# Netherlands Contribution on the Use of Alcohol/Drugs at the Workplace

Disclaimer: This information is made available as a service to the public but has not been edited by the European Foundation for the Improvement of Living and Working Conditions. The content is the responsibility of the authors.

*In the Netherlands there are no recent data on alcohol consumption or drug use at work. As far as there are data, they are quite old (2003) and from one single study. The data that is more recently collected reflect habitual alcohol consumption and drug use. Recent data suggest that alcohol consumption and drug use are relatively low in people with paid work. Unemployed and students, mainly men, are much more of a risk group. Sectors with relatively high alcohol consumption are horeca, building & construction, agriculture and social and other services. No sector information on drug use (at work) is available. The Netherlands has no specific legislation or other national initiative regarding alcohol consumption or drug abuse. The building & construction sectors does not pay attention to alcohol consumption or drug use. The transport sector is a little more active regarding the use of alcohol. Regarding prevention a literature study in the Netherlands (not just based on Dutch literature though) concluded that prevention of alcohol consumption is quite effective, except for those preventive actions that were implemented through the worksite.*

## QUESTIONNAIRE

### Block 1: Main sources of information dealing with the issue of alcohol/drug use at the workplace at national level and its relation with working conditions, etc.

**1.1 Are there national statistical sources (surveys, administrative registers including company reports as surveys / reports from the Labour Inspectorate, Labour doctors, etc) that provide information on the issue of alcohol/drug use at the workplace in your country? If so, identify them and explain their characteristics and methodology. Please refer both to general population health surveys/sources or general alcohol/drug use surveys/sources as to working conditions or workplace specific surveys/sources**

- Name of the statistical source
- Scope
- Goals
- Methodology
- Periodicity

Alcohol and drugs at the workplace are not a hot topic in the Netherlands, and there are no (recent) statistics that explicitly pay attention to this topic. The statistical sources are somewhat more indirect (see table 1).

In the National Working Conditions Survey of 2008 and 2009 (NWCS; NEA), the national survey on working conditions, employees are asked about the number of alcoholic drinks a week, so the question pertains to 'habitual' alcohol consumption, and not to alcohol consumption at work. There are no questions on drug use.

The Health Survey/Living Conditions Survey (www.cbs.nl) has information on drugs and alcohol use, but here too, questions relate to the habitual use and not to the use (before or) during work or at the workplace. In the Health Survey a distinction is made between use at weekends and the other days of the week. In the Health Survey people with an income from work can be identified. Data on alcohol consumption and drug use from the Health Survey are not regularly published. In the questionnaire several series of questions on the (habitual use of the) following drugs are asked: Cannabis, XTC/Ecstacy, Amphetamines, Cocaine, Heroin, LSD, performance enhancing substances, Paddo and GHB.

The Nemesis study (now performed twice; see table 1) is most recent and informative on the topic of this CAR. The Nemesis data are not publicly accessible, but the publications by researchers from the Trimbos institute/Netherlands Institute of Mental Health and Addiction are (e.g. Graaf et al, 2010). Work related information included is only about employment status.

**Table 1: Overview of statistical and administrative sources in the Netherlands**

Table 1 Summary – Overview of statistical and administrative sources in the Netherlands, only three sources identified.

| Name of statistical source | Scope | Goals | Methodology | Periodicity |
|---|---|---|---|---|
| **NWCS**<br><br>**(by TNO, Statistics Netherlands, Ministry of Social Affairs & Employment)** | Employees; representative sample since 2003; in 2003 the sample was about 10.000; n= 23000 a year since 2005 | To provide information on working conditions of ‘the’Dutch employee | Written questionnaire with the possibility to use internet (questionnaire is first sent in written form | yearly |
| **National Health Survey**<br><br>**(by Statistics Netherlands)** | A population sample consists of Dutch inhabitants (people from 0 years and older);<br><br>Survey is held since 1981; as ‘the health survey’ until 1996; after that it became part of the Living Conditions Survey (POLS). Since 2010 this survey stands alone again (n=15.000)<br><br>Employment status known. | To provide an overview of developments in health, medical contacts, life style and preventive behaviour in the Dutch population | From 1981-1996: sample of households; interviews with respondents at their home with written questionnaire;<br><br>Since 1990 (-2009) interviews with respondent at home with lap- top (CAPI); for respondent >16 years there is a separate questionnaire on health. | yearly |

