Good practice report and compilation of case studies

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Good practice report
Summary

Background

The overall objective of the EWA project is to develop and disseminate a cross-cultural tool-kit able to support the implementation of workplace-based interventions that will bring about reduced alcohol consumption and alcohol-related problems amongst the European workforce.

This report outlines the first phase of the EWA project, consisting of the preparation of 24 workplace case studies following a common protocol.

Methods

Companies that had carried out some type of alcohol interventions were engaged with, in order to present their experiences as “case studies”. This would help to identify examples of good practice while obtaining a general overview of what the situation is like across Europe: the common issues and the main differences.

A form, specifying the content and the format the case studies should have, was designed for standardised data gathering in order to facilitate subsequent analysis of the information.

Information collected included general data from the country and the participating company, information about the intervention itself (background and objectives, content and key elements, how was it developed and implemented...), information about the impact and evaluation of the intervention and lessons learnt from the experience.

Results

Thirteen European countries presented one or two case studies making up a total of 24. The participating countries were: Belgium, Catalonia (Spain), Croatia, England, Finland, Germany, Greece, Ireland, Italy, Poland, Portugal, Romania and Scotland. Data gathering was laborious and thorough. Once written in the required format, the case study was presented back to the companies to confirm the correctness of the data. Once approved, the case study was sent forward for analysis, and authors were contacted back in search of clarification or completion of information as needed.

At the level of analysis, conceptual and integrative efforts were made to overcome the intrinsic differences between companies and countries, in order to draw conclusions from the common elements. Lessons learnt exposed in the case studies were summarised and systematized.

Conclusions

The situation of companies in relation to the handling of alcohol issues in the workplace is very different across European countries and also within the same country, both in relation to content and level of development of the interventions.
Several case studies commented upon the importance of the development and implementation of an alcohol policy as a lasting contribution to the workplace. There was consensus in that policies should be supportive and not just punitive. Occupational health services played an important role in most occasions.

Although most case studies had attempted evaluation, very few produced accurate systematic examples. This is probably due to the fact that evaluation poses an important challenge to companies, mainly due to lack of resources, time constrains and confidentiality issues.

Initial hostility and suspicion was frequent amongst employees and sometimes employers, but, later on, interventions were well accepted, especially if employees and their representatives had been involved. Alcohol continues to be very embedded in traditions, and cultural change is needed: the workplace makes a good place to raise awareness and influence change to healthier patterns.

The conclusions extracted and the “lessons learnt” shared by the participating countries, constitute an important element for the design and implementation of phase 2 of the project (“Preparation of a pilot work plan for implementing new actions on alcohol in the workplace”), by providing hints of what pilot interventions should look like, and taking into account the warnings of what had worked and what hadn’t in other cases in the past.

The information gathered on the case studies of each country provides a very good idea of what is happening with regards to alcohol in the workplace in different European countries, and while there is a selection bias by choosing those specific cases and not others, efforts were made to recruit different types of companies in different sectors of activity: our challenge was to draw a picture of what common practice in the country of origin was like, so that the lessons learnt from the case studies were as wide, detailed and rich as possible.

Introduction

Europe has the highest drinking levels in the world, the highest alcohol per capita consumption and the highest alcohol-related harm problems.

Alcohol consumption has a very negative impact on work: globally, alcohol is the world’s number one risk factor for ill-health and premature death amongst the 25-59 year old age group, the core of the working age population.

However, very little scientific evidence exists on the effectiveness of alcohol interventions in the workplace. There is a lack of standardised approaches to alcohol interventions in the workplace and appropriate evaluation tools are missing too.

The EWA project aims to develop effective methods of engaging with European workplaces, and their workforces, to raise awareness and bring about individual and organisational change that leads to safer alcohol consumption, and thus a reduction in alcohol-related absenteeism, presenteeism and injuries.
The overall objective of the EWA project is to develop and disseminate a cross-cultural tool-kit able to support the implementation of workplace-based interventions that will bring about reduced alcohol consumption and alcohol-related problems amongst the European workforce.

This report outlines the first phase of the EWA project, consisting of identifying best practice examples from the preparation of 24 workplace case studies in 13 European countries following a common protocol.

Methodology

The thirteen participating countries engaged one or two companies each, that had carried out some sort of alcohol intervention. The aim was to identify examples of good practice amongst these companies and learn from their experience, presenting their programme in the form of a case study.

In order to standardise data collection and facilitate subsequent analysis of the information, a detailed protocol had been previously designed specifying the format and content the cases should have. The intention was to give clear instructions to the responsible persons from each country on how to summarise the information required, while not neglecting relevant information. The following information was requested:

- General data from the country including demographic, industrial and economic aspects; Health and Safety legislation; alcohol at workplace legislation, policies or guidelines; and provision of occupational health services at national level.
- General information about the participating company (sector, size, location ...)
- Information about the programme or intervention itself (background and objectives, content and key elements, how was it developed and implemented...)
- Information about the impact and evaluation of the programme / intervention.
- Lessons learnt from their experience.

Data gathering was laborious and thorough. Once written, the case study was presented back in the required format to the companies to confirm the correctness of the data. Once approved, the case study was sent forward for analysis, and authors were contacted again to request clarification or completion of information as needed.

Annex 1 includes the case study protocol, the identification template for each company, and the form explaining the information needed.

At the level of analysis, conceptual and integrative efforts were made to overcome the intrinsic differences between companies and countries to draw the conclusions from the common elements. Lessons learnt exposed in the case studies were summarised and systematized. Annex 2 shows the checklist used for extracting and analysing the information from the case studies.

This has allowed to draw a general picture of what good practice in managing alcohol at the workplace looks like in Europe, and the conclusions extracted and the “lessons learnt” shared
by the participating countries, will help in the design and implementation of the next step of the project, by providing hints of what pilots interventions should look like, and taking into account the warnings of what has worked and what hasn’t in other cases in the past.

The compilation of case studies is published as an independent document with the permission of the participating companies.

## Results

### Country description

The thirteen countries participating in the project were: Belgium, Catalonia (Spain), Croatia, England, Finland, Germany, Greece, Ireland, Italy, Poland, Portugal, Romania and Scotland. Estonia, despite not presenting a case study, will be participating in the next phase of the project, and the country description is included in this part of the report.

### Workplace + labour laws / policies

Table 1 shows a summary of the institutional responsibilities in Health and Safety and the existence of official policies, guidelines, advice and specific legislation for alcohol misuse in the workplace in the different countries.

**TABLE 1** Summary of institutional responsibilities in H+S, specific legislation for alcohol and official guidelines /policies and guidance on workplace and alcohol in the country.

<table>
<thead>
<tr>
<th>COUNTRY:</th>
<th>Belgium</th>
<th>Catalonia</th>
<th>Croatia</th>
<th>England</th>
<th>Estonia</th>
<th>Finland</th>
<th>Germany</th>
<th>Greece</th>
<th>Ireland</th>
<th>Italy</th>
<th>Poland</th>
<th>Portugal</th>
<th>Romania</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there specific legislation for alcohol misuse in the workplace?</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Are there official guidelines / policies on workplace and alcohol in the country?</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Is there official guidance or advice on workplace and alcohol available for companies</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
1. National Health and Safety workplace laws and policies and institutional responsibilities.

Countries who are or form part of a member state of the European Union must implement the European Community Directives on health and safety. In many cases the main law is a transposition of the Framework Directive 89/391/EEC to encourage improvements in the safety and health of employees, although in some countries current legislation on Health and safety is previous to the directive (i.e. The Health & Safety at Work Act 1974, England and Scotland). In some countries this main law has complementary or developing regulations, and in others the law is supported by jurisprudence (judicial decisions and customs).

In any case, all the countries included in this study have national laws on the health and wellbeing of employees in the workplace (table 2) that legislate on health issues as well as safety, hygienic conditions, ergonomics and psychosocial aspects, with a final aim of preventing occupational accidents and diseases. These laws provide a duty on employers to ensure a safe and healthy workplace, and determine the basic body of guarantees and responsibilities establishing an appropriate level of protection of the health of the workers in front of the risks derived from the working conditions.

The responsibility of health and safety issues most times corresponds to the Labour Ministry or both Labour and Health Ministries, although in some occasions it corresponds solely to the Health Ministry or other governmental departments or independent organisms (eg Ministry of Social Affairs in Estonia, Labour inspectorate in Poland or Health and Safety Executive in England and Scotland).

**TABLE 2**

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>INSTITUTIONAL RESPONSIBILITIES IN HEALTH AND SAFETY</th>
<th>Name of main Health and Safety law</th>
</tr>
</thead>
<tbody>
<tr>
<td>BELGIUM</td>
<td>Belgian legislation on welfare at work is the responsibility of the Federal Authorities. H+S depends on Labour Ministry</td>
<td>The Law of August 4 1996 on the wellbeing of employees in the workplace.</td>
</tr>
<tr>
<td>CATALONIA</td>
<td>In Catalonia the Public authorities with competences on Health and Safety are the Ministry of Enterprise and Labour, and the Ministry of Health of the Government of Catalonia.</td>
<td>Prevention of Occupational Hazards Act 31/1995</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Country</th>
<th>Relevant Authority and Details</th>
<th>Relevant Acts and Legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ENGLAND &amp; SCOTLAND</strong></td>
<td>The Health and Safety Executive is an independent body responsible for enforcing the H+S at work Act and a number of other Acts and Statutory Instruments relevant to the working environment: it acts in the public interest to reduce work-related death and serious injury across Great Britain’s workplaces. It is the national independent watchdog for work-related health, safety and illness.</td>
<td>Health &amp; Safety at Work Act 1974</td>
</tr>
<tr>
<td><strong>FINLAND</strong></td>
<td>Ministry of Social Affairs and Health</td>
<td>Occupational Safety and Health Act</td>
</tr>
<tr>
<td><strong>GERMANY</strong></td>
<td>Federal Ministry of Labour and Social Affairs (BMAS) &amp;Federal Institute for Occupational Safety and Health (BauA). OSH Inspectorates in Federal States’ accident insurance institutions</td>
<td>&quot;Arbeitsschutzgesetz&quot; (Occupational Health and Safety Act) &quot;Arbeitssicherheitsgesetz&quot; (Occupational Safety Act)</td>
</tr>
<tr>
<td><strong>GREECE</strong></td>
<td>Ministry of Labour and social security</td>
<td>1568/85 occupational health and safety law and presidential decrees 294/85 and 12/96</td>
</tr>
<tr>
<td><strong>IRELAND</strong></td>
<td>The Health and Safety Authority (HSA) has overall responsibility for the administration and enforcement of health and safety at work legislation in Ireland. It is a national statutory body established by government and linked to the Minister for Jobs, Enterprise and Innovation</td>
<td>The Safety Health and Welfare at Work Act 2005</td>
</tr>
<tr>
<td><strong>ITALY</strong></td>
<td>Health Ministry</td>
<td>Government Decree n. 81 dated 09 April 2008.</td>
</tr>
</tbody>
</table>
Several countries describe bodies responsible for enforcement and for scientific and technical matters related to Health and safety. In some countries these are separate bodies: eg in Catalonia/Spain The National Institute for Safety and Health at Work (INSHT) is the scientific and technical body of the State General Administration, whereas the Labour Inspectorate is responsible for enforcement. Similarly in Greece, the General Directorate of Working Conditions and Health is responsible for legislation, strategy, policies, organization, information, education, training and research issues, whereas the Labour Inspectorate (S.E.P.E.) is the inspection and enforcement authority.

In other countries these two functions are provided by the same body: for instance in England and Scotland (UK) the Health and Safety Executive (HSE) is an independent regulator which acts in the public interest to reduce work-related death and serious injury across workplaces in the UK. It is responsible for enforcing the H+S at work legislation, but it also provides advice, guidance and information to employers, employees and H+S professionals. Similarly in Ireland the Health and Safety Authority is the national statutory body with responsibility for enforcing occupational safety and health law, while promoting and encouraging accident prevention, and providing information and advice to all companies, organisations and individuals.

The European Agency for Safety and Health at Work (OSHA), has information, and in some cases entire texts, about Health and Safety legislation in European countries in 24 languages. http://osha.europa.eu/fop/spain/es/legislation/index_en.stm/ - normativa_nacional

2. Specific legislation for alcohol misuse in the workplace

Only in some countries there is specific legislation on workplace and alcohol or a specific mention is made in health and safety legislation. In all others, workplace and alcohol fall within...
the wider remit of health and safety and employment legislation or alcohol prevention acts, in most cases mainly referring to disciplinary procedures.

All countries have, however, legislation regarding alcohol for certain situations like driving (road traffic legislation) or activities like railway safety, air navigation and merchant shipping, which apply to certain jobs and workplaces. The common issue is risk to third parties, and this legislation tends to specify that acting under the influence of an intoxicant is an offence, and often has specific sections on testing. In Ireland, the Railway Safety Act 2005 does define safety critical tasks and what a safety critical worker is, and in Croatia occupations that require special criteria and for which alcoholism is a contraindication have been identified and are regulated under the "Ordinance on jobs with special working conditions".

Countries which have developed specific legislation on workplace and alcohol are Croatia, Estonia, Germany, Ireland and Italy.

In Croatia, the Act on Work Protection, article 64, 109,112,119, prohibits alcohol consumption before and during working hours, as well as bringing alcohol onto the premises. It also regulates that the employer has to inform employees, has to implement prevention programmes and organise case detection through testing (procedures for this are also regulated). This act also regulates removal from workplace in case of intoxication, alcohol testing in case of accident and disciplinary measures for the employee. Alcoholism is a contraindication for the majority of occupations that require special criteria of health conditions and mental capacities as set up by the “Ordinance on jobs with special working conditions”. These regulations can be accessed in Croatian at:

(http://narodne-novine.nn.hr/clanci/sluzbeni/2009_12_149_3635.html)

In Estonia, the Occupational Health and Safety Act (§ 12 (2) prohibits workers from working while under the influence of alcohol, narcotics or toxic substances or under the significant influence of psychotropic substances.

In Germany there is no general ban on alcohol applicable to all employees or all workplaces, and the focus is on prevention and offering help. Regulations for Prevention of Accidents (Unfallverhütungsvorschrift, UVV) §15 include: "The assured may not, by the consumption of alcohol, drugs or other intoxicant, be in a condition, which puts him or other in danger."§ 7 "Those who [as a result of ingestion of alcohol or other psychotropic substance] are no longer in a condition to perform their duties without danger to themselves or others must be discharged."

In Ireland the Safety Health and Welfare at Work Act 2005 includes a new provision on drugs and alcohol including the following:

An employee shall, while at work-

- 13.1(b) ensure that he or she is not under the influence of an intoxicant (defined as drugs and alcohol) to the extent that he or she is in such a state as to endanger his or her own safety, health or welfare at work or that of any person.
- 13.1(c) if reasonably required by his or her employer, submit to any appropriate, reasonable and proportionate tests for intoxicants by, or under the supervision of, a registered medical practitioner who is a competent person as may be prescribed.
In Italy, the Law n. 125 dated March 30 2001 sets up specific regulations for alcohol consumption in working places. It regulates the prohibition of alcohol consumption in working places, the conditions for alcohol testing by the occupational physicians, and prevents workers under the effects of alcohol from performing tasks with significant risks to self or third parties. This law also foresees that workers suffering from alcohol related diseases can access rehabilitative treatment programs without incurring in the loss of their jobs. The regulation, however, is difficult to apply, as standard criteria have not been determined. It is possible to download the text of the law (in Italian) from internet, using the search words: -LEGGE 30 marzo 2001 n. 125

In other countries, workplace and alcohol is touched upon broadly within the health and safety and employment legislation (Belgium, Catalonia, England, Finland, Poland, Portugal, Romania, Scotland) or alcohol prevention acts (Greece). These legislations might treat alcohol issues in a broad or indirect way, or the law can be interpreted and applied to alcohol.

For instance in Catalonia / Spain the main Health and safety law (Prevention of Occupational Hazards Act LPRL 31/1995) protects especially vulnerable workers, and states that health surveillance must not be discriminatory towards the worker, and should not be used as a company's management tool. The worker must give informed consent to the type of tests performed that have to be proportionate to the risks: in general, alcohol or other drugs tests should only be performed if justified by risk to self or others. This law also states that workers "shouldn't stay in a workplace when obviously in a transient state or situation that make them unfit for their job".

In Poland, the open catalogue of the employee’s basic duties included in the Labour Code (article 100) does not directly ban alcohol consumption, but abstaining from alcohol at work is considered an employee’s obligation as being under the influence of alcohol may endanger the safety of other employees and third parties, and as such violates the mandatory obligation to perform duties in a diligent and conscientious manner by limiting the person's capabilities. The employer should not allow an employee to assume his/her duties in case of a well-founded suspicion of alcohol consumption.

Collective agreements between employers and employees, although not legislative documents, can also emphasize the importance of implementing an effective alcohol and drug policy (Catalonia, Belgium, Finland) and clarify the role of the health and safety professionals and set up the legal framework.

3. Official guidelines/policies on workplace and alcohol

Belgium, Catalonia, England, Finland, Germany, Poland, Portugal and Scotland have developed official workplace guidelines and/or policies on alcohol.

In Belgium, a decision to publish a Collective Agreement (CAO) on Alcohol and substances was made due to the following reasons:

- Considerable legal uncertainty;
- Improvisation in handling substance abuse at work
• safety risks
• reduced productivity
• and danger for public safety

According to CAO 100 (Collective agreement on alcohol), every employer (regardless of size or activity of the company) must develop by consensus and implement their own effective alcohol and drug policy with an emphasis on prevention rather than on sanctioning of problem behaviour. Tests are not prohibited, but if an employer wishes to make use of tests, they should be included in a specific procedure of testing. The role of the occupational health doctor is also clarified. http://www.cnt-nar.be/CAO-COORD/cao-100.pdf

In Catalonia an "Agreement for the prevention and treatment of drug addictions in the workplace" was signed by the Catalan Government and main workers' unions in 2002.

In England and Scotland official guidelines are available through the Health and Safety Executive (HSE) www.hse.gov.uk and practical information on common problems and how to deal with alcohol and drugs issues for employers can be found on http://www.hse.gov.uk/pubns/indg240.htm and http://www.hse.gov.uk/pubns/indg91.pdf

In Finland, an Agreement of the Treatment and Care of Alcohol and Intoxicants in the Workplaces was signed by all principal Social Partners in Finland in 2006. The Agreement gives recommendations and explains the general procedures of the stepwise alcohol and intoxicants treatment and care process. It includes rules and sanctions if the procedure is not followed, e.g., under which conditions a dismissal process can be started.

In Germany, guidelines can be accessed at: ArbSChG: http://www.gesetze-im-internet.de/arbschg/index.html

Regulations for Prevention of Accidents (UVV):
http://www.bgw-online.de/internet/generator/Inhalt/OnlineInhalt/Medientypen/bgw_vorschriften-regeln/BGVA1__Grunds_C3_A4tze_20der_20Pr_C3_A4vention,property=pdfDownload.pdf

In Ireland a government recommendation on alcohol “required employers to have guidelines for workplace alcohol policies to manage the risks associated with alcohol in the workplace and to promote them as part of health and safety”. But to date no national alcohol strategy has been published.

In Poland there is a State Agency for Prevention of Alcohol Related Problems: one of its responsibilities is the creation of anti-alcohol policies in Poland. The general National Program for Prevention of Alcohol-Related Problems 2011-2015, although not workplace specific, includes some workplace-related issues and one of its five priority themes is “Prevention of alcohol-related harm among adults and reduce the negative impact of alcohol on the workplace”. It can be accessed at:


In Portugal, the “Health Promotion and Psychoactive Substances Use Prevention: Guidelines for Workplace Interventions” document was designed in 2010 by the Portuguese Institute on Drugs and Drug Addiction in collaboration with the National Work Conditions’ Authority to define a comprehensive strategy in the workplace area. This consensus initiative involves
increasing awareness and training occupational health professionals, and makes emphasis on prevention and rehabilitation of affected workers.

4. Official guidance/advice on workplace and alcohol available for companies and/or employees

Linked to the guidelines or policies, and in some cases complementary to or independently of them, the same countries mentioned above provide official guidance or advice on alcohol and the workplace.

In Belgium they are available in the web page [www.qado.be](http://www.qado.be)

In Catalonia, employers and employees can access free, official legal advice regarding alcohol at the workplace through the Ministry of Enterprise and Labour (Health and Safety at Work Department), and health professionals from Occupational Health Services can have official guidance on alcohol issues through the Ministry of Health (Drug Dependency Department).

In England guidance and advice are provided by the HSE, available at: INDG240 - "Don’t mix it! A guide for employers on alcohol at work". Apart from the Health and Safety Executive there are some local organizations (like Health Work in Liverpool) who provide support packages on health and safety and well being to employers and employees, including alcohol issues.

In Finland, a four-year project was launched in 2004 to introduce brief interventions for heavy alcohol consumers in occupational health care, and official guidance was provided to OH professionals. The idea was to make brief intervention a routine procedure among health care professionals after asking patients about alcohol use. Interactive training in small groups was provided and tailored to local needs.

In Germany the German Centre for Addiction Issues (DHS) sets up quality standards of occupational addiction prevention and addiction aid. Some guidance accessible in internet is:


Alcohol at the workplace – Practical advices for managers; Authors: German Centre for Addiction Issues (DHS) & Barmer GEK [http://www.dhs.de/fileadmin/user_upload/pdf/Arbeitsfeld_Arbeitsplatz/Alkohol_am_Arbeitsplatz_Praxishilfe_2011.pdf](http://www.dhs.de/fileadmin/user_upload/pdf/Arbeitsfeld_Arbeitsplatz/Alkohol_am_Arbeitsplatz_Praxishilfe_2011.pdf)

In Poland there is some guidance available e.g. e-learning platform for managers (Project “MEPMIS” - Maximising Employee Performance by Minimising the Impact of Substances in the Workplace) but they have not official/nationwide character

In Scotland Healthy Working Lives is the main body providing information and support for health and well-being in Scottish workplaces www.healthyworkinglives.com/. It provides advice on minimising workplace risks, managing ill-health and injuries, and promoting health at work. It runs an advice line and also provides a health promoting awards scheme for employers with bronze, silver and gold level awards, each with different levels of achievement criteria. Introducing an alcohol and drugs policy is a criterion for the silver level award. Organisations can access free advice and support, and in some cases free training, to assist towards achieving their award. Alcohol services in Scotland are provided by Healthy Working Lives through Alcohol Focus Scotland.

5. Promotion of mental health and wellbeing policies at workplace.

Many countries declare that they have general policies on wellbeing and promotion of mental health (stress prevention, diet, exercise, smoking...) In some it is legislated. For instance in Italy, the Legislative Decree N. 81/2008, requires employers to perform a risk assessment for work related stress and elements that can adversely affect mental well-being of workers, and companies must foresee corrective actions.

It is acknowledged that the workplace is a very good setting for health promotion activities for several reasons:

- the population, active and usually healthy, doesn't access the health system very often, and therefore workplace interventions can be a good way to reach them;
- benefits for the company and the employees are easily identifiable;
- the workplace is a limited / specific environment which facilitates design, implementation and evaluation of programmes, and the company can provide infrastructure and resources;

The workplace environment has an important influence in the workers: the workplace itself (including exposures and working conditions), and the high number of hours spent daily.

Several elements were identified that should be considered for the good functioning of the wellbeing programmes at workplace:

- setting long-term goals
- ensuring stable financing and support to guarantee consistency and continuity in undertaken activities
- Good collaboration between different sectors on all levels: local and national, involvement of different stakeholders, strengthening competencies of occupational health professionals and providing training for them.

6. Statutory requirements to provide alcohol services.

The role of the occupational health professional in the work environment in most participating countries is detection/diagnosis and control / follow up, with external referral for treatment. The occupational health professional is mainly involved with the fitness for work evaluation (especially in cases of risk to third parties) and with the recommendation of appropriate work restrictions or adaptations and the occupational reinsertion of the affected worker.
In several countries employers might have an obligation to set up an alcohol policy, and in some cases to advice the affected worker on possible treatments available (usually through the Occupational health department), but as far as we can ascertain from the presented case studies, no obligation lies with the companies to provide those services themselves, although some might provide economic funding for doing so on a voluntary basis.

7. Provision of OHS at national level: Brief description of Occupational Health / Prevention Services

Occupational health services in Europe have a multidisciplinary approach and are roughly staffed by two types of professionals (some variation might exist in different countries):

- Risk prevention specialists cover the following disciplines: safety, industrial hygiene, ergonomics, and psychosocial issues carried out by engineers, psychologists, chemists, etc. The aim of risk prevention specialists is to assess risks derived from work exposures and working conditions and advice employers on how to eliminate or reduce these risks.

- Occupational health professionals: occupational physicians and occupational nurses. In Occupational health services, the main tasks developed by health professionals are related to health promotion and preventive activities, mainly health surveillance and fitness for work evaluation and periodical medical examinations for workers. The clinical part in most countries consists of diagnosis or case detection, with referral for final diagnosis and treatment. However, in some countries a more integral approach is delivered, and occupational health professionals also carry out diagnosis and treatment (sometimes both general health and occupational injuries and diseases, sometimes occupational health problems exclusively), as well as sickness absence management.

The companies can organize health and safety services, via these disciplines, themselves (in-house or internal prevention service) or contract this service through an external occupational health service provider (out-sourced). Usually large companies are obliged or decide to do this, whilst most small and medium sized companies contract external services. 99% of all European businesses are, in fact, SMEs. They provide two out of three of the private sector jobs and contribute to more than half of the total value-added created by businesses in the EU.

In several countries in-house OHS can be seen mainly in public sector and large private enterprises, and outsourced OHS in most medium and small sized enterprises (Belgium, Croatia, Catalonia, Italy, etc).

The provision of health and safety services is regulated in many countries, and in all of them (except England) it is compulsory to offer some sort of occupational health / prevention services to all employees. Table 3 shows the distribution of countries:

<table>
<thead>
<tr>
<th>Is it compulsory for all companies to offer occupational health / prevention services to all employees (i.e. universal cover is guaranteed?)</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
For example, in Belgium, every employer, regardless the number of employees must have a contract with an External Service for Prevention and Protection at Work (non-profit organization). Most companies have external prevention service, and only very large companies have internal prevention service.

In Catalonia, as in the rest of Spain, occupational risk prevention and guaranteeing access to appropriate health surveillance are a legal obligation of employers. There are three types of OHS: In-house OHS (mainly in public sector and large private enterprises); outsourced OHS (in most medium and small sized enterprises and many large companies); the third possibility is that several companies set up a shared OHS (for reasons of geographical proximity or similar economic activity). It has to be noted that a very high number of private companies in Spain are medium or small.

Occupational health and safety services have a multidisciplinary approach and are staffed by two types of professionals:

- Risk prevention specialists: they are trained at University, and can be accredited for safety, hygiene, psycho-sociology and ergonomics. Their aim is to assess risks derived from work exposures and working conditions and advice employers on how to eliminate or reduce these risks.

- Occupational health professionals: occupational physicians and occupational nurses. In Occupational health services, their main tasks are preventive: health promotion, health surveillance, fitness for work evaluation and periodical medical examinations for workers.

In Croatia companies with more than 50 employees have to employ a person in charge of health protection for employees, and companies with more than 250 employees have an obligation to establish a Service for health protection. OHS is external service for all firms. There is a network of 150 OHS services country-wide. Their tasks are to provide regular physical examinations, education, screening for risks on workplaces, education of employers and employees, improvement of work conditions and health promotion. In practice, preventive physical examinations have been routinely performed and all other activities are dependent on the “good will” of employers and there is no enforcement of the law in those segments.

In England it is not compulsory to provide Occupational health in most cases as people can access medical support through the National Health Service. However, in some higher risk workplaces there may be requirements to carry out regular health checks e.g. where exposed to radiation, hazardous chemicals, dusts, asbestos etc to ensure personal health is not affected. In addition there is a requirement to provide access to eye tests for computer users. In most cases it is larger workplaces that have access to Occupational health support. May
Good practice report

have their own Dr’s on site or access local services where employees would be sent. The main prevention services include: lung function testing, blood/ urine testing, eye tests.

In Estonia risk management provision is compulsory in all companies. In workplaces with certain work-related risk factors both risk management and occupational medicine are compulsory. In Estonia, all occupational health care providers are private and working on a contract basis, whereas work-environment specialists (non-medical) can be employed by companies.

In Finland, employers are responsible for organising preventive health care for their employees. Employers can arrange occupational health services by themselves, together with other employers or purchase the services from a private provider. The Social Insurance Institution pays the employers that have concluded an agreement with their occupational health service on activities to maintain work ability, follow up and early support at the workplace 60% of the costs in compensation. If no such agreement has been made the compensation for the costs of preventive occupational health care is 50%. Correspondingly, entrepreneurs and other self-employed persons are paid compensation for the occupational health services they have arranged for themselves.

In Germany, employers are responsible for their employees' safety and health at work. They have a duty to implement the necessary OHS measures, taking into account the circumstances which affect employees' safety and health at work. Employers must review the effectiveness of the measures and, if needs be, adjust them to changes in the prevailing conditions. It is also part of their duty to strive to improve employees' safety and the protection of their health. Employers must appoint safety specialists and company physicians to support them and advise them on OSH questions.

Most companies have external prevention service, only very large companies have internal prevention service.

In Greece the employer is obliged to provide services of safety engineers/technicians in all workplaces, independently of the size of the company and an Occupational Physician if more than 50 employees or special risks exist.

In Ireland, all companies are required to provide information in relation to the prevention of accidents and injuries in the workplace.

In Italy companies must provide a risk prevention and protection service and a company doctor has to be appointed too. Risk management is often provided by an internal service, whilst occupational medicine is usually an externally collaborating physician.

In Poland the type of prevention services depends on the size of the company. Most firms, specially the small ones, have external prevention and occupational health services and the large companies have their own internal staff.

In Romania all companies have to purchase OSH external prevention services (these services are entirely private), and there is one component which is yearly performed, namely medical check-ups. All employees must undergo a yearly check-up, while some of them (based on the occupational hazards they are exposed to) could undergo these medical exams even more often (like catering staff).
In Scotland only very large companies have internal prevention service.

With regards to the nationwide provision of alcohol services in the workplace, the most common situation across the different countries seems to be external coordination with the primary and specialist public health services (Croatia, Catalonia, Scotland, Poland). For example in Scotland since implementation of a National policy: "Changing Scotland’s Relationship with Alcohol: A Framework for Action (2009)" with a whole population approach, the care provided has improved, brief interventions are delivered in primary care and specialized treatment is provided through Alcohol and Drug Partnerships (which receive public funding). Nevertheless, in some cases external provision of treatment is funded by the company (Catalonia, Ireland). In one of the Polish case studies external support is sought from a consultant psychologist.

**Employing body**

The case studies presented were mainly (67%) from large companies (501 or more employees), and the rest (33%) were medium companies (50-500 employees). The public and private sectors were roughly equally represented (54% were private companies). Alcohol services were provided internally and externally in the same proportion (46%), whilst some companies (8%) had a mixed provision of alcohol services (internal and external).

**Alcohol provision**

Thirty three per cent of the companies were locally-based and another 29% were nationally based. The remaining 38% were multinational companies.

**Company location**

The distribution of the companies by sectors of activity (ISIC Rev 4. codes) was not in accordance with usual European patterns, as the services sector was under represented.

This might be due to the fact that enterprises with safety issues (especially if risk to third parties is present) might be more interested and advanced in implementing alcohol programmes. It is noteworthy, too, that 3 companies were within the alcohol business industry (either for manufacturing or distribution), which, again, probably reflects a higher interest about workplace and alcohol issues from this type of companies.
In all but one country (England), all companies have an Occupational Health Service, being an in-house Occupational Health Service in all the case studies sent by the countries except for Croatia, and partially Belgium (in both Belgian case studies there is an internal prevention service for risk management -mainly safety-, with external provision of Occupational Medicine and Psychosocial). And in most cases (77.3%) the Occupational Health Service was involved in the implementation of the alcohol intervention.

We have to bear in mind, though, the size of the companies we are analyzing, and the situation would probably be very different in these same given countries if we considered small companies (which are the vast majority in European countries), as they probably wouldn't have the infrastructure and resources to set up well-being programmes, and more probably would contract external services for health and safety (outsourced prevention services are more common in small and medium sized enterprises in most countries).

Most companies declare that they have a policy on health and wellbeing.
Many case studies explain the development and implementation of a company's alcohol policy. Other case studies present an awareness raising programme, information and training for all the workers, or targeted training for certain groups (for instance managers). In some cases the programme was extended to reach collaborative enterprises (Italy), and even the general population (for example the 2 cases from Greece - both in the alcohol business - had programmes on responsible drinking addressed to the public).

A special mention has to be made of companies with safety critical workers. In these cases the existing or developed policies tend to be very clear-cut, with a zero tolerance for alcohol and frequently with some sort of detection methods described (random testing, testing after accidents, etc) and disciplinary procedures. In fact many companies, regardless of activity, do have some safety critical workers, and these tasks, jobs, and workers are often clearly identified, and, if necessary, regulated separately.

More detailed information about the OHS in each case study is available in table 4.

**TABLE 4**

<table>
<thead>
<tr>
<th>Brief description of OH+S Service in the company, if present:</th>
</tr>
</thead>
<tbody>
<tr>
<td>vg: Internal/External. Occupational medicine, occupational nursing, other disciplines involved (vg. safety, ergonomy, psychosociology, hygiene)</td>
</tr>
</tbody>
</table>

**Belgium:**

**Case I:** Internal prevention service for risk management (mainly safety) /External Occupational medicine and psychosociology. Other disciplines involved: occupational nursing, ergonomy, hygiene.

**Case II:** Idem

**Catalonia:**

**Case I:** With regards to occupational health service provision, they have an in-house service comprising a medical department staffed with one doctor and 2 nurses as well as a safety advisor accredited for ergonomy, hygiene and safety. The medical department carries out promotion and prevention activities, education and training for employees -targeted to the different groups-, health surveillance and fitness for work evaluation and offers first aid treatment. The company has its own insurance to cover clinical treatment for occupational diseases and work accidents of its workers. In practice this means that the medical department is responsible for providing treatment in these cases, through the company's insurance funding for medical tests and external aid from specialists or hospitals when necessary.

For the purpose of this programme they have a contract with a clinical laboratory for blood and urine samples, a contract with a supplier of alcohol breath-analysers and drug tool-kits, and they refer workers for external specialized treatment for drug-dependency problems to the Public Health System when needed.

**Case II:** In-house OHS staffed by 4 health and safety advisors (covering the specialties of Hygiene, Psicosocial, Ergonomy and Safety), 3 occupational health nurses, and 2 physicians,
one of them covering exclusively clinical duties, the other also with managerial duties as the head of the Occupational Health Service. The OHS is directly responsible for the health and safety of the employees, and carry out activities of health promotion, prevention and surveillance as well as education and training. Clinical treatment is provided, both in occupational health matters as in general health. They also refer patients for specialist care when necessary. Also through organised working groups it leads and coordinates the Occupational Health Services (most of them external) of the hundreds of enterprises in the Port. Some examples of APB OHS activities are setting common minimum standards and good practice policies and leading inter companies activities coordination. It also acts as a consulting and mediating body and has an inspection / supervision role to verify compliance to external audit of the enterprises in the Port. They also organise campaigns and meetings on risk prevention, and have open access on-line information with an aim to integrate and promote a preventive culture in the whole Port Community.

<table>
<thead>
<tr>
<th>Country</th>
<th>Case I</th>
<th>Case II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croatia:</td>
<td>External occupational medicine which is in charge of prevention physical examination and other activities if the firm is interested (education, health promotion, improvement of health conditions). Service for health protection is in charge of risk management. All employees have a hygiene supervision two times a year (microbiological screening on gastrointestinal infections and clinical screening on tuberculosis).</td>
<td>External occupational medicine which is in charge of prevention physical examination and other activities if the firm is interested (education, health promotion, improvement of health conditions). There are also clubs for treated alcoholics (something like AA clubs).</td>
</tr>
<tr>
<td>Finland</td>
<td>Occupational Health services are provided by internal arrangement. The occupational health professionals work as a specialist team independent of the employer. Their expertises represent occupational medicine, occupational nursing, psychology, and physiotherapy. Also other expert services can be offered such as ergonomic improvements in the worksites and hygienic measurements in the work environment.</td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td>Internal Occupational Health Service. Audi has an own health department, which coordinates the activities according to health. This department is part of a helping network and cooperates with external medical and social specialists as well as self-support groups.</td>
<td>Particular internal Occupational Health Services in the different departments and lower authorities according to the legal standards. The health and wellbeing policies are based on the manual for Occupational health and safety management system (Arbeitsschutzmanagementsystem, AMS).</td>
</tr>
<tr>
<td>Greece</td>
<td>Internal. Occupational physician, nursing staff, health and safety officer, and ambulance if necessary. Organisation of internal educational &amp; informational sessions on workplace health and safety issues.</td>
<td>Internal. Occupational physician, Safety, ergonomy, hygiene, first aid, emergency evacuation. Risk assessment: understanding the degree of risk associated with an activity and develop action plans to address the risks identified.</td>
</tr>
<tr>
<td>Ireland</td>
<td>The internal Occupational service is provided by a OH doctor and OH nurse and</td>
<td></td>
</tr>
</tbody>
</table>
includes pre-employment screening, risk assessment and health promotion. Alcohol programme is external and is provided through Employee Assistance Programme (EAP) which staff can access directly.

**Case II:** The internal Occupational service is provided by a OH doctor, OH nurses and an administrator and works closely with Human resources and health promotion officer. OHS includes pre-employment screening and on-going work related employee health issues. The company has a written Alcohol and Substance Abuse policy in place. The key elements include advice for managers /supervisors; counselling for staff and referral to EAP service and monitoring progress during treatment. The EAP service is provided externally.

**Italy**

**Case I:** Internal risk management Disciplines involved: safety, ergonomy, psychosociology, hygiene/External Occupational Medicine. No occupational nursing

**Case II:** Idem

**Poland**

**Case I:** Internal. Disciplines involved: safety, ergonomy, psychosociology, hygiene, occupational medicine, occupational nursing. (all of them). In some cases cooperation with external institution involved

**Case II:** Idem

**Portugal**

**Case I:** HSSE Service. Within the scope of Occupational Health we include nursing, , ergonomy, psychological support, anti-stress management, Industrial hygiene. Psychological support and anti-stress management are provided by external providers. Well being program managed by health and HR, ( who have the responsibility of the Health Insurance package)

**Romania**

**Case I:** There is an internal OHS Department with a Manager, a deputy, 2 other staff, an occupational health physician, and 12 trained employees for safety. However the performance of risk assessments, pre-employment medical check-ups, compulsory yearly medical checkups etc, can only be performed by external services (the internal occupational health physician only acts as a consultant).

The HR department, where 2 trained psychologists (specialized in organizational psychology) work, contributes to OSH activities on large scale (especially in assessing employees).

**Case II:** internal OSH office with 2 persons involved, and a team of 6 other trained employees. All OSH related activities (risk assessments, pre-employment medical check-ups, compulsory yearly medical checkups etc) are performed by external services which are contracted by the company.

**Scotland**

**Case I:** Internal OHS. Occupational medicine, occupational nursing. Main activities: health surveillance, immunisation, advice on health at work and a counselling service available. Other disciplines involved: separate health & safety function offering risk assessments and general H&S advice

**Case II:** Internal OHS. Occupational medicine, occupational nursing. The OHS offers a wide range of services to help protect staff from hazards of their work and to support staff with health problems to continue at, or return to, their work, assist the employer in meeting its legal requirements under Health and Safety, Employment and Disability legislation: Pre-
employment health assessment, health surveillance, ill health retirement, immunisation, management and self referrals, workplace visits / assessments, psychological support, promoting attendance, managing work-related stress, needlestick injuries, occupational therapy, physiotherapy, workstation advice. Mental wellbeing and work advice, and general health advice
Workplace alcohol policy and programme

1. Background and rationale

The following are the most common backgrounds and reasons for the programme identified among the different countries:

1. Alcohol consumption during working time or breaks (snack, lunch,...)
2. Alcohol consumption outside work with an impact on work (eg hangovers from binge drinking at weekends)
3. Safety reasons.
4. High risk detected in previous assessments.
5. Concerns about productivity and poor performance, lateness and absenteeism.
6. Concerns about adverse effects on company image and customer relations
7. The obligation to implement an action according to the existence of a law or a collective agreement (Belgium, Italy).
8. The participation of the company in a research study (Belgium).
9. As part of social corporate responsibility
10. Participation of the company in an awards scheme (Scotland)
11. Health promotion and prevention (Germany: target group apprentices)

2. Objectives

The programmes are mainly aimed at

- Contributing to a safer, healthier, more productive workplace (raising awareness about alcohol among staff, changing bad habits, reducing alcohol consumption, creating a positive impact on family and social life). (This is the objective most frequently mentioned by most countries)
- Reducing work accidents and reduction in disciplinary procedures through prevention.
- Reducing sickness absences both in number of episodes and length.
- Promoting and improving communication, relationships, working climate, feeling of belonging and commitment to the company, and the company’s image.
- Ensuring a consistent approach for all staff by reviewing existing policies and procedures, and training management to recognise signs and symptoms, and appropriately deal with alcohol problems.
- Complying with legislation, especially in countries where alcohol at the workplace is specifically legislated, or when there are jobs with risk to third parties’ in the company.
- Providing help to alcohol dependents either through the company itself or by coordinating with community resources (primary care, ex alcoholic clubs, etc.).
3. Description of alcohol policy and programme

3. 1. POLICY

3.1.1 Summary of content

Whilst most organizations mention the existence of internal regulations and value the importance of having them, some have not developed and implemented a formal policy. Policies make procedures clearer and fairer as the same rules will apply to everybody and avoid improvisation.

In those companies who have developed an alcohol policy, it usually includes sections on the following elements:

- the consumption of alcohol at and before coming to work;
- the possession of alcohol in the workplace
- the consumption and use of alcohol at workplace events, client entertaining or when staff are on workplace business
- disciplinary, but also supportive, procedures for breaches of the alcohol policy;
- procedures for dealing with suspected cases of alcohol misuse and with those under the influence of alcohol in the workplace;
- specific categories of workers (e.g. for workplace safety reasons), where appropriate, and potential use of sampling;
- Employee support and confidentiality in relation to alcohol concerns -including clear referral pathways and work adaptation / reinsertion if necessary.

3.1.2 Development of policy. Key elements

Action principles:

Sometimes an alcohol policy is developed as part of a wider programme, which includes other activities (awareness raising, information, training, treatment, etc) exclusively on alcohol; more frequently it is integrated with other projects to improve health and safety at work or includes other drugs too (most times alcohol policies are in fact "alcohol and drugs policy"); sometimes the alcohol interventions are part of a more general wellbeing promoting initiative, and this broader approach seems to be more effective and helps to gain in acceptance.

Pre-assessments of alcohol intake, done on the company's initiative or in the framework of a research study, help to trigger the start of an alcohol intervention and convince employers than an alcohol policy is needed (Belgium, Catalonia)

The alcohol policy is aimed at all workers, with the objective of favouring healthy habits and modifying risky attitudes and conduct, although some of the activities (for instance training) might be targeted to certain groups. And the policy should be sensitive to the concerns of all agents: employer, employees and their representatives.
Implementation in Stages:

In the majority of the cases described, the implementation of a policy is done in stages and the process can be long and has to be carefully planned. Firstly, the drawing up and approval of the alcohol policy can take several months and should go for consultation across the organisation. (In Scotland a 4 month process including the consultation period is described, in Catalonia and Belgium the process took longer). Secondly, the implementation of the alcohol policy itself: this is an on-going activity and ideally should be evaluated and periodically reassessed.

Setting up a leading group:

Several case studies describing policy development emphasize the importance of the involvement of all the parties (including workers representatives) from the very beginning, as this facilitates the process (Catalonia, Ireland). Irish case studies describe equal participation in decision making by management and unions, with equal responsibility and equal ownership. In many cases approval by the ethics or prevention committee is needed (Belgium, Catalonia)

The constitution of a leading group is important, as they should be responsible for coordinating the process and meeting regularly. The use of some guidance tools (provided by external professionals) might help to guide the process.

Some examples of the composition of the working group:

- Scotland: members from Occupational Health, Health & Safety, Human Resources, and Management. There is also trade union involvement.
- England: HR + support from external organisation
- Ireland: Occupational Health, Human Resources and the Trade unions and Professional Body representatives
- Poland: HR department, the unit managers, the prophylactics consultant, and the company physician.

3.2. AWARENESS RAISING, EDUCATION AND TRAINING

In this section, some examples are given from different countries on awareness raising campaigns, promotion and prevention activities, information and training provided, and other activities promoting behavioural change among employees.

Awareness raising campaigns, information and education:

- Awareness raising graphic campaigns with powerful or witty images or messages (Catalonia, Italy). If messages are accompanied by small gifts, this increases interest and participation (Catalonia, Greece)
- Distribution of tools like AUDIT
- Leaflets informing about alcohol hazards, and about the company alcohol policy (Belgium)
- Comprehensive manual to each participant (Scotland)
- Electronic manual for executives (Greece)
- Alcohol awareness packs and tools to assess current drinking levels (England)
- Online course may be useful (suggested in Scotland)
- One to one interviews and assessment of risky drinking with questionnaire (England)
- Promoting non-alcoholic drinks (Catalonia) accompanied with a recipe card for smoothies and fruit juices (England)
- Encourage active participation, in a fun way while delivering serious underlying messages (England, Catalonia, Greece).
- Make profit of corporate events to remind alcohol messages as employees are present in a much more relaxed and receptive state (Greece)
- Inclusion of articles on responsible consumption in the corporate magazine (Greece)
- Poster placements in locations such as the company restaurants and offices (Greece)
- In some cases, broadening the information/education/policy outside the company itself directly or indirectly (i.e.: Catalonia and Italy by agreements with local restaurants/food-drink suppliers; Italy: policy extensive to subcontractors; Greece: information campaigns to general population (for instance written message on all company (brewery) trucks)
- Seek support from governmental (Catalonia) and non-governmental agencies (Greece)
- As part of personal professional development plans of employees (i.e. annual internal seminars in Greece)

Training:

Training was provided internally, externally or with a combined composition. This latter form was sometimes a first step (train the trainers), where some specific groups (eg occupational health or health and safety professionals) were first trained by external providers to capacitate them to carry on with the training internally later on.

In some cases, a specific group (for instance line managers) was trained so the information could afterwards be cascaded to the rest of employees. Some programmes addressed information and training only to targeted groups like in Scotland (managers), or in Italy (HR+ Prevention and health protection service+ health and safety workers’ representatives). Others were addressed to all employees but with specific or wider training to managers (Belgium, England, Catalonia), and some offered general information to all employees. In Germany training was given to all apprentices and their instructors.

Information and / or training for all employees aimed to:

- Inform about the negative effects of alcohol intake on health.
- Inform about the negative effects of alcohol consumption on safety issues at work as well as on productivity and absenteeism.
- Explain the policy or rules and procedures of the company
• Provide information on the treatment possibilities and services for those who already have developed the pathology/dependence.
• Special emphasis is often given on new employees: for instance in Greece they watch a film and are informed about the company’s Alcohol Policy as part of their induction, and in Germany, the target group are all the apprentices in the company.

The final aim would be a change in attitudes and consequently in behaviour towards alcohol consumption.

Training for targeted groups:
Some companies develop activities targeted to certain groups: for instance, groups identified as high risk for consumption, or groups with a higher risk job or just youngest employees in general. In other companies the target group are managers or health and safety professionals.

Training might include:
• Recognizing signs or symptoms of substance use
• Providing knowledge and skills on how to act on this information (understanding the role for a direct superior in the new policy, enabling them in identifying and documenting/ recording the effects of drug and alcohol use, informing management on the critical cases at risk and referring the concerned workers to the occupational physician)
• Learning how to implement the policy (learning about regulations and procedures)
• Gaining skills on how to communicate with employees with poor performance due to substance abuse.

Elements used for interactive training:
The use of interactive elements increases the degree of involvement amongst the participants: for example, in Greece a driving simulator was used where visitors learned how they would have reacted if they were driving under the influence of alcohol, and in England "beer goggles" where used to demonstrate the risks.

Other tools used for information and training were slides or power point presentations, group exercises and role plays, DVDs, quizzes, small group discussions, company's intranet, especially made film about the policy (Greece), discussion of real cases, etc.

3.3. DETECTION OF CASES, TESTING AND DESCRIPTION OF PATHWAYS
The main pathways to detect people with alcohol problems identified through the case studies are:
1- Worker's own request: the worker may confidentially contact the OM department for consultation and / or counselling.

2- During health surveillance or fitness for work evaluation activities: the health professional might detect a problem related to alcohol or other drugs.

3- Case detection by targeted group of staff trained in signs recognition.

Alcohol and substance abuse might appear as an acute, recurrent or chronic problem. The occupational health professionals, if available in the company, should be the best situated for confidentially dealing with the medical aspects of the case, and might have resources for diagnosis, treatment and follow up.

But, many times, managers and supervisors play a key role in the early identification of alcohol and substance abuse problems among staff members. They are best placed to observe the workers behaviour and performance at work and, if adequately trained, can look for the early signs of alcohol and substance abuse, such as: deteriorating job performance, poor attendance, unauthorised absences during the day, poor relationships with co-workers, accidents, complaints by work colleagues or the public, irritability or moodiness, obvious signs of drinking or frequent hangovers.

These groups of trained staff might vary in the different countries. For example, in England, human resources and management are in charge of case detection and dealing with the case in accordance with the procedures set up by the policy; in Italy the head of the Prevention and Health Protection Service and work and safety workers' representatives would refer identified workers to the occupational physician; in Ireland managers and supervisors document the facts and confront the employee: referral to OHD would follow if the problem is acknowledged and disciplinary procedures if not. In Poland supervisory personnel are properly trained, making them aware that concealing alcohol-related problems is a form of mistaken help, and the supervisors who hide cases of alcohol-related disciplinary problems among their employees may face serious disciplinary actions themselves.

4- Case detection of risky drinkers might be done via questionnaire given to the workers in an alcohol campaign which would be confidentially dealt with (eg, Health @ Work, England).

5- During alcohol and/or drugs control tests done during working hours.

If testing is deemed necessary, the procedure to implement it should be clearly written and included in the policy. Testing might be especially relevant in those companies with zero tolerance to alcohol especially for safety reasons (Croatia, Catalonia, etc), but might pose a series of practical, ethical and technical complexities.

Different types of screening tests were used for control checks in the case studies.

- Detection of alcohol in exhaled air (alcotest). A breathalyzer can be used by trained, designated persons.
- Blood and urine samples: performed by the OM Department. The person taking the test should be informed of the toxins analysed and sign an informed consent.
Checks can be done in different situations:

- Planned checks: previously notified to the staff.
- Random checks: done without notification.
- Checks on suspicion of acute intoxication.
- Checks in case of accidents
- Follow up checks: arranged from the OM Department.

In case of refusal to do the test, the person would be treated as if positive.

3.4. ASSISTANCE PROVIDED (help / care offered):

3.4.1 Medical treatment (e.g. brief advice, referral for specialized treatment...),

In some cases, pathways are described on how to help the person identified as having alcohol problems to self-refer him or herself for external support: eg information is given about opportunities for support and help available in the territory for those who are drug-alcohol addicted (Catalonia, Italy, England), or the organisation established suitable referral avenues to aid their employees (England).

In other companies, a global response was given, including in the programme, not only prevention, but also treatment (Belgium), referral to external assistance or even specialized treatment and in some cases also reinsertion of people with drug problems (Catalonia, Germany, Poland). Follow up visits by OH doctor and nurse, mostly on a voluntary basis, is offered in some case studies.

In some case studies, where the occupational physician makes diagnosis of alcohol dependence, the physician refers the workers concerned to the diagnosis and treatment services of the local health service (Catalonia, Scotland, Poland, Italy) and liaises with the employer to put in reasonable adjustments.

Professional secrecy and confidentiality must always be observed.

According to the needs of each person, some or all of the following activities might take place:

- Brief intervention: for persons with high risk consumption. Done by trained OH Department health professional following a structured protocol.
- Counselling and treatment: referral to appropriate specialized centres for monitoring drug addiction and / or treatment. Attendance of family or friends might be encouraged after obtaining consent from the employee.
- Monitoring: joint monitoring of progress done by specialized centres and OH department, preserving confidentiality. Aim: assess adherence to treatment and predict and avoid relapses.
- Occupational reinsertion: supervised by the OH department proposing adaptations to the job. Liaison with employer to put in reasonable adjustments (Catalonia, England).

In the Finnish case study, a nation-wide project to introduce brief interventions for heavy alcohol consumers in occupational health care is described. Interactive training of health professionals in small groups was provided and tailored to local needs. The idea was to make
brief intervention a routine procedure among health care professionals following identification of potential problem drinkers using AUDIT - test. Brief interventions cover a range from one five-minute interaction to several 45-minute sessions. In Finland the recommendation is 15-20 minutes with one to four follow-ups. In the course of the project attitudes became more favourable about brief interventions, and at many workplaces the management strongly supported the preventive activities. The project provided new tools, networks and methods for integrating the brief intervention model into health care services throughout Finland. However, the introduction of brief intervention as a new model in health care has been slow and fraught with obstacles, the main ones being lack of time and adequate reimbursement.

3.4.2 Steps for occupational and social reinsertion

The policy and disciplinary procedures should include the purpose of helping the affected employee and facilitate the final aim of occupational and social reinsertion.

If deemed necessary, the occupational health physician or nurse, with the collaboration of the Health and Safety Advisor, should recommend an appropriate post adaptation to the Human Resources Department.

An interesting issue is described in a Polish case study, where employees who were previously dismissed on alcohol-related grounds and wish to come back to the company would be considered if they have undergone a certified therapy. The employer makes the decision under the advice of the safety / prevention consultant. Upon his / her return the worker is offered a temporary contract with a remuneration package matching the one from the past. This approach seems very humane and beneficial for both the employees and the company as in most cases such employees do not betray the trust the company put in them and the chance to come back to the labour market.

3.5. POLICY ENFORCEMENT MECHANISMS

All available policies describe disciplinary actions including dismissal. Other aspects described are prohibition of alcoholic and super alcoholic drinks consumption on premises, and in some cases communication of such a decision to all the restaurants that offer the lunch service to the employees of the company and spot visits during the lunch break to check compliance (Italy).

In Finland, the person signs an agreement about the conditions under which the treatment and care process is carried out; its duration, the site, and the right of the Occupational Health Care to give information about the process to the supervisor/manager. The person can be notified with a written or verbal notice/warning by the employer. When the treatment and care process is completed, there is an evaluation in which all involved parties can participate; the employer, the representative of the Occupational Health Centre, and the employee with a trade union representative, or a trusted person. If the treatment and care process does not end with a positive result, or if the person does not act in accordance with the signed agreement, the dismissal process can be started. Sometimes, the person is re-employed in a new location, or the treatment process is continued or started again.
3.6. MECHANISMS TO ENSURE SUSTAINABILITY OF THE PROGRAMME

In most of cases the funding or mechanisms to ensure the sustainability of the programme were not mentioned. The funding for the implemented policy or programme itself is seldom mentioned either.

In some cases the intervention in the company seems to be a "one-off" education / training / awareness raising campaign, and if a policy has been developed, the policy itself and its implementation tend to be the most important lasting contribution regarding alcohol in the workplace.

In other cases continuity is given great importance, through the ongoing implementation of the policy or assuring continuity of the programme: for instance on going sign detection of new cases through trained staff, informing new employees of the "no alcohol policy", on going testing of cases (Catalonia) and lunch breaks inspections for alcohol consumption (Italy). In one of the Greek studies, a clear and well organized structure related to responsible drinking was set up, with great emphasis given on passing the message of responsible drinking to the employees and sensitize them. Many other case studies have described companies that have been implementing alcohol programmes or activities for a long time (Catalonia, Poland, Germany, Finland,...), and ongoing activities take place through company’s communication channels(eg intranet, adverts, internal magazine, ...) or through the new employees’ induction programme.

In Germany, the prevention strategy is a permanent measure, and the financing is guaranteed in the long-term for a successful implementation.
Impact of the alcohol programmes

Evaluation is a very important element of any intervention or programme. Most case studies have attempted evaluation, however in many cases results are not yet available or detailed methods and results have not been provided by the company. Accurate and systematic evaluation examples are not common amongst our case studies since most companies do not have the resources to do it, there is lack of time or simply, evaluation had not been planned appropriately. In the cases where evaluation had been done, it was more qualitative than quantitative. In total, of the 24 case studies, 13 had done some kind of evaluation, 3 of them had done a baseline evaluation, and 8 had not attempted evaluation of the alcohol intervention.

Several countries evaluated their training course (Belgium, Catalonia, Scotland, Italy, England, Romania, Germany). In most cases, this evaluation was done short after the course and exclusively on the content, quality and adequacy of the course. A longer term evaluation monitoring would be interesting in order to show the long term effects of the campaign and its effects on awareness, knowledge, attitude and specially on behaviour, with improvement in workplace indicators in parallel with the reduction in alcohol consumption.

Only a few countries evaluated other elements not related exclusively to the training course, and for instance in Scotland all the participants were invited to complete an online survey asking about the training and alcohol & substance policy implementation process, and the perceived impact of the policy implementation itself.

In an Italian case study, quantitative evaluation was undertaken, through the determination of the number of accidents at work and their gravity which had clearly diminished, following the alcohol intervention; but detailed methodology was not provided.
In Belgium, a baseline evaluation with AUDIT questionnaire was done, and there are plans to repeat AUDIT every 5 years, but results are not available yet. A checklist has been developed too, for a qualitative audit of the policy. The checklist and the AUDIT procedure is available from the VAD website: www.vad.be (www.qado.be)

In the German Case study I, evaluation is the responsibility of the Health Department, who develop ongoing formal evaluation of some implementation processes, workshops and training sessions, and also gathers information on follow up of individuals who have attended for counselling. The evaluation found evidence of a positive cost-benefit effect by the programme for the company (saved disability life years, reduction of burden of disease, reduction cost of illness in the isolated case and enhanced satisfaction of employees), although detailed data were not provided.

