

Curb Heroin In Plants (C.H.I.P.): Revisiting a Mid-1970s Intervention Into Workplace Heroin Addiction Created and Led by Detroit Autoworkers

This article analyzes archival records to revisit Curb Heroin In Plants (C.H.I.P.), a public health intervention focusing on drug dependence that was created and led by Detroit, Michigan, autoworkers during the mid-1970s.

Responding to widespread heroin use in Detroit auto plants, C.H.I.P. combined methadone maintenance with counseling on and off the job to treat heroin dependence while supporting autoworkers in continuing in employment and family life. Although C.H.I.P. ultimately failed, it was a promising attempt to transcend medical/punitive approaches and treat those with substance use disorder in a nonstigmatizing way, with attention to the workplace dimensions of their disorder and recovery.

I argue that revisiting C.H.I.P. speaks to current public health debates about the intersection between the workplace and harmful drug use and how to create effective interventions and policies that are mindful of this intersection. For historians, C.H.I.P. is a valuable example of the crucial role of workplace actors in the early war on drugs and of an early methadone program that was not strongly concerned with crime reduction but incorporated social externalities (specifically job performance) to measure success. (*Am J Public Health*. 2019;109:406–411. doi:10.2105/AJPH.2018.304858)

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Public health professionals and the media are expressing significant concern regarding the impact of opioid use. According to the Centers for Disease Control and Prevention, opioid overdoses killed more than 42 000 US persons in 2016.¹ Opioid use and dependence is also a workplace issue. Workplace insurers spend about \$1.4 billion yearly on opioid medications.² One study claimed that opioids cost employers more than \$25 billion in 2007 as a result of increased absenteeism, illness, and workplace compensation.³ Alan Krueger has argued that prescription of opioid medication contributes to depressed labor force participation in parts of the United States.⁴ This intersection of substance use disorder and the workplace requires us to consider their relationship. Is drug use an external variable introduced into workplace settings, or do workplace factors condition drug use and drug dependence? If the latter is the case, what role should coworkers and the workplace play in addressing drug dependence?

As historian David Herzberg argued in this journal in 2016, concerns about drug use and dependency must be understood in a historical context. In this article, I answer Herzberg's call to remember that "many aspects" of dependency "are rooted in

society, culture, and politics,"⁵ with particular attention to the relationship between drug dependence and work under capitalism. Concerns about drug use by workers are not new. Scholars have shown that, in the early 1970s, drugs were a priority for public health professionals, law enforcement personnel, and policymakers all the way up to President Richard Nixon.⁶ Historian Mical Raz argues that, by promoting methadone maintenance as a crime reduction strategy, public sector actors "redefined the meaning of therapy, with the main beneficiary seen as society, rather than individuals seeking treatment," encouraging punitive approaches to the treatment of heroin users.⁷

However, the war on drugs was not fought only in the public sphere. Corporations, unionists, and workers also responded to the increased visibility of drug use and drug users in the United States. These actors played an important, often underappreciated role in shaping concerns over dependency and approaches to substance use, dependency, and recovery.

Tellingly, Raz showed that paid employment invariably accompanied crime reduction and cessation or reduction of drug use as the crucial metrics used to evaluate methadone treatments.⁸

To investigate the historical relationship between workplace factors and approaches to substance use, I researched C.H.I.P. (Curb Heroin In Plants), a 1970s worker-run methadone program treating Detroit autoworkers who used heroin. Unlike previous workplace programs that depended on employer surveillance of workers or worker-led programs that focused on industrial alcoholism, C.H.I.P. was founded by stewards at United Auto Workers (UAW) Local 961, which represented workers at Chrysler's Eldon Avenue factory. The stewards used a combination of methadone distribution, group therapy, and ongoing support at the workplace.

After receiving a substantial grant from the National Institute of Mental Health in 1973, C.H.I.P., in partnership with the University of Michigan's School of

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Public Health, expanded to treating heroin users from plants beyond Eldon Avenue as well as workers with alcohol use disorders. C.H.I.P. aimed to create durable change by addressing drug dependence among a non-stigmatizing peer group, with attention to work and family life in addition to drug use. Ultimately, an unsuitable therapeutic approach, overexpansion to meet overly ambitious goals, disorganization, and possible corruption wrecked the program. It did not meet its stated targets and was discontinued while under federal investigation.