| | | | | |
|---|---|---|---|---|
| | | | Since 2010 the methodology is a mixed-mode design (first people are asked to participate through internet (CAWI). Non-respondents are approached by telephone (CATI). | |
| **Nemesis I and II (by Trimbos Institute)** | Two large cohort population based studies; the first in 1996-1999; the second one started in 2010.<br><br>The sample is about n=7000 (18-64 yrs) in both studies.<br><br>Employment status known. | The Netherlands Mental Health Survey and Incidence Study (Nemesis) is a study aimed at identifying the incidence and development of mental health in the Netherlands | Face to face interviews; with specific testing (e.g. CIDI administration for establishment of mental health problems | Large study, twice in about 15 years |

**1.2. Are there any other sources of information (published after mid-2000s) that may provide valuable information on the issue (i.e. ad-hoc studies, sectoral studies, administrative reports, articles, published case studies, etc). If so, identify and describe them.**

The Trimbos institute/Netherlands Institute of Mental Health and Addiction, a WHO collaborating centre, covers the topic 'alcohol and drugs' as a 'knowledge institute' best. Recently the first results on a large cohort (Nemesis-2) have been published (Graaf et al, 2010). However, the link with ' work' is only superficially made by them (paid work or not, where the group which is NOT involved in paid work is differentiated into four sub groups, whereas the group in paid work is not differentiated other then by gender).

In 2003 a study has been conducted on the topic of alcohol and work (commissioned by the Ministry of Social Affairs and Employment, together with the Ministry of Health) (Schutten et al, 2003). The main aim of this study was to obtain some information on the prevalence of alcohol use just before, during and after working hours and to compare alcohol use between sectors. In addition, relations were studied between work and non-work factors and alcohol use before, during and after working hours. The study consisted of a telephone interview among 4289 respondents with a follow-up telephone interview among 640 respondents.

In 2005 Proper et al (2005) published a report on the effectiveness of interventions directed at stimulating a healthy lifestyle, i.e. activity ('**B** ewegen'), smoking ('**R** oken'), alcohol consumption (**A** lcohol), healthy eating ('**V** oeding') and enough recovery or recuperation ('**O** ntspannning'). The topic of a healthy lifestyle is also known by the acronym of 'BRAVO'. With respect to alcohol it is concluded that most interventions (not necessarily

restricted to the Netherlands!) designed to decrease alcohol are effective, except those implemented at worksites. Mainly due to lack of relevant studies, no conclusion could be drawn about the effectiveness on work-related outcome measures such as sick leave. Additionally, no research on the cost-effectiveness of alcohol interventions is performed within the selected studies.

The professional association of occupational health physicians (NVAB: Nederlandse Vereniging voor Arbeids en Bedrijfsgeneeskunde) has written a position paper on their involvement regarding alcohol and drugs in establishments (NVAB, 2007; Werven-Bruijne et al, 2011). Their main role is that of a consultant for both individual employees as well as for the employer and the company management.

## Block 2: Information on the extent of the use of alcohol and drugs at the workplace in your country, as well as the type of situations (sectors, occupations, working conditions, etc.) in which this use occurs, its consequences (production process, social relations at work) and the rationale behind it

### 2.1. Please provide the available data and information on the prevalence of drug/alcohol use at the workplace in your country, if possible differentiating data by:

- Type of substance
- Sectors => specific focus on the construction and transport sectors
- Occupational profiles
- Other relevant variables

As indicated earlier, there is few national data on drug use, but a little bit more on (habitual) alcohol use.

The NWCS (based on Dutch employees) only asks about alcohol consumption (Table 2). These figures indicate a relatively high alcohol consumption for men, for older employees (>55 yrs) and in the sectors of building and construction and horeca. In health care (with a high percentage of female employees), alcohol consumption is relatively low. Further in this paragraph I present the results of an older study (Schutten et al, 2003) where alcohol consumption before, during and after work is measured. In that study, alcohol consumption was highest in horeca, building and construction, agriculture and cultural and other services.

This survey does not provide information about drug use at the workplace.

