The Impact of Alcohol & Other Drugs in the Workplace

Final Project Report 2006

A collaborative project between SafeWork SA (Department of Administrative and Information Services) and Drug and Alcohol Services South Australia (Southern Adelaide Health Service)

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The Impact of Alcohol and Other Drugs in the Workplace project is a collaborative partnership between SafeWork SA (Department for Administrative and Information Services) and Drug and Alcohol Services South Australia (Southern Adelaide Health Service). The project has been jointly coordinated by these lead agencies, with the project management team consisting of the following members:

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The research for this project has been undertaken by Lindsay Breugem, Senior Research Officer, under the direction of the project management team. The project management team gratefully acknowledges the work of Lindsay who conducted the literature review, designed and delivered the survey and coordinated the stakeholder workshop. It is the quality of Lindsay’s work that has resulted in the success of the project and this high quality report.
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BACKGROUND

The South Australian Government held a Drugs Summit in 2002 which resulted in the announcement of 35 initiatives to address issues related to alcohol and other drugs in the South Australian community. The workplace setting was identified as a key area for investigation and in 2003 it was recommended that:

A project be undertaken to address the current knowledge gap in key industries in relation to the effects of drugs and alcohol in the workplace and recommend options for improved prevention and implementation strategies. Initially a scoping of the project will be undertaken to determine the parameters of a major research project which will: establish baseline data to consider the extent to which drugs and alcohol impact on safety, health and welfare in workplaces in South Australia; conduct an exhaustive literature review; conduct extensive industry consultation; identify the procedures and tools in place in SA that address drugs and alcohol in the workplace and the effectiveness of these prevention strategies. (South Australian Government 2003).

The resultant project, The Impact of Alcohol and Other Drugs in the Workplace, has been jointly coordinated by SafeWork SA (Department of Administrative and Information Services) and Drug and Alcohol Services South Australia (Southern Adelaide Health Service). Project management has consisted of a project team from both agencies and strategic guidance has been provided through a high level reference group with members from the business, union and academic sectors.

The aim of this project was to assemble the existing evidence for the nature and extent of alcohol and other drug related harm in workplaces and recommended practice in preventing and responding to that harm. The project consisted of three linked phases of research; a literature summary, telephone survey with South Australian workplaces, and a workshop with key stakeholders. Key outputs for the project include three research reports (see appendices 1-3) detailing findings from research activities undertaken and a series of recommendations outlining priorities for future action.
**CONTEXT**

The rationale for addressing alcohol and other drug related harm in workplaces is based on the recognition that most people are in employment and many people consume drugs, particularly alcohol. Therefore, the workplace is likely to reflect the alcohol and other drug issues experienced in the general community. Alcohol and other drugs burden individuals, industry and society in terms of health, social and economic costs and as such signal a major public health problem.

The workplace presents particular challenges when attempting to address alcohol and other drug related issues, in part due to the potential for serious harm arising from accidents, injuries and productivity implications. Alcohol and other drug related harm in the workplace may manifest in terms of physical harm, such as fatalities and injuries, and productivity related implications, such as a reduction in the available workforce or poor performance. In addition, alcohol and other drugs adversely impact workplace culture and morale and the health and welfare of the workforce. This project specifically sought to investigate the impact of alcohol and illicit drug use and related harm on the workplace.

**RESEARCH FINDINGS**

**Phase One**

Phase one of the research comprised of a summary of key literature pertaining to alcohol and other drug related harm in the workplace (full report available – Appendix 1). The aim of phase one was principally to highlight the major research undertaken and key issues of importance so as to inform the latter research phases of the project. The literature review has been divided into two broad sections exploring harms resulting from alcohol and other drugs in the workplace, and responses to these harms.

A key finding from the literature review is that there is a paucity of quality evidence demonstrating the impact of alcohol and other drug related harm in the workplace. In addition, there are serious reservations regarding the breadth and quality of existing data collections relating to alcohol and other drugs in the workplace. The lack of comprehensive research and data collections supports an imprecise representation of alcohol and other drug related harm in the workplace and impedes responses (both within workplaces and at a service level) to the issue. Despite the lack of comprehensive research and data
collections, the available evidence indicates that alcohol and other drug related harm in the workplace is a serious issue.

Alcohol and other drug related harm in workplaces can manifest in terms of physical harms (e.g. fatalities and injuries) and productivity related harms (e.g. poor performance, workforce reduction). In terms of physical harms, alcohol has been found to be a contributing factor in an estimated 4% of work-related fatalities (National Occupational Health & Safety Commission 1998) and between 3-11% of workplace injuries (National Health & Medical Research Council 1997). Other drugs are estimated to contribute to 2% of work-related fatalities [no reliable data exists examining the relationship between other drugs and workplace injuries]. In total, it is estimated that alcohol and other drugs are contributing factors in at least 5% of work-related fatalities. (National Occupational Health and Safety Commission 1998).

In 1998-99 alcohol and other drug use resulted in productivity related costs exceeding $2.9 billion in Australia (Collins & Lapsley 2002). These costs were borne through a reduction in the available workforce (due to illness or premature death) and absenteeism. In addition to these costs, in 1992-93 it was found that drug-related workplace accidents resulted in costs of over $1.5 billion, of which the cost to employers was estimated to be 650 million dollars (Phillips 2001). Alcohol and other drugs can affect workplace productivity in a number of ways including; increased absenteeism, lateness, staff turnover, accidents, increased workers compensation premiums and reduced performance (Phillips 2001).

The prevalence of alcohol and other drug use or impairment at work is difficult to gauge due to the nature of these activities. The 2004 National Drug Strategy Household Survey reports that approximately 4.4% of all Australians went to work affected by alcohol, whilst 2% of Australians went to work affected by illicit drugs. In addition, over 6% of participants reported that the workplace was their usual place of consumption of alcohol (Australian Institute of Health & Welfare 2005).

One of the most important factors to explore when examining the issue of alcohol and other drug related harm in workplaces is the relationship between consumption and impairment. It does not necessarily follow that a person is impaired simply because they have consumed alcohol or other drugs. A range of factors must be taken into consideration, including patterns of consumption and the relative effects of consumption on the workplace.

There is a range of responses which workplaces can implement to address potential and actual alcohol and other drug related harm. The main responses include; workplace alcohol and other drug policies, employee assistance programs and controls on use (including drug testing programs).

When examining potential responses to alcohol and other drug related harm in the workplace, it is important to consider the legislative obligations employers and employees
are required to comply with in respect to alcohol and other drugs. Under the South Australian Occupational Health, Safety and Welfare Act (1986), employers have a duty to ensure a safe working environment and safe systems of work are provided for staff. Section 21 of the Act also specifically requires that employees ensure they are not, by the consumption of alcohol or a drug, in such a state as to endanger their own safety at work or the safety of any other person at work.

Workplace alcohol and other drug policies are largely advocated as a first level response to problems in the workplace. The Alcohol and Other Drugs Council of Australia (2000) recommends that “Every Australian workplace should have an AOD [alcohol and other drug] policy as part of their broader occupational health and safety requirement, as part of their insurance arrangements.” It is important that policies are developed consultatively and have an education and dissemination plan embedded within the policy to ensure staff awareness.

Despite a lack of sound evidence evaluating the effectiveness of employee assistance programs in addressing alcohol and other drug problems in the workplace these programs have been widely accepted and implemented by workplaces and do provide one avenue where employees and employers can obtain assistance (Calogero, Midford et al 2001; Loxley, Tombourou et al 2004).

The most contentious effort to address alcohol and other drugs in the workplace is drug testing. There is a range of criticisms directed at testing programs. Principally, concerns have been raised regarding significant limitations in these programs, as they do not have the ability to accurately determine the amount of drug consumed, the time of consumption or the level of impairment experienced as a result of consumption. Whilst there is no consensus in the literature regarding the efficacy or appropriateness of workplace testing programs, the predominant conclusion is that testing is not justifiable as a routine measure for either preventing or reducing drug related harm in the workplace. (Pidd n.d). Workplace testing programs should not be implemented as a stand alone response but, if considered, should be incorporated as part of a comprehensive approach to workplace alcohol and other drug related harm.

The literature also highlighted the importance of recognising the role of the work environment as a precipitating factor in employee alcohol or other drug use. The structural, physical and psychosocial aspects of the work environment can have a profound impact on employees and workplace culture can influence the acceptability of work-related alcohol or other drug use.
The findings from the literature review highlight that a range of issues associated with alcohol and other drugs in the workplace are under-researched. Specifically, further research is required to determine the effectiveness of specific responses in reducing harm in the workplace. In addition, the insufficient evidence base examining the extent of alcohol and other drug related harm experienced by workplaces significantly hampers action in this area. Without a clear understanding of the scope of the problems, the opportunity to implement effective responses is diminished.

**Phase Two**

Phase two involved a targeted telephone survey with South Australian workplaces to identify the strategies in place to prevent and respond to potential and actual alcohol and other drug related harm in the workplace. The research design was exploratory and involved a descriptive, cross-sectional method. The survey was conducted via non-probability sampling across three industries, namely Construction, Transport and Manufacturing, with a cross-section of small, medium and large participating workplaces. Participating workplaces were also classified as ‘high’ or ‘low’ risk according to their worker’s compensation claims history.

A database of contacts was provided by Workcover Corporation and workplaces were contacted between the months August – October 2005 requesting their participation. Response to the survey was generally positive and a higher than anticipated response rate was received for this research phase (anticipated response rate: 40%, actual response rate: 67%).

The research involved semi-qualitative telephone interviews with 110 South Australian workplaces to develop a broader understanding of the following key areas:

- Issues affecting workplaces in relation to alcohol and other drug related harm;
- Current strategies in place to respond to alcohol and other drug related harm in South Australian workplaces;
- The strategies workplaces are considering implementing to further respond to alcohol and other drug related harm;
- The strategies workplaces think have had the most impact in reducing alcohol and other drug related harm;
- Areas where workplaces want greater support.

The results of the survey indicate that workplaces are generally concerned about the issue of alcohol and other drug related harm. Workplaces indicated significant concern about the potential impact that alcohol and other drugs may have on safety, with over seventy per cent of workplaces indicating concerns related to safety. In addition, productivity implications (including the effects of absenteeism) were highlighted by many workplaces as an issue arising out of alcohol and other drug use.
The most common response implemented by workplaces to address alcohol and other drug related harm were alcohol and other drug policies, with almost nine out of ten participating workplaces having a policy in place. Almost all workplaces with a policy used at least one mechanism for creating awareness of the policy, with the most common method being through the induction process. Workplaces with written policies generally had them in place for at least 3 years. Most workplaces with written policies indicated that they had found the policy to be a useful strategy to address alcohol and other drug related harm.

In addition to policies, workplaces used a range of specific strategies to respond to alcohol and other drug related harm. Key findings from this research indicate that the majority of workplaces (96%) had at least one specific strategy in place to address alcohol and other drug related harm.

The most common strategy implemented by workplaces was provision of Employee Assistance Programs [EAPs] and access to general counselling services, which were provided by almost 60% of workplaces surveyed. Almost 20% of all workplaces provided health or medical programs for staff.

Alcohol and other drug testing programs, which were utilised by almost half of participating workplaces, were the next most common strategy utilised by workplaces. Pre-employment testing was the most common form of testing that was undertaken. Random alcohol or other drug testing programs were implemented by just over a quarter of all participating workplaces.

In addition to formal strategies such as policies, testing and counselling services, workplaces employed a range of less formal, yet equally important, strategies in their response to alcohol and other drug related harm. Nearly a third of workplaces nominated a positive workplace culture as a protective factor against alcohol and other drug related harm. Workplaces recognised the value of open communication and a supportive environment in developing a positive workplace culture. Close supervision of staff was also identified as an important strategy for both detecting and reducing alcohol and other drug related harm.

When asked what types of strategies had the most impact in reducing alcohol and other drug related harm, workplaces identified testing programs, education, policies and disciplinary action as having the most impact.

Workplaces were particularly seeking avenues where greater support could be provided. The key area that workplaces want assistance with is clarification of their rights and responsibilities in relation to managing alcohol and other drug related harm in the workplace. Workplaces believed this could be achieved through advice, assistance, information and awareness.
Despite being concerned about alcohol and other drug related harm and generally wanting further assistance to respond, most workplaces were not considering implementing any additional strategies to enhance their existing responses.

The results of this phase of the project provide a valuable snapshot of what is currently occurring in South Australian workplaces and a basis from which to move forward. Besides providing many avenues from which to further address the issue, the research also highlights the need for greater support to assist workplaces to enhance their current responses to alcohol and other drug related harm. One of the challenges for future work will be to determine how best to harness workplaces' concern about this issue and translate this concern into further action.

Phase Three
Phase three of the research comprised a workshop with key stakeholders to review and discuss the findings of the previous research phases, and to pursue options for recommendations for future action and policy development. The workshop was held in May 2006 and was attended by 21 stakeholders from diverse sectors.

Outcomes of the stakeholder workshop largely reinforced findings from the literature review and telephone survey. In particular, participants highlighted drug testing as a major issue and noted the lack of clarity for workplaces regarding a number of issues (principally the availability of existing resources and services, the nature and extent of workplace drug-related harm and issues associated with testing programs).

Stakeholders noted that effective occupational health and safety initiatives were generally based on involvement of those affected, open communication, workplace culture, and quality practice. It was recognised that legislation may be utilised to ensure workplaces initiate responses to alcohol and other drugs, but to ensure sustainable and effective responses the issue must be owned by all involved.

The key areas for future action, as identified by workshop participants, centred on ensuring quality practice, addressing operational factors, investigating different approaches and increasing workplace motivation to respond to alcohol and other drug related harm. In addressing these key areas, participants noted that the following areas must be investigated in order to move forward:

- Development of measurable outcomes and performance indicators;
- Development of parameters for workplaces to operate within and investigate regulatory approaches;
- Improvement of education and information mechanisms;
- Development of a ‘clearinghouse’ type service to assist workplaces through access to information, resources and referrals.
Workshop participants identified a number of barriers that may impact the manner in which alcohol and other drug related harm in workplaces is addressed. These barriers include:

- Identifying the most appropriate legislative framework which the issue fits under;
- Cultural norms (need to recognise that workplaces reflect wider cultural norms and also reflect problems faced in the wider community);
- Need to be cognisant of the contentious nature of the issue and the potential for agenda driven responses;
- Legislative approaches may not yield the best results as the legislative approach is drawn out and the paucity of evidence for effective approaches makes legislative requirements for workplace responses difficult.

Despite these barriers, it was recognised that this project is well placed to achieve further action in this area due to the collaborative partnership between the lead agencies, industry representatives and key stakeholders.

The key outcomes of the stakeholder workshop centre on the following issues:

- Improved data collection practices (including an audit of existing data sources) to ensure the scope, nature and extent of drug-related harm in workplaces can be quantified;
- Improved availability and marketing of services and resources able to assist workplaces to address drug-related harm, possibly through the development of a clearinghouse service;
- Legislative approaches should be investigated thoroughly to determine potential impacts on employers and employees and where possible existing legislative frameworks should be utilised;
- The potential to address drug issues through existing OHS channels may be diminished somewhat if workplaces do not perceive drugs to impact on safety. In this case it may be more appropriate to address these issues through an industrial relations approach;
- Limited understanding of the effectiveness and appropriateness of alcohol and drug testing is clearly a major issue for stakeholders and requires careful attention through provision of accurate information to ensure informed decision making can occur.

The workshop demonstrated that it is essential to identify who will take responsibility and leadership for driving the issue and stakeholders should be engaged to ensure a partnership approach whereby all can own the issue. The participants in the workshop were able to provide a valuable contribution through their varied perspectives on the issues at hand.
DISCUSSION AND RECOMMENDATIONS FOR FUTURE ACTION

Findings from the three research phases present a largely consistent view of alcohol and other drug related harm in workplaces. The literature review, telephone survey and stakeholder workshop all acknowledge workplace alcohol and other drug related harm as a serious issue warranting both further research and resources to assist workplaces to respond. In addition, all three phases highlighted a sense of uncertainty regarding the extent of the problem and the most appropriate ways in which to respond. Beyond this, it is also clear from this research that strong leadership is required to address the issues and take responsibility for driving future responses. The findings from this research form the basis for a comprehensive set of recommendations addressing priorities in progressing the issues arising out of this project.

The recommendations identified in this report are synthesised from the findings from all stages of this project (literature review, industry survey and stakeholder workshop). These recommendations have been developed recognising that major gaps exist in the current knowledge base regarding alcohol and other drug related harm in the workplace. These gaps exist within the literature, data collections and evidence for best practice responses to workplace alcohol and other drug related harm.

The project identified the following priority areas for action:
1. Providing strategic leadership to address the impact of alcohol and other drug related harm in South Australian workplaces.
2. Identifying and disseminating best practice workplace responses to alcohol and other drug related harm, through appropriate resources and service provision.
3. Improving data collection practices that build on an assessment of current data sources.
4. Supporting further research investigating the effectiveness of workplace responses to alcohol and other drug related harm (building the evidence base).
5. Developing workforce capacity to ensure high quality service provision and resource development.

These recommendations recognise these factors and seek to address the current limitations impeding effective responses to alcohol and other drug related harm in workplaces.
1 | Leadership

This research highlights the need for strong leadership to guide future efforts in South Australia in responding to alcohol and other drug related harm in workplaces. Whilst recognising that the issue needs to be owned by all stakeholders, the research findings suggest that future responses to alcohol and other drugs in the workplace should be led by government, supported by employee and employer representatives. Accordingly, the following recommendations are made in support of a coordinated leadership approach for workplace alcohol and other drug issues:

**Recommendation 1.1**

It is recommended that the SafeWork Advisory Committee provides support for the development of an interagency committee that is responsible for developing a cooperative strategy to address the risks arising from alcohol and other drugs in the workplace. The strategy should include:

- Development of an education strategy
- Improvements in data collection practices (incorporating recommendations 3.1–3.6)
- Identification of research priorities (incorporating recommendations 4.1–4.4)
- Identification of opportunities for national linkages

**Recommendation 1.2**

It is recommended that membership of the proposed interagency committee include SafeWork SA, Drug and Alcohol Services South Australia, Equal Opportunity Commission, National Centre for Education and Training on Addiction, employer and employee representatives and others invited to participate as required. Consideration should also be given to having at least one member from the SafeWork Advisory Committee on the interagency committee.

**Recommendation 1.3**

It is recommended that the proposed interagency committee be chaired and administered by SafeWork SA.

