EDUCATION AND HEALTH STANDING COMMITTEE

INQUIRY INTO MENTAL HEALTH IMPACTS OF FIFO WORK ARRANGEMENTS

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 25 MARCH 2015

Members

Dr G.G. Jacobs (Chair)
Ms R. Saffioti (Deputy Chair)
Mr R.F. Johnson
Ms J.M. Freeman
Mr M.J. Cowper

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Hearing commenced at 10.33 am

Dr NATHAN GIBSON
Chief Psychiatrist, Office of the Chief Psychiatrist, examined:

Dr SIMON BYRNE
Psychiatrist, examined:

The CHAIR: Thank you very much, gentlemen, for your appearance before us today. We are the Education and Health Standing Committee. Graham Jacobs is my name; I am chairman of the committee. On my left is Rob Johnson and on his left is Janine Freeman. There may be two other members coming. They are a little late, but we may proceed. The purpose of this hearing is to assist the committee in its inquiry into the mental health impacts of fly in, fly out work arrangements. The hearing is a formal procedure of Parliament—hopefully not too formal—and commands the same respect given to the proceedings of the house itself. Even though the committee is not asking witnesses to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. On my right is Lucy Roberts and Daniel Govus—they are executive who help to keep us on the right track and run the committee, if you like; I just chair it—and Hansard is recording this proceeding. It is a public hearing and a transcript will be made of the proceedings for the public record. If you refer to any documents during your evidence, it would assist Hansard if you could provide the full title for the record. If there is anything you would like to say in closed session, please advise me.

Before we proceed, I need to ask you a few questions. Have you completed the "Details of Witness" form?

The Witnesses: Yes.

The CHAIR: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

The Witnesses: Yes.

The CHAIR: Did you receive and read the information for witnesses briefing sheet provided with the "Details of Witness" form today?

The Witnesses: Yes.

The CHAIR: Maybe I could kick off, gentlemen, and ask whether you could discuss with the committee the mental process a person goes through to reach a point of considering suicide. As part of that, what contributing factors are likely to play a role in moving a person towards suicide?

Dr Byrne: Maybe I can answer that question by referring to some of the work I have done. For five years, from 2005, I was a psychiatrist in the emergency department at Sir Charles Gairdner Hospital. Particularly in that role, as well as in many other places, of course, I had considerable experience in seeing people in a suicidal state and often post some suicidal action, like an overdose or seriously contemplating it, and therefore having been brought to or persuaded to go to a crisis service like an emergency department. It is important to understand that there are very different types of pathways to being in a suicidal frame of mind, to address your specific question. It is often said—for example, the WHO figures indicate—that 90 per cent of people who have attempted suicide have a diagnosable mental illness. This I think is sometimes a little confusing because the concept of mental illness is not a simple one. The classifications of mental illness that we use

include disorders like major depression or depressive illness, bipolar disorder and schizophrenia. These are the illnesses which nowadays tend to be described as severe mental illness. There are a number of others as well, but they are the three key illnesses. There are a number of other psychiatric diagnoses which do not really come under that category of severe mental illness. These are things like acute stress reaction, adjustment disorder, and personality disorder, although that sometimes can be very severe.

With that little bit of background, perhaps I can illustrate some of my work that I did at Sir Charles Gairdner Hospital. Supposing I was seeing a person post-overdose, who came into the hospital maybe the previous evening with an overdose and they had been medically treated, who was sufficiently recovered to be able to talk to me, and whose mental state was sufficiently clear from any effects of the drugs and so on to be able to be coherent and responsible. That is the point at which I can step in and ask what is going on. That presentation might be what we call an acute stress reaction. If somebody has had a variety of things happening—work, relationships, children, things in their life that they are not dealing with—something happens, which is usually the last straw. They might have a final argument with their partner, or whatever it is. Usually quite impulsively in that situation, with a degree of ambivalence about their suicidal intent, they take an overdose and they say, "I'm over it, I'm sick of this, I don't want to go on." The information I get from the person, sometimes fairly quickly after that, is, "Oh, that was a silly thing to do", or they would ring up somebody or tell somebody that they had done something foolish. Sometimes they would not do that; they would be found by somebody else. The next day when they were talking to me about it, they might say, "I realise that was an error. I shouldn't have done that." My task then in that situation, apart from clarifying that the person does not have an ongoing illness, is to help them problem-solve around those stresses and say, "You did this. Let's have a look at how you can do it differently", and maybe link them up with some other agency or service so they can get ongoing help. So that is one situation.