**Table 2. Alcohol consumption by Dutch employees**
Table Summary: alcohol consumption by Dutch employees

| | Do you drink alcohol? (% yes) | Average number of drinks per week (for those who drink) |
|---|---|---|
| **Total** | 73,4 | 7,8 |
| **Men** | **81,5** | **9,3** |
| **Women** | **63,8** | **5,5** |
| **15-24 yrs** | 70,9 | 7,4 |

| | | |
|---|---|---|
| **25-54 yrs** | 72,1 | 7,4 |
| **55-64 yrs** | **82,7** | **9,6** |
| **Agriculture** | 71,7 | 9,0 |
| **Manufacturing** | 75,2 | 8,6 |
| **Building & construction** | 79,7 | **10,1** |
| **Trade** | 71,4 | 7,42 |
| **Horeca** | 74,0 | **10,2** |
| **Transport & communication** | 70,7 | 8,8 |
| **Financial services** | 75,9 | 7,3 |
| **Business sector** | 74,9 | 7,3 |
| **Public Administration** | 78,4 | 7,9 |
| **Education** | 77,5 | 7,5 |
| **Health care** | **65,5** | **6,0** |
| **Cultural & other services** | 78,4 | 8,14 |

*Comment: Figures in bold are significantly higher or lower than average*

*Source: NWCS, 2009*

Results from Nemesis-2 are presented in Table 3. In this table a distinction is made between abuse and dependency (of alcohol or drugs). Alcohol or drug *abuse* is used when someone uses a lot of alcohol or drugs but despite the fact that this may or will cause problems, there is no addiction yet.

***Alcohol or drug abuse*** is indicated when one of the following criteria are met in case the individual :

- uses alcohol or drugs on a regular basis with the consequence of not being able any more to fulfil the obligations at work, school or at home;
- drinks alcohol or uses drugs on a regular basis in situations of physical danger (e.g. driving a car after using drugs or drinking alcohol);
- has been in contact with the court of justice in relation to alcohol or drugs;
- drinks alcohol or uses drugs on a regular basis despite the fact that this sustains a social, professional, mental or physical problem.

**Alcohol or drugs *dependency*** refers to the situation of addiction and is indicated when at least ***three*** of the following criteria are met:

- One drinks or uses larger quantities or longer than one intended;
- One wants to decrease or quit drinking or using or tried to do this without success;
- A lot of time is spent in obtaining alcohol or drugs and in consuming it. A lot of time may also have been spent on recovering from it;

- One has a strong habit or tolerance. Drinking or using of the same quantity has less effect than before. Or: one has to drink or use more to obtain the effect one wants.
- When quitting or abstaining from drinking alcohol or using drugs, one gets withdrawal symptoms like a hangover. Drinking or using is aimed at preventing these withdrawal symptoms.
- One sacrifices social or professional activities or some other activity on behalf of drinking alcohol or using drugs;
- One goes on with drinking alcohol or drug use despite the fact that the negative consequences for health and performance are known.

The data from Nemesis-2 presented in Table 3 show the abuse of and addiction to alcohol and drugs by Dutch people. The data could not be differentiated by other groups than presented, or by substance, since the data are directly taken from the report (Graaf et al, 2010). The data indicate that :

- People in paid jobs are relatively low on abuse of and addiction to alcohol and drugs.
- Women –employed or unemployed- have less or (sometimes) equal use, abuse or addiction to alcohol or drugs. Only on 'drug abuse' and 'drug addiction' women rate a 1 percent higher then men. This may be due to the higher medical consumption since sleeping pills and pain killers are included in the drug abuse rating.
- The main risk group regarding high alcohol consumption and drug addiction (but not drug use) is the group of unemployed & disabled (these groups were not differentiated in the report), within which particularly male respondents appear to be high on the abuse of and addiction to alcohol. Female respondents appear to be high on drug use.
- Students, male more than female, also rate high on alcohol abuse, alcohol addiction and drug abuse.
- Those on pension are lowest of all on abuse of, and addiction to alcohol and drugs.