Despite its failure, C.H.I.P. deserves attention from public health practitioners and historians. Its history speaks to current questions: Do users need to be removed from their immediate context, or can they be treated where they live and work? Should dependency be understood primarily as a disease, or should it be understood as an adaptation influenced by users' socioeconomic context? Investigating C.H.I.P. uncovers a creative and promising, if ultimately failed, intervention to combat drug use among workers that had the potential to positively influence workplace-centered substance use initiatives.

The demise of programs such as C.H.I.P. preceded a "tough on drugs" approach by the federal government, mirrored in the private sector, that accelerated the catastrophe of mass incarceration while failing to improve public health and a shift in workplace programs away from coworker interventions toward the use of external professionals.⁹ In historical perspective, C.H.I.P. stands out as a promising idea informed by convictions that work had a real impact on drug dependence and should be accounted for in recovery and as

an experiment of both historical importance and relevance to current research and practice regarding the relationship between work under capitalism and substance use disorder.

THE DRUG SCARE COMES TO WORK

In 1971, the *New York Times* sounded an alarm. The drug problem, for years a pre-occupation of US families, politicians, cultural commentators, and public health professionals, had moved beyond its roots in youth counterculture into the workplace. Agis Sapulka's front-page story, "Workers' Use of Drugs Widespread in Nation," began luridly:

A middle-aged worker at the Cadillac plant here goes daily into the men's room during his breaks, knots a piece of surgical tubing around his arm, cooks a dose of heroin in a bottle cap with a match and shoots the melted liquid into a vein. Then he goes back to his job.

According to the *Times*, no workplace was safe:

Heroin addicts have passed out in Detroit assembly plants; secretaries and office boys report being approached by marijuana dealers in the New York Telephone Company; service employes sniff cocaine in some Miami hotels. Mostly, it is the younger employes who take drugs, but union men and others say no one is exempt—white collar workers, assembly line workers, the skilled, the unskilled, the young, the middle-aged, black and white.

Calling on-the-job drug use "a problem of national proportions," Sapulka detailed the concerns of unionists, employers, corporate medical officers, and law enforcement; outlined the

rising use of preemployment urine tests to screen out drug users; and reported safety risks and crime resulting from workplace drug use. "Addicts" were in the workplace to stay, especially considering the coming influx of Vietnam veterans and high school students. "Eventually, industry will have to rehabilitate the drug user," concluded one auto plant medical director. "The prevalence of drug abuse is increasing at a high rate among young people and they are the reservoir of the future work force."¹⁰

Sapulka's emphasis on the automotive industry was appropriate. Detroit's auto factories seethed with danger, ill health, conflict, and misery. Companies drove workers hard in aging, unsafe plants to maximize profits and fend off foreign competition, fomenting conflict between employees and managers. Racial tension was widespread. Violence was a regular occurrence. The previous year, autoworker James Johnson had shot and killed two supervisors and a coworker at the Eldon Avenue Axle Plant.¹¹ In 1971, UAW vice president Irving Bluestone wrote to president Leonard Woodcock:

in some plant locations drug addiction has risen to alarming proportions. . . . None of us knows quite what to do about this problem, since apparently the medical profession itself has no concrete answers.¹²

UAW leaders discussed drugs throughout 1971. In June, the union issued a press release calling on automakers to join it in tackling drugs and alcohol.¹³

Many believed that workplace conditions contributed to the perceived spike in drug use and dependence. Sapulka's piece speculated that "the tedium of the job" drove autoworkers to

drugs. Denny Lemmond, a union official at a General Motors (GM) plant in California, attributed amphetamine use among workers in 1968 to employees attempting to meet the grueling pace of working 12-hour days over an extended period of time.¹⁴ In 1971, the Alliance for Labor Action surveyed thousands of industrial workers on drug use. Of those who reported drug use, 52.4% reported that it helped them meet the demands of their work; 38% said it helped them manage working overtime. However, 40.3% claimed drugs had no impact on their work.¹⁵ The worker shooting up in the Detroit plant reported that most of the users he knew had acquired their habit outside work, not on the job. This mixed historical testimony anticipates current work by Richardson et al., who noted that substance use disorder and employment trajectories intersect in a variety of ways.¹⁶

