A study of a staff alcohol policy in a large public health organisation, looking at the policy content, the policy development and implementation process, and the policy impact.

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DECLARATION

The contents of this thesis are entirely my own work and have not been submitted for any purpose to any other University.
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A study of a staff alcohol policy in a large public health organisation, looking at the policy content, the policy development and implementation process, and the policy impact.

Abstract
There are different approaches to dealing with alcohol related problems in the workplace. A literature review indicates that two of the models that underpin programmes to deal with alcohol related problems in the workplace are the disease model and the health promotion model. The disease model considers alcoholism as an illness and uses curative techniques to restore the individual to sobriety. The health promotion model looks at the determinants of health and promotes changes in the environment and structures, which would support healthy behaviour in relation to alcohol. Employee Assistance Programmes (EAPs) may have elements of both these models. Dealing with alcohol problems at work involves a captive audience and the workplace as a setting can be used to influence healthier lifestyles. A workplace alcohol policy is a mechanism through which alcohol related issues might be dealt with, and the necessary resources and commitment of managers and staff channelled to this end. The policy aims should be clear and unambiguous, and specific plans put in place for implementing all aspects of the policy. In the case of the alcohol policy in the organisation under study, the policy was underpinned by a health promotion ethos and the policy document reflects broad aims and objectives to support this. The steering group that oversaw the development of the policy had particular needs of their own which they brought to the development process. The common theme in their needs was how to identify and support employees with alcohol related problems within an equitable staff welfare system. The role of the supervisor was recognised as crucial and training was provided to introduce the skills needed for early intervention and constructive confrontation with employees who had alcohol related problems. Opportunities provided by this policy initiative to deal with broader issues around alcohol and to consider the determinants of health in relation to alcohol were not fully utilised. The policy formalised the procedures for dealing with people who have alcohol related problems in an equitable and supportive manner. The wider aspect of the health promotion approach does not appear to have been a priority in the development and implementation of the policy.
1 Introduction

The aim of this study is to evaluate a staff alcohol programme, which was introduced into a large healthcare organisation, the North Western Health Board (NWHB). More specifically, this will involve a study of the content of the policy with a particular look at the health promotion focus, the policy process whereby it was introduced, and its impact on the organisation.

Possible responses to alcohol related problems have been considered over many years. Internationally and in Ireland there have been different approaches to dealing with the problem, swinging from a punitive/judicial approach, to a prohibition/abstinence approach, to a disease focus/addiction approach, and most recently to a public health/health promotion approach.

The workplace is considered a suitable setting for action on alcohol problems as it provides for a focused view on workers in relation to problems and a captive audience for interventions. These interventions might range from disciplinary action through employee assistance schemes to health promotion approaches.

The success of a policy for dealing with alcohol problems in the workplace can depend on the process and implementation of the policy. The process through which the policy is developed, communicated and implemented can impact on the understanding of its function and its acceptance and pervasiveness.

Alcohol related problems have been the subject of comment and review in Ireland for many years. In 1966 the Report of the Commission of Inquiry on Mental Illness in Ireland, (Department of Health, 1966), described alcoholism as a disease and recommended that specialist treatment should be developed. In 1984 the report on the psychiatric services, Planning for the Future (Department of Health, 1984), challenged the move to specialised treatment services for alcohol problems and recommended a wider health promoting approach to influence behaviour.

The health promoting approach become evident in health policy from this time and in the 1990s several health policy and strategy documents were produced in which this approach was reflected (Department of Health, 1994, Department of Health, 1994, Department of...
Health, 1995, Department of Health, 1996, Department of Health & Children, 1997). Health promotion departments were being set up at the same time in regional health boards around the country and financial support was available for developing health promotion work.

Health promotion differs from other disease focused approaches in its use of a broad definition of health which moves away from the absence of disease concept to an acceptance of the wide range of social, emotional and physical variables which can impact on the way we feel. It looks at populations and communities in their own settings. It recognises that people define their health according to personal parameters and that diagnostic or prognostic tools can not predict a sense of wellbeing, whatever the physical status of the person. It is argued therefore that it is important to involve people in planning and developing health responses.

Health promotion acknowledges determinants of health such as education, security, living environment, employment type and environment, leisure facilities, as well as health and social services. These are outside the personal control of individuals and require a response from government and its agents other organisations.

This contrasts with the disease model that looks at health in terms of absence of disease and relies on the medical system and specialist services for treatment for this disease. This emphasis on curative medicine is prevalent in the western world. Within the structures of health care in Ireland it is reflected in the share of resources which go to acute care as opposed to other aspects of health services, approximately 75% to 25%.

On the international scene health promotion has emerged as a model within which the determinants of health might be tackled with the aim of reducing the burden of ill health and supporting wellbeing.

In 1986 the Ottawa Charter was agreed. It laid down five key elements of health promotion, which were to form the foundation of subsequent work:

- Building healthy public policy
- Creating supportive environments
- Strengthening community action
- Developing personal skills
- Reorienting the health services.


The workplace was recognised as an important setting for looking at health issues and was singled out by practitioners, policy developers and trade unions as being an area which merited attention. A document focusing on health promotion in the workplace in Ireland was produced in 1997 (Department of Health and Children, 1997). It recognises the unique position the workplace holds in promoting health and examined some models currently being implemented in Ireland.

Within the workplace alcohol as a specific problem also received special attention. The WHO produced a Publication in 1993, ‘Health Promotion in the Workplace: Alcohol and Drug abuse’, which recommended that comprehensive health promotion policies be designed for the workplace using the Ottawa Charter for Health Promotion as a frame of reference (WHO, 1993). The report concludes that in the area of alcohol and drug related problems this approach will increase the role of workers in their own health and address the environmental as well as individualistic elements of health.

In the NWHB health education was introduced as a separate approach in 1980. The emphasis, in line with national strategy at this time, was on schools and the development of Lifeskills materials and training for teachers. Over the next 10 years this programme was supported in schools to develop an integrated health education programme through the curriculum. At the same time health education officers were employed within the community care programme to support work in the community. The emphasis was on lifestyle factors and providing information and training in relation to smoking, alcohol, exercise, nutrition etc.
In 1994 the health promotion team first attempted to use policy to influence the wellbeing of employees of the NWHB. Three policies - nutrition, smoking and alcohol – were developed. It was hoped that the policies themselves would cause a cultural and attitudinal shift which in turn would lead to changes in behaviours and an opportunity to further consider the policy shift in an incremental way as the culture shifted (Murphy, 1996).

In this study one of these policies, the staff alcohol policy, will be examined. I will look at the development of the policy, and consider in particular the influences on its content, the role played by health promotion, the process of producing and implementing it and the role this process played in its effectiveness.

The challenge in the process was to shift the emphasis from a treatment focused model to one that acts on the evidence that the wider determinants, such as those listed above, can have a greater impact on our health.

To shift emphasis through policy development requires a framework through which it can be introduced and sustained. Organisational change in relation to alcohol through policy development and implementation is discussed by Beyer and Trice in their 1978 *Implementing Change, Alcoholism Policies in Work Organisations*. They propose that ‘a common mechanism for the translation of social or organisational goals into procedures for the realisation of those goals is the use of policy’.

Beyer and Trice put forward a model that they synthesised from a variety of approaches to change. This, they suggest, is a way of initiating, implementing and internalising organisational change.

The stages which they outline are:

- sensing of unsatisfied demands on the system;
- search for possible responses;
- evaluation of alternatives;
- decision to adopt a course of action;
- initiation of action within the system;
- implementation of the change;
- institutionalisation of the change.
The steps include looking at the evidence that there is a problem or potential problem which is putting demands on the organisation or where the current outcome is unacceptable, followed by looking at alternative means of dealing with the problem. The alternatives are weighed against cost and possible outcomes. The acceptability of outcomes is also looked at relative to the values in the organisation.

Strategy development includes the goals and proposed mechanisms for dealing with the problem. Policy formulation and dissemination of information follows. This covers the policy itself, the reasons for it, the desired outcomes and the rationale behind the strategy. Further training and the allocation of resources is necessary to support this.

At this stage it is expected that attitudes towards the policy would be formed according to the weight given by the organisation to the implementation and the explicit expectations around it. The ultimate step occurs when values held are modified to accept the policy and the goals of the policy are internalised into the system.

In this way policy development is seen as both a means and an end. It is the route to both introduce and implement change. If a model such as the one put forward by Beyer and Trice is used, evaluation can both consider the completeness of the implementation, and can also distinguish between different levels of incompleteness.

Similar stages to those outlined by Beyer and Trice are used in this study as a guide to looking at the literature around alcohol policy development and to comment on the completeness of the policy under review.

This study will look at the range of responses possible, consider the health promotion input, and look at the approach used in this case. It will look at the role of the policy development process in the content and emphasis and impact of the policy.
Chapter 2 will look at the literature on the areas of workplace policies dealing with alcohol and policy development. The place of health promotion will be considered within workplace alcohol policies and Employee Assistance Programmes will be reviewed. The stages in a policy process will be reviewed through the literature.

In Chapter 3 there will be an account of the methodology used in the study. Chapter 4 will look at the policy document itself and the findings from the documentary review and interviews in relation to its content and the process of developing and implementing it. The discussion and conclusions in Chapter 5 will look at the findings in light of the literature review including writing around health promotion, and comment on the outcome of the policy process and the policy as it impacts on the organisation.
2 Literature Review

2.1 Alcohol related problems

In 1994 Edwards et al sought to distil from information available what is relevant in the alcohol policy making process. This body of work places alcohol in a frame that suggests that alcohol as an agent should be the primary focus. It supports the approach that looks at the continuum of alcohol use along which problems can arise, and it proposes that the strategy to deal with problems needs to be aimed at the whole working population rather than just at those most at risk. (Edwards et al, pp 204).