[10.40 am]

For the second situation the label that is used is an adjustment disorder; again, it is a psychiatric diagnosis. It is what used to be called reactive depression, although we tend not to use that term anymore because it can be confused with depressive illness. An adjustment disorder is a little different from an acute stress reaction, because there is an ongoing problem that the person is having to deal with. The person might have an acute stress reaction and an adjustment disorder. It can be something like—the business of this committee has looked at the FIFO workers, and that is obviously topical. Perhaps the worker or the partner is staying home, and this has been going on for six months or so and involves changing their life; it is stressful, it is demanding and it is difficult. They have to come to terms with it somehow or other; it is not going to go away. It is not an acute crisis that you can just say, "Let's solve that crisis." It could be bereavement or a divorce, or another major life change, but they do not have an ongoing mental illness. My task in that situation is to clarify exactly what is going on for the person, clarify that they do not have a depressive illness, and clarify what sorts of supports they have, how they are making use of them, what other supports they might access, and what the role of counselling might be in helping them to work through the problem. But in that scenario again, not always at the start of the conversation with me, but often during that conversation, they come to a point where their intention about suicide, or to think about suicide, has changed, because they have some pathway, some way forward, some hope, some notion that there is some way out of this mess. They were not absolutely committed to doing away with themselves in the first place, but now they have a different pathway. That is the second scenario.

The third scenario is when the person actually has a depressive illness. We do in psychiatry identify depression as an illness. We call it an illness because there is an ongoing persistent change in the mood state related to a change in the way the brain is regulating mood. It can be identified by the severity of the symptoms. It is not the fact that the person says they are sad, or depressed, or they

are not coping. That could be an adjustment disorder or a stress reaction. It is the fact that when I get the story from them, I get this story of persistent, more or less unrelenting depression day after day, and nothing cheers them up, nothing makes them feel better. There is persistent self-blame and guilt, and also, in particular, a feeling of hopelessness. We use the word "hopelessness" and you might think that it is an intellectual idea. But in this situation it is an emotional state where the light has literally gone out. There is not light at the end of the tunnel. I am often in the situation where I am saying to people that I know that is how they feel, but it is not reality. Their perception of reality is distorted; there is no hope. In that situation, suicidality of course is much more of a hazard because the person's reasoning capacity about whether this would be a good choice or not, what impact it would have on others, can be quite distorted. They could be of the frame of mind where they think that it is never going to get any better, so what is the point of going on? They think, "I am a terrible person anyway, so who would miss me? They would be better off without me." It is a different frame of mind. If I identify that scenario, then I have to take steps to ensure that the person gets treatment for depression because they are not going to get over it, certainly in that conversation, or even in a short frame of time. It might need admission to hospital, or it might not; it depends upon the degree of risk and the safety and how they can be supported and contained.
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The CHAIR: Of those three areas—the acute stress reaction, the adjustment disorder and the true depressive illness—is there a personality disorder?

Dr Byrne: Personality disorder is a different concept all together. Personality disorder is an ugly term, and I and a lot of psychiatrists do not like using it; it sounds very labelling and it is a damaging statement to make to someone, "You have a personality disorder." But the concept is that the person has ongoing problems—over years, for probably most of their life—in the way in which they relate to other people and the way in which they deal with their own emotions. You can understand it in various ways. People who have those personality-based problems can be recurrently suicidal. It can be an expression of anger against other people or themselves; it can be an expression of not coping. That is also a difficult scenario. Sometimes they might actually overdose or self-harm in some other way. Often there is that ambivalence about their degree of suicidality in that situation. They have been pushed over the line and then they want to step back. The role of the psychiatrist there is more complicated because you are trying to identify how much at risk that person is at that point in time, as well as to identify what steps might be necessary to help that person get more effective treatment. In there as well—this is the trickiest part—is that often in that situation the person has a lot of difficulty taking responsibility for their own behaviour: "I did this thing but I couldn't help it"; "My emotions drove me to it"; or "The other person was being mean to me." That is in contrast to the person who has a more robust personality, who might be having a crisis, a stress reaction, when I can have a fair conversation about their choices and options, and people then are already figuring out that they need to do things differently. The personality disorder often might not have that degree of self-reflection where they can say, "I do need to take responsibility." Often they will want to be looked after or cared for or escape from the difficulties of their life.

