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Workplace safety and productivity

Introduction

10.1 Many of the physical and psychological effects of drugs diminish the safety and efficiency with which alcohol and other drug users perform their every day tasks. Not only does substance abuse reduce employees' on-the-job productivity, it contributes to absenteeism and low morale, and when illness leads to premature retirement or death, it reduces the size of the available workforce. In addition, as flagged in Chapter 3, drug use also impacts on the productivity of unpaid workers, those who perform domestic activities, care for children and perform voluntary work.[1]

10.2 Workplaces are faced with the challenge of providing a healthy and safe environment for their employees. This means that employers must pay attention to the problems that substance abusers bring into the workplace, and that interfere with their effective functioning and the general well being of their colleagues as well as impacting on business productivity. Employers must also be aware of the conditions within the workplace that may predispose workers to use or abuse drugs.

10.3 While there is not a great deal of research that has been done about the impact of substance abuse in the workplace, there are costs involved in the impact and the states, territories and the Commonwealth government have responsibilities collectively in this area.

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1 See Collins DJ & Lapsley HM, *Counting the cost: Estimates of the social costs of drug abuse in Australia in 1998-9*, Monograph series no 49, Commonwealth Department of Health and Ageing, Canberra, 2002, pp 27-28, 29.

Use and impacts

Consumption of alcohol and other drugs by workers

10.4 The consumption of alcohol and other drugs by workers has been examined in a number of studies and has been found to generally mirror consumption in the community at large. While relatively little information is available for illicit drugs in the workplace, recent data have been summarised by Phillips for alcohol. He showed that around seven per cent of workers drink at harmful levels and about 15 per cent drink above the low-risk level, as defined by the National Health and Medical Research Council.[2]

10.5 As Phillips commented, however:

> … it is not clear what relevance alcohol and drug consumption data have unless they are related to employment. Even the consumption of harmful and hazardous levels of alcohol, for example, may not be indicative of harm or hazard at the workplace.[3]

10.6 Surprisingly little work has been undertaken to estimate the prevalence of intoxication or being drug-affected at work. One of the few studies carried out is by Sargaison and it found that 0.8 per cent of a sample of coalminers had a blood alcohol level greater than 0.05 per cent when at work.[4] Another indication of the extent to which people work when drug-affected is available from the 2001 National Drug Strategy (NDS) Household Survey. Among survey respondents 4.3 per cent reported having gone to work during the past 12 months when affected by alcohol, and 2.3 per cent went to work under the influence of other drugs.[5]

Impact of substance misuse on productivity and safety

10.7 Even though we know that using tobacco, alcohol and illicit drugs affects the health, safety and productivity of workers, making a precise

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2 Phillips M, 'The prevalence of drug use and risk of drug-related harm in the workplace', in Allsop S, Phillips M & Calogero C, (eds), *Drugs and work: Responding to alcohol and other drug problems in Australian workplaces*, IP Communications, Melbourne, 2001, p 22.

3 Phillips M, p 26; National Health and Medical Research Council's guidelines for low risk drinking can be found in National Health and Medical Research Council, *Australian alcohol guidelines: Health risks and benefits*, NHMRC, Canberra, October 2001, p 5.

4 Sargaison J, *Report of the survey of substance abuse programs in the Queensland coal mining industry*, Queensland Mining Council, Brisbane, 1993, quoted in Phillips M, p 24.

5 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, Drug statistics series no 9, AIHW, Canberra, May 2002, p 37.

assessment of their impact is difficult. For example, ethical constraints make it impossible to conduct definitive controlled studies on the relationship of drug use and occupational accidents. Normand and others pointed out that the impact of drug use on work must be inferred from studies conducted in the laboratory and the field:

> Laboratory studies provide evidence regarding the effects of controlled, short-term exposure to specific drugs on the performance of specific tasks. Field studies provide evidence regarding the links between drug use (either self-reported or detected through other means) and a number of work behaviours, but they lack the controls needed to allow researchers to isolate specific drug effects.[6]

> … finding consistent relationships between relatively rare events such as alcohol and other drug abuse and accidents requires a carefully designed study with a large sample size and reliable measures - a difficult task indeed …[7]

Even if consistent relationships are found, the committee notes that it can be difficult to demonstrate causality.

