EDUCATION AND HEALTH STANDING COMMITTEE

INQUIRY INTO MENTAL HEALTH IMPACTS OF FIFO WORK ARRANGEMENTS

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
MONDAY, 3 NOVEMBER 2014

SESSION FOUR

Members

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

Hearing commenced at 2.12 pm

Ms FIONA-MARIE KALAF
Chief Executive Officer, Lifeline WA, examined:

The CHAIR: Fiona, thank you for appearing before us today at the Education and Health Standing Committee. The purpose of this hearing is to assist the committee in its inquiry into mental health impacts of fly in, fly out workforce arrangements. I am Graham Jacobs; to my left is Murray Cowper; to his left is Rob Johnson; to his left is Janine Freeman; to my right is the executive, Mathew Bates and Daniel Govus; and Hansard. This is a public hearing. It is a formal procedure of Parliament. We are not too formal but they are proceedings of the house itself really, and even though the committee is not asking you 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. I have to ask you these questions before we start. Have you completed the "Details of Witness" form?

Ms Kalaf: I have.

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

Ms Kalaf: Yes.

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

Ms Kalaf: Yes.

The CHAIR: Due to the time constraints we have, Fiona, basically thank you for just perhaps giving us an opening statement, a bit of a view, for five or 10 minutes and then we can get on to some questions. Thank you for what you have given us already. We have been able to look at the very good research report that was provided to us that Lifeline commissioned.

[2.15 pm]

Ms Kalaf: Thank you. In the interests of ensuring that everything I state accurately reflects the research —

The CHAIR: I am sorry about the competition here!

Ms Kalaf: I will try to shout. I thought the best way of handling it was to talk through the "Executive Summary", and then from there open up for any questions of course that you wish to ask.

The CHAIR: Thank you.

Ms Kalaf: To put it into context —

> The Sellenger Centre for Research in Law, Justice and Social Change at Edith Cowan University was commissioned by Lifeline WA to conduct research regarding Fly-in-Fly-Out/Drive-in-Drive-Out (FIFO) worker supports. The research aimed to identify the stressors associated with FIFO work and the ways in which FIFO workers cope with these stressors. —

That was a critical part of the research —

> The research further sought to reveal which services would best meet the needs of FIFO workers. A mixed method approach was used which included the completion of a survey by 924 FIFO workers and the conduct of interviews with a sample of 18 FIFO workers.

I would like to just let the committee know that there was no extension into families of FIFO workers, nor was this a longitudinal study; so, it was a point-in-time study. I would like to go through the key points of the quantitative survey findings, if I could —

> The respondents were 924 FIFO/DIDO workers, comprising predominantly males (81.2%) and almost exclusively Caucasian (86.5%). Roughly, eighty per cent of respondents were aged 49 years or younger. One in ten were divorced and half of the sample were parents.
>
> Regarding support services, one in five workers claimed their industry did not have on-site mental health or on-site counselling facilities and one in ten reported their industry as not having an Employment Assistance Program (EAP). Female workers were more likely to access an EAP, on-site mental health and counselling services, self-help information, and their supervisors, friends and family as support structures. While younger workers reported a likelihood to access on-site counselling, older workers were less likely to talk to friends during times of stress. Tradespersons and professionals were more likely to access hometown mental health services. Single respondents working high compression roster rotations were more likely to access telephone crisis lines as support structures.
>
> A significant number of FIFO workers were not likely to make use of any mode of mental health information and services; however, differences between demographic groups did exist. Low compression rotation workers were least likely to use any of the modes of mental health information and services. Older workers were less likely to use mental health information and services available online, whereas younger workers reported a likelihood to access information and services using these modes.
>
> All workers reported getting along very well with the people around them at both work and at home. High compression rotation workers who were parents reported the lowest relationship quality with family and friends compared to high compression workers who were not parents, and low compression workers who were both parents and not parents.
>
> Overall, workers reported engaging in fewer non-effective coping behaviours compared to effective coping behaviours (3 versus 4, respectively). Withdrawing emotionally and ignoring personal needs were the predominant non-effective coping behaviours. Respondents working high compression rotations and those who were partnered reported engagement in the most non-effective coping behaviours.
>
> Lower levels of job satisfaction were reported by labourers compared to all other occupation types. Parents reported higher job satisfaction than workers who were not parents. High compression rotation workers reported higher K-10 scores compared to those working lower compression rotations, and their K-10 scores were more prevalent within the "likely to have a severe disorder" range. Partnered workers reported higher levels of overall stress compared to singles.
>
> During rotation, stress generally increased and was reported at highest levels in the days leading up to leaving for work, and reduced steadily while away, dropping to lowest levels upon returning home. Females' stress levels reduced to lower levels upon arriving home, compared to men's stress levels, and professional workers who reported higher stress the day before leaving work compared to all other occupation types. Workers earning $200 000+ —

