Burden of common mental disorders in South African workplace settings

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ABSTRACT

Background: The presence of common mental disorders (CMDs) in the workplace is associated with high costs. However, there are limited current data available on the mental health disease burden in South African workplace settings. Legislation places a responsibility on employers to monitor and manage workplace health and safety, and mental health surveillance initiatives may be one mechanism to achieve that.

Objectives: The objectives of this paper were 1) to describe the burden of certain CMDs in employees who had participated in a mental health surveillance programme, based on the outcomes of validated psychometric tests for CMDs and 2) to compare the prevalence of CMDs measured using self-report scales with assessments from interviews with clinical psychologists.

Methods: This was a record review of employees from various companies contracted to an occupational health provider that conducts general workplace health surveillance, including mental health surveillance. The records contained data collected using validated psychometric measures, and included responses to four screening scales (PHQ-9, GAD-7, PC-PTSD-5 and CAGE) from 2 068 workers in full-time employment. Cronbach alpha coefficients were calculated to determine internal consistency for each scale. Prevalence of CMDs was calculated and reported by sex, age, and occupational category. Associations between CMDs and sex and age were estimated using multinomial logistic regression analysis. We also explored differences between diagnostic outcomes from the four self-report scales and clinical interview outcomes.

Results: The mean age of the employees was 34.2 years (20–60 years). More than 35% reported two or more CMDs. The prevalences of alcohol-use disorder, major depressive disorder, and generalised anxiety disorder were 3–4% – comparable with, or lower than, that in the general local population.

Conclusion: The relatively high prevalence of some CMDs in this study indicates a need for greater awareness of the importance of effective employee assistance programmes in the workplace.

INTRODUCTION

Mental illness has been described as the 'scourge of our times',[1] with South Africa sharing in the burden. As many as one in six South Africans suffer from disorders such as anxiety, depression or substance use, according to statistics released by the South African Depression and Anxiety Group.[2] Mental health disorders are generally characterised by a combination of abnormal thoughts, perceptions, emotions, behaviour and relationships with others,[3] and are often associated with distress and/or problems participating in social, work or family activities.[4]

Estimates of prevalence of CMDs in South Africa

There are few available large-scale population-based estimates of mental disease burden in South Africa. The South African Stress and Health (SASH) study was a population-based, nationally representative household survey of mental health,[5,6] and provides the most comprehensive prevalence data of CMDs to date. The SASH study reported the most common classes of lifetime disorders to be anxiety disorders (15.8%), substance-use disorders (SUDs; 13.3%) and mood disorders (9.8%). The 12-month prevalence of the most common individual mental disorders were major depressive disorder (MDD; 4.9%), agoraphobia without panic (4.8%), and alcohol-use disorder (AUD; 4.5%). Lower prevalence was reported for panic disorder (0.8%), generalised anxiety disorder (GAD; 1.4%), and post-traumatic stress disorder (PTSD; 0.6%). The 12-month prevalence for any anxiety disorder was 8.1%, and that for any SUD was 5.8%.[5,6] However, it has been suggested that the SASH study may have underestimated the prevalence of CMDs in South Africa.[7]

Others have reported CMD prevalences within defined groups (see Table 1). For example, there has been an array of reports on vulnerable populations, including low-income pregnant women,[8] medical students,[9] HIV-positive patients,[10] and first-year university students from historically marginalised communities.[11] All reported higher prevalences of CMDs than reported in the SASH study, which, as shown in Table 1, vary widely across studies, probably due to differences in the study populations and/or measuring instruments used. Further, international studies provided evidence of over-reporting prevalence of CMDs when using self-report scales, as opposed to clinical interviews.[12,13]

As far as could be ascertained, no general workplace population CMD prevalence estimates are available in South Africa. The small studies that have reported prevalences in defined groups (see Table 1) are often

framed as reports on high-risk (for adverse mental health outcome) occupational groups, including emergency medical personnel,[14,15] police officials,[16] and medical doctors.[17] These high-risk groups are considered to be more vulnerable to psychiatric consequences of (traumatic) workplace exposures, and report high levels of PTSD and AUD. The theme of traumatic exposure has recently been highlighted by reports of increased occurrence of CMDs among frontline medical staff during the COVID-19 pandemic.[18] In general settings, it appears that work characteristics (such as decision latitude and effort-reward imbalance) are more strongly associated with CMDs than is occupational category.[19-20] Broader socio-political contexts also matter. For example, South African reports often highlight the high prevalence of community-level traumatic exposures and associated PTSD, independent of occupational status.[21-23]

There is currently no clear contemporary picture of CMDs in the South African occupational context. The SASH data, based on the DSM-IV diagnostic system, are becoming dated, having been collected in 2003–2004, and some of the other studies cited above had small sample sizes and/or used measures that were not validated locally.

