Editorials

Alcohol, drugs, and the workplace:

an update for primary care specialists

In 2015 the UK Department for Work and Pensions started to review how to support benefit claimants, especially those with alcohol- and drug-related problems, back into work.[1] In response the British Medical Association (BMA) developed advice to help medical professionals support such patients to remain in or return to work.[2]

Although some employers provide access to occupational health support, only a minority provide access to an occupational physician. The government's Fit for Work service may partially fill the void but only in respect of sickness absence, and it does not support the unemployed. Consequently, many working-age people rely on GPs for fitness for work advice. Where an employer requests a report, the GP must establish the capacity in which they are acting and explain their professional role to patients. GPs should seek to understand the employer's alcohol and illicit drugs (substance) policy, and the support available to employees. GPs should also ensure that their own workplace policies address substance use.

THE SCALE OF THE PROBLEM

As this journal recently noted, a heavy health burden of morbidity and premature mortality is associated with illicit drug use and alcohol.[3] The true scale of substance misuse in working populations is difficult to quantify; however, previous surveys indicate that 13% of all working responders and 29% of workers aged <30 years reported drug misuse in the previous year.[4] Almost two-thirds of the UK population is of working age and, because three-quarters of this age group are employed, the impact of alcohol and illicit drugs in the workplace is substantial. Unsurprisingly, 40% of UK employers identified alcohol consumption as a significant cause of absence and lost productivity, while one-third reported drug misuse as a similarly negative factor.[5]

Alcohol or illicit drugs impair performance through poor decision making and impaired reaction times. They cause lost productivity, inferior goods or services, and errors and accidents, and can put at risk the safety of that individual, other workers, or the general public. Few studies have specifically examined this relationship, and the evidence relating to accidents at work is contradictory. Studies from different countries estimate that occupational injuries attributable to alcohol range between 7–40%.[2]

> *"Contrary to popular belief, the majority of people who have an alcohol misuse problem are in work."*

OCCUPATIONAL AND NON-OCCUPATIONAL RISK FACTORS

Drinking behaviour is directly correlated with earnings and household income. Type of occupation impacts drinking patterns and levels. Frequent drinking is more likely in the employed; those in managerial and professional jobs drink more frequently than those in routine and manual jobs.[6]

For illicit drug use risk factors include young age, male gender, urban living, frequent alcohol use, cigarette smoking, single status, neuroticism, and frequent clubbing.[2] Data suggest that rates of illicit drug use among workers may be lower than in the unemployed, although the gap is narrowing. Here, also, evidence suggests that type of occupation impacts drug use. In Scotland, those in routine and manual occupations were twice as likely to report using illicit drugs in the last year compared with managerial and professional occupations or the unemployed.[7] Newspapers portray a different picture due to newsworthiness: 40% of news stories involve professionals and celebrities, while (criminal offenders excluded) 6% of stories relate to non-professional workers and the unemployed.

Certain working conditions are associated with alcohol and illicit drug use: shift/night work, long hours, business travel, working remotely, business meals, poor communications, job stress, lack of supervision, physical danger, and interface with a demanding or aggressive public.

In England and Wales the highest alcohol-related mortality is among publicans and bar staff, male caterers, cooks and kitchen porters, and seafarers.[8] Low indicators include male farmers and drivers, and females who work with children. The highest mortality from drug dependency and accidental poisoning occurs in literary and artistic occupations, and in construction (male painters and decorators, bricklayers and masons, plasterers, roofers, and glaziers).[8] Male doctors were among the occupations with the highest indicators of alcohol-related deaths through the 1960s to the 1980s but appear to be at low risk now (presumably because of risk awareness).

DRIVING, DECLARATION, AND DISCLOSURE

Alcohol or illicit drugs contribute to 14% and 3% (respectively) of all fatal road accidents. In Britain for 2014–2015 the proportion of drivers who self-reported driving while over the legal alcohol limit or under the influence of illegal drugs was 6% and 1% respectively.[9]

Irrespective of whether people drive vocationally the law requires that drivers must not drive while impaired by alcohol or drugs, or with alcohol or drug levels in excess of statutory limits. The law also places a statutory duty upon drivers to inform the Driver and Vehicle Licensing Agency (DVLA) if they develop a 'prescribed disability' that bars them from driving, for example, epilepsy, or a 'relevant disability' that might make them a danger, for example, a visual field defect; or if they have been diagnosed with a condition likely to become a prescribed or relevant disability: a 'prospective' disability. This includes persistent alcohol or drug misuse or dependency.[10] Both conditions are considered prospective and prescribed. Recognising that few individuals with such problems self-declare to the DVLA, the General Medical Council (GMC) has advised doctors:

- to advise patients with a relevant or prospective disability of their obligation to inform the DVLA; and
- if the condition renders the patient unfit or unsafe to drive, to advise the individual to cease driving.