10.8 The Australian Coal Association, which has collected 'the only high quality, industry wide Australian data', highlighted the fact that:

> … there is no proven link between the presence of a drug and impairment and, most importantly, that post accident the presence of a drug should not be assumed to be the root cause of the accident without significant further evaluation ...[8]

Dr Gardner noted fatigue, shift design and rostering may all contribute as well.[9]

10.9 Despite the difficulties of establishing relationships, some objective evidence exists of the link between fatalities and drug use and estimates of impacts have been made. The most comprehensive Australian study of work-related fatalities, which was undertaken by the National Occupational Health and Safety Commission (NOHSC), examined coroners' reports for a large number of workplace deaths between 1989 and 1992. Of the 1235 deaths for which blood alcohol information was

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6 Normand J, Lempert R & O'Brien C, (eds), *Under the influence? Drugs and the American workforce*, Committee on Drug Use in the Workplace, US National Research Council and Institute of Medicine, National Academy Press, Washington DC, 1994, p 119.

7 Normand J, Lempert R & O'Brien C, p 159.

8 Gardner I, transcript, 15/8/02, p 1173.

9 Gardner I, transcript, 15/8/02, p 1173.

available, 'Raised blood alcohol appeared to have contributed to at least … 5.3 % of working deaths …'[10]

10.10 When both drugs and alcohol were detected together, at least 5.2 per cent of working deaths 'probably occurred in part because of one or both of these groups of substances'.[11] A similar result was found in a study of US fatal occupational injuries for the period 1993-94, by Greenberg and others.[12] According to Phillips, NOHSC's study also found that:

> Drugs appeared to contribute to 2 per cent of the working deaths, but information on drug levels was available in only about one-third of working deaths. The type of drugs found to have contributed to the fatal incidents included amphetamines, cannabis, barbiturates and narcotics ...[13]

10.11 In relation to workplace accidents, the evidence on the links with alcohol and drug use is less firm than that for fatalities. The International Labour Organization reported that:

> Over recent years, studies have shown that … in many workplaces, 20-25 per cent of accidents at work involve intoxicated people injuring themselves and innocent victims.[14]

However, no supporting evidence for this statement was provided and its accuracy was questioned by Dr Ian Gardner when he spoke to the committee. He reported the conclusion of a US National Research Council and Institute of Medicine report regarding the magnitude of the impact of alcohol and other drug use at work:

> Many of the effects found, although statistically significant, are small to moderate. Indeed, the available research, taken as a whole, should soften the concern about employee alcohol and other drug use often found in the popular media.[15]

10.12 Dr Gardner's view is shared by others. Phillips pointed out that the estimates of the contribution of alcohol to occupational injuries and fatalities:

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10 National Occupational Health and Safety Commission, *Work-related traumatic fatalities in Australia, 1989 to 1992*, Commonwealth of Australia, Canberra, December 1998, pp 50-51.

11 National Occupational Health and Safety Commission, *Work-related traumatic fatalities in Australia, 1989 to 1992*, p 51.

12 Greenberg M, Hamilton R & Toscano G, 'Analysis of toxicology reports from the 1993-94 census of fatal occupational injuries, *Compensation and working conditions: Fall 1999*, viewed 27/6/02, <http://www.bls.gov/iif/oshwc/cfar0032.pdf>.

13 Phillips M, p 28.

14 International Labour Organisation, InFocus Programme on Safety and Health at Work and the Environment. *Drug and alcohol abuse - an important workplace issue*, viewed 21/6/02, <http://www.ilo.org/public/english/protection/safework/drug/impiss.htm>

15 Gardner I, transcript, 15/8/02, p 1176.

> … are considerably lower than the figures presented by many commentators. For illegal drugs, the evidence base is much weaker and the estimates lower … The evidence suggests that costs are incurred as a result of drug-related accidents at work, but these are a small proportion of the overall costs arising from workplace accidents.[16]

10.13 Estimates have also been made of the impacts of drug use on absenteeism. Bush and Wooden found that smokers have been found to be 1.4 times more likely to be absent from work than those who have never smoked and ex-smokers 1.3 times more so. For those who engage in harmful drinking, the likelihood of being absent is 1.2 times that of other drinkers and non-drinkers.[17] Dr Gardner reported that positive results in pre-employment tests for marijuana among US postal workers was associated with greater numbers of accidents and injuries, more absenteeism and discipline problems and higher labour turn over.[18]