Mr R.F. JOHNSON: Simon, I get the impression that everything you said so far is in relation to your experiences from the five years you spent in Charlie Gairdner's, probably in emergency in helping people overcome attempts at suicide and self-harm and so on. Can I drill down a bit more and speak to what we are looking at; that is, what is happening with the FIFO workers. In your time at Charlie Gairdner's you would have seen some FIFO workers, I am sure, who had attempted self-harm, and you may be aware of some who were successful in their suicides; I do not know. Some people attempt to suicide not just in Perth, so they do not automatically go to Charlies. Some of the suicides are onsite on the mine sites or in the local towns, or wherever, and some of course are where they go back to live, such as Collie or Bunbury or wherever they come from to fly off from Perth to the mines. If they attempt suicide in, say, Collie, and they are a FIFO worker, would they automatically be brought up to somewhere like Charlies for someone like yourself to

assess and assist? With those who attempt suicide on the mine sites, did you have any role to play in assisting those people? In your opinion, what percentage—because people from all streams of life do suicide or attempt suicide, for all sorts of reasons, and I am sure you would agree with that. My final question in relation to this area: I have never believed that you have to be considered mentally ill to contemplate suicide. Something can happen on the spur of the moment and you just feel, "I've had enough; I just want to go now." You do not have to be mentally ill to do that. Would you agree with that scenario?

[10.50 am]

Dr Byrne: First, I have not worked in only the emergency department at Sir Charles Gairdner Hospital; I have been in psychiatry, mostly in Perth, for 30 years. I have worked at Heathcote and Graylands and had other roles in hospitals and private practice.

Mr R.F. JOHNSON: Perhaps I could enlarge that then to the 30 years' experience, instead of the five years.

Dr Byrne: I would not want to give the impression that the emergency department at Sir Charles Gairdner Hospital is the preferred location to see people with suicidality. The only reason I went to work there in 2005 was the vast numbers of patients who were presenting there. There had not been a consultant psychiatrist in the emergency department previously but, as you know, there have been huge problems with acute presentations to emergency departments and it is more about trying to meet the demand than providing a rational service. A more rational service really is one where the first point of contact is the primary healthcare worker. So going back to your question, if it is in Collie, it would probably be the GP. If it is on the mine site, it would be maybe the GP, or the medic or nurse onsite. It is important for those people to have the appropriate knowledge, training and skill to be able to make the necessary preliminary assessment and then to go through pathways. Say it was the GP in Collie, it might be that the GP themselves feel they are quite competent to handle that scenario and make the assessment and see it through, or maybe refer to a local psychologist or get advice from the community mental health clinic in Bunbury, and I think there may be a community mental health nurse outreaching from Bunbury to Collie. We are much better off now than we were 30 years ago in the sense that there are a lot better community services and local people know what are the local pathways.

Drilling down on your question a bit more, prior to that the dilemma is: is that suicidal person or the person who has overdosed actually going to be directed to seek help? They might seek help of their own accord; it might be a family member; at the workplace there might be processes. The other part of that question, if you like, relates to before the suicidal act, before the feelings of being on the brink. All psychiatrists, including me, have seen many, many people who are appropriately referred because they have suicidal thinking as well as problems in their life. I saw a FIFO worker this week in precisely that scenario. He lives with his parents in the hills. He was referred by his GP to a psychologist because his marriage is breaking up. The psychologist was concerned whether he might have a depressive illness and also about his level of suicidality. There is a good pathway there. This is well before anybody has actually attempted suicide, and I do not assess this man as likely to attempt suicide in the near future. You could call it preventative, but it is really more appropriate help to the person before they get to that point of crisis.

To your second point about not having to be mentally ill to consider suicide, I agree absolutely. I make two comments about that. When I make that distinction between severe mental illness and these other categories, like stress reaction and adjustment disorder, I think psychiatry or the mental health community is often quite reasonably criticised for pathologising, by having a label for different forms of human behaviour. What we call an acute stress reaction or an adjustment disorder, calling that a psychiatric diagnosis, well, we all have acute stress reactions, we all have adjustment disorder—do you want to call all of these psychiatric disorders? It is a kind of confusion really. The reason we have it as psychiatrists is that it helps us to think about how we are going to

categorise this. But to call it a disorder is misleading. It is more like, as you say, the person who thinks, "I've had enough."

The other scenario—I do not know whether it is within your scope—is more difficult. It is the concept of what you might call a rational suicide. It is not the emotive "I've had enough"; that is, "I've had enough of this relationship" or "I'm overwhelmed", because that might pass. You adjust the stress, you deal with the problems and you face up to the issues, and then you have no longer had enough; you have made the necessary changes in your life so you can go on. I have seen people with chronic illness, for instance. A typical example is a patient with chronic renal failure who has to have dialysis three days a week and who has a very restricted lifestyle. They feel very unwell, even with dialysis, and I am asked by the renal physician to go and see the person on dialysis because he wants to stop dialysis. This is equivalent to suicide because the person will die in two weeks. My task there is to determine whether the person has a depressive illness, which they might have and which could be treated and they might come to think differently. But if they do not and if the person is of that frame of mind, then this becomes an ethical question of what is the appropriate course of action; what does the family feel; has the person really given it an adequate consideration? But it is not an irrational judgement; it is an evaluation the person has made of their life situation.

