NOTES ON OCCUPATIONAL MALADJUSTMENT AND MANAGERIAL RESPONSE IN 36 LARGE SOUTH AFRICAN ENTERPRIZES

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OPSOMMING

'n Opname is onderneem om die voorkoms van sekere geestesgesondheidsprobleme in werksorganisasies en wyses waarop dit van bestuursweë gehanteer word, te ondersoek. Die gegewens weerspieël 'n algemene patroon wat dui op 'n toenemende besef van en bemoeienis met probleme van hierdie aard, veral ten opsigte van alkoholisme. Dit word gevolg deur emosionele probleme, maar daar is blykbaar heelwat onsekerheid oor die misbruik van dwelmmiddels. Gesamentlike pogings deur die nywerheid en gemeenskap word vereis om positiewe houdinge en ad hoc hulp in gekoördineerde programme en beleid te omskep.

Although scientific, social and economic developments over a number of years have stimulated a more enlightened view of the productive role and welfare of "the human assets of enterprise", the question remains whether this philosophy of work has been adequately translated into managerial policies and practices.

In following up the National Health Year 1979, and with a view to a healthy and productive work force in South Africa, a survey was undertaken to assess the incidence of certain mental health conditions or problems of adjustment affecting work performance, and ways these are being dealt with in work organizations. It also served as a follow-up of a survey conducted a decade earlier (Vlok, 1971), subsequently referred to as the 1971 survey, to ascertain whether significant trends have occurred. Finally, it served as a basis for comparing the local position with data reported in a similar survey conducted in America (Miner and Brewer, 1976). The latter survey was conducted late in 1970 by the American Society for Personnel Administration and the Bureau of National Affairs Inc. This will be referred to as the 1970 survey or the American survey.

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For the sake of brevity this report will deal mainly with some of the more significant empirical findings of the survey, rather than with theoretical issues and related research already documented in the abovementioned sources and elsewhere. Suffice it to state that the accumulative detrimental effects of mental health problems on productivity and human welfare in industry have been established beyond reasonable doubt. For example, Louw (1974) quotes figures based on the 1970 population census, indicating that the total cost to South African employers of untreated alcoholism among white and coloured employees only, amounted to more than R136 000 000 annually. Figures such as these are attributed to lost time, erratic performance and other direct costs. Indirect costs due to a general breakdown of motivation and human relations are more difficult to estimate. Be that as it may, if the total South African labour force is considered, of which some 20 % are likely to be suffering from some degree of mental ill health (du Plessis, 1973), the implications for employers, the national economy and public health cannot be ignored.

To establish and maintain a mentally healthy work force at least the following would be prerequisites: policies based on ethical considerations, supported by top management, systematically executed by trained personnel, paid for by the organization, and available to all employees. Also included would be: preventative measures such as proper selection, education and training, and personnel maintenance procedures; facilities for the identification of occupational maladjustment such as supervisory training, personnel control systems, and professional staff services; finally, clear guide-lines for coping with maladjustment and re-habilitation to aid supervisors, personnel departments, and internal or external sources to which cases are referred for counselling and treatment. Organizations will have to determine for themselves the extent to which they are prepared to subscribe to the notion of social responsibility, and to formulate this in realistic policies and practices if any progress is to be made.

The above will serve as some of the criteria when evaluating the present situation.

THE SURVEY

A questionnaire was dispatched to 90 of the largest South African companies, selected at random from the "top 100" listed in the Financial Mail Special Survey (1980) on the basis of various criteria. They were not necessarily the most labour intensive enterprises but by virtue of their size represented a sizable portion of South African manpower. Furthermore, in

the 1970 survey mentioned above it was noted that the larger companies were more likely to deal with the problem areas under consideration in any systematic manner. To the list were added ten large employers from the public sector. Personnel policies in this sector are more likely to be of a uniform nature.

Completed questionnaires were returned by 36 employers, which is disappointing from the viewpoint of representation, but not unlike the response rate usually obtained for surveys of this nature. To some extent the response rate in itself may reflect the perceived scope of and concern for mental health problems in industry.

The samples can not be considered as representative and the findings should not be generalized to all South African employers. It nevertheless portrays the position in a number of large organizations more likely to have extensive experience of the conditions considered, and policies, procedures or facilities to deal with such matters. The data is therefore likely to reflect the position under favourable circumstances, but may serve as a useful point of reference.