Impact of the workplace on substance abuse

10.14 The contribution of the workplace to alcohol and drug use is sometimes overlooked, according to Reilly. Workplace factors that may affect workers' drug and alcohol consumption include long working hours, poorly managed shiftwork, stress, workplace conflicts, negative managerial styles, bullying, harassment and peer pressure.[19] The Alcohol and other Drugs Council of Australia (ADCA) reported that isolation and boredom are other factors that may influence alcohol and drug use.[20]

10.15 The Employee Assistance Service NT stated that corporate entertaining and a workplace culture of drinking may also contribute to substance misuse.[21] NOHSC reported from its study of workplace fatalities that:

> The alcohol has been consumed at least partly in connection with work in 39% of these deaths. The alcohol had been consumed either at work during normal duties or at work-sponsored functions.[22]

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16 Phillips M, pp 40-41.

17 Bush and Wooden quoted by Collins DJ & Lapsley HM, pp 28-29.

18 Gardner I, transcript, 15/8/02, p 1172.

19 Reilly D, *Over the limit*, CCH's Australian Occupational Health and Safety, March 1999, p 24.

20 Alcohol and other Drugs Council of Australia, *Drug policy 2000: A new agenda for harm reduction*, ADCA, Canberra, June 2000, p 164.

21 Employee Assistance Service NT, transcript, 20/4/01, p 683.

22 National Occupational Health and Safety Commission, *Work-related traumatic fatalities in Australia: 1989 to 1992: Summary report*, p 18.

10.16 In commenting on the complexity of the relationship between drug use behaviour and the workplace Allsop and Pidd stressed that:

> … it is evident that the development and maintenance of drug-related harm in the workplace are the outcome of an apparently wide array of factors, including individual resilience and vulnerability, cultural and sub-cultural influences, and the way in which work is structured, supervised, and rewarded ...[23]

Costs imposed by substance abuse in the workplace

10.17 The loss of national productive capacity in the paid workforce that results from drug-attributable sickness and death is considerable. According to Collins and Lapsley, it comprises losses from absenteeism, reduction in the size of the workforce and reduced on-the-job productivity. The loss due to the first of these two factors in 1998-99 was estimated by Collins and Lapsley to have been $5.5 billion. Absenteeism accounted for 25.6 per cent of this sum and the rest to reduction in the workforce. As the losses from reduced on-the-job productivity could not be quantified, the actual loss is even larger. Tobacco was responsible for 46.1 per cent of the costs to national productivity in the paid workforce, followed by alcohol (35.7 per cent) and illicit drugs (18.2 per cent). [24]

Limits to knowledge about the impact of substance abuse on the workplace

10.18 Evidence suggested that it is clear that we have inadequate information available to guide our understanding of the relationship of substance abuse to performance in the workplace and its impact.[25] On the basis of an examination of 400 documents that comprised all published and unpublished literature in Australia between 1980-96, Associate Professor Allsop concluded that:

> … in terms of available information in Australia we actually have a dearth of information on which to judge the best approaches that we can take, whether or not there is a problem and what responses we should actually make.[26]

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23 Allsop S & Pidd K, 'The nature of drug-related harm in the workplace', in Allsop S, Phillips M & Calogero C (eds), Drugs and work: Responding to alcohol and other drug problems in Australian workplaces, IP Communications, Melbourne, 2001, pp 17-18.

24 Collins DJ & Lapsley HM, pp 27, 29, 53.

25 Alcohol and Drug Foundation Queensland, sub 200, p 5; Allsop S, transcript, 15/8/02, p 1168, 1171; Gardner I, transcript, 15/8/02, p 1174.