That is, more than $200 000 per annum —

> reported higher levels of stress while at work. Higher compression rotation and partnered workers reported higher stress in the lead up to leaving for work compared to lower

compression workers and singles. Workers with no children reported lower levels of stress upon returning home compared to workers with children.

I will skip over the qualitative findings and I will now just move to the recommendations. I am happy to take questions on those. There were five recommendations. The first was to develop supports that focus on increasing help-seeking behaviour within FIFO populations. The second recommendation was to develop targeted supports. The third of our recommendations was to develop pre-employment services to help people understand what to expect from FIFO and how to cope. The fourth recommendation was to develop ongoing post-employment support services that reduce stigma and address mental health literacy and coping skills. The fifth recommendation was to address organisational culture. I can talk to the detail under each of the recommendations if you would like to now.

The CHAIR: No, that is fine. I think we would like to go to questions, if you like, Fiona. Maybe I could just start off with a very simple question—maybe it is simple. You talked about high compression and low compression. What does that mean in real terms, and where is the cut-off point for that? What is considered a high-compression roster and what is considered a low-compression roster?

Ms Kalaf: I will just get that page. I thought you would ask me a question about that. I will just give you the definition of what we looked at. The roster compression is the ratio of work days to the ratio of leave days; so, the higher the compression, the more work days for less leave days. We found that people working more like 14–seven were the ones who were on the lower compression and evidencing lower levels of stress.

The CHAIR: So 14–seven is considered low?

Mr M.J. COWPER: Then what is high?

Ms Kalaf: Sorry; high compression. I got that around the wrong way. The higher the compression, the higher the stress.

Ms J.M. FREEMAN: No.

The CHAIR: What is a high compression roster? Does that mean, obviously, that there are lots of days at work and not much time off?

Ms Kalaf: Yes, that is right. That is how we are looking at it.

The CHAIR: In an ideal world, what would be considered a low-compression ratio and what would be considered a high-compression ratio?

Ms Kalaf: Our report did not specifically look at that. I could speculate on that and I can skip to the pages and start talking to some of those findings, but we did not actually come up with a specific recommendation around compression times. But we did analyse the data based on their roster types. If you can give me a moment, I can skip to those pages of the report, if you like.

Ms J.M. FREEMAN: Your report, when you look at the executive summary specifically, made a whole bunch of findings around the different high-compression, low-compression rosters and stress levels and depression and stuff like that, but you made no recommendations based on that? Is that what you are saying?

Ms Kalaf: Yes, that is correct. We felt, as well, that it was important that we made recommendations that we were able to make a contribution to. It was a Lifeline research report and we wanted to ensure that any of the recommendations were recommendations that we were in a position to facilitate implementation of as well.

Ms J.M. FREEMAN: Okay, so your recommendations were really restricted to what Lifeline could deliver. You would not have looked at recommendations around rosters, because you could not deliver on those?

Ms Kalaf: That is right.

Mr R.F. JOHNSON: It is a very good survey that was carried out, on the surface of it, but there is no actual data that you have been able to come up with or access that gives us the information as to the number of FIFO workers who have tragically ended their lives by suiciding. Now, I realise you have not got that, but nobody seems to have that, and that is a great pity, because we need that to be able to come up with some useful suggestions and recommendations in our final report. Very often we hear on the radio that people who are having problems are recommended to phone Lifeline and talk to some of your Lifeline people, your volunteers—touch wood, I have never had to phone you. Do you keep data in as much as the number of FIFO workers who might phone Lifeline expressing stress problems, depression, anxiety and possible thoughts of, tragically, suiciding?