In Romanian Case I, quantitative analysis of the satisfaction of employees with the intervention was performed, determining its impact in terms of achieving key objectives:

- **Awareness.** The simple recognition of the message was of 46%, and the increase of awareness of alcohol consumption effects after the campaign compared to the awareness before the campaign was of 25%.
- **Providing information.** The campaign determined the employees to look for extra information, mostly through the internet and also with the help of the occupational health doctor.
- **Knowledge.** A percentage of 60% of those who acquired knowledge about the acknowledged problem was recorded.
- **Attitude.** 19% of the evaluations identified significant improvements of the attitudes after the campaign.
- **Behavioural intention.** 28% declared an intention of changing behaviour.

In other cases partial or informal evaluation was performed (for instance interviews or verbal feedback from participants or employers). Some of the issues informed by the case studies from informal evaluation involve, for instance, an improvement in signs, symptoms and tests results of alcohol consumption observed by Occupational Medicine, and data on successful abstinence available from club of alcoholics in treatment (Croatia, Case I).

The second Catalan case study, has been implementing an alcohol intervention for more than 10 years, and although no formal evaluation was performed, the overall number of positive tests to alcohol consumption have drastically dropped from an initial 5-10 % to a 0.5%, and this drop has been more evident in the case of safety critical jobs and activities. The riskiest activities have improved their accident rates (although this cannot be certainly attributed to the alcohol policy), a change in culture has been observed: workers are now more aware of the risks of working under the influence of alcohol and also identify other people's drinking as a danger for themselves, and reckon that seeking help from the company through its OHS is the best way to tackle the problem. Improvement in work climate has been achieved in a double way

- **Directly by diminishing the number of interpersonal conflicts, many of them generated or associated to consumption of alcohol and other substances of abuse.**
- **And indirectly, demonstrating that companies are able of tackling alcohol problems whilst caring for workers who need help.
And last but not least, there are at the moment 65 fully rehabilitated employees that have retained their jobs in the company thanks to the alcohol programme.

Only in two cases (Croatia case II and Catalonia case I) on going, systematic, qualitative and quantitative evaluation of the impact of the programme was undertaken, and details of the methods, specific indicators and results of a systematic qualitative were given.

In Croatia (Case II), qualitative and quantitative evaluation is performed annually, at the end of every calendar year. The main indicators used are: number of positive alco-tests, absenteeism due to alcohol addiction problems, and alcohol related work injuries. Recorded results are analysed, and the evaluation results are used to set the objectives for the following year.

In the Catalan case study I, an evaluation and monitoring system of the programme was developed in a quest for continuous improvement. Key elements for this purpose were the establishment of indicators and the creation of an evaluation committee. A series of indicators were created in order to have reliable information on how the programme was working and to check whether the objectives were being achieved in terms of reduced absenteeism, lower consumption of alcohol and / or other drugs and decrease in accident rates. The following is a summary of the results described in the case study:

1. Increased safety (no workers are under the influence of alcohol and other drugs at work).
2. Reduced sickness absence (significant reduction in days lost to illness and unjustified days lost)
3. Reduction in the need for major disciplinary sanctions related to alcohol or drugs
4. Improvement in the company image and climate. This program has generated a motivational effect, staff feels supported and cared for. The public image of the company’s workers has improved, as assessed by both the company and the workers representatives, and most importantly by the company’s clients.
5. Greater awareness about alcohol and drugs problems, not only in the workplace, but in general. The values transmitted were:
   a. Zero tolerance for drugs and alcohol at work.
   b. Importance of education and training.
   c. Help is available to persons with problems
6. Decreased consumption (less positive test results)
7. Improving communication by promoting the participation of all parties and facilitating accessibility to information and help.
Lessons learnt

General issues

Alcohol and drugs issues are an important topic at an occupational level, and introducing measures for prevention and management is reasonable, often asked for by enterprises and economically cost-effective (Germany).

One of the issues most frequently mentioned in the case studies is that an agreed written health protocol and disciplinary policy is essential.

In view of the cases studied, the most cost effective intervention seems to be the design and implementation of a policy: if well planned and conceived it should not generate much cost, and implementing it in itself has a lasting, on-going effect unlike other one-off activities: its mere existence might act as a deterrent too. Rigid and vague policies should be avoided, and, although disciplinary measures have to be included, it has to be clear, too, that the final objective is to protect and to help, not to punish. Policies have to be periodically reviewed, updated and adapted accordingly.

Another important issue is to plan and design a good awareness-raising campaign and training activities, adapted to the roles and peculiarities of each target group.

With regards to the background, management should be made aware that drug issues affect all environments and tend to affect a subset of the population (therefore a percentage of the workforce will have alcohol problems). This percentage of people at risk can be identified by screening via a validated instrument based on self report. The results might convince management to take action and to develop a proper policy on substance abuse (Belgium, Germany), as confronting the situation with professional expertise is the preferred way to deal with this issues (Ireland). Moreover, the company is one of the major places where a healthier lifestyle as well as other positive patterns of behaviour can be promoted, and that can be put into life only if versatile preventive methods are introduced in full cooperation with both the employees and employers (Poland).

Alcohol issues are often subject to prejudice and taboos, whilst deeply embedded in the local culture and customs. The people in the company (both employers and employees) need time to prepare for the changes. A good idea might be start with a pilot and extend it, pointing towards a progressive implementation, especially if no previous interventions on alcohol have been made. (Catalonia)

The culture has to be ready to accept the changes being introduced, but acceptance in the organisation will grow progressively after introduction of the policy. (Scotland). The aim should be to create a cultural change among the workers so they accept the new policy considering it more as a health and safety opportunity rather than a depriving restriction (Italy). Change of culture should be promoted on a national level, so that workplace interventions are more likely to be effective. "Changes have also taken place in the general culture in Scotland over recent years so that more awareness about alcohol harm has developed and in addition, there is also more awareness of the public’s scrutiny of the behaviour of professionals" (Scotland).
Initial hostility or suspicion among some workers is frequent. Confidentiality, trust and working together are seen by unions as critical to the successful implementation of the intervention. Sometimes colleagues and managers feel that they were doing the right thing by keeping the problem hidden. Fortunately, there is a growing awareness among the employees of the opportunities to address alcohol related issues. This derives from both an increased sensitivity of employers and the fear that alcohol related accidents can lead to negative consequences for the company itself (Italy). Sometimes there may be also a lack of interest in the issue (Romania). This can be improved with interactive activities, involving the participants and presenting real cases.

Initial hostility by the company is also frequent, as they may feel that addressing the issue could lead to the suspicion that there exists a serious alcohol abuse problem within the company (Catalonia, Poland). Other companies, on the contrary see it as an opportunity for contributing to their organisation’s corporate social image (Scotland). To assure continuity, it is crucial that the company’s strategy gives this issue a continuous emphasis. Some companies send the message to their employees (with the aim of increasing their feeling of belonging) that they are their "public image" (Catalonia, Poland) or their ambassadors (Greece), hence emphasizing the importance of alcohol drinking not only during working hours but also outside working hours (for instance in a Greek case study from an alcohol business enterprise, the company’s policy states: "We expect our employees to promote and role model responsible drinking at all times, whether on company business or not. Putting our company’s reputation at risk by not drinking responsibly may be viewed as a breach of this policy and could result in disciplinary action"). The company transforms its employees into ambassadors of responsible consumption. In order to achieve the particular goal great emphasis is paid on information and education of the workforce under the wider prism of company social responsibility. Therefore, employees’ behaviour related to responsible alcohol consumption is not seen and handled as an internal risk issue, but as a further social theme of great importance. Most employers, however, notice this problem only in its final stages when the addicts no longer exercise any control of their actions, however, since becoming addicted is a long process, it is its early stages that are the best moments to provide assistance. Dismissing employees with such problems is by no means a solution since they do need to be provided with help.

Once a decision has been taken to embrace an “alcohol in the workplace” activity, an open environment has to be created in the company to raise concerns. Good team work, high participation and commitment of the whole company is very important (employees, workers’ representatives, management, production departments, human resources, occupational medicine and health and safety departments and health and safety committee) (Belgium, Catalonia, Germany). In any potential intervention it is especially important to get the participation and support of workers’ representatives right from the beginning, otherwise the possibilities of success diminish. Workers must be well informed that the intervention will have a supportive objective, in order to avoid hiding the problems due to an ill-understood protection of the employees’ interests, which would have a detrimental effect in helping the employees who genuinely require help (Poland).

In some instances success seems to be an effect of the involvement and high motivation of a small group of people (Poland, Ireland), but a global, systematic approach and an ability to delegate responsibility are necessary. Some examples are sharing a joint responsibility between management and unions or the selection of a trusted local resource person to liaise.
In fact, a joint approach is essential between unions and management for the credibility and success of the programme. The Irish case study approach involved equal participation in decision making, equal responsibility and equal ownership such as a rotating chairperson and secretary, formal mandates from unions and management and progress reports to ensure wide participation and ownership of the programme.

The planning of the activities is also important, so that they interfere as little as possible with the production processes (it should be done according to the work schedule) (Romania). In all countries the intervention described has been done during working hours and at the expense of the employer.

There is a striking difference in levels of support provided, policies and procedures from business to business. In many cases larger employers are able to provide a wider level of support and are able to invest more financially into staff health and wellbeing. With regards to multinational companies, they often have structures, occupational health provision, well-being programmes, alcohol policies, and a company culture in general which are more related to the central corporate and its own standards than to common practice in the base country itself. They tend to have alcohol policies in place for a longer time with a more consistent approach among workers and standardized procedures, and usually provide economic resources for ongoing education / information / training and awareness raising campaigns. Their alcohol policies tend to be embedded into their social corporate responsibility activities. They also try to encourage in their employees the feeling of belonging, and tend to give much importance to their corporate image. They reckon employees as their "public image", and even "the company's ambassadors", reason for which in several cases the alcohol policies not only regulate alcohol consumption during work, but outside work too.

Although the wish may be there to promote better health and wellbeing, due to organisational constraints smaller workplaces may not have the necessary budget, knowledge and facilities. As a result many rely on accessing cost free support from Government and voluntary sector agencies (England).

Good cooperation with primary care and specialized clinics or ex-alcoholic clubs, for instance, is very important, as it is to find funding for private treatment if establishing links with public services is not possible. In many cases, this is a key element for rehabilitation and social and occupational reinsertion.

The public policy of the country, together with the social security system resources might give good possibilities to develop anti-alcohol campaigns in the companies (Poland). In case of chronic alcohol problems treatment, changes in behaviour and rehabilitation follow a long process, with frequent relapses, so public and social support is essential too (Croatia)

**Lessons learnt for awareness raising campaigns, education and training.**

A one off awareness raising or education campaign in the absence of a wider alcohol intervention is unlikely to produce sustained change, however, for enterprises where no intervention had already been made, or where the culture is not ready, an information
campaign can be a very good first step encouraging enterprises toward developing a real policy in this area.

The content of the intervention should be adapted to the addressees, taking into account the level of knowledge they have prior to the intervention, and the objectives of our training. Sometimes information and training will be addressed to all employees, sometimes only to managers. Other times it will involve all employees but with specific or wider training to managers (for example in recognising signs or symptoms and providing knowledge and skills on how to act on this information and on how to implement the policy). Specific training for health professionals and management is a very important element to consider too. A very mixed nature of groups might make training sessions more difficult for the trainer to ‘pitch’ at the right level.

With regards to information, giving employees alcohol awareness packs and tools to allow them to assess their current drinking levels as well as providing them with the relevant information around units and safe drinking levels will hopefully empower them to make changes regarding their current drinking and long term health effects.

Training courses should not only aim to increase knowledge, but also attitudes, skills and confidence.

Practical cases and interactive strategies are valued positively by attendees. Information and training activities implemented through interactive strategies (such as driving simulator, beer goggles, etc) are very successful since they, in a fun, vivid way, and through personal experimentation, deliver the serious message of the dangers of drinking, facilitating an emotional engagement with the message. If information and training are on-going it is especially important that the message is continuously renewed to maintain interest.

Key elements for a successful campaign/programme (Greece):

- Inventiveness and innovation
- Interactivity
- Continuity

Specific training for health professionals and management is a very important element to consider too.

Lessons learnt for Policy

In many cases, an alcohol policy is written in conjunction with other drugs policies, or forms part of wider well being and health promotion at work activities. According to evidence, this improves effectiveness.

In some case studies, the creation of or collaboration with self help clubs has proven to be very useful (Catalonia, Croatia), given the nature and clinical evolution of chronic alcoholism, and its social implications.
Many case studies advocate for a proactive attitude from the company. For instance in Finland, the policy indicates that, alcohol- and other intoxicant-related problems should be identified at an early stage so that problems can be prevented and harmful effects minimized and eliminated at an individual and workplace level.

Another recurrent issue is that most case studies recommend tailored / custom-made policy, either adapting a good practice template (England) or with the guidance of an external adviser (Belgium), but the final result should be “adapted” to that particular enterprise, and the content agreed by all the parties involved.

Having a reviewed / updated policy and implementing it can be a cost/effective, long lasting instrument to deal with alcohol issues in the workplace. Implementing or updating an organisation’s alcohol policy has the potential to make a lasting contribution by its practice. This will have an ongoing effect on that organisation, especially compared with one-off events to provide information, such as leaflets, which tend to be quickly used up and then forgotten about.

Management frequently believes the alcohol and substance abuse policy is an important document to have. The policy sends a clear message that alcohol abuse is not accepted by employers, and raises awareness among employees that the organisation is serious in its approach to alcohol misuse. Policies make procedures clearer and fairer as the same rules will apply to everybody and for some people the policy can, in itself, act as a deterrent, via the realisation that alcohol abuse can result in a person losing their job if not resolved.

But all the participants in the case studies share the view that policies should include supportive elements and not merely disciplinary ones. For those with alcohol problems the employer can provide a supportive approach for staff willing to engage with treatment. This can be done by incorporating preventive work and by ensuring all staff have a heightened awareness of the issues. Occupational Health Departments can provide a clear path for advising and managing alcohol and substance abuse problems that impact on work performance.

Summary of key elements for a policy (in section 3.1 of this document elements can be found in more detail):

- It should outline clear procedures (a vague policy is of no use): for instance, it should outline procedures specifically in dealing with those under the influence of alcohol in the workplace and it should address consumption of alcohol on the premises (both on a daily basis and for special occasions like celebrations, parties, etc).
- It should not be exclusively punitive, but should include supporting mechanisms (both medical and occupational) for those who need them. Medical support could include care, treatment and/or referral to specialized treatment. Occupational support could include work adaptations and occupational reinsertion after rehabilitation.
- However, the policy has to make clear too, that disciplinary action could follow, and disciplinary procedures should be very clear.
- Safety critical tasks and workers should be identified, and policy, if necessary be adapted accordingly.
- A supporting – confidential atmosphere should be created to facilitate employees confiding sensitive alcohol issues to the appropriate persons. Guaranteeing access to occupational health and safety advice should be sought.
• Managers, human resources and occupational health professionals should have enough training (knowledge and skills) as to act appropriately.

Lessons learnt for Evaluation

Evaluation is an element lacking or not very well developed in most European study cases. Evaluation methods should be carefully planned before implementing the policy or programme.

In theory, the human resources departments of large companies could have or create the necessary systems as to manage the indicators to monitor and evaluate interventions on substance abuse. It could be an issue of good planning and convincing the company to perform the evaluation using the right indicators. In small companies it is not easy to do any form of quantitative evaluation. The figures of absenteeism and the number of cases that suffer from problems due to substance abuse are too small to find any significant result. Only meta analysis from projects in a lot of small companies could solve this problem, but in order to do so, data should be gathered in a similar way in all the different organizations. This is not an easy thing to do since data collection itself is an important cost in this kind of project. (Belgium). Besides, the health and work safety issues are quite complex, as they are the factors that can influence them, and some of the results are not always easily quantifiable or even measurable (Italy).

Frequently neither companies nor authorities are willing to put much effort and resources in the evaluation process, which is, in itself, time and resources consuming.

And even if the company wanted to perform an evaluation, there is a lack of standard procedures available for evaluation and there are no validated instruments for qualitative or quantitative assessment (Belgium). Through the EWA project we expect to be able to help improve this aspect.

Interesting initiatives

Some initiatives carried out in the case studies are described below, as examples of different or interesting ways of implementing aspects of the alcohol programme.

• Cascading information: Target groups, who have had adequate or more in depth training, can act as disseminators/information multipliers. (Germany, Scotland, Ireland).

• Health agent (Catalonia): this figure corresponds to an employee who volunteers to take care of and accompany throughout the process, workers with a positive result in an alcohol or drugs test who give consent to it and accept help from the company. It has proven to be a very useful figure, but finding a committed person who enjoys the full trust of both the company and the workers is a prerequisite. It is extremely
important to carry out a good selection and training process, and establish clear roles and functions as it is a very sensitive post.

- Employee Assistance Programme (EAP) (Ireland): established internally, available to all, easily accessible, self-referring and confidential. Aim of resolving problems before they led to a serious deterioration in behaviour or performance. Had the figure of a Local Resource Person, a person of “high integrity, discreet, compassionate, though firm when necessary”. The service not only addressed alcohol and drugs problems, but covered a wide range of issues which removed the potential of embarrassment for sensitive personal problems. As in the Catalan experience, finding the appropriate person is difficult, and currently the EAP service is provided externally, offering:
  - A confidential free-phone telephone support service for all staff.
  - Work-life information services via telephone/ email on a wide range of issues such as legal, finance and consumer information.
  - Telephone counselling and coaching service
  - Face to face counselling and consultation
  - Online services of information and guidance on a range of issues

- Healthy Working Lives awards scheme (Scotland): HWL is the main body providing information and support for health and well being in Scottish Workplaces. [www.healthyworkinglives.com](http://www.healthyworkinglives.com)

It provides advice on minimizing workplace risks, managing ill-health and injuries, and promoting health at work. It runs an advice line and also provides a health promoting awards scheme for employers with bronze, silver and gold level awards each with different levels of achievement criteria. Introducing an alcohol and drugs policy is one of the criteria for the silver level award. Organisations can access free advice and support, and in some cases free training, to assist towards achieving their award. Given that half of those taking part in one of the Scottish case studies training courses, had come to do so because of their participation in the Health Working Lives Award scheme, consideration should be given on how this scheme (or parts of it) could be replicated elsewhere.

-Viralco project (Belgium):

In 2006 the Health authorities recommended to develop a strategy for the implementation of early identification and brief intervention (EIBI) on alcohol in the Belgian system of occupational health. Securex developed an implementation strategy that would serve as a pilot for a posterior nation-wide implementation. Single Alcohol Screening Question (SASQ) and the Alcohol Use Disorder Identification test (AUDIT) were used as screening instruments (as promoted by NIAAA & WHO). Staff was trained with a programme developed in the Primary Health Care European Project on Alcohol (PHEPA). The software used during medical examinations was adapted to facilitate registration of screening results. Screening of patients during preventive health examinations became a quality objective for 2007 (this motivates staff since their response towards quality objectives decides about salary raise). The results were used to develop a benchmark and to give individual feedback to companies about risk behaviour of their employees. The introduction of an alcohol policy plan was offered to enterprises that scored above the average.
ANNEX I

Case study protocol

What are the aims of the protocol?

This case study protocol developed within the European Workplace and Alcohol (EWA) Project aims to help partners in Belgium, Catalonia, Croatia, England, Finland, Germany, Greece, Ireland, Italy, Poland, Romania, and Scotland to identify and prepare two workplace case studies (Work package (WP) 4) that demonstrate lessons from the development and implementation of workplace practices related to alcohol.

This task is essential to prepare the good practice review report (D 3) that will, along with the literature review, inform the content of the guidelines for the pilot interventions and the individual pilot intervention workplans (D 2). This protocol comprises two parts: identification template and form.

What type of cases are we looking for?

Cases can not only reflect success, but may also identify lessons learnt from failures and difficulties. The intention is to obtain a range of case studies that represent

- Different parts of Europe (north, south, east and west) and newer and older member states.
- Different workplace settings, ranging from large global companies to small and medium enterprises, as well as public and private employers.
- Interventions delivered “in-house” by companies and services delivered by external providers.

What needs to be done?

1. Identify each case, copy and fill in the template (one for each case) and send it before the 15th of April, 2011.
2. Complete the form and send it before 30th June 2011.
3. Help the SARD team with any queries or requests for additional information (July-September 2011).
4. Participate in the case study review seminar (October 2011).
5. Check and approve the final good practice review report (December 2011).

What should you take into account?
The case studies, when possible, should be prepared jointly by the EWA partner and the respective contact point in the chosen workplace setting.

The author should provide contact details for further analysis.

Instructions and recommendations are provided to help the standardization and analysis of information but forms are flexible enough to cover different types of cases. Try to stick to the length recommended and be as concise as possible but provide complementary links and references for further reading and analysis.

The template covers basic information about the type and location of the company.

The form covers 5 different areas of information:
- the country, its relevant alcohol policies and workplace and labour laws;
- a description of the employing body, whether or not it is public or private, its services and goods provided, the number of employees and general approaches to health and wellbeing;
- its current alcohol policies and programmes, including their rationale, key elements, history and implementation;
- any evidence of the impact of the policies and programmes on employee alcohol consumption and alcohol-related harm, sickness absence, accidents or productivity;
- lessons learnt of the good and bad aspects of implementing and managing the policy; and key take-home messages for other employing bodies.

Identification template

Respondent’s contact details:

Name: 
E-mail: 
Telephone: 
Country: 

Profession
- Practising health care professional
- Academician
- Manager or administrator
- Policy maker
- Other (please specify)

Case Nr: 1  2
Name of the case: 
City: 

Type of company (Please mark one response in sections a, b, c and d):

a) Ownership?
- public
- private
- voluntary

b) Sector (ISIC Rev 4. codes)
- Agriculture, forestry and fishing
- Mining and quarrying
- Manufacturing
- Electricity, gas, steam and air conditioning supply
- Professional, scientific and technical activities
- Administrative and support service activities
- Public administration and defence; compulsory social security
Good practice report

- Water supply; sewerage, waste management and remediation activities
- Construction
- Wholesale and retail trade; repair of motor vehicles and motorcycles
- Transportation and storage
- Accommodation and food service activities
- Information and communication
- Financial and insurance activities
- Real estate activities
- Education
- Human health and social work activities
- Arts, entertainment and recreation
- Other service activities
- Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use
- Activities of extraterritorial organizations and bodies

C) Company size?
- Very small enterprise (under 10 staff members)
- Small enterprise (10 to 50 staff members)
- Medium-size enterprise (50 to 500 staff members)
- Large enterprise (501 and more staff members)

How many are employed:

D) Location?
- Company is situated at one location (national or local)
- Company with a headquarters and one or more other branches/locations (national)
- Multinational company

Alcohol practice provision
- Internal service
- External service

Details of the contact point at the workplace
Name and last name: 
E-mail address:

Job
- Management
- Health professional
- Prevention work place risk responsible
- Human Resources
- Other:

Form

Country (2 pages common for both cases)

Instructions: This section should give information on the following aspects:
- **The country characteristics (basic facts about the country, population, etc)**

- **Economic context (general economic figures (GDP per capita), brief description of the economic and industrial activity, employment and unemployment rates)**

- **Relevant alcohol policies (references, links and description of the main elements - sources: WHO, WHO-EURO, HP-Source)**

- **Workplace and labour health laws/policies and institutional responsibilities (brief description, references and links) including:**
  - Provision of occupational health services at national level
  - Safety and health at workplace policies
  - Promotion of mental health and wellbeing policies
  - Alcohol and drugs at workplace policies and statutory requirements to provide alcohol services.

  *Other sources: Eurostat, United Nations Statistics Division and ILO*

**Employing body (1 page)**

*Instructions: This section should give information on the following aspects:*

- Description of the employing body: public (national/regional/municipal) or private (legal status), economic/industrial activity (ISIC Rev 4. codes), services and goods, the management and the structure and the number and job category of employees.
- General policies on health and wellbeing.
- Type of occupational health service provision (external or internal) and functions (surveillance of environment and health of workers, education and training, promotion and prevention activities, care and referral to health services).

**Workplace alcohol policy and programme (2 to 4 pages)**

*Instructions: This section should give information on the following aspects:*

- Background (workplace drinking norms and organizational culture, alcohol consumption and related problems) and history (previous attempts, etc)
- Rationale and objectives
- Key elements (Alcohol policy development (building partnership, union-management debate, strengths and weaknesses), surveillance (environment and health of workers), education and training (information and skills provided), promotion and prevention activities (raising awareness campaign, detection and brief advise, etc), care (pathways, confidentiality, etc...), social reinsertion.
- Implementation elements (responsibilities and roles, education and training tools, sustainability and policy enforcement mechanisms, evaluation database and
indicators, etc). NB. For external providers of services this will include detailed description of who delivers services and how services are delivered within workplaces - including the important issue of how workplaces are engaged. Whilst methods maybe similar for both case studies, the actual practice and experience within each workplace should be highlighted.
**Impact of the alcohol programmes (2 pages)**

*Instructions: This section should give information on methodologies and key findings:*

- (qualitative and quantitative) evaluation conducted (process, outcome and output) by internal or external services.
- Impact of the policy and programme in any of these areas:
  - Employee alcohol consumption, alcohol-related harm, alcohol knowledge and attitudes towards workplace alcohol drinking
  - Absenteeism (unauthorised absence, lateness, excessive levels of sickness, etc.) and injuries (accidents)
  - Work performance, productivity, cost-benefit, etc
  - Workplace climate and corporate social image
  - Coverage and employee acceptance and satisfaction (trainings, policy)

**Lessons learnt (1.5 pages)**

*Instructions: This section should give information on the lessons learnt of the good and bad aspects of implementing and managing the policy, the elements that work and do not work and provide key messages for other employing bodies and for policy makers.*

Qualitative and quantitative evidence underpinning process lessons (eg feedback from employees, interviews with managers/owners etc) should be incorporated and referenced.
Checklist for extracting and analysing the information from the case studies.

<table>
<thead>
<tr>
<th>Country description</th>
<th>General data</th>
<th>Alcohol policies</th>
<th>Workplace &amp; labour laws / policies</th>
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</table>

<table>
<thead>
<tr>
<th>Employing body</th>
<th>Identification template</th>
<th>Safety critical jobs</th>
<th>OHS: type &amp; functions</th>
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<tbody>
<tr>
<td>Description</td>
<td>General policies on health and wellbeing. Public/private, ISIC Rev 4 code, services + goods, management + structure, number + job category of employees</td>
<td>Yes / no</td>
<td>Functions: surveillance of environment and health of workers, education and training, promotion and prevention activities, clinical treatment provided and possibility of referral to other health services.</td>
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<table>
<thead>
<tr>
<th>Current workplace alcohol policies and programmes</th>
<th>Background and history</th>
<th>Rational &amp; objectives</th>
<th>Implementation elements</th>
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<tr>
<td>Description</td>
<td>Workplace drinking norms and organizational culture, alcohol consumption and related problems, previous attempts, etc. How the Alcohol policy began to develop (building partnership, union-management debate, strengths and weaknesses, acquisition of information, training and support from the professionals developing the policy)</td>
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<tr>
<td>1</td>
<td>Resources (human and economic)</td>
<td>2</td>
<td>Education and training tools.</td>
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<td>3</td>
<td>Indicators and evaluation methods designed. (Specify responsibilities + roles)</td>
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<thead>
<tr>
<th>Description of alcohol</th>
<th>POLICY 1.1 Summary of content, 1.2 Development (action principles, implementation in stages, setting up a leading</th>
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<tr>
<td>Good practice report</td>
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<tr>
<td><strong>Policy and Programme</strong></td>
<td>group).</td>
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<tr>
<td><strong>2</strong></td>
<td>EDUCATION, RAISING AWARENESS CAMPAIGN, TRAINING (eg. information and skills provided, promotion and prevention activities...). Training for all employees and training for targeted groups</td>
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<td><strong>3</strong></td>
<td>DETECTION OF CASES: DESCRIPTION OF PATHWAYS (eg. random, surveillance,...)</td>
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<tr>
<td><strong>4</strong></td>
<td>Assistance provided (care offered): 4.1 Medical treatment (eg. brief advise, referral for specialized treatment,...), 4.2 Steps for occupational and social reinsertion,...</td>
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<tr>
<td><strong>5</strong></td>
<td>Policy enforcement mechanisms.</td>
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<td><strong>6</strong></td>
<td>Mechanisms to ensure sustainability of the programme</td>
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<th>Evidence of the impact of the policies and programmes</th>
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<td><strong>Evaluation</strong></td>
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<td><strong>Impact for employee and employer</strong></td>
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<tr>
<th>Lessons learnt + key messages (for employing bodies + policy makers)</th>
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<tr>
<td><strong>Good and bad aspects, what works and what doesn’t</strong></td>
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<tr>
<td><strong>Qualitative and quantitative evidence</strong></td>
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<tr>
<td><strong>Interesting initiatives</strong></td>
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Case studies
Belgium is a federal state. Under the reform of the state, the pyramid of the unitarian state made way for a more complex three-level structure. At the top level, we now find the Federal State, the Communities and the Regions, all three of which are equal from the legal viewpoint. They are on an equal footing but have powers and responsibilities for different fields.

Apart from the Federal State and the Communities, there are the Regions. There are three Regions. The names of the three regional institutions are borrowed from the name of the territory they represent. So we refer to (from north to south) the Flemish Region, the Brussels-Capital Region and the Walloon Region.

Their powers have been extended in the course of the various reforms. During the second reform of the state in 1980, the Flemish and the Walloon Region were given their Parliament and Government. The Brussels-Capital Region, on the other hand, was only granted its institutions during the third reform of the State in 1988-89. The population elects the members of the Regional Parliament directly every five years.

The Regions have legislative and executive organs: these are known as the Regional Parliament and the Regional Government. One should not forget that in Flanders, the Community and Regional institutions were merged. So in Flanders, there is one Parliament and one Government.

Regions have powers in fields that are connected with their region or territory in the widest meaning of the term. So the Flemish Region, the Brussels-Capital Region and the Walloon Region have powers relating to the economy, employment, agriculture, water policy, housing, public works, energy, transport (except Belgian Railways), the environment, town and country planning, nature conservation, credit, foreign trade, supervision of the provinces, communes and intercommunal utility companies. They also have powers relating to scientific research and international relations in those fields.
In addition to the three Regions, the Federal State has three Communities. They are based on the "language". So we talk about the Flemish, French and German-speaking Communities.

The Flemish Community exercises its powers in the Flemish provinces and in Brussels, the French Community in the Walloon provinces, with the exception of German-speaking communes, and in Brussels, the German-speaking Community in the communes of the province of Liège that form the German language area.

Since the Communities are based on the concept of "language" and language is "dependent on the individual", a number of other powers are obviously associated with the Communities. The Community has powers for culture (theatre, libraries, audiovisual media, etc.), education, the use of languages and matters relating to the individual which concern on the one hand health policy (curative and preventive medicine) and on the other hand assistance to individuals (protection of youth, social welfare, aid to families, immigrant assistance services, etc.) They also have powers in the field of scientific research in relation to their powers and international relations associated with their powers.

To this day the social security system and the legislation on labour is still organised at the federal level. Since the last federal election (June 2010) this construction has been under debate. There are opposite opinions about this subject in the north and the south of the country. This inhibits the formation of a new federal government.

The next level down is still occupied by the provinces. Before the state reform of 1993, the provinces were only under the supervision of the central state. Now they are supervised by all the higher government authorities, in the context of the federal, community or regional powers.

At the bottom of the pyramid, we find the communes, which is the level of administration that is closest to the people. Like the provinces, they are under the supervision of the higher authorities. Depending on the powers exercised, they are supervised by the Federal State, the Community or the Region. In general, they are financed and audited by Regions.
The modern, private enterprise economy of Belgium has capitalised on its central geographic location, highly developed transport network, and diversified industrial and commercial base. The first country to undergo an industrial revolution on the continent of Europe in the early 19th century, Belgium developed an excellent transportation infrastructure of ports, canals, railways, and highways to integrate its industry with that of its neighbors. Industry is concentrated mainly in the populous Flanders in the north, around Brussels and in the 2 biggest Walloon cities, Liège and Charleroi, along the sillon industriel.

The GDP per capita in 2010 was 31,518 euro. Belgium imports raw materials and semi-finished goods that are further processed and re-exported. Except for its coal, which is no longer economical to exploit, Belgium has virtually no natural resources. Nonetheless, most traditional industrial sectors are represented in the economy, including steel, textiles, refining, chemicals, food processing, pharmaceuticals, automobiles, electronics, and machinery fabrication. Despite the heavy industrial component, services account for 74.9% of GDP, while agriculture accounts for only 1% of GDP. With exports equivalent to over two-thirds of GNP, Belgium depends heavily on world trade. Belgium’s trade advantages are derived from its central geographic location and a highly skilled, multilingual, and productive work force. One of the founding members of the European Community, Belgium strongly supports deepening the powers of the present-day European Union to integrate European economies further. About three-quarters of its trade is with other EU countries.
Case studies Belgium

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<td>Belgium</td>
<td>4.457.7</td>
<td>4.438.2</td>
<td>4.445.0</td>
<td>4.378.1</td>
<td>4.308.5</td>
<td>4.259.0</td>
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<td>57.0</td>
<td>56.5</td>
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<td>55.0</td>
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<tr>
<td>EU-27</td>
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<td>57.0</td>
<td>56.5</td>
<td>56.0</td>
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1. Quarterly average of the number of employees and self-employed persons, seasonally adjusted.
2. Harmonised data from yearly survey.
3. Euro area = EA-17

Sources: EUROSTAT, NAI

Unemployment, gross data in thousands and of period

Unemployment rate in percentages of the labour force

| Belgium | 0.3 | 0.7 | 0.9 | 0.5 | 0.4 | 0.9 | 0.9 | 0.8 | 0.5 |
| Euro area | 1.1 | 1.1 | 1.1 | 1.0 | 0.9 | 1.0 | 1.0 | 1.0 | 1.0 |
| EU-27 | 0.9 | 0.9 | 0.9 | 0.9 | 0.9 | 0.9 | 0.9 | 0.9 | 0.9 |

1. Fully unemployed persons receiving benefits, compulsorily and voluntarily registered job seekers, gross data.
2. Harmonised data derived from the Labour Force Survey (LFS, population older than 15 years), monthly adjusted.
3. Euro area = EA-17

Unemployed job seekers

- Relevant alcohol policies

The consumption of Belgium expressed as liters of pure alcohol per capita is intermediate compared with the level of our neighboring countries and decreases slightly compared to the EU mean, but remains well above Nordic and UK values (see figure).
-Workplace and labour health laws/policies and institutional responsibilities.

Provision of occupational health services at national level

The preparation and implementation of Belgian legislation on welfare at work is the responsibility of the Federal authorities. During the last decade many European directives and international conventions concerning wellbeing at work are converted into Belgian law.

The Law of August 4th 1996 on the wellbeing of employees in the workplace is the Belgian Basic Law in this area. This law acts on safety and health but also on all other domains of wellbeing at work. This includes the psychosocial aspects, the ergonomic approach, the hygienic conditions and the prevention of occupational accidents and diseases.

This law is the transposition of the Framework Directive 89/391/EEC to encourage improvements in the safety and health of employees.

A EDPB (External Service for Prevention and Protection at Work) is a non-profit organization that specializes in services to employers to implement this legislation. Every employer must have a contract with an EDPB, even if he employs only one person. The law defines five disciplines that must be present in each company. Few companies can organize all disciplines themselves in their internal prevention service. Only very large companies do this. Many small companies have no internal competence at all and rely completely on their external service for the implementation of the legislation.

The external service always consists of two sections:

1. A 'risk management' department, led by an engineer. It consists of five disciplines:

Safety
Safety and health at workplace policies

The content of the European directives on safety and health is implemented in legislation via the Belgian Codex about Wellbeing at Work. The decisions in this codex are constructed according to a philosophy that is innovative compared to those which were assumed in the General Regulations for Labor (ARAB), the former codification of rules on occupational safety and health.

While the current regulations are based on the prescription of specific targets the former ARAB contained more detailed regulations on resources. The law on wellbeing and the Codex define less detail on technical requirements and emphasize the need for appropriate prevention based on a proper risk analysis.

Much of the ARAB is now replaced by new “Royal Decrees” that form part of the Codex. In the foreseeable future ARAB will disappear because the remaining legislative issues will be transferred to the Codex. Collective agreements between employers and employees sometimes act on issues which cover wellbeing at work.

Alcohol and drugs at workplace policies and statutory requirements to provide alcohol services.

The National Labor Council had the consequences of substance abuse in the workplace on the agenda for a long time.

The reasons for publishing a collective agreement (CAO) on alcohol and substance use problems were numerous:

- Safety risks
- Reduced productivity
- Danger for public safety
- There was considerable legal uncertainty
- There was a lot of improvisation in handling substance abuse at work

CAO 100 places emphasis on the implementation of an effective alcohol and drug policy in the Belgian companies, and clarifies the legal framework. The role of the occupational health doctor is also clarified.

The collective agreement is valid for any private company in Belgium, regardless of size or activity of the company. A CAO itself is a non-legislative document. It is a framework which means that every employer must enter their own policies. The emphasis is mainly on
prevention rather than on sanctioning of problem behavior. Tests are not prohibited, but if an employer wishes to make use of tests, they should be included in a specific procedure of testing.

The CAO emphasizes the relationship between substance abuse and functioning. In fact, this is a very modern collective. The practical application relies strongly on the implementation of some form of performance evaluation in the company.

The CAO makes a distinction between two phases:

First phase: policy intention. The first phase is mandatory for every company. The purpose of the first phase is that the social partners in the company reach a consensus and the outlines of a policy. This written consensus will automatically be part of the work rules.

Second phase: The second phase is not mandatory but is recommended in companies where the "necessity" is present. The notion of 'necessity' is not defined, but you might think of: specific risk behavior, specific groups of employees, screening results during medical examinations, other qualitative information from the company, etc.

The process diagram above shows the content of phase 1 and phase 2. Phase 1 corresponds to the orange boxes. Vision Statement and sensitisation are the ideal start and are necessary to develop a policy.

In real life phase 1 will not be sufficient. If an employer wishes "appropriate behavior", he will have to develop further action as part of phase 2 of the collective agreement.

Phase 2 starts with an initial audit. This can be both qualitative and quantitative. In a qualitative audit current procedures and regulations are compared with the intentions mentioned in the vision statement. It examines the changes and innovations necessary to achieve the desired policy. It is important to determine the indicators on which the policy will eventually be evaluated. In this context it might be interesting to perform also a quantitative audit with validated instruments.
The further development of Phase 2 is translated into an action plan. An effective alcohol and drug policy, according to CAO 100 is based on four pillars that were developed by the VAD (Association for Alcohol and Other Drug Problems).

Working on the 4 different pillars is important to get involvement of all social partners but is also essential to achieve an effective policy for employees.

The procedures are particularly applicable to the hierarchy. These procedures must specify what the manager should do if he suspects problems concerning substance abuse. If the policy claims the necessity to introduce testing, one of these procedures should also describe the circumstances and conditions under which tests are used and how the results are handled.

The regulations must describe what is permitted in the company, where alcohol may or may not be consumed and how much. It should describe which sanctions are provided for non-compliance with the regulations.

Training and education are essential for the implementation of a preventive policy. The training of managers will ensure that conversations between supervisors and employees are held in the right manner.

Finally, it is important to draw a framework to help employees with an addiction problem who do not succeed on their own to adapt their behavior. Here is an essential role for the occupational health doctor who is trained to make an assessment on abuse and who can organize referral for specialized treatment.

**Viralco project**

In 2006 Health authorities recommended to develop a strategy for the implementation of early identification and brief intervention (EIBI) on alcohol in the Belgian system of occupational health. Meta analysis of RCT’s shows that brief interventions can reduce hazardous consumption with 30%. Securex provides occupational health care to 310000 people in Belgium. We developed an implementation strategy that should be considered as a pilot-study for nation wide implementation.
We used the Single Alcohol Screening Question (SASQ) and the Alcohol Use Disorder Identification test (AUDIT) as screening instruments as promoted by NIAAA & WHO. Staff were trained with a program developed in the Primary Health Care European Project on Alcohol (PHEPA). The software used during medical examinations was adapted to facilitate registration of screening results. Screening of patients during preventive health examinations became a quality objective for 2007. This motivates staff since their response towards quality objectives influences salary rise. The results were used to develop a benchmark and to give individual feedback to companies about risk behavior of their employees. We offered the introduction of an alcohol policy plan to enterprises that scored above the average.

107,370 employees were eligible for screening. 46% of the eligible population was screened with AUDIT. 13.13% of people screened were identified as risky drinkers. Men scored significantly higher than women (17.96% vs. 6.14%). Both the participation rate and the percentage of people at risk varied significantly among nurses and medical doctors. There was no correlation between % screened and % identified.

Blue collar workers are more at risk than white collar workers (16.82% versus 10.15%). There were also significant differences in risk behavior between age groups.
Case Nr: 1
Name of the case: Resilux
City: Wetteren Damstraat 4

Type of company:

Ownership
X public  [ ] private  [ ] voluntary

Sector (ISIC Rev 4. codes)
[ ] Agriculture, forestry and fishing
[ ] Mining and quarrying
X Manufacturing
[ ] Electricity, gas, steam and air conditioning supply
[ ] Water supply; sewerage, waste management and remediation activities
[ ] Construction
[ ] Wholesale and retail trade; repair of motor vehicles and motorcycles
[ ] Transportation and storage
[ ] Accommodation and food service activities
[ ] Information and communication
[ ] Financial and insurance activities
[ ] Real estate activities
[ ] Professional, scientific and technical activities
[ ] Administrative and support service activities
[ ] Public administration and defence; compulsory social security
[ ] Education
[ ] Human health and social work activities
[ ] Arts, entertainment and recreation
[ ] Other service activities
[ ] Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use
[ ] Activities of extraterritorial organizations and bodies

Company size?
[ ] Very small enterprise (under 10 staff members)
[ ] Small enterprise (10 to 50 staff members)
X Medium-size enterprise (50 to 500 staff members)
[ ] Large enterprise (501 and more staff members)

How many are employed:

Location?
X Company is situated at one location (national or local)
[ ] Company with a headquarters and one or more other branches/locations (national)
[ ] Multinational company

Alcohol practice provision
[ ] Internal service  X External service
Case I

Employing body

Since its foundation, the production of PET (polyethylene terephthalate) preforms and bottles has been the core business of RESILUX. The preforms are blown into bottles by RESILUX or by the customer and then filled with water, soft drinks, edible oils, ketchup, detergents, milk, beer, fruit juices, etc. The distinctive characteristic of the Belgian company is the high quality of the products and reliability of supply.

RESILUX NV, Belgium

RESILUX is a family company by origin that was founded in June 1994, and since 1997 it has been listed on the Brussels Stock Exchange (Euronext). The company has an extensive network of sales and service offices in various countries. Alongside the main unit in Belgium, RESILUX has also created production units in other countries in just a few years, i.e. Spain (1997), Russia (1998), Greece (2000), Switzerland (2000/2001), Hungary (2002) and a joint venture in the United States of America (2001). RESILUX has sales offices in the above countries, as well as in many other countries on different continents. All these countries have their own specific characteristics that influence the growth dynamics.

The strong position of RESILUX is due to a very high level of productivity, and its technological leadership, where the quality aspect comes first. Production is highly automated and production technology has to a large extent been optimised in-house. Part of RESILUX's know-how is protected by patents and registered designs.

In 2011 Resilux Belgium employs about 115 people. This is significantly more than in 2007 when the project was started.
Resilux has an internal prevention service which is mainly involved in safety at work. Occupational health is provided by Securex External prevention service. Securex also provides consultancy on psychosocial issues.

**Workplace alcohol policy and programme**

Resilux is a small company. The company has enjoyed fast growth over the last decade. No major malfunction has been recorded over the last years due to substance abuse. In the past there were no previous attempts to implement a policy on substance abuse. The company is relatively small and colleagues and supervisors are very close to each other.

There were no reports of employees or supervisors about alcohol consumption.

**-Rationale and objectives**

During preventive visits both the internal prevention advisor and the occupational health doctor noticed that in several occasions numerous empty beer cans could be found in the company premises. This proves consumption of alcoholic beverages during working time.

Several functions in the company are considered to be “safety functions”. This means the employee can bring persons into danger if not fit for work. The consumption of alcohol during work can cause unsafe situations and worries management and the prevention advisors.

A second finding that convinced management to take preventive action were the results of the Viralco project phase 1. Securex external prevention services presented the results of the screening that took place during visits to the occupational health doctor in the period 2007-2008. In this period 63 employees of Resilux visited the occupational health doctor. (eligible population for screening). 57 men and 6 women. 4 men refused to participate to the screening. 49 persons were screened with the AUDIT questionnaire. Participation rate is 77%. 9 employees scored higher than 8 on the AUDIT questionnaire. 18% of the Resilux population is at risk which was significant higher that the average found in the Viralco project.
Key elements

Phase 1: vision statement and policy intention

A working group was created to develop this first phase.

Although there was strong suggestion from the external consultant, Resilux management chose not to invite union representatives in the working group. They could only discuss the final document at the end of phase 1.

The following people were actively involved at the start of the process in Resilux:

- HR manager
- Prevention advisor
- Technical director
- Quality control
- Supervisor weekend-team
- Responsible for production
- Technical director assistant Securex
- Psychologist (from Securex)

The psychologist took the lead of three consecutive meetings. Each meeting was prepared with the help of two questionnaires prepared by Securex.

These questionnaires assess the current practice and desired policies of the various members of the group.
After the different meetings a text was conceived by the psychologist who was then submitted for comment by the members of the group and the members of the direction. The psychologist reworked the text based on the comments. Agreement was finally reached on a version that could be presented to the workers' representatives on the Committee for Prevention and Protection.

**Phase 2: introduction of policy on substance abuse**

After the development of the vision statement there was a consensus within the working group to develop the second phase.

- 2.1 Rules and Procedures
- 2.2 Raising awareness for all employees
- 2.3 Training for managers
- 2.4 Providing assistance

**2.1 Module Rules and Procedure**

For the module "Rules and Procedures there were two meetings with the group. The following questions were answered:

- What are the normal regulations in Resilux on bringing alcohol or other substances into the workplace?
- What are the regulations on consumption and availability of alcohol in the workplace?
- What are exceptional circumstances where normal regulations do not apply?
- What do we do when someone is actually unable to work due to substance abuse?

On the basis of these meetings the project consultant delivered a written document with all rules and procedures within Resilux concerning substance abuse at work. This document gives detailed description of responsibilities and roles of all stakeholders.

**2.2 Raising awareness for all employees**

A first attempt to educate employees about hazardous alcohol consumption took place during the screening procedure by Securex occupational health doctor. All employees who visited the doctor during annual medical visit were offered screening. All employees who were at risk (Audit score 8 or higher) received brief intervention. Employees with higher scores (+13) were assessed more properly and referred to specialized care if addiction was suspected (DSM IV criteria).

Resilux wanted to create social support for the introduction of a policy on substance abuse. Resilux provided 2 times 2 sessions of two hours. These sessions were given by an external consultant (psychologist from Securex) in collaboration with Resilux people responsible for
human resources and for prevention and safety at work. All employees were informed about the impact of substance abuse on working performance.

These sessions aimed to raise awareness and behavioural change among employees. All participants received a leaflet with the AUDIT questionnaire and basic information about hazardous alcohol consumption.

In addition, the employees were also informed about the vision statement of Resilux on substance abuse and work, and the rules and procedures that will be introduced. These sessions with direct participation of employees are part of the process to adjust the work rules.

2.3. Training module for direct superiors

Direct superiors play an important role in the approach of substance abuse at work. Adequate training was provided

- Recognizing signs of substance use
- Learning about regulations and procedures at Resilux
- Understanding en recognizing the role for a direct superior in the new policy
- Practising conversation: how to communicate with employees with mal performance due to substance abuse.

This was a highly interactive training, using various teaching techniques (slides, group exercises, role plays, DVD). Therefore, the number of participants was limited to 12. The training for direct superiors lasted a full day. All direct superiors followed the training.

2.4 providing assistance

The occupational health doctor plays an essential role in prevention, but also addresses individual situations. The occupational health doctor gives advice and takes into account the impact of alcohol and drug consumption for the determination of working capacity during medical examinations. Employees have regular periodical visits but also visit the occupational health doctor after a month absence from work. The occupational health doctor gives advice to employees and / or employer in spontaneous consultations in response to substance abuse (referral assistance, advice on temporarily adjusted work ...).

The occupational health doctor is bound to professional secrecy and can not deviate from the normal rules regarding confidentiality. Therefore he can not inform the employer about the medical reasons of any incapacity or advice for customized work, without the consent of the employee.

The occupational health doctor will contact the employees attending physician when necessary and makes the bridge between the organization and external assistance or even specialized treatment.
Impact of the alcohol programmes

The Viralco project was an implementation project and not a research project. There was no specific budget to develop any tools for qualitative or quantitative evaluation.

A research group with project coordinators from Securex and collaborators of VAD en VIGEZ came together several times to develop evaluation tools or indicators to evaluate the project. (VAD is the Flemish association on drugs and alcohol, VIGEZ is the Flemish association on health promotion and disease prevention). This only resulted in a sort of qualitative evaluation.

- Employee alcohol consumption, alcohol-related harm, alcohol knowledge and attitudes towards workplace alcohol drinking

Screening and brief intervention

The screening of Resilux employees took place before the alcohol policy was implemented. There were several proposals to develop a sort of quantitative evaluation.

At this time there is consensus to use the AUDIT questionnaire periodically (e.g. every 5 years) to estimate the evolution in terms of hazardous drinkers within the company. Screening results are mentioned above. Repetition of this screening is prepared but was not yet repeated after the introduction of the formal policy on substance abuse.

- Absenteeism and injuries

Since the size of the company is very small, this kind of evaluation was not taken into account.

- Work performance, productivity, cost-benefit. Workplace climate and corporate social image. Coverage and employee acceptance and satisfaction (trainings, policy)

This kind of evaluation was not foreseen at the start of the project. The research group with VIGEZ and VAD looked for validated instruments that were easy to use but could not identify such instruments.

Qualitative evaluation

VAD developed a checklist to do a qualitative audit about policy on substance abuse. Stakeholders were invited to fill in this checklist before and after the implementation of this alcohol policy. The first round of this audit is completed, but we have not yet received a report from VAD describing the results of this first audit. The checklist and the audit procedure is available from the VAD website: www.vad.be
All employees of Resilux attended the sessions to raise awareness. There was no formal quantitative or qualitative evaluation of this session. There was positive feedback from the psychologist who gave the sessions. She noticed from the comments that the situations mentioned in the session were recognizable for most employees. For many employees the session confronted them with their own consumption. The sessions were very interactive with a lot of collaboration from the public.

All direct superiors attended the whole day training. There was a quantitative evaluation of this session. Since this company has no experience to discuss performance of employees on a regular basis, the approach that was presented was relative new to most direct superiors. For many direct superiors the communication skills that were trained could very well be used to discuss other forms of mal performance that have nothing to do with substance abuse.

There is one major change. Since the start of the project no more empty beer bottles could be found on the company premises.

**Lessons learnt**

**Phase 1: Screening and brief intervention**

A major lesson is that screening a workers population by means of a validated instrument based on self report can identify people who are at risk.

In average the VIRALCO project identified 17,96% of men vs. 6,14% of women as risky drinkers. In Resilux the figure was a bit higher (18%)

A major problem is that not all employees are seen by the occupational health doctor on a regular basis. Another problem is that it is not always possible to screen the eligible population. In average only 46 % of employees attending the occupational health doctor were invited for screening and brief intervention. In Resilux this figure was significantly higher and reached 77%.

An important lesson is the fact that these results convinced management to take action and to develop a proper policy on substance abuse.

At first it seemed to be a good idea to repeat the screening to do a sort of quantitative evaluation. It is important to note that is not always to compare the working population over several years. Resilux is a fast growing company. Employment grows as well. A certain number of employees leave the company. There is also a bias while blue collar workers tend to visit the occupational health doctor more often than white collar workers.

**Phase 2: Implementing a formal policy on substance abuse**

Since this is a small company where unions are not very well represented, management chose not to invite union representatives into the working group that developed the vision statement and policy intention. Union representatives were not involved in developing rules and regulations. Only at the end of the process were they invited to agree officially with a change in the working regulations. Management trusted that the sessions that were given to
create awareness among employees were sufficient to create broad acceptance of the new policy. In this particular case this approach did work out.

Another important lesson is the fact that it is not easy to do any form of quantitative evaluation in a small company. The figures of absenteeism and the number of cases that suffer from problems due to substance abuse are too small to find any significant result. Only meta analysis from projects in a lot of small companies could solve this problem.

For this case data should be gathered in a similar way in different organizations. This is not an easy thing to do since data collection itself is an important cost in this kind of project.

In a large company the HR department can provide the necessary systems and can manage the indicators to monitor and to evaluate the policy on substance abuse. In this case it is only necessary to convince the HR department to use the right indicators. In a small company this is not so easy to organize.

The training sessions to implement rules and regulations are much easier to implement in a company where there is already a formal process of evaluation and a formal process to discuss performance on a regular basis. This is a more recent approach of management which demands coaching skills from direct superiors. This style of management is more broadly accepted in large organizations and is fairly new for small companies where the distance between management and people on the floor is relatively small.
Case studies Belgium

Template case II

Case Nr: 2
Name of the case: the organization wishes to remain confidential
City:

Type of company

Ownership?
X public ☐ private ☐ voluntary

Sector (ISIC Rev 4. codes)
☐ Agriculture, forestry and fishing
☐ Mining and quarrying
XManufacturing
☐ Electricity, gas, steam and air conditioning supply
☐ Water supply; sewerage, waste management and remediation activities
☐ Construction
☐ Wholesale and retail trade; repair of motor vehicles and motorcycles
☐ Transportation and storage
☐ Accommodation and food service activities
☐ Information and communication
☐ Financial and insurance activities
☐ Real estate activities
☐ Professional, scientific and technical activities
☐ Administrative and support service activities
☐ Public administration and defence; compulsory social security
☐ Education
☐ Human health and social work activities
☐ Arts, entertainment and recreation
☐ Other service activities
☐ Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use
☐ Activities of extraterritorial organizations and bodies

Company size?
☐ Very small enterprise (under 10 staff members)
☐ Small enterprise (10 to 50 staff members)
☐ Medium-size enterprise (50 to 500 staff members)
X Large enterprise (501 and more staff members)

How many are employed:

Location?
☐ Company is situated at one location (national or local)
X Company with a headquarters and one or more other branches/locations (national)
☐ Multinational company

Alcohol practice provision
☐ Internal service ☐ External service
Case II

Employing body

This company is a Belgian industrial group, created in 2005 by the merger of five components of the former Group. It is a European leader in floor coverings and fabrics and a major player worldwide in its sector. The company is vertically integrated, with production of raw materials, semi-finished and finished products. The company has 30 establishments, spread over 8 countries. The company has a staff of 3,200 and achieved sales totalling EUR 1.3 billion in 2010. In Belgium the group employs +/- 1000 people.

Raw Materials

The Group has not only focused on the production of floor coverings and fabrics, but has established a sound basis in the chemical supply chain too. From a number of derivatives of the petrochemical industry, raw materials are produced in several steps for the Group’s own production activities or for sale to other companies. The production of raw materials is split into four separate business units: Granules, Fibres, Yarns and Technical Textiles.

Soft Flooring

The company is a European leader in the production of soft flooring. Activities in soft flooring are divided into three business units, depending on the production method or the final destination of the products: Tuft, Needle Felt, and Bath Rugs.

Hard Flooring

In the 1990s the Group extended its activities to the production of hard flooring. the Group wished to respond to the increasing demand for floor coverings in wood (laminate, parquet) and the development of its activities in cushion vinyl.

Fabrics

The activities of the ‘Fabrics’ Division are varied and unique within the Group. The company produces woven fabrics which are used both in the furniture industry (chair covers) and for decorative purposes (cushions, curtains, etc.). The company is located in Flanders(Belgium). From there, this Division has acquired an important position in the European furnishing fabrics market.

The group has an internal prevention service who are mainly involved in safety at work. Occupational health is provided by Securex External prevention service. Securex also provides consultancy on psychosocial issues.
Workplace alcohol policy and programme

-Rationale and objectives

At the start the direction of the company was rather sceptical about this project. It was not considered a main priority. The company did not recall major incidents or problems due to alcohol or substance abuse. The rationale for the company to start with the implementation of an alcohol policy was basically the existence of CAO 100 (cfr supra). Management was convinced that the company should implement both phases of CAO 100. One of the psychologists of Securex External prevention services presented the Viralco project. This project was the trigger to start implementation.

-Key elements

A working group was created to develop phase 1 (vision statement and awareness raising).

The following people were actively involved in this process

• The internal prevention advisors for the different branches of the company in Belgium.
• The occupational health doctor (Securex)
• Two HR-officers
• 1 psychologist, specialist in developing alcohol policy (Securex)

The psychologist took the lead at three consecutive meetings. Each meeting was prepared with the help of two questionnaires prepared by Securex. These questionnaires assess the current practice and desired policies of the various members of the group.

After the different meetings a text was conceived by the psychologist who was then submitted for comment by the members of the group and the members of the direction. The psychologist reworked the text based on the comments. Agreement was finally reached on a version that could be presented to the workers’ representatives in the Committee for Prevention and Protection.

A second working Group developed rules and regulations for the company based on the vision statement. The working group consisted of HR people from the company with the consultancy of same psychologist that was involved in the development of the mission statement. During this process there were informal meetings with union representatives for building partnership.