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Dr Gibson: Beyondblue conducted a recent study on doctors and their mental health. You may have seen that. I think one in 10 medical students had thought about suicide in that preceding year, which is quite an amazing figure. The committee might have comments about medical students as a group, but they are generally a bright group and generally—not always—a well-adjusted group, yet there is still this evidence. That backs up Simon's comments there.

The other thing we cannot forget is that for some people, thoughts of suicide can be comforting in the sense that if it gets too much for them, they have a way out. Bizarrely it can be used as a strategy to calm oneself, for some people. It really does depend on the individual drives for that person. The other component which is really important to mention, as well as that sense of hopelessness, is that sense of public shame, of losing face. I am not saying that goes across all suicides, but in a lot of suicides, certainly with men where they lose their job or their wife is leaving them and there is a real sense of shame in the face of other people that they have done something which has brought shame upon them, that can be a very strong driver for certain groups.

Mr R.F. JOHNSON: Would that relate to FIFO workers in comparison to general members of the community?

Dr Gibson: I think that is probably just a general comment. It really does get down to the individual I think as to what is happening there. I would not think that FIFO workers in and of themselves are a particular personality cohort—Simon might comment on that—but those issues that are relevant for everyone else will be relevant for FIFO workers.

Mr R.F. JOHNSON: Would you say there is a higher than healthy percentage of FIFO workers who contemplate or actually do suicide compared with people in other occupations in the community?

Dr Byrne: This report has some figures relating to that—suggesting not. It is still a cause for concern, but —

Ms J.M. FREEMAN: That leads into my question which is about FIFO workers, who are demographically male with an average age of 35 to 40. We have had evidence also given to us by beyondblue that some of the risk factors—it is a question of whether you can have risk factors because you talk about acute stress reactions and so on—are isolation, self-efficacy or control, for males. When you look at those particular demographics, one piece of evidence that was given was that yes, there was this aspect of community out there which is stressed, but the FIFO workforce in

terms of flying people in and out, or driving them in and out, and putting them in isolation turns it up. Do you have any comments with respect to that? Also FIFO workers have the highest rate of divorce as well. In terms of that, are they risk factors that place them at greater risk of acute stress reactions, adjustment disorder and depressive illness?

[11.00 am]

Dr Byrne: Absolutely. The other interesting fact about seeing people post overdose or in the emergency department or the acute suicidality of people in crisis is that you very quickly realise when you are doing that work that by far the commonest immediate event preceding the suicidal behaviour is some relationship disruption; it is probably 80 per cent.

Ms J.M. FREEMAN: Eighty per cent did you say?

Dr Byrne: Yes, that is based on my experience; it is not a research figure. But it is pretty robust experience, almost to the extent that, it is not that I make assumptions but I am wondering about that with every person I see; what is happening in their relationships? It is not difficult to understand, of course, because close personal relationships, intimate relationships, are obviously one of the most vital things in anybody's life. Sometimes there is unhappiness, conflict, rupture, breach, not getting on. But coming back to the specifics of your question, a FIFO worker often has a young family and that is often why they are doing it, to get the mortgage paid off and that sort of thing. They think it will be okay. The stress of having a young family is significant. For women, being isolated at home with children under five is in itself a risk factor for depression because of the isolation and stress. It is supposed to be the happiest time of your life, and it can be, but it also can be really tough when the husband is there and not there; what that means for the relationship; how they then deal with each other; what they do during their recreation time. All of these factors compound that problem of relationship stress, which then feeds into stress reactions, adjustment disorders and divorce. Depressive illness can be a complication of those things—suicidality and alcohol and drug abuse during the time off. All of those factors add up.

Ms J.M. FREEMAN: What about that issue of isolation and control when they are actually on the job? Have people talked about that at all?

Dr Byrne: Yes. In fact, anecdotally, if we could talk about an instance of a person I saw recently, without giving any personal details, in his workplace his job is to be in a control room. I have a good idea of what that involves. He is on his own and he has to ensure that all his operations go smoothly. I had a discussion with his psychologist about him taking time off work and what we were weighing up together was that the work was a structure, and it was a distraction from the fact that he is going through a divorce. He is coping with his emotions. Is it better than sitting at home at his parents' place having nothing to do versus the minimal human contact? He goes home to the place where he sleeps, the donga. I had this conversation with him too: How do you deal with that? What do you do when you are alone like that? He said that at work it was not so bad; he just does the job. Then he just tries to sleep and go back to work.

