The Appropriate Model for Occupational Social Work and EAPs in South Africa: An Occupational Social Work Perspective

A Research Report

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Requirements for

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By

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8805489/T

May 2006

DEDICATION

To my mother

The artistic great-granddaughter of the Pedi and Venda people

Thank you for your guidance, love, support and encouragement since our formative years!

Molepa a boyang Tjelele lehweteng ga mmanaka tše dinaro!

You will always be a source of strength!

By God's grace,

O gole o kake tlou tšhukudu go wena ebe mošimanyana

Tsoma wešo mabothekwo bolatana!

Wa bo morula wa sepe senkgela batopi o nkgetše le baphodi ba marula!

Tlou!

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University of the Witwatersrand

May 2006

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I would like to extend sincere gratitude to the following people, who, in their own different ways, contributed to my personal growth and development and in a way the completion of this study:

- My wife, Deliwe, and our three sons, Thabang, Nkateko and Tshepo, who continuously make life enjoyable and worth walking that extra mile.
- My sisters and brother, Mokgadi, Khomotjo and Mapatla who, true to their names, made growing up a continuous enriching worthwhile exercise.
- My parents Motlalahothle and the Late Kobeni who recently passed on, my grandmother Ditshwanttšhi, my uncles and aunts whose upbringing and tutelage instilled values and principles which continue to instinctively guide my approach to life. Thank you for the education of life no other school could ever offer.
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- Sasol Mining's senior management whose continuous support, financial and otherwise, and practical engagement at work has enabled me to fast track my professional growth and development a thousand fold.
- Last but certainly not least, my research supervisor, Dr. Tebogo Mabe, and, the staff in the Discipline of Social Work at the University of the Witwatersrand, whose input continuously provided clarity of thought and direction in the completion of the study.

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May 2006

SACHRA 2005 PRESIDENTIAL GALA DINNER 9 APRIL 2005

A toast to South Africa

William Senoamadi

Colleagues

Ladies and Gentlemen

The closest you can ever get to a toast in African Culture is praise singing. So brace yourselves for the longest toast ever.

Lets us fill our glasses for a country where everything is just what it was supposed to be.
A country where the little town of Kommetjie that guards our shores in the South is just where it was supposed to be in much the same way as the ruins of Mapungubwe in the North are exactly where they are supposed to be. A country where the vast platelands of the Free State are kept in equilibrium by the peaceful village called Poding Tse Rolo in the Southern tip acting in perfect harmony with the industrialised town of Zamdela and Sasolburg in the northern tip.

To a country where our neighbours are exactly who they are supposed to be. A country where just next door the inhospitable dusty sands of Namibia are perfectly balanced by the beauty of Lake Malawi and Mozambique. A country where in the north of our borders the madness of a leader is perfectly juxtaposed by the beauty of Harare, Victoria Falls, and, the tranquillity of Lake Kariba. A country where just up north, the dull boring Botswana is a constant reminder of what ought to be.

A country where the ostriches and sheep that proudly strides the semi deserts of the Karoo and Oudtshorn are situated exactly where they were supposed to be in much the same way as the potatoes of Bethal, the mealies of Zeerust and the tomatoes of gaDikgale & Moeketsi in Limpopo are exactly where they are supposed to be.

The place where the gold of the Free Sate and Gauteng, the Platinum of Limpopo and North West are exactly where they are supposed to be in much the same way as the vast coal to fuel fields of Mpumalanga are just where they were meant to be.

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand

May 2006

This is a country where the blistering sun of Upington is perfectly balanced by the wetlands of St Lucia and the Wild Coast in much the same way as the Boabab trees of the Limpopo are just where they were supposed to be.

A country where Deliwe, the beautiful great granddaughter of the Swazi and the Shangaan people, married just who she was supposed to marry, Phatelang, the handsome great grandson of the Pedi and Venda people.

The place where Queen Modjadji of the Balobedu, King Molotlegi of the Bafokeng, King Zwelithini of the Zulus, King Moshoeshoe of the Basotho, King Mphephu of the Venda and King Holomisa of the Xhosa people are exactly who they were supposed to be in much the same way as the post 1994 past, present and future national presidents are exactly who they were meant to be.

Colleagues, this is a country where the past, present and future presidents of SACHRA are exactly who they are supposed to be in much the same way as the secretary of the colliery associations is just who it was supposed to be.

Ladies and gentlemen! Let us drink this toast in unison to a country where everything fits perfectly.

To South Africa!

©William Senoamadi

Sasol Mining (Pty) Ltd

First presented at the SACHRA Gala Dinner on 9 April 2005 where the writer was requested to propose a toast to South Africa.

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University of the Witwatersrand

May 2006

ABSTRACT

A casual scan of workplace based mental health services in South Africa reveals a developing tendency and trend towards the outsourcing of this service. Most companies that previously boosted relatively huge integrated and comprehensive workplace mental health services have ceased offering these services internally in favour of sourcing them from external service providers. Most occupational social workers who previously worked in these departments are now part of the outsourced services. Occupational social work theory advocates for practitioners to go beyond focusing on the individual by also seeking to impact on the environment and the community in the quest to serve the needs of their clients. Some services, particularly if the practitioner seeks to change the host organisation, are easier to render when the practitioner is within the organisation. The present study investigated, using robust statistical methods, firstly, the desirability of comprehensiveness and integration in workplace mental health services, and, secondly, whether observed levels of comprehensiveness and integration in service delivery in a single organisation that uses outsourced workplace mental health services are in line with desired levels. The research results indicate that host organisations desire more comprehensiveness and integration in workplace mental health services than is currently observed from an outsourced mental health service.

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand

May 2006

TABLE OF CONTENTS

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand

May 2006

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand

May 2006

LIST OF FIGURES

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand

May 2006

LIST OF TABLES

P.W. Senoamadi (8805489/T)
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School of Human and Community Development
University of the Witwatersrand

May 2006

CHAPTER 1: INTRODUCTION

1.1 Introduction

This chapter contains a brief background of the host company where the research was conducted, Sasol Mining, the rationale for the study, and the aims of the study. The chapter concludes with a detailed discussion of the research methodology.

1.2 Company Background

The study involves an investigation into occupational or rather workplace mental health services at Sasol Mining (Pty) Ltd. Sasol Mining is a wholly owned subsidiary of Sasol Limited, a South African public company with a strong international presence. Sasol Limited owns a number of companies in mainland Europe, Britain, Asia, the United States of America, the Middle East and closer to home Botswana, Mozambique, Nigeria, and, of course, South Africa; to mention but a few. Sasol employs well over 30 000 employees across all business units globally and generates annual revenues in excess of US$65 million (www.sasol.com).

Sasol Mining is the biggest single employer within the Sasol Group of companies and employs over 7200 employees. Of these, 20% are employed in professional, supervisory, management and staff positions, 60% in unskilled or semiskilled positions and a further 20% in skilled artisans and miners categories. The company

P.W. Senoamadi (8805489/T)
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School of Human and Community Development
University of the Witwatersrand
May 2006

owns 7 collieries of which two are in Sasolburg and 5 in Secunda which mine coal used by downstream Sasol businesses in the production of fuels and other products. Sasol Mining forms the beginning of the Sasol value chain and produces between 40 and 50 million tons of coal per year. Most of the coal produced by Sasol Mining is used in downstream activities, by other Sasol subsidiaries such Sasol Synfuels, Infrachem, Natref etc, in the production of high value added petro-chemical products ranging from petrol, diesel, jet fuel, mining explosives, fertilizer, paraffin to plastics and input a range of products used in the production of detergents etc. A small portion (± 3.5 million tons) of the coal mined in Secunda is exported to European markets (www.sasol.com).

Along with other Sasol business units Sasol Mining previously boosted internal occupational/workplace mental health services until the services were discontinued in 1996/7 mainly due to cost cutting measures and transformation interventions geared towards the refocusing of the company to generate improvements in productivity. Owing to these transformation initiatives, improvements in company results were impressive for Sasol Mining with production and company profitability increasing from 700 to 1500 tons per production machine per shift and R200 million to well over R1 billion between 1996 and 2003 respectively. These phenomenal achievements resulted in Sasol Mining wining the Global Coal Company of the Year Award, beating all coal-mining companies across the world, including, Europe, USA, China, Australia, South America etc (www.sasol.com).

P.W. Senoamadi (8805489/T)
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School of Human and Community Development
University of the Witwatersrand
May 2006

In 2001/2, Sasol Mining, along with other Sasol companies, introduced workplace mental health services for employees. On re-introduction, these services were outsourced to a well known reputable provider of workplace mental health services. The reintroduction of workplace mental services constituted part of the bigger repositioning of Sasol's Human Resources strategy that prioritized, amongst others, employee care as a key strategic thrust and along with this the introduction of a holistic HIV/AIDS intervention program.

1.3 Rationale for the study

Workplace mental health services in South Africa have evolved from the previous reality where big organisations employed a multi-functional team of occupational social workers, psychologists and other mental health professionals to render a range of psychosocial services to employees to the current scenario where these services are outsourced to an external party. Indeed, in the period up to the mid 1990s mining giants and petro-chemical companies such as Anglo American, Gencor, Harmony Gold Mines, and Sasol had relatively huge internal mental health services departments rendering services to employees at micro, meso, and macro levels. Social workers and other mental health professionals employed in these organisations had access to the decision-making machinery of the host organisation through the Human Resources Departments or company Hospitals.

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

Occupational social work services and workplace mental health services in general, outsourced or internal, must of necessity posses distinguishing characteristics that separate them from other mental health services rendered by sister organisations such as Family and Marriage Association of South Africa (FAMSA), local hospitals, government departments, private mental health practitioners etc. If this were not the case, companies would not have started these services in the workplace as they could simply rely on the nearby communities to do so.

The staff compliment of internal workplace mental health services or Psychosocial Services Departments, as they were then called, included psychiatrists, social workers, psychologists, and occupational therapists. For instance, in the early to mid 1990s Anglo American's Psychosocial Services Department in the Free State employed approximately 28 mental health professionals constituted of nineteen (19) occupational social workers, one (1) occupational therapist, one (1) psychiatrist, 4 psychologists and three (3) administration staff[1]. Other workplace mental health departments in the sister gold mines in the Carltonville, Klerksdop and Witwatersrand areas were also structured along these lines.

In the late 1990s to early 2000s, a worrying trend started to develop, a trend that demonstrated a general reduction of internal workplace mental health services to

[1] The writer worked in this department at Anglo American's Freegold Mines in the Free State during this period.

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

staff compliment of only one or two practitioners, mostly occupational social workers. The hitherto integrated psychosocial services departments were outsourced and no longer formed part of the host organisation's hierarchy.

It is clear that in South Africa today, the manner in which workplace mental health services are rendered is fundamentally different when compared to the early 1990s. These changed circumstances beg serious questions that occupational social work practitioners and other workplace mental health practitioners should be pondering with, i.e. what is the appropriate model for workplace mental health services in South Africa? Are the desired intervention levels for workplace mental health services and the concomitant occupational social work the same regardless of whether the services are internal or outsourced?

1.4 Aims of the study

This study sought to explore the appropriate model for workplace mental health services in South Africa through:

- An analysis of the desirability of comprehensiveness and integration in workplace mental health services, and,
- a comparison of the extend to which observed levels of comprehensiveness and integration are in line with desired levels through a modest study involving a single organisation, viz Sasol Mining (Pty) Ltd, that utilises an outsourced Employee Assistance Program (EAP) service.

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

1.5 Research methodology

1.5.1 Sampling procedures, research tools and data collection

A sample of ninety five (95) subjects consisting of middle, senior and executive managers and human resources practitioners at all levels at Sasol Mining was drawn randomly from the total population of five hundred and thirty one (531) people. The total sample constituted 18% of the total population of the relevant line managers and human resources practitioners.

A single questionnaire was designed; asking respondents to rate, on a five (5) point Likert scale, the extend to which specific workplace mental health services were desirable and the extent to which these services were observed from the organisation's external workplace mental health service (See Appendix B for the questionnaire). The research questionnaire consisted of approximately fifty (50) questions categorised into the following dimensions: (1) counselling/clinical services, (2) organisational services, (3) community services (4) accessibility of services, and, (5) relevance or appropriateness of services. Each of the dimensions tested was composed of a series of questions, the aggregate of which constituted the sum total of services for that dimension. The selection of the dimensions was based on the Frank and Streeter model which is considered an appropriate model for occupational social work practice in South Africa (Du Plessis, 1990).

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

The following meanings were attached to each number on the rating scale:

1 = strongly disagree

2 = disagree

3 = neither agree nor disagree

4 = agree

5 = strongly agree

Of the ninety five (95) questionnaires distributed, thirty two (32) questionnaires were returned. Of these, three (3) questionnaires were discarded as they were partially completed and the remaining twenty nine (29) questionnaires that were completed in full were used for the study. The twenty nine (29) questionnaires used represent at least 31% and 5% of the sample and the total population respectively. The high number of correctly completed questionnaires indicates that the research questions were valid, reliable and understandable.

1.5.2 Pre-testing

The research questionnaire was pre-tested to 10 respondents, to determine the validity and reliability of the questions. The results of this pilot study were not included in this study as they were solely used to make adjustments to the questionnaire prior to final distribution and application.

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

1.5.3 Data analysis

The results obtained for the variables tested were averaged to obtain a rating for each of the dimensions tested. This approach assumes equality of interval of the Likert scale and therefore the data was regarded as at least interval, rather than ordinal, during the process of testing for statistical significance. The results were subjected to two sets of tests, the *t*-test and the Tukey-Kramer procedure.

1.5.3.1 T-Test for Differences in the Means

A two-sample *t*-test was performed to determine if there was any statistical significance in the differences between the means of the two sets of a same sample study (Berenson and Levine, 1989; Cooper and Schindler, 2001; Levine et al, 1999).

