Prevention of alcohol-related harm in the workplace
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Prevention of alcohol-related harm in the workplace

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The last two decades have seen a growing body of research examining workers’ alcohol use and the relationship between work and alcohol consumption patterns. This research has largely been driven by concerns regarding workplace safety and workers’ productivity. Despite this, the nature and extent of alcohol-related harm in the workplace is not well understood—especially in the context of the Australian workplace. Until very recently, relatively little Australian data were available on workers’ alcohol use or the relationship between the workplace environment and workers’ patterns of alcohol consumption (Pidd, Berry, Harrison et al. 2006).

A clearer understanding of workers’ patterns of alcohol consumption and the complex relationship between alcohol consumption and the workplace is essential for developing interventions that will minimise the risk to workplace safety and workers’ productivity. Moreover, the workplace has potential to be a public health setting where strategies to both prevent and address risky alcohol consumption patterns could be implemented.

This Issues Paper examines the prevalence and patterns of alcohol consumption among Australian workers; the implications of alcohol consumption for safety and productivity; and the relationship between work and workers’ alcohol consumption patterns. The paper also delineates evidence for effective workplace interventions. The purpose of such an examination is to provide information that occupational health and safety (OH&S), human resource, and alcohol and other drug professionals can use to develop and implement effective responses to alcohol consumption in the workplace.

Prevalence and patterns of alcohol use among the Australian workforce

Recent secondary analyses of the National Drug Strategy Household Survey (NDSHS) data, undertaken by the National Centre for Education and Training on Addiction (NCETA; Berry et al. 2007; Pidd, Berry, Harrison et al. 2006; Pidd, Shtangey & Roche 2008) provide the most comprehensive examinations of the prevalence and patterns of alcohol use among the Australian workforce to-date. These analyses found that alcohol use and consumption patterns associated with risk of harm were significantly more prevalent among those in the paid workforce compared to those not in the paid workforce.¹

Key findings from these analyses indicated that:

- nearly half the workforce (47.8 per cent) drank at levels associated with risk of harm² at least occasionally and 11 per cent did so frequently (at least weekly)

- of the workforce surveyed, six per cent reported attending work at least once in the past 12 months while under the influence of alcohol of the workforce surveyed, 9.3 per cent reported drinking alcohol at work

¹ The only exception to this was for the unemployed (defined as those of working age and looking for work), who reported the highest prevalence of alcohol consumption associated with risk of harm.

² These were defined as at-risk of harm in the short-term as per NHMRC (2001) alcohol guidelines. New Australian guidelines concerning risk of alcohol-related harm were introduced in February 2009.
male workers were significantly more likely than female workers to frequently drink at levels associated with risk of harm\(^3\)

- young workers were significantly more likely than older workers to frequently drink at levels associated with risk of harm—with workers aged 14–19 years the most likely to drink at levels associated with risk of harm

- workers employed in the hospitality industry and those employed as tradespersons were most likely to report frequently drinking at levels associated with risk of harm

- workers with no dependent children, single workers, those living in rural locations and those with low education levels were more likely to report frequently drinking at levels associated with risk of harm.

The prevalence and patterns of alcohol consumption among the workforce have important implications for workplace safety, workers’ productivity, and the development and implementation of interventions to address alcohol-related harm. These implications are outlined below.

**Implications for workplace safety**

Attending work “under the influence” or drinking at work has obvious implications for workplace safety, due to the detrimental effects alcohol can have on cognitive functioning and psychomotor ability. However, surprisingly little is known regarding the extent to which workers’ alcohol use negatively affects workplace safety. Most of what is known comes from a small number of studies concerning non-fatal and fatal work-related trauma injuries. A recent review of hospital emergency department (ED) studies indicated that both national and international evidence concerning non-fatal work-related trauma presentations at hospital EDs was extremely limited (Pidd, Berry, Harrison et al. 2006). Few ED studies that focused on alcohol-related injuries distinguished between work-related and non work-related injury.

Those studies that did make this distinction identified that between four and 15 per cent of all workplace injuries treated at hospital EDs might be associated with alcohol use. However, in order to maximise the number of alcohol-related incidents available for analysis, many of these studies were conducted outside of normal working hours (e.g. from Friday night to Monday morning). This may result in an underestimation of the proportion of work-related injuries that are associated with alcohol use (Pidd, Berry, Harrison et al. 2006).

A study examining workplace fatalities that occurred in Australia between 1989 and 1992 identified that during this four year period a total of 1787 workers were fatally injured at work (Driscoll 2003; Driscoll, et al. 2001). Information on blood alcohol concentration (BAC) levels was available for 1252 (70 per cent) of these fatalities, of which 126 had a non-zero BAC level and 74 had a BAC level of 0.05 g/100 mL or greater. Based on information in coronial files, raised BAC levels appeared to have contributed to at least 64 fatalities (4.4 per cent of fatalities where BAC levels were available).

Emergency department and workplace fatality studies provide only partial evidence of the negative impact of alcohol use on workplace safety. Not all workplace accidents present at hospital EDs and BAC levels are unknown for a substantial proportion of workplace injuries and fatalities. While these studies provide evidence of the relationship between alcohol intoxication at work (i.e. alcohol consumption during work hours and/or attending work “under the influence”) and workplace safety, they say little about the relationship between workplace safety and alcohol use that occurs out of working hours. The residual effects of alcohol consumption can also negatively affect workplace safety. Alcohol use can result in hangover effects (nausea, headache, fatigue) that continue long after BAC levels return to zero. In addition, alcohol use can disrupt normal sleep patterns resulting in fatigue and impaired concentration (Kobayashi et al. 2002). Both hangover effects and fatigue are associated with decreased physical, cognitive and visual–spatial performance (Lilley et al. 2002; Stutts et al. 2003; Wiese et al. 2000).

