The Unions Look at Alcohol and Drug Dependency

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IN DISCUSSING THE PROBLEMS of alcohol and drug dependency, I feel that I face difficulties similar to those experienced by Catholic priests when they are asked to discuss sex. If I appear too knowledgeable, some people may become suspicious of what I do in private. If I proclaim my innocence, others will protest that my opinions are based on ignorance. So, like the priest, I must confess that most of what I know about the subject comes from books—but on the other hand I have read some pretty good books.

Before suggesting how unions might co-operate in programmes related to drug dependency, I would first like to examine the whole question of drugs, their use and their abuse.

What is a drug?

This may not seem like a very great problem to most people. Indeed, if I were to conduct a random survey on any street corner in Canada, most people would probably give fairly definite answers. If we were to summarise these answers, I would hazard a guess that they would fall into two general categories. Drugs would be something that the doctor prescribes or what some persons—other than the person being questioned—are taking for non-medical use. Since medicine and the medical profession are generally held in high esteem, the use of any prescribed drug would be viewed as legitimate. That this form of use, though usually beneficial, may lead to abuse is not always recognised. The widespread use of tranquillisers is an example of this phenomenon.

In the case of the non-medical use of drugs, there is a tendency within any given culture for one man's meat to be another man's poison.

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[1] Executive Vice-President, Canadian Labour Congress; Chairman of the Workers' Group, Governing Body of the International Labour Office. The present article is a slightly expanded version of a paper delivered by the author to a conference on " Drugs and alcohol: their effect on industry ", organised by the Workmen's Compensation Board of British Columbia, Canada, at Bayshore Inn, Vancouver, on 28 and 29 January 1972.

An example of this is the debate now going on in many community organisations and groups on the use of alcohol versus the use of marijuana. The persons attending the discussion meetings probably all drink tea or coffee, but since these have such widespread acceptance, few people are consciously aware of them as a form of drug use.

Between cultures, it may be a case of one man's pleasure being another man's religion. An example of this is mescaline, which is a recreation drug to the hip community of North America and, as peyote, a sacrament to members of the Native American Church. Over a period of time, the same substance can be viewed in entirely different ways. Thus, in Western culture, alcohol has been viewed religiously, medicinally and recreationally, depending on the era and the region.

The Le Dain Commission [1] defined a drug as any substance that by its chemical nature alters structure or function in the living organism. Such a definition encompasses foods, vitamins, air pollutants, virtually all foreign material and many materials normally present in the body. While this may seem too wide, one can see that the drug to which we may be devoting our attention is part of a complete spectrum of substances affecting humans. While the availability of substances in any community partially determines their use, much more important are the mores of the society. To illustrate this point, I would like to give a slightly facetious example.

Through our governments, we tax rather heavily the use of alcohol and tobacco. This policy originated from a combination of religious views on their use and a government need for revenues. Over the years, the latter has continued unabated, while medical opinion has tended to supplant the former. The present keepers of the new cultural strictures have mounted impressive documentation in support of their warnings. Alcoholism is the fourth greatest public health problem and cancer, with its links to tobacco consumption, is the second. However, at the same time, our governments are using the tax dollars to subsidise the consumption of butter, which by raising the cholesterol content of the blood is closely linked with heart disease—the number one public health problem. While I am not here to confuse further the government's efforts at tax reform, I do think it can be seen that the definition of a drug is not as simple as many people tend to believe and that the definition can change as the culture changes. Such a change appears to be occurring today in our society in relation to marijuana and its derivatives. These substances have been known to Western culture since the time of the Crusades, but their use in the West was practically non-existent until recently. Dr. Andrew Malcolm of the Addiction Research Foundation in Ontario

[1] Set up to inquire into the non-medical use of drugs. Its report was submitted to the Canadian Parliament in May 1969 and published in 1972.

has offered the following explanation for our past preference for alcohol over marijuana:

> It would seem that Western culture was too outgoing, too materialistic, too active to welcome a drug that facilitated the enjoyment of inner experience. Experience, for the West, was of the world, and the world was dazzling and infinitely stimulating in its complexity. When the Westerner felt the need for psychic change, he tended to think in terms of stopping the flow of sensory stimuli. He drank beer and, later, whisky and rum. He had no need to make his world more varied, because he already perceived it in overwhelming detail.