Certainly, several factors contributed to the prevalence of drug use at the Cadillac plant. Dealers operated inside the plant, and illegal gambling at work fueled the drug economy. Sapulka's informant said that some of the 25 to 30 fellow addicts in his area helped him conceal his use.¹⁷

Other auto plants had similar problems. According to historian Steven Jefferys, Chrysler generally ignored drug use and addiction as long as production was unaffected. However, some auto employers attempted to stop drug use.¹⁸ It appears that by 1974 Chrysler management had established programs aimed at drug use among employees.¹⁹ In the California plant where police arrested 13 workers in 1968 for selling drugs after an undercover investigation, GM opted for surveillance and prosecution. "Anyone caught is subject to

dismissal and turned over to police,” said the personnel director. Supervisory personnel were trained to identify drugs and ferret out users; plant security conducted locker searches armed with drug analysis equipment. Detroit’s Diesel–Allison plant, conversely, emphasized methadone maintenance and rehabilitation.²⁰

CURB HEROIN IN PLANTS

One of the most innovative interventions came from autoworkers themselves. Curb Heroin in Plants was founded by six union stewards at Chrysler’s Eldon Axle Plant. Concerned over “brothers deep in the quick sand of drugs” who owed money to in-plant loan sharks, the stewards decided “a drug clinic for the working addict” was necessary.²¹ As the language indicates, the all-male leadership originated the problem and the project in masculine terms. C.H.I.P.’s client base proved to be overwhelmingly male, which partly reflects the demographics of the workforce but also raises questions about the program’s effectiveness in reaching female autoworkers.

Initially, Marine Hospital hosted C.H.I.P. clients for therapy sessions led by project director Mack Mallory²² and union steward Donzell Williams. In September 1972, C.H.I.P. rented a storefront for therapy and methadone distribution near the Eldon Avenue plant. C.H.I.P. then was awarded a grant to pay five staff members: a director, assistant director, registered nurse, secretary, and counselor.²³ In February 1973, C.H.I.P. received a grant of \$1 million from

the National Institute of Mental Health²⁴ to

test the efficacy of treatment geared to the specific needs of employed addicts and to test the utilization of union shop stewards as outreach workers for bringing employed addicts into treatment.²⁵

C.H.I.P. provided methadone, individual and group counseling, career counseling, legal advice, and family support. C.H.I.P.’s approach intertwined therapeutic efforts and the employment situation. The program aimed “to utilize low methadone dosages throughout treatment, continually encouraging clients to remain on the job, while eliminating drug dependence.”²⁶

Methadone treatment spread rapidly in the late 1960s.²⁷ Historian Claire Clark argues that one important reason was its promise to restore users as productive workers; dependence may have been a disease, but it was one whose cure required sufferers, after methadone got them back on their feet, to begin climbing the ladder of economic achievement and social status once more.²⁸ Vincent Dole and Marie Nyswander, who pioneered methadone maintenance, “did not mention spiritual transformation” but did mention that 21 of their 22 initial methadone patients either had a job or were looking for one.²⁹ This indicates the important role employment outcomes played in evaluating the efficacy of responses to drug dependency, which would be reflected in C.H.I.P.