Bearing in mind that some companies operate in more than one category, the respondents represent a variety of business activity: construction (11,11 %), manufacturing (58,33 %), mining (5,56 %), transportation (13,89 %), distribution (16,67 %), public authorities (11,11 %), services (2,78 %), and agriculture (2,78 %). The total number of employees in these organizations were in excess of 395 000. Questionnaires were generally completed by heads of personnel under various designations, and psychological and medical staff.

By comparison the 1971 survey included 749 organizations, each employing more than 100 white workers. This could also be taken as an index of relative size. The survey however was limited to problem drinking among white employees only. The American (1970) survey covered 100 companies varying in size and of diverse industry composition. The differences among samples as well as the respective dates of the surveys should be considered where data is compared.

Furthermore, it should be realized that records or statistics on the conditions under consideration are not always readily available. The senior administrative and professional staff mentioned were considered to be in the best position to help with an assessment. However, responses to some of the questions were offered as informed opinions rather than

factual data. It would be more meaningful to look for trends or patterns than to compare specific figures.

For purposes of definition in the present survey, the following conditions were briefly described:

Problems due to the use of alcohol:

The problem drinker is the person who drinks to the extent that it materially reduces his work efficiency and makes it difficult for him to get along with himself and his associates. We are interested in all problem drinkers, whether they are "alcoholics" or not. Signs which could be indicative of an early phase of a possible drinking problem include:

- consistent tardiness or absence on Monday morning and frequent occurrences of leaving early on Friday afternoon;
- unexplained disappearance from an assigned post during working hours;
- recurring excuses for absence due to minor illness such as colds, stomach upsets or too frequent off-duty accidents;
- personality change.

Problems due to the use of drugs (e.g. marijuana, amphetamines, opiates)

Symptoms may vary with the type of drug and period over which it is used. Typical signs may include:

- deterioration of mental and physical capacities;
- disturbed perception of time;
- apathy;
- lethargy;
- euphoria;
- propensity to take risks, to be involved in accidents and frequent job changes.

Emotional problems requiring treatment

Emotional problems may vary from the mild upheavals most people experience periodically, to extreme cases of mental disease not frequently found in work organizations. This survey is concerned with employees having emotional problems to the extent that their work performance or that of associates is affected, and who could possibly benefit from counselling or treatment. This may be observed in personality change in a previously good

worker, such as arguments or criticism of others, recurring mistakes for which he defends himself or blames on others or on equipment, marked variation in mood, aggressiveness, complaints of being rejected or persecuted, disinterest in his work, high tension, excessive worries, depression, and various physical complaints or hypochondria.

RESULTS

The perceived incidence of problems is reflected in Table 1, from which it appears that alcoholism is still the number one mental health problem in industry. The incidence of drug abuse is reported significantly less often than either alcoholism or emotional problems, while the latter occupies an intermediate position. Alcoholism and emotional problems are both recognised definitely or to a limited extent significantly more often than denial or uncertainty of their occurrence, whereas opinions are more or less equally divided on the question of drug abuse.

TABLE 1

PERCEIVED PREVALENCE OF PROBLEMS
(N = 36 ORGANIZATIONS)

	ALCOHOL	DRUGS	EMOTIONAL
Definitely not	0,0 %	2,8 %	2,8 %
Uncertain	5,6 %	44,4 %	13,9 %
Yes, to a limited extent	63,9 %	36,1 %	66,7 %
Yes, definitely	30,6 %	16,7 %	16,7 %

The findings concerning alcoholism contrast sharply with those of the 1970 survey, when 79,2 % denied any problem of this nature, 2,6 % were uncertain, 12,9 % described it as a problem of limited extent, and only 5,4 % of all respondents recognized it as a definite problem.

It would appear, then that organizations have become more acutely aware of alcoholism as a personnel problem. Whether this represents a definite increase in incidence is difficult to determine. From the data in Table 2 it would seem that the situation has been fairly stable over the past two years. There is some indication of increases in alcoholism and emotional problems, whereas a decrease is suggested in the case of drug abuse.

