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Alcohol Harm – Measuring and Building Capacity for Policy Response and Action

AlHaMBRA Project

D5.3 AlHaMBRA Project Thematic Workshop –

Final Background Paper: Working Together to Prevent Harm due to Alcohol in the Workplace

Segura and Rabal

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AlHaMBRA PROJECT

Alcohol Harm Measuring and Building Capacity for Policy Response and Action

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D5.3 Final Background Document for the

AlHaMBRA Project Thematic Capacity Building Workshop

Working Together to Prevent Harm due to Alcohol in the Workplace

Co-hosted by the Spanish Ministry of Health, with support from the Program on Substance Abuse of the Public Health Agency of Catalonia

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Background Document for the AlHaMBRA Project Thematic Capacity Building Workshop

Working Together to Prevent Harm due to Alcohol in the Workplace

(Final version - following the workshop and mapping survey)

Workshop co-hosted by the Spanish Ministry of Health, with support from the Program on Substance Abuse of the Public Health Agency of Catalonia

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Contents

This document

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Preparation

This briefing document was initially prepared to provide relevant background information to the participants of the AlHaMBRA Project workshop - *Working Together to Prevent Harm due to Alcohol in the Workplace.*

It includes four parts:

1. General information regarding the workshop
2. A briefing document introducing themes and issues for debate in the workshop and a literature review.
3. Annexes 1 & 2 give additional information related to the first draft of the background briefing document, and the hosting Member State.
4. Annexes 3 & 4 describe the mapping methodology and the main results and conclusions drawn from the survey exercise.

The Briefing document has been prepared in stages as per the technical specifications of the AlHaMBRA Project contract

- For the workshop, a draft was prepared which was revised following peer-review by an external expert in the field (review annexed to this document – Annex 2).
- Following the workshop and the deployment of the web-based survey, a report on the survey was prepared with the main results and the conclusion reached.
- Following the workshop and the survey, the document was revised again to include key lessons from the workshop discussion outcomes and findings from the survey results. This is the final version of the document.

AlHaMBRA Project workshop, Working Together to Prevent Harm due to Alcohol in the Workplace

This AlHaMBRA Project workshop took place within the frame of the prevention strand of the EU beating cancer plan, focusing on national policy measures to support effective workplace strategies to tackle alcohol consumption and harm. The three interlinked sessions, as part of the Capacity-building Thematic Alcohol Policy Workshop Series, explored different actors' perspectives, priorities, barriers and solutions in designing and implementing effective action to tackle alcohol use and promote safe and healthy working contexts at different policy levels (European, national and local) and a variety of work settings and industries.

Outputs will include a peer-reviewed scientific summary; a set of presentations or short videos introducing the evidence and on-going European initiatives and experiences; and a workshop report, including recommendations for research and policy at the national and European levels.

The workshop is the sixth of the Thematic Alcohol Policy Workshops organised through the EC HADEA tendered contracts, to reduce alcohol harm under the Eu Beating Cancer plan.

ACKNOWLEDGMENTS AND DISCLAIMER

This workshop and associated materials are produced under the service contract for the **AlHaMBRA Project** (Alcohol Harm - Measuring and Building Capacity for Policy Response and Action, Contract No. 20197105). The information and views presented in the sessions are those of the independent experts and speakers, and hence represent their sole responsibility. Accordingly, the information and views presented during sessions cannot be considered to reflect the views of the European Commission and/or the Health and Digital Executive Agency or any other body of the European Union. The European Commission and the Agency do not accept any responsibility for use that may be made of the information presented during the workshop sessions or briefing document.

The workshop is co-hosted by the Spanish Ministry of Health, with support from the Program on Substance Abuse of the Public Health Agency of Catalonia

Executive summary

Workplace-based policies and interventions for preventing harmful alcohol consumption

According to European national surveys, between 5% and 20% of workers are either "addicted to alcohol or at risk of becoming addicted to alcohol" but the results vary greatly by country, sector, type of occupation, level of educational attainment and employment situation. Alcohol is associated with poorer workplace outcomes such as accidents, low productivity, absenteeism, presenteeism, and a higher risk of unemployment. In the EU14 countries, approximately 5% of men and 2% of women who drink report that alcohol has a negative impact on their work or studies.

Because employees spend so much time at work, the workplace can be an ideal environment for the introduction of health promotion and alcohol prevention activities. However, interventions involving alcohol and health in the workplace can be hampered by organisational and other barriers such as privacy concerns, fear of punishment and lack of awareness of the dangers of alcohol at work. Tensions and competing interests among the stakeholders involved in workplace prevention must also be investigated and discussed.

Methodology

A review of peer-reviewed and grey literature was undertaken to identify studies, policies, reports and strategies related to workplace interventions for alcohol use. This was complemented by a mapping of existing actions and policies in the EU and other countries, identification of key areas of policy overlap, barriers to implementation and recommended topics for discussion in the workshop. It was also complemented by an online survey, of experts in the field of alcohol and work, addressing alcohol-related harm in the workplace and identifying tools for establishing workplace alcohol harm reduction policies.

Key findings and conclusions

The heterogeneity of interventions and the variability of results indicates that interventions need to be tailored to many variables; from type and size of a company to the resources available, local regulations, cultural values and the target population. In this regard, communication and harmonisation between European legislation, regulations and programmes is essential, to avoid *reinventing the wheel*. Regarding effectiveness, interventions evaluated with a robust methodology, such as with a randomized selection of participants and a control group, showed little improvements on alcohol consumption, or not better than no intervention or control interventions (information, leaflets etc.). Most of the interventions evaluated using a before-and-after design showed apparent effectiveness in reducing alcohol consumption. Even so, the lack of a control group in these studies makes it difficult to discern the real effect of the intervention, although some of them found alcohol reductions maintained after extended follow-up evaluation, and involved comprehensive structures that were evidence-based.

Furthermore, a lack of robust evaluation of interventions and the limited number of workplace interventions carried out in Europe makes it hard to draw conclusions that can be applicable to Member States. There is also a lack of data and statistics at the national level regarding alcohol prevention initiatives, and the cost of these interventions in the workplace.

A number of implementation barriers and facilitators were identified in the review. Particularly interesting are the issues between choosing secondary interventions (preventing relapse) or tertiary prevention interventions (reducing negative consequences), which involve different strategies and approaches, and both have benefits and limitations. The roles of workplace culture, the existence of referral pathways in the workplace, the manager's role

in alcohol prevention, lack of awareness of the issue, and ethical problems are all worth taking into consideration when implementing these types of interventions.

Employees' fear of being stigmatized and losing their job as a barrier to effectiveness is one of the most robust findings of the triangulated study: being put forward as a key barrier by the literature review, the survey and the stakeholders in the thematic workshop. This barrier is compounded by a lack of training for occupational health professionals and occupational risk prevention specialists, as well as a lack of educational and training initiatives for managers and co-workers to support prevention strategies.

This being said, with adequate attention and collaboration between the relevant workplace actors, there are several promising initiatives and plans for work in the field of workplace alcohol prevention (and associated healthy lifestyle promotion) in Europe, which have been highlighted in the review, mapping and survey work, which are detailed in this report and give public health experts reason to feel hopeful for the future.

Briefing document - Comprehensive literature review

Workplace-based policies and interventions for preventing harmful alcohol consumption

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Background

In people aged 15 to 65, alcohol is the seventh leading risk factor for death and disability-adjusted life years (DALYs) (1) and the first risk factor for ill health and premature death (2). Europe has the highest alcohol consumption per capita worldwide[1] and the European Commission has set a target of achieving a relative reduction of at least 10% in the harmful use of alcohol by 2025, as agreed by Member States as part of the Sustainable Development Goals[2].

According to European national surveys, between 5% and 20% of workers are either "addicted to alcohol or at risk of becoming addicted to alcohol" (3) but the results vary greatly by country, sector, type of occupation, level of educational attainment and employment situation. An Irish survey(4) found that that 4.2 percent of employed respondents missed work days due to alcohol consumption in the previous year. In the EU14, approximately 5% of men and 2% of women who drink report that alcohol has a negative impact on their work or studies (5). Some industries (construction, farming, horticulture, transportation) and occupational categories (blue-collared workers, managers) appear to be particularly vulnerable for alcohol consumption, and workplaces provide forums for health education and opportunities to identify those who have problems with alcohol and illicit drugs, as well as captive audiences (6).

The European Workplace and Alcohol (EWA) was a European project that collected best practices, piloted interventions, and developed recommendations to reduce alcohol-related harm in the workplace. According to the EWA evidence review, alcohol is associated with poorer workplace outcomes such as accidents, low productivity, absenteeism, presenteeism, and a higher risk of unemployment (2).

Because employees spend so much time at work (6), the workplace can be an ideal environment for the introduction of health promotion and alcohol prevention activities (7). However interventions involving alcohol and health in the workplace can be hampered by organisational and other barriers such as privacy concerns, fear of punishment and lack of awareness of the dangers of alcohol at work (8). The tensions and competing interests among the stakeholders involved in workplace prevention must be investigated and discussed. This document draws on the evidence gathered during the EWA project for the capacity building thematic workshops as part of the AlHaMBRA Project.

History and trends in policy action

[1] https://www.oecd-ilibrary.org/sites/82129230-en/1/3/2/2/4/index.html?itemId=/content/publication/82129230-en&_csp_=e7f5d56a7f4dd03271a59acda6e2be1b&itemIGO=oecd&itemContentType=book#

[2] https://www.europarl.europa.eu/doceo/document/E-9-2021-002908-ASW_EN.html

One of the five priority themes in the EU strategy to support Member States (MS) in reducing alcohol-related harm (9), was to "prevent alcohol-related harm among adults and reduce the negative impact on the workplace." This priority theme's goal was to "contribute to the reduction of alcohol-related harm in the workplace and promote workplace-related actions." This EU strategy called for action measures such as a policy to prevent alcohol-related harm, including information and/or education campaigns in all workplaces, as well as assistance and specialized care for employees with alcohol-related issues.

The European action plan to reduce the harmful use of alcohol 2012–2020 (10) outlines a variety of strategies for addressing alcohol-related harm at the local level. Policies promoting alcohol-free workplaces, a managerial style that reduces job stress and increases job reward, and optional workplace interventions that are available on request, such as psychosocial skills training, brief advice, and alcohol information programs, are all examples of strategies to reduce alcohol-related harm in the workplace.

According to data from the WHO database from 2018[3] 17 European MS have national guidelines for the prevention and counselling of alcohol problems in the workplace, and testing for alcohol in the workplace is governed by legislation in 11 MS. According to a 2017 progress report (11) social partners representing employers and employees are involved at the national level in action to prevent and address alcohol-related harm in the workplace in 19 MS.

Methodology and results of the literature review for Alcohol and Workplace

This section is divided into three parts that correspond to the three strands of this study (i) A review of peer-reviewed and grey literature (ii) Thematic Capacity Building Workshop and (iii) Survey design and implementation.

Methodology of the review of peer-reviewed and grey literature

RESEARCH QUESTION

Are workplace-based policies or interventions effective in preventing harmful alcohol consumption?

We conducted a systematic review of workplace-based policies or interventions for reducing alcohol consumption and a grey literature search. As well as reviewing the effectiveness of these interventions, we also undertook a qualitative review of the peer-reviewed evidence which identified process variables described in the development and implementation of programs and policies, barriers, and facilitators, to understand potential areas of improvement and development.

SEARCH STRATEGY

Peer reviewed literature

Sources consulted were PubMed, PsycINFO, Health evidence, Web of Science, Cochrane Library, and the WHO database. Searches were limited to papers published between 2000-2021. Searches were run in June 2021 and re-run one month before the final analysis and any further studies identified were retrieved for inclusion.

Inclusion criteria were workplace-based policies, programs, or interventions, implemented in or through the workplace setting, with the aim of preventing harmful alcohol consumption in working adults. Examples include lifestyle interventions, health promotion programs, brief interventions by occupational health professionals at the workplace (either face to face or web-based), screening of alcohol consumption, or self-help sessions. Studies that

[3] Global Health Observatory Data Repository (European Region) https://apps.who.int/gho/data/node.main-euro.A1195?lang=en&showonly=GISAH

targeted adults outside of the workplace, (e.g., community or primary care interventions), or employees under 18 years of age were excluded.

The initial methodology developed was aimed at identifying only interventions or policies developed in European Union Member States and other countries participating in the Health Programme[4] , so other countries were excluded from the initial analysis. Following the development of the search strategy and the extraction of the results, we modified it to include all workplace-based interventions, regardless of their country of implementation, due to the very low number of interventions in European countries. Types of studies included were meta-analyses, reviews, or individual research studies, examining the impact of interventions, programmes, and/or policies to prevent harmful alcohol consumption in the workplace.

Grey literature

Regarding grey literature databases and websites, a search of the terms of "alcohol + workplace" was carried out in grey literature repositories and specific websites for workplace stakeholders: Open Grey, Grey lit, Eurofound, WHO, OECD, OSHA, ILO, Movendi. Google structured searches were conducted for all EU countries plus Iceland, Norway, Serbia, Moldova, and Bosnia & Herzegovina (countries in the EU Health Programme) for workplace interventions or policies in each country.

Based on the mixed methods approach, process evaluations were studied, to extract:

- Efficacy in terms of health (e.g., alcohol use, psychological well-being measures, etc.) and workplace related (e.g., absenteeism) outcomes
- Implementation in terms of acceptability and feasibility (barriers and facilitators)
- Return on Investment or cost-effectiveness

Results of the review of peer-reviewed and grey literature

The search of peer review databases yielded 6459 results, following the screening process, 57 articles met the inclusion criteria (13 articles reviews, 44 workplace-based interventions). Eight from an EU country (plus Iceland, Norway, Serbia, Moldova and Bosnia & Herzegovina).

Grey literature searches resulted in 24 documents for inclusion in the qualitative analysis.

The flow of papers through the selection process is shown in Figure 1: PRISMA flow diagram.

[4] European Union Member States plus Iceland, Norway, Serbia, Moldova and Bosnia & Herzegovina.

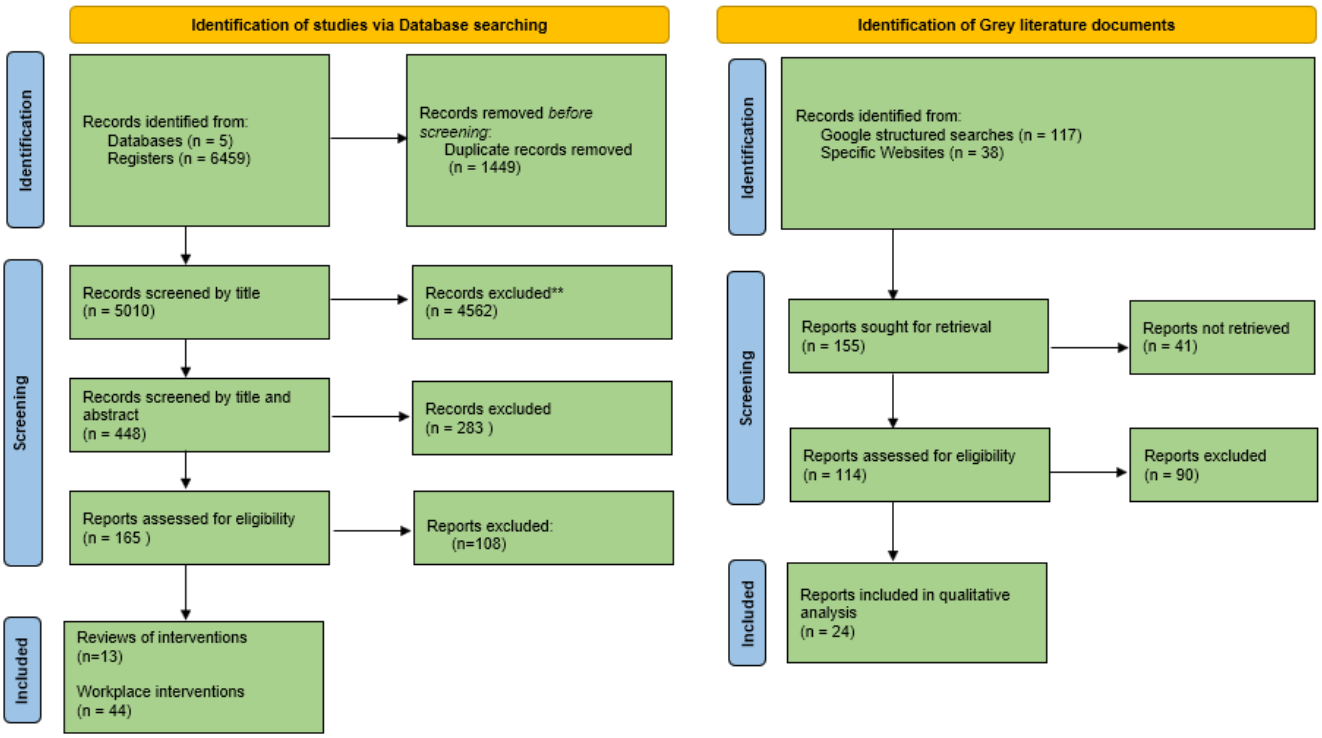

Figure 1: PRISMA diagram

INCLUDED STUDIES AND FINDINGS

Recent reviews on alcohol and workplace interventions and policies

Alfred et al. 2021 (12) is the most recent review on the topic, focusing on alcohol workplace policies (AWP), it does not assess the effectiveness of workplace interventions, but instead developed a narrative synthesis of their findings.

Coenen et al. 2020 (13) conducted a meta-analysis to examine socioeconomic inequalities in the effectiveness and adherence to workplace health promotion programs. Overall, they found that health promotion programs had no or little effects on lifestyle behaviours such as alcohol consumption, physical activity, diet, and smoking, which the authors considered to be consistent with the modest and inconclusive findings of other reviews of workplace health promotion activities.

A systematic review and meta-analysis of randomized control trials of e-mental health interventions in occupational settings (Philips et al. 2019) (14) that included alcohol misuse as one of the outcomes found that “the pooled effect on alcohol intake was small and nonsignificant”.

A systematic review (Yuvaraj et al. 2019) (15) of the effectiveness of workplace interventions in reducing harmful alcohol consumption among employees found a positive effect of these interventions to reduce alcohol consumption in workers with risky alcohol use defined as >15 standard drinks per week.

A 2018 overview of reviews in an Australian context, by Mewton et al. (16) on universal prevention of alcohol and drug use found evidence to support universal preventive interventions for alcohol in family and school settings, but in the case of alcohol and workplace there was insufficient evidence. A thorough Cochrane review of

implementation strategies**,** (17) didn't find clear evidence of effective strategies to improve the implementation of workplace-based interventions.

A systematic review of risk factors for alcohol use in male-dominated industries by Roche et al. (18) found that factors associated with risky alcohol use could be categorized into seven domains: demographic (being male, middle age), individual (depressed, negative life events), social norms at work (permissive drinking norms), work conditions (high workloads and job stress, low collegial support), team environment (supervisory abuse), work-home interference (using alcohol to unwind after work), and structural/socio-economic (lower SES workers). This review made recommendations such as addressing workplace drinking norms, reducing job workloads and stress, and improving workplace support.

An update of alcohol screening and brief intervention (ASBI) randomized controlled trials by Schulte et al. (19) analysed the expansion of ASBI in non-medical settings (workplace and social services). The randomized controlled trials, like in previous reviews, were so diverse that conclusions could not be drawn.

An overview of systematic reviews of population-level interventions to reduce alcohol-related harm in various settings, including workplace by Martineau et al. (20) found weak evidences for alcohol-targeted workplace interventions. Similar conclusions were found in a systematic review of the impact of worksite wellness programs by Osilla et al. (21) indicating a lack of strong intervention evaluation.

A 2011 review on prevention interventions of alcohol problems in the workplace by Ames and Bennett found that drinking rates were not significantly reduced overall (22). They also proposed a guided framework for integrating alcohol prevention approaches that includes three perspectives: the target of the intervention; program reach (and overlap); and program fit. This is shown below in Figure 2.

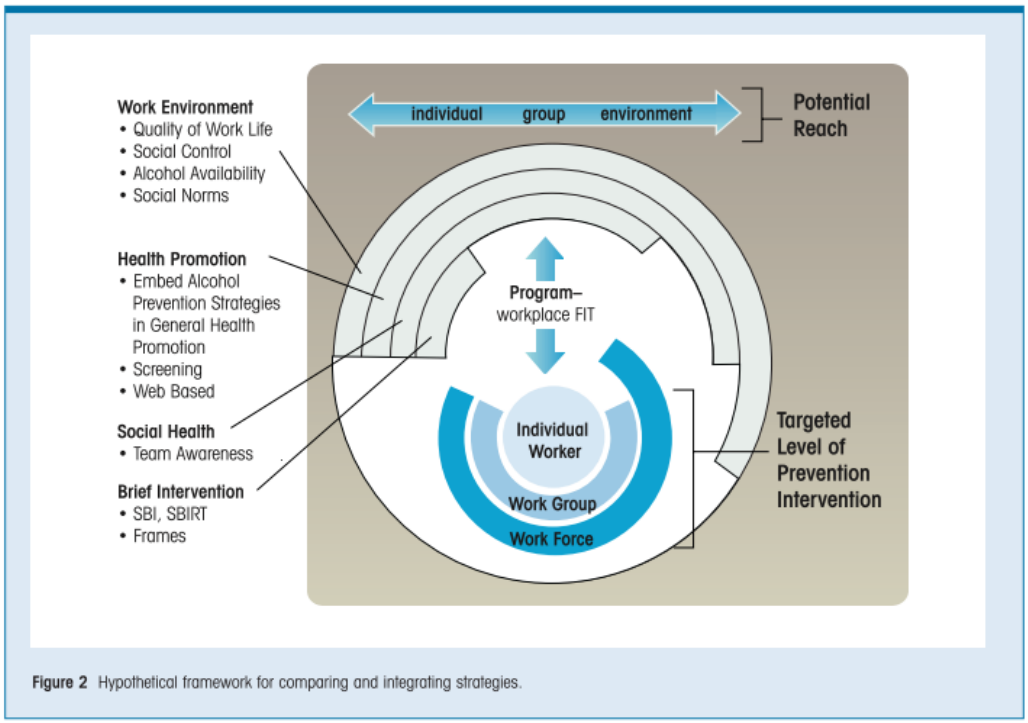

Figure 2- Guiding Framework (Ames & Bennett, 2011)

A systematic review of workplace interventions for alcohol-related problems (23) found few methodologically adequate studies of work-place alcohol interventions. Study designs, types of interventions, measures employed,

and types of workplaces varied considerably, making comparison of results difficult, but they found some indications that brief interventions could potentially have beneficial effects.

INCLUDED INTERVENTIONS

Overall, 44 intervention studies between 2000 and 2021 on alcohol at workplace were found via database searching, but only 8 of them were conducted in a European country. The table in the Annex 1 provides a summary of their main characteristics of the European based studies.

There have been a low number of studies done in Europe on workplace alcohol, generally low effectiveness of interventions, with Education and Brief interventions the most common instruments used. Of the eight interventions for workplace and alcohol there were four with a randomized controlled trial design: three found no differences between intervention and control groups (24-26) and one was inconclusive (27).

Only one intervention (28) had a quasi-experimental design (control group but not randomized allocation) and found no significant effect, although a subgroup analysis showed reductions in binge drinking. Two out of the three interventions that had a before-and-after design (29) and (30) showed effectiveness in reducing alcohol consumption. The lack of a control group makes it difficult to discern the real effect of the intervention, but they maintained alcohol reductions after long follow-up times and involved comprehensive structures with evidence-based interventions. One intervention (31) found no significant effect.

Due to the reduced number of workplace interventions developed in European countries, we widened the inclusion to consider all interventions, irrespective of country. Out of the 44 studies, almost all alcohol and workplace interventions between 2000 and 2010 had been already included in the ten mentioned reviews and effectiveness analysis, while most of the interventions developed between 2010 and 2021 had not been analysed. Thus, we summarized the findings of these reviews while analysing in detail the interventions developed between 2010 and 2021 (table in Annex 2).