Union and company representatives communicated with therapeutic staff “regarding [client] functioning and adjustments in the work situation, which gives us about 2/3 of the day that our clients can be observed by someone from C.H.I.P.’s counseling staff.”³⁰ C.H.I.P.

personnel claimed that this allowed them “to treat the total ambience of the client, thereby vastly enhancing rehabilitation.” Deploying union stewards as drug counselors was presumably intended to strengthen the bond between workplace and recovery while enhancing identification between clients and a caregiver who could understand their circumstances on and off the job. By 1974, C.H.I.P. had more than 20 staff members and was also treating alcohol users, who received counseling “along with appropriately provided relaxers and vitamins.”³¹

Clients were recruited “by union contacts, fellow workers, or by word of mouth.”³² According to C.H.I.P., it was crucial to reach the user “while he is still an employed, productive worker. By doing this, the chances of decreasing his drug or alcohol dependency are vastly enhanced.”³³ C.H.I.P. leaders did not elaborate on why they believed this, but it reflects the broader thinking and practice of the time: that employment was an important lever in shifting dependent behavior. As argued in a 1972 GM document on treating workplace alcoholism, “The alcoholic usually ignores or rejects the efforts of family or friends but it is not easy for him to ignore the possibility that he may lose his job.”³⁴

In 1974, industrial psychologist Walter Reichman contended that

when a worker is motivated to enter a treatment program by his work organization his chances for cure and for a productive work and personal life are higher than if he enters treatment from any other source.³⁵

C.H.I.P. claimed its program would also produce economic benefits for the employer, including “continued employment

with decreased absenteeism, tardiness, sickness, accident and hospitalization rates, and improved work productivity.”³⁶

C.H.I.P.’s National Institute of Mental Health grant funds arrived in 1973. In February, with 70 clients already enrolled, C.H.I.P. partnered with the University of Michigan’s School of Public Health for a program evaluation. According to the program’s contract, C.H.I.P.’s goals were ambitious: (1) eliminate drug dependency in 200 addicts recruited into the program; (2) increase the probability for each enrolled addict of continuous employment, high work productivity, and improved work attendance, health status, and psychosocial functioning; and (3) increase knowledge and improve attitudes among plant intake personnel (e.g., shop stewards).³⁷

GROWING PAINS AND A SUDDEN END

By summer 1974, the UAW was touting C.H.I.P. as a success, issuing a press release highlighting a *Detroit News* article about the program. Steward Willie Grant claimed that the program had “cured” 450 users, with 250 clients currently enrolled. According to Grant, having stewards as counselors meant that workers/clients could access assistance in their recovery while at work: “If a man takes the cure, he knows that we are always available for counselling right on the job.” The article closed with a happy story about Grant serving as the best man at a client’s wedding:

He had been spending his entire check on heroin and was in hock to the loan sharks. After he got started in the program, I took him to the personnel office and got him to purchase a \$50 savings bond a week. Now he has money

in the bank, a lovely fiancée, and is looking toward the day when he can buy a home.³⁸

The University of Michigan's evaluation of the program in June 1974 told a different story than the boasts of C.H.I.P. and the UAW. Of the three stated objectives, the second, improving job-related outcomes through better worker health, was altered because of a lack of data on productivity. The third, increasing knowledge among plant intake personnel, was abandoned because not all individuals who worked on the program received the same training and there was high turnover. Indeed, data collection proved a significant challenge. Stewards and family members were to complete surveys paralleling the ones clients took about their well-being and functioning. However, not enough stewards filled out surveys, and no clients granted permission to survey a family member. Recordkeeping was standardized only after the University of Michigan came on board, so the evaluation focused on the 66 clients who enrolled after that time, with limited attention paid to the 70 previously enrolled. Unable to reach the goal of 200 clients from the Eldon Avenue plant, let alone the 250 claimed by Grant, C.H.I.P. expanded eligibility, enrolling 13 clients from three other plants.³⁹

Of these 66 clients, 60 were male and 59 were African American. Only three had referred themselves to the program. The median tenure of heroin use was four years. The clients reported an average yearly income of \$9600 and an average daily drug expenditure of \$50, which meant an average of \$13 000 in drug expenses yearly. Researchers speculated that, absent generous family income support,

clients were either overestimating the cost of their habit or underreporting the extent to which they participated in illegal activities to secure additional income.⁴⁰

The small sample of clients and data problems led researchers to admit that their results were of limited significance. The evidence they did have showed that C.H.I.P. was not especially successful in transitioning clients away from drug use or improving their attitudes and performance on the job. Of the 66 tracked clients, only five completed their course of therapy, remained abstinent, and were considered "cured." A total of 51.6% of urine tests taken in clients' second to fifth months of enrollment were drug free; this figure dropped to 41.6% between the fifth and ninth months. Using data from questionnaires given to 58 clients upon enrollment and the responses of 12 clients who completed the questionnaires at enrollment and again after three months, researchers estimated a 5.4% improvement in clients' family and child relationships and a 7.2% increase in other metrics of well-being; however, positive attitudes toward employment decreased by 0.1%.