**Recommendation 1.4**

It is recommended that opportunities for strategic direction and linkages at a national level be investigated and pursued by the proposed interagency committee.
2 | Education and Dissemination of Information

A key outcome of this research is recognition of the need to clarify employer and employee responsibilities in relation to alcohol and other drugs. In particular, it was noted that workplaces want guidance in interpreting the practical implications of existing legislation in South Australia and assistance to make informed decisions regarding appropriate responses to alcohol and other drugs in their workplace. These findings demonstrate the importance of a comprehensive education and dissemination plan in South Australia to raise the issue of workplace alcohol and other drug related harm and provide avenues where support can be accessed.

The following recommendations support a comprehensive educative approach aimed at dissemination of best practice evidence to workplaces:

**Recommendation 2.1**
It is recommended that a comprehensive education and dissemination plan be developed detailing resources and support services available to assist workplaces in responding to alcohol and other drugs.

**Recommendation 2.2**
It is recommended that the draft guidelines for responding to workplace alcohol and other drug related harm developed in conjunction with this project be endorsed and developed for publication. The guidelines include:
- Practical information on how to identify and assess the risks associated with alcohol and other drugs and how best to control those risks.
- Clarification of employer and employee responsibilities under all relevant legislation.

**Recommendation 2.3**
It is recommended that existing resources and expertise on alcohol and other drugs be assembled to assist employers to make informed decisions.

**Recommendation 2.4**
It is recommended that existing services are enhanced through the development of a portal website and adjunct telephone support service to provide central access to up to date information on workplace alcohol and other drug issues and links to relevant websites and resources.
Recommendation 2.5
It is recommended that a promotion/dissemination strategy be developed that targets employers, opinion leaders, the SafeWork SA inspectorate, business advisers, private providers, employee and employer representatives, workers compensation insurance providers and claims agents, and others as identified.

Recommendation 2.6
It is recommended that an evaluation plan be developed to assess the impact of promotional campaigns and service utilisation.

Recommendation 2.7
It is recommended that workplaces are encouraged to incorporate the following components within their response to alcohol and other drugs:
- A comprehensive policy (including dissemination plan) developed through consultative processes
- Identification of the factors which influence work-related alcohol and other drug use and associated problems
- A focus on positive workplace culture
- Access to employee support services (such as employee assistance programmes)

Recommendation 2.8
It is recommended that workplaces only consider implementing drug testing if it is part of a comprehensive strategy (as per recommendations 2.2 and 2.7) to address alcohol and other drug related harm that is developed through extensive consultation with those affected.

3 | Improved Data Collection

Findings from phase one of this research indicated that there are serious limitations in terms of the breadth and quality of data collections relating to alcohol and other drugs in the workplace. One of the key challenges in addressing the impact of alcohol and other drugs in workplaces is ensuring workplaces are motivated to proactively address the issue. In order to facilitate workplace responses, there is a need to provide evidence that alcohol and other drugs constitute a serious problem which needs to be addressed. The nature and extent of alcohol and other drug related harm in workplaces can only be demonstrated through quality data. The lack of comprehensive, standardised data collection practices leaves the nebulous understanding of alcohol and other drug related harm in workplaces unchallenged.

The paucity of reliable and valid data exists across all industry and jurisdictional sectors and has serious implications for future responses to alcohol and other drugs in the workplace. Consequently, the following recommendations are made for improvements to current data sets and collection techniques.
Recommendation 3.1
It is recommended that the existing problem of inadequate baseline data be addressed through the strategy developed by the proposed interagency committee.

Recommendation 3.2
It is recommended that an audit of existing data sets be conducted to determine gaps and potential useability.

Recommendation 3.3
It is recommended that indicators of use, impairment and harm be identified to assist the practical assessment of the nature and extent of workplace alcohol and other drug problems.

Recommendation 3.4
It is recommended that relevant agencies who collect data (or have the potential to collect data) that pertains to alcohol and other drug related harm in the workplace, adopt a standardised approach for data recording to allow for ongoing analysis and comparison.

Recommendation 3.5
It is recommended that opportunities to integrate data on alcohol and other drugs in the workplace into national data sets for occupational health and safety and workers’ compensation be investigated, in particular linkages to the National Data Set (NDS) and the Comparative Performance Monitoring (CPM) reports.

Recommendation 3.6
It is recommended that specific probing questions in relation to alcohol and other drugs are incorporated into the SafeWork SA accident investigation process and that these be captured on existing databases for ongoing analysis.

4 | Research Priorities

It is recognised that there is a need to improve the quality of evidence for workplace responses to alcohol and other drug related harm. Future research should examine the effectiveness of specific workplace interventions to inform best practice guidelines which workplaces can follow. It is considered essential that further, well-designed research be undertaken in order to demonstrate both the features and outcomes of best practice responses.

Recommendation 4.1
It is recommended that controlled research be undertaken to evaluate workplace responses to alcohol and other drug related harm in terms of improved outcomes.
Recommendation 4.2
It is recommended that well designed research be undertaken that improves the collection of data and supports the development of datasets that may be used to improve responses to alcohol and other drug related harm.

Recommendation 4.3
It is recommended that funding for future research be investigated through grant schemes and government funding schemes.

Recommendation 4.4
It is recommended that future research activities be undertaken with the specific intention to enhance knowledge of incidents of alcohol and other drug related harm in workplaces. These research activities should aim to complement suggested improvements to current data collection techniques.

Note on recommendation 4.4: It is important to acknowledge the disincentives which may contribute to under-reporting of incidents and issues arising from alcohol or other drugs in the workplace. These disincentives may include concerns of punitive or disciplinary action and the potential impact on workers compensation (if applicable). Further it is recognised that not all incidents may be captured through improvements or alterations in current data collection. There is a need therefore to initiate research activities which develop an understanding of the existing and potential barriers to adequate data collection and the ways in which these can be addressed.

5 | Development within SafeWork SA, Drug and Alcohol Services South Australia and Private Service Providers

In order to facilitate the achievement of improved outcomes for workplaces, it is essential that agencies and individuals providing services and information receive appropriate training to support high quality service provision. It is recognised that frontline professionals involved in managing issues related to workplace alcohol and other drug harm must be provided with adequate education and training to fulfil these roles.

Recommendation 5.1
It is recommended that SafeWork SA address the hazard of alcohol and other drugs in the workplace with the Occupational Health and Safety (OHS) Inspectorate and the Help and Early Intervention Centre. Training should be provided to the OHS inspectorate that includes up to date information on the scope of options available to employers for controlling the risks from alcohol and other drugs in the workplace.
**Recommendation 5.2**

It is recommended that training be provided to staff at the Alcohol and Drug Information Service and staff at the proposed telephone support service in terms of responses to workplace alcohol and other drug issues and resources available.

**Recommendation 5.3**

It is recommended that service providers, such as Employee Assistance Program providers, are engaged with to ensure that information regarding workplace alcohol and other drug issues is consistent and accurate.

**6 | Carriage of the Recommendations**

The recommendations outlined in this report represent the identified priorities for a coordinated, strategic approach to alcohol and other drug related harm in workplaces. The implementation of these recommendations will result in significant benefits for South Australian workplaces through enhanced service provision and the availability of high quality resources outlining evidence based approaches. In addition, improvements in data collection practices and a commitment to future research will yield benefits for many stakeholders through a more complete understanding of the impact of alcohol and other drugs in workplaces.

The recommendations are proposed in anticipation that specific resources may need to be attached to ensure they are attained. With support from the SafeWork SA Advisory Committee, the proposed interagency committee would be well placed to implement many of these recommendations if endorsed.

**Recommendation 6**

It is recommended that the SafeWork Advisory Committee take carriage of the recommendations outlined in this report.
CONCLUSION

The research undertaken for this project emphasises that work-related alcohol and other drug use is not a problem isolated to the individual. Due to the breadth of harms and the potential for significant impacts, stakeholders at all levels must be engaged to enhance existing responses and support services. Alcohol and other drug-related harm in the workplace requires more than a response levelled at the individual; it requires a holistic, comprehensive approach that is supported by all concerned.

It is evident that alcohol and other drug related harm in workplaces is critically under-researched. The research conducted for this project demonstrates that it is essential that further, well designed research be undertaken to determine the effectiveness of workplace responses for reducing alcohol and other drug related harm in the workplace. An insufficient evidence base, combined with inadequate data collections, hampers action and unless addressed will inevitably lead to less than desirable outcomes. It is pertinent to also investigate further how to integrate alcohol and other drug issues within existing frameworks to increase chances of acceptability and reduce the burden of compliance on workplaces.

Perhaps the most encouraging component of this research is that there is clearly an impetus to address workplace alcohol and other drug issues further. Workplaces require much more information and direction, as they are concerned about the potential impact of alcohol and other drugs in their workplace and it is clear that, for many, the issue of alcohol and other drugs is a ‘hot topic’. This suggests that the timing may be right for further strategies aimed at assisting workplaces and creating awareness of potential alcohol and other drug harms in workplaces.

One of the key challenges for improving workplace responses to alcohol and drugs lies in identifying who will take responsibility and leadership for driving the issue. A key challenge will be drawing stakeholders together to ensure a partnership approach whereby all can own the issue. However, this research project has certainly demonstrated that there is a clear mandate to further address alcohol and other drug related harm in workplaces, and with strategic guidance and leadership positive outcomes for workplaces can be achieved.
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Appendix 1

Phase One Summary Report

Literature Summary
INTRODUCTION

The following report details a summary of the literature pertaining to alcohol and other drug [AOD] related harm in the workplace. The aim of phase one of ‘The Impact of Alcohol and Other Drugs in the Workplace’ project is to highlight key issues in this area and provide sufficient background information to inform further phases of the project. The report presents an overview of the nature of alcohol and other drug harm in workplaces and the extent to which this harm occurs. The summary is divided into two broad sections – the first examines alcohol and other drug related harms in the workplace and the second section details responses to these harms.

The workplace is not impervious to alcohol and other drug issues – most people are in employment and many people consume drugs, particularly alcohol. As noted by the National Health and Medical Research Council [NHMRC] (1997, p43), ‘Alcohol, like many other health issues is not compartmentalised into work and non-work settings.’ Alcohol and other drug use are but one of many challenges workplaces must confront. The workplace does present particular challenges due to the potential for serious harms – including social and financial costs resulting from accidents, injuries and productivity losses. Alcohol or other drug harm occurring in the workplace context impacts on many groups including government, service providers, employers, employees and their co-workers, carers and families, and the social and financial costs are borne across the community.

Note: This report adopts the South Australian Occupational Health, Safety and Welfare Act (1986) definition of workplace which states; ‘“Workplace” means any place (including any aircraft, ship or vehicle) where an employee or self-employed person works and includes any place where such a person goes while at work.’

1 Harms

Alcohol and other drug related harm in the workplace setting can be broadly conceptualised as encompassing two key areas:

- Fatalities and injuries and;
- Productivity related concerns

In addition to these harms, there are a range of incidental harms resulting from alcohol and/or other drug use which may impact on the workplace. These include; impacts on the health and welfare of the workforce, reduced morale, and interference with the work environment due to relationship problems such as violence or abuse. The following section seeks to delineate the extent of harms based on the available evidence. Following this is an examination of prevalence of use in the workplace and the relationship between use and harm.
1.1 Fatalities

Finding: Alcohol is a contributing factor in an estimated 4% of work-related fatalities whilst other drugs are estimated to contribute to 2% of work-related fatalities. In total, alcohol and/or other drugs are involved in at least 5% of work-related fatalities in Australia.

Discussion

Phillips (2001b, pp27-30) outlines the role of alcohol and other drugs in workplace fatalities and concludes that data from the National Occupational Health and Safety Commission’s second Work-Related Traumatic Fatalities Study provide a reasonable estimate of AOD involvement in work-related fatalities that is congruent with international data. NOHSC's report estimates that alcohol and other drugs combined contribute to at least 5% of work-related fatalities (National Occupational Health and Safety Commission 1998). The estimates for South Australia were higher with alcohol a contributing factor in at least 6.4% of work-related fatalities, whilst other drugs were associated with 3.2% of work-related fatalities in the period 1989-1992 (National Occupational Health and Safety Commission 1999). Work-related fatalities may occur in locations external to the workplace and thus have the potential for further impact. For example, alcohol and other drugs have been shown to contribute to work-related road fatalities for both the working person and bystanders (Mitchell, Driscoll et al. 2004). These results indicate that the scope of harm attributable to work-related alcohol and other drug use spreads beyond the immediate working environment.

The types of drugs, other than alcohol, found to be involved in work-related fatalities include amphetamines, barbiturates, cannabis and narcotics (National Occupational Health and Safety Commission 1998, p18). Where other drugs were a factor, stimulants were the only type of other drug to be implicated in South Australian work-related fatalities (National Occupational Health and Safety Commission 1999, p31). It must be noted that due to limited data availability, particularly in relation to drugs other than alcohol, these figures may be under-representative of actual occurrences. There is also the special issue of poly-drug use. Curry and Theodorou (2002, p258) note that poly-drug use is becoming more widespread. There are particular concerns relating to the concurrent use of certain substances. For example, when cannabis and alcohol are combined the interactive effects result in increased intoxication and impairment (Curry & Theodorou 2002, p260). Clearly, the exacerbating effects of poly-drug use need to be considered in relation to the impact on the workplace.
The Australian data appear congruent with international comparisons which show that in one examination of work-related fatalities in the United States approximately 5% returned positive alcohol or other drug readings in toxicology reports (Greenberg, Hamilton et al. 1999). In terms of industry specific trends, Phillips (2001b, p29) notes that ‘… risky industries do not appear to have a much greater proportion of alcohol-related fatalities than less hazardous industries – a finding that contradicts many popularly held opinions.’

1.2 Injuries

**Finding:** Alcohol use is associated with 3% to 11% of workplace injuries, whilst the involvement of other drugs is likely to be approximately 2%.

**Discussion**
The NHMRC (1997, pp11-2) and Phillips (2001b, pp30-6) note the disparate nature of estimates of alcohol and other drug involvement in workplace injury. The NHMRC (1997, p12) concurs with the findings of three reviews which found alcohol to be a factor in between 3 and 11% of workplace injuries. Obtaining a reliable estimate for the involvement of drugs other than alcohol is more problematic due to a lack of available data. Considering that drugs other than alcohol are involved in 2% of work-related fatal injuries, the potential exists to extrapolate this figure to injuries in general, in the absence of a sound evidence base.

English and colleagues (1995, pp219-20) determined aetiologic fractions of morbidity and mortality caused by alcohol, tobacco and illicit drugs and found that hazardous and harmful alcohol consumption caused 7% of occupational and machine injuries. In addition, they determined ‘… that there is sufficient evidence that alcohol causes occupational and machine injuries.’ [emphasis in original]. The relationship between drugs other than alcohol and occupational and machine injuries was not addressed.

There is a dearth of literature and adequate data collection regarding alcohol and other drug involvement in fatal and non-fatal workplace injury. The evidence outlined in the preceding sections indicates that alcohol and other drugs are associated with fatal and non-fatal workplace injury. Whilst some examples of the prevalence of this involvement are given here, the true extent of alcohol and other drug-related workplace injury is largely unknown, particularly for non-fatal injury. Estimates of alcohol and other drug involvement in work injuries are likely to be conservative due to a number of factors. For instance, the sensitive nature of the issue may result in underreporting of incidents and further, alcohol and other drug testing may not be routinely conducted following a work-related injury.
1.3 Productivity

**Finding:** Alcohol and other drug use result in reduction in the workforce and absenteeism costs which exceed $2.9 billion. Drug-related workplace accidents result in costs of approximately $1.3 billion – half of which is borne by employers.

**Discussion**

The breadth of productivity-related harm caused through alcohol and other drug-related impairment is addressed extensively. Phillips (2001b, p36) notes that alcohol or other drug use may affect workplace productivity in the following ways:

- Losses caused by accidents
- Increased workers’ compensation premiums resulting from increased (drug-related) claims
- Reduced work rate and poor quality of work because of inebriation or hangover
- Increased sickness absence
- Increased staff turnover and associated costs of training replacement workers
- Increased incidence of lateness for work
- Theft and damage to plant and machinery

These productivity implications are largely supported by Collins and Lapsley (2001, p111) who add that the morale and health of the workforce can be impacted. The Alcohol and Other Drugs Council of Australia [ADCA] (2000b, p18) notes that work-related AOD use can also impact the safety and productivity of co-workers, again indicating that the scope of alcohol and other drug harm is broader than the individual.

According to Collins and Lapsley (2002, p53), alcohol and other drug use resulted in costs in excess of 2.9 billion dollars in Australia in 1998-99 due to reduced workforce and absenteeism; costs associated with lost productivity on-the-job were not quantifiable in their study. Utilising data from the 1995 Industry Commission Inquiry into Work, Health and Safety, Phillips (2001b, p37) determined that the total costs associated with drug-related workplace accidents in 1992-3 were in excess of one and a half billion dollars. Of this amount, the cost to employers was estimated at 650 million dollars. Whilst it may be possible to suggest that drug use could potentially result in positive outcomes for productivity (e.g. the use of stimulants by long distance truck drivers to combat fatigue and facilitate more hours on the road), the overarching view is that productivity is negatively impacted by work-related alcohol and other drug use.
1.4 Use/Impairment at Work

Finding: Reliable data that provide an overall estimate of the prevalence of AOD use or AOD related impairment at work are not available, however 4.4% of participants in the 2004 National Drug Strategy Household Survey indicated they went to work affected by alcohol and 2% went to work affected by illicit drugs.

Discussion
Due to the nature of the activity in question, it is perhaps not surprising that a sound evidence base regarding the prevalence of use or impairment at work does not exist. The Inquiry into Substance Abuse in Australian Communities determined that ‘Surprisingly little work has been undertaken to estimate the prevalence of intoxication or being drug-affected at work’ (House of Representatives Standing Committee on Family and Community Affairs 2003, p274, emphasis in original). The best overall picture comes from preliminary results from the 2004 National Drug Strategy Household Survey which show that 4.4% of participants reported going to work affected by alcohol and 2% went to work affected by illicit drugs (Australian Institute of Health and Welfare 2005). In addition, just over 6% of survey respondents reported the workplace was their usual place of consumption of alcohol and 11% indicated that the workplace was their usual place of consumption of pharmaceuticals for non-medical purposes (Australian Institute of Health and Welfare 2005).

