomas, VI 00801
809/773-1992

Office of Alcohol and Drug Abuse Programs
103 South Main Street
State Office Building
Waterbury, VT 05676
802/241-2170

Washington Department of Social and Health Services
Bureau of Alcoholism and Substance Abuse
Office Building 44W
Olympia, WA 98504
206/753-5866

Office of Alcohol and Other Drug Abuse
1 West Wilson Street
P.O. Box 7851
Madison, WI 53707
608/266-3442

Department of Health
Division of Alcoholism and Drug Abuse
1800 Washington Street East
Building 3, Room 451
Charleston, WV 25305
304/348-2276

Alcohol and Drug Abuse Programs
Hathaway Building
Room 354
Cheyenne, WY 82002
307/777-7115/7118

E

Additional Resources

Employers considering implementation of a workplace drug abuse program may find useful the following selections as resources for educational, decisionmaking, training, and operational aspects of such programs. This section is not intended as a comprehensive listing. It includes a few resources to help get a program started or to refine a program: audiovisual and multimedia packages, periodicals, and organizations that can be utilized for ongoing technical assistance consultation. No endorsements are implied by the inclusion of the resources. They are listed as examples of materials available to assist those responsible for initiating or operating Employment Assistance Programs.

Audiovisual

Cocaine: Beyond the Looking Glass. Film or video, 28 minutes. Available from Hazelden, Center City, MN. A short film about the physiology and psychology of cocaine addition and its treatment.

Drug Information Series. Three 17- to 21-minute videos. Available from Southerby Productions, Long Beach, CA. Brief presentations on the signs and symptoms of drug abuse and how employers can confront workers they suspect of abuse.

Drug Screening on the Job: Potent Weapon, Potent Problems. Film. Available from Bureau of National Affairs, Washington, DC. An overview of drug testing.

Employee Assistance Programs—Benefits to Workers, Benefits to Business. Film. Available from Bureau of National Affairs, Washington, DC. Analysis of EAPs from both the employee and employer viewpoints.

Everybody Wins. Film or video, 35 minutes. Available from Hazelden, Center City, MN. An overview of the structure and operation of an Employee Assistance Program.

Everything Looks So Normal. Film. Available from Coronet/MTI, Chicago. Overviews substance abuse problems and possible solutions in a large manufacturing/shipping worksite.

Inside EAP. Film or video, 18 minutes. Available from Learning Systems, Inc., Princeton, NJ. Presents the actual case of an employee and a spouse receiving help through an EAP.

Substance Abuse: Managing Its Effects on Job Performance. Videos, 62 minutes ("The Supervisor's Role"); 38 minutes ("The Employee's Role"). Available from DuPont Training Services, Wilmington, DE. Two-videotape set with leader's manual providing training in education, prevention, and intervention for both employees and supervisor.

Whose Problem Is It? Film. Available from Coronet/MTI, Chicago. Focuses on a worker with a marijuana problem and how he ultimately enters an assistance program, after a near-accident takes place. Denial and coworker coverup problems are also examined.

Your Move. Film or video, 30 minutes. Available from Hazelden, Center City, MN. Case presentation of a supervisor confronting an employee with a performance problem and getting the employee to make contact with the EAP.

Multimedia Packages

Stop Drugs at Work: The Solution/Prevention Program. Combines videotapes and various print materials. Available from Random House Professional Business Publications, New York, NY. This package is designed to help companies develop and implement drug policies and programs and is supplemented by a telephone hotline for consultation purposes. Developers of the package include Mark Gold, MD, and Peter Bensinger.

Workplace Substance Abuse—An Intervention Model. Combines a video, training/program development guide, and brochures for workers. Available from National American Wholesale Grocers Association (NAWGA). Designed especially for labor-based worksites, this multimedia package offers guidelines for combatting substance abuse, including policy, legal issues, and EAP setup.

Employee Assistance Programs: Benefits Problems and Prospects. Combines a 209-page report and resource guide with a 30-minute video (also available separately). Issues of EAP involvement in drug testing are appraised, along with an overview of the role of EAPs in the workplace (the video includes two case studies, one of an in-house and one of an external EAP). Available from the Bureau of National Affairs, Inc. (BNA), Rockville, MD.