26 Allsop S, transcript, 15/8/02, p 1168.

10.19 In addition, according to Associate Professor Allsop, what information we have is more than 10 years old, and painting a national picture of the situation is difficult because the data needed are not collected in a standard manner across different jurisdictions.[27] Furthermore, reported Dr Gardner, the existing Australian standards for recording workplace accidents and their causes may in fact inhibit the collection of data that accurately reflects the impact of substance abuse on workplace safety. So too may workplace practices which encourage early return to work after accidents.[28] Dr Gardner also said, the standards for recording lost time injury and their unintended consequences for managing injured workers should be examined.[29]

10.20 It is important that we fill the gaps in our knowledge about the prevalence of substance abuse among employed persons and the relationship between substance abuse and workplace safety and productivity. A study of the prevalence of substance abuse in the workplace, coordinated by the NOHSC, could go some way to filling these gaps. It might consider not only the impact of substance abuse on impairment in the workplace but other impacts as well, such as the characteristics of the working environment and non-occupational factors such as mental ill-health, prescription drug use and chronic medical conditions. [30]

Conclusion

10.21 The committee believes that a study such as outlined above would be valuable, especially in relation to establishing workplace policies and programs to combat alcohol and drug-related harm. Such a study is also significant in relation to the issue of alcohol and drug testing in the workplace which is discussed later in this chapter.

10.22 The committee also believes that collection of data in a nationally standardised manner is a prerequisite for the study recommended above and must be pursued.

Recommendation 114

10.23 **The committee recommends that the Commonwealth, State and Territory governments, with input from unions and industry, fund a well-designed study coordinated by the National Occupational Health**

27 Allsop S, transcript, 15/8/02, pp 1169-1170, 1185.

28 Gardner I, transcript, 15/8/02, pp 1172-1173.

29 Gardner I, sub 287, p 6.

30 Gardner I, sub 287, p 5.

and Safety Commission to investigate:

- **the prevalence of substance abuse in Australian workplaces; and**
- **the relationship of substance abuse to impairment, harm and lost productivity, in the context of other factors that also impact on workplace safety and productivity.**

Recommendation 115

10.24 **The committee recommends that the Commonwealth government, through the National Occupational Health and Safety Commission:**

- **promote the development of standard methodologies for collecting data relating to workplace harm;**
- **ensure the standards developed encourage safe practices; and**
- **work with State and Territory governments and other stakeholders to ensure that these data are collected in all jurisdictions.**

Role of government

Commonwealth, state and territory governments

10.25 The states and territories have responsibility for making laws about workplace health and safety and for enforcing those laws. With the exception of Tasmania and South Australia, workplace alcohol and drug issues are generally not addressed in the principal occupational health and safety legislation (OHS) in Australian jurisdictions. In most jurisdictions, legal obligations to address substance abuse problems in the workplace arise through:

- duty of care provisions that require employers to take all reasonable steps to ensure the health and safety of all workers as outlined by the NOHSC[31]; and

31 National Occupational Health and Safety Commission, 'Duty of care', viewed 18/12/02, <http://www.nohsc.gov.au/OHSLegalObligations/DutyofCare/dutycare.htm>.

- other legislation that makes specific provision for alcohol and drug consumption, for example, in connection with safety in mines, reported Dr Gardner.[32]

10.26 State and territory OHS agencies have developed guidance on dealing with alcohol and drugs in the workplace. All emphasise the need to involve employers and workers in designing a comprehensive program, and tailoring policy to fit the needs of particular industries or workplaces.[33]

10.27 The Commonwealth government has an interest in workplace issues both as a large employer and in its role of coordinating, stimulating and leading national action on significant matters. The *Occupational Health and Safety (Commonwealth Employment) Act 1991*, administered by the Commonwealth Department of Employment and Workplace Relations, aims 'to secure the health, safety and welfare at work of employees of the Commonwealth and of Commonwealth authorities'. The Act requires Commonwealth agencies to put in place a policy of employer-employee cooperation in promoting and developing measures to ensure the employees' health, safety and welfare at work, and adequate mechanisms for reviewing the effectiveness of the measures.

10.28 The NOHSC provides a forum for the Commonwealth, state and territory governments, employer organisations and trade unions to develop national approaches to OHS matters. In regard to OHS legislation, the commission has the power to declare national OHS standards and codes of practice. These are developed to provide national consistency but are not legally enforceable unless state and territory governments adopt them as regulations or codes of practice under their principal OHS Acts.[34]

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32 Gardner I, transcript, 15/8/02, p 1182.