This process resulted in a document of 14 pages with rules and procedures. This document was officially accepted by the union representatives in the Committee for Prevention and Protection and was recorded in the labor regulations.

Surveillance (environment and health of workers). Promotion and prevention activities (raising awareness campaign, detection and brief advise, etc),

According to Belgian legislation medical supervision is compulsory for any employee who has occupational health risks (chemical risk, physical risk, biological risk, psychosocial risk or ergonomic risk). Also employees who have a security function (eg driving a vehicle) have an annual medical examination.
As part of the VIRALCO project screening and brief intervention was offered to all employees during annual medical visit. Not all employees are subject to mandatory medical surveillance. This is based on a risk analysis.

On the basis of the Securex database we can estimate the eligible population in 2011. Almost 80% of the employees in the industrial plants are under medical surveillance. Although annual medical visit is required, not every employee attends this annual visit.

In the year 2007 we recorded 318 medical visits for the group. 79% of the eligible population was screened with AUDIT. 7.5% was identified with risk behaviour and received brief intervention. All other employees received a leaflet that explained the risk of alcohol.

Results of screening:

-care (pathways, confidentiality, etc...), social reinsertion.

Employees can be identified with an addiction problem during the screening process. More often addiction is presumed by the direct superior and the employee is referred to the occupational health doctor. In these cases he will make an assessment on abuse and he will organize referral for specialized treatment.

-Implementation elements (responsibilities and roles, education and training tools, sustainability and policy enforcement mechanisms, evaluation database and indicators, etc).

Training direct superiors

At start the company was not motivated to provide a whole day of training for the direct superiors. The training was implemented in different phases.

At first there was a half day session for all direct superiors. The objective was raising awareness. New policy was presented and details on rules and procedures were provided.

There was a theoretical approach to give structure on how to have a conversation with an employee about his malfunctioning at work. In this session there was no role playing.

There were very positive reactions from direct superiors after the half day session. The direction decided to expand training with another half day session. In this session there was a
more practical approach which included role playing. Objective was to practice conversation techniques to discuss malfunctioning at work.

There was also a sensibilisation of the senior colleagues who are in charge at the working floor (supervisor or meestergast). The supervisors are closest to the employees and often catch the first signals of poor performance. They will report this to their direct superior. In determining malfunction the direct superior will monitor improvement. He may be assisted where necessary by HR, but initially it is the direct superior who is responsible for taking action.

**Impact of the alcohol programmes**

The Viralco project was an implementation project and not a research project. There was no specific budget to develop any tools for qualitative or quantitative evaluation.

A research group with project coordinators from Securex and collaborators of VAD en VIGEZ came together several times to develop evaluation tools or indicators to evaluate the project. (VAD is the Flemish association on drugs and alcohol, VIGEZ is the Flemish association on health promotion and disease prevention)

In the vision statement was quoted that HR department of the company coordinates the development of the policy and would monitor the proper application. The department initiates the necessary training and will be responsible for the evaluation of this policy. They will make necessary adaptations where necessary. HR will provide the necessary systems, develop and manage documents and indicators to monitor and to evaluate the policy on substance abuse.

*Quantitative evaluation :*

- Employee alcohol consumption, alcohol-related harm, alcohol knowledge and attitudes towards workplace alcohol drinking

There were several proposals to develop a sort of quantitative evaluation.

At this time there is consensus to use the AUDIT questionnaire periodically (eg. every 5 year) to estimate the evolution in terms of hazardous drinkers within the company. Screening results are mentioned above. Repetition of this screening is prepared but was not yet repeated after the introduction of the formal policy on substance abuse.

- Absenteeism (unauthorised absence, lateness, excessive levels of sickness, etc.) and injuries (accidents)

Other ideas that did not reach consensus in the working group.
• Recording absence at work after weekend / holiday, recording accidents, ...: this may be an indirect measure of the effects of substance abuse.
• Anonymous registration of the number of interventions by a direct superior in connection with performance problems due to substance abuse.
• Number of interventions due to “incapacity to work” where substance abuse is suspected.

As this project is still in process there are no final results of quantitative evaluation.

**Work performance, productivity, cost-benefit, etc**

This kind of evaluation was not foreseen at the start of the project. The research group with VIGEZ and VAD looked for validated instruments that were easy to use but could not identify such instruments.

**Qualitative evaluation**

VAD developed a checklist to do a qualitative AUDIT about policy on substance abuse. Stakeholders were invited to fill in this checklist before and after the implementation of this alcohol policy. The first round of this AUDIT has been completed. We have not yet received a report from VAD describing the results of this first AUDIT. The checklist and the AUDIT procedure is available from the VAD website: [www.vad.be](http://www.vad.be)

- **Workplace climate and corporate social image**

There was no “formal” evaluation based on validated instruments. This kind of evaluation was not foreseen in this project. We could not identify any validated instruments to do so.

- **Coverage and employee acceptance and satisfaction (trainings, policy)**

As mentioned before management was not motivated at first to provide a whole day of training for the direct superiors. The training was implemented in different phases.

Because of positive evaluation of the first phase aimed on sensibilization, management decided to give more training to direct superiors on how to talk about performance problems and how to cope with substance abuse. The training programs were evaluated and got very good evaluation from direct superiors. Detailed description of evaluation is available if wanted.

Union representatives were consulted in different levels of approval of the new policy on substance abuse. Those representatives who are member of the official committee for prevention and protection at work were consulted when the initial vision statement was formulated.
Lessons learnt

Phase 1: screening and brief intervention

A major lesson is that screening a workers’ population by means of a validated instrument based on self-report can identify people who are at risk.

In average the VIRALCO project identified 17.96% of men vs. 6.14% of women as risky drinkers. In this company this figure was a bit less (8%)

A major problem is that not all employees are seen by the occupational health doctor on a regular basis. Another problem is that it is not always possible to screen the eligible population. On average only 46 % of employees attending the occupational health doctor were invited for screening and brief intervention. In this company this figure was significantly higher and reached 76%

A specific questionnaire was used to identify barriers for screening. The results are presented in a poster.

Phase 2: implementing a formal policy on substance abuse

The major effects described are based on expert opinion from our psychologist who was the external coach to accompany the project.

In her opinion you could see a shift in mentality among HR collaborators. At first direct superiors had quite a different opinion on the problems due to substance abuse. Their major problem was how to get rid of people addicted to alcohol or drugs.

Supervisors and direct superiors do not look at the company as a social institution. These people are into production and consider malfunction as a real problem to reach production targets. This project changed mainly the opinion of HR collaborators on the subject of substance abuse. They are convinced that the company has a responsibility towards its employees to attend problems due to substance abuse. The opinion of direct superiors has not altered in the same way. It is important to understand that no company considers a policy on substance abuse as a main priority. It is only one of the possible reasons for malfunction.

The major effect is raising awareness of direct superiors. They never really looked at the problem as a reason for malfunction that can be monitored. After training direct superiors felt much more prepared to cope with mal performance. The taboo to discuss substance abuse is broken. Direct superiors feel more comfortable discussing the dysfunction instead of focussing on the abuse.

In fact this project acted as a real “eye opener” for direct superiors to monitor productivity more appropriately. The communication techniques trained during the project could very well be used to deal with other types of dysfunction that have nothing to do with substance abuse. This was definitely one of the main reasons why this program was very well evaluated by direct superiors. It is also one of the main reasons why this kind of project will only work in companies who focus on coaching their employees to better performance.
At this moment the new policy on substance abuse has been implemented for about one year. It is still too early to make final evaluation on the effects of the new policy.

Evaluation

One of the main lessons learnt is the fact that it is not easy to evaluate such project in a standard way. There are no standard procedures available for evaluation. There are no validated instruments for qualitative or quantitative assessment. This was not a scientific project but rather a project to implement new legislation. Companies and authorities are not willing to put much effort and resources into the evaluation of these types of processes. This is definitely a lesson to learn in further follow up of this kind of project.
Catalonia

Country description

- Location: North-east corner of the Iberian Peninsula
- Official languages: Catalan, Spanish and Aranese
- Capital: Barcelona
- Population: 7,535,251 inhabitants (2011*)
- Surface area: 32,107 km²
- Population density: 232.8 hab/km² (2009)
- Currency: euro
- GDP per capita: 28,046 euros (2009)
- Immigration rate: 12.5 per 1,000 cit. (2008)
- Government: Generalitat of Catalonia

Catalonia\(^1\) is an autonomous community and exercises its self-government in the Spanish State in accordance with the Constitution of 1978 and the new Statute of Autonomy, approved in 2006. The Generalitat is the institutional system around which Catalonia’s self-government is politically organised and it dates from 1359. It consists of the Parliament, the Presidency, the Government (formed by the Executive Council) and other self-governing institutions such as the Síndic de Greuges (guarantor of the rights and liberties of citizens) and the Sindicatura de Comptes (control of the economic accounts of Catalan public institutions). The Generalitat has extensive competencies in matters such as education, health, citizen security and civil protection, culture, linguistic policy, industry, urban development, housing, regional politics, transport and the environment, among others.

Geography has played a favourable role with regard to the economy. Its location in the Peninsula and the Mediterranean has made it a top rank strategic position as a port in the south of Europe, by road transport, motorways and rail transport; by sea, due to a port that is constantly growing, and by air, benefiting from the platform that the new Terminal T1 in Barcelona airport represents. Industrial activity has grown, particularly in the Barcelona

\(^1\) Generalitat of Catalonia Institutional web page. Available in http://www.gencat.cat/catalunya/eng/
This set of circumstances has led to strong growth and it has enabled Catalonia to historically become the industrial vanguard of Spain. Industrial activity is very important for the overall economy of Catalonia, particularly in the chemical, food, energy, metal and transport material sectors. Nevertheless, in recent years, special attention has been paid to logistics and the knowledge economy, an activity that is growing all over Europe. The commitment to new technologies and the audio-visual industry is already giving a distinct personality to the Catalan economy. The technological district of Barcelona, 22@, is a good demonstration of this purpose, to replace the old and often contaminating industries of Poblenou with new technology companies. At the beginning of the decade, Newsweek ranked Barcelona among the top ten technological cities in the world, and in a report prepared by Cushman & Wakefield consulting company in 2008, it was ranked as the fifth most attractive city in Europe for business, after London, Paris, Frankfurt and Brussels. This report also considered Barcelona to be the city with the best quality of life in Europe. Another field for which Barcelona is noted is its business schools, a point of reference all over the world.

In line with this diversification of economic initiatives, the great debate is the reinforcement of infrastructures, particularly with regard to the so-called Mediterranean Axis which, coming up from Algeciras, communicates with Europe after passing by the whole Eastern coast of Spain. The Mediterranean Axis will be reinforced with a high speed train, in line with the AVE line that connects with France. The ports of Barcelona and Tarragona are key points of an economic growth strategy that is considered fundamental to guarantee its competitiveness.

In recent years, tourism has increased in such a way that it has become one of the most notable economic activities of Catalonia. This phenomenon has had a particular impact on the consolidation and expansion of commercial activity. The tourist demand has positioned Barcelona port as the leading one in Europe with regard to cruises and over two million people have arrived in Catalonia by this mode.

Financial activity is based on the savings banks, institutions with a long tradition in Catalonia which traditionally focused on small savings. In recent years, these banks have extended their activity to other sectors and they have a strong presence in the main Spanish companies. In their main activity, they have ventured to open offices all over Spain and have mobilised cultural and heritage centres outside of Catalonia.

In the context of the current global economic crisis, unemployment is a big issue in Catalonia nowadays. The unemployment rate in Catalonia\(^2\) was 19.01% at the end of March 2011 according to the Spanish Institute of Statistics, with a total of 727,600 jobseekers. The activity rate in Catalonia was 63.07%, with 3.09 million people with a job contract. In Spain as a whole, at the end of March 2011 there were 4,910,000 million unemployed people from a total population of 47 million, which represents 21.29% of the active population.

**Legislation**

**Institutional responsibilities:**

The Spanish Constitution establishes the competency of the Autonomous Communities with regard to the regulation of certain areas, and their ability to create legislation via their own Parliaments. The Statue of Autonomy is the fundamental law for the Autonomous Communities, including Catalonia.

In Catalonia, the Ministry of Enterprise and Labour, and the Ministry of Health of the Government of Catalonia are the public authorities with responsibility in Health and Safety.

- **Labour Authority:**

  In Catalonia, and the rest of Spain, the bodies responsible for enforcement and for scientific and technical matters related to Health and Safety are separated.

  - Enforcement is the responsibility of the Labour Inspectorate. In Catalonia, competencies on Labour Inspectorate have been recently transferred from the central government, and now depend on the Catalan Ministry of Enterprise and Labour.

  - The scientific and technical public body responsible for promotion, advice, research and training in Health and Safety in Catalonia is the Health and Safety at Work Department of the Catalan Ministry of Enterprise and Labour. It has representation in each of the four Catalan provinces.

  Another scientific body, in this case attached to the Spanish Labour Authority, is the National Institute for Safety and Health at Work (INSHT) which is the scientific and technical body of the Spanish State General Administration.

- **Health Authority:**

  - The new Public Health Law of Catalonia has allowed the creation of a public Catalan Central Occupational Health Unit (dependent from the Catalan Ministry of Health), with a network of Local Occupational Health Units. These Occupational Health Units have advice and training functions for health professionals from the Occupational Health Services, including the promotion of alcohol initiatives and other well-being programmes.
Spanish health and safety legislation includes: basic provisions in general laws like the Workers’ Statute, General Social Security Act and the General Health Act; specific regulations like the Prevention of Occupational Hazards Act (LPRL 31/1995) (the mainstay of H&S legislation); sectorial and occupational regulations (driving and transportation, construction industries, nuclear plants operators, etc); provisions laid down by collective agreements; regulations issued by the regions or Autonomous Communities; and Community Directives on health and safety which Spain has to implement.

With regards to specific regulations, the Prevention of Occupational Hazards Act 31/1995 is the main Health and Safety law. It determines the basic body of guarantees and responsibilities and establishes an appropriate level of protection of the health of the workers in front of the risks derived from the working conditions. It has complementary regulations like Rules and Procedures for Occupational Health Services (RD 39/1997).

There is no specific legislation about alcohol in the workplace. However, the Prevention of Occupational Hazards Act LPRL 31/1995 protects especially vulnerable workers, and states that health surveillance must not be discriminatory towards the worker, and should not be used as a company's management tool. The worker must give informed consent to the type of tests performed that have to be proportionate to the risks: in general, alcohol or other drugs tests should only be performed if justified by risk to self or others. This law also states that workers "shouldn't stay in a workplace when obviously in a transient state or situation that makes them unfit for their job".

Another important piece of legislation, the Workers' Statute, establishes disciplinary routes including disciplinary dismissal if "alcohol or other drugs intoxication negatively affect work".


**Official guidelines on alcohol and the workplace** in Catalonia are provided by the "Agreement for the prevention and treatment of drug addictions in the workplace", signed in 2002 by the Catalan Government and main workers' unions.

Other general guidelines and policies on alcohol, but not specific to workplace, include the "Director Plan on Mental Health and Addictions", "Health and Addictions Plans of Catalonia", "Parliament agreement on Drugs" and "Strategy for drug prevention 2009-2015."

In Catalonia, employers and employees can access free, official legal advice regarding alcohol at the workplace through the Ministry of Enterprise and Labour (Health and Safety at Work Department), and health professionals from Occupational Health Services can have official guidance on alcohol issues through the Ministry of Health (Drug Dependency Department).

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3 EUROFUND. INDUSTRIAL RELATIONS. HEALTH AND SAFETY. Available at: [http://www.eurofound.europa.eu/emire/SPAIN/HEALTHANDSAFETY-ES.htm](http://www.eurofound.europa.eu/emire/SPAIN/HEALTHANDSAFETY-ES.htm). (Eurofund is a tripartite EU agency - provides expertise on living and working conditions, industrial relations and managing change in Europe)
Provision of alcohol services.

Alcohol services are provided through the Public Health System (primary care as well as inpatient and outpatient specialized services).

In Catalonia, the Programme "Beveu menys" ("Drink less") has been working since 1995 in collaboration with WHO to disseminate strategies for early detection and brief intervention in alcohol issues in Primary Health Care with an aim to reduce alcohol related harm in accordance with various Catalonian governmental initiatives.

Provision of occupational health services at national level

In Catalonia, as in the rest of Spain, occupational risk prevention and guaranteeing access to appropriate health surveillance are a legal obligation of employers. There are 219,031 registered doctors in Spain (476 doctors / 100,000 inhabitants) of which 10,500 have a title of specialists in Occupational Medicine, and it is estimated that 5,500 are currently working as Occupational Physicians in Spain (no official data are available).

NATURE OF OCCUPATIONAL HEALTH SERVICES

There are three types of OHS: In-house OHS (mainly in public sector and large private enterprises), outsourced OHS (in most medium and small sized enterprises and many large companies). The third possibility is that several companies set up a shared OHS (for reasons of geographical proximity or similar economic activity). It has to be noted that a very high number of private companies in Spain are medium or small.

Occupational health and safety services have a multidisciplinary approach and are staffed by two types of professionals:

- Risk prevention specialists: these professionals have a University degree and can be accredited for safety, hygiene, psycho-sociology and ergonomics. Their aim is to assess risks derived from work exposures and working conditions and advice employers on how to eliminate or reduce these risks.

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5 Data obtained from the document "Ponencia para el Grupo de Trabajo «Profesionales Sanitarios» de la CNSST. «ESTUDIO DE LA DOTACIÓN E INTEGRACIÓN DE PROFESIONALES SANITARIOS EN LOS SERVICIOS DE PREVENCIÓN». 2000"
- Occupational health professionals, including occupational physicians and occupational nurses. In Occupational health services, the main tasks developed by health professionals are preventive: health surveillance and fitness for work evaluation and periodical medical examinations for workers. Also health promotion is undertaken. With regard to diagnosis and treatment there are two parallel systems in Spain with National Health System covering not work related pathology and “Mutual Insurance Companies” covering work accidents and occupational diseases.

**Template case I**

Name of the case: Port Barcelona  
City: Barcelona

**Type of company:**

Ownership?
☐ public ☐ private ☐ voluntary

**Sector (ISIC Rev 4. codes)**
☐ Agriculture, forestry and fishing
☐ Mining and quarrying
☐ Manufacturing
☐ Electricity, gas, steam and air conditioning supply
☐ Water supply; sewerage, waste management and remediation activities
☐ Construction
☐ Wholesale and retail trade; repair of motor vehicles and motorcycles
☒ Transportation and storage
☐ Accommodation and food service activities
☐ Information and communication
☐ Financial and insurance activities
☐ Real estate activities
☐ Professional, scientific and technical activities
☐ Administrative and support service activities
☐ Public administration and defence; compulsory social security
☐ Education
☐ Human health and social work activities
☐ Arts, entertainment and recreation
☐ Other service activities
☐ Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use
☐ Activities of extraterritorial organizations and bodies

**Company size?**
☐ Very small enterprise (under 10 staff members)
☐ Small enterprise (10 to 50 staff members)
☐ Medium-size enterprise (50 to 500 staff members)
☒ Large enterprise (501 and more staff members)
☐ How many are employed: 555
Location?
- ☒ Company is situated at one location (national or local)
- ☐ Company with a headquarters and one or more other branches/locations (national)
- ☐ Multinational company

Alcohol practice provision
- ☒ Internal service
- ☐ External service
Case I

Employing body

The structure and organisation of the Port of Barcelona is complex. We have to differentiate two bodies: the Port of Barcelona (which generates 32,100 jobs), and the Barcelona Port Authority: the governing body responsible for managing the Port of Barcelona with 555 employees.

The Port of Barcelona is the primary transport and services infrastructure in Catalonia, and is also a benchmark in the Euromed region. With links to 850 ports across five continents, the Port is the leading Spanish State port for international traffic.

The Port is highly diversified, with over 30 terminals able to transport all kinds of products. The main traffic comprises containerised cargo and high-value goods, such as consumer goods, electronic goods and motor vehicles.

The Port generates 32,100 jobs and channels 23% of Spanish foreign trade.

In addition to its commercial activities, the Port of Barcelona operates in two other core areas: cruises and its successful urban port (Port Vell).

- Cruises: 2.4 million cruise passengers travel through Barcelona every year, making the Port the leading cruise port in Europe and the Mediterranean. It is the world’s fourth-largest turnaround port.

- Urban port: The Port Vell is a prime example of how port and city can coexist in harmony. It contains a wide range of cultural, recreational and social amenities, which attract over 16 million visitors every year.

(NB: These two areas are not included within the scope of the alcohol programme and policy).

Barcelona Port Authority (APB) is the governing body responsible for managing the Port of Barcelona. It reports to the Spanish National Ports and Harbour Authority, which implements government port policy. The national authority also coordinates and monitors efficiency of the 28 port authorities that manage the 44 ports of general interest in Spain.

Under the provisions of Spanish Law 33/2010 of 5 August 2010, amending Law 48/2003 of 26 November 2003 on the financial and services regime for ports of general interest, the APB is required to fulfil the following functions:

- Providing general port services; authorising and monitoring basic port services.
- Managing the port service area and port use.

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6 Summarized from Port of Barcelona institutional web page: http://www.portdebarcelona.es/en/home_apb
Case studies Catalonia

- Planning, design, construction, maintenance and operations pertaining to works, port services and navigational aids.
- Managing the public port area and area covered by the navigational aids.
- Managing the port’s financial assets and resources.
- Promoting industrial and commercial activities linked to maritime transport and port traffic.
- Coordinating operations involving different transport modes within the port precinct.

The Barcelona Port Authority has established the values that must guide its behaviour as an institution: appreciation for and commitment to people, ethical and professional management, client orientation, social responsibility and innovation.

In summary, we can simplify APB’s functions if we think of the Port of Barcelona as a city with a land area of 830 ha and 32,000 inhabitants (workers) and millions of tourists/visitors (cruises and touristic attractions in Port Vell), where APB acts as a “city council” with its own police, administrative staff, maintenance brigade, etc.

Management, structure and number and job category of employees.

- Port of Barcelona: a total of 32,000 employees in over 500 small and medium enterprises. 10% of these enterprises had 1-5 employees, 65% 6-50 employees and 25% more than 50 employees\(^7\). Enumerating the different jobs would be impossible, but in terms of risk to third parties, the safety critical jobs would be:

- Drivers: 1000 lorry drivers come in and out daily.
- Dock workers: over 1000 in number, contracted by different enterprises. Handling of goods or materials and management of mechanical means represent a danger inherent to their profession. They need high professional qualifications and must be in adequate physical and mental conditions to work with the best guarantees.

- Barcelona’s Port Authority (APB): a total of 555 employees: administrative staff (300 approx.), Port Local Police (160), and maintenance staff (60 approx.)

- General policies on health and wellbeing.

The Barcelona Port Authority designs and develops a Port Community Health Plan every 5 years.

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\(^7\) Logistic Community Statistics 2000
Case studies Catalonia

- Type of occupational health service provision and functions (surveillance of environment and health of workers, education and training, promotion and prevention activities, care and referral to health services).

The Barcelona Port Authority (APB) has an in-house Occupational Health Service (OHS), staffed by 4 health and safety advisors (covering the specialties of Hygiene, Psychosocial, Ergonomy and Safety), 3 occupational health nurses, and 2 physicians, one of them covering exclusively clinical duties, the other also with managerial duties as the head of the Occupational Health Service. The APB OHS is directly responsible for the health and safety of its 550 employees, and carry out activities of health promotion, prevention and surveillance as well as education and training. Clinical treatment is provided, both in occupational health matters as in general health, as the OHS acts as a collaborative entity to the Spanish Public Health Service: APB company doctors can issue official prescriptions, sick notes, etc. (only a few companies retain this quality nowadays). They also refer patients for specialist care when necessary.

But the commitments of APB OHS are more complex: through organised working groups it leads and coordinates the Occupational Health Services (most of them external) of the hundreds of enterprises in the Port.

Some examples of APB OHS activities are setting common minimum standards and good practice policies and leading inter-company activities coordination, in an environment such as this, where so many different enterprises have to interact. It also acts as a consulting and mediating body and has an inspection / supervision role to verify compliance to external audit of the enterprises in the Port. They also organise campaigns and meetings on risk prevention, and have open access on-line information with an aim to integrate and promote a preventive culture in the whole Port Community.

Workplace alcohol policy and programme

- Background and history

The current alcohol policy was introduced in 2001, and its main asset is precisely its ongoing implementation since then.

General legislation applies to driving and alcohol within the Port, and although maybe some enterprises had an internal alcohol policy, no collective alcohol policy specific for workers of the Port was in place before 2001.

As explained above, the Port is a complex network of interacting enterprises with a total of 32,000 workers spread over a very large area. Before 2001 there were 80 places available for alcohol consumption in the Commercial Port Area, whereas now there are only 2 left, with only low grade alcoholic drinks being served. A general culture of minimizing the harmful effects of alcohol to health and work accidents was a widespread issue, not only in the Port, especially amongst the older generations.
- **Rationale and objectives**

The programme's objectives were to raise awareness about the risks and diminish the consumption of tobacco, alcohol, cocaine and other substances of abuse.

It was addressed to the 32,000 workers comprising the entire Commercial Port Community (touristic zones of Cruises and Port Vell were separated, not included areas).

**Objectives:**

- Health promotion: improve health and quality of life of the workers of the Port by promoting healthy lifestyles.
- Raise awareness of the risks of consuming or attending work under the effects of alcohol or other drugs.
- Diminish the offer, demand and consumption of drug-dependency substances in the workplace, and diminish the number of persons with high risk consumption.
- Diminish risk situations and incidents: generating a new preventive culture, where working under the effects of alcohol or other drugs is not socially accepted. Testing for alcohol and other drugs would be performed, and workers under the effects of substances would be asked to abandon their posts. Help would be offered to the worker.
- Increase safety and diminish accidents at work: addressing the effects that these substances have on workers behaviour and ability, especially when risk to self or others is an issue.
- Improve work climate.
- **Key elements: Alcohol policy development (building partnership, union-management debate, strengths and weaknesses)**

- **Key elements:**

The introduction of a collective alcohol policy in the Port came after a proactive initiative from the APB OHS. At the beginning some considered that this could damage the Port's image, as public opinion could link the name of the Port with "alcohol problems". However, the OHS overcame this initial rejection explaining that, although the prevalence of alcohol problems in the Port was no higher than in other similar working environments, the problem nevertheless existed, and it was common sense to confront it.

After obtaining approval and trust from the company, they were allocated a budget for the purpose and had leeway to develop the programme. The programme was developed mostly with internal resources, including the design of the outstanding graphic campaign. They began by researching methodologies already applied, as well as other experiences in working environments, and sought supervision from the Catalanian Department of Health through its Program on Substance Abuse who was happy to support this pioneering initiative.

Once the general lines of the programme had been established, it was presented the health and safety committee, the workers' representatives and the company and once approved, the
company made an official institutional presentation of the programme to the authorities involved and representatives of the whole Commercial Port Community.

The programme had, therefore, large support and commitment from all the stakeholders, to the extent that the Dockers Union have adopted it in its common rules and procedures (collective agreements).
The APB OHS developed an informative, awareness raising graphic campaign called TAC&cia, TAC standing for Tobacco, Alcohol, Cannabis and other drugs. There was one generic poster for Tobacco, Alcohol and Cannabis and other drugs, and individual posters for each three. The leaflets were monographic and included general information, information to identify high risk consumption (for example alcohol units calculation chart, Fagerström test for tobacco,...) and information regarding ways of obtaining confidential help.

The theme of the whole campaign was based on SMS messages. It commenced with a 2 week pre-campaign as adverts on Port's buses just saying: "You have a message from TAC&cia". This raised curiosity in the Commercial Port Community, preparing the land for the next step. After this 2 weeks, all available means were used to spread the campaign: new adverts on buses and bus stops, illuminated panels in the Port, adverts and messages in both internal daily press.

Leaflets were made available in the most visited places, like workplaces, dressing rooms, offices, bars, OHS, rest and recreational areas,... A telephone line was available 24 hours a day throughout the campaign.

Also briefings were organised for managers/supervisors of enterprises in the Commercial Port Community and for health professionals of the different Occupational Health Services according to methodology proposed by the Department of Health.

Case detection: There were several ways for detection, all following informed consent and a standardised procedure: random screening, in case of suspicious behaviour, systematically in case of accident, follow-up of diagnosed cases and during health surveillance and fitness for work evaluation. An estimated 98% of dock workers, 75% of APB's, and more than 60% of overall Port's workers, pass a medical examination annually.

Care offered:

- Preventive: brief advice by corresponding OHS in case of detection of high risk consumption.
- Specialized treatment: referral for a therapeutic treatment safeguarding confidentiality with the final aim of maintaining and facilitating reincorporation to the original workplace once successfully rehabilitated.
- Support groups: its creation and functioning was supported and facilitated.
We have to bear in mind that, in the vast majority of cases, case detection and implementation of the policy and programme was not the responsibility of APB (directly responsible for its 555 employees), but of the different OHS of the multiple enterprises in the Port.

**Policy enforcement mechanisms:** There was, therefore, a large disparity with regards to implementation of the policy through enforcement or disciplinary measures.

However, the riskiest occupations were well targeted:

- **Drivers:** more than 1,000 lorries come in and out the Port every day. Most of these lorry drivers are self employed, and do not benefit nor can be disciplined under the alcohol prevention programme. However they are bound to road safety legislation enforced by APB through Port's police officers.
- **Dockers:** through the inclusion of the policy in their internal rules and procedures (this had been agreed by workers and their representatives and was legally binding). The more than 1000 dock workers belong to many different enterprises, but through the "ESTIBARNA" group they have links to APB and share a common Occupational Health Service as well as a Trade Union.

**Impact of the alcohol programmes**

Although no formal evaluation process was planned, the benefits of the programme have been evident through the years, and strong proof of it is that the programme is still in place.

Moreover, there are a number of indicators that can be of use with regards to alcohol:

- The overall number of positive tests to alcohol consumption have dropped from a 5-10 % to a 0.5%, and this drop has been more evident in the case of dock workers. With regards to Port's traffic testing, over 2000 tests were performed by Port's Police Officers in 2010 with a 1.5% of positive results.\(^8\)
- The Port's riskiest activities have improved their accident rates: road traffic accidents have dropped, and dock workers accidents have diminished in number and severity (last fatal accident among dock workers 10 years ago).
- There has been a change in culture: workers are now more aware of the risks of working under the influence of alcohol and the previous permissive culture has improved. But not only this: workers also identify other people's drinking as a danger for themselves, and reckon that seeking help from the company through its OHS is the best way to tackle the problem. The general culture years ago was to "help" the colleague by covering the problem, which obviously was of help to nobody.

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\(^8\) Port's Police Department annual report 2010.
The public image of the Port has not been damaged, on the contrary, the programme has helped the Port to be seen as a healthier, safer organism that cares about the workers in it. The programme has also improved links and communication between enterprises, enhancing the sense of "belonging" to a common objective, and indirectly it has helped to promote a common culture of risk prevention.

Improvement in work climate: this has been achieved in two ways
- Directly, by diminishing the number of interpersonal conflicts, many of them generated or associated to consumption of alcohol and other substances of abuse.
- And indirectly, demonstrating that companies are capable of tackling alcohol problems whilst caring for workers who need help.

And last, but not least, there are at the moment 15 fully rehabilitated employees that have retained their jobs in APB, and over 50 amongst the dock workers.

**Lessons learnt**

- Enthusiasm of the professionals of the OHS in the project is extremely important.
- Support and commitment must be sought from workers and their unions or representatives, as well as from the company: management and human resources must be sensitized and committed.
- It is also very important to ensure appropriate funding for the project: if despite enthusiasm the project becomes a series of trials and errors, the OHS will lose credibility and further attempts will have less possibilities.
- Although funding may need to be higher at the beginning, arrangements must be made to ensure the continuity of funding: otherwise the good results and enthusiasm of the first moments will dilute and sustainability of the programme will be difficult. In fact, what the persons responsible for this programme value most is not the initial response and results from its implantation, but the change in culture it has originated.
- Institutional support is important too, as its quality guarantees the project.
- In this case it was given by the Catalonian Department of Health through its Program on Substance Abuse. Its institutional logo appeared in the awareness-rising campaign and the documents produced.
- It is necessary to have some deterrent or disciplinary mechanisms in place. In this case alcohol testing to workers played an important role, and alcohol controls to drivers by Port’s Police officers was a very visible activity.
- Another important issue is to diminish accessibility to alcohol. The number of alcohol dispensing points has dropped from over 80 to just two in the last 10 years in the Commercial Port, and only low grade alcoholic beverages are served now.
- On an individual basis, when offering help and care to workers with alcohol problems we have to try to involve friends and family, other health professionals and social services and facilitate access to social aids, as well as financial advise and support.

Foresight and scope for improvement:
The persons responsible are, nevertheless, cautious about the success of the alcohol programme, as the decrease in the consumption of alcohol might be due not just to the programme, but also to a generational change (younger workers are more aware of the dangers of alcohol and work).

They also worry that the drop in alcohol intake observed must partially respond to a shift to other drugs of abuse: in fact the consumption of cannabis has largely increased in the last years as shown in the table below.

The evaluation process is complex, even more in this type of working environment, but it is an important tool that should be incorporated in the design of the programme.

Initial results from the programme might not be spectacular. The most important thing is to achieve a shift in habits and attitudes, and sustain this new culture on time.
**Template case II**

**Name of the case:** FCC Tarragona-Lleida Delegation.  
**City:** Reus

**Type of company**

*Ownership?*
- [ ] public  
- [x] private  
- [ ] voluntary

**Sector (ISIC Rev 4. codes)**

- [ ] Agriculture, forestry and fishing  
- [ ] Mining and quarrying  
- [ ] Manufacturing  
- [ ] Electricity, gas, steam and air conditioning supply  
- [x] Water supply; sewerage, waste management and remediation activities  
- [ ] Construction  
- [ ] Wholesale and retail trade; repair of motor vehicles and motorcycles  
- [ ] Transportation and storage  
- [ ] Accommodation and food service activities  
- [ ] Information and communication  
- [ ] Financial and insurance activities  
- [ ] Real estate activities  
- [ ] Professional, scientific and technical activities  
- [ ] Administrative and support service activities  
- [ ] Public administration and defence; compulsory social security  
- [ ] Education  
- [ ] Human health and social work activities  
- [ ] Arts, entertainment and recreation  
- [ ] Other service activities  
- [ ] Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use  
- [ ] Activities of extraterritorial organizations and bodies

**Company size?**

- [ ] Very small enterprise (under 10 staff members)  
- [ ] Small enterprise (10 to 50 staff members)  
- [ ] Medium-size enterprise (50 to 500 staff members)  
- [x] Large enterprise (501 and more staff members)

**Location?**

- [ ] Company is situated at one location (national or local)  
- [ ] Company with a headquarters and one or more other branches/locations (national)  
- [x] Multinational company

**Alcohol practice provision**

- [x] Internal service  
- [ ] External service
Case studies Catalonia

Case II

Employing body

FCC is a private, multinational company specialised in public services.

FCC was created in March 1992 through the merger of two prestigious companies: Construcciones y Contratas, founded in Madrid in 1944, and Fomento de Obras y Construcciones, founded in Barcelona in 1900 and listed on the stock exchange since December of that year. FCC currently is a member of the Ibex 35 index of the most liquid stocks on the Spanish stock market.

FCC is one of Europe's leading citizen services groups in terms of both revenues and profitability. It has traditionally focused on growth through diversification: originally founded as a construction company, in 1911 it branched into municipal services with a contract to clean and maintain Barcelona's sewer network.

Its business portfolio is now highly diversified. FCC is structured in different international departments to run its core businesses: environmental services and water management, construction of large infrastructure, cement production, and renewable energy production.

It has a footprint in 54 countries worldwide and over 44% of its revenues come from outside Spain (mainly Europe and the US).

Revenues in 2009 amounted to 12.700 billion euros and the group had 92,324 employees.

The company is keen to develop a safe and healthy environment for the workers and is OHSAS 18001 certified through its occupational risks prevention plan. They are proud of having created a real preventive culture in the company and care about their corporate social responsibility.

With regards to corporate responsibility, the FCC Group operates within a framework of business ethics and respect for relations with its stakeholders, coupled with a commitment to act responsibly and sustainably with the goal of creating wealth and well-being in society.

This case study refers to the Lleida-Tarragona delegation of the Environmental Services Department. It operates within the "Water supply; sewerage, waste management and remediation activities" sector (ISIC Rev 4. codes)

The Lleida-Tarragona delegation delivers public services of street-cleaning and waste collection to several cities, towns and small villages in this area of Catalonia. The delegation has 1,200 employees distributed in different branches spread across a wide geographical area. The different branches are under a common management team and share the same Occupational Health Service.

The job categories in the Lleida-Tarragona delegation are: administrative staff and production department with head of production, managers, drivers, machine operators and cleaning workers. The job positions with risk to third parties are drivers and machine operators. The production department work in 3 fixed shifts: morning, afternoons and nights.

It has a well established health and safety committee and broad workers' representation including health and safety representatives.

With regards to occupational health service provision, they have an in-house service comprising a medical department staffed with one doctor and 2 nurses as well as a safety advisor accredited for ergonomy, hygiene and safety. The medical department carries out promotion and prevention activities, education and training for employees -targeted to the different groups-, health surveillance and fitness for work evaluation and offers first aid treatment. The company has its own insurance to cover clinical treatment for occupational diseases and work accidents of its workers. In practice this means that the medical department is responsible for providing treatment in these cases, through the company's insurance funding for medical tests and external aid from specialists or hospitals when necessary.

For the purpose of this programme they have a contract with a clinical laboratory for blood and urine samples, a contract with a supplier of alcohol breath-analysers and drug tool-kits, and they refer workers for external specialized treatment for drug-dependency problems to the Public Health System when needed.

**Workplace alcohol policy and programme**

During health surveillance and fitness for work evaluation activities within the Occupational Medicine Department, a number of employees were found to drink alcohol and consume drugs during and outside working hours (this consumption, however, was later on evaluated and was found to be no higher than the general population). Easy access to alcohol is granted during working hours outside the premises, as a high proportion of the employees spend most of their working time outdoors in the streets. It was usual practice to have snacks or lunch time breaks in nearby bars where alcoholic drinks are available. Although disciplinary procedures existed and the premises were alcohol free, no alcohol policy was in place previously. No previous attempts had been made to implement an alcohol preventive programme.

**-Rationale and objectives**

The programme was developed according to the company's philosophy and its logo: "FCC, S.A. a healthy and safe company". The main objective of the programme was the prevention of
alcohol and drug related harm, offering help to employees when needed, but with a zero tolerance for alcohol and drugs.

Action principles:

- Giving a global response and including in the programme, not only prevention, but also treatment and follow-up of people with drug problems.
- Integrated with other projects to improve health and safety at work
- Aimed at all workers, with the objective of favouring healthy habits and modifying risky attitudes and conduct.
- Sensitive to the concerns of all sectors

General objectives:

- Contribute to a safer, healthier, more productive workplace.
- Reduction in work accidents and reduction in disciplinary procedures through prevention.
- Reduction in sickness absences both in number of episodes and length.
- Promote and improve communication, relationships, working climate, feeling of belonging and commitment to the company, and the company’s image.

Specific objectives:

- Inform and sensitize the workforce on alcohol and other drugs: myths, effects and risks derived from their use, especially in the working environment.
- Optimize the communication pathways so workers can explain their concerns about health issues (suggestions post-box, health agents, ...)
- Identify and modify those work environment factors which can facilitate alcohol and other drugs intake.
- Surveillance of alcohol and drugs consumption, specially in those jobs with 3rd persons' safety implications.
- Diminish and eliminate alcohol and drugs consumption inside and outside work.

Key elements

Alcohol policy development (building partnership, union-management debate, strengths and weaknesses)

The idea of creating an alcohol prevention programme for the company was triggered by the detection of cases through health surveillance and medical examinations. However it has to be pointed out that the initiative to develop the programme was jointly taken by all the departments involved: human resources, production, occupational medicine and health and safety departments.
Workers representatives were invited to participate in the process right from the beginning, which later on has proven to be very useful.

The first attempts to tackle the problem began with actions from the Occupational Medicine Department to raise awareness and inform the workers, but soon it became evident that isolated actions did not achieve the expected outcomes (specially with regards to social and occupational reinsertion) and that training and internal coordination needed improvement. To these effects, external technical support was sought from the Health Department of the Government of Catalonia through its Programme on Substance Abuse; with regards to training, campaigns, etc, the cost was funded by the company, although no specific budget was allocated to the programme.

The development and implementation of the current project is, therefore, the fruit of the participation and commitment of the whole company with a high degree of participation (employees, workers' representatives, management, production department, human resources, occupational medicine and health and safety departments and health and safety committee), and team-work has been decisive in its success.

As we stated above, the Tarragona-Lleida delegation covers 1,200 employees scattered over a wide geographical area. The implementation of the programme was progressive. It began officially in 2008 with the 180-employee branch in Reus and is expanding progressively to the other branches, currently covering 750 employees.

Surveillance (environment and health of workers), education and training (information and skills provided), promotion and prevention activities (raising awareness campaign, detection and brief advise, etc), care (pathways, confidentiality, etc...), social reinsertion.

The program was implemented gradually following a three stages PLAN OF ACTION:

**STEP 1: AWARENESS-RAISING:**

During the awareness-raising phase, education and training activities were carried out.

**Education:**

The goal was to educate all employees of the dangers entailed by the consumption of alcohol and / or other drugs at work and the associated health and safety risks with a final aim of obtaining a change in habits.

A graphic campaign was designed for the purpose. Posters with attractive, positive messages related to alcohol and other drugs that caught the attention of the employees where hang on given times. We attach pictures of the graphic campaign which are in themselves very attractive, although the witty "play on words" with slang terms for drugs and alcohol is difficult to translate. This poster hanging was reinforced on occasions with little presents (biscuits, fruit juices,...) related to the current slogan. The presents had a label attached with the company's chosen motto "AT WORK, DRUGS AND ALCOHOL 0.0"
Training:

Training activities were aimed at all the employees in the Delegation, and began with the management team. They were tailored to the different groups and had a very practical approach, stimulating participation and including case discussions. During training sessions the rules and procedures of the preventive programme were explained or reminded and the situation of the programme was evaluated.

Contents of the training programme:

- Analysis of the results of staff surveys. Discussion of problems found.
- What has been done to prevent and reduce the problems?
- How to prevent / help? How to act?
- Rules of the preventive programme.

Most of the training was done with in-house resources, but some of the training activities had the participation of external experts, like the Program on Substance Abuse from the Health Department of the Government of Catalonia and the Catalan Autonomic Police (effects of drugs and alcohol in driving, criminal liability arising from consumption, ...)

STEP 2: DETECTION AND CONTROL:

The aim was to identify those who may have problems with alcohol and / or other drugs. Clinical information obtained was strictly confidential.

There were three main pathways:

- Worker’s request: the worker may confidentially contact the OM department for consultation and / or counselling.
- During health surveillance or fitness for work evaluation activities: the health professional might detect a problem related to alcohol or other drugs.
- During alcohol and/or drugs control tests done during working hours.

Three different types of screening tests were used for control checks.

- Detection of alcohol in exhaled air (alcotest). A breathalyzer was used by trained, designated persons.
- Detection of drugs in saliva (DrugTest). This was carried out by OM Department. The person having the test was informed of the drugs of abuse analyzed: cocaine, heroin,
cannabis, amphetamines, benzodiazepines and methamphetamines in the last 24-36 hours.

- Blood and urine samples: performed by the OM Department. The person having the test was informed of the toxics analyzed and signed an informed consent.

Checks were done in five different situations

- Planned checks: previously notified to the staff.
- Random checks: done without notification.
- Checks on suspicion of acute intoxication.
- Checks in case of accidents
- Follow up checks: arranged from the OM Department.

In case of refusal to do the test, the person would be treated as if positive.

**STEP 3: INTERVENTION**

Once a problem with alcohol and/or other drugs had been detected, health, social and occupational resources were activated to help the affected worker.

The employee was invited to attend the OM Department where the situation and proposed help was explained. At this point participation of family, friends,... was encouraged for support of the person. If deemed necessary, post adaptation was recommended to the Human Resources Department, with the collaboration of the Health and Safety Advisor. Follow up visits were arranged on a personalized, voluntary basis. The clinical information provided by the employee was strictly confidential.

According to the needs of each person, some or all of the following activities might take place:

- Brief intervention: for persons with high risk consumption. Done by trained OM Department health professional following a structured protocol.
- Counselling and treatment: referral to appropriate specialized centres for monitoring drug addiction and / or treatment. Attendance of family or friends was encouraged after obtaining consent from the employee.
- Monitoring: joint monitoring of progress done by specialized centres - OM department, preserving confidentiality. Aim: assess adherence to treatment and predict and avoid relapses.
- Occupational reinsertion: supervised by the OM department proposing adaptations to the job.

With the agreement of the health and safety committee and for the purpose of helping the affected employee and facilitate the final aim of occupational and social reinsertion, the disciplinary procedures already in place were adapted and new policies were introduced.
POLICY FOR MEDICAL EXAMINATIONS:

- Initial medical examinations of all categories in the company: alcohol and other drugs detection was introduced with the consent of the worker.
- Mandatory periodic medical examinations (safety critical fitness for work evaluation for drivers and machinists): alcohol and other drugs detection was introduced with the consent of the worker.

A positive outcome equals a "Not fit for the job".

POLICY FOR ALCOHOL AND/OR OTHER DRUGS TESTS RESULTS

Definition of positive following a planned, random or follow-up testing: anything exceeding 0.0 in the case of alcohol (breath test repeated after 10 minutes to ratify the result), and any positive test results for drugs.

<table>
<thead>
<tr>
<th>Negative test result</th>
<th>The worker continues to work unless clearly intoxicated despite a negative result, in which case referral to OM department should follow for further evaluation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive test result</td>
<td>Results &lt; 0.25 mg / l : five opportunities before disciplinary dismissal</td>
</tr>
<tr>
<td></td>
<td>Results ≥ 0.25 mg / l : three opportunities before disciplinary dismissal</td>
</tr>
</tbody>
</table>

Impact of the alcohol programmes

An evaluation and monitoring system of the programme was developed in a quest for continuous improvement. Key elements for this purpose were the establishment of indicators and the creation of an evaluation committee.

EVALUATION COMMITTEE

It is formed by company's representatives (Production Department, Human Resources and Occupational Health Service, including health professionals and safety advisors) and legal representatives of the workers. The alcohol Program on Substance Abuse from the Health Department of the Government of Catalonia acted as an external, assessing member of the committee.
The functions of the committee are:

- Evaluate the correct development and the effectiveness of the programme.
- Evaluation of program indicators.
- Assure continuous improvement of the program, reviewing and adapting contents
- Study real cases that may arise during the course of the program.
- Be informed of disciplinary procedures imposed.
- Meet prior to the imposition of disciplinary sanctions for gross misconduct.

No clinical information is disclosed to the evaluation committee.

**INDICATORS**

A series of indicators were created in order to have reliable information on how the programme was working and to check whether the objectives were being achieved in terms of reduced absenteeism, lower consumption of alcohol and/or other drugs and decrease in accident rates.

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>INDICATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sickness absence</td>
<td>- Number of days lost for common illnesses and accidents.</td>
</tr>
<tr>
<td></td>
<td>- Number of days lost for work accidents</td>
</tr>
<tr>
<td></td>
<td>- Number of not medically certified days lost</td>
</tr>
<tr>
<td>Alcohol consumption at work</td>
<td>% of positive tests</td>
</tr>
<tr>
<td></td>
<td>% of negative tests</td>
</tr>
<tr>
<td></td>
<td>% of rejections to testing</td>
</tr>
<tr>
<td></td>
<td>% of workers accepting detoxification programme</td>
</tr>
<tr>
<td>Accident rates</td>
<td>Accumulated frequency index</td>
</tr>
<tr>
<td></td>
<td>Accumulated severity index</td>
</tr>
</tbody>
</table>

The evaluation and monitoring has taken place since the implementation of the preventive program of alcohol and/or other drugs in 2008.
Main results for the Tarragona-Lleida delegation are presented below linked to the general and specific objectives.

RESULTS:

With regards to general objectives:

1. **INCREASED SAFETY AT WORK**
   Safety at work has improved as no workers are under the influence of alcohol and other drugs at work. The company opts for authorizing someone to be relieved of duty, rather than risking a workplace accident. Tests and follow ups have increased progressively.

2. **REDUCED SICKNESS ABSENCE**
   A significant reduction in days lost due to illness and unjustified days lost has been observed, falling from 654 in 2008 to 330 in 2010

![Graph showing decrease in unjustified days lost and accumulated sickness absence](image)

3. **REDUCTION IN THE NEED OF DISCIPLINARY PROCEDURES**
   No need for major disciplinary sanctions related to alcohol or drugs since the implantation of the programme. After a total of 1,599 tests during 2009 and 2010, only 3 persons had minor disciplinary sanctions.

4. **IMPROVEMENT OF THE COMPANY’S IMAGE AND SENSE OF BELONGING OF STAFF**
   This program has generated a motivational effect, staff feel supported and cared for. The public image of the company’s workers has improved, as assessed by both the company and the workers representatives, and most importantly by the clients (Town Halls of the different cities and towns covered) who greatly appreciate the implementation and results of the programme and encourage its continuation.

With regards to the specific objectives:

5. **INCREASED AWARENESS OF THE WORKFORCE**
   Greater awareness about alcohol and drugs problems, not only in the workplace, but in general. The values transmitted are:
   - a. Zero tolerance for drugs and alcohol at work.
   - b. Importance of education and training.
   - c. Help is available to persons with problems
6. DECREASED CONSUMPTION
The OM department is aware that risky consumption habits have been modified in many cases. The number of positive test results has diminished.

7. ESTABLISHMENT OF COMMUNICATION CHANNELS
This programme has promoted right from the beginning the participation of all parties involved, creating direct channels of communication and facilitating accessibility of workers to information and help, as well as encouraging new ideas and suggestions. The figure of the Health Agent has been introduced, and its functions will be explained in the next point.

The programme is highly valued by the employees as shown by the results of the evaluation questionnaire in Reus (the first workplace where the programme was implemented and for which comparative data exist): an improvement can be seen in 2010 compared to the previous year.

Lessons learnt
- The most important issue is team work. Management, human resources, production department and occupational health and safety must all act in coordination. It would be useless to try to implement a programme led by only one of these departments. It
is specially important to get the participation and support from workers' representatives right from the beginning, otherwise the possibilities of success diminish.

- Specific training for health professionals and management is another important element.
- Another important issue is to plan and design a good awareness-raising campaign and training activities, adapted to the roles and peculiarities of each target group. Things that help are: introduce imaginative ideas, surprise people, innovate, try not to repeat all the time same initiatives. For example in this campaign giving small incentives like biscuits, fruit juice, etc helped to enhance the message of the campaign.
- Give time to prepare for the changes. Start with a pilot and extend it.
- An agreed written health protocol and disciplinary policy is essential. Transmit the idea that the final objective is helping, not punishing.
- Explaining real cases: on a voluntary basis, workers who have benefited from the programme in the past explain their experience to workers from other branches. In this company workplaces are many kilometres apart from each other: this helps maintain anonymity of the worker.
- Health agent: this figure corresponds to an employee who volunteers to take care of and accompany (either home or to OM Department) a worker with a positive result in an alcohol or drugs test. It has proven to be a very useful figure, but finding a compromised person with full trust both from the company and from the workers is a prerequisite. It is extremely important to carry out a good selection and training process, and establish clear roles and functions as it is a very sensitive post.
- Referral for specialized treatment for drugs and alcohol problems: it is very important to find funding for private treatment or establish links with public services as, in many cases, this is a key element for rehabilitation and social and occupational reinsertion.
Country description

BASIC FACTS ABOUT REPUBLIC OF CROATIA

The Republic of Croatia (RoC) is situated in southeast Europe, with a surface area of 56,594 km² and a population of 4,434,000 inhabitants. The gross domestic product is 14,242 USD per capita according to estimate for the year 2009. In 2009, the working population was 1.76 million out of which 1.5 million actively worked and 263,000 were unemployed. The registered unemployment rate was 14.9% (1).

In the past 20 years in Croatia no cross-sectional study to determine prevalence of alcohol induced mental disorders in the Croatian population was performed. The data for the estimated prevalence of alcohol addiction in the Republic of Croatia was taken from the relevant publication of the World Health Organization (WHO), from data obtained from the Croatian Health Survey in 2003 and from experts’ opinions. According to the WHO estimate for 2005 (2,3), persons aged 15 and above in Croatia have consumed 12.6 liters of pure alcohol (47% wine, 37% beer, 15% liquor and 1% from other sources). According to data for the period from 2003 to 2005 the annual consumption of pure alcohol per alcohol consumer was 26.32 liters. Alteration trends in alcohol consumption for the period from 2001 to 2005 were estimated as stable. In 2003, 70% of the male population aged 15 or above had consumed alcohol with 18.3% secondary and 11.7% of primary abstinent while in the female population the rate of primary abstinence was 31.3% and secondary 22.4%. According to estimate, during 2003 there were 14% of the male and 0.8% of the female population who occasionally drank to excess (with at least 60g of pure alcohol in at least one episode of drinking per week). The prevalence of disorders related to alcohol consumption for 2004 was estimated at 4.88% for the male and 1.11% for the female population.

According to data from the Croatian Health Survey from 2003(4), the prevalence of excessive alcohol consumption was 12.3% for men and 0.7% for women.

According to the established estimate from specialists at the Alcoholism Reference Center of RoC (5), the prevalence of alcohol addiction in Croatia is about 6% which means a population of 240,000 persons that are addicted to alcohol, with approximately 15% of people with excessive consumption of alcohol.

Mental disorders caused by alcohol represent the leading cause of hospitalizations due to mental disorders in Republic of Croatia (6), with a total of 9,148 hospitalizations and a rate of 23.5% of the total number of psychiatric hospitalizations for the year 2002. The ratio of hospitalized men compared to women for the aforementioned year was 5.3/1. The hospitalization rate due to mental disorders caused by alcohol for 2002 was 206.2 per 100,000 inhabitants, and it was highest for men aged 40 to 59 (703.4/100, 000).
Resources for prevention and treatment of mental disorders caused by alcohol in the Republic of Croatia are inadequate. Psychiatric service for alcoholism and other addictions is organized as a separate subspecialty in psychiatry with several decades of tradition of a self-organized network of clubs for people treated for alcoholism. Clubs are conceptualized as citizens’ associations and persons treated for alcohol addiction enter the clubs after a phase of institution-based treatment and rehabilitation. However, the Republic of Croatia at the present moment does not have an organized and recognizable system for prevention of mental disorders caused by alcohol. In September 2010, the Croatian Government established the “National Strategy for Prevention of Adversely Usage of Alcohol and Alcohol Induced Disorders for the Period 2011 to 2016” (7). The aforementioned strategic document brings a series of general guidelines without specific objectives and without previous analysis of the actual state. Since there is no data on the estimated range of the population’s needs, nor about the present state in the Republic of Croatia, considering capacity of services, nor the number of medical professionals employed full time or part time in treatment and prevention of alcohol related disorders, it is logical that there are no clear frameworks for intervention in the period that this document covers. Moreover, no parameter that could be used for evaluation of the realization of this strategy was included.

WORKPLACE AND ALCOHOL – PRESENT STATE IN THE REPUBLIC OF CROATIA, LEGAL FRAMEWORK

Legislation in the RoC (8,9) clearly shows the attitude of society and state policy towards alcohol consumption at the workplace. But it does not influence regular (or occasional) alcohol consumption outside the workplace - after working hours. Decreased productivity at the workplace caused by alcohol is not the result of alcohol consumption during working hours exclusively, rather it is caused by alcohol consumption during workers’ free time as well. Workers who drink more have poor working ability despite the fact that they drink during the working week after working hours and outside of the workplace (10). Therefore measures and actions taken within the company, with the objective of preventing damaging habits of alcohol consumption as well as identification of workers who have these medical issues and sending them to get professional help, are well justified.

Legal acts in the Republic of Croatia regulate the problem of alcohol at the workplace through several laws. The Act on Work Protection (8) (article 64) prohibits alcohol consumption before and during working as well as the entering of alcohol beverages into the work place. It also regulates that the employer needs to conduct prohibition by appropriate measures. They include, in most cases, the following activities: prohibition of alcohol entering and consumption, workers’ education on alcohol adversity and its adverse affects to working capability (e.g. by organizing lessons for workers, printing brochures about this subject etc.), production and application of addiction prevention programs according to identified needs, organizing testing with the aim of detecting possible alcohol-intoxicated workers (testing with workers’ consent, test procedures, type of devices, sorts of recording and confirmation of the results), editing protocol for the employer’s (or its authorized representative) cooperation and practice with work protection experts, professionals in occupational medicine, workers’ commissioners for health protection with the objective of conducting measures for the prevention of substance abuse (alcohol).
The same Act (8) regulates the employer’s obligation to temporarily remove a worker from the workplace if he is under the influence of alcohol, determination of alcohol intoxication level to be done with an appropriate alcoholmeter. In the case that a worker refuses alcohol testing it is considered that he is intoxicated. If a worker is at the workplace under the influence of alcohol and refuses to leave the workplace, he can be removed by the authorized security service. This Act (8) (article 109, 119 and 112) also regulates the fines for the worker if he violates this Act (working under alcohol influence, entering and consumption at the workplace). The person responsible for this procedure can also be fined.

This Act (8) (article 64) regulates the exemptions for substance (alcohol) controlling if the person has written justification that he is in the treatment program or rehabilitation from addiction (outpatient treatment). In such a case, the employer is entitled to request the assessment of the health and psycho-physical ability of the worker to perform a certain job. The practical implementation of this part of the regulations could present a serious problem for employers in the case that a worker in this treatment program comes to the workplace under the influence of alcohol and the employer cannot test him for alcohol or remove him from the workplace.