Of the nine interventions that used a randomized control design, two were clearly not effective, other two were effective in reducing alcohol consumption and alcohol-related accidents compared to the control group, and the other five were inconclusive.

Interventions that had a quasi-experimental design (control group but not randomized allocation) showed mixed results. Three interventions were not effective. The only study that was found effective targeted workers under disciplinary action whose employment contract could be terminated in case they failed to adhere to treatment. Regarding interventions that had a before-and-after design, eight out of ten showed effectiveness in reducing alcohol consumption but the lack of control group makes it hard to have conclusive evidence of their effectiveness.

QUALITATIVE RESULTS

Secondary vs Tertiary prevention

Different levels of intervention are used depending on the level of risk from alcohol use in the target population. Secondary prevention focuses on identifying harmful alcohol use before the onset of overt symptoms and early detection before there are managerial issues and loss of workforce (32). These initiatives have bigger scope, with more potential people as the target, but are likely to achieve more modest individual results, since they target people with moderate drinking risk and there's less room for improvement. Nevertheless, the overall impact of this prevention can be considerable since it targets a bigger population.

Tertiary prevention focuses on providing support to people who already have problematic drinking including alcohol dependence. This target has been found to yield bigger decreases in alcohol-reduction interventions (15), but it tackles the problem when it already has had an impact, which comes at a cost. Also, it leaves the majority of people who are at risk of developing a problem out of alcohol prevention initiatives.

This dichotomy between secondary and tertiary prevention was analysed in the WIRUS project (33): "Risky drinking employees primarily need secondary prevention, yet Occupational Health Services (OHS) primarily focus on tertiary prevention" (...) the vast majority of risky drinkers (9 out of 10) would, according to international intervention guidelines, benefit from simple secondary prevention interventions, yet OHS alcohol prevention activity was more focused on tertiary than on secondary prevention". In the review (12), the authors identified a tendency for alcohol policies to "disporportionally address" tertiary prevention by being directed to dependent drinkers.

Workplace culture

If management does not consider the prevention of alcohol use as a priority, workplace culture can be a barrier for implementing alcohol policy, alcohol use linked to socialization and networking at work can make management less inclined to tackle alcohol problems (34). Factors that have been found to present an increased risk of harmful alcohol use in workers are: availability of alcohol at the workplace, work pressures, peer group pressure, co-worker collusion, lack of supervision, financial hardship, financial independence, physical danger, and interface with a demanding or aggressive public (35).

The report from Eurofound also found that reasons for alcohol consumption can be related to the work culture and environment (3) "such as arduous working conditions, irregular working practices or psychological stress at work", and that non-work related factors can include cultural tolerance of alcohol in the workplace and ease of access.

Referral pathways in the workplace

Clear referral pathways are key to facilitate support and care to employees who present signs and symptoms of substance dependence (29). This can include identifying community support organizations, and training managers to help employees that need access to these type of services (36).

For example, in Baby et al 2019 participants weren't aware of the existence of "path to care" workplace referrals or the organizational policies around alcohol abuse (32). This can create the problem that even if interventions and referral opportunities exist in a workplace, employees might not make use of it due to lack of awareness.

The manager's role in alcohol prevention

An analysis of the manager's role in workplace alcohol prevention found (37) that managers with a greater number of employees demonstrated the highest level of organizational alcohol policy knowledge and were more inclined to initiate early alcohol interventions·. In their findings, alcohol policy knowledge was associated with inclination to intervene, becoming a potential facilitator when implementing workplace-based alcohol policies and interventions.

This is particularly important in Small and Mid-size Enterprises (SMEs) since setting up a prevention plan for alcohol needs that the managers are more aware of their own health, and in turn they can be more inclined to take an interest in the health of their staff (38).

Low perception of risk

Lack of awareness of alcohol risk is a common barrier for prevention implementation. A study in Spain (39) found that the **perception of risk consumption was low when compared to the quantified risk**. Thus, they recommended that the training campaigns and health promotion initiatives incorporate knowledge of alcohol consumption risk. This has been also found in analysis of barriers and facilitators for co-produced cultural approaches (36) with the

"common belief among stakeholders that alcohol use was not a major issue in the workplace.". The WIRUS project in Norway also found evidence that "risky drinking was quite common among employees, yet OHS' alcohol prevention activity was limited"(33). Among employees, 60% of the study population in an intervention (32) reported lacking knowledge about alcohol-related harms or the implications of increased alcohol use, and in another (40), workers that had high risk didn't consider themselves to be people who drank too much.

In some contexts alcohol consumption after work is "seen as a transition ritual"(41) and as a tool for strengthening group cohesion, as drinking together was viewed as an investment that lead to positive outcomes for the work environment. The low perception of risk can be due to a perceived low prevalence of alcohol problems in the workplace. However an analysis of alcohol use at work (42) found that despite the relatively low prevalence of alcohol-related absence and inefficiency, even one employee can have substantial negative consequences for the workplace in terms of loss of productivity, workplace safety and the broader psychosocial environment.

Utilization rates/preferences/enrolment for alcohol interventions

Workplace interventions can have problems in participation rates. Low enrolment can be a problem, and the reasons for this include preferences for self-help rather than being a part of workplace interventions, as well as fears of stigmatization (24). In an analysis of face-to-face vs online occupational health screenings (43) respondents were more inclined to disclose mental health issues online than with a physician, with an increased likelihood in people who were "male, younger, with lower educational attainment or lower trust in physicians, taking medication, or having a lower risk on alcohol abuse". It has also been found that employees with lower levels of health-related factors were less likely to participate in health promotion activities at work (44). Even in workers that wish to change health behaviours (45) the "no-help option was selected fairly frequently and mostly in relation to alcohol and smoking". There is also some discussion of whether framing alcohol within a well-being approach might increase enrolment and acceptance (36) but the evidence is not clear.

It can be important to take into account the likelihood of following through an intervention depending on the alcohol risk. For example, in an alcohol education intervention, Tinghög & Tinghög, 2016 (28) found that those who dropped out and only participated in the first questionnaire had reported higher rates of alcohol consumption.

Small businesses vs big businesses

The issue of prevention programs in small companies' vs big companies is also a key theme. SMEs may have difficulty following rigid prevention plans that involve a complex degree of interventions (38). It has been found that larger employers are more likely to implement measures than smaller ones (34) and more likely to have enough resources for them. But this poses a problem since most of the employers belong to micro, small, or medium enterprises that also carry a bigger burden of alcohol impact (38).

In a cluster randomizes trial of alcohol prevention, (46) found that only 29% of businesses with 50-99 employees had alcohol screening for their employees, while 71% of large companies (more than 750 employees) had those programs. This can be due to costs, but an estimation of return on investment of health programs in small companies (47) suggested that they can benefit and have a positive ROI.

Small business employees have been found to be more likely to participate in worksite wellness programs (48), although in this study, large business employees experienced improvements in alcohol use while small business employees didn't reflect that result.

Cost of interventions, return on investment

There is lack of data to evaluate the return on investment for alcohol interventions. The cost of the different interventions varies considerably, between more complex and long programs to very short interventions that

require low investment, but most studies don't report the cost of the intervention. Some programs mention that there was budget allocation without specifying the amount (7, 28, 49).

An intervention focused on occupational accident risk (30) showed a net saving of about 15 € for each 1 € invested in alcohol testing. A comprehensive lifestyle intervention for cardiovascular risk (50) reported a cost of $300 per participant, which was moderated from previous more expensive interventions by a cooperative agreement with a school of nursing.

One study (47) reported an annual program cost per eligible employee of $89.82 dollars and suggested that small businesses could have a positive ROI from effective risk reduction programs. More comprehensive and methodologically stronger study designs seem to provide smaller financial returns (51) and some authors (28) go as far as questioning the likelihood that employers are willing to single out alcohol as an issue to perform such large and expensive interventions.

Stigma and negative consequences of alcohol disclosure

There are considerable challenges regarding ethical considerations, particularly privacy and confidentiality issues (34). Some reviews have found that employees were wary of the potential negative consequences of self-disclosure of alcohol and mental health problems in the workplace (19, 52).

However, stigma is contextual, depending on the beliefs and attitudes towards alcohol, and can't be taken for granted. For example, one intervention found no issues on fears for participation when they were expecting it to be a considerable barrier (27). Careful assessment of the stigma in the specific context where it is intended to implement a program could be part of the intervention plan.

In the intervention by Spicer et al 2016 (53), only 19% of the eligible employees responded to the initial survey even when there were protections put in place to ensure privacy. The authors attribute this low participation to a reluctancy of sharing personal details related to alcohol consumption and fear of a breach in confidentiality.

Who is at risk? Problematic businesses

Alcohol and drug consumption by workers has been found to be more relevant in certain sectors (construction, farming, hospitality (especially Ho.Re.Ca), transport) and it also has been seen in occupational categories depending on the type of addictive substance "alcohol among blue-collar workers, cocaine among professionals in ICT and financial services" (3). In relation to occupational careers, alcohol consumption tends to be higher among people in managerial and professional roles compared to lower paid roles (54).

The review by Anderson and Martinic (55) found three particularly at-risk groups to intervene: "those working in the retail alcohol trade, labourers in the construction industry, and seafarers and dockers". According to the Securex 2008 study on alcohol consumption among Belgian employees (in Dutch), the tolerance of Belgian enterprises to drinking alcohol at work is higher for white-collar workers (20% were allowed to do it daily compared with an average of 5%) and for workers in the private sector (19% compared with 12% in the public sector) (3).

Methodology of the Thematic Capacity Building Workshop

WORKSHOP STRUCTURE

This AlHaMBRA Project workshop took place within the frame of the prevention strand of the EU beating cancer plan, focusing on national policy measures to support effective workplace strategies to tackle alcohol consumption and harm. The three interlinked sessions, as part of the Capacity-building Thematic Alcohol Policy Workshop Series, explored different actors' perspectives, priorities, barriers and solutions in designing and implementing effective

action to tackle alcohol use in workplaces at different policy levels (European, national and local) and a variety of work settings and industries.

Outputs include a peer-reviewed scientific summary; a set of presentations or short videos introducing the evidence and on-going European initiatives and experiences; a host country report and this workshop report, including key messages and conclusions from the event.

The sessions opened with a welcome message from the hosting Member State, Spain and the AlHaMBRA Project leader, from SICAD, Portugal. This was followed by a series of presentations grouped into three session topics and continued with breakout small group discussions focusing on a set of pre-prepared questions. Feedback from groups was then shared with all the participants by the rapporteurs in each group, wrapped up with a brief summary by the Chair and topic experts/presenters.

Structure and contents of the three sessions:

	Session one	**Session two**	**Session three**
Welcome	Welcome and introduction		
Presentations and Q&A around key topics	• *European context on the alcohol prevention in the workplace*, representatives of EU-OSHA, WHO Global Occupational Health Programme • *State-of-the-art / best practices at European Level*	• *Alcohol prevention at workplace: the main actors' perspectives* • *Stakeholders' perspectives – coordination of prevention efforts*	• *Key implementation challenges – Promoting disclosure and health in different work contexts*
Breakout small group discussions and feedback to main group	***Intersectoral priorities*** *1. Specific regulations (transport, education etc)* *2. Intersectoral coordination (Labour/Health/Road Safety)* *3. Coordination among health actors (occupational health/health system)*	***Overcoming barriers*** *1.The impact of working conditions and psychosocial risks on alcohol consumption at work* *2.Increasing awareness of alcohol-related risk in the workplace* *3.Embedding alcohol prevention at the workplace – from promotion/prevention to occupational health* *4.Improving coordination to support workers through prevention, treatment and reintegration initiatives*	***Implementation challenges*** *1.Self-employed, small and medium companies* *2.Large companies and multinationals* *3.Risky, high-impact and sensitive work areas* *4.New working conditions after COVID (teleworking, safety measures)*
	Summary and wrap up		

ATTENDANCE

The sessions brought together over 95 participants from the EU and beyond.

Session 1 brought together 92 participants, and Session 2 brought together 69 participants. Across both sessions, participants represented 19 EU and 14 non-EU countries, and came from diverse sectoral backgrounds – public administration, academic, enterprise, clinical and civil society.

See Annex 2 for a breakdown of participation by session, country and sector.

Results from the Thematic Capacity Building Workshop

LESSONS LEARNED FROM THE WORKSHOP

During the online sessions panellists presented their knowledge, perspectives, and experiences, through short videos and live question and answer sessions. Then, in small-group discussions, with a pre-assigned moderator and rapporteur, participants were instructed to reach a level of consensus on responses to a concrete policy question. Their discussion and points for further consideration were reported back to and discussed with the whole group to arrive at key messages and proposed actions to address alcohol-related harm in the workplace. The main take-home messages raised and supported by participants are summarized in *Box 1* below.

Box 1: Main messages coming out of workshop sessions

- There is robust evidence of the **high impact of alcohol on workplace** health and safety and **loss of productivity.**
- The workplace is a good setting to reach **adults and implement addiction prevention strategies**, but there is wide variation around Europe, and harmonisation is needed.
- All actors **need to be involved** when designing the initiatives, **health professionals, employees, employers and more**.
- It is more cost-effective to prevent alcohol problems than to replace workers with alcohol use disorders.
- Major barriers to alcohol prevention at the workplace include **stigma, cultural attitudes and how alcohol is often viewed as a private behaviour**.
- Health roles are split among different actors (even between different health systems - general health and occupational health), with suboptimal communication systems, which cannot ensure worker privacy.
- There is a **lack of data and statistics**, and a lack of resources (especially acute for SMEs and freelance workers)
- It is essential to **clarify roles and responsibilities** and to improve coordination between stakeholders, involving unions at all stages of design and planning.
- One important step forward is to have a **national framework/alcohol policy, including a zero alcohol in the workplace** clause, and involve workers in the process;
- On the other hand, action is most effective when implemented at the local level and embedded in the local community and coordinated with the general and specialised health services.
- We need to **consider multiple levels of risk** (not an individual problem) – collective aspects of alcohol need to be addressed collectively
- **Testing can be a tool in a wider prevention policy**, but it is important to not have a punitive approach and to protect workers' privacy and confidentiality of outcomes
- **Training:** Occupational health professionals and workplace risk-prevention specialists need in-depth training, as well as educational and training initiatives for managers and co-workers to help with prevention strategies
- Further research is needed to support the knowledge base on the impact of alcohol and ongoing **prevention initiatives in companies of different sizes**, sectors and in different national contexts, including cost analysis, implementation research ineffective interventions, and possible links between alcohol and workplace violence and sexual assault (in-company and 3rd party).

Methodology of the Survey.

A survey has been designed to (1) to map and collect information for each member state on the address alcohol related harm in workplaces, striving to understand the complexity of harm reduction alcohol policies in the workplace and provide tools for their implementation, (2) to acquire basic understanding of the functioning of

Occupational Safety and health (OSH) structures in the different countries regarding the implementation of alcohol prevention programs, (3) to identify of barriers towards the implementation of alcohol prevention programs in the workplace in the different member states, and (4) to identify best practices.

SURVEY STRUCTURE

The survey was structured into four main parts. The first section (10 questions) collected data on alcohol prevention programs in the country, and on the actors and role of Occupational Safety and Health in companies. The aim to provide information on the OSH structure for each member state. The second (14 questions) intended to identify barriers in the implementation of alcohol consumption prevention programs in the workplace. And the third one (13 questions) aimed at collecting information about Occupational Health Services alcohol consumption-related problems and best practices.

SURVEY IMPLEMENTATION AND TARGET POPULATION

The survey was developed and conducted online. Data was collected using the Jotform platform (https://www.jotform.com/) on the commercial account of the FCRB (Spain). The participants of the survey were identified by a previous mapping of key actors in the implementation of alcohol prevention programs in the workplace. It included 171 key stakeholders from 39 countries others than Spain, 95 from Spain and 38 EU-OSHA national focal points (one from each country). In total 304 key actors were identified.

DISSEMINATION

The survey was sent through a link to the online form (https://eu.jotform.com/220533441253344) as part of a personalised e-mail and with a formal invitation letter in English to the 304 key stakeholders. In total, 41 completed surveys were received from 21 countries.

RESULTS FROM THE SURVEY

Only 5% of the respondents answered that in their country there are no alcohol prevention policies in occupational health and safety legislation. However, 21% responded that these programs are not implemented in their country.

Approximately half of the respondents mentioned that alcohol prevention programs are usually provided by companies and the other responded that they are provided by governments or public administration. The size of the company and the economic sector determine the organization of occupational safety and health (OSH) prevention services at the company level.

The actors that play an important role in the establishing of alcohol prevention programs in the workplace is the Internal Occupational Safety and Health (OSH) services, followed by the Ministry of Health (Department Health Promotion), the Ministry of labor, and the Labor Unions and Workers` association and employers. The Ministry of labor is in charge of Occupational Safety and Health responsibilities in most countries (55%) or both Ministry of labor and health in 35% of the respondents.

The most highly ranked barrier to the implementation of alcohol prevention programs in the workplace by respondents were the lack of protocols followed by the fact that workplace alcohol prevention is not a priority for management and companies do not consider themselves responsible for alcohol use disorders among their workers.

Another important barrier found was the difficulty for companies to access the data of workers registered in the national health system to facilitate their intervention in the alcohol prevention. In addition, in some countries there were no regulatory framework to test employees for alcohol and drugs and in 45% of the countries, the regulatory

framework is applied only in some cases depending on the profession, as in the case of pilots or bus drivers, or in the collective agreement.

Regarding, training to deal with alcohol consumption-related problems, 60% of respondents affirm training to occupational health professional is offered. 10% respond that this training is mandatory

Periodic check-ups are mandatory in most countries, but alcohol consumption is only addressed in 17% of countries, mostly directly through questionnaires during the check-up. Only 14 countries responded to the question of whether there are referral mechanisms from the workplace to the addiction treatment system, 7 answered no. And 11 said that the employer can take disciplinary control measures depending on the company's policies.

Discussion (including limitations)

Main results

The heterogeneity of interventions and the variability of results indicates that interventions need to be tailored to many variables, from type and size of company to resources available from Health and Labour departments, regulations, different cultural values and statistics associated to alcohol in each country, sector and occupation of the target population. Some decisions such as the election between secondary and tertiary prevention, the role of the managers or the ethical issues need to be tailored to the objectives.

Regarding effectiveness, the interventions with a more robust design were the most likely to be inconclusive or show no effectiveness. Interventions with a randomized selection of the participants and a control group showed little improvements on alcohol consumption, or not better than no intervention or control interventions (information, leaflets etc.). Most of the interventions that had a before-and-after design showed apparent effectiveness in reducing alcohol consumption. Even so, the lack of a control group makes it difficult to discern the real effect of the intervention, although some of them maintained alcohol reductions after long follow-up times and involved comprehensive structures that were evidence-based.

A main limitation is that many workplace interventions in different industries do not get published in peer-reviewed journals; and of those that do, many are low quality interventions, with no control group. Also, the limited number of workplace interventions carried out in Europe makes it hard to draw conclusions that can be applicable to Member States.

Another limitation is the lack of data regarding cost of the interventions. Out of the interventions analysed, only four reported costs, but the interventions had very different methods, time allocated for the intervention and personnel involved, so it’s difficult to extrapolate conclusions regarding return on investment.

Many topics appeared in the analysis of barriers and facilitators. Of particular interest are the issues between choosing secondary or tertiary prevention interventions, which involve different strategies and approaches, and both of which have benefits and limitations. The roles of workplace culture, the existence of referral pathways at the workplace, the manager’s role in alcohol prevention, lack of awareness of the issue and the ethical problems are worth taking into consideration when implementing this type of interventions.

The mapping exercise, for good practice and initiatives to reduce and prevent alcohol use or harms in workplace settings, identified a number of promising, innovative and evidence-based approaches through the literature review. The results of this mapping are described in the next section, and were presented and discussed at the Thematic Capacity Building workshop.

Mapping of existing actions

Key actions in the EU and other countries identified through the literature review and the stakeholder interviews

The **FASE - Alcohol at the workplace** project (56) published a list of good practices, programmes or projects in European countries (57).

The **European Workplace and Alcohol** (EWA) project co-funded by the European Commission had the aim of creating effective methods for raising awareness of the risks associated with alcohol consumption and to effect organizational change that results in a reduction in alcohol-related absenteeism and injuries. To achieve this, they developed and disseminated a workplace toolkit (58) and guidelines for safer alcohol consumption among European employees. They also created a report on best practices with recommendations for policymakers at the EU, national, regional, and local levels (59).

Recommendations from the toolkit:

- have a comprehensive, written workplace alcohol policy
- where resources allow, adopt a comprehensive health-related alcohol program
- review working practices, leadership styles and other factors that can cause work-related stress and, potentially, lead to alcohol heavy drinking
- make workplaces “alcohol-free”.

This toolkit is organized into three levels of intervention based on the elements introduced and the resources invested by the organization: basic, intermediate, and comprehensive as shown in Figure 4 below.

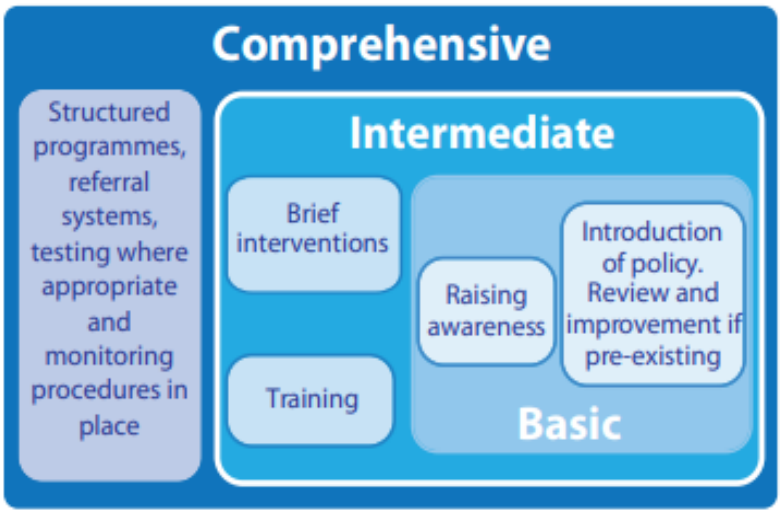

Figure 4 - Levels of intervention- EWA

Eurofound report

After researching the presence of alcohol and drugs in the working population, the European Foundation for the Improvement of Living and Working Conditions, published their report “*Use of alcohol and drugs at the workplace*” (3). This report contains a list of sources, national statistics and figures on the prevalence of alcohol/drug use at the workplace in the EU27 Member States and Norway.

The Eurofound report analysed how substance use is addressed in workplace legislation in Europe:

- National labour codes and worker statutes (Bulgaria, the Czech Republic, France, Latvia, Lithuania, and Spain)
- Specific mention of impairment in laws regarding health and safety at work (Austria, Estonia, Ireland, Luxembourg, Slovakia, Slovenia, and Sweden)
- Collective agreements between 'social partners' such as labour unions (Belgium, Germany, and Denmark
- General laws on drug use with specific mention of the workplace (Italy, Poland, Slovakia, and Slovenia)."

European data on alcohol and workplace

Regarding alcohol and workplace, the European Commission has carried out several Special Eurobarometer on EU citizen's attitudes towards alcohol, the most recent being the Special Eurobarometer 331 from 2010. The report from the European Foundation for the Improvement of Living and Working Conditions (3) surveyed representatives from all Member States and listed all available country surveys on alcohol prevalence.

WIRUS[5] **(Workplace Interventions preventing Risky Use of alcohol and Sick leave)** is a research project funded by the Norwegian Directorate of Health, with the goal to provide knowledge about alcohol consumption, develop workplace interventions and learn about its implementation barriers and facilitators and cost benefit and cost-effectiveness analysis of them. It includes a systematic literature review on sickness absence and alcohol consumption a Randomized control trials on alcohol interventions to evaluate alcohol consumption, sickness absence and presenteeism (60). It is focused on employees who are risky drinkers, i.e., employees who drink more than the World Health Organization (WHO) recommends, without having developed serious health consequences or alcohol addiction (secondary prevention).