In a revealing aside, researchers speculated that perhaps negative attitudes toward auto work were normal: "given the nature of the work, attitudes toward the job, including relations with fellow workers, do not provide a good measure of psycho-social adjustment." There was no evidence that participating in C.H.I.P. affected clients' work attendance positively. After one year, the C.H.I.P. evaluations had not demonstrated that the program's approach had improved clients' work life. Although evaluation evidence did suggest gains in

participating clients' well-being, it also revealed that the program had fallen far short of its goal of transitioning 200 workers from heroin use to abstinence. Moreover, there is little evidence that C.H.I.P. staffers evaluated or addressed the possibility that workplace factors were contributing to drug dependency among clients, although it is not possible to know this for certain without a clearer understanding of what exactly was provided, especially in terms of employment counseling. However, only 13 of 58 reported clients were receiving occupational therapy in the first month of the program and eight of 29 by the third month.⁴¹

Significant administrative and procedural issues plagued C.H.I.P. In July 1972, UAW research assistant John Ditzhazy reported that the initiative had not met deadlines and was behind schedule in its research program.⁴² In 1973, Ditzhazy wrote that Mallory and Williams, two C.H.I.P. leaders lacking administrative experience, "need assistance in just overcoming routine tasks."⁴³ Although perhaps these judgments can be dismissed as critiques on the part of someone who may not have supported the program or its leaders, and certainly one wonders whether the UAW could have provided more administrative aid, evidence supports the view that C.H.I.P. was poorly run.⁴⁴

In February 1975, for example, the *Detroit Free Press* reported that the Federal Bureau of Investigation, at the prompting of the regional branch of the Drug Enforcement Agency,

is investigating reports that nearly \$1 million in federal funds was mishandled or misappropriated over the past two years. Three principal officials have been suspended by the union pending the federal investigation's outcome.⁴⁵

Although the outcome of that investigation is unclear, apparently no criminal charges resulted. However, it spelled the end for the C.H.I.P. experiment.

What began as an innovative, promising idea to tackle drug dependence among workers foundered because of mismanagement and possible corruption. The program grew too much and too quickly, treating alcohol users and clients outside the original Eldon plant to satisfy grant proposal goals, and staffers were guilty of overpromising and underdelivering.

C.H.I.P.'s goals were both poorly defined and overambitious. Most problematically, C.H.I.P.'s approach to heroin-using workers was flawed. Although stewards understood the milieu of the plant, they were not health workers, trained addiction counselors, or recovered addicts. Perhaps this is why the therapeutic regimen was erratic, particularly the misguided use of methadone to encourage abstinence from opiates as opposed to its prevailing use as maintenance to forestall heroin withdrawal and thus support health and social functioning. Moreover, C.H.I.P. limited itself to treating the individual user on and off the job instead of seeking to change workplace factors (e.g., an exploitative labor process, in-plant racism, unsafe work, and acceptance of drug sales and use in the plant) that may have contributed to drug use among workers.

Nevertheless, C.H.I.P.'s history is valuable for historians and public health researchers alike. Investigating C.H.I.P. in the context of early 1970s concerns over drug use among workers reveals that the US workplace was a key site of anti-drug and anti-addiction efforts: corporations, unions, and workers need

to be better understood as actors shaping the nation's responses to drug use and drug dependency. In addition, investigating C.H.I.P. expands our historical knowledge of the extent of drug use and concern over drug use in the early 1970s to include the workplace, restores the role of workplace issues and responses in the early war on drugs, and recovers an intriguing road not taken in drug treatment.