The Labor Act (9) (article 108.) gives the employer a possibility to cancel a working contract in cases of its violation.

The Ordinance on Jobs with Special Working Conditions (11) states categories of positions/occupations that can be performed only by persons that, besides the general conditions for employment, meet special criteria considering age, gender, qualification, health conditions and mental capacities. It also states the contraindications for performing the aforementioned jobs, hence diseases and conditions that disable a person for working in that profession. Alcoholism presents a contraindication for the majority of occupations with special working conditions, or if the person is already employed, in which case he has to change the workplace.

In case of work related injury, Application for Work Related Injury has to be submitted to the regional office of the Croatian Institute for Health Insurance (CIHI). The application is filled in by the employer in one part, and the general practitioner responsible for the worker in the rest of the form (12). Only exceptionally, the application can be filled in and delivered to CIHI by the worker himself. In the application form there are two questions connected to workplace alcohol consumption: whether an injured person was under the influence of alcohol and was tested for alcohol with the test result. Unfortunately this part of the application is not always completed and even if it is, in most cases it is based on the subjective assessment of the person who fills in the form. Data on alcohol testing is rarely present.

Measurement of alcohol concentration is practically mandatory if an injury occurs in traffic, during transportation to work or home from work. If the police come to the scene of an accident and perform the testing, they make the records and provide the copy to the employer. In the case of serious work related injuries, when a worker is hospitalized due to injury, sometimes hospital personnel test alcohol levels in blood/urine on their own initiative, without legal obligation. Injury caused by irresponsible behavior at the workplace is not recognized as work-related injury by the insurance institute. For that reason it is not possible to make the relevant estimate of alcohol consumption ratio (responsibility) at the workplace as a cause of work related injuries. The Croatian Institute for Health Protection and Safety at Work receives applications of all recognized work related injuries and based on given data
does the statistical analysis and suggests measures for prevention. But due to the reasons mentioned above, the number of work related injuries of workers that were identified (for sure) as under the influence of alcohol is severely underestimated. During the year 2010, there were 16,026 recognized work related injuries and in only 9 cases alcohol consumption by workers was recorded at the time of injury. So it is impossible to determine if alcohol consumption at the work place is negligible or a very important factor in the occurrence of work related injuries.

Reference


(9) Zakon o radu (N.N. 149/09)


(11) Pravilnik o poslovima sa posebnim uvjetima rada (N.N.5/84)

(12) Pravilnik o pravima, uvjetima i načinu ostvarivanja prava iz obveznog zdravstvenog osiguranja u slučaju ozljede na radu i profesionalne bolesti (N.N. 01/11)
Template case I

Case Nr: 1
Name of the case: Petrokemija
City: Kutina

Type of company

Ownership?
☒ public ☐ private ☐ voluntary

Sector (ISIC Rev 4. codes)
☐ Agriculture, forestry and fishing
☐ Mining and quarrying
☐ Manufacturing
☐ Electricity, gas, steam and air conditioning supply
☐ Water supply; sewerage, waste management and remediation activities
☐ Construction
☐ Wholesale and retail trade; repair of motor vehicles and motorcycles
☐ Transportation and storage
☐ Accommodation and food service activities
☐ Information and communication
☐ Financial and insurance activities
☐ Real estate activities
☐ Professional, scientific and technical activities
☐ Administrative and support service activities
☐ Public administration and defence; compulsory social security
☐ Education
☐ Human health and social work activities
☐ Arts, entertainment and recreation
☒ Other service activities – Chemical industry
☐ Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use
☐ Activities of extraterritorial organizations and bodies

Company size?
☐ Very small enterprise (under 10 staff members)
☐ Small enterprise (10 to 50 staff members)
☐ Medium-size enterprise (50 to 500 staff members)
☒ Large enterprise (501 and more staff members)
☐ How many are employed: 2346

Location?
☐ Company is situated at one location (national or local)
☐ Company with a headquarters and one or more other branches/locations (national)
☒ Multinational company

Alcohol practice provision
☒ Internal service ☒ External service
Case I

Employing body

Petrokemija d.d.

Manufactured products:

Mineral fertilizers, carbon black, clay – based products, betonites and additives for foundries, cattle feed additives, pet litter, cleaning products, maintenance, engineering, mechanical engineering services, electro services, measurement and regulation technology.

Management:

Ownership structure: Stock Exchange Company

Number of employees:

2346 workers, on May 31st, 2011.

Job Category of Employees (based on education)

<table>
<thead>
<tr>
<th>QUALIFICATION</th>
<th>NUMBER OF EMPLOYEES</th>
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</thead>
<tbody>
<tr>
<td>Ph.D.</td>
<td>1</td>
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<tr>
<td>M.Sc.</td>
<td>13</td>
</tr>
<tr>
<td>B.Sc.</td>
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<td>2-year college</td>
<td>87</td>
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<tr>
<td>Secondary school</td>
<td>632</td>
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<tr>
<td>Skilled</td>
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<tr>
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<td>90</td>
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<tr>
<td>Unskilled</td>
<td>226</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>2346</strong></td>
</tr>
</tbody>
</table>
**General policy towards health and wellbeing**

In company, there are periodic medical examinations for workers who work at the workplace with special working conditions.

Occasional actions for blood pressure measurements and controlling of blood sugar are organized in cooperation with primary care physicians (Outpatient Clinic Kutina).

**Type of occupational medicine service:**

Petrokemija d.d. uses services from an external specialist in occupational medicine. Medical services are combined, in outpatient clinic and occasional visits to workplaces. Visits to workplaces are organized as team work: a specialist in occupational medicine, a representative of Protection Affairs and if needed a representative of Human Resources.

Health education is conducted but rarely, after periodical medical examinations have been done.

**Workplace alcohol policy and program and impact of the alcohol programs**

Systemic treatment of alcoholism and prevention of alcohol induced disorders in Petrokemija started in 1974. It was noticed that it is not possible to resolve or prevent this social and health problem without active work from clubs for alcoholics in treatment as the way of self-help and under guidance from a professional therapist so the first club was then founded. The survey about drinking habits at workplace served as foundation for this.

The survey collected following data:

- name and surname of worker,
- if the worker often goes to work under influence of alcohol,
- was the worker removed from work due to alcohol consumption,
- did the worker drink at work,
- was the worker treated for alcoholism,
- did the worker repeat drinking after treatment was finished,
- was a disciplinary act initiated,
- was a social worker notified about drinking problem.

After that, questionnaires were updated with data on:

- age,
- qualification grade,
• years of working experience,
• years of working experience in Petrokemija,
• marital status of employee.

Ever since that time, under the leadership of Protection Affaires, constant workers’ testing started with alco-test (Dräger). Testing was done and still goes on, by work protection engineers, they could be self initiated or by request from manager of certain working units.

In the company today there is zero tolerance to alcohol, specially introduced due to the sensitivity of chemical industry, the sector in which Petrokemija is working.

Detection of workers who come to work under the influence of alcohol is done by several ways, most often through information from managers. Upon their requests, because of various work violations, workers are tested. Work violations could be, among other things, unauthorized absence from work or arriving to the workplace under the influence of alcohol.

Determination of workers’ alcohol intoxication could be done by Protection Affaires even upon request from the doorman who controls alcohol entry and suspects workers’ intoxication.

In the aforementioned cases with positive results, the person who initialized testing sets up a meeting with the administrative service within HR that consists of a social worker, a jurist and a psychologist and also, if needed, a manager from HR can be included. The behavior of the worker who violates working responsibilities is recorded and the worker is encouraged to start treatment for alcohol addiction in one of the addiction clinics.

After hospitalization, the worker continues treatment in a club for alcoholics in treatment. That is mentioned as a recommendation in the discharge letter from the hospital. The club is active two times per week, in afternoon hours, for sessions of 90 minutes in length, under the supervision of a professional worker, a therapist and a long term abstinent who is educated for working in the club.

One of the ways to determine drinking problems for workers is through periodical medical examinations of workers who work at workplaces with special working conditions. This is determined by Petrokemija Ordinance on Workplaces with Special Working Conditions. In that case, the occupational medicine physician refers the worker to addiction treatment. The worker can also be sent for an extraordinary medical examination if he/she for any reason cannot manage working assignments that are within the range of his/her job description.

Workers’ and managers’ education on alcohol induced problems is done through lectures that are organized by HR and performed by health protection engineers and a psychologist who is also the therapist in the club for alcoholics in treatment. If needed, external experts, doctors from an eminent clinic for addiction treatment, participate.

There is also collaboration and partnership between HR and Protection Affaires, management and unions. In proven cases of alcohol intoxication on workplace, determined by alcohol testing and results with workers’ personal data, time of testing and quantity of alcohol in expiration, HR are notified and then they start the procedure of sending the worker for treatment.
The Petorkemija Club for Alcoholics in Treatment is one of the few that are left in companies in Croatia and it has continued after all the others stopped working during the war in Croatia and privatization.

Besides Petorkemija Club for Alcoholics in Treatment, companies that still have active clubs are: “Podravka” in Koprivnica, “Rafinerija” Rijeka, club „ZET” (Zagreb Municipal Transit System), “Poštar” u Zagrebu i „Rafinerija Sisak“ whose work was initiated and helped by club „Petrokemija“ several years ago.

Upon the initiative of and with help from club „Petrokemija“, in year 1999, a club for alcoholics in treatment (CAT) in the city, named CAT Kutina was established. Club Petrokemija also initiated the establishment of the Union of Clubs for Alcoholics in Treatment of Sisak Moslavina County.

Evaluation of the efficacy of treatment is performed through the club for alcoholics in treatment where the records are kept on regular meeting attendance and of total abstinence time. Workers who are successful in abstinence from one to five years receive “Appreciations”. If they are still active in the club, they receive “Appreciations” for every five years. Data from the last systemic records of club members from 1982 to 2003 show that there were 300 persons and members of their families. At the moment, the data from 2003 to 2011 are being prepared and they will be finished by December 31st, 2011.

Data from occupational medicine show that the percentage of workers with alcohol consumption problems has decreased by 20 – 30 % in period from year 2002 until 2011. This is the result of various factors:

- alcohol abuse prevention program in Petrokemija, mentioned previously,
- higher level of controlling of alcohol entering in Factory,
- higher level of controlling of alcohol consumption during working hours,
- personal employment of occupational medicine physician Ivica Kostecki. He educates workers about the damage caused by alcohol and tobacco to health during every pre-job and periodic medical examinations.

The therapist of CAT Petrokemija and the president of the Union of Clubs for Alcoholics in Treatment of Sisak Moslavina County also successfully finished and presented the project Prevention of Alcoholism in Teenagers (P.A.K.T. in Croatian). That project was presented by the county at a meeting of children friendly cities in Karlovac, Croatia when the topic was addiction prevention.

With regards to sick days that were caused by excessive alcohol consumption, there are no special records, except in the worker’s personal file. There is also no data about work related injuries occurred under alcohol influence.

Lessons learnt
After 37 years of systemic dealing with alcohol induced work disorders, social and health problems of workers in Petrokemija, managers and professional services are sensitive and educated enough to consider those issues so they can be a good practice model for the rest of private and public companies in Croatia.

The club for alcoholics in treatment represents a group of people that are close to the addict so he/she can address the group with problems of relapse without fear of being judged. It is known that alcoholism is a relapsing disease so timely interventions in some cases prevent hospitalization and repeated abstinence can be induced just through club meetings. This represents significant savings for the Company but also for the community.

Template case II

Case Nr: 2
Name of the case : Badel
City: Zagreb

Type of company

Ownership?
☐ public ☒ private  ☐ voluntary

Sector *(ISIC Rev 4. codes)*
☐ Agriculture, forestry and fishing
☐ Mining and quarrying
☐ Manufacturing
☐ Electricity, gas, steam and air conditioning supply
☐ Water supply; sewerage, waste management and remediation activities
☐ Construction
☐ Wholesale and retail trade; repair of motor vehicles and motorcycles
☐ Transportation and storage
☐ Accommodation and food service activities
☐ Information and communication
☐ Financial and insurance activities
☐ Real estate activities
☐ Professional, scientific and technical activities
☐ Administrative and support service activities
☐ Public administration and defence; compulsory social security
☐ Education
☐ Human health and social work activities
☐ Arts, entertainment and recreation
☒ Other service activities – Alcohol beverages manufacturer
☐ Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use
☐ Activities of extraterritorial organizations and bodies

Company size?
☐ Very small enterprise (under 10 staff members)
☐ Small enterprise (10 to 50 staff members)
☐ Medium-size enterprise (50 to 500 staff members)
☒ Large enterprise (501 and more staff members)
Case studies Croatia

☐ How many are employed: 504

Location?
☐ Company is situated at one location (national or local)
☐ Company with a headquarters and one or more other branches/locations (national)
☒ Multinational company

Alcohol practice provision
☒ Internal service ☐ External service

Case II

Employing body

BADEL 1862 Wines, Spirits & Soft Drinks PLC

Manufactured products:
Wines, spirits and soft drinks

Number of employees:
570 in Badel 1862 PLC (all location included)

Job Category Of Employees (based on education)
Elementary school: 85 – 14,91 %
Unqualified worker: 75 – 13,16 %
Low professional qualification: 6 – 1,05 %
Middle professional qualification: 51 – 8,95 %
Middle professional qualification – specialist: 10 – 1,75 %
High school: 221 – 38,77 %
Bachelors: 23 – 4,04 %
Faculty graduates: 99 – 17,37 %

General policy towards health and wellbeing

- Preliminary and periodically system examinations for people who work at workplace with special working conditions (workers on manufacturing lines, workers in cellars,
vineyard workers, tractor drivers, forklift truck drivers, drivers, electricians, machinists, workers in distillery, workers at compressors),
- Blood pressure controls in company,
- Health education according to extended program for the persons who work with food in tourism and catering and extended program about food and personal hygiene for persons who work with food,
- Toxicology courses and
- First aid courses.

**Type of occupational medicine service:**

Occupational medicine services are assured through specialized outpatient clinics with which the company has contracts on working cooperation, based on workplace locations. Occupational medicine work consists of working in clinic but also occupational medicine specialists are coming to company and participate in Work Protection Boards.

**Workplace alcohol policy and programme**

1. **Background and history**

The alcohol policy is conducted with the Program for Workplace Alcohol Addiction Prevention. The background of this program is an internal normative act that is compatible with legislation. The preventive program has been conducted systematically since 2003.

Internal procedures have assigned objectives, and the methodology and results accomplished are monitored.

2. **Rationale and objectives**

Due to specific products the employing body makes significant efforts for prevention and health education so the risks from alcohol consumption at the workplace can be decreased. In that regard, according to the law, consumption of alcohol is forbidden at the workplace.

Due to work safety, prevention of work related injuries, for reasons of workers’ health protection and protection of company’s material assets, zero alcohol tolerance applies.

During the period of the last 8 years that the Program has been active, a planned reduction of positive alcohol test results has been accomplished and brought to within acceptable parameters.

3. **Key elements:**

- Alcohol policy development
In order to accomplish those results a positive relationship between management and union helped in solving problems related to alcohol abuse at the workplace in such a way as to give support to worker that has a problem with alcohol, during treatment and curing in institutions and out of them.

- **Surveillance of workplace and health of workers**

Actions for alcohol testing are conducted by the person in charge. Testing is performed upon request from direct management, directors and so-called irregular actions when the person responsible wants to control a working unit or wants targeted alcohol testing of a certain person who is under suspicion of alcohol influence.

Regular actions are performed by the person responsible for testing.

- **Education and training**

In the opening stages of the Program for Workplace Alcohol Addiction Prevention for prevention purposes, the Club for Alcoholics in Treatment was registered and active. As the number of participants decreased individual treatment was introduced.

- **Promotion and prevention activities**

There are articles and advice in the internal magazine connected to recognition of early symptoms of alcohol addiction and early detection.

- **Treatment**

When alcohol consumption at the workplace is proved, the worker is referred to his/her chosen primary care physician who will determine the extent of the future treatment.

- **Social reinsertion**

As mentioned before, Badel 1862 PLC had the Club for Alcoholics in Treatment inside the company but today, considering the decreasing number of workers who have alcohol addiction problems, they are enrolled in clubs near their home.

**4. Implementation elements**

Ever since it was implemented, the Alcohol Addiction Prevention Program has included an annual database of positive results and recording of measurements taken for each worker personally so the alcohol addiction can be eliminated. There are also recordings about relapses.
Impact of the alcohol programs

Qualitative and quantitative evaluation (internal and external services)

Evaluation is performed at the end of every calendar year. Recorded results are analyzed and objectives for the next year are set.

Primary objectives are: to reduce the number of positive test results and to reduce the number of work absence days caused by alcohol addiction problems as well as eventual work related injuries.

Impact of the policy and program in any of these areas

Due to the application of the alcohol addiction prevention program, quantitative and qualitative changes and movement occurred. The program is permanent and continuous.

- Absence from work
  Positive movements accomplished

- Work performance, productivity, cost-benefit
  By means of an active policy to repress the consequences of addiction diseases to workers’ health, as well as to their working capacity, and preventive work in non-recruiting new cases, positive results were achieved even in increasing work capacity and productivity.

- Workplace climate and corporate social image
  An open corporative social policy in the matter of the consideration not to hide and to accept problems, as well as finding solutions, led to increased satisfaction of the worker who has a problem with alcohol addiction as well as the satisfaction of his/her colleagues who provide support. In the beginning of the program’s application, those persons were stigmatized, marked and often laughed at but today they are accepted as members of team with a problem that needs to be solved. The working environment is included as much as needed and also provides support.

Lessons learnt

Working environment is included as needed and provides support to workers who have problems with alcohol addiction. More help from society and government is needed (ministries, offices of state authorities) in solving all the difficulties that the club for alcoholics in treatment encounters in its activities. Especially when real treatment and real changes in behavior are adopted after one or two years or more, in the club for alcoholics in treatment and not in the period of two to three weeks spent at the rehabilitation clinic.
Estonia

Country description

Estonia is one of the Baltic countries and a member of the European Union since 2004. The population of Estonia is 1,34 million people. However, it is good to keep in mind that the true number of population will be seen only after the 2010-2011 population censuses and analyses of the results due to the fact that the official emigration figures are possibly underestimated by up to 30-60% and real outmigration at the beginning of the 21st century was much higher than numbers from statistics demonstrate. The difference is caused by the fact that many people who left the country did not register it as emigration and often, the outmigration was not even perceived as final emigration, although the stay abroad lasted long-term.

Since the year 1991, an annual growth rate has been negative as there was a fall in births and a sharp rise in mortality rates (total population change was -2,2 per 1000 inhabitants during the years 2000 to 2009) and only in 2010 it became positive being 0,03 (the number of deaths was 15 790 and 15 825 of births). According to Statistics Estonia, the average life expectancy in 2009 was 75 years. The mortality rate of under-5-year-olds decreased 2,6 times from 1990 to 2008. The absolute and relative growth in male life expectancy from 1990 to 2009 exceeds the growth in female life expectancy as males’ life expectancy at birth increased by 5.16 years (8,0%) from 64.68 to 69.84, and females one by 5.10 years (6,8%) from 74.97 to 80.07.

Nowadays, the traditionally higher impact of infant and child mortality on the life expectancy has been replaced by the growing role of mortality in the working ages. Probability of dying between the ages of 15 and 60 per 1000 population has declined 83% for men (301 in 1990 and 249 in 2008) and 79% for females (107 in 1990 and 84 in 2008).

The three main groups of causes of death determining the majority of overall changes in mortality and life expectancy are diseases of the circulatory system (56% of total deaths), cancer (22%) and external causes of death (8%). More than 4/5 of all deceased are attributed to these three groups of causes.

From the perspective of quality of life, it is important to take into account not only fatal, but also non-fatal health outcomes measured as healthy life expectancy. The last available indicator of healthy life expectancy was below the average of the so-named old EU member states by 7-10 years in 2007. Female healthy life expectancy in Estonia exceeds significantly, 9,3 years, the healthy life expectancy of men. E.g. this difference is only 2,6 years in Sweden. Metabolic risk factors are common among the inhabitants in Estonia, as 54% of population had raised blood pressure, 9,7% raised blood glucose, 53,7% overweight, 59,2% with raised cholesterol in 2008. Estimated prevalence of daily smoking was 27,2% and physical inactivity 19,6% in 2008 (WHO NCD Country Profiles, 2011).
In 2010, unemployment rate was 16.9% (www.stat.ee).

The standard of living used to be measured as gross domestic product (GDP) in Estonia in 2010 was 18,355 USD per capita at purchasing power parity (PPP). As of 2010, the gross national income (GNI) per capita at PPP is used as the indicator of the living standard. While GDP indicates the total value of final goods produced in a given territory (including the goods produced by foreign companies), the GNI is based on the income of the permanent residents of the country and also takes into account revenue acquired abroad. In the case of Estonia, the difference between GDP and GNI is not very large: the GNI is 6-7% higher than GNI (UNDP calculations based on the IMF database). In Estonia, 15.1% of GDP (Eurostat 2008) was spent on social protection, which is one of the lowest levels of total expenditure on social protection among the EU countries.

While the years from 2000 to 2007 were characterized by very quick economic development in Estonia, the economic crisis changed the situation completely as Estonia suffered a very steep downturn between 2008 and 2010.

The Global Competitiveness Report 2010-2011 ranked countries based on various indicators and Estonia had 33rd position by combined global competitiveness, 22nd position by higher education and training, 37th position by innovation among 139 states.

By World Bank ranking Estonia belongs to the category of countries with very high human development and has belonged to that group since 2005.

**Alcohol consumption in figures**

Estonia is a post-Soviet country with a historical tradition of regular intake of strong spirits and binge drinking is still common. Even though the market share of light mixed alcoholic drinks and beer has increased, strong spirits still account for over 50% of pure alcohol consumed (Estonian Institute of Economic Research).

In 2010, consumption of alcohol in Estonia was 9.7 litres per capita in pure alcohol and it was 4.1% less than in 2009, when 10.2 litres per capita were consumed. This figure does not include alcohol purchased by tourists. Sales of illegal alcohol amounted to 0.6 litres per capita in 2009 and it have increased during the past few years. Total adult (15+) per capita consumption of pure alcohol, average 2003-2005 was 15.6 litres in Estonia. There are 10.9% of lifetime abstainers and 18.2% of former drinkers, accordingly 70.9% are drinkers. So, in fact, on average 21.96 litres of pure alcohol were consumed by adult drinkers per capita, 36.06 litres per adult male and 12.15 litres per adult female (Global Status Report on Alcohol and Health 2011). In 1994, total adult per capita alcohol consumption was about 8 litres per year in Estonia, and by 2004 it had increased to 16 litres.

The adolescent population in Estonia shows a higher proportion of harmful alcohol consumers and higher volumes consumed compared with European averages. So, alcohol consumption by the young people is of particular concern, as in Estonia alcohol has been tried by 60% of 10-13-year-olds, and 55% of the 14-15-year-olds had been drunk at least once; 52% of 14-15-year-olds and 69% of 16-18-year-olds are regular alcohol drinkers. Currently only 10% of teenagers compared to 29% of adults are not drinking alcohol beverages in Estonia. (National Institute of Health Development).

**Alcohol policy**
Alcohol policy in Estonia during 1990-2004 had only minor changes and was without clear directionality; eg. while alcohol sale to minors was criminalized, the average excise tax of alcoholic beverages was slightly reduced. The Estonian Ministry of Social Affairs commissioned a study in 2004 to find the most appropriate interventions for strengthening Estonian alcohol policy. The study found that the combination of interventions in place was neither the most effective nor cost effective. However, a large majority of the population is in favour of strengthening alcohol policy at the timed according to the surveys done by Estonian Institute of Economic Research. Suggestions for strengthening alcohol policy included increase of alcohol taxation by 50%, a ban of alcohol advertising, wider restrictions on alcohol sales (both time and place), increased frequency of random breath testing on roads and initiation of brief counselling in primary health care.

Excise tax on alcohol has been increased on four occasions since 2005 for all alcoholic beverages except wine (did not increase on the first occasion). Compared to the 2004 level, excise tax increased 45% by the beginning of 2010. In 2009, value added tax (VAT) was increased from 18% to 20%.

A nation-wide restriction on the time of off-premise sales of alcoholic beverages was introduced in the summer 2008. Currently, off-premise sale of alcoholic beverages is prohibited from 10 p.m. to 10 a.m. throughout Estonia. On the other hand, there is still wide availability of alcohol sales outlets: there were 4,4 alcohol retail shops per 1000 inhabitants in Estonia in 2010.

Since 2008, advertising of alcoholic beverages on television and radio has been prohibited in Estonia from 7 a.m. to 9 p.m. before, prohibition of TV advertisement ended at 8 p.m. for alcoholic beverages other than spirits. However, time allocation studies of Estonian adolescents show that at 9 p.m. 37% of this age group is still watching TV and thus exposed to alcohol advertising while at midnight only 10% of adolescents would be exposed.

Measures against drink-driving such as random breath testing on roads are widely applied. The legal blood alcohol concentration (BAC) limit for motor vehicle drivers in Estonia is 0.02% of blood volume (or 0,1 mg/l in breath). These levels were established in 2000 when drinking-driving became a criminal offence.

Over the past decade, the price of alcoholic products has been increased modestly when compared to prices of other goods. Public awareness campaigns on the inadmissibility of drink-driving, hazards associated with alcohol, thresholds of harmful alcohol consumption and other topics organised most often by Estonian Institute for Health Development or Estonian Road Administration, have increased both in frequency and volume in recent years. These interventions in combination with other measures have been associated with a fall in the proportion of drivers tested who were over the limit from 3,5% in 2002 to 0,8% in 2009 (Estonian Road Administration 2010). The proportion of car accidents where a person was injured and a drunk driver was involved has declined from 22,9% in 2001 to 16,5% in 2009. However, more than half of these were younger than 30 years old in 2009.

Interventions on a personal level, such as alcohol counselling, have had very low priority in Estonia. A new initiative for early identification and counselling of alcohol-related health problems was launched in primary health care in 2011 by Estonian Institute for Health Development. Autumn 2011, initiated by the Department of Public Health of the Ministry of Social Affairs, a project of a Green Book was started and the book should be published in 2013.
Since 2010, the alcohol consumption per capita and legal sales, estimated by Estonian Institute of Economic Research, shows a decreasing trend since the year 2009 in Estonia (Table 1). Thus, the preventive actions have been effective. Hence, illegal sales and alcohol export and consumption by tourists still stay at the same level during 2006-2009.

Table 1. The consumption of 100% alcohol in litres per capita 2006-2009 in Estonia (source: Estonian Alcohol Market, Estonian Institute of Economic Research 2010).

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal sales</td>
<td>14,11</td>
<td>15,24</td>
<td>14,46</td>
<td>12,82</td>
</tr>
<tr>
<td>Exports by tourists</td>
<td>2,78</td>
<td>2,36</td>
<td>2,31</td>
<td>2,63</td>
</tr>
<tr>
<td>Illegal sales</td>
<td>0,63</td>
<td>0,43</td>
<td>0,52</td>
<td>0,60</td>
</tr>
<tr>
<td><strong>Total consumption</strong>*</td>
<td><strong>11,35</strong></td>
<td><strong>12,56</strong></td>
<td><strong>12,06</strong></td>
<td><strong>10,16</strong></td>
</tr>
<tr>
<td>Consumption by tourists in Estonia</td>
<td>0,60</td>
<td>0,74</td>
<td>0,60</td>
<td>0,63</td>
</tr>
</tbody>
</table>

*total consumption equals legal sales minus exports by tourists minus consumption by tourists plus illegal sales

Although the consumption of strong and light beverages and beer show little decrease in 2009, it showed the highest amounts in the year 2008 (Table 2).

Table 2. Consumption of alcoholic beverages litres per capita by beverage in 1999 and in 2008 and 2009 (source: Estonian Alcohol Market, Estonian Institute of Economic Research 2010).

<table>
<thead>
<tr>
<th></th>
<th>1999</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong alcoholic beverages</td>
<td>5,12</td>
<td>13,50</td>
<td>10,67</td>
</tr>
<tr>
<td>Beer</td>
<td>57,40</td>
<td>77,56</td>
<td>71,87</td>
</tr>
<tr>
<td>Light alcoholic beverages</td>
<td>7,19</td>
<td>23,57</td>
<td>18,28</td>
</tr>
</tbody>
</table>
Alcohol-related harms

Along with other Baltic countries Estonia shares a post-Soviet background and in 1994 saw the worst mortality peak of the last 20 years in all of Europe. By 2009, the proportion of premature death, before age 65, in all deaths had declined to 26%, from 33% in 2000. However, men still accounted for 72% of the premature deaths in 2009, which largely explains sex differences in life expectancy. Only interventions targeting hazardous alcohol consumption can annually avert 1000-3000 DALY’s when implemented individually, and almost 7500 DALY when implemented in combination interventions targeting tobacco smoking behaviour (Lai et al. 2007).

Estonia belongs to the countries with high risks connected with alcohol consumption such as number of alcohol related psychosis, injuries, suicide and traffic accidents as a result of driving while intoxicated.

The standardized death rate (SDR) from chronic liver disease and cirrhosis almost doubled from 11.5 per 100 000 inhabitants in 1994 to 21.7 in 2005 in Estonia. Among the amenable years of life lost, for men, liver cirrhosis ranks at ninth position, but for females, at sixth position (Lai et al 2005). At the same time, SDR due to accidental poisoning by alcohol was 13.4 per 100 000 in Estonia.

Deaths caused by alcohol related diseases during the period 2001 and 2009 are in decline (respectively, there were 569 versus 382 deaths of men and 206 versus 129 deaths of females), as well deaths caused by diseases partly related to alcohol are in fall (respectively, 4624 versus 3790 deaths of men and 5912 versus 5173 deaths of females)(Statistics Estonia).

Occupational safety and health (OSH) services in Estonia

Occupational Health and Safety Act (OHS Act) entered into force July 26, 1999. It prohibits for workers to work while under the influence of alcohol, narcotics or toxic substances or under the significant influence of psychotropic substances (§ 12 (2)). The full text in English is available on the webpage of the Estonian Labour Inspectorate (http://www.ti.ee/index.php?page=11).

In February 2010 the Ministry of Social Affairs adopted a new Occupational Health and Safety Strategy for 2010-2013. The goals of the strategy are targeted on legal environment, awareness raising, training, occupational health services as a part of health service system, identifying and addressing new risk factors in the work environment. There is also a detailed action plan for the implementation of the strategy. However, no quantitative targets on very important figures like the numbers of occupational accidents and occupational diseases are mentioned, nor is the reduction of consumption of alcohol beverages targeted. This strategy is not a document for a wider audience. The ILO Framework OHS Promotion Convention, No 187 is not yet ratified by Estonia, so it is not set up to formulate, implement and periodically review
a coherent national policy on Occupational Safety, Health and the Working Environment in consultation with the most representative organisations of employers and workers.

Whereas the trade union membership is as low as 7% in Estonia, it is the government that makes labour market policy, and social partners do not have veto rights over changes in legislation. But in general, there is a well organised system for early identification of occupational and work related diseases, and according to the risk assessment done by the employers, all workers with any health risk factors should have a medical check-up at least once in three years. So for example, ca. 50% of working population has had a check-up done by occupational health physician during the period of the last three years. Routine brief intervention on alcohol problems is not done during these regular check-ups. But in autumn 2011, the Health Development Institute begun the training session for family physicians and occupational health physicians to introduce the brief intervention of alcohol problems. This training is not specifically targeted on the working population and work-related items, but for all population.

All occupational health services are provided by private firms, and it is not a part of health care services provided by the contracts with the Estonian Health Insurance Fund. All services should be paid by employers. The physicians should be registered in the Health Board and altogether there are 101 occupational health physicians in the registry (October 2011), but only ca 50% of them are currently working as occupational health physicians (details are available on the webpage of Estonian Health Board, see www.terviseamet.ee).

Important links:

Health Board www.terviseamet.ee

Ministry of Social Affairs www.sm.ee

Labour Inspectorate www.ti.ee

Health Development Institute www.tai.ee ; www.alkinfo.ee ; www.terviseinfo.ee

Estonian Institute of Economic Research www.ki.ee

Eesti Karskusliit www.ave.ee

A-kiinik www.akliinik.ee

Figure 1 shows that in 2009 Estonia was third (after Austria and Czech Republic) in alcohol consumption (12 litres per capita per year) among population aged 15 years and over. Figure 2 shows the increased alcohol consumption per capita (15+) in Estonia and Finland during the period 2002-2009.
Case study 1

Name of the case: the organization wishes to remain confidential

Type of company:

Ownership?
☐ public ☐ private x voluntary

Sector (ISIC Rev.4, codes)
☐ Agriculture, forestry and fishing
☐ Mining and quarrying
☐ Manufacturing
☐ Electricity, gas, steam and air conditioning supply
☐ Water supply; sewerage, waste management and remediation activities
☐ Construction
☐ Wholesale and retail trade; repair of motor vehicles and motorcycles
☐ Transportation and storage
☐ Accommodation and food service activities
☐ Information and communication
☐ Financial and insurance activities
☐ Real estate activities
☐ Professional, scientific and technical activities
☐ Administrative and support service activities
☐ Public administration and defence; compulsory social security
☐ Education
☐ X Human health and social work activities
☐ Arts, entertainment and recreation
☐ Other service activities
☐ Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use
☐ Activities of extraterritorial organizations and bodies

Company size?
☐ Very small enterprise (under 10 staff members)
☐ Small enterprise (10 to 50 staff members)
☐ Medium-size enterprise (50 to 500 staff members)
☐ x Large enterprise (501 and more staff members)
☐ How many are employed: 3600

Location?
☐ x Company is situated at one location (national or local)
☐ Company with a headquarters and one or more other branches/locations (national)
☐ Multinational company

Alcohol practice provision
☐ Internal service ☐ x External service (health advising during health surveillance by side of OHS; conferences and training in connection of Health Promotion Hospitals’ program)
Case I

Employing body

Organisation and mission

The Hospital is a juridical body by private law, established in 1998 and one of the biggest health care organisations in Estonia. There are altogether 3475 people working at the Hospital; 593 of them are medical doctors, 1140 are nurses, 917 are assistant nurses and 825 are technical staff. The number of outpatient visits per year is up to 420,000. About 13% of the visits are made to emergency medicine units. The number of inpatients yearly is around 44,000. The most common reasons for hospitalization are respiratory illnesses, perinatal diseases, congenital abnormalities and injuries.

The main mission of Hospital is to be recognised as a leader in ensuring the continuity and development of Estonian medicine through high-level integrated medical treatment, training and research. Hospital provides inpatient, outpatient and community-based services to patients residing all over Estonia.

Organizationally, there are 17 clinics and 18 medical services in the Hospital. The clinics are: Anaesthesiology and Intensive Care Clinic, Children’s Clinic, Clinic of Dentistry, Dermatology Clinic, Ear Clinic, Eye Clinic, Haematology and Oncology Clinic, Heart Clinic, Internal Medicine Clinic, Lung Clinic, Neurology Clinic, Psychiatry Clinic, Radiology Clinic, Sports Medicine and Rehabilitation Clinic, Surgery Clinic, Traumatology and Orthopaedics Clinic, and Women’s Clinic. The medical services are Administrative Service, Analysis and Marketing Department, Andrology, Blood Centre, Catering Service, Centre of Medical Information, Chancery Service, Financial Administration, Infection Control Department, Informatics Administration, Internal Auditing, Pathology Department, Personnel Administration, Pharmacy Administration, Surgery Assistance, Technical Administration, Transplantation Centre and United Laboratories.

The Hospital is the largest provider of medical care in Estonia. In several fields (kidney, bone marrow and liver transplantation and congenital heart disease surgery) it is the medical institution in Estonia with specialists at the highest level.

The Centre for Occupational Health and Health Control is located at the Department of Sport Medicine and Rehabilitation.

The Hospital plays a substantial role in training both undergraduate and post-graduate students as well as in the development of the country’s medical research and science.

The Hospital is a member of the International Network of Health Promoting Hospitals and Health Services since 2000. The Hospital is also a member of the Global Network of Tobacco-Free Health Care Services Network.

Legislation and organization of health control examinations in the Hospital
The Estonian Occupational Health and Safety Act (OHSA) § 14 prohibits workers to work under the influence of alcohol, narcotics or toxic substances or under the significant influence of psychotropic substances (http://www.ti.ee/index.php?page=11).

According to the occupational health and safety rules, all health care workers (HCW) must pass the regular health surveillance at least after each 3 years of service. HCW is called back to health control more frequently if the worker is exposed to high occupational risks (radiation, chemicals, etc.) or if she/he has serious health problems. In general, when HCW fills the health declaration, she/he must also answer questions about alcohol use. When health problems of HCW are suspected to be alcohol-related, an intervention is performed by OH nurses or medical doctors.

The internal regulation of the Clinic's Working order stipulates that a worker who uses alcohol during working hours is disengaged without preliminary caution. There is a zero-tolerance of alcohol use among the hospital staff. This strict sanction has positively influenced the behaviour of the medical staff since no sanctions have been implemented in the Clinics during the last 20 years.

**Workplace health policy and programme**

The Hospital participates in several international and European cooperation programs such as Health Promoting Hospitals (HPH), Healthcare Services and European Network of Smoke-free Hospitals. The Hospital's health politics is based on the international standards of these networks. The purposes of the health programs are planned and managed at different levels, structures and sectors of the developmental program of the Hospital.

Healthy lifestyle topics (including anti-alcohol policies) are prioritized in the internal training programs, local and international meetings and conferences of the hospital staff and in HPH networking. The current 21st HPH international Conference took place in Gothenburg and the representatives of the Hospital participated with oral and poster presentations in the conference (Gothenburg, 22-24 May, 2013).

Since the Hospital does not accept any alcohol use during working hours among its staff members and because alcohol use is prohibited in the premises of the Hospital, there could be no special need for alcohol prevention programs for the employees. But given that health care workers (HCW) are forming public and patient opinion in general, the prevention programs of alcohol consumption among nurses and caregivers in the Hospital (lectures, seminars etc) are still running on. This is needful not only for better management of private life of hospital personnel, but also for stimulation of healthier behaviour among the patients.

**Training courses for health care workers on alcohol counseling**

In the frame of general health promotion programmes, the Hospital has started to pay more attention on the prevention of alcohol consumption among both the patients and the employees. The entire Hospital personnel participated in the "Early diagnostics and advisory of patients with excessive use of alcohol” - training during autumn 2011 organized by the
National Institute of Health Development (NIHD) and the Training Centre of the Hospital. The target groups were nurses, medical doctors and other medical experts. Also HCW-s of the Hospital participated in the training courses. The NIDH has published a number of information materials (leaflets, books and guidelines) about alcohol hazards and prevention which were distributed among the participants. More information in Estonian language is provided by internet. In total 18 publications about alcohol hazards in Estonian language are attainable for interested groups (nurses, physicians, patients, mentors and consultants) (www.alkoinfo.ee).

The achieved knowledge is not used only for counselling of patients with alcohol problems, but also for development of good general alcohol politics in the Hospital.

**Alcohol consumption among nurses of the Hospital**

A questionnaire study was carried out among registered nurses in the Hospital during spring term 2011. The Copenhagen Psychosocial Questionnaire II (COPSOQ II) was used to measure psychosocial work-related risks among the Hospital nurses. The electronic questionnaire was sent to all nurses in the Hospital (n=906). About half of the questionnaires were returned and analyzed for the study. The results showed, that 44% used alcohol quite rarely, while one quarter of the nurses said that they never drink alcohol and 25 % used alcohol once or several times per month, but 8 % used alcohol more regularly. The results proved that the nurses represent an occupational group with a healthy life style – they use alcohol rarely. Only a small group of the Hospital nurses need counseling and some intervention on alcohol abuse.

**Summary**

Based on the above study, the training projects and health promoting programs, the hospital staff has become more aware about alcohol related problems. Despite good results on early diagnostics, intervention and prevention of alcohol-related problems among hospital staff, better control over alcohol behaviour can be achieved, if:

- Intervention studies of alcohol use could be carried out not only among the nurses but also among the other health care staff members (physicians, administrators and caregivers);
- During regular health examinations in the OH Centre, more attention were to be paid on the early signs of unhealthy uses of alcohol.
- More frequent collaboration and exchange of ideas between OH physicians, alcohol advisors and psychologists in the Hospital were to be established in prevention of alcohol-related problems;
- As a partner of the Health Promotion Hospitals network in Estonia, regular monitoring interventions on alcohol-related problems were to be included in the health promotion activities in the Hospital.
Finland

Country description

Finland in figures

Finland is one of the Nordic countries and a member of the European Union since 1995. The population is 5.3 million people with 0.3 % as an annual population growth rate. Life expectancy is 76 years for men, and 83 years for women. Income group is high (World Bank) with GDP per capita (PPP) $35,400. Urbanization rate is 85 % of total population.

Finland is a modern welfare state with a high standard of education, equality promotion and national social security system which is currently challenged by ageing population. Over the years, Finland has been one of the top-ranking countries on the Global Gender Gap Index (2010).

Alcohol consumption in figures

In 2008, alcohol consumption in Finland was 10.3 among population aged 15 years, which is somewhat lower than the EU average 10.8 (Figure 1; OECD, 2010). The use of alcohol in Finland is considerably higher than in other Nordic countries like Norway (6.8), Sweden (6.9) and Iceland (7.3). Between the years of 1961-2008, the alcohol consumption per capita increased as much as 30 % in Finland. (Alcohol consumption is defined as annual sales of pure alcohol in liters per person aged 15 years and over.)

Figure 1

In Finland, the increase of alcohol consumption has happened in the context of rapid economic growth, increased prosperity and wider availability of alcohol. Since the 1970s, adult per capita alcohol consumption has been in decline in many Western countries (Figure 1). Finland is an exception, total alcohol consumption being on increase, even if the opinions of Finns on alcohol policy have become stricter over time. The proportion of those calling for stricter alcohol policies rose from 55 % to 88 % from 1994 to 2006.

Alcohol-related harms

The documented unhealthy increase in the use of alcohol has been a reason for much debate and health concern in Finland. Age-standardized death rates of liver cirrhosis and alcoholic liver diseases have significantly increased among men and women between the years of 2000-2005 (WHO Mortality Database). In 2005, alcohol was claimed to be the leading cause of death for men, and a close second for women.

Alcohol is also found to be a contributory factor in suicides, and alcohol intoxication is involved in nearly one quarter of deaths caused by accidents or other forms of violence. Alcohol is
implicated in many social problems such as family conflict, arrests, drinking driving, job instability and frequent short periods of sick leave.

It is estimated that the direct costs of alcohol-related are 800 - 1,000 million euro per year, with additional indirect costs of 3,300 - 6,300 million euros per year.

**Alcohol campaigns**

As a response, a variety of preventive campaigns and alcohol policies have been initiated in Finland in order to bring alcohol consumption under control – including health warnings and restrictions on TV advertising.

A new Alcohol Program for 2008-2011 was launched by the government as a continuation of the previous Alcohol program for 2004-2007. The program is focused on co-operation for reducing alcohol-related harm. Methods of harm reduction include: renewed alcohol policy; substance abuse prevention; and care and services for substance abusers. The government supports the new alcohol program through a large-scale health promotion policy.

A new initiative is to lower the alcohol content of beer. There are positive results from Sweden showing that diluting the standard class beer reduces ‘binge drinking’ or heavy episodic drinking particularly among young people. In Sweden beer sold in grocery and other stores has a maximum alcohol content of 3.5 percent. In both countries alcoholic beverages containing more than 4.7% of alcohol are sold from state-run alcohol outlets (In Finland Alko).

The preventive actions have been quite successful since the alcohol consumption shows a decreasing tendency for the third year in a row in Finland. In 2010 the per capita consumption was ten liters of 100% alcohol, which is a decrease of 2% on the previous year. The overall consumption of alcohol has decreased since 2008.

The reported positive change in the alcohol consumption is also reflected in the drink categories: the consumption of mild alcoholic beverages has increased in Finland, while the consumption of strong alcohol spirits has decreased. The current trend has continued since 2006.

**Alcohol monopoly – Alko Inc.**

One reason for the changes in the use of alcohol is that alcohol prices rose in Finland. The prices of alcohol beverages were, on average, 4% higher in 2010 than during previous years.

There is a national control (Alko monopoly) of sales of alcohol beverages in Finland. Alko is a government owned company administered and controlled by the Ministry of Social Affairs and Health. Alko has the sole right for the retail sale of drinks containing alcohol. The only exceptions for this are fermented beverages containing up to 4.7% alcohol by volume and wines sold by Finnish farm wineries containing up to 13% alcohol by volume.

Alko’s functions and operations are defined in the Alcohol Act and in a related decree. Alko is an essential element of the Finnish alcohol system, which aims to regulate alcohol consumption and curb its adverse effects.
Alko has been very active in promoting preventive programs in multiple ways. One good program is ‘In the Company of Children’, which is targeted on young parents with children. The aim is to regulate parents’ use of alcohol in the company of children.

Drinking patterns in Finland – gender differences

Finland is typically a beer drinking country. Of the recorded adult (15+) alcohol consumption by type, the share of beer is 46 %, while the share of spirits (distilled beverages) is 28 %, wine is 23 %, and others (e.g., fermented beverages made from maize, rice or cider, fruit wine, etc) is only 3 %.

There is a clear gender difference in drinking preferences; men drink beer while women prefer cider and milder wines.

The alcohol consumption of Finns is unevenly distributed. A small part of the population does not drink at all, a large part drinks a little, most of them moderately, and a small part excessively.

Men consumed virtually all of the alcohol in Finland until the late 1960s. Gradually, more women have started to drink alcohol. Today, 12 % of (adult) women say they never drink alcohol, while 30 % say they drink alcohol at least once a week. The corresponding figures for men are 10 % and 49 %. The share of women’s alcohol consumption has increased, but is still remarkable small (25 %) of the total alcohol consumption.

In the Finnish drinking culture it is rare to combine alcohol with midday or evening meals during the normal week. Alcohol is mostly consumed during weekend evenings and nights. There are some changes in drinking patterns, since drinking more often (but less quantity) during the week is today more common than it was a generation ago. This pattern is notable particularly among middle-aged women and men.

Drinking to get drunk, or binge-drinking, is still common in the Finnish drinking culture. In Finland heavy episodic drinking is considered risky if a woman drinks five or more and a man seven or more drinks of absolute alcohol on at least one occasion weekly. According to a rough estimate, about one fifth of men and about 10 % of women, who say they drink alcohol, exceed the safe-use guidelines in Finland.

It is estimated that there are 300 000 working alcoholics or heavy drinkers in Finland. 'Heavy drinker' is a term used to refer to a consumer of alcohol who drinks amounts of alcohol that exceed ‘normal social’ or ‘healthy’ drinking. The term alcoholic refers to a person who has a chronic neuron-level disease. He/she might not drink often, but on those occasions is unable to properly stop drinking regardless of the extreme problems that drinking causes. The Finnish Medical Society defines alcoholism as a chronic and recurring brain disease.

According to a recent European College of Neuropsychopharmacology publication (2011), alcohol-related disorders were found to be among the three most important contributors to the burden of disease in the selected 30 European countries participating in the study. The study found clear gender differences in this regard: women were cited to be more affected by
depression, while for men alcohol use disorders was the biggest relative contributor to the disease burden in Europe. Also regional differences were notable. (See more information about the study: www.ecnp.eu).

**Occupational safety and health (OSH) services in Finland**

In Finland all employers are responsible for organizing preventive occupational health care for their employees. The goal of occupational health care is to sustain and promote health and well-being of employees. Occupational health services are planned as a cooperative effort at the workplace by the occupational health professionals, the workplace HR department and the person responsible for occupational safety and health questions (OSH committee or delegate).

Employers can arrange occupational health services either by themselves, together with other employers or purchase the services from a private or a municipal service provider. The Social Insurance Institution pays the employers 60 % of the costs in compensation. Correspondingly, entrepreneurs and other self-employed persons are paid compensation for the occupational health services.

Provisions on occupational health care are laid in the Occupational Health Care Act, Occupational Safety and Health Act, the Primary Health care Act, and the Health Insurance Act.

In 2006, an Agreement of the Treatment and Care of Alcohol and Intoxicants in the Workplaces was signed by all principal Social Partners in Finland. The Agreement gives recommendations and explicates the general procedures of the stepwise alcohol and intoxicants treatment and care process. It includes rules and sanctions if the procedure is not followed, e.g., under which conditions a dismissal process can be started.

**Alcohol prevention as part of OSH services – brief interventions**

According to recent Finnish studies, 30-60 % of alcoholic dependencies can be successfully treated. The first step is to identify the problem by using AUDIT-test and then start step-to-step treatment process, or brief intervention.

A four-year project was launched in 2004 to introduce brief interventions for heavy alcohol consumers in occupational health care. The idea was to make brief intervention a routine procedure among health care professionals to ask about patients’ alcohol use. Interactive training in small groups was provided and tailored to local needs.

Brief interventions are practices in health care which aim to identify real or potential alcohol-related risks and motivate patients to do something about hazardous drinking. Brief interventions cover a range from one five-minute interaction to several 45-minute sessions. In Finland the recommendation is 15-20 minutes with one to four follow-ups.

In the course of the project attitudes became more favorable about brief interventions, and at many workplaces the management strongly supported the preventive activities. The project provided new tools, networks and methods for integrating the brief intervention model into health care services throughout Finland. (Source: From theory to practice. Integration of a brief intervention into health care work and occupational health care. Edited by Kaija-Liisa Seppä. Report of the Ministry of Social Affairs and Health, Helsinki, 2008)
A recent dissertation study (2010) proved that introduction of brief intervention as a new model in health care has been slow and fraught with obstacles. The study evaluated the views of professionals (physicians and nurses) towards implementing brief interventions. The major problem was lack of time and adequate reimbursement.

Altogether 59% of the surveyed health care professionals (n=473) in primary, occupational and specialized health care were positive in the matter of asking patients’ alcohol consumption and 68% could bring up alcohol problems for discussion. However, only 19% believed that they could influence patients’ drinking very well or quite well. Respondents’ own alcohol consumption did not correlate with these attitudes. Even if alcohol screening and brief interventions were found to be slower than hoped in becoming part of health care professionals’ everyday work, the attitudes had become more favorable. (Source: Janne Kääriäinen: Stepwise, Tailored Implementation of Brief Alcohol Intervention for Risky Drinkers in Health Care. Tampere University Press, Tampere 2010).

A new study was published in 2010 by a research team at FIOH exploring alcohol-related harms and their prevention policies (Kivistö, Jurvansuu, and Hirvonen 2010). The study examined the need for prevention and analyzed the actions being undertaken to prevent harmful effects of excessive alcohol use in eight Finnish workplaces and their OHS (Occupational Health Services). The need for preventive actions was considerable at both workplaces and their OHS, but actions were mainly focused on acute problems. In many workplaces alcohol policy documents were missing.

Problem drinking was brought up in OHS, but advisory material was poorly shared. Practices for preventing alcohol-related harm were not in place, and co-operation between the workplace and OHS proved to be far from effective. (Source: Marketta Kivistö, Hanna Jurvansuu & Leena Hirvonen: Alcohol and the workplace - need for actions to prevent alcohol-related harm in the workplace. Finnish Institute of Occupational Health, Research report: 38 in Finnish with English abstract.)

Important links:

www.thl.fi
National Institute for Health and Welfare

www.ttl.fi
Finnish Institute of Occupational Health

www.kela.fi
National Insurance Institute

www.stm.fi
Ministry of Health and Social Affairs

www.alko.fi
Alco Inc. is an independent limited company wholly-owned by the Finnish Government and administered and supervised by the Ministry of Social Affairs and Health

www.a-clinc.fi

The A-clinic foundation operates to reduce alcohol, drug and other addiction problems

www.paihdelinkki.fi

AddictionLink has been the most popular site in Finland to deal with substance abuse and addiction

www.tekry.fi

Finnish Center for Health Promotion

www.elamantapaliitto.fi

Association for Healthy Lifestyles

Figure 1

2.7.1 Alcohol consumption among population aged 15 years and over

<table>
<thead>
<tr>
<th>2008 (or nearest year available)</th>
<th>Change per capita, 1980-2008</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Country</td>
<td>% Change over period</td>
</tr>
<tr>
<td>------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Turkey</td>
<td>-22</td>
</tr>
<tr>
<td>Malta</td>
<td>-32</td>
</tr>
<tr>
<td>Norway</td>
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<td>Czech Republic</td>
<td>Luxembourg</td>
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</table>

Source: OECD Health Data 2010; Eurostat Statistics Database; WHO (2010).

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**Template case I**

**Case Nr:** 1  
**Name of the case:** City of Helsinki  
**City:** Helsinki

**Type of company:**

140
Ownership?

- [ ] public
- [ ] private
- [ ] voluntary

**Sector (ISIC Rev 4. codes)**

- [ ] Agriculture, forestry and fishing
- [ ] Mining and quarrying
- [ ] Manufacturing
- [ ] Electricity, gas, steam and air conditioning supply
- [ ] Water supply; sewerage, waste management and remediation activities
- [ ] Construction
- [ ] Wholesale and retail trade; repair of motor vehicles and motorcycles
- [ ] Transportation and storage
- [ ] Accommodation and food service activities
- [ ] Information and communication
- [ ] Financial and insurance activities
- [ ] Real estate activities

- [ ] Professional, scientific and technical activities
- [ ] Administrative and support service activities
- [ ] Public administration and defence; compulsory social security
- [ ] Education
- [ ] Human health and social work activities
- [ ] Arts, entertainment and recreation
- [ ] Other service activities
- [ ] Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use
- [ ] Activities of extraterritorial organizations and bodies

**Company size?**

- [ ] Very small enterprise (under 10 staff members)
- [ ] Small enterprise (10 to 50 staff members)
- [ ] Medium-size enterprise (50 to 500 staff members)
- [x] Large enterprise (501 and more staff members)
- [ ] How many are employed: about 40 000

**d) Location?**

- [x] Company is situated at one location (national or local)
- [ ] Company with a headquarters and one or more other branches/locations (national)
- [ ] Multinational company

**Alcohol practice provision**

- [x] Internal service
- [x] External service
Case I

Employing body

Background description

The City of Helsinki is Finland’s biggest employer, with close to 40,000 workers. The City is in charge of education, health care and social services for the residents of Helsinki. The City maintains public transportation, libraries and cultural services, and organizes and supports recreational activities for the residents of Helsinki. The City produces energy, provides clean water and upkeeps streets and other city infrastructure.

Helsinki is situated in Southern Finland, on the shores of the Gulf of Finland. The population of Helsinki is 578,000. The City of Helsinki provides services to the growing, diversifying and ageing population.

According to a survey commissioned by the European Commission, as many as 93 % of Helsinki residents are satisfied with the public transport services in Helsinki. The survey was carried out in 75 European cities in 2009. The questionnaire included 23 questions on different factors affecting the quality of life. Helsinki received a high rating also for several other aspects of the quality of life including safety, parks, other green spaces, outdoor recreation and sporting possibilities and cultural activities.

The operations of the City of Helsinki are divided into 45 departments and functional centers. Among these is the Administration Centre which is in charge of the general planning, preparation and executive body of the city. The City Planning Department directs construction operations and development activities of living and working environments in the city through town planning. Other departments include: the Financial Management Services; the City Library; the City Museum; the Symphony Orchestra; the City Transport; the Education Department; the Environment Center; the Health Department; the Helsinki Zoo; the Personnel Center. The Cultural Office provides performing and working facilities for artists and arts institutions, supports cultural events and their production, produces arts programs and promotes regional culture. Helsinki Energy is the biggest energy company in Finland producing and distributing electricity and heat in the city region. The Port of Helsinki organizes shipping services of Finland’s largest passenger harbor and general cargo harbor.

In 2010, altogether 39 198 employees were working in the City of Helsinki. The range of occupations is varied; there are more than 800 occupations ranging from construction and transport workers to school teachers, nurses and symphony orchestra players. Most of the employees (84 %) are employed by full-time and permanent work contracts, while 16 % of the employees have short-term contracts or are employed as substitutes.

Due to the kind of services provided, 75 % of the employees are women, while men are in a minority (25 %). The mean age of the employees is about 46 years. The biggest age groups are the ones who are 50 years of age or older.
The City of Helsinki Occupational Health Centre

One of the City of Helsinki departments is the Occupational Health Centre, which provides health care services to the employees and workplaces within the City of Helsinki. (http://www.hel.fi/tyke).

The Occupational Health Centre offers comprehensive and preventive services that promote employees’ wellbeing at work. The Helsinki City Occupational Health Centre is responsible for providing occupational health services to the almost 40,000 employees working in the City departments. Their customers represent 800 different occupations, and therefore a versatile supply of health services is needed.

The Occupational Health Center is an internal unit for the City of Helsinki employees only. The occupational health professionals work as a specialist team independent of the employer.

The aim is to support the employees’ work ability and well-being. Medical care services are focused on illnesses weakening work-related health and well-being.

The permanent staff of the Occupational Health Center consists of 132 professionals. The working methods are based on teams including a nurse, a medical doctor, a physiotherapist and a psychologist. The receptionists take care of appointments and guidance.

The Occupational Health Center has its own laboratory and x-ray service. There are four occupational health stations in different parts of Helsinki. The employees can choose those health care unites which are most accessible and suitable for them.

The occupational health director and the development manager are responsible for the development of new projects and for improving services in accordance with the customers’ needs. The administration unit takes care of the administrative functions as well as financial and staff issues.

Active health promotion is the central idea of the activities of the Occupational Health Center. Health promotion is defined as an activity of enabling people to increase control over their health and its determinants, and thereby improve their health.