Akan (Working life's competence center for drug and addiction problems)

Akan is a model for the prevention of drug, alcohol and gambling problems in the workplace. It is based on tripartite cooperation between the Norwegian Confederation of Trade Unions (LO), the Norwegian Confederation of Enterprises (NHO) and the Norwegian State.

It is also a training program for managers and employees to prevent and deal with problematic use of alcohol, drugs, medicines and gambling.

The Akan-model consists of three elements:

- Establish a policy for alcohol, drugs and gambling-activities within the workplace, make it known among all employees and integrated as part of the company culture &HSE-work
- Empower leaders to intervene early, and inspire employees to take action when it comes to hazardous alcohol and drug use, as well as gambling
- Offering help for those with an alcohol, drug or gambling-problem by individual Akan-contracts in cooperation with the occupational health care system or the person's doctor

European Monitoring Centre for Drugs and Drugs Addiction

[5] https://presenter.no/en/wirus-information/

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is the leading authority on illicit drugs in the European Union. The EMCDDA has developed a miniguide. This mini-guide on health and social responses "Workplaces and drugs" is one of a large set, this provides an overview of the topic, shares experiences and discusses future challenges. Case studies describing substance use in the workplace and prevention measures taken are presented. This miniguide also guide in what to consider when planning or delivering health and social responses to drug-related problems at the workplace, and reviews the available interventions and their effectiveness. It also considers implications for policy and practice.

The Lisbon-based agency of EMCDDA provides independent scientific evidence and analysis on all aspects of this constantly changing threat to individual lives and wider society. Its work contributes to EU and national policies to protect Europe's citizens from drug-related harms.

European Workplace Drug Testing Society (EWDTS)

The EWDTS was formed at the end of the First European Symposium on Workplace Drug Testing, held in Huddinge, Sweden, in March 1998. The EWTDS provides a focal point for the exchange of ideas and information about how drug testing can be considered or used within a workplace. EWDTS is a forum for discussion.

The EWDTS brings together the users and providers of these services, plus the equipment suppliers. Employees and their representatives; Human Resources; Occupational Health; Risk Assessors; Compliance Officers; Lawyers (for the company and for the employees); Drug Counselling and Treatment Providers.

In this forum of discussion, concerns and misunderstandings can be discussed and resolved. European and other regulatory issues can be explored against the background of different cultural and legal expectations. New technical developments can be evaluated in conjunction with the people who have to deal with the practical application of workplace policies

MENTUPP (Mental Health Promotion and Intervention in Occupational Settings)

It is a project on mental disorders and alcohol prevention in the workplace with the aim of improving mental health in the workplace by developing, implementing and evaluating a multilevel intervention targeting mental health difficulties in Small and Medium Enterprises (SMEs) in the construction, health and ICT sectors.

EMPOWER (The European platforM to PromOte Wellbeing and HEalth in the workplace)

EMPOWER is a European project to reduce the impact of mental health problems at the workplace including alcohol consuming problems, specially iniciatives for tackling stigma in alcohol prevention programs. The aim is to develop, pilot and evaluate a cultural and gender-sensitive multi-modal and integrative eHealth platform compiling the most feasible, brief and cost-effective interventions currently available in Europe to promote health and wellbeing and prevent common mental disorders using a variety of strategies to reduce the negative impact of mental health problems in the workplace.

Flemish expertise centre on Alcohol and other Drugs (VAD)

VAD is the umbrella organization of the Flemish organizations that work on alcohol and other drugs in Belgium. It is the partner organization of the Flemish government in the context of the prevention policy for alcohol and other drug problems. It offers reliable and independent advice and materials on alcohol, illegal drugs, psychoactive medication, gambling and gaming. VAD is also the umbrella organization of the Flemish organizations that work on alcohol and other drugs.

HUUGO program

HUUGO is a Finnish program that aim to help work communities to prevent, identify, face and solve substance abuse problems in the workplace. It includes activities carried out by the experts of the adult substance abuse prevention unit. The Occupational Safety Center acts as an important partner . The operation is based on the recommendation on the handling of substance abuse issues at workplaces, jointly accepted by all labor market organizations. It provides information, training and tools for dealing with substance abuse problems in the workplace

Main policy areas of overlap (cross-sectoral issues)

Main policy areas involving more than one sector

Workplace safety regulations fall in the area between **Health** and **Labour and Employment**, with an ongoing debate of competencies at various levels that creates an important barrier for the implementation of workplace alcohol initiatives. On the level of government organization, work between Health and Labour departments has not always been as coordinated as some professionals think it should be. The administrative separation between Health and Labour creates organizational barriers and can result in a lack of action due to not clear competencies in the topic.

This organizational barrier has been found both in the literature review and in the interviews with stakeholders, and it also permeates the relationships between occupational doctors and employers, with the question being of who is responsible for health and safety at work (38). There is a lack of clarity of the roles for occupational doctors, and in many times, this leads to a lack of coordinated efforts to address alcohol at work.

Another policy area that has been traditionally involved in tackling alcohol at workplace is the **transport** sector. About 25% of all road fatalities in Europe are alcohol related (61), and there is a direct relationship between lowering alcohol consumption at work and a decrease of fatal accidents. For instance, a health promotion program in Italy on prevention of alcoholism (62) was aimed at raising awareness of safe behaviour when driving and at work. It also assessed the risk of workers who drank alcohol during their lunch break and their likelihood of being involved in an accident on the road or at work. This multisectoral approach included meetings with associations of businesses and consumers, associations of contractors and workers, unions, and restaurants in the area.

Traditionally, **Mobility and Transport** government bodies already include policies and measures that can help tackling workplace alcohol consumption such as legal limits to alcohol, and routine and random alcohol tests. Involvement of Transport stakeholders in prevention of alcohol and drug abuse is common, the Eurofound report found initiatives like the action week in 2009 aimed at preventing alcohol use by the Estonian Transport and Road Workers' Trade Union (ETTA) or the 2010 an 'action plan' against the consumption of alcohol and other drugs implemented by the railway branch of CCOO (worker's union), together with the railway company Euskotren.

Involving representatives from **Taxing, Consumers and Marketing** departments and organizations are crucial, since the reduction of the availability of alcohol through taxes and price increases, and the restriction of opening hours of selling and consumption, are key initiatives that can directly help to reduce the impact of alcohol in the workplace.

Topics recommended for discussion

From the triangulation of the Key interviews, the Systematic Review and the Grey literature review we have selected a few topics which deserve further discussion, and were addressed in the Thematic Workshop.

Ethical issues

Fears of stigmatization and issues around alcohol declaration at work have appeared as a barrier both in the literature and interventions, and in the interviews with representatives from companies and trade unions. Regarding interventions, it can be a barrier to recruitment and can affect the number of people who complete the interventions. This is important to make sure that high-risk employees are confident in the process to share their issues. From the point of view of companies, many do not want their customers to think they might have alcohol consumption problems among their employees. Representatives of the trade unions also pointed out that often the worker does not want to acknowledge the problem and/or hide it.

Punitive measures are one of the biggest concerns for worker unions, and this especially visible in agreements and common forums where administration, employers and unions participate, as it has been a point of friction. Privacy issues also can extend to the lack of communication between health services (public healthcare system - company's occupational health service - private healthcare providers) due to the inability to share medical history between health systems. Although this can be a local issue since it is related to the organization of each health system.

Roles and positions of the different stakeholders

Roles need to be defined in the alcohol prevention policy, and there are issues about communication between stakeholders. These issues become strong barriers to deploying alcohol policies or interventions. The administrative separation between Labour and Health departments can dilute responsibilities in workplace alcohol regulation, creating tensions due to the lack of leadership and problems of coordination. Also, it is a barrier that alcohol has not been a priority by OSHA.

From the interviews with occupational doctors their initiative is limited if they can only perform as advisors and cannot do anything without the permission of the company board. There is lack of training for technicians from occupational health services to do their job well. Also, there is a lack of awareness among occupational health doctors in companies and external occupational health services.

From the interviews with companies, there are different interests and capability of investing in alcohol and health policies, particularly differences in big and small companies, and self-employed workers. For trade Unions

objections are generally articulated around fear of repercussions for workers, testing with punitive objectives or lack of privacy and confidentiality.

How to increase the current low perception of risk

This is one of the most repeated barriers, appearing often in the literature as well as in the interviews with the different stakeholders. Companies do not identify the problem (especially in the case of SMEs), and only excessive consumption (tertiary prevention) is considered as the potential problem. There is a lack of preventive culture and awareness on the subject, and a lack of awareness of the tools that are available to help with the issue, and addiction is not considered an occupational disease.

Who is at risk?

From the literature review some problematic businesses have been signalled, especially construction, farming, Hospitality/HoReCa, transport, and drinking industry. Also, the interviews detected more recent problems such as the effect of telework in alcohol consumption, self-employed workers who they fall outside the typical workplace interventions as they can't be reached, as well as new jobs such as messengers and riders, that can pose a problem for third parties.

Issues regarding interventions

Differences between secondary and tertiary prevention frameworks. What kind of strategies need to be followed

in alcohol prevention? Secondary prevention focuses on problems before they appear, has a bigger scope with more people helped but more modest results, target people with low risk or no problematic drinking.

Tertiary instead, focuses on people who already have problematic drinking, narrower target, better results for interventions.

Lack of data on cost of interventions and return on investment

The literature review highlighted the difficulty at evaluating the cost of the interventions analysed due to the great heterogeneity between them. The issue of cost has also appeared in interviews, especially for SMEs, where health programs at workplace can be an economic burden.

How workplace culture affects the awareness of alcohol issues and interventions

Availability of referral pathways at workplace, lack of tools to detect alcohol problems and how to improve alcohol policies at workplace and awareness of resources available. Analysis of manager's and organization's roles in alcohol prevention. How to improve utilization rates/preferences/ enrolment for alcohol interventions.

Small businesses have different needs and resources than big businesses. Different strategies and frameworks depending on the size of the company, how size affects alcohol prevention.

Conclusions

General issues / key messages for effective approaches

- Interventions should not include punitive / punishable aspects:
    - There is a need for objective, anonymous, non-sanctionable detection that does not require medical personnel
    - There is a need for action protocols at the enterprise level
- Small vs large companies, industries at risk and the impact of workplace culture: there have to be different protocols for different company profiles (e.g., large companies, SMEs, freelancers).
- Seek tripartite agreements - administration, employers and unions - to go beyond punitive actions.
- Experts suggest treating the issue under a broader health-promotion umbrella (together with other topics such as healthy diet or sleep), but there are mixed results in the literature.
- Take advantage of already established platforms to both provide and receive information.
- Send information through:
    - Employers (through guilds and associations)
    - External prevention services
    - Mutual insurance companies
- Investing in quality research and data can help removing the ideological barrier. This would help to destigmatize and quantify (monitor) the problem in an objective way.
- Consider the unemployed.
- Copy models that have been successful, such as the PAIMM program in Catalonia, aimed at providing treatment for health workers in which professionals have anonymity.
- Increase the number of workers (or sectors) which require a compulsory medical examination.

Specific messages / Concrete ideas

- Workshops
    - Solution-oriented rather than information-oriented.
    - That are valuable and provide professionals with tools to address multiple sensitive issues (not just related to substance use).
    - Convey that consumption in small quantities can already be a risk at work.
    - In larger companies: peer-to-peer initiatives, where each worker can share experiences and knowledge that might help others.
    - Labour lawyers who explain to employers the possible legal repercussions of not protecting employees' health adequately.
- Provide incentives for companies to take these actions, e.g., through some form of accreditation
- Facilitate (especially in SMEs) reducing economic burden to the company, through economic aid.
- The administration should promote:
    - Unification of medical history (occupational health, and public and private healthcare systems)

- Campaigns in companies targeted by sector and company size.
- Promote an intersectoral communication space. Led by the Ministry in charge of Occupational Health. It should include employers, social agents, mutual societies and other groups such as associations or guilds.
- Provide the self-employed with material with information that could be disseminated with the help of key actors, such as associations and insurance companies.

Implementation in SMEs

- Simple and straightforward action protocols and early detection tools. It is difficult to make programs, but if they have a case, they are very interested in being able to take concrete steps to take action.

Conclusions from the survey results

Section 1. Workplace alcohol prevention programs by country

- Legislation, regulations and programmes among European countries are very unequal. Most countries mentioned having alcohol prevention policies in occupational safety and health legislation, almost half are indirectly. Moreover, 21% stated that these policies are not implemented, and only 31% of these policies are stand-alone initiatives. There is a need for harmonization between European countries in order to achieve the same level of prevention ad protection practices for workers. It is important that, in addition to legislation, it is enforced.

- The lack of data makes it difficult to track and monitor the reality of countries in alcohol prevention initiatives in the workplace. It is important to develop monitoring and surveillance systems that provide standardized information at local and European level.

- Alcohol prevention programmes are run by companies in half of the countries surveyed, and by the government in the other half. Coordination between companies and government has the potential to make these interventions more efficient, for this it is necessary that both sides are involved.

- Internal Occupational Safety and Health (OSH) services, the Ministry of Health – Department Health Promotion follow by the Employers' Associations, Labor Unions and Workers' Associations and the Ministry of Labor are the main actors in the implementation and development of workplace alcohol prevention programmes. However, the influence they have on decision-making seems to differ from country to country. This could hamper communication between countries when coordinating policies at the European level, therefore it is necessary to define the institution in charge in each country and those in positions of responsibility.

- In most countries it is the Ministry of Labor who administers responsibilities under Occupational Safety and Health (OSH). In one third of the countries these responsibilities are shared with the Ministry of Health. This should be considered when coordinating policy setting at the European level.

- On the other hand, occupational safety and health (OSH) prevention services at the enterprise level depend on the size of the enterprise and the economic sector to which it belongs. Therefore, rules and policies must take these aspects into account in order to protect workers in all sectors and sizes of enterprises equally.

Section 2. Barriers in the implementation of alcohol prevention programs in the workplace

- Difficulty in accessing data on workers registered in the national health system to facilitate their intervention in alcohol prevention is one of the main barriers to implement prevention programs. In only 35% of the countries is there a regulatory framework for alcohol and drug testing of workers, and in 45% of the countries it only applies to certain cases such as pilots or drivers. In this regard, it is important that there is a regulatory framework that defines protocols that respect data protection and allow access to workers' health data to facilitate the detection and prevention of alcohol consumption problems.

- The lack of protocols was identified as the main barrier in the implementation of workplace alcohol prevention programmes, according to the perspective of the participating social partners. The lack of protocols hinders the implementation of legislation and makes management difficult. This is reinforced by the fact that companies do not see themselves as responsible for alcohol use disorders among their workers and are not aware of the impact of alcohol at work. Awareness-raising and sensitisation strategies in companies, workers and employers are strategies that could tackle this barrier. This is an important issue that needs to be taken into account when implementing legislation, programmes and interventions.

- Another important barrier identified was the worker's fear of seeking help to address their potential drinking problems, mainly for fear of losing their job or being stigmatised for their drinking. This aspect was noted in most of the countries as being very relevant. To overcome this barrier it is necessary to handle each case with confidentiality and have policies that protect the worker and build trust.

Section 3. Occupational Health Services alcohol consumption-related problems

- It was found that 40% of Occupational Health professionals is not offered training to deal with alcohol consumption-related problems, and in few exceptions this training is mandatory. Lack of training of occupational health and safety professionals to deal with alcohol-related problems might be one of the issues hampering early detection of problems and intervention. In this sense, including professional training and making it compulsory could help prevention. Companies' resources must be taken into account when setting up this training.

- It is mandatory for occupational health services to carry out regular health checks in most countries, but only 16% of countries addressed alcohol consumption during health check-up. The lack of periodic health check-ups that address alcohol consumption is a barrier to recognising potential drinking problems in workers. Addressing alcohol use at health check-ups would also improve early detection and intervention.

- In 73% of countries, depending on company policies, the employer can take disciplinary control measures in the case of workers with alcohol problems. This indicates that, for the most part, companies can manage problem drinking according to their own policies and there are no national guidelines. Harmonising these policies locally and globally can help protect workers with alcohol problems.

Section 4. The role of OSH and actors in alcohol prevention, early detection of alcohol-related problems and intervention (through paradigmatic case studies).

- Based on the case responses we can conclude that there are wide differences between countries in detecting, intervening and treating cases of alcohol problems at work.

- In the first case, it was observed that a significant percentage of small companies without regular health check-ups do not detect alcohol consumption problems. The 40% responded that "the company will not know about the cause of the accident". A similar characteristic among those countries who responded that the company would be notified, is that in these countries there are more actors that could intervene and detect these cases and that there are more mechanisms, regulation and legislation that allow for communication between the occupational health system and the workplace. It is therefore important for countries to have OSH and health services capable of detecting and intervening, both internally (e.g., HR, occupational health services) and externally (e.g., national legislation, primary care).

- In the second case, most countries state that in situations where a possible alcohol consumption problem has been detected in a medium-sized company with an external occupational health service, the worker is most likely to visit his or her GP and may seek treatment. More than 75% responded that "The man would visit his GP" This suggests that in most countries, where cases have been detected, workers have a high likelihood of being treated. This underlines the importance of regular health check-ups that address alcohol consumption.

- Two important conclusions can be drawn from the third case. The first is that when the worker self-detects a possible problem with alcohol consumption, he or she is more likely to seek treatment outside the company. And the second conclusion is that workers are more likely to seek help when they detect a consumption problem, in this case through a health campaign organised by the company. Only 14% responded that "She would ignore the problem". In this regard, it is recommended to encourage health campaigns within and outside companies that address problems related to alcohol consumption at work. Workers should also be provided with different referral mechanisms to national health systems that ensure confidentiality in the workplace.

- In the fourth case, it was observed that in the overwhelming majority of countries a worker with an alcohol consumption problem who repeatedly exhibits negative behaviours would lose his or her job, and he or she will not work for that company again. Only two countries answered that "He will be able to work on your consumption problem while your behaviour is monitored by the company". Intervention and treatment systems supported by the national health system are necessary for effective case management to help workers return to work while they recover their health.

Triangulation: review, workshop and survey –

Conclusions and Recommendations

- The main finding coming out of triangulation of in the workshop sessions, literature review and in the survey results, was **the considerable heterogeneity of prevention strategies and interventions across Europe.** In this regard**, harmonisation between European legislation, regulations and programmes is essential.**

- In addition, there is a **lack of robust evaluation of interventions**, data on the cost of the interventions and the limited number of workplace interventions carried out in Europe.

- Another important finding is **the lack of available data** to inform workplace policies. According to the survey results, 70% of countries reported no statistics at national level about alcohol prevention initiatives in the workplace, a finding that aligned with the workshop conclusions around the **lack of data and statistics.** During the review of the literature, it was also found that there was missing information on prevention costs and cost-benefit analysis.

- **There is also a heterogeneity in the roles and influences of the different stakeholders on the decision-making process for interventions**. Clarifying roles and responsibilities, as well as improving coordination among stakeholders, was a critical point put forward by participants in the workshops, and also found in the literature.

- Along the lines of clarifying roles and responsibilities, the results of **the survey point at the division of responsibilities between the Ministries of Health and Labour, a topic that was also mentioned in the workshops**. In addition, differences in the roles of workplace culture, the existence of referral pathways at workplace, were problems identified in the survey, the workshop and the literature. This issue needs to be considered when implementing legislation, programs and interventions. Linked with this, and replicated by the results of the survey, one important barrier that was presented by stakeholders was that in most countries it was not possible or **difficult to access data on workers registered in the national health system** to facilitate their intervention in alcohol prevention, and the suboptimal communication systems between the different health roles.

- **The survey also pointed out that the size of the enterprise and the economic** sector to which it belongs influence occupational safety and health (OSH) prevention services at the enterprise level. As a result, rules and policies must consider these factors in order to protect workers in all sectors and sizes of businesses equally. Likewise, the responses obtained in the survey with reference to cases revealed the differences in detection and intervention that exist between small and large companies. Overall, it was observed that small and medium sized companies have difficulty in managing, detecting and intervening cases of alcohol consumption. This need for further research on company conditions was found at the literature review and in the workshop.

- **The lack of concern regarding alcohol issues** found in the literature review was also found in the survey; indicating that companies do not hold themselves accountable for alcohol-related disorders among their employees and are unaware of the impact of alcohol at work.

- Although one of the conclusions of the workshop was that action was most effective when implemented at local level, the survey found that companies didn't perceive that alcohol prevention at work was a priority for the local administration. This may be one of the main reasons why in most workplaces and countries there are no protocols in this area. The **lack of co-designed Protocols,** from the perspective of the participating social actors, is **the main barrier in the implementation of alcohol prevention programs in the workplace.**

- **Stigma as a barrier is one of the most robust findings of this triangulation**, being put forward as a key barrier by the literature review, the survey and the stakeholders at the workshop. **Fear of being stigmatized and losing their job is one of the biggest deterrents for seeking help of the OSH** and is linked to cultural attitudes (around separate private and work domains) as well as the lack of clarity in protocols and resources. This is also a key issue in the discussions between company representatives and worker's unions.

- The review of the literature and the interviews with key stakeholders pointed out a barrier that has been also found in the survey, **the lack of training for occupational health professionals** and workplace risk-prevention specialists, as well as educational and training initiatives for managers and co-workers to help with prevention strategies.