Some research has been conducted to ascertain the on the job consumption of alcohol and other drugs in specific occupational groups, however small sample size and other limiting features preclude the ability to generalise findings. Mabbott and Hartley (1999) undertook research which examined the use of stimulants by Western Australian heavy truck drivers and found that 27% (n=65) of the sample self-reported stimulant use (prescription, illicit and over the counter) to combat fatigue on the job and the most commonly used stimulant was amphetamines. Williamson and colleagues (2001) found, in a survey of Australian long distance heavy vehicle drivers, that over 30% rated ‘stay awake drugs’ as the most effective strategy to combat fatigue. Results from two studies (n=4193, n=749) involving Australian police officers found 26% reported drinking at work at least sometimes and 23% were affected by their co-workers alcohol consumption (Davey, Obst et al. 2000b, 2001). In a study involving South Australian construction industry pre-vocational trainees and apprentices, Pidd (2003) found that 19% regularly consumed alcohol in work-related hours and 6.7% reported marijuana use during work-related hours.

Whilst the results from the above studies cannot demonstrate the prevalence of workplace alcohol and other drug use across industry or occupational sectors, they do indicate that alcohol and other drug use occur in the workplace and provide impetus to determine the extent of harm arising from impairment. These studies also highlight how different workplace factors and contexts may contribute to differential AOD harms.
1.5 Relationship between Use and Harm

**Finding:** The practice of assessing harm in terms of levels of consumption is a flawed approach. A more effective approach is to examine harm in terms of patterns of consumption and impairment.

**Discussion**

Equating alcohol and other drug harm in the workplace with levels of exposure is problematic in that it is not absolute that exposure to substances will cause harm. The value of examining harm in terms of patterns of consumption and impairment, rather than simply consumption or exposure, is highlighted by Newcomb (1994) and supported by Allsop and Pidd who remark that ‘Identifying harm solely in terms of drug consumption is a flawed approach’ (Allsop & Pidd 2001, p9). Phillips (2001b, p26) also questions the relevance of general consumption data in elucidating the debate regarding workplace alcohol and other drug use and related harm. The chief concern with consumption data is that general consumption levels may or may not translate to problems at work. A more useful way of approaching the issue might involve assessing patterns of consumption and the effects of any consumption on the workplace directly. The rationale supporting this is that some patterns of consumption are more harmful than others. For example, an individual whose consumption pattern involves drinking two glasses of wine with dinner probably will not impact on the workplace, but an individual whose consumption pattern involves a few beers on their lunch break is more problematic for the workplace.

There is some evidence of employees under-estimating or discounting the effects of alcohol and other drugs on their work. For example, Allsop (1987, cited in Nicholas, Allsop et al. 1996, p6) states that:

> Paradoxically, it is not the relatively small number of very heavy drinkers in the workplace who are associated with the greatest level of harm. Rather, it is the much larger group of usually moderate drinkers who may occasionally drink hazardously who are associated with the greatest amount of harm in the workplace.

Similarly, Pidd (2004, p279) reports that a sample of South Australian apprentices believed that work-related alcohol use would not impact on health and safety at work. Likewise, in a study of Australian police officers, 22% stated that their drinking at work did not impact their performance at work (Davey, Obst et al. 2001, p145). The National Rural Health Alliance (1998) also observes that the ‘hangover’ effects of alcohol on performance are underestimated in Australia. Again, this reinforces the value of examining alcohol and other drug-related harm in the workplace in terms of patterns of consumption.
2 | Responses

The major responses to alcohol and other drug related harm in the workplace detailed in this section are:

- Workplace Alcohol and Other Drug Policies
- Health Promotion
- Employee Assistance Programs, Counselling and Other Interventions
- Controls on Drug Use

2.1 Workplace Alcohol and Other Drug Policies

Finding: Alcohol and other drug policies are an integral part of the organisational response to workplace alcohol and other drug harm.

Discussion

Workplace AOD policies constitute an important level in the response to AOD issues. The Alcohol and Other Drugs Council of Australia (2000a) notes that whilst not all workplaces have a formal AOD policy in place, all workplaces have some form of policy regarding AOD use even if it is an unwritten, unspoken, ‘common knowledge’ agreement. ADCA (2000a) suggests that ‘Every Australian workplace should have an AOD policy as part of their broader occupational health and safety requirement, and as part of their insurance arrangements.’ The importance of a workplace AOD policy is highlighted by Pidd (2003) who found that apprentices who were employed in a workplace which had no AOD policy engaged in more work-related illicit drug use than those employed where a clear policy was in place. In terms of effective policy, Duffy and Ask (2001) provide an outline of the key ingredients for a workplace AOD policy. Zinkiewicz and colleagues (2000, p71) suggest that merely having a policy is not enough – there must be adequate dissemination of the policy and education regarding it in the workplace.

There is some evidence to suggest a discrepancy exists between the size of a workplace and its capacity to deal with AOD related issues. Allsop and Phillips, (cited in CCH OHS Magazine 2004, p21), supported by Richmond and colleagues (1992), state that larger companies are more likely to have a policy or program in place to address AOD issues, yet a respondent to the Inquiry into Substance Abuse in Australian Communities advises that small businesses are more likely to experience problems associated with drug use in the workplace (Gardner, cited in House of Representatives Standing Committee on Family and Community Affairs 2003, p285). This sentiment is supported by Pidd and Cormack (2000) who outline the importance of managing AOD issues despite the difficulties that small businesses encounter due to resource availability.
2.2 Health Promotion

**Finding:** The effectiveness of workplace health promotion in terms of costs and outcomes is not certain. However, what is known from other domains indicates that well designed health promotion activities provide a useful avenue for the prevention of harm.

**Discussion**

Historically, workplace health promotion has relied on an individualistic focus despite the shift away from this approach in other health promotion domains (LaMontagne 2004, Health Canada n.d). This individualistic approach ignores the interplay between the individual and the structural, physical and psychosocial environments within which they exist. Workplace health promotion should go beyond the individual to recognise the aspects of the work environment that may impact workers health including AOD use (World Health Organization Expert Committee on Health Promotion in the Workplace 1993). However, it is also evident that simplistic notions of these activities as narrowly focused interventions to promote individual lifestyle and behaviour change impede workplace health promotion. Allsop and Pidd (2001, pp18-9) offer the most stinging criticism of a simplistic approach: ‘Simplistic, individually focused responses are likely at best, to be ineffective and, at worst, to exacerbate problems.’

Allsop and colleagues (1997, pp60-5) reviewed the limited research relating to workplace health promotion and concluded that methodological flaws detracted from some promising interventions. Richmond and colleagues found that the effectiveness of workplace health promotion activities, in terms of costs and outcomes, was not clearly articulated. Further, there are barriers to implementing health promotion activities in the workplace. For instance, in their research within the New South Wales Police Service and Australia Post, Richmond and colleagues (1999, 2000) concluded that workplace culture can detrimentally impact on workplace health promotion activities. In particular they hypothesised that an entrenched aversive culture would require years of activity to build an effective response (Richmond, Kehoe et al. 1999, p1520).

There is a dearth of evidence relating to workplace health promotion initiatives. Webb (1999, pp36-7) notes that there are certain aspects, or outcomes, of health promotion that cannot be measured. However, this does not mean that health promotion is a less valid response to workplace AOD issues. Loxley and colleagues (2004, p174) concluded that evidence from other domains supports the use of activities such as brief interventions for reducing workplace alcohol and other drug use and the associated harms.
2.3 Employee Assistance Programs, Counselling and Other Interventions

**Finding:** The effectiveness of Employee Assistance Programs [EAPs] in reducing alcohol and other drug related harm in the workplace remains largely unevaluated, whilst the evidence base for counselling and other interventions in the workplace as a specific setting is poor. Evidence from other domains suggests that these interventions do provide a potential avenue for addressing alcohol and other drug related harm in the workplace context.

**Discussion**

Allsop and colleagues (1997, pp69-72) determined that whilst there is a considerable amount of literature that appears to support the use of EAPs in terms of their ability to successfully rehabilitate clients, the lack of sound evaluation and scientific investigation in the literature they reviewed requires that such support needs to be accepted with reservations. Loxley and colleagues (2004, p172) reported that no conclusive evaluations exist which establish the effectiveness of EAPs in addressing AOD problems. In defence of EAPs and the workplaces who utilise them, Nicholas and partners (1996, p27) acknowledge that EAPs are difficult to evaluate without extensive resources. However, given that EAPs have been widely accepted and implemented, they do provide a potential avenue for addressing alcohol and other drug related harm (Calogero, Midford et al. 2001, p104; Loxley, Toumbourou et al. 2004, p172).

There are many interventions for workplace alcohol and other drug issues not covered within the scope of health promotion activities or employee assistance programs. Workplaces may not provide access to an EAP per se but may still offer access to counselling or other interventions such as peer support programs, educational activities and specific workplace programs to prevent or reduce alcohol and other drug related harm in the workplace. In addition, there are community based and private practice services that may be utilised to assist employees facing alcohol or other drug related problems (Calogero, Midford et al. 2001, p92). Allsop and colleagues (Allsop, Bush et al. 1997, pp81-5) reviewed literature pertaining to various workplace interventions and found that in general the quality of evidence was poor but there were some promising activities related to behavioural counselling and awareness raising strategies.

Whilst there may be a limited evidence base to support the introduction or continuation of activities aimed at reducing or preventing alcohol and other drug related harm in the workplace as a specific site, evidence available from other domains may be cautiously extrapolated to the workplace setting. For example, Calogero, Midford and Towers (2001, p104) note that many prevention, counselling and treatment methodologies offer effective responses to alcohol and other drug problems in the broader community and these interventions have the potential to be effective in the workplace if adapted for the context.
Further to counselling and other intervention activities, workplace occupational health and safety initiatives present a framework for addressing and responding to workplace alcohol and other drug issues. Certainly, workplaces may not formally address alcohol or other drugs in a policy or intervention sense but may have comprehensive occupational health and safety guidelines which offer an avenue to respond to alcohol and other drugs.

2.4 Controls on Drug Use

**Finding:** There is limited evidence to support simple control measures, such as bans on use, as a means to reduce harm. Alcohol and other drug testing is a contentious strategy and the available evidence does not support the implementation of testing as a mainstream response for dealing with workplace drug and alcohol issues due to various limitations.

**Discussion**

Controls on drug use include efforts to remove access to alcohol or other drugs in the workplace, legislative approaches to alcohol and other drugs in the workplace and testing protocols to determine exposure to alcohol and other drugs. Corry (2001, p106) notes that the aim of controls on alcohol and other drugs in the workplace centre on regulating use that can impact on the workplace. Workplaces may therefore prohibit the consumption of substances at various locations or times in order to reduce problems arising out of consumption. Allsop and colleagues (1997, pp72-7) reviewed the evidence for workplace controls and found literature relating only to tobacco, indicating that research relating to controls on alcohol and other drugs is severely limited. This is supported by Corry (2001), who notes that there is very limited evidence referring to controls on alcohol and other drugs compared with tobacco. In terms of legislative controls, Occupational Health, Safety and Welfare legislation sets out the various obligations and responsibilities of employees and employers relating to alcohol and other drugs in the workplace and provides a legal framework for addressing alcohol and other drug issues in the workplace (Phillips 2001a, pp138-44).

The most contentious effort to control alcohol and other drugs in the workplace is testing for alcohol and other drugs. The literature regarding workplace drug testing consistently highlights that it is an inappropriate mechanism for intervening in workplace alcohol and other drug use. Pidd (n.d) provides a comprehensive analysis of the different forms of drug testing and concludes that drug testing is unreliable and inaccurate for determining fitness for duty and impairment. The problems associated with drug testing in the workplace are further outlined by ADCA (2004, p4) which acknowledges that drug testing is an inadequate measure of impairment, results in highly punitive responses, is often implemented in isolation and few organisations evaluate its effectiveness in reducing workplace AOD harm. This is supported by Crouch and colleagues (1989 cited in Richmond, Heather et al. 1992, p82) who outline that many millions of dollars are spent on drug testing in the United States in the absence of cost-benefit analyses. The NHMRC (2001, pp40-1) concludes that the
available evidence does not support the implementation of testing programs as a means to counter alcohol-related problems in the workplace.

One of the main criticisms of workplace testing for illicit drugs is that most forms only detect the presence of drug metabolites – a finding which does not necessarily indicate impairment, simply consumption (Kapur 1994 cited in Macdonald 1997, p252). Macdonald (1997) concludes that drug testing is not justifiable based on his review of the epidemiological, laboratory and scientific evidence. One alternative option to intrusive drug testing regimes is the use of an impairment measuring system. These systems require the employee to complete a series of activities to detect impairment, yet suffer the same fate as many other activities in that they are yet to be comprehensively evaluated (Nolan 2001, pp72-3).

There are certainly contradictions within the literature around workplace drug testing. There is some evidence to suggest that implementing a drug testing regime has a deterrent effect for prospective employees in particular (Allsop et al 1997, Normand et al 1994, Baker 1997, cited in Loxley, Toumbourou et al. 2004, p174). Yet, others suggest that rather than acting as a deterrent to workplace drug use, drug testing can simply result in changes to drug taking behaviour such as employees turning to substances that are less likely to be detected (Crow & Hartman 1992). In this way, drug testing does not solve workplace drug issues; rather it shifts the problem to a more furtive level. Further, Allsop and Phillips (1997, p1) note that the success of pre-employment testing in reducing workplace drug issues is exaggerated and that testing of existing employees has not been shown to have a positive effect on productivity, safety or reduce drug-related impairment, in fact Pidd (n.d) even suggests that drug testing may have a negative impact on productivity.

The different variations of drug testing clearly occupy a place in the overall response to workplace AOD harm. Respondents to the Inquiry into Substance Abuse in Australian Communities noted that drug testing may be a requirement in certain scenarios where issues of public safety are concerned (Gardner and ADCA , cited in House of Representatives Standing Committee on Family and Community Affairs 2003, p288), and Loxley and colleagues (2004, p174) conclude that in vocations that have safety critical components, such as airline pilots, testing for alcohol and other drugs is more likely to be accepted. Whilst there is by no means consensus regarding workplace drug testing, the predominant conclusion in the literature is that drug testing is not justifiable as a routine measure for either preventing or reducing drug related harm in the workplace.
3 | Work Environment

The work environment and culture of the workplace can have a profound impact on employees. Employees do not exist in isolation – the structural, physical and psychosocial aspects of the environment within which they exist affect them. Workplace culture can influence the acceptability of alcohol and other drug use. In the police force, for example, it is suggested that a culture of drinking within the force, and availability of alcohol, impact on police officers drinking patterns (Hagen, Egan et al. 1992, ; Davey, Obst et al. 2000a, 2000b, 2001). The notion of workplace culture and availability impacting on work-related alcohol and other drug use is supported by Lillibrige, Cox and Cross (2002, p226) in their research with nurses. They found that the availability and ease of access to drugs in the workplace were key drivers in nurses’ substance use. Pidd (2003) also found that certain employment arrangements, such as employment status (full-time, part-time or unemployed vocational students), workplace size and the presence of policies addressing alcohol and other drugs, can impact on work-related alcohol and other drug use. The role of work environment is further highlighted by the fact that, in 39% of work-related fatalities where alcohol was a contributing factor, the alcohol was consumed either at work or at a work-sponsored event (National Occupational Health and Safety Commission 1998, p18).

The NHMRC has found that risk factors for alcohol related work injuries include complex relationships between the individual and environment (1997, p32; 2001, p31). In terms of the aspects of the work environment which drive people to use alcohol or other drugs, Midford (2001, p53) highlights the work of Hagen, Egan and Eltringham (1992) who determined that pressure, stress, lack of control over work, equipment quality, competitiveness and frequency of workplace arguments were associated with higher alcohol consumption in certain occupations. In addition, Allsop and Pidd (2001, pp12-9) report that a range of factors such as, alienation, stress, work culture and structural features of the workplace, may impact on work-related AOD use.

4 | Data Collections

The issues outlined in this report highlight that there are serious reservations regarding the breadth and quality of data collections relating to alcohol and other drugs in the workplace. For instance, it is evident that blood alcohol concentration [BAC] is not a routine check in work-related fatalities – even those that are work-related road fatalities. Mitchell, Driscoll and Healey (2004) report that BAC was only available for 81.4% of Australian work-related road fatalities whilst other drug levels were available in only 46.2% of work-related road fatalities. In South Australian work-related fatalities in the period 1989-1992, BAC was available in only 80.8% of cases and information on other drug levels was only available for 27.2% of fatalities (National Occupational Health and Safety Commission 1999, pp30-1).
However, it must be acknowledged that in certain circumstances (such as delayed sample collection after death), the collection of accurate data regarding an individual’s alcohol or other drug levels may be hampered by technical concerns. It remains though that the lack of comprehensive, standardised data collection techniques allows for and supports an imprecise representation of alcohol and other drug related harm in the workplace. The paucity of reliable and valid data extends to nearly all facets of the problem of alcohol and other drugs in the workplace; injury and prevalence data, the impact of policies and interventions and more. This has serious implications for all levels of the response to this harm – if the true scope of the problem cannot be comprehended how can effective responses be developed?

CONCLUSION

This report has highlighted that the consistent theme with regard to workplace interventions is that further, well designed research needs to be undertaken to determine the effectiveness of these strategies for reducing alcohol and other drug related harm in the workplace. In addition, an insufficient evidence base from which to move forward hampers action. Inadequate data collections and the absence of baseline data will inevitably lead to less than desirable outcomes. Further impeding action in this area is a clear lack of action and consensus regarding the major issues and how best to address these. As outlined by ADCA (2000a), much of the evidence in Australia is anecdotal in nature and there are many ‘unknowns’. What is clear is that work-related alcohol and other drug use and related harms are under-researched and there is no ‘one size fits all’ approach to address the issues.

What must be remembered is that work-related alcohol and other drug use is not a problem isolated to the individual – it is a whole of workplace problem due to the breadth of harms and the potential for significant impacts. As such, alcohol and other drug-related harms in the workplace require more than a response levelled at the individual; it requires a holistic, comprehensive approach that is supported by all concerned.
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Appendix 2

Phase Two Summary Report

Survey Results
EXECUTIVE SUMMARY

Alcohol and other drug use present a significant burden to the community and as such signal a major public health concern. The workplace brings together people in society and reflects general health problems. Alcohol and other drugs cost individuals, industry and society through social and economic burden.

SafeWork SA and Drug and Alcohol Services South Australia are working in partnership to address the impact of alcohol and other drugs in workplaces through a joint research project. The project is aimed at assembling the existing evidence for the nature and extent of alcohol and other drug related harm in South Australian workplaces and recommended practice in preventing and responding to that harm.

The following report details the results of research undertaken for phase two of The Impact of Alcohol and Other Drugs in the Workplace project. This research phase is designed to identify the strategies South Australian workplaces use to prevent and respond to potential and actual alcohol and other drug related harm.