The main activities include:

- Systematic evaluations of the working environment
- Endorsing preventative measures which eliminate reasons for illnesses in the workplace
- Giving information in the subject of employees’ health
- Giving information on occupational hygiene, ergonomics and also environmental and safety risks in the workplace

Occupational Safety and Health (OSH) Action Plan for 2010-2013
Based on the Occupational Safety Act (9 §), the City of Helsinki has an Action Plan for Safety and Health at Work for 2010-2013. According to the Action Plan, all safety and health issues should be integrated into all actions when developing, planning and remodeling workplaces. These actions have to be carried out in close cooperation with the employees or/and with their representatives.

The Action Plan has been discussed and agreed upon in the Occupational Safety and Health Committee of the City of Helsinki. There are safety committees at different organizational levels; at the department and office levels, and in bigger workplaces, workplace safety committees can be formed in order to ensure a high safety standard.

The objective of the OSH Action Plan is to support and maintain a high safety standard in all workplaces within the City of Helsinki and to promote well-being and work capacity of all employees of the City. The approach is proactive by maintaining high safety preparedness and by anticipating future risks.

The action plan has to be evaluated and monitored once a year in a seminar and if needed, new items can be included on the agenda.

The OSH Action Plan for 2010-2013 includes seven specified targets which have to be reached during the three-year period. One such target is to minimize sickness absences from 5.3 % to 5.0 %. Another target is to minimize the number of work-related accidents by launching a Zero-accident forum.

**The best smoke-free workplace in Finland**

As part of health promoting activities, the city Helsinki was declared a smoke-free city in 2007. Accordingly, smoking was banned in all workplaces within the City of Helsinki. No designated smoking areas are arranged indoors, and smoking is allowed only during the employees’ lunch breaks and other breaks based on labor contracts when the employees can leave the workplace. During the work hours smoking is not allowed.

The Occupational Health Center offers smoking cessation groups for those who want to quit smoking. In 2011, the city of Helsinki was awarded the best smoke-free workplace in Finland.

**Work and health Survey**

Work and health Survey is administered every second year to all employees within the City of Helsinki by the Occupational Health Center. The Survey questionnaire is based on the Healthy Workplace Framework and Model (WHO, 2010). The sets of questions are grouped within the four broader areas; the Physical work environment; the Psycho-social work environment; Person’s health resources; and Enterprise, Workplace-Community. In addition, some personal health practices (lifestyle) questions are included, among them questions about the use of alcohol.

In 2010, altogether 22 467 City of Helsinki employees answered the Survey questionnaire, the response rate was 65 %.
A tool-kit has been published giving practical examples how the results can be benefited in real workplace situations.

Use of alcohol

The Survey includes three questions about the use of alcohol. The questions are derived from the Audit test (The Alcohol Use Disorders Identification Test). The AUDIT test focuses on identifying the preliminary signs of harmful drinking and mild dependence. It is used to detect alcohol problems experienced within the last year.

**How often did you have a drink containing alcohol in the past year? How many drinks did you have on a typical day when you were drinking in the past year? How often did you have six or more drinks on one occasion in the past year?**

The results show that during the past year, 45% of the City of Helsinki employees used alcohol 2-4 times a week, 17% used alcohol more often, while 27% used alcohol once a month or less often. Ten percent did not use alcohol at all.

Half of the employees used 1-2 drinks on a typical day, 29% said they had 3-4 drinks, while 14% said they had 5-6 drinks on a typical day, and some had 7 or more drinks.

One third said they never had 6 or more drinks on one occasion, 46% said they did so less often than once a month, while 16% said they had 6 or more drinks once a month, and the rest did so once a week or daily or almost daily.

The last question can be seen as a manifestation of ‘binge drinking’, which seems to be much more typical among the younger employees than among the older employees.

The Alcohol Policy of the City of Helsinki

The City of Helsinki has an Alcohol Policy - in Finnish ‘Päihdeohjelma’ which translates into English as a *Policy on Intoxicant Substances*.

The Policy is based on the Agreement of the Treatment and Care of Alcohol and Intoxicants in the Workplace which was signed by all major Finnish Social Partners in 2004. The signed Agreement explicates the general procedures of the alcohol and intoxicants treatment and care process. Since it is signed by major Finnish Social Partners, it is widely used as a model in the workplaces all over Finland.

The model can be adapted and modified according to the needs of each workplace; this has been done in the City of Helsinki. The basic aim of the Policy is to ensure a safe and intoxicant-free work environment for all employees within the City of Helsinki. According to the Policy,
alcohol- and other intoxicant-related problems should be identified at an early stage so that problems can be prevented and harmful effects minimized and eliminated at an individual and workplace level.

The Policy emphasizes that all employees should be made aware of the harmful effects of alcohol and other intoxicants on the quality of work and on the psycho-social functioning of the workplaces.

It is the duty of all employees within the City of Helsinki to act proactively so that harmful alcohol-related effects do not emerge in the workplace. All employees should know the rules and sanctions as explicated in the Policy – particularly when the rules are being dishonored or violated (e.g., dismiss from work).

The Policy includes guidelines for intervention when alcohol-related problems emerge in the workplace. Depending on the situation, the supervisor, the trade union or safety representative, or a colleague can intervene. However, it is the obligation of the supervisor/manager to act, when the effects of alcohol and other intoxicants are harmful or destructive, or when there are well-known alcohol-related behaviors such as tardiness, leaving early and coming late, and frequent short-term absences from work.

The Policy describes a stepwise procedure. The supervisor can first recommend and advice treatment and care within the Occupational Health Center or at an A-clinic, which offers brief-intervention or other help and consultation. If the person does not act in accordance with the treatment process, or there are no clear changes in his/her behavior, or the person quits the process without a good reason, then the so-called alcohol treatment and care process (in Finnish ‘Hoitoonohjaus’) will be started.

The alcohol treatment and care process means that the person is ordered to visit the Occupational Health Center, where the personnel is informed about his/her alcohol- or intoxicant-related harm in the daily work functions. The person signs an agreement about the conditions under which the treatment and care process is carried out; its duration, the site, and the right of the Occupational Health Care to give information about the process to the supervisor/manager. The person can be notified with a written or verbal notice/warning by the employer.

When the treatment and care process is completed, there is an evaluation in which all involved parties can participate; the employer, the employee, the representative of the Occupational Health Center, the trade union representative, or a trusted person. If the treatment and care process does not end with a positive result, or if the person does not act in accordance with the signed agreement, the dismissal (firing) process can be started. Sometimes, the person is re-employed in a new location, or the treatment process is continued or started again.

The Alcohol Policy of the City of Helsinki is a stepwise process aiming at a positive solution. The Policy is based on the Labor Protection Legislation about the co-operation in the workplace (44/2006) so that all involved parties are being properly treated regarding confidentiality and fairness.

Sources:

Helsingin kaupunki – Henkilöstöraportti 2010 (in English the City of Helsinki Annual Personnel
Germany

Country description

Country characteristics & economic context

Germany is a federal republic in Europe. The country consists of 16 states while the capital and largest city is Berlin. Germany covers an area of 357,021 km² and has about 81,729 million inhabitants (density: 229 people per km²). About one tenth of the German population are foreigners. Germany is the most populous member state and the largest economy in the European Union. The Country is also member of the United Nations, NATO, the G8, the G20, the OECD and the Council of Europe, and took a non-permanent seat on the UN Security Council from the 2011-2012 term. The Human Development Index counts Germany to the very high developed states (0,905) on worldwide ninth rank. Germany has a highly developed welfare system and a health policy that insures a high level of medical care for all citizens.

Germanys nominal GDP per capita lies about 40.273 US$ in 2010 and has the world’s fourth largest economy. In its annual projection for 2011, the Federal Government expects a continuing upswing, with gross domestic product forecast to grow this year at a real rate of 2,3%. Automobiles, products for precision engineering, electronic equipment, chemical and pharmaceutical products as well as other products are manufactured and exported. The service sector contributes approximately 71% of the total GDP, industry 28% and agriculture 0,9%. In accordance to the revenue “Fortune Global 500” 37 of the 500 largest stock-market-listed companies are headquartered in Germany. But also small and medium enterprises play a significant role in Germany’s economy. About 60% of the employees work in small and medium enterprises. The average unemployment rate in 2010 was at about 7,7%. Total employment reached records levels in 2010 at 40.5 million persons, this is also the highest level since reunification of Federal Republic of Germany (FRG) and German Democratic Republic (DDR). Almost all of the newly created jobs are positions requiring social insurance contributions, and most of them involve full-time employment. The Federal Government anticipates that the sustained economic expansion will further improve the situation on the labour market, albeit at a more moderate tempo. In 2011, the number of employed persons is projected to increase by 320,000 on average compared to 2010, to a total of 40.8 million persons.
Table 1: Selected key figures for macroeconomic trends in the Federal Republic of Germany [1]

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<th>2009</th>
<th>2010</th>
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<td><strong>Year-on-year changes in %</strong></td>
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<tr>
<td>Gross domestic product (price-adjusted)</td>
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<td>Employment (domestic)</td>
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<td>Unemployment rate in % (as defined by the Federal Employment Agency) [2]</td>
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<td>7.0</td>
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<td>GDP by expenditure (price-adjusted)</td>
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<td>Private households and private non-profit institutions serving private households</td>
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<td>Machinery and equipment</td>
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<td>Construction</td>
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<td>Exports</td>
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<tr>
<td>Imports</td>
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<td>14.2</td>
<td>6.5</td>
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<tr>
<td>External balance of goods and services (contribution to GDP growth rate) [3]</td>
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<td>13.0</td>
<td>6.4</td>
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<tr>
<td>Gross wages and salaries per person employed (nominal)</td>
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<td>0.4</td>
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<tr>
<td></td>
<td>-0.2</td>
<td>2.2</td>
<td>2.1</td>
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</table>

[2] Based on total number of persons employed;

**Sources:** Federal Ministry of Economics and Technology: Annual Economic Report 2011.
Relevant alcohol policies

Germany is a country with a tolerant attitude towards alcohol consumption. Excessive consumption of alcoholic beverages is on the one hand disapproved but on the other hand also more or less tolerated.

In the year 2009, per capita consumption for the total population remained at a high level with 9.7 l pure alcohol. Compared to 2008, there was a slight reduction in per capita alcohol consumption in 2009. The reduction was due to a decrease in consumption of beer to 109.6 l, of wine to 20.1 l, and of spirits to 5.4 l per resident in the year 2009. Comparisons regarding alcohol consumption for the year 2005 reveal that Germany belongs to the nations with the highest per capita consumption in the European Union. Analyses of national health statistic data revealed 74,000 annual death cases in Germany attributable to either at-risk drinking of alcohol alone or to the combined consumption of alcohol and tobacco. According to analyses for men in Germany, 12.8% of the total loss of life years and years lived with disabilities caused by all diseases and injuries are attributable to alcohol consumption. For the year 2007, the economic costs of alcohol-related diseases in Germany were estimated to be 26.7 billion €. Respective costs of 125 billion € were estimated for the European Union. Additionally, intangible costs, such as pain, suffering and life years lost caused by alcohol, were estimated to be 270 billion €. Compared to the preceding year, the tax revenue from alcoholic beverages has increased by 0.6% to 3.3 billion € in 2009. The German taxes on alcoholic beverages are clearly below the European Union average. The German alcohol industries’ expenditure for sales promotion in TV, print media, radio and billboard advertising amounted to 471 M € in 2009.

Three social subsystems in Germany are more or less directly concerned with alcohol consumption. The first is the legal system, with the police and the legislative system, including regulating authorities. Their primary concerns are the consequences of dependence, which are interpreted according to an ethical-judicial model. The second subsystem is the health and social system, which includes general practitioners, counsellors, psychotherapists, social workers and other healing professions, who directly offer professional help. Self-help organisations belong to this system because of their own involvement. Physical, psychological or social treatments are all prominent. Dependence and abuse are defined according to the medical or psychosocial model of illness. The third subsystem, the educational system, takes an intermediate position between the regulating and helping authorities. It offers indirect help in the first place by preventing the disorder and in the second place by supporting the recovery.

Prevention policy in Germany aims at making people aware of the general problems of psychotropic substances, and includes creating a critical and objective attitude towards alcohol. Two institutions shape the prevention policy. The Federal Centre for Health Education (BZgA) is a governmental institution that works on principles and guidelines of practical health education, trains professionals working in the field of prevention and coordinates and emphasises health education. The German Centre for Addiction Issues (DHS) is an umbrella
organisation of institutions working in the field of dependence that represents the interests of its members to the government and other federal authorities. One of the tasks of this institution is to identify relevant topics of substance related problems, risks, misuse and dependence, to stimulate technical discussion, and to develop appropriate conceptualisations.

There are very few legal restrictions on alcohol production in Germany. In measures affecting the availability of alcohol, a distinction is made between beverages containing distilled spirits and other alcoholic beverages, which are mainly wine, beer and sparkling wine. Structural preventive measures taken by the government in order to restrict the general availability of alcohol are:

- Closing time in restaurants and public houses, and no off-premise retail sales of alcoholic beverages during general shop closing hours, which are on weekdays from 8 p.m. to 6.30 a.m., on Saturdays from 4 p.m. and no sales on Sundays and public holidays.
- Prohibition of sale and consumption of distilled spirits to persons under 18 years and of other alcoholic beverages to people under the age of 16.
- Measures concerning specific situations like prohibition of sale of alcoholic beverages to obviously drunk persons or the possibility to prohibit alcohol sales during mass events like football games.
- No sale of distilled spirits in vending machines.
- Structural preventive measures by making it easier to purchase non-alcoholic beverages, i.e. at least one non-alcoholic beverage has to be offered at the same price as the cheapest alcoholic one.

The content of advertisements is restricted by voluntary rules except the law for the protection of youth in public which bans alcohol and tobacco advertising in cinemas before 6 pm since April 2003. Beyond this, the restrictions of the European Convention on Transfrontier Television have been obligatory since 1989.

Violations of traffic regulations and laws are strictly punished, following a graded system that includes fines, withdrawal of driving licence, and legal consequences for drivers and cyclists. In 1998 a BAC limit of 0.05 per cent was introduced. As early as in 1990, there was provision for a general medical-psychological examination of driving competence for a driver caught driving at any BAC level above 0.11 per cent. Further measures have been the introduction of a probationary driving licence for beginners. The frequency and extent of police controls have been intensified. Implementing the controls has been made easier for the police by equating the breath alcohol measurement with the blood alcohol measurement in 1998.

Current preventive measures aim at a sensible, moderate consumption of alcoholic beverages, with exceptional abstinence in specific situations or for specific groups. Recommendations on the quantity of drinking have varied greatly since the mid-1960s when they were high and varied considerably between 100 grams and 160 grams of pure alcohol per day. In the 1970s these values were lowered to between 60 and 100 grams of pure alcohol per day for healthy grown-ups. Since the 1980s separate limits for men and women have been introduced and recommended levels have been lowered to not more than 40 grams of pure alcohol per day for men and 25 grams for women. These limits were lowered again in the 1990s. Today the
recommended limits are not more than 30 grams of pure alcohol per day for men and 20 grams for women. Using the concept of standard drinks 30 grams means about three drinks and 20 grams about two drinks. In addition, specific circumstances are described when people are recommended not to drink at all. These periods of exceptional abstinence include pregnancy and lactation, driving a car, during the working hours or while under the influence of medicine.
### Table 2: Alcohol Policy in Germany

<table>
<thead>
<tr>
<th>Policy</th>
<th>Requirement</th>
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<tbody>
<tr>
<td>Excise tax on beer / wine / spirits</td>
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<tr>
<td>National legal minimum age for off-premise sales of alcoholic beverages</td>
<td>16 / 16 / 18</td>
</tr>
<tr>
<td>(selling) (beer / wine / spirits)</td>
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</tr>
<tr>
<td>Restrictions for on-/off-premise sales of alcoholic beverages:</td>
<td></td>
</tr>
<tr>
<td>Time (hours and days) / location (places and density)</td>
<td>No / No</td>
</tr>
<tr>
<td>Specific events / intoxicated persons / petrol stations</td>
<td>No / Yes / No</td>
</tr>
<tr>
<td>National maximum legal blood alcohol concentration (BAC) when</td>
<td>0.05 / ZT / 0.05</td>
</tr>
<tr>
<td>driving a vehicle (general / young / professional), in %</td>
<td></td>
</tr>
<tr>
<td>Legally binding regulations on alcohol advertising / product placement</td>
<td>Yes / Yes</td>
</tr>
<tr>
<td>Legally binding regulations on alcohol sponsorship / sales promotion</td>
<td>No / No</td>
</tr>
</tbody>
</table>

ZT = Zero tolerance

Sources: World Health Organization 2011

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**Workplace and labour health laws / policies and institutional responsibilities**

**Provision of occupational health services at national level**

**The German OSH system**

In Germany, "occupational safety and health" is considered as a broad concept, which covers prevention of occupational accidents, occupational diseases and work-related health risks. It includes measures to design work in a human-friendly way, questions of working time (e.g.
working on Sundays or public holidays) and protection of persons requiring a particularly high level of protection (e.g. young persons and pregnant women). Occupational safety and health does not include questions to do with employment (e.g. employment contracts) or payment (e.g. wage agreements). The following constitute fundamental legislation in the field of OSH:

- the "Arbeitsschutzgesetz" (Occupational Health and Safety Act)
- the "Arbeitssicherheitsgesetz" (Occupational Safety Act)
- the "Siebte Buch Sozialgesetzbuch" (Seventh Volume of the Code of Social Law), which deals with statutory accident insurance, and
- the "Gefahrstoffverordnung" (Ordinance on Dangerous Substances)

**Employer responsibility**

Employers are responsible for their employees' safety and health at work. They have a duty to implement the necessary OSH measures, taking into account the circumstances which affect employees' safety and health at work. Employers must review the effectiveness of the measures and, if needs be, adjust them to changes in the prevailing conditions. It is also part of their duty to strive to improve employees' safety and the protection of their health. Employers must appoint safety specialists and company physicians to support them and advise them on OSH questions.

**Federalism**

Germany is a federal republic comprised of independent federal states and that structure is reflected in the OSH system. The lion's share of OSH legislation is "federal law" (i.e. national law), enacted by the "Bundestag" (Germany's lower house of parliament) with, if necessary, the approval of the "Bundesrat" (the upper house of parliament). Ordinances, on the other hand, are mainly adopted by the federal government and also usually require the Bundesrat's approval in order to be made law with final effect. The following are extensively involved from an early stage in the acts and ordinances prepared by the Federal Ministry of Labour and Social Affairs (abbreviated to BMAS in German) in the field of safety and health at the workplace:

- the federal states - (LASI)
- the trade unions' umbrella organisation (DGB)
- the employers' umbrella organisation (BDA)
- the umbrella associations of the accident insurance institutions and
- the professional associations concerned

The Federal Ministry of Labour and Social Affairs is supported in its work by experts at the "Bundesanstalt für Arbeitsschutz und Arbeitsmedizin" (Federal Institute for Occupational Safety and Health, BAuA). The job of monitoring adherence to this federal legislation is entrusted to the federal states. Each federal state has thus installed its own OSH inspectorate (referred to as a "Gewerbeaufsichtsamt" or "Staatliches Amt für Arbeitsschutz"), the tasks of which include the following:

- monitoring adherence to legislation
• advising employers
• in specific cases, ordering the implementation of measures needed to ensure employees' safety and health

Dualism

The German OSH system rests on two pillars - state-provided OSH activities and those performed by the statutory accident insurance institutions. The latter are the

• Deutsche Gesetzliche Unfallversicherung (German Statutory Accident Insurance, DGUV)
• Bundesverband der Landwirtschaftlichen Berufsgenossenschaften (Federal Association of Institutions for Statutory Accident Insurance and Prevention in the Agricultural Sector, BLB).

Membership is compulsory for all enterprises and public authorities, which means that all employed persons in Germany have insurance cover for occupational accidents and diseases. The accident insurance institutions, and thus the insurance benefits paid in the event of an occupational accident or disease, are financed by means of employer contributions. The accident insurance institutions' tasks range from employing all suitable means to prevent occupational accidents and diseases as well as work-related health risks to ensuring effective first aid is in place. To this end, meetings of representatives of the accident insurance institutions adopt accident-prevention regulations (abbreviated to "UVV" in German), which have to be approved by the Federal Ministry of Economics and Labour. Compliance with the UVVs is monitored by the "Technische Aufsichtsdienste" (Technical Inspection Services, TADs) of the relevant accident insurance institution. Another primary task of the TADs is to advise employers and employees.

Information/ coordination/ cooperation

To make sure that there is no duplication in the OSH inspection work performed by the state institutions and the Berufsgenossenschafts, the two sides have to work closely together and exchange knowledge. They notify each other about company inspections they have carried out and the main findings of such inspections. Various bodies exist for them to pass on information, coordinate activities and agree cooperation projects.

Sources: European Agency for Safety and Health at Work, 201.1

Safety and health at workplace policies

“Gemeinsame Deutsche Arbeitsschutzstrategie” (GDA) (Common German Occupational Safety and Health Strategy)
The federal government, the states and the institutions of accident assurance agreed a common, nation-wide occupational safety strategy, based on international and European standards. In November 2007 it was confirmed by the 84th Conference of Ministers of Labour and Social Affairs (ASMK).

The central aim of the Common German Occupational Safety and Health Strategy (“Gemeinsame Deutsche Arbeitsschutzstrategie”, GDA) is to preserve, improve and to promote safety and health of employees through an efficient and systematic perceived safety at work, complemented by measures of workplace health promotion. Particularly the safety and health awareness among employers and employees has to be strengthened. It’s the basis for concerted action to achieve mutually agreed health and safety goals.

The collaboration of the supervisory services of the statutory accident insurance and health and safety institutions of the states in advising and monitoring of facilities should be improved and also the rules and regulations in health and safety should be user-friendly and transparent.

The legal basis of the GDA and the collaboration between their institutions are laid down since November 2008 in the Employment Protection Act and in the Social Security Code VII.

The Federal Institute for Occupational Safety and Health (BAuA) supports the Federal Ministry of Labour and Social Affairs (BMAS) as an institution of the GDA by providing and imparting knowledge in tasks of development, management and updating linked to the GDA. Furthermore, the BAuA performs the office function for the National Safety and Health Conference and the Occupational Health Forum.

Promotion of mental health and wellbeing policies

Legal Framework for Health Promotion on workplace

Since 1989 the health insurance companies in Germany is in charge to participate in prevention of work-related health hazards. In 2007, the legislature has amended the rule as a standard insurance benefit (§§ 20a and 20b SGB V).

Prevention Guide

The guide “Common and consistent fields of action and criteria for implementation of §§ 20 Abs. 1 and 20a SGB V” of the Statutory Health Insurance (GKV-Spitzenverband) contains binding regulations for the design of services by health insurance. According to the most common threats and dangers it includes the fields of action, which are incorporated in the policies of health insurance:

- Prevention and reduction of work-related physical strain,
- Health-oriented staff canteen food,
- Promotion of individual skills for coping with stress at work
- Reduction of taking drugs.
**Bonus for health-conscious behaviour**

The statutory health insurance companies can provide in their statues special bonus models. These include actions of workplace health promotion (§ 65a Abs. 2 SGB V).

**Tax exemption of actions of workplace promotion**

With the Annual Tax Act 2009 § 3 Nr. 34 Income Tax Act was implemented. Companies can offer their employees free of income tax measures for promoting the general state of their health (Prevention courses) or measures of workplace promotion to a sum to 500 € per year per employer and employee. Employers, who offer their employees appropriate health benefits, don’t have to prove the so called “cash benefit” with taxes and social contributions. Condition for the tax exemption is that in terms of quality, purpose and focus of a measure sticks to the standards of §§ 20 and 20a SGB V. Measures, which are listed in the Prevention Guide are tax free. These include spine training, courses for smoking cessation, healthy nutrition and stress management (§ 3 Nr. 34 EStG).

**Alcohol and drugs at workplace policies and statutory requirements to provide alcohol services**

At about 30 years workplace alcohol policies and programmes are part of a modern staffing policy in private enterprises or public administration in Germany. Often it’s integrated in programmes of workplace health promotion.

The employer is in duty of care to save the employee’s health and life. Regulations are the Employment Protection Act (Arbeitsschutzgesetz, ArbSchG) and the Regulations for Prevention of Accidents (Unfallverhütungsvorschrift, UVV). There is no general ban on alcohol, which is applicable to all employees or all workplaces. The Regulations for Prevention of Accidents at Work do not include this ban either. They rather focus on prevention and help offers.

§15 of these regulations includes all relevant clause: Unfallverhütungsvorschrift Grundsätze der Prävention (01.01.2004): "The assured may not by the consumption of alcohol, drugs or other intoxicant not into a condition shift, which puts him or other in danger."

§ 7 "Those who [as a result of ingestion of alcohol or other psychotropic substance] are no longer in a condition to perform their duties without danger to themselves or others, must be discharged."

Workplace programmes are usually developed in the form of EAP (Employee Assistance Programme), in which workers can get help for alcohol related problems within the workplace. These programmes are generally introduced through poster campaigns and by publication of leaflets for personnel.
Case studies Germany
## Template case I

**Case Nr: 1**

**Name of the case**: AUDI AG

**City**: Ingolstadt

### Type of company:

**Ownership?**

- [ ] public
- [x] private
- [ ] voluntary

**Sector** (*ISIC Rev. 4. codes)*

- [ ] Agriculture, forestry and fishing
- [x] Mining and quarrying
- [ ] Manufacturing
- [ ] Electricity, gas, steam and air conditioning supply
- [x] Water supply; sewerage, waste management and remediation activities
- [ ] Construction
- [ ] Wholesale and retail trade; repair of motor vehicles and motorcycles
- [ ] Transportation and storage
- [ ] Accommodation and food service activities
- [ ] Information and communication
- [ ] Financial and insurance activities
- [ ] Real estate activities
- [ ] Professional, scientific and technical activities
- [ ] Administrative and support service activities
- [ ] Public administration and defence; compulsory social security
- [ ] Education
- [ ] Human health and social work activities
- [ ] Arts, entertainment and recreation
- [ ] Other service activities
- [ ] Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use
- [ ] Activities of extraterritorial organizations and bodies

### Company size?

- [ ] Very small enterprise (under 10 staff members)
- [ ] Small enterprise (10 to 50 staff members)
- [ ] Medium-size enterprise (50 to 500 staff members)
- [x] Large enterprise (501 and more staff members)

**How many are employed**: 48,000

### Location?

- [ ] Company is situated at one location (national or local)
- [x] Company with a headquarters and one or more other branches/locations (national)
- [ ] Multinational company

**Alcohol practice provision**

- [ ] Internal service
- [x] External service
Case I

Employing body

The Audi group is a German automobile manufacturer and headquartered in Ingolstadt, Germany, where Technical Development, Sales and Administration as well as the greater part of vehicle manufacturing operations are based. Comprising the two brands Audi and Lamborghini, the Audi Group is one of the world’s leading carmakers in the premium and supercar segments.

Audi brand increased its vehicle deliveries in over 80 markets in the fiscal year 2011 and sold more than 1.3 million cars in the past year, at the same time increasing revenue to €44.1 billion. Operating profit for the Audi Group rose to over €5.3 billion in the past fiscal year. The operating return on sales climbed from 9.4 to 12.1 percent.

The Audi badge – the four rings – is the emblem of one of Germany’s oldest car manufacturers. It symbolizes the merger in 1932 of what until then had been four independent vehicle manufacturers: Audi, DKW, Horch and Wanderer. They are the origin of the present day Audi AG. The company’s actual roots go back further still. All the way back in 1899, August Horch, who named the company Audi ten years later, built his first car. Audi AG celebrated “100 Years of Audi” in 2009.

Volkswagen AG, Wolfsburg, is the major shareholder of Audi AG and controls around 99.55 percent of the share capital. Volkswagen AG includes the Consolidated Financial Statements of the Audi Group in its own Consolidated Financial Statements. Control and profit transfer agreements exist both between Volkswagen AG and Audi AG, and between Audi AG and its principal German subsidiaries.

Audi has seven manufacturing plants around the world: Ingolstadt (Germany) since 1969, Neckarsulm (Germany) since 1969, Bratislava (Slovakia) since 2005, Győr, (Hungary), Changchun (China) since 1995, Brussels (Belgium) since 2007 and Aurangabad (India) since 2006. In addition to the site in Changchun, the company is currently building a new facility in China. The Audi AG employs 48.000 people in Germany, all in all 64.000 employees.

According to the developing of their health strategy Audi identified several changes in working conditions. Below, the trends 2000 to 2020 are highlighted:

- **Global competition**

  Maintenance request in work + profitability as inescapable framework requirement, challenge No. 1: Preserving the industrial production in central Europe successfully + developing

- **Developing productiveness**
Reduction of gross motor skills, decrease of fine motor skill requirements + loss of process related working interruptions, increasing strain

- **New technologies**
  Lifelong learning to a greater extent, changing tasks, development of competences is necessary, new working substances + proceedings

- **Quality standards**
  Trend according to optimized = further exactly defined processes in production; increase of complexity, restricted freedom of action, process control

- **Knowledge work / lifelong learning**
  Control of knowledge explosion + complexity, fragmentation in fields of knowledge and competences

- **Services**
  Increasing requirements to social competence, motivation, flexibility, temporal “availability”

These changes can only be encountered with healthy staff. Prevention is targeted to the complete staff and part of occupational health management and in conformity with health and safety standards. Audi has developed the prevention program “AUDI Checkup”, in which 90% of the staff members participate. Individual health promotion and occupation health events are offered, e.g. “Addiction prevention in the discussion” for apprentices, “Non-smokers taste better”, “Contextual abstinence activities”, “Fit in office” or “Fit in machine shops”.

Furthermore, work and mental health are a focused issue. Strengthening and using resources as well as the identification of health risks are part of the Audi-campaign HELP – occupational integration and support management for staff members in straining situations for mental health. The prevention program alcohol and drugs focusses the guidelines risk prevention, harm reduction and helping concerned persons consistently.

Human resource development and continuous increase of competence include “healthy guidance”. The health competence of occupational actors and partners as well as the sustainability has to be developed. The previous qualification offers were extended with the workshop module “Mental health” including addiction- and prevention-related contents.

Another component of Audi’s health management is social counselling, case management and internal and external cooperation. Since 25 years psychosocial and medical counselling is implemented in the health centres. Approximately 5% of the staff members are counselled with the positive result: “Human and economic success arises; indeed the theme needs a continuous and consistent dealing in the company”. In 2008 Audi implemented a special medical consultation hour “Mental Health”.

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Sustainability and efficacy of resources as a consequence of health management is another aim. Parts are agreements of objectives according to health state and a staff profit sharing. Sustainability in order to preserve and promote health is even located in the Audi business plan. To strengthen prevention in the political framework is also an element.

Audi has its own health department, which coordinates the activities regarding health. This department is part of a helping network and cooperates with external medical and social specialists as well as self-support groups.

**Figure 1: Audi Checkup**

![Audi Checkup](image)

**Figure 2: Prevention and health promotion at Audi – Audi Checkup and further development of health promotion programmes**

![Diagram showing Audi Checkup and health promotion programmes](image)
Workplace alcohol policy and programme

For Audi and the company’s management respectively, several triggers for the decision to develop and to implement a workplace alcohol policy stood in the foreground. The concerns about the public image as well as safety aspects play an important role. Furthermore, the alcohol policy an important part of the workplace health promotion program. Another trigger was an education campaign for young employees. The initiative was started and implemented by the management in cooperation with the work council already in 1985. It was a fundamental decision of the company and is based on an occupational consensus to integrate occupational addiction prevention into the Audi health-management-strategy. This does not only concern some locations or specific work areas but is valid nationwide in the whole company from the beginning.

The main aim of a workplace alcohol policy mentioned by the company is the prevention of alcohol problems which cause productivity loss and absenteeism. The aim is to educate employees about the risks of alcohol consumption at the workplace and develop a close link with alcohol information centres/helpdesks. Last but not least it is intended to improve the health of employees, improve the company safety and the improvement of the company image.

The “prevention program alcohol and drugs” is an integrated component of the Audi health-management policy. It contains the following goals:

1. Risk prevention
2. Targeting drug related problems
3. Support of people concerned.

The prevention strategy contains behavioural and structural prevention and is a permanent measure/offer. Target groups are disseminators/information multipliers, all staff members, line manager, supervisors and apprentices. For a successful implementation the financing is guaranteed in the long-term.
Table 1: Influencing factors – fields of action of occupational prevention

<table>
<thead>
<tr>
<th>Company</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>- strain / work load</td>
<td>- medical status</td>
</tr>
<tr>
<td>- hazardous materials, physical factors, occupational environment</td>
<td>- nutrition</td>
</tr>
<tr>
<td>- safety and health</td>
<td>- activity, fitness, sports</td>
</tr>
<tr>
<td>- guidance, social support</td>
<td>- drugs, drug consumption</td>
</tr>
</tbody>
</table>

- Structural & behavioural prevention

One doesn’t work without the other

- ergonomics, organisation of work, occupational medicine
- industrial hygiene, protective equipment
- technical occupational safety
- manager, colleagues, social counselling, occupational physician, staff association
- early diagnosis, acute care / emergency aid, health promotion, rehabilitation
- occupational catering
- activity program, healthy sports
- addiction prevention, counselling, activities
Measures of universal prevention are an alcohol testing policy especially for employees who work with potential dangerous products. Furthermore, managers are trained to identify alcohol problems at an early stage. They are also instructed to take disciplinary measures if an employee was deemed to be under the influence of alcohol during working hours. Audi has an occupational manual “alcohol & drugs” where concrete actions are described.

In the section of selective prevention, the company is linked with professional alcohol services where employees with alcohol problems could be forwarded. As regards to support and care, the company has own medical staff to take care of employees experiencing alcohol related problems. Also, employees could be forwarded to external services if required. At this point, the cooperation with other companies, organisation and counsellors in the context of the prevention program alcohol and drugs should be highlighted. The company is part of a helping network and cooperates with external medical and social specialists and self-support groups.

Alcohol policy implementation generally includes the broad dissemination of written information, training or discussion groups for employees and staff, and extra training for managers. The developed measures are applicable to all company employees.

Several management tools are listed, such as alcohol awareness training for the staff and small discussion groups. Extra training can be organised or additional information produced. Different guidelines were developed for different departments in order to give support by handling with alcohol related problems. The management/supervisors receive alcohol policy training prior to the dissemination of information packages among employees (guidance how to implement the policy).

As regards to dissemination of the alcohol policy, the policy contains written material on the implementation and content. The information is disseminated in the workplace by posters, by brochures and by intranet. The information packages, which are distributed to all employees contains an alcohol information package and a copy of a formalised alcohol policy, including details of how and why it was set up has been adapted. An inter-organisational media about the alcohol policy is produced.

The participation of the employees is an elemental part of the company’s alcohol policy. First of all, employees are involved in training and discussion about alcohol use (in the workplace). Also small group discussions are offered. Workshops are arranged for employees and managers, where the guidelines for the handling of employees “at risk” are introduced. Also, training sessions are organised for the group of employees who are responsible for safety within the company. The discussions involve representatives of several departments (e.g. personnel, medical services). Furthermore, social education trainings are offered which also refer to the theme alcohol and drug consumption.
Impact of the alcohol programmes

The Audi health department has documented the alcohol policy program in cooperation with internal specialists. The documentation is a continuing activity. The self-evaluation has been done by the company, responsible for the evaluation is also the Audi health department. The company has evaluated (elements of) the process of policy implementation as well as workshops and training sessions. The company is also gathering on the dissemination and utilisation of information packages. Supervisors are asked to fill in an evaluation form after completing their training (about the contents of the course, the applicability of the contents and the materials used).

As a main result of the evaluation, it is pointed out that employees get a good chance to modify their lifestyles and their environment. There is even an evidence effect by the programme for a positive cost-benefit calculation for the company. These effects are reflected in saved disability life years, reduction of burden of disease, reduction cost of illness in the isolated case and enhanced satisfaction of employees.

For example, in 2008 316 staff members took part in psychosocial counselling measures. In Figure 3 and 4 you can see that staff members who were counselled regarding psychosocial issues, mostly came because of alcohol-related problems. 113 of 206 persons with alcohol-related problems (55%) were assisted in due to therapy or stabilisation. 81 persons (39%) were still in an situation of instability and 12 (5,8%) left the company. According to experience, there is clearly a smaller amount of drug consumers, who were counselled. From 22 registered staff members, for 3 of them a therapy was initiated, 13 were stabilized, 5 were in the status of instability and 1 person terminated employment.

Figure 3: 316 employees in psychosocial consultation measures 2008
The process of monitoring 3 years after counselling shows that 57 of 75 persons with alcohol related problems were stabilised (76%), no one was in therapy, 31 persons were instable (41%) and 12 employees left the company (16%).

The data for drug consumers appears quite different. From 75 included persons, 39 were three years after stabilised (52%), 3 were in therapy (4%), 1 was still instable and 57 persons left the company (76%).

**Figure 4: Psychological consultation in the health centres – Process monitoring- 3 years after first counselling**
Figure 5 shows the percentage of participants and their special counselling needs with regard to the overall Audi prevention program Audi Checkup from July 2006 to June 2011. Demands for counselling were mainly related to nutrition and activity (about 30.5%), but also 18.1% of the participants made demands for information about drugs, especially tobacco.

Figure 5: Counselling for health promotion July 2006 – June 2011 (50% of Checkup participants)
Furthermore, in 2011 Audi surveyed again the amounts regarding to psycho-social counselling in the occupational health centres. From a total of 358 employees who demanded psychosocial counselling 39% came because of alcohol-related problems and 1% because of drug-related problems (see figure 6). It is obvious, that enlightening the issue “alcohol & drugs” is an important topic on occupational level and the measures for alcohol and drug prevention are reasonable and are demanded.

Figure 6: Psychosocial consultation in the health centres – 358 employees in consultation in 2011

Figure 7 gives an overview about the sustainability goals of the occupation addiction prevention.

Figure 7:
Audi has mentioned in its Businessplan 2010 the project “Efficiency of resources in consequence of health management”. The aims are the stability of fundamental processes of the Audi health management, ensuring the qualification of the actors and important partners (managers of departments...), ensuring of a broad participation in the Audi health management in all sections and therefore an improvement of effectiveness and efficacy of health management. A health economic sub-goal is the limitation of the predicted increase disease-related absenteeism.

**Lessons learnt**

The company stated some pre-conditions for success for the alcohol prevention program and also the main lessons to be learnt from it: Accepted human resources policy, well defined interaction of company sub-groups and focussing on target problems by all divisions and general acceptance of the approach and the results. Because there is a big acceptance and success of the Audi prevention program, in every sense the prevention program can be transferred to other companies and/or in other countries.
Template case II

Case Nr: 2
Name of the case: Name of the case: Bundesministerium für Verkehr, Bau und Stadtentwicklung (Federal Ministry of Transport, Building, and Urban Development)

City: Berlin
Type of company:

Ownership?
☒ public  ☐ private  ☐ voluntary

Sector (ISIC Rev 4. codes)
☒ Agriculture, forestry and fishing
☐ Mining and quarrying
☐ Manufacturing
☐ Electricity, gas, steam and air conditioning supply
☐ Water supply; sewerage, waste management and remediation activities
☒ Construction
☐ Wholesale and retail trade; repair of motor vehicles and motorcycles
☒ Transportation and storage
☐ Accommodation and food service activities
☐ Information and communication
☐ Financial and insurance activities
☐ Real estate activities
☐ Professional, scientific and technical activities
☐ Administrative and support service activities
☐ Public administration and defence; compulsory social security
☐ Education
☐ Human health and social work activities
☐ Arts, entertainment and recreation
☐ Other service activities
☐ Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use
☐ Activities of extraterritorial organizations and bodies

Company size?
☐ Very small enterprise (under 10 staff members)
☐ Small enterprise (10 to 50 staff members)
☐ Medium-size enterprise (50 to 500 staff members)
☐ Large enterprise (501 and more staff members)
☒ How many are employed: 1,600

Location?
☒ Company is situated at one location (national or local)
☐ Company with a headquarters and one or more other branches/locations (national)
☐ Multinational company

Alcohol practice provision
☐ Internal service  ☒ External service
Case II

Employing body

**Bundesministerium für Verkehr, Bau und Stadtentwicklung (BMVBS) (Federal Ministry of Transport, Building and Urban Development)**

The Ministry is part of the public administration and headed by the Federal Minister of Transport, Building and Urban Development. He coordinates and is responsible for the work of the department, which comprises the Ministry and a total of 69 executive agencies. The Ministry has a total staff of 1,600 at its Berlin and Bonn offices. More than one half of its staff are based in Bonn.

The Political Coordination Directorate-General reports directly to the Minister and assists him in his political responsibilities, in public relations work and in cooperation with other ministries, the German Bundestag, the Bundesrat and other institutions.

The Central Services Directorate-General performs the administrative functions at the Ministry itself and its executive agencies. It has key management tasks in the fields of the budget, staff, organization, the modernization of administrative processes, technical infrastructure and property maintenance. Together with its executive agencies, the Federal Ministry of Transport, Building and Urban Development is responsible for over 26 billion euros of public funds and a staff of around 27,000. In addition, representatives of the Ministry represent the interests of the Federal Government as the owner or co-owner of enterprises in the transport, building and housing sectors, for instance airport operators and housing companies.

The Environmental Policy, Infrastructure and Policy Issues Directorate-General develops and implements key strategic policies. The main focus of its activities is on ensuring that transport and building policies are environmentally friendly and that their climate change impact is minimized, as well as creating the appropriate regulatory framework for an efficient transport system, namely transport infrastructure that meets requirements and the funding of this infrastructure. In addition, its staff devote a lot of effort to the promotion of research and foreign trade.

The Land Transport Directorate-General is responsible for all issues relating to rail and road transport. It also represents the interests of the Federal Government as the owner of Deutsche Bahn AG. The major responsibility of the Road Construction Directorate-General is the renewal, upgrading and construction of federal trunk roads. The road network for which the Federal Government is responsible currently comprises around 12,000 km of federal motorways and around 41,000 km of federal highways.

The Waterways and Shipping Directorate-General is responsible for the 7,300 km of inland waterways and the 23,000 km² of maritime waterways in our country. One of the key areas of...
the activities of this directorate-general is participation in international institutions in which, for instance, issues relating to the law of the sea and shipping law are discussed and resolved.

The day-to-day activities of the Aviation and Aerospace Directorate-General also extend beyond Germany’s borders. Its objectives are to ensure fair rules of international competition and to ensure that air transport – the volume of which is growing worldwide – is efficient, safe, secure and environmentally friendly.

The Spatial Planning, Urban Development and Housing Directorate-General is responsible for urban development and spatial planning, building and housing law, and rent law. One of its main priorities is to ensure the provision of housing that meets the needs of public welfare, especially given the current demographic trends. This directorate-general also has responsibility for the urban development assistance programmes, especially those relating to urban restructuring and the “Social City” programme. It also devotes special attention to the development of rural infrastructure.

The Building, Construction Industry and Federal Buildings Directorate-General is responsible for building policy issues, improving the energy efficiency of buildings, public procurement, Baukultur (improving the quality of the built environment), civil engineering and the construction industry. In addition, it has technical responsibility for federally owned civil buildings in Germany and abroad.

The health and wellbeing policies in the BMVBS are based on the manual for Occupational health and safety management system (Arbeitsschutzmanagementsystem, AMS) which is a fixed standard in this organisation. Managers, employees and apprentices are educated regularly in workshops.

Workplace alcohol policy and programme

Introduction

The conception “Prev@WORK” is a proven method of addiction prevention, established and implemented by the Berlin Center for Drug Prevention (Fachstelle für Suchtprävention des Landes Berlin). It integrates drug prevention in occupational health and safety as a part of the occupational orientation, preparation and apprenticeship. Line manager as well as instructors in the companies are counselled in preventive and health promoting framework requirements and get educated in questions of early identification of drug abuse, possibilities to intervene and the help system. Since 2008 the programme is applied in the BMVBS.

In workshops, apprentices are sensitised to consumption risks. Alternatives in behavior and possibilities for further support are worked out. With this programme young people are reached in their everyday life and elucidated before they develop a problematic consumption. The transfer in other German states of the innovative approach of health promotion in the occupational context is funded through the Federal Ministry of Health since March 2011.
Theoretical basis

The programme is based on the concept of prevention and early intervention: harmful consequences can be reduced more effectively when young people are educated about risks and risky behavior and simultaneously when their protection factors are strengthened. According to the setting approach of the HO, workplace is an ideal location to reach young apprentices early. To ensure the sustainability of the programme, standards of effective addiction prevention have to be observed.

The workshops for apprentices and instructors are firstly based on the concept Theme Centered Interaction (TCI) from Ruth C. Cohn. In essence it is the goal of TCI to facilitate the interaction between tasks and individuals in order to encourage the development of factual, social and self-competence. The workshops are aimed to promote working in groups. This leads to a working atmosphere that frees motivation and creative potentials. The workshops according to the concept TCI are intended to have a lasting effect.

Secondly the Transtheoretical Model (TTM) according to Prochaska & DiClemente is part of the concept Prev@WORK. The TTM is a model of intentional change and focuses on the decision making of the individual. The core constructs, around which the other dimensions are organized, is the stages of change. These represent ordered categories along a continuum of motivational readiness to change a problematic behaviour. The most apprentices can be located at the stages precontemplation and contemplation, which means, that there is no intention to change consumption behaviour in the foreseeable future respectively they are aware that a problem exists and are seriously thinking about overcoming it but have not made a commitment to take action yet.

Target groups, aims and contents of the workshops

First of all decision makers such as managers, Employee Committee, departements which campaign for the apprentice’s interests or quality managers and occupational health managers are supposed to be involved in the programme. Aims are to strenghten preventive structures as well as reassessing the culture of a workplace. Obligatory rules and standards shall be established and responsibilities fixed. The reduction of addiction risk factors as well as encouragement of health promoting measures/structures and developing a works agreement for addiction prevention are tasks of the decision makers.

Furthermore, instructors or lecturers are supposed to develop a risk behaviour preventive attitude, which means that they receive knowledge from the external provider background and have to reflect their own consideration. It is a aim to develope their competence to act appropriate in case of drug abusing apprentices. They shall be enabled to identify problematic consuption and be prepaired for communication and counselling techniques. In addition,
cooperation with regional help services helps decision makers to act responsible in case of risky drug/alcohol consumers. The contents of the workshops for instructors are:

- Abuse and addiction: Facts and Figures, theories of addiction development, instruments for diagnosis
- Framework and rules
- Own consideration
- Communication and counselling techniques
- Intervention: behaviour related to resistance, proactive counselling techniques.

Apprentices are the third target group of the programme Prev@WORK. They shall receive basic knowledge about the risks of drug consumption and addictive behavior. They are supposed to reflect their own (consumption) behavior and develop risk competences in handling with drugs. They are promoted to consume responsibly and learn about contextual abstinence. It is the aim to reduce harmful consequences as well as reducing non-productive time and error ratio regarding to drug consumption. They are offered two workshops with each 13 tuition units (a break of at least three months between the two workshops is recommended). Two professional Prev@WORK-trainers realise the workshops with about a group size of 20 participants. The methods of realisation are based on the standards of effective addiction prevention and findings of proven communication theories. Interactive methods are used as well as group work, discussions and feedback. Furthermore the medium film and a test are integrated parts of the workshops. All results are going to be visualised and the participants get a handout with the contents, further prevention information and a certificate.

Contents of the workshops for apprentices:

- Drugs / risky behaviour,
- Legal basis,
- Development of addiction,
- Risk and protection factors,
- Reflection / own consideration,
- Personal resources and risk competence,
- Support and help.

*Figure 1: Prev@WORK – Frame and Implementation*
Implementation process

Since May 2006 the Berlin Center for Drug Prevention (Fachstelle für Suchtprävention des Landes Berlin) assists and advises the BMVBS in implementing drug-preventive measures in apprenticeship. The process was initiated through the Haupt-Jugend- und Auszubildendenvertretung (HJAV), a department which campaigns for apprentice’s interests. The HJAV searched for professional counselling and support at the Berlin Center for Drug Prevention in order to enact a works agreement “Addiction Prevention in the apprenticeship of the BMVBS”. Core of this agreement was, that nationwide every apprentice of this ministerial division participates in workshops with drug preventive contents.

Main points of the counselling and development of the project:

- 2006: Generation of a short programme “Drug prevention in apprenticeship” with recommendations for planning and with regards to content of the workshops
- 2007: Presentation of the conception in the meeting of the main employee committee of the ministry
- Enact in September 2008: Amendment of the manual for Occupational health and safety management system (AMS) of the subordinated offices of the BMVBS of the component “Addiction Prevention in the apprenticeship”.
- September 2008: Realisation and evaluation of a pilot workshop for members of the HJAV, representatives of administration and the coordination office for occupational health and safety

Case studies Germany

- Since December 2008 nationwide implementation of the Prev@WORK-workshops for apprentices in the BMVBS
- 2009/2010: Generation of a manual “Prev@WORK” by order of the BMVBS to dissemination to the operating professionals at other apprenticeship locations of the BMVBS
  ➔ Aim: Nationwide implementation for all apprentices of the BMVBS and the subordinated offices and a sustainable quality management.

Impact of the alcohol programmes

Evaluation of the basic workshop for apprentices

In the period December 2008 to October 2011 the Berlin Center for Drug Prevention has conducted 41 workshops with 492 apprentices of the BMVBS. 363 (75%) of the participants were males. 484 participants delivered the evaluation form. 149 (30%) of the apprentices were under 18 years old, 264 (55%) between 18 and 21 years, 56 (12%) were between 22 and 25 years old and 14 (3%) over 25 years.

The quality appraisal of the workshop through the participants and the contentedness with the realisation of the workshop was perceived in a positive way.

The interviews show, that the trainers imparted the contents of the workshops very well. Almost all participants (92%) declared, that their amount of new knowledge increased and that the intensive duration of two days were appropriate (93%).

The majority of the participants consider processing the theme drug prevention as important (92%). Especially interactive methods as well as including the wishes and questions of the participants are rated positively.

The qualitative feedback to the question: “What did you like best?” underline the advantages of the interactive workshop conception Prev@WORK:

- “even to talk about it”
- “coping tasks independently, to be proactive”
- “questions were answered openly and honestly in the group”
- “the participants were included, so it was not boring”
- “something to remember”

Evaluation of the workshops for instructors
Additionally, in the duration September 2009 to September 2011 four one-day-workshops “Addiction prevention in apprenticeship” for instructors of the BMVBS were realised. 58 participants took part, 55 delivered the evaluation form. 13 participants were female, 32 male and 10 stated no sex. 7 participants were between 21 and 30 years old, 11 between 31 and 40 years. 18 persons were in the age between 41 and 50 and 13 participants were over 50 years old. 6 instructors did not state an age.

The quality appraisement of the workshop through the participants and the contentedness with the realisation of the workshop was perceived in a positive way. The majority (34) mentioned that the duration was (rather) adequate, 20 persons remark that they wish more time for the handling of the theme. 51 instructors mentioned that they got more knowledge through the training. The majority of the participants estimates, that the acquired skills can be put into occupational practice. 35 participants also mentioned, that they would take part in a follow-up event.

The interviews show, that the trainers imparted the contents of the workshops very well. Especially the high number of participating instructors who commented positively, that the acquired skills can be put into practice (91%) underlines the standard of quality of the conception, to realise measures according to addiction prevention on diverse levels in companies.

**Evaluation of the advanced workshops for apprentices**

In the duration October 2010 to October 2011 11 advanced workshops for apprentices of the BMVBS were realised. The offer was used by 122 apprentices, all of them delivered the evaluation form. 24 persons were woman, 79 men. 19 persons stated no sex. 2 participants were under 18 years old, 87 between 18 and 21 years and 28 persons between 22 and 25 years old. 4 participants were above 25 years old, 1 person stated no age.

119 participants were (rather) content with the advanced workshop, 3 apprentices were (rather) discontent with the event. The results of the interviews show, that the trainers put the contents across very good. All participants rate the duration for exchange and discussion as adequate.

Nearly all participants (84%) mentioned that they won new knowledge in the workshop. The conveyed contents motivated 80% for self-reflection.

The results show, that the apprentices connect the correlation between risk competence and aims in life on the one hand and the (actual) drug consumption on the other hand. As an amount of new knowledge they appraise also the reflection of their own behaviour. The verbally transmitted feedback made clear, that the intrinsic motivation for a responsible handling with drugs was raised. Especially the interactive methods, answering of questions and the groups according to size are rated positively.

**Lessons learnt**
**Basic workshop for apprentices**

On the basis of the existent overall results it can be recorded, that there is a high demand for knowledge and a great interest for the theme “prevention of drug abuse and addiction”.

Also it can be asserted, that the Prev@WORK-concept for workshops of the Berlin Center for Drug Prevention is appropriate in due to contents and methods to start a conversation with apprentices about consumption risks, to transfer knowledge target group appropriate and convey skills for a responsible handling with drugs as well as contextual abstinence.

The workshops are adjusted currently by including the suggestions for improvement as well as actual prevention themes – e.g. through the adjustment of sheets with data of drug consumption or working sheets and reflection in reference to alcohol.

**Evaluation of the workshops for instructors**

The results of the interviews, the personal feedback of the participants and the trainer’s observation lead to the conclusion, that a remarkable number of instructors has an additional demand in training their competences in counselling techniques. It is recommended to offer interested instructors, managers with special responsibilities (contact persons for psychosocial questions or similar) and the HJAV of the ministry further workshops which contain communication and counselling techniques.

**Evaluation of the advanced workshops for apprentices**

In the Prev@WORK advanced courses the medium- and long-term effects of the basic workshops are evaluated.

The first results are limited in proving sustainability of the workshops, because

- Apprentices took part in the advanced workshops, who participated on the basic workshop in another location.
- The workshops in other locations were in some extent significant shortened and were not exactly oriented at the Prev@WORK manual as well as the quality standard of addiction prevention (e.g. using interactive methods). Furthermore in personal feedbacks the participants told the trainers that they were not content with the quality of these workshops.

However the first results shall be mentioned with a view to quality management and to a continuous reinforcement process:

All in all the results in sustainability show, that the contents of the basic workshop can be effective in the long-term and the majority of the 122 interviewed apprentices were motivated for reflection (65%) and they used the contents to handle with third persons (61%) as well as self-reflection (54%).
In the assessment of the increased reflection of the own drug consumption after the workshop has to be kept in mind, that the apprentices are a very heterogeneous group regarding to their consumption patterns.

It can be stated that apprentices who never take alcohol/drugs and if applicable participants with moderate/responsible consumption tend not to answer the statement “I am aware of my consumption” with a “yes”. A “no” at this point is therefore not inevitably a negative result.

**Prev@WORK – Nationwide model project**

Since March 1st, 2011 the Berlin Center for Drug Prevention has organized the implementation of the programme Prev@work in seven states of Germany. It is funded by the Federal Ministry of Health (BMG). In addition to Berlin, the German states Hamburg, Hessen, Mecklenburg-West Pomerania, Lower Saxony, Saxony and Saxony-Anhalt participate in the programme. Furthermore, professionals from Sylt were enabled to take part. The demand is as great as diverse: Professionals of the drug prevention, representatives of federal authorities and commercial enterprises, vocational schools as well as institutions of vocational orientation and preparation are going to be qualified in the realisation of the programme. Beside the trainer’s course the participants get manuals with detailed background knowledge, implementation plannings for the workshops, concrete descriptions of the inserted methods as well as the purposed materials, working sheets and a CD with data for presentations.

The new learned things will be realised in pilot workshops, which are implemented in all states in the duration of the project. A following day of practice provides the evaluation of the transfer. Effectiveness and assignability will be evaluated through the academic institution StatEVal / Freie Universität Berlin.

**Perspectives**

Chambers of Industry and commerce (Industrie- und Handelskammer IHK) have already shown interest in the implementation of Prev@WORK. To attract health assurance companies as a partner could be a new step because the Prevention Guide (Leitfaden Prävention) of the Statutory Health Insurance 2010 (GKV-Spitzenverband) describes in detail drug prevention in workplaces as a measure of health promotion, which has to be accessed by all staff members.

“Aim of the measure: Raising awareness of employees, employers and management regarding the influence of – also in minor amounts – alcohol and other drugs on productivity, occupational safety and unfitness to work.”

To do justice to a holistic health promotion / drug prevention in workplaces, on the one hand apprentices have to be brought into focus; on the other hand – beside diverse established offers of health promotion – programmes of addiction prevention have to be a permanent fixture of the sponsoring of Health Assurance.
Greece

Country description

Greece, also known as Hellas and officially known as the "Hellenic Republic", is the most southeastern country in Europe. It occupies the southern part of the Balkan Area bordering Albania, FYROM and Bulgaria from the north, and the European part of Turkey from the northeast. The Aegean Sea lies to the east of mainland Greece, the Ionian Sea to the west, while the Mediterranean Sea is its southward frontier. The country covers a total area of 131,957 square kilometers.

According to preliminary results of the recent Census of Population conducted by the Hellenic Statistical Authority (official statistical body) in May 2011, the permanent population of Greece is 10,787,690; 5,303,690 (49,2%) males and 5,484,000 (50,8%) females (HSA, 2011).

Greece is a parliamentary republic. It has been a member of the European Union since 1981 and a member of NATO since 1952. It is also a founding member of the United Nations. It joined the Eurozone in 2001. The capital of the country is Athens which lies in Central Greece. The main harbor of Greece is Piraeus, the second largest in the Mediterranean Sea, after Marseilles in France, located in the south-westwards of Athens.

Greece is divided into nine geographic regions. The population of each region according to the 2001 census shows that the majority of the population lives in Central Greece (HSA, 2010), and in particular in the Capital, Athens. The current (as of 2011) official administrative districts of Greece are 13 “peripheries” (nine on the mainland and four island groups), which are further subdivided into 325 municipalities (Law 3852/2010).