**Implications for productivity**

In 2004–2005 alcohol misuse accounted for approximately $3.6 billion in productivity-related costs in Australia (Collins & Lapsley 2008). These costs were attributable to alcohol-related absenteeism and lost production and resources caused by a reduction in the available workforce due to alcohol-related death and premature retirement due to alcohol-related illnesses. Using data obtained from the NDSHS, Pidd, Berry, Roche et al. (2006) estimated the annual

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\(^3\) This is with the exception of some industry groups, where females were equally as likely as males to drink at high risk levels.
cost of alcohol-related absenteeism to be at least $437 million and possibly as high as $1.2 billion in 2001. High-risk drinkers were up to 22 times more likely to be absent from work due to their alcohol use compared to low-risk drinkers (Roche et al. 2008). However, workers who usually drank at low-risk levels, but on occasion drank at high-risk levels, accounted for approximately half the cost of alcohol-related absenteeism (Pidd, Berry, Roche et al. 2006).

Alcohol use may also contribute to lower “on-the-job” productivity. Alcohol-related reductions in “on-the-job” productivity may be due to “presenteeism” where workers attend work suffering a hangover or alcohol-related fatigue—which can negatively affect performance. Productivity may also be reduced due to co-workers “covering” for workers who are unable to work effectively because of their alcohol use. Currently, little is known about the extent or nature of alcohol-related reductions in “on-the-job” productivity.

Implications for interventions

Understanding the prevalence and patterns of alcohol use among the workforce also has implications for designing and implementing interventions that will address alcohol-related harm in the workplace. The counter-intuitive finding that around half of all alcohol-related absenteeism is accounted for by workers who normally drink at low-risk levels, but on occasion drink at high-risk levels (Pidd, Berry, Roche et al. 2006), highlights the need to take a “whole-of-workplace” approach. Traditionally, workplace interventions have focused almost exclusively on heavy or “problem” drinkers. While these workers are of concern, more attention needs to be placed on the much larger number of workers who usually drink at low-risk levels, but occasionally drink at high-risk levels.

Data concerning the prevalence and patterns of alcohol consumption among the workforce also allow us to develop a profile of high-risk workforce groups and develop cost effective targeted interventions. Those at particular risk of alcohol-related harm are:

- workers employed in the
  - hospitality industry
  - agriculture industry
  - manufacturing industry
  - construction industry
- workers employed in blue collar occupations
- young workers (Berry et al. 2007; Pidd, Berry, Harrison et al. 2006; Pidd et al. 2008).

Alcohol use as an occupational health, safety and welfare issue

The research reviewed above indicates a substantial number of workers exhibit alcohol consumption patterns that place them at-risk of harm and that these consumption patterns can have a negative impact on their productivity and their health and safety. Thus, alcohol use in the workforce is an occupational health, safety and welfare issue.

Most Australian workplaces use OH&S legislation to deal with alcohol-related risks to safety. Such legislation requires employers to take reasonable steps to ensure a safe workplace and requires employees to take reasonable care to protect their own safety (and the safety of others) at work. While the specific wording of OH&S legislation varies across jurisdictions, alcohol (and other drug) use is either explicitly or implicitly referred to as a potential safety risk in relevant jurisdictional legislation.

In Victoria, the issue of alcohol and workplace safety is covered under the Occupational Health and Safety Act 2004 (the Act). According to WorkSafe Victoria, the Act requires:

- employers to provide and maintain a working environment that is safe and free from risks to health (Section 21). Without in any way limiting the generality of this duty, employers have duties with respect to; plant, substances and systems of work; providing facilities for and information, instruction training and supervision to their employees; and monitoring their health and safety (Sections 21(2) and 22)
- employers and self-employed persons to ensure that persons other than employees (which would include the public) are not exposed to risks to their health or safety arising from the undertaking of the employer or self-employed person (Sections 23 and 24)
- employees to take reasonable care for their own health and safety and that of others (for example, ensuring they are not, by use of alcohol, affected in a way that may put themselves or others at risk); and to cooperate with employers in their efforts to comply with OH&S requirements (Section 25).

There are also specific legislative provisions in place for some occupational groups in relation to alcohol consumption in the workplace. For example, there is legislation to protect public safety in transport (covering commercial road transport, the railways, civil aviation and marine transport) through restrictions on
the use of alcohol and drugs, and mandatory testing. The OH&S (Mines) Regulations 2007 require mine operators to introduce strategies to protect persons at a mine from risks associated with the consumption of alcohol. The Mines Regulations also impose duties on employees regarding alcohol consumption.

WorkSafe Victoria provides guidelines to assist employers to establish a workplace alcohol policy that is ethical and legal, and that will benefit both the organisation and the employee. These guidelines are available at: [www.worksafe.vic.gov.au/wps/wcm/resources/file/ebcbac435c9a4e1/alcohol_workplace.pdf](http://www.worksafe.vic.gov.au/wps/wcm/resources/file/ebcbac435c9a4e1/alcohol_workplace.pdf)

Patterns of alcohol consumption that are associated with risk of harm are not only a potential workplace safety risk, but also a potential risk to the health and wellbeing of individual workers and the wider community. Thus, there is also a public health imperative to address potentially harmful patterns of alcohol consumption among the workforce.

The workplace as a setting for addressing alcohol-related harm

There are a range of reasons why the workplace offers potential as a unique and cost-effective setting for intervention and prevention strategies concerning alcohol-related harm. They include:

- The majority of people who engage in harmful alcohol use are employed and therefore, the workplace provides convenient access to large numbers of people who otherwise may not seek assistance
- Full-time employees spend a substantial amount of time at the workplace, maximising opportunities for exposure to intervention and prevention strategies
- Employers have substantial influence over employees’ work-related behaviours, particularly those that are relevant to workplace safety and productivity
- Industrial relations and OH&S legislation and frameworks exist that can incorporate alcohol-related issues that affect the workplace
- Messages concerning harm minimisation and “safe” or “responsible” levels of consumption delivered in the workplace are likely to extend into the wider community via employees’ interaction with family and friends.