This exploratory research involved semi-qualitative telephone interviews with 110 South Australian workplaces to develop a broader understanding of the following key areas:

- Issues affecting workplaces in relation to alcohol and other drug related harm;
- Current strategies in place to respond to alcohol and other drug related harm in South Australian workplaces;
- The strategies workplaces are considering implementing to further respond to alcohol and other drug related harm;
- The strategies workplaces think have had the most impact in reducing alcohol and other drug related harm;
- Areas where workplaces want greater support.

Results indicate that workplaces are generally concerned about the issue of alcohol and other drug related harm. Workplaces in this research are most concerned about the potential impact that alcohol and other drugs may have on safety, with over seventy per cent of workplaces indicating concerns related to safety.

Workplaces utilise policy and a range of strategies to respond to alcohol and other drug related harm. Key findings from this research indicate that the majority of workplaces (96%) had a policy or at least one specific strategy in place to address alcohol and other drug related harm.
Workplaces generally used policies as a first line response to alcohol and other drug related harm with almost nine out of ten participating workplaces having a policy in place. Provision of an Employee Assistance Program or access to counselling services was the most common specific strategy utilised by workplaces. Alcohol and other drug testing programs, which were utilised by almost half of participating workplaces, followed this.

In addition to formal strategies such as testing and counselling services, workplaces employed a range of less formal, yet equally important, strategies in their response to alcohol and other drug related harm. Nearly a third of workplaces nominated a positive workplace culture as a protective factor against alcohol and other drug related harm. However, workplaces believed that testing and education had the most impact in actually reducing this harm.

Workplaces were particularly able to provide avenues where greater support could be provided. The key areas that workplaces want assistance with is clarification of their rights and responsibilities in relation to managing alcohol and other drug related harm in the workplace. Workplaces believed this could be achieved through advice, assistance, information and awareness.

Despite being concerned about alcohol and other drug related harm and generally wanting further assistance to respond, most workplaces were not considering implementing any additional strategies to enhance their existing responses. One of the challenges for future work in this area is to determine how best to harness workplaces concern about this issue and translate this concern into further action.

Responses from workplaces involved in this research provide many avenues from which to further address the issue of alcohol and other drug related harm in workplaces. This research also highlights the need for greater support to assist workplaces to enhance their current responses to alcohol and other drug related harm.
INTRODUCTION

The Impact of Alcohol and Other Drugs in the Workplace project is a joint initiative of SafeWork SA and Drug and Alcohol Services South Australia. The project seeks to assemble the existing evidence for the nature and extent of alcohol and other drug related harm in workplaces and recommended practice in preventing and responding to that harm. The project involves three linked phases of research:

■ Phase One: Literature Review
■ Phase Two: Targeted telephone survey
■ Phase Three: Stakeholder Workshop

The following report presents the results of phase two of this research project. Phase two comprised a targeted telephone survey of South Australian workplaces to identify the strategies in place to prevent and respond to potential and actual alcohol and other drug related harm in the workplace. This report presents an overview of the results of the survey together with analysis and discussion of these results.

1 | Methodology

1.1 Method
The research design was exploratory in nature and involved a descriptive, cross-sectional method. Data collection comprised a semi-qualitative telephone interview, a copy of which is attached (Appendix 2D). Responses were recorded in note form by the interviewer. Interviews were conducted with workplaces in three target industries (construction, transport and manufacturing) and were selected via a non-probability sampling approach, quota sampling, which is outlined further in section 1.2. A pilot of the survey was conducted in July 2005 from which adjustments were made to the question set. The survey commenced in August 2005 and all interviews were completed by the end of October 2005.

Due to the nature of the qualitative methodology utilised, the results of this research are not applicable to all workplaces and thus are not generalisable. The results do provide a useful snapshot of the experience of a small number of South Australian workplaces and can inform further research which may be extrapolated to cover a greater proportion of South Australian workplaces.
In order to ensure a range of perspectives were gained through this research, Health and Safety Representatives (HSRs) in the target industries involved in the telephone survey were contacted to ascertain their views on the impact of alcohol and other drugs in the workplace. Over 500 HSRs were contacted in September 2005 via email through the HSR register held by Workcover Corporation. A reminder was sent to all contacts two weeks after the initial request. HSRs were asked to respond to a brief set of questions which had been modified from the original set used with workplaces. Thirteen responses were received by mid-October. See Appendix 2B for results.

1.2 Sampling

The survey sample comprised workplaces in the construction, transport and manufacturing industries. The decision to survey a sample of target industries rather than a sample of all workplaces was based on the need to refine the scope of the project and direct the research to areas of need.

In selecting the target industries consideration was given to a number of issues. There is no clear basis in the available evidence for identifying which industries experience the highest levels of alcohol and other drug related harm. As a result, a decision was taken to examine those industries with the highest levels of occupational related harm, irrespective of cause. In addition, it was considered pertinent to align the target industries with state and national priority areas. The construction, transport and manufacturing industries have been consistently identified as high risk in terms of general health and safety concerns and appear prominently in Australian worker’s compensation statistics (see www.workcover.com).

The sampling approach involved identifying ‘high-risk’ and ‘low-risk’ workplaces within each industry cluster. This was determined through assessing overall workers compensation statistics for the companies. High risk workplaces were identified as those who had higher than industry average workers compensation claims in terms of numbers and costs, whilst low risk workplaces were lower than the industry average. The clusters included a cross-section of small, medium and large workplaces (based on Australian Bureau of Statistics definitions). The following matrix details the cells within the sample:

<table>
<thead>
<tr>
<th>Construction</th>
<th>Manufacturing</th>
<th>Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Risk</td>
<td>High Risk</td>
<td>High Risk</td>
</tr>
<tr>
<td>Low Risk</td>
<td>Low Risk</td>
<td>Low Risk</td>
</tr>
<tr>
<td>Small</td>
<td>Small</td>
<td>Small</td>
</tr>
<tr>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td>Large</td>
<td>Large</td>
<td>Large</td>
</tr>
</tbody>
</table>
A target of 90 participating workplaces was set based on the need for five workplaces in each of the 18 cells. A response rate of approximately 40% was anticipated requiring an initial database of 234 workplaces, which was supplied by Workcover Corporation. Sixty-nine workplaces were removed from this database for a number of reasons (including current investigations or prosecutions, insufficient contact details, duplicate listings, sole traders and no longer operating) leaving 165 workplaces eligible for participation.

Workplaces were contacted through a three-stage mailout commencing in August 2005.

1.3 Analysis
Data analysis was conducted using the computer software Statistical Package for Social Sciences (SPSS version 13.0). Data were analysed through a series of crosstabulations and using non-parametric statistical tests where appropriate. In addition to the use of the Statistical package for Social Sciences, qualitative data were analysed through input into word processing software to allow for identification of themes and repetition.

The question set and pattern of responses delineate a clear set of five domains of results. These can be simply expressed as follows and provide the focus for the presentation of results in this report:
- Identification of issues
- Current strategies
- Intention to respond further
- Strategies that have had greatest impact
- Areas for support

2 Description of the sample
The pool of potential participants was 165, of which 33.3% (n=55) either refused participation directly or were not pursued any further after several call-backs. One hundred and ten workplaces participated in the survey, representing 66.7% of the potential pool.

Table 1 indicates the distribution of completed interviews across the 18 cells; figures in brackets indicate the percentage of workplaces as a proportion of the potential participating workplaces in each category. The initial target was five interviews per cell; some cells were oversubscribed due to higher than expected participation rates.
Appendix 2: Phase Two Summary Report: Survey Results

Table 1: Distribution of workplaces

<table>
<thead>
<tr>
<th></th>
<th>Construction</th>
<th>Manufacturing</th>
<th>Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High Risk</td>
<td>Low Risk</td>
<td>High Risk</td>
</tr>
<tr>
<td>Small</td>
<td>5</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Medium</td>
<td>6</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Large</td>
<td>7</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>TOTAL (As % of potential category participants)</td>
<td><strong>18</strong> (60%)</td>
<td><strong>16</strong> (67%)</td>
<td><strong>21</strong> (68%)</td>
</tr>
</tbody>
</table>

Targets for participation across all risk and size categories were exceeded, except for the category of small businesses which fell three short of the target 30 workplaces.

It is important to consider the characteristics of workplaces that did not participate. Overall, 38.6% of high risk workplaces and 27.3% of low risk workplaces that were eligible to participate refused participation or were not pursued after several callbacks. Fifty percent of eligible small workplaces refused participation or were not pursued, compared with 35.5% of medium workplaces and 2.9% of large workplaces.

The initial sample provided by Workcover Corporation estimated the size of companies based on worker’s compensation levy amounts. As part of the data collection process, workplaces were asked how many people their organisation employed. Workplaces were then re-categorised based on this data and all results in this report refer to the actual company size. It was found that workplaces often varied from the estimated size provided in the original database with 21 being a different size to that originally indicated. This particularly impacted the small cells. The variations in size encountered are listed in table 2:

Table 2: Variations in company size

<table>
<thead>
<tr>
<th>Expected Size</th>
<th>Actual Size</th>
<th>Number of occurrences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>Medium</td>
<td>10</td>
</tr>
<tr>
<td>Small</td>
<td>Large</td>
<td>1</td>
</tr>
<tr>
<td>Medium</td>
<td>Small</td>
<td>3</td>
</tr>
<tr>
<td>Medium</td>
<td>Large</td>
<td>4</td>
</tr>
<tr>
<td>Large</td>
<td>Medium</td>
<td>3</td>
</tr>
</tbody>
</table>

1 Further information regarding sample characteristics, including non-participators, can be found in Appendix 2A.
2.1 Location
Twenty workplaces, representing 18.2% of the total number of participating workplaces, were identified as being located in a regional area.

2.2 Size
Workplaces were asked to report the number of employees to determine actual size. Based on these figures, small businesses (those employing less than 20 people) accounted for 24.5% (n=27) of the sample, whilst 44.5% (n=49) were identified as medium businesses (employing 20-199 people) and 30.9% (n=34) were identified as large businesses (employing 200 or more people). The median number of employees across all participating workplaces was 62.5.

2.3 Risk
Fifty per cent of workplaces (n=55) were identified as high-risk workplaces and 50% (n=55) were identified as being ‘low-risk’ workplaces.

2.4 Gender
Workplaces were asked what percentages of employees were male and female. The mean percentage of males in the workplaces was 82.8%; the mean percentage of females in the workplace was 17.2%. Just over three quarters (75.5%, n=83) of workplaces indicated that males comprised 75% or more of their workforce, 5.5% (n=6) workplaces indicated that the percentage of male employees in their workplace was 50% or less.

2.5 Age
Workplaces were asked what percentages of employees were in the following size categories: 15-24, 25-44, 45-54, and over 55. The mean percentage of employees aged 15-24 years was 12.9%, the mean percentage of employees aged 25-44 years was 49.2% and the mean percentage of employees aged 45-54 was 26.1%. The mean percentage of employees aged 55 or over was 11%. There was a significant correlation between the size of an organisation and the age profile of its workforce in that the larger the organisation the higher percentage of employees aged 15-24 years (Kruskal Wallis df= 2, p=.013, n=106).

2.6 Employment Status
Workplaces were asked about the employment status of their employees. The mean percentage of casual employees was 19.6%, the mean percentage of part-time employees was 3.4%, the mean percentage of full-time employees was 70.4% and the mean percentage of labour hire employees was 6.6%. A strong negative correlation was found between the percentage of casual employees and size of organisation – the larger the organisation the lower the percentage of casual employees (Spearman’s Rho r = -.246, n=105, p<.05).
2.7 Levels of Supervision
Thirty-two workplaces, representing 29.1% of workplaces, indicated that the level of supervision in their workplace was low, 40% (n= 44) reported that supervision was moderate and 30% (n=33) reported that supervision was high. The mean ratio of supervisors to staff members was 1:9.46 and 93.6% (n=103) of workplaces indicated that supervisors had contact with staff on a daily basis. A significant correlation between size of organisation and the ratio of supervisors to staff members was found – the larger the organisation, the more staff per supervisor (Spearman’s Rho r= .591, n= 98, p< .01).

2.8 Occupational Health and Safety Training
Workplaces were asked how often Occupational Health and Safety training was engaged in for management and operational staff. For senior and middle management occupational health and safety training was done mostly on an annual basis, whilst for operational staff, occupational health and safety training was done mostly ‘as required’. Seven workplaces, representing 6.4% of the sample, stated that occupational health and safety training was never engaged in for any of the designated groups.

3 Issues

Responses were obtained from all workplaces (n=110) to the question: “What are the main issues for your workplace in relation to employee use of alcohol or other drugs?” Multiple responses were allowed and 143 responses were obtained. Safety was the most frequently nominated issue for workplaces as shown in table 3 (figures in brackets indicate what percentage of workplaces in each size category nominated this response).

Table 3: Issues reported according to company size

<table>
<thead>
<tr>
<th>Size</th>
<th>Safety</th>
<th>Productivity</th>
<th>Absenteeism</th>
<th>Not an issue</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>17 (63%)</td>
<td>5 (18.5%)</td>
<td>3 (11.1%)</td>
<td>4 (14.8%)</td>
<td>4 (14.8%)</td>
</tr>
<tr>
<td>Medium</td>
<td>39 (79.6%)</td>
<td>4 (8.2%)</td>
<td>3 (6.1%)</td>
<td>5 (10.2%)</td>
<td>9 (18.4%)</td>
</tr>
<tr>
<td>Large</td>
<td>23 (67.6%)</td>
<td>4 (11.8%)</td>
<td>2 (5.9%)</td>
<td>4 (11.8%)</td>
<td>17 (50%)</td>
</tr>
<tr>
<td>TOTAL (% of all workplaces)</td>
<td>79 (71.8%)</td>
<td>13 (11.8%)</td>
<td>8 (7.3%)</td>
<td>13 (11.8%)</td>
<td>30 (27.3%)</td>
</tr>
</tbody>
</table>

There was no difference in the frequency of specific issues (e.g. safety, productivity etc) reported across the two (high and low) risk levels.

2 Note – results in this section should be interpreted with caution as respondents may indicate or recognise potential areas for concern in addition to actual areas of concern or problems they have experienced.
3.1 Safety
Workplaces generally expressed concern regarding alcohol and other drugs and their impact on safety in the workplace, with 71.8% of all workplaces nominating this (n=79). Over one-third (n=27) of those who nominated safety as an issue for their workplace reported that the use of machinery and/or equipment was a primary concern for them. These workplaces spoke of the danger associated with heavy machinery use such as cutting equipment, earthmoving equipment and forklifts. Workplaces were concerned with both the impact on the equipment user if affected by alcohol or other drugs and the potential to cause injury to other staff or members of the public. Some workplaces mentioned specific incidents that had occurred which had compromised safety or resulted in injury, but more often workplaces discussed their concern for the potential for accident or injury to occur.

Responses relating to safety in the workplace were frequently (n=13) framed in terms of situations or environments being ‘dangerous’ or people endangering themselves or others. Some workplaces felt that their workplace or industry was hazardous at the best of times and as such, the implications of being under the influence of alcohol or other drugs were potentially very serious.

3.2 Productivity
Workplaces were concerned with a number of factors related to productivity and absenteeism. These include; non-attendance, a drop in productivity due to being affected by alcohol or other drugs and making mistakes on the job. Workplaces who indicated that their main issue was productivity related explained this in terms of staff being:
- ‘no use to us’,
- ‘unreliable’,
- ‘not being as productive’,
- ‘not turning up to work’,
- ‘absenteeism from hangovers’, and
- ‘calling in sick’.

In addition, workplaces spoke of losing time if there was a problem related to alcohol or other drugs and concerns regarding staff performance.

3.3 Other Issues
Some workplaces (11.8%, n=13) stated that alcohol and other drugs were not an issue, or not a concern for their workplace at all. Of those who stated that they didn’t believe alcohol or drugs presented any issues for them, they explained this in terms of being ‘lucky’, being a ‘small group’, or simply that it just wasn’t an issue in their workplace.

Five workplaces referred to tensions they face when dealing with alcohol and other drug related issues. Three of these, two of which were regional, indicated that workforce availability issues precluded them from addressing problems. These workplaces were concerned about the limited pool of potential employees from which they had to draw on. In addition, two workplaces described a ‘moral dilemma’ which impacted on their ability to address alcohol and other drug-related problems as they did not want to penalise a good workforce who may occasionally use certain substances on a recreational basis.
4 | Current Responses

Workplaces were asked several questions pertaining to current strategies in place to respond to alcohol and other drug related harm. Over 95% of workplaces (n=105) indicated that they had a policy and/or at least one specific strategy in place to address alcohol or other drugs. The following section delineates workplaces’ responses regarding the policies and strategies they utilised.

4.1 Policy

The most common response workplaces utilised were alcohol and other drug policies with over 88% (n=97) of all workplaces having a policy in place. Table 4 indicates the types of policies (written, informal or no policy in place) according to company size and risk status (figures in brackets indicate percentage within the size and risk category).

Table 4: Type of policy according to size and risk status

<table>
<thead>
<tr>
<th>SIZE</th>
<th>RISK</th>
<th>Informal Policy</th>
<th>Written Policy</th>
<th>No Policy</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMALL</td>
<td>High Risk</td>
<td>2 (20%)</td>
<td>6 (60%)</td>
<td>2 (20%)</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Low Risk</td>
<td>9 (53%)</td>
<td>5 (29.4%)</td>
<td>3 (17.6%)</td>
<td>17</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>11</td>
<td>11</td>
<td>5</td>
<td>27</td>
</tr>
<tr>
<td>MEDIUM</td>
<td>High Risk</td>
<td>1 (3.8%)</td>
<td>21 (80.8%)</td>
<td>4 (15.4%)</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>Low Risk</td>
<td>4 (17.4%)</td>
<td>16 (69.6%)</td>
<td>3 (13%)</td>
<td>23</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>5</td>
<td>37</td>
<td>7</td>
<td>49</td>
</tr>
<tr>
<td>LARGE</td>
<td>High Risk</td>
<td>1 (5.3%)</td>
<td>17 (89.4%)</td>
<td>1 (5.3%)</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Low Risk</td>
<td>0 (-)</td>
<td>15 (100%)</td>
<td>0 (-)</td>
<td>15</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>1</td>
<td>32</td>
<td>1</td>
<td>34</td>
</tr>
</tbody>
</table>

The majority of workplaces (72.7%, n=80) had written policies in place to address alcohol and other drug related harm. No major difference was observed between high risk and low risk workplaces in terms of having a policy but there was a difference in the type of policy. High risk workplaces were more likely to have written policies and less likely to have an informal policy (chi square = .037). A significant positive correlation was found between the size of an organisation and the existence of any policy, in that larger organisations were more likely to have a policy (Mann Whitney U z=-2.293 p=.022 n=108); and that policy was more likely to be written than informal (Mann Whitney U z=-4.277 p=.000 n=96).