Preliminary results of the 2011 census show a decrease in the country's population which is currently 10,787,690, a drop of 1.6%, in the last decade. As statistics from 1971, 1981, and 2001 show, the Greek population has been ageing in the past several decades, showing a rapid increase in the percentage of elderly people and a large decrease in the percentage of the population aged 0-14 years old. In regards to migration, Greece receives many undocumented immigrants due to its crucial geopolitical position and the tense political scenery in the Arab countries (EurActiv, 2011). The volume of legal immigrants is also large. Thus, Greece is confronting three related demographic challenges. The first is the ageing of the population and the second is population decline in the near future. The third challenge is that natural population growth is diminishing and migration is the main engine of slow population growth (Economou, 2010).

Economic Context
Greece is a member of the European Union, the eurozone, the OECD, the World Trade Organization and the Black Sea Economic Cooperation Organization.

The economy of Greece is the 32nd largest in the world by nominal gross domestic product (GDP) and the 34th largest at purchasing power parity (PPP), according to data from the World Bank for the year 2010. Per capita, it is ranked 24th by nominal GDP and 23rd at PPP according to the 2009 data.

The public sector accounts for about 40% of GDP, while the service sector contributes 78.5%, industry 17.6%, and agriculture 4%. The shipping industry is steadily one of the country's most important industries. It accounts for 4.5% of GDP, employs about 160,000 people (4% of the workforce), and represents 1/3 of the country's trade deficit. Tourism is another important industry, since Greece attracts more than 16 million tourists each year, thus contributing between 15% and 25% to the nation's Gross Domestic Product (HSA, 2011).

Following the economic boom that took place during the '90s, since the end of 2009 the Greek economy has been facing a severe economic crisis with crucial consequences for the international economy, as a result of a combination of international and local factors (Kouretas & Vlamis, 2010). The primary characteristics of the crisis include a large fiscal deficit, enormous public debt, decreasing GDP, increasing unemployment and the continuous deterioration of Greece's competitive position. The country has received a financial support package from the EU, the European central Bank and the IMF, according to which strict austerity measures have been applied aiming at reducing the fiscal deficit and restoring market confidence (Economou, 2010).

Workplace and labor health laws/policies and institutional responsibilities

By law the Hellenic Ministry of Labour and Social Security is responsible for all issues concerning the Occupational Safety and Health (OSH) at national level. Under the Ministry there are two main state OSH authorities: 1. The General Directorate of Working Conditions and Health, which is responsible for all OSH aspects (including legislation, strategy, policies, organization, information, education, training and research issues), and, from an administrative point of view, is also the authorized host organization of the Greek FOP in the Hellenic Ministry of Labour and Social Security. 2. The Labour Inspectorate (S.EP.E.), which, as the responsible inspection and enforcement authority it implements the national labour legislation. Through the establishment of a national OSH social dialogue, the above mentioned authorities in close collaboration with the national OSH social partners and other involved scientific organizations and institutions, are essentially contributing to the common mission of enhancing the conditions in the working environment, protecting the safety and health at work by decreasing work-related accidents and occupational diseases and promoting an OSH prevention and protection culture in Greece (EASHW, 2010).

According to the 1568/85 law concerning occupational health and safety and the presidential decrees 294/85 and 12/96, employers have the main responsibility for the safety and health of their employees, providing services of protection and prevention. More specifically, in all workplaces, regardless of the company size, the employer is obliged to provide services of safety engineers/technicians. In enterprises that employ more than 50 employees the employer is obliged to employ an occupational physician. This is also the case for enterprises
that involve exposure to chemicals, carcinogens, etc., even if the company size is smaller than 50 employees. In order to comply with the aforementioned obligations, safety engineers/technicians or occupational physicians in workplaces can be exclusively employed by the company or provide their services as external consultants (e.g. External Protection and Prevention Services).

**Alcohol policies**

Generally, the European policies that have been adopted by many Member States and have taken sufficient legal form as regards to alcohol use are centered on the trade aspects of alcohol in a health – oriented frame which emphasizes the dangerous effects of alcohol use. Therefore, the European policies, which take the form of laws aim at the control of alcohol. The main parameters of these policies are the following (Commission of the European Communities, 2006):

- Legal determination of alcohol drinks
- Restrictions on the accessibility of alcohol
- Legal frame about driving under the influence of alcohol
- Prices and taxes of alcohol
- Restrictions on the advertisement and sponsorship
- Places of free alcohol consumption

**Greece**

Alcohol consumption is part of the Greek culture and an essential element of Greek eating habits. Alcohol -especially wine- is traditionally part of everyday Greek meals. As regards alcohol consumption, Greece is ranked at a medium position among other EU-countries (WHO, 2008).

Concerning alcohol policies in Greece and particularly in reference to workplaces, a comprehensive review was conducted with a number of Greek and English keywords used to search a variety of electronic databases. However, findings were relatively few, yet revealing the Greek reality in terms of alcohol policies.

With regard to the applied measures and policies on alcohol in Greece, these are related to three main aspects (Ministry of Health and Social Solidarity, 2008):

- qualitative control of the production of alcoholic drinks
- prohibition of alcohol trade and consumption for youths under 17 years old
- prohibition of driving with alcohol concentration in blood higher than 0.5%

The effective enforcement of alcohol trade prohibition among youths is rather controversial, since there are no further control and monitoring measures for alcohol consumption among these ages. On the contrary, checks as regards to alcohol consumption and driving are rather continuous and consistent. In Greece no further specific policies are implemented on alcohol.
Particularly as far as alcohol in the workplace is concerned, there are no established restrictions although further preventive actions in labour places are predicted in the National Act of Action for the Restriction of Damaging effects of Alcohol in Health (Ministry of Health and Social Solidarity, 2008).

It can be stated that in Greece each company is responsible for alcohol consumption within its offices and facilities. Therefore, multinational companies that operate according to international standards obtained by the central corporate are the main bodies that foresee alcohol policies. Consequently, the case studies presented below have been taken from multinational companies. Both companies are in the alcohol production and trade industry.

References


**Template case I**

**Case Nr: 1**

**Name of the case : Athenian Brewery S.A.   City: Athens**

**Type of company:**

**Ownership?**

☐ public  ☒ private  ☐ voluntary

**Sector (ISIC Rev 4. codes)**

☐ Agriculture, forestry and fishing
☐ Mining and quarrying
☐ Manufacturing
☐ Electricity, gas, steam and air conditioning supply
☐ Water supply; sewerage, waste management and remediation activities
☐ Construction
☐ Wholesale and retail trade; repair of motor vehicles and motorcycles
☐ Transportation and storage
☐ Accommodation and food service activities
☐ Information and communication
☐ Financial and insurance activities
☐ Real estate activities
☐ Professional, scientific and technical activities
☐ Administrative and support service activities
☐ Public administration and defence; compulsory social security
☐ Education
☐ Human health and social work activities
☐ Arts, entertainment and recreation
☐ Other service activities
☐ Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use
☐ Activities of extraterritorial organizations and bodies

**Company size?**

☐ Very small enterprise (under 10 staff members)
☐ Small enterprise (10 to 50 staff members)
☐ Medium-size enterprise (50 to 500 staff members)
☒ Large enterprise (501 and more staff members)
☐ How many are employed: 1,100

**Location?**

☐ Company is situated at one location (national or local)
☐ Company with a headquarters and one or more other branches/locations (national)
Case studies Greece

☒ Multinational company

Alcohol practice provision
☒ Internal service  ☐ External service

Case I

Employing body

Athenian Brewery S.A. is the largest company of beer production and trade in Greece and a member of Heineken N.V. Three beer factories operate in three different areas of Greece, Athens, Thessaloniki and Patra. The company also owns a unit of water bottling that was inaugurated in 1993. Athenian Brewery S.A. has a large production of a great variety of beer brands, while it also produces the natural mineral water IOLI.

This large enterprise permanently employs 1,000 people. According to 2009 data provided by the company, approximately 55,4% of them work in the production of beer and mineral water, 28,7% on wholesale and retail trade, 3,9% in the financial sector of the company, and 0.5% in the marketing sector. The employing body consists of 85% male and 15% female employees.

Athenian Brewery S.A. is an export company, trading in 11 countries all over the world. It develops strategies of growth and expansion to current as well as new markets.

The company sets consumers’ and employees’ needs, including health and safety, at the heart of its business. In fulfilling this promise, strict specifications are applied in all stages of production.

Specific policies are put in place in terms of the well being of the company’s employees. Specifically, the company ensures that:

- equal opportunities are met
- discrimination in relation to sex, nationality, age, beliefs, physical skills is avoided
- communication and freedom of expression are facilitated
- initiatives are invited
- reliable attraction and selection procedures are implemented for new employees
- meritocratic evaluation takes place
- health and safety are taken care of
- continuous education is provided

Athenian Brewery S.A. takes a proactive approach to the health and well being of its employees by providing Private Health Insurance programs to everyone. Moreover, strict internal measures are applied in order to secure health and safety of employees in the workplace. Since Athenian Brewery S.A. includes large production units, specific national and international standards in reference to occupational health and safety indicated by the law are
followed and audited regularly (internally & externally). All of these standards are met as the company is compliant to the standard procedures; i.e employs an occupational physician, a health and safety officer, nursing staff and ambulance whenever necessary, etc. The company monitors accident frequency/severity in the workplace on a daily basis and the number of “the days without accident” is showcased publicly at every plant. In addition to the strict application of these standards the company also organizes frequent internal educational and informational sessions for its employees regarding workplace health and safety issues. In addition, the company is certified with the OHSAS 18001:2007 system in reference to health and safety in the workplace.

Moreover, recognizing its crucial position in the Greek beer market, the company places great emphasis on targeted prevention actions in relation to responsible alcohol consumption. These activities aim at the sensitization of the general public but also the employees of the company.

Responsible drinking for Athenian Brewery S.A. is not only associated with the amount of alcohol units in the human body. The one crucial principle applicable to all adult consumers is that “always drink in moderation, at the right place, at the right time, and for the right reasons”.

**Workplace alcohol policy and programme**

*Workplace alcohol policy*

The workplace alcohol policy of Athenian Brewery S.A. aims at encouraging employees’ responsible behavior concerning alcohol consumption. This principle is included in “the 8 Principles of Athenian Brewery S.A. on responsible alcohol consumption”.

1. Responsible beer consumption suits the balanced and healthy lifestyle adopted by the majority of adult beer drinkers.
2. A well-informed citizen is responsible for their personal behavior
3. “Athenian Brewery S.A.” commits to provide consumers with proper information regarding the responsible consumption of alcohol.
4. “Athenian Brewery S.A.” demands that every employee behave responsibly.
5. “Athenian Brewery S.A.” is responsible for the legitimacy of every commercial activity and for discouraging irresponsible consumption
6. “Athenian Brewery S.A.” wishes to discourage irresponsible and abusive consumption of alcohol, using means of regular communication and targeted activities.
7. “Athenian Brewery S.A.” commits to record and promote all activities associated with its Responsible Consumption Policy.
8. “Athenian Brewery S.A.” fully complies with the Responsible Consumption Policy of Heineken Group, mandatory for every subsidiary.
Workplace alcohol programmes

Responsible alcohol consumption is one of the main pillars of Athenian Brewery’s Corporate Social Responsibility (CSR) policy. The company implements an integrated programme including a number of actions that aim at sensitizing public and its employees about the benefits of moderate alcohol consumption. The activations are signed by the Heineken brand and are part of the brand’s global initiative entitled “Enjoy Heineken Responsibly”.

The goals of the program are:

- raising awareness of the general public and the company employees about responsible alcohol consumption
- attitude change in terms of responsible alcohol consumption

The message ‘Enjoy Responsibly’ is displayed on all product packaging of Athenian Brewery, and on all its commercials. In addition, the company’s corporate website, as well as all the micro sites of every Athenian Brewery brand include sections dedicated to responsible consumption and request from users to state whether they are over 18 in order to gain access. A website exclusively dedicated to responsible drinking is also developed by the company: www.enjoyheinekenresponsibly.com. Further to that, a section dedicated to responsible consumption is also available on www.responsibeerity.gr the company’s site exclusively for its CSR activities.

As stated above, the program is addressed to both the general public and the company employees; it thus has an internal and external target audience. The activities for the employees are organized by the Communications & Corporate Affairs Division in cooperation with the HR Division. Five basic initiatives of the programme are set forth below:

1. The internal communications program “Cool@work” targeted to company employees. It aims at fostering a healthy and responsible alcohol behavior within Athenian Brewery’s organization. The program includes:

   - Design of an informative brochure containing the “Decalogue of responsible consumption” (10 tips on moderate drinking) in cooperation with the NGO “Sobers”. Each employee has received the Decalogue and is motivated to follow the tips.
   - Design of an informative brochure containing the “Policy of Athenian Brewery for responsible consumption of alcohol”
   - Development of an electronic manual for all the executives which provides advice on dealing with high risk groups
   - Communication of the strategy for responsible consumption in corporate events and distribution of t-shirts with the message “Proud to stay cool” (on an ad hoc basis)
• Inclusion of articles on responsible consumption in the corporate magazine as well as in the corporate intranet “Heiport”
• Poster placements in locations such as the company restaurants and offices
• Distribution of the film “Living the alcohol policy. The movie” to all the newcomer employees.

2. Athenian Brewery S.A. has also collaborated since 2008 with the NGO “Sobers- Cheers” a specialized NGO on alcohol consumption issues. As part of their collaboration they have designed and implemented interactive programmes targeted to promote moderate drinking for both consumers and the company’s employees.

Consumers

Athenian Brewery supports “Sobers” NGO activities through Heineken brand, which is also the exclusive sponsor of the “Sober Driver” campaign, a campaign designed to appeal mainly to younger people. The aim of “Sober Driver” is to promote the habit of designating one person from each party, the “sober driver”, who would refrain from alcohol and be responsible for the safe transportation of their company of friends at home. The “sober driver” participates in the enjoyment, without consuming alcohol, thus remaining sober in order to drive. “Each time you go out, let just one of your friends stay cool!” is the campaign’s main slogan.

In 2009, 23 events took place in different regions of Greece with a total of 8,200 participants. In addition, 35 bars were selected and supplied with brochures, posters, cards, stickers and pins containing the message “Sober Driver”. Between 2010 and 2011, informative materials of the “Sober Driver” campaign were distributed to 410 bars and cafés in Athens and Thessaloniki - the major cities of Greece, 21 cinemas, 17 theatres and 48 food chain retailers across Greece.

The “Sober Driver” campaign also includes activities, seminars and public speeches, held in Universities and local communities to raise public awareness for alcoholism. In 2010-2011, over 15,000 people have attended more than 45 meetings, exhibitions etc. In addition, there has been a series of presentations and interviews with the media - print, TV, Radio. For two months, January and February 2011, a “Sober Driver” TV commercial has been running on almost every major channel in Greece.

Employees

Athenian Brewery has developed in cooperation with NGO “Sobers” the Decalogue of Responsible Consumption, 10 practical tips on moderate drinking. During the 2009 annual company ball, the Decalogue was distributed to all employees in an effort to sensitize and raise awareness about responsible consumption. A leaflet with the Decalogue was also
given to the company’s employees in 2012 as well. In addition, all employees received a DVD with the President of the NGO addressing the issue of responsible consumption.

3. The moderate alcohol consumption policy of the company also includes several informational programs for the general public aiming at raising awareness on responsible drinking. Some of the programs that were implemented in cooperation with different external bodies, are the following:

- Advertising programme with the message “Do not drink and drive”. (2008-09)
- A written message on all company trucks warning people that: “When you drink and drive you are a danger to others. Think about it.” (2008-2012)
- Athenian Brewery S.A. in cooperation with the Yellow Pages distributed informative brochures about safe driving and moderate alcohol consumption to drivers in toll stations, etc. (2008-09)
- Athenian Brewery S.A. in cooperation with the Local Press in Thessaloniki (the second largest city in Greece) implemented the initiative “Don’t drive after drinking”. The action included breathalyzer tests outside large night clubs as well as distribution of informational brochures about responsible consumption of alcohol. (2008-09)
- Athenian Brewery S.A. in cooperation with the TV channel “ANT1” implemented the action “Alcohol. Not tonight. I drive”. This was an interactive action, which employed a driving simulator to show each participant how he would have reacted as a driver, in case he was sitting behind the wheel intoxicated. (2008-09)

4. Pan-Hellenic survey on knowledge about alcohol

In May 2011, within the framework of the cooperation with the NGO “Sober-Cheers” and under the supervision of experts from the University of Macedonia and the Technical Institution of Serres, the first Pan-Hellenic survey on knowledge about alcohol was conducted. The objective of this survey was not only to record data about alcohol consumption but also to facilitate the creation of communication channels with the community about issues related to alcohol consumption. The survey was conducted through telephone interviews, among a sample of 1,000 individuals.

The results were presented at a special event on November 23rd 2011, with the participation of executives of Athenian Brewery as well as government representatives. The public had the chance to attend the event live via the company’s web platform for Social Corporate Responsibility (www.responsibeerity.gr) and submit questions via twitter.

5. Other interactive communication initiatives

Athenian Brewery S.A. also developed a series of activities which focus on the active involvement of the public in experiential learning. These are:
“The Responsibles” Ambassadors for responsible alcohol consumption

“The Responsibles” was an initiative implemented between autumn 2011 and spring 2012 in collaboration with the “Horeca” customers’ network. Young actors gave short performances in well-known Athenian bars. The scenarios were based on the “The Decalogue of Responsible Consumption” (see also Cool @ Work). Each 5-minute act presented one of the Ten Rules in an original and funny way. At the end of the acts patrons were given promotional material on responsible drinking and Heineken branded memorabilia.

The “Responsibles” appearances and messages have been widely spread to the public through social media (Facebook, Twitter, Youtube).

Driving simulator

Athenian Brewery S.A. has designed a driving simulator in order to educate public about the importance of responsible consumption and driving. Since 2009, Athenian Brewery S.A. has given public the opportunity to take the driver’s seat and “drive” in a virtual environment in order to understand how they would have reacted as a driver, in case they were sitting behind the wheel after having consumed 2 or more drinks. The simulator usually is located at frequented public spots (i.e main town squares) and at the end of the experience participants receive informational material.

To date, the simulator, apart from Athens, has travelled to seven popular districts (Paros, Halkidiki, Thessaloniki, Mykonos, Irakleio, Chania and Rhodes) while the participants have exceeded 2,000 people.

“It’s just an illusion”

“It’s just an illusion” is an interactive PC video game that allows the player to understand the impact of alcohol on his/her reflexes and his/her ability to drive. At the end of the game a message is displayed about responsible alcohol consumption and each player gets a “Sober Driver” badge and gifts from Heineken.

During summer 2010 more than 3,000 patrons in 97 selected consumption points in Athens, Skiathos and Santorini had the opportunity to play the “It’s just an illusion” video game. In 2011 the program continued in about 65 bars and cafes in the prefectures of Korinthia and Achaia and about 2,000 patrons
Alcohol Testing Devices Distribution

In order to maximize the impact of its message and gain the benefits of third party endorsement, Athenian Brewery S.A. joined forces with the largest Greek Media Group – Lambrakis Publishing Corporation (DOL) - and enhanced together the “don’t drink and drive” campaign through the large scale initiative “Watch every step”.

The programme consisted of three simultaneous evening events at the most frequented traffic spots of Athens for 3 consecutive Saturdays in June & July 2012, where drivers received in total 50,000 alcohol testing devices and informational material about moderate drinking.

The public was engaged by receiving the “responsible driver’s kit”, which included an alcohol testing devise, a tailor-made Athenian Brewery leaflet with practical tips on moderate drinking and a Heineken branded creative fridge magnet.

It should be noted that all activities mentioned above were to a great extent interactive achieving very good degree of involvement for both employees and the general public. Even thought the general public was the main target, employees were always kept informed about the actions.

Impact of the alcohol programmes

No cases of alcohol related harm or alcohol related absenteeism have been reported. In addition employees were asked to fill in surveys that measured their knowledge about the messages received on responsible alcohol consumption. According to the survey results, employees are considered well educated on issues of safe alcohol consumption.

No detailed information was provided by the company concerning the evaluation methods used to assess the interventions or more analytic data concerning the impact of the actions.

Lessons learnt

The Communication & Corporate Affairs Division that provided all information regarding the company’s alcohol policy and programs argued that the policy of responsible consumption of the enterprise is rather effective. Moreover, it stressed that continuous emphasis is placed on this particular issue. The implementation of several actions both for the public and the employees in the framework of responsible drinking is a crucial part of the company’s strategy considering its position in the market of alcohol.

So far, the feedback we received from Athenian Brewery’s experience with regards to responsible alcohol consumption in Greece, confirms that Greek people consider alcohol part of their culture and deeply rooted in traditional entertainment habits that still go on today. Therefore, it tends not to be connected to alcoholism and risk behaviors. As a result, when
they come across information about responsible drinking, they often feel distant from the matter.

Athenian Brewery S.A. considers the implementation of interactive strategies (such as the driving simulator which shows vividly the risks of driving under the influence of alcohol) very successful. The company supports the idea that this kind of activities are much more effective since, through personal experimentation, it is easier for people to come closer to the experience of responsible drinking and the dangers of not taking it into consideration. Therefore, through emotional engagement they become aware of the essential fact of responsible consumption.

Apart from the actions targeted to its employees, Athenian Brewery S.A. also gives great emphasis to the continuous renewal and inventiveness of its activities. As a result, the message is passed through innovative, smart and enjoyable ways ensuring greater emotional involvement in the matter.

In summary, activities implemented give emphasis on:

- Inventiveness and innovation
- Interactiveness
- Continuity

All of the above are used to communicate the company’s commitment to responsible consumption to both employees and the general public. Moreover, Athenian Brewery S.A. follows specific practical ways of implementing this kind of actions that strengthen their impact while making their implementation easier:

- external co-operation with experts and NGOs that work on issues of safe alcohol consumption
- internal communication methods in the workplace (announcements on the intranet, distribution of communication material to employees, internal publication of the company’s Responsible Alcohol policy, rules of responsible commercial communication, self-regulations)
- internal communication of the message in corporate events, during which all employees are present, in a much more relaxed and receptive state.
## Template case II

**Case Nr:** 2

**Name of the case:** DIAGEO HELLAS S.A.  
**City:** Athens

**Type of company:**

<table>
<thead>
<tr>
<th>Ownership?</th>
<th>public</th>
<th>private</th>
<th>voluntary</th>
</tr>
</thead>
</table>

**Sector (ISIC Rev 4. codes):**

- Agriculture, forestry and fishing
- Mining and quarrying
- Manufacturing
- Electricity, gas, steam and air conditioning supply
- Water supply; sewerage, waste management and remediation activities
- Construction
- Wholesale and retail trade; repair of motor vehicles and motorcycles
- Transportation and storage
- Accommodation and food service activities
- Information and communication
- Financial and insurance activities
- Real estate activities
- Professional, scientific and technical activities
- Administrative and support service activities
- Public administration and defence; compulsory social security
- Education
- Human health and social work activities
- Arts, entertainment and recreation
- Other service activities
- Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use
- Activities of extraterritorial organizations and bodies

**Company size?**

- Very small enterprise (under 10 staff members)
- Small enterprise (10 to 50 staff members)
- Medium-size enterprise (50 to 500 staff members)
- Large enterprise (501 and more staff members)

**Location?**

- Company is situated at one location (national or local)
- Company with a headquarters and one or more other branches/locations (national)
- Multinational company

**Alcohol practice provision**

- Internal service
- External service
Case II

Employing body

Diageo is one of the world's leading premium drinks businesses with an outstanding collection of beverage alcohol brands including Smirnoff vodka, Johnnie Walker Scotch whisky, Baileys Irish cream liqueur and Guinness beer.

Diageo is a global company, trading in more than 180 markets around the world. The company is listed on both the New York Stock Exchange (DEO) and the London Stock Exchange (DGE). For more information about Diageo, its people, brands, and performance, visit Diageo.com.

Diageo is a medium size enterprise. Employees’ distribution among the departments of the company is as follows:

- Sales: 45%
- Consumer Marketing: 8%
- Customer Marketing: 14%
- Finance: 14%
- Supply Chain: 6%
- Other functions: 13%

The employing body consists of 57% male and 43% female employees.

The company takes a proactive approach to the health and wellbeing of its employees. Apart from the Private Health Insurance programmes which are offered to all employees, many training activities take place, e.g. H1N1 training, anti-stress, first aid seminars.

Workplace alcohol policy and programme

Diageo actively supports effective and targeted alcohol policies at a national and global level. Establishing consensus on alcohol policy issues, such as responsible marketing, blood alcohol concentration levels, legal purchase age, tax policy and other regulatory measures - such as how to deal with illicit alcohol - is essential to Diageo’s goals for a sustainable future.

Diageo employees are considered as the company’s ambassadors. They enhance the reputation of the brands by demonstrating the benefits of moderate drinking when they decide to have a drink. This is why Diageo prepared and distributed globally the Employee Alcohol Policy, which addresses not only alcohol at work but also drinking and driving, abiding by laws, excessive drinking and more. Diageo is committed to ensuring that all its employees understand the nature and the effects of alcohol drinking. All employees are trained on the Employee Alcohol Policy about Responsible Drinking, so that they promote the Policy principles on every occasion.
Training about the company’s Employee Alcohol Policy is carried out through annual internal seminars. In these informative gatherings Diageo’s values in general and alcohol values in particular are presented and communicated further to the body of employees. As regards newly recruited personnel, they are informed about the company’s Alcohol Policy as part of their induction. Upon being informed about the policy, they also sign an acceptance form, pledging to comply with it. Moreover, the Employee Alcohol Policy is translated into Greek and is available for all employees on the intranet and the global internet resource of the company that promotes responsible drinking (DRINKIQ.com).

Diageo places great emphasis on the continuous communication of the Policy through regular informational initiatives that remind employees of the Policy basic principles, its key points, as well as their personal responsibility as Diageo ambassadors. These regular schemes take the form of ad-hoc internal communication initiatives. For instance, in the case of a brand event through internal communication there is always a phrase regarding alcohol, such as “drink responsibly”, serving as a reminder of Diageo’s Responsible Drinking to all its employees as well as a way of strengthening Diageo’s alcohol consumption values. It should also be mentioned that according to the policy, any breach of the policy needs to be reported to the HR department and that depending on the severity of the incident it may be handled as a disciplinary matter (the company holds the right to terminate the employment relationship with an employee).

**Impact of the alcohol programmes**

In Diageo, according to the information provided, all employees are very well educated and there is neither alcohol-related harm nor absenteeism. This is indicated by the regular controls carried out by the HR department of the company and the available data collected on risk behaviour due to alcohol consumption from the same department. Absenteeism is reported in Diageo. Nevertheless, absenteeism specifically due to alcohol related reasons is not recorded. Alcohol related incidents – according to company policy - when and if they occur are reported separately.

As regards the employees’ education about Diageo’s Alcohol Policy, internal value surveys take place, which investigate the particular issue. These surveys indicate that the Employee Alcohol Policy is well communicated, comprehended and applied to the body of Diageo’s employees.

**Lessons learnt**

The workplace alcohol policy of Diageo is quite effective. The company supports further the particular theme, since it is deemed as one of its crucial current and future objectives.

Detailed information was not provided as regards particular actions on alcohol prevention in the workplace. However, a clear and well organised structure related to responsible drinking has been revealed. Its main components were as follows:
• Inductive information provided to all newcomers on the company’s Employee Alcohol Policy
• Corporate website on responsible consumption
• Continuous internal communication of the message regarding responsible consumption:
  o in all the ad-hoc brand events
  o in internal informative seminars on Diageo’s values

One can conclude about Diageo’s policy on alcohol consumption in the workplace that great emphasis is placed on internal informative ways of continuous communication of the values of Diageo on responsible alcohol consumption. **Continuity** seems to be the key element of Diageo in order to pass the message of responsible drinking to its employees and sensitize them.

Moreover, what is quite interesting about the policy of the particular company as regards its employees’ alcohol consumption is the fact that it transforms its workforce into ambassadors of responsible consumption. In order to achieve the particular goal great emphasis is placed on information and education of the workforce under the wider prism of CSR. Therefore, their behaviour related to responsible alcohol consumption is not seen and handled as an internal risk issue, but as a further social theme of great importance.
Ireland

Country description

1.1 Location and population

Ireland is situated on the most westerly edge of Europe. The island is divided between the Republic of Ireland, which covers just under five-sixths of the island and the remainder is Northern Ireland a part of the UK. The population of the Republic of Ireland is 4.58 million people based on the 2011 census, which represents an increase of 8.1% since the last census in 2006 (CSOa, 2011).

1.2 Irish economy

Ireland went through a period of rapid economic growth between 1995 to 2006. Since 2008, the economy has been negatively affected by the recent recession. The sharpest decline in Gross National Product (GNP) and in Gross Domestic Product (GDP) occurred in 2009, 10.7% and 7.6% respectively (at constant prices) (CSO, 2010). GNP is a better measure than GDP of the value added accruing to residents of the country. In Ireland, GNP is now considerably lower than GDP because of income-flows to non-residents, especially profits and dividends of foreign direct investment enterprises. The main economic sectors are pharmaceuticals, Information technology, financial services, tourism and agriculture.

1.3 Employment

Employment fell from 2.1 million in 2008 to 1.9 million in 2009, the first major fall in 16 years. The number of unemployed people more than doubled. In 2008, 126,700 people were unemployed in comparison to the latest figures for July 2011 (seasonally adjusted) which stood at 447,900 people unemployed. The standardized unemployment rate in July 2011 was 14.3% in comparison to 5.7% in 2008 (CSOb, 2011).

1.4 Alcohol Policy in Ireland

During the last two decades (1990-2010), there were many committees established by government to examine alcohol issues with a total of fifteen reports published. However, few of the recommendations have been implemented despite the rise in harmful drinking patterns and alcohol related harm (Hope & Butler 2010). The first of the reports in 1996, National Alcohol Policy Ireland, was based on the WHO public health approach and outlined the most
effective alcohol policies to reduce alcohol harm which was repeated in subsequent reports, in particular the Strategic Task Force on Alcohol Reports (2002, 2004) with a clear set of recommendations. One of the recommendations “required employers to have guidelines for workplace alcohol policies to manage the risks associated with alcohol in the workplace and to promote them as part of health and safety”. A recent comprehensive review of alcohol policy in Ireland during the last two decades summarises the lack of a coherent response.

During the decade 1990-2010, most of the policy choices (taken) were counter to the public health evidence base with the exception of a reduction in the BAC level. . . Between 2002 and 2004, there were signs of a possible policy shift towards public health alcohol policy – large tax increase on spirits, proposed legislation to restrict alcohol marketing, new laws to restrict and sanctions those who sold alcohol to intoxicated persons and restrictions on cheap alcohol promotions. However, it was short lived and by 2005 the strength of the industry lobby and the political unwillingness to take pro-health decisions resulted in a default to ‘business as usual’ which continues to the present time. One exception is random breath testing where road deaths have been reduced since the introduction in 2006, which illustrates the benefits of evidence based policies. (Hope & Butler 2010, p12-13)

In early 2009 the government agreed that alcohol should be integrated into the National Drugs Strategy and established another steering group to detail an implementation plan. To date no national alcohol strategy has been published.

1.5 Employment Law in Ireland

Employment Law in Ireland covers a wide range of legislation which is summarised by the Citizens Information Board (CIB 2011). However, only the key pieces of legislation relevant to workplace alcohol policy will be discussed here. There are also several mechanisms for resolving employment issues including the Rights Commissioner Service, Labour Relations Commission (mediation service) and the Equality Tribunal for claims under the equality legislation. The Safety Health and Welfare at Work Act 2005 consolidated and updated the existing health and safety laws in the workplace. It includes a new provision on drugs and alcohol including

An employee shall, while as work-

13.1(b) ensure that he or she is not under the influence of an intoxicant (defined as drugs and alcohol) to the extent that he or she is in such a state as to endanger his or her own safety, health or welfare at work or that of any person.

13.1(c) if reasonably required by his or her employer, submit to any appropriate, reasonable and proportionate tests for intoxicants by, or under the supervision of, a registered medical practitioner who is a competent person as may be prescribed.

However, section 13.1(c) has not come into force yet and awaits a regulation issued by the Minister of Enterprise and Employment which specifies safety critical and high risk work activities. The Railway Safety Act 2005 does define safety critical tasks and a safety critical
worker and has specific sections on testing and making provision for random breath testing of employees. Safety critical task means driving a train, controlling the movement of persons on a train or working in a maintenance capacity and a safety critical worker means a person who performs such safety critical tasks. The Act imposes duties on safety critical workers including “not to perform a safety critical task while being unfit” which is defined as being under the influence of an intoxicant to such an extent that his or her ability to perform a safety critical task with exposing a person (including himself or herself) to danger or risk of danger is for the time being impaired. In Air Navigation (Notification and Investigation of Accidents and Incidents, Regulation 1997) and Merchant Shipping regulations (Investigation of Marine Casualties Act 2000) intoxicant testing of employees in limited circumstances following accidents or incidents is provided for. In March 2006, the Labour Court upheld the principle that alcoholism is a disability under the Employment Equality Acts 1998-2004 and therefore an employee suffering from a disability should not be discriminated against on the basis of their illness (SIPTU 2009). However, employers are not obliged to provide any facility or treatment that employees can reasonably provide for themselves. This provision does not limit the obligations and entitlement of employees or employer under the Employment Equality Act or other statute or common law. The Road Traffic Acts 1968 to 2011, specifies that driving while under the influence of an intoxicant is an offence. The Acts specifies the legal BAC limit which from September 2011 will be reduced to 50mg%. Random breath testing of drivers has been in place since 2006. In June 2011, a new provision was introduced where motorists involved in a serious road accident must undergo a mandatory blood alcohol test. In addition, roadside testing for suspected drug drivers is due to commence in September 2011. Given these changes to the road traffic acts, the director of an EAP service provider in Ireland (Quinlan 2011) has suggested that

“Employers who serve alcohol at company sponsored events need to be aware that if an employee is over the limit for alcohol at a roadside Garda (Police) checkpoint after a company sponsored reception or training and is involved in a serious road accident afterwards, under Section 80 (1) of the Safety, health and Welfare at Work Act 2005, company directors and managers may have personal liability”

Other relevant legislation includes the Misuse of Drugs Acts which restricts the production, cultivation, supply and possession of controlled drugs (a mixture of illegal and prescribed drugs). Data Protection Acts oblige that information is obtained fairly, kept safe and secure and retained no longer than is necessary which has importance for sensitive information such as personal health records. Under the European Convention on Human Rights Act 2003, the right to privacy of the individual is protected except in certain circumstances such as in the interest of public safety and for the protection of health or for the protection of the rights of others. The Health and Safety Authority (HSA) has overall responsibility for the administration and enforcement of health and safety at work legislation in Ireland. The HSA strategy in the area of Occupation Health seeks “to protect workers’ health from any existing and emerging work related hazards and to encourage workplace practices that promote good health” (HSA, 2011). However, there is no specific mention of alcohol in the HSA strategy. In describing the case studies, the employing bodies requested anonymity.
Template case I

Case Nr: 1
Name of the case: the company wishes to remain confidential

City:

Type of company:
Ownership?
☐ public ☑ private ☐ voluntary

Sector (ISIC Rev. 4. codes)
☐ Agriculture, forestry and fishing
☐ Mining and quarrying
☒ Manufacturing
☐ Electricity, gas, steam and air conditioning supply
☐ Water supply; sewerage, waste management and remediation activities
☐ Construction
☐ Wholesale and retail trade; repair of motor vehicles and motorcycles
☐ Transportation and storage
☐ Accommodation and food service activities
☐ Information and communication
☐ Financial and insurance activities
☐ Real estate activities
☐ Professional, scientific and technical activities
☐ Administrative and support service activities
☐ Public administration and defence; compulsory social security
☐ Education
☐ Human health and social work activities
☐ Arts, entertainment and recreation
☐ Other service activities
☐ Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use
☐ Activities of extraterritorial organizations and bodies

Company size?
☐ Very small enterprise (under 10 staff members)
☐ Small enterprise (10 to 50 staff members)
☒ Medium-size enterprise (50 to 500 staff members)
☐ Large enterprise (501 and more staff members)

How many are employed:

Location?
☐ Company is situated at one location (national or local)
☐ Company with a headquarters and one or more other branches/locations (national)
☒ Multinational company

Alcohol practice provision
☐ Internal service ☒ External service
Case I

Employing body

The company is a private medium sized manufacturing enterprise with approximately 400 employees with two workplace sites in Ireland. It is part of a multinational pharmaceutical company and has been manufacturing in Ireland since the late 1950’s. The focus of this case study is the main worksite where the majority of workers are employed. Over two-thirds of the workforce is skilled while one-third is classified as operatives. The proportion of workers under 30 years of age is 41% while 59% is over 30 years.

The role of the Occupational Health Service (OHS) is to protect the health and well-being of all employees. The provision of Occupational Health Services is in-house (internal) which began with the availability of a visiting doctor up to the mid 1980s then progressed to the appointment of a full time occupational health nurse and now includes a specialist Occupational Health Physician. The occupational health service includes pre-employment screening and risk assessment on a regular basis in each of the work areas of the plant. Since 2005, the OHS has moved from a reactive approach to a more pro-active approach involving health promotion with a focus on heart and bone health, exercise, nutrition and cancer prevention in co-operation with several agencies such as the Irish Hearth Foundation, Irish Cancer Society and local Pharmacies. The occupational health service estimate that about 60% of employees have participated in the health promotion initiatives. There is an open door policy for employees to attend the occupational health services with any medical issue. The Occupational Health Service may also recommend an employee, where appropriate and with consent of the employee, to the current Employee Assistance Programme which is confidential and is provided by an external service provider.

Workplace alcohol policy and programme

An Employee Assistance Programme (EAP) was established internally in the company in the early 1990s and ran successfully for ten years. The approach taken was a fine example of best practice. The process began when a Senior Manager in the Personnel Department undertook a one year EAP course. A Senior Shop Steward representing employees separately participated in an EAP course “to learn how alcohol abuse was being dealt with in other workplaces and to consider how we might address the problems in our own workplace”. After reviewing the learning from the course together, they agreed to work on a joint initiative. A working group was set up to develop an appropriate system to deal with employees whose behaviour and/or performance at work was affected by problems outside the workplace. From this came the realisation that a joint approach was essential between unions and management for the credibility and success of the programme. The approach involved equal participation in decision making, equal responsibility and equal ownership such as a rotating chairperson and secretary, formal mandates from unions and management and progress reports to ensure wide participation and ownership of the programme (SIPTU 2009). The Employee Assistance Service, as it was known, was defined as
“A structured service, designed to provide a confidential, experienced source of help to employees with problems that adversely affect performance or personal well-being. The service provides information, advice, guidance, counselling and where appropriate referral to specialised outside agencies”

The service was available to all, easily accessible, participation was voluntary and confidential with the aim of resolving problems before they led to a serious deterioration in behaviour or performance. Another key aspect of the EAP was the selection of a Local Resource Person who introduced and developed the service on a part-time basis, a person of “high integrity, discreet, compassionate, though firm when necessary”. The service not only addressed alcohol and drugs problems, but covered a wide range of issues which removed the potential of embarrassment for sensitive personal problems. When the local resource person running the EAP retired in 2000, the company decided to switch to an external service provider for the EAP as they believed there was no other suitable person to fill the role. The current Employee Assistance Programme aims to support and encourage staff to reach optimum levels of work/life effectiveness and well-being and to advise and assist staff distressed by personal and/or workplace problems. The EAP service provides:

- A free-phone telephone support service which is confidential to all staff.
- Work-life information services via telephone/ email on a wide range of issues such as legal, finance and consumer information.
- Telephone counselling and coaching service
- Face to face counselling and consultation
- Online services of information and guidance on a range of issues

The EAP service is self-referral and confidential. The EAP service is promoted by means of flyers and posters by the Occupational Health Service were appropriate. However, the employee representative suspects that many employees are not fully aware of how the service works. The counselling service has a problem solving focus with a maximum of six sessions seen as adequate. A wide range of issues can be addressed including addictions, depression, stress, relationship/family issues and traumatic events. The process involves an initial assessment by phone followed by face to face counselling where necessary. Referral for long-term counselling intervention can also be provided.

The management of long term sickness is overseen and monitored on a regular basis by the company’s internal Occupational Health Service. Human resource personnel provide leadership training for line managers and if issues arise such as lateness for work, lack of performance, absenteeism pattern (which can be alcohol related) or under the influence of alcohol/drugs at work, action is taken under the company disciplinary procedures.

**Impact of alcohol programme**

The working party of the first EAP (1990-2000) conducted a review of the service, based on the frequency of its use, the range of issues addressed and the penetration to all grades of employees in the company and concluded that the project was a success. However, no figures were available to quantify the impact of the EAP and no outputs were measured. This was intentional as the defining characteristic of the service was the insistence on confidentiality at all times. No statistics were reported so that it would not be possible for an individual to be
identified. While there were many successful stories of employees returning and maintaining their job following alcohol treatment, not all were, as indicated by management. Despite several rehabilitation programmes, some employees were not successful and their alcohol abuse continued to impact on their work performance which eventually resulted in dismissal.

The current EAP (2000-2011), provided by an external service provider compiles a short summary of utilisation of the services used which has no individual client information. The number of cases seen each year is about 6-8% of the workforce. Addiction has not featured as a client issue for the past several years. A possible explanation is that addiction issues are dealt with by employees independently and outside the sphere of the workplace, which is more likely to be the case or that addiction issues are not present in this workforce, which is highly unlikely given the national trends of increased harmful drinking patterns and alcohol problems.

**Lessons learnt**

The key success elements of the first EAP (1990-2000) were - joint responsibility between management and unions, the selection of a trusted local resource person, confidentiality and voluntary participation, in-house service and provision of a wide range of issues. The significance for other workplaces was summarized by the trade union (SIPTU 2009) as follows

“The provision of a broad-based Employee Assistance Service can assist and support employees in achieving a healthy, well-balanced and fulfilled life and can be a resource of great potential in any company. If implemented with sensitivity, it can also be a major contribution to improved relations within the organisation facilitated by shared ownership of the project between management and the unions”.

However, it would appear that the reliance on the local resource person which was a key aspect to its success was also a weakness, it that the company felt there was no appropriate person to replace him when he retired and therefore switched to an external provider of the new EAP. Looking back over the last 30 years, management felt there was success with tackling alcohol problems in the workplace and highlighted the constructive role the unions played, the importance of the local resource person and the fact the company was willing to pay for employee alcohol treatment. The key message from management to other companies was that drug issues tend to be a subset of the population and professional expertise is the preferred way to deal with them “ don’t try to fix it yourself, identify professional expertise for referral and professional advice”.

Addiction issues related to work performance were originally part of an initiative implemented through a joint management/union Employee Assistance Service. The qualitative evaluation suggested success, although no outcomes measures were examined. This was intentional so as to ensure confidentiality. Currently, addiction issues related to work performance are not evident in the company, based on the EAP utilisation and feedback from Occupational Health Services, suggesting employees use treatment services in other health care settings.
Case studies Ireland

Template case II

Case Nr: 2
Name of the case: the company wishes to remain confidential

Type of company:

Ownership?
X□ public □ private □ voluntary

Sector (ISIC Rev 4. codes)

□ Agriculture, forestry and fishing
□ Mining and quarrying
□ Manufacturing
□ Electricity, gas, steam and air conditioning supply
□ Water supply; sewerage, waste management and remediation activities
□ Construction
□ Wholesale and retail trade; repair of motor vehicles and motorcycles
□ Transportation and storage
□ Accommodation and food service activities
□ Information and communication
□ Financial and insurance activities
□ Real estate activities
□ Professional, scientific and technical activities
□ Administrative and support service activities
□ Public administration and defence; compulsory social security
□ Education
□ Human health and social work activities
□ Arts, entertainment and recreation
□ Other service activities
□ Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use
□ Activities of extraterritorial organizations and bodies

Company size?
□ Very small enterprise (under 10 staff members)
□ Small enterprise (10 to 50 staff members)
□ Medium-size enterprise (50 to 500 staff members)
X□ Large enterprise (501 and more staff members)

How many are employed:

Location?
X□ Company is situated at one location (national or local)
□ Company with a headquarters and one or more other branches/locations (national)
□ Multinational company

Alcohol practice provision
□ Internal service □ External service
Case II

Employing body

The employing body is a major public Acute Hospital in Ireland which provides a wide range of health services. The hospital has a workforce of 3,000 employees representing a broad spectrum of job categories from porter to senior consultant.

The Occupational Health Department (OHD) has a Director (Occupational Health Physician), 2.5 nurses and an administrator. The Occupational Health Service is in-house (internal) and includes pre-employment screening, opportunistic screening and on-going work related employee health issues. Attendance at the OHD is via self-referral (which represents the majority of attendances) or via formal management referral from Human Resources and managers. Self-referrals are mainly health issues (musculoskeletal conditions, injuries, mental health concerns, skin complications) and management referrals are mainly focused on absenteeism and conflict issues. A Health Promotion Officer (in-house) is attached to the hospital and provides initiatives with a focus on promoting good health. A recent successful initiative was encouraging employees to become involved in the government incentive bike promotion. An Employee Assistance Programme (EAP) is provided by an external service provider which offers professional advice (legal queries) and counselling (solution focus) with an entitlement of six sessions. The uptake of the EAP service is about 3-5%.

Workplace alcohol policy and programme

The hospital has an Alcohol and Substance Abuse policy for a number of years. The policy clearly outlines the employer’s commitment to helping staff with alcohol problems in what could be described as a supportive approach.

“Staff who experience difficulties in their work as a result of alcohol or substance abuse are encouraged to seek help at the earliest possible opportunity and the hospital is committed to helping them to deal with their problem in a confidential and supportive way”.

The focus is about addressing alcohol abuse when it interferes with an employee’s ability to perform his or her duties at work. While some workers in hospitals do engage in safety critical tasks this has not be specified in the policy as the relevant section in the Health and Safety Act 2005 has not been enacted by the Minister, as yet. The development of the Hospital Alcohol and Substance Abuse policy was a joint approach involving Occupational Health, Human Resources and the Trade unions and Professional Body representatives. The Occupational Health Department (OHD) is the lead department in advising, managing and monitoring the Alcohol and Substance abuse issues in the hospital. The responsibilities of OHD include the following
• Advise managers, supervisors and Human Resource on the most appropriate means of dealing with alcohol and substance abuse problems.
• Support staff in addressing their substance abuse problems
• At the individual level, offer initials assessment, counselling and referral to EAP service provider or other relevant rehabilitation programmes.
• The OHD monitors the health and welfare of the person during treatment with the agreement of the staff member.
• Once a staff member has completed treatment the OHD determines the employee’s fitness for returning to work.
• After successful treatment it is envisaged by the OHD that the staff member will be able to return to normal duties without any ill effects on promotion or employment prospects.

The other key groups in the workplace important for the successful implementing of the alcohol and substance abuse policy are Managers and Supervisors, the Department of Human Resources and the Trade Union or Professional body representatives. **Manager and Supervisors** play a key role in the early identification of alcohol and substance abuse problems among staff members. They are best places to observe the workers behaviour and performance at work and can look for the early signs of alcohol and substance abuse chronic problems as mentioned in the policy, such as

- Deteriorating job performance
- Poor attendance
- Unauthorised absences during the day
- Poor relationships with co-workers,
- Accidents
- Complaints by work colleagues or the public
- Irritability or moodiness
- Obvious signs of drinking or frequency hangovers

In keeping with the policy, the advice to Managers and Supervisors is to monitor and record unsatisfactory work performance issues, present the facts as recorded to the individual and discuss. If a problem exists and the staff member accepts it, the issue is referred to the Occupational Health Department with a referral letter outlining concerns and where appropriate treatment is determined. However, if the worker does not accept that there is a problem, “*the case is dealt with in accordance with the standard disciplinary procedures.*” In the case of an acute situation where a staff member is thought not to be in a fit state to carry out his or her duties due to signs of intoxication the actions required are for the supervisor to inform line manager and if agreed there is a problem the staff member is informed, removed from their place of work and arrangements made to get the person home safely. Human Resources are notified of the incident and subsequent to the event the person is advised of their unacceptable behaviour and reminded of the OHD services. However, where it is a single incident and the person is not thought to have a chronic alcohol problem the issue is dealt with under the hospital disciplinary policy. The role of the **Department of Human Resources** is to provide guidance, support and training for managers and supervisors in helping them deal with work problems related to alcohol and substance abuse. Human Resources also play an important role in promoting awareness of the alcohol and substance abuse policy to all
members of staff. The **Trade Unions or staff representatives** are invited to be involved provided the staff member has no objections and can encourage their members to undergo treatment. The trade unions have a network of selected people in the different areas of the hospital which meet on a regular basis and discuss emerging issues of concern. This provides an important mechanism for feedback to the unions.

**Impact of alcohol programme**

When the alcohol and substance abuse policy was introduced there was some scepticism among some workers. However, it is now well accepted and there is a greater awareness among all employees of the policy and protocols of how alcohol and substance abuse issues are to be handled. There is also a shift in the attitudes of workers about alcohol in the workplace. Over a decade ago, it was seen as acceptable that workers might have a few drinks at lunchtime and return to work. However, that behaviour is seldom if ever seen now among workers. No quantitative evaluation has taken place of the impact of the Hospital Alcohol and Substance Abuse Policy. The number of alcohol related cases each year are very low (single figures).

**Lessons learnt**

The Occupational Health Department believes the alcohol and substance abuse policy is an important document to have. The policy sends a clear message that alcohol abuse is not accepted by employers. For those with chronic alcohol problems the employer provides a supportive approach for staff willing to engage with treatment. For some people the policy can act as a deterrent, the realisation that alcohol abuse can result in a person losing their job if not resolved. It is felt there is a need to build on the policy and incorporate preventive work and to ensure all staff have a heightened awareness of the issues and are aware that Occupational Health Department provides a clear path in advising and managing alcohol and substance abuse problems that impact on work performance. Confidentiality, trust and working together are seen by unions as critical to the successful implementation of the Hospital Alcohol and Substance Abuse Policy. What continues to be a challenge is for the person with alcohol abuse problems to recognise themselves that they have a problem and a desire to resolve the problem. The sensitivity of this issue requires different approaches for different circumstances. But ultimately, if the issue of alcohol abuse is not resolved termination of the job is the last option.

**References**


Italy

Country description

Italy is the fourth most populous country in the European Union (after Germany, France and the UK); it has a population density of 201,24 inhabitants per square kilometre.

The population is concentrated mainly along coastal and flat areas. Life expectancy is 78.9 years for male and 84.2 years for female.

Number of inhabitants as of December 2009

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Percentage of inhabitants divided per age (%)

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14</td>
<td>14.9</td>
<td>13.3</td>
</tr>
<tr>
<td>15-64</td>
<td>67.6</td>
<td>64.0</td>
</tr>
<tr>
<td>65 and more</td>
<td>17.6</td>
<td>22.8</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

The territory of Italy covers 301,336 km²; only about one-fourth of the total area is plain.

To the north it is delimited by the Alps and it borders France, Switzerland, Austria and Slovenia. To the centre and the south it extends along the Mediterranean sea to become a Peninsula surrounded by the Tyrrhenian, Adriatic and Ionian seas. Insular Italy is composed by Sicily, Sardinia and many other smaller islands. The independent microstates of San Marino and the Vatican City are enclaves within Italy.
Italian administrative structure is constituted by State Administration, Regional Administrations, Province and Municipality Administrations.

There are 20 Regions, 110 Provinces and 8094 Municipalities in Italy.

The Italian political system is conducted through a parliamentary, democratic republic with a multi-party system. Executive power is exercised collectively by the Council of Ministers, which is led by the President of the Council of Ministers. Legislative power is vested primarily in the two houses of parliament, and secondarily on the Council of Ministers. The judiciary is independent of the executive and the legislative branches. Italian Regions may also adapt their own laws on some important social life sectors.

![Map of Italy](image)

**Bold font indicates Regions and medium font refers to Provinces.**

Please find below some data defining the Italian socio-economic situation in the year 2009:

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inhabitants</td>
<td>60,340,000</td>
</tr>
<tr>
<td>GDP Euro</td>
<td>1,205,536,400,000</td>
</tr>
<tr>
<td>Total population (15 - 64 years)</td>
<td>39,407,000</td>
</tr>
<tr>
<td>Labour force</td>
<td>24,592,000</td>
</tr>
<tr>
<td>Employed persons</td>
<td>22,651,000</td>
</tr>
</tbody>
</table>
Case studies Italy

<table>
<thead>
<tr>
<th>Persons looking for a job</th>
<th>1,941,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non labour force</td>
<td>14,815,000</td>
</tr>
<tr>
<td>Employment rate</td>
<td>57.5 %</td>
</tr>
<tr>
<td>Unemployment rate</td>
<td>7.9 %</td>
</tr>
</tbody>
</table>

**Productive sectors:**

**Agriculture:**

The agricultural sector holds a very low percentage in national economic background. In the year 2009 Italy employed around 1.05 million labour force units in the agricultural sector.

**Industry:**

Italy, which stands out for its manufacturing production, differs from the remaining industrialized countries in its wider diffusion of family SMEs.

Italian industry is varied and advanced. It is developed mainly in the following sectors: shipbuilding, household electrical appliances, chemicals, pharmaceuticals, iron and steel industry, food farming. It is also one of the leading countries for motor vehicles production, automotive design and for its luxury fashion products.

**Tertiary Sector**

In Italy this is the most important economic sector. Within this sector tourism is of primary importance.

**WORKPLACE SAFETY**

In Italy norms on workplace safety derive mainly from the adoption of European Directives, the main current regulation is the Government Decree n. 81 dated 09 April 2008. This regulation specifies basic standards that work equipment, systems and workplaces must have.

Moreover companies must provide a risk prevention and protection service to assist employers in evaluating workers’ health risks and to adopt measures to prevent employees health damages due to dangerous work equipment, systems or substances.

A company doctor (called competent doctor) is also appointed to perform health checks and medical examinations to evaluate workers’ suitability to perform specific tasks that can be risky for their health. He also compiles information, collectively and anonymously, on the significance of medical tests performed to make employers aware of risky situations.

The monitoring of the correct enforcement of this regulation is implemented by governmental bodies which are responsible for the surveillance activities. In practice, most of the monitoring
is carried out by local health authorities. They are public entities afferent to Regions which provide citizens with diagnostic health services, care and prevention. Indeed local health authorities include hospitals, units for basic health assistance with general medicine doctors and prevention departments.

Within Local Health Units there are specific services that have the task of monitoring workplaces. In Veneto Region the appointed operational unit is the Service for Prevention and Safety in Working Places (S.P.S.A.L.). There is also another unit responsible for the monitoring of workplaces, normally building sites or railway lines, namely the Provincial Department of Labour within the Ministry of Labour.

With reference to the issue of alcohol consumption in working places, the regulation of reference is Law n. 125 dated March 30 2001. Art. 15 states that it is forbidden to take or give alcohol to those who perform a range of activities carrying high risks of injuries to workers or the possibility to cause damages to third persons.

According to this regulation competent doctors or SPSAL doctors may perform tests on blood alcohol levels to workers responsible for activities "at risk", but since a standard level has not been set yet, such performance can not be usefully applied.

The same regulation foresees that workers suffering from alcohol related diseases can access rehabilitation treatment programs without incurring the loss of their jobs.

In addition, according to the Legislative Decree n. 81/2008 a competent doctor may verify the absence of alcohol dependence conditions in workers subjected to medical checks. Unfortunately standard criteria to determine the above mentioned situation have not been set, therefore at present this regulation is difficult to apply.

To conclude, there are regulations prohibiting alcohol consumption in working places and preventing that workers suffering from alcohol dependence situations perform “delicate” tasks. Notwithstanding the practical implementation of such regulations is difficult because measures to render such prohibitions effective are lacking.

It is worth mentioning that in Italy there is a regulation in force stating that people driving motor vehicles must not have a blood alcohol level higher than 0.5 g / litre. This prescription is frequently verified by the police controlling the road traffic and helps to spread awareness on the problems that alcohol can cause.

In any case, however, among the employers there is a growing awareness of the opportunities to address alcohol related issues. This derives from both an increased sensitivity among company directors and to the fear that alcohol related accidents can lead to negative consequences for the company itself.

With regard to policies on mental well-being, according to the Legislative Decree N. 81/2008, employers must perform a risk assessment analysis for work related stress, and therefore in this field some research has also been put in place to analyze which elements at work and in the overall business organization can adversely affect mental well-being of workers. Companies must carry out corrective actions in case this need emerges.
Case studies Italy

Template case I

**Case Nr:** 1  
**Name of the case:** ASI  
**City:** San Donà di Piave

**Type of company:**

**Ownership?**
- [ ] public
- [X] private
- [ ] voluntary

**Sector ([ISIC Rev 4. codes](https://www.iseostat.org/iseostat/en/iseostat/iseostat.html))**

- [ ] Agriculture, forestry and fishing
- [ ] Mining and quarrying
- [ ] Manufacturing
- [ ] Electricity, gas, steam and air conditioning supply
- [X] Water supply; sewerage, waste management and remediation activities
- [ ] Construction
- [ ] Wholesale and retail trade; repair of motor vehicles and motorcycles
- [ ] Transportation and storage
- [ ] Accommodation and food service activities
- [ ] Information and communication
- [ ] Financial and insurance activities
- [ ] Real estate activities
- [ ] Professional, scientific and technical activities
- [ ] Administrative and support service activities
- [ ] Public administration and defence; compulsory social security
- [ ] Education
- [ ] Human health and social work activities
- [ ] Arts, entertainment and recreation
- [ ] Other service activities
- [ ] Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use
- [ ] Activities of extraterritorial organizations and bodies

**Company size?**
- [ ] Very small enterprise (under 10 staff members)
- [ ] Small enterprise (10 to 50 staff members)
- [X] Medium-size enterprise (50 to 500 staff members)
- [ ] Large enterprise (501 and more staff members)

**Location?**
- [X] Company is situated at one location (national or local)
- [ ] Company with a headquarters and one or more other branches/locations (national)
- [ ] Multinational company

**Alcohol practice provision**
- [ ] Internal service
- [X] External service
Case I

Employing body

ASI case study.