During the past decade there has been considerable effort by employers, unions, and employer organisations to address the issue of alcohol-related harm in the workplace. However, while some of the responses to this issue are constructive and based on models of best practice, many are either contentious or ill-informed (Allsop & Pidd 2001). Two reasons for this may be:

1. a lack of understanding about the relationship between the workplace and workers’ consumption patterns
2. a lack of information about effective intervention strategies.

Understanding the relationship between the workplace and alcohol use

Theoretical explanations of the relationship between the workplace environment and workers’ alcohol consumption patterns can be categorised as having a stress/alienation, control or culture perspective. Each perspective has implications for the design and implementation of interventions.

Stress/alienation

Most research into the relationship between the workplace and workers’ alcohol consumption patterns has adopted a stress or alienation perspective. The former proposes that stressful workplace experiences (e.g. physically or psychologically demanding work) and events (e.g. accidents or repetitive injury and disputes) create stress that could be alleviated by drinking alcohol (Trice & Sonnenstuhl 1990). Workplace stressors can include skill under-utilisation, pay inequity, low pay, boredom, hazardous work, shiftwork, role conflict and job insecurity, poor worker/management relations, and low job satisfaction. Grunberg et al (1998; 1999) found that work stressors indirectly influenced alcohol consumption. Work stress influenced job satisfaction, which in turn, influenced beliefs about drinking as an effective method of coping with stress.
The alienation framework proposes that the workplace can lead to alienation if the work is boring and monotonous, or workers have little control over work pace or planning. These conditions can create a sense of dissatisfaction or powerlessness that is relieved by drinking alcohol (Trice & Sonnenstuhl 1990). The relationship between alienation and drinking is also indirect. Alienation influences job satisfaction, which in turn, influences a set of beliefs about the utility of drinking as a means of coping (Greenberg & Grunberg 1995).

From a stress or alienation perspective, harmful patterns of consumption can be reduced or eliminated by:

- removing or reducing the impact of workplace factors that lead to stress or alienation
- changing worker’s beliefs about the effectiveness of drinking to reduce the effects of stress or alienation and/or by encouraging alternative coping strategies.

Control

An alternative explanation focuses on the relationship between workplace controls and alcohol consumption. From this perspective workplace factors can restrict or encourage the availability of alcohol and, therefore, drinking. Lack of workplace controls such as low visibility of workers (e.g. working away from the workplace), lack of supervision and lack of formal policies regarding alcohol use can lead to greater availability of alcohol. There are two types of availability—physical and social (Ames & Grube 1999).

“Physical availability” refers to access to alcohol in a given environment and the associated costs or barriers to obtaining it. Physical availability can be objective (e.g. legal, organisational and geographical factors affecting the cost of obtaining alcohol) or subjective (e.g. perceptions of availability, including beliefs about how easy or difficult it is to obtain alcohol).

“Social availability” refers to the degree of normative support for drinking alcohol, which can vary according to the situation. For example, while drinking at a work-related social function might receive significant normative support, there may be less normative support for drinking during working hours. Social availability can also be objective (i.e. actual drinking and approval of drinking by family, friends and others) or subjective (i.e. individual perceptions of alcohol-related norms).

From a workplace control perspective, harmful patterns of alcohol consumption can be reduced or eliminated by:

- introducing and effectively disseminating a formal workplace alcohol-use policy
- improving the quantity and/or quality of supervision in the workplace.

Culture

A cultural explanation of the relationship between the workplace and alcohol consumption proposes that the workplace is a cultural environment distinct from the wider community and as such can either support or inhibit alcohol use. Most workplaces have formal and/or informal rules and norms regarding appropriate behaviour in the workplace. Workplaces have developed procedures from these rules and norms, to regulate work behaviour. These rules, norms and procedures extend to alcohol and include defining what constitutes problematic and non-problematic drinking in the workplace. Drinking norms at work may differ from an individual worker’s norm for drinking away from the workplace. For example, workers may be pressured to join co-workers in regular “end of the working week” drinking rituals despite their normal social drinking patterns. Normal social drinking patterns, for some individuals, may not involve any regular pattern of drinking. Thus, workers who don’t normally drink in their own leisure time may find it is expected of them at work.

Ames and Janes (1992; Janes & Ames, 1993) proposed that work-related risk factors for harmful alcohol use could best be understood as dimensions of workplace culture. These dimensions included:

- the normative regulation of drinking (workplace factors that form and maintain beliefs, values and behaviours concerning drinking)
- quality and organisation of work (factors that contribute to stress or alienation)
- drinking subcultures (naturally occurring workplace groups that share the same sets of beliefs and practices concerning drinking)
- factors external to the workplace (the interaction between work and social life).

An integrated model

More recently, Pidd and Roche (2008) outlined an integrated model which proposes that the workplace contains stressors, controls and subcultures, and that
interaction between these factors results in an overall workplace culture that either supports or discourages risky alcohol consumption. They argued that the influence of this model extends beyond the workplace. That is, workplace culture shapes not only the drinking behaviours of individuals and social groups within the workplace, but also the drinking behaviours of individuals and social groups external to the workplace. Elements of this integrated model include:

- workplace customs and practices (e.g. workplace subcultures and social networks, co-worker behavioural norms at work and in work-related settings, the workplace industrial relations climate and administrative/management culture)
- workplace conditions (i.e. environmental factors that impact directly on drinking alcohol or indirectly via stress or alienation)
- workplace controls (i.e. factors that contribute to the availability of alcohol in the workplace)
- external factors (e.g. workers’ pre-existing attitudes, beliefs and behaviours regarding drinking, the values, behaviours and expectations of family members, and the social and cultural norms of the wider community).