Dr. Malcolm hypothesises that alcohol was the drug that best harmonised with our style of living. It reduced the pressures inherent in a competitive, aggressive life style without reinforcing discontent and a desire to turn away from it. Marijuana appears to have the reverse effects. However, it is more likely that people with a quietistic view of life will be drawn to marijuana than that the use of marijuana in itself will be at the origin of a quietistic view of life. That is, drugs will tend to reinforce a person's normal view of life. Indeed, the placebo effect in relation to drugs shows that people can induce the desired effect without the actual presence of chemical agents.

All societies appear to have used drugs for one purpose or another. The difference today is that we tend to use a greater number of drugs with increasing frequency. A United States task force report on mind-altering drugs concluded that: " In terms of drug use, the rarest or most abnormal form of behaviour is not to take any mind-altering drugs at all.... If one is to use the term 'drug user', it applies to nearly all of us."

Why?

The question arises of why we take a greater number of drugs. As far as I know, there is no one satisfactory answer to this question, but I will make a few rather obvious observations.

First of all, drugs are more readily available. The drug industry has produced a vast array of new chemical cures for physical and psychological ills. This has been accompanied by a greater willingness on the part of people to consume drugs—at least for medical reasons.

Secondly, there has been a decline in the old religious and legal prohibitions. Tobacco may be medically harmful to you, but few would view it as being morally harmful. Indeed, the Le Dain Report related modern drug use to " the collapse of religious values ". Organised religion seems to be falling out of favour to be replaced in a few instances by the chemical pursuit of truth and of the religious experience.

In a greater number of cases, the replacement is simply a seeking out of pleasure. Or, if you prefer the reverse side, one is looking for a relief from tension. While much is written about anomie and alienation, most people just want to feel comfortable—physically and psychologically. Dr. Malcolm has concluded that: " It would seem that the search for

pleasure through the alleviation of mental conflicts on the one hand and the direct experience of perceptual distortion and euphoria on the other is now a characteristic of our society." This search for pleasure and experience has been increased by the rise in the amount of leisure time which we have at our disposal.

It is in the context of a search for pleasure that I would see the problems surrounding drug use, rather than viewing drug-taking as the source of the breakdown of society or of the birth of a new faith. Nevertheless, for a minority in society, either of these extreme options may be true. Those who suffer severely from feelings of powerlessness, meaninglessness, normlessness, cultural estrangement, self-estrangement and social isolation may take drugs to " improve " their situation, only to find it worsen. On the other hand, those seriously pursuing the mystical experience may take drugs to reinforce their other efforts to seek it out. While many people take a variety of drugs with few ill effects, the increased availability and acceptance of drugs may result in the likelihood that those tending to either extreme outlined will use drugs experimentally with disastrous effects.

Who are the people vulnerable to this danger? Unfortunately, we don't know until the damage has been done. While the majority of people do not take drugs for pathological reasons, neither did the addict originally. Few, if any, persons become addicted upon consuming one dose of a drug. The why for any one person is uncertain, and one answer will not fit all persons. For this reason, Blue Shield—the large North American sickness insurance organisation—could only define alcoholism as " a complicated illness which can be identified as one part physical, one part psychological, one part sociological and one part alcohol ". While no absolute statements can be made, I feel that in general when we come to look at treatment we must consider how the tension can be eliminated or reduced and what are the alternative sources for pleasure.

Dependency

The same problem exists in defining dependency as we encountered with drugs and the reasons for their use. The World Health Organisation has defined drug dependency as " a state, psychic and sometimes also physical, resulting from the interaction between a living organism and a drug, characterised by behavioural and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence ".[1] The World Health Organisation has listed the principal forms of dependency as being of the morphine, barbiturate-alcohol, cocaine, cannabis, amphetamine, khat and hallucinogen types.

[1] WHO: *WHO Expert Committee on Drug Dependence, Sixteenth Report*, Technical Report Series No. 407 (Geneva, 1969), p. 6.

Even in this list there are some gaps. For example, volatile solvents such as those contained in glue appear not to be included. While these generally do not lead to dependency, their use by older children and younger adolescents is of concern in the field of drug abuse.