For scholars of public health, revisiting C.H.I.P. is informative about the history of workplace-centered interventions and methadone. But this history also contributes to current discussions about the relationship between employment and drug use. Draus et al. pointed out that this relationship is complex, confounding easy binaries of drug use hampering regular employment or poor employment situations fostering harmful use. They noted that many workers use drugs to meet “daily task demands”⁴⁶; in the case of 1970s auto work, monotony, harassment, and frustration were common. According to psychiatrist Clemens Fitzgerald, auto-workers used drugs and alcohol to achieve an “ultra-state,” assuming a separate personality divorced from their job while simultaneously performing it.⁴⁷

That auto work both supported and indeed encouraged harmful substance use lends credence to the conclusion of Richardson et al. that, although the work context can provide a meaningful alternative to “drug-scene related risk,” there needs to be attention to the quality of that work and the role it plays in the lives of workers.⁴⁸ Because it balanced drug treatment with workplace support, C.H.I.P. had the potential to address this pressing issue. That it did not address the work context

more directly was a crucial oversight, and the present discussion provides historical support for the Draus et al. contention that

policy and practice might be informed by a more nuanced, ethnographically and economically informed understanding of the relationship between drug use, economic circumstances, subsistence practices, and emotional states.⁴⁹

CONCLUSION

During the two decades after the dissolution of C.H.I.P., professionals supplanted coworkers and peers in workplace-sited treatment of employee substance use; third-party providers, rather than internal company or union-led efforts more grounded in workplace cultures, became the predominant supplier of employee assistance; and approaches strongly linked with stigmatization and termination (e.g., drug testing) became more common, with the encouragement of Ronald Reagan's administration. Thus, this article joins Clark's work in complicating the narrative of treatment moving from punitive to liberal. As pointed out by Clark, we need to account for how the punitive approach to drug use resurged in the 1980s.⁵⁰ Perhaps the failure of bottom-up experimental solutions such as C.H.I.P. played a part. Greater consideration of the changing outlook and priorities of workplace actors in responding to drug use will help us better understand the decade's transitions to punishment and professionalization.

Raz and Clark showed that punitive assumptions built into methadone maintenance, resulting from a focus on crime reduction as a desired outcome, hampered its utility as a treatment

of opioid use and encouraged this punitive turn.⁵¹ The example of C.H.I.P. is interesting as a methadone maintenance intervention not primarily founded on concerns about criminality and the attendant surveillance and stigmatization that focus encouraged in the provider-client relationship. C.H.I.P. itself was not without stigmatization. It also prioritized a nonmedical outcome: improved work performance. However, had C.H.I.P. been successful, it may have served as a model for methadone maintenance outside medical and criminal justice settings, reducing stigma faced by patients and helping them maintain working and family lives while receiving treatment.

Although C.H.I.P. is long gone, the issue it responded to—that work under capitalism can foster and support both harmful substance use and recovery, challenging practitioners to reconcile people's working life with therapeutic interventions to best aid their health—remains pressing and unresolved. Viewing C.H.I.P. in the context of history and current practice reminds us that many of those living with a substance use disorder are workers, and effective treatments must involve both them and their work. *AJPH*

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CONFLICTS OF INTEREST

No conflicts of interest.

HUMAN PARTICIPANT PROTECTION

No protocol approval was needed for this study because no human participants were involved.