Impact of CMDs in the South African workplace

The human and economic costs of mental illness in the workplace are well documented.[24-27] For example, one report estimated the loss of earnings due to major depression and anxiety disorders at R54 121 per affected adult per year, with the total annual cost to the South African economy amounting to more than R40 billion.[26] It has been estimated that 50% of workplace accidents are related to substance abuse, and that an undetected substance abuser can cost an employer 25% of that person's wages.[28] International data show an increased risk for workplace accidents and injuries where CMDs are present.[29,30] Poor mental health at work also has personal implications, from increased demands to manage the condition, to reduced personal accomplishment and sense of self-worth, and unstable employment.[24,31]

The Occupational Health and Safety Act (Act No. 85 of 1993) places a responsibility on employers to monitor and manage workplace health and safety. Many larger organisations have their own occupational health surveillance programmes in place to achieve this. From a mental health perspective, workplace concerns are bi-directional. First, occupational exposure may pose a risk for mental health injury (either

Table 1. Selection of South African studies reporting prevalence of common mental disorders

			Prevalence of mental disorders assessed with different tools (%)														
			MDD		GAD		PSTD				AUD		Panic disorder	Any anxiety disorder	SUD	
Source	Study population	N	IV	other	IV	other	PC-PTSD-5	IV	other	CAGE	IV	AUDIT	IV	other	IV	other
General population estimates																
Herman et al., 2009 (SASH study)[5]	Population-based sample (12-month prevalence)	4 351	4.9	-	1.4	-	-	0.8	-	-	4.5	-	0.8	8.1	1.4	-
Peltzer, Phaswana-Mafuya, 2018[35]	Population-based survey	26 453	-	-	-	-	-	-	-	-	-	-	-	-	-	4.4
Peltzer, Pengpid, 2019[36]	Nationally representative community-based sample	15 201	-	-	-	-	-	-	2.1	-	-	-	-	-	-	-
Vulnerable groups																
Freeman et al., 2008[37]	People living with HIV and AIDS	900	11.1	-	0.4	-	-	0.7	-	-	12.4	-	0.1	-	1.9	-
Van Heyningen et al., 2017[8]	Low-income, pregnant women, urban setting	376	22.0	-	2.0	-	-	11.0	-	-	13.0	-	3.0	23.0	6.0	-
Kagee et al., 2017[10]	South Africans seeking HIV testing	485	14.2	-	5.0	-	-	4.9	-	-	19.8	-	-	-	-	-
Bantjes et al., 2019[11]	1st year university students from historically marginalised communities	1 402	-	13.6	-	20.8	-	-	-	-	-	5.6	-	-	-	3.1
Van der Walt et al., 2020[9]	SA medical students	473	-	25.0	-	-	-	-	-	-	-	-	-	20.5	-	-
Occupational groups																
Bekker, Van Velden, 2003[38]	SA National Defence Force	618	-	-	-	-	-	-	-	-	-	13.3	-	-	-	-
Ward et al., 2006[15]	Emergency medical service personnel	1 099	-	-	-	-	-	-	2.4	22.5	-	-	-	-	-	-
Rossouw et al., 2013[17]	Medical doctors	132	-	30.0	-	-	-	-	-	-	-	-	-	-	-	-
Van Wijk et al., 2020[14]	Emergency medical service personnel	268	-	12.3	-	-	11.9	-	-	14.9	-	-	-	-	-	-

Notes: PHQ-9 = Patient Health Questionnaire-9; IV = interview; GAD-7 = Generalised Anxiety Disorder scale-7; PC-PTSD-5 = Primary Care Post-traumatic Stress Disorder for DSM-5; AUDIT = Alcohol-use Disorder Identification Test; Other includes various validated/adapted measures

by contributing to mental distress such as PTSD, or by exacerbating existing poor mental health). Second, poor mental health affects workplace safety by increasing the risk of accidents and injuries. Mental health surveillance may provide a mechanism for employers to manage these bi-directional concerns, although there is debate about the degree to which prevalence of CMDs is a good measure of the need for mental health services.[32-34]

It remains largely accepted that mental health surveillance systems, which prompt for the early warning of deteriorating mental health and monitor the effects of workplace exposure on employee mental health, are mutually beneficial to the employer and employee. Early warning systems could assist with both clinical management and workplace accident prevention.