Leaving aside the question of what are the possible dependency drugs, how can we say when dependency exists? When does the social drinker become the alcohol-dependent person? The coffee drinker, the caffeine-dependent person? The patient under sedation treatment, the tranquilliser-dependent person? Again, there appear to be no absolute lines. Even if a person becomes dependent on a drug, it is not necessarily bad for himself or society. We have to look at whether dependency in a given case results in physical, psychological or social harm.

In one sense, we are free to choose what we shall be dependent upon. Our choice may be chemical pleasure of various types or combinations. It may be for a religion, family, music, books, work, favourite foods, hobbies or something else. Indeed, we usually combine chemicals and one or more of the latter. In a finite world, our choices cannot provide an absolute solution. We may lose our faith, love of our spouse, our interest in work, music, books, etc., as well as run into problems with drugs. Our society has generally opted for what might be termed the " square " types of dependencies. We have done so for the simple reason that they tend to have a much higher rate of success than do short-cut chemical means. I would think that it is essential for any drug treatment programme to reinforce the " square " options of most interest to the person undergoing treatment. Dr. Malcolm has stated his choice of options this way: " The fullest possible use of the human mind in all its rational and emotional complexity is finally the most natural and at the same time the most civilised alternative to the use of psychoactive drugs."

Extent of drug use

While defining a drug may prove elusive, we have enough statistical evidence to show levels of very extensive use, if not abuse, of a wide range of drugs.

In 1968, Canadians bought 3,000 million aspirins—a pretty hefty number for a people whose grandparents probably shunned their use on most occasions. As noted earlier, most people tend to see abuse only in the area of non-medical use. However, the facts show that abuse is occurring through prescriptions. Tranquillisers were unknown over twenty years ago, but by 1969 they accounted for 24 per cent of all prescriptions in Toronto. Since 1950, over 12,000 patents have been issued for tranquillisers, barbiturates and stimulant preparations. By 1970, North Americans were spending over $500 million on sedatives annually. The production and importation of barbiturates in Canada alone amounted to 556 million standard doses.

At the same time, on the stimulants side, the figure for amphetamines, a product almost unknown until after the Second World War, was 55.6 million standard doses. All these were obtained by prescription and their total far exceeds the accepted estimates of our health needs. Indeed, the situation had developed by 1966 to a point where it was estimated that on any day in Canada 7 per cent of the population over 15 years of age would be using *on prescription* a mood-modifying drug. Dependency and death were the results. In British Columbia, in 1968, 158 persons died from overdoses of barbiturates, compared with 109 in 1967. Reported poisonings from tranquillisers in Canada went up from 63 in 1961 to 973 in 1967. The use of amphetamines in standard doses, which are 10 to 15 milligrams, resulted in dependency, and in the form of " speed "—i.e. methamphetamine in doses of 150 to 250 milligrams—its use has spread among the young, with deadly results. In the latter case, an unknown quantity is manufactured illicitly. This supply is often contaminated with impurities to further increase the health hazards.

The use of unprescribed drugs has been increasing sharply, though this may not represent dependency. In 1969, the Narcotics Addiction Foundation of British Columbia found that over 12 per cent of high school students used solvents, of which glue sniffing was the main form. However, neither dependency nor death was very frequent and use is usually discontinued when the person reaches his twenties.

More serious is the use of opiate narcotics. In its interim report, the Le Dain Commission found that 62 per cent of the known addicts in Canada lived in British Columbia. While at that time users, as a percentage of the population, were declining, recent events seem to indicate that this trend has been reversed. The effects of the use of narcotics, especially heroin, have been described in the most dire terms. While overdoses will kill, the prime cause of many of the bad side effects associated with regular use relate more to the illegal market in which the supply is obtained. High cost tends to result in crime if you are poor. Impurities in the supply and from the means of injection are an important cause of health problems. In addition, the use of narcotics has previously been confined largely to marginal groups in society where nutritional and psychological problems usually precede drug consumption. J. H. Jaffe has stated that:

> The popular notions that the morphine addict is *necessarily* a cunning, cringing, malicious, and degenerate criminal who is shabbily dressed, physically ill and devoid of the social amenities could not be further from the truth.... Good health and productive work are ... not incompatible with addiction to opiates.[1]

That such a pattern of " normal " behaviour was an exception in the past does not mean it must be so in the future. Indeed, recent reports indicate that young people are beginning to become Sunday heroin users.

