

Drugs in the Workplace: A Manager's Guide

by
Vincent H. Eade
and
Michael A. Jonak

Drugs in the workplace is a growing problem that threatens a valuable human resource — the employee. Managers in the hospitality industry can take a proactive stance in meeting the problem head on. The authors discuss what managers can do.

Perhaps the greatest challenge facing the hospitality industry in the next decade is drug and alcohol abuse, a problem so insidious it can devastate an employee personally, as well as affect a company's vulnerable bottom line. It is estimated that drug and alcohol abuse cost U.S. businesses nearly \$100 billion annually in lost productivity.¹ A recent Gallup Poll revealed that one in four U.S. workers have personal knowledge of co-workers using illegal drugs on the job.² Additionally, industry statistics reveal a strong correlation between substance abuse and decreased productivity, increased employee absenteeism, requests for early shift releases, and worker compensation claims.

Employees who are substance abusers (i.e., over-indulgers in alcohol or drugs) can be characterized as follows:³

- 4-16 times more likely to be absent
- twice as likely to leave work early
- three times more likely to report to work late
- one third more sick benefits
- four times as many accidents
- five times as many worker compensation claims

Because of the pervasiveness of the problem, coupled with the fact that substance abuse and the workplace cannot exist together in harmony, today's managers need to become familiar with the types of drugs that currently saturate the organizational environment, their recognizable symptoms, and the potential consequences employees face because of substance abuse.

Stimulants Invade the Workplace

America's workplace is in the midst of a "stimulant" craze as opposed to the "downer" syndrome of the 1960s. Employees using stimulants display distinct symptoms of excitability during abuse episodes. It is not unusual for them to exhibit paranoia, grandiosity, or a false sense of invincibility with psychotic or violent behavior, pressured speech during the "high," and slurred speech when the abuser "crashes" or "is coming down" from the heightened effects of the drug.

Toxic effects of stimulants include sweating, foul body odor, poor dental traits, rapid pulse, dilated pupils, euphoria, agitation, progressive weight loss, and insomnia followed by hypersomnia.

Some of the medical consequences employees face as a result of their involvement with stimulants are premature aging, sinusitis, bronchitis, heart palpitations, heart infections, heart attacks, strokes, blood infections, tuberculosis, or impairment of the immune response system.

The most common stimulants that plague the hospitality industry follow:

- amphetamines (i.e., benzedrine, dexedrine, methamphetamine, "speed," etc.)
- caffeine
- cocaine
- crack (smokable cocaine)
- crystal methamphetamine or "ice," a new smokable methamphetamine relatively easy to make with a longer half-life than cocaine and significantly less expensive
- PCP, an animal tranquilizer that can cause permanent insanity in humans

Sedatives Also Take Their Toll

Sedatives or "downers" complete the workplace drug inventory. An employee using sedatives will become lethargic, have slurred speech, suffer from somnolence, and have bouts of depression and mood swings, often accompanied by weepiness or "chemical cries." Their pupils can either become dilated or constricted, depending on the particular sedative used.

The toxic and medical effects of sedatives include diminished respiration, hallucinations, dry mouth, constipation, difficulty with concentration, lack of good judgment, poor memory, and possibly coma or

Table 1
Employee Assistance Programs

Services offered	Percentage of companies offering the service
Alcohol/drug abuse	99%
Mental disorders/emotional stress	98%
Marital/family problems	98%
24-hour crisis hotline	56%
Legal counseling	56%
Health education (smoking, weight)	46%
Retirement counseling	33%
Career counseling	30%
Termination/out-placement	30%
AIDS education/support groups	26%
Health risk screening	13%
Financial counseling	10%

even death. Some of the sedatives most frequently found in the workplace are as follows:

- alcohol (alcohol is a drug and should be regarded as such by hotel and restaurant managers!)
- barbiturates (tranquilizers or sleeping pills)
- codeine
- demerol
- heroin
- loads (codeine and doriden - produces a semi-comatose condition)
- marijuana
- valium
- xanax

A number of sedatives are available through prescriptions. Therefore, the workplace is subjected not only to illegal drugs, but also to drugs available through the local pharmacy.