The disease focus on alcohol problems allows the majority to support treatment and services for the minority, the ‘problem’ drinkers, with no requirement to accept the evidence that the entire population’s general style and level of drinking impacts on the prevalence and incidence of drinking problems. Edwards et al summarise the evidence around this in saying ‘any belief that alcohol is a circumscribed problem because, supposedly, its ‘misuse’ only affects a small minority of the population who can be tidied away and classified as deviants or ‘alcohol abusers’ is mistaken’. (Edwards et al, 1994 pp 202)

Using a broad definition of alcohol-related problems helps clarify the nature of the response. Social and psychological problems are considered alongside acute and physical problems. There is a need for treatment approaches for those with acute problems but to separate treatment from prevention in this area is unhelpful (Edwards et al 1994). Public health and health promotion measures should work hand in hand with treatment. It is understandable that people will not embrace health promotion if there is a perceived unmet need for treatment facilities. Overall the area of alcohol related problems is multi-faceted and requires a ‘mix rather than a master-stroke’ (Edwards et al 1994 p 211).

2.2 The need for a policy

In considering what response is required, there is a need to look at the evidence that there is a problem and what form this takes in the organisation.
The International Labour Office (ILO) carried out a survey in Europe in 1993, *Alcohol and Drugs in the Workplace: Attitudes, Policies and Programmes* (Smith, 1993). The participants were concerned about the harmful effects of alcohol, particularly absenteeism, reduced motivation, accidents and performance. Similar findings are included in Gills article Alcohol Problems in Employment: Epidemiology and Responses (1994) (citing Blose and Holder, 1991; Webb et al, 1992; Emery, 1986) and in the *Guidelines for Health Authorities* brought out by the HEA in Britain in 1988.

The ILO study found a ‘lack of clarity’ around these perceived concerns. It was felt that this might reflect a ‘lack of information (and) uncertainty about what are considered problems’ (Smith 1993, p 12) It is interesting to note also that while the respondents to the ILO survey said that costs were important, both in relation to the direct costs associated with alcohol problems and the cost of prevention and assistance, they did not show a major interest in obtaining cost-related information in this area (Smith, 1993).

In the WHO report *Health Promotion in the Workplace: Alcohol and Drug Abuse* it was recommended that there be a way of ‘ascertaining the risk of abuse, preferably by means of joint labour/management co-operation’ (WHO 1993, p 22)

The role that the workplace itself might play in contributing to the risk of problems because of alcohol has also been noted (Lyster and McEwan, 1988, Plant, 1079b, the Trade Union Congress, UK, 1986, Van Den Bergh, 1990; cited in Gill 1994). In the ILO study the workers were more likely than the employers to consider that work conditions and stress levels contributed to alcohol problems. Moos, (quoted in the Smith, 1993 study p 27), also notes that while it is possible to determine the effect of alcohol on the individual the ‘impact on co-workers and supervisors has been overlooked’. Gill refers to Kreitman (1986) and his finding that the ‘majority of employees reporting having experienced alcohol-related problems at work, belonged to the light and moderate drinking groups’ (in Gill, 1994, p 234).

WHO notes that attention must be paid to ‘the development and maintenance of working conditions conducive to the well-being of the workforce as a whole and to the prevention of alcohol and drug–related problems’ (WHO 1993 p 2).
It would seem that even in those employments where data is not available to quantify problems associated with alcohol use there is a value placed on programmes to minimise harm, based on expected benefits and personal experience. Gill notes that management must accept that, while it may not be the primary motivation, there is a moral duty to introduce alcohol policies in the workplace (Gill, 1994).

There is an emphasis on performance-related criteria as indicators for the need for an alcohol policy. However, we have seen several writers outline needs which reflect the need to address working conditions, stress levels of workers, as well as the overall impact alcohol related problems have on the workforce. These would be in line with a health promoting approach.

2.3 **Approaches to alcohol issues**

Responding to alcohol as an issue in the workplace has been on the agenda since the beginning of the 20th century. Controls on availability and consumption were put in place to control problems (WHO, 1993). The emphasis, at this time, was clearly on alcohol as the agent of harm rather than on an individual’s predisposition.

In the 1930s, post prohibition in the USA, the concept of ‘alcoholism’ was described which was based on the disease model of addiction. People were willing to accept that alcohol problems were a threat to a minority of drinkers rather than a threat to the community as a whole. The response therefore could be aimed at this minority without a need for further social control. This allowed people off the hook since the ‘disease’ was out of their sphere of influence and required a specialist, professional approach.

This disease focus influenced the approaches to dealing with problems relating to alcohol, and programmes were developed which reflected the principles of Alcoholics Anonymous (AA). Such programmes were often located in employee assistance programmes (EAPs) in the workplace.

In Ireland AA was set up in 1946 and developed a close relationship with the mental health services and brought a bias towards the disease model and the
promotion of abstinence. In 1966 the Report of the Commission of Inquiry on Mental Illness in Ireland confirmed alcoholism as a disease and recommended that specialist treatment should be furthered developed (cited in Butler, 1994).

The focus on the disease model continued to influence the development of Irish workplace policies. The Midland Health Board in its discussion document *Problem Drinking and Alcoholism, Towards a Personnel Policy*, 1979, addressed alcoholism as a treatable disease and suggested that steps be taken to deal with workers who are alcoholic. It looked at programmes in the workplace which would “find and help .... hidden alcoholics". (Midland Health Board, 1979).

There were, however, some moves away from the narrow individual disease orientation. The Irish Employer-Labour Conference Working Party on Alcoholism met in September 1981 to:

Assess the economic and social effects of alcoholism on business and industry and on employed persons. To recommend suitable procedures and arrangements for coping with the human, social and economic problems involved.

The document acknowledged the difference in expert opinion on the fundamental questions as to the nature of and appropriate treatment for alcoholism. It noted that the term ‘alcohol dependence syndrome’ had replaced ‘alcoholism’ in the WHO International Classification of Diseases, and choose to use the term ‘drink-related problems’ for its own deliberations.

In its recommendations, issued in 1983, a move to a broader health promoting approach can be seen. It suggested that: there be education programmes in the workplace; that there be a long term policy aimed at changing the social attitude to the use of alcohol; and that employment’s adopt agreed programmes to deal with alcohol related problems (Irish Employer-Labour Working Party, 1983).

It is clear however from subsequent literature and policy documents that while the aim of ‘changing the social attitude’ in relation to alcohol was now on the agenda the reality was that emphasis still rested on treatment of individual drinkers and the disease model of care.
Simple Guidelines for Dealing Successfully with Alcohol and Other Problems at Work issued by the Irish National Council on Alcoholism (INCA) in Dec 1983 reflect this continuing emphasis on treatment of individual drinkers. It suggests that a programme for dealing with the problem should include: ‘initial discussion; written policy; visibility; co-ordination; a diagnostic counselling service; training; procedures for case handling; constructive intervention; treatment; aftercare; and evaluation’.

In 1984 the Civil Service produced its Programme to deal with Alcoholism. In its foreword the Minister for the Public Service, John Boland says ‘Alcoholism progressively affects the mental and physical health of those suffering form it, their relationship with their families and with other people and their capacity to do their work efficiently’.

The text in the programme states that the alcoholic ‘must bear partial responsibility’ for the problem. The aims of this programme which are to educate civil servants on the dangers of excessive drinking and to support those who have developed ‘the problem’ to persevere with treatment. The ultimate aim being ‘a satisfactory work performance’ (Dept of the Public Service 1984).

In this same year in the report on the psychiatric services, Planning for the Future, (Department of Health 1984), challenged the reliance on specialised treatment services for alcohol problems and recommended a wider health promoting approach to influence behaviour. There was a recognition in this report of the wider determinants of alcohol related problems and support for the WHO recommendations around reducing consumption through restricting availability, education, and other measures of demand reduction. Planning for the Future marked out a new direction and noted the evidence that residential treatment was no more effective than community interventions for those with serious problems as well as outlining and recommending a broader approach which should include health promotion and education.

The disease model of looking after those with alcohol problems, however, continued to find favour with the institutions in Ireland and over the years specialist treatment and the numbers using their services grew. The National
Alcohol Policy, (Department of Health 1996), and other health policy and strategy documents were produced in the 1990s and supported a health promotion approach. However the impact of these documents on regional planning or action is not obvious, although the structures for supporting a more health promoting approach continued to be put in place.

The role of health promotion in relation to alcohol related problems evolved with the changing emphasis nationally. The Irish National Council on Alcoholism (INCA) was established in 1966 to ‘educate the public about alcoholism as a disease and the needs of alcoholics’ and a working party came together in 1968 to draw up a drug policy. (Report of the commission of Inquiry on Mental Illness, 1966, p82 quoted in Butler, Oideas 1994’).

This resulted in the setting up, in 1974, of a Health Education Bureau (HEB) that had drug education in their broader brief. The HEB held a conference in 1979 on ‘Education Against Addiction’ at which teachers were introduced to the idea of ‘Lifeskills’ as a holistic programme in which life issues for young people were addressed. Alcohol was dealt with in a way that was non directive and relativistic (Butler, 1994). This is a basic model to be later revisited in looking at introducing Health promotion models to other settings such as the workplace.

The HEB was closed in 1987 in the midst of voiced concern around Lifeskills as an approach. Commentators noted at the time that there was still a force within Irish society that favoured traditional, authoritative and didactic strategies.

The Health Promotion Unit was set up in the Department of Health and in 1990 the Chair of Health Promotion was established in Galway University. The Minister for Health, Dr Rory O’Hanlon TD, at the launch of the Centre for Health Promotion in the University emphasised the area of health promotion in the workplace stating ‘the work environment represents an important stage on which the wider agenda of health promotion can be acted out’ (Centre for Health Promotion Studies, 1992).

In 1991 the health promotion service in the NWHB was reorganised so that a manager of health promotion at senior level was appointed and given sole
responsibility for health promotion for all population groups and in all settings. The team expanded to include people with a special interest in the workplace, physical activity, and nutrition.

Reflecting the national move to use a health promoting approach, the service in the NWHB, looked at ways of influencing the health of the population. Particular attention was given at the time to the area of staff health. It was felt that this could be supported through healthy policy development as per the Ottawa Charter. The 1996 service plan for the service contains the goal ‘to reduce the damage done to health by the abuse of alcohol’ and the action, under the heading re-orienting health services ‘the development of a Board Alcohol Policy’ (Murphy, 1997 appendix 3 p9).

Stuart Hanmer-Lloyd (1990) (in Doogan and Means p 94) advocates that:

The alcohol issue should NOT be seen in isolation, and in persuading companies to adopt an alcohol policy it is recommended that alcohol should be included in perhaps a healthy lifestyle campaign.