**Table 3 – Alcohol and drug abuse or addiction in the Netherlands for those with paid work and those with no paid work**

Table 3 Summary – Alcohol and drug use (abuse and addiction) in the Netherlands by either having a paid job or not. The group of having no paid job is differentiated in those doing the household, are a student, are unemployed or disabled or hold a pension. Drugs could be Cannabis, Cocain, Club drugs (e.g. XTC, GHB), hallucinating drugs, opiates, other drugs like sleeping or relaxation drugs, stimulants and pain killers.

| | **Men** | **Women** | **Total** |
|---|---|---|---|
| **Any substance abuse, ever in life (%)** | | | |
| **Total** | 27,7 | 10,3 | 19,1 |
| **Paid work** | 26,3 | 10,9 | 19,5 |
| **Housewife or -man** | 44,3 | 6,6 | 7,5 |
| **Student** | 27,8 | 14,0 | 21,0 |
| **Unemployed, disabled** | 47,1 | 14,9 | 32,2 |
| **On pension, other** | 21,2 | 6,1 | 16,2 |
| . **Any substance abuse, last 12 months (%)** | | | |

| | | | |
|---|---|---|---|
| **Total** | 6,8 | 3,2 | 5,2 |
| **Paid work** | 6,6 | 2,5 | 2,6 |
| **Housewife or -man** | 16,2 | 9,1 | 12,7 |
| **Student** | 16,2 | 9,1 | 12,7 |
| **Unemployed, disabled** | 14,7 | 6,9 | 11,1 |
| **On pension, other** | 1,6 | 0,5 | 1,2 |
| . **Alcohol abuse, last 12 months (%)** | | | |
| **Total** | 5,6 | 1,8 | 3,7 |
| **Paid work** | 5,2 | 1,8 | 3,7 |
| **Housewife or -man** | 6,6 | 0,8 | 1,0 |
| **Student** | 12,8 | 6,3 | 9,6 |
| **Unemployed, disabled** | 7,2 | 1,8 | 4,7 |
| **On pension, other** | 0,9 | 0,0 | 0,6 |
| . **Alcohol addiction, last 12 months (%)** | . | | |
| **Total** | 1,0 | 0,5 | 0,7 |
| **Paid work** | 0,9 | 0,4 | 0,7 |
| **Housewife or -man** | 0,0 | 0,1 | 0,1 |
| **Student** | 1,8 | 0,1 | 1,0 |
| **Unemployed, disabled** | 1,6 | 2,7 | 2,1 |
| **On pension, other** | 0,6 | 0,5 | 0,6 |
| . **Drug abuse, last 12 months (%)** | | | |
| **Total** | 0,9 | 0,8 | 0,9 |
| **Paid work** | 0,6 | 0,6 | 0,6 |
| **Housewife or -man** | 0,0 | 0,8 | 0,7 |
| **Student** | 2,4 | 2,3 | 2,3 |
| **Unemployed, disabled** | 4,1 | 1,8 | 3,0 |
| **On pension, other** | 0,0 | 0,0 | 0,0 |
| . **Drug addiction, last 12 months (%)** | | | |
| **Total** | 0,8 | 0,7 | 0,7 |
| **Paid work** | 0,6 | 0,4 | 0,6 |
| **Housewife or -man** | 0,0 | 0,9 | 0,8 |

| | | | |
|---|---|---|---|
| **Student** | 0,9 | 0,4 | 0,7 |
| **Unemployed, disabled** | 2,5 | 3,2 | 2,8 |
| **On pension, other** | 0,0 | 0,0 | 0,0 |

*Source: Nemesis (Graaf et al, 2010)*

As shortly referred to before, there is only one report with data on alcohol consumption at the workplace, but this is not very recent (Schutten et al, 2003). However, since these data appear to be unique in the Netherlands on the topic at hand, the main findings of this study will be presented in short below. The results of this study indicated that:

- 11% of the working population never drinks;
- about 4% of those who do drink, drinks alcohol now and then before they go to work or during working hours;
- about 38% of the working population drinks after working hours; and 12% does this at least once a week;
- about 21% of the work force (including those who don’t drink) drinks excessively, whereas about 5% has an alcohol addiction;
- Alcohol consumption is highest in the horeca (13,2 glasses/week; 31% uses alcohol just before/after work once a week), building and construction (12,3 glasses/week; 13,1% uses alcohol just before/after work once a week), agriculture (11,8 glasses/week/14,2% uses alcohol just before or after work once a week), and cultural and other services (10,1 glasses/week; 6,5% uses alcohol just before or after work once a week). Alcohol consumption is lowest in health care (6,2 glasses/week; 4,5% uses alcohol just before or after work); Although the average alcohol consumption of workers in the transportation sector is not very high (8,9%), a relatively high percentage of workers in this sector drinks alcohol just before or after work once a week : 13,1 % (the workers in this sector rank fourthe, after horeca, agriculture and trade).
- Social and personal factors are more related to drinking behaviour than work-related factors.