Employers Can Organize Employee Assistance Programs

In the war against drugs in the workplace, the enemy is heavily armed and the manager faces an uphill battle in the struggle. However, the hospitality industry is responding with a number of programs that are setting the trend for the 1990s.

In an effort to aid employees with drug problems, employers have developed employee assistance programs (EAPs). These company-sponsored programs offer counseling services, as well as referrals to drug rehabilitation and treatment centers. Numerous employers agree to pay for initial visits and/or cover treatment costs through insurance plans. Table 1 represents a cross-section of employee assistance services offered by 409 companies in the United States.⁴

It becomes apparent that many programs can be offered by smaller-sized restaurant operators; if not on an employer-paid basis, then certainly these services can be arranged strictly on a referral basis. In this era of benefits/compensation cost containment and balance, operators will have to determine the best approach to serve employee needs. However, since smaller operators in the hospitality industry are being hit hardest by the labor shortage, an EAP may provide an inducement for employee retention or recruitment. Larger hotel/restaurant operators have already realized their EAPs can offer a competitive edge in the labor market. Also, a distinction needs to be made between a one-time or casual drinker and the addict or abuser.

A second step being taken by hospitality industry employers in their fight against drugs in the workplace is utilization of professional treatment centers for their employees. Referrals are done on an in-patient/out-patient basis, a partial or total employer paid basis, or a non-employer paid basis. It is interesting to note that while numerous managers do refer their employees to these rehabilitation centers, few have taken the time to visit one of these establishments. Managers should make the time to visit a treatment center so they can knowledgeably answer questions posed by referred employees. Employees contemplating entering a "rehab" program will express anxieties and fears about the cost of treatment as well as the fate that awaits them at the treatment center. Informed managers can alleviate a number of these concerns if they have taken the time to investigate and understand how a rehabilitation program works. Managers should also be advised that pre-admitted employees/patients will worry about the loss of their job, the financial survival of their families, and their discovery by co-workers. Proactive managers can anticipate these questions and develop a supportive mentality.

Rehabilitation Occurs in Two Places

In-patient treatment at a drug and alcohol treatment center occurs in two phases. The first four to seven days of treatment consist of detoxification. The time frame may fluctuate depending on the severity and length of the addiction. A primary medical concern is prevention of delirium tremens (DTs), a bonafide medical emergency; 15 percent of untreated DTs are fatal. The syndrome begins with tremulousness and continues to disorientation, agitation, delirium, hallucinations, and high fever, with the potential for death. Which patients will develop DTs is an unknown factor; thus it is critical that alcoholics be medically supervised during the embryo stages of withdrawal. Managers need to convey this message to those employees who claim they can "beat it on their own." The length of alcohol use and age and general physical health of the patient are often the determinants of who lives or dies from untreated DTs.

The treatment of DTs has been reduced to a fairly standard approach. It begins with the administration of a sedative(s) such as valium, librium, phenobarbital, etc., plus necessary fluids and other supportive medical measures. These sedatives control the wild

rebound of Rapid Eye Movement (REM) sleep that occurs when the addict withdraws from alcohol. REM sleep, that cycle characterized by a seemingly erratic fluttering of the eyes underneath the lids corresponding to a purposeful dreaming phase of sleep, is what is responsible for a "refreshed feeling" that normal people feel in the morning. The alcoholic, when drinking, destroys this sleeping pattern and is constantly cheating himself of necessary REM time. Thus, the alcoholic's sleep cycle becomes like a coil spring and every drink tightens the coil, putting this person deeper and deeper on the red side of the physiological ledger. Then, on withdrawal, like a train hitting the brakes, the alcoholic's body tries to reverse the cycle and the coil rebounds out of control.

REM sleep then accelerates dramatically, causing confusion, agitation, delirium, and eventually death, if unchecked. It is precisely at this point that medication can reverse this runaway process and control this wild action/reaction sequence. If managed appropriately, withdrawal can be medically safe and limited to a period of five to seven days. The critical period of withdrawal is two to three days after the patient's last drink. Timely managerial intervention can make the difference.

At the end of detoxification, patients are taken off all medication and begin phase two of their treatment, which consists of full participation in group therapy and Alcoholics Anonymous (AA) or Narcotics Anonymous (NA), which provides an honest, fearless approach critical to recovery from a substance abuse problem.

