Abstracts_Axis_4

The determinants of addictive behaviours: contributions of scientific research and studies? Prevention strategies

Alcohol, drugs and prevention in the workplace: What strategies are effective? Findings from resent research.

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Abstract:

Knowledge production on employment and substance abuse is increasing. The majority of the studies are American. In addition, we find studies from Sweden, Norway, Germany, France, England, Taiwan, China, Canada, New Zealand and Australia.

Alcohol is still the most widely used drug in the work context, although the use of other drugs also occur. In the studies we have reviewed, the estimate of the proportion of employees with risky alcohol use lies between five and fifteen percent. Most international studies mainly focus on use or exposure at work. Studies in Norway and Sweden focus more than the other studies on "afterworking" (to drink with colleages after work/work-related alcohol consumption related to representation, work travels, seminars etc.). Some studies have indicated that certain industries are more vulnerable than others, but even if industries such as construction or hotel and restaurant more frequently are mentioned than others, the picture is not clear. The degree of exposure is related to factors such as availability of alcohol and drugs, the extent of liberal norms and drinking cultures, as well as different characteristics of working conditions (mobility, visibility), organization and management/leadership.

Both newer and older research points to associations between substance use and absenteeism, accidents, performance and quality of work performed. The relationship between substance use and sickness absence is in recent research clearest where there is a risky or *problematic* alcohol consumption among some of the employees, and the relationship between *high* alcohol consumption and sickness absence seems unclear.

Several studies suggests factors outside as well as inside the work environment to explain work-related alcohol use and use of other drugs among employees. Demographic variables such as gender, age, marital status have been shown significant. The main message is that both in the community in general and the workplace especially, men more than women get intoxicated, younger more than older, and single more than married.

Recent studies have found correlation between stress, long working hours, harassment at work and risky alcohol use. We have found studies that show that drinking norms at work among other employees it is reasonable to compare oneself with, affects the individual employee's drinking patterns.

Recent studies on prevention interventions show promising results in interventions carried out in connection with health and lifestyle controls, as well as in the Internet-based interventions. Brief interventions, team awareness training and colleague references are measures that appear to have potential for good results. Several studies suggests the combination of several measures or interventions. One study suggests a broad working life approach combining regulation of availability, strict policy fronted by leaders and drug testing regime. Some studies point out specifically that prevention interventions undertaken with the involvement and participation of employees, focusing on both individual and organizational change, are more effective.

Prevention of alcohol and drug use in the workplace – Pompidou Group – Strasbourg – 15-16 October 2014

Subject area 4
PSYCHOSOCIAL RISKS AND ADDICTIVE BEHAVIOUR
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INTRODUCTION
Analysis is an essential precondition for any decisions, action or policies. The reference framework adopted at the last conference is a simple model for carrying out the necessary analysis. It can be used by all concerned and is universal in purpose. At the same time, it makes it possible to think through, organise and assess prevention policies, in particular in the workplace. These policies must tie in with the national policies in this area. Does the model have an operational function? It is open to being challenged and to evolving. It enables us to consider a phenomenon in all its complexity, rather than approaching it from a reductionist angle.

The question is whether addictive behaviour should be included among psychosocial risks. If so, what are the consequences?
First approach: descriptive approach.
You first ask, "What is happening in the company?", and do so on an exhaustive basis.
Then, "What is happening in the company that is harmful?", both for the company and for its employees.
Lastly, "What objectives are we going to choose?" Either a single one or several together: optimising the company, protecting individuals, valuing individuals' potential…
The method employed will be descriptive and epidemiological.

In confining ourselves to the harm for individuals, this method will in turn identify any dysfunctions, or "pathologies", and classify them. The first group comprises "non-specific" pathologies encountered in the public at large. They flow into the workplace environment and may be regarded as "imported" pathologies. They have a varying impact on the operation of companies and are also altered by the requirements of and conditions in the workplace. For instance, the occurrence of glaucoma in a computer operator, where there are several similar cases among his or her relatives and, in particular, ancestors; addictive behaviour from adolescence; previous episodes of depression, including among ancestors… We are therefore dealing with sick persons who are working. They are ill and in employment.