TABLE 2

PREVALENCE OF PROBLEMS COMPARED WITH TWO YEARS PREVIOUSLY (N = 36 ORGANIZATIONS)

	ALCOHOL	DRUGS	EMOTIONAL
Lower	5,6 %	16,7%	8,3%
Same	75,0 %	55,6%	61,1%
Higher	16,7 %	8,3%	22,2%
Not stated	2,8%	19,4%	8,3%

The figures are rather small to allow definite conclusions. Increase in the incidence of all three conditions are however reported in the American survey, particularly the use of hard drugs. This differs from the present findings, but there appears to be a problem of evaluation in this area as indicated by the number of respondents who omitted this part of the question in both surveys. Apart from problems of identification, additional factors to consider include the cost of hard drugs and the composition of the South African labour force. It would also be of interest to investigate whether cultural or sub-cultural factors are involved in the use and spread of hard and soft drugs, and to what extent these are temporary phenomena. At least one respondent commented on the increase in the use of marijuana by migrant labourers.

Table 3 supports the findings on the incidence of problems in the three areas under consideration. The majority of respondents estimated the number of cases involved at less than 5 % of all employees. However, the average estimate for alcoholism (5,5 %) is significantly higher than for drug abuse (3,1 %), the latter category also showing the largest number of omitted responses. The average figure for emotional problems (4,1 %) again occupies an intermediate position.

TABLE 3

ESTIMATED PERCENTAGE OF ALL EMPLOYEES PROBABLY HAVING PROBLEMS OF THE NATURE DESCRIBED (N = 36 ORGANIZATIONS)

	ALCOHOL	DRUGS	EMOTIONAL
Less than 5 %	55,6 %	69,4 %	66,7 %
5 % to 9 %	25,0 %	13,9 %	19,4 %
10 % to 14 %	13,9 %	2,8 %	11,1 %
15 % or more	5,6 %	0,0 %	0,0 %
Omitted	0,0 %	13,9 %	2,8 %

Due to problems of identification these figures are probably too conservative. They are in excess, however, of the figures cited as underestimates in the 1970 American survey, when the incidence of alcoholism was reported at between 1,9 % and 3,2 %, drug abuse between 0,2 % and 1,6 % and emotional problems at 1,4 % for different organizational groups. The estimated figure for alcoholism obtained by companies with special facilities for detecting such problems was 5,3 %, which approximates the figure in the present survey.

It is also of interest to note that the percentage of alcohol problems is more than double the 2 % reported in the 1971 survey, again reflecting a greater awareness of this problem area if not an actual increase in its occurrence. It also approaches the 6 % figure quoted by Louw (1974) for the South African working population.

Respondents were also asked to indicate if any employee group or groups are particularly susceptible to the problems mentioned (Table 4). It should be noted that the frequencies with which particular worker categories are indicated, and expressed as percentages of the number of respondents, are small and that some respondents indicated more than one category within each area.

In none of the problem areas the perceived frequency in any category of employees is significantly higher than the combined frequencies in the "no group differences" and "omission" categories. This seems to suggest that these problems tend to be of an individual nature rather than group characteristics. The 1971 survey has also indicated that alcoholism, at least, occurs throughout the occupational spectrum. In the American survey, however, a significantly higher incidence of alcoholism and use of hard drugs was reported for production workers than for office or managerial personnel.

TABLE 4

EMPLOYEE GROUPS PARTICULARLY SUSCEPTIBLE TO PROBLEMS (N = 36 ORGANIZATIONS)

	ALCOHOL	DRUGS	EMOTIONAL
Office personnel	11,1 %	2,8 %	22,2 %
Production personnel	19,4 %	8,3 %	13,9 %
Sales personnel	30,6 %	2,8 %	5,6 %
Service personnel	5,6 %	0,0 %	5,6 %
Managerial personnel	11,1 %	0,0 %	8,3 %
Black personnel	30,6 %	25,0 %	8,3 %
White personnel	19,4 %	2,8 %	16,7 %
Coloured personnel	33,3 %	11,1 %	13,9 %
Shift workers	25,0 %	13,9 %	13,9 %
Physically handicapped workers	0,0 %	0,0 %	5,6 %
Recently returned national servicemen	2,8 %	0,0 %	5,6 %
No discernible group trends	11,1 %	22,2 %	33,3 %
Other	2,8 %	0,0 %	2,8 %
Omitted	2,8 %	33,3 %	11,1 %

From Table 5 it appears that in the majority of organizations there is a comparative lack of formal policy in respect of all the problem areas. It would seem that the "lack of policy and even an unwillingness to face up to the problem" observed in the 1971 survey with regard to alcoholism is still applicable to some extent. Of the three problem areas, however, alcoholism is probably the best known at this point in time and receives the greatest amount of managerial attention.

