Western Australian Branch

AASW

Submission to the Western Australian Parliament Education and Health Standing Committee, Legislative Assembly Re: Inquiry into mental health impacts of FIFO work arrangements

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Introduction

Who we are

The Australian Association of Social Workers (AASW) is the professional body representing more than 8000 social workers throughout Australia. We set the benchmark for professional education and practice in social work and have a strong voice on matters of social inclusion, social justice, human rights and issues that impact upon the quality of life of all Australians.

Social Workers make up approximately a third of the allied health workforce for public mental health services and comprise the fourth largest professional group in the public mental health workforce across Australia. There are 1,650 AASW-accredited Mental Health Social Workers (AMHSW) in private practice eligible to provide mental health services through the Medicare *Better Access to Mental Health Care* and the Access to Allied Psychological Services (ATAPS) programs. Additionally AASW Accredited Social Workers are eligible to provide counselling services through the National Disability Insurance Agency and the Veterans and Veterans Families Counselling Services (VVCS).

Our submission

Social workers have an ongoing commitment to delivering better mental health outcomes for individuals, groups and communities. Therefore we welcome the opportunity to provide a submission to the Western Australian Parliament, Legislative Assembly Education and Health Standing Committee on mental health impacts of FIFO work arrangements.

Fly in fly out work (FIFO) work arrangements occur across a number of industries such as resources, tourism, health and human services. For the purposes of this submission the focus is on the mining industry but one should be mindful that the issues identified and recommendation made can also be applied to other workforces such as health and allied health.

The submission draws on recent published research on the impact of FIFO work practices (see references) and the qualitative comments provided AASW Accredited Mental Health Social Workers (AMHSW) who provide Employee Assistance Program services (EAP) for FIFO workers predominately in the mining industries.

The AASW WA Branch does not seek to appear before the Committee to present our case. Should the Committee seek clarification or wish examine more closely points raised we would welcome the opportunity to appear to amplify any matters in our submission.

Explanation of terminology used in the submission:

FIFO: includes fly -in fly- out workers and drive- in drive-out workers

Swing: refers to the roster of number of work days on site and number of non work days of site e.g. 14 days on/7 days off.

Shift: refers to the number of hours of continuous work, with standard shift referring to consistent start and finish time each day and rolling shift refers to change of start and finish time over the duration of a swing/roster

Our responses

Though there is a growing Australian body of research on FIFO work practices, understanding the impact of a FIFO lifestyle on mental well-being is limited by the empirical research available. The House of Representative Standing Committee on Regional Australia (2013) recommended 'a comprehensive study into the health effects of FIFO/DIDO work practices and lifestyle factors.' (Recommendation 8) to better inform public policy making, industry practices and community based support services.

The Australian Institute of Family Studies (2014 p2) concluded that based on existing research, a FIFO lifestyle can have a diversity of impacts from potentially positive to negative 'according to a range of contextual factors, such as workplace culture, types of rosters and recruitment practices as well as community, home and personal factors'.

1. The contributing factors that may lead to mental illness and suicide amongst FIFO workers

a) **Not all workers are the same**: evidence from the literature (AIFS 2014; Meredith, Rush and Robinson 2104) and from accredited mental health social workers (AMHSW) indentified demographic differences in the capacity of FIFO workers to deal with life challenges.

The Lifeline WA study (Meredith, Rush and Robinson 2104) found compared to the general population there is a higher prevalence of psychological distress amongst FIFO workers (collectively 30%). At the same time the study found on average FIFO workers reported being able to deal with life challenges, though high income earners employed in the category of professionals and tradespersons reported a higher level of self-efficacy than lower income workers such as labourers.

Single workers and workers without children reported engaging in more constructive coping strategies than partnered workers and divorced workers primarily with children (Meredith, Rush and Robinson 210). While the Lifeline WA study did not identify FIFO women experiencing greater stress, reference is made to other research that FIFO rosters were an additional stressor for women and that women were not prepared for dealing with the FIFO life style of needing to live a 'double life'. Also the research consulted did not make mention or provide empirical evidence on the experience or specific needs of Aboriginal and Torres Strait Islander FIFO workers.

Those with higher educational attainment are more willing to seek formal and informal support services, suggesting that the stigma associated with help-seeking is in fact lower within this group than for lower skilled workers.

b) **Not all employers are the same**: evidence from the literature and AMHSW indentifies variation in employment practices, working conditions and organisational culture impacts on mental health wellbeing. For example, poor quality of accommodation and food, a lack of onsite sporting/recreational facilities and overly onerous rules during work time and personal time can lead to significant levels of worker reported stress (AIFS 2014; Meredith, Rush and Robinson 2104).