The objectives of this paper were 1) to describe the burden of certain CMDs in employees who had participated in a mental health surveillance programme, based on the outcomes of validated psychometric tests for CMDs and 2) to compare the prevalence of CMDs measured with self-report scales with assessments from interviews with clinical psychologists.

METHODS

Records from an organisation conducting occupational health surveillance, which includes a mental health screen, were reviewed. The records were those of full-time salaried workers from several companies in three provinces, viz. Western Cape, Eastern Cape, and KwaZulu-Natal, who participated in the surveillance programme in 2019. Mental health data from four brief screening scales and a psychological interview were extracted from 2 068 records. The participants comprised semi-skilled and skilled workers who had completed a minimum of Grade 10 schooling (a set requirement to enable meaningful completion of the screening scales).

Measurements

Data were extracted from records of participants who had completed a clinical screen that consisted of four brief scales, viz. the Patient Health Questionnaire-9 (PHQ-9) – a screening, diagnostic, and monitoring tool that measures the severity of depression in primary care settings;[39] the Generalized Anxiety Disorder Questionnaire-7 (GAD-7) – a screening, diagnostic, and monitoring tool that measures the severity of generalised anxiety in primary care settings;[40] the Primary Care Post-traumatic Stress Disorder Screen for DSM-5 (PC-PTSD-5) – developed as a brief screen for PTSD in primary care settings using updated DSM-5 criteria;[41] and the 4-item CAGE to determine problematic alcohol-use.[42] Serious mental disorders (e.g. schizophrenia) were not included due to the lack of locally validated self-report measures to identify such conditions.

Participants were interviewed by clinical psychologists if their responses reached pre-determined scale-total thresholds (i.e. ≥7 for PHQ and GAD, and ≥1 for PC-PTSD-5 and CAGE) to determine the diagnostic likelihood using DSM-5 criteria.

Data analysis

The scores for the four scales and the interview data were analysed. For each scale, participants were categorised into two groups, depending on whether or not their scores met the diagnostic criteria for that scale. Co-morbidity was defined as meeting the criteria for two or more disorders. Prevalences of individual CMDs, with 95% confidence intervals, were calculated. Disease burden, based on scale outcomes (scores) was reported by age, sex, and occupational category; differences were calculated using Chi-square tests. The associations between CMDs and sex and age were estimated using multinomial logistic regression. Only variables where differences, using Chi-square tests, were significant at $p < 0.1$ were included in the regression analysis. Cronbach alpha coefficients were calculated to determine internal consistency for each scale. All analyses were performed using SPSS for Windows version 26.

Ethical approval was provided by the Health Research Ethics Committee of Stellenbosch University (#N20/07/078).

RESULTS

The mean age of the study participants was 34.2 years (± 8.6 years), ranging from 20 to 60 years; 33.5% were women. All 11 official languages were spoken, with English (19.2%), Afrikaans (17.2%), isiXhosa (12%), Setswana (11.7%), and isiZulu (11.6%) being the most common. The mean scores of each scale are shown in Table 2. All scales had high internal consistency, as indicated by Cronbach's alpha.

The prevalences of the four CMDs are presented in Table 3: 4.5% of the workers met the scale threshold for MDD, 5.0% for GAD, 1.9% for PTSD, and 7.2% for AUD. A total of 11% of participants met the criteria for any of the CMDs, as assessed by the four scales. The highest burdens of MDD and AUD were in the 20–29 years age group (6.6% and 10.3%, respectively). Women reported a higher burden of MDD than men (6.3% and 3.6%, respectively), while men reported a substantially higher burden of AUD than women (9.1% and 2.4%, respectively). There were no significant differences in CMD prevalence across occupational categories.