The significance testing was based on the following hypotheses:

Null hypothesis H_O: $\mu_1 = \mu_2$ (the mean of desired = the mean of observed)

Alternative hypothesis H_A: $\mu_1 > \mu_2$ (the mean of desired> the mean of observed).

Alpha (α) =0.05 or 95% confidence level.

The null hypothesis was rejected if the calculated *t*-test statistic (t_{calc}) was found greater than the upper critical value (t_{crit}).

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

The decision rule for this study was as follows:

Reject H_O if ($t_{calc} > t_{crit}$)

Otherwise do not reject H_O

Taking into account all relevant factors t_{crit} of 1.672522103 was calculated using Microsoft Excel. Thus based on the above decision rule the null hypotheses was accepted if t_{calc} was equals to or less than 1.672522103.

Acceptance of the null hypothesis was used as confirmation that observed levels of comprehensiveness and integration in the delivery of workplace mental health services provided by an outsourced workplace mental health service was in line with the desired levels. Conversely, rejection of the null hypothesis served as confirmation that observed workplace mental health services provided by an outsourced workplace mental health services were not in line with desired levels of comprehensiveness and integration in the provision of workplace mental health services.

1.5.3.2 The Tukey-Kramer Test

The statistical tool for testing differences between the means of more than two independent samples (c means) is the analysis of variance (ANOVA). The Tukey-Kramer Test was used for the testing of ANOVA. The test statistic for ANOVA is the F-ratio, that is the ratio between the between-groups and the within groups (Berenson and Levine, 1989; Cooper and Schindler, 2001; Levine et al, 1999).

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

A hypothesis testing was based on the following:

Null hypothesis H_O: $\mu_1 = \mu_2 = \mu_3 = \mu_4$

Alternative hypothesis H_A: The means are not equal

Alpha (α) =0.05 or 95% confidence level.

The decision rule for this test will be based on the following:

Reject H_O if ($F_{calc} > F_{crit}$)

Otherwise do not reject H_O

The purpose of the Tukey-Kramer test was to establish, if anything, which of the c means were significantly different from each other. The procedure compared the actual differences between the c means with the upper critical value which was obtained from the studentised range distribution.

1.6 Summary

Workplace mental health programs in South Africa have evolved from the previous reality where these services were offered internally to the current reality where these services are sourced from outside the organisation. This study sought to (1) investigate whether comprehensiveness and integration is desired from a workplace mental health service, and (2) whether the observed levels of comprehensiveness and integration in service delivery are in line with the desired levels. A single

P.W. Senoamadi (8805489/T)
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School of Human and Community Development
University of the Witwatersrand
May 2006

questionnaire was designed and distributed to a sample of 95 respondents drawn from a population of 531. Of the 95 questionnaires distributed at least 32 were returned. Of these 29 were used for the purpose of the study whilst 3 questionnaires were discarded as they were not completed in full. Two statistical tests, the *t*-Test and the Tukey-Kramer procedure, were conducted to determine whether there was any statistical significance in the differences between the means of the desired and the means of the observed and whether the differences in the means can be explained by some other arbitrary factors.

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter discusses the concept of work as both a source of meaning and difficulty to men and women. The second section of this chapter discusses workplace mental health services and starts with the definition of workplace mental health services and their distinguishing characteristics in comparison to their community counterparts. The third section of this chapter discusses EAPs and their focus areas and draws a distinction between the international and the South African approach. The latter focuses mainly on clinical one-to-one counselling services, which is considered inadequate and unable to address the holistic needs of employees. Lastly, this chapter introduces the Frank and Streeter model and generic social work practice theory as the antithesis of the flaws in the current South African EAP approach.

2.2 Work and its Contradictions

The centrality of work to the very being of human existence is well documented. Karl Marx, whilst lamenting the lack of worker control on the means of production, saw work as a potentially liberating activity (Googins and Godfrey, 1987: 52). Freud viewed work as a conduct of life that attaches the individual firmly to reality and a means through which individuals gain a secure place in the community (Ibid).

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

According to Freud "the communal life of human beings has a two-fold foundation, the compulsion to work…and the power of love" (Neff, 1985).

In an article entitled *On Human Work,* John Paul II, elevates work to higher spirituality and describes it as a way of sharing in the activity of the Creator (see Gaburro and Cressotti, 1998, O'Boyle, 1990; O'Boyle, 2005; Wisman, 1998). According to Pope John Paul II, work enables man to achieve self-creation and to express and augment his dignity (Wisman, 1998). In fact according to the Pope, "…*the primary basis of the value of work is man himself*, who is its subject... in the final analysis it is always man who is *the purpose of the work*, whatever it is that is done by man…. The word of God's revelation is profoundly marked by the fundamental truth that *man,* created in the image of God, *share by his work in the activity of the Creator*…" (O'Boyle, 528: 2005).

O'Boyle (1990), concurs with John Paul II's analogy of work but goes further to equate work with physical need which, taken together, constitute the two most "fundamental needs that flow directly from the materiality of human nature" and arrives at the conclusion that through work individuals achieve two things, individual development and belonging. According to this perspective, individual development occurs because through work and at the workplace, individuals gain skills, become more independent and achieve self-determination. By the same token, work takes place through teams and this achieves a sense of belonging as

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

people socialize in teams, communicate with one another cooperate, blend and develop interpersonal bonds (Ibid). In fact, O'Boyle (1990) elevates the sense of belonging achieved at work to a higher status and equates the role played by the workplace environment with that of the family. Consequently, O'Boyle argues that "teams…become workplace families that provide some assurance that the individual members are not alone in meeting their own physical needs…and the needs of their dependents…Man needs to belong in order to survive because, he cannot meet his material needs on individuality alone" (O'Boyle, 39: 1990).

The significance of work to people is also reflected in daily interactions when mundane questions like 'what do you do' are asked. Without exception, everyone immediately responds by explaining the type of work they do and the company they work for with unparalled pride and enthusiasm. All other roles the incumbent plays in society are temporarily forgotten. The fact that one is also a father, a husband, a mother and perhaps even a volunteer in the local community does not seem to matter. It is clear therefore that through work individuals develop and acquire their identity, social standing in the community, recognition and a sense of fulfillment. In short, work gives people meaning and a sense of purpose in life. But there is the other side to work.

Work can also be a source of stress and great difficulties experienced by men and women. In a paper presented to a conference on "Work, Family and Health",

P.W. Senoamadi (8805489/T)
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School of Human and Community Development
University of the Witwatersrand
May 2006

Wislnack examines the importance of work for the individual's wellbeing and specifically states that work related stress often leads people to consuming alcohol in larger quantities and in less desirable ways (in Beach and Martin 1995). In a British study on occupational ill-health, statistics collected showed that "55 per cent of all reported cases of stress/depression and half of all reported cases of exhaustion were perceived as being caused by work" (Bradley and Sutherland, 5: 1994). Factors leading to work induced stress range from job demands to the fast changing work environment. Dewe (1994) predicts that the coming periods will be characterised by an increasingly troubled workforce owing to the fast changing work environment of mergers, acquisitions, job losses and restructuring as these factors often lead to uncertainty and fear among workers.

The contradiction that work can be both the source of meaning and stress to people is further complicated by the fact that in other roles, as members of society, as parents and grandparents, men and women are continuously faced with daily demands that are in themselves sources of personal difficulties. In fact, Bartlett (in Simmons and Aigner, 1985) correctly illustrated this phenomenon when describing how the demands placed upon people emanate from the various life situations. "These have to do with daily living, such as growing up in the family, learning in school, entering the world of work, marrying and rearing a family, and also with the common traumatic situations of life such as bereavement, separation, illness, or financial difficulties" (Bartlett, 1970 in Simmons and Aigner, 1985).

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

It is commonly accepted that people do not leave their private and personal problems at home when they come to work and further that individuals cannot function to their fullest potential when they are plagued by difficulties due to the continuous "interaction between personal and working lives" (Clement, 18: 1998; www.sundaytimes.co.za). A combination of work and non-work related troubles can disable people and prevent them from playing their work roles effectively. Research highlights the multiple levels of interdependence between individual mental and physical health and the spheres of family and employment (Baca-Zinn and Eitzen, 1989). These realities enabled the penetration of helping professions in the workplace.

2.3. Workplace mental health services

2.3.1 Workplace mental health services defined

The term workplace mental health service is used to refer to services rendered in the work environment for the purpose of the improvement and sustenance of the mental well-being of employees and their families. Workplace, mental health services are not necessarily an extension of other mental health services available in the community. Instead, workplace mental health services are different from other mental health services in a fundamental way and indeed possess some key characteristics that distinguish and separate them from other mental health services.

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University of the Witwatersrand
May 2006

The first obvious difference is the fact that the chosen field of practice for workplace based mental health services is the workplace and the targeted recipients of services are employees whilst other mental health services are normally community based and render services to a broad spectrum of people.

Most community based mental health services focus on a specific field of mental health. Examples include:

- Family and Marriage Association of South Africa (FAMSA) whose main focus is the mental wellbeing of families,
- National Institute for Crime Prevention and Rehabilitation of Offenders (NICRO) which focuses on the rehabilitation of criminal offenders,
- Child Welfare whose area of interest is the mental wellbeing of children, and,
- The South African National Council on Alcoholism and Drug Dependence (SANCA) which deals with the rehabilitation of people with substance dependency problems etc.

Other community based mental health services, such as provincial and local government mental health service departments, deal with all issues pertaining to the mental wellbeing of their clientele and are not specializing in any field. Just as

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School of Human and Community Development
University of the Witwatersrand
May 2006

community based mental health services reflect a broad spectrum of specialist and non-specialist services, workplace mental health services also have a fair share of specialist and non specialist services. Typically, specialist services in the workplace tended to be mainly alcohol, substance abuse rehabilitation and stress management programs (Bradley and Sutherland, 1994; Chadderton and Milne, 1994).

Furthermore, workplace mental health services are different from their community counterparts in that they are more or less deeply embedded into the organisational processes of the host company, they are part of the organisational discourse and reflect and nourish the organizational culture, organizational learning, problem solving and adaptation mechanisms (Berridge and Cooper, 5: 1994). "This is unlike some external counselling which can be opposed to the values of work; it is also different from much of traditional welfare provision which is designed to counteract or offset the damaging effects of work" (Ibid). In fact, workplace mental health services support the values of work and the host organisation and normally seek to achieve better alignment between the individual and organisational needs.

2.3.2 About EAPs

Berridge and Cooper (1994) define the EAP as "a programmatic intervention at the workplace, usually at the level of the individual employee, using behavioural science knowledge and methods for the recognition and control of certain work-and non work-related problems, (notably alcoholism, drug abuse and mental health) which

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School of Human and Community Development
University of the Witwatersrand
May 2006

adversely affect job performance, with the objective of enabling the individual to return to making her or his full work contribution and to attaining full functioning in personal life". It is clear from the definition that the main focus of EAPs is on the individual whereby the objective is mainly to assist the individual employee to overcome work or non work related difficulties.

Like other parts of the world, EAPs were introduced in the South African workplace to assist employees with their personal problems due to the recognition that people cannot perform to their fullest potential when they are experiencing difficulties. According to the Services SETA, EAPs are necessary because "ideally we should all be able to separate work from home. But increasingly, outside stresses and problems are affecting many employees' performance at work. People are finding it more difficult to cope and the result is loss of productivity and growing absenteeism". Naturally, "this affects an organisation's own productivity and profitability" (www.serviceseta.org.za). The role of EAPs therefore, is to mitigate possible losses on productivity and reduce absenteeism by assisting employees deal with their difficulties more effectively (Annonymous, 2004).

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MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

Elsewhere, EAPs focus on a number of issues. According to Berridge and Cooper (1994) a detailed list of EAPs focus areas includes the following:

Table 1 Counselling issues of EAPs

AIDS	Grievances	Relocation
Alcohol Abuse	Indebtedness	Retirement
Bereavement	Induction	Sexual harassment
Career development	Job training	Smoking
Lay-off	Stress (work related)	Chronic illness
Demotion	Legal matters	Stress (extrinsice)
Disability	Literacy & education	Substance abuse
Discipline	Marital problems	Verbal abuse
Divorce	Performance evaluation	Violence
Family problems	Physical fitness	Vocational guidance
Financial advice	Promotion	Weight control
Gambling	Racial harassment	Women's career
Goal setting	Redundancy	Young worker's problems

Source: Berridge and Cooper (1994)

Services offered by EAPs in most countries, particularly the US, New Zealand and Britain include a wide range of services rendered at individual, family and organisational level. The South African EAP community has chosen five focus areas as key priority areas for EAP interventions. These are HIV/Aids, loss and trauma, stress, managing people with disabilities and substance abuse and has developed a website providing detailed Toolkits to EAP practitioners on how to deal with each of these problems (www.serviceseta.org.za). However, there are major concerns with the South African EAP approach. Firstly, the identified focus

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May 2006

areas constitute only a fraction of issues facing the employers and their employees. Secondly, the identified services mainly lend themselves to interventions at the level of the individual. Furthermore, a perusal of South African Services SETA's EAP website and conference papers presented at previous EAP National Conferences clearly indicates that the focus of EAPs in South Africa is on the individual and not so much about the individual's surrounds (see Anonymous, 2003; Anonymous, 2004; Gasson, 2003, Matlhape, 2003; Sission, unknown). This is not incidental and mainly derives from the orientation of the professionals running the EAPs. In South Africa, EAPs are often led by sister professionals other than social workers whose background training focuses more on the individual than their environment.