TABLE 5

EXTENT TO WHICH ORGANIZATIONS HAVE WRITTEN POLICIES ON PROBLEM AREAS (N = 36 ORGANIZATIONS)

	ALCOHOL	DRUGS	EMOTIONAL
Yes	41,7 %	25,0 %	8,3 %
No	58,3 %	69,4 %	86,1 %
Omitted	0,0 %	5,6 %	5,6 %

Respondents also reported on their use of typical procedures in dealing with problem cases, if not written policies. These include discharge only, warning followed by discharge, discipline short of discharge, toleration, discretion of supervisors, in-company counselling or treatment, referral to outside agencies, and also the absence of general rules. Again a small number of respondents omitted the question while other organizations use a variety of these

procedures within each problem area. Responses were arbitrarily classified and are summarized in Table 6.

TABLE 6

CLASSIFICATION OF TYPICAL PROCEDURES USED IN DEALING WITH PROBLEM CASES (N = 36 ORGANIZATIONS)

	ALCOHOL	DRUGS	EMOTIONAL
Disciplinary measures	14,8 %	15,7 %	3,7 %
Laissez-faire procedures	8,3 %	11,1 %	6,5 %
Counselling or treatment	61,1 %	31,9 %	54,2 %

The most typical response is to refer cases of problem drinking for counselling or treatment. Significantly less use is made of either disciplinary measures or laissez-faire procedures, although these are also in evidence.

A significant trend towards more sophisticated or professional help is revealed when the above is compared with the 1971 findings, when only 16,8 % of respondents reported such referrals, 41,7 % used disciplinary measures, and approximately the same percentage adopted a laissez-faire approach. Discipline without immediate discharge also occurs frequently in the American survey (and is observed in the present data), possibly as a motivating factor since referrals for treatment also figure prominently.

Employees with emotional problems are also likely to be referred for professional treatment. Disciplinary action in these cases occurs significantly less frequently than with either alcoholism or drug abuse.

In the latter problem area referral for treatment is also reported, but not significantly more so than disciplinary measures, and significantly less than in other problem areas. Management is likely to adopt a stricter attitude where drug abuse is concerned. This is also observed in the American survey, where international consultation is seldom reported for drug abuse, more frequently for emotional problems, and most often for problem drinking. External referrals also occur less often for drug abuse, which may be associated with the smaller incidence of drug problems, particularly in organizations without production workers. The authors comment that even though a harder line is taken in cases of drug abuse, management is nevertheless not quite sure what to do with problems in this area.

TABLE 7

RATING OF SUCCESS IN DEALING WITH PROBLEMS
(N = 36 ORGANIZATIONS)

	ALCOHOL	DRUGS	EMOTIONAL
Good	22,2 %	2,8 %	19,4 %
Reasonable	55,6 %	38,9 %	52,8 %
Poor	19,4 %	30,6 %	16,7 %
Omitted	2,8 %	27,8 %	11,1 %

Despite the variation of managerial responses in each of the problem areas, the majority of respondents describe their success in dealing with problem cases as reasonable (Table 7), significantly more so than either good or poor in the case of drinking and emotional problems. The exception is the area of drug abuse, where opinions on success are more evenly divided between reasonable and poor. Again this seems to be the area of uncertainty, also evidenced by the number of omissions. As far as problem drinking is concerned, the popular response of satisfaction observed in the 1971 survey seems to have shifted in the direction of a more considered "reasonable". Rather than any alternative interpretation, this could suggest a greater awareness and a more critical assessment of the problem area.

Using the measure of success as a criterion, various courses of action as classified before were compared for mental health problems in general (Table 8). On the whole, and in agreement with the American data, the most satisfactory results are reported for internal and external treatment rather than alternative procedures. A slight tendency for internal treatment to be rated more favourably in the case of problem drinking, and external treatment more favourably with the other two conditions, did not reach the level of statistical significance as it did in the American survey. It should be noted that internal facilities or contributions to the rehabilitation of problem drinkers are probably more available or better formalized than in the case of either emotional problems or drug abuse.