Accredited mental health social workers also noted that their clients reported that the attitude of management (in particular line manager) effected how much an employee divulged about their health/metal health circumstances and the degree to which they sought assistance for example

to get home in a family emergency. These social workers also noted that large organisations did not necessarily demonstrate better work practices/work culture.

c) **Rosters and Shifts:** there is considerable evidences (AIFS 2014; Meredith, Rush and Robinson 2104) that some rosters have more deleterious effects on worker and family wellbeing. Highly compressed rosters (where the work cycle is significantly longer in length than the time on leave from work) were more likely to be experienced as stressful by the worker and/or their partners.

   The research evidence that the more time spent away from family and friends impacts negatively on physical and emotional well-being and family relationships is borne out by comments made by the clients of accredited mental health socials workers. Their clients generally reported a preference for 14/7; and 14/14 and 8/6 'swings' ,with the 4/1 'swing' avoided even when there are much higher financial rewards attached.

   Length of shifts and rolling shifts are also indentified as contributing to worker stress. Shifts longer than 12 hours and shifts with short breaks between finish time and the next start time make it difficult for workers to relax during non work time or to engage in effective coping strategies such as exercise, socialising, or having enough sleep.

d) **Roster rotation**: Research evidence and AMHSW report that worker stress increases in days leading up to leaving home for work, reduces steadily while at work and is at its lowest level in the initial days at home. There are some demographic differences with partnered workers experiencing greater stress in the days leading up to leaving for work and in the first few days after returning home. Workers without children experienced less stress as they moved through their 'swing' than those who have children. (AIFS2014; Meredith, Rush and Robinson 2104)

   AMHSW also noted that family conflict is heightened in days just prior to returning to work.

e) **Non effective coping strategies:** these include withdrawing emotionally and ignoring needs**;** irritability; poor diet and alcohol and drug consumption all contribute to poor mental health. It is likely that rotation and shift characteristics reinforce avoidance behaviours rather than strategies that address personal needs.

   The research and AMHSW identify that roster schedules also contribute to difficulties FIFO workers have to initiate effective coping strategies such as organising and keeping appointments with offsite health, mental health and support services. .

f) **Lack of individual autonomy and decision-making**: a work place culture that emphasise following regulations and monitoring (for safety) that restricts the choices workers have during work time and 'off time' (such as meal times, freedom to move, time to clean their room, and drink in their room) in the long term has a negative impact on individual autonomy and decision-making. The Lifeline WA research notes 'some FIFO workers appeared to display a highly 'trapped' outlook regarding their situation and ability to change it. Having committed themselves to significant ongoing financial obligations (i.e. mortgages), they felt unable to leave FIFO work, regardless of their stress and dissatisfaction with it' (Meredith, Rush and Robinson 2104 p82).

2. The current legislation, regulations, policies and practices for workplace mental health in Western Australia

This submission does not make comment on current legislation, regulations and policies for workplace mental health Western Australia. Comments are directed to the matter of practices for workplace mental health.

a) **Availability of workplace mental health or counselling services:** not all workplaces/ employers offer mental health related support services on site or offsite. Lifeline WA (Meredith, Rush and Robinson 2104, p.46) found that 'nearly one in five workers claimed that their industry no did not have on-site mental health or onsite counselling facilities... and one in ten reported their industry did not have an Employee Assistance Program .

b) **Underuse of onsite mental health and counselling services**: Lifeline WA (Meredith, Rush and Robinson 2104 p8) attributed the underuse to a 'suck it up princess, you just do its' workplace culture. A significant number of FIFO workers were not likely to make use of any mode of mental health information and services, however, there are differences based on demographics. Females are more likely to access a range of informal and formal support structures and services, while males primarily turn to informal support structures such as friends. Younger males (19-20) and females are more likely to access onsite counselling while older males (+50) are less likely confirming for this age group a perceived stigma associated with metal health help seeking behaviour.

