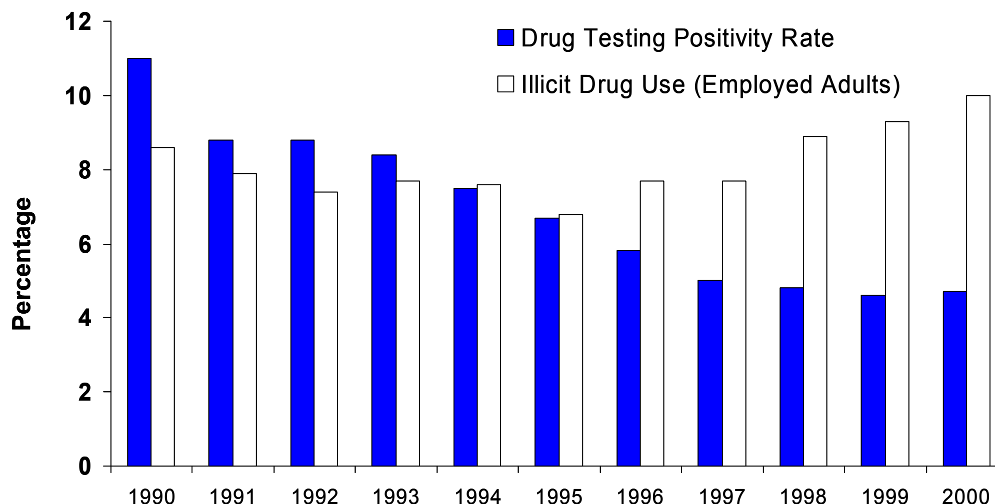
PART I
EXECUTIVE SUMMARY
Small Business Wellness Initiative

Problem Statement

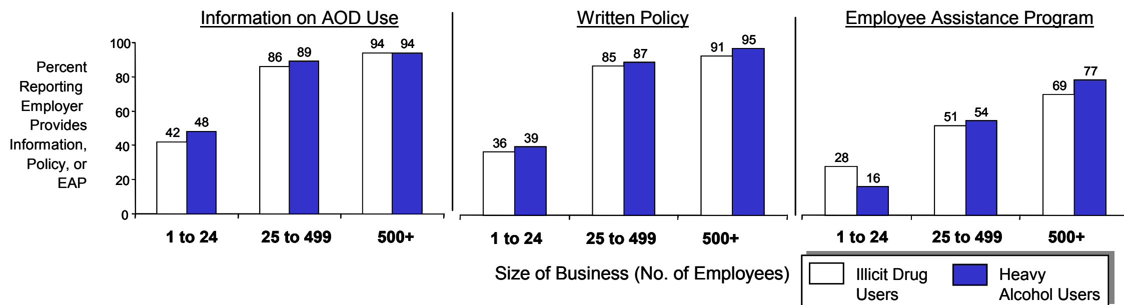
Illicit drug use and problem drinking among adult workers have shown little sign of lessening over the past 10 years. The 2003 National Survey on Drug Use & Health (NSDUH/NHSDA)[1] shows that over 74% of illicit drug users and 76% of those dependent on substance abuse are employed. The NSDUH, tracking employee drug use since 1990, shows an increase in illicit drug use among full-time workers. The primary response among businesses has been in the area of detection and deterrence, typically through employee drug testing. Thus, it is helpful to compare the positive drug testing rates with NSDUH trend data. Figure 1 suggests the need for alternative methods in prevention. The white bar shows the NSDUH illicit drug rates. The shaded bar is drawn from Quest Diagnostics[2], the leading provider of drug testing in the United States and shows positive test rates from 1990 to 2000. While businesses are finding lower positive rates among employees, there has been an increase in illicit drug use in the general working population.

Figure 1. Trends in Illicit Drug Use and Drug Testing (adapted from Bennett and Lehman, 2002)[3]



There are a number of explanations for this discrepancy. For example, drug users have learned to be more covert in their use or have avoided companies that test. Perhaps the most compelling explanation can be found in the NSDUH data; small businesses (which typically do not drug test) have the highest rates of drug and alcohol abuse and lowest levels of policy development. Figure 2 shows that smaller businesses are also least likely to have policies and counseling services (Employee Assistance Programs). Additional NSDUH data indicates the highest risk occurs in specific occupations within the small business population (Transportation, Construction and Service and Hospitality). The current project is designed to fill the need for workplace substance abuse prevention services to these at-risk businesses within these industries.