Shain et al (1986 p 86) look at a health promotion approach and propose that any planned programme needs to address the complex system of health-related beliefs, attitudes, values and behaviours to bring about sustainable change. They suggest that any input should:

- influence beliefs and attitudes about health and how to improve, maintain or restore it;
- promote awareness of alcohol use in the context of life style as a system of interrelated behaviours;
- stimulate the formation of intentions to make changes in alcohol use and in other behaviours that may encourage or support its excessive use;
- promote actual changes in the areas of alcohol use and other behaviours that may encourage or support its excessive use;
- stimulate high-risk alcohol users to seek help.

Pattison and Kaufman (1982) described EAPs focused on alcohol as Job Based Alcoholism Programmes (JAPs) based on the understanding that ‘alcoholism is a treatable health problem, not a moral weakness’ (Pattison and Kaufmann, 1982, p 956). The belief was that the alcoholic had to hit rock bottom before being open to help, and that the JAPs would speed up this process. This was to be achieved through constructive confrontation, which challenged workers on the basis of poor
work performance and offered choices through an agreed policy in a non punitive, non-judgemental way. If this did not have the desired outcome then the strategy of ‘crisis precipitation’ was used which activated the disciplinary procedure while still offering assistance.

Walker and Shain (1983) describe Employment Assistance Programmes (EAPs) as being of two types, one disease focused which identified the problem-drinker and applied constructive coercion/confrontation (Trice, 1962; in Pattison and Kaufman 1982) to motivate him to accept assistance. The second was a broad brush approach where it was considered that there were many potential problems for workers, alcohol problems being just one type, and a voluntary approach to assistance was favoured. The focus of this broad approach is dependant on the concept of health to which they are aligned, this may be a narrow absence of illness approach or a broad health promoting approach which covers physical, mental and social wellbeing (Shain et al 1986).

EAPs emerged in the 1980s absorbed many of the existing Occupational Alcoholism Programmes (OAPs) and JAPs. These EAPs provided the more broad-brush approach and were considered to have less stigma attached than the OAPs/JAPs. Pattison and Kaufmann (1984) saw the emergence of the new EAPs as being influenced by:

- the need to broaden the scope of alcohol programmes supported by both management and unions;
- to reduce the stigma attached in participating in the programme by repackaging it to deal with other issues as well a alcohol;
- the use of impaired work performance as an indicator of problems and the recognition that this may be for reasons other than alcohol use;
- the increase in the range and number of practitioners lobbying for treatment.

Shain et al suggest that the problem in relation to EAPs and what they call HHPs (Health Promotion Programmes) alone is that they deal with extremes, the former looks after the ‘walking wounded’ and the latter reaches the ‘conspicuously well’ (Shain et al 1986 p196). The difficulty with this is that it leaves the moderately at risk group untouched. They suggest that the above steps can be used to develop, what they call, an ‘Employee Health and Assistance Programme’ (EHAP) which
would meet the needs of this middle group. This would address the needs of the people with alcohol related problems and also include a programme around health promotion.

2.4 Evaluation of alternatives

There is a need to consider the possible responses to the needs identified, taking into account the specific needs of the organisation and weighing them against possible outcomes, cost and the perceived added value (Beyer and Trice, 1978).

The ILO study in 1993 noted that ‘for the most part there is no system of priorities which determine how health care or social assistance services apply to drug and alcohol problems of workers’ (Smith, 1993 p 20). It seemed from that study that workplaces generally opted for an individualised approach and the provision of health and/or welfare measures as a response to problems arising. These tended to be tailored to meet the needs of the workers and the workplace (Smith, 1993, p 20).

It is important that the existing culture and practice within the organisation is considered and time is taken to consider what happens currently and what needs to change as a result of a policy (Alcohol Concern & ISDD 1999). The policy that is developed should be flexible and adaptable to meet the demands of the various company cultures and structures (Doogan, 1990).

The WHO in the recommendations of their document on workplace interventions around alcohol, states that interventions should include programmes to increase workers’ knowledge and, if necessary, change their attitudes. The WHO also recommends that training for workers which would enable them to develop skills relevant to the self management of problems associated with alcohol use, such as stress management and assertiveness be provided (WHO 1993).

Training might be given to both personnel staff in relation to the introduction of the policy and to line managers in relation to its content, context and specifics in relation to dealing with problems.
The environment and structures in which a programme is developed impact on its effectiveness. Ames and Janes (1991) quoted in Gill (1994) emphasised the impact of the social and environmental factors within the workplace that influence drinking behaviour, and they advocate as part of a prevention strategy ‘change and reorganisation of the environment’. The WHO stresses the need for a commitment by management to look at and remedy problems which may be contributing to undue stress (WHO 1993).

Where EAPs are the chosen response, Normand et al (1994 p 246), recommend that supervisors are trained in constructive confrontation and referral. Constructive confrontation is described as ‘assembling the evidence of deteriorated performance, confronting the employee with that evidence, describing what will be required to bring job performance back to an adequate level, and referring the employee to the EAP for assistance with any underlying problem that is affecting work performance’. Supervisors should be discouraged from attempting to counsel employees regarding their personal problems or from overlooking problems until they become so severe that disciplinary action is needed.

The recognition of problems at the earliest stages and a mechanism for early intervention is a component of many EAPs. It has been found however that employees and supervisors, because of fear of labelling, (Walker and Shain, 1983), might not use EAPs, which concentrate on crisis intervention and treatment.

The place of treatment in dealing with alcohol problems in the workplace should be clear. Some, who advocate treatment as an effective intervention, once problems are identified, favour speedy referral. This however may relegate the supervisor to a referral agent and dilute their motivation for the basic strategy of constructive confrontation.

Walker and Shain 1983 put forward the view that the referral to treatment (i.e. formal labelling of the person) may pose problems in itself and can result in the adoption of a sick role and the generation of a self-filling prophecy. They also look at the evidence around spontaneous remissions and recovery, and note that remission following treatment seems to be unrelated to the type, duration or intensity of the intervention (Baekland et al 1975; Bergin 1971; Edwards 1975;
Edwards et al 1977; Polich, 1980; Emrick 1975; Hill et al 1967; Sanchez-Craig, 1974; in Walker and Shain 1983). Treatment options should therefore be carefully weighed up and there should be clear reasons for using any particular approach.

Pattison and Kaufman (1982) report Schramm and DeFillippi’s (1975) findings that constructive confrontation accounted for a greater proportion of improvement than did treatment programmes. A study by Trice and Beyer (1984) showed that constructive confrontation of employees by supervisors had independent positive effects on work performance, regardless of any further treatment. They point to the evidence that EAPs seem to be quite successful once identification and constructive confrontation has happened. It is possible that the process of identification and constructive confrontation itself may be responsible for much of the observable outcomes.

Confrontation used alone was, however, shown to have negative outcomes and the balance between constructive input and confrontation was very important. The use of formal discipline was also shown to have a negative effect on work performance (Trice and Beyer, 1984).

The alternatives range from a broad health promoting approach to a narrow identification, referral and treatment approach with some EAPs falling in between. The choice between these needs to be made on the basis of identified need and evidence of effectiveness. The investment in health promotion is long term and has to be sold much harder than a disease focused treatment programme.

One approach, which included a health promotion focus, was the Dublin Healthy Cities Plan (O’Rourke1999). This recognised the need to look at several areas of health but each was treated as a separate project that might stand alone, according to need. The document suggested policies for drugs and alcohol, smoking, physical activity and healthy eating.

It is suggested that an alcohol policy should include the promotion of a healthier lifestyle, a greater awareness of sensible drinking habits, the early signs of alcohol abuse and alcohol dependency, and special assistance to employees whose problems require individual attention (O’Rourke 1999).
All the alternative responses available have common features. In considering alternatives, the needs of the organisation and the context in which the policy is being developed influences the choice of approach and content.

### 2.5 Policy development

The development of an explicit policy needs to reflect the identified needs, consider the range of responses possible and reflect the alternative chosen for the organisation. It should lay out the goals and the mechanism for implementing the policy. The aim of any policy should be clear. Edwards et al (1994) suggest that the aim should be ‘to reduce alcohol problems’ and that all measures should be a means to that end.

Alcohol Concern and the ISDD in 1999 state that:

> The main aim of a drug and alcohol policy and associated programme of action is to minimise the damage of substance misuse by promoting responsible attitudes to alcohol and drugs within the organisation and offering assistance for employees who need it.

It is fundamental to any policy development that the aim be explicit and understood, and that the approach used in the policy reflects the desired outcome. In deciding which alternative and course of action is the preferable strategy, the goals and implementation should be explicit (Beyer and Trice, 1978). If there is an intention to move from a disease focus to a health promotion focus, this needs to be spelt out. A strategy to produce a policy and put it into operation is also needed in order to provide a plan against which progress can be measured.

Staff at every level must know and understand the purpose and content of the policy and it must be clear that it aims to address problems and assist staff (Alcohol concern & ISDD 1999). The study by Beyer and Trice (1978) has shown that the greater the familiarity with an alcohol policy and its strategy the greater the use of the policy by supervisors.

The British Health Education Authority (HEA) guidelines suggest that a range of interested parties should be consulted in the development of a policy. These might include managers, union representatives, occupational health, health education, catering, addiction and alcohol specialists, consultants and special
interest groups such as women’s representatives. A working party, which is not representative, or failure to consult a wider group can result in problems in implementing the policy (HEA, 1988).

Workers and management stated that there was usually broad agreement between management and unions on dealing with alcohol problems. However, workers placed more value on full consultation in relation to this than employers did (Smith, 1993). Trade unions should be actively involved in the policy’s development and operation (Winstanley, 1987 in Gill 1994). The problem is an employer and employee one and the attitudes and support of the trade unions are very important. Commitment by the workers organisations should be a part of the process (WHO, 1993).

Once the aims and objectives have been agreed and pre-policy development consultation has happened the group set up to formulate the policy should include key players as appropriate to the particular organisation. For example this might include occupational health, personnel, unions, management, health promotion, specialist substance misuse services (Alcohol Concern & ISDD, 1999, Means and Doogan 1990, HEA 1988). A senior member of the organisation might usefully be involved in planning and promoting the policy (HEA, 1988, Alcohol Concern & ISDD, 1999).