Ms J.M. FREEMAN: It is not the healthiest situation for him, would you say?

Dr Byrne: No.

Mr M.J. COWPER: How many of these relationship breakdowns you have been dealing with have an undercurrent or a precursor of financial stress?

Dr Byrne: All of them.

Mr M.J. COWPER: All of them?
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Dr Byrne: Well, I do not know. Obviously I see people who are not coping. Whether there are other people out there who are happily making the dollars and paying off their mortgages, I do not know. The ones I see —

Mr M.J. COWPER: That is what I am referring to, the ones you see.

Dr Byrne: — are worrying about money, how long the job will last and all of those sorts of issues. It is definitely another worry.

The CHAIR: Of those categories, those that you see in your experience, how would you break up in the cohort acute stress, adjustment disorder and depressive illness? If you had 100 per cent, for instance, in that area, how many would you see that would have acute stress reaction, how much would be that adjustment disorder phenomenon, and how many would be depressed?

Dr Byrne: I guess there are two questions there. One is: how common are those things in the community? Secondly, how common are they amongst the people who seek help or who might attempt suicide, which is not quite the same thing? How common are they in the community? The epidemiological data shows that at any one time—so in any six-month period—about five per cent of the population, male or female, will be suffering from a depressive illness, so one in 20 people. Nothing like that number seek help. When you go out and do proper surveys and knock on doors, you find that is what is going on, but nothing like that number seek help. Stress reactions and adjustment disorders have not really been measured in any modern epidemiological surveys, but if you go back to previous research, which is difficult to interpret, it is over 50 per cent at least. Everybody has stress reactions and everybody has an adjustment to sort out at some time in their life. Everybody has had at least bereavement, divorce or some personal tragedy.

Mr M.J. COWPER: A teenager.

Dr Byrne: A teenager, absolutely—all of these things. That is why I am critical of calling these psychiatric diagnoses, because when it applies to everybody, it is a bit meaningless.

Ms J.M. FREEMAN: Some of the comments we have had in hearings is that some people are suited to FIFO and some are not. There has been some suggestion that you can psychologically test and screen out the FIFO workforce for people who may have suicidal tendencies. Given that pretty much everyone has acute stress, adjustment disorder and depressive illness, do you believe that employers could introduce some psychological testing of FIFO workers to ensure that they limit the risk?

Dr Byrne: I think you would have to be careful with that.

Ms J.M. FREEMAN: So do I.

Dr Byrne: It could be a bit of a blunt instrument really if at any one point in time you are trying to assess whether this particular person has ever thought of suicide. I do not think that would be very discriminatory. I think the people with a severe personality disorder would tend to be self-excluded; they tend not to stay in employment anyway. We are talking about the average mature adult. They do sort of screen out the drug and alcohol abuse and try to monitor that, and that is important. But beyond that, to me it would be more meaningful, rather than saying let us figure out if they are one of the people who are going to fall in a hole, to take a more preventative approach and say, "You're going to be our employee. What's going on in your life? What sorts of stresses are you going to experience? What sorts of stresses will your family experience? What might we need to do to ensure that you will be able to do this job without falling over?"

[11.10 am]

Ms J.M. FREEMAN: In terms of that, do you have any other preventative aspects, given treatment that you recommend people to go to? Do you believe employers can play that preventative role? Do you have any suggestions about what employers can do to make a difference?

The CHAIR What would the system look like, Simon? Would there be a system that you could set up?

Dr Byrne: I suppose there would be. Obviously, what they now call mental health literacy—it is another of those silly terms, isn't it—there needs to be education. Some of that goes on, but it is not always delivered in the appropriate manner. I saw a fellow in the navy the other day and he is going through a terrible time. The armed forces have made an effort to talk about mental health and to share that with their troops, but what he was getting now that his mental health problems had become common knowledge amongst his peers, was the reaction of, "Oh, are you all right, mate?" He feels completely stigmatised by it all. There is an issue that mental health happens to all of us, not just the other bloke, and the education needs to be delivered in that format. We are all in the same boat here. It is not: are you one of those? Then there are warning signs: Are you drinking more? Are you having too many fights at home? Have you seen enough of your kids? Are you cranky with your workmates?

Mr M.J. COWPER: Do they become self-prophesising for most people?

Dr Byrne: How do you mean?

Mr M.J. COWPER: Do they almost become your reality? People start worrying about certain aspects, or symptoms of it; does that occur?