If the patient continues to drive and the attempts to persuade them to stop are unsuccessful, the doctor must disclose relevant medical information directly to the DVLA in the public interest. Advice on how to approach this difficult ethical situation

"... people with a history of drug misuse ... can be effective workers ... when well supported by employers and health professionals."

is available from both the DVLA[10] and the GMC.[11]

THERAPEUTIC BENEFITS OF WORK

Few extended studies have been conducted in primary care exploring factors predicting recovery from alcohol or illicit drug dependency. The best predictor of recovery is continuous uninterrupted treatment.[12] For unemployed misusers, getting a stable job is a key step towards sustained recovery from dependency. However, most employers are reluctant to employ substance misusers, even those who have completed rehabilitation. Few UK employers have recruited individuals with previous alcohol and drug problems (9% and 6% respectively).[5] Yet the employers' experiences of recruiting recovering misusers are often positive, with low turnover and absence, and high motivation and productivity.[2]

MANAGEMENT

Some laws and regulations mandate specific abstinence periods, for example, in pilots. For unregulated roles, specified drug-free periods are arbitrary and of little benefit in determining readiness for employment.[2] The most significant predictor is completing treatment; followed by training; voluntary work; and support to find work. In supporting people back into work it is important that health professionals avoid applying arbitrary abstinence periods. Employers can only help employees if they know about any problems they have. This assumes the employer is enlightened and has a workplace substance use policy that focuses on helping people and treating the issue as a health problem rather than as a disciplinary issue. GPs should advise patients to familiarise themselves with their employer's policies and support services, including whether they provide access to an employee assistance programme.

CONCLUSIONS

Contrary to popular belief, the majority of people who have an alcohol misuse problem are in work. GPs should be aware that alcohol and illicit drug use is prevalent in people who are in work. However, people with a history of drug misuse and drug treatment can be effective workers, particularly when well supported by employers and health professionals.

Paul J Nicholson,
Corporate Health Consultant, Independent.

Grant Mayho,
Global Occupational Health Lead, Pfizer.

Provenance
Commissioned; externally peer reviewed.

Competing interests
Paul J Nicholson and Grant Mayo were authors of the BMA report, however, neither had any funding and there is no association with the drinks industry.

DOI: 10.3399/bjgp16X687661

ADDRESS FOR CORRESPONDENCE

Paul J Nicholson
16 North Block, County Hall, London SE1 7PJ, UK.
E-mail: pjnicholson@doctors.org.uk

REFERENCES

1. Department for Work and Pensions. *An independent review into the impact on employment outcomes of drug or alcohol addiction, and obesity. Call for evidence.* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/448830/employment-outcomes-drug-alcohol-obesity--independent-review.pdf (accessed 4 Oct 2016).
2. Nicholson PJ, Mayho G, Sharp C. *Alcohol, drugs and the workplace — the role of medical professionals.* London: British Medical Association, 2016. https://www.bma.org.uk/advice/employment/occupational-health/alcohol-drugs-and-the-workplace (accessed 4 Oct 2016).
3. Jones R. Matters of substance. *Br J Gen Pract* 2016; DOI: 10.3399/bjgp16X683017.
4. Health and Safety Executive. *The scale and impact of illegal drug use by workers.* Bootle: HSE, 2004.
5. Chartered Institute for Personnel and Development. *Managing drug and alcohol misuse at work. Survey report.* London: CIPD, 2007.
6. Office for National Statistics. *General Lifestyle Survey overview — a report on the 2011 General Lifestyle Survey.* Newport: ONS, 2013.
7. Scottish Government. *Scottish crime and justice survey 2012/13: drug use.* Edinburgh: Scottish Government Social Research, 2014.
8. Coggon D, Harris EC, Brown T, *et al. Occupational mortality in England and Wales, 1991–2000.* Newport: ONS, 2009.
9. Department for Transport. *Reported road casualties Great Britain: 2014. Annual report. Moving Britain ahead.* 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/467465/rrcgb-2014.pdf (accessed 4 Oct 2016).
10. Driver and Vehicle Licensing Agency. *Assessing fitness to drive — a guide for medical professionals.* 2016. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/526635/assessing-fitness-to-drive-a-guide-for-medical-professionals.pdf (accessed 4 Oct 2016).
11. General Medical Council. *Confidentiality: reporting concerns about patients to the DVLA or DVA.* 2009. http://www.gmc-uk.org/Confidentiality___reporting_concerns_to_the_DVLA_or_DVA.pdf_58821800.pdf (accessed 4 Oct 2016).
12. Parmenter J, Mitchell C, Keen J, *et al.* Predicting biopsychosocial outcomes for heroin users in primary care treatment: a prospective longitudinal cohort study. *Br J Gen Pract* 2013; DOI: 10.3399/bjgp13X669220.