TABLE 8

SUCCESS RATES REPORTED FOR VARIOUS PROCEDURES
(N = 36 ORGANIZATIONS)

	GOOD	REASONABLE	POOR	OMITTED
Discipline	1,9 %	18,5 %	9,3 %	1,9 %
Laissez-faire	2,8 %	12,0 %	7,4 %	2,8 %
Treatment	27,8 %	88,9 %	26,4 %	4,2 %

Disciplinary procedures are rated reasonable to poor. Few procedures of this nature are rated unequivocally successful. The same applies to laissez-faire procedures, where very few successes are reported. Apparently neither warning or dismissal, nor toleration or indecision by itself seems to solve the problem of occupational mental ill health. As noted before, however, a variety of supplementary procedures including some of those mentioned may have a role to play in co-ordinated programmes to cope with problems of this nature.

TABLE 9

SOURCES FOR IN-COMPANY COUNSELLING
(N = 36 ORGANIZATIONS)

	ALCOHOL	DRUGS	EMOTIONAL
Supervisors	44,1 %	16,7 %	33,3 %
Personnel department	41,7 %	36,1 %	52,8 %
Medical or psychological staff	41,7 %	33,3 %	33,3 %
No counselling offered	5,6 %	13,9 %	5,6 %
Others	5,6 %	2,8 %	2,8 %
Omissions	5,6 %	19,4 %	5,6 %

Table 9 indicates that relatively few organizations (on average 8,3 %) offer no counselling of any kind. However, a further 10,2 % appear to be in some doubt and have omitted this item, particularly with regard to the problem of drug abuse. The combined figure for problem drinking alone, amounts to 11,1 % of all organizations where counselling is absent or in doubt. Even so, this is quite the reverse of the 1971 figure of 93,6 % reporting no facilities for counselling, even if the different composition of the 1971 sample is taken into consideration.

Within problem areas no significant differences were observed between the use of supervisors, personnel departments, and professional staff as counsellors. In the American sample personnel departments were cited most often as a source of counselling, followed by medical staff and supervisors. Staff psychologists were mentioned infrequently. The latter distinction is not made in the present survey, and it is not known how many organizations have psychological services at their disposal apart from psychologically trained staff working in personnel departments.

Supervisors are used significantly more often to deal with cases of problem drinking than cases of drug abuse. Apart from the relative incidence of these conditions, it is probable that supervisors are more often involved in integrated programmes for dealing with the better

known problem of alcoholism. On the other hand, drug abuse is more likely to be seen as a problem requiring direct managerial action or more specialized attention.

TABLE 10

TECHNIQUES USED TO AID SUPERVISORS IN DEALING WITH PROBLEM EMPLOYEES
(N = 36 ORGANIZATIONS)

	ALCOHOL	DRUGS	EMOTIONAL
Policy statement or written suggestions	22,2 %	16,7 %	11,1 %
Supervisory training meetings	25,0 %	16,7 %	19,4 %
Referral to or consultation with company physician or psychologist	30,6 %	25,0 %	36,1 %
Referral to or consultation with personnel department	63,9 %	41,7 %	50,0 %
Outside referral sources	38,9 %	19,4 %	25,0 %
In-company staff education	11,1 %	8,3 %	5,6 %
None of the above	5,6 %	13,9 %	0,0 %
Omitted	2,8 %	19,4 %	5,6 %

It seems that supervisors carry a large portion of the responsibility for industrial mental health. The question arises whether they are trained for their roles as counsellors or assisted in other ways by management. Table 10 lists some of the techniques used to aid supervisors in dealing with problem employees. The largest frequencies in all problem areas again stress the role of the department, hopefully equipped to deal with problems of this nature. This is followed by referrals to or consultation with either staff specialists or external sources. On the whole, liaison with professional facilities, policy statements, and supervisory training suggest organized procedures for dealing with problems, especially in the area of alcoholism. Company educational programmes are reported infrequently, indicating a stronger emphasis on corrective than preventative measures. This could be associated with the relative incidence or perceived incidence of problems.

