New Zealand Journal of Psychology, 1985, 14, 15–19

Occupational Alcoholism: The Relevance for New Zealand Organisations of Employee Assistance Programmes*

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The relevance of the Trice and Roman model of employee assistance programmes (EAPs) in New Zealand is discussed. There are difficulties in implementing EAPs with regard to specificity of job descriptions; documentation of work performance; standard of supervisory training; and also with regard to the characteristics of industries themselves. While the model may be relevant to New Zealand's larger organisations, research is required to determine how best to meet the needs of smaller industries in dealing with the problem drinker.

Model of Intervention

Occupational alcoholism is a topic attracting increasing attention and a model of intervening with workers who have drinking problems has been developed by Trice and Roman (1972). This occurred in response to the problems and costs in the workplace associated with alcohol abuse[1]. The strategy used is referred to as an employee assistance program (EAP) and it has been implemented with considerable success in the United States (Asma, Eggert & Hilker, 1971) where formal EAPs have been in operation since the end of World War II (Trice & Schonbrunn, 1981). Eighteen programmes exist now in New Zealand and there are also 44 organisations working towards the establishment of EAPs, or with partial programmes[2]. A further 70 have indicated an interest in developing a programme so with this increasing activity it is important to examine the relevance of EAPs for New Zealand organisations and to examine the adequacy of the model.

In essence the Trice and Roman (1972) model is based upon the supervisor's "right and duty" to intervene where an employee's work performance does not reach specified standards, as this can be an effective means of identifying problem drinkers since the majority have difficulty maintaining a satisfactory work record (Trice, 1962; 1964; 1965a; Kurtz, Googins & Williams, 1980).

The contribution of supervisors in the Trice and Roman (1972) model is significant for not only are supervisors the people most likely to observe the decline in a problem drinker's work performance, but they are also the people for whom it is the "legitimate and explicit expectation" that employees will perform work tasks satisfactorily. When performance is not of a satisfactory standard it becomes the supervisor's responsibility to motivate the employee to improve. If necessary, the supervisor can confront the employee and recommend referral for assessment and/or counselling so that the employee can regain a satisfactory standard of work. However, referral is optional only; it is not a necessary element of the model (Roman & Trice, 1972).

Because of its simplicity, the model has considerable appeal for organisations wishing to intervene constructively with problem drinkers for no new managerial skills or complex procedures are needed (Trice & Roman, 1972). Disciplinary procedures differ from normal only to the extent that the supervisor can offer referral for confidential counselling, with the guarantee of job security.

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[1]Estimates of the extent of the problem in industry range between 3 per cent (Stevenson, 1942) and 19 per cent of the workforce (Parker & Brody, 1982). Problem drinkers have up to 8.3 times more absenteeism than the norm (Schramm, Mandell and Archer, 1978). The job performance of problem drinkers declines as their dependency increases (Trice, 1962; 1965a). The on-the-job accident rate for problem drinkers under 40 years of age is higher than for non-problem drinkers. The off-the-job accident rate for all problem drinkers is higher. (Observer and Maxwell, 1959).

[2]See the *Report of the Alcoholic Liquor Advisory Council* for the year ended 31 March 1984. Presented to the House of Representatives. E.26. P.9.

In accordance with the normal supervisory role requirements (Kurtz, 1982), the supervisor needs "only to be alert to the signs of impaired performance and to be equipped to deal effectively and realistically with it." (Trice and Roman, 1978, p. 171).

However, implementing the model in New Zealand is not a straightforward matter as many industries do not have the organisational structures necessary for the development of an employee assistance programme of the kind described by Trice & Roman (1972).

General Problems with the Trice and Roman Model

The model as presented by Trice and Roman (1972) assumes that for every job there are standards of performance that have been agreed upon and understood by the supervisor, the union delegate and the employee. Such standards are necessary in order for the supervisor to be able to measure decline both confidently and objectively. But in many New Zealand industries there are no precise descriptions of either adequate or inadequate performance so it is impossible for a supervisor to make an accurate assessment of an employee's decline in work performance. Furthermore, the intervention model assumes that having measured a decline in work performance, there is a system for documenting it; and documentation is essential if confrontation with an employee is to be objective. It is also necessary if an appropriate referral is to be made to an outside agency for assistance for the employee.