Ms Kalaf: No, we do not keep demographic data on callers in terms of workforce type and nature of their work. We deliberately do not capture that information, which does make it challenging to be able to give some guidance back to this inquiry in that sense. What we also found, and it overlays with the community more broadly, is that there are three main barriers to help-seeking in the FIFO environment. The first barrier is the barrier of knowledge—so, not knowing what services and supports are available; indeed, not even necessarily knowing that calling home to a family member or friend could in fact be a form of support. The second barrier—and we found these being relatively specific to FIFO—was the barrier of accessibility, or perhaps I ought to say inaccessibility; so, not having access to services even if the FIFO worker knew that those supports were available. For instance, if somebody did have a diagnosed mental illness and needed to seek regular treatment, working on some of the rosters would mean that they were simply unable to have a weekly counselling session if indeed that was part of the treatment required. In many instances, not having access to mobile phone or internet coverage meant that very simple things, like not being able to call home or, when you do call home, having only a limited time on the phone, compared to in other instances where workers reported being able to call home and perhaps Skype their children to bed, for instance, which made a huge difference in terms of stress levels for those who are parents, obviously. But by far and away the biggest barrier—the first being the barrier of knowledge, and the second being the barrier of accessibility— to help-seeking behaviour was the barrier of stigma. Particularly the qualitative research indicated that people simply did not feel comfortable seeking help for fear of being called soft or weak or, worst case —

Ms J.M. FREEMAN: Princess!

Mr R.F. JOHNSON: “Toughen up, princess!”

Ms Kalaf: Yes, “Toughen up, princess”, for fear of perhaps not being put back onto roster or not getting a promotion.

Mr R.F. JOHNSON: That is a concern, obviously. You obviously must get FIFO workers who phone Lifeline. In your experience, is that the case? I mean, you do not know the quantity compared to the other areas of people who phone Lifeline with problems they want to discuss, but there are obviously a reasonable number, would you suggest?

Ms Kalaf: I would suggest that a reasonable number of our calls made from WA would come from people working FIFO. or family members.

Mr R.F. JOHNSON: Or their families, yes. That is important as well.

Ms J.M. FREEMAN: Just with that, you said you deliberately do not capture the information. Why do you deliberately not capture the information?

[2.30 pm]

Ms Kalaf: Because of the nature of our service, when people call us, we do not ask a number of questions about them. We do not have a deliberate mechanism to capture information so it cannot be consistent. If someone happens to disclose something to us, typically their gender but sometimes

their age, marital status or working type, we may capture that. When somebody is calling and they need a suicide intervention, we focus on taking them through a care model rather than asking questions. It has also been proven in crisis lines that asking too much about the individual in what is supposed to be a confidential frame can actually limit the person's ability or desire to open up and, indeed, stay on the phone, bearing in mind that some of these interventions can sometimes take a few hours but a typical call to us lasts for, I think, 26 minutes—over 20 minutes.

Mr R.F. JOHNSON: In that time, I would imagine if it was a FIFO worker, they would give some information that would tell you that they were a FIFO worker. Would it not be useful to be able to capture that information, without intruding on their privacy and taking away the benefits of the time that you want to spend trying to steal them away from committing the act of suicide? Would it not be better for you to be able to capture that if they are quite clear in saying that they are a FIFO worker, a FIFO worker's family or whatever so you can have a bit of a database?

Ms Kalaf: We can certainly start trying to capture occupation, bearing in mind, the way the Lifeline 13 11 14 line works, it is nationally routed so it is to the first available operator regardless of where they are across Australia. Because a call emanates from Western Australia does not mean it is answered in Western Australia. There are 39 Lifeline centres that operate the telephone crisis support line. It is a matter of also ensuring that everybody is doing that consistently.

The CHAIR: FIFO workers can come from over east as well.

Ms Kalaf: Absolutely.

The CHAIR: On this high-compression, low-compression roster question, one of the findings of the report that you have been talking about, there was a belief amongst workers that rosters should be capped at three weeks on-site and that would reduce fatigue as a result of long day/night shifts and stress. What is your view on that?

Ms Kalaf: Our research did not specifically go into what the optimum compression for rosters would be but it did look at the impacts on people who were partnered or who had children. It may well be that different types of compression suit people with different personal circumstances. There is not actually one right answer across the board and people in different points of their family life and their personal life may be better or less well suited to certain roster types.

The CHAIR: How many workers are we talking and how many of the cohort believed that three weeks would be an optimal cap for on-site work?

Ms Kalaf: I do not have the answer to hand; it is in this research report. I am not sure whether it is appropriate for me to table this or to send it back to the committee.

The CHAIR: We already have your report. From the report's summary, it looks as though that was a key finding, that is all, and the belief amongst workers was that the on-site component of the work should be capped at three weeks. Is that just talk or is there some validity behind that statistically that a lot of people and how many people, for instance, believe that when they were surveyed?