Based on scales totals, 146 employees (7.1%) met the criteria for a single diagnosis, 51 (2.5%) met the criteria for two

Table 2. Employee's scores for the four scales, internal consistency, and threshold for diagnosis of disorder

	Scale			
	PHQ-9	**GAD-7**	**PC-PTSD**	**CAGE**
Associated CMD	Major depressive disorder	Generalised anxiety disorder	Post-traumatic stress disorder	Alcohol-use disorder
Threshold for diagnosis*	≥ 10	≥ 10	≥ 3	≥ 2
Mean ± SD	2.0 ± 3.5	1.7 ± 3.2	0.2 ± 0.6	0.2 ± 0.7
Range	0–25	0–21	0–5	0–4
Cronbach's alpha	0.85	0.90	0.69	0.68

* as determined by the relevant scale

Table 3. Prevalence of common mental disorders, by age group, sex, and occupational category

			Disorder											
	All		Major depressive disorder			Generalised anxiety disorder			Post–traumatic stress disorder			Alcohol–use disorder		
	n	%	n	%	95% CI	n	%	95% CI	n	%	95% CI	n	%	95% CI
All employees	2 068	-	93	4.5	3.6–5.5	103	5.0	4.0–6.1	39	1.9	1.4–2.7	149	7.2	6.1–8.5
Age group (years)														
20–29	679	32.8	45	6.6	4.9–8.8	47	6.9	4.9–9.4	21	3.1	1.9–4.8	70	10.3	8.1–12.9
30–39	917	44.3	37	4.0	2.9–5.5	39	4.3	3.0–5.9	13	1.4	0.7–2.5	60	6.5	4.9–8.4
40–49	325	15.7	6	1.8	0.7–4.0	10	3.2	1.5–5.9	2	0.7	0.1–2.6	12	3.6	1.7–6.5
50–60	147	7.1	5	3.4	1.1–7.8	7	5.1	2.1–10.3	3	1.8	0.2–6.3	5	3.6	1.0–8.9
Sex														
Female	693	33.5	44	6.3	4.7–8.4	43	6.2	4.4–8.5	19	2.8	1.6–4.6	17	2.4	1.3–4.2
Male	1375	66.5	50	3.6	2.6–4.7	59	4.3	3.1–5.6	22	1.6	1.0–2.4	125	9.1	7.6–10.8
Occupational category														
Administrative/clerical	326	15.8	14	4.3	2.4–7.1	11	3.3	1.6–6.0	10	3.1	1.3–6.0	24	7.3	4.5–11.2
Security services	281	13.6	9	3.2	1.5–6.0	9	3.2	1.5–6.2	4	1.5	0.4–3.7	23	8.1	5.2–12.1
Qualified technicians (mechanical/electrical)	254	12.3	13	5.1	2.8–8.6	10	4.0	1.8–7.4	5	1.8	0.5–4.5	20	7.9	4.8–12.2
Other/unknown	248	12.0	8	3.2	1.4–6.3	17	6.7	3.6–11.2	1	0.4	0.0–2.3	15	5.9	3.3–9.7
Navy personnel	246	11.9	11	4.5	2.3–7.9	7	2.9	0.9–6.6	-	2.0	0.7–4.7	13	5.3	2.9–8.9
Hospitality/catering	131	6.3	10	7.6	3.7–13.6	13	9.6	4.9–16.6	3	2.1	0.3–7.4	6	4.5	1.2–10.4
Marine officers	118	5.7	5	2.5	0.5–7.3	3	3.6	0.7–10.1	0	0	0.0–3.2	2	6.1	2.5–12.2
Technical assistant (not formally qualified)	112	5.4	9	7.1	3.1–13.6	16	13.0	6.4–22.6	4	2.9	0.6–8.1	14	11.4	6.0–19.1
Telecoms technician	111	5.4	7	6.3	2.6–12.6	5	4.9	1.3–12.0	3	2.9	0.6–8.2	9	7.7	3.4–14.6
Professional engineer	103	5.0	3	2.9	0.6–8.3	6	5.7	1.6–14.0	2	2.2	0.3–7.9	9	9.0	4.0–16.9
Firefighter	85	4.1	4	4.7	1.3–11.6	5	6.3	1.7–15.2	2	2.6	0.3–9.2	7	7.9	3.0–16.4
Professional musician	53	2.6	3	5.7	1.2–15.7	3	5.7	1.2–15.7	3	4.9	0.6–16.5	4	7.3	1.5–19.9

CI: Confidence interval

diagnoses, 24 (1.2%) met the criteria for three diagnoses, and 7 (0.3%) met the criteria for four diagnoses. A total of 228 employees met any scale threshold criteria, with 146 (64%) meeting the criteria for a single diagnosis, 51 (22.4%) for two diagnoses, 24 (10.5%) for three diagnoses, and 7 (3.1%) for four diagnoses.

Based on Chi-square test results, age and sex were included in the multinomial logistic regression. As shown in Table 4, the odds of employees being diagnosed with MDD if they were female, using the PHQ-9 scale, were almost twice that than if they were male (OR 1.81, 95% CI 1.19–2.75). There were no significant associations between MDD and age.