Second group: "specific pathologies"
These occur in the workplace and because of the type of work and the way companies operate. Examples include pleural mesothelioma linked to exposure to asbestos and blood diseases linked to the use of solvents. The causalist approach comes on top of the descriptive approach here. In addition to taking account of the causal link, attempts are made to determine whether the harm caused is directly or indirectly, partially or fully, the result of the operation of the company. The working environment can cause diseases. Occupational diseases were among the first to attract our attention and played a part in building occupational health policies.

This gives rise to three comments:

1. These two groups of pathologies impact to varying degrees on the operation of companies. In both cases, companies have a duty to tackle them.

2. The two types of pathologies require two types of management in terms of prevention, care and the operation of companies, even though the dysfunctions may sometimes be identical.

3. Pathologies brought into companies and those caused by them do not have the same effects in terms of companies' responsibilities and obligations. They do not involve the same management and health policies. They do not require the same resources to be employed.

PSYCHOSOCIAL RISKS

Harm analysis has evolved gradually, especially since account has been taken of employees' mental health and of workplace morale. Initially, psychosocial risks only concerned stress and its effects, as companies and occupational health teams did not at the time have a mental health culture. A broader approach has now emerged, and sometimes now goes too far. This is because we are obsessed with taking ever greater account of corporate responsibilities. Psychosocial risks are now generally referred to as "the whole range of risks for mental, physical and social health caused by working conditions and organisational and relational factors likely to interact with the mind". That is the definition used, for instance, in the policies concerning all French public servants. Many different definitions have been given, reflecting the vagueness of the concept. The range of types of harm covered here is very broad and varied, which leads to large numbers of different kinds of prevention measures. It is therefore preferable to speak of corporate "prevention policies". "Psychosocial risks" is also a phenomenon with an infrequent characteristic; it involves a feedback loop between causes and effects and makes it necessary to consider a whole series of spontaneous regulating factors which take effect gradually and regularly. This means that between initial diagnosis and the implementation of a policy, a spontaneous process will develop which will either improve or worsen the situation, and will definitely alter its relevance. The initial determinants for which the relevant company is responsible will no longer have the same role or the same impact after a certain time. It should also be underlined that feedback loops are difficult to identify. As psychosocial risks are defined jointly by companies and employees, it is not really a scientific and purely health concept, but an operational and regulatory concept. On top of this, there is now also the concept of "quality of life in the workplace" – a further operational concept which it is hard to define accurately. When the various definitions are considered, it can be seen that they vary depending on whether emphasis is placed on the effects, the determinants, the means employed or the strategies chosen for bringing it about or restoring it. The addition of this concept makes things still more complex.

This calls for several comments:

1. The causal link with the operation of companies is the basis for the concept of psychosocial risks.

2. It is necessary to be able to identify problems within companies which cause psychosocial risks and to indicate the causal links.

3. The use of the term "risk" also involves the probability of occurrence of the dysfunctions and the pathologies caused here. As we are dealing with a risk, this means that it can be assumed that, given the same working conditions, some employees will develop disorders while others may not.

The concept of "prior vulnerability" of individual employees would then have to be introduced. But how can such vulnerability be assessed and how can it be taken into account in company management from a preventive angle? Very generally, there is a tendency to avoid taking this vulnerability into account, as it is hard to assess and analyse its impact in the occurrence of the dysfunctions caused. This is all the truer since the general trend is towards the exhaustive protection of employees and exacting emphasis on the duties of companies, which are sometimes even regarded as causing diseases. The reference framework adopted previously takes on board the scientifically validated assertion that all phenomena have multiple causes, that the determinants are of different kinds and origins, that they come from different spheres and that their causal mechanisms are not identical. Is it therefore right to regard companies as the sole cause of psychosocial risks?