33 Guidelines for drugs and alcohol and the workplace are provided in WorkCover New South Wales, *Drugs, alcohol and the workplace: A guide to developing a workplace drug and alcohol policy*, WorkCover NSW, Sydney, 1995; WorkCover Corporation of South Australia, *Guidelines for drugs, alcohol & the workplace, Adelaide: WorkCover S.A., 2001*; WorkSafe Western Australia: *Guidance Note: Alcohol and other drugs at the workplace*, viewed 28/6/01, <http://www1.safetyline.wa.gov.au/pagebin/pg000055.htm>; and, for Queensland, Workplace Health & Safety, *Brochure 034: Alcohol and drugs and the workplace*, viewed January 2001, <http://www.whs.qld.gov.au/brochures/bro034v1.pdf>; Work Health Authority, Northern Territory, *Developing an alcohol policy and getting help*, Bulletin No. WH 15.01.04, Department of Industries & Business, Northern Territory, September 2000.

34 National Occupational Health and Safety Commission, 'Regulatory framework', viewed 18/12/02, <http://www.nohsc.gov.au/OHSLegalObligations/RegulatoryFramework/regulatoryframework.htm>.

National Occupational Health and Safety Strategy

10.29 The National OHS Strategy 2002-2012 was developed by the NOHSC and released in May 2002 with the endorsement of the Workplace Relations Ministers' Council. The strategy lays out the national priorities for government, industry and employees to improve OHS and sets minimum national targets for reducing the incidence of workplace deaths and injuries. Progress will be reported annually to the ministerial council.[35]

10.30 The strategy identifies nine areas requiring national action which include comprehensive OHS data collections, a coordinated research effort, a nationally consistent regulatory framework, and OHS awareness and skills development. Activities in these areas underpin the five national priorities, one of which is to strengthen the capacity of government to influence OHS outcomes.[36]

Promoting health and safety in the workplace

10.31 Calogero and others have stated that workplaces have responded to the threat of drug-related harms by developing a variety of strategies, some of which date back to the 1940s. These approaches to reducing the risk of harm from drug use include policies using control strategies, disciplinary measures, drug testing, prevention and treatment.[37]

Policies and programs

10.32 According to Dr Gardner, national and international OHS agencies all support the development of clearly laid out workplace policies and programs to address alcohol and drug issues.[38] Duffy and Ask stressed, when developing policy, three broad principles must be incorporated: the emphasis must be on prevention, policies must be rooted in the culture of the workplace, and they should complement assistance to employees with drug-related problems. That assistance may consist of counselling, advice

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35 National Occupational Health and Safety Commission, *New national OHS strategy endorsed by ministers*, media release, 29/5/02, viewed 17/6/02, <http://www.nohsc.gov.au/NewsAndWhatsNew/MediaReleases/mr-29052002.htm>.

36 National Occupational Health and Safety Commission, *National OHS strategy 2002-2012*, pp 6-8, viewed 18/12/02, <http://www.nohsc.gov.au/nationalstrategy/Strategy2sep.pdf>.

37 Calogero C, Midford R & Towers T, 'Responding to drug-related harm in the workplace: The role of prevention, counselling, and assistance programs', in Allsop S, Phillips M & Calogero C, (eds), *Drugs and work: Responding to alcohol and other drug problems in Australian workplaces*, IP Communications, Melbourne, 2001, p 88.

38 Gardner I, transcript, 15/8/02, p 1172.

and/or links with external treatment agencies[39], and is best provided when it is fully integrated with the workplace OHS setting and policies[40] and Dr Gardner said has significant input from those who know and understand the workplace.[41]

10.33 Evidence to the committee stated one of the ingredients needed to develop good policies to address drug-related harm is the use of extensive consultation between employers, workers[42] and other stakeholders.[43] Duffy and Ask listed some of the other factors that make for good policy. Policies must:

- apply to all employees regardless of status;
- be organisation-specific and comprehensive;
- include instructions and procedures for responding to drug-related incidents; and
- consider drug testing as a potential and complex option that can be applied only to limited domains.[44]

10.34 They also stated that implementing policies in a pragmatic, effective way is best done through:

- gradual and informed change;
- publicising the policy in an appropriate and equitable way;
- engendering employee compliance through the definition of roles and responsibilities, and education and training; and
- evaluating the implementation process.[45]

OHS practices have the best chances of succeeding when supported by good supervision and performance management.