- Alcohol consumption assessment through health check-ups is only assessed in 16% of the countries surveyed, a finding that resonates with the lack of resources and prevention mentioned by representatives of OSH and the lack of assessment tools. Addressing alcohol consumption during health check-ups is voluntary. Addressing it at regular check-ups can contribute to the early detection of alcohol problems

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Appendix 1. Effectiveness - Summary of European interventions

Study	Design	Type	Follow-up	Instrument	Outcome	Results
Gómez-Recasens et al. 2018 (Spain)	Nonrandomized, single group study no control	intervention alc.	36 m	Comprehensive intervention: Policy change, information, health monitoring, brief intervention, counselling	Standard drinks/Risky consumption	Effective. Risky alcohol consumption 14.7%-> 10.6% on the first year maintained after follow-up
Boß 2018 (Germany)	3 arm RCT	intervention alc.	6 m	Web-based modules Personalized normative feedback, motivational interviewing, goal setting, problem-solving and emotion regulation	Standard Units of Alcohol	Not effective. All groups showed reductions of mean weekly SUA(unguided: -8.0; guided: -8.5; control: -3.2) no significant difference between the unguided and guided intervention
Brendryen 2017 (Norway)	RCT, control group	intervention alc.	6 m	Brief intervention (control) and intensive intervention Control group= health booklet Intervention group = 62 sessions of 3-10 mins each	drinks per week	Inconclusive. At 2 months after the intervention, there was a decrease in in drinks per week (5 to 6 less). At 6 months trend towards beneficial effects, but inconclusive
Tinghög 2016 (Sweden)	quasi experimental evaluation, pre- and post-test, control group	intervention alc.	6 m	Education	frequency of drinking drinks per occasion binge drinking	No significant effect. Subgroup: Employees with higher consumption reduced binge drinking
Marques 2014 (Portugal)	control group	intervention alc.	5 ½ y	alcohol and drug testing	accidents	Effective. 3.7 times more likely to have an accident if untested compared to tested
Tinghög 2014 (Sweden)	pre post, control group	intervention alc.	12 m	Educational prevention program	AUDIT-scores, frequency of binge drinking and alcohol-related knowledge	Not effective. No significant effects of either lower mean AUDIT scores or less frequent binge drinking
Hermansson 2010 (Sweden)	randomized control study	intervention alc.	12 m	Screening and then randomized to brief Intervention or comprehensive intervention	AUDIT score Carbohydrate-deficient transferrin hazardous or harmful scores	Not effective. No significant differences between control, brief intervention and comprehensive intervention AUDIT positive: 51.3% -> 22.8% CDT positive: 57.6% -> 34.2%

Mattila 2003 (Finland)	RCT	wellbeing intervention	12 m	Education, incentives for lifestyle changes	g/week	Alcohol consumption increased in intervention and control group with no significant differences

Appendix 2. Effectiveness - Summary of interventions 2010-2021

Study	Design	Type	Follow-up time	Instrument	Outcome	Results
(Schouw, Mash, & Kolbe-Alexander, 2020) (7)	before-and after study no control	lifestyle intervention	24 m	Education, policy changes, physical activity promotion, provision of food, brief behaviour change counselling…	AUDIT score	Harmful alcohol use decreased 21% -> 5 %
(Won et al., 2020) (63)	before-and after study no control	mental health promotion	-	Brief intensive counselling	AUDIT-K score	AUDIT K-score 7.42 -> 6.63
(Baby et al., 2019) (32)	before-and after study no control	mental health promotion	3 m	Brief intervention	ASSIST score	"average number of days when alcohol was consumed 4.79/sd-4.57) -> 1.62 (sd-3.21)" Average ASSSIT score 17.68(sd-6.11) -> 6.56(sd-4.16)
(Boß et al 2018) (24)	3 arm RCT	intervention alc.	6 m	Web-based modules Personalized normative feedback, motivational interviewing, goal setting, problem-solving and emotion regulation	Standard Units of Alcohol	All groups showed reductions of mean weekly SUA (unguided: -8.0; guided: -8.5; control: -3.2) no significant difference between the unguided and guided intervention
(Gómez-Recasens et al., 2018) (29)	nonrandomized, single group study no control	intervention alc.	36 m	Policy change, information, health monitoring, brief intervention, counselling…	Standard drinks/Risky consumption	risky alcohol consumption 162-> 105 on the first year

(Pidd et al., 2018) (64)	cluster nonrandomised controlled trial control group	intervention alc.	12/24 m	Policy change: 1. a formal co-designed workplace alcohol policy; 2. employee education 3. training for supervisory staff 4. a referral pathway	3-item AUDIT-C	No significant intervention effect.
(Schwatka et al., 2018) (48)	observational 3-year cohort study no control	lifestyle intervention	12/24 m	information and telephone counselling	drinks per week (0-7) vs 8+	Companies with less than 50 employees from 14.7% to 11.6%, +500 employees: from 8% to 6.8%.
(Brendryen et al., 2017) (27)	RCT control group	intervention alc.	6 m	Brief intervention (control) and intensive intervention Control group= health booklet Intervention group = 62 sessions of 3-10 minutes each	drinks per week	at 2 months after the intervention, there was a decrease in in drinks per week (5 to 6 less). At 6 months trend towards beneficial effects, but inconclusive
(LeCheminant, Merrill, & Masterson, 2017) (65)	before-and after study no control	lifestyle intervention	24 m	Health assessments, four behavior change campaigns	drinks/day	Baseline 1.31 alcohol drinks/day 1 year 1.16 2 year 1.10
(Kuehl et al., 2016) (66)	randomized prospective trial control group	lifestyle intervention	24 m	Education	Alcohol Consumption	reduction of alcohol use at 12 months, marginally significant reduction at 24 month follow up
(Spicer & Miller, 2016) (53)	prospective controlled before-and-after control group	intervention alcohol.	8.7-10.6 m	Transtheoretical mode of change (Prochaska), group sessions, motivational interviewing and classroom activities	number of drinks consumed in the past 30 days	56% had fewer drinks and consumed alcohol on 32% fewer days
(Tinghög & Tinghög, 2016) (28)	quasi experimental evaluation, pre-test and post-test control group	intervention alcohol.	-.	Education	freq. of drinking, drinks per occasion, binge drinking	"No significant effect."

(Burgess, Lennox, Sharar, & Shtoulman, 2015) (67)	Quasi experminetal with non equivalent groups	intervention alcohol.	30 days after intervention	counselling	AUDIT score	AUDIT scores intervention group 13.79 -> 3.76 control group 3.59 -> 3.79
(Burnhams, London, Laubscher, Nel, & Parry, 2015) (68)	Cluster RCT control group	intervention alcohol.	post-intervention: 2 weeks follow-up: 3 moths		past 30 day use of alcohol five or more drinks at one sitting	mean number of days having five or more drinks: control arm 1.6 -> 2.1 days intervention condition 2.1 -> 1.4 days
(Ito et al., 2015) (69)	RCT control group	intervention alcohol.		Brief intervention	total drinks in previous7 days/ no of binge drinking episodes in 28 days/alcohol-free days in previous 28 days	all three groups demonstrated improvements (i.e. reductions) in drinking behavior across all outcomes.
(Khadjesari, Freemantle, Linke, Hunter, & Murray, 2014) (70)	2 group RCT control group	intervention alcohol.	3 m	Brief intervention	AUDIT - C score	no statistically significant difference in past week alcohol consumption
(Pidd, Roche, & Fischer, 2015) (71)	pilot RCT control group	intervention alcohol.	4 m	Psychosocial skills training	AUDIT - C score	"At T2, a significantly larger (p=0.008) proportion of control group participants (61.1%) usually drank more than four drinks compared to intervention participants (20.8%)."

(Reynolds & Bennett, 2015) (46)	Cluster RCT control group	intervention alcohol.	1m and 6 m	policy and skills training	drinking frequency	"Participants in both programs reduced monthly alcohol intake across the 6 months of the study."
(Watson et al., 2015) (72)	pilot RCT control group	intervention alcohol.	6 m	Screening and brief intervention	changes in AUDIT score and reported alcohol consumption	changes in AUDIT score and reported alcohol consumption
(Goetzel et al., 2014) (47)	pre post prospective study no control	lifestyle intervention	1 y	wellness services, annual HRA, individual wellness report. Unlimited access to phone-based health coaching and an array of online, interactive wellness tools	High alcohol consumption	high alcohol consumption (−1.75%) Mean T1 = 8.34 Mean T2= 6.59
(Marques et al., 2014) (30)	control group	intervention alcohol.	5.5 y	alcohol and drug testing	accidents	3.7 times more likely to have an accident if untested compared to tested
(Tinghög, 2014) (31)	pre post control group	intervention alcohol.	12 m	Education	AUDIT-scores, frequency of binge drinking and alcohol-related knowledge	no significant effects of either lower mean AUDIT scores or less frequent binge drinking
(Huang et al., 2013) (50)	pre post no control	lifestyle intervention	6 m	Education, motivational calls	alcohol consumption	21% of the participants changed action stage in alcohol consumption, but no decrease in alcohol consumption
(Hwang et al., 2012) (73)	pre post no control	lifestyle intervention	6 m	Education, diary to maintain new behaviours	drinking frequency, and amount	The no drinking group increased by 11.0%, and the over drinking group (consuming >1 bottle) decreased by 3.1%.

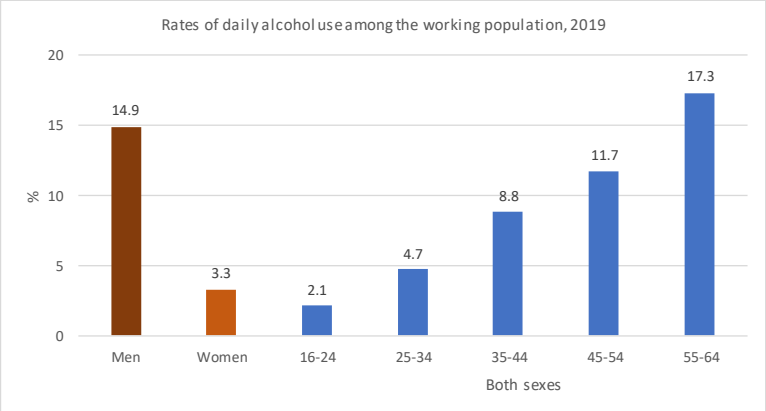
					consumed per occasion	
(Hagger, Lonsdale, & Chatzisarantis, 2011) (49)	single arm randomized controlled trial control group	intervention alcohol.	1 m	Mental Stimulation	Intention, attitude, alcohol units, heavy drinking	no differences between groups

Annex 1. The situation in the hosting Member State, Spain

Approximately nine percent of the Spanish population consume alcohol on a daily basis (1) and five percent of the population aged 15-64 show a pattern of risky alcohol use (2). In Spain, 77.5% of the working population consider the use of alcohol and other drugs in the workplace to be a significant problem (3). Traditionally health promotion and prevention activities take place in the primary care setting but the workplace is increasingly being recognised as an appropriate setting for alcohol prevention activities and general health promotion interventions.

How common is alcohol use in the workplace / among workers?

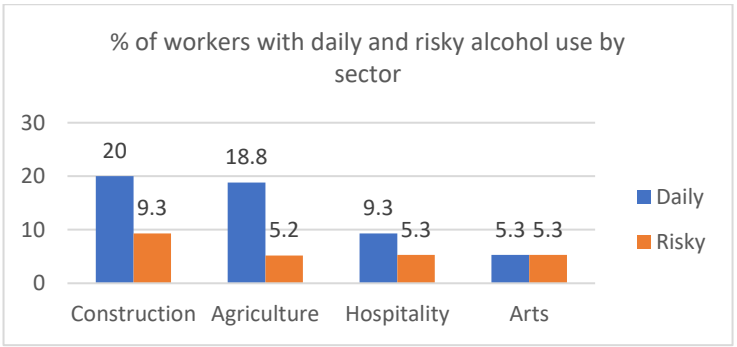
According to the 2019/2020 Survey on the Consumption of Psychoactive Substances in the Workplace in Spain (included as part of the Household Survey on Alcohol and Drugs in Spain (EDADES)) rates of drinking among workers are similar those found in surveys of the general population; 9.6% of the working population aged 16-64 consume alcohol daily (men: 14.9%; women: 3.3%) and 4.3% of the working population use alcohol at a risky level (3).



Source: Observatorio Español de las Drogas y las Adicciones. Encuesta 2019-2020 sobre consumo de sustancias psicoactivas en el ámbito laboral en España. Madrid: Ministerio de Sanidad; 2021

Alcohol use by sector

The construction sector has the highest rates of both workers who use alcohol daily and those who drink at risky levels, 20% and 9.3% respectively. Rates of daily use were second highest in the agricultural sector 18.8%.



Source: Observatorio Español de las Drogas y las Adicciones. Encuesta 2019-2020 sobre consumo de sustancias psicoactivas en el ámbito laboral en España. Madrid: Ministerio de Sanidad; 2021

Policy and action on alcohol and other drugs and workplace in Spain

In Spain national public health legislation includes the prevention of workplace risks and health promotion in the workplace. Policies and action related to alcohol and other drug use are informed by national surveys, research studies and other information systems as well as EU level strategies and strategies from other countries. Data is collected on alcohol use and its impact both via general population surveys and surveys of workers. Information on

alcohol use is generally collected within surveys on other drug use. Data is also collected on actions taken by workplaces to promote health and prevent risk and illness.

National strategies promote intersectoral collaboration and collaboration between national and regional administrations and with diverse stakeholders including NGOs, civil society organisations, trade unions and business associations. Many of these organisations and stakeholders undertake or support health promotion and prevention activities in the workplace. As part of their commitment to international collaboration of workplace health and safety Spain has hosted the European Agency for Health and Safety and Work (EU-OSHA) since 1997.

Alcohol and the workplace at national level

The Prevention and Health Promotion Strategy of the Spanish National Health System

The Prevention and Health Promotion Strategy of the Spanish National Health System was implemented in 2013 and includes alcohol consumption as one of the principal risk factors for chronic and non-communicable disease. In the future, the intention is to address prevention and promotion in the workplace

The National Drug Plan and National Strategy of Addictions

The National Drug Plan (4) coordinates the elaboration, implementation and evaluation of Spanish drug related policy and actions by public administrations and non-governmental organisations. A key strategy within the Plan is *The Spanish National Strategy on Addictions 2017-2024* (5).

Workplace and alcohol within the National Strategy on Addictions:

- The Working Group on Workplace and Drugs (including alcohol) was launched in 2017 to input to the development of the National Strategy and to monitor developments in the workplace setting
- The 2019/2020 Survey on the Consumption of Psychoactive Substances in the Workplace in Spain was included as part of the Household Survey on Alcohol and Drugs in Spain (EDADES)
- The workplace is specifically mentioned in objectives for prevention and risk reduction, and for knowledge management and research.

The Spanish Workplace Health and Safety Strategy

The National Institute for Workplace Health and Safety (INSTT) is responsible for promoting and supporting the improvement of working conditions in accordance with legislation on workplace risk prevention and the *Spanish Workplace Health and Safety Strategy 2015-2020* (6).

The Strategy is a key initiative of the National Commission for Health and Safety at Work (CNSST) chaired by the Ministry of Labour and Social Economy and Vice-Chaired by the Ministry of Health. The CNSST is composed of representatives of public administrations at the National and Autonomous Community level and of the cities of Ceuta and Melilla, and representatives of key business and trade union organisations.

The Strategy promotes intersectoral collaboration and collaboration with the different Autonomous Communities. It also aims to target high risk groups and specifically includes in its lines of action promoting health by fostering a workplace culture which supports healthier lifestyles (6). The forthcoming 2022-2027 strategy, currently being prepared, includes among its lines of action promoting addiction prevention plans and programs in the workplace, developed in cooperation between employers and workers.

The Strategy collects data and promotes workplace safety via actions including via:

- The *National Survey on Addressing Workplace Risks in Companies* (ESENER-2-España) (7) collects data on workers' health promotion measures implemented in Spain, including addiction prevention (alcohol, tobacco, other drugs)

- Working Group on Road Safety prepared a 2016 report which highlighted the risks of, and the need to prevent, alcohol and other drug use in the workplace to protect road safety.

The Spanish Network for Workplace Health and Safety

The INSTT is a national reference centre of EU-OSHA. Within this framework the INSTT created the Spanish Network for Workplace Health and Safety (RESST) part of a European network coordinated by EU-OSHA. In 2013 it launched the Healthy Workplaces project which invites businesses and organizations who demonstrate their commitment to promoting a healthy workplace to join a Spanish Healthy Workplaces Network (8)

Regional level action

Examples of action at Regional level include:

La Rioja, Mano a mano, Programa para la prevención y asistencia de las drogodepencias en el medio laboral (http://manoamano.riojasalud.es/index.html) (Hand in hand, Program for the prevention and treatment of drug dependency in the workplace)

Catalunya, A la feina, alcohol i drogues 0,0 (At work, alcohol and drugs, 0.0) (https://drogues.gencat.cat/es/professionals/prevencio/programes_i_recursos/ambit_laboral/)

Action by other key stakeholders

Unions and employee associations

Workers unions and employee associations such as the Trade Union Confederation of Workers' Commissions (CCOO), the Workers' General Union Syndicate (UGT), the National Employers' Federation, the Association of Small and Medium Enterprises, Catalonia (PIMEC) have all developed materials and tools for businesses and organizations to promote healthy workplaces and for tackling alcohol and other drug problems at work.

Companies and employers

According to the National Survey on Addressing Workplace Risks in Companies (ESENER-2) 40% of companies in Spain implement some kind of health promotion activity related to preventing addictions e.g., to tobacco, alcohol or drugs (7).

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Annex 2. Peer-Review Report on first draft

This report is intended to compliment and complete the information provided in the briefing documents and executive summary which have the aim of giving relevant background information to the participants of the AlHaMBRA workshop – *Alcohol and the workplace.* The workshop objective is to facilitate clear communication and exchange of perspectives and priorities, and to establish sustainable connections which can endure after the events to enhance and promote health in all policy initiatives. To achieve this, participants need a grounding in the topic which enables them to join in discussions and address the most relevant overlapping cross-sectoral concerns.

Reviewer: Professor Giuseppe Masanotti, University of Perugia **Title of background document:** *Workplace-based policies and interventions for preventing harmful alcohol consumption*
Short biography – Position, institution and background in the field: Director, CeSPES Experimental Centre for Health Promotion and Education, Dept. of Medicine and Surgery, University of Perugia, Italy Prof. Masanotti is the Director of the Experimental Centre for Health Promotion and Education (CeSPES), at the University of Perugia, Italy since 2019. Board Member of the European Network for Workplace Health Promotion, since 1998. His main field of research focuses on workplaces. In particular, with a salutogenic, health promotion and education approach guarantee the health of organizations, collaborators and community. Other aspect is the organization and evaluation of quality and risk management in/of health organizations.
Global evaluation of the briefing document: In general, I find the document well structured. Technically absolutely nothing to say. The only point I would discuss is the research query (see below). But I also understand that you have to put a limit somewhere. If the document is addressed to policy makers, I think it is still "scientific" it should be a bit more simple or re-organized (example: putting the details on the procedure of selection of papers, etc.) this with other issues can go in annex and who is interested can go and read it. I believe that, for the aim given, gives all the information in order to create a common background and make possible a proactive discussion on the issue. In other words, a successful workshop!
Specific areas or messages to add or amend: Limited to "of interventions, programs, and/or policies to prevent harmful alcohol consumption in the workplace". The best program on alcohol "prevention" is the one that does not seem to deal with the issue! or is not the main issue, but mixed with other issues for example: "campaign on occupational accidents and on that occasion someone talks about alcohol, alcohol and it's interactions with prescribed drugs"... Once you think there is someone that needs help, you have a second "level" of actions. Or radically change prospective and go for a salutogenic approach.
Further references or information of interest in this area: Salutogenesis Manual, Open Access: https://link.springer.com/book/10.1007/978-3-319-04600-6 The Handbook of Salutogenesis, Open Access at: https://link.springer.com/book/10.1007/978-3-030-79515-3 Midanik, L. T., Soghikian, K., Ransom, L. J., & Polen, M. R. (1992). Alcohol problems and sense of coherence among older adults. Social science & medicine (1982), 34(1), 43–48. https://doi.org/10.1016/0277-9536(92)90065-x

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Annex 3. Mapping exercise and Stakeholders in Catalonia

Mapping exercise: Methods and activity to map activity – Interviews with key stakeholders

Mapping of key actors in the implementation of alcohol prevention programs in the workplace.

There are four means by which key actors in the implementation of alcohol prevention programs in the workplace were identified:

1. Interviews with key actors in Catalonia and Spain, including the Ministry of Health, to provide information about other key actors both at a national and European level.
2. Search of OSH structure in the different EU members through relevant websites, such as EU-OSHA, ETUC, EMCDDA, CHAFEA or BusinessEurope. As well as previous and ongoing projects and networks concerning alcohol consumption prevention at an EU level such as RARHA, EWA, DEEP SEAS or FAR SEAS.
3. Identification of key national partners through EU-OSHA focal points.
4. Contact with AlHaMBRA partners that have provided key actors from Portugal, Slovenia and Netherlands.

The interviews with stakeholders in Catalonia were conducted as part of a local pilot for the broader stakeholder mapping and opinion gathering to kick start the identification of topics for discussion in the Thematic Workshop on Alcohol in the Workplace.

The Key actors' information was gathered in an excel file. It included 171 key stakeholders from 39 countries other than Spain, 95 from Spain and 38 EU-OSHA national focal points (one from each country). In total 304 key actors were identified.

Key sectors and stakeholders for this topic

Mapping of existing actors for each member state included representation of five different sectors.

1. Employer's associations
2. Workers' unions
3. Occupational Health Services
4. Health Care Professional Bodies
5. Public institutions responsible for occupational health (i.e., Ministry of Health and/or Labour).

Main implementation barriers per sector

Barriers in implementation were identified through the interviews[6], and will be contrasted with inputs from the survey, and workshop.

General barriers

- Addiction is not considered an occupational disease.
- Lack of tools to detect alcohol problems.
- Lack of communication between health services (public healthcare system - company's occupational health service - private healthcare providers).

Barriers related to the administration

- Alcohol is not a priority. There should be a top-down prioritization.
- Added difficulty due the administrative separation between the Department of Health and Labour.

Barriers related to companies

Companies are perceived to have a general lack of understanding regarding different issues within the topic:

- Lack of awareness. Companies do not identify the problem (especially in the case of SMEs), and often do not find it not conceivable that working conditions can be a catalyst for onset or relapse in consumption, and only excessive consumption is considered as the potential problem. There is a lack of preventive culture and awareness on the subject, and a lack of awareness of the tools that are available to help with the issue.
- Stigma for companies. They do not want their customers to think they might have alcohol consumption problems among their employees.
- SMEs: Health promotion is voluntary and not a legal requirement. Doing so would also be an added expense that many cannot afford.

Barriers related to workers' unions

- Fear of punitive consequences.
- Often the worker does not want to acknowledge the problem and/or hide it.
- In most cases [all sectors in Spain, except for railway workers] the worker must give consent to undergo any type of check-up.

Barriers related to occupational health services

- They are only advisors and cannot do anything without the permission of the company board.
- Lack of training for technicians from occupational health services to do their job well. There is a lack of awareness among occupational health doctors in companies and external occupational health services.
- They are subject to confidentiality.
- They do not know the company because it's an external service.
- Lack of compulsory medical examinations (should be essential in some sectors).

In addition, a country-by-country review of the Eurofound registers was carried out, checking in each country whether national legislation is in place, whether there is:

- National guidelines;
- Legislation on alcohol testing
- Surveys available
- Alcohol prevention programs in the workplace (provided by companies or government)
- Data and Statistics available on workers receiving alcohol prevention actions
- Statistics at national level to establish if workers are in favour of alcohol prevention initiatives in the workplace

- Ministry responsible of OSH
- Availability external training in dealing with alcohol consumption-related problems available for Occupational Health professionals/managers/business owners
- Available guidelines on drug/alcohol testing at work
- Information on OSH regular health check-ups
- Information on check-ups addressing alcohol consumption
- Referral mechanisms established directly from workplace health settings and the addiction treatment system
- Public entity (e.g., Public Health agency) that supports companies to help them manage alcohol consumption related programs?
- Best practices

This information was complemented and contrasted with the information collected in the survey, thus validating or weakening these data. Other organisations and good practices were also identified. The data were collected in Excel tables. For each country, a table was constructed by synthesising the responses, thus obtaining a country profile with the points mentioned above.

Annex 4. Survey Report

Table of Contents

Methodology

1. Survey

1.1. Survey Design

As part of AlHaMBRA Project, a survey was designed to (1) to map and collect information for each Member State on initiatives to address alcohol related harm in workplaces, striving to understand the complexity of harm reduction alcohol policies in the workplace, and provide tools for their implementation; (2) to acquire basic understanding of the functioning of Occupational Safety and Health (OSH) structures in the different countries regarding the implementation of alcohol prevention programs; (3) to identify barriers to the implementation of alcohol prevention programs in the workplace in the different Member States; and (4) to identify best practices.

The survey was designed based on the previous results of the systematic review, and the mapping of existing actions and policies in the EU undertaken also as part of this AlHaMBRA Project task. It also took into account the results of the European Workplace and Alcohol (EWA) project, which collected best practices, piloted interventions, and developed recommendations to reduce alcohol-related harm in the workplace. The AlHaMBRA Project systematic review undertook a qualitative review of the peer-reviewed and grey literature, with a view to identifying studies, policies, reports, and strategies related to workplace interventions for alcohol use; as well as barriers and facilitators, to understand potential areas of improvement and development. As described above, these results were complemented by a mapping of existing actions and policies in the EU and other countries, identification of key areas of policy overlap, barriers to implementation, and, finally, recommended topics for discussion in the workshop. Based on these combined previous endeavours, 19 key points were identified to build the survey.

1.2. Survey Structure

The survey was structured into four main parts. The first section (10 questions) collected data on alcohol prevention programmes in the country, and on the actors involved and the role(s) of Occupational Safety and Health in companies. The aim was to provide information on the OSH structure for each Member State. The second section (14 questions) was intended to identify facilitators and barriers in the implementation of alcohol consumption prevention programs in the workplace. The third part (13 questions) aimed at collecting information about the main issues encountered by Occupational Health Services in dealing with alcohol consumption-related problems, and best practices (Table 1).
Finally, a fourth part comprised set of questions (a total of 34) collect information on the role of OSH and actors in alcohol prevention through the presentation of four paradigmatic case studies that contextualise possible situations (Table 2, below).