Wider consultation should take place once a draft policy is available. The formulated policy document is the focus around which action is planned. This plan of action should be communicated clearly to everyone involved along with the rationale behind it, how it will be implemented and the desired outcomes (Beyer and Trice 1978, Alcohol concern & ISDD, 1999).

2.6 **Implementation of the policy**

The implementation plan should include plans to use available resources or provide additional resources as necessary. The policy needs to be disseminated widely and the necessary information and training provided to let people know about it.
The available internal resources for implementation range from occupational health (medical services), to personnel/welfare, unions, and specialist services such as addiction, and health promotion. In the ILO study the most frequently used internal resource was the personnel/welfare service. The next most frequent used were the medical services and the union staff representative service. External resources were often used in conjunction with the internal services. These were self-help groups or private treatment centres. With the increasing acceptance of occupational safety and health services and the contribution they make to the welfare of workers, they provide an important base to address alcohol and drug problems (Smith, 1993, p33).

Existing resources may also include programmes, which in themselves do not exist to support the policy on alcohol but may be beneficial. Examples include health promotion and occupational safety and health programmes, and training on stress and facilitation (WHO, 1993). Health promotion resources are often sparse and therefore it is essential that that approach is promoted and mainstreamed through other services.

The role of the supervisor is pivotal in the operation of the EAP (Walker and Shain 1983; Ames and Delaney 1992, cited in Gill 1994). When one of the objectives of the programme is to provide support and help as early as possible, it is important to consider the blocks to this happening and to look at how a workplace alcohol programme deals with them (Normand et al, 1994, Roman 1988, cited in Gill 1994).

Employees often received sympathetic treatment, which allowed them not to face problems until a crisis arose at which point they are referred into the EAP (Doogan 1990). Trice and Roman (1972) and Googins and Kurtz (1980, 1981), (cited in Normand et al 1994 pp251), note a number of barriers to supervisors using the system: ignorance of the programme and its procedures; attempts by supervisors to solve the workers’ problems themselves; the feeling that referring an employee for help may reflect poorly on the supervisor; fear of harming the employee and his/her family. The pervasiveness of the policy will impact on the likelihood of use by supervisors. The more it is seen being used and evident in the culture of the
organisation the more likely they will be to use it themselves (Beyer and Trice, 1978).

It is vital that senior managers and supervisors understand their role in the policy process and what their responsibilities and accountability is in relation to it. This role may require a change in attitude and a shift in the value system within an organisation, or sections of it, to embrace broader health promoting approaches. In order to accept and support a programme employers need to be convinced that the advantages outweigh any disadvantages (Gill, 1994).

2.7 Institutionalising the policy

Walker and Shain (1983) suggest that problems that arise when implementing workplace policies may be much more than lack of support from key players or supervisors not being trained properly. The model may not be compatible with the objectives and structures of the employing organisation. This reiterates the need to develop the policy in the light of the organisation’s culture and context and to provide leadership.

Support for policies can be supported by internalised values. Williams 1970, (cited by Trice and Beyer in Pattison and Kaufman 1982 pp955), proposes that ‘persons must hold internalised values that are to some degree compatible with the social values underlying particular social controls or attempted social controls will be evaded or resisted’. This may take the form of understood work expectations and standards that are held as ‘felt obligations’. If these expectations are internalised, then a worker who fails to meet these obligations persistently will be seen to be letting himself and the group down. The second internalised value, which is used to support workplace policies, is that of a humanitarian approach. This is the constructive element in the programme and is seen to be fair in offering sympathy and assistance.

It is important that a system is set up to monitor the use of the policy (Beyer and Trice, 1978). Ideally there should be an ongoing review that can quickly highlight problems and success. At a minimum there should be a built-in annual review where the lead person can check in with key deliverers and, if necessary, reconvene the steering group for wider comment (Alcohol concern & ISDD, 1999).
It is difficult to define success and it may mean different things to management, unions, employees and specialists. Gill (1994) looks at penetration rates, case counts, work performance and economic evaluation and reviews work carried out in these areas. The choice of indicators of success in any organisation will reflect their needs and priorities. The needs of decision-makers within the organisation should be considered and a review should be planned to give the type of information required for the particular purpose and use it is needed (WHO, 1993).

Normand et al (1994, p 263) recommends in relation to EAP’s dealing with alcohol that;

EAP’s should be evaluated in terms of the amount and quality (including process evaluation) of the services they provide and not just by patient count. Researchers should seek to understand how EAP’s contribute to a range of different outcomes in a range of different settings.

The learning from evaluation should be used for informing future planning. Therefore it is an important element in the process (WHO, 1993).

2.8 Conclusion

There are various responses possible in responding to the demands and perceived needs within the organisation. These must be looked at in the light of the organisational culture and the context in which the policy is being developed.

An alcohol policy may take a health promotion approach and look at health in its broadest sense and include alcohol in a comprehensive approach to staff wellbeing which aims to influence beliefs and attitudes, promote awareness and support healthy environments. Alternatively it may concentrate on identifying and engaging only those with serious problems, initially in a constructive non punitive way but when all has failed it will come under an agreed disciplinary routes.

Most commonly organisations tailor their policies to suit their own needs and values. It is however important that these custom made policies are explicit and unambiguous in their aims and are based on sound evidence of what works.

The development of the policy document should include consultation with key stakeholders and the trade unions should be involved. Senior management must be on board and the policy should have a senior sponsor.
How a policy is implemented has a major bearing on its effectiveness in achieving its aims. Therefore a strategy for implementation should be agreed and known. This strategy should include a comprehensive plan for disseminating the policy and for providing the training necessary to implement it. Line managers especially should be engaged, their support for the policy fostered and support given to them in relation to their role in its implementation.

Beyer and Trice say that the ultimate test is whether the policy is internalised by the organisation and that where necessary values shift to accommodate and support it and that it is used (Beyer and Trice, 1978).
3 Methodology

3.1 Case Study

A case study methodology was used in this study, which focused on one event, i.e. an alcohol policy development process in a large public health service. This method is used so that insights might be gained which would have wider implications for policy development in general and for dealing with alcohol related issues in the workplace. As Denscombe’s outlines in his discussion of case studies the aim is ‘to illuminate the general by looking at the particular’ (Denscombe, 1998 p 30). This approach allows for in-depth study and a detailed look at the details of the event under study.

The policy development process chosen for study was that of a staff alcohol policy in the North Western Health Board, a large public health service with over 5,000 employees. The development and introduction of the policy in question was took place over 18 months from 1996 to 1998. The study examined the origins of the policy, the process of arriving at a written policy, the adoption of this written policy by the organisation and the implementation of it within the organisation.

The case study approach allows for a focus on relationships and processes to consider what the links are and their impact. While end products and outcomes are of interest the processes through which these are arrived at are highlighted. This offers the opportunity to look at why there are certain outcomes and not just what these outcomes are.

Different sources of information and types of data informed the investigation and the collection of documents and qualitative interviews were used. A review of documentation relating to the preparation stage, the planning, the formulation and the implementation of the policy was carried out. Relevant files from sections in the organisation, the personnel department, the Chief Executive Officer’s office, hospital and community care offices, and health promotion department were identified and reviewed. The project officer also provided information held by her on the project that was relevant to the review. Information from all the different sources was copied and pulled together into one file in chronological order to make it easier to review.
This case study is specific to one event but this event is representative of other policy development. It has common elements with other existing policy documents within the health organisation, including health promotion policies on nutrition and smoking, and follows an organisational pattern used in the formulation of new policy. It is reasonable to propose that the findings of the study of this policy could be generalised to other examples of policy development that are similar.

### 3.2 Interviews

A steering group was set up to oversee the development and implementation of the policy. This group consisted of a senior health promotion officer, a representative from personnel, the substance misuse service, occupational health and line management. The Health Promotion Officer for the NWHB was not part of the steering group but played a pivotal role developing the strategy for the policy and in presenting it to the senior management team.

I had recently being promoted to a senior position within the health board and this made access to the members of the steering group easier and the interview process more relaxed. People were interviewed individually. It was not possible to interview the personnel representative who had moved jobs and was not available, the training officer who replaced him in personnel was interviewed. He did not sit on the steering committee but was involved in the implementation of the policy. The Health Promotion Officer of the Board was also interviewed. She did not sit on the group but played a pivotal part from a health promotion perspective in the policy development process.

The interviews took place in a location agreed with the interviewees for their convenience and lasted between twenty minutes and an hour (averaging 40 minutes). The interviews with the steering group were recorded, with their permission, and transcribed.

A semi-structured, qualitative interview technique was used with a menu of main questions and a list of probes. Before the interviews several main questions were prepared which would direct the discussion. These aimed to cover the overall subject and each of the major stages in the formation of the policy. They were
sequenced so that they flowed from one stage to the next. The main menu of questions included:

- What data was available to indicate a need for the policy?
- What was the background to the policy being developed?
- What do you understand the aims and objectives of the policy to be?
- What was the role of health promotion in the process?
- How was the policy document developed?
  - Who was directly involved?
  - Who was consulted?
  - Were the trade unions involved?
- How was it adopted formally and implemented?
  - Training
  - Education and awareness
  - Environmental or other structural changes
- Who is responsible for maintaining the policy?
- What is your impression of the current status of the policy?
- Is there anything you would like to see happen now?

Follow up questions were used in some interviews where the interviewee introduced a related idea or topic which was not in the menu of questions or which had not arisen in any other interview. This was to elaborate and explore the implications of what was said (Rubin and Rubin, 1995, p 151)

The aim was to trace the process through the experience of those involved and include all of the essential elements of the policy (Rubin and Rubin, 1995). The questions varied according to the role the person played in the process and were informed by points of interest raised during previous interviews.

Because the events being recalled had occurred some years previously, background preparation was crucial in that prompts could be supplied to jog peoples memories and to show that the interviewer was prepared and informed on the topic.
Contact was made with two trade unions who represent workers in the organisation, the Irish Nurses Organisation (INO), and the Services, Industrial, Professional, Technical Union (SIPTU). They were asked about their involvement in the process and their perception of the impact of the policy.

I also discussed this policy initiative with the Chief Executive Officer (CEO) of the Health Board. The discussion covered his recollection of the process of policy development, his current knowledge of the policy and his impression of its impact on the organisation. He held a senior managerial position in the organisation at the time of the policy development and the post of CEO for the last three years.