In New Zealand only a limited amount of information about an employee's performance is documented. Often supervisors are reluctant to use the documentation system that is available, for a number of reasons. For instance, as is the case elsewhere, some supervisors resent having to record work performance because of the extra work it involves (Googins & Kurtz, 1981), without realising that documentation can assist them to function better in their own role. And they may also be unwilling to document employee behaviour for fear of a possible adverse reaction from unions.

In relation to confronting a problem drinker the information that is most pertinent e.g. hangovers, mood changes, friction, or irritability (Maxwell, 1960) may be difficult to document. Conversely, the behaviours which can be documented are of little use to the supervisor: for instance, whilst most industries document absenteeism, Maxwell (1960) has shown that absenteeism is a late correlate of problem drinking, and Pell & D'Alonzo (1970) found that over half of the problem drinkers in their survey had no problems with absenteeism. Also if a reliable record of inadequate performance is required before a problem drinker can be confronted then it lengthens the time before a supervisor may intervene. As a result there is a long period when supervisors and co-workers share "a collective awareness" of another's drinking problem, but during which no legitimate intervention may occur. Estimates of the period in which a supervisor is unable to act range from three months (Kurtz et al, 1980) to seven years (Shirley, 1982). Faced with this situation a supervisor has the choice either of confronting the problem drinker with insufficient evidence, or of making the case with undocumented, unsubstantiated recollections of past behaviour (Kurtz et al, 1980).

To establish in New Zealand the early intervention system that Trice and Roman (1972) claim is possible it is necessary to develop alternative, or additional methods to their model. New methods may need to accept that what happens in the workplace is that an employee is first identified as a problem drinker, then indications of impaired work performance are looked for. The new methods may also have to accommodate the difficulties supervisors experience with documentation. Even so when identification of the problem is accurate and documentation complete, confrontation of the troubled employee is not an inevitable outcome (Kurtz et al, 1980).

Studies indicate that a number of factors can inhibit a supervisor's willingness to intervene with a problem drinker (Trice, 1965a; Kurtz et al, 1980; Googins & Kurtz, 1981). Some training programmes for supervisors are designed to overcome these influences (Older, Phillips & Purvis, 1978; Googins & Kurtz, 1979), while other programmes are designed to inform supervisors about an industry's policy and the mechanics of using the industry's programme (Bibby, 1979).

A necessary component of any training programme for supervisors is the development of communication skills needed for confronting the problem drinking employees. These skills the Trice and Roman model assumes all supervisors have, but the evidence for that is lacking and as Etchen & Roman (cited by Kurtz, 1982) comment "the design of supervisory training in occupational alcoholism has proceeded without the guidance of scientific evaluation." (p. 277). Thus Kurtz (1982) calls for "top priority" to be given to research in supervisory training.

The issue of scientific design and evaluation of supervisory training is also of major relevance to New Zealand organisations. At a time when many industries have yet to realise the benefits which result from systematically training supervisors, people working with alcohol programmes in industry are asking how and where to begin the training of supervisors to cope with the problem drinker. It has been suggested that the use by supervisors of an industry's policy and programme depends upon the extent to which they see the new activity as an integral and essential part of their role (Googins & Kurtz, 1979). But it is unlikely that the tasks required by the employee assistance programme will be incorporated into the daily activities of supervisors since many New Zealand supervisors have not received clear instructions about basic job requirements.

Characteristics of New Zealand Industries

It is in the small New Zealand industry that the problems of unspecified job standards, limited documentation and the absence of routine supervisory training are most apparent; and the typical New Zealand industry is small with most employing fewer than 20 people.[3] In fact it is very small by American standards, for in the United States a small industry is one that may employ as many as 500 people on one site.

Trice and Roman (1972) acknowledge the limitations of their model with small industries and this therefore raises the question of its relevance for New Zealand, where the majority employ few people on one site. Furthermore, any proposal to implement their model in manufacturing industries here needs to consider two other matters: the first concerns the question of personnel and health/welfare systems in industry and the second concerns the importance of social distance in supervisor/employee interactions.

