IJNRD.ORG ISSN : 2456-4184
INTERNATIONAL JOURNAL OF NOVEL RESEARCH AND DEVELOPMENT (IJNRD) | IJNRD.ORG
An International Open Access, Peer-reviewed, Refereed Journal

The need for addiction intervention programs at the workplace

Authors: Fr Pereira Joseph,

Authors Details – Founder Trustee, Management, Kripa Foundation (NGO),

Corresponding Author – Patricia Dsouza, ED to Founder Trustee, Management, Kripa Foundation (NGO)

Address: Kripa Foundation, Near Urdu High School, Papdy Post Office, Taluka – Vasai, Dist. Palghar – 401 207.

Keywords: Substance, Referral, Workplace, Programs

Abstract

A new ILO research estimates that 50 million individuals worldwide are drug dependent. After cancer and heart disease, alcoholism is the third leading cause of death. A study sponsored by the Ministry of welfare in 1989 in 33 cities reported that the age group of 16-35 was worst affected, most respondents were aware of the ill effects of drugs on health and there has been a rapid growth of drug abusers in industrial areas. Industrial workers have been identified as a vulnerable group in numerous studies on alcoholism and drug misuse that have been carried out in different regions of the world. More than 60% of drug users and around 75% of those with alcohol-related issues are said to be employed. Alcohol and drug use at work hinder an employee's ability to function efficiently and safely while carrying out their duties. According to studies on the human and financial implications of drug addiction, chemical abuse has significant direct and indirect costs for businesses. Reduced productivity, absenteeism, workplace accidents, increased medical expenses, the loss of qualified staff, the waste of skilled labour, strained labour relations, theft, and expenses related to preventive, treatment, and deterrence programmes are a few of these. Substance abusers have a two-fold increase in absenteeism compared to other employees. Between 20 and 25 percent of workplace accidents include drunk people hurting both themselves and uninvolved others. Employees with chemical dependency may claim three times as many sickness benefits and five times as many compensation claims. In addition to true chemical dependence, problems can also result from occasional or moderate users, who, due to their greater numbers, are more likely to consume substances to which they are not normally tolerant. Noting that substance use can range from recreational to frequent to problematic, despite the fact that it is frequently thought of as an addiction or dependence. There are thus various effects on people's lives and jobs. Years of casual use of a chemical without progressing to dangerous usage, being at different positions on the spectrum at different periods, etc. are all possibilities.

Keywords: workers, substance abusers, employees, workplace, alcohol, drug, chemical dependency

Introduction

According to research, occasional or moderate drinkers may have "hangover"-like symptoms after consuming large amounts of alcohol even after their blood alcohol levels have returned to zero. Hence, laboratory research suggests that work performance and decision-making skills may be impacted even if alcohol intake is limited to personal time (weekends) when the person is not working.

In view of the above scenario, an employee assistance program aimed at creating awareness about the problem, identifying individuals suffering from addiction, and referring them to organizations offering treatment would be in the interests of both the employee and the enterprise [9] [13].

Any effort to develop such a program is bound to encounter a variety of barriers. Some of them are:

- Substance abuse is largely seen by the management as a personal problem of the workers unless the individual involved is indispensable and has become a liability for the enterprise [19] [26].
- Certain forms of substance abuse like smoking and drinking are socially accepted and not considered to be worthy of attention unless the individual is rendered dysfunctional and incapable of functioning [23].
- Rather than assume the responsibility of the treatment of the addicts, management prefers to deal with them through disciplinary proceedings [15].
- With a view to safeguarding the reputation of their enterprise, management is generally hesitant in accepting that the problem exists.
- Because of the legal proceedings, most addicts are scared to come out and seek assistance.
- In order to protect their jobs, the addicts resort to denial.

In some enterprises the deleterious impact of Substance Abuse in terms of absenteeism, sick leave, low productivity, etc may be quite pronounced and hence a need for a preventive strategy well established [10] [19] [23].

