# The workplace & AOD use: Research & best practice approaches

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**Overview**

- Background to NCETA:
    - Who we are and what we do

- Patterns of use & implications for safety and productivity:
    - What we know and what we don't know

- Minimising the risk:
    - What works

- How to tailor a response for individual workplaces:
    - How NCETA can help

**NCETA**

- One of three national alcohol & drug research centres
- Funded by the Australian Government Department of Health and Ageing & the South Australian Department of Health

- Two main areas of research/practice
    - Alcohol and drug workforce development
    - Workplace alcohol and drug issues

**Workers' alcohol & drug use**

- Until relatively recently, very little was known about workers' AOD consumption at work or away from the workplace.
- NCETA has undertaken a substantial amount of research to identify these and the prevalence and patterns of AOD use among the workforce.
- Allows workplaces to identify and profile AOD-related risk to safety and productivity

**Research reports**

2006 report

- Reviewed existing evidence on workplace interventions
- Reviewed existing evidence on workplace alcohol use and related injury
- Secondary analysis of 2001 NDSHS data (N = 26,744)
- Secondary analyses of hospital separations and coronial data

<u>2008 reports</u>

- Secondary analysis of 2004 NDSHS data (N = 29,445)
- Alcohol use in the Australian workforce
- Drug use in the Australian workforce
- Resulted in unique & novel data on:
- Prevalence & patterns of AOD use among the Australian workforce
- Extent of AOD risk to safety & productivity in Australian workplaces
- *"….as much as 90% of the mistakes of thinking are mistakes of perception"* deBono, 1999

**Alcohol**

- Our most popular 'drug'
- The vast majority (over 80%) of Australians over 14 years old drink.
- Short-term harm
    - Intoxication harms
    - Low risk
    - (Male) ≤ 6std drinks – (Female) ≤ 4 std drinks/occasion
- Long-term harm
    - Long-term heavy use harms
    - Low risk
    - (Male) ≤ 28 std drinks – (Female) ≤ 14 std drinks/week

Using the concept of a standard drink, Australia has developed a set of drinking guidelines which are based on extensive evidence concerning the harm associated with different consumption patterns.

These guidelines set down recommended drinking levels associated with low and high risk of harm.

For example, to drink at low risk, males should drink no more than 6 std drinks on any one day, should have at least one alcohol free day, and should drink on average no more than 28 std drinks per week.

For females it is slightly less, no more than 4 std drinks per day with a weekly average of no more than 14 std drinks.

Thus the guidelines distinguish between short term harm – which can be defined as the harm associated with intoxication such as accidents and violence and harms associated with long-term heavy use such as cancer, and cirrhosis of the liver.

The guidelines also distinguish between levels of risk, and these levels increase as the number of standard drinks consumed increases. The guidelines also distinguish between frequencies of consumption.  Previous guidelines focused on average levels of consumption, which is ok, but the types of harms associated with alcohol use is likely to vary according the frequency of drinking,.  For example if you drink on average 35 std drinks a week, the type of harm you expose yourself to will vary depending on whether your drink them all at once or only drink 5 a day

Implications for safety & productivity

- Between 1989-1992, alcohol contributed to 4-5% of all workplace deaths
- 4% to 11% of all workplace injuries in Australia are related to alcohol use
- In 2004/05 alcohol use cost Australian business an estimated $3.6B in terms of lost productivity
- In 2004/05 illicit drug use cost Australian business an estimated $1.6B in terms of lost productivity
- Alcohol and illicit drug use is also associated a range of other workplace problems including:
    - poor performance
    - low morale
    - theft
    - bullying
    - arguments
    - violence
    - turnover
    - harassment

Implications for workplace responses
Identification of 'at risk' workforce groups

- Industry & occupational groups
    - Hospitality industry
    - Tradespersons

- Gender groups
    - Males in general
    - Female supervisors, managers & hospitality industry workers

- Young workers

**The type of drug**

Much of the risk to workplace safety & productivity is likely to come from alcohol use not illicit drug use

Alcohol

- 89.4% use
- 43% short-term harm
    - 17% monthly
    - 8% weekly
- 11% long-term harm
- 5.9% worked under influence of alcohol
- 3.9% absent due to alcohol use
- Cost of alcohol-related absenteeism $437M-$1.2B (2001)

Illicit Drugs

- 17.3% use (last 12 mths)
- 10.4 % use (last mth)
  - 13.5% cannabis
  - 4.4% ecstasy
  - 3.9% amphetamines
  - < 3% other drugs
- 2.5% worked under influence of drugs
- 1.0% absent due to drug use
- Cost of drug-related absenteeism $213-$503M (2004)

Alcohol-related absenteeism (2001)

- (long term risk consumption)

|  | No of workers | days off | % |
|---|---|---|---|
| High risk drinkers | 220,000 | 563,000 | 21% |
| Risky drinkers | 629,000 | 816,000 | 30% |
| Low risk drinkers | 5,798,000 | 1,304,000 | 49% |

- High risk (heavy) drinkers = av 2.6 days off
  - Only 220,000 regular heavy drinkers
- Low risk (light) drinkers = av 0.25 days off
  - 5.8 Million regular light drinkers !

