Background and purpose

Based on 21 European studies, Anderson & Baumberg (2006) estimated that productivity losses contributed 47% of the total €125bn social cost of alcohol to Europe. A large recent Australian study found clear evidence that detrimental drinking patterns increased the risk of absenteeism (Roche et al 2008), with frequent high risk drinkers being as much as 22 times more likely to report alcohol-related absenteeism. Harmful alcohol use and episodic heavy drinking also increase the risk of presenteeism, including arriving to work late and leaving work early or disciplinary suspension, resulting in loss of productivity; turnover due to premature death; disciplinary problems or low productivity from the use of alcohol; inappropriate behaviour [such as behaviour resulting in disciplinary procedures]; theft and other crime; and poor co-worker relations and low company morale (Mangione et al. 1999).

Structural factors at the work place can increase the risk of alcohol use disorders (Head et al 2004), and work place-related burnout can increase the risk of alcohol dependence (Ahola et al 2006). Despite the structural relationships between the work environment and the risk of alcohol use disorders, surprisingly few intervention studies have investigated the impact of changing work structures on reducing workplace alcohol-related harm, with brief advice programmes, and programmes attempting to change workplace attitudes toward on-the-job substance use, in addition to training workers to recognize and intervene with co-workers who have a problem being the most promising (Webb et al 2009). There is thus an enormous potential for the better development and implementation of workplace policies and actions that improve wellness at work and lessen the impact of alcohol on health and productivity at the work place, as well as reducing the wider social costs due to alcohol.

Historically, poor information and understanding of the risks of alcohol are perceived by the European population, and extensive evidence suggests that the impact of school-based and public education is very limited in changing alcohol-related behaviour (World Health organization 2009). This would suggest the need for more targeted interventions, such as brief interventions in primary health care settings and those at the work place. The workplace is also important in reaching the middle aged, who are at increasing risk of hazardous and harmful alcohol consumption and of alcohol-related harm, which, unless prevented, could track through to retirement and older age (Anderson 2009). However, it should also be noted that, and although this is not a main aim of EWA, to be effective, work place alcohol policies and other similar targeted interventions need to be embedded within and backed up by broader effective and cost-effective structural policies, such as those that regulate the price, availability and marketing of alcohol (Anderson et al 2009).

Throughout Europe, little is known about the extent and depth of work place policies on alcohol. The European Commission co-financed FASE project, which, amongst other activities, aimed to collect examples of good work place practices for alcohol-related harm across all of the European Union, has identified only a small number of such practices. This suggests that further and more extensive initiatives are needed to identify and document such practices. It also suggests that further support is needed to develop toolkits, which can be implemented to achieve the potential of better and more extensive workplace policies on alcohol.