All workplaces with written policies were asked how long the policy had been in place, results are outlined in figure 1. Most workplaces had their written policies in place for a duration of five years or more.
Whilst the majority of workplaces had written policies in place to address alcohol or other drugs, 17 workplaces had informal policies in place. Informal policies were described as ‘Everybody knows they’re not allowed [to use alcohol or other drugs] at work’, to more specific descriptions such as ‘Total ban on drugs and alcohol, when they join they are told’.

Workplaces were asked to describe their workplace drug and alcohol policy, 22.7% (n=22) described their policy as being ‘zero tolerance [to alcohol and other drugs]’. Other descriptions highlighted conditions set out in the policy, namely the company position on alcohol or other drug use and associated issues. Of those who had a written drug and alcohol policy, one quarter (n=20) had some form of training associated with the policy.

Workplaces with a written policy were asked how staff were made aware of the policy. Workplaces were able to nominate up to 4 methods of policy awareness and 151 responses were received. Results are outlined in figure 2.
The most common method of raising staff awareness of the workplace alcohol and other drug policy was through the induction process followed by inclusion in an employee handbook. The third most common method of creating policy awareness was by having employees sign a copy of the policy at their employment. Two workplaces with a written policy did not nominate any methods of creating policy awareness.

Several significant differences were observed across the risk and size categories in how companies made staff aware of policies. In excess of 60% (n=20) of large workplaces and 59.5% (n=22) of medium workplaces who had a written policy used the induction process for policy awareness, whereas no small workplaces nominated this as a form of policy awareness they used. Meetings were more frequently nominated by high risk workplaces as a mechanism for raising policy awareness, (29.5%, n=13 v low risk 11.8%, n=4).

Workplaces were asked what would happen if the workplace drug and alcohol policy was breached (informal or formal policy). Eighty-seven workplaces provided information in response to this question of which 18.4% (n=16) indicated that a breach of the policy would result in instant dismissal. No differences were observed across risk or size categories for instant dismissal. A further 34.5% (n=30) indicated that if the policy was breached it would depend on the severity of the breach or other circumstances surrounding the breach as to how it would be handled.

Fifty-nine workplaces with written policies were able to provide information as to why that policy was in place (see figure 3). The most common reason provided was because workplaces were concerned about safety, with 21.3% (n=17) nominating this.

![Figure 3: Reasons for policy implementation](chart)

Comments from workplaces reflected a range of opinions as to the usefulness of policy as a tool to address alcohol or other drug related issues in their workplace. Almost three-quarters of workplaces (n=58) with a written policy in place indicated that they had found the policy to be useful in addressing alcohol and other drugs in their workplace. Some workplaces found that the policy was useful in itself as a deterrent; others saw it as something that was ignored, whilst others believed it need to be revisited often to keep the issue at the forefront. Many workplaces (n=18) believed the policy was useful because of its role in
outlining responsibilities and consequences. A selection of comments from workplaces is provided below to highlight the range of opinion and experiences conveyed:

“If you have issues we can help. It’s an effective deterrent; it’s not about making judgements or changing things that are socially acceptable”

“It’s the guidelines for everybody, you can’t have a rule that nobody knows about”

“Most people acknowledge it as a requirement of the industry”

“If we were blessed with a huge population of potential employees we could use it to its fullest extent. We’re damned if we do and damned if we don’t”

“It is useful but it’s a static document that’s left on the shelf and forgotten. If it was a mandatory requirement it would be easier”

“Of course it is [useful]. We cannot and will not deviate from that at all”

“You’ve got to cover yourself with that type of thing”

“Puts the fear of God into people, simple as that”

“Not only useful but an absolute necessity”

4.2 Strategies

Workplace alcohol and other drug policies generally provide an overarching framework through which specific strategies can be implemented to address alcohol and other drug related harm. Workplaces utilised a range of specific strategies to address alcohol and other drug related harm. Most workplaces (n=96) had at least one strategy (separate from having a policy) in place to address alcohol or other drug related harm. Eight workplaces had a strategy in place but did not have a policy in place.

The two most common strategies utilised by workplaces were counselling services (falling broadly under the category of ‘Employee Support Strategies’) and testing programs. Each will be discussed in depth followed by an examination of other strategies utilised. Figure 4 demonstrates the breadth of strategies nominated.

![Current Strategies to Address Alcohol and Other Drugs](image)

Figure 4: Current strategies
4.2.1 Employee Support Strategies

Workplaces utilised a range of strategies which broadly constitute support-type services. These include employee assistance programs, other counselling services and health and medical programs. Overall, the most frequently utilised specific strategy was provision of counselling services for staff (including Employee Assistance Programs - EAPs) with 59.1% (n=65) of all workplaces having this in place.

Comments from workplaces regarding the usefulness of EAPs and counselling services were generally positive. Several workplaces (n=10) commented that they felt the service was useful due to the simple fact that it was being utilised by staff. The following comments show how some workplaces have found these services:

“Absolutely vital. Extremely useful. One of those things, it works – it works very well”
“Brilliant. Served its purpose, we use it due to the time factor to counsel employees”
“I’d rather get someone on the straight and narrow, costs too much to get a new employee”

Under-utilisation of EAPs or counselling services were the only negative comments made by workplaces about these services. One workplace hypothesised that this was because staff didn’t want people telling them what to do whilst another commented that it was difficult for staff to have trust in the service. Issues of access were raised, with two regional workplaces commenting that restricted services in their area resulted in a lack of appointments available.

Health and medical programs were utilised by a further 18.2% (n=20) of all workplaces. Descriptions of these programs ranged from simple medical screening to actively providing access to Quit services and health promotion campaigns.

4.2.2 Testing

Alcohol or other drug testing was the second most frequently utilised strategy, with 46.4% (n=51) of all workplaces indicating that they had a testing program. Over 90% (n=46) of workplaces that employed testing had a written policy in place addressing alcohol or other drugs. Large organisations utilised testing programs more than medium or small workplaces; 76.5% (n=26) of all large workplaces employing a testing program compared with just over 40% (n=20) of medium workplaces and 18.5% (n=5) of small workplaces. A significant correlation was found between workplace size and testing in that large organisations utilised testing more (Mann Whitney U test z=14.991, p=.000, n=108). No significant differences were observed in the prevalence of testing across risk levels.
Workplaces that had implemented a testing program were asked what substances were tested for and 49 workplaces provided responses. Just over half of these workplaces (51%, n=25) tested for drugs only, whilst 44.9% (n=22) tested for both alcohol and drugs and 4.1% (n=2) tested only for alcohol.

Workplaces who utilised testing were also asked whether the testing was random, pre-employment, for cause or another type of testing. Forty-nine workplaces provided information in response, results are shown in table 5 (figures in brackets indicate what percentage in the size/risk category nominated that form of testing). Over half of those who provided responses employed more than one form of testing (55.1%, n=27). Of those who utilised only one form of testing (n=22), the majority used pre-employment testing (59.1%, n=13).

Table 5: Form of testing according to size and risk status

<table>
<thead>
<tr>
<th>SIZE</th>
<th>RISK</th>
<th>Random (%)</th>
<th>Pre-employment (%)</th>
<th>For Cause (%)</th>
<th>Other (%)</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMALL</td>
<td>High Risk</td>
<td>1 (10%)</td>
<td>1 (10%)</td>
<td>1 (10%)</td>
<td>0 (-)</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Low Risk</td>
<td>2 (11.8%)</td>
<td>0 (-)</td>
<td>0 (-)</td>
<td>1 (5.9%)</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td>3 (11.1%)</td>
<td>1 (3.7%)</td>
<td>1 (3.7%)</td>
<td>1 (3.7%)</td>
<td>6</td>
</tr>
<tr>
<td>MEDIUM</td>
<td>High Risk</td>
<td>6 (23.1%)</td>
<td>7 (27%)</td>
<td>7 (27%)</td>
<td>1 (3.8%)</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Low Risk</td>
<td>4 (17.4%)</td>
<td>6 (26.1%)</td>
<td>1 (4.3%)</td>
<td>0 (-)</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td>10 (20.4%)</td>
<td>13 (26.6%)</td>
<td>8 (16.3%)</td>
<td>1 (2%)</td>
<td>32</td>
</tr>
<tr>
<td>LARGE</td>
<td>High Risk</td>
<td>9 (47.4%)</td>
<td>12 (63.2%)</td>
<td>10 (52.6%)</td>
<td>0 (-)</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>Low Risk</td>
<td>7 (46.7%)</td>
<td>8 (53.3%)</td>
<td>8 (53.3%)</td>
<td>2 (13.3%)</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td>16 (47.1%)</td>
<td>20 (58.8%)</td>
<td>18 (52.9%)</td>
<td>2 (5.9%)</td>
<td>56</td>
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</table>

Workplaces were able to provide comments regarding testing and through this it became evident that workplaces faced several problems associated with testing. These problems are highlighted by comments made by workplaces:

“It’s an invasion of privacy”
“No investigation or evaluation done”
“Invasion of privacy by company to do it”
“But people can get around it though and also false positives are problematic”
“Couldn’t get support of union for two years”
“Don’t have zero tolerance for cannabis as global shortage ... means recruitment is very difficult”
“Couple of positive tests have come back but it’s costly”
“Have a breathalyser machine but it hasn’t been calibrated so it’s not calibrated for use”
Some workplaces (n=3) utilised testing programs because it was one way of showing they were doing something to address alcohol or other drug issues. This mindset is highlighted by the following comments:

“If we didn’t do it [testing] we’d certainly be seen to be naïve and possibly even negligent if we had an accident that was drug or alcohol related”

“It [testing] enables me to sleep at night”

“[we do it for] safety and need proof of doing something to address safety. It’s the only way we achieve a good result”

It was found that workplaces who utilised testing generally had more formal strategies (e.g. EAP or counselling services, health or medical programs etc) in place than workplaces who did not use testing. Those that did not use testing more frequently utilised the less formal strategies of supervision, culture or informal policies.

4.2.3 Other Strategies
In addition to formal strategies, workplaces also described a range of other formal and informal strategies that assisted their response to alcohol and other drug related harm. The most common of these strategies was workforce culture. Over 30% of workplaces (n=34) indicated that they felt the culture of their workplace was a factor that positively impacted on alcohol and other drug related issues.

Workplaces who identified the culture of their workplace or workforce as a strategy to reduce alcohol or other drug related harm were asked to describe this further. These descriptions were generally related to the type of people they felt they had employed and a sense of knowing the staff and being available to communicate. Ten workplaces also identified that a family environment was a factor in the workplace culture that was beneficial in addressing alcohol and other drug related issues. Selections of comments from workplaces are outlined to capture their actual experience:

“Hands-on management – lots of contact with staff. Directors see every person who works in the company every day. Good workforce culture, not the type of guys that would come to work affected by drugs or alcohol”

“Family business has had a prevailing influence on staff”

“Stable workforce – long term staff who are mostly older, responsible, family people”

“Very loyal staff with low turnover. Staff speak with management, high levels of trust”

“Very close knit group, active informal relationship networks. People inform management if problems”
These comments provide a sense of what workplaces are referring to when describing factors related to workplace culture. Workplaces also identified culture through terms such as:


A further 18.2% (n=20) of workplaces nominated the level of supervision in their workplace as a strategy. These workplaces discussed how when staff were under close supervision it was easier to see if there were any problems and potentially easier to detect if someone is under the influence of alcohol or other drugs. Close supervision was also seen as a deterrent to being under the influence of alcohol or other drugs whilst at work.

Other strategies identified by workplaces included additional policies (other than specific alcohol and other drug policies). Almost 15% (n=16) of workplaces with additional strategies in place nominated other policies as an additional strategy they used. Fourteen workplaces also indicated that specific work practices in their workplaces impacted positively on alcohol or other drug related issues. Examples of work practices that were seen to have an impact include: no late-early shifts, four day on-four day off system, reporting system, allowing people to decline shifts with no questions asked, buddy systems and selective recruitment practices.

4.3 Multi-Faceted Approaches

Many workplaces utilised a combined approach to respond to alcohol and other drug related harm. Policy was generally used as the first level response to alcohol and other drugs with 97 workplaces having a policy in place. Over 90% of workplaces (n=88) with a policy in place implemented an additional strategy (or multiple strategies) to address alcohol or other drug related harm. Nine workplaces with policies in place utilised the policy in isolation – they did not have any further strategies to address alcohol and other drug related harm. Eight workplaces utilised strategies but did not have a policy in place.

Workplaces with a written policy were more likely to have multiple strategies (defined as more than one specific strategy) in place with 78.8% of these having multiple strategies, whereas only 35.4% of workplaces with an informal policy had multiple strategies in place. Almost three quarters (n=41) of high risk workplaces had multiple strategies in place compared with 60% (n=33) of low risk workplaces. Nearly 30% (n=8) of small workplaces had multiple strategies in place compared with 71.4% (n=35) of medium workplaces and 91.2% (n=31) of large workplaces\(^3\). Over 96% (n=49) of workplaces who utilised testing implemented this in conjunction with at least one other strategy.

\(^3\) When referring to multiple strategies in this section, policy has not been counted as a strategy – therefore to qualify as having multiple strategies in place workplaces must have more than one specific strategy in place.
5 | Intention to Respond

Responses were obtained from all workplaces (n=110) to the question: “Are there any strategies you are considering implementing?” Multiple responses were permitted and 122 responses were obtained. Figure 5 outlines workplaces intention to implement additional strategies based on their risk status.

The majority of workplaces indicated that they were not considering implementing any additional strategies to address alcohol or other drugs in their workplace (70%, n=77). In excess of 20% (n=16) of all workplaces that were not considering further strategies indicated that the reason for this was they didn’t feel it was an issue for them or they felt their current strategies were adequate given their situation. A further 5.2% (n=4) indicated that resources (financial or otherwise) prevented them from implementing further strategies. Of those that weren’t considering implementing further strategies, one did not have a policy or any strategies in place; 10.4% (n=8) had a policy in place but no strategies; 24.7% (n=19) had a strategy in place (with or without a policy to go with it) and 63.6% (n=49) had multiple strategies in place (with or without a policy to go with it).

A strong positive correlation was found between the number of employees in an organisation and whether they were considering further strategies, in that the larger an organisation, the more likely it was to be considering further strategies (Mann Whitney U z=-3.852, p=.000, n=108). In addition, it was found that high risk organisations were more likely than low risk organisations to be considering implementing further strategies (chi square continuity correction of significance = .004). Table 6 presents results for workplaces intention to respond according to size (figures in brackets indicate what percentage in size category gave that response).

Table 6: Intention to respond according to size

<table>
<thead>
<tr>
<th>SIZE</th>
<th>Considering strategies</th>
<th>Not considering strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>2 (7.4%)</td>
<td>25 (92.6%)</td>
</tr>
<tr>
<td>Medium</td>
<td>15 (30.6%)</td>
<td>34 (69.4%)</td>
</tr>
<tr>
<td>Large</td>
<td>16 (47.1%)</td>
<td>18 (52.9%)</td>
</tr>
</tbody>
</table>
Thirty per cent (n=33) of workplaces indicated that they were considering implementing further strategies to respond to alcohol or other drug related harm in their workplace. Of those considering further strategies, 36.4% (n=12) were considering more than one additional strategy. The most common reason for considering further strategies was to strengthen or enhance existing responses (39.4% n=13). Figure 6 shows the strategies that were being considered for implementation by workplaces according to risk levels.

Figure 6: Strategies being considered

The most frequently nominated strategy that workplaces were considering was testing, with over two-thirds (n=22) of those considering further strategies nominating this. Of these, 81.8% (n=18) were ‘high risk’ workplaces. Over 60% (n=14) of those considering testing were of medium size whilst 31.8% (n=7) were large and 4.5% (n=1) were small. Half of those considering testing (50%, n=11) nominated this as the only additional strategy that they were considering implementing.

The next most frequently nominated strategy that workplaces were considering was policy (18.2%, n=6), whilst a further 18.2% (n=6) nominated health or medical programs. Other strategies nominated included training (n=3), implementation of an Employee Assistance Program or other counselling program (n=2), and other strategies such as a newsletter, information provision and awareness raising.

6 | Impact

Workplaces were asked what strategies they thought had resulted in the most impact in reducing alcohol and other drug related harm. All workplaces responded to this question, multiple responses were allowed and 151 responses were received. Figure 7 outlines the strategies that workplaces believed had impacted on alcohol and other drug related harm in workplaces.
There were no differences observed across the three size categories in terms of the strategies nominated. The only major difference noted in the risk level categories was that high risk workplaces nominated policy twice as frequently as low risk workplaces as having the most impact (n=14 v n=7). Four respondents indicated that nothing had worked to reduce alcohol and other drug related harm in workplaces, whilst a further 11 were unsure what, if any, strategies had any impact. Over 85% of workplaces (n=95) were able to nominate at least one strategy that they believed had reduced alcohol and other drug related harm. Twenty-six workplaces (27.4% of those who responded to this question) reported testing programs as having the most impact in reducing alcohol and other drug related harm. Of those who nominated testing as having the most impact, 30.8% did not currently have a testing program in place. Other strategies identified as having an impact were education and awareness strategies, nominated by 23.2% (n=22), policy, nominated by 22.1% (n=21) and disciplinary processes by 21.1% (n=20).

Workplaces who nominated specific strategies as having an impact in reducing alcohol and other drug related harm were asked why they believed the strategy they nominated had an impact. Forty-six workplaces nominated testing programs or disciplinary processes and these responses were frequently framed around the ‘deterrent’ effect of these strategies. More than three quarters (n=35) of workplaces who nominated testing or disciplinary procedures discussed these as being a deterrent in some way. The comments below provide an indication of this theme:

“[testing] makes people think twice”
“People know you are serious if you do testing”
“Fear factor”
“If you don’t comply, you don’t work”
“Instant dismissal sends out a message”
“Is your job worth coming in drunk?”
“When someone gets caught out it sends a huge message to the rest of them”
“If you want a job you don’t drink, it really is the big stick over their heads”
Support

Workplaces were asked what support is required to assist them to further address alcohol and other drug related harm. All workplaces provided a response to this question, multiple responses were allowed and 149 responses were received. Figure 8 shows responses to this question according to risk level.