3.3 Analysis
The documentation retrieved was noted and a description of the process outlined chronologically. The interviews with the steering group and the health promotion officer were transcribed and analysed under the framework used to trace the process. Notes were taken at the shorter interviews with the Chief Executive Officer and the trade unions representatives.

The interviews were examined to extract themes and each one was marked off with a note in the margin on the area it referred to. These themes were grouped together accordingly and reported under the headings of the study. The aim of the interpretation of the interviews was to look at the meaning in relation to its implication for the policy process. This required the themes to be examined against the evidence from literature.

Overarching themes were pulled out to look at their implication for the process involved. One of these was the theme of dealing with individuals with problems because of alcohol. Although this was only one part of the overall policy it was a recurring theme in the interviews. It became apparent that the overall policy was influenced by the strong feelings that members that the steering group had about dealing with individual staff who had alcohol related problems.
4 Findings
This chapter will look at the policy document (see appendix 1 for full document) and review the development and implementation of the policy based on documentary research and interviews with the key players in the process. Through the findings the policy process will be traced to look at the background, and at the aims of the policy, and comment on its implementation and final impact. The commentary will follow the stages of policy development as used in the literature review for follow through.

4.1 Overview of the policy document
The policy document under review was completed and adopted by the NWHB in November 1997. It was produced in the context of health promotion and the National Alcohol Policy. In its introduction it endorses prevention work, in particular sensible drinking guidelines and early intervention.

The statement of policy goes from the general, the recognition that ‘the well-being of its own employees can be put at risk by the misuse of alcohol’ to the specific, dealing with alcohol as it ‘adversely affects employees’ health, (and) job performance’.

There are performance-related features: ‘problems can be helped and in most instances the employee enabled to restore their job performance to a satisfactory level’. The section on how the policy works outlines the steps to be taken with an individual worker once it is identified that they have a problem.

The health promoting elements in the aims include ‘to promote awareness and greater understanding of the risks associated with alcohol use’ and ‘to develop an environment which promotes the reduction of harm from alcohol misuse’. The latter is somewhat tempered by the addition of ‘through early intervention, education and support’. The objectives include education, early intervention, assessment and treatment. It is specified that supervisors will receive training in the skills needed to identify and advise those with problems because of alcohol. Sensible drinking guidelines are included in the document and contact numbers for treatment services are printed on the back.
As well as the policy leaflet itself, there were also support documents developed for training. These included training notes for managers/supervisors (see appendix 2) and support notes and handouts for use at the training sessions. These provided more background information on the policy, supporting information on signs of alcohol use and suggested procedures for dealing with problems. It also outlined the role of the individual departments and services in the NWHB.

4.2 Background to the development of the policy

Consideration was given to developing an Employee Assistance Programme (EAP) for the organisation in the early 1980s. Files show that this was raised at meetings in personnel and that examples of EAPs from elsewhere were considered. Nothing further happened at the time, and one interviewee for the present study suggested that it was ‘politically too much of a hot potato’ (respondent D).

In 1993 the NWHB developed a policy for dealing with alcohol as an issue in the population. This recommended an immediate health promotion campaign to reduce the harm caused by alcohol and the move to community services for those with serious problems caused by alcohol, to be delivered through the GPs. It also recommended that services be moved off the Mental Health sites to make them more acceptable, (NWHB, 1993). A review of the approaches to alcohol inside and outside the organisation took place. This placed alcohol on the board agenda as a topic and made it more acceptable to deal with it inside the organisation (respondent C).

As part of this review the mental health team responsible for alcohol services raised the issue of a policy for NWHB employees. The development of a staff alcohol policy was proposed and work on the policy was planned in partnership with health promotion.

In 1994 the health promotion service was reorganised so that a manager of health promotion at senior level was appointed and given sole responsibility for health promotion for all population groups and in all settings. The team expanded to
include people with a special interest in the workplace, physical activity, and nutrition.

In the same year, the health promotion service in the NWHB offered a large manufacturing company, employing 4,500 people, support around lifestyle issues and as part of this alcohol was considered as a specific topic. This company was the largest employer in the area and attracted a lot of young workers from 15 years of age upwards. An addiction counsellor was released by the NWHB to develop this work and a half days training was delivered to 120 supervisors, managers and union representatives. In preparation for this intervention the addiction counsellor did research into alcohol programmes elsewhere and she met with the trade unions and colleagues to look at the issues and possible approaches.

Arising out of this work, the health promotion service considered that this approach might be a valid way of working in workplace settings around alcohol. It was felt however that there was a need to get ‘our own house in order’ before offering a package to other organisations (respondent D). There was also the added motivation of the possibility of being able to market the package outside the board, ‘if we were going to deliver it elsewhere as a purchasing product ….it would only stand to sense that we should have it in our own (Board)’ (respondent D). It was reported that at this time there was an interest in working with industry to assist them in developing alcohol policies. The question arose ‘how can we do that when we have no alcohol policy ourselves?’ (respondent B).

The health promotion service looked at the model of working through policy development which would have ‘an impact on peoples’ health as distinct from the more traditional stuff in terms of health education and that might…..see health gain out the other end of it’. It was hoped that the policies themselves would cause a cultural and attitudinal shift, which in turn would lead to changes in behaviours. Three policies were developed nutrition, smoking and alcohol (respondent C). The senior manager in health promotion was given the role of developing and implementing the policies.
Within the organisation there were several interest groups in relation to alcohol. The personnel department was concerned with reaching people before a disciplinary crisis arose, and occupational health department was concerned with staff health while ‘line managers were looking for an answer as to what to do with people who have a problem’ (respondent C).

The National Alcohol Policy (NAP) was published in the same year as this policy document. The policy document refers to the NAP and endorses its prevention message around sensible drinking guidelines and detecting early signs of alcohol dependency (Department of Health, 1996). It had been several years in gestation and had attracted submissions from groups including one from this health board. The people interviewed did not feel that it impacted greatly on the local policy, ‘we led out within the board by our own alcohol policy, which happened before the NAP’ (respondent D), ‘the National Alcohol Policy hadn’t the slightest impact’ (respondent B). However it was felt that individuals in and associated with the Health Promotion Unit in the Department of Health were helpful and a useful source of information.

Alcohol policies and Employee Assistance Programmes from other organisations in Ireland and abroad were sourced and used as reference materials for developing ideas (Alcohol Concern, 1992, HEA, 1988, Employment Department Group, 1991)

4.3  The need for a policy

Beyer and Trice suggest that organisations look at their needs in relation to an alcohol policy for staff, in terms of actual needs, potential needs or as a reflection of current practice that is unacceptable (Beyer and Trice 1978).

The health promotion service came to the policy process needing to develop internally a model for working with alcohol which could be used with employers in the region and to reorient the organisation’s way of working for health towards the Ottawa Charter. Others around the table had other needs that influenced their input into the policy.
Absenteeism, accidents and deterioration of work performance, were recognised by the steering group as being potential indicators of alcohol related problems. However, the NWHB did not have systems in place to collect such information and there was a reliance on data from elsewhere which suggested that a percentage of problems in these areas were related to alcohol use. There is no reason to suppose that the employees of the NWHB are any different to employed groups elsewhere. One interviewee said that there was 'no information available that would suggest that we had a problem in the Board' (respondent D) another that there was 'no hard and concrete information in the Board' (respondent C).

There was a sense that 'the problem was bigger than was manifesting itself' (respondent C). Two interviewees talked about the likely number of people within the organisation with problems, based on the prevalence in the general population. It was suggested by one (respondent E) that up to 4% and by another (respondent F) that 20% of the 6,000 workforce could be coping with problems because of alcohol.

People relied on personal experience and anecdotal evidence of there being a problem, 'everyone knew of someone' (respondents B, C) and in some cases had dealt personally with people (respondents F, H).

A response for those people identified with alcohol related problems emerged as the main concern for the policy steering group. They felt that while there was an informal policy that dealt with these people which was supportive and provided access to services and treatment (respondents F, H), there was 'a certain hypocrisy about the way we dealt with it (alcohol problems), ....depending on who the person was and whether the line manager was reasonably close or whether a line manager had a particular problem themselves or whatever' (respondent A).

The theme of fairness came up in several interviews. There were comments such as ‘there should be a standard which we are all working towards....you need guidelines or the policy to help’ (respondent F), ‘that there is a fairness in the way people are treated’ (respondent A), ‘the agenda was to try to get equity into the system' (respondent C), there should be a definite policy so that 'everyone would
be singing from the one hymn book’ (respondent E). This reflected the need for a more equitable and standardised approach to dealing with alcohol problems.

This was balanced by a perceived need for action, that ‘people weren’t protected too much’ (respondent A), that the situation where an employee might ‘never get the belt that brought (him/her) to reality to deal with the problem’ be avoided (respondent C).

Among those with problems it was felt that identification should be as early as possible. There was a sense that people were needlessly reaching a crisis because warning signs were not being acted on, ‘if you had got them two years earlier when the warning signs were there, you might have saved them’ (respondent C), ‘the earlier you get in, the better chance you have of helping the person’ (respondent F).

Therefore the main concern for the majority on the steering group was identifying and dealing with workers who have alcohol related problems in a fair, timely and proactive way.

One interviewee raised the issue of the wider impact of alcohol use, outside those with serious problems. She pointed out that ‘the ineffectiveness of some people who have alcohol abuse problems to a dependency level, really impacts greatly on a wider workforce’. She also suggested that ‘the bulk of people who are only “misusing” (alcohol)….those are the people that impact on work most’. And that there is a need to take away a layer of this policy and go back in and look to see what can be done for this group (respondent D).

This is a point also made by Edwards et al (1984) in looking at the fact that the majority of problems caused by alcohol are among the general population of drinkers.

Members of the steering group were most concerned about identifying and responding to individuals with problems because of alcohol. They felt this should be done in a standard fair way, which was not left at the discretion of managers. There should also be clear access to services and treatment.
While raising awareness and education were seen as possible components of a policy by some interviewees, the needs of those with problems seemed to take priority. There was no felt need to explore a wider response that would deal with the determinants of health or base the policy in a health promotion approach for the entire workforce.