Table 1. Survey Structure, key points, survey questions and type of question.

Section	#	Key Points	#	Survey Question	Type*
1. Workplace alcohol prevention programs and actors on the role of OSH in companies.	1	National guidelines	1	Are there alcohol prevention policies in safety and health at workplace legislations?	SC
	2	Legislation on alcohol testing			
	3	Alcohol prevention programs in the workplace	2	Are alcohol prevention programs in the workplace a reality in your country?	SC
	4	Provided by	3	Are alcohol prevention programs typically provided by companies or by the administration (i.e., the government)?	MC
	5	Statistics workers receiving alcohol prevention actions	4	Are there statistics available in your country (official data or collected through research studies) to establish what percentage of workers have received any of the following alcohol prevention actions at the workplace? (please mark all that may apply)	SC
	6	Statistics at national level to establish if workers are in favour of alcohol prevention initiatives in the workplace	5	Are there statistics at national level available in your country (official data or collected through research studies) to establish if workers are in favour of alcohol prevention initiatives in the workplace?	SC
			6	Please provide references and/or links to the sources of these prevention programmes or data	Op
	7	Key Actors OSH	7	Can you please list the actors that play an important role (from policy to implementation) in making alcohol prevention programs in the work place a reality in your country?	MC
			8	Could you please provide the names and websites of most relevant actors of each aforementioned group.	Op
	8	Ministry responsible of OSH (7)	9	In your country, which ministry are Occupational Safety and Health (OSH) administration responsibilities under?	SC
	9	Organization of health Occupational Safety and Health (OSH) prevention services at company level	10	What are the variables that determine the organization of health Occupational Safety and Health (OSH) prevention services at company level in your country?	MC
2. Barriers in the implementation of alcohol consumption prevention programs in the workplace	10	Availability external training in dealing with alcohol consumption-related problems available for Occupational Health professionals/managers/business owners (36)	11	Does the OSH professional in a company have access to the data of workers registered in the national health system to facilitate their intervention in alcohol prevention?	SC
	11	Guidelines on drug/alcohol testing at work	12	Is there a regulatory framework giving the employer the right to test employees for alcohol and drugs?	SC
	12	Identifying barriers in the implementation of alcohol consumption prevention programs in the workplace	*Please rate from 1 to 5 the importance of barriers in the implementation of alcohol prevention programs in the workplace (1 star being not at all important and 5 stars extremely important)*		
			13	Lack of protocols on what do to, how to do it and definition of responsibilities (who does what) among stakeholders	RQ
			14	Lack of objective means of early detection of alcohol addiction	RQ
			15	Lack of clarity on follow- up and potential actions to be taken towards workers identified as having a potential alcohol use problem	RQ
			16	Companies do not see themselves as responsible for alcohol use disorders among their workers (no legal basis as an "occupational disease")	RQ
			17	Lack of awareness by companies on the impact of alcohol in the workplace	RQ
			18	Companies fear that implementing such programs may negatively affect their corporate image	RQ

			19	Companies/public authorities fear reactions of workers and their unions	RQ
			20	Fear of generating stigma towards workers participating in alcohol consumption prevention programs, leading to other psychosocial risks at work (such as stress, depression, etc)	RQ
			21	Lack of communication mechanisms between OSH services at the company level and national or regional public health services	RQ
			22	Alcohol prevention at work is not a priority for the administration	RQ
			23	Please specify any other barriers that could arise in your country/region.	RQ
			24	What do you think would be the main cause for workers to hesitate in seeking help to address their potential alcohol consumption problems? (please pick one)	RQ
3. Occupational Health Services: alcohol consumption-related problems and best practices	13	Training to deal with alcohol consumption-related problems	25	Are Occupational Health professionals (internal or external)/managers/business owners offered training to deal with alcohol consumption-related problems from a source external to the company (public administration, accreditation entities, professional bodies, etc.)?	SC
			26	Is this training mandatory?	SC
	14	OSH regular health check-ups	27	Are Occupational Health Services (internal or external) required to carry out regular health check-ups?	MC
	15	Check-ups address alcohol consumption?	28	How likely would it be that these health check-ups detect alcohol consumption or alcohol consumption-related problems?	SC
			29	During health check-up appointments, do Occupational Health professionals address alcohol consumption?	Op
			30	How is it addressed?	SC
			31	How/With what instruments and under which circumstances?	Op
	16	Referral mechanisms established directly from workplace health settings and the addiction treatment system	32	Are there any referral mechanisms established directly from workplace health settings and addiction treatment system?	SC
			33	Can the employer take disciplinary control measures in the case of workers with alcohol problems?	SC
	17	Teleworking an alcohol consumption	34	Is alcohol consumption during teleworking monitored or taken into account?	SC
	18	Is there any public entity (e.g., Public Health agency) that supports companies to help them manage alcohol consumption related programs?	35	Is there any public entity (e.g., Public Health agency) that supports companies to help them manage alcohol consumption related programs?	MC
	19	Best practices	36	Do you know of good and best practices in your national/regional/local context that promote alcohol-free workplaces?	SC
			37	Please give reference details of any published papers, reports, websites on this good/best practice and materials (web page, references, other relevant documents such as implementation manuals, training manuals, guidelines, posters, etc.).	Op

*SC Single Choice; MC Multiple Choice; Op Open Question

The cases in part 4 represent different workers with different working situations and different alcohol consumption problems that may be encountered in the workplace. They were developed with the objective of identifying how legislations at the country level might result in alternative possible interventions and thus variable consequences for the workers. It also seeks to determine whether early detection of alcohol-related problems is possible, and which agents are involved in this detection and intervention. These

results could identify the unequal treatment that workers receive depending on the country to which he or she belongs, and highlight inequalities in the intervention.

Table 2. Cases description and key points.

Case 1	#	Key points
A 37-year-old woman who works as a driver for a transportation company with 5 other employees. Specific medical examinations or periodic controls of workers' use of alcohol and other drugs are not performed in her company. She has had multiple minor road traffic accidents while on duty due to moderate alcohol consumption, leading to a subsequent whiplash trauma, but all have happened outside the premises of the company. At the clinical follow-up with the insurance company, they suspect that the accidents are alcohol-consumption related. The mutual insurance company could carry out an alcohol check-up, but probably won't follow-up in case of identifying problems, and would send the person to Primary Care (NHS). As this alcohol consumption will not be identified, she goes back to work, and the company has no record of the cause of her accident. The woman's alcohol use will get worse, and, with it, her risk of having an accident.	1	Young adult woman (37 years) with a high-risk work (driver)
	2	Small Company (5 employees)
	3	No medical controls
	4	Occupational disease due to alcohol consumption
	5	Unreported alcohol consumption
	6	High risk of having an accident.
Case 2		
A 55-year-old man works as a cook at a nursing home with 60 other workers. The company has an external Occupational Health Service which conducts regular health check-ups. During an annual check-up, abnormal levels of hepatic enzymes in his blood are detected, and he is advised to visit with his General Practitioner (GP). As it is not compulsory, he chooses not to visit his GP, and his consumption worsens. The company is taking steps to fire him for low productivity.	1	Adult man (55 years old)
	2	Medium company (60 employees)
	3	External Occupational Health Service which conducts regular health check-ups
	4	Alcohol consumption detected
	5	He does not want to visit his doctor
	6	Risk of losing work
Case 3		
A 21-year-old-woman works in a warehouse operating heavy machinery along with 270 other employees. The company has an Internal Prevention service (i.e., it is part of the company) with an Occupational Health department. Every year, they conduct health promotion activities, and this year's focus is on alcohol consumption. As a result of this campaign, she has started to see that she might have an alcohol consumption	1	A 21-year-old-woman
	2	High risk job (machinery)
	3	Large Company (270 employees)

problem. If she goes to her GP and takes a sick leave, the company could fire her, as her job entails risks to third parties. Additionally, having to seek treatment could interfere with her work schedule. Thus, she is hesitant to address the issue.	4 Internal Prevention service with an Occupational Health department 5 Self-detected, not reported alcohol consumption

Case 4	
A 24-year-old self-employed welder who works for a large metal structure building company. He has hired an Occupational Health Service to fulfil the legal requirements for working for the building company and accessing all construction sites. Though these health check-ups are compulsory, workers often do not turn up for them, and inspections are scarce. After three years working with them, the worker receives a warning for regular absenteeism on Monday mornings and some antisocial behaviour - propensity to start arguments, irritability… The Occupational Health worker, who is a psychologist, thinks the worker might have a potential alcohol use problem.	1 A 24-year-old self-employed welder 2 Large metal structure building company 3 Hired an Occupational Health Service 4 Compulsory health check-ups 5 Potential alcohol related disorder

In total, the final survey comprised 71 questions, of which 62 were closed single or multiple-choice questions and 9 were open questions. These open-ended questions were mainly used to expand on the information provided by each of the sections.

1.3. Pilot survey and approval

The draft survey (Annex B) was reviewed by William Cockburn, Nadia Vilahur, Head and Project Manager of the Prevention and Research Unit, respectively, at EU-OSHA; and contents were discussed in the context of two meetings held on June 1st and July 7th 2021. In addition, the survey was reviewed by Dolores Solé from the National Institute for Occupational Safety and Health Spain (INSST) and was piloted by Richard Wynne from the European Network for Workplace Health Promotion (ENWPH). The final survey in English was approved by the European Health and Digital Executive Agency (HaDEA – project funding agency) and the General Directorate for Intervention on Addictive Behaviours and Dependencies in Portugal (SICAD – project coordinators) and EU-OSHA.

1.4. Survey implementation

The survey was developed and conducted online. Data was collected using the Jotform platform (https://www.jotform.com/). This platform was chosen for its versatility, and because it has appropriate tools for the survey design, and guarantees data protection in accordance with EU regulations.

The approximate time to fully complete the survey was estimated at 30 minutes. The information collected was treated to be anonymously. A data protection and privacy disclaimer were included in which respondents were guaranteed that the information provided will be treated in a lawful, fair and transparent manner protecting privacy and rights in accordance with the relevant EU regulations.

1.5. Target population

The target respondents of the survey were identified through a previous mapping of key actors in the implementation of alcohol prevention programs in the workplace. These key actors were identified by: (1) interview with key actors in Catalonia and Spain, including the Ministry of Health, to map national and European key actors; (2) searches of OSH structure in the different EU Members States through relevant websites, such as EU-OSHA, ETUC, EMCDDA, CHAFEA or BusinessEurope. As well as previous and ongoing EU-level projects and networks on alcohol consumption prevention, such as RARHA, EWA, DEEP SEAS and FAR SEAS; (3) Identification of key national partners through EU-OSHA focal points; (4) Contact with AlHaMBRA Project partners who facilitated contact with key actors from Portugal, Slovenia and The Netherlands; (5) internet searches of the actors and institutions in each of the Member States.
The key actors' information was gathered in an Excel file, which included 171 key stakeholders from 39 countries other than Spain, 95 from Spain and 38 EU-OSHA national focal points (one from each country); in total 304 key actors were identified (Table 3).

1.6. Dissemination

The survey was sent through a link to the online form as part of a personalised e-mail, and with a formal invitation letter in English to the 304 key stakeholders (Annex C). EU-OSHA focal points were contacted in the same way with the permission of EU-OSHA (Annex D). For the Spanish key stakeholders, the survey was first sent to Belén Pérez, from INSST, the Spanish focal point for EU-OSHA, who sent it to other stakeholders. In addition, we asked respondents to forward the survey link to other appropriate contacts in relevant fields, who could respond to this survey.

In order to obtain as many survey responses as possible, we encouraged the respondent to answer as many questions as possible, but also informed them that if he/she was unable to answer all the questions, for whatever reason, he/she could return us the partially completed form.

On June 2, the above-mentioned personalised mailings were sent. By 27 June, only 17 experts had responded to the questionnaire. Reminders were sent on 28 of June and 6 July, resulting in 24 more responses by the 1 August. In total, 41 completed surveys were received from 21 countries (Table 3).

Table 3. Countries e-mailed to and responding to the survey.

	Sent to			
Country	**Emailed to**	**Focal point**	**Total emailed**	**Filled out survey**
Albania		1	1	1
Austria	4	1	5	3
Belgium	7	1	8	2
Bosnia & Herzegovina	1	1	2	1
Bulgaria	5	1	6	
Croatia	8	1	9	3
Cyprus	5	1	6	1
Czech Republic	3	1	4	
Denmark	4	1	5	
Estonia	5	1	6	1
Finland	6	1	7	3
France	4	1	5	1
Germany	7	1	8	1
Greece	8	1	9	
Hungary	8	1	9	1
Iceland	4	1	5	
Ireland	5	1	6	
Italy	8	1	9	1
Kosovo		1	1	
Latvia	6	1	7	1
Lienchenstein	1	1	2	
Lithuania	4	1	5	1
Luxemburg	6	1	7	
Malta	3	1	4	4
Moldova	1		1	
Montenegro	1	1	2	
Netherlands	7	1	8	1
North Macedonia		1	1	
Norway	5	1	6	
Poland	9	1	10	1
Portugal	6	1	7	1
Romania	6	1	7	
Scotland - UK	2		2	1
Serbia	4	1	5	
Slovakia		1	1	
Slovenia	10	1	11	4
Spain	95	1	96	8
Sweden	6	1	7	
Switzerland	1	1	2	
Turkey		1	1	
United Kingdom	1		1	1
Total general	**266**	**38**	**304**	**41**

1.7. Analysis

The data obtained were analysed individually, by country, and globally, by region (EU). The extracted data were introduced in Excel tables, for each country a table was constructed synthesizing the responses, thus obtaining a country profile (see Annex E).

Where more than one questionnaire was received per country, the responses were cross-checked for consistency. Where answers were not consistent, the following criteria was used to resolve discrepancies: first, the answer of the respondent who reported feeling more competent in the area was selected. If the more competent respondent did not answer the question, the answer of the next most competent respondent was used. In the case of respondents who felt equally competent, the more frequent answer was used. For the questions in the third section of the questionnaire, on barriers towards the implementation of alcohol prevention programs in the workplace, where the answers are given on a Likert scale from 1 to 5, the average of the answers was calculated. And finally, for the questions collecting reference details of any published papers, reports, websites on this good/best practice and materials, all those mentioned by the respondents were collated.

With these responses consolidated by country and with the data previously obtained in the mapping exercise, a profile was created for each country, which includes the key points of the questionnaire, as described in Table 1. Excel tables were constructed to group the responses for each of the sections of the questionnaire. The data were processed individually by country.

With the consolidated country data, an overall descriptive analysis was performed, using the responses for the 21 countries. The percentage of each response to each survey question was calculated. In this way, we show an overall picture of the European countries. In addition, a comparative table was developed, in which the response of each country for each question are shown (Annex A).

The responses to the cases (part 4) were analysed by grouping the countries according to the answer to the last question of each case, which asks " In your region/country, what would be the most likely outcome in a case like this?". We grouped similar responses across countries, and hereby attempted to identify patterns between countries depending on the outcome.

Finally, we grouped the responses by country to study patterns between case responses. Additionally, we ordered the responses of the 4 cases by country, and looked at the country responses as a whole. These responses were scored, with 1 being the most desirable response and 4 being the least desirable (Table 4).

Results

We received responses from 21 of the 41 countries to which the survey was sent (Figure 1). From Spain 8 people responded, Malta and Slovenia 4, from Austria, Croatia, and Finland 3, from Belgium 2, and one person from each of the other responding countries (Table 3).

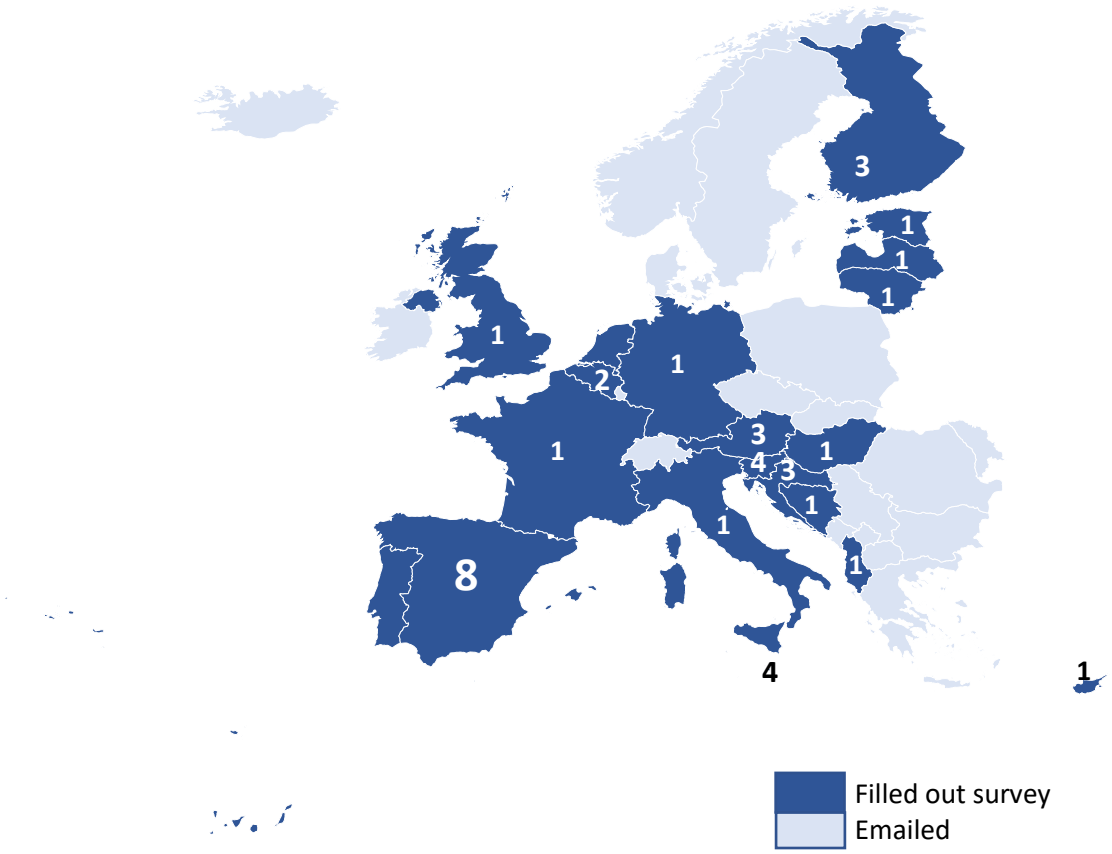

Figure 1. Map of the EU country participation

The main survey results are presented below, organized by sections, with graphic representation of the results for each section. In addition, the information is detailed in a table, which shows the response of each country for each of the questions. One table is presented per section (Annex A, Tables A1, A2 & A3).

Section 1. Workplace alcohol prevention programs by country

In this first section, it was found that only 5% of the respondents answered that in their country there are no alcohol prevention policies in occupational health and safety legislation (Figure 2). However, 21% responded that such programmes are not implemented in their country, one-third think these programmes are mainly part of a mental health promotion and risk initiatives, and another third mainly as part of a broader lifestyle and risk prevention approach (Figure 3). Approximately half of the respondents mentioned that alcohol prevention programmes are usually provided by companies and the other half responded that they are provided by governments or public administration (Figure 4).

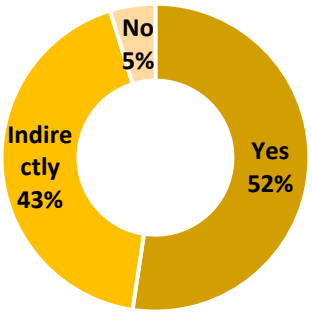

Figure 2. Are there alcohol prevention policies in safety and health at workplace legislations?

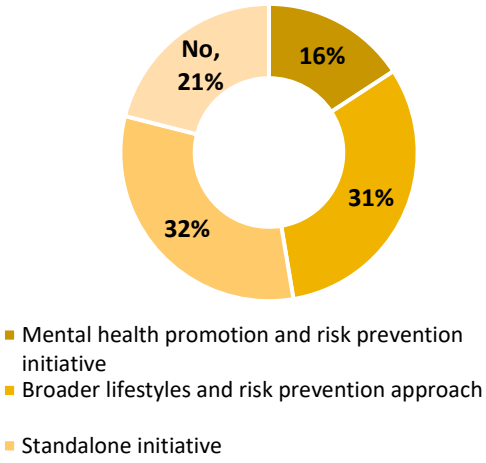

Figure 3. Are alcohol prevention programs in the workplace a reality in your country?

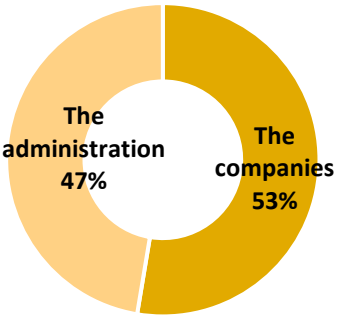

Figure 4 Are alcohol prevention programs typically provided by companies or by the administration (i.e., the government)?

The following table shows that more than 71% (15 Countries) said that there are no national level statistics available to determine whether employees are in favour of workplace alcohol prevention initiatives.

Table 2. Are there statistics at national level available in your country (official data or collected through research studies) to establish if workers are in favour of alcohol prevention initiatives in the workplace?

	n	%
Received information/raising awareness campaigns	2	9,5
Received training	1	4,8
Have been (randomly or not) tested for alcohol consumption	1	4,8
Referrals to specialist centres	2	9,5

Regarding **the actors that play an important role** (Figure 5) in the establishing of alcohol prevention programmes in the workplace respondents considered the most important to be the internal Occupational Safety and Health (OSH) services, followed by the Ministry of Health (Department Health Promotion), the Ministry of Labour, and the Labour Unions and Workers` association and employers.

In most countries the ministry in charge of Occupational Safety and Health responsibilities is the Ministry of Labour (55%), followed by both Labour and Health (35%). Only 10% of the responding countries said it is only the Ministry of Health with OSH responsibilities (Figure 6). In half the countries, the size of the company determines the organization of occupational safety and health (OSH) prevention services at the company level (Figure 7), followed by the economic sector (24%).

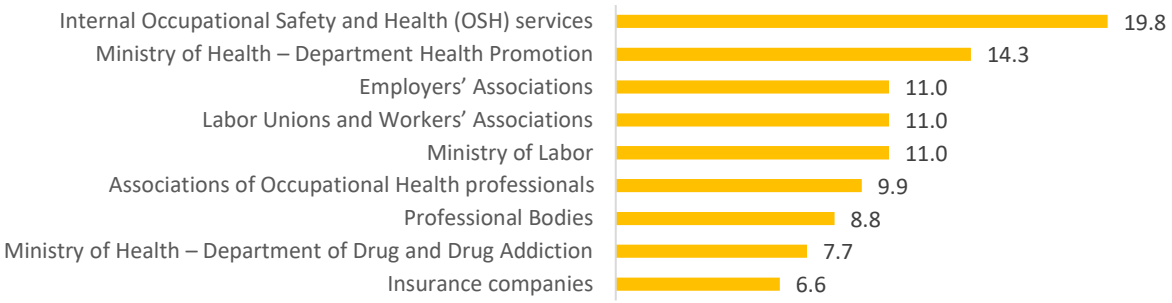

Figure 5. Please list the actors that play an important role (from policy to implementation) in making alcohol prevention programs in the work place a reality in your country? Responses are shown in percentages (%)

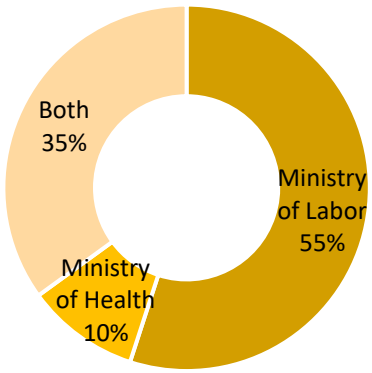

Figure 6. In your country, which ministry are Occupational Safety and Health (OSH) administration responsibilities under?