The percentages in this report by Schutten et al (2003) are somewhat higher than those reported by Graaf et al (2010). This may be caused by the fact that the definitions used are somewhat different. An excessive drinker in the study of Schutten et al (2003) is someone who drinks at least 20 glasses a week or at least once per week 6 glasses or more (men) or at least 14 glasses a week or at least once per week 4 glasses or more (women). Someone is considered to have an addiction when he or she had a rating of 2,5 or more on a 6-item scale to rate negative consequences of alcohol consumption and is an excessive drinker (Schutten et al, 2003).

**2.2. Please provide data and information on the rationale and consequences of drug/alcohol use at work. Focus on construction, transport:**

Based on the NWCS as well as reported by Schutten et al (2003) alcohol ín the Netherlands is relatively high in the building & construction sector but not so much in transportation. The reason as to why alcohol or drug use is high in some sectors and not in others is hypothesized to be related to its accessibility. In case of alcohol, access is relatively easy in the horeca (and

the data supports its effect), whereas regarding drug use, access is hypothesized to be relatively easy in health care. Regarding the latter, we do not have data in the Netherlands.

As for the Building and construction sector, the reason why the alcohol consumption is relatively high may be due fact that the culture of 'having drinks' is highly prevalent (e.g. it is customary that on Friday afternoon the boss visits the work location and 'drinks beer with the boys'). It is also tradition that all agreements, new contracts etc. are celebrated. In addition alcohol consumption is not an issue that is easily to be discussed, it is a taboo subject.

Contact with the Occupational Health and Safety Institute of the ***Building and Construction sector*** in the Netherlands (Arbouw) indicated that they have a survey of their own which includes some questions on (habitual) alcohol consumption, but not on drug use. They define excessive use as drinking 35 or more glasses of alcohol a week. Using this definition less than 2% of the workers in building & construction drink excessively. Most 'excessive' drinkers are in the age-group of 20-24 years.

There are no specific sector activities directed at alcohol consumption.

The sector has no information on drug use.

There is no testing policy in the building and construction sector on alcohol or drugs. When there is a problem of excessive drinking this is treated as an individual level problem and discussed with the occupational health physician.

As for the ***transport sector***, no specific information is available on alcohol or drug use. They do pay attention to lifestyle. The sector has an Occupational Health and Safety Organisation (Healthy Transportation/Gezond Transport), but they do not have any specific information on alcohol consumption and drug use. At present, they run a sector programme called 'fit to drive' (in Dutch: Fit op de rit), but it mainly pays attention to exercise and physical activity, food consumption, taking time to recover. No attention is given to alcohol or drugs at present.

A key informer from the Netherlands Institute of mental Health and Addiction, who also closely worked with the sector organization indicated that two educational films on alcohol use were made within the framework of this campaign (fit to drive), but that, unlike the films on the topics of exercise, physical fitness, food consumption and recovery, these were not put on the website but only presented on request during presentations for transport companies.

This key informer also indicated that recently there was a test by the Ministry of Transportation and Public Works on Alcohol-locks in the city of Utrecht. Before drivers started the truck they had to blow into an apparatus that registered the amount of alcohol in their breath. When alcohol was detected they could not start the truck. This test has had no consequences at the moment. This will not become usual practice.

A study performed in the transportation sector (commissioned by the Ministry of Transportation and Public Works) and studied the causes of fatigue in truck drivers did pay attention to alcohol consumption (Jettinghoff, Houtman & Evers, 2003). This study showed that in 2003 75% of the truck drivers drank alcohol against 88% in the Dutch population. On average they drank 7 glasses of alcohol a week. Comparing this to the data of the Dutch work force as presented in table 2 (from 2010), it can be concluded that the truck driver (mostly men) drinks less than the average male employee. Despite the fact that this study suggests

that truck drivers consume less alcohol than the average employee, it was still found to be associated to fatigue (not to chronic fatigue complaints, but with the risk of having actually fallen asleep behind the wheel in the last two years; Jettinghoff et al, 2003).

The transportation sector has no information on drug use and does not pay specific attention to this issue. Within the Netherlands Institute on Mental Health and Addiction, since two years they provide support, not only on alcohol policies for companies, but they broaden it up to 'ADM policies': Alcohol, drugs and medication policies. But in general the (ab)use of drugs and medication is still even a much more sensitive topic than the (ab)use of alcohol.