4.4 Approaches to alcohol issues

The policy document includes in its objectives, awareness raising and education, and the development of an environment, which promotes the reduction of harm. It acknowledges that alcohol is the agent of harm and that it is the way it is used that creates problems. It states that ‘The concerns around alcohol will be dealt with through a caring, well-being workplace initiative’ (NWHB policy document, 1996).

One interviewee said that ‘one of the biggest driving factors in relation to the alcohol policy was the staff welfare, that was a bigger factor than alcohol doing harm in a general sense’ (respondent C). Another stated that the policy should be about ‘focusing on the people with major problems that influence their work and their absenteeism rates’ was expressed strongly (respondent E). A third said that ‘what I felt and worked for was that we had a policy to support and help people when they were in difficulty, that was the sole purpose of the policy’ (respondent F).

Although the document was presented in a health promotion context, there was obviously some tension between a treatment approach and the broader health promotion approach. The lead person form health promotion was happy that the health promotion role, in leading out on the broader agenda, was not overt. He felt that the health promotion service objectives could be met through influencing the organisation and through the policy itself. He believed that change would happen in incremental steps, the first of which was the policy.

The health promotion team in the NWHB had a record of achievement around the lifeskills approach to health education. There is no evidence that that approach was considered or discussed as a possible model for a holistic employee health initiative on this occasion. It would have met some of the requirements set out by
Shain et al in looking at a model to address the complex system of health-related beliefs attitudes, values and behaviours necessary to bring about sustainable change (Shain et al, 1986).

The perception of the role that health promotion played in the process varied. Most of the interviewees felt that it didn’t matter that the lead came from health promotion ‘no it didn’t make any difference….I personally think they should come out of personnel’ (respondent F), ‘it is a personnel policy….I don’t really think it made much difference where it came from’ (respondent E), ‘I don’t know that the health promotion label was a difference, the key thing was that someone had to take the drive and initiative to do it….I think the topic gave it legitimacy rather than where it was coming from’ (respondent C).

Others saw a benefit in health promotion leading out, for example, one interviewee recognised the value of it being under the umbrella of health promotion as people didn’t then see it as a mental health or addiction issue (respondent D). The focus was still on the treatment approach but health promotion was seen as a “softer” way of introducing it.

It was considered that the approach should be seen within the framework of a staff welfare programme and that there would be visible help and support. Under this approach supervisors might be more likely to watch out and report signs of problems. It was felt that if the policy was seen as part of the disciplinary mechanism they may be reluctant to use it, ‘if they saw it as a disciplinary (mechanism) they are going to cover up ….they will try to look after the person themselves and it doesn’t work’ (respondent F), ‘if it was going to work it couldn’t be punitive, it must be seen under wellbeing’ (respondent D).

All of these considerations are based on the need to respond to problems arising for individual drinkers who are experiencing problems.

### 4.5 Evaluation of alternatives

Alternatives tend to be tailor made to meet the needs of the workers and the workplace (Smith, 1993). The project leader accepted at the outset that the people coming to the table to formulate the policy did so with their own agendas.
This was seen by him as positive in relation to their ownership of the project and brought ‘energy for the thing’ (respondent C).

There were two other staff health policy documents dealing with nutrition and smoking, in place in the organisation at the time of developing the alcohol policy. These may have influenced the development of this policy document. The decision to develop three policies in parallel, all of which impact directly or indirectly on staff welfare, was a conscious one. It was part of a service strategy within health promotion to forward the principles from the Ottawa Charter, to promote healthy public policy and to create healthy environments. It was considered that health promotion’s involvement in this work would ‘reinforce the concept of health promotion and being seen to practice as (they) preach’ and further to show that ‘health promotion is more than talk and …are beginning to operate integral to the Board’ (Murphy, 1997). There was therefore a clear health promotion agenda in leading out on this policy.

Examples of EAPs and work based alcohol programmes were collected from Ireland, Northern Ireland, Scotland, Wales and the USA and used as reference documents. The project worker drew on her knowledge of what was happening elsewhere, her discussions with colleagues and relevant literature. The rest of the group were happy to allow her to lead out on the content, once they were kept informed.

The written objectives in the policy document include ‘to educate employees on sensible drinking, and the harmful effects of misuse of alcohol, drugs/mood altering substances’. It did not, however, emerge from the interviews that this objective was focused on, in the process of developing the policy or in its implementation. Some of the people interviewed commented that it was intended to include action on ‘some sort of an educational programme’ but that it never ‘really materialised’ (respondent B). The policy itself contained information on the signs of alcohol harm and guidelines to sensible drinking which dovetailed with the health promoting messages to the general public at the time. There seemed to be an intention to follow up with an educational programme but this did not happen. One person said that this was ‘stage two or three or four but it ended once the training ended’ (respondent D).
The training element of the policy placed emphasis on the skills around communication in general and constructive confrontation, and gave participants information on signs of alcohol related problems and sensible drinking. The aim of this was seen as ‘very much the notion of seeing the warning signs and how to actually tackle, how to engage in the initial discussions with an employee around, not their drinking, but around their actual work’ (respondent C).

The inclusion of guideline around the use of alcohol in the workplace or during working hours was debated. People remember the nature of that debate differently. Some remembered it being discussed and did not know what the final outcome was. One person remembered that ‘people would have wondered, or queried or niggled a little bit but it wouldn’t have gone any further ’(respondent D). Another person stated that there was heated debate and strong opinions expressed on the issue. ‘We talked about alcohol being used at health board functions during working hours, I’m not sure whether we put that in or not’ (respondent E).

The WHO suggests that the employer’s policy on tolerating or banning alcohol contributes to problems by influencing availability. However it is also acknowledged that this may be influenced by the context and the culture and notes that ‘in some cultures the message will be that, if drinking takes place, it should be sensible drinking with due regard to time, place and quantity. In other cultures, total abstinence would be the norm’ (WHO 1993, p11).

The policy document itself under the heading ‘How does the policy work’ says that ‘the health board promotes safe drinking and the good practice of clear regulations re alcohol in the workplace. The board further supports the use of non-alcohol drinks during catering and hospitality arrangements ’(policy document). This however was not emphasised in the training or follow up sessions, and is left to the interpretation of the reader.

One respondent in particular felt very strongly about ‘people who want to prescribe for other people’, ‘individuals have rights to make up their own minds, provided you inform people and they have knowledge...we are not here to dictate’. The bottom line was she felt that ‘common sense has to prevail...I don’t expect to
see people drinking to excess but there’s a balance’ (respondent F). In this there was a resistance to a paternalistic attitude in relation to alcohol availability and use at work.

The objectives in the policy relating to individuals with problems because of alcohol include detecting early signs of alcohol dependency, early intervention offer appropriate referral and treatment and to restore health and job performance. The idea that the policy should be a mechanism for promoting and supporting early interventions was strongly stated by some interviewees ‘the earlier you get in the better the chance you have of helping the person’ (respondent F).

Respondents B and H felt that the policy tied into the board’s general approach to dealing with alcohol related problems in the population, and early intervention was strongly advocated ‘rather than letting it become a crisis situation’.

One interviewee stressed the importance of early interventions with people who themselves are working with people who are not well ‘you don’t want bad care or anything to happen to a patient because you haven’t been observant enough’ (respondent F).

There was a feeling among interviewees that assistance was being offered too late, ‘we were getting people at the end stage, when they hit the disciplinary procedure and the general sense was that if you got people earlier you would have been able to do a lot more with them’ (respondent C). However it was acknowledged that supervisors may have been reluctant to intervene as they may be ‘afraid to lift the lid on the thing’ and the importance of giving them the confidence that ‘there is a whole raft of back up they can plug into’ (respondent C). This reflects the preoccupation with treatment and the reliance on it as a response to problems identified. There were concerns raised about the difficulty in accessing residential treatment and a feeling that more treatment options were needed (Respondent E).

Occupational health was mentioned as having made a big difference to the support available for the welfare of staff, ‘the best thing that happened to this
board in the last number of years was the establishment of occupational health.....to support the welfare of staff’ (respondent F). Three people singled them out for mention, one mentioning the importance of the development of the service and its use for referrals at an earlier stage (respondent B). A representative from occupational health expressed concern at the use of the service at the end stages of problems. She would like to see much more support being provided to managers to cope and deal with problems themselves (respondent E).

4.6 Policy development

The policy document was developed to support the process of implementation. To do this a steering group comprising of senior representatives from health promotion, occupational health, personnel, line managers and addiction service met three times over a five month period from March 1996 to July 1996. The addiction counsellor was dedicated to this work for a period of time and supported the group in researching and drawing up documents for their consideration. It was pointed out by one interviewee that ‘one of the key mechanics of it was you had somebody involved who was willing to do a lot of footwork and spade work and put stuff on the table and keep coming back and revising it ….other things fell for the want of that’ (respondent C).

This person played a key role in the writing up and implementation of the policy, ‘(She) did it all, from beginning to end (respondent B), ‘she was king pin, the linch pin of it’ (respondent A), ‘seconding her out of her existing job to do some work on it was one of the key features, …(it) harvested the good will in terms of the committee, you had them there to take decisions and to modify stuff and everything else was made easy for them’ (respondent C).

A senior manager who led out on the policy was mentioned as a key player in its development. The lead taken by this person was seen to be independent of his position at the time (in health promotion) but it reflected his skills and commitment, ‘wherever he is, he usually drives the thing’ (respondent F), (he) led this out very well, I would see him as being the driving force behind this happening’ (respondent D).
The lead person laid out the process through which the policy would be developed and implemented in May 1996 as follows:

- discuss and clear the idea in principle with key players;
- get steering group together to advance project;
- prepare and clear concept formally at the management team;
- draft policy and agree at steering group;
- spread the consultative net..discuss draft with a consultative group of senior managers;
- agree refined draft at steering group;
- engage staff associations and refine if necessary;
- develop draft implementation plan.. dissemination of policy..skills training programme for managers / supervisors;
- develop support material for managers..handbook;
- engage service in terms of initiatives, broader health promoting…support..early identification orientation;
- develop some form of review and evaluation mechanism;;
- organise linkages to develop the initiative to enable full expansion of intervention into external organisation, as a service initiative;
- develop funding opportunities for the expansion of the project.
- maximise positive publicity potential (Alcohol file, HP service).