Ms Kalaf: I would have to find the exact page that might give that data. I am so sorry that I do not have that information to hand at the moment.

The CHAIR: If you would undertake to give that information to us, that would be fine. We will send you a list of requirements.

Ms Kalaf: I tried to swot up on the weekend.

Ms J.M. FREEMAN: Can you just explain the difference between Lifeline and beyondblue, for example? Beyondblue has made a submission to us. I am interested in the difference between the two organisations.

Ms Kalaf: Lifeline specifically works in the area of suicide prevention and crisis support. Our primary services are our telephone crisis support service, which is 13 11 14, and an online

crisis support service. It is specifically aimed at those who are in emotional crisis and at risk of suicide as opposed to, more generally, people who may be dealing with anxiety, depression or broader mental health issues. They are the main services that Lifeline offers.

Ms J.M. FREEMAN: Beyondblue has a crisis line as well. If someone rings them and they are suicidal, do they refer it to you?

Ms Kalaf: Beyondblue does refer to Lifeline.

Ms J.M. FREEMAN: Does Lifeline refer back to beyondblue if it is not a suicide?

Ms Kalaf: If it is not a suicide and it is about seeking information on mental health, anxiety or depression, we will refer back to beyondblue.

Ms J.M. FREEMAN: That is very interesting. Thank you for that.

Some of the evidence that was said by beyondblue was that one of the critical risk factors for depression and anxiety is social isolation and lack of convention in the community. Subsequently, the AMWU discussed community in accommodation and how important it was to be able to go back into a similar community of four or five neighbours because you go there for such a period of time. Is there anything in the research that talked about the need for stable accommodation versus motelling or the changeover in accommodation so that you had your place, your feeling of being in the alternative home with the alternative neighbours?

Ms Kalaf: There were some aspects around workplace conditions but certainly when you stop for a moment and think about the fact that pretty much regardless of rosters or rotations, workers are spending more time on-site than they are at home, it becomes this balance of what is home and what is community. Is it actually the workplace that is home or is home the community? Certainly, to be able to have a more stable environment, to have a sense of community on-site and to have some level of regularity was something that we did find. We also found that some of the potential supports could be more social-based interaction, and some of the qualitative findings were around not just having places to go and drink and eat together but as a positive coping mechanism, a lot of workers would go and do some exercise or sport but, in many instances, there seemed to be limited opportunity to do team-based sports. We do know that there is a high correlation between emotional wellbeing and physical activity and social activity. If there is a way to encourage high levels of group interaction in terms of sports and recreation time, that would definitely be a benefit.

Ms J.M. FREEMAN: One of the things that Murray Cowper has raised a number of times is that when you take people into camps instead of in and out of the local communities, you remove that capacity for them to be involved in local sporting organisations. If they are in a camp and they are not in Onslow, for example, they are not volunteering for the local area and stuff like that. In terms of what you were just saying then, which is that aspect of being able to be involved in team sport, is that limited because they are in a camp site and so you have a limited pool of people who want to play that sport, whereas they would be better off in an on-site community like Karratha?

Ms Kalaf: There is the potential for that to be much more beneficial, absolutely, and also the potential on camp sites to have more organised activities was another finding.

Ms J.M. FREEMAN: Or for camp sites to go into the community. They tend to be very controlled. Did that come out in your findings?

Ms Kalaf: No, it did not come out specifically.

Ms J.M. FREEMAN: What about the capacity to leave the on-site accommodation and go into a town to participate in sport and social connections?

Ms Kalaf: That did not specifically, but the lack of self-efficacy did come out. You could say that that was a subset of a lack of self-efficacy.

The CHAIR: What is self-efficacy?

Ms Kalaf: Decision-making and being able to do, within reason, things that you wanted to do at times. The opposite in many camp sites is the highly regulated–type environment. It came out fairly strongly that that gave rise to stress for a number of respondents.

Ms J.M. FREEMAN: That certainly came out in the beyondblue contribution to us—people felt they had lack of control over them.

Ms Kalaf: Yes, that is right.

The CHAIR: This inquiry was requested by Parliament for us to do an inquiry into this issue in and around FIFO suicides. What prompted Lifeline to commission the mental health research report that you have done or has been done for you? What prompted you?