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20. Sapulkas, "Workers' Use of Drugs."
21. Box 39, File 3, UAW Region 1 Collection, Reuther Library.
22. It is difficult to ascertain Mallory's background and qualifications. According to one document produced by C.H.I.P., which describes him as an external hire, he was not one of the six union stewards who initiated the program; however, a *Detroit News* article adapted by the UAW as a press release did identify him as part of Local 961. C.H.I.P.'s own materials describe him as a project director. I am not aware of whether he had any medical training or previous experience in public health, rehabilitation, or counseling. According to the C.H.I.P. records held at the Reuther Library, Mallory did apparently receive training from the National Institute of Mental Health and the National Drug Abuse Training Center during 1973.
23. The grant is referred to as a "St. Boniface grant" (Box 39, File 3, UAW Region 1 Collection, Reuther Library).
24. Box 39, File 3, UAW Region 1 Collection, Reuther Library.
25. Deborah Hastings-Black to Jordan Sims, February 7, 1975, Box 39, File 3, UAW Region 1 Collection, Reuther Library.
26. Box 39, File 3, UAW Region 1 Collection, Reuther Library. There is contradictory evidence about C.H.I.P.'s goals with respect to substance use. According to the program evaluation contract, C.H.I.P. aimed to eliminate drug dependence among 200 workers. In a *Detroit News* article, steward Willie Grant bluntly stated that "[w]e do not subscribe to continuing medication in the form of methadone." Conversely, a C.H.I.P. brochure noted that the program seeks "[f]otal abstinence in some cases and methadone maintenance in others." The University of Michigan program evaluation reported that clients were being treated with methadone, a placebo, or no medication and divided those treated with methadone into detoxification and maintenance groups. However, the evaluators did define "the greatest success of methadone therapy" according to whether clients tested free of heroin and methadone, indicating that abstinence was a primary focus of C.H.I.P.'s methadone regime.
27. Clark, "Chemistry Is the New Hope," 193.
28. *Ibid.*, 195.
29. *Ibid.*, 205.
30. "Application for Substance Abuse Services Project," Box 39, File 3, Reuther Library.
31. Box 39, File 3, UAW Region 1 Collection, Reuther Library.
32. *Ibid.*
33. *Ibid.*
34. "General Motors Employee Alcoholism Recovery Program," Box 123, File 4, UAW Region 1 Collection, Reuther Library.
35. Walter Reichman, "The Troubled Employee Program," paper presented at the second Mid-Ohio Valley Industrial Seminar on Alcoholism and Drug Abuse, August 6, 1974, Box 1, File 11, Harrison Trice Additional Papers, Kheel Center, Cornell University, Ithaca, NY.
36. Box 39, File 3, UAW Region 1 Collection, Reuther Library.
37. *Ibid.*; "Evaluation of C.H.I.P. Program—Year 01," June 10, 1974, Box 39, File 3, UAW Region 1 Collection, Reuther Library.
38. The press release was adapted from Jack Crellin, "How One UAW Local Battles Heroin," *Detroit News*, June 10, 1974, Box 39, File 3, UAW Region 1 Collection, Reuther Library.
39. "Evaluation of C.H.I.P. Program—Year 01."
40. *Ibid.*
41. *Ibid.*
42. John Ditzhazy to John Bennet, July 21, 1972, Box 39, File 3, UAW Region 1 Collection, Reuther Library.
43. John Ditzhazy to Tony Conole, August 4, 1973, Box 39, File 3, UAW Region 1 Collection, Reuther Library.
44. "UAW C.H.I.P. Incorporated Board Meeting," June 19, 1974, Box 39, File 3, UAW Region 1 Collection, Reuther Library; Willie Grant to Homer Jolly, August 2, 1974, Box 39, File 3, UAW Region 1 Collection.
45. Saul Friedman, "UAW's Drug Plan Probed for Abuses," *Detroit Free Press*, February 26, 1975, Box 39, File 3, UAW Region 1 Collection, Reuther Library.
46. Paul J. Drais, Juliette Roddy, and Mark Greenwald, "'I Always Kept a Job': Income Generation, Heroin Use, and Uncertainty in 21st Century Detroit," *Journal of Drug Issues* 40 (2010): 841–869. This article links 21st-century African American male heroin users to initial exposure during the region's 1970s heroin epidemic, which is of course the context for C.H.I.P.
47. Rachel Scott, *Muscle and Blood* (New York: E. P. Dutton and Co., 1974), 155.
48. Richardson et al., "Pathways Linking Drug Use."
49. Drais et al., "'I Always Kept a Job,'" 844.
50. Clark, "Chemistry Is the New Hope," 193.
51. *Ibid.*, 210; Raz, "Treating Addiction," 79–80.

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