This plan was taken from guidelines for putting an EAP in place. Although the project officer said ‘we didn’t sit down and strategically work our way through it’ (respondent D) she also said that it was used as a check list at the meeting to check what had happened and what needed to happen. It was left to the project leader and officer to support the process through the various stages.

It has been seen in the literature review that there is a need for clarity of aims. The project leader and officer had a plan to develop and implement the policy. However, the group that was meeting to develop the policy had varying needs and opinions on what should be contained in the policy and its ultimate objective.

The aims of the policy itself, as laid down in the document are:

- ‘to promote awareness and greater understanding of the risks associated with alcohol/substance misuse;
- to develop an environment which promotes the reduction of harm from alcohol or substance misuse through early intervention, education and support.’ (policy document in appendix 1).

Taken in their broadest meaning these aims could coincide with the benchmark set out by Edwards et al ‘to reduce alcohol problems’ (1994) and reiterated in this study by the lead person (respondent C). This would require an understood
meaning of the aims which included an approach to tackle the environmental and structural elements of alcohol harm within a total population programme.

Among the people interviewed the understanding in relation to the aims of the policy differed from some of the stated aims. As seen before, the emphasis tended to be on standardising an approach to those who were experiencing problems because of alcohol use. People were concerned about the ‘ad hoc’ approach to the problem and the fact that the approach taken to dealing with problems was entirely dependent on the manager of the person involved. It was felt that there was a lack of equity in the existing approach.

Examples of what the interviewees considered the policy aimed to achieve were:

‘the approach would not be the fragmented way that we currently ...had at the time. That we would have an approach that would be board wide’ (respondent A);
‘that managers would be able to not only identify staff who were developing substance problems but also they would have the skills to do something about it rather than letting it become a crisis situation’ (respondent B)
‘alcohol and the harm alcohol does...was the overriding thing...this was an opportunity and a vehicle to advance that forward in a particular niche so it was part of that bigger agenda’ (respondent C);
‘the biggest driving factor in relation to the alcohol policy was the staff welfare....(and) the line managers not knowing, and wanting to know how to deal with it’ ‘to try to get equity into the system’ (respondent C)
‘to have a framework by which you can implement interventions’ (respondent D);
‘we should have a definitive policy so that everyone would be singing form the one hymn book, that managers would be trained to recognise it as early as possible and not just continue to ignore it ‘ (respondent E).
‘that we had a policy to support and help people when they were in difficulty...that was the sole purpose of the policy’ (respondent F)

The aims as outlined by the group reflect the orientation towards meeting the needs of individuals with problems in the workforce. One person talked of the ‘bigger agenda’ in relation to the harm alcohol does but in another part of the interview focuses on the welfare of staff and skilling up line managers to deal with problems.

4.7 Implementation of the policy

A report was sent to the Management Team of the health board in April 1996 after the first meeting of the steering group. The final document was presented to the

Two meetings were held in October 97 to which representatives from the unions representing staff in the NWHB were invited to hear about the document and comment on its implementation. Five people attended meetings held in Donegal and Sligo.

A SIPTU representative, contacted as part of the study, remembered being at the briefing session. He said that he attended one meeting but that ‘there was no follow up’. His memory of the meeting was that the unions were supportive of the policy. He said that he has not seen the document referred to in recent years and has had no experience of unmet need in relation to dealing with people with alcohol problems. He strongly believes that alcohol should be dealt with in a wider staff welfare initiative where it would be one aspect of wellbeing.

Briefings for the unions were held after the policy was developed to give them the opportunity to hear about the policy and the planned training. Shop stewards were also included in the training where they were not already at supervisory grades. It was acknowledged in hindsight that ‘If we were introducing a policy like that again… the unions would find it as advantageous to sit around the table as we would’ (respondent C). The new partnership arrangements (Department of the Taoiseach, 1999) between employers and employees will provide a means to develop such input in the future. Currently this is being used to look at the introduction of a bullying policy in this health board.

Overall the wider consultation in relation to the policy document and its contents was limited.

Training was offered to all staff supervising five or more people in the health board and 500 people attended. Training sessions were held in local centres throughout the board for ease of access. This took place between September 1997 and April 1998. As well as the scheduled sessions a number of “mop up” sessions were held to accommodate those who missed out.
The training was designed to:

‘enhance and contribute to alcohol and drug education within the workplace in order to retain as best as possible the valued services of an employee whose work performance may be deteriorating due to alcohol or drugs’ (NWHB, 1996).

This was carried out by introducing supervisors, occupational health nurses, personnel staff, shop stewards, health and safety reps and managers to:

- education on drugs on alcohol;
- basic helping/communication skills, i.e. listening and empathy;
- how to implement these in relation to employee intervention (NWHB, 1996).

There was a deliberate attempt to have a mix of people from different workplaces and grades as participant in each training session. At the end of this it was hoped that the people receiving the training would be able to intervene at an earlier stage, cope better with alcohol related problems, be familiar with their role in the introduction and implementation of an alcohol policy within the organisation.

The training was facilitated through the personnel department and a letter was sent to each manager requesting that staff be freed up to attend. Clerical administrative support was arranged. After the training, every line manager who attended got copies of the policy to distribute to their staff. As it was a core principle of the implementation process that all supervisors receive the training before implementing the policy, line managers or supervisors who did not attend the training did not receive the document directly. It is possible that some of these did not subsequently receive it through another route and some employees may never have got it. Every GP in the area got a copy of the policy with a covering letter.

Training was a core part of the implementation of the policy and was used as the opportunity to clarify with supervisors and managers their role in it. Among the group interviewed the understanding of the training varied according to the closeness of people to the process. Some interviewees placed high value on it and clearly articulated its aims, while others were not aware of the content or extent of the training. The project worker felt that it was a crucial aspect of the
policy being adopted and was part of the process of explaining the policy to those who were going to implement it.

Comments on the training include ‘it would have been to give people some skills in terms of actually dealing, in a kind of role play, with how to bring up issues in relation to alcohol, how you would open discussion. It gave information on alcohol and its effects and … looked at peoples own attitudes’ (respondent B). It was about ‘giving people the sort of tools and techniques to have the first engagement with people’ (respondent C).

The evaluation carried out at the end the training was analysed and collated by the lead trainer. Personnel also got informal feedback from people who were present saying that the day was excellent. Some of the interviewees had received informal feedback that was very positive. One said that he ‘hadn’t come across anything so positive’ (respondent A), another that she had heard people say that it was hugely valuable for themselves and their family (respondent B).

The project worker did a formal evaluation of the type of training used in this project in another setting, and found the key learning was around the core skills of constructive confrontation. People said that they would use the skills learned in other situations such as with other staff issues or even with their children. This core set of skills could be used as a broad management tool for dealing with staff issues at work.

As a follow on to the training for supervisors, all employees were invited to awareness/information sessions. These were held over one or two hours and aimed to introduce the staff to the policy and inform them of its use. The sessions were held throughout the Board area in locations which everyone had access to. Approximately 600 people attended these sessions. The total number of staff employed by the NWHB at that time was approximately 4,500.

Responsibility for implementing the policy was considered to lie with line managers, ‘the line managers, would have the absolute responsibility’ (respondent B), ‘its down to telling managers what they should do, they should act as managers’ (respondent E). This interviewee qualified this statement by saying that
this meant managing every problem well and having an open mind as to what may be causing problems and reacting appropriately.

### 4.8 Institutionalisation of the policy

The steering group felt that it was difficult to measure the impact of the policy. Most people considered the impact in terms of numbers of interventions that had occurred since its introduction. There was no reference to its impact in relation to culture change or wider aspects around staff welfare which were not directly linked with alcohol problems.

Where there was information about individual interventions it was noted that these were still at a late stage of alcohol related problems. Those who came to the attention of the occupational health service were usually at the end stages of the process and at risk of disciplinary action, and these are very few. It is possible that the development of the occupational health service in itself, even without an alcohol policy, could account for these referrals.

The welfare system allows for individual managers to arrange support for people identified by them as they see fit. Thus people may be referred to private counselling or treatment centres and there is no central record of this. It is also difficult to gauge whether early interventions are happening, as was the intention, as there is no mechanism in place to gather this information.

People stated that there was an intention to formally evaluate the policy and its implementation, but this did not happen. The project worker expressed an interest in seeing this happen and learning from it.

Reflecting the emphasis on recognising problems and individual interventions, interviewees expressed concern that the Board does not have some sort of ‘information system’ which would capture information on ‘how many interventions have been done with staff, how many early interventions have been done and has anyone lost their job?’ (respondent D).

The interviewees offered some examples of what they perceived as the impact of the staff alcohol policy under study. ‘It has legitimised the welfare treatment of
It has ‘opened up the link and the partnership between services’ (respondent D), ‘it had people with different agendas sitting at the table and linking in’ (respondent C). This was an example of an impact that might be seen as health promoting in reorienting health services and partnership working. This in itself is a significant move forward in breaking down traditional barriers between treatment and non treatment services. However it would seem that the reliance on this networking to carry through the aims of the policy in areas which were not a priority for the group, was not sufficient in this case.

Sustaining the policy was a theme in all interviews and the challenge of keeping people informed and skilled in its implementation was identified as a problem. It was acknowledged by all the people interviewed that while the development of the document and implementation of the training was given a lot of attention, a plan to maintain the policy or review it was not put in place.

The managers who came into the system after the initial training had taken place have not had formal training on the policy. It was felt that the policy should be included in the induction process (respondents A, B, C, E, F) and the training necessary for supervisors and managers should be made available. The best way for new managers to get to know the policy is to see it working and to ‘see when colleagues need help how it is done’ (respondents F, H). This would imply an internalisation of the policy so that it becomes commonly referred to and used. It is part of the everyday management tools.

Interviewees commented on the lack of follow up on the policy, ‘a huge push and a lot of training done and very little follow up afterwards’ (respondent C), ‘putting a huge effort into getting something started and then not actually maintaining it and no policy will remain implemented and fresh unless it gets consciously driven on’ (respondent B), ‘the last link didn’t happen which is how often do you visit this again and review it’. One interviewee felt that the policy should be ‘visited every
so often’ and service heads need to ‘know what they are accountable for’
(respondent E)

The steering group felt that there was a need to revisit the policy and review it. Comments in relation to future work included: ‘Keeping the training and awareness raised all the time’ (respondent B); ‘Target the groups we know to be vulnerable like student nurses’ (respondent B); ‘Tell the managers that they should act as managers’ (respondent E); ‘Bring back some senior people and say is it OK? How are you finding it?’ (respondent F); ‘That key people say that this is so important that it needs to happen’ (respondent D).