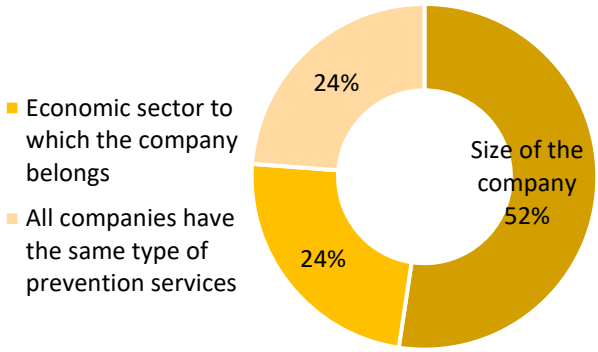

Figure 7 What are the variables that determine the organization of health Occupational Safety and Health (OSH) prevention services at company level in your country?

Section 2. Barriers in the implementation of alcohol prevention programs in the workplace

In this second part of the questionnaire, it was found that only in one country (Croatia) the companies could easily access the data of workers registered in the national health system to facilitate their intervention regarding alcohol prevention. However, 25% of the countries could access these data upon request (Figure 8.).

In four countries (Albania, Bosnia and Herzegovina, Hungary and UK) there was no regulatory framework to allow testing of employees for alcohol and drugs. In 45% of the countries, the regulatory framework is applied only in some cases depending on the profession, as in the case of pilots or bus drivers, or in the collective labour agreement (Figure 9).

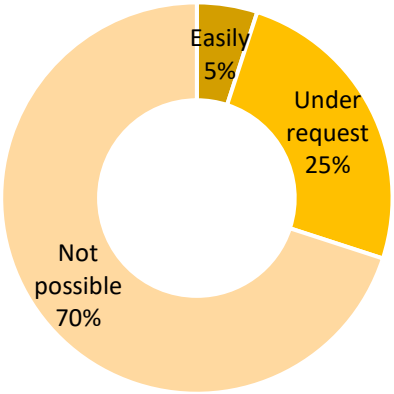

Figure 8. Does the OSH professional in a company have access to the data of workers registered in the national health system to facilitate their intervention in alcohol prevention?

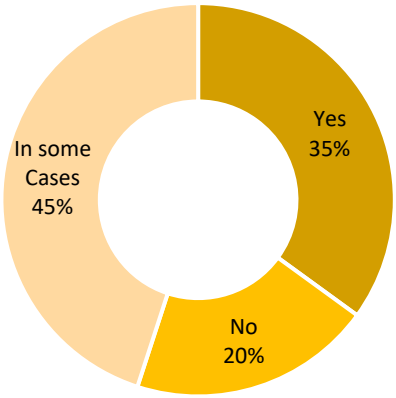

Figure 9. Is there a regulatory framework giving the employer the right to test employees for alcohol and drugs?

The barriers to the implementation of workplace alcohol prevention programs most highly ranked by respondents were the lack of protocols followed by the fact that workplace alcohol prevention is not a priority for management and companies do not consider themselves responsible for alcohol use disorders among their workers. Figure 10 shows from highest to lowest the score of barriers in percentage. Lack of protocols received the highest score

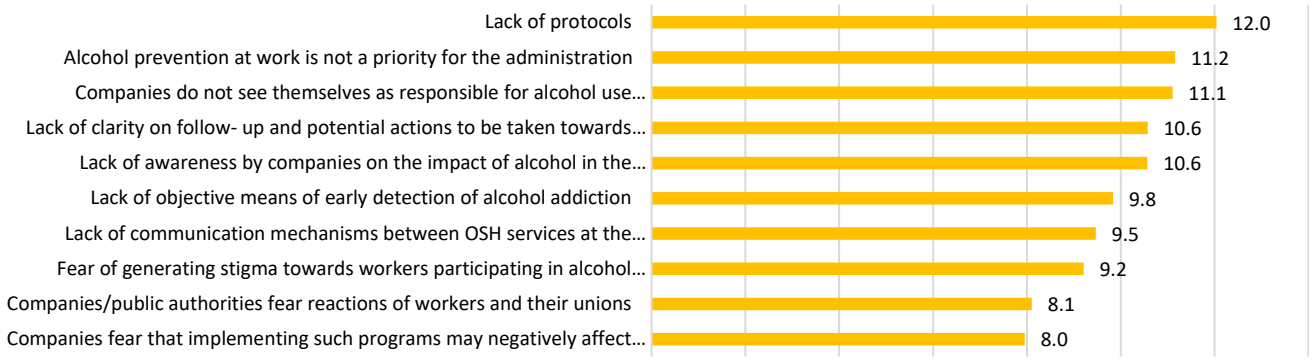

Figure 10. Most Important Barriers in the implementation of alcohol prevention programs in the workplace (%)

Section 3. Occupational Health Services alcohol consumption-related problems

Regarding, training to deal with alcohol consumption-related problems, 60% of respondents affirm training to occupational health professional is offered. 10% respond that this training is mandatory (Figure 11).

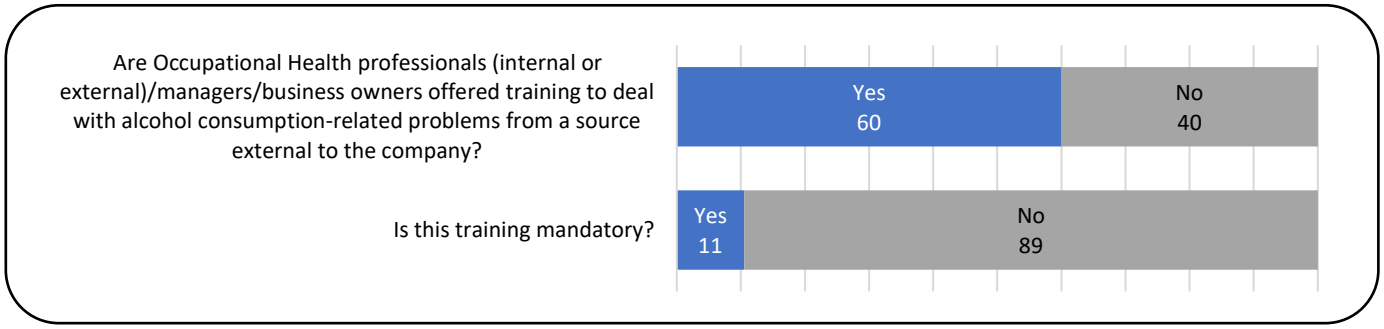

Figure 11. Occupational health professional training to deal with alcohol consumption-related problems.

Periodic checks are required in 67% of the countries responding to the survey, and in 20% of them if there are third party risks. Health check-ups address alcohol consumption in 17% of the countries and are optional in 61%. In the Netherlands, alcohol consumption is not allowed to be addressed during this control. In most countries, alcohol consumption is directly addressed through questionnaires during the check-up (Figure 12).

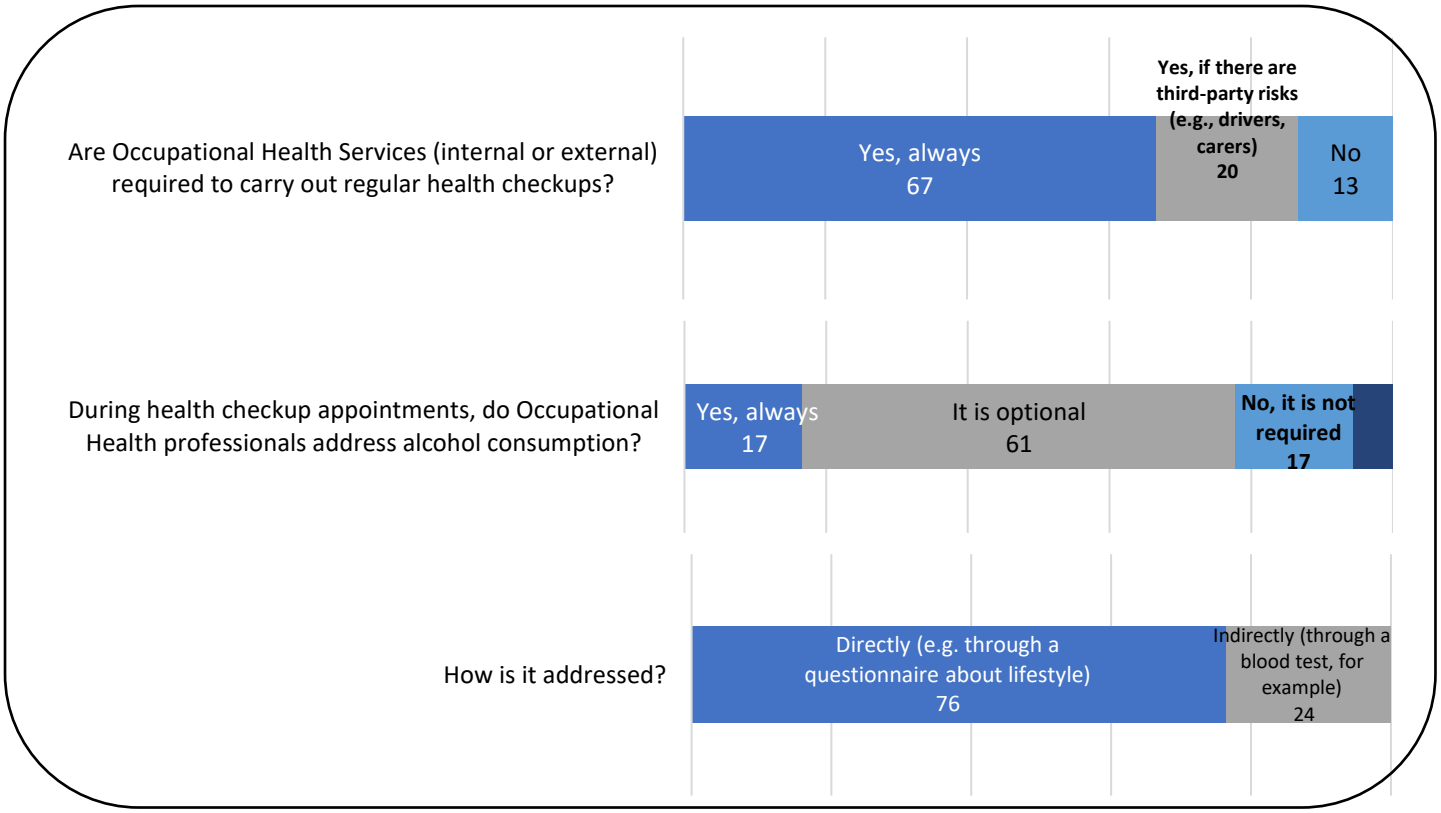

Figure 12. Occupational health check-ups

In 7 countries out of 14 responding to this question, there are mechanisms for referral from workplace to addiction treatment system. The employer can take disciplinary control measures based on company policies in 11 countries, and cannot take disciplinary measures in 4 countries (Germany, Italy, Portugal and Slovenia). No country answered to know if there was any monitoring of alcohol consumption during teleworking. (Figure 13.)

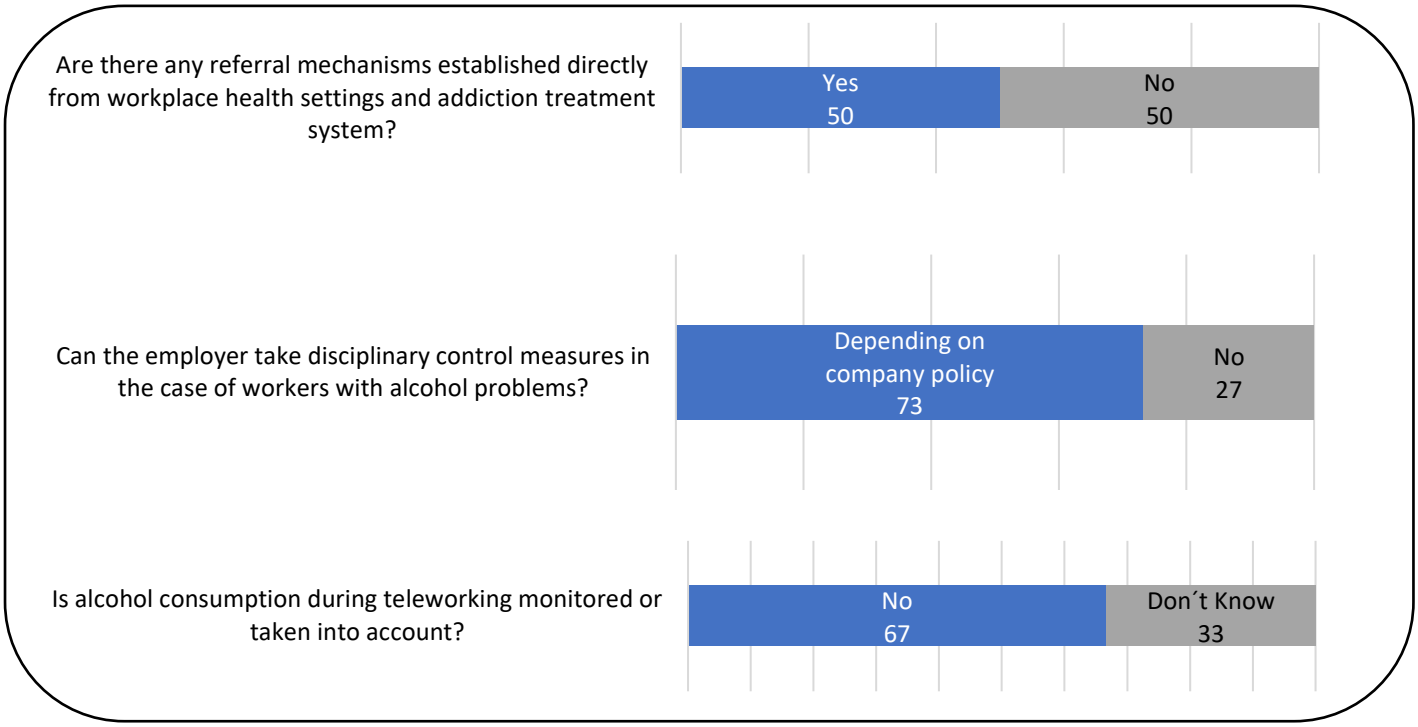

Figure 13. Referral mechanisms from workplace health settings and addiction treatment system

Section 4. The role of OSH and actors in alcohol prevention, early detection of alcohol-related problems and intervention (through paradigmatic case studies).

This section presents figures with the main outcomes of the cases that correspond to the answer of the last question of each case that states " In your region/country, what would be the most likely outcome in a case like this?".

In the first case (37-year-old woman driver) the most frequent answer (40%) among respondents was "The company will not know about the cause of the accident", which shows that in most cases there is probably no monitoring and control (Figure 14).

Among the countries that responded that "The company would be notified", which would be a desired action, we observed some similar characteristics; such as, that there are more actors that could intervene and detect these cases, and that there are more mechanisms, regulation and legislation that allow for communication between the occupational health system and the workplace (Annex VI Table A4).

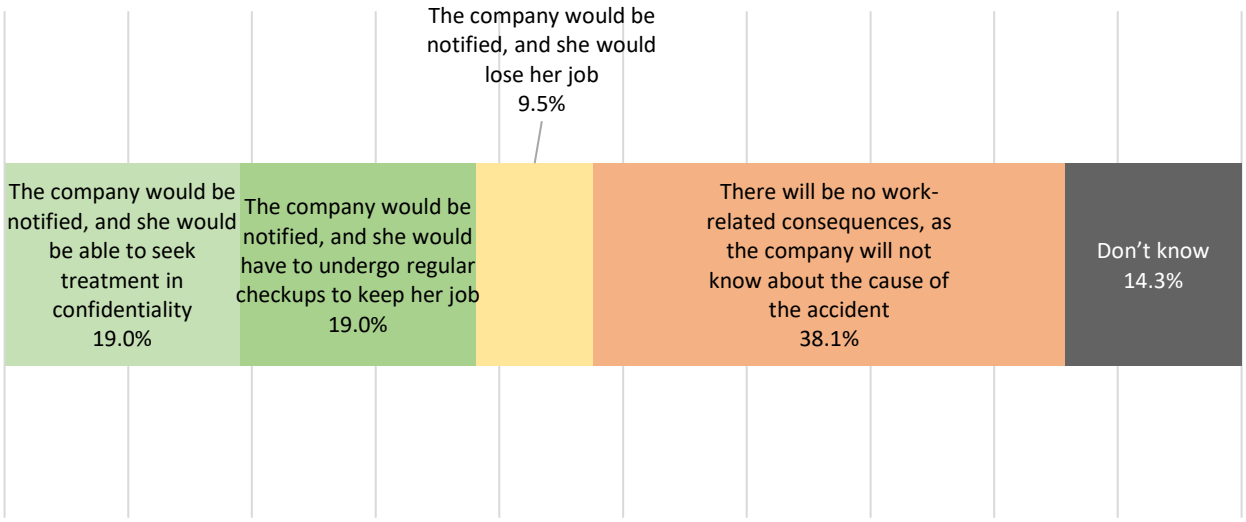

Figure 14. Main outcome CASE (1) 37-year-old woman driver

In the second case (55-year-old male cook), more than 60% responded that "The man would visit his family doctor, and could seek treatment confidentially" (Figure 15). When grouping the responses by outcome, there was no clear pattern among the responses identified, but it is noted that the countries that responded that the company would fire him and he would lose his job, also responded that they did not know what the legislation regulating alcohol consumption in the workplace is in medium-sized companies, and that a company is unlikely to detect a worker's drinking problem without regular medical check-up (Table 4) .

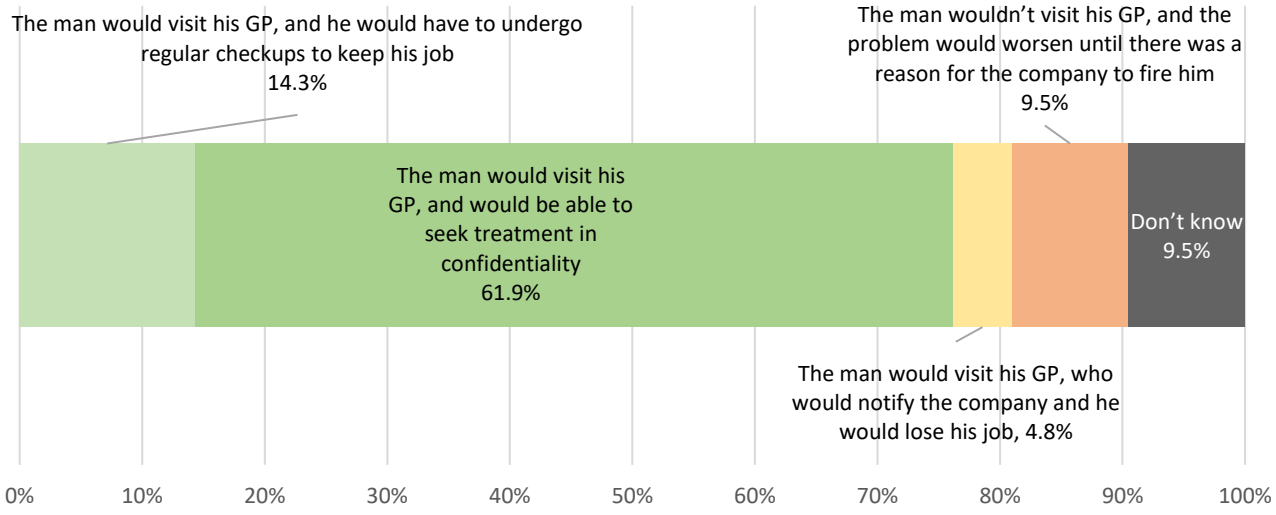

Figure 15. Main outcome CASE (2) 55-year-old male cook who was found to have abnormal levels of liver enzymes in his blood.

In the third case (21-year-old-woman operating heavy warehouse machinery - Figure 16) the most common answer was "She would seek treatment outside the company" among respondents, and they also stated that the woman would probably seek help from the National Health System Professionals/Internal Occupational Health Service; while the group answering "She would ignore the problem", thought that she would seek help from the family doctor.

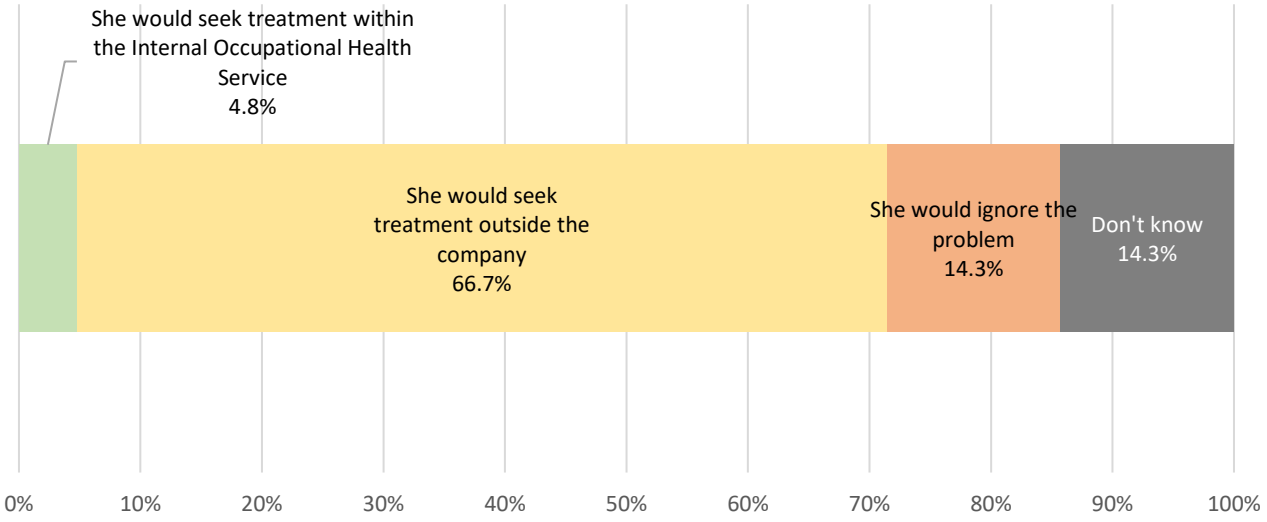

Figure 16. Main outcome CASE (3) 21-year-old-woman operating heavy warehouse machinery, who has started to perceive that she might have a problem with alcohol.

In the last case (24-year-old self-employed welder) most countries answered that "The company will finalize his contract and he will not work for that company again"; however, no clear pattern was found and only two

countries answered that "He will be able to work on his consumption problem while his behaviour is monitored by the company" (Figure 17).

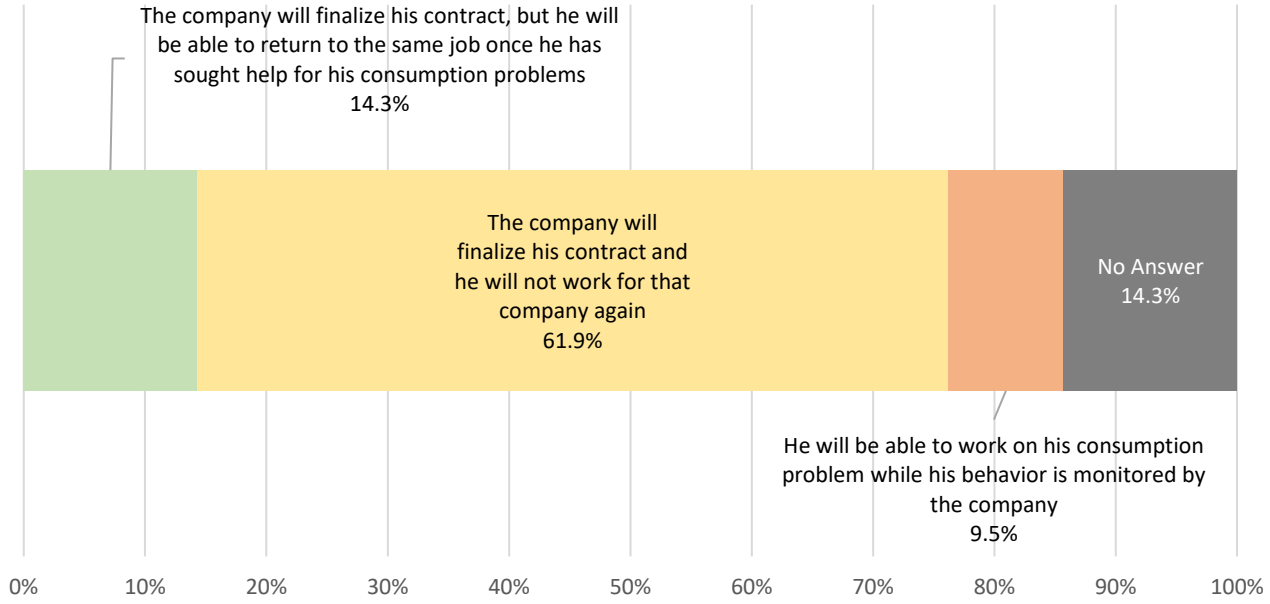

Figure 17. Main outcome CASE (4) 24-year-old self-employed welder who works for a large metal structure building company.