Firstly, in the United States 97.2 per cent of employee assistance programmes are dependent on either personnel or medical departments (Roman, 1982). This relationship allows for easy administration of programmes and it means that supervisors and employees accept them as an extension of services already provided by the organisation. In New Zealand however, there is a need to examine how employee assistance programmes can function independently of either medical or personnel departments since the majority of industries do not have either of these services.[4] Yet in a recent article in this journal, Bull (1983) has argued that workers should be referred to company medical staff for assessment, and/or counselling, and for a computer based health assessment. While this may be suitable for large industries the majority of New Zealand industries need something more simple and practical.

Secondly, Trice and Roman (1972) maintain that in order for confrontation to be successful social distance between the supervisor and problem drinker must be as great as possible and the amount of social interaction minimal. However, in New Zealand, the majority of people work in small industries where the social distance between supervisors and employees is likely to be small and the amount and nature of social interaction high.[5] In such situations it is unrealistic to assume that a supervisor will not know the reason for erratic work performance or will not at least attempt to find out. Furthermore, in some instances social closeness and a knowledge of family relationships may increase a supervisor's willingness to confront the employee (Trice, 1965a), but in others it may

[3]See the *New Zealand Offical Yearbook* 1982, 888, 781–782.

[4]Only 10 per cent of Christchurch's factories have any type of health service for their employees. Dr Malpress, Medical Officer, Department of Health speaking at a seminar "Physiotherapy in Industry", Christchurch Public Hospital, July 9, 1983.

[5]"Small business constitutes more than 70 per cent of all businesses, (and) provides about 400,000 jobs. . . . The sector generally has good industrial relations because of close owner and staff contact . . .". David Caygill, Minister of Trade and Industry, The Press (Christchurch), February 5, 1985, p. 15.

be a hindrance (Trice, 1965a; Kurtz et al., 1980); so it would be worthwhile to determine which is the case for New Zealand supervisors.

It is also important to know whether confrontation in the small industry is formal and based on documented evidence of erratic work performance, informal with reference to personal problems, or some combination of both. A further question to answer is which method, if any, is effective in the typical New Zealand industry.

Responsibility for Employee Welfare

Surveys in the United States show that the most frequently mentioned reason for an industry deciding to implement a programme for the problem drinker is the belief that the organisation has a responsibility for the health and welfare of its employees (Roman, 1982). American industries have a history of providing health and fitness programmes and of contributing toward medical expenses so that an employee assistance programme can easily be seen as an extension of this. However, such a view is new to many New Zealand industries. Some managers believe the primary responsibility for health and welfare rests with the state, and appear uncertain as to how much industry can, and should participate.

Despite the difficulties some New Zealand industries have attempted to deal systematically and fairly with problem drinkers, but the questions remain as to which factors, attitudes and beliefs influenced decisions to implement an employee assistance programme.

Emphasis On Treatment

Employee assistance programmes in New Zealand have followed the approach of offering access to treatment (McClellan, 1982). But in emphasising referral to treatment, the potential of the supervisor to deal with problems is eroded and an assumption is made that all poor performers need treatment. Yet as Thorpe and Perret (1959) have discovered the work performance in at least a third of cases may improve despite refusal of treatment.

Emphasis upon referral for treatment places supervisors in a difficult position: on the one hand, they are instructed not to diagnose an employee's problem or discuss employee's drinking but, on the other hand, they are told to refer the employee to an alcohol treatment centre. Yet to make such a referral a supervisor presumably must first have made some assessment about the nature of the problem.

Final Comment

Employee assistance programmes based on the Trice and Roman model may be relevant for New Zealand's larger industries where job descriptions are clearly outlined; where there is a sophisticated and regular appraisal of work; and where there are personnel and health care services. But for the majority where there is an absence of these systems and services, alternative methods of intervening with a problem drinker are needed. Resources need to be directed towards developing and testing new methods. An appropriate starting place would be to ask supervisors in small industries what their difficulties are; what attempts they have made to overcome them; and what they have learned about how to intervene with the problem drinker. Then programmes relevant to their needs could be developed.

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