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39 Duffy J & Ask A, 'Ten ingredients for developing and implementing a drug and alcohol policy in your workplace' in Allsop S, Phillips M & Calogero C, (eds), *Drugs and work: Responding to alcohol and other drug problems in Australian workplaces*, IP Communications, Melbourne, 2001, p 78.

40 Alcohol and other Drugs Council of Australia, *Drug policy 2000: A new agenda for harm reduction*, p 165; Public Health Association of Australia, sub 159, p 17.

41 Gardner I, transcript, 15/8/02, p 1175.

42 Alcohol and other Drugs Council of Australia, sub 61, p 19; Gardner I, transcript, 15/8/02, p 1172; The Western Australian Network of Alcohol and other Drug Agencies, sub 91, p 11.

43 Alcohol and other Drugs Council of Australia, *Drug policy 2000: A new agenda for harm reduction*, p 165.

44 Duffy J & Ask A, pp 79-82.

45 Duffy J & Ask A, pp 82-84.

10.35 An example of a successful workplace program is that run for the building industry by the Building Trades Group of Unions Drug and Alcohol Committee. This program:

- was developed by workers for workers working from the bottom up;
- uses peer education strategies;
- raises awareness in the workplace;
- employs a harm reduction approach;
- emphasises the need for workers to take responsibility for their own and others' safety; and
- informs workers with drug and alcohol problems of available treatment options.

Mr Sharp reported that the program is now operating in four states.[46] Dr Gardner said that overseas programs also provide useful insights into successful approaches.[47]

10.36 From programs such as these one we can learn more about designing and implementing effective interventions to add to existing knowledge. Associate Professor Allsop advised we also know that:

> ... there are a number of industries that are well protected from harm. We can learn a lot by looking at those industries that have low levels of harm and by finding out why that is. … we will [probably] find that those companies that have good occupational health and safety, good levels of supervision and good safety records are likely to be the industries that have lower levels of alcohol and drug related harm. We need to identify effective interventions … [48]

10.37 In commenting to the committee on the current approach to dealing with drug use in the workplace, Dr Gardner identified seven elements that characterise this approach:

- legislative compliance;
- fitness for duty testing;
- employee and supervisor education;
- provision of employee assistance program programs delivered in the workplace;

46 Sharp T, transcript, 15/8/02, p 1177.

47 Gardner I, transcript, 15/8/02, p 1175.

48 Allsop S, transcript, 15/8/02, p 1171.

- limited support of residential treatment facilities;
- performance appraisal and counselling; and
- disciplinary proceedings including dismissal.[49]

Dr Gardner suggested that all of these elements need further consideration to ensure they best meet current working conditions.[50]

Recommendation 116

10.38 **The committee recommends that the Commonwealth, State and Territory governments fund a study coordinated by the National Occupational Health and Safety Commission to:**

- **investigate existing workplace policies and interventions to reduce the impact of drugs on workplace safety and productivity, with the aim of identifying best practice and areas that need change;**
- **trial innovative approaches to reducing the impact of drugs in the workplace;**
- **disseminate widely the best practice findings of these investigations and trials; and**
- **recommend any legislative changes deemed necessary to promote the adoption of best practice.**

10.39 Little information is available on the extent to which organisations have put in place workplace policies that address drug-related harm. ADCA reported that in many workplaces there are no formal policies[51], particularly the Employee Assistance Service NT said among small companies[52] and, Dr Gardner noted that on the basis of experience in the United States, small companies are the ones where drug abuse appears to be more prevalent.[53]

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49 Gardner I, transcript, 15/8/02, p 1174.