There is a bulk of literature on the effects of alcohol. Most of it dates from the previous century. Generally, the literature shows that excessive (and longstanding) alcohol consumption leads to physical and mental problems with serious consequences for the drinker and his or her social environment, to cardiovascular problems (high blood pressure, arrhythmias, brain haemorrhage) and increased risk of cancer in the mouth and digestive tract (e.g. NIGZ, 2004; Fleming et al, 1997; WHO, 1996; Xin et al, 2001). Several studies find a curve-linear relation between alcohol consumption and sickness absence (Marmot et al, 1993; Vahtera et al, 2002; Salonsalmi et al, 2009). In addition, several studies show a relation between excessive alcohol use and problems at work like coming in late, leaving early, conflicts with colleagues, accidents at work and aggression at the workplace (Mangione et al, 1999; McFarlin et al, 2001; McFarlin and Fals-Stewart, 2002; Webb et al, 1994).

# Block 3: Identify legislation and agreements at national level concerning alcohol/drugs use at the workplace, specifically those related to testing practices

## 3.1. Please identify and describe the main existing legislation and agreements concerning the prohibition/limitation of alcohol/drug use at work:

In the Netherlands there is no specific legislation or no national agreement on alcohol consumption and drug use at work.

Within the framework of the **Occupational Health and Safety Act**, the employer and employee are both responsible for the health and safety at work.

- An employer has to make sure that risks at work are identified and risks are removed or exposure to the risks reduced as much as possible. For example in the horeca employees have a higher risk for alcohol problems because of the continuous availability, whereas in health care or pharmacies personnel has easy access to all kind of medication. As an employer you have to assess these risks (RI&E) and have to take preventive measures (art.3; art. 5);
- The employer has to have a sickness absence policy (art. 4);
- The employer has to educate his employees about the risks at work and about the preventive measures taken (incl. on alcohol and drugs).
- Employees have to be aware and take on knowledge about the risks at work (when identified) and the measures taken to prevent them. Employees also have a responsibility as to the health and safety of their colleagues and clients/patients/passengers.

Some **high-risk sectors** additionally pay attention to alcohol and drugs.

One example is the Airline industry in the Netherlands. In 2005 they (the 10 Dutch airlines) signed a protocol by which they prevent alcohol (excessive), medicine and drug use amongst flight personnel. This protocol is evaluated by the Ministry of Transportation and Public Works in 2009 (www.rijksoverheid.nl/.../f9110c4c-21d4-47db-b1f7-ba9de7681fa1.pdf).

The protocol is translated into policy and measures by the airline companies who signed the protocol (n=10). It is concluded that self-regulation is better than no regulation at all. Amongst the personnel the rules regarding alcohol, medicine and drug use are known. However, they do not always know the content of these rules. Personnel indicates they know more and act responsibly. Still there are some employees that take risks regarding these substances. It is concluded that the effect of the protocol can be increased by more communication.

## 3.2. Specific focus on legislation / agreements regarding testing practices intended to control the use of alcohol/drugs at work.

The key informer of the Netherlands Institute of Mental Health and Addiction indicated that employees in some other (high risk) sectors and high-risk companies like the drilling platforms (at sea), the shipping industry (particularly when transporting chemicals and other dangerous substances) employees are tested before they are allowed to go onboard and that alcohol use is strictly forbidden. When alcohol or drugs are found an employee can be suspended from his/her duties. This kind of testing always takes place with the consent of the employee. The employee may refuse to be tested, but may risk suspension in that case.

Testing of alcohol takes place by analyzing the expired air on alcohol. Testing on drugs (or drug residu) takes place with a saliva swop. The latter may indicate drug use in the (recent) past, but is no proof of the fact that the person is still under the influence of drugs. Blood has to be taken and analysed to confirm alcohol and/or drug use.

Testing on drug and alcohol use at work –when it is done- is done by the occupational health physician (OHP). But this professional sees him or herself as a consultant of employer and employee. The employer and employee are the key persons in this process and may both request testing.

From a health legislative perspective there are two situations.