AA and NA utilize a 12-step approach that includes a personal inventory of the disastrous effects the addiction has on patients' lives. These steps provide structure and guidance during recovery and aid the employee's continued sobriety.

In-patient treatment lasts for a minimum of two to six weeks. To prevent relapses, it is imperative employees continue with post-treatment meetings and support groups such as AA or NA. Managers may consider making this a condition of continued employment.

In-patient Treatment Offers Advantages

In-patient treatment offers a number of advantages over the out-patient option. First, it gives total, supervised separation from the drug. Second, the employee receives intensive therapy. It also allows the employee uninterrupted time to gain a new perspective on life. Finally, it represents the necessary break from a past, negative lifestyle.

Table 2 lists a number of statistics provided by the Alcoholics Anonymous organization. These figures reveal that this disease is a non-discriminatory victimizer. Research now indicates hereditary factors can be linked to alcoholism much the same as diabetes or heart disease.

Table 2
Factors Relating to Addiction (AA)

Ages of Members		Percentage
31 - 50		52
51 and older		27
21 - 30		18
20 and under		3
Sex of Members		Percentage
Male		66
Female		34
Members' Vocations	Percentage	Men/Women
Labor	25	12
Professional	24	22
Sales and business	22	16
Office and clerical	2	10
Homemaker	2	15

New Disciplinary Approach Taken by Managers

The third trend prevalent in the industry designed to deal with drugs in the workplace is the new disciplinary approach being taken by managers. Historically, intoxication or drunkenness on the job always resulted in immediate discharge. The following excerpt from the collective bargaining agreement between the Culinary Workers Union, Local 226 (the largest culinary local in the United States), and signatory hotels represents traditional union/management attitudes toward the problem:

Article 6, Section 6.01, Paragraph (b). Cause for (Immediate) Discharge. Where there is reasonable cause to believe that an employee is under the influence of alcohol or a controlled substance, the employee, after being notified of the contents of this subsection, must consent to an immediate physical examination at an independent medical facility or suffer the penalty of discharge.

The employer shall pay for the cost of the examination and the employee shall be paid for all the time required for the examination. A blood alcohol level of .1 provides an absolute presumption that an employee is under the influence of alcohol.

Thus, under this type of contract language, no "rehab" consideration has been articulated. Arbitrators have expressed three general

opinions relative to disciplinary cases involving intoxication:⁵

- The employee with an alcohol problem is no different than any other disciplinary problem and should be held to the same standards.

- An alcoholic employee has a treatable disease and is entitled to the same considerations as any other sick employee. Arbitrators sharing this view will consider reinstatement of the employee if during the time from discharge to the arbitration hearing, the person has admitted to his or her problem, has entered a rehabilitation program, and is involved in post-treatment AA or NA counseling.

- This final approach requires management to grant the employee a leave of absence to seek treatment prior to being discharged. Upon successful completion of rehabilitation, the employee is to be returned to the job and given "one last chance," provided he or she certifies continued treatment through AA or NA.

This last approach would appear to be the most favored by arbitrators today and represents a balanced approach to the problem. The employer needs a productive employee and the employee needs an empathetic employer who realizes the employee is an asset and truly a human resource who can once again be productive if given the opportunity to seek treatment prior to losing a job.

The massive extent of the drug problem in the workplace should not only concern today's manager, but it should also provide the motivation to promote a proactive mentality. If managers truly believe employees are human resources, then a genuine concern for their well-being is mandated.

Managers must become knowledgeable in drug detection, counseling, and treatment resolution. Additionally, they should not be duped by the prevailing myths about drugs, especially alcohol. For instance, those who claim "It's only beer and not alcohol" are misinformed. Alcoholism is genetic and should be viewed as a disease. Managers are to be cautioned that all addicts share the greatest myth of all: the denial that a problem exists.

Managers must take a firm, fair, and direct stance in the face of denial and strongly indicate the risk and potential loss of employment if treatment is not sought. In the final analysis, a "win-win" situation will be achieved, with both the employer and employee as beneficiaries if rehabilitation treatment is successful.

References

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Vincent H. Eade is an assistant professor in the Harrah College of Hotel Administration, University of Nevada; **Michael A. Jonak** is a clinical assistant professor in the Department of Family Practice, University of Nevada.