The proposal to develop and implement a staff alcohol policy was initiated by health promotion. It was underpinned by a health promotion ethos and the document reflects broad aims and objectives to support this. The steering group were interested in and had energy for developing the policy. They had particular needs of their own which they brought to the policy development process. The common theme in their needs was how best to identify and support employees with alcohol related problems within an equitable staff welfare system. The role of the supervisor was recognised as crucial and training was provided to introduce the policy and skills needed for early intervention and constructive confrontation. The wider aspect of the health promotion approach does not appear to have been a priority in the development and implementation of the policy.
5 Discussion and Conclusions

5.1 The need for a policy
The policy development process was lead by health promotion who seemed to have a clear intention to introduce a broad definition of health and follow the principles of the Ottawa Charter. It appears that this was not explicit to the members of the policy steering who brought their own agenda to the table.

The perceived need for a policy within the steering group was based on personal experience and anecdotal evidence. Most senior managers interviewed had dealt with a handful of crisis situations around alcohol in their working career but these were very difficult and needed a high level of skill and a lot of time. There was an overall feeling that these problems merited a standardised and fair approach.

Three of the people interviewed commented on the unmet need in relation to potential employees who might be effected by alcohol. This was based on general estimates of the prevalence of alcohol related problems and alcohol dependency in working populations.

From the interviews there is no evidence of any resistance to the health promotion perspective, but this took a backseat to the primary need identified by the key players, i.e. to help employees with alcohol related problems and restore their job performance.

There was no articulated need to introduce a broad based, workplace-wide programme which would start to tackle the wider aspects of alcohol related problems. The steering group was satisfied if the policy met the need to help individuals with alcohol related problems.

5.2 Approaches to alcohol issues
Some health promotion elements were included in the written objectives of the policy e.g. awareness raising, education and an environment which promotes the reduction of harm. If we revisit the elements which Shain et al suggest should be included in a health promotion approach we will see that the policy does not cover the broader aspects outlined, i.e. to:
• influence beliefs and attitudes about health and how to improve, maintain or restore it;
• promote awareness of alcohol use in the context of lifestyle as a system of interrelated behaviours;
• stimulate the formation of intentions to make changes in alcohol use and in other behaviours that may encourage or support its excessive use;
• promote actual changes in the areas of alcohol use and other behaviours that may encourage or support its excessive use;
• stimulate high-risk alcohol users to seek help (Shain et al 1986 p 86).

This is a broad approach, which can be designed to look at one topic or at a range of health determinants within which one topic can be targeted. It includes, as one part of the approach, the area of engaging with high-risk users which is the area that this steering group felt was the greatest need for them.

The policy document makes reference to the National Alcohol Policy and endorses the ‘important prevention messages’ (policy doc, appendix 1). It would seem that the use of the National Alcohol Policy was selective. This may have been because of the timing of its publication. The national policy sets out objectives for workplace interventions in relation to alcohol including ‘promotion of a healthier lifestyle, a greater awareness of sensible drinking habits’ as well as early recognition of problems and special assistance for those with problems (Department of Health, 1996).

5.3 **Evaluation of the alternatives**

In this policy under study, health promotion took second place to the immediate needs of managers and supervisors, which were to deal with individuals with problems because of alcohol use. The policy put in place a system that would: identify signs; intervene as early as possible; constructively confront the employee; and, if necessary, refer for treatment. Within this range of responses, identification and referral for treatment came out strongly among interviewees as the preferable way of dealing with ‘the problem’. Early intervention was used in this case as a step towards formal treatment. Constructive confrontation as an intervention in its own right did not appear to be appreciated fully. It can be seen in the policy document that the section on ‘how the policy works’ is more aligned to a personnel procedure for dealing with workers with alcohol problems than a staff wellbeing initiative.
This approach might deal with the employees with serious alcohol problems but it does not address the overall problem. Edwards et al, from their vast review of the evidence, conclude that the majority of alcohol problems lie within the majority of the employees. A population approach is required to see the greater benefit from interventions (Edward et al 1994). One interviewee made this point and was concerned that the focus on the whole workforce was lost. She also noted the impact of those with significant problems on their colleagues and the need to address this as an issue (respondent D).

The WHO, among others, recommend that attention is given to supporting broad staff health initiatives which in turn will give people skills to cope better with alcohol problems (WHO 1993). A trade union representative in this study also strongly advocated this approach and said ‘there should be a wider staff welfare initiative which would include alcohol’ (respondent H).

Although the NWHB alcohol policy is referred to as an Employee Assistance Programme in the training notes, it fits the description of a ‘Job Based Alcoholism Programme’ as outlined by Pattison and Kaufman (1982, p956) and which aims to:

- challenge workers on the basis of poor work performance
- offer choices through an agreed policy in a non-punitive and non-judgemental way
- if these steps fail, activate the disciplinary procedures while still offering assistance

This may not have been the initial aim of the steering group or the health promotion service, but from this study it would appear that this is what is in place. It seems that the policy development and implementation group were satisfied with an implementation plan which would meet their greatest need, i.e. to provide treatment for the people with major alcohol problems which were effecting their work. For most people on the group, if it achieves this, it has done its job.

5.4 Policy development
The policy document outlines the written aims and objectives in the broad terms in which they were conceived. It was acknowledged by the project leader that while health promotion had a focus on the ‘sort of harm that alcohol does’, other people came to the table ‘without that picture, they would be coming with their own
particular string to play’. It was considered by him that this injected energy into the process because ‘people were coming with their own agenda’ (respondent C).

It would appear that the steering group sought the inclusion of specific objectives to meet their own needs and were happy to have others included as long as they were complementary, or at least benign, in relation to their own needs. Wider consultation among the workforce and their representatives did not happen as part of the policy development process. People interviewed tended to be aware of the areas of the policy that met their own needs but were not as clear about broader aspects.

Authors such as Beyer and Trice emphasise the need for clarity around the aims and objectives for a policy. While it may be possible to formulate a policy without explicit aims and objectives it will be impossible to implement it effectively under the same conditions (Beyer and Trice 1978).

At the stage of implementation there is a need to make the broader aims of the policy explicit. There was always the risk of the less tangible health promoting focus would be lost if it was not spelt out and a commitment to it secured. As it turned out energy flowed into the individually focused work and objectives, and an action plan around broader aspects of employee wellbeing or structural changes were not formulated.

When aims are not made explicit at the start, the subsequent process facilitates the involvement of managers with different needs and perspectives in implementing the policy, but increases the likelihood of important aims not being achieved. It is important that a clear decision is made at the outset on what is an acceptable outcome to the process.

5.5 Implementation of the policy
This policy initiative succeeded in bringing more equity into the system for dealing with individual staff who have alcohol related problems, but it has not changed significantly the organisation’s culture in relation to the use of alcohol. It has resulted in a shift from an emphasis on a disciplinary approach to a welfare approach in dealing with staff who have problems relating to alcohol. The
intended support work on developing an environment to promote the reduction of harm and on education and awareness did not happen.

The high level of commitment by the NWHB to this policy initiative was reflected in the resources committed to the training programme, which involved a full time trainer with other people assisting at various locations around the board area. Clerical support was available to set up and support the training. Five hundred line managers were released to attend the training. No other strategy or policy, except the national strategy ‘Shaping a Healthier Future’, had the same direct penetration to supervisors.

There were some ‘mop-up’ training sessions arranged within a certain time frame after the initial training but once these finished in April 1998 no further training took place. Managers and supervisors who have been appointed since April 1998 have not received training. It is up to the local manager to provide copies of the policy and inform them that it exists.

A full evaluation of the policy and its implementation was not carried out. The project officer collected some baseline information during the development of the policy but this was not used to measure changes.

5.6 **Institutionalising the policy**

In order to have long term changes in the nature and extent of alcohol problems it is necessary, as proposed by Beyer and Trice, to see a change in the underlying values of the organisation to match the policy aims. This change in values needs more than an approach to individuals with problems. It needs an organisational shift to support the wellbeing of staff within which alcohol problems can be addressed. It needs recognition of the determinants of health at work - environment, supervision, training, and feedback -that influence how a person copes. It needs investment in support for staff wellbeing, be that stress management, assertiveness or facilities for physical exercise, and a choice of healthy food. Some models look at a health promoting organisation approach and suggest that a broad programme to tackle lifestyle factors be put in place. This approach did not form part of the implementation of the policy under review.
5.7 Conclusions

At the time the NWHB policy was being developed there was evidence available on the value of a broader health promoting response to alcohol related problems in the workplace. The National Alcohol Policy was published in 1996 and the authoritative work by Edwards et al, which summarised the global evidence on the subject, was published in 1994. Both advocate a broad population approach to deal with the problems that arise because of alcohol use. Within this approach a planned response to those who have significant problems would be included.

The move to develop a policy on alcohol in the NWHB was influenced by the health promotion service. It was intended that the policy be used to promote the broad, health promoting approach to alcohol problems and develop a model which could be used in other workplace settings.

The policy in its written aims and objectives includes the health promoting perspective and has broad aims around healthy environments, education and awareness. The findings in this study, however, suggest that the emphasis of the policy, as it developed, was on identifying individuals who have problems, (usually significant), because of alcohol use, and referring them on to the appropriate treatment source. This is closer to a treatment centred approach than to a health promotion one.

The shift in emphasis as the policy evolved reflected the needs of the steering group which were based on their experience of dealing with people on the staff with alcohol related problems. A policy that met the need to provide an equitable and supportive response to staff with alcohol problems also met this expressed need within the steering group.

This need to deal with individuals with alcohol related problems took precedence over the needs of the health promotion service to develop a broader approach that would include all staff. This highlights the need for the aims and objectives of a policy to be stated clearly and unambiguously at the start and a plan agreed for the implementation of all aspects of the policy. This study identifies some of the difficulties encountered in moving towards a health promoting approach.
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