Figure 2. Percentage of Full-Time Workers (Age 18-49), Reporting that Their Workplace Provides Information Has a Written Policy, or Provides Access to an EAP: By Establishment Size and Current Alcohol or Drug (AOD) Use (1997 NHSDA Survey Results)



Prevention Intervention: The Small Business Wellness Initiative

The Community Initiated Prevention Intervention (CIPI) program calls for a research-driven and community-based solution to the problem of workplace substance abuse. The current project, entitled the "Small Business Wellness Initiative" (SBWI), followed the CIPI philosophy in terms of organization, goals, strategy, and training solutions. In addition, the SBWI utilized rigorous research methodology to explore in greater depth those risk and protective factors associated with worker drug abuse. To our knowledge, this was the first study to assess the unique set of risks associated with substance abuse in the small business population.

Organization. The Tarrant Council on Alcoholism and Drug Abuse, a non-profit organization, partnered with two local agencies to implement and evaluate two evidence-based workplace prevention programs. The partners were the regional North Texas Small Business Development Center—Technology Assistance Center (SBDC-TAC) and Organizational Wellness & Learning Systems (OWLS). The Tarrant Council and OWLS are located in Tarrant County/Fort Worth, Texas and The SBDC-TAC is located in Dallas, Texas. This collaborative arrangement designed a program delivery model (*Path of Assistance*) that delivers services along a natural path of dissemination from the TAC at the regional SBDC to local Small Business Assistance Centers (SBAC) and then to small businesses, their employees and families.

Research Strategy. The SBWI outreached small businesses and delivered two interventions to the target population in three neighboring counties in North Texas: Dallas, Denton, and Tarrant. Businesses were recruited primarily through a small business database, phonebook, and chamber of commerce listings with supplementation from local community referrals (e.g., through SBACs) and direct marketing by the outreach team. Small businesses were randomly assigned to receive one of two classroom training interventions or a no-training control condition. In the two intervention conditions, needs assessments were administered to small business owners. Following recruitment, employees completed surveys typically two weeks before (pretest) and after (posttest) receiving the training or, in the case of controls, one month apart. All employees received surveys six months following training.

Replication Capacity. Tarrant Council and OWLS together developed core strategies to both support the above research as well as to develop a replication process so that others can disseminate SAMHSA Model programs to Small Businesses. First, the SBWI was based on four core foundational strategies (customer focus; partner role definitions/accountability; research

productivity; project management). Second, a set of presentations, outreach, and coalition retreat materials were developed to enhance readiness for small business assistance centers as well as small businesses. Third, process analyses were conducted and synthesized into case studies. Finally, a website was developed (www.sbwi.org) that houses replication resources for others to use.

Goals and Objectives. The mission of the SBWI—as stated in project recruitment materials—was "to enhance the health, productivity and quality of work life for small business leaders, their employees and their communities." The primary research goal was to determine the effectiveness of two programs in preventing substance use and related problems in small business settings within three counties. In addition, we tested the short-term effects of training on two sets of risk and protective factors – *Work Related* and *Personal* - that relate to substance abuse. A full list of these factors can be found in the Research Report (see *Risk Factors in the Target Population*). The primary service delivery goal was to develop a strategic and aggressive community outreach model by coordinating the efforts of three local organizations. Through such partnership, we sought to create a *Path of Assistance* that can be used by other Small Business Regional Centers throughout the United States. Secondary service goals include effective community liaisons, flexibility regarding scheduling for small businesses, an incentive program, adequate referral to community services, and alignment with employee assistance programming for small businesses.

Training Solutions. The first training program, *Team Awareness for Small Businesses (or Team Awareness*^{SB}*),* integrates team building exercises with peer referral and stress management skills.[4] The original 8-hour *Team Awareness* training has been identified in the National Registry of Effective Prevention Programs (NREPP) by the Center for Substance Abuse Prevention and is a SAMHSA Model Program. Because of business time constraints, *Team Awareness* has been condensed to 4 hours. Previous research shows that *Team Awareness* increases employee help-seeking and supervisor responsiveness to troubled workers, as well as enhances the work climate and reduces problem drinking. These results are achieved by:

- Promoting social health
- Promoting increased communication between workers
- Improving knowledge and attitudes towards alcohol and drug-related protective factors in the workplace (such as company policy or Employee Assistance Programs)
- Increasing peer referral behaviors

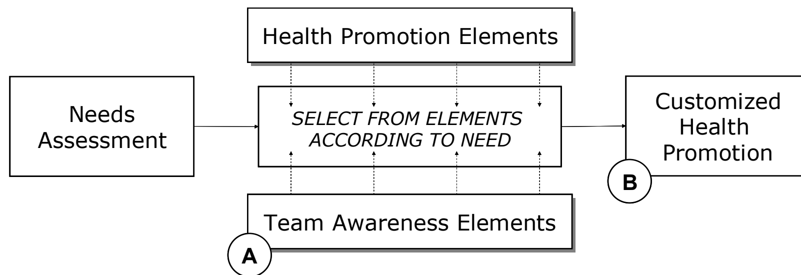
Team Awareness ^{SB} is highly interactive and uses group discussion, communication exercises, a board game, role play, and self-assessments. Modules cover policy ownership, enabling, stress management, listening skills, and peer referral.