Figure 8: Areas for support according to risk level

Eighty-three workplaces gave 122 responses regarding what support they would like. In addition to the responses outlined in figure 8, 19.1% of workplaces (n=21) were unsure what support could be provided to workplaces to assist them to respond to alcohol and other drug related harm and 5.5% (n=6) stated that no further support was required. Of those who were unsure of any areas where support was required, seven stated that this was because alcohol and drugs are not an issue for their workplace and five indicated that they had not given the issue any thought.

Figure 8 also demonstrates differences found across risk levels. High risk workplaces were slightly more likely to suggest areas for support with 55% (n=68) of suggestions coming from high risk workplaces and 45% (n=54) coming from low risk workplaces. Figure 8 shows that high risk workplaces more frequently nominated several areas for support. Only one high risk workplace indicated that no support was required, compared to five low risk workplaces.

The most frequently nominated forms of support were advice or assistance with 34 workplaces nominating these. Of these, 32.4% (n=11) indicated that they wanted specific assistance with testing. Specifically, workplaces wanted their rights and responsibilities clarified and clear guidelines on what they can do and how to do it. A further 17.6% (n=6) of those who nominated advice or assistance, specifically mentioned increased support in the form of advice or assistance for small businesses to address alcohol and other drug
related harm. These workplaces acknowledged that small businesses operate in a complex environment and as such require special assistance.

Of those nominating advice or assistance as a potential support mechanism, 17.6% (n=6) indicated that it would be beneficial if workplaces had access to a central body where they could access specific advice relating to workplace alcohol and other drug issues. Six workplaces suggested that the media provides an avenue that could be utilised to provide greater focus on workplace alcohol and other drug issues.

Legislation and other government action were suggested by seventeen workplaces as potential support mechanisms. These workplaces reported that it would be easier to respond to alcohol and other drugs if legislation was in place to make it mandatory across all workplaces to address issues. They believed this would make it easier as the impetus is then being driven by the government rather than workplaces, possibly creating a more equal situation where all workplaces had to deal with the issue. Greater support from government departments in a general sense was also suggested as a useful support mechanism.

The suggested support areas of advice, assistance, awareness, education, information and resources are quite similar and constitute a dense set of complex opinions from workplaces. However, a consistent theme emerged from all responses to the question regarding support and this was that workplaces want clarity; clarity across a whole range of issues from the simplistic, such as what information is available and where to access it, to more complex concerns such as when they can test people, how they can test and whose responsibility it is to address alcohol and drug issues.

Several workplaces (n=7) advocated for a change of responsibility, or greater accountability, in some sense. There were three key areas where these workplaces suggested change should occur: employees should take responsibility of the problem, or employers should take responsibility or the government should take responsibility for addressing alcohol and other drug related harm in workplaces.

It was observed that workplaces who had testing programs in place generally advocated more formal support mechanisms such as legislation, education and responsibility changes, whilst those who did not use testing suggested more passive support measures such as advice, assistance or no areas for support.

Responses to the question regarding support highlight that workplaces experience a sense of confusion regarding a range of issues associated with workplace alcohol and other drug related harm. This confusion stems from not knowing the extent of the problem across workplaces, not knowing where they stand or what to do and not knowing where to access help to address these problems. This sense of confusion is best conveyed through the words of workplaces:
“Everyone’s aware of the problem but not exactly aware of whose responsibility it is”

“Advice and support - somewhere you can call for someone to tell you where you stand”

“Awareness of how to detect if it is a problem in the workplace? What services exist? Legal issues - where do employers stand? It’s a very grey area at the moment. What support will companies get to prevent issues occurring?”

“Need to know exactly what we are able to do, most industries are unclear legally what will stand up?”

“Need to know first and foremost the legalities of what we’re required to do and some tips on how”

8 Other Comments

Workplaces were invited to provide any other comments in relation to alcohol and other drug related harm in the workplace. Respondents used this opportunity to provide significant comments, many of which were positive feedback to this study. The range of comments made at the conclusion of the interview demonstrate the breadth of problems and concerns experienced by workplaces in relation to alcohol and other drugs.

Workplaces discussed their perception of alcohol and other drugs problems in the workplace, demonstrating conflicted opinions. Some workplaces believed it to be simply a non-issue, others believed it to be a serious issue warranting greater focus whilst others were unsure of the extent of the problem.

‘It’s a prime industry for people to experience drug and alcohol problems but I’ve never seen it. In my time I’ve not seen any drug or alcohol issues in construction. It’s very rare frankly to find people on site affected by alcohol. Drugs are a different problem as you can’t tell.’

The theme of not being sure what responsibilities workplaces had in relation to alcohol and other drugs was also reflected in their further comments. Two workplaces expressed particular concern about the legal implications of not addressing alcohol and other drugs. Only one workplace expressed concern that the research would lead to changes in legislation that would place a greater imposition on workplaces to address issues.

Workplaces also discussed a range of problems they had experienced whilst addressing alcohol and other drug issues. These included:
“When testing was introduced, had some issues with staff not being happy ...”
“Union makes it difficult to address, union has an impact on the way builders do business”
“Unions are the major stumbling block, all care and no responsibility, they don’t employ people”
“Tension between zero tolerance and 0.05 [BAC] driving limit”
“Did have an incident where employee was involved in drugs and terminated for another reason as couldn’t test. Made it very hard for us, we knew what was going on but couldn’t do anything about it at the time”
“Other companies haven’t addressed alcohol and drugs and are competing for the same work but haven’t had the costs of addressing it. A lot of companies are not complying - there’s no supervision. Random checks are no good because the word gets out [referring to random roadside checks in the transport industry].

Several workplaces (n=9) indicated that alcohol is provided to staff at the workplace. Workplaces mediate the potential risks arising from this through strategies such as limiting the provision of alcohol or a set number of drinks per person or giving staff alcohol to take home.

9 | Discussion

What are the main concerns for workplaces?
Workplaces involved in this research were generally interested in the issue at hand. There appeared to be a motivation for workplaces to participate in the research as indicated by the higher than expected survey response rate of 67%. Workplaces showed concern for the issues raised throughout the course of the interviews and provided generally positive feedback regarding the research.

Workplaces were rarely dismissive of the issue of alcohol and other drugs and generally recognised the inherent risks associated with alcohol and other drug use impacting on the workplace. This is demonstrated through the prominent theme of safety related concerns in responses. Workplaces’ concern for safety and productivity are echoed in the literature regarding the impact of alcohol and other drugs on workplaces. Major harms in workplaces related to alcohol and other drugs include fatalities, injuries and productivity related concerns. The literature suggests that alcohol and other drugs are contributing factors in approximately 6.4% and 3.2% of work-related fatalities in South Australia respectively (National Occupational Health and Safety Commission 1999). In addition, it is estimated that alcohol and other drugs are implicated in 3-11% of workplace injuries (National Health and Medical Research Council 1997) and result in significant costs due to absenteeism and reduction of available workforce (Collins & Lapsley 2002). Whilst this is the most
comprehensive data available, it must be noted that population level changes in patterns of use over time may have impacted on the levels of these harms.

The prominence of safety concerns in workplaces provides one avenue for further addressing alcohol and other drugs. Indeed some workplaces acknowledged that it was more appropriate to drive the issue as a safety message rather than a punitive approach.

**What are the main strategies workplaces use?**

A range of strategies are described in the literature that workplaces can implement to address alcohol or other drug related issues. These include workplace alcohol and other drug policies (as a first-line response), and specific strategies such as controls on use (including testing), health promotion activities, employee assistance programmes and other counselling. Workplaces involved in this study had implemented many of these strategies. Nearly all workplaces had at least one strategy in place to address alcohol and other drugs in their workplace.

Policy can be conceptualised as an overarching framework through which specific strategies are implemented to address alcohol and other drug related harm. Policy was the most common response workplaces used to address alcohol and other drugs. The Alcohol and Drugs Council of Australia [ADCA] (2000a) notes that even though some workplaces may not have a formal policy in place, in practice all workplaces have some form of policy even if it is an unwritten, unspoken, ‘common knowledge’ agreement. This was generally reflected in workplaces responses regarding their policies, with the exception of 13 workplaces who had no policy. A number of workplaces (seventeen) had informal policies in place as described by ADCA.

Where policies were in place, most workplaces utilised at least one method of making staff aware of the policy’s existence. However, simply having a policy and staff knowing that it exists does not mean that the policy is effective or useful in achieving its intended purpose. This is supported by Zinkiewicz and colleagues (2000) who suggest that there must be adequate dissemination of the policy and education regarding it in the workplace. Some workplaces identified that their policy was static, not enforced or followed.

Support-type strategies such as Employee Assistance Programmes and other counselling services were widely supported by workplaces with 65 offering these services to their employees. Despite a lack of evidence for the effectiveness of these strategies in workplaces as a specific setting, evidence from other domains suggests the provision of these services is a worthwhile avenue for further intervention. In addition, workplaces looked favourably at these strategies as they provide benefits to staff beyond simply addressing alcohol and other drug issues. A number of workplaces (n=8) indicated that EAP or counselling services were available to the families of staff in addition to staff themselves.
Testing programs were widely implemented across the workplaces involved in this study. Just under half of all workplaces involved already had testing in place and a further 20% were considering implementing a testing program indicating workplaces’ support for this strategy to reduce alcohol and other drug related harm. This support is not reflected in the literature which consistently highlights that testing is not an appropriate mechanism for intervening in workplace alcohol and other drug use.

There are many problems associated with testing, some of which were recognised by workplaces involved in this research. However, there was clear support from workplaces for testing as a deterrent measure against alcohol and other drugs despite this being at odds with the literature. In particular, Crow and Hartman (1992) note that testing may simply result in people changing their consumption to avoid detection and in this way testing is not acting as a deterrent, it is merely shifting the problem.

Interestingly, workplaces that did use testing generally had more formal strategies in place than those who did not test. These workplaces also nominated more formal support measures than workplaces who did not test who nominated passive support measures. This may indicate that workplaces who use testing are more accepting of formalised measures in general as a response to alcohol and other drug related harm.

A positive workplace culture was frequently identified by workplaces as a strategy to reduce harm arising from alcohol or other drugs. From workplaces’ comments it can be seen that a positive culture may be a protective factor for workplaces, reducing alcohol or other drug harm by fostering open communication, positive relationships and a supportive environment. This notion is consistent with the literature. Trice and Sonnenstuhl (1990) note that “Work organizations [sic] are very prominent cultural entities and, as such, embrace their own drinking norms, rationales and social controls”. In this way, workplace culture can be a protective, mediating factor against alcohol or other drug related harm. Whilst workplace culture can also be recognised as a contributing factor for alcohol and other drug related harm (Pidd 2005), workplace culture was generally identified as a specific strategy to reduce alcohol and other drug related harm by workplaces involved in this research.

What support do they want?
Workplaces conveyed a general sense of confusion about most issues associated with alcohol and other drug related harm when asked about areas they feel support is required. Workplaces felt that there is a paucity of information available to them about workplace alcohol and other drug issues and if it is available then they don’t know how to access it. In addition, workplaces felt that a lack of focus on workplace alcohol and other drug issues is compounding their inadequate understanding of the associated problems and how to address them.

It is evident from workplaces’ comments that they at least want more information, clear guidelines and a legal framework (which they understand) within which to operate.
consistent theme throughout the interviews with workplaces was their lack of understanding on a range of issues related to alcohol and other drugs. It is therefore not surprising that workplaces want greatest support in the areas of; education, training, awareness, media campaigns, information, resources, advice and assistance. Workplaces clearly would like greater clarification and this may assist them to be more able to respond further to alcohol and other drug related harm.

It was interesting to note that some workplaces wanted a tighter legal framework to assist them to respond to alcohol and other drug issues in the workplace. At present there is no comprehensive legislative framework in Australia to mandate workplace policies or other formal responses aimed at alcohol and other drugs. Some workplaces in this study felt that if there was such a framework then the way in which they respond would be clearer and all workplaces would be on an even playing field. In addition, a legislative obligation to respond eliminates the need for individual workplaces to devise their own response and some workplaces felt that this would make it simpler to put strategies in place.

**What do they think works and how does this tie in with what they're doing?**

According to the workplaces involved in this research, the strategies which have the most impact in reducing alcohol and other drug related harm in workplaces are testing, education, policy and disciplinary processes. These strategies are generally consistent with the strategies that workplaces are already utilising, those they are considering and the areas where they would like support. It may be useful then to consider targeting further support to the areas that workplaces have specified.

**What are they considering and why?**

Workplaces were generally not considering implementing further strategies, with 70% not considering any additional strategies. The reasons underpinning why workplaces are not considering further strategies are somewhat unclear. It is possible to hypothesise a number of reasons for this. Firstly, it may be indicative of the requirements placed on workplaces which they may see as unrelated to their core business – making a profit and staying in business. Workplaces also may see alcohol and other drugs as a periphery issue rather than an issue of high importance to be dealt with comprehensively. More high risk workplaces were considering implementing further strategies than low risk workplaces which may be indicative of high risk workplaces’ recognition of their status as more risky. Some workplaces provided reasons as to why they weren’t considering further strategies and these included, current responses being adequate, alcohol and other drugs not being an issue and resource implications. Beyond these reasons, some workplaces indicated in their comments that it should not be the responsibility of employers to address alcohol and other drugs.

Given that workplaces generally recognised the potential harms arising from alcohol and other drugs in workplaces, it is pertinent to consider how to harness these concerns and translate this into awareness and action. One possible approach is to utilise existing Occupational Health and Safety [OHS] frameworks. The usefulness of approaching
workplace alcohol and other drugs through OHS systems has been highlighted by workplaces in this research and in the literature. Phillips (2001) notes that Occupational Health and Safety is largely accepted across Australian workplaces and has a statutory framework supporting its implementation. In addition, Phillips recognises that:

Successful responses to alcohol and other drug related harm in the workplace will be consistent with, and a component of, mainstream OHS strategies. Importantly, they will be embraced by all segments of the workforce as consistent with personal safety, rather than being perceived as interference with private behaviour.

**Differences across risk and size categories**

Several areas of difference were observed across the size and risk status of workplaces and these have been reported throughout the results. It is clear that small workplaces have a particularly complex task when responding to alcohol and other drugs. It is noted in the literature that it is important for small workplaces to address alcohol and other drugs despite limited resource availability (Pidd & Cormack 2000). Specific characteristics of small workplace compared with their medium and large counterparts in this research include:

- A higher percentage had a policy only and no additional strategies
- They utilised testing, EAPs and counselling less
- Those that had policies had only developed them within the last 5 years – no policies were in place longer than 5 years
- More had informal policies and less non-specific alcohol and other drug policies
- None mentioned legislation as a possible area for support
- More were unsure what support was required
- Only one was considering testing
- Over 90% weren’t considering any additional strategies
- A higher percentage nominated productivity and absenteeism concerns as issues for them

In addition, differences were found between high risk and low risk workplaces. High risk workplaces had policies in place longer, nominated legislation more frequently as a support mechanism, utilised EAPs less, had more written policies and were considering testing more than low risk counterparts.

The differences between responses from workplaces across the risk and size categories can only be explained through hypothesis. It is clear that differences across the size categories could be linked to resource availability in terms of financial and staff availability. It is more difficult to explain the major differences uncovered across the risk categories. High risk workplaces appeared to engage in more strategies to respond to alcohol and other drug issues in general, this may be a reflection of their understanding of their risk status.
Testing Programs

Drug and alcohol testing programs generate significant controversy and were a notable ‘hot topic’ for workplaces in this research. It is important to consider the appropriateness and effectiveness of testing programs as tools to reduce alcohol and other drug related harm in workplaces. The literature suggests that testing programs are unreliable, inadequate and suffer from a lack of evaluation (Alcohol and Other Drugs Council of Australia 2004, Pidd n.d). A major literature review conducted by Allsop and colleagues (1997) concluded that “…far from being an unequivocal tool of intervention, drug testing is fraught with existing (and potential) social, ethical, and financial problems.” Problems associated with the implementation of testing programs are compounded by significant gaps in available data relating to alcohol and other drug related harm in workplaces. These gaps make it difficult to promote any strategies, testing in particular though, as a ‘solution’ due to a lack of sound evidence for their effectiveness.

Of interest within this research is that over 30% of those who thought that testing had the most impact in reducing alcohol and other drug related harm in workplaces did not have a testing program in place. Only 31.8% (n= 7) of those considering implementing a testing program actually nominated testing as having the most impact in reducing alcohol and other drug related harm in workplaces. As such it is unclear why these workplaces are considering testing at all or believe testing is the most effective strategy to reduce alcohol and other drug related harm. Similar to other areas within this research, workplaces did experience confusion regarding workplace testing with some workplaces believing that it was illegal and others believing it to be a legal requirement. Again this is evidence that a knowledge vacuum exists in relation to workplace alcohol and other drug issues in general.

Implications

It is important to reiterate that whilst it is encouraging that many workplaces are taking steps to address alcohol and other drug related harm, in the absence of sound evidence for the effectiveness of the strategies they are implementing it is not possible to advocate here for one approach versus another.

It is also important to recognise that some workplaces may implement a raft of strategies whilst others may have no formal strategies in place. This does not infer that one workplace manages alcohol and other drug related issues any better than the other – the fact that a workplace simply has strategies in place does not mean that they are effective, appropriate, implemented or utilised well. In this sense it is difficult to distinguish between those who manage workplace alcohol and other drug related harm effectively simply based on whether they have strategies in place. It is perhaps more important to consider organisational culture and willingness to address alcohol and other drug related harm as markers of effective approaches.
CONCLUSION

In conclusion, the research carried out for this phase of The Impact of Alcohol and Other Drugs in the Workplace project has provided some insight into the experiences of a small number of South Australian workplaces in managing alcohol and other drug issues. Whilst this research is not designed to be representative due to the small sample size, the results do provide a useful starting point from which further research can be carried out to gain a greater understanding of the needs of South Australian workplaces in reducing alcohol and other drug related harm.

It is encouraging to note that the majority of workplaces involved in this research currently have at least one strategy in place that address alcohol and other drugs. Whilst most workplaces were generally concerned about alcohol and other drugs, particularly the potential impact on safety, the majority of workplaces indicated that they were not considering implementing further strategies. This presents a challenge for future efforts in this area in terms of how to harness workplaces’ concern and translate this into further action.

A proportion of workplaces involved indicated support for highly formalised support mechanisms such as a tighter legislative framework and making it mandatory for workplaces to address alcohol and other drug related harm. Some workplaces also recognised the value of approaching alcohol and other drug related harm through existing occupational health and safety channels. This presents an avenue for further investigation into how workplaces can be assisted to respond to alcohol and other drug related harm, and importantly, what agencies would be best equipped to provide this support.