There were no associations between GAD or PTSD, and either age or sex (Tables 5 and 6). Although occupational category met Chi-square test criteria for inclusion in the regression model for GAD, no significant associations with GAD were found.

There was a strong association between AUD and both sex and age (Table 7). The odds of employees being diagnosed with AUD if female, using the CAGE scale, were about four times lower than if male (OR 0.23, 95% CI 0.13–0.42). The odds of employees aged 20–29 years being diagnosed with AUD were about three times that of those aged 50–60 years (OR 3.71, 95% CI 1.32–10.42).

Table 4. Association between MDD, and age and sex

Characteristic	n	OR	AOR	95% CI	p value
Age group (years)					
20–29	679	0.62	1.87	0.73 – 4.80	0.196
30–39	917	0.07	1.07	0.41 – 2.79	0.886
40–49	325	0.67	0.51	0.15 – 1.70	0.274
50–60	147	1.00 (ref)	-	-	-
Sex					
Female	693	0.59	1.81	1.19 – 2.75	0.006
Male	1 375	1.00 (ref)	-	-	-

AOR: adjusted odds ratio

A third of employees (n = 697, 33.7%) met the scale criteria for an interview with a clinical psychologist. Two hundred and twenty-eight (11.0%) were diagnosed with one or more CMD, using the scales, but only 145 (7%) were clinically diagnosed with one or more CMD. The prevalence of all four individual CMDs based on the self-report scales was significantly higher than that based on the clinical diagnosis (Table 8).

DISCUSSION

When compared to general population data (SASH study 12-month prevalence), the prevalence of mood and anxiety disorders was lower in this working group. The protective effect of employment on depression has previously been described,[43,44] and could have contributed to the lower prevalence of MDD in our study participants. While the same may apply to anxiety,[44] the lower prevalence of anxiety disorders may be an artefact of data collection, as only certain anxiety disorders were

Table 5. Association between GAD, and age and sex

Characteristic	n	OR	AOR	95% CI	p value
Age group (years)					
20–29	679	0.26	1.30	0.56–3.00	0.539
30–39	917	0.28	0.76	0.33–1.76	0.522
40–49	325	0.54	0.58	0.21–1.60	0.294
50–60	147	1.00 (ref)	-	-	-
Sex					
Female	693	0.42	1.52	0.97–2.36	0.066
Male	1 375	1.00 (ref)	-	-	-

AOR: adjusted odds ratio

Table 6. Association between PTSD, and age and sex

Characteristic	n	OR	AOR	95% CI	p value
Age group (years)					
20–29	679	0.46	1.58	0.36–6.91	0.544
30–39	917	0.34	0.71	0.16–3.25	0.661
40–49	325	1.00	0.37	0.05–2.67	0.323
50–60	147	1.00 (ref)	-	-	-
Sex					
Female	693	0.58	1.78	0.90–3.50	0.095
Male	1 375	1.00 (ref)	-	-	-

AOR: adjusted odds ratio

Table 7. Association between AUD, and age and sex

Characteristic	n	OR	AOR	95% CI	p value
Age group (years)					
20–29	679	1.31	3.71	1.32 – 10.42	0.013
30–39	917	0.82	2.27	0.80 – 6.40	0.123
40–49	325	0.10	1.10	0.34 – 3.60	0.870
50–60	147	1.00 (ref)	-	-	-
Sex					
Female	693	1.45	0.23	0.13 – 0.42	< 0.001
Male	1 375	1.00 (ref)	-	-	-

AOR: adjusted odds ratio

Table 8. Diagnoses of CMDs, determined by screening scales and clinical interview

Mental disorder																Diagnostic tool							
MDD				GAD				PTSD				AUD				Scale				Interview			
PHQ-9		IV		GAD-7		IV		PC-PTSD-5		IV		CAGE		IV		Total diagnoses		Total with ≥ 1 CMD		Total diagnoses		Total with ≥ 1 CMD	
n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
93	4.5	74	3.6	103	5.0	62	3.0	39	1.9	25	1.2	149	7.2	83	4.0	384	18.6	228	11.0	244	11.8	145	7.0

included in the screening scale measurements. The GAD-7-scale identified cases of clinically diagnosed generalised anxiety, as well as panic and post-traumatic stress disorder. This observation that the GAD-7 scale screens for more than GAD follows international findings,[45] and suggests that the scale might serve as a screen for a broader range of anxiety disorders. Further research is needed to explore this. The prevalence of PTSD was comparable to that reported in other population-based studies, while the prevalence of AUD was comparable to that in the SASH study but lower than that reported in other local studies. This was unexpected given the reported increase in alcohol abuse in South Africa since the SASH study was conducted.[46] The context (screening during occupational health surveillance) might have biased responses, resulting in under-reporting of alcohol abuse. The finding that a third of those diagnosed with any CMD had more than one CMD was consistent with recent local studies.[47,48]