Dr Byrne: Yes, that can happen. People can self-diagnose and say, "Gee, I'm falling", and back off. The education needs to be balanced with sensible referral pathways. If stuff is going on, who is the first port of call?

Mr M.J. COWPER: The police department does psychological profiling of potential recruits. I have had this discussion with the Commissioner of Police that under the current regime neither he nor I would have got a guernsey in the police force. I just worry how that is interpreted in that situation. This is not talking about mental illness per se; it is talking about whether someone is suitable for a particular role or a particular job, which is a little bit different, I understand. It is something that has been going on for some time.

Dr Byrne: It is worrying, especially when there is this tendency to generalise the notion of mental illness to include stress reactions and adjustment disorders and things that happen in people's lives. I have seen in recent years with the growth in mental health awareness that it actually can become an additional problem for the person. They find that they are then denied employment or insurance because they have a mental health history. It is a barrier to accessing treatment. That is why I think it is important at the educational level to normalise a lot of stuff and say that this stuff could be going on, but it does not necessarily mean that the person has a mental illness, although it could put them at risk and they need to talk to someone who will then figure out what needs to be done, without that person then overreacting and saying, "Oh, he's thought of suicide, I'm going to send him to Sir Charles Gairdner Hospital." That is not helpful.

Dr Gibson: Can I just pick up on a point Simon made earlier, which was the issue of knowing the person? Each person has their own set of triggers and whilst you can do the broad education, as someone said, you cannot generalise everyone. So the testing tools we might use are blunt and broad; they are non-specific and they are not sensitive. It is that idea as part of a program about employers knowing their employee; you are not only interested in your employee but actually know something about them, know where their strengths and weaknesses are. It is about a normalised process where you are not saying, "This is mental illness. We have to put you in a box and shine a light on you to make sure you are not exploding." It is about knowing you—it is not extensive; we do not know everything about you—and kind of knowing how you operate and who you are. If we see you starting to go off the rails, we will put some support around you. A range of people will come in. As you say, you can actually exclude some people who may be really off the scale, as far as their risk issues are early, but for most people the risk issues are only going to be known as you get to know the person when they are in the job.
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Dr Byrne: Perhaps if I could add something which perhaps I did not fully expand on before. With those risk factors, I think we sometimes make the mistake of saying, "Let's tick the risk factors." If the person has the risk factors, then we have to put them in the "mental illness" category or the "about to suicide" category and ship them off and do something. But what we forget is that those risk factors are points of intervention, to identify that risk factor is there—the person does not have enough support, there are problems in their marriage, or they are drinking too much. They are things which often can hopefully be modified and the person can be helped to change.

Ms J.M. FREEMAN: Speaking of modifying those risk factors, if we think about a FIFO worker who gets on a plane and flies into an area, we have had evidence here, and certainly there are strong opinions from some members of Parliament, such as the member for Pilbara, that you would reduce those risk factors of isolation from family by placing people into those communities.

Dr Byrne: The families?

Ms J.M. FREEMAN: Yes. For example, if you are working at Cape Lambert, you can live in Wyndham.

The CHAIR: Wickham is a good example.

Ms J.M. FREEMAN: Yes, you can live in Wickham or Newman and places like that. Do you have any view that that would reduce the issues if there was a lesser culture of fly in, fly out and more of a culture of creating community around where people work on mine sites?

Dr Byrne: It is a big question.

Ms J.M. FREEMAN: Yes, it is a huge question.

Dr Byrne: And you must think that it is not only the worker, but also the family, and if there are children, the children as well and the problems of developing the community. I think Karratha is now a reasonably established community, but it has taken a long time. If you say that it is a wife with young children—that would be the commonest scenario perhaps—then she is taken away from her other family supports and so on. It could be great for some people, but it is not a panacea. There are other ways of addressing isolation than shifting the family. The way in which, say, the employer —

Ms J.M. FREEMAN: Rosters people.

Dr Byrne: — rosters people and fosters appropriate social interaction around the workplace. Employees are not allowed to drink when they are at work. That is good, but what are they going to do when they go home? They cannot play football all night. How do you help people to not feel isolated and alone? We are in the age of technology; we have Skype. We have all of these things. There are lots of ways you can help people to be in touch. I would not want to say that moving the family is not ever a good idea—some people might go for that—but I do not think it is going to work for everybody.

Ms J.M. FREEMAN: There has to be a choice though, perhaps.

Dr Byrne: It would have to be a choice.

Mr M.J. COWPER: Sometimes the choice is not given.

Ms J.M. FREEMAN: In terms of acute stress reaction and adjustment disorders and depressive illness, what role does fatigue have in those endeavours?