The second program (*Choices in Health Promotion*) draws from both *Team Awareness* and a variety of health promotion programs (stress management, time and spiritual health, healthy eating, active lifestyle, tobacco/smoking control, parenting skills). This health promotion approach follows the logic of *The Healthy Workplace,* another SAMHSA Model Program.[5] *Choices* is four hours in length and is customized using information from the needs assessment. This customized approach was delivered for the first time through the current CIPI project. A number of the health programs have been scientifically developed and shown to be effective in reducing personal stress, illicit drug use, and alcohol consumption and improving healthy lifestyle habits (coping skills, diet and weight management).[6] The *Choices* program capitalizes on the fact that substance abuse is closely linked to health status. Health promotion programs can provide needed secondary drug and alcohol abuse prevention. Many individuals who are heavy drinkers or occasional drug users-but not yet in serious

trouble-can be reached through a health promotion program. They may be highly resistant to participating in a drug and alcohol abuse program, but will have little reluctance to enroll in a health promotion program.

As noted in Figure 3, each *Choices* program was customized based on a needs assessment conducted with the small business owner. The needs assessments occurred in a one or two hour face-to-face interview by a SBWI research staff member using a 10-page questionnaire with 10 sections: business description, owner-employee relations; policies and training; insurance/workers compensation/EAP; alcohol and drug use; health and productivity; owner perception and stress; time management; owner perceptions of meaningful work; and training preferences.

Figure 3. Distinction between two training intervention models.



(A) This uses a modified version of *Team Awareness;* all businesses in this condition receive the same program elements.

(B) This uses a group of elements drawn from both Health Promotion and *Team Awareness*; businesses in this condition receive different sets of elements according to risks identified in the needs assessment.

Research staff reviews SBO responses to the needs assessment and determined which elements from our *Team Awareness* and *Choices in Health Promotion* menus should be included in the training. The requisite materials were assembled into a PowerPoint™ presentation, along with all videos, handouts, and accessories. These were then delivered by an SBWI trainer to employees in a classroom setting. Typically, the small business provided training space on location to make attendance convenient. Our experience suggests that between 8 and 20 employees in a session make up the ideal number of participants for both *Team Awareness* and *Choices*.

Synopsis of Outcome Research Design

Businesses within industry were randomly assigned to receive either the interventions or a control condition. The SBWI successfully recruited 40 businesses, all of which received pretest surveys (14 in construction, 10 in transportation/utilities, and 16 in hospitality/service). Of these, 13 received *Team Awareness*, 12 received *Choices*, and 15 were assigned to the no-training control group. Businesses ranged in size from 8 to 360 employees and averaged about 34 workers per businesses (54% White; 25% Hispanic/Latino; 19% Black). We note that 16% of all participants used Spanish as their primary language and many of these spoke Spanish only. Accordingly, all survey and training materials were translated. Initial rates of participation were somewhat lower for the control condition (58%) than either for Team Awareness (82%) or Choices (63%). Employee retention rate from pre-to-post was 79%. Pre-to-post retention was similar for the Team (77%), Choices (78%) and Control (80%) conditions. Retention from pre-to-training was 88% for both interventions (88% Team, 90% Choices). Pre-to-follow-up employee retention rate was 69%. Pre-to-follow-up retention varied across the Choices (77%), Team (71%) and Control (58%) conditions.