It needs to be emphasized that:

- People at the workplace constitute a vulnerable category for substance abuse because of various stresses and strains operative on them [14] [30].
- Dismissal of a trained, skilled and experienced worker because of substance abuse is much costlier than the investment on its prevention and treatment [6] [7] [8] [10] [20] [21].
- The work place provides an ideal setting for contacting people at risk and helping them to cope with the dangers of SA.
- A positive response will not only nip the problem in the bud but will also provide an environment conducive to higher profitability for the enterprise.
- For an individual worker the establishment of a preventive strategy will lead to improved health, higher capability, better performance, increased income and refinement in the quality of life. For an enterprise, it should certainly reduce absenteeism, accidents and breakdowns in the production processes and result in assuring production targets [4] [24].

Methods

The study includes client data from the time period of Jan 2000 – Dec 2001, this refers to 387 clients admitted for the institution-based rehabilitation program at the Kripa Foundation, Mumbai.
The data is analyzed in terms of frequency and percentages. Means and Standard deviations are used wherever applicable.

Results
The socio-demographic data of the clients give an idea of the kind of target population that one is addressing while establishing employee assistance programs.

Table 1. Demographic characteristics of the sample

Sample characteristics	f	%	M	SD
Age group				
12-17	5	1.3		
18-23	22	5.7		
24-30	70	18.1		
31-45	212	54.8	37.62	9.56
46-60	75	19.4		
61&above	3	0.8		
Total	387	100.00		
Marital status				
Married	223	57.6		
Unmarried	131	33.9		
Divorced	17	4.4		
Separated	12	3.1		
Widower	4	1.0		
Total	387	100.0		
Educational status				
Illiterate	6	1.6		
Literate	2	0.5		
Primary	6	1.6		
Secondary	82	21.2		
SSC	101	26.1		
HSC	50	12.9		
Under graduate	16	4.1		
Graduate	108	27.9		
Post graduate	12	3.1		
Higher education	3	0.8		
Missing	1	0.3		
Total	387	100.01		
Self income				
Nil	183	47.3		
501-1000	7	1.8		
1001-2000	18	4.7		
2001-3000	22	5.7		
3001-5000	48	12.4		
5001-7500	29	7.5	1001-2000	2.66
7501-10,000	36	9.3		
10,000&above	39	10.1		
Missing	5	1.3		
Total	387	100.0		
Occupational status				
Unemployed	168	43.41		
Employed in service sector	131	33.85		
Self employed	63	16.28		
Student	8	2.07		
Retired	17	4.39		
Total	387	100.00		

The demographic profile in Table 1 showed that a majority (54.8 %) of the clients were in the age group of 31-45 years (M=37.62, SD= 9.56) followed by 19% in 46 –60 age bracket, 18% between 24- 30 years, 5% between 18-23 years, 1%between 12-17 years and a minimal above 60 years. The age range of the clients was 15-64 years. It is disheartening to note that the majority of the addicts were in the productive years of their life.

More than half of the clients admitted to the detoxification and deaddiction program were married (57.6%) while some were unmarried (33.9%). A few were divorced (4.4%) or separated (3.1%) and a minimal number were widowed (1%). The spouse children and other family members of the addict also have to face the financial, emotional and social consequences of the chemical dependency of the addict.

The educational status of the sample showed that many clients had completed graduation (27.9%) closely followed by those who had done their matriculation (26.19%) and secondary education (21.2%).

As far as the occupational status of the clients is concerned, almost half of the clients were unemployed (43.41%). More than a quarter were employed in the service sector (33.85%). Fewer were self employed (16.24%), while a minimal number were retired (4.38%). About 2 % of the sample were students.

Self-income status of the clients showed that almost half of the sample did not have any income (47.3%). About 12% of the clients had income in the range of 3001-5000 Rs, 9.5 % earned in the range of 7500-10,000 and 10% had income above 10,000. The income figures correspond with those of the occupational status both underlying the fact that half of the clientele were unemployed and did not have any personal earnings. The mean self-income lay in the range of 1001-2000. It should be noted that although many clients do not have any self-income, they still managed to maintain their addiction, often through means like borrowing money, taking a loan, or through illegal means of stealing, peddling drugs, and the like.