Whilst methods of operation differ from one EAP service to another, a typical process in the handling of these problems involves a set of common approaches amongst all EAPs (Roman and Blum, 1985; Berridge and Cooper, 1994). In most instances, EAP intervention, begins with identification of impaired job performance of an employee and this serves as the main source for referral for EAP assistance. Once the employee has been referred, he or she would have a series of one to one therapeutic sessions with an EAP practitioner with a view to identifying and assisting the employee to overcome difficulties that were the source of their impaired performance. Just as impaired performance originated or rather necessitated intervention by the EAP, improved performance of the employee emanating from the successful resolution of the employee's problems would then

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May 2006

mark the conclusion of the EAP intervention. "[T]he technique at the heart of the EAP is employee counselling, defined by the British Association for Counselling thus: "the task of counselling is to give the client an opportunity to explore, discover, and clarify ways of living more resourcefully and toward a greater well-being" (Berridge and Cooper, 6: 1994)

However, the services offered by EAPs and the modus operandi as illustrated above, are mainly inclined towards changing the individual with little attempt at impacting the environment which might as well be the source of problems. But problems do not always originate from within the individual. The dogmatic focus on changing the individual is not enough since problems do not always originate from within the individual. As it happens, the employee's surroundings are in some cases major sources of personal difficulties and changing the individual will not solve problems if the individual is not the source of those difficulties. Commenting on a somewhat different subject matter, Ballé (1994) correctly makes the point that unsolved problems will always come back and laments the fact that "[w]e naively believe that the future will be very much like the past, only bigger and better, and today's losers will catch up somehow if we just keep at it…. As a result, 'problems' keep cropping up and, true to our philosophy we then spend a lot of time and effort 'problem solving'. Yet this is not enough" (Ballé, 1994: 15-16).

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May 2006

A holistic approach to the helping process is necessary because to quote Donella Meadows, "[t]he bottom line message….is quite simple: the world is a complex, interconnected, finite, ecological–social–psychological–economic system. We treat it as if it were not, as if it were divisible, separable, and infinite. Our persistent, intractable global problems arise directly from this mismatch. No one wants to generate hunger, poverty, pollution, or eliminate the species. Very few people favour arms races or terrorism or alcoholism or inflation. Yet those results are consistently produced by the system–as–a–whole, despite many policies and much effort directed against them. Many social policies work: they solve problems permanently, but some problems consistently resist solution in many cultures and over long periods of time. Those are the problems for which a new way of looking is required" (in Ballé, 1994: 40). Some of the answers to these complex interconnected problems in the helping process can be found in occupational social work. A perusal of current university curriculum for occupational social work indicates a clear focus on the individual, the environment, and the community thereby ensuring a systems approach in the helping process.

2.3.3 Generic social work practice

Occupational social work draws its practice methods, principles and values from mainstream social work practice; hence, it is appropriate that a discussion of occupational social work is preceded by the definition of social work and a brief delineation of the practice principles and the practice methods.

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May 2006

Several authors sought to define the core themes of social work in many different ways. In 1959 Boehm defined social work as a profession that "seeks to enhance the social functioning of individuals, singly and in groups by focusing upon their social relationships which constitute the interaction between man and his environment". Germain and Gittermain (1980) defined social work as being concerned with "relationships between human beings and their interpersonal and organizational environments, with helping to modify or to enhance the quality of transactions between people and their environments, and with seeking to promote environments that support human well being". Other definitions of social work practice include themes such as "helping people to achieve their life tasks", "helping people realize their individual and collective aspirations" "addressing socioemotional needs", "transactions between people and their environments" "making the surroundings more responsive to needs" (Pincus and Minahan, 1973; Konopka, 1983; Toseland and Rivas, 1984; Simmons and Aigner, 1985).

Simons and Aigner (1984) make a distinction between social work and psychology, on the one hand, and, social work and psychiatry on the other hand and note that "social work is concerned with the whole person. It focuses on the whole range of requisites for well being. Unlike clinical psychology and psychiatry, which are concerned only with psychological needs, social work considers the gamut of people's needs and goals; that is social work is concerned with the ability of

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May 2006

individuals to satisfy their basic needs, to accomplish the life tasks that confront them, and to realise aspirations and values" (Simmons and Aigner, 1985). It is clear that generic social work intervention seeks to address individual needs through impacting on the individual and the environment with a view to enhancing their ability to achieve their life tasks.

The other major aspect that separates social work practice from sister helping professions is the conceptualisation of the client system. Indeed social work has resisted the temptation of adopting the easy route of seeking to see the individual as the sole source of his/her psychosocial problems. Social work transcends the narrow definitions of the client by adopting a broader conceptual framework of the person-in-system approach (Toseland and Rivas, 12: 1984). In terms of this approach the individual employee is looked at in relation to his environment, including the company he works for and the surrounding community.

The focal point of social work practice is best described by Pincus and Minahan (1973) through their concepts of a client system and a target system. The concept of the client system is used to denote the fact that the beneficiaries of social work intervention may range from the individual, the family, the group, the organization to the community. On the other hand, the target system is used to indicate the fact that the object that needs to be changed to address the needs of the client system can be the individual, the organization, the group, or indeed the community.

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May 2006

Whether the one entity or the other becomes the target or client system depends on the nature and source of the problems at hand. Therefore, these distinctions are very important not only at a conceptual level but also at a pragmatic level as they determine the level at which social work interventions are pitched.

In addition to the distinction between the target and client systems, another useful concept used in social work practice is the concept of personal troubles and public issues. Borrowed from the sociologist, C. Wright Mills, the concept of private troubles refers to those difficulties that originate from within the individual and the solution of which can only be found by changing the individual (Pincus and Minahan, 14: 1973). In contrast, when the problem originates from within the organization, such as when many people are experiencing the same difficulty, the focal point of social work intervention becomes the organization or community that produced those social ills (Pincus and Minahan, 14: 1973). The dynamism inherent in the social worker's ability to intervene at the level of the individual, the organization and community levels is enabled by an array of a body of knowledge, skills and helping tools especially designed for each form of intervention.

Essentially, social work uses three main forms of intervention, viz. social casework for intervening with families and individuals, social group work when seeking to achieve intrapersonal and interpersonal change and community work when seeking to change the organization, institutions or the community (McKendrick, 1988).

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May 2006

McKendrick (Ibid), specifically makes the point that, in practice, the social worker will use the skills and tools demanded by the issues at hand because "no effective social work practice can be concerned exclusively with either individual change or environmental change". This is true because the social worker "engaged with individuals and families, or with small groups, must also be concerned with the environment that affects clients' well-being; while the practitioner engaged in community work works with larger groups composed of individuals and sub-groups, and to be effective must also have skills in working at these levels". (Ibid) The detailed discussions of the social work helping methods are beyond the scope of this paper. For now, suffice to emphasise that unlike sister helping professionals social workers in an occupational setting have a rich body of knowledge, skills, helping tools and methods to address needs of employees and their families regardless of the origin or the source of those problems (McKendrick, 1988; Perlman, 1957; Heap, 1978; Konopka, 1983, Toseland and Rivas, 1984).

2.3.4 About occupational social work

The realm of occupational social work and the concomitant area of the provision of mental health services in the workplace have previously received lot of attention and debates. These debates ranged from the necessity of social work practice in the workplace, the workplace as a valid field of practice; to the nature and form such practice should take.

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University of the Witwatersrand
May 2006

A 1960 study by Dlamini into the role of social work in the workplace effectively invalidated the workplace as a field of social work practice (Du Plessis, 1990). Dlamini believed that social work was no different from personnel management and thus postulated that personnel managers could simply assume the role of dealing with employees' personal problems. In 1974, Marcow's study found pockets of occupational social work in South Africa (Ibid). Whilst this showed the broadening of the practice base for social workers, Marcow raised concerns that there was little knowledge amongst practitioners of relevant literature and that due to lack of contact there was no homogeneity in the field.

In 1983 Abramowitz and Epstein raised concerns that social work in the workplace could service corporate ends rather than a humanitarian agenda thereby assuming a conservative rather than a progressive character of the field (Abramowitz and Epstein, 1983, 13). While Patel expressed reservations about unfair advantages given to the employed over their counterparts, she noted that such services could be highly successful owing to the availability of a captive group for traditional social work interventions (Patel, 1991: 20).

In 1991, Du Plessis presented a model developed by Frank and Streeter as a conceptual framework for the role of social workers in an occupational setting. The Frank and Streeter Model is based on generic social work theory and proposes three

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May 2006

dimensions that should set out and shape the role of an occupational social worker. Graphically, the Frank and Streeter model can be presented as follows:

Table 2: Frank and Streeter Model – The role of an occupational social worker

Level of intervention	Individual	Organisation	Community
	Cell 1	**Cell 2**	**Cell 3**
Nature of intervention	- Diagnostic Assessment - Counselling - Referral - Information - Group Work	- Human Resource Development - Program Planning - Evaluation - Mediation - Team Building	- Corporate giving - Public Relations - Industrial Development - Consumer Education
	Cell 4	**Cell 5**	**Cell 6**
	- Diagnostic Ass - Counselling - Day Care - Alcohol and Drug Treatment	- Needs Assessment - Organisational Development -Strategic Planning - Advocacy	- Economic Development - Research - Mediation - Policy Analysis - Lobbying

(Source: Du Plessis, 1991)

This model acknowledges the individual employee as the client whilst taking into account the reality that factors from the immediate environment as well the transactions between the person and the environment have a major influence on the individual's normal functioning. In accordance with this model, social work interventions must focus on either the environment or the person, depending on the source of difficulties.

The Frank and Streeter model enables the occupational social worker to go beyond a limited focus of addressing problems at an individual (micro) level to also focusing on the organisation (meso) and the community (macro) levels depending on the

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May 2006

nature and the source of the problems. This dynamic occupational social work intervention is in line with a systems' approach to dealing with problems and difficulties facing men and women in the workplace. A systems approach provides a superior technique in assisting people deal with problems such as stress, alcohol and drug dependency, HIV/AIDS and other difficulties. This allows occupational social workers to use the "uniqueness of their location to intervene in the broader systemic and policy issues in the workplace and beyond that impact on worker and community well being" (Du Plessis, 1990: 230). This model is superior because it transcends the narrower focus of most EAPs' predominant clinical approach to helping employees. An integrated systems approach to dealing with difficulties experienced by employees such as the one proposed by Frank and Streeter offers opportunities for comprehensiveness and integration in service delivery.

2.3.5 Comprehensiveness and integration defined

Throughout this article, there is a continuous reference to the concepts of comprehensiveness and integration in the delivery of mental health services in the workplace. But what is comprehensiveness and integration? Dewe (1994), defines these terms by reminding practitioners of the various levels of intervention in the helping process, viz primary, secondary and tertiary levels. Linked to the three levels of intervention, services are comprehensive and integrated when efforts to improve mental wellbeing dynamically focus on the individual, the organisation or the community based on the identified cause of the difficulties at hand.

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May 2006

Comprehensiveness is necessary because interventions that focus on the individual employee alone become irrelevant and only offer partial solutions if they "place all the onus on the individual, or fail to recognise the wider contextual-structural issues" within which behaviour takes place (Dewe, 25: 1994).

Therefore, services are comprehensive and integrated if interventions can dynamically take place at any of the three levels, i.e. the individual, the organisation or the community on the one hand while the practitioner is able to render primary, secondary and tertiary services across all intervention levels on the other hand. This is important because the mental health practitioner is no longer constrained by the limitations associated with single focused orientations. In practice, the practitioner starts by determining the nature and the source of the problem and if the source of the difficulty lies with the organization then the organization becomes the object for intervention. Conversely, the same also applies where the community is the source of difficulties. To illustrate, a workplace mental health practitioner intervenes at organizational levels when working with stakeholders to alter the working environment in order to reduce the incidence of stress among employees. A workplace mental health practitioner intervenes at a community level when working with the nearby community to address problems experienced by employees due to the lack of early childhood development facilities. The key aspect in this approach, as Lazarus (1991) suggested, is to view the individual in a

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May 2006

relationship with the work environment rather than seeing the work environment and the individual as two separate entities to be manipulated individually.

2.4 Outsourcing as business strategy

The act of outsourcing has been a major feature of the business landscape nationally and in other parts of the world. Previous writers defined outsourcing as "….having an outside vendor provide a service that you usually perform in-house", or "…paying other firms to perform part or all of the work" or "deciding to obtain selected goods and services from outside the company" (Laabs, 1997; Structural Cybertics, 1996; in Embleton and Wright, 1998). According Kakabadse and Kakabadse (2000) outsourcing is "a form of predetermined external provision with another enterprise for the delivery of goods and/or services that would previously have been offered in house" involving companies divesting from "peripheral and supplementary businesses in order to focus on core business' and vertical deintegrating" (Kakabadse & Kakabadse, 670: 2000). Although outsourcing initially involved a move away from peripheral or supplementary activities, Winterton (2005), postulates that the outsourcing trend grew in popularity in recent years resulting in the development of extreme forms such the outsourcing of manufacturing and human resources.

The main reason for outsourcing is normally the "achievement of competitive advantage" over competitors (Hines and Rich, 1998), the need to save costs and the

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May 2006

need to focus on the core business of the company. In case of the former, businesses outsource certain functions such the production of inputs when those inputs are readily available in the market and can be obtained cheaper (Blumberg, 1998; Embleton and Wright, 1998; Kakabadse and Kakabadse, 2000). In the case of the latter, outsourcing takes place in order to relieve company resources, including managerial time from the burden associated with managing the outsourced services. According to Power *et al.* (2004), many organisations are naïve about cost savings because these are not always realised in most organisations and that in instances where cost savings are achieved, such savings are reversed in the long run. The most plausible advantage and perhaps the main reason for most outsourcing initiatives involving such functions as payroll, human resources departments, occupational health departments and indeed workplace mental health services is the need for the company to focus on the core business rather than to be distracted by what is considered peripheral activities (Blumberg, 1998; Power 2004; Martin, 2004).