While the data do not reveal significant differences within or between categories, the general pattern is consistent with that reported in the American survey: aid to supervisors in the area of problem drinking and to a lesser extent where emotional disturbance is concerned. Little help is offered in the less known area of drug abuse, including less use of professional sources such as medical staff.

Table 11 lists some of the facilities with which liaison have been established. As suggested above the greatest variety of these concern problems of alcoholism. These include

hospitals and clinics, SANCA, and outside medical or psychological practitioners. As might be expected, the services of AA is also used to a considerable extent in this problem area. Professional sources for coping with drug abuse are used significantly less often on a regular basis than for any of the other problem areas. For coping with emotional problems liaison is mainly limited to outside practitioners, hospitals and clinics.

TABLE 11

EXTENT TO WHICH LIAISON HAS BEEN ESTABLISHED WITH OUTSIDE FACILITIES (N = 36 ORGANIZATIONS)

	ALCOHOL	DRUGS	EMOTIONAL
Outside medical or psychological practitioners	41,7 %	27,8 %	50,0 %
Hospitals or clinics	50,0 %	25,0 %	36,1 %
Clergy	5,6 %	2,8 %	2,8 %
Police	2,8 %	11,1 %	0,0 %
AA	36,1 %	5,6 %	0,0 %
SANCA	44,4 %	22,2 %	2,8 %
Department of Social Welfare	11,1 %	8,3 %	5,6 %
National Council for Mental Health	8,3 %	8,3 %	8,3 %
None of the above	19,4 %	27,8 %	25,0 %
Others	5,6 %	0,0 %	0,0 %
Omitted	2,8 %	25,0 %	11,1 %

Conceivably some use of outside facilities is made when required, without any formal liaison. The question whether treatment and rehabilitation facilities should be provided within the organization of outside is also relevant in this context, and opinions on the matter are summarized in Table 12.

TABLE 12

OPINIONS ON WHETHER TREATMENT AND REHABILITATION FACILITIES SHOULD BE PROVIDED WITHIN INDUSTRY OR OUTSIDE

	ALCOHOL	DRUGS	EMOTIONAL
Within	11,1 %	2,8 %	8,3 %
Outside	44,4 %	55,6 %	30,6 %
Partly within and partly outside	44,4 %	33,3 %	55,6 %
Omitted	0,0 %	8,3 %	5,6 %

Evidently most respondents prefer treatment to be provided wholly or partly outside of industry. The choice between these alternatives is divided evenly where problem drinking is

concerned. Indications are that organizations at present are more likely to partake in alcohol programmes than previously, 44,4 % preferring exclusive external treatment as compared with 75,6 % in 1971.

Opinions on the treatment of drug abuse and emotional problems differ significantly. The former is considered a problem mainly to be dealt with outside the organization, whereas a greater extent of internal involvement is accepted where emotional problems are concerned.

Reasons put forward for preferring external treatment and rehabilitation include statements to the effect that the number of cases encountered do not warrant the provision of internal facilities or staff, that expert help is available outside of the organizations, and in a few instances that organizations cannot be held responsible for health problems of this nature.

Arguments in favour of involvement of both the organization and outside facilities express the desirability of joint action for therapeutic reasons. Depending on the severity of the condition internal help can be supplied or cases can be referred for specialized help elsewhere. A number of respondents are of the opinion that treatment or follow-up of treatment in the work environment where a person normally spends most of his time is also required and even preferable.

Practical assistance on the part of the organization include matters such as leave policies with regard to employees needing time off for treatment and medical aid benefits to afford such treatment. The first of these is expressed in leave policies as summarized in Table 13.

TABLE 13

LEAVE POLICIES WITH REGARD TO EMPLOYEES NEEDING TIME OFF FOR RECOVERY OR REHABILITATION
(N = 36 ORGANIZATIONS)

	ALCOHOL	DRUGS	EMOTIONAL
Regular paid sick leave only	27,8 %	22,2 %	33,3 %
Regular paid leave only	5,6 %	5,6 %	13,9 %
Unpaid leave only	2,8 %	0,0 %	2,8 %
Regular paid sick leave followed by unpaid leave	30,6 %	22,2 %	25,0 %
No leave; termination only termination only	2,8 %	5,6 %	0,0 %
Other	33,3 %	33,3 %	25,0 %
Omissions	0,0 %	11,1 %	8,3 %

Significantly more organizations provide sick leave with or without additional paid and unpaid leave than organizations providing regular or unpaid leave, or no leave at all. There are however a number of variations not covered in the table, and these are applied with some flexibility according to merit and circumstances.