A cultural perspective has two important implications for interventions designed to minimise alcohol-related risk in the workplace. First, cultural models highlight the complexity of the relationship between work and drinking alcohol. A range of factors both internal and external to the workplace can individually, or in combination, contribute to a specific culture of workplace drinking. Thus, an assessment of the relevance of a number of variables needs to be conducted before designing and implementing specific interventions.

The second implication is that workplace interventions need to acknowledge the pivotal role of workplace culture. Workplace culture not only has a direct influence on workers’ alcohol consumption patterns but can also mediate the influence of workplace conditions, workplace controls and external factors. Central to the concept of a workplace drinking culture are the workplace alcohol-related norms of both management and workers and the way in which the workplace deals with alcohol-related issues. Thus, interventions need to go beyond a focus on individual “problem” workers to include strategies (such as education and training programs) that target the pre-existing values, beliefs and behaviours of all employees.

The basis of effective workplace responses to alcohol-related harm

Research into the prevalence and patterns of alcohol consumption and the relationship between work and patterns of alcohol consumption indicates the need to incorporate a “whole-of-workplace” primary prevention approach when considering appropriate workplace responses to alcohol-related harm. Many traditional responses to alcohol-related harm in the workplace have taken a secondary prevention approach. That is, the focus has largely been on identification and treatment referral of impaired or alcohol dependent workers. However, this approach is at best a limited response to alcohol-related harm in the workplace. While the identification and referral of impaired or alcohol-dependent employees is important, this approach fails to consider the much larger number of employees who individually may experience few alcohol-related problems, but together account for a much greater proportion of alcohol-related harm in the workplace. Thus, contemporary Australian (Pidd & Roche 2008), American (Bennett & Lehman 2003), and international literature (ILO 2003) have argued for a shift away from the traditional workplace secondary prevention focus to a broader primary prevention approach. There are three basic components of such an approach that are central to effective workplace intervention strategies.

1. The development and implementation of a formal workplace policy

A formal written policy forms the basis of any response to alcohol-related harm in the workplace. The policy should be a comprehensive document that provides a clear statement outlining the work organisation’s position on alcohol and a set of guidelines and strategies for dealing with all aspects of alcohol-related issues in the workplace. The policy needs to clearly state its objectives, the methods of achieving these objectives, and the roles and responsibilities of those who will implement the policy. To be effective, policies need to be:

- widely disseminated
- implemented throughout the entire workplace
- specifically designed to meet the operating conditions of the workplace.
Policies are likely to be effective if they are based on a needs analysis and risk assessment that identifies infrastructure that can support the policy and factors that contribute to alcohol-related risk. Such an approach allows for the development of a tailored policy to suit the needs and resources of individual workplaces.

2. The provision of education and training
Awareness and education programs are effective ways of ensuring all workers are aware of the organisation’s alcohol policy. Such programs can also contribute to the health and wellbeing of workers by providing information about alcohol-related harm in the workplace, workplace factors that may contribute to risk, and general alcohol-related health information including access to rehabilitation and treatment. In most cases, the success of any workplace response to alcohol-related harm is dependent on changing existing attitudes and behaviours relating to alcohol use. The provision of regular, ongoing worker education plays a crucial role in this regard.

The credibility, acceptance and success of any workplace alcohol policy is also dependent on the attitudes and actions of supervisors, managers, safety personnel, worker representatives, and other key staff who are responsible for the policy’s implementation. Providing training for staff that will implement the policy and manage workplace alcohol-related issues is an important component of any workplace response to alcohol-related harm. In order to contribute to a culture of safe alcohol consumption among workers, education and training programs need to be regular, ongoing and adaptable to changing circumstances.

3. Access to rehabilitation and treatment
An important component of any workplace response is access to rehabilitation and treatment. To avoid the costs associated with dismissal, workers with serious alcohol-related problems should be encouraged to seek treatment or counselling services. They should be provided with paid or unpaid leave to access treatment and be assisted to locate and attend treatment services. Some employers may choose to provide these services via an employee assistance program (EAP) or pay for private services; others may use community based non-profit services. While access to treatment and rehabilitation may be compulsory when workers breach conditions of the alcohol policy, workers should also be given the opportunity to access these services voluntarily.

Other strategies
A number of intervention strategies have been utilised by Australian workplaces as responses to alcohol-related harm. While research concerning the efficacy of workplace interventions is limited, there is a substantial body of evidence indicating prevention and counselling/treatment responses in other settings are effective in preventing alcohol problems and reducing harm for the individual and the wider community (Loxley et al. 2004). There is good reason to believe strategies that have been effective in the wider community, could be adapted and applied in the workplace. However, these intervention strategies should acknowledge the differing needs, resources and environments of individual workplaces. It is unlikely that any single intervention strategy will be appropriate for all workplaces. In addition, the effectiveness of any intervention is likely to be dependent on the ability of the intervention to acknowledge and address the existing workplace culture concerning alcohol use.

A recent systematic review of workplace interventions for alcohol-related problems (Webb et al. 2009) revealed few quality studies; however, four strategies were identified that had the potential to produce positive results:

- health promotion
- brief interventions
- peer interventions
- psychosocial skills training.