   Based on the Lifeline WA research it would seem that there is a relationship between income level and preference for onsite or offsite mental health services. High income earners (professional and trades) had a preference for offsite/ home support services (perhaps because they could afford to) whilst lower income workers more often used onsite services.

c) **Occupational Health and Safety:** ensuring safe work practices is designed to support workplace health/mental health. But there is evidence that the challenge to ensure the job is done within the allocated time frame and done safely can contribute to worker stress. The Lifeline WA (Meredith, Rush and Robinson 2104 p83) reported that some workers felt unable to apply self-perceived common-sense judgments and also reported feeling vulnerable to intensive scrutinising, intimidation and threats of job loss'.

d) **Effective coping strategies:** there is evidence that most FIFO workers engage in more personally effective coping behaviour than less effective coping behaviours (AIFS 2014; Meredith, Rush and Robinson 2104). In the Lifeline WA study the effective coping strategies most preferred were 'acceptance, seeking friends, exercise and joking'. Again working more compressed rosters and being partnered made it less likely to engage in personally effective coping behaviour.

e) **Tele- communication**: regular communication with family and friend whilst on the worksite is essential to effectively coping with the FIFO life style (AIFS 2014; House of Representative Standing Committee on Regional Australia 2013; Meredith, Rush and Robinson 2104). Access to mobile phone, internet coverage and strong wifi signal are not only essential for connecting with informal support structures but also with online counselling, mental health information and self care programs.

f) **Getting to and from work**: AMHSW reported on challenges raised by clients in relation to getting to and from work. This can involve having to travel long distances from home to work,

long waits at the airport and the need to meet the cost of travelling from home to the airport, all of which can produce fatigue and stress. For example many employers return their workers to Perth and then the worker must finds their own way home, requiring some additional hours of travel to rural WA towns, interstate or to New Zealand. Some FIFO workers resolve to remain in Perth because the 'swing' off site time is too short to travel 'home', whilst others do not return home because of the travel costs. This can mean that some workers are away from their social supports for an extensive period of time or when they may need it most.

3. The current initiatives by government, industry and community, and recommend improvements

The following recommendations for improvements are framed within a public health model for mental health based on promotion, prevention and early intervention (Hosie, G Vogl, Hoddinott, Carden, Comeau 2014), This would be directed to ensuring increased community awareness and mental health promotion; increased access to information utilising a wide range of communication channels; expanded workplace onsite and offsite programs (including peer to peer support; self help and professional services) tailored to specific at risk groups; support mental health work based training including peer support and promote research and advocacy.

a) **Need for research** to identify the variables/characteristics that promote mental health resilience within FIFO workers in order to develop policies and practices that address the physical, emotional and social needs of FIFO workers.

   As the impetus for this inquiry was the nine suicides of Pilbara FIFO workers over the past 12 months, research should be undertaken to examine the demographics of the deceased; employment history; employment/work conditions; accesses to mental health information and supports and the nature of other available employee services and so on. Drilling down to identify common threads and unique features surrounding these deaths with reference to other similar research on FIFO suicides should provide useful information on what improvements need to be made to current government and industry policy and practices as well as community matters that impact on the mental health of FIFO work arrangements.

b) **Improved recruitment processes** to provide adequate and accessible information to prospective employees and their families on the implications of FIFO employment. Screening processes to investigate the applicant's ability to live in remote locations with the possibility of a site visit prior to finalising appointment.

c) **Improved induction processes** that inform and prepare employees for transitioning between work and home; how to cope effectively with the impact of FIFO work; how to indentify symptoms associated with mental health problems; strategies for self care and normalise support seeking behaviours. The induction could include relevant family members and should be aimed at increasing self care/ self help strategies.

d) **Employers/organisations need to develop information targeted** to specific employee groups to increase their awareness of the availability of mental health and health services. This information should be provided at time of recruitment and reinforced during the course of employment to increase self care/ self help strategies and help seeking behaviours.

e) **Post employment support services** are required across employers/organisations to ensure the provision of mental health (and health) support structures and services**.** These services

need to be consistently promoted to keep awareness in the forefront of employees' minds. Design of services need to target at risk groups differently, taking into consideration particular group preferences for face to face onsite and offsite support; on line support; and peer to peer support.

f) **Work culture** can be a barrier to supporting good mental health and help seeking behaviour. The reluctance of the majority FIFO workers to seek formal support either in person, online or by telephone is connected to a workplace culture of not appearing 'soft' as well as a more general view held by the wider population of stigma and fear associated with mental health problems and seeking help. Strategies need to be developed from the ground up and from the top down that it is 'OK' to ask for emotional support and a 'good' employee is one who knows when they need help and seeks it. An organisational culture needs to be fostered that that supports self-efficacy and addresses workers' sense of powerlessness to exercise control over their lives in the highly regiment confines of the FIFO work environment.

g) **Employment awards/contracts** needs to be reviewed particularly with reference to roster and shift arrangements. Lifeline WA (Meredith, Rush and Robinson 2104 p 8) suggests 'capping rosters 'to a maximum of 3 weeks away from home would reduce the stress of family separation'. Shift rotations should be reviewed to ensure best practices are maintained that support the worker health and mental health.

References

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