Addictive behaviour, which is human behaviour with multiple determinants, takes three forms:

- Occasional consumption or use: there are potential risks but they do not materialise.

- Harmful use: single or repeated use which causes identifiable harm.

- Addiction.

As for all types of human behaviour, there are many different determinants; their impact on the occurrence and continuation of the behaviour varies between individuals; some cannot be changed by the environment, for instance genetic determinants (present in certain individuals who develop a certain type of addictive behaviour); but there are also avoidable determinants, of which there are very large numbers and which must be clearly identified.

Is it therefore right to include addictive behaviour among psychosocial risks? Clearly yes, as some determinants stem from the workplace and how it operates.
In making this assertion, we are saying that:

- companies can cause addiction,

- they have a duty and are able to take steps to reduce and eliminate avoidable determinants for which they are responsible,

- they therefore have a specific but non-universal task.

And in making this assertion, we are also saying that there are other determinants of addictive behaviour for which companies are not responsible. They are not therefore responsible for everything and cannot address all problems. However, this does not relieve them of the responsibility for dealing with addictive behaviour brought into the workplace. Their responsibility is limited to dealing in the most relevant manner with such addictive behaviour. In this case, a policy has to be put in place which is separate from the policy on psychosocial risks. If addictive behaviour is regarded as a psychosocial risk, the objective of companies and employees will be to address only workplace-related determinants. Addressing these avoidable determinants will clearly be beneficial for everybody. But will it be effective, given that other outside determinants already exist or have emerged? In which case, it might be said that the measures taken are not relevant, which is not necessarily true. If addictive behaviour is regarded solely as a psychosocial risk, prevention and care would be based on a reductionist approach, which would diminish the effectiveness of the assistance provided for employees. In terms of prevention, a distinction must always be made between individuals, citizens and employees. Employees are not just employees. Accordingly, the risk-reduction policies can only be carried out in and by companies, but they must be conducted in co-operation with outside bodies. That is the guarantee of success. The problem will therefore be to link up the prevention, assistance, support and care policies conducted inside and outside the workplace.

The International Conference of 15 and 16 October 2014

Prevention of alcohol and drug use in the workplace
From a declaration of intent to the implementation of a policy: users' guide to the Reference Framework, good practices, research findings

The relationship between work and the use of psychoactive substances (alcohol, drugs, psychotropic medicines, tobacco): identifying individual and collective determinants in order to take preventive action. Contribution of biomedical and occupational sciences.
Gladys Lutz

1. Biomedical and epidemiological knowledge about the relationship between subjects, their environment and psychoactive substances

1.1. Determinants of the use of psychoactive substances and the relationship with work

- Products currently in use: Illicit drugs, new synthetic products, psychotropic medicines, alcohol, tobacco.
- Use and misuse of psychoactive substances: users, circumstances, effects, functions. Regulated uses, harmful uses, loss of control.
- Figures on work-related uses: studies on stress, studies on specific occupations, desired effects on work, risks, damage.

1.2. Discussion and controversy about the use of such scientific data

- Concentration on the individual and legal aspects of work-related use of psychoactive substances leading to a tendency to overlook occupational or collective determinants
- One-sided interpretation of substance use as a risk in its relationship with work: Obscures certain short and medium-term positive effects of psychoactive substance use, which do need to be taken into account in an overall prevention strategy (health and safety)
- Failure to take account of psychotropic medicines
- Lack of data on the true occupational dangers of psychoactive substance use: "licit" v. "illicit" products.

The biomedical, epidemiological and legal sciences, which generally work together, have narrowed their approach to the relationship between psychoactive substances and work down to a standard interpretation. They place the emphasis on individual determinants and solely on the risk aspect of the use of such substances, namely personal conduct which is harmful to health, safety and productivity within companies.