Ms Kalaf: Up to about 18 months ago, in 2012, I was repeatedly, in my capacity as chief executive, being asked to give comment on FIFO worker emotional wellbeing—to give comment on whether this was detrimental to mental health or, in fact, positive to mental health. A number of positives and a number of negatives have been cited about FIFO work. I and my team were finding it quite difficult to see any evidence one way or the other. When I was asked to present a Lifeline view, all I was really able to present was a number of individuals' opinions on the matter. It was very hard to find some research base. Whilst it is large by number of respondents, it was a fairly short and sharp piece of research conducted in the first half of calendar year 2013. We released the findings in July 2013. So that alone was what prompted us to do the research. We were keen, and still are keen, for discussion and dialogue and a greater level of understanding around FIFO worker emotional wellbeing to take place. We did have some concerns about the nature of the work and the rotations and what the impact might be, not only on the workers but on families as well. As I mentioned before, to our knowledge, there has not been a longitudinal study that can look definitively at cause and effect. We did find a number of factors. We felt in our cohort there was a statistically meaningfully larger number of divorced people than the community in general but, again, we were not able to demonstrate cause and effect or, indeed, whether there is any relationship. We also found that typically those who were not in a relationship found it less stressful working FIFO.

The CHAIR: What has been the response of the resources industry, particularly, to your report? What sort of feedback have you gained?

Ms Kalaf: Mostly, we have had a lot of interest, a lot of dialogue and, I think, we are just starting to see some action. That is in varying sorts across different organisations. For obvious reasons, FIFO does seem to be here to stay. There has not been any discussion necessarily around whether it is the right mechanism or the wrong mechanism but rather taking it as a given that this style of work will be here for the long term, so then how do we make that better for workers and also for their families? What I would like to see now is some programs and some evidence base that show us a difference. For instance, our first recommendation, as glib as it may sound, is to increase the help-seeking capacity of FIFO workers. What we do know again through research, more broadly, is that once people do take a step to seeking help for anxiety, depression, mental illness or even for emotional crisis, they will tend to be on a path to recovery or a path to betterment. What we are seeing in our research at least is a low propensity to seek help, which is really of concern.

[2.45 pm]

Ms J.M. FREEMAN: But you said it yourself, as part of that low propensity to seek help, are they not hampered in terms of that by the stigma, the "suck it up, princess", the fear of losing employment and things like that? It is not just as simple as giving them the organisations; it is actually removing the impediments.

Ms Kalaf: That is right; those three barriers: the barrier of knowledge, access and stigma. Therefore, changing the behaviours of these people working these rotations, to change the behaviour to make it okay to seek help but actually so that they will start to seek help.

Ms J.M. FREEMAN: The AMWU's evidence actually took it to the next line, which said that it is actively punitive. It said that workers would come off their depression medication when they went on site because they were concerned about having to fill in a form that identifies they are on prescribed medication for depression and they had to come off those, because otherwise it would turn up in their urine test and they did that for fear of reprisal and fear of not being put on the next plane, the next roster.

Ms Kalaf: I would find that very concerning that there would be a workplace that would take punitive action, either directly or implied, against somebody for taking prescribed medication. I do not know the nature of the work or the worksite, but as a general rule, if somebody has a prescribed medication and they are fit for work, then it would seem concerning that—which was another key part of our recommendation around improving the mental health literacy amongst all workers who are working FIFO, that there seemed to be a low level of understanding around what mental illness was or what mental health is. So, having a greater level of literacy and understanding then breeds a greater level of tolerance and a greater level of comfort to seek help as well, without the fear of being punished. Certainly, that area of stigma came up very, very strongly both in the qual and quant research findings.

Ms J.M. FREEMAN: In terms of the stigma, do you think it is greater than the general population?

Ms Kalaf: Yes, I do think it is greater than the general population. The reason I say that is from our research and from the demographic of the respondents being mostly male, mostly Caucasian, and I think the average age was 39, my intuitive sense would be that the stigma would be greater in that cohort than in the general population.

The CHAIR: Fiona, when I asked you about how the report was received by the resources industry, I think you said that you are starting to see some action. Can you tell me what action you are starting to see in response?

