International Journal of Drug Policy 28 (2016) 48–54

Contents lists available at ScienceDirect

International Journal of Drug Policy

journal homepage: www.elsevier.com/locate/drugpo

Research paper

Do workplace policies work? An examination of the relationship between alcohol and other drug policies and workers' substance use

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ARTICLE INFO

Article history:
Received 28 October 2014
Received in revised form 18 August 2015
Accepted 24 August 2015

Keywords:
Workplace policies
Alcohol
Drug use

ABSTRACT

Background: There is growing interest in workplace policies as a strategy to prevent or manage alcohol and other drug (AOD) problems. This study is the first to explore the prevalence and impact of AOD policies in Australian workplaces using a nationally representative dataset.
Methods: A secondary analysis of the 2010 National Drug Strategy Household Survey was conducted (n = 13,590). Descriptive analyses explored the prevalence of AOD policies. Multinomial and logistic regression assessed the relationship between policies and health behaviours.
Results: Workplace AOD policies were associated with reduced employee substance use. Having any AOD policy in place was associated with significantly decreased odds of high risk drinking (OR: 0.61). In terms of specific policy types, policies on 'use' and 'use plus assistance' were associated with significantly decreased odds of high risk drinking (OR: 0.64 and 0.43, respectively). 'Comprehensive' policies were associated with significantly decreased odds of drug use (OR: 0.72). AOD policies were not significantly related to absence due to AOD use, attending work under the influence, or usually consuming AOD at work.
Conclusion: These findings provide empirical support for the value and efficacy of policies to reduce alcohol and drug problems. While basic policies on 'use' were associated with a reduction in high risk drinking, more comprehensive policies were required to impact drug use. Notably, alcohol/drug testing in isolation does not appear to be related to reduced employee substance use. Scope exists for Australian workplaces to implement effective AOD policies. This could result in considerable benefits for both individuals and workplaces.

Introduction

A health issue gaining prominence in Australia and internationally is the prevalence of employee alcohol and other drug (AOD) use (Frone, 2006; Pidd, Shtangey, & Roche, 2008; Roche, Pidd, Berry, & Harrison, 2008). In 2013, approximately 36% of Australian employees consumed alcohol at risky or high risk levels, and 16% had used at least one illicit drug in the past 12 months (Roche, Pidd, & Kostadinov, 2015). Similar patterns were found for the United States, with 14% of employees using illicit drugs and 35% drinking at risky levels (Frone, 2006, 2008).

Workforce alcohol and other drug use is associated with substantial negative consequences (Drugs and Crime Prevention Committee, 2006), including workplace injuries (Spicer, Miller, & Smith, 2003), missing work, poor quality work, arriving late/leaving early, doing less work, arguing with colleagues (Amick et al., 1999), withdrawal behaviours (Lehman & Simpson, 1992), absenteeism (Bass et al., 1996; Pidd, Berry, Roche, & Harrison, 2006) and presenteeism (de Graff, Tuithof, van Dorsselaer, & ten Have, 2012). It has been estimated that alcohol-related absenteeism alone costs businesses up to $2 billion per year in Australia (Roche et al., in 2015), $4 billion in America, and €9 billion in the European Union (Anderson & Baumberg, 2006; Bouchery, Harwood, Sacks, Simon, & Brewer, 2011).

The workplace provides an important opportunity to prevent, identify and manage health problems among employees, including AOD use. An increasingly common strategy is the implementation of workplace AOD policies (Pidd & Roche, 2006, 2014). These policies seek to curb employees' substance use and promote a safe and healthy working environment.

Workplace AOD policies may comprise one or more diverse strategies, including written policies prohibiting the use of alcohol or drugs at work; providing counselling and assistance; and alcohol/drug testing. The policies of an organisation are likely to influence perceptions of acceptable employee behaviour, the physical availability of drugs and alcohol in the workplace, and the extent

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http://dx.doi.org/10.1016/j.drugpo.2015.08.017
0955-3959/

to which colleagues are perceived to use alcohol or drugs at work. These factors are all associated with employee substance use (Ames & Grube, 1999; Ames & Janes, 1992; Bacharach, Bamberger, & Sonnenstuhl, 2002; Biron, Bamberger, & Noyman, 2011; Frone, 2009). Workplace policies therefore have potential to prevent and reduce AOD use and related harms among employees.

There are promising indications that workplace AOD policies may be beneficial in reducing employee substance use, and thus prevent the above costs and negative outcomes. For instance, evidence consistently demonstrates that employees are more likely to quit smoking if their workplace has supporting policies or programs in place (e.g. Alexander, Crawford, & Mendiondo, 2010; Bauer, Hyland, Li, Steger, & Cummings, 2005; Kouvonen et al., 2012). However, the relationship between workplace policies and alcohol and illicit drug use has been less thoroughly explored. This is in spite of the growing international interest in, and use of, drug testing (Pidd & Roche, 2014).