The association of increased prevalence of CMD diagnosis with an increase in age, reported in the SASH and other studies, was not seen in our study, perhaps due to the large discrepancies between the numbers of employees in each age group. Nevertheless, the higher prevalence of CMDs in the 20–29 years age group may speak to a need for closer monitoring of new entrants into the labour market.

With regard to sex, South African women tend to report more severe mood symptoms than men, using the PHQ-9,[49] consistent with observations that they are more frequently diagnosed with MDD than men.[50] This was reflected in our study findings. Similarly, South African men tend to report more indicators of problematic alcohol-use on the CAGE than women,[49] and are more often diagnosed with AUD,[5] which is supported by our results.

No data on stressful or traumatic workplace exposures were available, but the finding that there were no significant differences in CMD prevalence across occupational categories suggests that there was little occupation-specific vulnerability in this sample. This finding also provides support for reports that, depending on context, work characteristics may be stronger contributors to CMD than occupation.[20]

For each mental disorder in this study, self-report scale scores suggested a higher prevalence of CMDs than did the clinical interview outcomes. This is not unusual, considering that personnel participating in mental health evaluations have been found to more readily report symptoms of distress when undergoing self-report screening than when participating in person-to-person clinical interviews.[51] It would thus be important to more fully consider the role of screening measures as a valid mode of occupational mental health surveillance, where outcomes would need to be further investigated to determine clinical mental health status.

Some of the scales used here – the PHQ-9, GAD-7, and PC-PTSD-5 – have been validated locally and may be fit for purpose.[49] However, the difference in self-reported and clinical diagnoses of AUD points to the need for a scale with higher specificity than the CAGE. A tool like the AUDIT (Alcohol Use Disorder Identification Test) may be more appropriate for local use.[52] For all four screening scales in this study, further research is required to confirm scale validity in local workplace contexts.

Limitations

The study was a cross-sectional profile of workers who participated in a health surveillance programme, and the findings do not represent any larger community or industry in South Africa. Specifically, these employees were drawn from working environments where a system of occupational mental health promotion was well-established – perhaps informing a relatively higher degree of mental health awareness, symptom articulation, recognition and reporting, as well as mental health-seeking behaviour than that usually found in workplaces in South Africa.[53] In addition, the employees had relatively good access to mental health services (e.g. through the occupational health surveillance referral system from where the data came), which may have resulted in a lower prevalence of CMDs. Given the generally limited access to mental healthcare in the wider South African workforce, the prevalences reported in this study are probably conservative estimates.

Further, although all participants had completed at least 10 years of formal schooling, the role of language remains a challenge. Screening measures rely on respondents' literacy with regard to the semantic descriptions of mental distress. Although most of the scales used have evidence of local validation, language proficiency was not measured, and might have influenced responses.

CONCLUSION

This study provides a description of CMD prevalence in a sample of workers. The relatively high current prevalence of AUD, MDD, and GAD suggests that these CMDs are the most likely to occur in the workforce. Occupational health programmes should take cognisance of mental health aspects, in addition to conditions such as HIV, TB, obesity, hypertension, etc. The study was conducted prior to COVID-19 and thus there may now be a far greater burden of CMDs in workplaces. There is a need for greater awareness of the importance of effective employee assistance/wellness programmes (and other mental health programmes) in the workplace.

KEY MESSAGES

1. Mental health surveillance programmes in the workplace are important.
2. The main CMDs that should be screened for are AUD, MDD and GAD.
3. It is important to use appropriately validated scales for screening CMDs.
4. To mitigate the risk of over-reporting, scales should be used to screen, rather than diagnose CMDs.

DECLARATION

The authors declare that this is their own work; all the sources used in this paper have been duly acknowledged and there are no conflicts of interest.

AUTHOR CONTRIBUTIONS

Conception and design of the paper: CHvW
Data acquisition: CHvW
Data analysis: CHvW, JHM, WAJM
Interpretation of the data: CHvW, JHM, WAJM
Drafting of the paper: CHvW, JHM, WAJM
Critical revision of the paper: CHvW, JHM, WAJM

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