Ms Kalaf: We are starting to see, firstly, more conversations, which may sound glib, but, frankly it was not being talked about before and, as I said before, it is important that we raise the awareness, lower the stigma and improve the literacy. So, when we start hearing informed, safe and respectful conversations about the importance and value of mental health and emotional wellbeing in the workplace, it may not sound like a lot is happening, but that can I think be taken as quite a shift. What we would like to see more of is more on-boarding. So, more information to help workers understand what the FIFO lifestyle might be like, not only what it is like physically, but how they can keep themselves safe from stressors. Some stressors can emerge through physical stress—dehydration, for instance—so making sure that workers have access to that right level of information before they even start and then once they have started to ensure that there is a scaffolding of information throughout the time they are employed. So, from day one or week one or even month one, they may be given some information about where to go and how to seek help if they feel that they are not coping emotionally. That information may not be relevant to them at that time, but perhaps down the path for a range of reasons they may find themselves at a point of emotional crisis or distress. And what we also do know is that people in those circumstances tend to withdraw. So, if that information is not readily available to them and it is somewhere back in their induction pack which they received six months earlier, they are perhaps less likely to go back to that and find out how to access it.

What our research did find is that most of the respondents said they did not have an EAP or there was not on-site help, but then talking to employers, most of the employers were telling us, "Well, we do have that on site and we do have EAPs in place." So, it seems to be a lack of knowledge in some instances or, as I say, an induction kit given to someone on day one but perhaps not followed up with the scaffolding approach. Some other pieces around that are things like where there is information on various services and supports that are available; where that information is in a more public place as opposed to left in the privacy of someone's room, people seem less likely to have

taken it from public environments, possibly for fear of stigma or being seen to take a brochure on beyondblue or the EAP.

The CHAIR: In relation to the Kessler psychological test, which is a predictor of psychological distress, I suppose, should all workers have this test? Should it be universal? Should it be one that should be adopted in trying to give an indication that those people that could be in distress —

Ms Kalaf: All FIFO workers, you mean?

The CHAIR: Yes. And when would you use it? Would you use it at the beginning or serially through their work time?

Ms Kalaf: A lot of work would be needed to be done around that in terms of privacy, who is collecting that information, how is it used? And my sense would be that there would need to be some level of cultural shift and trust that was in place before it seemed appropriate for people to have a K10 or be, in a sense, forced to undertake a K10 and worried, if what you said before is true, that it could be used against them, rather than used to help support them and used in a productive and positive way rather than in a punitive way. I think I would be —

Ms J.M. FREEMAN: If it is not done in an environment that is about support and knowledge and that sort of culture, it could actually be counterproductive to people seeking help.

Ms Kalaf: Yes, that is right, and people may try to falsify, for instance. Potentially, perhaps, there is an opportunity to use it in an aggregated form, but again respondents would need to feel pretty confident. My intuitive sense is saying that respondents would need to feel pretty confident that their confidentiality was being protected or that they had a workplace culture that was going to use the findings in a supportive way, not in a punitive way.

Mr M.J. COWPER: The danger there is it could be skewed. If people do not have the confidence in being able to respond in an accurate manner, then it detracts from doing it in the first place.

Ms Kalaf: Absolutely.

Ms J.M. FREEMAN: In terms of the work that Lifeline does and after someone has an attempted suicide or suicidal ideation, is there sort of work that came out of the study or work that you do about returning people to work after that and the way that people can be returned to work in a safe and supported way?

Ms Kalaf: We did not look into that in terms of this research report, nor did we look into it specifically in terms of FIFO workers. However, return to work and return to as normal a routine and life as possible after a suicide attempt is important. Again, it is critical to that, that a workplace would provide a supportive environment. Regardless of sector, regardless of rotation, regardless of rosters, not all workplaces necessarily provide that level of support. That is fine if the worker can get their support else were. If they can get their support through medical professionals, through family, through friends and through social networks, but if they are unable to get that in some way either through work or outside of work, that may prove challenging for some workers to go back into an environment without essentially any support.

Ms J.M. FREEMAN: I just have one last question. In terms of talking about EAPs, employee assistance programs, one of the things that the AMWU talked about was third parties and the capacity for people, if they had an issue, to go to third parties. So, I am just interested, in terms of your discussions with employers subsequent to the report, whether those EAPs or the support mechanisms for people to talk about illness was a third party, a removed party—again, it is this fear factor aspect of things.

Ms Kalaf: Sorry, can you restate that?

Ms J.M. FREEMAN: I just wondered are EAPs considered to be third parties by workers. Are they considered to be confidential and outside and not stigmatised in terms of going to them?