Project Outcome Findings

Outcome analyses were conducted in different hypotheses domains: (1) proximal effects; short-term or pre-to-post changes in a select group of risk and protective factors for substance use; (2) distal effects; any changes in substance use from pre-training to six-month follow-up; and (3) training engagement effects. Experimental results suggest that *Team Awareness*^{SB} improved some aspects of workplace climate and help-seeking and *Choices* reduced alcohol use. Due to the number of statistical tests performed, findings are somewhat mixed and small to moderate in strength. Still, key positive findings for *Team Awareness*^{SB} include improvements in organizational wellness climate, use of positive coping skills, and help-seeking and reductions in alcohol dependence (measured by the CAGE) and drinking climate. Key findings for *Choices* include improvements in exercise habits, and reductions in several substance use outcomes (alcohol use, problem drinking, and tobacco use). Additional analyses suggested that, compared to controls, both training programs increased employee disapproval of using marijuana with effects being sustained in the *Team Awareness*^{SB} condition. Overall, employees had more consistently positive responses to *Team Awareness*^{SB}. EAP utilization records showed that over 20 intervention participants contacted the EAP since project start-up. Other qualitative findings include positive reactions from small business owners, improved used of drug free workplace policies, and active utilization of the website, www.sbwi.org. Nearly 500 non-research participants have also been served through out-reach/dissemination efforts (see Research Report Appendices).

Conclusions

Those wishing to extend prevention efforts to small businesses should pay special attention to time requirements and the necessary allocation of human resources for recruitment. Once businesses agree to participate, every effort is needed to maintain a positive relationship both with the small business owner (or primary contact) as well as with employees. We originally experienced difficulties in outreaching and marketing this special population. Of the 278 valid businesses randomly culled from the Dun & Bradstreet database, only 6% agreed to participate. In contrast, of the 70 businesses contacted through community referrals, 21% signed up for the study. Because this is the first time evidence-based prevention is being delivered to small businesses, we have diligently documented all lessons learned in the areas of outreach; needs assessment; employee enrollment, recruitment, and retention; balance of research and service delivery; and general project management. In addition, Small Business Assistance Centers should be considered as only one resource or partner for enhancing outreach and community coalition efforts. The Research Report (Part II) and the Replication Manual (Part III) describe our findings in depth.

References

1 Substance Abuse and Mental Health Services Administration. (2004). *Overview of Findings from the 2003 National Survey on Drug Use and Health* (Office of Applied Studies, NSDUH Series H-24, DHHS Publication No. SMA 04-3963). Rockville, MD. Available online at http://oas.samhsa.gov/NHSDA/2k3NSDUH/2k3OverviewW.pdf (accessed March 20, 2005). Also, Substance Abuse and Mental Health Services Administration. (2002). *2001 National Household Survey on Drug Abuse* (NHSDA). Available: http://www.samhsa.gov/oas/nhsda/2k1nhsda/vol1/toc.htm [accessed October 21, 2002]. The NHSDA was renamed NSDUH in 2003.

2 Quest Diagnostics (2000). Positive drug test results in 1999 decline to record low in Quest Diagnostics workplace drug testing index. Retrieved May 2, from http://www.questdiagnostics.com/brand/company/news/ b_comp_news_0620b00.html

3 Figure adapted from Bennett, J.B., & Lehman, W.E.K. (2002). Preventing workplace substance abuse: Beyond drug testing to wellness. American Psychological Association, Washington, DC. (see p. 35). The figure only shows rates till 2000. For 2001 to 2003, the Quest Diagnostic rates continued to remain low at 4.6%, 4.4%, and 4.5% consecutively. The NHSUD rates were as follows for 2001 to 2003 were for part-time (PT) and full-time (FT) workers over age 26. 2001, PT = 8.2%, FT = 9.9%; 2002, PT = 11.3%, FT = 12.3%; 2003, PT = 11.7%, FT = 12.2%. Recent Quest Diagnostics data can be found at http://www.questdiagnostics.com/employersolutions/dti_07_2004/dti_index.html. NHSUD Data were taken from Table H.17 for the 2001 report and Table G.10 for the 2003 (2002) report.

4 Team Awareness was developed by Dr. Joel Bennett and colleagues at Texas Christian University (Institute of Behavioral Research). The Team Awareness training has been identified in the National Registry of Effective Prevention Programs (NREPP) by the Center for Substance Abuse Prevention and is a SAMHSA Model Program.

5 Many of the health promotion programs were developed by The Center for Workforce Health (Dr. Royer Cook and associates), which combine messages of health promotion (stress management, healthy eating, active lifestyle, tobacco/smoking control, parenting skills) with substance abuse prevention. The Choices program also includes a module on spiritual health, developed by Dr. Bennett, entitled Time and Presence.

6 Cook, R. F., Back, A. S., McPherson, T., & Trudeau, J. (2002). A field test of an integrated health promotion and substance abuse prevention program for the workplace. In Bennett, J.B., & Lehman, W.E.K. (2002). Preventing workplace substance abuse: Beyond drug testing to wellness. American Psychological Association, Washington, DC. (pp. 97-133).