Table 2 Referrals of clients in the entire sample (N=387)

Referrals	f	%
Referrals from other sources.	341	88.11
Referrals from organized sector.	41	10.60
Referrals from unorganized sector	5	1.29
Total	387	100.00

Table 2 shows the majority of the clients (88.11%) were referred to the center by sources such as family, friends, employers, ex-addicts, and Kripa staff. Of the entire group (N=387) about 10 % of the referrals were from the organized sector i e from the welfare department of the enterprises where these clients were employed while 1.29% were from the unorganized sector.

Table 3 Referrals of the employed clients (N=131)

Referrals	f	%
Referrals from other sources.	90	68.70
Referrals from organized sector.	41	31.30
Total	131	100

Look at Table 2, it illustrates that of the clients holding service in the organized sector (33.85% of the entire sample), a majority were referred from other sources mentioned above while more than a quarter of the clients (31.30%) were referred to the center by their respective enterprises. Many of the people who develop problems

of substance abuse are at work. This fact implies that initiatives taken to prevent alcoholism and drug abuse at the work place will have definite advantage for health, safety and the welfare culture of the enterprise [29]. The need of regular awareness, identification and referral programs for the chemically dependent population of the employed in the organized sector is very evident. Many industries today suffer from the problem of addiction in their employees. It takes a toll on production, increasing workload on fellow workers and decreasing productivity and is a drain on the monetary and the human resources of the industry.

Thus, it is the need of the time that every industry, small or large should have employee assistance programs to treat those afflicted by addiction.

Table 4 Event of discharge in clients referred by different sources

Referrals	Discharge		Discharge on medical grounds		Exit		Total	
	f	%	f	%	f	%	F	%
Referrals from other sources	323	83.46	5	1.29	11	2.84	339	87.60
Referrals from the organized sector	31	8.01	2	0.52	1	0.26	34	8.78
Referrals from the unorganized sector	4	1.03	0	0.00	1	0.26	5	1.30
Total								
Missing	358		7		13		378	97.68
Total							9	2.32
							387	100.00

Clinical experience has shown that clients referred from the work place tend to be more compliant and complete the program in order to get the certificate necessary to keep their jobs. It is displayed in Table 4 that the Interactions with the welfare department of the enterprises bring forth these trends and such feed back when exchanged by both parties leads to better understanding of the client their needs and the disease process.

Table 5 Religion of the entire sample (N=387)

Religion	f	%
Hindu	220	56.8
Christian	113	29.2
Muslim	29	7.5
Parsi	1	0.3
Sikh	8	2.1
Jain	3	.8
Buddhist	13	3.4
Total	387	100.0

The religious distribution of the client population is indicated tin Table 5 which indicates that more than half were Hindu (56.8%) followed by Christians (29.2%), Muslims (7.5%), Sikh (2.1%), Buddhist (3.4%), Jain (0.8%) and Parsi (0.3%). Hindu being the most represented religion in India the finding in this respect was as expected. The Christian population was larger than is represented in India probably because majority of referrals at Kripa foundation are sourced through the Indian Archdiocese.

Table 6 Type of substance abuse in the entire sample (N= 387)

Substance	f	%
Alcohol	257	66.4
Drug	28	7.2
Polydrug	102	26.4
Total	387	100.00

Table 7 Type of substance abuse in clients referred by the organized sector (N= 41)

Substance	f	%
Alcohol	40	97.56
Drug	0	00.00
Polydrug	1	2.44
Total	41	100.00

A look at the type of substance abuse in Table 6 and Table 7, makes it clear that a majority of the clients were addicted to alcohol alone or with any form of tobacco (66.4%). About a quarter of them (26.4%) fell in the category of poly drug abuse, using other substances in combination with alcohol. The group using drugs alone without alcohol is quite small (7.2%). In clients specifically referred by the enterprises also for almost all of the clients the substance of abuse is alcohol. No doubt alcohol is widely abused than any other substance in the work place. Studies have shown that while "social drinking" within clearly understood boundaries does not immediately cause any problem, there is no guarantee of this "causal drinking" not turning into a frequent state of intoxification and physical psychological dependency with serious medical and social consequences [17] [18]. This underlines the fact that alcohol serves as a gateway drug to hard drugs and addicts take to alcohol as a supporting substance in their multi-drug use [22] [29].