Ms Kalaf: I can answer that question from personal opinion, but in terms of our research, we did not specifically look at the answer to that question. A huge part of stigma was the fear that people were going to be found out from using the EAP. It certainly did not come through so much as to whether the EAP—so the provider—was third party or within the organisation. It was more, "Somehow someone would know that I used that service and, therefore, that could be problematic for me." So that was the issue that we found.

The CHAIR: Just very quickly, Fiona, from your knowledge, the psychosocial support on site in the mining industry, what is your view in and around how that is covered as far as the number of sites that have on-the-ground people, psychosocial support, for people to access in the FIFO space?

Ms Kalaf: It would seem that depending on whom you speak to there is either enough or not enough. Look, across the state we are low on the number of mental health professionals and psychiatrists so it is a broader issue than only a FIFO workplace. That said, it would seem that there is probably room to have more psychosocial supports on site. But the issue, fundamentally, is whether or not people will seek help. What our research was very strongly focused on was the propensity of workers to seek help. So, if the help were available, what was their propensity to seek it? What we found was that it was low and that alone is of great concern. So, we found that, you know, in that sense, even if there was support available, because workers' propensity to seek help was low that was what needed to shift.

Ms J.M. FREEMAN: I suppose that is my question is: Why is it low to seek help? If it is there, what stops them? You are saying it is knowledge, stigma and accessibility.

Ms Kalaf: Yes. As I say, sometimes people do not know it is available. When they do, they do not have access to it. But the biggest barrier was that of stigma. Even if they had the knowledge and access, they were still stopped from seeking help by their own fear of being stigmatised.

Ms J.M. FREEMAN: If you have got an industry—like, we have had AMEC here and their line was: there is no problem greater in FIFO than anywhere else; it is just the same as the general public. "Yes, suicides are a problem; it is a problem for men; it is a problem for a certain age group. But it is no different for us than it is for anywhere else." I can get you the actual quote that, basically, used your research and said it was the same as—if I could do it quickly —

[3.00 pm]

Ms Kalaf: I have heard that quote before. In many respects it is not an untrue statement, based on our research. However, the thing that is fundamentally different is the nature of the work and the rotations and the rosters. I keep carping on about this: the knowledge, accessibility and the stigma means that people just are not able, for a range of reasons, to seek the help that they need to seek. That is what is important. If you have an environment where people can go home at the end of the day and on the way home, or once a week they can go and have their face-to-face counselling session, this is very different in a FIFO environment. That means that different types of supports and different types of mechanisms are going to be appropriate. We also know that men seek help at different rates and in different ways from the way women seek help. Given that our research and most other industry stats seem to say it is a heavily male-dominated environment, that gives rise to the opportunity to work specifically and develop specific mechanisms that change the behaviours of men to encourage them to seek help in those environments.

Our research also found that there was a higher level of divorced people. Divorced people have different needs; perhaps different needs in terms of access to children, perhaps in terms of financial considerations and perhaps in terms of legal considerations as well. Maybe there are other supports that are available, not just emotional support but also some financial support, some legal advisory that help relieve that ever getting to a point of emotional crisis, for instance.

The CHAIR: Excuse Murray; he has to go. Before I make my closing statement, while Janine is —

Ms J.M. FREEMAN: I actually did find it. No, I did not. Keep going, sorry. I will show it to you afterwards; I quoted you.

The CHAIR: On the issue of employee assistance programs, we might hear from other mining companies in the future, but FMG has been the only company so far to indicate that it provides full-time on-site support in the form of its chaplaincy program. Other companies have highlighted the existence of employee assistance programs but FMG appears to be the only company with a permanent on-site counselling service. It will be really interesting to see in our future deliberations how extensive and how widely employee assistance programs are in the industry.

Ms Kalaf: I think also the employee assistance programs may not be on site. The notion is that they are available but if you work on a roster or a rotation such that you cannot actually make a phone call and get a meeting, then it will prove challenging. As our research found, perhaps predictably, once you get home, stress levels are lower. Perhaps you do not take the initiative to make the call. That is not unusual in terms of men's help-seeking behaviour but across the board in the community. I think the other critical —

The CHAIR: It might be important, though, after the stressors of a workday on site, when you go home to your, I hate to say it, donga—when you go home to your facility—that that would be the time that maybe you would want to talk to someone. If there is someone on site, like the chaplain or some other person representing the employee assistance program, that is the time that people perhaps would access it and it is perhaps the time that could make a difference.

Ms Kalaf: Absolutely.

The CHAIR: Not making a phone call after work.