Health promotion
Workplace health promotion programs have a long history and in general, have been effective for improving worker wellbeing and productivity in the workplace (Bergstrom et al. 2008; Kuoppala, Lamminpaa & Husman 2008). However, the use of health promotion programs is a relatively recent strategy for responding to alcohol-related harm in the workplace. In general, health promotion programs do not specifically focus on alcohol consumption. Rather, they involve a range of health promotion strategies including education and other interventions that focus on improving the overall health of employees. The basic premise of health promotion programs is that healthy lifestyles and heavy alcohol consumption are incompatible. It is argued that incorporating alcohol issues within the context of health concerns might be an effective method of motivating behavioural change concerning alcohol use (Shain et al. 1986). The limited
research that is available indicates that alcohol (and other drug) prevention programs can be introduced into health promotion programs without detracting from the overall objective of improving workers’ health in general (Cook et al. 2003) and can reduce levels of risky alcohol consumption (Cook et al. 1996; Heirich & Sieck 2000, 2003; Richmond et al. 2000).

**Brief interventions**

Brief interventions have been used in a variety of settings and can also be used in the workplace. Brief interventions are characterised by their low intensity and short duration. They aim to identify potential problems with alcohol use and motivate those identified as being at-risk of alcohol-related harm to change their consumption patterns (Babor & Higgins-Biddle 2001). While brief interventions are not intended to treat serious dependence issues, they are a valuable tool for the identification and early treatment of potentially problematic or risky alcohol use. Typically, brief interventions involve identifying an individual’s consumption patterns and providing feedback in the form of information and advice concerning any identified patterns associated with risk of harm. Research evidence indicates brief interventions can be an effective method of reducing levels of risky alcohol consumption in a range of settings (Ballesteros et al. 2004; Nilsen et al. 2008; Roche & Freeman 2004; Vasilaki et al. 2006). Brief interventions have been shown to be an effective strategy for workplaces (Anderson & Larimer 2002; Doumas & Hannah 2008; Walters & Woodall 2003), particularly if incorporated into broader primary prevention interventions such as health promotion programs (Heirich & Sieck 2000; Richmond et al. 2000).

**Peer interventions**

Peer interventions involve the use of peers as agents of change and have been shown to demonstrate effectiveness for addressing a wide range of social and health-related behaviours (Rivera & Nangle 2008). While mostly targeting adolescents, peer interventions can also be an effective strategy for adults. Applied to the workplace, peer interventions are based on the premise that co-workers are in the best position to recognise and respond to workers with alcohol problems. Peer interventions involve the use of trained co-workers to recognise alcohol problems among their peers and intervene appropriately. Evaluations of these programs indicate that they have been effective in identifying and addressing problem behaviours and have contributed to reducing alcohol use and related harm (Sonnenstuhl 1996; Spicer & Miller 2005).

**Psychosocial skills training**

Psychosocial interventions use a range of strategies including motivational interviewing, cognitive behaviour therapy, problem solving, goal setting, social skills training, contingency management and coping strategies. The type of strategies used, and the way in which they are implemented, depend to a large extent on whether the intervention occurs in a clinical or primary prevention setting. There is a strong evidence base for the effectiveness of alcohol-related psychosocial interventions in both clinical (Assanangkornchai & Srisurapanont 2007) and primary prevention settings (Foxcroft et al. 2003). Psychosocial skills training involves the provision of training that focuses on an individual’s knowledge, attitudes and life skills and the limited research that is available indicates potential for workplace settings. Cook and colleagues (Cook et al. 1996, 2004) evaluated a psychosocial skills intervention that involved the provision of workplace training to raise levels of awareness, motivation and knowledge of the risks and benefits of alcohol use. Results indicated that the training had a positive effect on consumption patterns, motivation to reduce consumption, and personal problems associated with drinking. Similarly, Bennett et al. (2004) evaluated a workplace psychosocial skills training program that focused on group dynamics and co-worker support and found the training reduced levels of problem drinking and levels of alcohol-related absenteeism.

**Workplace drug testing**

Workplace drug testing is a strategy that is becoming commonplace. One reason for the popularity of workplace drug testing is that it appeals to logic. That is, testing can identify workers who are impaired by alcohol (or other drug) use and safety and productivity can be improved by removing these workers from the workplace. Underlying this simple logic is the assumption that testing can detect impairment. However, while there is strong evidence for the efficacy of breath analysis as an indicator of blood alcohol concentration (BAC) and for a cut-off level of 0.05g/100mL to be indicative of impairment due to alcohol intoxication, no such evidence exists.
for the most commonly used methods to detect other drug use (i.e. urinalysis or saliva testing).

A detailed examination of the issues surrounding testing as response to other drug-related harm is beyond the scope of this paper. The focus of this paper is on alcohol and as such the main advantages and disadvantages of alcohol testing as a response to alcohol-related harm in the workplace are briefly outlined. There is very little research concerning the effectiveness of workplace alcohol testing in reducing either alcohol use or alcohol-related harm. The few studies that have examined the effectiveness of workplace testing tend to focus on drugs other than alcohol and in general, this research provides little support for the efficacy of testing (Bennett & Lehman 2003; Macdonald 1997).

The main advantage of breath analysis is that it can detect impairment that results from alcohol intoxication. However, breath analysis cannot detect impairment that results from the after-effects of heavy drinking. Hangover and fatigue can continue to negatively impact workplace safety and productivity long after BAC levels have returned to zero. In addition, breath analysis on its own is likely to have little effect in detecting or reducing alcohol-related absenteeism. These are important limitations given that while only a small proportion of workers drink alcohol at work, or attend work “under the influence”, a very large proportion drink alcohol at risky levels at least occasionally outside of working hours (Pidd, Berry, Harrison et al. 2006). A further limitation of breath analysis (and drug testing in general) is the focus on individual workers. Breath analysis in the workplace does little to address physical and social factors within the workplace environment that may contribute to drinking and alcohol-related harm.

Summary

The evidence that has been reviewed indicates that the prevalence and patterns of alcohol consumption among the workforce have important implications for workplace safety, workers’ productivity and the development and implementation of interventions to address alcohol-related harm in the workplace. This review also outlined a range of reasons why the workplace offers potential as a unique and cost-effective setting for intervention and prevention strategies concerning alcohol-related harm within the workplace and the wider community. However, to-date, the workplace remains a largely under-utilised prevention and intervention setting.