**Essential components of an effective response**
**The importance of good communication**

Essential components of an effective response

1. A formal written alcohol & drug policy

- Effectiveness of the policy development & implementation depend on:
  - consultation
  - feasibility study and risk assessment
  - comprehensiveness
  - dissemination
  - on-going implementation/evaluation process

2. Education

- Essential for effective policy dissemination & acceptance
- Helps prevent alcohol & drug problems in the workplace
- Should:
  - Include an explanation of how the policy operates
  - Explain the roles & responsibilities of all employees

- o Provide information on the health & safety implications of alcohol & drug use
  - o Provide information on where/how to seek assistance
  - o Be on-going & delivered via a variety of media

3. Training

- Essential for policy implementation and management
- Needs to target key employees:
  - o Supervisors/managers
  - o OH&S staff/employee reps
- Should:
  - o Outline rationale for policy & what it covers
  - o Detail how to implement the policy & procedures
  - o Enhance capacity to identify & manage alcohol & drug related harm
  - o Build communication, interviewing, and supervision skills
  - o Be ongoing, & adaptable to changing circumstances

4. Access to counselling & treatment services

- A range services are available:
  - o Employee assistance program (EAP)
  - o Community non-profit organisations
  - o Public & private service providers
- Should be first & second & even third option of policy
- Anonymous voluntary access should also be allowed
- Leave provisions should be made available
- Confidentiality should be assured

**Other effective strategies**

Brief interventions

Brief assessment of alcohol & drug use followed by feedback on how this use may be affecting the worker's health & safety
- Supported by substantial evidence of efficacy
  - o Both in workplace & other settings
- Easy to implement, little training required
- Can be delivered by:
  - o External health professionals
  - o Internal OHS&W staff
  - o Provision of alcohol & drug use diaries and self-help booklets
  - o Computer on-line intervention

Health promotion

- Use of alcohol & drug interventions (brief and intensive counselling) embedded within a broader workplace health program
- Employees more accepting of alcohol & drug interventions (risky use is inconsistent with healthy lifestyle)

- Known efficacy of workplace health program builds on efficacy of alcohol & drug brief interventions
- Reduces alcohol & drug related risks and improves employee health and welfare

## Psychosocial skills training

- Provision of training that focuses on knowledge, attitudes, & 'life skills'
- Used in a wide variety of settings for a wide variety health-related behaviours
- Most commonly used in school drug education programs
- Workplace training focuses on:
    o workplace social & safety environment
    o group process
    o perceptions and tolerance of co-workers who use
    o attitudes toward policy
- Effective in changing attitudes toward use, reducing use that impacts the workplace, and improving teamwork

## Peer intervention

Use of trained peers (co-workers) to recognise and intervene with problem workers and change attitudes toward on-the-job use
- Substantial support for efficacy in range of settings
- Particularly efficacious when strong sense of identity among target group members
- Long history of workplace use (Canada, US, Australia)
- Can also:
    o improve management/union relationship
    o increase management/union partnerships in a range of issues

## Drug testing?

The US as an example:
- Different legal framework
- Different rationale for testing
- Different quality control mechanisms
    o Mandatory guidelines
    o Certification by government agency
    o MRO

Other issues:
- Focus on illicit drugs
- Focus on use, not on problems associated with use
- Accuracy of POCT on-site tests
- The problem of false negatives at POCT
- The cannabis problem

Some evidence that testing has a deterrent effect
- Effect relatively small
    o 0.6 times less likely for instant dismissal
    o 0.7 times less likely for referral to treatment
- Similar effect for other responses
    o 0.7 times less likely for AOD education

- o 0.7 times less likely for AOD policy
  - o 0.8 times less likely for EAP

- Drug testing is not a substitute for good management
- Drug testing can mask risk
  - o Workers may change their behaviour to avoid detection
  - o Workers may fail to report near misses and minor accidents/injuries

The main aim of drug testing is to eliminate drug-related risk to OH&S by eliminating drug use. However, instead of eliminating use, workers may simply change their behaviour to make their drug use less detectable, without reducing the risk of drug-related harm.

For example, the most common form of testing program is pre-employment screening. Applicants are aware in advance that testing is a part of the employment process, and may simply abstain from drug use for a sufficient period, and then resume use after gaining employment.

Alternatively, they may utilise many of the over the counter medications that are useful for masking drug use (eg Sudafed). In addition, samples can be contaminated, or substituted, at time of collection.

Of more concern, however, is that changes in workers' behaviour, that are directed at avoiding detection rather than reducing risk, may have serious consequences for the health and safety of workers.

For example, marijuana metabolites can remain in an individual's system for up to 30 days after use. Due to this long window of detection, a worker may shift from occasional use of marijuana to chronic (but less detectable) alcohol use, or use of other (more dangerous) illicit drugs with a shorter detectable period.

**Final points**

Management of AOD-related risk is no different to the management of any other OH&S or productivity risk.

- Risk assessment
  - o identify nature/extent of risk and factors that contribute to this risk
- Needs assessment
  - o strategies to remove/minimise this risk are identified
- No 'one size fits all'
  - o a range of different strategies may be necessary
  - o stand-alone responses may not be effective
- The influence of workplace culture
  - o employees' consumption patterns
  - o the success/failure of response strategies
- Importance of employee involvement
  - o consultation
  - o development
  - o implementation
- Consultancy & Advice on:
  - o Workplace AOD policies

- o Workplace AOD intervention strategies
- o Tailored employee awareness & education sessions
- o Tailored supervisor and OHS staff training programs
- o Evaluation of education, training & intervention strategies

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