50 Gardner I, transcript, 15/8/02, p 1174.

51 Alcohol and other Drugs Council of Australia, *Drug policy 2000: A new agenda for harm reduction*, p 165.

52 Employee Assistance Service NT, transcript, 20/4/01, p 683.

53 Gardner I, transcript, 15/8/02, pp 1173, 1182.

10.40 ADCA has called for 'national guidelines and appropriate legislative frameworks for the implementation and monitoring of workplace alcohol and other drug policies' in all medium and large workplaces.[54]

> There should be a national impetus for workplaces to develop alcohol and other drug policies. Every Australian workplace should have an alcohol and drug policy as part of their broader occupational health and safety requirements, and as part of their insurance arrangements. The provision of best practice policy guidelines could significantly improve the quality of individual workplace alcohol and drug policies and practices. This role of encouraging and monitoring the development of alcohol and drug policies should be a national initiative, supported at both a state / territory and local agency level.[55]

Conclusion

10.41 The committee supports the need to further investigate effective interventions to reduce drug-related harm in the workplace. The committee believes that workplace alcohol and drug policies need to have a higher profile and supports ADCA's suggestion that every Australian workplace have an alcohol and drug policy under Occupational Health and Safety requirements and as part of their insurance package. Insurance companies could be encouraged to offer premium incentives to businesses who adopt this practice.

Recommendation 117

10.42 **The committee recommends that the Commonwealth, State and Territory governments promote the implementation and monitoring of workplace alcohol and other drug policies by developing national guidelines and appropriate legislative frameworks.**

Drug and alcohol testing

10.43 Dr Gardner reported that drug and alcohol testing is carried out routinely in some workplaces, and is a legislative requirement for certain defined hazardous industries, such as coal mining. In other cases, employers have interpreted their duty of care obligations to provide a safe working

54 Alcohol and other Drugs Council of Australia, sub 61, p 19.

55 Alcohol and other Drugs Council of Australia, *Drug policy 2000: A new agenda for harm reduction*, pp 165-166.

environment to include testing of employees.[56] Recent press reports suggest that the use of testing is spreading, for example in the transport industry and the Victorian building industry.[57]

10.44 Testing may be carried out randomly or targeted at particularly high risk individuals or areas of work; it is also used in recruiting workers and after accidents. The tests used may employ breathalysers and urine, blood, hair and saliva sampling. Alternatively they may test for impairment. Some submissions to the inquiry stressed that tests should focus on impairment rather than on the presence of drug metabolites in body fluids.[58]

10.45 Alcohol and drug testing not only safeguards employees and those with whom they come in contact, it also identifies those who need help. The Western Australian Network of Alcohol and other Drug Agencies maintains that it is important that testing programs be part of comprehensive workplace alcohol and drug policies.[59] In conjunction with workplace education, counselling, treatment and rehabilitation, testing allows for earlier intervention in the using career of affected workers than might otherwise be the case and improves these workers' contribution to the workforce. According to the Salvation Army (Southern Territory) the proactive use of screening devices and drug recognition techniques is useful in industry-based occupational safety initiatives.[60] In addition, Jackel's work showed testing produces a cultural shift in attitudes to drinking and drug taking, as the NSW police found when drug testing was instituted.[61]

10.46 Corry reported a number of secondary benefits have also been identified from testing, for example, it could reduce theft and the likelihood of blackmail, and foster public trust of organisations.[62] The last two points are of particular importance for public agencies, such as the police.

10.47 Workplace testing received support in some submissions to the inquiry, for example, mandatory testing for people in authority whose work

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56 Gardner I, transcript, 15/08/02, p 1182.

57 'Workers face workplace drugs tests', *Australian Associated Press*, Melbourne, 04/6/02.

58 Allsop S, transcript, 15/8/02, p 1171; NSW Users and AIDS Association, sub 128, p 6.

59 The Western Australian Network of Alcohol and other Drug Agencies, sub 91, p 11.

60 Salvation Army (Southern Territory), sub 43, p 5.

61 Jackel G, 'Workplace drug and alcohol policy and testing – the NSW police experience', *Conference Papers Collection*, CD-ROM, 2nd Australasian Conference on Drugs Strategy, Perth, Western Australia, 7-9 May 2002, p 5.