In the following table that groups the results by country for each case, the cases are scored according to responses from 1 to 4, with the most desirable response in public health terms being 1, and the least desirable response being 4. There are 3 countries with the most desirable response scores (Cyprus, Hungary and Malta), while the least desirable response scores were obtained by Poland and Austria. The lowest (best) total scores are coloured green (less than 7) with higher (worse) scores in yellow (8 and 9) and orange (10 and 11). Countries that answered don't know or did not answer any case are not considered and are coloured white.

Table 4. Main results of cases by country

	What would be the most likely outcome of a case like this in your country?	Albania	Austria	Belgium	Bosnia and Herzegovina	Croatia	Cyprus	Estonia	Finland	France	Germany	Hungary	Italy	Latvia	Lithuania	Malta	Netherlands	Poland	Portugal	Slovenia	Spain	United Kingdom
Case 1	The company would be notified, and she would be able to seek treatment in confidentiality						1		1							1				1		
	The company would be notified, and she would have to undergo regular check-ups to keep her job							2		2		2			2							
	The company would be notified, and she would lose her job	3											3									
	There will be no work-related consequences, as the company will not know about the cause of the accident		4			4					4			4			4	4	4		4	
	Don't know			X	X																	X
Case 2	The man would visit his GP, and he would have to undergo regular check-ups to keep his job				1	1						1				2	2	2	2	2	2	
	The man would visit his GP, and would be able to seek treatment in confidentiality		2	2			2	2	2	2			2			2	2	2	2	2	2	
	The man would visit his GP, who would notify the company and he would lose his job	3																				
	The man wouldn't visit his GP, and the problem would worsen until there was a reason for the company to fire him													4	4							
	Don't know										X											X
Case 3	She would seek treatment within the Internal Occupational Health Service																				1	
	She would seek treatment outside the company	2		2	2	2	2	2	2	2		2	2		2	2	2		2			
	She would ignore the problem		3															3		3		
	Don't know										X			X								X
Case 4	The company will finalize his contract, but he will be able to return to the same job once he has sought help for his consumption problems				1		1									1						
	The company will finalize his contract and he will not work for that company again	2	2	2		2		2		2		2	2		2		2	2	2		2	
	He will be able to work on his consumption problem while his behaviour is monitored by the company								3											3		
	No Answer										X			X								X
	Total by country	10	11	6	4	9	6	8	8	8	4	7	9	8	10	6	10	11	10	9	9	0

Conclusions and recommendations

Section 1. Workplace alcohol prevention programmes by country

- Legislation, regulations and programmes among European countries are very unequal. The prevention interventions and treatment options received by a worker with alcohol-related problems may vary greatly according to the country. There is a **need for harmonisation between European countries** in order to achieve the same level of prevention and protection practices for workers.

- Despite the large majority of countries reporting having alcohol prevention policies in occupational safety and health legislation, almost half are indirect rather than explicit clauses on alcohol; only 31% of the policies mentioned are stand-alone initiatives. Moreover, 21% stated that these policies are not implemented. In this regard, it is important that, **in addition to legislation, it is enacted and enforced**. To this end, **monitoring and surveillance must be established**.

- Alcohol prevention programmes are mainly run by companies in half of the countries, and by the government in the other half. **Coordination between companies and government has the potential to make these interventions more efficient**; for this to happen, it is necessary that both sides are involved.

- Lack of data makes it difficult to track and monitor the reality of countries in alcohol prevention initiatives in the workplace. In over 70% of countries there are no statistics available at the national level, and the statistics available are mostly provided by specialist centres. It is important to **develop monitoring and surveillance systems that provide standardised information at local and European level**. As far as possible, these systems should be harmonised and allow for analysis and comparison between European countries.

- Internal Occupational Safety and Health (OSH) services, the Ministry of Health – Department Health Promotion – followed by the Employers' Associations, Labour Unions and Workers' Associations and the Ministry of Labour are the main actors in the implementation and development of workplace alcohol prevention programmes. However, the influence each actor has on decision-making seems to differ from country to country. This could hamper communication between countries when coordinating policies at the European level, therefore it is **necessary to define and make transparent the institution in charge in each country, and those in positions of responsibility**.

- In addition, in most countries it is the Ministry of Labour which is responsible for Occupational Safety and Health (OSH). In one third of the countries these responsibilities are shared with the Ministry of Health. This should be considered when **coordinating policy setting between health and labour directorates at the European level**.

- On the other hand, occupational safety and health (OSH) prevention services at the enterprise level depend on the size of the enterprise and the economic sector to which it belongs. Therefore, rules and policies must take these aspects into account in order to **protect workers in all sectors and sizes of enterprises equally**.

Section 2. Barriers in the implementation of alcohol prevention programs in the workplace

- Difficulty in accessing data on workers registered in the national health system, in order to facilitate their access to alcohol prevention interventions, is one of the main barriers to implementing prevention programmes. In only 35% of the countries is there a regulatory framework for alcohol and drug testing of workers, and in 45% of the countries it only applies to certain cases such as pilots or drivers. In this regard, it is important that there is a **regulatory framework that defines protocols that respect data protection and allow access to workers' health data to facilitate the detection and prevention of alcohol problems**.

- The lack of protocols was identified as the main barrier in the implementation of workplace alcohol prevention programmes, according to the perspective of the participating social partners. The **lack of protocols hinders the implementation** of legislation and makes management difficult. This is an important issue that needs to be taken into account when implementing legislation, programmes and interventions.

- In addition to the points above, this is reinforced by the fact that companies do not see themselves as responsible for alcohol use disorders among their workers and are not aware of the impact of alcohol at work. Additionally, respondents consider that alcohol prevention at work is not a priority for the local administration. **Awareness-raising and sensitisation strategies in companies, workers and employers** are strategies that could tackle this barrier.

- Another important barrier identified was the worker's fear of seeking help to address their potential drinking problems, mainly for fear of losing their job or being stigmatised for their drinking. This aspect was noted in most of the countries as being very relevant. To overcome this barrier, it is necessary to **handle each case with confidentiality and have policies that protect the worker and build trust**.

Section 3. Occupational Health Services alcohol consumption-related problems

- Among the main problems related to the intervention of occupational health services to identify and manage cases related to alcohol consumption, it was found that 40% of Occupational Health professionals are not offered training to deal with alcohol consumption-related problems; and this training is only mandatory in a small minority of countries. Lack of training of occupational health and safety professionals to deal with alcohol-related problems might be one of the issues hampering early detection of problems and intervention. In this sense, **including professional training and making it compulsory could help prevention**. Companies' resources must be taken into account when setting up this training.

- In most countries it is mandatory for occupational health services to carry out regular health checks, but in only 16% of countries is alcohol consumption consistently addressed, directly through a lifestyle questionnaire or other direct method, during health check-up appointments. The lack of periodic health check-ups that address alcohol consumption is a barrier to recognising potential drinking problems in workers. **Addressing alcohol use at health check-ups would improve early detection and intervention**.

- In 73% of countries, depending on company policies, the employer can take disciplinary control measures in the case of workers with alcohol problems. This indicates that, for the most part, companies can manage problem drinking according to their own policies and there are no national guidelines. **Harmonising these policies locally and globally can help protect workers with alcohol problems, reduce stigma and promote help-seeking**.

Section 4. The role of OSH and actors in alcohol prevention, early detection of alcohol-related problems and intervention (through paradigmatic case studies).

- Based on the case responses we can conclude that there are wide differences between countries in detecting, intervening and treating cases of alcohol problems at work.

- In the first case, it was observed that a significant percentage of small companies without regular health check-ups do not detect alcohol consumption problems. That is, 40% responded that "the company will not know about the cause of the accident", and 50% that “the company would be notified”. Among the 50% who answered this, 10% think that she would lose her job and 40% that she would be able to seek treatment. A similar characteristic among those who responded that the company would be notified, is that in these countries there are more actors that could intervene and detect these cases and that there are more mechanisms, regulation and legislation that allow for communication between the occupational health system and the workplace. It is therefore **important for countries to have OSH and health services capable of detecting and intervening, both internally** (e.g., HR, occupational health services) **and externally** (e.g., national legislation, primary care).

- In the second case, most countries state that in situations where a possible alcohol consumption problem has been detected in a medium-sized company with an external occupational health service, the worker is most likely to visit his or her GP and may seek treatment. More than 75% responded that "The man would visit his GP”. This suggests that in most countries, where cases have been detected, workers have a high likelihood of being treated. This underlines the **importance of regular health check-ups that address alcohol consumption**.

- Two important conclusions can be drawn from the third case. The first is that when the worker self-detects a possible problem with alcohol consumption, he or she is more likely to seek treatment outside the company, mainly from the professionals from the National Health System. Only one country responded that the worker would seek help from the Internal Occupational Health Service. And the second conclusion is that workers are more likely to seek help when they detect a consumption problem, in this case through a health campaign organised by the company. Only 14% responded that "She would ignore the problem". In this regard, it is recommended to **encourage health campaigns within and outside companies that address problems related to alcohol consumption at work**. Workers should also be provided with different referral mechanisms to national health systems that **ensure confidentiality** in the workplace.

- In the fourth case, it was observed that, in the overwhelming majority of countries, a worker with an alcohol consumption problem who repeatedly exhibits negative behaviours would lose his or her job, and he or she will not work for that company again. Only two countries answered that "He will be able to work on his consumption problem while his behaviour is monitored by the company". **Intervention and treatment systems supported by the national health system, as well as awareness-raising among employers on the benefits of keeping recovered staff, are necessary for effective case management to help workers return to work while they recover from their health problem**.

ANNEX A – Results: Survey responses by country

Table A1. Detailed response of each country in the first part of the survey "Workplace alcohol prevention programs by country"

	Are there alcohol prevention policies in safety and health at workplace legislations?			Are alcohol prevention programs in the workplace a reality in your country?					Are alcohol prevention programs typically provided by companies or by the administration (i.e., the government)?			Are there statistics at national level available in your country (official data or collected through research studies) to establish if workers are in favour of alcohol prevention initiatives in the workplace?					Can you please list the actors that play an important role (from policy to implementation) in making alcohol prevention programs in the work place a reality in your country?										In your country, which ministry are Occupational Safety and Health (OSH) administration responsibilities under?			What are the variables that determine the organization of health Occupational Safety and Health (OSH) prevention services at company level in your country?		
				Yes, mainly as Part of				No																									
Country	Yes	Indirectly	No	Psychosocial risk prevention initiative	Mental health promotion and risk prevention initiative	Broader lifestyles and risk prevention approach	Standalone initiative		The companies	The administration	Other	Received information/raising awareness campaigns	Received training	Have been tested for alcohol consumption	Referrals to specialist centres	Not available in my country	Internal Occupational Safety and Health (OSH) services	Employers' Associations	Labour Unions & Worker Associations	Professional Bodies	Associations of Occupational Health professionals	Insurance companies	Ministry of Health – Department of Drug and Drug Addiction	Ministry of Health – Department Health	Ministry of Labour	Ministry of Labour	Ministry of Health	Both	Size of the company	Economic sector to which the company belongs	All companies have the same type of prevention services
Albania		X			X					X						X	X	X					X	X				X			X		
Austria		X				X				X					X		X	X	X			X				X			X			X		
Belgium	X						X		X						X		X	X	X					X	X		X			X			X		
Bosnia and Herzegovina		X						X								X								X	X				X					
Croatia	X						X			X						X	X							X	X	X				X				X	
Cyprus	X					X				X						X	X	X	X	X		X			X	X			X	X					
Estonia	X					X				X						X	X			X				X										X	
Finland	X							X	X							X	X	X	X	X	X			X			X							X	
France	X					X			X							X	X				X					X			X					
Germany		X						X	X							X	X			X		X	X						X	X					
Hungary	X					X			X					X		X	X	X			X	X		X			X			X					
Italy	X					X			X							X	X		X	X	X			X	X				X					

Latvia			X					X	X							X	X									X			X	X			
Lithuania	X									X						X						X						X	X				
Malta		X					X			X						X	X		X	X	X		X				X		X	X			
Netherlands	X						X		X							X	X	X		X	X	X	X	X		X			X				
Poland		X					X		X			X							X						X	X							
Portugal		X					X			X						X		X					X		X	X			X	X			
Slovenia	X				X				X			X				X	X	X		X				X	X			X				X	
Spain		X			X					X			X			X	X	X	X	X			X	X	X	X						X	
United Kingdom		X														X								X				X					
Total	11	9	1	0	3	6	6	4	10	9	0	2	1	1	2	15	18	10	10	8	9	6	7	13	10	11	2	7	11	5	5		

Table A2. Detailed response of each country in the second part of the survey Barriers in the implementation of alcohol prevention programs in the workplace

	Does the OSH professional in a company have access to the data of workers registered in the national health system to facilitate their intervention in alcohol prevention?			Is there a regulatory framework giving the employer the right to test employees for alcohol and drugs?			Please rate from 1 to 5 the importance of barriers in the implementation of alcohol prevention programs in the workplace (1 star being not at all important and 5 stars extremely important)										What do you think would be the main cause for workers to hesitate in seeking help to address their potential alcohol consumption problems? (please pick one)		
Country	Easily	Under request	Not possible	Yes	No	In some cases	Lack of protocols	Lack of objective means of early detection of alcohol addiction	Lack of clarity on follow- up + potential actions to be taken towards workers identified.	Companies do not see themselves as responsible for alcohol use disorders	Lack of awareness by companies on the impact of alcohol in the workplace	Companies fear implementing programs may negatively affect corporate image	Companies/public authorities fear reactions of workers + unions	Fear of generating stigma towards workers participating in alcohol prevention programs, → other psychosocial risks at work	Lack of communication mechanisms between OSH services at the company level and public health services	Alcohol prevention at work is not a priority for the administration	Fear of losing their job	Confidentiality concerns; fear of the consequences of seeking help regarding work colleagues/supervisors	Not being able to identify that they might have an alcohol consumption problem
Albania		X			X		5	5	5	5	5		5	5	5	5	X		
Austria			X	X			3	3	2	5	5	3	2	4	3	4		X	
Belgium		X				X	4	3	3	3	3	2	4	3	2	3			X
Bosnia and Herzegovina			X		X		5		3	5	4	2	3	4	5	5		X	
Croatia	X			X			4	3	4	4	3	4	3	3	4	3	X		
Cyprus						X	5	2	5	5	5	2	2	2	5	5		X	
Estonia		X				X	4	4	4	5	3	3	1	1	3	3	X		
Finland			X	X			4	3	3	4	3	1	1	3	3	4	X		
France			X			X	4	2	2	3	2	3	2	1	1	2	X		
Germany			X				4	4	1	4	4	2	3	3	1	3		X	
Hungary			X		X		4	5	5	4	3	3	3	3	3	3	X		
Italy		X				X	5	5	5	5	5	2	4	5	2	5	X		
Latvia			X	X			4	3	3	5	5	4	5	4	5	5		X	
Lithuania			X			X	4	4	4	3	3	2	2	2	3	3		X	
Malta			X			X	4	5	4	4	4	3	3	3	3	3	X		
Netherlands		X				X	5	4	4	4	4	5	4	5	5	4			X
Poland			X	X			5	3	5	3	4	5	2	5	5	5	X		
Portugal			X	X			5	3	5	1	2	3	2	2	1	5			X
Slovenia			X	X			4	4	4	4	3	3	3	4	3	4	X		
Spain			X			X	4	4	4	4	4	4	4	3	4	4			X

United Kingdom			X		X		4	4	4	3	4	3	3	3	4	5		X							
Total	1	5	14	7	4	9	89	73	78	82	78	59	60	68	70	82	10		7	4					

Table A3. Detailed response of each country in the second part of the survey Occupational Health Services alcohol consumption-related problems

	Are Occupational Health professionals (internal or external)/managers/business owners offered training to deal with alcohol consumption-related problems from a source external to the company?		Is this training mandatory?		Are Occupational Health Services (internal or external) required to carry out regular health check-ups?			During health check-up appointments, do Occupational Health professionals address alcohol consumption?				How is it addressed?		Are there referral mechanisms directly from workplace health settings + addiction treatment system?		Can the employer take disciplinary control measures in the case of workers with alcohol problems?		Is alcohol consumption during teleworking monitored or taken into account?	
Country	**Yes**	**No**	**Yes**	**No**	**Yes, always**	**Yes, if there are third-party risks (e.g., drivers, carers)**	**No**	**Yes, always**	**It is optional**	**No, not required**	**No, not permitted**	**Directly (e.g., lifestyle questionnaire)**	**Indirectly (e.g., through a blood test)**	**Yes**	**No**	**Depending on company policy**	**No**	**No**	**Don´t Know**
Albania				X	X					X			X			X		X	
Austria	X			X		X			X			X			X	X		X	
Belgium	X			X					X			X			X	X		X	
Bosnia and Herzegovina		X		X			X								X				X
Croatia		X		X		X			X				X		X				X
Cyprus		X		X					X					X		X			X
Estonia				X	X				X			X		X		X			X
Finland	X			X		X			X				X					X	
France		X		X	X				X			X				X		X	
Germany	X			X					X			X					X	X	
Hungary	X				X			X				X			X				X
Italy				X	X			X				X		X			X	X	
Latvia	X			X	X					X						X		X	
Lithuania				X						X			X					X	
Malta	X			X			X					X		X		X		X	
Netherlands	X			X							X	X		X		X		X	
Poland		X		X	X				X			X			X	X		X	
Portugal	X		X		X				X			X		X			X		X
Slovenia			X		X			X				X		X			X	X	

Spain		X		X	X			X				X			X		X		X	
United Kingdom																				X
Total	9	6	2	17	10	3	2	3	11	3	1	13	4	7	7	11	4	14	7	

ANNEX B - Survey Questionnaire

Workplace and Alcohol

Thank you for your availability and time to respond to this survey on action to tackle alcohol related harm in workplaces, striving to understand the complexity of harm reduction alcohol policies in the workplace and provide tools for their implementation, as part of the EU-funded service contract AlHaMBRA Project (Alcohol Harm - Measuring and Building Capacity for Policy Response and Action, Contract No. 20197105).

Should you require further information, please contact: alcohol.europa@gencat.cat.

Introduction

This Data Protection Notice describes the measures taken to protect your personal data with regard to the action involving the present data processing operation and what rights you have as a data subject.

European Health and Digital Executive Agency (HaDEA or Agency) protects the fundamental rights and freedoms of natural persons and in particular your right to privacy and the protection of your personal data.

Your personal data are processed in accordance with Regulation (EU) No 2018/1725[1] on the protection of individuals with regard to the processing of personal data by the Union institutions, bodies, offices and agencies and on the free movement of such data.

[1] Regulation (EU) 2018/1725 of the European Parliament and of the Council of 23 October 2018 on the protection of natural persons with regard to the processing of personal data by the Union institutions, bodies, offices and agencies and on the free movement of such data, and repealing Regulation (EC) No 45/2001 and Decision No 1247/2002/EC (OJ L295/39 of 21.11.2018).

Why and how do we process your personal data?

In the context of the implementation of the service contract n. 20197105 **"AlHaMBRA Project"** concluded between European Health and Digital Executive Agency (HaDEA), on the one part and the General Directorate for Intervention on Addictive Behaviours and Dependencies in Portugal (SICAD), SICAD, is releasing a mapping survey coordinated by GENCAT and ESADE to gather knowledge, share best practice and capacity building for evidence-based alcohol policy and harm-reduction across multiple sectors.

The purposes of this processing activity of personal data are the following:

- obtain informed consent to process the data,
- contextualize the responses to be collected from the mapping survey on mechanisms and regulations for dealing with alcohol in the workplace, which will feed into the development of the briefing paper and workshop.
- analysing aggregate data for reporting purposes to the contracting authority, HaDEA, in terms of compliance with the specifications of the service contract, and DG SANTE of the European Commission in terms of public health policy impact of the workshop.

Your personal data will not be used for an automated decision-making including profiling.

Your personal data **will not be transferred** to third countries or international organisations.

Who is the 'data controller'?

The data controller, is the Head of Unit A2 at the European Health and Digital Executive Agency (HaDEA), managing the EU Contract No. 20197105. (AlHaMBRA Project - Alcohol Harm – Measuring and Building Capacity for Policy Response and Action).

Who is the 'data processor'?

The data processors are:
The General Directorate for Intervention on Addictive Behaviours and Dependencies in Portugal (SICAD), leader of the joint contractors in the EU Contract No. 20197105. (AlHaMBRA Project - Alcohol Harm – Measuring and Building Capacity for Policy Response and Action).
The Department of Health of the Government of Catalonia (GENCAT, in Barcelona, Spain), member of the joint contractors in the EU Contract No. 20197105. (AlHaMBRA Project - Alcohol Harm – Measuring and Building Capacity for Policy Response and Action).
The ESADE Business School (Barcelona, Spain) member of the joint contractors in the EU Contract No. 20197105. (AlHaMBRA Project - Alcohol Harm – Measuring and Building Capacity for Policy Response and Action).

Third party tools used for the organisation of Thematic Capacity Workshop on the topic "Working Together to Prevent Harm due to Alcohol in the Workplace"
The survey data will be collected online using Jotform (https://www.jotform.com/) business account of FCRB (Spain). Jotform stores the registration forms and the data collected in their EU Data Center (https://www.jotform.com/help/871-how-to-store-your-data-on-eu-servers/).

Which is the legal basis for processing your personal data?

The legal basis for the processing activities are:
- Article 5(1)(a) of Regulation (EU) 2018/1725 because processing is necessary for the performance ofa task carried out in the public interest (or in the exercise of official authority vested in the Union institution or body);
- Article 5(1)(d) of Regulation (EU) 2018/1725: the data subject has given consent to the processing ofhis or her personal data for one or more specific purposes; **Which personal data do we collect and further process?**

In order to carry out this processing operation, the sub-processor, FCRB, acting for HaDEA, collects the following categories of personal data:
- identifiers: name, surname, e-mail address,
- professional details: organisation, role in the organization, country;

These are **mandatory** data, collected directly from you through the survey for the purposes outlined above. If you do not provide your personal data, we cannot process your answers to the survey. When proceeding with the survey form you give us permission to store and use your data.
We do not process special categories of personal data.
We **do not process special categories** of personal data.

How long do we keep your personal data?
GENCAT, acting for HaDEA only keeps your personal data for the time necessary to fulfil the purpose of collection or further processing, namely for the duration of the AlHaMBRA Project (ending February 2023).

How do we protect and safeguard your personal data?
All personal data in electronic format are stored in a password-protected file on the server of GENCAT.
In order to protect your personal data, a number of technical and organisational measures in place. Technical measures include appropriate actions to address online security, risk of data loss, alteration of data or unauthorised access, taking into consideration the risk presented by the processing and the nature of the personal data being processed. Organisational measures include restricting access to the personal data solely to authorised persons with a legitimate need to know for the purposes of this processing operation.

Who has access to your personal data and to whom is it disclosed?