One reason for the under-utilisation of the workplace as a setting to address alcohol-related harm may be due to the complexity of the relationship between the workplace and workers consumption patterns as outlined in this review. Further adding to this complexity is the degree to which the alcohol—and other drug—use of employees is regarded by key stakeholders as a safety issue, a health and wellbeing issue or an industrial relations issue. Quite often, there is a perception that the viewpoints of the main stakeholders (i.e. employers and employees) differ substantially on how alcohol-related harm in the workplace should be addressed.

To examine this issue in more detail, the perspectives of three key stakeholders (i.e. employers, employees and alcohol and drug service providers) were sought. This examination was restricted to the Victorian environment and involved the Victorian Employers Chamber of Commerce and Industry, the Victorian Trades Hall Council, and the Victorian Alcohol and Drug Association (VAADA). The issue of addressing alcohol—and other drug—related harm in the workplace from the perspective of each organisation is presented on the next page.
Perspectives from three key stakeholders

The different perspectives of the three key stakeholders indicate a substantial amount of agreement on key issues concerning the development and implementation of responses to alcohol-related harm in the workplace. All three organisations caution against workplace testing, recommend a proactive whole-of-workplace approach based on the principles of harm minimisation, and support an occupational health and safety and worker wellbeing approach to the issue. These perspectives also provide substantial support for the role of alcohol and other drug (AOD) service agencies. While VAADA outlines issues that would need to be addressed for this role to be realised, the examples of best practice outlined on page 13 provide evidence that these issues can be overcome when key stakeholders work together to develop and implement programs tailored to suit their specific needs.

An employer perspective

The Victorian Employers’ Chamber of Commerce and Industry (VECCI) is the peak body for employers in Victoria, informing and servicing more than 15,000 members, customers and clients around the state. Victorian employers are represented by VECCI at a state level as a partner of other state-based chambers and in the consideration of national issues that have an impact on the local business community. Members are provided with a range of high-quality, cost-effective services including workplace relations advice, training, publications, business tools and templates and specialist consulting services.

VECCI has developed a fit-for-work policy template that employers can use to develop a workplace AOD policy. Recognising that a range of factors such as fatigue, illness and AOD use can affect fitness for work, the policy template emphasises a response that focuses on addressing safety and productivity risk regardless of the cause. The policy template is designed to be a guide for employers and outlines suggested policy scope statements, relevant definitions, processes for implementing the policy and a summary of responsibilities for supervisors and managers.

In providing this policy template, VECCI advises employers that any policy they develop needs to be tailored to the specific needs and resources of their individual work organisation. VECCI also emphasises the importance of consultation with employees when developing and implementing any policy. In particular, employers need to implement an effective dissemination strategy in order to ensure that all employees are aware of the policy and how it works.

VECCI advises that a proactive, rather than reactive, focus should be adopted when addressing fit-for-work issues. Responses to AOD risk to safety and productivity need to take a whole-of-workplace approach and not just focus on individual “problem” drinkers or drug users. In this regard VECCI advises employers to exercise caution when considering workplace AOD testing. The opinion of VECCI is that employers need to show just cause for testing, with testing only being justified if required by legislation or if a strong safety case can be made. For many small businesses, workplace testing that is consistent with Australian standards can be an overly expensive strategy. Testing can also shift the focus from one on workplace safety to one on disciplinary processes resulting in AOD use becoming an industrial relations, rather than a work performance issue.

VECCI believes that there is limited assistance for small businesses when it comes to dealing with employee AOD use that negatively affects workplace safety and productivity. A number of organisations provide information and guidelines to assist employers with the development and implementation of AOD policies. However, strategies contained in these guidelines, such as the provision of an employee assistance program (EAP) or the provision of three or four warnings before dismissal are more suited to large well-resourced organisations and beyond the limited resources of the much larger number of small businesses that employ only a few workers.

Similarly, AOD agencies can provide advice on treatment and counselling options and on how employees can access these services. However, this is a tertiary treatment approach that focuses on the individual workers. There is little assistance to small businesses on how to proactively prevent or manage AOD-related performance and safety issues within the workplace environment.
VECCI believes that a small business community approach is needed whereby AOD service providers and OH&S organisations work with community business groups and networks to provide assistance relevant to small businesses. The focus of this assistance should be to provide relevant information that can build the confidence of small business managers to respond to AOD risks to safety and productivity in a proactive way.

A trade union perspective

The Victorian Trades Hall Council (VTHC) endorses the Australian Council of Trade Unions (ACTU) Alcohol and Other Drugs in the Workplace Policy. The ACTU policy was developed to provide a framework for employers and employees to follow when dealing with AOD issues and associated occupational health and safety obligations. The policy recommends that a workplace AOD program should be:

» developed and coordinated jointly in consultation between the employer, workers and their representative
» part of a comprehensive health and safety prevention program
» related to safety at work
» concerned with preventing impairment
» applicable to all parties in the workplace
» consultative, educative and rehabilitative—not punitive
» able to maintain confidentiality at all levels.

From a trade union perspective any response to AOD-related harm in the workplace should be positive and proactive, rather than negative and punitive. This perspective acknowledges that there may be cases where serious or persistent breaches of an agreed policy may warrant disciplinary action in association with remedial measures.

As a health issue, workers who may have AOD problems should be provided with the opportunity to obtain assistance and be entitled to the same rights and benefits as any worker who is ill. Problems in this area should not affect job security, or other employment conditions and workers should be entitled to the same respect, sick leave and confidentiality as workers with any other health problem.