Table 8 Substance of use in the entire sample (N=387)

Substance of use	Yes		No	
	f	%	f	%
Narcotics				
Opium	6	1.6	381	98.4
Morphine	6	1.6	381	98.4
Corex	21	5.4	366	94.6
Heroin	10	2.6	377	97.4
Brown sugar	65	16.8	322	83.2
Cannabis				
Marijuana	2	0.5	385	99.5
Ganja	36	9.3	351	90.7
Grass	8	2.1	379	97.9
Hashish	12	3.1	375	96.9
Charas	51	13.2	336	86.3
Bhang	6	1.6	381	98.4
Stimulants				
Amphetamines	0	0.0	387	100.0
Cocaine	7	1.8	380	98.2
Hallucinogens				
LSD	2	0.5	385	99.5
Depressants				
Alcohol	355	91.7	32	8.3
Anti anxiety drugs (tranquilizers)				
Valium	9	2.3	378	97.7
Diazepam	4	1.0	383	99.0
Calmpose	3	0.8	384	99.2
Nitravet	30	7.8	357	92.2
Trika	4	1.0	383	99.0
Sleeping Pills	14	3.6	373	96.4
Prescription drugs				
Phensidryl	18	4.7	369	95.3
Corex	21	5.4	366	94.6
Relipen	1	0.3	386	99.7
Spasmoproxyron	9	2.3	378	97.7
Tidigesic	5	1.3	382	98.7
Pain Killer	6	1.6	381	98.4
Mandrax	2	0.5	385	99.5
Fortwin	7	1.8	380	98.2
Nicotine	63	16.3	324	83.7
Tobacco	261	67.4	126	32.6
Gutka	33	8.5	354	91.5

The analysis of specific drugs presented in Table 8, further highlights the fact that alcohol addiction is prevalent in a large majority of the sample (91.7%). Among the hard drugs Brown sugar (16.8%), Charas (13.2%) and ganja (9.3%) seem to be popular. Nicotine (smoked) (16.3%) and tobacco (chewed) (67.4%) are often used along with the other hard drugs and their use is ingrained in the cultural fabric of the society. Of the tranquillisers Nitravet (7.8%) and other sleeping pills (3.6%) seem to be consumed by a moderate number. Prescription drugs which often get sold over-the –counter tend to be abused among them cough suppressants like Phensidryl (4.7%) and Corex (5.4%) being the most consumed.

Within the Workplace

Assessment of workplace issues linked to substance use disorders are usually not addressed in a systematic or effective manner. The majority of currently used measures concentrate on workplace requirements rather than employees' views of barriers between work and personal life [14] [16].

The reasoning for workplace interventions is that these settings allow for effective monitoring and offer a captive population that can be reached by programs for curative and preventative health care [2] [4] [25] [30]. The following are three phases that can be taken to cope with problems brought on by substance usage at work:

Phases One:
Creating and enforcing a drug-free workplace policy that emphasises:

1. Clearly stating that drug use is not permitted at work and encouraging staff members who may be struggling with substance use disorders to voluntarily seek help [25] [30].

2. A workplace policy that aims to ensure the health and safety of all employees, uphold the reputation and quality of the product, prevent the employer's assets from self-destruction, and safeguard the organization's image [25] [30].

Phases Two:
Providing the necessary staff with information on the intervention techniques:

1. Organising regular awareness events for employees, managers, and supervisors.
2. Creating policies and guidelines for managing employees that are drug or alcohol dependent
3. Taking corrective action by providing assistance.
4. For top management: Identify the issue and write a thorough data-based report on the employee's poor job performance, including particular dates, leaves of absence or other dates when the person was absent from work, missed deadlines, or inaccuracies in the given task.
5. Set up a confidential one on one meeting with the employee.
    a. Talk about the current circumstances, the decline in job performance, and any feedback.
    b. Cite specific dates and incidents related to subpar performance in the report. These ought to be factual and shouldn't sound like qualitative assertions.
    c. Clearly state what is expected of the employee.
    d. If the employee agrees to improve, hold him to it and arrange a mutually convenient time for him to show progress.
    e. Avoid believing empty promises.
    f. Keep an eye out for changes; if nothing changes, refer him to the HR team for a more thorough evaluation. They could then direct him to a facility for treatment. If the employee declines assistance, management may take necessary measures.