However, outsourcing does not denote to the downscaling of expectations regarding the range of services, performance levels and desired organizational impact from the outsourced services. If this were the case, companies would simply adopt the strategy of ending the provision of those services rather than sourcing the services from the external environment. In light of this fact, it therefore follows that the outsourcing of workplace mental health services was motivated mainly by

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May 2006

the need for companies to focus on core business and further that these services, albeit being externalised, are in fact considered essential for the success of the business.

2.5 Summary

Contradictions inherent in the concept work are that for men and women work serves as both a source of meaning and a source of stress and personal difficulties. Employees find themselves in a precarious situation because in addition to work induced stress men and women experience personal difficulties in their other roles as parents, grandparents and members of society. These difficulties can be very debilitating and thus making it difficult for employees to fulfil their work roles effectively. This necessitated the introduction of mental health services in the workplace.

Workplace mental health services, internal or otherwise, have distinguishing characteristics that differentiate them from their community counterparts in that; they are fully rooted within the company and are part of the host organisation's discourse and culture. In addition, whilst the workplace mental health services support and seek to enhance the values of work and profitability of the host company, some community counterparts might as well be the antithesis of the values of work, productivity and profitability of companies.

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May 2006

Two major forms of workplace mental health services discussed in this chapter are EAPs and occupational social work. The focus of EAPs is to assist the individual employees overcome work and non-work difficulties. Generic social work practice values and principles require that interventions focus on the inter-relationships between the individual and their environment. The Frank and Streeter Model of occupational social work provide opportunities for comprehensiveness and integration in service delivery. Workplace mental health services are considered comprehensive and fully integrated if the practitioner is able to intervene at the primary, secondary and tertiary levels on the one hand and if the practitioner is able to intervene at the individual, organisation and community level on the other hand. The essence of comprehensiveness and integration is that the practitioner is not constrained by the narrow focus of always seeking to change the individual.

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May 2006

CHAPTER 3: EMPIRICAL FINDINGS AND INTERPRETATION OF RESULTS

3.1 Introduction

This chapter contains the presentation, discussion and interpretation of research results. The chapter starts with a presentation of the demographics, which shows that the sample or rather the composition of respondents perfectly reflected the population. The chapter ends with a detailed discussion of the substantive results obtained from the study covering each of the dimensions tested.

3.2 Demographics

3.2.1 Gender

The distribution of respondents is reflected in figure 1 below:

Figure 1 Distribution of respondents by gender

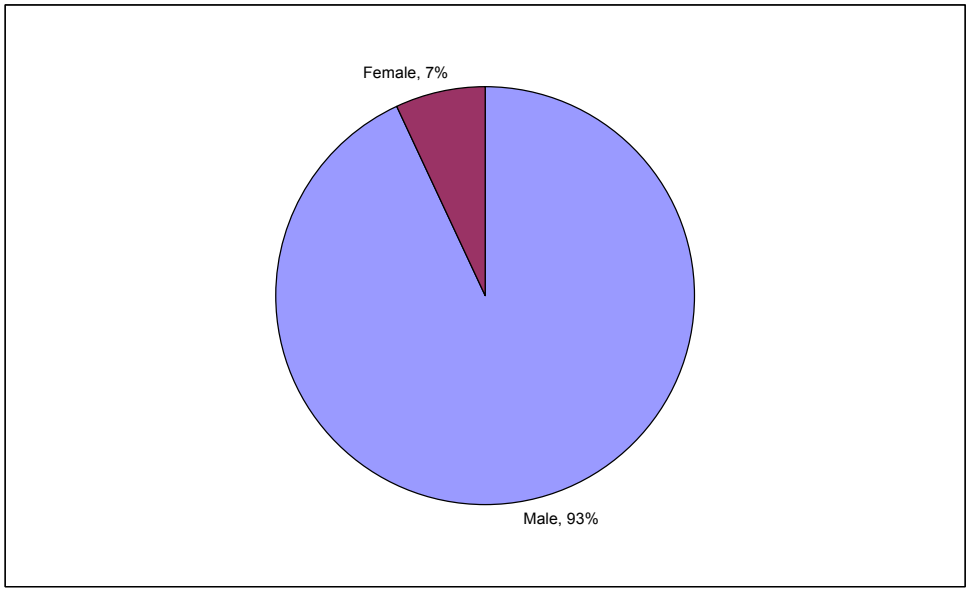

Figure 1 indicates that of the twenty nine (29) respondents, 93% were males and 7% females. The high representation of males in the sample is due to the demographic composition of Sasol Mining employees. The demographics of Sasol Mining

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May 2006

employees pretty much reflect those of the mining industry in general, which generally shows a high concentration of males over females.

3.2.2 Occupational level

The detailed breakdown of the respondents by occupational level, is in Figures 2 below:

Figure 2: Breakdown of respondents by occupational level

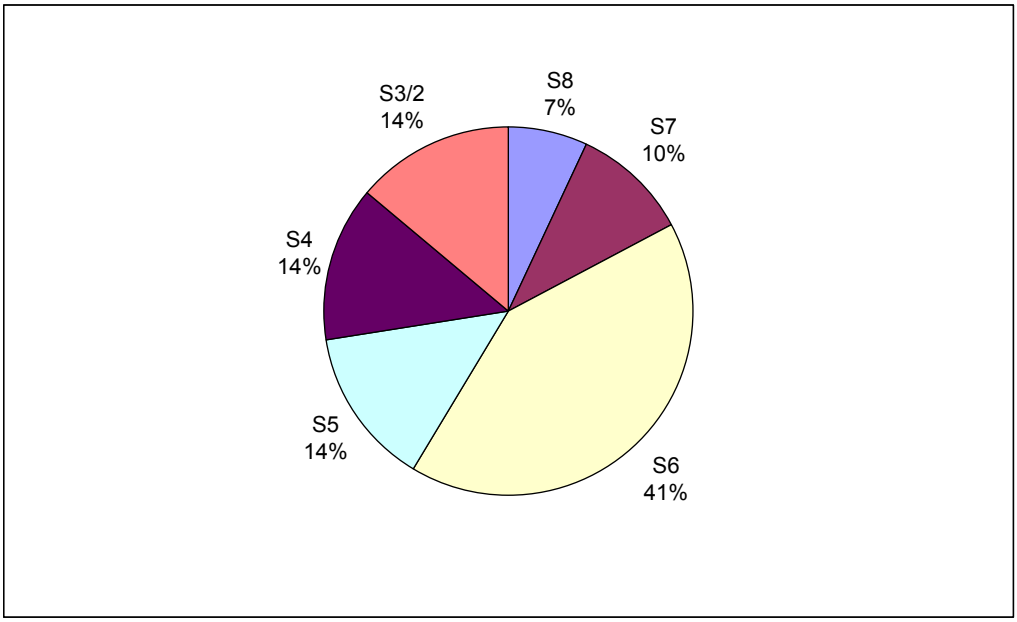

Figure 2 above indicates that all occupational levels in the Salaried Personnel[2] category were equally represented in the sample. This is significant, as this category consists mainly of decision makers within the company as well as originators of most referrals to workplace mental health practitioners.

[2] Overall, the classification of employees generally fit the following descriptions: S3/2 = Top Management, S4/5 Senior Management, S6 & 7 = Middle Management and S8 High Level skilled and clerical positions (Swanepoel et al (2000).

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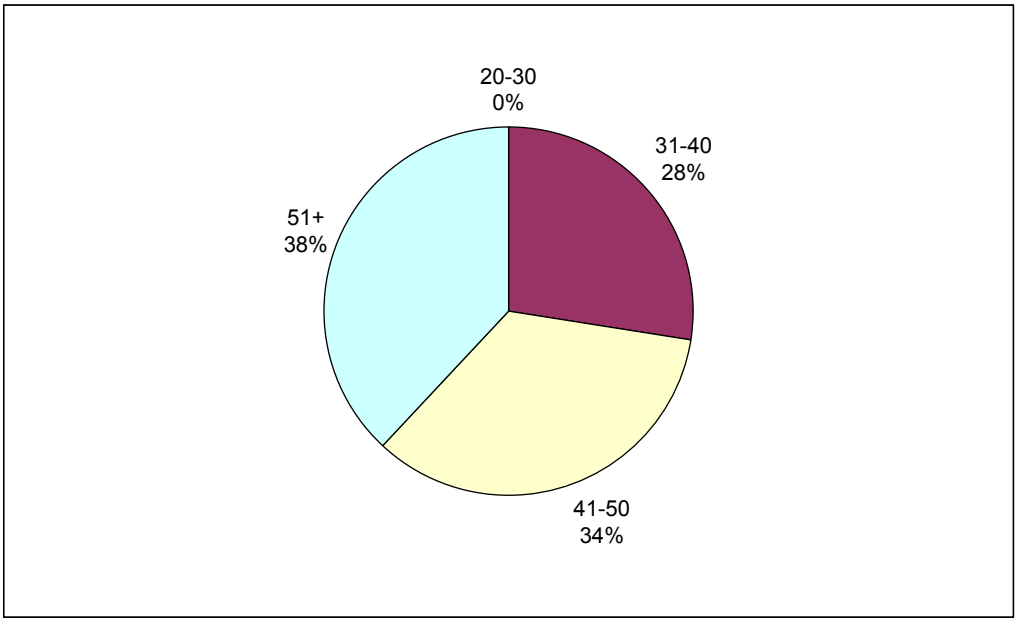
May 2006

Of major importance is the equal spread between decision makers and people involved in referral, viz 42% for S5, S4 and S3/2, and 58% for S8, S7 and S6 respectively. Overall, the results confirmed that the composition of respondents by occupational level represented the target population adequately.

3.2.3 Age

Figure 3 below indicates that a major portion of respondents, i.e seventy two percent (72%) is at least 41 years old and higher.

Figure 3: Breakdown of respondents by age



As the results indicate 28% of respondents were aged 31-40 years old, 34% 41-50 years of age and 38% 51 years of age and higher. The fact that the respondents were selected randomly from the total population confirms that the respondents' age is consistent with Sasol Mining's aging workforce..

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May 2006

3.2.4 Department

The breakdown of respondents by department is in Figure 4 below.

Figure 4: Breakdown of respondents by department

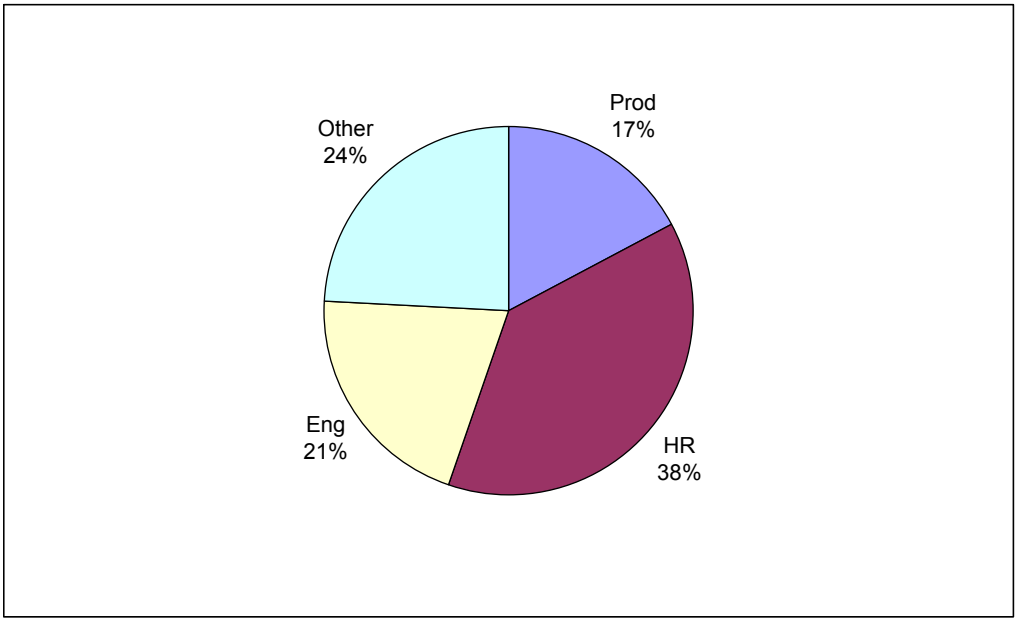

Figure 4 indicates that of the 29 respondents 38% worked in the human resources department, 17% in production, 21% in engineering and the remaining 24% in support services, procurement and supply management (PSM), transport, mineral rights and strategic capacity management (SCM) departments. The high representation of the human resources department in the sample is understandable considering the pivotal role played by the human resources practitioners as gatekeepers and a link between the company and mental health practitioners.

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May 2006

Overall, a closer examination of the demographics of the respondents indicates that the sample represented the population suitably and that the results obtained from the study are not due to some other arbitrary criteria such as age, sex, occupation or level. That the research results obtained are attributable to other factors other than the demographics of the respondents is confirmed by the Tukey-Kramer Test results tabulated in Tables 3 to 6 below. This conclusion is significant as it the implies that the research results reported in Figures 5 to 8 below are mainly attributable to phenomena inherent in the current workplace mental health services arrangements.