62 Corry A, 'Controls on drug use' in Allsop S, Phillips M & Calogero C, (eds), *Drugs and work: Responding to alcohol and other drug problems in Australian workplaces*, IP Communications, Melbourne, 2001, p 113.

involves making drug law and policy and contact with drugs and drug users.[63]

10.48 According to Dr Gardner, the evidence base does not support a requirement that drug screening programs be part of a test of fitness for duty. Only where considerations of public safety are concerned, such as airline and heavy vehicle operations, should testing be undertaken.[64] The ADCA, while opposing workplace drug testing in principle, also supported the view that it was reasonable to test for drugs where there was a risk to public safety and security.[65]

10.49 There are a number of further concerns with testing that were outlined in evidence:

- it is seen by some as an invasion of privacy[66] and legislative changes may be needed to adequately safeguard privacy where testing is carried out following injury;
- Dr Gardner said apart from being fraught with interpretational difficulties, problems arise in relation to considerations of chain of custody issues and false positive test results;
- he also said testing distracts attention from the contribution of other personal factors and workplace characteristics to workplace harm;
- Dr Gardner also suggested the efficacy of the computer screen-based tests that are widely used in sections of Australian industry to test impairment is unproven by large scale published studies[67]; and
- NSW Users and AIDS Association reported testing may not be as cost-effective as alternative approaches to reducing drug-related harm.[68]

Conclusion

10.50 The committee notes that although workplace testing offers benefits and received some support, it is also a contentious issue. As we saw earlier in this chapter, very little is known about the extent to which people go to

63 Catholic Women's League of Australia, transcript, 14/6/01, p 1018; Community Coalition for a Drug Free Society, sub 251, p 3; Festival of Light, sub 100, p 1.

64 Gardner I, transcript, 15/8/02, p 1176.

65 Alcohol and other Drugs Council of Australia, *Drug policy 2000: A new agenda for harm reduction*, p 166.

66 Australian Medical Association, transcript, 21/5/01, p 904; NSW Users and AIDS Association, sub 128, p 6; Nolan J, 'Employee drug testing: Some recent legal developments', in Allsop S, Phillips M & Calogero C, (eds), *Drugs and work: Responding to alcohol and other drug problems in Australian workplaces*, IP Communications, Melbourne, 2001, pp 62-63.

67 Gardner I, transcript, 15/8/02, pp 1172, 1174.

68 NSW Users and AIDS Association, sub 128, p 6.

work when intoxicated or drug-affected. Nor do we know, with the exception of alcohol, precisely what relationship there is between a positive result and impaired performance.

10.51 The committee is concerned about the flimsy basis on which drug testing has been built, given that we have inadequate information at present on the relationship of drug use to impairment, and large scale studies to validate the tests have not yet been carried out. The committee has already recommended further research on the relationship of substance abuse to workplace impairment, safety and productivity. It now also recommends that a better basis for the tests be established and guidelines for best practice in testing developed. It is important that privacy issues be addressed as well. Until all these steps have been taken, the committee believes that it is premature to recommend that all workplaces should be required to implement testing.

Recommendation 118

10.52 **The committee recommends that the Commonwealth, State and Territory governments, with input from unions and industry, fund a large-scale study to assess the efficacy of devices that purport to measure workplace drug use and impairment.**

Recommendation 119

10.53 **The committee recommends that the Commonwealth, State and Territory governments identify the privacy concerns relating to drug testing in the workplace, examine the need for legislative changes to address these concerns, and enact any needed changes.**

Recommendation 120

10.54 **The committee recommends that, following finalisation of the studies recommended in Recommendations 114, 116 and 118, the Commonwealth, State and Territory governments develop guidelines for best practice implementation and use of workplace drug testing.**

Implementing the recommendations

10.55 In order to reinvigorate efforts to curb the impact of substance use on the workplace, Dr Gardner suggested that a national summit should be held to focus attention on the issues involved. The summit's aims should be:

- to review existing knowledge, including international experience, so that a way forward can be identified; and
- to make plans the implementation of suggested changes, including the funding and conduct of necessary research.[69]

The committee agrees that such a summit would be a useful move in reactivating national approaches to improving workplace safety and productivity. It would contribute to the national OHS priority of strengthening the capacity of government to influence OHS outcomes.

Recommendation 121

10.56 **The committee recommends that the Commonwealth government:**

- **convene a national summit on the issues relating to reducing the impacts of alcohol and other drugs on workplace safety and productivity that will;**
- **involve all stakeholders and relevant international speakers; and**
- **develop proposals for the further development of the initiatives recommended in Recommendations 114-120 in this chapter.**

69 Gardner I, transcript, 15/8/02, p 1174.