When dealing with problematic personnel, keep the following in mind:

1. Instead of defining the issue and claiming that alcohol or other drug use is the issue, place the emphasis on bad performance.
2. Discuss abuse only if a person is using drugs or alcohol at work or otherwise incapacitated.
3. Don't offer counsel. Remember that there is a great deal of denial linked with the disease of addiction.
4. Avoid assisting behaviours such as defending the worker, covering up, falling for his sympathy-seeking tricks, and losing one's temper.

Phases Three:
Arranging for the treatment of any drug or alcohol dependent personnel [9] [12] [15].

Referring a problematic employee to a facility for treatment and helping him become a productive worker again provides the following advantages instead of terminating their employment [9] [12] [27].

1. Ensures the resolution of issues.
2. Restores the problematic employee's productivity.
3. Helps the organisation focuses on constructive matters.
4. Enhances the organization's atmosphere and morale at work.

Summary and future guidelines:

Community

1. Targeting all community groups with early intervention is crucial.

2. The community has to implement thorough awareness campaigns that provide information, healthy substitutions, and messages on how to say "No" to drugs.
3. A comprehensive strategy is required; for a full recovery, prevention initiatives [1] [11] [21] [23] [28], medical assistance, self-help groups, and treatment facilities must all be linked [9] [12].
4. According to a recently completed mental health survey in India, 22.4% of adults are estimated to have drug use disorders, including alcohol use disorders [3].
5. It is crucial that important community stakeholders participate and are involved.
6. Governmental organisations must be engaged.

Workplace

1. Regular awareness campaigns for all hierarchy-level personnel are beneficial [5].
2. Employees with substance use problems must be identified early through inadequate job performance, and HR staff must be taught to refer them to treatment facilities [9] [12].
3. As their tasks differ, it is necessary to organise distinct programmes for management, supervisory level staff, medical personnel who operate in industries, the security department, and employees.
4. The company can set policies like not supplying alcohol during team meals or business meetings.
5. There should be posters about healthy substitutions posted in strategic locations.
6. The individuals who are seeking for help to stop and recover should form self-help groups.

Conclusion:

Substance abuse is a widespread problem in industrial cities and its impact can be felt at the work place in terms of decreased productivity, increased accidents, strained labor relations, and wastage of skilled manpower. Enterprises can no longer afford to ignore the problem of substance abuse among their employees as a “personal problem”. They need to take active steps in setting up preventive strategies in the form of employee assistance programs for the welfare of the enterprise and the individual employee.