Dr Byrne: It is important in a commonsense sort of way for all of us. We are more inclined to be emotional and to overreact if we have not had adequate rest.

Dr Gibson: A bit like alcohol and drugs; they are a facilitator rather than something in and of themselves.

[11.20 am]

Dr Byrne: If you think of the young mother, with the crying baby and the toddler, it is an excellent illustration. What a difference a few nights' sleep makes. A young mother who is desperately distressed then becomes a person who can handle things. That is similar to stress and adjustment reactions. Rational problem-solving has often been one of the helpful pathways to dealing with things. The more people are able to be calm and relaxed about how they go about their rational problem solving, the better. In depressive illness, sleep is often disrupted by the illness process as well, and then that is something that has to be treated. As I mentioned previously, the stress reactions and the adjustment disorder, if not dealt with, can progress to depressive illness, including through fatigue and overwhelming a person's capacity for problem solving and dealing with things.

The CHAIR: In your working knowledge, what role does bullying and harassment in the workplace play, particularly if you have had any experience with FIFO workers, in causing concerns with mental health, emotional health and wellbeing?

Dr Byrne: You certainly see people, especially probably in private practice, where people have ended up being unable to work. One of the precipitants has been workplace harassment or workplace bullying. I do not have personal experience of it specifically in relation to FIFO workers, but I certainly have seen people in other work capacities where I think it is quite surprising. There is a bit of popular stigma about people who have a bad back or who have suffered workplace bullying as being malingering or not wanting to work, but for some of the people I have seen with this prolonged emotional collapse following workplace bullying, I find it alarming to see how a person can be like that for years. A patient I am seeing at the moment finds it difficult to go out of the house. Meeting any new person causes severe anxiety reactions. I worked for a year in Newfoundland in Canada and saw a fellow there who was not a FIFO worker, but a ship's officer. He had experienced bullying at work. They go away on the fishing boats for six months at a time—similar to FIFO in that sense—and he was fairly damaged. This is a bit of a rambling answer, but what I have particularly seen in relation to the bullying is the person who then is unable to work, rather than it being an acute scenario.

Ms J.M. FREEMAN: We saw Kevin Briggs last week, who is a US police officer from California. He is going around talking to people about being first responders, and stress and things like that.

The CHAIR: People jumping off bridges.

Ms J.M. FREEMAN: Yes—well, not so much people jumping off the bridge, but being the person who is dealing with that and the stress that seeing that sort of thing as a first responder creates. He talked about a number of methods; he suffered from depression and he outlined that he is on medication. But one of his strategies for ongoing health is meditation; he does transcendental meditation, which we now call mindfulness. Do you have any comments around whether that is an effective way of helping people deal with acute stress reaction, adjustment disorders or depressive illnesses? Is that something that is being looking at at the moment?

Dr Byrne: Yes. We have seen the growth of meditation and mindfulness over the past 20 or 25 years in all sorts of areas of health—not only mental health, but also in the area of chronic pain and other problems. It is now widely available and there are many skilled practitioners who can teach these skills in group or individual formats. Again, it is not a panacea. It is something that I include as part of my practice, but I explore with people what they do themselves already that might be related to that. For some people, their regular game of golf has the same impact, depending on whether they actually leave everything at the door of the clubhouse and get out there.
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The CHAIR: It does the opposite to me.

Dr Byrne: Does it?

The CHAIR: It upsets me!

Dr Byrne: Yes, and this is what I explore with people: what impact does it have on you? Some people who go for training cannot relate to it, they cannot deal with it and it does not help at all. In the acute stress situation, or when people are very symptomatic with anxiety or depression, there is a point at which you cannot do it; you have to bring it down to a certain point before a person can do it. For instance, if a mining company said it was going to rollout mindfulness for all their workers and it was going to work for everybody and help everybody, I would say that I think that is unlikely, but it is certainly a useful tool for many people.

Ms J.M. FREEMAN: Do you do it in the health system at the moment?

Dr Gibson: Mindfulness has a lot of evidence behind it in the research. In fact, for young people with behaviour disturbance there has just been set up a new therapy called mindfulness-based therapy at Bentley. A couple of world experts have just come out and provided the training for 50 Child and Adolescent Mental Health Service staff. It is actually out there and, as Simon said, it is becoming inculcated across different strategies. There are apps for it as well that people use; for example, the Smiling Mind app. Again, not everyone likes to use an app; not everyone feels as though that is a useful thing, but it is one, if you like —

Ms J.M. FREEMAN: I think you pinpointed it, Simon: it is that capacity to be doing something that leaves behind the stuff that makes you anxious or stressed, to be able to focus on what you are doing at the time.