3.3 Clinical/counseling services

Respondents were required to indicate levels of desired and observed services for clinical one-to-one services. The results for this dimension indicate that the null hypothesis was accepted for at least three focus areas under this dimension viz. helping employees deal with marital problems, HIV/AIDS, industrial trauma and depression. This indicates that there is congruence between observed and desired services for interventions geared towards assisting employees deal with marital problems, HIV/AIDS issues, industrial trauma and depression. On the other hand, the results show that observed services from the outsourced workplace mental health service provider were far lower than the desired levels regarding interventions for stress and substance abuse. According to the *t*-Test results the biggest gap between the observed and desired service levels is on services geared

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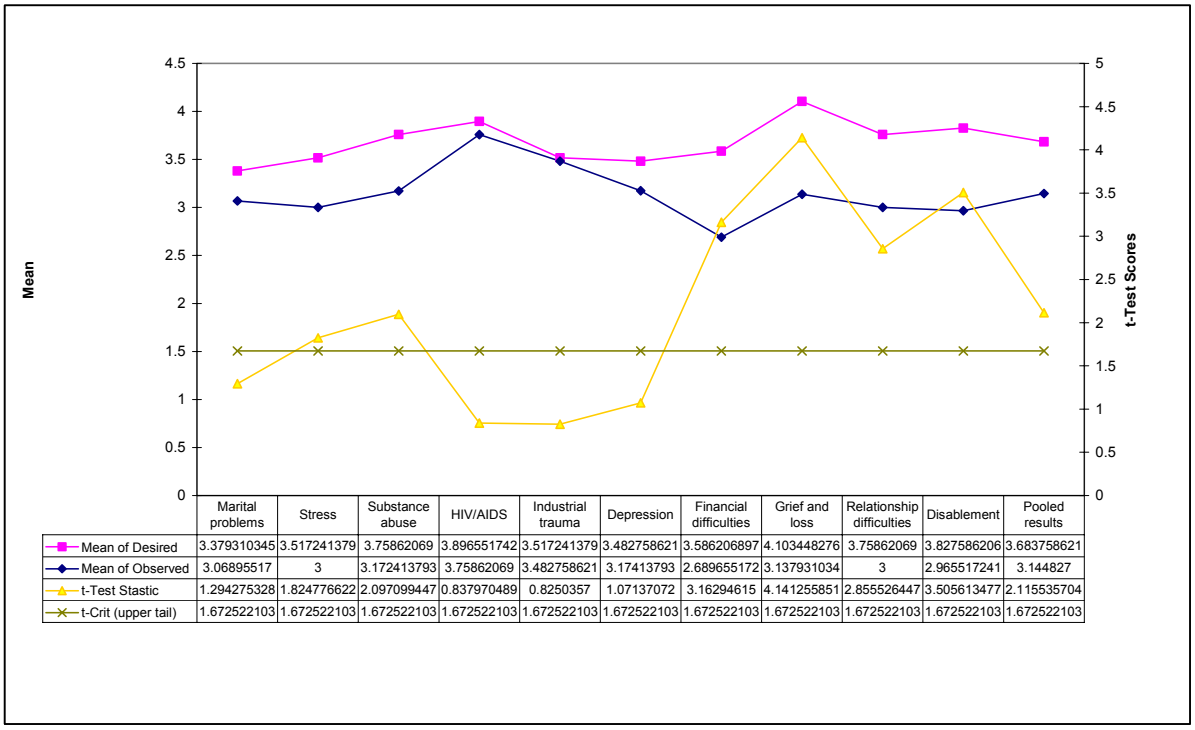
University of the Witwatersrand
May 2006

towards helping employees deal with financial difficulties, grief and loss, relationship difficulties and disablement.

Figure 5: Mean scores and *t*-Test scores clinical/counselling services



	Marital problems	Stress	Substance abuse	HIV/AIDS	Industrial trauma	Depression	Financial difficulties	Grief and loss	Relationship difficulties	Disablement	Pooled results
Mean of Desired	3.379310345	3.517241379	3.75862069	3.896551742	3.517241379	3.482758621	3.586206897	4.103448276	3.75862069	3.827586206	3.683758621
Mean of Observed	3.06895517	3	3.172413793	3.75862069	3.482758621	3.17413793	2.689655172	3.137931034	3	2.965517241	3.144827
t-Test Stastic	1.294275328	1.824776622	2.097099447	0.837970489	0.8250357	1.07137072	3.16294615	4.141255851	2.855526447	3.505613477	2.115535704
t-Crit (upper tail)	1.672522103	1.672522103	1.672522103	1.672522103	1.672522103	1.672522103	1.672522103	1.672522103	1.672522103	1.672522103	1.672522103

The results indicated in Figure 5 above further indicate that the null hypothesis was also rejected for the pooled results thereby indicating that overall, the current observed service levels for clinical one-to-one counselling services were below the desired levels. At this level, workplace mental health services currently rendered by the an outsourced mental health service are lower despite South African services SETA identifying some typical one-to-one services as priority areas for EAPs in South Africa, viz, stress, substance abuse and disablement services. Stress and

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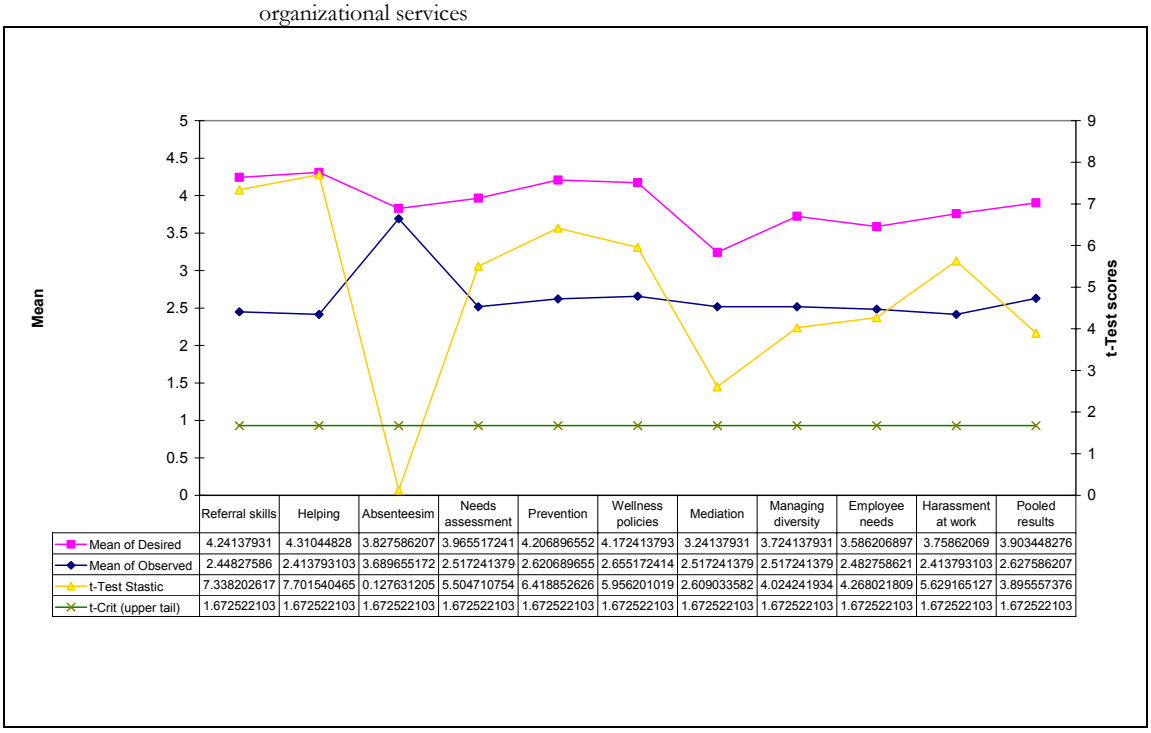
May 2006

substance abuse problems need urgent attention, as they constitute major issues for the South African workforce.

3.4 Organisational services

Respondents were required to answer ten (10) questions to test for the levels of desired and observed services for organisational services. The results for this dimension are reported in Figure 6 below.

Figure 6: Mean scores and *t*-Test scores for organizational services



	Referral skills	Helping	Absenteesim	Needs assessment	Prevention	Wellness policies	Mediation	Managing diversity	Employee needs	Harassment at work	Pooled results
Mean of Desired	4.24137931	4.31044828	3.827586207	3.965517241	4.206896552	4.172413793	3.24137931	3.724137931	3.586206897	3.75862069	3.903448276
Mean of Observed	2.44827586	2.413793103	3.689655172	2.517241379	2.620689655	2.655172414	2.517241379	2.517241379	2.482758621	2.413793103	2.627586207
t-Test Stastic	7.338202617	7.701540465	0.127631205	5.504710754	6.418852626	5.956201019	2.609033582	4.024241934	4.268021809	5.629165127	3.895557376
t-Crit (upper tail)	1.672522103	1.672522103	1.672522103	1.672522103	1.672522103	1.672522103	1.672522103	1.672522103	1.672522103	1.672522103	1.672522103

Figure 6 indicates that the null hypothesis for organizational services was accepted for one item only, viz. absenteeism, thereby confirming the adequacy of observed organisational services programs geared towards the reduction of absenteeism in the

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MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

workplace. The null hypothesis was rejected for all other items for the organisation services. This indicates that the inadequacy of the following, services from an outsourced workplace mental health service:

- Services geared towards the empowerment of managers with referral skills and basic helping skills,
- Continuous assessment of employee needs,
- Proactive anticipatory programs to prevent problems before they occur,
- Initiation of policies that will improve the mental wellbeing of employees,
- Mediating between conflicting groups to improve relations at work,
- Training for employees and managers on managing diversity and race relations better, and,
- Intervention programs to prevent harassment at work (including sexual harassment).

That the respondents believe the above organisational services are, if anything, inadequately attended to represent a major missed opportunity for outsourced workplace mental health services., an opportunity to impact on the mental wellbeing of employees in a fundamental way, viz. to prevent the onset of problems before they occur. Interventions at organisational services are anticipatory in nature and reach out to more employees, than the current South African EAP orientation of only focusing on one-to-one clinical counselling services, and can potentially yield

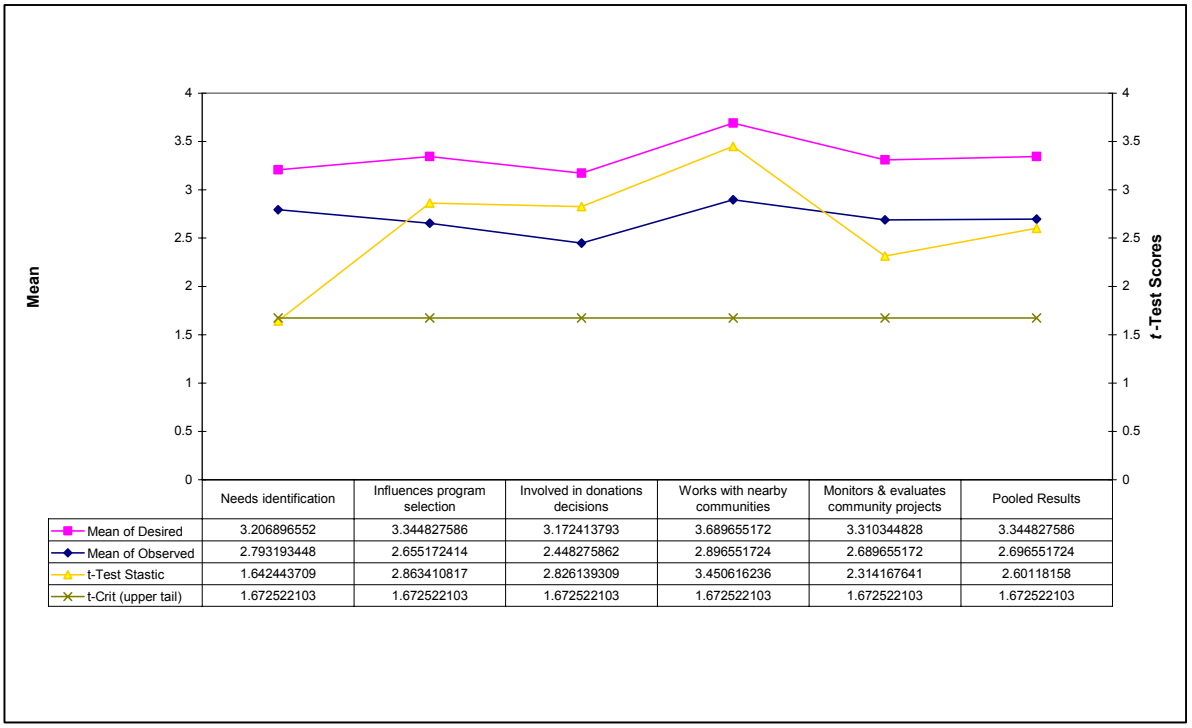
P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

greater results in terms of creating a healthy workforce thus contributing to the success of the host organisation.

3.5 Community services

The respondents were required to answer five questions to test for the levels of desired and observed levels for community services. The results for these dimensions are in Figure 7 below:

Figure 7: Mean scores and *t*-Test scores for community services



	Needs identification	Influences program selection	Involved in donations decisions	Works with nearby communities	Monitors & evaluates community projects	Pooled Results
Mean of Desired	3.206896552	3.344827586	3.172413793	3.689655172	3.310344828	3.344827586
Mean of Observed	2.793193448	2.655172414	2.448275862	2.896551724	2.689655172	2.696551724
t-Test Stastic	1.642443709	2.863410817	2.826139309	3.450616236	2.314167641	2.60118158
t-Crit (upper tail)	1.672522103	1.672522103	1.672522103	1.672522103	1.672522103	1.672522103

These research results indicate that the null hypothesis was accepted for needs identification indicating that the respondents were satisfied with the workplace mental health service's level of involvement in this aspect of service delivery. The

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

null hypothesis was however rejected for the other four aspects tested for the community services dimension. The results confirmed that the outsourced mental health service delivered lower than desired services levels regarding the following services:

- Assistance in the selection of community programs the company could support financially,
- Involvement in company decisions on donations the company could make to community projects,
- Collaboration with community organizations to address common problems that affect employees and the nearby community, and,
- Assistance in the implementation of mechanisms to monitor and evaluate the efficacy of community projects sponsored by the company.