As a safety issue, the focus of any AOD policy should be on impairment. Unions believe there has been a growing focus by employers on possible AOD-related impairment at work, even though there is little evidence AOD use plays a significant role in workplace accidents. This focus often comes at the expense of proper attention to more common causes of workplace impairment. Workplace factors that can be an impairment risk equal to that of AOD use include fatigue, exposure to hazardous chemicals, heat stress, high noise levels and work stress. For employers to meet their occupational health and safety obligations, they need to provide a working environment free from occupational hazards that can cause impairment. Thus, if the impairment is related to working conditions, employers should initiate steps to remove the impairment hazards and ensure that workers are allowed to recover. As it is recognised that workplace conditions can also contribute to workers’ AOD use, the same approach should be taken for AOD impairment.

Unions recognise that in certain workplaces prescribed rules and regulations exist that result in AOD testing being unavoidable. However in general, trade unions discourage workplace testing. With the exception of breath analysis, current workplace drug tests can only detect prior exposure, not impairment and as such drug testing is inconsistent with an impairment approach to workplace safety. With drug testing the issue becomes a moral/legal issue rather than an impairment/safety issue. Testing compromises workers’ right to privacy by extending employer control over worker behaviour that occurs away from the workplace and in the worker’s own time and away from the workplace, and by requiring workers to provide information concerning the use of prescription medication that employers would not normally be entitled to. Moreover, rather than addressing the causes of AOD impairment, testing shifts all the focus and responsibility onto the individual worker. Rather than a fit-for-work issue AOD use becomes a “fit and proper person” issue.

While acutely aware of the potential harm associated with AOD use, trade unions recognise that the underlying causes of use may be personal and/or social in nature, related to the work environment and needs to be addressed in a strong, consistent, humane and evidence-based manner, by the employer, workers and their representative organisations.
An AOD service provider perspective

The Victorian Alcohol and Drug Association (VAADA) is the peak body representing AOD services in Victoria. Their membership comprises agencies working in the AOD field, as well as those individuals who are involved in, or have a specific interest in, prevention, treatment, rehabilitation or research that minimises the harms caused by alcohol and other drugs. The vision of VAADA is for a Victorian community in which the harms associated with drug use are reduced and general health and wellbeing is promoted. As a peak organisation, VAADA’s main purpose is to ensure that the issues for people experiencing the harms associated with AOD use and the organisations that support them are well represented in policy and program development and public discussion.

The Victorian Alcohol and Drug Association believe that the AOD field can have a key role in the development and implementation of workplace responses to alcohol-related harm. In particular, AOD agencies could work with employer and employee groups to ensure responses are non-punitive. Such responses would be consistent with a harm minimisation approach, including when and where to intervene. Intervention in the workplace needs to be justified in terms of minimising the harm to the worker and/or co-workers and not be used as a method for sacking or disciplining workers. Similarly, prior drug use should not be seen as a barrier to employment. In this regard, VAADA sees the growth of drug testing in the workplace as problematic. Refusal of employment to a job applicant, or the dismissal of an employee, for failing a drug test is inconsistent with a non-punitive, harm minimisation approach.

According to VAADA, services that AOD agencies could provide include education, information and pathways into treatment. However, if non-government AOD organisations were engaged in the provision of these services, several issues would need to be addressed. Of particular importance is the issue of demand for services and system capacity to deliver. Providing assistance to employers to implement AOD-related policies and programs and providing assistance to employees referred to treatment and counselling via workplace interventions have the potential to increase agency workloads. According to VAADA, the AOD field already suffers from poor planning concerning future demand for services and a poor funding base. Thus, service demand forecasting and planning, and changes in funding arrangements may be necessary for the AOD field to effectively respond. This may include the development and implementation of fee-for-service business models for agencies that assist workplaces.

A second issue concerns the need to raise awareness of evidence-based, best-practice responses to alcohol-related harm in the workplace within the AOD field. Many AOD workers and agencies are unaware of the limited evidence for the efficacy of workplace testing and unaware of alternative models of best practice in the workplace. This could be rectified through the provision of relevant education and training. An additional method may be through the development of an industry-based workplace AOD program for AOD workers. As with most workplaces, AOD risk to safety and productivity is an issue for the AOD sector. However, to-date, no industry-wide workplace AOD program for AOD workers exists. The development of such a program would not only reduce AOD risk to safety and productivity in the AOD sector, but raise AOD workers’ awareness of best practice responses.

Finally, there is the issue of accreditation and work practice standards. Workers employed in Victorian AOD agencies are required to hold a Certificate IV in AOD work as a minimum qualification and agency codes of practice and funding agreements to some extent ensure quality work practice standards. However, AOD workers who are employed within self-funded industry programs, in individual workplaces, or by fee-for-service workplace testing and intervention organisations are not required to hold minimum qualifications or be registered as an accredited AOD worker.
Examples of best practice

Incolink Victoria: An industry-wide peer intervention approach

Contact person: Mr Gary Wright (03) 9668 3069

Why the program is run
A national AOD safety and rehabilitation program operates throughout the Australian building and construction industry. The program aims to reduce AOD-related harm by:

- raising awareness of the health and safety implications of AOD use
- implementing a workplace policy to safeguard workers
- providing training to promote peer intervention
- assisting workers and their families with advice, welfare and rehabilitation.

Program description
A peer education and intervention approach underpins the program. Education and intervention in the workplace are carried out by trained co-workers rather than outside specialists. The program is based on harm minimisation principles that focus on safety, with messages that emphasise how unsafe behaviour caused by AOD use can affect everyone in the workplace.

The program works within existing building industry industrial, occupational health and safety, and training frameworks and structures. The focus of the AOD policy contained within the program is on workplace safety and the involvement of elected safety committees, peer support and access to rehabilitation. Consistent with industry-wide disciplinary policies, the AOD policy operates on a three warning system, leave provisions are provided for workers to attend treatment, and job security is ensured for affected workers who undertake and commit to treatment/rehabilitation.