The recipients of your personal data will be:
authorised GENCAT staff authorised ESADE staff and
authorised HaDEA and DG Santé staff in charge of the alcohol portfolio (only aggregate data). Such staff abide by statutory, and when required, additional confidentiality agreements.

On a need-to-know basis and in compliance with the relevant current legislation, bodies charged with monitoring or inspection tasks in application of EU law (e.g., EC internal audit, Court of Auditors, European Anti-fraud Office (OLAF), the European Ombudsman, the European Data Protection Supervisor, European Public Prosecutor's Office (EPPO)).
The information we collect will not be given to any third party, except to the extent and for the purpose we may be required to do so by law.

What are your rights regarding your personal data?

You have the right to access your personal data and to request your personal data to be rectified, if the data is inaccurate or incomplete; where applicable, you have the right to request restriction or to object to processing, to request a copy or erasure of your personal data held by the data controller. If processing is based on your consent, you have the right to withdraw your consent at any time, without affecting the lawfulness of the processing based on your consent before its withdrawal.
Your request to exercise one of the above rights will be dealt with without undue delay and within **one month.**
If you have **any queries** concerning the processing of your personal data or wish to exercise any of the rights described above, you can contact HaDEA Data Protection Officer (DPO) at HADEADPO@ec.europa.eu

You shall have right of recourse at any time to the European Data Protection Supervisor at EDPS@edps.europa.eu.

Confidentiality disclaimer
We guarantee the information you provide will be treated lawfully, fairly and transparently protecting your privacy and your rights in accordance with the provisions of
Regulation (EU) 2016/679 of April 27, 2016 (RGPD)
To proceed with the pre-registration, please check the box below to give us permission to store and use your data in this way. You can withdraw your consent at any time by sending an email to alcohol.europa@gencat.cat *

☐ I agree to my data being collected, stored and used in this way

Please choose your country *
Are there alcohol prevention policies in safety and health at workplace legislations?
Yes
Yes, but only indirectly (i.e., as part of a broader health promotion approach)
No
Don't know

Are alcohol prevention programs in the workplace a reality in your country?
Yes, mainly as part of a psychosocial risk prevention initiative
Yes, mainly as part of a mental health promotion and risk prevention initiative
Yes, mainly as part of a broader lifestyles and risk prevention approach Yes, mainly as a standalone initiative
No
Don't know

Workplace alcohol prevention programs

Are alcohol prevention programs typically provided by companies or by the administration (i.e., the government)?
The companies
The administration

Are there statistics at national level available in your country (official data or collected through research studies) to establish if workers are in favour of alcohol prevention initiatives in the workplace?

Yes
No
Don't know

Please provide references and/or links to the sources of these prevention programmes or data

Can you please list the actors that play an important role (from policy to implementation) in making alcohol prevention programs in the work place a reality in your country?

Internal (i.e., in house/part of the company) Occupational Safety and Health (OSH) services
Employers' Associations
Labour Unions and Workers' Associations
Professional Bodies
Associations of Occupational Health professionals
Insurance companies
Accreditation associations
Ministry of Health – Department of Drug and Drug Addiction
Ministry of Health – Department Health Promotion
Ministry of Labour

Are there statistics available in your country (official data or collected through research studies) to establish what percentage of workers have received any of the following alcohol prevention actions at the workplace? (please mark all taht may apply)

Received information/raising awareness campaigns
Received training
Have been (randomly or not) tested for alcohol consumption
Referrals to specialist centres
These statistics are not available in my country

Could you please provide the names and websites of most relevant actors of each aforementioned group.

In your country, which ministry are Occupational Safety and Health (OSH) administration responsibilities under?

Ministry of Labour
Ministry of Health
Both
Don't know

What are the variables that determine the organization of health Occupational Safety and Health (OSH) prevention services at company level in your country?

Size of the company
Economic sector to which the company belongs
All companies have the same type of prevention services
Don't know

Barriers in the implementation of alcohol prevention programs in the workplace

Does the OSH professional in a company have access to the data of workers registered in the national health system to facilitate their intervention in alcohol prevention?

Easily
Under request
Not possible
Don't know

Is there a regulatory framework giving the employer the right to test employees for alcohol and drugs?

Yes

No
Don't know

Please rate from 1 to 5 the importance of barriers in the implementation of alcohol prevention programs in the workplace (1 star being not at all important and 5 stars extremely important)

Lack of protocols on what do to, how to do it and definition of responsibilities (who does what) among stakeholders

1 2 3 4 5
Least important Most important

Lack of objective means of early detection of alcohol addiction

1 2 3 4 5
Least important Most important

Lack of clarity on follow- up and potential actions to be taken towards workers identified as having a potential alcohol use problem

1 2 3 4 5
Least important Most important

Companies do not see themselves as responsible for alcohol use disorders among their workers (no legal basis as an "occupational disease")

1 2 3 4 5
Least important Most important

Lack of awareness by companies on the impact of alcohol in the workplace

1 2 3 4 5
Least important Most important

Companies fear that implementing such programs may negatively affect their corporate image

1 2 3 4 5
Least important Most important

Companies/public authorities fear reactions of workers and their unions

1 2 3 4 5
Least important Most important

Fear of generating stigma towards workers participating in alcohol consumption prevention programs, leading to other psychosocial risks at work (such as stress, depression, etc)

1 2 3 4 5
Least important Most important

Lack of communication mechanisms between OSH services at the company level and national or regional public health services

1 2 3 4 5
Least important Most important

Alcohol prevention at work is not a priority for the administration

1 2 3 4 5
Least important Most important

Please specify any other barriers that could arise in your country/region.

What do you think would be the main cause for workers to hesitate in seeking help to address their potential alcohol consumption problems? (please pick one)

- Fear of losing their job
- Confidentiality concerns; fear of the consequences of seeking help regarding work colleagues/supervisors (stigma, loss of career perspectives, etc.)
- Not being able to identify that they might have an alcohol consumption problem Not knowing where to seek help

Are Occupational Health professionals (internal or external)/managers/business owners offered training to deal with alcohol consumption-related problems from a source external to the company (public administration, accreditation entities, professional bodies, etc.)?

- No
- Don't know

Is this training mandatory?

- Yes
- No
- Don't know

How/With what instruments and under which circumstances?

During health check-up appointments, do Occupational Health professionals address alcohol consumption?

- Yes, always
- It is optional
- No, it is not permitted
- No, it is not required
- Don't know

How is it addressed?

- Directly (e.g. through a questionnaire about lifestyle)
- Indirectly (through a blood test, for example)

Are Occupational Health Services (internal or external) required to carry out regular health check-ups?

- Yes, always
- Yes, if there are third-party risks (e.g., drivers, carers)
- Yes, when it is a large company (250 or more employees)
- No
- Don't know

Are there any referral mechanisms established directly from workplace health settings and addiction treatment system?

- Yes
- No
- Don't know

Is alcohol consumption during teleworking monitored or taken into account?

- No
- Don't know

Do you know of good and best practices in your national/regional/local context that promote alcohol-free workplaces?

- No

Can the employer take disciplinary control measures in the case of workers with alcohol problems?

- No

Don't know

Please give reference details of any published papers, reports, websites on this good/best practice and materials (web page, references, other relevant documents such as implementation manuals, training manuals, guidelines, posters, etc.).

PART 4

Case 1

A 37-year-old woman who works as a driver for a transportation company with 5 other employees. Specific medical examinations or periodic controls of workers' use of alcohol and other drugs are not performed in her company. She has had multiple minor road traffic accidents while on duty due to moderate alcohol consumption, leading to a subsequent whiplash trauma, but all have happened outside the premises of the company. At the clinical follow-up with the insurance company, they suspect that the accidents are alcohol-consumption related. The mutual insurance company could carry out an alcohol check-up, but probably won't follow-up in case of identifying problems, and would send the person to Primary Care (NHS). As this alcohol consumption will not be publicised, she goes back to work, and the company has no record of the cause of her accident. The woman's alcohol use will get worse, and, with it, her risk of having an accident.

Practical case studies

The following questions related to hypothetical cases in the workplace are designed to detect barriers and challenges that may apply in different workplace contexts with different worker profiles. Please answer the questions for each one of the examples specifically AS IT WOULD HAPPEN IN YOUR COUNTRY.

Which OSH and health services would intervene in a case like this in your country/region?

Mutual insurance company
Primary Care
Medical Emergency Services
National Labour Inspectorate
Internal Occupational Health Service
External Occupational Health Service
None of the above
Don't know

In your country, how likely would it be that any of the actors involved would have detected the worker's risky alcohol use

1 2 3 4 5

Extremely unlikely Extremely likely

Who would have detected it?

Mutual insurance company
Primary Care
Medical Emergency Services
National Labour Inspectorate
Internal Occupational Health Service
External Occupational Health Service
None of the above
Don't know

What are the mechanisms/regulation/legislation that enable this communication between occupational health system and workplace?

13. If she had wanted to seek help for her alcohol consumption problem, would resources have been available in her workplace?

Yes
No
Don't know

If this case had occurred in your country, how likely would it have been for the company to detect the worker's alcohol consumption problem before she had an accident?

1 2 3 4 5

Extremely unlikely Extremely likely

How likely would it be that she knew these resources existed?

1 2 3 4 5

Extremely likely Extremely unlikely

What legislation regulates Occupational Health in a company like this one (i.e., small company with risk to third parties)? If possible, please specify law and specific article and provide a brief summary of contents in English and the link if available. What would be the most likely outcome of a case like this in your country?

The company would be notified, and she would be able to seek treatment in confidentiality
The company would be notified, and she would lose her job
The company would be notified, and she would have to undergo regular check-ups to keep her job There will be no work-related consequences, as the company will not know about the cause of the accident
The problem would be ignored by the company

What legislation regulates alcohol consumption in the workplace in a company like this (i.e., medium-sized company with no third-risk parties)? If possible, please specify law and specific article and provide a brief summary of contents in English and the link if available.

Same as the previous case
Don't know

How likely would a company in your country have been to detect a worker's alcohol consumption problem without the regular medical check-up?

1 2 3 4 5

Extremely unlikely Extremely likely

Case 2

A 55-year-old man works as a cook at a nursing home with 60 other workers. The company has an external Occupational Health Service which conducts regular health check-ups. During an annual check-up, abnormal levels of hepatic enzymes in his blood are detected, and he is advised to visit with his General Practitioner (GP). As it is not compulsory, he chooses not to visit his GP, and his consumption worsens. The company is taking steps to fire him for low productivity.

In your country/region, what is the most likely course of action the Occupational Safety and Health (OSH) service would have taken if they had discovered an alcohol use disorder?

Seek treatment for the person in confidentiality
Notify the company
Ignore the problem

In your country/region how would the Occupational Health Service liaise with his GP to inform about his risky alcohol use?

There are established channels of communication between the National Health System and OSH actors
There would be no way to liaise with his GP
Don't know

How likely would it be that he knew these resources existed and used them?

1 2 3 4 5

Extremely unlikely Extremely likely

If he had wanted to seek help for his alcohol consumption problem, would resources have been available in his workplace?

Yes
No
Don't know

In your region/country, how often are promotion actions accompanied by concrete tools (helplines, referrals) to seek help in case of self-identifying an alcohol problem?

1 2 3 4 5
Never Very frequently

Case 3

A 21-year-old-woman works in a warehouse operating heavy machinery along with 270 other employees.
The company has an Internal Prevention service (i.e., it is part of the company) with an Occupational Health department. Every year, they conduct health promotion activities, and this year's focus is on alcohol consumption. As a result of this campaign, she has started to see that she might have an alcohol consumption problem. If she goes to her GP and takes a sick leave, the company could fire her, as her job entails risks to third parties. Additionally, having to seek treatment could interfere with her work schedule. Thus, she is hesitant to address the issue.

In your region/country, what would be the most likely outcome in a case like this?

The man would visit his GP, and would be able to seek treatment in confidentiality
The man would visit his GP, who would notify the company and he would lose his job
The man would visit his GP, and he would have to undergo regular check-ups to keep his job
The man wouldn't visit his GP, and the problem would worsen until there was a reason for the company to fire him

What legislation regulates Occupational Health in a company like this one (i.e., big company with an Internal Occupational Health department and which carries out risky work)?

Same as in all previous cases
Same as case 1 (transporting agency with 6 employees)
Same as case 2 (cook in nursing home with 60 employees)

If possible, please specify law and specific article and provide a brief summary of contents in English and the link if available.

How likely would it be that he knew these resources existed?

1 2 3 4 5
Extremely unlikely Extremely likely

What would the most likely outcome of a case like this be?

She would seek treatment within the Internal Occupational Health Service
She would seek treatment outside the company
She would ignore the problem

Once the worker has acknowledged the fact that she might have an alcohol consumption problem, would resources be available to her that would help her address it within the company?

1 2 3 4 5
Extremely unlikely Extremely likely

In your region/country, how often are promotion actions accompanied by concrete tools (helplines, referrals) to seek help in case of self-identifying an alcohol problem?

Very frequently
Frequently
Occasionally
Rarely

Very Rarely
Never
Don't know

Where would the woman likely turn to seek help?

Internal Occupational Health Service
Professionals from the National Health System

In your country/region, which OSH actors would intervene in a case like this one?

The company's Internal Occupational Health Service
The company's External Occupational Health Service
Occupational Health Service hired by the self-employed worker
Insurance Company
Medical Emergency Services
Professionals from the National Health System

if possible, please specify law and article?

Are self-employed workers required to have an organization oversee their risk prevention?

Yes
No
Don't know

Case 4

A 24-year-old self-employed welder who works for a large metal structure building company. He has hired an Occupational Health Service to fulfil the legal requirements for working for the building company and accessing all construction sites. Though these health check-ups are compulsory, workers often do not turn up for them, and inspections are scarce. After three years working with them, the worker receives a warning for regular absenteeism on Monday mornings and some antisocial behaviour - propensity to start arguments, irritability… The Occupational Health worker, who is a psychologist, thinks the worker might have a potential alcohol use problem.

In your country/region, are self-employed workers obliged to undergo regular health check-ups?

Yes, regardless of the company they work with
Yes, for certain occupations/companies
No
Don't know

What is the most likely outcome once the building company temporarily finalizes his contract to address his alcohol consumption problem?

The company will finalize his contract and he will not work for that company again
The company will finalize his contract, but he will be able to return to the same job once he has sought help for his consumption problems
He will be able to work on his consumption problem while his behaviour is monitored by the company

Would these check-ups be able to detect alcohol consumption problems?

Yes
No
Don't know

Would you be willing to be contacted to gather more detailed information on this topic?

Yes, through a follow-up questionnaire
Yes, through a short interview

I would prefer not to be contacted for further details

What legislation regulates risk prevention and health promotion among the self-employed

Same as in all previous cases
Same as in case 1 (transportation company with 6 employees)
Same as in case 2 (cook in nursing home with 60 employees)
Same as in case 3 (warehouse worker with 270 employees)

In your country, what would be the most effective way a self-employed person could receive information concerning health promotion issues, such as alcohol prevention (e.g., through what type of organization)?
Role in the organization:
How competent did you feel responding this questionnaire?

Very competent
Competent
Somewhat competent
Not competent
I prefer not to answer

Additional comments or suggestions for consideration in the workshop or survey
Telephone number (+ country code):

Contact details

We would like to have your contact information to inform you of the progress of the AlHaMBRA Project initiatives and in case any clarification is needed on your responses.

Name and surname:
Organization/affiliation:
E-mail address:

ANNEX C - Invitation letter key stakeholders

Dear NAME
ORGANIZATION
COUNTRY

We are contacting you, to ask you for your contribution to the AlHaMBRA *project (***Alcohol Harm - Measuring and Building Capacity for Policy Response and Action).** Given your expertise and knowledge in the workplace safety and health field, we would like to request your help in identifying the main stakeholders, regulations, best practices and barriers in your country concerning the prevention of alcohol problems in the workplace.

AlHaMBRA Project is a tendered service contract awarded by the European Commission under the EU health programme to support European Member States (MS) in knowledge gathering, sharing best practice and capacity building for evidence-based alcohol policy and harm-reduction. One task of the contract is focused on Member State knowledge exchange and capacity building with specific foci on 3 key topics: Alcohol and Workplace; Production and consumption of illicit/unrecorded alcohol and; application of e-Health tools to reduce alcohol related harm.

On the area of Alcohol and Workplace, AlHaMBRA Project has undertaken a review of the latest evidence and recently organized an on-line capacity building workshop with the title '*Working Together to Prevent Harm due to Alcohol in the Workplace*' structured in three interlinked online sessions (Information and videos of these sessions will be available in the coming days in this link https://alh-thematic-workshop6-alcoholinworkplace.onsitevents.com/)

To compliment and extend this work, AlHaMBRA Project is now implementing a mapping survey at European and at country level to identify best practices and define major policy concerns, implementation barriers and points of future discussion. For this, we ask you to kindly complete the following questionnaire that will help us to acquire a basic understanding of the functioning in your country of OSH structures regarding the implementation of alcohol prevention programs, to identify barriers and best practices.

https://form.jotform.com/220533441253344

The survey takes approximately 30 minutes to complete and the information collected will be used anonymously. All information gathered will inform the final AlHaMBRA Project report on this topic.

We encourage you to respond to as many questions as possible, but if you are unable to answer all questions, for whatever reason, we would also appreciate it if you can still submit the partially completed form.

In addition, we would be grateful if you can forward this link to other suitable contacts in relevant fields, who could respond to this survey.

Ideally, we would like to receive your completed questionnaire by the 15th of June, or at your earliest convenience.

Should you require further information, please contact **Michael Silva or Lidia Segura** through the e-mail address: alcohol.europa@gencat.cat

Many thanks and looking forward to your collaboration,

Joan Colom
Director of the Program on Substance Abuse
Public Health Agency of Catalonia

ANNEX D - Invitation letter EU-OSHA focal Point

Dear NAME
ORGANIZATION
COUNTRY focal point

EU-OSHA has facilitated contact with you to request your contributions and input to the EC Contract **AlHaMBRA Project** *(***Alcohol Harm - Measuring and Building Capacity for Policy Response and Action).** Given your expertise and knowledge in the workplace safety and health field, we would like to request your help in identifying the main stakeholders, regulations, best practices and barriers in your country concerning the prevention of alcohol problems in the workplace.

AlHaMBRA Project is a tendered service contract awarded by the European Commission under the EU health programme to support European Member States (MS) in knowledge gathering, sharing best practice and capacity building for evidence-based alcohol policy and harm-reduction. One task of the contract is focused on Member State knowledge exchange and capacity building with specific foci on 3 key topics: Alcohol and Workplace; Production and consumption of illicit/unrecorded alcohol and; application of e-Health tools to reduce alcohol related harm.

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To compliment and extend this work, AlHaMBRA Project is now implementing a mapping survey at European and at country level to identify best practices and define major policy concerns, implementation barriers and points of future discussion. For this, we ask you to kindly complete the following questionnaire that will help us to acquire a basic understanding of the functioning in your country of OSH structures regarding the implementation of alcohol prevention programs, to identify barriers and best practices.

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The survey takes approximately 30 minutes to complete and the information collected will be used anonymously. All information gathered will inform the final AlHaMBRA Project report on this topic.

We encourage you to respond to as many questions as possible, but if you are unable to answer all questions, for whatever reason, we would also appreciate it if you can still submit the partially completed form.

In addition, we would be grateful if you can forward this link to other suitable contacts in relevant fields, who could respond to this survey.

Ideally, we would like to receive your completed questionnaire by the 20th of June, or at your earliest convenience.

Should you require further information, please contact **Michael Silva or Lidia Segura** through the e-mail address: alcohol.europa@gencat.cat

Many thanks and looking forward to your collaboration,

Joan Colom
Director of the Program on Substance Abuse

ANNEX E - Country profile table (example)

Country		Estonia	
Key Point	**Survey question**	**Survey Results**	**Eurofound**
National guidelines / Legislation on alcohol testing	**Are there alcohol prevention policies in safety and health at workplace legislations?**	Yes	No
Alcohol prevention programs in the workplace	**Are alcohol prevention programs in the workplace a reality in your country?**	Yes, mainly as part of a broader lifestyles and risk prevention approach	No programs, lack of issue as a problem
Provided by	**Are alcohol prevention programs typically provided by companies or by the administration (i.e., the government)?**	The administration	
Statistics workers receiving alcohol prevention actions	**Are there statistics available in your country (official data or collected through research studies) to establish what percentage of workers have received any of the following alcohol prevention actions at the workplace? (please mark all that may apply)**	These statistics are not available in my country	no
Statistics at national level to establish if workers are in favour of alcohol prevention initiatives in the workplace	**Are there statistics at national level available in your country (official data or collected through research studies) to establish if workers are in favour of alcohol prevention initiatives in the workplace?**	Don't know	no
	Please provide references and/or links to the sources of these prevention programmes or data	https://en.tai.ee/en/r-and-d/health-promotion	
Key Actors OSH	**Can you please list the actors that play an important role (from policy to implementation) in making alcohol prevention programs in the work place a reality in your country?**	Internal (i.e., in house/part of the company) Occupational Safety and Health (OSH) services Professional Bodies Ministry of Health – Department Health Promotion	
	Could you please provide the names and websites of most relevant actors of each aforementioned group.	https://en.tai.ee/en/r-and-d/health-promotion	
Ministry responsible of OSH (7)	**In your country, which ministry are Occupational Safety and Health (OSH) administration responsibilities under?**	Ministry of Social Affairs*	Ministry of Social Affairs, Estonian Temperance Union(AVE) and Labour Inspectorate
Organization of health Occupational Safety and Health (OSH) prevention services at company level	**What are the variables that determine the organization of health Occupational Safety and Health (OSH) prevention services at company level in your country?**	All companies have the same type of prevention services	
Availability external training in dealing with alcohol consumption-related problems available for Occupational Health professionals/managers/business owners (36)	**Does the OSH professional in a company have access to the data of workers registered in the national health system to facilitate their intervention in alcohol prevention?**	Under request	no

Guidelines on drug/alcohol testing at work	**Is there a regulatory framework giving the employer the right to test employees for alcohol and drugs?**	Depend on profession	no. While the Occupational Health and Safety Act obliges' the employer to suspend a worker who is intoxicated, none of the laws allow the employer to test the worker for the use of any substances
Training to deal with alcohol consumption-related problems	**Are Occupational Health professionals (internal or external)/managers/business owners offered training to deal with alcohol consumption-related problems from a source external to the company (public administration, accreditation entities, professional bodies, etc.)?**	Don't know	
	Is this training mandatory?	No	
OSH regular health check-ups	**Are Occupational Health Services (internal or external) required to carry out regular health check-ups?**	Yes, always	no
	How likely would it be that these health check-ups detect alcohol consumption or alcohol consumption-related problems?		no
Check-ups address alcohol consumption?	**During health check-up appointments, do Occupational Health professionals address alcohol consumption?**	It is optional	
	How is it addressed?	Directly (e.g., through a questionnaire about lifestyle)	
	How/With what instruments and under which circumstances?		
Referral mechanisms established directly from workplace health settings and the addiction treatment system	**Are there any referral mechanisms established directly from workplace health settings and addiction treatment system?**	Yes	no
	Can the employer take disciplinary control measures in the case of workers with alcohol problems?	Depending on profession	
Teleworking an alcohol consumption	**Is alcohol consumption during teleworking monitored or taken into account?**	Don't know	
Is there any public entity (e.g., Public Health agency) that supports companies to help them manage alcohol consumption related programs? (40)	**Is there any public entity (e.g., Public Health agency) that supports companies to help them manage alcohol consumption related programs?**		no

Best practices	**Do you know of good and best practices in your national/regional/local context that promote alcohol-free workplaces?**	according to OSH Law - it's prohibited to work under influence of alcohol	-
	Please give reference details of any published papers, reports, websites on this good/best practice and materials (web page, references, other relevant documents such as implementation manuals, training manuals, guidelines, posters, etc.).	https://www.riigiteataja.ee/en/eli/ee/Riigikogu/act/528122021001/consolide	