[1] In L. S. Goodman and A. Gilman: *The pharmacological basis of therapeutics*, 3rd edition (New York, Macmillan, 1965).

Most controversial in recent years has been the use of marijuana. The numbers who have tried it or its derivatives have increased in the past decade from the hundreds to the hundreds of thousands. While the effects vary with the amount taken, it appears that among some frequent users psychological dependence does occur. However, the evil effects which at one time were supposed to result rarely do. Indeed, the exceptions are usually cases in which a person, unstable before the use of marijuana, becomes more so through its over-use. The famed link between marijuana and heroin addiction would appear to be a myth. Alcohol and barbiturates (and probably tobacco) have apparently been the drugs most often associated with opiate narcotic use in Canada. The Le Dain Commission observed that the pattern may be changing to include marijuana and other psychedelic drugs. It should be noted that this may be a case more of general dependence on drugs than of what used to be termed addiction. Of course, as the new pattern becomes more acceptable, we may witness increasing problems in this area. Research on alcohol indicates that as the general level of consumption goes up, so too do the instances of alcoholism. A similar phenomenon may occur with marijuana.

Although marijuana has received the most publicity recently, alcohol continues to be the major drug consumed for recreation purposes. Over 80 per cent of Canadians over 15 years of age use alcohol. Their average consumption of alcohol, in all beverage forms, was 1.83 gallons in 1967, up 25 per cent from 1951. Between 1951 and 1966, the number of alcoholics increased by 63 per cent. A recent study by the Alcoholism Foundation of British Columbia showed that 35 per cent of persons dying by accident, homicide or suicide had been drinking before their deaths.

The average cost of an alcoholic to his employer in Canada is estimated at about 25 per cent of his earnings. In 1960, Sydney Katz estimated that the national cost per working day was $1 million. In the United States the annual cost to employers has been estimated at $6,000 to $8,000 million, equivalent to twice the time lost annually by all US workers because of strikes. An even higher figure was given recently by James M. Roach, retiring Chairman of General Motors, who estimated that industry suffers annual losses of some $8,000 to $10,000 million a year in property damage, workmen's compensation, medical claims and insurance, and for health and welfare services.[1] Sickness absenteeism

[1] Remarks made to the Alcoholism Recovery Institute Luncheon, New York, 3 November 1971. The extent of the problem in industry was also underlined by A. R. Huntington in the paper he presented to the drugs and alcohol conference, when he quoted Dr. Robert G. Wiencek: " Drug abuse has recently become a problem in industry. In industry in Ontario there are about 100,000 alcoholics; in the US industries, about 2 million. The National Council on Alcoholism estimates that 3 per cent of the workforce are problem drinkers and that drinking interferes with the work performance of 1 per cent. Addiction to narcotics will surpass the prevalence rate of alcoholism in industry by the end of 1971." E. D. McRae told the same conference that " it is usually agreed that 3 per cent of any labour force will be problem drinkers ".

of alcoholics in North America is about two-and-a-half times that of others. As pointed out by Dr. Colin Hardie, Medical Director of the BC Telephone Company, Vancouver, in his address to the drugs and alcohol conference, studies conducted in the United States indicate that the alcoholic will average 20 to 25 days' absence a year for alcoholism alone and that he will have a greater number of absences than other workers for other illnesses. An alcoholic is also more accident-prone, as the risk of injury increases by 50 per cent after consumption of about three quarts of beer or seven ounces of spirits.[1] Not only does the alcoholic endanger himself, but also his fellow employees who, incidentally, have to take up the slack caused by the alcoholic's inefficiency. Moreover, as noted by Lewis F. Presnall at the conference, any assessment of the total impact of the problem on industry must also take account of the deterioration in the performance, attendance or emotional stability of employees whose spouses are addicted.

In examining the extent of drug use and dependency, I have focused largely on specific drugs. However, the major development to me is not the growth in use and abuse of single drugs but the multiple use of drugs. Even if we do not abuse any one drug, most of us are becoming more dependent on drugs as such. While in any one case there may be no danger to our physical and psychological lives, there may be a growing danger for society as a whole.