Ms Kalaf: Absolutely. The other thing that is important is that the literacy of mental illness and emotional wellbeing was low. Workers did not even know that things like staying hydrated can actually reduce emotional distress. Improving literacy around what emotional wellbeing is and mental health is can make a big difference as well. Some people who were accessing positive coping behaviours did not necessarily even identify that that was the case. They did not know that they were doing that in order to technically improve their emotional wellbeing, but the net effect was that was the case. I think that is another key part for some people, and perhaps indeed for many people, seeking professional counselling or seeking informal conversations with a chaplain or an on-site counsellor could be really beneficial. In other instances it may well be that being able to make a regular phone call home every day or every few days can be another important mechanism to reduce stress or to stop the stress mounting up as well.

Mr R.F. JOHNSON: Do you accept that FMG has set a very good standard by having a chaplain on site to be able to assist people who are stressed, depressed, suffering anxiety or any of those mental health disorders to be able to deal with it there and then rather than, as you say, wait until they go off site, in one week's time, two weeks' time, whatever? FMG seems to be the only one to do that at the moment, from what I can gather.

Ms Kalaf: Yes, it sounds very powerful. If the culture is such that people are encouraged and it is okay to reach out and seek help in that manner, that is absolutely a big, big step in the right direction.

Mr R.F. JOHNSON: That is what I have heard, that "Twiggy" Forrest has really got things going properly in mental health areas and trying to prevent going that further step to contemplating drastic action by FIFO workers. That is good.

Ms J.M. FREEMAN: Can I also just ask in terms of chaplains: that depends on their training and capacity. From the point of view of Lifeline, you would want to make sure that person has the skill bases to have that discussion.

Ms Kalaf: Yes, that is right. You would want to make sure that whoever was doing that counselling or that conversation had the right methods and mechanisms to handle that conversation. You would also, in the perfect world, wish to make sure that there are a number of people on site who are educated in mental health first aid and in suicide first aid. That is not only just about having the right language, but actually being able to intervene if somebody is presenting as suicidal; being actually able to intervene in the moment and prevent that suicide from occurring.

Ms J.M. FREEMAN: I do not think I could do that. It is pretty amazing. It must be very challenging training, I could imagine, in terms of that.

I want to correct the record for Hansard—it was an ABS 2007 survey of mental health and it said of 16 million Australians, half would have a lifetime mental disorder and 4.1 million people had experienced lifetime mental disorder but did not have symptoms in the 12 months prior to the survey interview. Effectively, they were saying we are no different.

The CHAIR: FIFO is no different.

Ms J.M. FREEMAN: FIFO is no different to the general public. I suppose you have said stigma is different. It sounds to me like access is different and knowledge is different. In summary, would you say that FIFO is significantly different in terms of mental illness and issues around mental illness than the general population?

Ms Kalaf: No, I would not say that. I would not say that FIFO workers had specifically a higher level of mental illness or a lower level of emotional wellbeing, but what I would say, through our research, is that they have a lower propensity to seek help and lower access to help, lower knowledge of the help and a much higher stigma to overcome; therefore, they have a higher risk. If some of those elements, particularly the knowledge and the access and of course the cultural shift, can occur, then it means somebody who perhaps has a pre-existing mental illness and is working in this environment can actually seek help in an open, safe and responsible manner that will make a difference to them.

Ms J.M. FREEMAN: Given the issues around efficacy or control, and family and those sorts of things—I understand you are saying if they have a pre-existing illness, it is a higher risk factor—but do you also think there is a higher risk factor for people because of those exposure issues of isolation, control, the family and social consequences? Is it a higher risk?

Ms Kalaf: Certainly there could be, but I am loath to say with certainty because we have not done any longitudinal studies. We know from our research that stress levels were higher at certain points, and higher than the average population at certain points as well, but we do not know what effect that higher level of stress has over time. That is the missing link, unfortunately.

Ms J.M. FREEMAN: We agree with you—that is the missing link.

The CHAIR: Thank you, Fiona. I need to read this closing statement.

Thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for the correction of minor errors. Any such corrections must be made and the transcript returned within 10 days. If the transcript is not returned within this period, it will be deemed that you are happy with it and it is correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. However, Mat will send you a list of supplementary information that we would be grateful to receive from you. That information elaborating on particular points we would be happy to receive when you return your corrected transcript. Thank you for making time to come and see us today.

Ms Kalaf: You are welcome.

Hearing concluded at 3.11 pm