Where other variations are added approximately 76 % of the organizations provide some form of regular and extended sick leave as compared to 31 % in 1971. This seems to reflect a change of attitude and a greater acceptance of alcoholism as an illness. The present data do not reveal significant differences in policies with regard to the different problem areas considered. The American survey reports similar leave policies in dealing with drinking and emotional problems. For drug abuse, however, fewer companies provide regular paid sick leave and there are more terminations without any leave. Also there are more omissions of this question. Conceivably, in the absence of a clear policy on drug abuse action tends to be more severe than in the case of drinking or emotional problems.

TABLE 14

EXTENT TO WHICH MEDICAL AID BENEFITS COVER ANY PART OF THE COST OF TREATMENT
(N = 36 ORGANIZATIONS)

	ALCOHOL	DRUGS	EMOT IONAL
Yes	47,2 %	38,9 %	80,6 %
No	50,0 %	50,0 %	11,1 %
Omitted	2,8 %	11,1 %	8,3 %

Table 14 reflects the extent to which medical aid benefits cover any part of the cost of treatment. Responses with regard to the treatment of alcoholism are divided approximately evenly between positive and negative. In response to a similar question in the 1971 survey, only 24,5 % of respondents reported the availability of such aid. This supports the general trend of progress since 1971 also observed in Table 13 with regard to the treatment of alcoholism. The discrepancy between the availability of time and financial aid is however also apparent.

Similarly, in the area of drug abuse the division between affirmative and negative responses is not significant, but more respondents seem to be uncertain as to whether employees are covered or not. There is also some degree of uncertainty in the area ,of emotional disturbance, but significantly more respondents indicate the provision of medical aid benefits than for either alcoholism or drug abuse.

The above deviates from the American findings (1970) in that less aid is provided for the treatment of drug addiction in American companies. Similarly, however, emotional problems are better covered than drinking problems.

With regard to both leave policies and medical aid benefits, a few respondents indicated differential treatment according to the level of employment.

Table 15 summarizes opinions expressed on the employment of rehabilitated workers, other things being equal. On the whole, positive attitudes are reflected, and if omissions are added to uncertain responses, it would seem that significantly few organizations are unequivocally opposed to the employment of such persons. This is particularly true in the case of alcoholism, which may reflect greater familiarity, experience, and success with alcohol programmes.

TABLE 15

EMPLOYMENT OF REHABILITATED PERSONS OTHERWISE CONSIDERED SUITABLE FOR A POSITION
(N = 36 ORGANIZATIONS)

	ALCOHOL	DRUGS	EMOTIONAL
Yes	69,4 %	55,6 %	52,8 %
Uncertain	22,2 %	30,6 %	36,1 %
No	8,3 %	8,3 %	5,6 %
Omitted	0,0 %	5,6 %	5,6 %

The next item in the questionnaire (Table 16) involves a certain degree of value judgement. It concerns the basic question of whether organizations should become involved in personal problems of employees or not. On the other hand it should be kept in mind that the problems described in the questionnaire were to a greater or lesser extent all defined in terms of organizational performance or relevance.

TABLE 16

OPINIONS ON WHETHER ORGANIZATIONS SHOULD BECOME INVOLVED IN PERSONEL PROBLEMS OF EMPLOYEES
(N = 36 ORGANIZATIONS)

	ALCOHOL	DRUGS	EMOTIONAL
As a rule, yes	72 ,2 %	72 ,2 %	69,4 %
As a rule, not	5,6 %	5,6 %	8,3 %
Sometimes (state circum-stances)	22,2 %	22,2 %	22,2 %

Table 16 shows more positive than negative or conditional responses in each of the problem areas. Among the conditions stated were the position of the particular employee in the organization, length of service, the severity and nature of the case, individual characteristics of the employee and the nature of his job requirements. Last but not least the willingness of the employee to accept help and receive treatment was mentioned.