Union support for company treatment programmes

While the image of the derelict alcoholic still lingers on, statistics show that only 3 per cent of alcoholics are on skid road. Half of those dependent on alcohol are employed! With the increasing use of other drugs, I expect we shall see a corresponding rise in problems on the job associated with other drugs. However, alcoholism is the major problem at present and we have had most experience in relation to it, so I shall concentrate on it in my examples. The principles involved, though, would apply to any form of drug use affecting work performance.

As we have seen, the economic loss to industry due to alcoholism is high. For that reason many companies find it in their self-interest to initiate a programme to deal with this problem—that is, assuming they don't avoid the issue by firing alcohol-dependent employees [2] and are not paralysed by what has been called the " company disgrace " syn-

[1] Hardie also referred to other studies showing that alcoholic employees have more than twice as many occupational accidents and up to ten times as many non-occupational accidents as non-drinkers.

[2] " The addict's chances of being hired elsewhere are poor and he has a habit to support—the only possible source of support is crime. If the employer routinely discharges the addict, he is compounding the community problems of drug addiction and crime." Huntington, op. cit.

drome.[1] In terms of treatment, often the only way to get alcoholics to take positive action is to threaten them with the loss of their jobs. Earl M. Patton, Programme Consultant for the May Street Centre (a Toronto treatment centre for employees with drinking problems), calls this " constructive coercion " and in his address to the conference underlined " the necessity for creating a real meaningful, serious crisis in the life of the problem drinking employee ". Loss of income generally works more often than the exhortations of family and friends. These two reasons, plus a union's concern for the welfare of its members, indicate that the union can play an important role in any treatment programme. However, the degree of co-operation extended by the union will depend on a number of factors.

First, the programme may be initiated by management without consulting the union. The result will be that the union sees the programme as a company one and the best medical services may not be properly utilised as a result. Unfortunately, this lack of consultation appears to be the rule rather than the exception. A 1968 survey by the Industrial Conference Board of 120 sizeable manufacturing firms in the United States revealed that only 17 firms fully consulted with the union representing their employees, and another 22 to some extent. Only 8 companies described their programme as jointly operated. Only 12 per cent had any provisions relating to alcoholism in their collective agreements. An example of such a clause is to be found in the collective agreement the Steelworkers' Union has with the basic steel companies:

> Without detracting from the existing rights and obligations of the parties recognised in other provisions of this agreement, the company and union agree to co-operate at the plant level in encouraging employees afflicted with alcoholism to undergo a co-ordinated programme directed to the objective of their rehabilitation.

Unless there is consultation and co-operation before and during the programme, it will not be as successful as it could and should have been.[2]

Second, the effectiveness of any programme will be affected by the general relations between union and company. If the union believes that the company is breaking part of the collective agreement, it is most unlikely that it will co-operate with management in the area of treatment

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[1] By Presnall, op. cit. Presnall believes that " there is still a marked tendency for people to feel that if the company develops a behavioural control programme, the firm will be tagged with a label such as ' the company with all those drunks ', or ' dope fiends ', or ' pill-poppers '." He maintains that " contrary to these fears, companies that have developed effective control programmes have indeed found that such action enhances the company's image as a responsible, up-to-date firm."

[2] Enlightened management fully recognises this: cf. Dr. Colin Hardie: " There must be consultation between the company and the union or unions involved, and the support of the union or unions involved must be obtained for the programme. Without the union support, any treatment and rehabilitation programme will be in trouble from the start." Op. cit. Unfortunately, as the figures cited in the text demonstrate, union support is sought after all too rarely.

for alcoholics. For example, given a hostile atmosphere, what is the union's reaction likely to be when the company doctor says that an active shop steward has an alcohol dependency problem? Even if the union agreed with the doctor, it would quite likely fight any action on the company's part. If this sounds unreasonable, it should be remembered that industrial relations are but a form of human relations. And which one of us, during an argument with our wife, is willing to grant the validity of a secondary point raised by her until the major one is cleared up? Unfortunately, in these circumstances there are no winners and one big loser—the alcohol-dependent person.