In addition, there is little research available on the nature, extent or impact of AOD workplace policy implementation, either in Australia or internationally. A 2004 National Worksite Health Promotion Survey found that the majority of organisations in America prohibited alcohol and drug use (91% and 93%, respectively), but that provision of support for AOD problems was much less common (36%) (Linnan et al., 2008). Australian data from 1996 similarly found a high prevalence of smoking- and alcohol-free workplaces (46% and 77%, respectively) (Richmond, Heather, & Holt, 1996b), and fewer tobacco and alcohol programs (43% and 24%, respectively) (Richmond, Heather, & Holt, 1996a) among the top 600 companies in Australia.

However, there is a paucity of current nationally representative data regarding workplace AOD policies in Australia. Organisations seeking to promote healthier behaviours amongst their employees urgently require up-to-date, accurate, and evidence-based information regarding the nature, extent, and effectiveness of such policies. The current study therefore sought to explore the prevalence and types of AOD policies present within Australian workplaces and industries, and the relationship between AOD policies and substance use behaviours among employees who drink or use drugs.

Method

Dataset

This study involved secondary analyses of the 2010 National Drug Strategy Household Survey (NDSHS). The NDSHS is a national triennial cross-sectional study of awareness, attitudes and behaviour concerning alcohol, tobacco and other drugs amongst Australians aged 12 years and over. The NDSHS utilises a multi-stage stratified sampling technique. Data are weighted by age, gender, and geographical location to provide a nationally representative sample of the total Australian population. The survey was administered in all Australian states and territories. Full details of the sampling and weighting procedure are available elsewhere (Australian Institute of Health and Welfare, 2011). The total number of useable surveys returned was 26,648, with an overall response rate of 50.6%. For the purposes of the current study, only data from participants who were aged 14 years and above and in the paid labour force at the time of survey completion were included. This resulted in a total analysis sample of 13,590.

Measures

Demographic characteristics

Demographic characteristics of interest were age, sex, gross personal income, marital status, education (completed high school yes/no), rurality and industry. Rurality (major cities/inner regional and outer regional/remote) is a measure of participants' location at the time of survey completion, based on the Australian Standard Geographical Classification (Australian Bureau of Statistics, 2011). Industry of occupation was classified according to the Australian and New Zealand Standard Industrial Classification (ANZIC) (Australian Bureau of Statistics, 1993).

Workplace policies

Participants were asked to indicate from the following 10 multiple response options which drug and alcohol policies, if any, their workplace had in place: unsure if an alcohol or drug policy exists; none; no policy on alcohol or drug use; a policy on alcohol use; a policy on drug use; drug testing; alcohol testing; provision of education or information concerning alcohol or drugs; access to any type of assistance with alcohol or drug problems; and access to any type of assistance with quitting smoking. For the purposes of the current study, the 'smoking' and 'unsure' options were excluded.

Responses were aggregated and re-coded into two policy variables. The first policy variable allowed for analysis of the prevalence and impact of different types of AOD policy. It comprised six umbrella categories, with each category representing policies of similar type and scope. The six categories were: 'none'; (no policies in place); 'use' (a policy on alcohol/drug use only); 'use plus testing' (a policy on alcohol/drug use *and/or* drug/alcohol testing); 'assistance' (provision of information/education/assistance only); 'use plus assistance' (a policy on alcohol/drug use *plus* information/education/assistance); and 'comprehensive' (a policy on alcohol/drug use *plus* drug/alcohol testing *plus* information/education/assistance).

The second policy variable allowed for analysis of the prevalence and impact of having 'any policy' in place, compared to having 'no policy'. The six response categories were collapsed into two dichotomous categories, whereby the 'no policy' group was re-coded as 'no policy in place', and all other groups as 'policy in place'.

Substance use behaviours

Level of alcohol consumption was assessed according to the Alcohol Data Reporting Standards (Roche, Pidd, & Taylor, 2011) and incorporated the NHMRC short-term low risk drinking guidelines (National Health and Medical Research Council, 2009). Accordingly, participants were classified as either low risk drinkers (four or less standard drinks on a single occasion – i.e. without blood alcohol level reaching zero between drinks), risky drinkers (i.e. "binge" drinkers: five-ten standard drinks on a single occasion) or high risk drinkers (11 or more standard drinks on a single occasion) on a weekly basis. Abstainers were excluded from analyses involving alcohol consumption.

Participants were asked to indicate frequency of use of cannabis, ecstasy, meth/amphetamines, cocaine, inhalants, hallucinogens, heroin, ketamine, GHB, painkillers, tranquillisers, sleeping pills, steroids, methadone and other pharmaceuticals for non-medical purposes in the last 12 months. Given the relatively low proportion of participants who reported using most drug types, a combined variable (use of at least one illicit drug in the last 12 months) was created.

Participants were additionally asked to report the number of work days they had missed in the past 3 months due to their personal use of alcohol and drugs; whether they had attended work under the influence of alcohol or drugs in the past 12 months; and whether they usually drank alcohol or consumed drugs at work. Due to the small number of participants who reported