1. there is a voluntary contact between OHP and the employee. In this case the OHP has to keep his confidentiality towards the employee/patient and he cannot inform the employer about what information (e.g. on alcohol or drug use) became available to him through this contact.
2. The employer asks for a contact between OHP and an employee. In this case there has to be a

- necessity (e.g. there is an alcohol or drug policy in the company; prevention is the core of the policy not the checking, checks relate to activities or parts of the company where there are health and safety risks for the employee or others or considerable damage to the company)

- the information cannot be obtained any other way, criteria are valid, method used is valid, research is not a burden for the employee, no health contra-indication, directed at the actual use of alcohol or drugs before or during work;
- the method should be in proportion to the aim of the check;
- employees should know beforehand why, when and where the check will take place;
- the judgement should be based on enough relevant research

General accepted case law is that the OHP can only inform on the results of the check in terms of conclusions. It is also important that the results of the testing are first presented to the employee in order to give him or her the opportunity to ask for a second opinion in case he or she wants to.

So it is the employer who has to decide if there are tasks or positions/jobs in the organisation for which alcohol consumption or drug use pose an increased risk to the employee, to their colleagues, to third parties or to the organisation. The employer can decide that for these specific jobs specific qualification are needed and pre employment testing on alcohol and drug abuse or addiction could be part of an alcohol and drug policy.

**Describe changes, evolution development of regulation / agreements on testing, drawing the attention to the review in light of the improvement of the testing methods**

No development on this issue is taking place.

# Block 4: Identify and describe national prevention programmes to combat the use of alcohol/drugs at the workplace, especially those based on agreements and cooperation of the social partners:

There are no national programmes on alcohol consumption or drug use in the Netherlands. Some activity is seen in high risk sector like the Dutch Airlines. But no activities regarding alcohol consumption or drug use are enrolled in sectors like building & construction or transport. In the transport sector life style is an issue and gets sectoral attention with the program ‘Fit to drive’ (in Dutch: Fit op de rit). But this programme is directed at life styles other than alcohol consumption or drug use.

Developing and using a policy on alcohol or drugs is mainly left to the employer. Motives for employers to do something may be (NIGZ):

- Safety considerations
- The vitality of the company with healthy employees who have a heart for the business
- The costs related to sickness absenteeism
- Case law
- The image of the company
- Social responsibility of the employer
- Professionalism

There are some organisations which disseminate material and act as consultant on the topic on behalf of organisations, but these are public (and not occupational) organisations. Apart

from the Trimbos institute/Netherlands Institute of Mental Health and Addiction, organisations like the NIGZ (National Institute on Health Care) play an important role in the development and implementation of interventions directed to prevent, decrease or quit alcohol consumption (and drug use).

# Commentary by the NC

The topic of alcohol and drugs at work has not been a hot topic in the Netherland. This is particularly the case for drug use at work. The Netherlands Institute of Mental Health and Addiction is a centre of knowledge on this issue and has done (twice in about 20 years now) a large survey/cohort study in which this topic was addressed. Drinking alcohol and using drugs at work is not specifically addressed, but only the habitual alcohol consumption and drug use of the public, with the possibility to identify workers and employees.

In addition, the information that is obtained is not about alcohol and drug use at the workplace, but habitual use of alcohol and drugs.

Only in one study, performed in 2003 and commissioned by the two relevant Ministries (Health and Social Affairs and Employment) alcohol consumption (and not drug use) before, during and after work was considered. However, risk groups identified at sector level were comparable as those identified on the basis of habitual alcohol use.

There is no specific legislation on alcohol consumption and drug use at work and only within the framework of more general legislation the employer and employee are held responsible.

Regarding prevention of excessive alcohol consumption (and not drug use) a Dutch report was quite optimistic as to the prevention opportunities. Based on the literature it was concluded that most interventions designed to decrease alcohol consumption are effective, except those implemented at worksites!

The public debate in the Netherlands is more on teenagers whose drinking increased excessively (coma-drinking) and not on workers. Data from the Netherlands Institute of Mental Health and Addiction support the notion that the prevalence of excessive alcohol consumption and drug use is relatively low in the working population. Other groups (unemployed, disabled, students) are much more at risk.