It must be recognised that there are a multitude of time and resource pressures facing workplaces. As such addressing alcohol and other drug related harm may not be high on the list of priorities for many workplaces. Again, this provides an incentive to promote alcohol and other drug issues through the existing occupational, health and safety framework. Occupational health and safety training has been largely accepted by workplaces in this research, and is mostly done on annual basis in these workplaces. It is pertinent to investigate further how to integrate alcohol and other drug issues within this framework without placing too great a burden on workplaces.

Perhaps the most encouraging component of this research is that there is clearly an impetus to address workplace alcohol and other drug issues further. Workplaces require much more information and direction, are concerned about the potential impact of alcohol and other drugs in their workplace and some are taking action to address these concerns. It is clear that for many workplaces the issue of alcohol and other drugs is a ‘hot topic’ – there was a significant level of interest across most workplaces who participated in this study. This
suggests that the timing may be right for further strategies aimed at assisting workplaces and creating awareness of potential alcohol and other drug issues that workplaces could face.

Further research possibilities should be investigated to determine priority areas for action. There is a clear mandate to further address alcohol and other drug related harm in workplaces and the workplaces involved in this research provide many avenues where support strategies can be enhanced.
References


Pidd, K. (n.d) Drugs and Alcohol "Abuse" and Testing of Workers for the Presence of Drugs and Alcohol. National Centre for Education and Training on Addiction Bedford Park


APPENDIX 2A

ADDITIONAL SAMPLE CHARACTERISTICS

The following tables outline the distribution of workplaces, non-participators and reasons for non-participation, across the 18 cell sampling matrix.

The distribution of workplaces in the original sample is outlined in Table 1. The distribution of workplaces from the original sample who did not participate in the survey (for whatever reason) is shown in Table 2. Table 3 shows, of the non-participators, those who were not suitable for participation or not contactable. Table 4 shows the potential pool of workplaces for the survey which is the original sample (n= 208) minus those who were not suitable or not contactable (n= 43). Table 5 outlines the distribution of those who refused to participate or were no longer pursued after several callbacks (deemed to be passive refusal). Table 6 outlines the distribution of workplaces.

Table 1: Original Sample

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Table 2: Non-participators

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### Table 3: Not suitable for participation or not contactable

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### Table 4: Potential Pool

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### Table 5: Not willing to participate or not pursuing

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### Table 6: Workplaces

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APPENDIX 2B

HEALTH AND SAFETY REPRESENTATIVE RESPONSES

In order to ensure a range of perspectives were gained through this research, Health and Safety Representatives (HSRs) in the three target industries were contacted to ascertain their views on the impact of alcohol and other drugs in the workplace. HSRs were contacted in September 2005 via email through the HSR register held by Workcover Corporation. A reminder was sent to all contacts 2 weeks after the initial request. HSRs were asked to respond to a brief set of questions which had been modified from the original set used with workplaces. A total of 13 responses were received by mid-October. The responses are summarised below:

Q1: Employees:
Size: 2 x medium workplaces, 11 x large workplaces (Range: 70 – 5400)

Q2: Issues:
- Zero tolerance
- None really – self disciplined and know what is expected
- Generally the drugs used are prescribed
- Work performance. Safety risk –themselves and others
- Danger to machinery operation
- The manner in which drugs and alcohol can diminish a person’s attitude to safety and general alertness, thereby endangering themselves and others
- Workgroup are drivers and there is a zero drug/alcohol requirement by law
- Danger to employees, breach of security, increased absenteeism, inappropriate interpersonal interactions
- Testing procedures and problems
- Safety, reduced performance, dependence, discrimination, drug and alcohol awareness
- Use of equipment near general public
- Policy doesn’t reflect community standards and expectations or industry standards
- Driving forklifts, tow trucks while under influence

Q3: Responses:
- Testing program, no counselling, possible instant dismissal
- Haven’t had the need to have any
- Zero tolerance and random testing
- Policy and procedures focusing on work impairment, disciplinary process
- Counselling and send user home
- Random drug and alcohol testing, allow staff to address problems
Random alcohol testing and for cause drug and alcohol testing
- Drug and alcohol policy, no alcohol available at work social functions, confidential free counselling service
- Zero tolerance
- EAP, OHS policies
- Zero tolerance, firing offence, counselling available
- Drug and alcohol policy - very wishy washy
- Counselling, warning system, no testing

Q4: Most Impact:
- Loss of site access which ends up with loss of job
- None
- Zero tolerance and random drug testing
- Didn’t have a problem
- Advertising on policies and procedures
- Allowing affected employee time to clean up their act. Allowing the worker to continue working in a non-safety related role
- Random breath testing, the fear of losing your job
- Drug and alcohol policy and not allowing on site and counselling
- Zero tolerance
- Stress management, manageable workloads, awareness raising
- Zero tolerance, firing offence, remove the problem from the workplace
- Random testing, zero drug and alcohol policy
- Drug or alcohol tests

Q5: Support:
- Counselling for people at risk, cheaper testing, address issue of people using drugs on days off but still in system when tested
- Random testing
- Zero tolerance, random testing
- Privacy law issues
- Trained counsellors, free drug screening ad hoc
- Employer to treat each case on its merits, equity between how positive alcohol and drug tests are treated
- Support system - counselling for first offence, follow up monitoring, not a one strike and your out policy
- Less stressful working conditions, less emphasis on casual/part time employment, stable employment, job security
- Legislate, training
- Anonymity in accessing information
- Expand counselling availability, paid time off for counselling, AA meetings
- Commitment from senior management
- Union support
Q6: Other comments:

- Need total commitment of unions in regard to testing
- An issue that will never go away, however interested in knowing other companies strategies
- Time has come when testing must prove impairment not simply that a person has used drugs. Treat as an illness
- Employer seems to be more concerned about the cost of the test rather than the deterrent value
- Awareness raising of issue is a must
APPENDIX 2C

PARTICIPANT LETTER OF INVITATION

August 2005

Dear Sir or Madam,

We are currently conducting research to identify the strategies workplaces use to prevent and respond to potential and actual alcohol and other drug related harm in the workplace. Approximately 230 South Australian businesses are being contacted to participate in the research, the results of which will support the development of policy recommendations to the South Australian government.

We request your participation in a brief telephone survey which will take approximately 20 minutes to complete. A copy of this survey is attached together with further information regarding the project. Participation is completely voluntary and the names of respondents will not be identified in any way to ensure anonymity.

The project has been developed in consultation with key agencies in order to ensure relevancy and appropriateness. Business SA and SA Unions are supporting the project and are represented as members on the project reference group.

The Senior Research Officer, Ms Lindsay Breugem, will contact you in the following week seeking a convenient time for you, or your nominee, to be interviewed. If you would like further information, please contact Lindsay on (08) 8274 3323 or via email: breugem.lindsay@sa.gov.au.

We thank you in advance for your consideration of this matter and look forward to your involvement in the project.

Yours sincerely,

Michele Patterson
Executive Director
Workplace Services, Department for Administrative and Information Services

Keith Evans
Executive Director
Drug & Alcohol Services South Australia, Southern Adelaide Health Service

Workplace Drug & Alcohol Project
C/- 161 Greenhill Road
Parkside SA 5063

Government of South Australia
The Impact of Alcohol and Other Drugs in the Workplace project is a joint initiative of Workplace Services and Drug and Alcohol Services South Australia. The project is being conducted in response to the South Australian Drugs Summit which identified alcohol and other drug issues as having significant social and economic costs to the community.

The current phase of the project seeks to access information from South Australian workplaces to identify the strategies workplaces use to prevent and respond to potential alcohol and other drug-related harm. Participation in this project will support the development of policy recommendations to the South Australian Government, best practice guidelines to support workplaces and future research priorities.

Over 230 South Australian workplaces in various sectors are being contacted to participate in this research. Participation in the survey is entirely voluntary and confidential and the names of respondents will not be identified in any way. No individual responses will be accessed by Workplace Services staff with all information de-identified prior to distribution. All participating workplaces will be provided with an executive summary of the results of the research.

It is recognised that alcohol and other drug issues are a community-wide problem requiring community-wide responses. Workplaces are one of many settings affected by the costs of alcohol and other drug misuse. Alcohol and other drugs can result in serious occupational health and safety concerns for workplaces, decreased productivity and low morale. It is hoped that this research will be able to identify effective strategies to reduce harms in the workplace associated with alcohol and other drugs.

If you would like further information please contact Ms Lindsay Breugem on (08) 8274 3323 or via email: breugem.lindsay@sa.gov.au
APPENDIX 2D

QUESTIONNAIRE SENT TO WORKPLACES

Outlined below are the survey questions for The Impact of Alcohol and Other Drugs in the Workplace Project. The survey takes approximately 20 minutes to complete and the results will be entirely confidential; the names of respondents will not be identified in any way.

Demographic Information

1. Approximately what percentage of your workforce is:
   - Male
   - Female

2. What percentage of all employees are:
   - Aged 15-24 years
   - Aged 25-44 years
   - Aged 45-54 years
   - Aged over 55 years

3. What percentage of all employees are:
   - Casual employees
   - Part-Time employees
   - Full Time employees
   - Labour Hire

4. How many employees in your organisation?

5. Please outline the nature of supervision for most people in your organisation:
   - Low – individuals supervised as part of a group
   - Moderate – some individual attention
   - High – regular interaction between supervisors and staff members

6. Please indicate the ratio of supervisors to staff members for most people in your organisation:

7. For the majority of your workforce, how regularly do supervisors have individual contact with staff members?

8. Please indicate the frequency of Occupational Health and Safety training undertaken by the following groups:
   - Senior Management
   - Middle Management
   - Operational Staff
Perceptions

9. Please describe the main issues for your workplace in relation to employee use of alcohol or other drugs.

Current Responses specifically addressing alcohol and/or other drugs

The following questions are designed to obtain information regarding strategies your workplace uses which specifically address alcohol and/or other drug issues. These may include policies, specific programs for staff or other strategies such as controls on use.

10. Please describe any strategies your workplace has in place which specifically address alcohol and/or other drugs through:
   - Policy (e.g. what is in the policy, when/why did it commence)
   - Services or programs (e.g. Employee Assistance Program)
   - Other strategies (e.g. controls on use)

Other general responses

The following questions are designed to obtain information regarding strategies, not specific to alcohol or other drugs, which may impact on their use and related harms. These may include policies such as OHS, services such as health promotion activities or counselling, or other strategies such as supervision, training or workplace culture.

11. Please describe any other strategies, which do not specifically relate to alcohol and/or other drugs, but may impact on the harms experienced.
   - Policy
   - Services or programs
   - Other strategies

Capacity

This section is designed to obtain information regarding your organisation’s capacity to address alcohol or other drugs and the support required to facilitate this.

12. Are there any strategies you are considering implementing?
13. What strategies, if any, do you think have had the most impact in reducing alcohol and other drug-related harm?
14. What support would make it easier for workplaces to address alcohol and other drug-related harm?

The Senior Research Officer, Ms Lindsay Breugem, will contact you in the following week seeking a convenient time for you, or your nominee, to be interviewed. If you would like further information, please contact Lindsay on (08) 8274 3323 or via email: breugem.lindsay@saugov.sa.gov.au.
Appendix 3

Phase Three Summary Report

Stakeholder Workshop
INTRODUCTION

The following report outlines findings from phase three of The Impact of Alcohol and Other Drugs in the Workplace project. This phase comprised a workshop with key stakeholders to review and discuss the findings and implications of the project’s prior research phases, and pursue options for recommendations for future action and policy development.

The stakeholder workshop complemented the previous two research phases completed for The Impact of Alcohol and Other Drugs in the Workplace project. Phase one involved a summary of key literature pertaining to drug-related harm in the workplace, whilst phase two comprised a targeted telephone survey with South Australian workplaces to identify the strategies in place to prevent and respond to drug-related harm.

The stakeholder workshop was held in Adelaide on 4 May 2006. The workshop was facilitated by Professor Steve Allsop, Director of the National Drug Research Institute and a member of the project reference group. The workshop brought together twenty one stakeholders from the following sectors:

- Industry
- Research
- Policy
- Employee/Employer representatives
- Health
- Occupational Health and Safety
- Private providers

(For a full list of attendees please see Appendix 3A)

The project team and reference group recognised the need to engage high-level stakeholders and as such, potential participants were specifically selected. Invitations were targeted towards stakeholders identified as having the ability and expertise to contribute to the development of practical and achievable outcomes. Prior to the workshop, stakeholders were provided with reports outlining the findings from phases one and two of the project.

1 Unless otherwise specified in this report, the term ‘drug’ will refer to alcohol and other drugs.
CONTEXT

Due to the varied backgrounds of participants, workshop facilitator Professor Steve Allsop (Director, National Drug Research Institute) provided contextual information to ensure all participants had an understanding of the core issues relating to drug use. Professor Allsop presented models of addiction behaviour and their relevance for the workplace. These models were used to explain the drivers and patterns of drug consumption and the relationship between drugs and the workplace. (See Appendix 3B for a copy of this presentation).

An overview of research conducted to date for The Impact of Alcohol and Other Drugs in the Workplace project was provided by the project’s research officer to ensure participants had an understanding of the context of the project and the scope of the stakeholder workshop. (See Appendix 3C for a copy of this presentation).

All participants had the opportunity to ask questions in relation to these presentations in order to clarify any issues of concern or areas of interest.

SESSION 1
Implications for South Australian Workplaces

The first interactive session with participants involved group discussions regarding the implications of the two background presentations and the ‘headline’ issues arising out of these.

1.1 Testing
All groups reported drug and alcohol testing of employees as a major issue which required clarification and examination in order to improve employer understanding of its strengths and limitations.

It was recognised that testing programs may change the nature of drug consumption due to the potential for employees to turn to substances that are less likely to be detected. It was reported that testing was widespread but not necessarily an effective control. In the words of one participant, testing had been:

“... the marriage of marvellous marketing and mundane management.”

There was discussion regarding State occupational health and safety [OHS] legislation with some believing that controlling workplace drug use through testing is an implicit requirement under this legislation. This discussion highlighted that there are many different
points of view and interpretations of current legislation. From this it was evident that there is a need to clarify the specific OHS legislative requirements in relation to managing the risk from drugs in the workplace.

1.2 Supervision
Participants also discussed possible alternatives to testing programs and it was noted that supervision, or staff observation, was a potentially effective alternative for addressing drug-related harm in workplaces. It was suggested that the industries with the lowest level of supervision due to work isolation, remoteness and autonomous work might experience higher levels of drug-related harm.

1.3 Regulation
It was recognised that small businesses are particularly challenged in regard to complying with legislation. However, having specific minimum standards that all workplaces are required to comply with, may assist workplaces to more effectively address drug-related harm. The rationale supporting this centred on the cost implications of workplaces responding to drugs and that it is more equitable if all workplaces must adhere to the same requirements. Another advantage of implementing specific regulatory requirements is the potential for less ambiguity due to a clear standard of responsibilities and obligations. Stakeholders highlighted the need for a cautious approach to the issue of regulation due to the potential impost this could place on workplaces.

1.4 Policy
A variety of responses to drug-related harm were reported to exist across workplaces. Whilst one participant remarked that “It would be good to have available a range of different types of best practice policies ranging from testing to EAPs [Employee Assistance Programs]”, it was also noted that there is a risk of workplaces not developing their own tailored policy through appropriate consultative processes if there is an ‘off-the-shelf’ response available.

There is also the uncertainty of how best to accurately measure the cost-benefit effectiveness of workplace responses to drug-related harm and it was suggested that it might be more appropriate to examine indirect measures of harm (e.g. work performance, absenteeism) due to the often hidden nature of drug taking behaviour.

Participants recognised that workplaces with good general management systems (e.g. OHS, supervision, environmental policies) may have low drug-related harm whereas other workplaces with specific drug policies in place may still experience high levels of harm. This was considered to be suggestive of the workplace culture influencing the likelihood of harm. It also highlights the need for a holistic approach to drug-related harm in workplaces, which incorporates a focus on positive workplace culture, a general commitment to workplace health and safety and recognition of the factors contributing to drug-related harm.
SESSION 2

Effective Occupational Health & Safety Initiatives - Lessons for responses to drug-related harm

After discussing the implications of the two presentations, groups were asked to think of an effective OHS initiative and discuss what made the initiative effective. The purpose of this session was to identify elements of successful OHS initiatives which could be applied to drugs in workplaces. Several broad themes emerged including: involvement of those affected, open communication, workplace culture and quality practice. Participants’ comments from this discussion are summarised below:

2.1 Involvement of those affected
Stakeholders recognised that effective workplace responses to drugs need to be developed through a transparent process of consultation coupled with management participation and commitment. In addition it was suggested that identifying appropriate ‘champions’ in the workforce would enhance the credibility of drug responses. Finally, it was noted that it is important to achieve workforce ‘buy-in’ through participation and ownership.

2.2 Open communication
It was noted that a key element of effective workplace responses to OHS issues in general (including drugs) is open and consistent communication. Stakeholders nominated a number of strategies that can be utilised to facilitate communication of the workplaces’ intent and direction. These strategies include providing feedback, creating awareness, education, publicising and promoting initiatives and having a communication strategy in place.

2.3 Workplace culture
In addition to ensuring involvement of staff and appropriate communication, the importance of integrating drug responses within those systems, which influence positive workplace culture, was highlighted.

Stakeholders nominated several strategies that could be utilised to develop a positive workplace culture and assist the integration of drug responses into the workplace. These include utilising a team-based approach, encouraging positive role-modelling and peer support mechanisms. Further, stakeholders suggested that it would be beneficial to recognise and reinforce positive behaviour.
2.4 Quality practice

Stakeholders considered it essential that drug responses be integrated into a total management/quality framework whereby the issue is addressed on an ongoing basis. It was suggested that the following elements be considered to ensure a quality approach to drug-related harm:

- Consistency – that is, using a consistent approach to managing drugs as other identified HR issues,
- Compliance – that is, establishing clear boundaries through internal policies and procedures, developed in consultation,
- Incremental change – that is, reinforcing positive behaviours through education and information and,
- Monitor and review – that is, establishing an evaluation process that is ongoing and integrated into future planning

In addition, it was thought that integrating responses to drugs within this broader focus would enhance acceptance within the workplace.

The important role of management in developing effective responses to drug-related harm was also highlighted. Stakeholders reported that a clear message from top-level management is required but also that the approach needs to be embraced by all levels to ensure the vision or commitment shown by top-level management is supported.

Finally, it was suggested that legislation may need to be used to ensure that workplaces initiated responses to the hazard of drugs. However stakeholders noted that for sustainable and effective responses the issue needs to be owned and driven by everyone involved.