The lower than desired observed community services represents yet another missed opportunity to address gaps in community services that make it difficult for employees to achieve their life tasks whilst also imparting skills to members of the community. The one example in this regard is the development of early childhood development facilities in the community. A company mental health practitioner who engages members of the nearby community to solve problems associated with the absence of early childhood development facilities addresses the immediate need

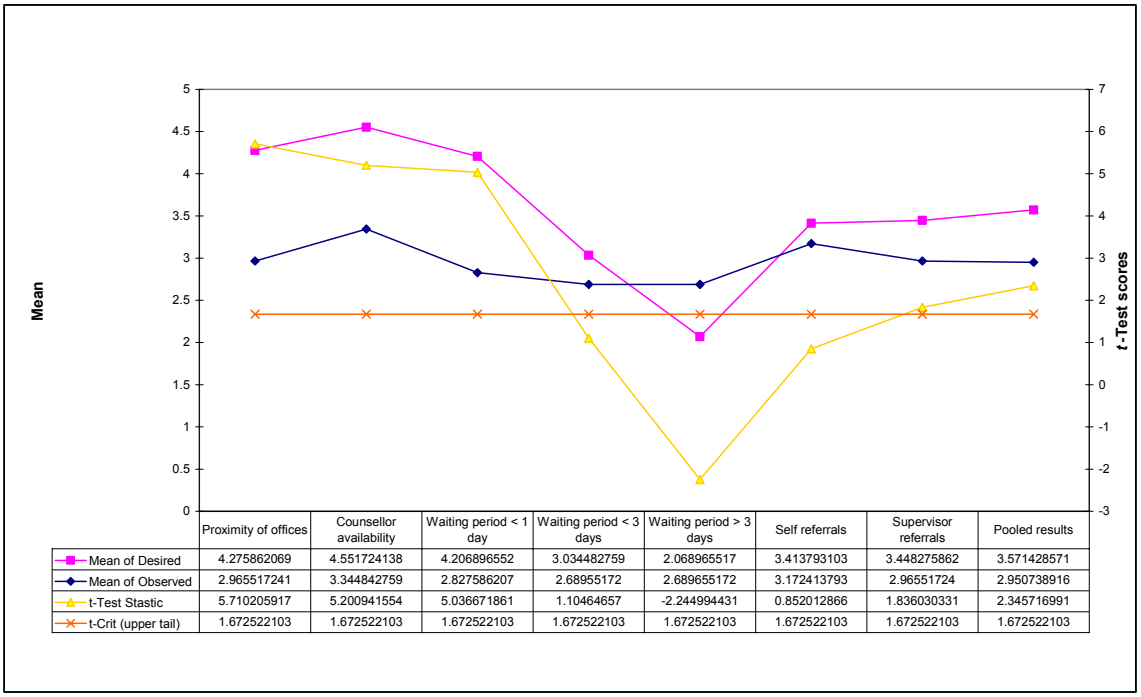
P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

for these facilities whilst also transferring skills and the needed know-how which will later be used by community members in solving other similar problems.

3.6 Accessibility

The study required respondents to answer seven (7) questions to determine whether observed levels of service accessibility were in line with the desired levels. The accessibility results are presented in the Figure 8 below:

Figure 8: Mean scores and *t*-Test scores for accessibility



	Proximity of offices	Counsellor availability	Waiting period < 1 day	Waiting period < 3 days	Waiting period > 3 days	Self referrals	Supervisor referrals	Pooled results
Mean of Desired	4.275862069	4.551724138	4.206896552	3.034482759	2.068965517	3.413793103	3.448275862	3.571428571
Mean of Observed	2.965517241	3.344842759	2.827586207	2.68955172	2.689655172	3.172413793	2.96551724	2.950738916
t-Test Stastic	5.710205917	5.200941554	5.036671861	1.10464657	-2.244994431	0.852012866	1.836030331	2.345716991
t-Crit (upper tail)	1.672522103	1.672522103	1.672522103	1.672522103	1.672522103	1.672522103	1.672522103	1.672522103

The research results for accessibility confirmed that currently counsellors are able to assist an employee within three days of the request having been made. On average waiting periods of longer than three days were neither desired nor observed. Furthermore, the null hypothesis was accepted for self and supervisor referrals

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

indicating congruence between observed and desired levels for these aspects of the accessibility dimension. This is good and actually indicates that under normal circumstances, the outsourced workplace mental health services are highly accessible. However, the results indicated accessibility problems pertaining to two important areas. These are:

- Proximity of the offices of the outsourced workplace mental health services to employees, and,

- Immediate availability of counsellors to assist and support employees and their families in case of a work related accidents.

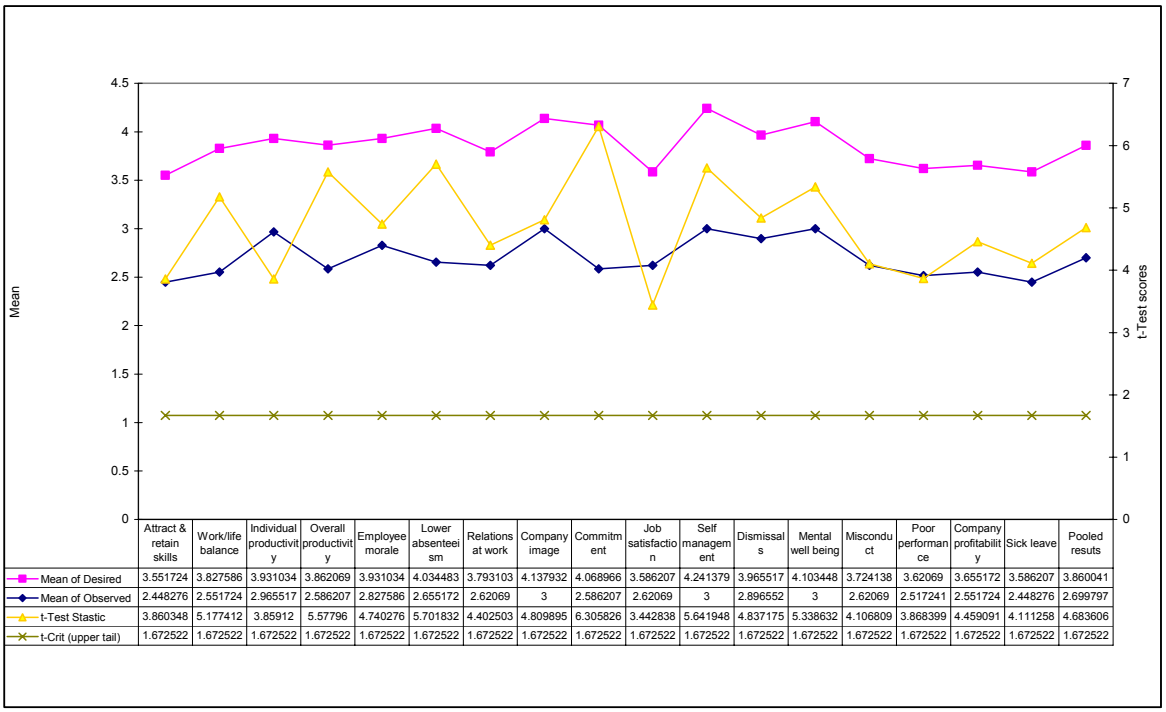
Overall, the outsourced mental health services are accessible to employees during the normal course of business. However, the respondents felt levels of office proximity and the swift availability of the mental health practitioners during crises were inadequate.

3.7 Appropriateness and relevance of services

Respondents were required to answer seventeen questions to determine the appropriateness and relevance of the current workplace mental health services. A summary of the results for this dimension is reported in Figure 9 below:

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

Figure 9: Mean scores and *t*-Test scores for the appropriateness/relevance of services



	Attract & retain skills	Work/life balance	Individual productivity	Overall productivity	Employee morale	Lower absenteeism	Relations at work	Company image	Commitment	Job satisfaction	Self management	Dismissals	Mental well being	Misconduct	Poor performance	Company profitability	Sick leave	Pooled resuts
Mean of Desired	3.551724	3.827586	3.931034	3.862069	3.931034	4.034483	3.793103	4.137932	4.068966	3.586207	4.241379	3.965517	4.103448	3.724138	3.62069	3.655172	3.586207	3.860041
Mean of Observed	2.448276	2.551724	2.965517	2.586207	2.827586	2.655172	2.62069	3	2.586207	2.62069	3	2.896552	3	2.62069	2.517241	2.551724	2.448276	2.699797
t-Test Stastic	3.860348	5.177412	3.85912	5.57796	4.740276	5.701832	4.402503	4.809895	6.305826	3.442838	5.641948	4.837175	5.338632	4.106809	3.868399	4.459091	4.111258	4.683606
t-Crit (upper tail)	1.672522	1.672522	1.672522	1.672522	1.672522	1.672522	1.672522	1.672522	1.672522	1.672522	1.672522	1.672522	1.672522	1.672522	1.672522	1.672522	1.672522	1.672522

The research results indicate that the *t*-Test Statistic came consistently higher than the *t*-Crit (Upper tail) for each of the items tested resulting in the rejection of the null hypothesis for all items tested for the dimension of appropriateness/relevance of the outsourced workplace mental heath services. According to the research results, the respondents could not observe any of the desired benefits from the current outsourced workplace mental health service.

A summary of the specific benefits found lacking in the current outsourced workplace mental health service is in Table 3 below:

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

Table 3: Benefits lacking in the current outsourced workplace mental health service

- Improved productivity of the company in general
- Improved work attendance and lower absenteeism
- Improved cooperation between employees and management
- Improved image of the company as a result of being seen as a caring employer
- Improved employee commitment to the company
- Improved job satisfaction of employees
- Improved employee ability to manage personal problems
- Lower rate of alcohol related dismissals
- Improved mental well being of employees
- Reduction of time spend reprimanding employees for misconduct/poor performance
- Improved profitability of the company
- Reduction in sick leave usage.

The fact that respondent could not observe any of these benefits in the current workplace mental health service indicates fundamental gaps in service delivery. Previous studies on workplace mental health services proved unequivocally that employees and employers would normally benefit from such services through reductions in absenteeism, improvements in productivity levels, lower alcohol related dismissals etc (Beach and Martin, 1995; Berridge and Cooper, 1994; Bradley and Sutherland, 1994; Du Plessis, 1991; Googins and Godfrey, 1987; Matlhape, 2003).

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

3.8 Tukey-Kramer Procedure

The Tukey-Kramer procedure was conducted to determine, if anything, which of the c means were significantly different from each. The purpose of this test was to compare if there were any significant differences between the means for the observed and desired results based on department and occupational level. The results for the Tukey-Kramer tests are reported in Table 4 to 7 below.

Table 4: Tukey-Kramer Test: Multiple Comparisons for Observed by Department

Tukey Kramer Multiple Comparisons

Group 1: Engineering		**Group 1 to Group 2 Comparison**		**Group 2 to Group 3 Comparison**	
Sample Mean	2.656463	Absolute Difference	0.323129	Absolute Difference	0.363265
Sample Size	6	Standard Error of Difference	0.457162	Standard Error of Difference	0.485843
Group 2:HR		Critical Range	1.846934	Critical Range	1.962807
Sample Mean	2.979592	**Means are not different**		**Means are not different**	
Sample Size	11				
Group 3: Other		**Group 1 to Group 3 Comparison**		**Group 2 to Group 4 Comparison**	
Sample Mean	2.616327	Absolute Difference	0.040136	Absolute Difference	0.16035
Sample Size	5	Standard Error of Difference	0.545448	Standard Error of Difference	0.43552
Group 4: Production		Critical Range	2.20361	Critical Range	1.759503
Sample Mean	2.819242	**Means are not different**		**Means are not different**	
Sample Size	7				
MSW	1.622801	**Group 1 to Group 4 Comparison**		**Group 3 to Group 4 Comparison**	
Q Statistic	4.04	Absolute Difference	0.162779	Absolute Difference	0.202915
		Standard Error of Difference	0.501146	Standard Error of Difference	0.527441
		Critical Range	2.024632	Critical Range	2.130863
		Means are not different		**Means are not different**	

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

Table 5: Tukey Kramer Test: Multiple Comparisons for Observed by Level

Tukey Kramer Multiple Comparisons

Group 1: S3 and S2		**Group 1 to Group 2 Comparison**		**Group 2 to Group 3 Comparison**	
Sample Mean	2.969388	Absolute Difference	0.362245	Absolute Difference	0.239116
Sample Size	4	Standard Error of Difference	0.551611	Standard Error of Difference	0.394358
Group 2: S4 and S5		Critical Range	2.22851	Critical Range	1.593207
Sample Mean	2.607143	**Means are not different**		**Means are not different**	
Sample Size	8				
Group 3: S6 and S7		**Group 1 to Group 3 Comparison**		**Group 2 to Group 4 Comparison**	
Sample Mean	2.846259	Absolute Difference	0.123129	Absolute Difference	0.443878
Sample Size	15	Standard Error of Difference	0.506896	Standard Error of Difference	0.712127
Group 4: S8		Critical Range	2.04786	Critical Range	2.876994
Sample Mean	3.05102	**Means are not different**		**Means are not different**	
Sample Size	2				
MSW	1.622801	**Group 1 to Group 4 Comparison**		**Group 3 to Group 4 Comparison**	
Q Statistic	4.04	Absolute Difference	0.081633	Absolute Difference	0.204762
		Standard Error of Difference	0.780096	Standard Error of Difference	0.678081
		Critical Range	3.151589	Critical Range	2.739447
		Means are not different		**Means are not different**	