Dr Byrne: And if you have intrusion from the other stuff, you are able to say, "Oh, yes, I'm going broke; oh, there you go. I'm just going to enjoy this golf game."

Ms J.M. FREEMAN: Yes, and to a certain extent a mining company might not rollout mindfulness to a whole bunch of boofy blokes on a mine site, but they may say, "If you come and do this activity, we're going to give you some tools to leave that stuff behind and just focus on this activity." That is their mindfulness about how they are delivering.

Dr Byrne: Absolutely; 100 per cent.

The CHAIR: I have one more question about drugs and alcohol and what part they play in depression, acute distress and the reactive concerns. In your experience, are alcohol and drugs a cause driver to this or is this just using drugs and alcohol almost like self-medication? Where are drugs the major cause and the driver to depression or these concerns with emotional health and wellbeing, or are they in response to the underlying condition and are used essentially just as self-medication to escape the worry?

[11.30 am]

Dr Byrne: You get both scenarios and you can usually figure it out in the history you get from the person. You get the person who has not been remarkable in their use of drugs and alcohol, which can be difficult to distinguish because what is sometimes remarkable in a community is not in another. The overuse of alcohol is widespread in Australia and people will often define their use as okay, but when you go into the details it is actually not okay. If you figure out that this person's use of alcohol has been moderate and then there is a change, or they are using drugs which previously they might have had a couple of goes at recreationally and now they are intensively using, you can often see it is part of a reactive pattern. But then you do see other people who have an established substance abuse problem. It might have initially been the stresses that pushed them into it, but it now dominates their life and it has to be addressed as a primary problem. Even in the stress situation I always say to people that they will cope with the situation better if they stop using alcohol and drugs to make themselves feel better. I know it makes them feel better in the short term, but it does not actually work. Usually people hear that and ease up.

Dr Gibson: I think the important thing is not to categorise these as separate: drugs and alcohol are often interbound with any associated mental illness. They are often used at that point of stress so

they can be a precipitant for a particular action or self-harm. It is really quite arbitrary to try to define them as separate or in one way —

Dr Byrne: To deal with both.

Dr Gibson: You have to deal with both; you have to manage the whole person.

The CHAIR: Is it true to say that, for instance, in a stressful situation alcohol could disinhibit someone and then make them more prone to suicide?

Dr Byrne: Absolutely.

Dr Gibson: Simon would have seen a number of people in the ED who came in suicidal and intoxicated and the following morning they are not intoxicated—they may have a hangover—and they are not suicidal anymore. They say, "I don't know what I was thinking."

Ms J.M. FREEMAN: What about amphetamines?

Dr Byrne: Did you have a specific question?

Ms J.M. FREEMAN: Actually, more than amphetamines, we are told that there is extreme use of Kronic and similar types of synthetic drugs in FIFO. Of course you cannot measure that, because they are either using it when they come home or are using the drugs that do not get picked up by the testing. We were told that in Karratha people were presenting at the ED and the hospital could not tell what drug they had taken but that it was having an aggressive psychological effect on them. Have you had that example in ED?

Dr Byrne: I have been in psychiatry in Perth for 30 years. When I was at Heathcote we started seeing people with what we called amphetamine psychosis. This was the 1980s. Amphetamines were quite rare then, and we did not see it very much. But amphetamines are horrible, horrible, horrible drugs. In the EDs we used to say, "Bring back heroin." It sounds silly, doesn't it, but people who came into the ED after taking heroin probably did not die and were not mentally damaged. From the time I started working in ED or a bit before I have had these waves of people with methamphetamine in ED and now I talk to people in Albany, Bunbury or Merredin, for example, and someone was telling me the other day that methamphetamine is everywhere now, in country towns and all over the place. It makes people paranoid, it makes people unable to deal with their emotions, it makes them think that they are bulletproof, it makes them think all their problems go away. They are poisonous, poisonous drugs. I could not exaggerate enough about how harmful powerful amphetamines are.

Mr R.F. JOHNSON: I think we have seen that over the past few nights on TV.

Dr Byrne: Yes.

The CHAIR: Thank you very much, gentlemen, for your evidence before us today. A transcript of this hearing will be forwarded to you for the correction of minor errors. Any such corrections should be made and the transcript returned within 10 days from the date of the letter attached. If the transcript is not returned, we assume that you are happy with it and it is deemed correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on particular points, please include that as a supplementary submission for the committee's consideration when you return your corrected transcript; that will be gratefully received. Thank you for your time today.

Hearing concluded at 11.35 am