In summarising this session, the workshop facilitator noted that workplace drug programs are more accepted when:

- They are embedded in a broader health program,
- The focus is on safety rather than interfering in people’s private lives,
- There are no exceptions, as policies and procedures are inclusive of all.
SESSION 3
Key Areas for Potential Action

Lyn Barnett (Project Manager) provided an overview of potential areas where future action may be directed by presenting the following model to the group for feedback:

Participants discussed the key areas for potential future action based on the model presented. Testing was again a significant issue for participants and discussion was focused on the various complexities associated with this strategy. The key points raised in relation to testing included:

- the potential impact on worker’s compensation entitlements
- who will do the testing
- some workplaces test due to insurance arrangements
- there is a need to ensure accurate information for informed decision making
- significant legal concerns exist in regard to privacy, confidentiality and legitimacy
- significant care needs to be taken in interpreting test results
- different forms of testing identify different issues
- the presence of drugs versus level of impairment

A broader discussion around potential areas for action raised a range of issues in relation to quality, operational factors, approaches and motivation.
3.1 Quality
Stakeholders recognised the value of developing performance indicators to assist industry in having measurable outcomes. Improvements in surveillance and data collection were highlighted as a key priority area to address, as there is a need for more reliable data regarding the extent of drug-related harm in workplaces.

Stakeholders also indicated that there needs to be an assessment of the resources currently available to support workplaces to address drug-related harm. Following this assessment it was suggested that there should be a communications strategy developed to provide information and the availability of resources and services.

3.2 Operational Factors
Stakeholders highlighted a range of operational factors associated with responding to drug-related harm that need to be addressed. The key factors included concern that some things are not detectable (drugs and their effects); defining how prescription medications fit into workplace responses to drug-related harm and the tension between community and workplace expectations. It was also recognised that there needs to be a focus on work impairment rather than simple exposure/detection of substances. These issues again highlight the need for an educative approach to ensure workplaces are supported to make informed decisions.

3.3 Approaches
In examining potential areas for action it was noted that a variety of approaches should be promoted and that programs should be tailored to suit industries and workplaces. A risk based model for workplaces was favoured building on the previously identified need to focus on work impairment.

Workplaces can be supported in their response to drug-related harm through the development of information networks and other mechanisms to assist informed decision making. According to stakeholders, it is also imperative that workplaces are educated as to how to operate within the boundaries of existing legislation. A key suggestion made by stakeholders was to develop a ‘clearinghouse concept’ to provide easy access to expertise and information, and to market available approaches other than testing programs.

3.4 Motivation
In order to facilitate proactive responses in workplaces, it was suggested that there needs to be an acceptance that drug-related problems exist in workplaces and that this be supported with evidence about the associated risk. To further support workplace motivation, a clear rationale is required coupled with provision of effective education for workplaces.
SESSION 4
Where to Next?

After discussing areas for potential action, stakeholders were asked to provide advice on how to move forward. From this discussion four distinct themes emerged: measurable outcomes and performance indicators; developing parameters and regulation; education and information mechanisms; and clearinghouse/expertise. Discussion groups were formed based on these themes with participants selecting the group in which they wished to participate. Each group was required to identify what could be done to progress their area and to make recommendations for how this could be achieved.

4.1 Measurable outcomes/performance indicators
Key recommendations regarding the development of performance indicators and measurable outcomes were firstly to address the issue of surveillance and the lack of existing baseline data. It was suggested that to achieve this, that firstly a data audit be conducted to determine the scope and quality of existing data-sets. It was also noted that there is a requirement to identify indicators of use, impairment and harm to determine not only the extent of workplace drug problems, but also the nature of these problems. Following from this it was suggested that a hierarchy of performance indicators be developed in relation to potential responses to workplace drug-related harm. The hierarchy could delineate the level of cost, intrusiveness and accuracy of responses. Finally, it was noted that these actions should be driven at a strategic level (e.g. led by government, key stakeholders) at first but that ultimately the process needs to be owned by all involved.

4.2 Developing parameters/regulation
Stakeholders highlighted a need to identify the extent of work-related drug problems in order to determine the resources required to address it. Stakeholders were also cognisant of the fact that drug-related harm may not be the greatest OHS issue workplaces face and this will impact the level of motivation for industry to respond. It was suggested that the feasibility of specific strategies for specific industries be considered rather than a blanket approach for all workplaces.

Stakeholders recommended that a gap analysis be conducted to identify the scope and variety of legislation that impacts on drug issues in the workplace. Given that a risk based approach already exists under OHS legislation, stakeholders recommended that greater education might be required regarding the interpretation and application of this legislation. In addition, future action needs to take account of broader legislative frameworks (e.g. Equal Opportunity, Industrial Relations, Workers’ Compensation) and the discrepancies that exist. Finally, it was recommended that all responses should be led by government with a tripartite approach (comprising Government, employee and employer representatives) that reflects state and national parameters and priorities.
4.3 Education/information mechanisms
Stakeholders within this group noted that there is a need to provide information to workplaces clearly delineating responsibilities and obligations. In addition, it was suggested that it would be beneficial to increase general awareness of drugs as an OHS issue and this could be achieved through the use of existing structures and ongoing training to reinforce drug use as a safety issue. A key issue in workplace education is to assist workplaces to identify the extent of the problem and provide education regarding control options. Attention also needs to be directed towards developing models of best practice for workplaces to draw on.

In terms of service provision for workplaces, stakeholders recommended that the availability and marketing of existing resources needs to be improved. This could be achieved through synthesising existing resources and services available to workplaces and disseminating these. One of the key tasks in this sector is to identify which agency/s would be best equipped to develop, promote and disseminate information.

4.4 Clearinghouse
Stakeholders recommended that workplaces be provided with existing information, resources, services and data to refer to in the form of a ‘clearinghouse service’. The clearinghouse service could incorporate simple resource development activities and referral to services. It was suggested that SafeWork SA would be the agency best equipped for this type of service provision. Stakeholders suggested that to drive this concept forward, recommendations should be made to government and a key stakeholder group be developed. The importance of having a national framework through which workplace drug-related harm can be addressed was also highlighted.

SESSION 5
Barriers to Moving Forward

The final discussion involved identifying barriers to moving forward with participants providing a broad range of perspectives in this discussion.

One of the key barriers identified was that there is uncertainty regarding which legislation drug-related harm fits under – industrial relations or OHS. It was recognised that there may be industry opposition to the OHS framework if workplaces do not perceive drugs as a safety issue – in this case an industrial relations framework may be more appropriate. A potential avenue for addressing this barrier is to encourage a general risk management approach used in OHS legislation to drug-related harm in terms of identifying hazards, assessing risk and implementing control mechanisms.

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2 A clearinghouse is a central access point providing a systematic collection of resources regarding a specific body of knowledge. A clearinghouse collects, collates and disseminates information to interested stakeholders.
A further barrier related to cultural norms was described in the following way: “We can’t expect workplaces to be islands of sobriety in a community awash with drugs and alcohol”. This comment reflects that the cultural norms that exist in Australia need to be taken into account in any response as the problems faced by workplaces reflect the problems in society in general. As such a harm minimisation approach to workplace drug-related harm is required to address issues in a balanced way.

It was noted that passionate views and moral beliefs ensure that this is a highly contentious issue. There is potential for agenda-driven responses to flourish in the absence of informed decision making and similarly, unsubstantiated opinion may ‘hijack’ debates regarding the most appropriate ways to address drug-related harm in workplaces. Furthermore, barriers were identified in utilising a legislative approach to address drug-related harm. Participants felt that the legislative process is drawn out and, at this stage, it is not appropriate to prescribe what workplaces have to do when there is a paucity of evidence demonstrating effective approaches. An alternative could be to use existing legislation by educating workplaces on how to operate within these boundaries and focus on supporting informed decision making.

Despite the barriers identified, it was also recognised that this project is well placed to progress further action in this area due to the collaborative partnership between SafeWork SA, Drug and Alcohol Services South Australia, industry and key stakeholders.

**RECOMMENDATIONS**

The group was in agreement that the key areas of importance to consider when forward planning are:

- The need to identify the extent of the problem (by using existing data sources or developing new databases)
- That industry wants clarification (either through guidelines, setting appropriate parameters or through clarifying relevant legislation)
- The need to assemble existing resources and expertise and potentially develop new sources of information
- The provision of assistance for workplaces to develop performance indicators to assist them to identify likely hazards, assess the risks and develop controls for hazards
- To investigate the feasibility of having a central information mechanism from which information can be disseminated
SUMMARY

The outcomes of this stakeholder workshop largely reinforce findings from the previous two research phases in this project. This is demonstrated through the focus on alcohol and drug testing as a key issue for participants and concerns expressed by workplaces regarding the lack of clarity regarding a number of issues (principally the availability of existing resources and services, the nature and extent of workplace drug-related harm and issues associated with testing programs).

The key outcomes from the stakeholder workshop centre on the following issues of importance:

- Improved data collection practices (including an audit of existing data sources) to ensure the scope, nature and extent of drug-related harm in workplaces can be quantified;
- Improved availability and marketing of services and resources able to assist workplaces to address drug-related harm, possibly through the development of a clearinghouse service;
- Legislative approaches should be investigated thoroughly to determine potential impacts on employers and employees and where possible existing legislative frameworks should be utilised;
- The potential to address drug issues through existing OHS channels may be diminished somewhat if workplaces do not perceive drugs to impact on safety. In this case it may be more appropriate to address these issues through an industrial relations approach;
- Limited understanding of the effectiveness and appropriateness of alcohol and drug testing is clearly a major issue for key stakeholders and requires careful attention through provision of accurate information to ensure informed decision making can occur.

One of the key challenges for improving workplace responses to drugs lies in identifying who will take responsibility and leadership for driving the issue. Participants recognised that this may be problematic in that no one wants to own it and as a result key stakeholders – in the safety, industrial relations, health or industry sectors – may attempt to pass the issue on to others. A key challenge will be drawing stakeholders together to ensure a partnership approach whereby all can own the issue. It is clear that to engage workplaces on this issue there is a need to not only identify the existence of drug problems in workplaces, but also demonstrate the benefits of responding to these problems.

Participants in the workshop were able to provide a valuable contribution through their varied perspectives on the issues at hand. It is certainly encouraging to note the interest in this project as evidenced by the diversity of participants attending this workshop.
APPENDIX 3A

STAKEHOLDER WORKSHOP ATTENDEES

Professor Steve Allsop (Facilitator)
Director
National Drug Research Institute

Ms Lyn Barnett
Manager, Retail, Wholesale, Storage & Transport Team
SafeWork SA

Mr Peter Besanko
OHS Coordinator
Mitsubishi Motors Australia Limited

Ms Marina Bowshall
Population Health Policy and Communication
Drug and Alcohol Services South Australia

Ms Lindsay Breugem
Senior Research Officer, Workplace Drug and Alcohol Project
SafeWork SA/Drug and Alcohol Services South Australia

Ms Simone Cormack
Director, Population Health Programs & Deputy Executive Director
Drug and Alcohol Services South Australia

Mr Kim Daniel
Project Officer
SA Unions representative and Construction and Other Industries Drug and Alcohol Program

Mr Geoff Day
President, Mining and Energy Division (SA Branch)
Construction, Forestry, Mining and Energy Union

Mr Trevor Evans
Manager, Industrial Relations and Human Resources
Australian Hotels Association (SA)

Mr Michael Guarna
Principal Policy Officer
Equal Opportunity Commission

Ms Janet Hall
Team Leader
Health, Safety, Environment & Injury Management
Business SA
APPENDIX 3B:
BACKGROUND PRESENTATION

Steve Allsop
Director
National Drug Research Institute

What is a drug?
- Drugs can be synthetic, semi-synthetic, or natural
- Psychoactive drugs have effects on the central nervous system (CNS) and can affect mood, cognition and behaviour

Drug effects and drug related problems
- Related to patterns of use

Intoxication

Intoxication

Regular use

Dependence

What increases or decreases risk of drug problems?
- Three factors and the relationship among these

Drug
- e.g. Pharmacology
- Amount used and
- How often
Drug use

- Drug use is an outcome of:
  - Individual resilience and vulnerability
  - Cultural and sub-cultural influences
  - Work structures, supervision and quality of working life
- Different patterns of drug use result in different kinds of problems
- Different factors influence the development of problems
- Specific problems require specific responses and usually in several areas (e.g., what we do about the individual and the environment in which s/he works)
- As with any OSH problem, it is important to correctly "diagnose" the risk and develop specific responses

Patterns of drug use

- Patterns of drug use in the workplace are affected by patterns of use in the community and the subpopulation from where you recruit your staff
- What do the patterns of drug use in the community and the structure of your workplace tell you is likely to be the greatest risk for your workplace?
- Patterns of drug use can change fairly quickly

Problems in the workplace

Consequences of drug use are NOT restricted to a minority of heavy users or "addicts" who are easily identified
Often problems can arise from occasional use/intoxication
When developing a workplace response, think in terms of what will you do about:
- Intoxication
- Regular use
- Dependence
The Impact of Alcohol and Other Drugs in the Workplace
SafeWork SA and Drug and Alcohol Services South Australia

**Project Background**
- Collaborative project between SafeWork SA and Drug and Alcohol Services South Australia
- South Australian Drug Summit Initiative
- **Purpose:**
  - To assemble the existing evidence for the nature and extent of alcohol and other drug related harm in workplaces and recommend practice in preventing and responding to that harm

**Project Methodology**
- Three phase methodology
  1. Literature Summary
  2. Telephone Survey
  3. Stakeholder Workshop
- Final report to draw together results of three phases and provide practical outcomes for workplaces and policy direction for government

**Alcohol and Other Drugs at Work...**
- Alcohol, illicit drugs and illicit use of licit substances
- We are concerned about any alcohol or other drug use that impacts on the workplace. This may include:
  - Use that occurs at the workplace
  - Use that occurs before or after work that impacts on the workplace
  - Use during breaks or at locations outside work (e.g. at lunch)
  - Impairment at work due to alcohol and drug use

**Phase One Findings: Evidence**
- 2004 NDSHS data show that:
  - 5.2% went to work affected by alcohol
  - 13% went to work affected by illicit drugs
  - The workplace was the usual place of alcohol consumption for 6% of respondents
- However, use does not automatically infer that a worker is impaired

**Phase One Findings: Harms**
- Alcohol is a contributing factor in approx. 6.4% of work-related fatalities
- Other drugs are contributing factors in approx. 3.2% of work-related fatalities
- Alcohol is a contributing factor in 3-11% of work-related injuries
- Productivity costs of alcohol and drugs is $2.9 billion in FY 1998/99

**Phase One Findings: Responses**
- Workplace alcohol and other drug policies
- Employee Assistance Programs
- Controls on use (inc. testing)
- Health promotion activities

**Phase One: Summary**
- Poor quality of available evidence
- Inadequate data collections – in SA work-related fatalities only 80.8% had alcohol levels available and 27.2% had other drug levels
- Running on wisdom and popular opinion
- Problems overstated – Hype
- Existing responses not evaluated
Phase Two

- Targeted telephone survey of South Australian workplaces across three industries (selected based on levels of occupational harm irrespective of cause)
- High-risk and low-risk workplaces
- Small, medium and large workplaces
- Target: 90 workplaces (5 in each of the 18 cells)

Response Rate

- Anticipated response rate: 40%
- Actual response rate: 66.7%
- Participation target exceeded by 22%

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<th>Industry Sector 1</th>
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Description of the sample

- 18.2% regional, 81.8% metropolitan
- Equal split – high and low risk
- Highly male dominated workplaces
- Most employees in the 25-44 age group
- Most employees full-time
- In 94% of workplaces, supervisors had daily contact with staff
- OHS training generally done on an annual or ‘as required’ basis

Results: Issues

- Safety most frequently nominated, 71.8% (n=79)
  – Use of machinery/equipment
  – Risk to themselves or others
  – Dangerous environments
- Productivity & Absenteeism nominated by 19.1% (n=21) of workplaces
- 13 workplaces (11.8%) indicated that alcohol and other drugs were not an issue at all

Results: Current Responses

- 95% (n=105) of workplaces had a policy or at least one specific strategy in place
- Policies generally provide an overarching framework through which specific strategies can be implemented

Results: Policy

- 88.2% (n=97) had a policy
  – 80 had written policy
  – 17 had informal policy
- Most policies had been in place for 5 or more years
- 97.5% (n=78) of those with a written policy had a formal mechanism in place for policy awareness
  – Induction, handbook, sign at employment most common
- High risk and large workplaces were more likely to have written policies

Results: Strategies

- EAP and counselling services most common strategy with 59% (n=65) workplaces implementing
- Testing was the second most frequent strategy utilised, 46.4% (n=51)
- 18.2% (n=20) utilised health/medical programs

Results: Strategies

- 35.4% (n=34) nominated positive workplace culture as a protective strategy
- 18.2% (n=20) nominated the level of supervision in their workplace as a strategy to reduce impact of alcohol and other drugs

Results: Intention to respond further

- 70% (n=77) of workplaces not considering further strategies
- Testing most common strategy being considered (78.8% of those considering further strategies nominated testing)
- Of those considering testing (n=23), 82.6% were high risk workplaces

Results: Impact

- Strategies that had the most impact in reducing AOD related harm:
  – Testing (n=26)
  – Education/Awareness (n=22)
  – Policy (n=21)
  – Disciplinary action (n=20)
- Testing and disciplinary action are seen to be effective due to a deterrent effect
### Results: Support
- Workplaces most wanted support in the form of:
  - Advice/Assistance (n=23)
  - Legislation/Government action (n=17)
  - Awareness (n=15)
- However, 19.1% (n=21) of workplaces were unsure what, if any, support would assist them to further respond

### Summary
- Most workplaces are concerned about the impact alcohol and other drugs may have in their workplace
- Most workplaces have at least one response in place to address alcohol and other drug related harm
- Most workplaces are not considering doing anything further to address alcohol and other drug issues

### Summary
- There is a clear focus on testing – 46% currently using, 21% considering it – yet only 24% nominated this as the most effective strategy
- Most workplaces identified areas where enhanced support can be provided
- Potential to address through OHS framework (supported by workplaces)

### Key challenges
- How to harness workplaces’ concern and turn this into action?
- Service provision/support services – which agencies are best equipped?
- Developing a best practice model

### Phase Three – Stakeholder Workshop
The aim of this workshop is to bring together a group of high-level stakeholders to:
  - Review and discuss the findings and implications of the literature review and workplace survey and;
  - Pursue options for recommendations for future action and policy development

### Stakeholder Workshop
- Representatives from following sectors:
  - Health
  - OHS
  - Research
  - Policy
  - Industry
  - Employees
  - Employers
  - Private Providers