These sciences do not investigate the collective determinants and the processes of well-being and reliability to which psychoactive substances can also contribute. These aspects, which complement those described by the biomedical and legal sciences to promote prevention, are investigated by the occupational sciences.

2. Findings of the occupational sciences on the relationship between work and use of psychoactive substances

2.1. Determinants of the use of psychoactive substances and the relationship with work

- Features of modern work organisation: quality control, individualisation and intensification of work, flexibility, health and safety measures
- Factors affecting the use of psychoactive substances linked to the modern working environment: stress, intensity of production, competition, individual performance assessments, professional culture, non-standard working hours, musculoskeletal disorders (MSDs), psychosocial disorders (PSDs), lack of job security, etc.
- The occupational functions of psychoactive substance use: individual and collective defence strategies, socialisation, performance enhancement and coping strategies, recovery strategies.

All of these aspects of use identified by the occupational sciences (through occupational psychodynamics and psychosociology, ergonomics and clinical ethnology) are the products of individual and collective determinants. Subjects' psychoactive substance uses are influenced by biomedical, psycho-social and organisational processes. While the existence of individual, private determinants in each subject should not be ruled out, an investigation of collective determinants is just as essential. This forms part of the indispensable process when organising prevention or catering for paradoxical occupational behaviour, namely taking risks to cancel out others and secure one's health and safety (along with that of others). The aim here is to explain how and why professionals can be prompted to take psychoactive substances to do their work well. Questioning the occupational determinants that influence the use of such substances is the same as raising the question "what is the professional purpose of psychoactive substance use?" so as to identify and act upon the occupational reasons for such use (in the biomedical, cultural, organisational, psychosocial and other fields).

2.2. Subjects of discussion and controversy

Occupational sciences provide a useful complement to medical and legal data, showing that:

- psychoactive substance use has collective and occupational determinants, not just individual and private ones;
- the use of alcohol, illicit drugs and psychotropic medicines can be resources forming part of health and care practices, which may be concealed to varying extents, and have various important professional and health functions;
- any overall prevention strategy in the occupational health and safety field must identify these determinants. If the various key players within a company and its occupational health services identify these determinants, this can open up the scope for preventive action to include the processes which are the sources of psychoactive substance use, so as to tackle them and hence to prevent any risks which may be linked to these uses. Risks to health and safety.

What influences the approach of substance abuse by occupational physicians? A qualitative study.

Lambrechts M [1 2], Ketterer F [3], Vanmeerbeek M [3], Symons L [4], Mairiaux P [5], Peremans L [4 6 7], Remmen R [4], Godderis L [1 8].

Abstract

Background

The impact of substance abuse is huge in the working environment. Occupational physicians (OPs) can play an important role in the prevention and management of substance abuse in the working population. However, little is known about the factors influencing their approach.

Aims

To describe OPs own experiences and their attitudes and decision-making regarding to alcohol, illicit drugs, hypnotics and tranquillizers in providing appropriate care to employees.

Methods

This qualitative study involved face-to-face in-depth interviews with 16 Belgian OPs. The data collected were transcribed and analyzed using the Integrated model for Change as a framework.

Results

OPs are mainly confronted with the use of alcohol, hypnotics and tranquilizers among employees. They have only few experiences with illicit drugs. Their approach is mainly determined by contextual factors, as size and type of companies, type of occupational health service, company culture, and an existing alcohol and drug policy. Also their attitudes towards alcohol or drugs related work had a strong influence.

Safety problems due to substance abuse were important cues to action. OPs are acting differently depending on the type of drug. A lot of barriers to handle substance abuse in an efficient way were mentioned such as lack of time, legal restrictions on their tasks and long waiting lists in the specialized alcohol and drug institutions.

Conclusions

The way OPs behave in response to substance abuse among employees is complex. Their management of substance abuse should be supported by initiatives both at the individual and at the collective level.

Keywords

Occupational physicians – Substance abuse – Alcohol and drug policy – Belgium

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