While the national program is similar across jurisdictions, the way in which it is implemented within Victoria is unique. In Victoria, the program is implemented and managed by Incolink. Incolink is a joint enterprise of building industry employer associations and unions that administers redundancy funds, portable sick leave benefits, and provides a range of other services (including the AOD program) to building industry employers and employees.

The project officer employed by Incolink to manage the AOD program is also a trained AOD worker and provides frontline counselling to building workers with AOD problems. This approach is unique to Victoria and has the advantage of allowing for the provision of frontline counselling services to be delivered in a timely manner by a counsellor who has both building industry experience and a detailed understanding of the issues facing building workers. In addition, Incolink employ financial and personal counsellors, allowing for a holistic case management approach to be taken when counselling workers for AOD issues.

In Victoria the AOD policy is incorporated into building industry Enterprise Bargaining Agreements and AOD training is included in all building industry safety, first-aid, and shop steward training. Alcohol and drug safety training is also provided to all building trades apprentices by Incolink’s apprentice support officer. As with other jurisdictions, the program is disseminated to building workers through induction programs, site noticeboards, site flyers and posters. In Victoria, the program is also disseminated through Incolink’s On-Site magazine that is produced quarterly and sent to workers’ postal addresses. The AOD program usually uses 1–2 pages of this magazine to promote the program and specific harm reduction campaigns. This not only allows for workers to be consistently reminded of the program, but also allows for the program and its services to be more widely disseminated to workers’ family members.

While the program targets all drug use and periodically conducts drug specific (e.g. amphetamines) campaigns, the traditional focus of the construction and building industry program has been on alcohol. Building workers have a long history of heavy alcohol use. One traditional alcohol-related practice among building workers is “having a few drinks” with your workmates after work. Last summer Incolink conducted their Thirsty? Water First campaign which was designed to minimise alcohol-related harm associated with this practice. The main message of the campaign was “after a big day on the job, satisfy your initial thirst with water”. This campaign was disseminated through on-site posters and flyers and the On-Site magazine.

What’s good about this program?
The construction and building industry program takes a whole-of-industry approach and works with the three main industry stakeholders—workers, employers and unions—to ensure it addresses the complex culture of the building industry. The program focuses on improving workplace safety by teaching workers to take responsibility for their own safety and that of their fellow workers in relation to AOD use; and improve worker wellbeing by enabling workers with AOD problems to access treatment options.
Barwon Health: An organisation specific health promotion approach

Contact person: Dr Rudi Gasser (03) 5226 7628

Why the program is run

Barwon Health is Victoria’s largest regional health service, providing healthcare to more than 450,000 people in Geelong and South Western Victoria. Health services available through Barwon Health cover the full spectrum from emergency and acute to mental health, primary care, community services, aged care, sub-acute care and rehabilitation. Barwon Health is the largest employer in the Geelong and South Western Victoria areas, employing over 5000 people in a diverse range of occupations.

Barwon Health is currently implementing a new workplace AOD policy. The key objectives of this policy are to reduce the risks posed by AOD use in the workplace and reduce the incidence of AOD-related harm among staff. It aims to do this by:

- addressing organisational factors that may contribute to AOD misuse
- ensuring suitable AOD training is provided to supervisors, employee representatives and other staff responsible for policy implementation
- ensuring suitable AOD information and education is provided to all employees
- ensuring appropriate support and assistance is available to employees with AOD-related problems (including access to leave provisions to attend treatment)
- ensuring Barwon Health sponsored events are conducted in line with the Barwon Health “Responsible Serving and Use of Alcohol Guidelines”.

The policy is implemented by supervisors and allows for the management of AOD-related risk to safety and productivity in line with Barwon Health Performance Management Policy. However, the overall aim of the AOD policy is to create a supportive environment that focuses on health promotion and improving worker wellbeing.

Program description

Where alcohol or drug use is identified as a potential risk to the safety or productivity of an employee, the employee is offered assistance through Barwon Health’s StaffCare Program. Employees can also voluntarily access assistance through StaffCare. StaffCare is an employer-provided service dedicated to the physical and psychological health and wellbeing of Barwon Health employees. StaffCare focuses on providing occupational health services, however, limited general practice and medical care is also provided. Generally employees requiring ongoing support are referred on to specialist services, with StaffCare becoming the link between the workplace and the external service provider. StaffCare operates separately from Barwon Health’s human resource and disciplinary processes. Employee contact with StaffCare is client based and confidential.

Most employees are referred to StaffCare through the AOD policy due to alcohol dependency, work-related drink driving, or an alcohol incident at work. However, the Barwon Health AOD policy recognises that alcohol-related harm is a much wider issue and takes a broad comprehensive approach targeting all workers. One way it does this is through health promotion, which is an important component of StaffCare’s work. A health promotion component is always added to any incidental employee contact at StaffCare. For example, any health issue detected at pre-placement medicals (e.g. smoking, weight outside of a range) allows for StaffCare to offer advice and support in a non-threatening way. This form of health-related brief intervention extends to alcohol use. StaffCare has implemented a voluntary cardiovascular risk screening program targeting employees aged 45 years and over. This program involves baseline assessment of blood pressure and cholesterol levels and a health/lifestyle questionnaire that contains questions concerning alcohol use. If at-risk patterns of consumption are identified, feedback on the health risk involved is provided and advice and support on reducing the risk is offered.

What’s good about this program?

Barwon Health’s approach focuses on organisational-wide improvement rather than individual workers. The policy is about providing appropriate care and support for employees, including rehabilitation if necessary. Training and education of managers and supervisors is an important part of the program. This training and education emphasises that the focus should be a whole-of-workplace approach to impairment and fitness for work rather than trying to identify and remove isolated, individual extreme cases of alcohol-related harm.
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