REFERENCES

1. Murthy P, Prabhu L, Pandian D. Community Interventions in Substance use disorders In Community Psychiatry in India. In: Behere PB, Tnadon L, editors. New Delhi: Publication Committee, Indian Psychiatric Society; 2011. pp. 36–49.
2. Ames, G. M., & Bennett, J. B. (2011). Prevention interventions of alcohol problems in the workplace: A review and guiding framework. Alcohol Research and Health, 34(2), 175–187.
3. Gururaj G, Varghese M, Benegal V, Rao GN, Pathak K, Singh LK, et al. NMHS collaborators group. Summary. Bengaluru: National Institute of Mental Health and Neuro Sciences; 2016. National Mental Health Survey of India, 2015-16. NIMHANS Publication No. 128.
4. Trubow, G.: Privacy law and practice (New York, Matthew Bender, 1991), pp. 9-18 to 9-21.
5. Murthy P Principal author and Scientific Editor. Partnerships for Drug Demand Reduction in India. Ministry of Social Justice and Empowerment, Govt of India, United Nations Drug Control Program, International Labour Organization, European Commission Publication. 2002.
6. Making the Grade: A Guide to School Drug Prevention Programs. Drug Strategies, 1999.
7. Tibbits MK, Bumbarger BK, Kyler SJ, Perkins DF. Sustaining evidence- based interventions under real-world conditions: Results from a large-scale diffusion project. Prevention Science. 2010;11(3):252–262.
8. Mentoring—A Proven Delinquency Prevention Strategy. Office of Juvenile Justice and Delinquency Prevention, Juvenile Justice Bulletin, April 1997.
9. Ranganathan S. Treatment for Alcoholism-The Community Approach. Chennai: TT Ranganathan Clinical Research Foundation; 2007.
10. Manual on prevention of Substance Abuse in small enterprises, 2000.
11. Cook, R., & Schlenger, W. (2002). Prevention of substance abuse in the workplace: Review of research on the delivery of services. Journal of Primary Prevention, 23(1), 115–142.
12. Ranganathan S. Conversation with Shanthi Ranganathan. Addiction. 2005;100:1578–83.
13. Murthy P, Manjunatha N, Subodh BN, Chand PK, Benegal V. Substance use and addiction research in India. Indian Journal of Psychiatry. 2010;52(Suppl1):S189.
14. Bennett, J. B., Patterson, C. R., Reynolds, G. S., Wiitala, W. L., & Lehman, W. E. (2004). Team awareness, problem drinking and drinking climate: Workplace social health promotion in a policy context. American Journal of Health Promotion, 19(2), 103–113.

15. Chavan BS, Gupta N. Camp approach: a community-based treatment for substance dependence. The American Journal of Addictions. 2004;13:324–5.
16. Murthy P. ILO project on Community Based Drug Rehabilitation and Workplace prevention. Project report. Submitted to the International Labour Organization. 1999.
17. Blum, T. C., Roman, P. M., & Martin, J. K. (1993). Alcohol consumption and work performance. Journal of Studies on Alcohol, 54, 61–70.
18. Mangione, T. W., Howland, J., Amick, B., Cote, J., Lee, M., Bell, N., et al. (1999). Employee drinking practices and work performance. Journal of Studies on Alcohol, 60(2), 261–270.
19. Ministry of Social Justice and Empowerment's recently released report on the "National Survey on Extent and Pattern of Substance Use in India" (2019)
20. Understanding Substance Abuse Prevention, Toward the 21st Century: A Primer on Effective Programs. Center for Substance Abuse Prevention, Monograph, 1999.
21. United Nations Office of Drugs and Crime. International standards on drug use prevention. Vienna, Austria: United Nations; 2013. [April 6, 2016]. Retrieved from http://www.unodc.org /unodc/en/prevention/prevention-standards.html.
22. Ontario Human Rights Commission: Policy Statement on Drugs and Alcohol Testing (Toronto, Nov.1990).
23. J. B. Bennett W. E. K. Lehman G. S. Reynolds (2000) Team awareness for workplace substance abuse prevention: The empirical and conceptual development of a training program Prevention Science 1 157–172 10.1023/A:1010025306547 11525346
24. Hingson R, McGovern T, Howland J, Heeren T, Winter M, Zakocs RC. Reducing alcohol-impaired driving in Massachusetts: The Saving Lives program. American Journal of Public Health. 1996;86(6):791–797. [PMC free article] [PubMed]
25. Management of alcohol- and drug – related issues in the work place, International labour organization 1996.
26. ILO: Conditions of Work Digest, Vol. 12, No. 2, "Workers' privacy: Part III: Testing in the workplace" (Geneva, 1993).
27. Equal Employment Opportunity Commission Technical Assistance Manual on the Employment.
28. Murthy P. Geneva: Commissioned by the International Labour Organization; 2002. Case study of the KSRTC workplace programme as an exemplary workplace programme for the prevention of alcohol and drug abuse.
29. Provisions of the Americans with Disabilities Act: Chapter VIII, "Drug and alcohol abuse" (Washington, DC, 1983).
30. National Institute on Drug abuse research monograph series. Drugs in the work place: research and evaluation data Vol II, 1990