L’ Azienda Servizi Integrati (company of integrated services) – ASI S.p.A., with Headquarters in San Donà di Piave (province of Venice), 21, Nazario street, is a share holding company whose shareholders are a few municipalities of Veneto Region. Its area of activity comprises the design and management of the water pipe system, water distribution services and management of the sewage system and waste water management. The main governing body of the company is the Board of directors.

The organizational management is composed of the General Director and seven mid level managers. The organigram shows different operational sections managed by a person responsible for the coordination and management of its activities. The company staff includes 54 office personnel and 92 workers.

The company comprises different offices and operational structures distributed throughout the territory under its jurisdiction, such as: the administrative offices, the operational offices, production and depuration plants as well as the related networks of water and sewage. Emergency intervention teams are also available to intervene at any time for repair or other emergency needs.

The territory under its jurisdiction is about 600 Km2 and it serves a population of 130,000 inhabitants that during the summer time, due to tourism, increases by at least 500,000 persons, especially in the coastal areas of Caorle, Eraclea, Jesolo.

ASI has obtained the UNI EN ISO 9001:2008 (Quality Management Systems) and has already initiated the process for obtaining the UNI EN ISO 14001:2004 Certificate (Environmental Management Systems).

The company has established an internal service of Prevention and Health Protection. An external occupational physician is in charge of the health surveillance. He uses a well defined protocol that considers the company’s area of activity and potential health risks. The company has adopted a surveillance programme that is applied at all levels, all types of activity and employees/workers.

ASI has adopted a policy document on Quality – Environment and Safety that shows its commitment to continuous quality improvement in full respect of the legal framework related to this area of activity, prevention of incidents at work as well as injuries and professional diseases through adoption of safety measures and training of workers.
Policy and programme related to alcohol at the work place

In February 2008, the Local Health Authority nr 10, Department of Addiction Services, in collaboration with the Occupational Physician of ASI, implemented an information and awareness project related to the potential safety problems deriving from the use of alcoholic or super alcoholic drinks during working hours. The project included:

1. Meetings with managers to explain the objectives and activities of the project.
2. Meetings with the persons responsible for the work safety issues and representatives of trade unions to explain the objectives and activities of the project.
3. Meetings with the occupational physician to define the project implementation and coordination aspects.
4. Training sessions on the use of alcohol and drugs in the workplace involving the staff in charge of human resources management, the head of the Prevention and Health Protection Service, and the elected representatives of the workers on work safety issues. These training sessions were aimed at enabling the type of staff mentioned above in identifying and documenting / recording the effects of drug and alcohol use, informing management on the critical cases at risk and referring the concerned workers to the occupational physician. In the case of alcohol dependence being diagnosed, the occupational physician refers the concerned workers to the diagnosis and treatment services of the local health service.
5. Training sessions for the workers aimed at informing and creating awareness on the risks related to the use of alcohol in the workplace, negative effects of such substances on their health, work safety issues, productivity as well as absenteeism. The sessions included also information on the treatment possibilities and services for those who already have developed the pathology/dependence..
6. The training sessions were organized in the premises of the company. Each session included about 25-30 participants and lasted for one hour. The main components of the program were as follows:
   o Presentation of the project and its objectives
   o Interactive training on the effect and consequences of the use of alcohol in the workplace
   o Discussion on the information provided during the training
   o Distribution of educational material such as leaflets and brochures to be used whenever deemed necessary.
   o Distribution to the participants of a training manual

Number of training sessions: 5. Number of workers involved: 135. Total number of workers: 147. Participation rate: 92%

The 8% of absentees were employees of the administration, while the workers of the production area had a participation rate of 100%.

Following the training sessions, the company has adopted the following decisions:

- Prohibition of alcoholic and super alcoholic drinks consumption
• Communication of such a decision to all the restaurants that offer the lunch service to the employees of the company.
• This rule was applied to all the contractors of the company contractors that offer service or perform other activities (for ASI SpA).

The management has undertaken on the spot visits during the lunch break in the contracted restaurants to check whether the new rules were observed.

So, during 2008, the management has made:

Formalized control visits: 12
Random checks / visits: about 20
Infractions: 1

For the workers involved in the infraction, the disciplinary measures foreseen in the National Contract were imposed. A formal notice was sent to the contractor, informing that, in case of repeated infraction, failure to observe the new rules would cause the termination of the contract.

Results Obtained:

Evaluation of results related to the information and training courses as well as those related to the adoption of the policy prohibiting alcohol consumption in the workplace, is not an easy task. The health and work safety issues are quite complex and the factors that can influence them are not always measurable. As far as the ASI case is concerned, the most significant aspect is the fact that in 2008, year in which the new policy and measures were adopted, the data on the number of accidents at work and their gravity have been drastically reduced, thus changing the general negative trend to a positive one. It is important to underline that besides the information and training courses organized during 2008, the company has applied an intense control and surveillance program as well as a massive information and education campaign that started in the beginning of the year and reached most of the employees/workers. Below, you will find the data related to the last six years:

<table>
<thead>
<tr>
<th>Year</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>25.7</td>
<td>38.1</td>
<td>48.7</td>
<td>30.0</td>
<td>19.9</td>
<td>16.6</td>
</tr>
</tbody>
</table>

An important aspect has been the cultural change among the workers, who have consequently accepted the new policy, considering it more as a health and safety opportunity rather than a depriving restriction. This new culture, initially derided and not well accepted by the contractors or visitors to the company, has quickly found consensus and now nobody is surprised any more by the contractual condition prohibiting the alcohol consumption or by the fact that there’re no alcohol drinks on the table during the lunch break.
Application of the new policy

At the moment of employment the new employee is informed of the “no alcohol policy” during working hours, including the hours when he/she is on call during the holidays or night hours. The on site controls during the lunch break continue, although they are less frequent. The control visits aim at verifying the observation of the “no alcohol” consumption rule/policy by the ASI employees, restaurants as well as the employees of ASI contractors.
Template case II

Case Nr: 2
Name of the case : ASVO  
City: Portogruaro (Ve)

**Type of company:**

- **Ownership?**
  - public
  - private
  - voluntary

**Sector (ISIC Rev 4. codes)**

- Agriculture, forestry and fishing
- Mining and quarrying
- Manufacturing
- Electricity, gas, steam and air conditioning supply
- Water supply; sewerage, waste management and remediation activities
- Construction
- Wholesale and retail trade; repair of motor vehicles and motorcycles
- Transportation and storage
- Accommodation and food service activities
- Information and communication
- Financial and insurance activities
- Real estate activities
- Professional, scientific and technical activities
- Administrative and support service activities
- Public administration and defence; compulsory social security
- Education
- Human health and social work activities
- Arts, entertainment and recreation
- Other service activities
- Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use
- Activities of extraterritorial organizations and bodies

**Company size?**

- Very small enterprise (under 10 staff members)
- Small enterprise (10 to 50 staff members)
- Medium-size enterprise (50 to 500 staff members)
- Large enterprise (501 and more staff members)

Adriano Fontanel

**Location?**

- Company is situated at one location (national or local)
- Company with a headquarters and one or more other branches/locations (national)
- Multinational company

**Alcohol practice provision**

- Internal service
- External service
Case II

Employing body

ASVO S.p.A., headquartered in 63 Manin Street, Portogruaro (Venice), is a public corporation joint-stock co., whose shareholders are a few municipalities of Veneto. The company is in charge waste management (collection and disposal of solid waste) in the territory of the municipalities involved (business code: ISIC Rev 4 E-39). The target market includes 11 municipalities for a total number of about 94,000 users.

The governing body of ASVO S.p.A. is the Board of Directors, currently composed of 5 members appointed by the member municipalities.

The company structure includes a General Director and two Executives responsible for specific areas.

In addition to the company staff (about 170 people) each summer about 50 seasonal workers are employed to compensate for the increased working load due to the presence of tourist in the major seaside resorts of Bibione and Caorle.

The company adopts the following effective tools of governance:

- Environmental Management System in compliance with ISO 14001:2004;
- Model of organization, management and control, in compliance with Legislative Decree 231/2001, able to: 1) ensure the fairness and transparency in managing business activities; 2) protect own brand/image and those of subsidiaries companies; 3) comply with the expectations of shareholders and the work of own employees.
- Safety Management System in compliance with UNI INAIL Guidelines rev. 2001; ASVO S.p.A. is committed to preserve, especially with preventive initiatives, the health and safety of workers, in accordance with the regulations. These objectives are pursued through a strong commitment in spreading the culture of safety and well-being at work at all company levels.

ASVO S.p.A has adopted a quality/environment/safety-oriented corporate policy (please check the company web site http://www.asvo.it/ With regard to safety and well-being at workplaces, the policy document mentions that the Board of Directors and the different management levels of the company (in compliance with industry regulations) are fully committed to improving health and safety standards, especially concerning accident prevention, injuries and occupational diseases, by ensuring the adequacy of workplaces and the training of workers.

The company has set up an internal health service for the Prevention and Protection. An external occupational physician carries out the health surveillance in the company, in
compliance with a specific protocol defined by himself on the basis of the type of duties carried out by the workers and related risks. In addition, it is active a specific surveillance program at all levels of the company that covers: workplaces, work activities, workers

Policy and program related to the alcohol consumption in the workplace

Concerning the problem of alcohol consumption in the workplace, the cornerstone legislation is the Law N. 125 of 30 March 2001, and specifically article 15 stating the prohibition of consumption and supply of alcoholic drinks and spirits for those workers who perform work duties at high risk of accidents or for the safety and health of third parties. ASVO Spa applies this rule to the drivers of trucks used for waste collection.

In addition, the Legislative Decree N. 81/2008 states that the competent occupational physician has to verify the absence of alcohol dependence.

In order to reduce alcohol consumption the company has implemented the following actions:

- Introduction of a specific rule in the company's disciplinary system prohibiting the consumption and possession of alcoholic drinks;
- Issue of a special Order of Service prohibiting the consumption and possession of alcoholic drinks;
- Ban alcoholic drinks from the conventions with restaurants where employees usually have lunch during their break from work shift;
- Ban of alcoholic drinks from Christmas gifts for the employees;
- Ban of alcoholic drinks from the friendly business meetings (e.g. year-end business meeting);
- Monitoring on a regular basis of the possible presence of alcohol in workplaces (changing rooms, trucks, etc.) carried out by appointed staff.

Intervention methodology

From June to December 2008, some social-health professionals working at the Social Service for Addictions (Ser. D.) and the Service for the Prevention and Safety in the Workplace (S.P.I.S.A.L.) of the Local Health Authority n.10 “Veneto Orientale” carried out some information activities for the ASVO employees about the possible serious implications for their safety in the workplace due to the alcohol consumption.

This intervention was aimed at:

- changing the bad habits of workers;
- improving business climate;
- increasing awareness on health in the workplace;
• improving the motivation to work;
• achieving a positive impact on family and social life.

We implemented the following steps:

1. Meetings with the company board in order to present the project and its objectives;
2. Meetings with security managers and trade unions for the presentation of the project and its objectives;
3. Meetings with the occupational physician in order to define the collaboration in managing and implementing the project activities;
4. Training sessions for the human resources staff, the person responsible for the prevention and protection service, the representative of the workers for safety issues;
5. Information meetings to sensitize the employees about risks and effects of alcohol and drugs consumption on health, work safety, productivity and absenteeism. In addition, information was provided about opportunities for support and help available in the territory for those who are drug-alcohol addicted;
6. The hour-and-half long meetings took place at ASVO and were addressed to 7 groups of 25-30 workers. Each meeting was organized as follows:
   • Presentation of the project and its main objectives;
   • Collection of entry questionnaires delivered by the company the day before the meeting. The questionnaires were aimed at understanding the depth of the employees’ knowledge about drug and alcohol consumption issues;
   • Training session led by the operators of Ser.D. focused on the effects of alcohol and drugs consumption on life and health of people;
   • Training session led by S.P.I.S.A.L. focused on the legislation on safety in the workplace, especially concerning alcohol and drugs consumption;
   • Plenary discussion on the information provided;
   • Distribution to workers of promotional materials related to the project
   • Delivery of an exit questionnaire in order to verify the knowledge acquired by the participants.
7. Feedback with the occupational physician, the human resources responsible, the responsible of the prevention and protection service, the representative of workers for safety issues, about the outcome of information and sensitization meetings and the level of knowledge and attention measured by the exit questionnaire.

Following the above mentioned intervention, in 2010 the occupational physician carried out several health checkups to assess the possible alcohol dependence of workers (adoption of alcohol clinical index) through medical examinations, blood tests and checkups of hepatic functional parameters.

**Results:**

In this company there was already a high level of awareness about the negative effects of alcohol consumption in the workplaces. Thanks to the commitment of health operators in informing and sensitizing workers about the potential severe risks for their health caused by
alcohol consumption, this intervention strengthened and supported the company’s policy. However, no efforts have been made to measure its impact on the attitudes of the workers.

Poland

Country description


<table>
<thead>
<tr>
<th>Parameter</th>
<th>x 1000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>38192.2</td>
<td>100</td>
</tr>
<tr>
<td>Life expectancy EU 15 80.0 yr</td>
<td>75.19 yr</td>
<td></td>
</tr>
<tr>
<td>Employed population</td>
<td>13771.1</td>
<td>36.1</td>
</tr>
<tr>
<td>Unemployment</td>
<td>1473.8</td>
<td>9.5</td>
</tr>
<tr>
<td>Agriculture</td>
<td>2149.9</td>
<td>15.6</td>
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<tr>
<td>Industry</td>
<td>3923.4</td>
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<td>Services</td>
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<td>56.0</td>
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<td>Public sector</td>
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<td>36.1</td>
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<td>Private sector</td>
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<td>73.7</td>
</tr>
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<td>Company size 1-49 workers % of workforce</td>
<td></td>
<td>46</td>
</tr>
<tr>
<td>Company size 50-249 % of workforce</td>
<td></td>
<td>22</td>
</tr>
<tr>
<td>Company size 250 + % of workforce</td>
<td></td>
<td>32</td>
</tr>
<tr>
<td>Employed in high risk activities</td>
<td>6458.1</td>
<td>47</td>
</tr>
<tr>
<td>Nonfatal occupational accidents</td>
<td>800/100 000</td>
<td>-</td>
</tr>
</tbody>
</table>
Case studies Poland

<table>
<thead>
<tr>
<th></th>
<th>4.5/100 000</th>
<th>-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatal occupational accidents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational diseases</td>
<td>6/100 000</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: Assessment and Recommendations on Strengthening Stewardship of the Ministry of Health for Improvement of Health Promotion at the Workplace in Poland. A Consultation Report by Professor Jorma Rantanen, MD, PhD, Specialist in Occupational Health, WHO Consultant

- GDP per capita, $ 18,705,918 (total)
- 870 € / 1,290 $, monthly (2010)\(^{10}\)
- GDP per capita in Purchasing Power Standards (PPS) (EU-27 = 100) - 62%
- Inflation 2.7% 2010

Workplace health promotion in Poland\(^{11}\)

Table 2. Type of WHP activities in Polish companies (%)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aesthetics and comfort of the social facilities</td>
<td>77</td>
<td>49</td>
<td>45</td>
<td>53</td>
</tr>
<tr>
<td>Vaccinations against the flu and hepatitis</td>
<td>31</td>
<td>47</td>
<td>46</td>
<td>47</td>
</tr>
<tr>
<td>Smoking</td>
<td>78</td>
<td>45</td>
<td>33</td>
<td>-</td>
</tr>
<tr>
<td>Additional medical check-ups</td>
<td>48</td>
<td>43</td>
<td>44</td>
<td>31</td>
</tr>
<tr>
<td>Sport activities</td>
<td>36</td>
<td>42</td>
<td>41</td>
<td>41</td>
</tr>
<tr>
<td>Workstation modification</td>
<td>39</td>
<td>31</td>
<td>34</td>
<td>36</td>
</tr>
<tr>
<td>Health education</td>
<td>41</td>
<td>27</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>Medical and rehab. services.</td>
<td>53</td>
<td>25</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>Coping with stress trainings</td>
<td>14</td>
<td>13</td>
<td>6</td>
<td>23</td>
</tr>
<tr>
<td>Support for alcohol abusers</td>
<td>14</td>
<td>12</td>
<td>7</td>
<td>9</td>
</tr>
</tbody>
</table>


\(^{11}\) Source: Statutory research of NCWHP NIOM Poland
### Case studies Poland

#### Work organization changes to limit stress

<table>
<thead>
<tr>
<th></th>
<th>Very good</th>
<th>Good</th>
<th>Weak</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aesthetics and comfort of the social facilities</td>
<td>78</td>
<td>60</td>
<td>42</td>
<td>0.00001</td>
</tr>
<tr>
<td>Vaccinations</td>
<td>69</td>
<td>55</td>
<td>34</td>
<td>0.00001</td>
</tr>
<tr>
<td>Sport activities</td>
<td>67</td>
<td>45</td>
<td>32</td>
<td>0.00001</td>
</tr>
<tr>
<td>Medical check-ups</td>
<td>53</td>
<td>32</td>
<td>29</td>
<td>0.001</td>
</tr>
<tr>
<td>Work organization changes to limit stress</td>
<td>41</td>
<td>30</td>
<td>21</td>
<td>0.01</td>
</tr>
<tr>
<td>Treatment/rehab. Financing</td>
<td>39</td>
<td>25</td>
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#### Supporting healthy nutrition

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<td>Treatment/rehab. Financing</td>
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#### Other

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Tab 3. WHP and financial situation of a company (%)

### Tab 4. WHP and size of a company (no. of employees)

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<td>54</td>
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<tr>
<td>Medical check-ups</td>
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<td>Treatment/rehab. financing</td>
<td>22</td>
<td>25</td>
<td>45</td>
<td>0.001</td>
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</table>
Coping with stress trainings | 15 | 28 | 43 | 0,00001
Health education | 8 | 13 | 27 | 0,0001

Main obstacles for WHP in Poland

- Lack of stable financial structure to support systematic promulgation of WHP in Poland. Previous activities were financed by various grants: that meant not enough consistency and continuity in undertaken activities (that makes setting long-term goals very difficult).
- WHP issues are not included enough in national health policies (National Health Program, and thematic health programmes supervised by Ministry of Health).
- Not enough consistency and collaboration on WHP between different sectors on all levels: local and national.
- A lot of important WHP actors think that WHP equals accident prevention or medical prevention. As the result some WHP implementations lack modern methodology recommended by WHO and ENWHP.
- The set up of National Council for Workplace Health Promotion (initiated by the Ministry of Health). The council should consist of representatives from all important stakeholders (both public administration and social partners). The council will be responsible for development of long-term WHP strategies in Poland.
- Elaboration and implementation and financing by the Ministry of Health National Workplace Health Promotion Program.

Recommendations for future WHP activities in Poland

Ensuring continuity and high quality of WHP in Poland through supporting (including resources) National Centre and Polish Network for WHP. This support refers to the following specific areas:

- Strengthening competencies of occupational medicine professionals and other important stakeholders in the field of WHP. This includes systematic training programmes, professional educational materials, seminars, consultancies.
- Particular activities like regional WHP strategies, WHP programmes in certain branches or organizations.

Alcohol policy in Poland

In 2008 the rate of mental disorders occurrence due to use of alcohol, treated in outpatient clinics in Poland fell slightly as compared with 2007 and amounted to 467 (476 in 2007) per 100 thousand people. In specific provinces this rate ranged from 369 to 691 per 100 thousand persons. Rate of hospitalization of disorders due to alcohol consumption (including mental disorders) was 6% lower in 2008 than in the preceding year and amounted in Poland to 277 per 100 thousand people. In specific provinces value of this rate ranged between 178 per 100 thousand people in Kujawsko-Pomorskie province and 423 per 100 thousand people in Podlaskie province. From data received from the Chief Labour Inspectorate it stems that (given all the accidents in 2009, those caused by the consumption of alcohol, other intoxicants and psychotropic drugs constituted 1.3% of the general number of employee accidents. In 2007, the ratio was...
equal to 1.2% of the general number of accidents. The greatest number of accidents due to alcohol consumption took place in the Mazowieckie province – 23, Dolnośląskie province – 13 and Śląskie province – 12. 129 accidents in total were reported at the national level\(^\text{12}\).

According to The State Agency for Prevention of Alcohol-Related Problems (PARPA) there are three complementary action programs implemented at various levels of administration which constitute the basis for Polish model for the solving of alcohol-related problems:

1. The first one, which is the broadest and most prominent within the system, is municipal programs for the prevention and solving of alcohol-related problems implemented by 2.500 municipal authorities in Poland. The important body operating in this field is municipal board for the solving of alcohol-related problems, which is an interdisciplinary team composed of specialists in the field of prevention, sociotherapy, welfare, addiction therapy, counteracting domestic violence, public order and justice, operate at each municipal council.

2. The second pillar of Polish model for the solving of alcohol-related problems are provincial programs for the prevention and solving of alcohol-related problems adopted each year by councils at individual provinces.

3. The third basic element of Polish model for the solving of alcohol-related problems is the National Program for the Prevention and Solving of Alcohol-Related Problems. The latest program adopted for implementation in the years 2006-2010, similarly to three previous ones, has been developed by the State Agency for the Prevention of Alcohol-Related Problems (PARPA). The document synthesizes and describes majors alcohol-related problems observed in Poland, presents principles and goals of the program, as well as methods and indicators for attaining set goals. It also stipulates specific tasks for individual ministries and central agencies together with recommendations for municipal and provincial authorities. The implementation of tasks stipulated in the program is consistently monitored. Each year, based on internal analyses and materials submitted by ministries, central administration agencies, municipal and provincial authorities and NGOs, PARPA prepares an in-depth report on the observance of the act on upbringing in sobriety and counteracting alcoholism, an integral element of which is the description of tasks implemented as part of the National Program for the Prevention and Solving of Alcohol-Related Problems. Following the approval by the government, the document is submitted for acceptance to the Parliament\(^\text{13}\).

The State Agency for the Prevention of Alcohol-Related Problems (PARPA) is a specialist government agency subordinated to the Minister of Health. It develops and presents expert opinions on draft laws and action plans in the scope of alcohol policy. PARPA operates under art. 3 of the act on upbringing in sobriety and counteracting alcoholism, one of the most important obligations of PARPA is the preparation of draft National Program for the Prevention and Solving of Alcohol-Related Problems and draft allocation of funds for its implementation.

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The issues related to alcohol consumption and remaining under the influence of alcohol on work premises are regulated by the Polish employment legislation, additionally there may exist regulations within particular companies.

Polish regulations make a distinction between people who are under the influence of alcohol depending on their blood alcohol concentration (BAC) or the result of a breath sample test: a person whose BAC ranges between 0.2 and 0.5 grams of alcohol in every 100 millilitres of blood (or between 0,1 and 0,25 milligrams of alcohol in 1 dm3 in the breath sample) is considered to be mildly intoxicated whereas a person whose BAC is above 0.5 grams of alcohol in every 100 millilitres of blood (or above 0,25 milligrams of alcohol in 1 dm3 in the breath sample) is considered to be intoxicated.

It must be clearly stated that the open catalogue of the employee’s basic duties included in the Labour Code (article 100) does not directly stipulate maintaining strict guidelines regarding sobriety of the employees, nevertheless, abstaining from alcohol at work is considered an obligation as an employee under the influence may endanger the safety of other employees and the third parties. Moreover, it is believed that being under the influence limits a person’s abilities to perform their professional duties and as such violates the mandatory obligation to perform duties in a diligent and conscientious manner.

In case of a well-founded suspicion of an employee arriving at work under the influence or that they have consumed alcohol on the premises, it is imperative that the employer should not allow them to assume their duties.

Arriving at work with a clear intention of performing one’s duties or performing them when under the influence of alcohol, even in cases of mild intoxication, or consuming alcoholic beverages at work is a gross misconduct of basic duties. As a result, having excluded the employee from work, the employer has the right to dismiss them for disciplinary reasons without notice on conduct grounds (article 52 §1 p.1 of the Labour Code). Nevertheless, the Labour Code also allows for a dismissal with a notice, and it is up to the employer’s decision which form of dismissal is selected, if any. The employer may select one of three types of administrative sanctions provided under the provisions of the Labor Code (article 108), namely: an official reprimand or condemnation note (non-financial), or a fine (financial).  

14 Booklet on psychoactive substance abuse for enterprises published under a project titled "Maximizing employee performance by minimizing the impact of substances in the workplace", the adaptation for the Polish environment by: Eliza Goszczyńska, Elżbieta Korzeniowska, Kamila Knol, Piotr Pankonin, Piotr Plichta, Jacek Pyżalski, Krzysztof Puchalski, Patrycja Wojtaszczyk.
Case studies Poland

Template case I

Case Nr: 1
Name of the case: Rafako

City: South of Poland

Type of company:

Ownership?
☐ public ☐ private ☐ voluntary

Sector (ISIC Rev 4. codes)
☐ Agriculture, forestry and fishing
☐ Mining and quarrying
☐ Manufacturing
☐ Electricity, gas, steam and air conditioning supply
☐ Water supply; sewerage, waste management and remediation activities
☐ Construction
☐ Wholesale and retail trade; repair of motor vehicles and motorcycles
☐ Transportation and storage
☐ Accommodation and food service activities
☐ Information and communication
☐ Financial and insurance activities
☐ Real estate activities
☐ Professional, scientific and technical activities
☐ Administrative and support service activities
☐ Public administration and defence; compulsory social security
☐ Education
☐ Human health and social work activities
☐ Arts, entertainment and recreation
☐ Other service activities
☐ Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use
☐ Activities of extraterritorial organizations and bodies

Company size?
☐ Very small enterprise (under 10 staff members)
☐ Small enterprise (10 to 50 staff members)
☐ Medium-size enterprise (50 to 500 staff members)
☐ Large enterprise (501 and more staff members)

How many are employed:

Location?
☐ Company is situated at one location (national or local)
☐ Company with a headquarters and one or more other branches/locations (national)
☐ Multinational company

Alcohol practice provision

☐ Internal service (in cooperation with external institution) ☐ External service
Case studies Poland

Case I

Employing body

Established in 1949 and employing ca. 1900 people, RAFAKO company has been always tied to the power generation industry, offering design and manufacture of boilers and environment protection plants. Since 1993 RAFAKO S.A. is a joint stock company whose shares are quoted on the Warsaw Stock Exchange. RAFAKO is a leader on the Polish power generation equipment market and the biggest boiler producer in Europe. Ca. 80% of boilers operated by Polish utilities have been delivered by RAFAKO. The Company is also a leader within the field of flue gas desulphurization plants based on wet lime and semi-dry methods.

The Company is based in Racibórz, where the headquarters and main production facilities were built, including five production workshops and design offices. During the past few years new production workshops in Radomsko and Wyry were established as well as design offices in Rybnik, Częstochowa and Belgrade. In 2009 a new division was created in Pszczyna offering design and delivery of dust removal equipment.

RAFAKO offers general contracting within the scope of fossil fired power generation units, boiler island in particular, including PC boilers for sub- and supercritical steam parameters, CFB boilers, HRSG and stoker fired boilers as well as flue gas cleaning plants and equipment. The Company also offers boilers for waste incineration and biomass combustion.

RAFAKO is certified with ISO-9001, ISO-14001, ISO-18001, EMAS and PED. The Company is approved according to UDT, ASME, TRD and other foreign regulations. In 2001 RAFAKO was awarded with Polish Quality Award for its successful implementation and constant improvement of Total Quality Management rules.

Approximately half of the staff are “white-collar workers” (mainly technicians and engineers). The rest of the employees are “blue-collar workers” (of whom most are welders). The majority of the staff carry out their duties directly within the process of production. One third of the staff has a university degree (mainly technical). Approximately 10% of the employees are women.

RAFAKO is the biggest employer within its region. It supports local social, cultural and sporting activities.15

General policies on health and well-being

15 http://www.rafako.com.pl/activity
The company promotes a healthy lifestyle among its employees on a large scale; additionally it uses its welfare funds to organize activities, facilitating a healthy lifestyle and widely understood recreation through organizing excursions, family events or giving holiday grants. As part of the former type of activities a prophylactics specialist produces a news program about a healthy lifestyle that is later broadcast on the PA system. The topics covered include stress and professional burnout-busting techniques, myths on alcoholism, alcohol co-dependency as well as other ones resulting from the needs of the employees and a current agenda of the prophylactics specialist. The employees upon request can later obtain an electronic summary of the broadcasts together with supporting educational materials.

The company doctor provides general medical help at RAFAKO, however, with problems requiring a more detailed diagnosis, which may include alcohol-related issues. The employees are referred to external specialist medical facilities. It is worth mentioning that what used to be common practice in many companies was to ask a company physician for a sick leave with a view to concealing one's alcoholism, which is no longer the case due to a consistent implementation of a “healthy” approach to solving alcohol-related problems at work.

When it comes to solving alcohol-related problems RAFAKO cooperates closely with a local Prevention and Alcohol Abuse Outpatient Clinic. Moreover, RAFAKO’s cooperation with Alcohol Abuse Inpatient Clinic also brings fruitful results.

**Workplace alcohol policy and programme**

RAFAKO is located in a part of Poland where social acceptance of alcohol consumption used to be relatively high. Hence twenty years ago there appeared a necessity to implement a systematic approach to dealing with the negative effects of alcohol-consumption among the employees.

RAFAKO has been systematically dealing with the negative effects of alcohol-consumption among its employees since the mid-eighties. Initially, the activities were part of the Employee Assistance Program, yet since 1994 they are a product of RAFAKO’s participation in an international program in cooperation with leading Polish scientists and institutions dealing with problems related to alcohol consumption at work.

It is the feeling of the staff who deal with solving the alcohol-related problems at work that the activities performed during the program were consistent with the ones implemented previously, which constituted an additional motivating factor. What the respondents stress is that the participation in the initial training session provided a strong positive impulse to continue and develop the initial policy. The fact that since the very beginning the activities have been coordinated by the same person i.e.: the head of the HR is of crucial importance.

The company’s mission is by no means a direct support of the employees’ health but rather the manufacture of a high quality product. Nevertheless, to achieve that one has to face the weaknesses and strengths of the human nature. Therefore, it is not the possible alcohol-dependence that becomes the starting point for the activities that are targeted at the employees but the declining work quality observed by the supervisors. As a result, systematic control of the employees at their workstations has become a crucial element of the current policy.
The simplest metaphor of the alcohol prophylactics implemented at RAKAFO is the traffic lights, which illustrate three-color zones, namely green, amber, and red. This distinction facilitates an individual approach in the area of remedial and prophylactic activities.

- **the green zone** comprises most employees without alcohol or substance abuse problems who are, nevertheless, exposed to constant health promotion programs.
- **the amber zone** includes a risk group of employees who abuse alcohol or other substances, which directly influence their mental and physical condition at work.
- **the red zone** comprises employees who are dependent on alcohol or psychoactive substances and who can be reinstated as fully operational employees after effective treatment.

A fragment of the policy paper below illustrates the approach of the staff responsible for the implementation of the health promotion programs which include alcohol prophylactics: ‘the company is one of the main places where a healthier lifestyle as well as other positive patterns of behaviour can be promoted, and that can be put into life only if versatile methods of prophylactics are introduced in full cooperation with both the employees and employers. A company may create a welfare system that will reverse the negative effects of broken homes observed in so many countries. Some companies may follow this scheme through viewing their employees as ‘human resources’ and promoting the health, safety, and well-being of the team members.

A psychologist who is employed as a consultant under a contract of mandate offers help and advice to both the management and other employees on the issues of a broadly understood mental well-being of the employees. One of the major tasks of the consultant is the issue connected with the anti-alcohol policy. His expertise is positively perceived and what needs to be stressed is that he has become a permanent feature of the company horizon. His work does not only include assisting the management in taking the right measures but it mostly serves individual employees who come looking for help in solving the problems which may affect their professional career. A positive change in the perception of the role of the consultant has been observed as more employees come to him for help.

Employees whose professional performance is disturbed by alcohol-related problems face individualized disciplinary actions for example dismissal on conduct grounds. What must be stressed, however, is that if employees who were previously dismissed on alcohol-related grounds wish to come back to the company, their application may be considered if they have undergone a certified therapy. The management and the prophylactics consultant make the decision. Upon their return they are offered a temporary contract with a remuneration package matching the one from the past. This approach seems very humane and beneficial for both the employees and the company as in most cases such employees do not fail the trust the company put in them and the chance to come back to the labour market.

The team initializing and coordinating the activities related to the healthy lifestyle policy in the workplace comprises the head of the HR department, the unit managers, the prophylactics consultant, and the company physician. These are the supervisors who assess the work quality that may be used as a direct indicator of alcohol-related problems. In cases of well-founded suspicions of problems it is their responsibility to recognize the problem and react appropriately. A lot of effort is put into the proper training of the supervisory personnel and making them aware that concealing alcohol-related problems is a misguided form of help. The
supervisors who hide cases of alcohol-related disciplinary problems among their employees may face serious disciplinary actions themselves.

The number of violations of the rules of procedure related to alcohol abuse ranges from a few to several cases a year.

Impact of the alcohol programmes

RAFAKO has created the most recognized example of the consequences of the implementation of the anti-alcohol policy entwined in a broader context of creating a healthy workplace. When asked why RAFAKO got so deeply involved in this form of activity, one of the coordinators replied that ‘it is the people who create the company. The employee is also its cost. The expenses connected with the work force grow steadily, therefore, all possible actions aiming at reducing them for example limiting certified sicknesses that significantly lower the production growth, are necessary, beneficial, and bring good results for both the employer and the employees. We explain to our staff that their health depends solely on them, that their unhygienic lifestyle not only weakens their physical but also mental health. The problem of psychoactive substance abuse is also present but at RAFAKO it has become marginal. It must be remembered that most employers notice this problem only in its final stages when the addicts no longer exercise any control of their actions. However, since becoming addicted is a long process, it is its early stages that are the best moments to provide assistance. Dismissing employees with such problems is by no means a solution since they do need to be provided with help.

In the past the company assessed the levels of employee satisfaction as well as evaluated the activities promoting a healthy lifestyle, however, the latter were not part of a systematic research. The respondents believe that presently there exists a need for a better measuring tool to be used. The levels of satisfaction have been increased and the artificiality of activities promoting a healthy lifestyle carried out by the company are measured with ‘soft’ indicators, such as low staff turnover or the number of children of the employees joining the company.

Lessons learnt

The activities performed so far allow for the following conclusions:

1. Occupational physicians may constitute a hurdle in the implementation of anti-alcohol programs. Therefore, in the process of their training more attention should be paid to increasing their awareness of health, especially mental health promotion in the workplace including the issue of fair labour practices towards employees abusing alcohol.
2. Cooperation with the trade unions and making them aware that their ill-understood protection of the employees’ interests may have a detrimental effect in helping the employees who genuinely require help.
3. One of the major elements of professional socialization is a mature approach of the management and supportive policy of the board of directors.
4. personal changes in the board of directors constitute an uncertainty factor as to the continuation of the company’s current policy.

5. The anti-alcohol policy at RAFAKO is characterized by an action approach. The evaluation and advertising of its activities are limited.

6. The respondents believe that healthier employees generate a smaller cost for the employer.

7. The program coordinator pinpoints the most important conclusions of their twenty-year-long program:
   - maintaining good mental condition of the employees is a worthy cause
   - educating the employees as an important element of managing change
   - the effectiveness of anti-alcohol programs increases when they are applied early with regards to the people who may abuse alcohol
   - a professional system of employee evaluation serves as an early ‘detector’ of possible problems not necessarily pertaining to alcohol abuse
   - it is beneficial to invest in good training sessions. For a long time the company acted on an impulse that was provided by the participation in training sessions and the cooperation with prominent scientific research centres, therefore, the cost of training the employees should be treated as an investment, not cost.

8. The company neither promotes nor hypes its achievements in the domain of anti-alcohol campaigns as such activities might generate too much attention leading to the suspicion that there exists a serious alcohol abuse problem within the company.

9. Cooperation with vocational schools and assuming patronage over them enables the future employer to shape an appropriate standing towards professional responsibilities and work discipline. Therefore, special attention needs to be paid when it comes to the professionalism of the staff training new employees as in certain cases the staff working with pupils may constitute an obstacle when it comes to the implementation of a healthy lifestyle policy.

10. The respondents from the company believe that it is the public policy of the country together with the social security system that give the biggest possibilities to develop the anti-alcohol campaigns.

11. The lack of alcohol-related issues during OHS training sessions for new employees is sheer negligence. Therefore, RAFAKO introduces its own idea for a introductory session for the new employees, which incorporates the elements of alcohol-related issues.

12. The previous successes seem to be an effect of the involvement and high motivation of a small group of people. To some extent this success is also due to a systematic approach and an ability to delegate responsibility. Therefore, one of the potential failures in the promotion of a healthy lifestyle in the future may result from a lack of followers.
Case Nr: 2
Name of the case: the company wishes to remain confidential

City: 

**Type of company:**

Ownership?
X public

**Sector (ISIC Rev 4. codes)**

- Agriculture, forestry and fishing
- Mining and quarrying
- Manufacturing
- Electricity, gas, steam and air conditioning supply
- Water supply; sewerage, waste management and remediation activities
- Construction
- Wholesale and retail trade; repair of motor vehicles and motorcycles
- Transportation and storage
- Accommodation and food service activities
- Information and communication
- Financial and insurance activities
- Real estate activities
- Professional, scientific and technical activities
- Administrative and support service activities
- Public administration and defence; compulsory social security
- Education
- Human health and social work activities
- Arts, entertainment and recreation
- Other service activities
- Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use
- Activities of extraterritorial organizations and bodies

**Company size?**

- Very small enterprise (under 10 staff members)
- Small enterprise (10 to 50 staff members)
- Medium-size enterprise (50 to 500 staff members)
X Large enterprise (501 and more staff members)

How many are employed: 30,000

**Location?**

- Company is situated at one location (national or local)
X Company with a headquarters and one or more other branches/locations (national)
- Multinational company

**Alcohol practice provision**

X Internal service (majority but also with contribution of external institutions)
- External service
Case II

Employing body

The Service is a uniformed and armed apolitical department subordinate to one of the Polish ministries.

Organizational units of the Service, hereinafter called “organizational units” are:

1. Central board of the Service
2. District units
3. Local units
4. Training and education centers for the staff.

The statistics from March 2011 show that the Service employs about 27 500 officers and about 2 800 civil servants. 7 311 of the employees are at least 31 years old and women constitute about 19,9% of the entire group. Their levels of education are as follows:

- 34,4% - higher education,
- 11% - higher vocational education,
- 3,6% - post-secondary school education,
- 50,4% – secondary school education,
- 0,1% – vocational or primary school education.

One of the articles from the Service act (likewise in general Labour Code) stipulates that appearance at work under the influence of alcohol or other illegal substances is considered a violation of work discipline.

General policies on health and well-being

The policy of assisting and protecting the employees’ health is coherent and holistic. Since 2004 the unit responsible for the activities is the interdisciplinary unit concerning staff’s health and safety issues.

The use of the word *interdisciplinary* in this context means the presence of physicians (including psychiatrists), psychologists, nurses and occupational safety and health specialists in this unit (which coordinates work of the several regional units). Regional units, to some extent, have autonomy in analyzing local needs and creating activities promoting healthy lifestyle as well as addressing issues concerning the problem of alcohol abuse. The regional occupational medicine services employ at each region: a doctor (head of the unit), 2 psychologists and a nurse. The main task of such team is to conduct the activities covering prophylactic health protection for officers and subsequent employees.

The approach to the support and well-being of the employees is based on the assumption that the mental and physical health of the staff is the guarantee of the safety in the unit. This
humanistic attitude seems innovative in regard to the uniformed services (regarding “total” image of the Service).

However, considering the fact that in social and aid work these are the care-givers themselves who become the tool for achieving the goals, the care for their mental and physical well-being is understood.

The tasks concerning health, prophylaxis, and safety mostly fall under the responsibility of assigned medical units within the Service structure. Nevertheless, the Service also cooperates with specialized public units in the matters of psychological and therapeutic health. Unfortunately in the current situation the number of employees in occupational medicine units doesn’t give opportunities to conduct health promotion and prevention activities. Harm reduction tasks are fulfilled by the public sector – mostly advisory mental health institutions and hospitals (in acute cases).

Supporting the health and well-being of the employees as well as shaping positive social relationships among the employees but also among the employees and the service are facilitated by, among others, creating an offer by trade unions and HR units e.g:

- excursions,
- competitions,
- family events
- sport and recreation activities,
- sports camps etc.

Handling chronic and traumatic stresses as well as professional burnout are the primary goals of the work health promotion activities implementing by the WHP psychologists. The activities most frequently have an educational character and are organized in the form of field workshops in the Service’s training and education centers for the staff. In some inspectorates stress and burnout prophylaxis takes shape of comprehensive action including a preliminary diagnosis and measuring the effectiveness of the anti-stress program (with the use of the AVEM questionnaire).

It is imperative to say that the occupational health services constantly find new areas that require their care and attention. Two of the many examples are: training sessions for professional semi drivers who are often exposed to long-term stress resulting from their professional responsibilities and stress management coaching session for the intervention services. The staff members’ problems working directly with other people are also a subject of significant attention. There also exists a plan to ‘vivify’ the health promotion laboratory that works in the educational and training center which organizes in-service trainings for the employees of the Service. The cooperation among various units concerning identification of harmful factors (predominantly psychosocial) in work environment has been initiated. The next step will be preparation and implementation of programs eliminating or reducing those factors and their negative influence. Recently, a new anti-mobbing procedure has been drawn up. Another element connected with the implementation of good atmosphere at work is the formation of women’s council.

Another assumption under consideration is the conversion of the occupational medicine services into civil services. The occupational health and the occupational safety and health service unit aims at a better organization and formalization of their preventative and
interventional activities. The changes are evolutionary considering the specific nature of the Service. Till now the procedures concerning rules and intervention strategies in cases of severe stress have been accepted by the general director and implemented.

This evolution also pertains to the alteration of the initial diagnosis paradigm which measures employee suitability, what is meant by that is the introduction of the element of “predispositions” for the service as a positive pole of the diagnosis instead of ‘no contraindications’. In the initial two years of employment referred to as the ‘adaptation stage’/phase a new employee (an officer) is assessed twice and the procedure also involves the assessment of both his mental health and generally understood well-being.

The occupational health service does not only deal with training and different forms of aid but what constitutes an important element of their health promotion activities is that they themselves partake in trainings and other forms of coaching. Occupational medicine psychologists took part in an organized training conducted by the well known psychological school in Poland. The series of workshops concerned the methodology of work of occupational medicine psychologists. The coaches integrated elements of behavioral-cognitive and psychodynamic therapy with humanistic approach.

The Service cooperates with important national institutions such as The State Agency for the Prevention of Alcohol-Related Problems (PARPA) or Nofer Institute for Occupational Medicine in Lodz (NIOM) when it comes to health promotion programs.

**Workplace alcohol policy and programme**

Under the Polish law it is forbidden to fulfill professional duties at work under the influence of alcohol. In the Service such conduct is viewed as a gross violation of work discipline and may result in the termination of the contract. It is also forbidden to drink alcoholic beverages during business trips, coaching sessions, or meetings of extramural students at schools etc. (if organized by the Service).

The Polish Law stipulates that the Service officers may be summoned to the unit at any given time, therefore, they must be free from the effects of alcohol at that time. Internal occupational health service has noticed significant quantitative and qualitative changes demonstrating a decreasing consumption of alcohol by their employees. Both unit managers and the employees are less and less tolerant of signs of problematic alcohol consumption by the staff.

It is important to highlight a growing interest of the occupational medicine service of the Service in alcohol-related problems, which results from an internal needs analysis report pertaining to health promotion. Another reason behind the increased offer and a more systematic approach to the problems of the mental health and well-being of the officers are a
few individual incidents related to the mental health of the employees. There may have been few of them, yet they had grievous consequences\(^\text{16}\).

There have been some cases of road accidents and incidents caused by the officers under influence of alcohol (while off-duty). When the investigation proves the alcohol influence the officer is dismissed from work. Due to this the activities aimed at lifestyle and alcohol consumption have been implemented. They mostly cover the issue of awareness concerning negative influence of psychoactive substances.

The activities aiming at solving the problem of alcohol consumption in the workplace performed before 2004, which was when the occupational health service were reorganized, were less coordinated and were of temporary and interventional nature in comparison with the contemporary objectives. That was due to the fact that the Service lacked a specialized unit dealing with the general health and safety of the staff members. In those times the legislation banned from work the officers with diagnosed alcohol disease even in situations when they were in the state of abstinence.

The organizational policy concerning the problem of alcohol consumption in the workplace is strictly related to the specificity of work. On the one hand, due to the fact that this is work service, the policy against the employees who arrive at work under the influence of alcohol or drink on the premises is highly restrictive and is treated as a gross violation of work discipline and may result in disciplinary dismissal from the Service. This organizational policy is also connected with the work responsibility of the Service staff since the possible consequences directly influences their own safety and the safety of other people as well. On the other hand, however, attempts have been made to facilitate appropriate conditions in which no employee experiencing alcohol-related problems or suffering from alcohol dependence would fear the consequences of revealing the problem and can find psychological help. The help is offered anonymously and is voluntary-based. All forms of assistance are organized in a way that participation should be positively perceived by the employees, (not as actions directed against them) even if this help is connected with unhealthy behaviours such as alcohol abuse.

The core activities in the promotion of the staff’s health are conducted within a psychological care system for the officers and other staff members. These tasks are partially achieved in the form of prophylactic activities such as educational actions, prophylactic materials, and support and also during assessment meetings that assess the employees’ suitability for a given position, and this is where elements of minimal anti-alcohol intervention are introduced. They are usually one or four-day stress-prevention training sessions or stress-prevention workshops.

Other forms include sports camps for long time employees and visits whose aims are observations of their work performance. Another systemic solution was introduced to handle problems resulting from work-induced high stress. It is worth mentioning that holistic

\(^{16}\) The situation of work dismissals is only a dozen or so cases per year mostly based on off-duty situations. In 2009 the medical boards diagnose alcohol or other substances abuse in 10 officers.
solutions are found in regards to the problems of health and well-being of the staff members, what is more, all stress-prevention activities are fully integrated with the alcohol prophylactic training sessions, which are mostly educational activities. The last problem was in fact integrated with the problem of illegal substance abuse (within the National Program of Drug Abuse Prevention). Moreover the program for reducing health consequences of tobacco consumption has been implemented. The organization also takes part in the national program of mental health promotion.

**Impact of the alcohol programmes**

The decisions relating to the actions are partially decentralized and are made by the occupational health service unit and occupational safety and health unit in the particular region and are coordinated by the occupational health service and occupational safety and health unit in the central board of the Service. This type of system was established in 2010 when the Service created systemic solutions whose aim was to improve the work conditions and safety in the workplace. These tasks are fulfilled by the occupational health services (physicians, psychologists, nurses) that provide prophylactic care by conducting preventative medical examinations and promotion of a healthy lifestyle. The Service makes use of a monitoring system of early psychological intervention for the staff members who experienced traumatic incidents. The monitoring of early psychological intervention in cases of severe stressful work incidents has been implemented. It is obligatory for all officers to take part in support activities in cases of firearm usage, the deadly cases of other employees (connected to work tasks) or other persons influenced by the officers’ activities.

Additionally, the members of occupational health service (psychologists) participates in the process of evaluating the employees’ predispositions for particular positions at work.

Such a task is fulfilled among all by worksite visits. It could be assumed that the problem of occupational medicine interventions following the cases of serious stress has been thoroughly resolved.

As mentioned before the key actors of the anti-alcohol activities in the anti-alcohol policies in the organisation and health promotion activities are the representatives of the occupational health service and the occupational safety and health service. The anti-alcohol educational activities have been incorporated in the anti-stress and professional burnout profilactics. They are generally comprised of uniformed educational modules referring to the detrimental effects of alcohol consumption as well as the mechanisms behind risky drinking, and competence training sessions in these areas.

The anti-alcohol prophylactics are on the one hand centrally coordinated, yet on the other, modified and tailored to reflect the local needs. It is the occupational health service and the occupational safety and health service that customize them in cooperation with the management and employees.

This results in the diversity of programs, for example one region may require the utilisation of liver function tests, the results of which may demonstrate alcohol dependence or a possibility of such dependence. Additionally, local structures are created to provide support for the people with the aforementioned problems, yet, these are not always easy to build and often
fall on stony ground. No structured evaluation research is done to assess either the application of the results or the anti-alcohol programs but of course, in a broader meaning, evaluation and monitoring related to health and safety issues are provided. Once a year the occupational medicine unit reports its activities covering:

1. Monitoring of illnesses
2. Monitoring of work absence
3. Monitoring of occupational service
4. Monitoring of work accidents and their consequences
5. Monitoring of special (unusual) cases

**Lessons learnt**

1. The activities performed so far allow for the following conclusion:
2. Alcohol consumption in the workplace is not an isolated problem but it should be perceived in broader categories, namely those of the employees health.
3. Anti-alcohol activities (which are initialized by the occupational medicine unit) are incorporated into the broader area of the psycho-social stress at workplace. Developing skills in coping with stress among the staff seems to be adequate trend in creating workplace alcohol policy by the Service.
4. There is a need to diagnose knowledge and awareness concerning alcohol influence using a reliable and unified instrument.
5. On the one hand, it is known that dismissals for disciplinary reasons on conduct grounds are rare, on the other hand the internal research shows a relatively low level of awareness of the detrimental effects of alcohol.
6. The successes that are achieved are often a result of the personal energy and involvement of passionate individuals, and are not a result of a systemic approach to handling challenging work problems.
7. The specific organisational rules of the Service pose as a one of possible impediments. It mostly refers to the vertical system of change implementation, as a result of which the changes do not always reflect the needs of the employees and the management.
8. Supervisors’ low level of consciousness about their role in the process of positive change as a risk factor.
9. A consequent, gradual, non-revolutionary implementation of changes in highly formalized structures seems to be bringing positive results.
10. The role of the leader in the health promotion area in the uniformed services ought to be analyzed (e.g. in terms of rules of cooperation with formal leaders) and strengthened.
11. Existing problems in the strategy concerning the decision making process in the area of supporting the well-being of the employees might partially result from how it may be socially perceived. It must be stated here that the uniformed services are viewed as privileged due to certain solutions concerning their employment for example the right to an early retirement.
12. It is the employees themselves who make a conscious decision to use the help of psychologists without being referred to them. Psychological help is no longer perceived unmanly or as a sign of weakness.
13. An element which can positively influence dealing with alcohol-related problems are positive social relations among the group members within the Service.
14. A positive role of the trade unions in the shaping and implementation of the health promotion activities.
15. Conversely, what may have a detrimental effect on the working environment are more or less serious conflicts among the services (based on different roles and tasks of the particular divisions of the Service)
16. The creation of the prestige of the service seems to be a conducive element serving as a factor improving the well-being of the employees.
The “Health Promotion and Psychoactive Substances Use Prevention: Guidelines for Workplace Interventions” document was designed in 2010 by the Portuguese Institute on Drugs and Drug Addiction in collaboration with the National Work Conditions’ Authority to define a comprehensive strategy in the workplace area. This effort involved the contribution of several public and private organizations and companies, representatives of employees unions, as well as representatives of employers’ confederations (the national social partners). We are now starting the dissemination stage, which involves increasing awareness on this topic among the several workplace actors, as well as training of occupational health professionals.

With this document, we intend to address the specific needs of workplace setting, as far as substance abuse is concerned.

One of the most important propositions of these guidelines is that employees who have psychoactive related problems should be seen as people who need support for a disease, either with regard to referral, throughout the course of rehabilitation or in relapse prevention phase.

Nevertheless, the organizational approach must consider a global strategy and should highlight preventive intervention, by developing actions considering preventing alcohol-related harm among adults and reducing the negative impact on the workplace.

In our National Plan to Reduce Alcohol Related Problems, we have a clear link to this topic, throughout the “adults and workplace” priority area. Harmful and hazardous alcohol consumption is one of the main causes of premature death among adults and also generates a negative impact on worker productivity (e.g. through absenteeism or alcohol use during working hours).

Therefore, the general goal of this area is to prevent the harmful consequences of alcohol use in this setting, and to minimize the negative effects in the workplace.
Case studies Portugal

Template case I

Case Nr:  1
Name of the case :BP

City:

Type of company:

Ownership?
  □ public  ☒ private  □ voluntary

Sector (ISIC Rev 4. codes)
  □ Agriculture, forestry and fishing
  □ Mining and quarrying
  □ Manufacturing
  □ Electricity, gas, steam and air conditioning supply
  □ Water supply; sewerage, waste management and remediation activities
  □ Construction
  □ Wholesale and retail trade; repair of motor vehicles and motorcycles
  □ Transportation and storage
  □ Accommodation and food service activities
  □ Information and communication
  □ Financial and insurance activities
  □ Real estate activities
  □ Professional, scientific and technical activities
  □ Administrative and support service activities
  □ Public administration and defence; compulsory social security
  □ Education
  □ Human health and social work activities
  □ Arts, entertainment and recreation
  ☒ Other service activities
  □ Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use
  □ Activities of extraterritorial organizations and bodies

Company size?
  □ Very small enterprise (under 10 staff members)
  □ Small enterprise (10 to 50 staff members)
  □ Medium-size enterprise (50 to 500 staff members)
  ☒ Large enterprise (501 and more staff members)

How many are employed:

Location?
  □ Company is situated at one location (national or local)
  □ Company with a headquarters and one or more other branches/locations (national)
  ☒ Multinational company

Alcohol practice provision
  ☒ Internal service  □ External service
Case I

Employing body

BP is a private company that works in oil and gas retail in Portugal.

BP is one of the world's largest energy companies with well-established operations in the UK and the rest of Europe, North and South America, Asia, Australia, Africa and Russia. BP has transformed from a local oil company into a global energy group. Our organization is structured into two business segments, a number of functions and four regions. Some 79,700 people working together in 85 countries across six continents. Our exploration activities cover 29 countries; our 22,100 service stations serve around 13 million customers each day.

Our ISIC code is the “4661 - Wholesale of solid, liquid and gaseous fuels and related products”; please note that BP Portugal does not have a direct codification in ISIC but in NACE which is the European Codification.

Regarding the Legal Status in English, BP Portugal is a Private Limited Liability Company with Private Shares.

In Portugal BP has the following structure

BP Portugal: 233 employees

Areas: Administrative: 34; Commercial: 78; Professional: 67 (Finance, Legal, HSSE, IT, HR,...); Operations: 54.

General policies of wellbeing:

We can consider the global policies and the local ones

- Global policies: Healthy Performance is achieved through:

  - Healthy People – our employees and our neighbours in local communities
  - Healthy Plant – working safe and working smart in healthy, energising environments
  - Healthy Process – using healthy working processes and helping people to make healthy working decisions

- Local Policies:

Following these main policies, adapting them to Portugal.

BP Portugal meet all legal requirements on Occupational Health aspects, and regarding the well being programmes we have in place a stress program where we run some activities, namely a Physiological support conducted by external staff, shiatsu massage or physiotherapy, Flu immunization, Cardiovascular assessments, health training, Health Insurance and other activities.
**Type of occupational health service provision.**

We have 1 Health Manager, who acts as Occupational Health Manager Portugal, coordinating all health issues and represents the company in this field, and 3 contractors, a Occupational Health Physician and 2 Nurses, all of them in a part-time basis. The activities carried out in the following fields: surveillance of environment and health of workers, education and training, promotion and prevention activities, care and referral to health services).

This team is part of the HSSE Iberian Team and responded in a direct line to HSSE Iberia Manager and through a dotted line to Health Director Europe.

**Workplace alcohol policy and programme**

**Background**

BP Portugal’s main activity is storage, transport, distribution and marketing of liquid fuels and liquefied petroleum gas, trying to engender a wide variety of energy needs in various sectors of economic activity. We are currently 233 employees (...). Our actions are defined by creating corporate goals compatible with sustainable development of society, while preserving environmental and cultural resources for future generations, respecting diversity and promoting inclusion with the aim of reducing social disparities. Our performance goes beyond financial results. We continuously work on quality and differentiation of our products. We are a responsible company whose final purpose is low-carbon energy savings.

**Policy on alcohol and drug related problems**

**Objectives**

This policy aims to prevent and control the alcohol and drug use and abuse in order to reduce workplace risks to health and safety of all workers, respecting individual rights. This policy does not replace or repeal other stricter rules already in practice in more sensitive areas of the Company. (...)

**Scope**

This policy applies to all employees of the Company, provided there are no specific rules on the same subject (...). All contracts with third parties should reflect the need for compliance with the policy of alcohol and drugs, when moving the Company's facilities and / or are representing the company or in acts associated with his image, even outside of any of its facilities. However, some conditions must be safeguarded, such as respecting workers' rights, strict observance of rules of custody, due care at the time of analysis, confidentiality of the
results and assuring physical conditions and respect for ethical and legal principles that will allow the necessary detection procedures to monitor the consumption of alcohol or drugs.

Limits

BP does not allow in any case, consumption, sale, possession and / or distribution of alcoholic beverages or utensils intended for alcohol or drug use in any of the facilities. It is not allowed to enter or remain in any of the Company's facilities (...) an employee who is obviously under the influence of alcohol or drugs. The use of prescribed medicines is not included in the concept of drug abuse and it should always be clarified with the occupational doctor if interferes with psychomotor abilities. (…)

Detection and Monitoring Procedures

If there is a suspicion that the employee is during working time under the influence of alcohol or drugs, his presence at the workplace will depend on the screening test result. The employee's noncompliance may result in his removal from the workplace or interruption of work while out of the Company, until the presentation of a certificate of aptitude for work under the current policy in BP issued by the Occupational Health Physician. If the employee accepts the tests and a blood alcohol rate greater than 0.2% is found, he or she will have to leave service immediately and may only resume it after achieving a negative test result. In order to contribute to a gradual awareness of the effects of alcohol BP Portugal holds daily random alcohol testing. All employees who conduct screening tests for alcohol may require the immediate rebuttal ATT - since the result is higher than 0.2 g / l - to be held no later than two hours after the mentioned test. Testing drug use may be performed by rapid detection (screening) or duly certified laboratories. In case of a positive value, a counter-evidence LAFTM is always performed. A counter-evidence of screening tests for drugs of abuse is performed automatically by the appropriate laboratory, each time the screening result is positive.