Periodicals

Business and Health. A monthly journal oriented to health and human resources issues in the workplace; includes regular attention to alcohol and drug abuse. Contact: Washington Business Group on Health, 229½ Pennsylvania Avenue, S.E., Washington, DC 20003.

Corporate Commentary. A quarterly journal oriented to research on health and human resources issues in the workplace; includes regular attention to alcohol and drug abuse. Contact: Washington Business Group on Health, 229½ Pennsylvania Avenue, S.E., Washington, DC 20003.

Drug Abuse Update. A monthly newsletter summarizing news stories and professional articles on various aspects of drug abuse, including a section for employers. Contact: Families in Action, 3845 North Druid Hills Road, Decatur, GA 30033.

Drugs in the Workplace. A monthly newsletter that provides a summary of newsworthy events of concern to employers, plus updates on prevention, detection, treatment, and recent court rulings. Contact: Business Research Publications, 817 Broadway, New York, NY 10003.

EAP Digest. A bi-monthly professional journal focusing on Employee Assistance Programs. Contact: Performance Resource Press, 2145 Crooks Road, Suite 103, Troy, MI 48084. (313) 643-9580.

The U.S. Journal of Drug and Alcohol Dependence. A monthly newspaper with information about treatment programs, EAPs and other efforts within the workplace, research on substance abuse, and legislation or advocacy efforts in this area. Contact: 2119-A Hollywood Boulevard, Hollywood, FL 33020. (305) 920-9433.

Organizations

American Medical Society on Alcoholism and Other Drug Dependencies (AMSAODD). 12 W. 21st Street, New York, NY 10016. Professional society that certifies physicians for competence in serving patients with chemical dependency problems.

Association of Labor-Management Administrators and Consultants on Alcoholism (ALMACA). 1800 North Kent Street, Suite 907, Arlington, VA 22209. The largest professional/trade association for those involved in the EAP field.

Employee Assistance Society of North America (EASNA). 2145 Crooks Road, Suite 103, Troy, MI 48084. The second major association for those working in the EAP field.

National Health Information Clearinghouse (NHIC). P.O. Box 1133, Washington, DC 20013-1133. Published bibliographies and other materials on health promotion topics, including some related to alcohol and drug abuse in the workplace.

National Institute on Drug Abuse (NIDA). 5600 Fishers Lane, Rockville, MD 20857. Maintains hotline and technical assistance service for employers regarding drug abuse in the workplace, and has many publications that may be of value to those developing workplace-based programs.

Hotline: 1/800-843-4971. Staffed by experts with drug abuse, employee assistance, and business backgrounds. This hotline is open from 8 AM to 8 PM weekdays and is designed to provide information to employers about drug abuse treatment and prevention programs (including Employee Assistance Programs), drug testing, available resources for consultation, and drug abuse policy.

National Study on Workplace Drug Abuse Programs. Human Interaction Research Institute, 1849 Sawtelle Boulevard, Suite 102, Los Angeles, CA 90025. Supported by a grant from the National Institute on Drug Abuse and other sources, the National Study is conducting the first major national research study of drug treatment, prevention, and education activities in EAPs. Other components of the study include local area profiles of EAPs, a computerized searchable information resource on drugs in the workplace, and publications targeted to both employers and professionals.

Drugs in the Workplace (DAWP) Computer Bulletin Board is a collaborative effort of the National Study and the UCLA/ADP Drug Abuse Information Management Program, funded by a contract from the State of California. Accessible by modem with an IBM/compatible microcomputer, this Bulletin Board offers continuously updated information on literature, re-

search, and other activities regarding drugs in the workplace. Access telephone number: (213) 825-3736.

Washington Business Group on Health (WBGH). 229½ Pennsylvania Avenue, NE, Washington, DC 20003. A membership organization of approximately 200 of the Fortune 500 companies, devoted exclusively to health and human resource policy and cost management needs of major employers.

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