Third is the priority society puts on treatment, and this will be determined largely by our attitudes. Research and education have played a large role in this century in changing the view we have on alcoholism. The work of provincial bodies devoted to this, as well as private organisations, is to be lauded. The World Health Organisation emphasised this when it wrote that " the need for compulsory treatment appears to bear an inverse relation to the degree of public understanding, lack of stigma, and the availability of adequate treatment services for voluntary patients ".

The fourth factor—the availability of community resources—stems directly from the third. The four Rs of combating industrial alcoholism are recognition, referral, rehabilitation and re-employment. Without there being somewhere a person can go for help, no significant success can be achieved. Treatment centres should preferably be public rather than owned by the company. I say this because, first, such facilities are needed by many persons, and not just those employed by a major company; and secondly, a person referred will have access to more services than one company will provide and have a greater feeling of confidentiality than he would with a company nurse or doctor. That these centres should comprise professional services is essential.[1] The traditional treatment service of drying-out, provided by hospitals, was termed by the World Health Organisation as being of " scarcely more value to the patient than detention in prison ".

Fifth, we have to plan our economy for full employment and provide guaranteed assistance for those unable to work. It is of little use to tell a man that he must stop drinking and get a job if locally there is no employment to be had. Although unemployment by itself does not cause drug dependency or employment by itself cure the problem, a job is a very valid alternative to a life of drug dependency. For many people it is the most effective alternative. That young people under 25 years old are berated for their experimentation with drugs—not to mention their

[1] The potential effectiveness of such centres may be gauged from provisional statistics given by Earl M. Patton: " Of our 450 referrals, 85 per cent are back on the job and functioning in an acceptable manner. Some have received promotions. The other 15 per cent are accounted for by deaths, unavailability, and those who didn't make it." Op. cit.

receiving welfare—at the same time that unemployment rates are annually over 6 per cent for the general population and over 11 per cent for them, is one of the tragic ironies of today.

Where an employed person needs treatment, the existence of a sickness benefit plan with coverage for alcoholism, or for some other source of income during the time of treatment, may be very crucial in gaining the person's co-operation. This factor is most evident in the case of the person whose financial problems were the major cause of his becoming drug dependent.

The prime concern of any union is the welfare of its membership, especially as this is reflected in their pay cheques. Any threat by the company to a member's source of income will meet stiff union opposition. From what I have already said it may be seen that in this instance the conflicting roles may actually do harm to an employee if the threat to his employment is a consequence of alcohol addiction—though other employees may benefit in so far as the company's respect for the union is maintained. If the five requirements of labour-management consultation on the programme, good general industrial relations, high priority by society for treatment, availability of community resources, and full employment policies are met, then good drug treatment programmes should work effectively.

Summary

In this brief review, drug dependency has been considered in a way which may seem to bear little special relationship to unions. In a way, this was deliberate, for the question of drug dependency, though it may have special application in the workplace, is fundamentally a human question and a problem of society as a whole. Dr. Unwin put it well when he wrote:

> We need to shift our focus away from specific drugs and their dangers, towards the user, his life experiences, and the society within which he lives. Such a reorientation should enable us to identify or initiate valid alternatives to drug misuse, especially in a form of meaningful responsibilities and exhilarating challenges for contemporary youth.

During my remarks I have quoted a variety of facts about drug use and abuse, but all the statistics in the world do not add up to one single person I know. On the other hand, many of those whose actions form the basis of statistics are members of labour unions. As we are concerned that our members should get a decent wage for their labour, so too are we concerned that they should live to enjoy it in a society that meets their needs. Where these needs—whether they be housing or marital counselling, recreation areas or full medical treatment—are unmet, we mean to fight together to gain them. To gain them not just for ourselves but for everyone. To do this, we must begin where our efforts at other

reforms began—at the workplace. Our health and safety committees have always striven to reduce and eliminate hazardous working conditions. The abuse of drugs on the job must cease, not only for the benefit of those directly suffering but also for the safety of others. The danger that a drug abuser can present to his fellow employees is as great as that presented to them by faulty equipment. In rectifying this situation, we hope to have the co-operation of management and of public bodies operating in this area. But no matter what their response, we will not cease our efforts to develop an enlightened approach to this question.