ACCIDENTS

Whenever there is a serious accident involving BP employees detection procedures must be performed.

REHABILITATION

Employees with alcohol or drug related problems will be encouraged to go into a rehabilitation program. BP, through its services, gives advice about the most adequate rehabilitation programs, on a case by case basis, considering motivating their participation. After the rehabilitation program there will be an adaptation phase, with monitoring of health services. This phase will give clues about the success rate of treatment, work capacity and the necessity for training or change of working station. Testing and rehabilitation results will be strictly
confidential for the whole company, excepting Medical Services, who are obliged to give strict compliance with the duty of confidentiality.

**TRAINING**

BP promotes increasing awareness and information to all employees and contractors, direct and indirect, to allow the proper implementation of this policy on this topic.

**IMPLEMENTATION**

After a transitional period of adaptation, standards of this policy came into force on the 1st October 2001. The individuals or legal persons who cooperate with BP or provide services to the company were informed of the content of this policy, and under their responsibility, to observe the conduct of its activities and the adequate corresponding measures to comply with this policy.

**Lessons learnt**

The whole process of discussion around this letter of intentions allowed approaching a subject with some complexity between the various stakeholders of the company, it being possible to reach an agreement for its implementation. Restate the importance of broad discussion of the topic and the decision of the non-consumption of alcohol and drugs while working. The possibility of creating an Internal Regulation properly certified by the state authorities in the work, has been the greatest difficulty, but its implementation remains foreseen.
Case studies Romania

Romania

Country description

Romania is situated in the south-eastern part of central Europe on either side of the Carpathians Arch, on the lower course of the Danube, and covers an area of 237 500 km.

**The population** comprises 22 430 457 inhabitants (as of 2001). The distribution of the nationalities is: Romanians 89.5%, Hungarians 6.6%, Germans 0.3%, Ukrainians 0.3%, Serbs, Croats, Russians 0.2%, Turks 0.2%, and Roma 2.5%.

**The official language** is Romanian. Other languages spoken in Romania are Hungarian and German.

**Form of government**: Republic. The powers are divided between a President (head of state, head of the army, with powers to name the prime-minister and to represent the republic), a Parliament with two chambers (Senate and Chamber of Deputies) whose members are directly elected for four-year terms (the Legislative, with power to issue laws and establish the Government) and the Government (the Executive) led by the prime minister (head of government).

**Administratively**, according to the Constitution of Romania, its territory is organized into communes, town and counties. At the county level there are 41 counties (Judete) and the municipality of Bucharest. At the commune/town level there are 103 cities and 211 others small towns (for urban areas) and 2827 communes (for rural areas). Each county is governed by an elected county council and an individually elected county council president. Local councils and elected mayors are the public administration authorities in villages and towns. The county council is the public administration authority that coordinates the activities of all villages and town councils in a county. Central government is represented at local level by the prefect. The prefect is the representative of the central government at the local level and directs any public services of the ministries and other central agencies at the county level. The prefect is named by the government. A prefect may block the action of a local authority if he deems it unlawful or unconstitutional. The matter is then decided by an administrative court.

**Economy.** Romania is a country of considerable potential: rich agriculture lands, diverse energy sources (oil, natural gas, coal, hydro, nuclear and wind), a substantial industrial base encompassing almost the full range of manufacturing activities, an educated work force, and opportunities for expanded development in tourism on the Black Sea, the Danube Delta and in the Carpathian Mountains.

Romania, which joined the European Union on 1 January 2007, along with Bulgaria, began the transition from Communism in 1989 with a largely obsolete industrial base and a pattern of output unsuited to the country's needs. The country emerged in 2000 from a punishing three-year recession thanks to strong demand in EU export markets. Domestic consumption and
investment have fuelled strong GDP growth in recent years, but have led to large current account imbalances. Romania’s macroeconomic gains have only recently started to spur creation of a middle class and address Romania’s widespread poverty. Corruption and red tape continue to handicap its business environment. Inflation rose in 2007-2008, driven in part by strong consumer demand and high wage growth, rising energy costs, a nation-wide drought affecting food prices, and a relaxation of fiscal discipline. Romania's GDP contracted markedly in the last quarter of 2008 as the country began to feel the effects of a global downturn in financial markets and trade, and GDP fell more than 7% in 2009, prompting Bucharest to seek an emergency assistance package from the IMF, the EU, and other international lenders. Drastic austerity measures, as part of Romania's IMF-led agreement led to a further 1.9% GDP contraction in 2010. The economy returned to positive growth in 2011.

The main industries are automobile industry, petrochemicals, cement and construction, aircraft, textiles, food and beverages, mining, tourism, metallurgical industry and arm industry.

Driven by the recession, unemployment officially peaked at 7.8% in December 2009 but then dropped to 6.9% by the end of 2010 despite substantial layoffs in the public sector, and declined further to 6.74% in January 2011. The explanation for the decrease of unemployment during a crisis is because, according to Romanian legislation, unemployed persons are accounted for 1 year since the loss of job and then, even if they did not get another job, taken off the list.


The alcohol industry is very active in all countries of Europe, including in Romania. Romania is an example of a country where new open market systems permit global alcohol companies to utilize modern marketing campaigns to introduce new alcohol products. The economical power of these companies influences in a directly or indirectly way, the health policy. In this case the public health sector and governments are challenged to respond with national and local public health strategies to minimize the consequences of alcohol consumption.

The data regarding monitoring alcohol consumption in Romania are extremely poor and scarce. The last survey about health determinants by the Romanian Ministry of Health is from 2007. The only studies done in Romania in the past 10 years in the area of alcohol were international studies as ESPAD “The European School Survey Project on Alcohol and Other Drugs” or HBSC “Health Behaviour in School-aged Children”. In the “European Status Report on Alcohol and Health 2010” a country profile for Romania is presented. According to this report, in Romania, in the period 2003 – 2005, the registered alcohol consumption is 11.3 litres of pure alcohol per capita. However it is estimated that the non-registered alcohol consumption is 4 litres of pure alcohol per capita, which amounts to a total consumption of 15.3 litres of pure alcohol per capita. The average pure alcohol consumption per capita in Europe is approx. 9.51 litres for people over 15 years old. Compared with other countries from Europe, only in 7 countries (Russia, Ukraine, Andorra, Czech Republic, Moldova, Estonia and Hungary) is the average level of alcohol consumption higher. In conclusion, we can say that the figures regarding alcohol consumption in Romania are among the highest in the world.

The WHO has collected data about the risk of harmful alcohol use in the world. Compared to the Netherlands and the USA the alcohol related mortality in Romania, especially for liver
circumstances, rates higher. Despite the fact that Romania shows high figures of alcohol consumption and alcohol related harm, most Romanians realize that drinking alcohol has serious health risks. In comparison with Europe, Romanians seem more aware of health risks. For example 68% of Romanians realize that drinking alcohol can increase the risk of heart disease (compared with 53% of Europeans); 62% of Romanians realize the relation between drinking and depression (49% of Europeans do). From all the 27 Countries in Europe, the Romanians are more aware of the risk of cancer related to alcohol, respectively 57%. On average in Europe only 36% of the population is aware of this risk. (European Status Report on Alcohol and health 2010, pg 285-286) - Alcohol in Romania.pdf.

Among the policies and strategies existing at European level we include "The European Charter on Alcohol" issued by the World Health Organization, adopted in 1995 by all the EU member states which states, the ethical principle according to whom all children, adolescents and young people have the right to grow up in an environment protected from the negative consequences of alcohol. In the same spirit, the World Health Organization Resolution, urges Member States to promote harm reduction strategies for the physical, psychological, mental and social aspects resulting from the harmful use of alcohol, this being put into reality by the project of draft global strategy on reducing the harmful alcohol consumption.

Nationally, the National Anti-Drug Agency (Agentia Nationala Antidrog), coordinated national antidrug policies in 2003 (including alcohol) and provided, according to the Romanian law, the coordination between the institutions, governmental and non-governmental organizations in the field involved in the activities from the National Anti-Drug Strategy.

The National Anti-Drug Strategy in the period 2005-2012 is developed in accordance with the provisions of the new European strategy in the field and establishes the general and specific objectives for reducing drug demand and supply, to strengthen international cooperation and development of an integrated global system for information, evaluation and coordination of drug phenomenon.

Since 2009, there is an ongoing national program to prevent tobacco, alcohol and drugs - 2009-2012 - approved by Government Decision no 1101/2008 and published in the Official Gazette, Part I, No. 672 of 30/09/2008. Within the national program structure is comprised sub programme no. 3, "Prevention of alcohol in the school population", which has as a key element maintaining the consumption of drugs, including alcohol and tobacco, at a low level in Romania, with the overall objectives of alcohol prevention among adolescents from the group 15-17 years, by developing personal and social attitudes.

In terms of legislation, directions provided by the EU documents or by the WHO are broadly included in the Romanian legislation. Thus there are legislative provisions governing:

- Control of production and sale;
- Excise duty. A very important provision of the Law for restructuring Health (Law 95/2006) foresees a type of tax called hypothecated tax, namely the tax on Alcohol and Tobacco specifically assigned to be spent for health-related costs. Accordingly it foresees that for alcoholic beverages (those beverages other that beer and wine and as foreseen within the Fiscal code-Law 571/2003) a sum of 200 Euros has to be paid for each hectoliter (or 2 Euro/liter) and that these sums are collected by the Ministry of Finance and channeled to the Ministry of Health for investment in health infrastructure related projects.
Case studies Romania

- Blood alcohol concentration while driving a vehicle (zero tolerance) – Article 79 of OUG 195 regarding traffic on public roads.
- Advertising – It is prohibited to advertise alcoholic beverages (directly or indirectly) on radio and TV programs between the hours 06.00 – 22.00. Also, the advertising of alcoholic beverages is not allowed in venues before, during or after shows dedicated to minors. Furthermore, any advertisement which suggests that these products present therapeutic properties or have sedative or stimulant effects or solve personal problems and which give negative imagine about abstinence are also banned. The spots that promote distilled spirits will end with the warning, audio and visual: “Excessive alcohol consumption seriously harms the health” (The Code of Regulation of the Audiovisual Content Decision no 187 from 3rd of April 2006).
- Alcoholism treatment - According to Government Ordinance no 109/119, there are taxes on health-damaging activities, and among these activities alcohol consumption is also found. These fees are paid to the Special Fund for Public Health which is managed by the Ministry of Public Health. The fees come from: legal entities that made alcohol advertising, a 12% share of the value of these receipts and legal entities income from sales of beverages alcohol, a 2% share, after deducting excise duties and VAT.

Romanian legislation no longer prohibits alcohol consumption in the workplace. The decree 400/1981, which banned alcohol during the working hours, was repealed by the law no. 319 of 14 July 2006. Chapter 2, art 5 letter k of the decree contains the following provision: “denial of access in unity of people who came to work drunk”. For those who defied the law, sanctions were not neglected. In the event of an accident, it could lead to a prison sentence of up to 20 years and the partial denial of civil rights.

Law no 319 of 14 July 2006, regarding occupational health and safety, no longer prohibits drinking at work, giving each employer free hand to set their own policy. This law is the foundation in safety and health of employees. General obligation of employers is to ensure the safety and protection of workers to prevent occupational hazard and to inform and train workers. Measures to be implemented are: avoiding risks, risk assessment that cannot be avoided, adapt work to man, provide appropriate guidance and develop a prevention policy.

The law states specific notions to define attributes and responsibilities for the involved institutions within the system as follows: “Health promotion – a process that provides individuals and communities with the opportunity to control and improve health in relation to physical, mental and social and contribute to reducing inequalities in health”.

Another problem of alcohol treatment in Romania is the attachment of the alcohol addiction treatment clinics to the psychiatric hospitals. The pavilions and departments of alcohol related problems treatment are inside psychiatric complexes both from a physical standpoint as well as from a organizational of the health systems and hospitals. This leads to a lot of prejudice, misconceptions and, by implication, to a lack of appeal to these services.

In Romania, mental health was approached as a field exclusively related to the health sector for many years. The Ministry of Health, according to the Governmental Decision no 168/2005 regarding the Ministry of Health organizing and functioning, established the health policy, including the mental health policy in Romania. Mental health prevention and treatment issues are addressed by the health promotion specialists in the public health directorates, primary
care services provided by the family doctors, dispensaries, and by the professionals providing secondary care services in the through hospitals, clinics and mental health laboratories. (http://mentalhealth.epha.org/pdf/Romania%20report.pdf).

Template case I

Case Nr: 1
Name of the case: the company wishes to remain confidential
City:

Type of company

Ownership?
☒ public ☐ private ☐ voluntary

Sector (ISIC Rev 4. codes)
☐ Agriculture, forestry and fishing
☐ Mining and quarrying
☐ Manufacturing
☐ Electricity, gas, steam and air conditioning supply
☒ Water supply; sewerage, waste management and remediation activities
☐ Construction
☐ Wholesale and retail trade; repair of motor vehicles and motorcycles
☐ Transportation and storage
☐ Accommodation and food service activities
☐ Information and communication
☐ Financial and insurance activities
☐ Real estate activities
☐ Professional, scientific and technical activities
☐ Administrative and support service activities
☐ Public administration and defence; compulsory social security
☐ Education
☐ Human health and social work activities
☐ Arts, entertainment and recreation
☐ Other service activities
☐ Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use
☐ Activities of extraterritorial organizations and bodies

Company size?
☐ Very small enterprise (under 10 staff members)
☐ Small enterprise (10 to 50 staff members)
☐ Medium-size enterprise (50 to 500 staff members)
☒ Large enterprise (501 and more staff members)
☐ How many are employed: 900

Location?
☐ Company is situated at one location (national or local)
☒ Company with a headquarters and one or more other branches/locations (national)
☐ Multinational company

Alcohol practice provision
☐ Internal service
☒ External service
Case I

Employing body

The company is a regional operator of the public water and waste water services throughout an entire county. It holds a first class operating licence, granted by the National Authority for Regulating Public Utilities and Communal Services. This is an official acknowledgement that the operator has the capacity to ensure services for a large area of operation, and also uses modern equipment and technology. Since 2005, the company has implemented the quality, environment, health and occupational safety management system, certified by the Romanian Society for Quality Assurance.

In 2010, it achieved the first position in the top of the Companies of its county, for the appropriate line of business category. This is the second achievement of this kind in a row. The company gained a trophy of excellence and held the top position in the previous year, as well. The presence in this rating confirms the economic efficiency of the company.

The company has a total of 911 employees, of which 212 are women, and a number of 101 employees who are employed in particular working conditions. Of the total staff, 25% are persons with higher education, of which 9 employees hold a PhD. Of the total personnel management functions (80 people), 32.5% are held by persons of the female gender. The average age in the company is 42 years.

The company hired an occupational health doctor who works in the occupational health and safety department. In order to promote OSH and Workplace Health Promotion (WHP) activities the company has trained a total of 12 employees in the area of OSH and 4 managers and supervisors in the area of WHP. These employees together with the OSH officers and the occupational health doctor are required to ensure compliance with the OSH legislation in force.

The main problems that workers face are: alcohol, tobacco, personal hygiene.

In the company workplace health promotion activities were carried out by attending courses of first aid, occupational hygiene, issuing the newspaper of the company with visibly displaying occupational health policies, providing to the employees brochures, magazines, and other information materials on health promotion and lifestyle related issues, providing internal training, posting on the server of the company the OSH procedures and verification by the officers of OSH and the occupational physician on how these activities were implemented.

A special aspect is the Committee of Safety and Health at Work where the occupational health doctor periodically presents the activities of Occupational Medicine. The recommendations of the occupational health doctor enclosed in the report are aimed at, besides the improvement of working conditions (ventilation, wearing protective equipment, etc.), personal hygiene measures compliance such as proper washing with water, soap and nail brush, providing appropriate sanitary facilities, water at the workplace (for drinking and washing), medicinal alcohol, first aid kits.
Recommendations have been launched to reduce the frequency and intensity of musculoskeletal disorders through better team work organization, use of levers, pulleys, mechanical means of lifting and carrying of weights, smoking cessation for all staff, but especially for those exposed to respiratory hazards and microbiological agents, the control of endowment and appropriate use of the personal protective equipment.

For the personnel working effectively in water during the interventions personal protective equipment is necessary and adequate space for heating and change wet clothes with dry equipment.

Externally the company organizes and engages in projects such as: "Open doors day", "World Water Day", "World Environment Day, "Quality Day", "The Cross of Companies" and other actions aiming to promote environmental education.

The company, in collaboration with the Department of wastewater from a German City Hall have established a Vocational training centre which aims to develop skills in water and environmental protection. In 2010 this Vocational training centre enrolled in the campaign “Safe and healthy workplaces 2010-2011”, dedicated to the safety of workers in maintenance initiated by the OSH European Agency. In this regard OHS promotion courses, a guide of best practice, will be held through the Vocational training centre Foundation.

**Workplace alcohol policy and program**

The company has the duty to ensure the health, safety and welfare of their employees according to Law no 319 of 14 July 2006, regarding occupational health and safety.

While for many people, drinking alcohol is a positive part of life and does not cause any problems, the misuse of alcohol can lead to reduced productivity, increased absenteeism and accidents at work. Alcohol reduces coordination and reactions, weakens vision and hearing and impairs thinking and discernment.

The need for intervention came also from observations made by management staff. Following these observations, unannounced alcohol verification tests were performed in some groups of workers.

The main concerns of the management were:

- Loss of productivity and poor performance
- Lateness and absenteeism
- Safety concerns
- Effects on team morale and employee relations
- Adverse effects on company image and customer relations.

Internal regulations of the company prohibit the introduction, distribution, facilitating the introduction or distribution of alcoholic beverages in the unit to be consumed at work, the sanction is termination of employment. However given that there are employees who work
outside the company perimeter with a sustained physical effort an effective monitoring of alcohol consumption at the workplace or of people turning up intoxicated cannot be achieved. There were cases of people turning up at work intoxicated and the measures that have been applied were disciplinary sanctions or termination of employment.

The company wanted to implement an awareness of the harmful effects of alcohol in the workplace but also in social life program. The program aimed to change the beliefs and attitudes, to provide new information and encourage adoption of new practices or lifestyle changes, all related to alcohol consumption.

The sessions were based primarily on risk communication, employees being helped to understand the nature and seriousness of risks so as to take informed decisions about how to treat these risks. General information was also provided about alcohol and an overview of the legislative rules on alcohol.

The number of staff to whom the campaign was address was approximately 900. The company management considered that all staff can be negatively influenced by alcohol consumption therefore all the staff were guided to participate at the information sessions by the department chief and HR manager.

A plan for rolling out the activities was drawn up. The planning was done according to the work schedule which differed from one section to another, depending on the activity. So in the central department where there is a schedule of 8 hours per day, sessions were held during the work program, for the water plants with a shift work schedule the sessions were organized at the end of the shifts.

The duration of the intervention was 10 days. The 900 employees participating in the sessions were divided into groups of roughly 25 employees (more or less 38 groups of employees were formed). The information session lasted 2 hours presenting two topics: "Control of alcohol consumption in the workplace" and "Hygiene in the workplace." The whole activity of information and awareness was held at the company headquarters, in a specially arranged classroom. Specially designed posters and leaflets were used tackling alcohol issues with information enclosed as well as a quiz to evaluate their knowledge on these issues.

The desired main objectives were:

- Rising of the employee’s awareness regarding the danger of alcohol consumption both for consumers as well as for the people around (colleagues, outside people).
- Identifying and training the employees with alcohol problems.

The methods used were:

- Informative sessions with PowerPoint presentation of the negative effects of alcohol consumption and penalties, accidents occurred as well as negative examples occurred through alcohol consumption.
- Distribution of posters and leaflets

The staff in charge of the implementation of the project were:

- The OHS officer
- Members of the OHS committee
• HR manager
• The occupational health doctor who was involved in the presentation.

The informative materials (posters, leaflets, roll-ups, PowerPoint presentations) disseminated during the informative sessions were prepared by Romtens Foundation and the company provided the meeting room for the sessions. The PowerPoint presentations included: general information about alcohol, the consequences and effects of alcohol consumption, alcohol and problems at work and in family affairs and legislation. The leaflets containing notes on good practice and posters emphasizing alcohol consumption consequences were distributed throughout the yard and exhibited throughout the company. Great interest was shown regarding the importance of accident and occupational disease prevention.

The company knew that this is a sensitive area and one which requires careful handling, so a confidential counselling support was offered for those how wanted to discuss an issue relating to alcohol use. Employees were able to speak confidentially to their manager, Human Resources or the occupational health doctor. All the time employees were assured that the situation will be handled sensitively and with confidentiality.

The difficulties that were encountered:

• Lack of interest from the workers;
• The desire for education (lack of knowledge/interest for the information);
• Choosing a period of time in the middle of the work schedule (i.e after 3.5 hours of work)

All these difficulties were dealt through:

• Involving the participants in the analysis process, i.e. needs identification and the related problems;
• Presenting real cases.

Impact of the alcohol programmes

The company was willing to roll out this campaign. The final evaluation followed the awareness raising campaign about alcohol consumption.

This testing took place very close to the end of the campaign. At the same time the campaign was very short. A longer term evaluation monitoring would be interesting in order to show the long term effects of the campaign.

The evaluation showed that the objectives of the program have been completely achieved. Also the evaluation aimed to find out if all the employees have received the information about the consequences of the alcohol consumption.

The evaluation was done through questionnaires and interviews with key persons.

An analysis of quantitative data obtained from unfolding the campaign was done and determined its impact in terms of achieving key objectives:
• Awareness. The simple recognition of the message was of 46%, and the increase of awareness of alcohol consumption effects after the campaign compared to the awareness before the campaign was of 25%.
• Providing information. The campaign determined the employees to look for extra information, mostly through the internet and also with the help of the occupational health doctor.
• Knowledge. A percentage of 60% of those who acquired knowledge about the acknowledged problem was recorded.
• Attitude. 19% of the evaluations identified significant improvements of the attitudes after the campaign.
• Behavioural intention. 28% declared an intention to change behaviour.

Lessons learnt

This program led to increased knowledge and awareness of employees on alcohol abuse and solutions to this problem. The time allocated to this type of program was very short, but it sought to be a first step towards developing a real policy in this area. The aim of the project was, to lesser extent, that the employees should not only gain awareness, but also change behaviour and adopt best practices. However it is known that a campaign based primarily on communication cannot produce sustained change in the absence of a wider program of health related behaviour changes which includes health services, technology or changes in policies and procedures.

A positive result of this campaign was the improvement of the company image in the local community and among its employees, due to the perception that it is a company that is concerned with (cares for) their own employees.

One of the themes in which there is interest is to find an effective policy concerning (non) consumption of alcohol in the workplace. A policy in which the alcohol test is the last resort and in which the employer will treat a drinking problem as a health issue and not as a cause for dismissal or disciplinary sanctions. The company wants to find a policy which will involve the management, will support and will watch over its implementation and place the employee’s health first.

A key message for other employing bodies and for policy makers is “People want to quit bad habits, the important thing is how you present it!”.
Case studies Romania

Template case II

Case Nr: 2
Name of the case: the company wishes to remain confidential
City:

Type of company:

Ownership?
☐ public ☒ private ☐ voluntary

Sector (*ISIC Rev 4. codes*)
☐ Agriculture, forestry and fishing
☐ Mining and quarrying
☒ Manufacturing
☐ Electricity, gas, steam and air conditioning supply
☐ Water supply; sewerage, waste management and remediation activities
☐ Construction
☐ Wholesale and retail trade; repair of motor vehicles and motorcycles
☐ Transportation and storage
☐ Accommodation and food service activities
☐ Information and communication
☐ Financial and insurance activities
☐ Real estate activities
☐ Professional, scientific and technical activities
☐ Administrative and support service activities
☐ Public administration and defence; compulsory social security
☐ Education
☐ Human health and social work activities
☐ Arts, entertainment and recreation
☐ Other service activities
☐ Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use
☐ Activities of extraterritorial organizations and bodies

Company size?
☐ Very small enterprise (under 10 staff members)
☐ Small enterprise (10 to 50 staff members)
☒ Medium-size enterprise (50 to 500 staff members)
☐ Large enterprise (501 and more staff members)
How many are employed: 260

Location?
☒ Company is situated at one location (national or local)
☐ Company with a headquarters and one or more other branches/locations (national)
☐ Multinational company

Alcohol practice provision
☐ Internal service ☒ External service
Case studies Romania

Case II

Employing body

The company is a leading manufacturer in the industry and automotive components. It produces automotive lighting (first assembly and after-sales). Products are manufactured according to ISO TS requirements (ISO 9001 automotive correspondent) and the specific requirements of its customers.

Prevention and protection activities are a priority in the whole group and are run according to ISO 14001 and OHSAS 18001 certifications obtained during 2009. The certification was granted by the Swiss company SGS.

At the factory level there are several initiatives aimed at improving working conditions primarily for employees. These initiatives are: "Safety Week" (raising the awareness of the employees on the importance of following the specific regulations of safety and health at work by distributing brochures and information material and organizing interactive activities, rewarding employees with initiatives in the field), "HSE Week" (raising the awareness of the employees on the importance of respecting the environment by distributing leaflets and materials and by organizing interactive activities).

The workplace has 260 employees with equal distribution of the labour force in terms of worker’s gender. Employees’ predominant age is below 35 years and most of them have secondary education. The program of the staff working directly for production is of 3 shifts / day and the employees from the administrative structure have a regular working program in one shift.

The workplace has signed a contract with a clinic for occupational health services. Inside, the company runs an extensive employee awareness campaign regarding workplace risks through various activities: "Health and Safety at Work Week", an internal monthly publication and other means of information.

Workplace alcohol policy and program

The company has a responsibility to ensure a safe workplace for its employees. And a good way the company can show their concern for the safety and health of its employees is to develop and implement a policy focused on workplace health promotion.

The company, together with Romtens Foundation, has implemented an information and awareness-raising campaign for the employees on the effects of alcohol consumption, this representing the main risk factor for the employees.

The need for such an intervention has emerged as a result of an increased awareness generated by the increase in the number of employee overtime generated by the employee’s
absenteeism, the increase in the amount of sick leave, the increase in the employer’s costs for paid sick leave, and the overload on the colleagues who are replacing those who are on sick leave and have to be paid extra.

The presumption that these problems are due to excessive alcohol consumption was based on statements of employees, colleagues of those who have problems with drinking and of the heads of departments. It was found that most performance problems are associated with increased levels of alcohol, due to drinks for lunch or after a party the night before.

At the workplace, the indirect costs of alcohol consumption result in low productivity and performance, inefficient use of working time, being late and absenteeism. Alcohol affects staff morale and relationships, leads to inappropriate behaviour and lack of discipline. Cases of violence have not been reported but there were complaints of employees who had to work overtime and take over the task of the colleagues with alcohol problems.

It was desired in the first phase to inform the employees about the effects of alcohol consumption. The objective was the reduction of employees’ health problems and subsequently decreased employee absenteeism generated by medical causes among workers.

The target group were all employees of the company because among them all were consumers of alcohol and others were likely to become consumers.

The target group consisted of 260 employees, 51% female and the average age being 36 years.

Information and education sessions for the employees were held in the form of interactive sessions containing: PowerPoint presentations, thematic films, sharing of leaflets and assessment questionnaire, all the above being presented by specialists: the health promotion doctor and the occupational health doctor from the Department of Public Health of the county.

These sessions were conducted during working hours. In planning the sessions a very important role was played by the HR managers and the Health and Safety managers who set the times and composition of the groups so that the absence for 2 hours of a group of employees does not harm the production process. They formed groups of 25 people.

The following were submitted for the attention of the employees:

- General information about alcohol
- The effects and consequences of alcohol consumption
- Alcohol and problems at work
- Legislation

**Impact of the alcohol programmes**

At the end of the campaign that lasted 15 days, questionnaires were applied to all employees that participated in the session.
These questionnaires contained questions about the negative effects of alcohol consumption on health, questions to know if the workers knowledge regarding the issue has been enriched. It was found that 75% of respondents correctly answered the questions.

Some of the most delicate questions were related to the intention to change the behavior which included an acceptance of alcohol-related problems. To this question only 15% of those polled answered “yes”.

In addition to the application of questionnaires an evaluation was made which was performed on the spot through observation and through interviews with the heads of department. It found increased productivity and decreased absenteeism due to alcohol consumption. This was largely due to the fact that employees understood the company's position vis-à-vis the consumption of alcohol in the workplace, the employees being much more careful not to drink alcohol before coming to work or during meal breaks.

### Lessons learnt

The campaign objective to inform employees about the harmful effects of alcohol at the workplace was accomplished. The company is aware that such a campaign of information, raising awareness, and sensitization cannot produce changes in behaviour in the absence of a program and policy to support not only non-consumption at work but also the adoption of a healthy lifestyle alcohol-free in the social life.

The company deemed this campaign to be a first step towards developing a policy for workplace health promotion which will also treat other health problems, not only those related to alcohol consumption, such as: healthy eating, smoking, stress, etc..
Scotland

Country description

Size and location

Scotland is a part of the United Kingdom (UK) and occupies the northern third of Great Britain. Scotland's mainland shares a border with England to the south and covers an area of approximately 78,772 square kilometres. There are three distinct regions:

- the Highlands and Islands
- a densely populated Central Belt, which includes the main cities of Edinburgh and Glasgow

It is also home to almost 800 small islands, including the northern isles of Shetland and Orkney, the Hebrides, Arran and Skye.

Edinburgh, the country's capital, is one of Europe’s largest financial centres. Glasgow is Scotland's largest city, and was once one of the world’s leading industrial cities. Scottish Waters consist of a large sector of the North Atlantic and the North Sea, containing the largest oils reserves in the European Union.

The main economic and industrial activity is:
- Agriculture and forestry
- Fishing
- Oil and gas
- Energy
- Whisky
- Electronics
- Textiles
- Construction
- Major trading partners
- Banking
- Investment, Insurance and Asset Servicing
- Tourism

The current population of Scotland is just over 5.2 million (2011 Census). The main ethnic groups are 89% Scottish, 7% English, Irish or Welsh and 4% others. The Scottish unemployment rate in currently (January 2011) 8% which is slightly higher than the UK rate of
7.9% but it is falling whereas the UK rate is rising. 2.8 million are in employment. The per capita GDP is estimated (2009) to be £19,744.

Scotland has partial self-government within the United Kingdom as well as representation in the UK Parliament. Executive and legislative powers have been devolved to the Scottish Government and the Scottish Parliament, however the UK Parliament retains power over a number of reserved matters which are outlined in the Scotland Act 1988.

Health, however, is a devolved matter and this has seen Scotland being at the forefront of introducing ground-breaking public health policies, with Scotland being the first country in the UK to introduce a ban on smoking in public places and the first to pass legislation to introduce a minimum price per unit of alcohol.

**Government Policy**

The current government set out its strategic objectives in 2007. There are 5 objectives:

1. **Healthier** Help people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care.
2. **Safer and Stronger** Help local communities to flourish, becoming stronger, safer places to live, offering improved opportunities and a better quality of life.
3. **Smarter** Expand opportunities for Scots to succeed from nurture through to life long learning ensuring higher and more widely shared achievements.
4. **Wealthier and Fairer** Enable businesses and people to increase their wealth and more people to share fairly in that wealth.
5. **Greener** Improve Scotland's natural and built environment and the sustainable use and enjoyment of it.

In 2009 the Scottish Government launched Changing Scotland's Relationship with Alcohol: A Framework for Action. This acknowledged the scale of Scotland’s alcohol problems and for the first time set out a whole population approach to reducing harm, with a stated aim of reduced alcohol consumption across the population. (This replaced the previous approach which had focused on particular groups such as binge drinkers and harmful drinking by young people.)

The other key areas for action identified in the Framework were:

- supporting families and communities
- positive public attitudes, positive changes
- improved treatment and support. On this point the government has introduced a target for the delivery of alcohol brief interventions in primary health care and also provided more funding to Health Boards for treatment services.

The Framework also set out the Government’s intention to introduce a minimum unit price for alcohol and this was included as one of the measures in the 2010 Alcohol etc (Scotland) Bill. Due to lack of parliamentary support, minimum pricing was removed from the Bill, however a number of other measures including restrictions on multi-buy discounting and price promotions were passed and became law in 2011. The Alcohol etc (Scotland) Bill Policy Memorandum clearly set out the scale of the problem in Scotland which required to be addressed:

“There were over 42,000 hospital discharges in 2007-08 due to alcohol related illness and injury, and mortality as a direct result of alcohol has more than doubled since the early 1990s.
New research also estimates that alcohol is a contributory factor in 1 in 20 deaths in Scotland with a quarter of male deaths and a fifth of female deaths in the 35 to 44 year old age group being alcohol attributable. It is now estimated that one Scot dies every three hours as a result of alcohol misuse. Scotland has one of the fastest growing rates of chronic liver disease and cirrhosis in the world, leading the Chief Medical Officer to add alcoholic liver disease to the list of “big killers”, alongside heart disease, stroke and cancer. Life expectancy in some parts of Scotland is falling way short of life expectancy elsewhere, and the Scottish Government believes alcohol plays a significant part in these inequalities. Those in deprived communities are around five to six times more likely to be admitted to hospital (and to die) due to alcohol misuse than those from the most affluent areas”.

The strength of the evidence base linking price, consumption and harm was recognised and action to address the ridiculously cheap alcohol available in Scotland was seen to be critical to redressing the historically high levels of alcohol-related harm. The election of a majority Scottish National Party government in 2011 resulted in a re-introduction of legislation to set a minimum unit price for alcohol and the Alcohol (Minimum Pricing) (Scotland) Act was passed by an overwhelming majority in the Scottish Parliament in 2012. The new law was planned to come into force in April 2013 however, legal challenges have been mounted by lawyers representing the alcohol industry resulting in delays in the implementation of this groundbreaking piece of legislation.

Workplace and labour health laws/policies

The Health and Safety Executive is independent regulator which acts in the public interest to reduce work-related death and serious injury across workplaces in the UK (including Scotland). The Health and Safety at Work etc Act 1974, is the primary piece of legislation covering occupational health and safety in the United Kingdom. The Health and Safety Executive is responsible for enforcing the Act and a number of other Acts and Statutory Instruments relevant to the working environment.

Healthy Working Lives is the main body providing information and support for health and well-being in Scottish workplaces. It provides advice on minimising workplace risks, managing ill-health and injuries, and promoting health at work. It runs an advice line and also provides a health promoting awards scheme for employers with bronze, silver and gold level awards each with different levels of achievement criteria. Introducing an alcohol and drugs policy is one of the criteria for the silver level award. Organisations can access free advice and support, and in some cases free training, to assist towards achieving their award.

Healthcare in Scotland is mainly provided by the National Health Service which is part of UK government funded public health care system (which is managed separately in Scotland). There are 14 NHS Boards across Scotland which each provide a broad range of local health services, including primary and acute care services. In addition there are 30 Alcohol and Drug Partnerships, which receive funding from their local NHS Board and local authority to commission local alcohol and drugs treatment services.
Template case I

Case Nr: 1
Name of the case: This case study wishes to remain anonymous.

Type of company:

Ownership?
☒ public ☐ private ☐ voluntary

Sector (ISIC Rev. 4. codes)
☐ Agriculture, forestry and fishing
☐ Mining and quarrying
☐ Manufacturing
☐ Electricity, gas, steam and air conditioning supply
☐ Water supply; sewerage, waste management and remediation activities
☐ Construction
☐ Wholesale and retail trade; repair of motor vehicles and motorcycles
☐ Transportation and storage
☐ Accommodation and food service activities
☐ Information and communication
☐ Financial and insurance activities
☐ Real estate activities
☐ Professional, scientific and technical activities
☐ Administrative and support service activities
☐ Public administration and defence; compulsory social security
☐ Education
☒ Human health and social work activities
☐ Arts, entertainment and recreation
☐ Other service activities
☐ Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use
☐ Activities of extraterritorial organizations and bodies

Company size?
☐ Very small enterprise (under 10 staff members)
☐ Small enterprise (10 to 50 staff members)
☐ Medium-size enterprise (50 to 500 staff members)
☒ Large enterprise (501 and more staff members)
☐ How many are employed: approx 44,000

Location?
☐ Company is situated at one location (national or local)
☒ Company with a headquarters and one or more other branches/locations (national)
☐ Multinational company

Alcohol practice provision
☐ Internal service ☒ External service
Case I

Employing body

The employing body is a local division of a national government organisation which provides the majority of national health care services for a major Scottish city and its surrounding areas.

The organisation has around 40,000 employees in total which deliver services across an acute division (mainly hospitals with about 28,000 employees) and primary health care which normally has the first contact with patients (such as doctors and health visitors etc). The acute division is split into 7 directorates and primary health care has 7 Community Health Partnerships.

The organisation has a generally health promoting focus and its mission statement is ‘delivering better health’. It has its own Occupational Health service and its own Human Resources team and a range of specific health and safety and occupational health policies. The organisation has an alcohol and drugs policy which was evaluated and updated in 2010 as part of its participation in the Healthy Working Lives awards scheme. As a further part of this process, alcohol & drugs in the workplace training for managers (the intervention) was also made available.

Workplace alcohol policy and programme

Policy

The organisation was formed in 2006 from a number of previously separate bodies. This resulted in the organisation having a range of alcohol and drugs policies which were at times contradictory and therefore did not provide consistent guidance for either managers or staff. Recognising the need for one policy which covered the whole organisation, a review was conducted in 2010 and a single policy was developed which included best practice from the previous policies. The policy which was developed is an ‘alcohol and substance policy’ so this includes guidance on drugs and other substances (including prescribed drugs). The policy forbids the use of alcohol in any circumstances during working time or on any of the organisation’s property.

The policy review process was carried out by a working group with members from Occupational Health, Health & Safety, Human Resources, and Management. There was also trade union involvement. The group reviewed all the previous policies and devised a draft single policy which then went out for consultation across the organisation. During the consultation some concerns raised were by the trade unions about the wording regarding prescription drugs. These concerns were primarily around the level of obligation on staff to have to disclose the use of prescribed drugs. The group discussed these concerns and were
able to reword the policy in a way that met with the agreement of all parties. The entire review process, including the consultation period, took around 4 months. A sample copy of the organisation’s alcohol and substance policy is separately available if required.

**Training**

To raise awareness and support understanding of the aims of the new policy, the organisation was offered alcohol and drugs in the workplace training through the Healthy Working Lives programme.

All managers were offered the opportunity to participate in the training but this was not compulsory and so only those who ‘volunteered’ took part. A total of 12 sessions were offered resulting in 133 people taking part in the training. The opportunity to participate in the training was offered internally by the Health & Safety team who circulated information on the course, arranged the dates and venues and took the names of those wishing to take part.

Each training session lasted approximately three and half hours and covered the following topics:

1. **Background**
   - Patterns of alcohol and drugs misuse in Scotland
   - Costs of alcohol and drugs misuse in Scotland and to employers
   - Definitions of problem drinking (hazardous, harmful and dependent)
   - Summary of the types of treatments available

2. **Detecting and recognising a problem**
   - Signs of problem behaviours
   - Physical effects and problem signs
   - Identifying who is at highest risk of developing a problem

3. **Responding to a problem**
   - Planning an interview
   - Conducting an interview
   - Case studies

4. **Referrals**
   - Identifying local referral agencies
   - Advice on choosing and contacting an agency

5. **Managing the ongoing process**
   - Reporting processes
   - Confidentiality
6. Summary of the key aspects of an alcohol and drugs policy

The training was interactive and used a number of different formats including quizzes, small group discussions and trainer led activity. In addition each participant was provided with a comprehensive participant manual which provides support information on all of the topics covered in the training.

The training was delivered by Alcohol Focus Scotland as part of its collaborative work with the Scottish Centre for Healthy Working Lives. The trainer who delivered the course is affiliated to Alcohol Focus Scotland’s network of trainers (affiliated trainers are trained and supported by Alcohol Focus Scotland). All the trainers delivering this programme have existing specialist knowledge and skills in the delivery of training to raise awareness of alcohol related harms, but to enable delivery of this specific programme all also undertook additional specialist training which included:

- undertaking a specific alcohol and drugs in the workplace trainers course and
- shadowing and co-training with trainers already experienced in the programme before delivering the programme themselves.

All the participants were invited to complete an end of course questionnaire on the day of the training.

**Impact of the alcohol programmes**

All of the participants were also invited to complete an online impact survey on the training and alcohol & substance policy implementation process. This survey was carried out approximately two months after the final training session was delivered - this meant that for some participants several months had elapsed since doing their training. Just under one third of those who completed the training responded to the online impact survey.

**Data gathered by Quantitative methods** (primarily the online impact survey)

Overall the impact of the alcohol and drugs in the workplace training (which followed the introduction of the new alcohol and substance use policy) was found to be positive, with the majority of attendees finding the information provided useful.

When asked what had led people to participate in the training:

- 73% said it was part of the process of review of the organisation’s alcohol and substance policy.
• 27% said it was due to the organisation taking part in the Healthy Working Lives Award scheme.
• 23% said it was due to contact with the local Healthy Working Lives Team.
• 47% cited ‘other factors’ with the majority of these suggesting that they (or their line manager) saw it as part of professional development for their role as a manager.

Value of the training to the participant and to the organisation:

• 86% of those completing the online survey said yes they felt the training was of value to them.
• 86% said yes that they felt the training was of value to their organisation.

Increased confidence and skills:

• 74% either agreed or strongly agreed that the course had improved their confidence in being able to deal with potential alcohol and drug related issues in the workplace (19% were neutral and 7% disagreed).
• 74% either agreed or strongly agreed that the course had increased their skills/tools to deal with potential issues relating to alcohol/drugs in the workplace (and again 19% were neutral and 7% disagreed).

Actions taken since the attending the training

• 32% said they had read (or re-read) the organisation’s alcohol and substance use policy.
• 28% said they had provided support or guidance.
• 20% said they had been in contact with Alcohol Focus Scotland or Healthy Working Lives.
• 8% said they had been in contact with local support agencies.
• 28% said they had taken other action. Comments showed that the majority of this involved taking action with staff such as offering them the opportunity to attend the training. However 12% commented that they had taken no action.
• When asked for any examples of good practice arising since the training 10% made a comment regarding their increased knowledge and/or skills.
• When asked if they had raised awareness of the alcohol and substance use policy with staff 83% replied yes. Of these 36% said they had held a meeting or had discussions with staff and 74% said they had provided the policy to staff by email or other means, such as staff or team meetings and/or displaying information on notice-boards.

Data gathered by Qualitative methods

Occupational Health personnel report that that the numbers of people being referred to them (or self-referring) have increased since the training. It is felt that this is likely to be due to number factors including greater awareness of alcohol problems, and staff having a better understanding the process. Overall there is a general feeling that the culture has gradually changed. In the past alcohol problems may have been noticed but not acknowledged and
sometimes managers felt that they were doing the right thing by keeping the problem hidden. Since the implementation of the new policy and the training managers are now much more aware of the need to deal with such problems through an appropriate process. They are also more aware of the possible negative consequences of a problem left unmanaged for the workplace, such as impact on colleagues, patients etc, as well as for the person themselves.

In addition sickness absence data shows a reduction over the last year, however this part of an ongoing trend. Over the last few years the Scottish Government has been actively scrutinizing NHS absence and a management process had been brought into place to deal with absence more effectively. Consequently absence has reduced.

Suggestions for further development and improvement

Data gathered by Quantitative methods (primarily the online impact survey)

When asked for suggestions for improvement to the course the following comments were received by those completing the online impact survey:

- Three said they didn’t feel any changes were needed.
- There was one request for a worked example of how to deal with a drugs problem.
- There was one request for more information on HR processes for managing alcohol problems.
- There was one request for more information on mental health.
- There was one request for more incorporation of the organisation’s alcohol and substance policy into the training.

When given the opportunity to make any other comments three people said gave comments on how enjoyable and/or useful they had found the course; one person suggested that an online course may be useful; one person suggested the impact survey should have been delivered sooner; and two people suggested that they didn’t feel the training was necessary as they already had all the relevant information and were aware of the policy.

Data gathered by Qualitative methods

The Health and Safety Manager said that in his opinion the organisation had implemented the policy to the best of its ability. A review all the various organisational policies had been going on for some time and it had been decided to introduce the alcohol and substance policy later in the process as it was felt to touch on more sensitive and ‘prickly’ issues than some of the other policies being reviewed. Overall the Health and Safety Manager feels the organisation now has a robust alcohol and drugs policy and that the key principles of the policy have been widely understood and accepted by managers and the workforce. Some of previous alcohol and drug policies were silent on the use of alcohol in the workplace and so were open to interpretation and misinterpretation. When the new policy was introduced staff in the organisation were ready to have a policy which was more directive and was clear which activities were prohibited, such as the consumption of any alcohol in the workplace (for example at events such as retireal functions).
A learning point suggested for other organisations who are seeking to review or introduce an alcohol and drugs policy, is that it is beneficial if the organisational culture is ready to accept the changes being introduced. Co-operation and buy-in make the implementation process much easier and more positive.

It was also noted that changes have taken place in the wider Scottish culture over recent years which in turn have had an impact on workplace culture. Specifically there is greater public awareness about the health and social harms which alcohol can cause to individuals but also to those around them. Further there is increased public scrutiny of the behaviour of professionals.

With regard to the introduction of the training sessions, the Health and Safety Manager said that based on some of the feedback he had received, a small change that he would consider introducing in future would be to provide more information about the content of the course to attendees in advance. Some of those who attended the training already had had a high level of knowledge and skills in this area and therefore had felt the course didn’t provide a lot for them, whilst others who had less knowledge in this area had found it very helpful.

The trainer also commented on the very mixed experience and knowledge levels within some groups and noted that this had made some training sessions difficult to ‘pitch’ at the right level. Some groups had professionals with very indepth knowledge of substance misuse (eg doctors) mixed with participants with little knowledge or understanding of this area and who wanted more time spent on the basic aspects. For future it would be beneficial to group the participants based on their level of knowledge and expertise on the topic matter to ensure all get useful outcomes from the training.
## Template case II

**Case Nr:** 1  **Name of the case:** NHS Shetland  
**City:** Lerwick

### Type of company:

<table>
<thead>
<tr>
<th>Ownership?</th>
<th>public</th>
<th>private</th>
<th>voluntary</th>
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</thead>
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### Sector (ISIC Rev 4. codes)

- Agriculture, forestry and fishing
- Mining and quarrying
- Manufacturing
- Electricity, gas, steam and air conditioning supply
- Water supply; sewerage, waste management and remediation activities
- Construction
- Wholesale and retail trade; repair of motor vehicles and motorcycles
- Transportation and storage
- Accommodation and food service activities
- Information and communication
- Financial and insurance activities
- Real estate activities
- Professional, scientific and technical activities
- Administrative and support service activities
- Public administration and defence; compulsory social security
- Education
- Human health and social work activities
- Arts, entertainment and recreation
- Other service activities
- Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use
- Activities of extraterritorial organizations and bodies

### Company size?

- Very small enterprise (under 10 staff members)
- Small enterprise (10 to 50 staff members)
- Medium-size enterprise (50 to 500 staff members)
- Large enterprise (501 and more staff members)
- How many are employed: approx 44,000

### Location?

- Company is situated at one location (national or local)
- Company with a headquarters and one or more other branches/locations (national)
- Multinational company

### Alcohol practice provision

- Internal service
- External service
Case studies Scotland

Case II

Employing body

National Health Service Shetland is a local division of the National Health Service and provides the majority of national health care services for the Shetland islands (roughly 100 miles off the coast of Scotland). NHS Shetland is responsible for the development and provision of healthcare facilities for both residents and the transient population based on the North Sea oil installations, fishing vessels, etc.

A range of in-patient, day-patient, out-patient, accident and emergency, and local community services are provided at one hospital, 10 health centres and a number of other locations in the community including schools, mobile units, the remoter islands and patients’ own homes.

The organisation has a health promoting purpose and ethos with one of its strategic objectives being ‘To continue to improve and protect the health of the people of Shetland’.

Service delivery within the organisation is structured into three main elements:

1. Local Community Services - 10 health centres providing health services (including GP services) to the local community. In addition four islands receive remote services from their nearest health centre.
2. Shetland-wide services – these are mainly provided through Gilbert Bain Hospital in Lerwick which has an Accident & Emergency Department, a Surgical Service and a Medical Ward.
3. Support services for NHS Shetland - this incorporates a number of support services including Human Resources Team, Occupational Health Team, Health Improvement Team, Finance, Information Technology and the Senior Management Team.

The function of the Occupational Health team is described as working for the health and well-being of staff and for excellent patient care. It works to deliver this aim with a wide range of services to help protect staff from work-related hazards and to support staff with health problems to continue at, or return to, their work. The Occupational Health team recognises the benefits of work on health. The team also supports NHS Shetland as an employer in to meet its legal requirements under Health and Safety, Employment and Disability legislation.

The Occupational Health team consists of one Senior Occupational Health Nurse and two Occupational Health Nurses and an administration team. There is also a visiting Consultant Occupational Health Physician one week in each month. Services are delivered across NHS Shetland which allows an enhanced service to be provided to NHS Shetland staff whilst also having a significant positive impact on the public health of the working age population in Shetland.

The organisation has a range of policies relating to health and well being including:

- an Alcohol and Drugs policy (updated in 2010)
- a Health and Safety policy
- a Mental Health and Wellbeing at Work policy
In addition all NHS Shetland staff are provided with quarterly news updates on a broad range of health-related topics. These have included:

- mental well-being and work
- eating well and reducing health risks.

**Workplace alcohol policy and programme**

**Policy**

It should be noted that whilst NHS Shetland has a health promoting focus which is reflected in the culture of the organisation, as highlighted earlier, Scotland is experiencing historically high levels of alcohol consumption and associated harm and the impact of this is also being experienced in Shetland.

NHS Shetland have undertaken a series of alcohol surveys with local residents so as to better understand drinking behaviours and culture in Shetland. Results of these surveys have highlighted the need to challenge some people’s perceptions around alcohol and its use in Shetland. To begin to change cultural perceptions and drinking behaviour Shetland have a ‘Drink Better’ strategy, which has a vision of a Shetland where people drink in moderation and not to get drunk. This vision is deemed to be a local priority for both NHS Shetland and the Alcohol and Drug Partnership.

NHS Shetland has a drug and alcohol policy which was reviewed and updated during 2010. The review process was carried out by a working group with representatives from health improvement/public health department, the Health and Safety Committee, the Health Board the Area Partnership Forum (this Forum includes staff representatives and also union representatives). On completion of the review the working group presented the revised policy document to a series of Committees within NHS Shetland. The review process took approximately six months.

A sample copy of NHS Shetland’s alcohol and drug policy is separately available, if required.

**Training**

The Health Improvement Team takes the lead for NHS Shetland in promoting the Healthy Working Lives scheme to local employers. The team arranged for an alcohol and drugs training for managers session to be delivered in Shetland. Information on this was circulated to staff in NHS Health Shetland via a staff development bulletin and the opportunity was also opened for several local organisations to participate. Twenty people took part in the training session. The majority of the participating staff from NHS Shetland came from the Healthy Working Lives Team, who were keen to gain more understanding about the course and the general subject of alcohol and drugs in the workplace so as to be able to better promote this locally.
The training session lasted approximately three and half hours and covered the following topics:

- Background
  - Patterns of alcohol and drugs misuse in Scotland
  - Costs of alcohol and drugs misuse in Scotland and to employers
  - Definitions of problem drinking (hazardous, harmful and dependent)
  - Summary of the types of treatments available

- Detecting and recognising a problem
  - Signs of problem behaviours
  - Physical effects and problem signs
  - Identifying who is at highest risk of developing a problem

- Responding to a problem
  - Planning an interview
  - Conducting an interview
  - Case studies

- Referrals
  - Identifying local referral agencies
  - Advice on choosing and contacting an agency

- Managing the ongoing process
  - Reporting processes
  - Confidentiality
  - Stigma
  - Relapse
  - Work performance

- Summary of the key aspects of an alcohol and drugs policy

The training was interactive and used a number of different formats including quizzes, small group discussions and trainer led activity.

In addition each participant was provided with a comprehensive participant manual which provides support information on all of the topics covered in the training.

The training was delivered by Alcohol Focus Scotland as part of its collaborative work with the Scottish Centre for Healthy Working Lives. The trainer who delivered the course is affiliated to Alcohol Focus Scotland’s network of trainers (affiliated trainers are trained and supported by Alcohol Focus Scotland). All the trainers delivering this programme already have specialist knowledge and skills in the delivery of training to raise awareness of alcohol related harms, but to enable delivery of this specific programme all also undertook additional specialist training which included:
undertaking a special alcohol and drugs in the workplace trainers course
shadowing and co-training with trainers already experienced in the programme before delivering the programme themselves.

Impact of the training programme

All the participants were invited to complete an end of course questionnaire on the day of the training. All of the participants were also invited to complete an online impact survey of the training and alcohol & drugs policy implementation process.

Data gathered by Quantitative methods (primarily an online impact survey)

Overall the impact of the alcohol and drugs in the workplace training was found to be positive, with the majority of attendees finding the information provided useful. Most people who made comments highlighted that it built on what they already knew and increased their confidence levels in taking action in support of their organisation’s drug and alcohol policy and / or in promoting drugs and alcohol policies in general.

When asked what had led people to participate in the training:

- 50% said it was due to their organisation taking part in the Healthy Working Lives Award scheme.
- 50% cited ‘other factors’ with the majority of these suggesting that they (or their line manager) saw it as part of professional development for their role.

Value of the training to the participant and to the organisation:

- 100% of those completing the online survey said they felt the training was of value to them.
- 100% said that they felt the training was of value to their organisation.

Increased confidence and skills:

- 75% either agreed or strongly agreed that the course had improved their confidence in being able to deal with potential alcohol and drug related issues in the workplace (25% were neutral).
- 75% either agreed or strongly agreed that the course had increased their skills/tools to deal with potential issues relating to alcohol/drugs in their workplace (again 25% were neutral).

Actions taken since the attending the training:

- 75% said they had used some of the learning from the course. Of this 75% there were specific comments which included:
  - 1 person said it helped to inform other training (on mental health).
2 people said it had led them to be more aware of alcohol issues and how to raise them.

75% said taken some action following the course. Of this 75% there were specific comments which included:

- 2 people said they had provided support or guidance.
- 1 person said they had followed up with all the workplaces that had participated in the training.

When asked for any examples of good practice arising since the training 100% of the comments provided related to improved confidence.

When asked if they had undertaken activities to raise awareness of the alcohol and substance use policy with staff since the training 50% confirmed that they had. Of this 50%:

- Half said they had held a meeting or had other discussions with staff.
- The remaining half said they had provided the policy to their staff by email or other means.
- 1 person also added that they had provided additional alcohol and drugs information to staff.

Data gathered by Qualitative methods

As course participants were from a number of different organisations it was not been possible to gather qualitative data from each of these. From discussions held with various representatives from NHS Shetland it was felt that they were unable to measure the impact from the training process at this point. However it was highlighted that those who had participated felt more confident and enabled. It was felt that this increased confidence would in turn allow these staff to promote the benefits of having an alcohol and drugs policy and how best to use this, both within NHS Shetland and also with other local employers.

A further key benefit of this training was felt to be the opportunity it gave to engage with local workplaces. It provided a good starting point for discussion and the training offered an attractive opportunity for local employers to engage with the Health Improvement Team. This engagement enabled the start of a process to raise awareness of the problems associated with Scotland’s, and Shetland’s, heavy drinking culture as well as giving the opportunity to discuss actions to redress the harm.

Discussion with representatives of the local organisations involved highlighted that for a key factor in their decision to participate in the training was that they saw this as a positive and easy way of contributing to their organisation’s corporate social responsibility. On completion they felt the training had offered very useful guidance in helping them to review and update their alcohol policy and practice.
Suggestions for further development and improvement

Data gathered by Quantitative methods (primarily the online impact survey)

When asked for suggestions for improvement to the course the following comments were received from those completing the online impact survey:

- Three said they didn’t feel any changes were needed.
- One suggested that more info on how to deal with a drugs problem would be useful.
- One suggested they would have liked more role play practice.

Data gathered by Qualitative methods

From discussions held with various representatives from NHS Shetland, it was felt that the training provided an ‘easy win’ for everyone. That is to say that it was seen firstly by the participating organisations as an easy way to help demonstrate their corporate social responsibility, and secondly by the NHS Health Improvement Team as an positive and attractive way to engage with local businesses. It was also felt that training of this kind has the potential to contribute to meaningful and sustainable change, as subsequent actions to implement or update an organisation’s alcohol policy and practices will ensure on-going impact. It is felt that this was more effective that the provision of one-off alcohol awareness events which provide information but have limited impact on practices and behaviour.

There were seen to be some advantages in holding a training session with representatives from a mixture of organisations as this was both time and cost efficient and further allowed the impact to be spread across a broad range of participants and organisations. However the disadvantage was that this made follow up and measurement of the impact much more challenging and limited.

Acknowledging that half of those who participated in the training had done so because of their participation in the Health Working Lives Award scheme, consideration should be given on how this scheme (or elements of it) could be replicated elsewhere.
Acknowledgements
GENCAT and all the EWA project partners would like to acknowledge their gratitude to all the companies and organisations and their workforces that took part in the EWA pilot projects and contributed to the compilation of case study experiences.