Additional comments volunteered by respondents include a number of problems, some of which may be peculiar to the particular organization and others of a more general nature. These include a tendency on the part of line management to discredit attempts at rehabilitation as a result of past experience with cases of relapse, an increase in the use of marijuana among migrant labourers, the inability of some members of organizations to adapt to organizational change and development, the problem of identification where medical diagnosis is obscured by other health problems, and the lack of treatment facilities particularly for some employee groups. The need for research to explain the high incidence of alcoholism is also mentioned.

Other comments indicate the importance of early recognition, that some degree of self-help and personal responsibility is also required, the importance of co-operation between organization and external treatment facilities for feedback of results and follow-up activities in the work environment. The need for managerial support in the execution of policy is also emphasized.

On the whole, commentary suggests a generally tolerant attitude where the employee is willing to co-operate.

CONCLUSION

This survey was undertaken to assess the scope of certain mental health problems in work organizations and ways these are being dealt with by management. It also served as a follow-up of an investigation conducted a decade earlier to ascertain whether significant trends have occurred. Finally, it served as a basis for comparing the local position with data reported elsewhere.

The general pattern emerging from the data reflects a growing awareness of and concern for problems of this nature, particularly in the area of alcoholism. This is closely followed by emotional problems, but a good deal of uncertainty in the area of drug abuse is apparent.

Due to problems of identification the incidence of cases reported are probably underestimated. In as far as figures are comparable the present data nevertheless reflect a substantial increase over those reported a decade earlier in both local and American surveys. Even if the present figures are accepted they represent considerable cumulative effects on productivity and human welfare.

Recognition of these problems has not lead management generally to introduce formal policies to deal with such cases. Procedures commonly employed however reveal a shift in the direction of professional help rather than disciplinary measures or a laissez-faire approach only. There is also a greater use of internal counselling facilities and liaison with external treatment resources, particularly where alcoholism is concerned. This area is probably dealt with in a better organized manner, whereas more leniency in the case of emotional disorder and stricter measures in the case of drug abuse are in evidence. Frequency of cases and the nature of facilities available no doubt are determining factors, but there are indications of an appreciation of the importance of joint action on the part of management and community. Practical assistance in the form of paid sick leave and medical aid benefits for purposes of treatment reflect a greater recognition of such conditions as health problems, and the social responsibility of organizations in this regard, apart from considerations of good business and personnel management.

Questions on the moral obligation of management, the reemployment of rehabilitated persons, and additional comments by respondents seem to reflect a generally tolerant attitude where the employee is willing to co-operate, and a considerable latitude to treat cases on merit.

Despite indications of progress, at least in certain problem areas and among the larger organizations better equipped to deal with such problems systematically, there remains much to be done by way of education and the provision of treatment facilities if the requirements for a mentally healthy work force set out in the introduction to this paper, are to be fully met. Concerted effort on the part of government, industry and community will be required to an even greater extent in future to mould positive attitudes and ad hoc aid into co-ordinated policies and programmes.

ABSTRACT

A survey was undertaken to assess the scope of certain mental health problems in work organizations and ways these are being dealt with by management. The general pattern emerging from the data reflects a growing awareness of and concern for problems of this nature, particularly in the area of alcoholism. This is closely followed by emotional problems but a good deal of uncertainty in the area of drug abuse is apparent. Concerted effort on the part of industry and community is required to mould positive attitudes and ad hoc co-ordinated policies and programs.

REFERENCES

Du Plessis, G.M. Mental health in industry. *Public Health*. 1973, *73*. 269-279.

Financial Mail Special Survey: Top Companies. April, 25, 1980, 23-34.

Louw, E. Alcoholism and the employer - A positive policy. *Rehabilitation in South Africa*. 1974, *18*(33), 75-79.

Miner, J.B. & Brewer, J.F. The management of ineffective performance. In Dunnette, M.D. (Ed.) *Handbook of Industrial and Organizational Psychology*. Chicago, Rand McNally, 1976, 995-1029.

Vlok, A. Die probleemdrinker en sy werkgewer. In Blignaut, F.W. (Red.) *Verslag van die Projek Alkoholisme: Die persoonlikheid en behandeling van die alkoholis in Suid-Afrika*. Deel IV. Pretoria, R.G.N., 1971.