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

Table 6: Tukey Kramer Test: Multiple Comparisons
for Desired by Department

Tukey Kramer Multiple Comparisons

Group 1: Engineering		**Group 1 to Group 2 Comparison**		**Group 2 to Group 3 Comparison**	
Sample Mean	4	Absolute Difference	0.461967	Absolute Difference	0.444474
Sample Size	6	Standard Error of Difference	0.346228	Standard Error of Difference	0.329838
Group 2: Human Resources		Critical Range	1.39876	Critical Range	1.332544
Sample Mean	3.538033	**Means are not different**		**Means are not different**	
Sample Size	11				
Group 3: Other		**Group 1 to Group 3 Comparison**		**Group 2 to Group 4 Comparison**	
Sample Mean	3.982508	Absolute Difference	0.017492	Absolute Difference	0.011502
Sample Size	7	Standard Error of Difference	0.379539	Standard Error of Difference	0.367949
Group 4: Production		Critical Range	1.533337	Critical Range	1.486515
Sample Mean	3.526531	**Means are not different**		**Means are not different**	
Sample Size	5				
MSW	0.930783	**Group 1 to Group 4 Comparison**		**Group 3 to Group 4 Comparison**	
Q Statistic	4.04	Absolute Difference	0.473469	Absolute Difference	0.455977
		Standard Error of Difference	0.41309	Standard Error of Difference	0.399453
		Critical Range	1.668885	Critical Range	1.613791
		Means are not different		**Means are not different**	

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

Table 7: Tukey Kramer Test: Multiple Comparisons for Desired by Level

Tukey Kramer Multiple Comparisons

Group 1: S3 and S2		**Group 1 to Group 2 Comparison**		**Group 2 to Group 3 Comparison**	
Sample Mean	3.586735	Absolute Difference	0.265306	Absolute Difference	0.151361
Sample Size	4	Standard Error of Difference	0.417758	Standard Error of Difference	0.298664
Group 2: S4 and S5		Critical Range	1.687743	Critical Range	1.206602
Sample Mean	3.852041	**Means are not different**		**Means are not different**	
Sample Size	8				
Group 3: S6 & S7		**Group 1 to Group 3 Comparison**		**Group 2 to Group 4 Comparison**	
Sample Mean	3.70068	Absolute Difference	0.113946	Absolute Difference	0.02551
Sample Size	15	Standard Error of Difference	0.383893	Standard Error of Difference	0.539323
Group 4: S8		Critical Range	1.550928	Critical Range	2.178866
Sample Mean	3.877551	**Means are not different**		**Means are not different**	
Sample Size	2				
MSW	0.930783	**Group 1 to Group 4 Comparison**		**Group 3 to Group 4 Comparison**	
Q Statistic	4.04	Absolute Difference	0.290816	Absolute Difference	0.176871
		Standard Error of Difference	0.590799	Standard Error of Difference	0.513539
		Critical Range	2.386829	Critical Range	2.074696
		Means are not different		**Means are not different**	

This Tukey-Kramer procedure is a *post hoc* test in that the hypothesis of interest is formulated after data collection and analysis of the results is completed (Levine et al, 1999). Overall, the results obtained from the Tukey-Kramer tests indicate that there are no significant differences in the means of the observed and desired when

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

these means are assessed in terms of departments and occupational level. It is obvious that subjection of the results to the Tukey-Kramer procedure base on other biographical data will yield similar result. This implies therefore that explanations for the results obtained in this study are not attributable to some other arbitrary factors such as occupational level or the respondents' respective departments.

3.9 Summary

The research results revealed that there is a gap between desired and observed services rendered by an outsourced workplace mental health service provider when these services are assessed against service provision levels of the Frank and Streeter model. Subjection of the research results to the Tukey-Kramer procedure confirmed that the research results are not attributable to some other arbitrary criteria such as the demographics of the respondents. This indicates therefore, that the current gap between desired and observed workplace mental health services can be explained by phenomena inherent in the manner in which outsourced mental health services are rendered.

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

CHAPTER 4: CONCLUSION AND RECOMMENDATIONS

4.1 Introduction

This chapter starts with conclusions obtained from this study. This is followed by the a presentation of recommendations to address the identified gaps in the provision of workplace mental health services and lastly the writer concludes this section with an identification possible areas for future research.

4.2 Conclusion

The results of this study confirmed that there is differences between the desired focus areas and the observed focus areas in a typical outsourced workplace mental health service. It is clear from the study that integration and comprehensiveness in the provision of mental health services in the workplace is indeed required. The study also indicates that desired services from workplace mental health practitioners go beyond the one to one counselling services reminiscent of most EAP programs in South Africa and that host organisations desire workplace mental health service providers to render a assortment of services including community and organisational services. In addition, accessibility and appropriateness/relevance of the workplace mental health services is required. The consistent revelation that observed levels of comprehensiveness and integration are lower than the desired levels does not invalidate the value of workplace mental health services. Far from it, the study does in fact validate the appropriateness of workplace mental health services and actually indicates that more, rather than less, is desired.

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

Although this study was conducted at Sasol Mining only, it is less likely that a different set of results would have been obtained had the same study been conducted in another company in South Africa. This is so because the Sasol Mining approach of sourcing workplace mental health services from the external environment is highly prevalent, and, in many instances, the service provider, mental health practitioners and methods of rendering these workplace mental health services are the same across companies.

4.3 Recommendations

The research results obtained in this study call for a number of adjustments in the running of workplace mental health services in South Africa. These adjustments are listed and discussed below:

- The immediate priority is obviously the need to expand current services that focus on the individual and the family at a clinical level to include services at both the organisational and community levels.
- The second priority area is accessibility of workplace mental health services particularly around office proximity and counsellor availability in cases of emergency. In this regard, the locations of offices of the mental health practitioners need reconsideration with a view to locating the offices closer to the mines. This is important, considering that, most Sasol Mining employees rely on public transport for mobility and the inadequacy of

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University of the Witwatersrand
May 2006

public transport system means many employees are not able to use the outsourced workplace mental health services fully.

- Another factor needing attention relates to accessibility and the readiness of services to attend to emergencies. In this regard, the service providers of outsourced workplace mental health services should strike a balance between staffing levels for normal run of the mill days and the need for the ability to dispatch a corps of skilled counsellors in cases of need. One way of addressing this dilemma is through networking and the development of strong linkages with mental health practitioners in the nearby communities.
- The service provider and the host organisation need to develop and implement purposeful intervention programs to address alcohol and substance dependency and stress amongst workers in order to close the gap between desired and observed intervention levels for this aspect of mental health.
- The gap between desired levels of comprehensiveness and integration and the observed levels for appropriateness/relevance of services clearly indicates a disconnect between the host company and the workplace mental health service providers. This might be due to complacency on either side or might as well be that one of the unintended consequences of the externalisation of workplace mental health services is the creation of this disconnect between the host company and the service provider. Whatever the reason it is clearly necessary to develop strong linkages between the

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MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

mental health service provider, the decision makers, and the initiators of most of the referrals.

- In addition, considering the lack of fit between desired and observed levels or the appropriateness or relevance of services, it is necessary for the host organisation to update the service provider on the organisation's changing needs so that the mental health service provider is able to render services that are relevant to the host company on a continuous basis. Conversely, the service provider of outsourced mental health service should seek to understand needs of the host company on an ongoing basis. This is very important considering that workplace based mental health services are required to render services that are relevant to the host company and the individual employees.
- Lastly, the study focused only on one organisation, which, as it happens, uses outsourced workplace mental health services and thus could not look at the views of decision makers in organisations that use internal workplace mental health services, let alone the views of practitioners of mental health services in the workplace. This calls for further research to confirm the universality of the need for comprehensiveness and integration in service delivery as established in this study. This study also looked at perceptions of comprehensiveness and integration from the point of view organisational consumers of workplace mental health services and did not consider the views of the service providers and employees who constitute recipients of

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

these services whether and how much levels comprehensiveness and integration in service delivery are desired. Further research is therefore necessary to determine and further investigate the required levels of comprehensiveness and integration in the provision workplace mental health services from the perspective of practitioners and employees.

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
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University of the Witwatersrand
May 2006

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P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
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May 2006

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P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

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University of the Witwatersrand
May 2006

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May 2006

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University of the Witwatersrand
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APPENDIX A: DETAILED HYPOTHESIS TEST RESULTS

Table 8 Hypothesis Test Results for Counseling Services

Items Tested	***Mean***		***t-Test for the differences in the means***			
	Mean of Desired	**Mean of Observed**	***t*-Test Stastic**	***t-Crit (upper tail)***	***p-Value***	**Null Hypothesis**
Marital problems	3.379310345	3.06895517	1.294275328	1.672522103	0.100441172	Accept
Stress	3.517241379	3	1.824776622	1.672522103	0.036685237	Reject
Substance abuse	3.75862069	3.172413793	2.097099447	1.672522103	0.020256292	Reject
HIV/AIDS	3.896551742	3.75862069	0.837970489	1.672522103	0.20280484	Accept
Industrial trauma	3.517241379	3.482758621	0.8250357	1.672522103	1	Accept
Depression	3.482758621	3.17413793	1.07137072	1.672522103	0.144299253	Accept
Financial difficulties	3.586206897	2.689655172	3.16294615	1.672522103	0.001261478	Reject
Grief and loss	4.103448276	3.137931034	4.141255851	1.672522103	5.87942	Reject
Relationship difficulties	3.75862069	3	2.855526447	1.672522103	0.003008037	Accept
Disablement	3.827586206	2.965517241	3.505613477	1.672522103	0.000452282	Reject
POOLED RESULTS	**3.683758621**	**3.144827**	**2.115535704**	**1.672522103**	**0.019422655**	**REJECT**

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

Table 9: Hypothesis Test Results for Organisational Services

Items Tested	***Mean***		**t-*Test for the differences in the means***			
	Mean of Desired	**Mean of Observed**	***t*-Test Stastic**	***t-Crit (upper tail)***	***p-Value***	**Null Hypothesis**
Referral skills	4.24137931	2.44827586	7.338202617	1.672522103	4.77704	Reject
Helping skills	4.31044828	2.413793103	7.701540465	1.672522103	1.19957	Reject
Absenteesim	3.827586207	3.689655172	0.127631205	1.672522103	0.449449028	Accept
Needs assessment	3.965517241	2.517241379	5.504710754	1.672522103	4.7852	Reject
Prevention	4.206896552	2.620689655	6.418852626	1.672522103	1.5703	Reject
Wellness policies	4.172413793	2.655172414	5.956201019	1.672522103	8.95442	Reject
Mediation	3.24137931	2.517241379	2.609033582	1.672522103	0.005811363	Reject
Managing diversity	3.724137931	2.517241379	4.024241934	1.672522103	8.66281	Reject
Employee needs	3.586206897	2.482758621	4.268021809	1.672522103	3.84239	Reject
Harassment at work	3.75862069	2.413793103	5.629165127	1.672522103	3.02366	Reject
POOLED RESULTS	**3.903448276**	**2.627586207**	**3.895557376**	**1.672522103**	**0.000131887**	**REJECT**

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

Table 10: Hypothesis Test Results for Community Services

Items Tested	***Mean***		***t-Test for the differences in the means***			
	Mean of Desired	**Mean of Observed**	***t*-Test Stastic**	***t-Crit (upper tail)***	***p-Value***	**Null Hypothesis**
Needs identification	3.206896552	2.793193448	1.642443709	1.672522103	0.0530512	Accept
Influences program selection	3.344827586	2.655172414	2.863410817	1.672522103	0.002943639	Reject
Involved in donations decisions	3.172413793	2.448275862	2.826139309	1.672522103	0.00325972	Reject
Works with nearby communities	3.689655172	2.896551724	3.450616236	1.672522103	0.000535249	Reject
Monitors & evaluates community projects	3.310344828	2.689655172	2.314167641	1.672522103	0.012175724	Reject
POOLED RESULTS	**3.344827586**	**2.696551724**	**2.60118158**	**1.672522103**	**0.005931068**	**REJECT**

Table 11: Hypothesis Test Results for Accessibility

Items Tested	***Mean***		***t-Test for the differences in the means***			
	Mean of Desired	**Mean of Observed**	***t*-Test Stastic**	***t-Crit (upper tail)***	***p-Value***	**Null Hypothesis**
Proximity of offices	4.275862069	2.965517241	5.710205917	1.672522103	2.23946	Reject
Counsellor availability	4.551724138	3.344842759	5.200941554	1.672522103	1.45177	Reject
Waiting period < 1 day	4.206896552	2.827586207	5.036671861	1.672522103	5.036671861	Reject
Waiting period < 3 days	3.034482759	2.68955172	1.10464657	1.672522103	0.137018255	Accept
Waiting period > 3 days	2.068965517	2.689655172	2.244994431	1.672522103	0.985632047	Accept
Self referrals	3.413793103	3.172413793	0.852012866	1.672522103	0.19891802	Accept
Supervisor referrals	3.448275862	2.96551724	1.836030331	1.672522103	0.035832012	Reject
POOLED RESULTS	**3.571428571**	**2.950738916**	**2.345716991**	**1.672522103**	**0.011278663**	**REJECT**