Irene Houtman, TNO Work & Employment

### Interviews are held with:

- Drs. Suzanne Weingart, Trimbos Insititute/Netherlands Institute of Mental Health and Addiction
- Dr. Margriet van Laar, Institute/Netherlands Institute of Mental Health and Addiction
- Dr. Jan Warning, director of Arbouw
- Jan Jansen, Manager NIGZ

### Literature:

- Fleming MF, Barry KL, Manwell LB, Johnson K, London R. Brief physician advice for problem alcohol drinkers. A randomized controlled trial in community-based primary care practices. JAMA 1997; 277(13):1039-1045.
- Graaf, R. de, Have, M. ten & Dorsselaer, S. De psychische gezondheid van de Nederlands bevolking –Nemesis-2: opzet en eerste resultaten (The mental health of the Dutch people –Nemesis 2: design and first results). Utrecht: Trimbos Instituut, 2010;
- Jettinghoff, K., Houtman, I.L.D. & Evers, M.S. oorzaken van vermoeidheid bij vrachtwagenschauffeurs in het beroepsgoederenvervoer (Causes of fatigue in truck drivers in freight transport). Hoofddorp: TNO, 2003.
- Marmot MG. Work and Other Factors Influencing Health. In: European Occupational Health Programme, editor. A Healthier Work Environment Basic Concepts and Methods of Measurement. Copenhagen: World Health Organisation Regional Office Europe, 1993: 232-246.
- Mangione TW, Howland J, Amick B, Cote J, Lee M, Bell N et al. Employee drinking practices and work performance. J Stud Alcohol 1999; 60(2):261-270.
- McFarlin, S. K., & Fals-Stewart, W. Workplace absenteeism and alcohol use: A sequential analysis. Psychology of Addictive Behaviors, 2002;16:17−21.
- McFarlin, S. K., Fals-Stewart, W., Major, D. A., & Justice, E. M. Alcohol use and workplace aggression: An examination of perpetration and victimization. Journal of Substance Abuse 2001; 13: 303−321.
- NIGZ. Feiten over alcohol; informatie over de werking en risico's van alcohol (Facts about alcohol; information about the impact and risks of alcohol). Eerste druk ed. Woerden: NIGZ, 2004.
- NVAB-STANDPUNT inzake de rol van de bedrijfsarts in het kader van het alcohol- en drugsbeleid binnen ondernemingen (Position paper of the professional association of occupational health physicians on the alcohol and drugspolicy in establishments). Eindhoven, 2007. http://nvab.artsennet.nl/web/show/search?searchstring=alcohol%2C+drugs&id=119856&from=0&to=10&googlefilter=&q=alcohol%2C+drugs&domain=NVAB
- Proper, K.I., Bakker, I., Overbeek, K. van, Bergstra, B, Verheijden, M.W., Hopman-Rock, M. & Mechelen, W. van. Naar een gericht BRAVO-beleid door bedrijfsartsen (Towards a pointed BRAVO-policy by occupational health physicians). Amsterdam: Body&Work, 2005.
- Salonsalmi A; Laaksonen M; Lahelma E; Rahkonen O. Drinking habits and sickness absence: The contribution of working conditions. Scandinavian Journal of Public Health, 2009; 37(8): 846-854.
- Schutten, M, Eijnden, R.J.J.<. van den & Knibbe, R.A. Onderzoeksrapportage Alcohol en Werk (Research report on alcohol and work). Rotterdam: IVO, 2003.
- Vathera, J.; Poikolainen, K.; Ala-Mursula, L.; Pentti, J. Alcohol intake and sickness absence : a curvilinear relation 2002 American Journal of Epidemiology, 2002; 156 (10): 969-976
- Webb, G. R., Redman, S., Hennrikus, D. J., Kelman, G. R., Gibberd, R., & Sanson-Fisher, R. The relationships between high-risk and problem drinking and the occurrence of work injuries and related absences. Journal of Studies on Alcohol, 1994; 55: 434−446.
- Werven-Bruijne, I. van, Horsten, R. & Weel, A. De rol van de bedrijfsarts bij het alcoholbeleid (The role of the occupational health physician in the organizational alcohol policy). TBV, 2011, 19(5):213-216.

- WHO. A cross-national trial of brief interventions with heavy drinkers. WHO Brief Intervention Study Group. Am J Public Health 1996; 86(7):948-955.
- Xin X, He J, Frontini MG, Ogden LG, Motsamai OI, Whelton PK. Effects of alcohol reduction on blood pressure: a meta-analysis of randomized controlled trials. Hypertension 2001; 38(5):1112-1117.

- **ID:** NL1111019Q
- **Author:** Irene Houtman
- **Institution:** TNO Work & Employment
- **Country:** Netherlands
- **Language:** EN
- **Publication date:** 04-05-2012
- **Subject:** Workplace health promotion