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

Table 12: Hypothesis Test Results for Appropriateness/Relevance Services

Items Tested	***Mean***		***t-Test for the differences in the means***			
	Mean of Desired	**Mean of Observed**	***t*-Test Stastic**	***t-Crit (upper tail)***	***p-Value***	**Null Hypothesis**
Attract & retain skills	3.551724138	2.448275862	3.86034803	1.672522103	0.000147795	Reject
Work/life balance	3.827586207	2.551724138	5.177411941	1.672522103	1.58094	Reject
Individual productivity	3.931034483	2.965517241	3.859120198	1.672522103	0.000148382	Reject
Overall productivity	3.862068966	2.586206897	5.577959876	1.672522103	3.65346	Reject
Employee morale	3.931034483	2.827586207	4.740276304	1.672522103	7.5321	Reject
Lower absenteeism	4.034482759	2.655172414	5.701831754	1.672522103	2.31012	Reject
Relations at work	3.793103448	2.620689655	4.40250337	1.672522103	2.43262	Reject
Company image	4.137931934	3	4.809894976	1.672522103	5.8921	Reject
Commitment	4.068965517	2.586206897	6.305825941	1.672522103	2.40667	Reject
Job satisfaction	3.586206897	2.620689655	3.442837749	1.672522103	0.00054809	Reject
Self management	4.24137931	3	5.641948151	1.672522103	2.88398	Reject
Dismissals	3.965517241	2.896551724	4.837174884	1.672522103	5.34976	Reject
Mental well being	4.103448276	3	5.338632224	1.672522103	8.79716	Reject
Misconduct	3.724137931	2.620689655	4.106809266	1.672522103	6.5934	Reject
Poor performance	3.620689655	2.517241379	3.868398816	1.672522103	0.000144003	Reject
Company profitability	3.655172414	2.551724138	4.459091293	1.672522103	2.00351	Reject
Sick leave	3.586206897	2.448275862	4.111257598	1.672522103	6.49668	Reject
POOLED RESULTS	**3.860040568**	**2.69979716**	**4.683605724**	**1.672522103**	**4.683605724**	**REJECT**

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

APPENDIX B: RESEARCH QUESTIONNAIRE

Workplace Mental Health Services Questionnaire

1. My name is Phatelang William Senoamadi; I am a final year MA student with the University of the Witwatersrand.
2. I am currently undertaking a research on workplace mental health services in partial fulfilment for the requirements of the above mentioned degree.
3. The purpose of this questionnaire is to assess the degree to which current workplace mental health services are congruent to what is desired.
4. Kindly assist by answering each question by way of a tick ✔ to indicate the extent to which each service is desirable in **Section A** and in **Section B** to indicate the extent to which you believe a particular service is currently being rendered.
5. The meaning of each number on the rating scale is as follows:

   1 = strongly disagree

   2 = disagree

   3 = neither agree nor disagree

   4 = agree

   5 = strongly agree

6. Throughout this questionnaire the words ***mental health professional*** are used to refer to the ***social worker*** or the ***psychologist*** or the ***EAP practitioner*** who is currently rendering services to the company. Currently Sasol Mining uses external EAP services.

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

7. Please ***answer all questions***.
8. As you answer the questions kindly keep in mind that ***there are no right or wrong answers*** and no one will ever know your answers and participation in this study.

Thanking you in anticipation

Phatelang William Senoamadi

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
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University of the Witwatersrand
May 2006

SECTION A: SERVICES EXPECTED/DESIRED FROM A WORKPLACE MENTAL HEALTH SERVICE

Please answer all questions by ticking in the relevant box to indicate your answer.

An Example		**1**	**2**	**3**	**4**	**5**
A0	In this company mental health practitioners should be available on a 24 hour basis				✔	

Please indicate the extend to which you **believe workplace mental health professionals should give attention to each of the following** (*answer all questions)*		**1**	**2**	**3**	**4**	**5**
A1	The mental health professional in this company should help employees deal with **marital** problems more effectively					
A2	The mental health professional in this company should help employees deal with **stress** more effectively					
A3	The mental health professional in this company should help employees deal with **drug and alcohol** problems					
A4	The mental health professionals in this company should help employees who have the **AIDS virus** by providing ongoing support.					

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

Please indicate the extend to which you **believe workplace mental health professionals should give attention to each of the following** (*answer all questions)*		**1**	**2**	**3**	**4**	**5**
A5	The mental health professionals in this company should help employees after they had experienced a **traumatic incident**					
A6	The mental health professionals in this company should help employees when they have personal problems such as **depression**					
A7	The mental health professional in this company **should help employees deal with their financial difficulties** more effectively					
A8	The mental health professionals in this company **should help employees deal with grief/loss issues**					
A9	The mental health professionals in this company **should helps employees deal with family and other relationship difficulties**					
A10	The mental health professionals in this company **should help employees deal with issues affecting people with disabilities**					
B1	The mental health professionals in this company **should train and equip supervisors and managers with skills on how to identify and refer employees with problems for assistance.**					

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

Please indicate the extend to which you **believe workplace mental health professionals should give attention to each of the following** (*answer all questions)*		**1**	**2**	**3**	**4**	**5**
B2	The mental health professionals in this company **should train and equip supervisors and managers with skills on how to handle employees who have problems**					
B3	The mental health professionals in this company **should run programs and interventions to address employee absenteeism**					
B4	The mental health professionals in this company **should continuously conduct needs assessment to identify company and employees' needs**					
B5	The mental health professionals in this company **should assist us by running preventative programs to prevent problems before they occur**					
B6	The mental health professionals in this company **should assist in developing proactive policies that will improve employee well-being**					
B7	The mental health professionals in this company **should assist by mediating between conflicting groups to improve relations at work**					
B8	The mental health professionals in this company **should equip managers and employees with skills to manage diversity and race relations better**					

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

Please indicate the extend to which you **believe workplace mental health professionals should give attention to each of the following** (*answer all questions)*		**1**	**2**	**3**	**4**	**5**
B9	The mental health professionals in this company **should assist proactively identifies employees' needs and assist with ways to address those needs**					
B10	The mental health professionals in this company **should assist with interventions to prevent harassment in the work (including sexual harassment)**					
C1	The mental health professionals in this company **should assist in identifying community needs that the company can focus on**					
C2	The mental health professionals in this company **should assist in the selection of community programs that the company can support financially**					
C3	The mental health professionals in this company **should be involved in company decisions on donations that the company makes to community projects**					
C4	The mental health professionals in this company **should work jointly with community organizations to address common problems that affect employees and the nearby community**					
C5	The mental health professionals in this company **should help the company implement mechanisms to monitor and evaluate effectiveness of community projects sponsored by the company**					
D1	The offices of the mental health practitioners **should be located in close proximity**					

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

	to the location of employees					
D2	In case of a major **work related accident**, mental health practitioners **should immediately be available to counsel and support traumatised employees and their families**					
D3	The **waiting period** for a request for an employee to see a mental health practitioner **must be within a day of the request having been made**					
D4	The **waiting period** for request for an employee to see a mental health practitioner **may be more than a day but less than 3 days** of the request having been made					
D5	The **waiting period** for an employee to see a mental health practitioner **may be more than 3 days of the request having been made**					
D6	**Most of the time employees should voluntarily seek the help of the mental health practitioner** when they experience personal problems (i.e. the majority of employees who receive or have received the workplace mental health service did so on their own)					
D7	**Most of the time supervisors and managers should refer employees** to see the mental health practitioners for assistance with personal problems (i.e. the majority of employees who receive or have received the workplace mental health service did so at the instance of the supervisor).					

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

I believe workplace mental health service can benefit the company by *(Answer all questions)*		**1**	**2**	**3**	**4**	**5**
E1	Attraction and retention of skilled and talented employees					
E2	Balance between work and personal life for the employees					
E3	Improved productivity of the employees who previously received assistance from the mental health practitioner					
E4	Improved productivity in the company as a whole					
E5	Improved morale for our employees					
E6	Improved work attendance and lower absenteeism					
E7	Improved cooperation between management and employees					
E8	Improved image for the company as a result of being seen as a caring employer					
E9	Improved employee commitment to the company					

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

I believe workplace mental health service can benefit the company by *(Answer all questions)*		**1**	**2**	**3**	**4**	**5**
E10	Improved job satisfaction of our employees					
E11	Improved employee ability to manage their personal problems					
E12	Lower rate of alcohol related dismissals					
E13	Improved mental well being of our employees					
E14	A reduction of supervisor or management time spend on reprimanding employees for misconduct					
E15	A reduction of supervisor or management time spend on reprimanding employees for poor work performance					
E16	Improved profitability of the company					
E17	A reduction in the usage of sick leave					

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

SECTION B: SERVICES CURRENTLY BEING RENDERED

Please indicate by way of a tick ✔ to indicate the extend to which you believe each service is currently being rendered.

		1	2	3	4	5
AA1	The mental health professional in this company helps employees deal with **marital** problems more effectively					
AA2	The mental health professional in this company helps employees deal with **stress** more effectively					
AA3	The mental health professional in this company helps employees deal with **drug and alcohol** problems					
AA4	The mental health professionals in this company help employees who have the **AIDS virus** by providing ongoing support.					
AA5	The mental health professionals in this company helps employees after they had experienced a **traumatic incident**					
AA6	The mental health professionals in this company helps employees when they have personal problems such as **depression**					

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

		1	**2**	**3**	**4**	**5**
AA7	The mental health professional in this company helps employees deal with their **financial** difficulties more effectively					
AA8	The mental health professionals in this company helps employees deal with **grief/loss issues**					
AA9	The mental health professionals in this company helps employees deal with **family and other relationship difficulties**					
AA10	The mental health professionals in this company deals with issues affecting **disablement and people with disabilities**					
BB1	The mental health professionals in this company **train** and equip **supervisors and managers with skills** on how to identify and refer employees with problems for assistance.					
BB2	The mental health professionals in this company **trained and equipped supervisors and managers with skills** on how to **handle** employees who have problems					
BB3	The mental health professionals in this company run programs and interventions **to address employee absenteeism**					

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

		1	2	3	4	5
BB4	The mental health professionals in this company continuously conduct **needs assessment** to i**dentify company and employees' needs**					
BB5	The mental health professionals in this company assist us by running **preventative programs** to prevent problems before they occur					
BB6	The mental health professionals in this company assist in developing **proactive policies** that will improve **employee well-being**					
BB7	The mental health professionals in this company assist by **mediating** between conflicting groups to i**mprove relations at work**					
BB8	The mental health professionals in this company equip managers and employees with **skills to manage diversity and race relations** better					
BB9	The mental health professionals in this company assist **proactively identifies employees' needs** and **assist with ways to address those needs**					
BB10	The mental health professionals in this company assist **with interventions to prevent harassment in the work (including sexual harassment)**					

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

		1	2	3	4	5
CC1	The mental health professionals in this company assist in **identifying community needs** that the company can focus on					
CC2	The mental health professionals in this company assist in **the selection of community programs** that the company can support financially					
CC3	The mental health professionals in this company are **involved in company decisions on donations** that the company makes to community projects					
CC4	The mental health professionals in this company **work jointly with community organizations** to address common problems that affect employees and the nearby community					
CC5	The mental health professionals in this company helps the company **implement mechanisms to monitor and evaluate effectiveness of community projects sponsored by the company**					
DD1	The offices of the mental health practitioners are located in close **proximity** to the location of employees					
DD2	In case of a major **work related accident**, mental health practitioners are immediately available to counsel and support traumatised employees and their families					
DD3	The **waiting period** for a request for an employee to see a mental health practitioner is					

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

	within a day of the request having been made					
DD4	The **waiting period** for request for an employee to see a mental health practitioner is **more than a day but less than 3 days** of the request having been made					
DD5	The **waiting period** for an employee to see a mental health practitioner is **more than 3 days** of the request having been made					
DD6	Most of the time **employees voluntarily seek the help** of the mental health practitioner when they experience personal problems (i.e. the majority of employees who receive or have received the workplace mental health service did so on their own)					
DD7	Most of the time **supervisors and managers refer** employees to see the mental health practitioners for assistance with personal problems (i.e. the majority of employees who receive or have received the workplace mental health service did so at the instance of the supervisor).					
I believe that since implementation of mental health services in the workplace the we have derived the following benefits						
EE1	Attraction and retention of skilled and talented employees					
EE2	Balance between work and personal life for the employees					
EE3	Improved productivity of the employees who previously received assistance from the mental health practitioner					

P.W. Senoamadi (8805489/T)
MA (Industrial Social Work)
School of Human and Community Development
University of the Witwatersrand
May 2006

EE4	Improved productivity in the company as a whole					
EE5	Improved morale for our employees					
EE6	Improved work attendance and lower absenteeism					
EE7	Improved cooperation between management and employees					
EE8	Improved image for the company as a result of being seen as a caring employer					
EE9	Improved employee commitment to the company					
EE10	Improved job satisfaction of our employees					
EE11	Improved employee ability to manage their personal problems					
EE12	Lower rate of alcohol related dismissals					
EE13	Improved mental well being of our employees					
EE14	A reduction of supervisor or management time spend on reprimanding employees for misconduct					

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EE15	A reduction of supervisor or management time spend on reprimanding employees for poor work performance					
EE16	Improved profitability of the company					
EE17	A reduction in the usage of sick leave					

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SECTION III: BIOGRAPHICAL DATA

I work in the following area (*Select only one answer)*		
F1	Production	
F2	Human Resources	
F3	Engineering	
F4	Other (please specify)_____	

I am a level ___ in terms of categorisation of levels within the company (*Select only one answer)*

F5	Level 8	
F6	Level 7	
F7	Level 6C	
F8	Level 5	
F9	Level 4	
F10	Level 2/3	
F11	Other (please specify) _____	

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I fall within the following age group (*Select only one answer)*		
F6	20 to 30 years old	
F7	31 to 40 years old	
F8	41 to 50 years old	
F9	51 years and higher	

I am (*Select only one answer)*

F6	Female	
F7	Male	

Thanks for your input and the time you spent filling this survey. Kindly return the complete questionnaire to william.senoamadi@sasol.com or (011)522-5990.

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