

Construction site employees:

Edith Cowan University 1Life Suicide Prevention Strategy Research Report

Produced by:

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life



Table of Contents

OVERVIEW OF OCCUPATIONAL GROUP	3
EXISTING LITERATURE: REASONS FOR COMPROMISED WELLBEING.....	3
EXISTING LITERATURE: STATUS OF SUICIDE PREVENTION.....	5
INDIVIDUAL.....	5
ORGANISATIONAL.....	5
INSTRUMENT	6
METHODOLOGY.....	7
QUANTITATIVE DATA COLLECTION	7
QUALITATIVE DATA COLLECTION.....	7
LIMITATIONS	8
QUANTITATIVE RESULTS	8
PREDICTORS OF THOUGHTS OF SELF-HARM, THOUGHTS OF SUICIDE AND ACTING ON THOUGHTS OF SELF-HARM AND SUICIDE	9
QUALITATIVE RESULTS	11
OCCUPATIONAL ISSUES.....	11
RECOGNISING THE SIGNS OF A MENTAL HEALTH ISSUE.....	11
SUICIDE AND SELF-HARM	12
RECOGNISING A PERSON AT RISK OF SELF-HARM OR SUICIDE	13
RESPONDING TO THE SITUATION	13
WHAT STOPS PEOPLE FROM ASKING FOR HELP/SEEKING SUPPORT?	13
WHAT COULD BE DONE TO INCREASE THE LIKELIHOOD THAT PEOPLE SEEK HELP?.....	14
RECOMMENDATIONS.....	14
APPENDIX 1 – ADDITIONAL QUANTITATIVE RESULTS	15
APPENDIX 2 – ADDITIONAL QUALITATIVE RESULTS	18
OCCUPATIONAL ISSUES.....	18
PERCEPTIONS OF MENTAL HEALTH ISSUES	18
RESPONDING TO A SITUATION WHERE A MENTAL HEALTH ISSUE IS RECOGNISED	19
RECOGNISING A PERSON AT RISK OF SELF-HARM OR SUICIDE	19
DRUG AND ALCOHOL USE	19
SUPPORT.....	20
REFERENCES.....	21

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Overview of Occupational Group

Occupational wellbeing is typically described in a variety of ways, often comprising multiple components and measured using a variety of instruments (Karasek, 1979; Peltomaki & Husman, 2002). Although occupational wellbeing includes consideration of a worker's physical ability to work (Saaranen, Tossavainen, Turunen, & Vertio, 2006), more recent literature has focused on the worker's coping strategies, personality characteristics and positive work experiences (Cotton & Hart, 2003). Occupational wellbeing can be understood as an evaluation of the "affective, motivational, behavioural, cognitive and psychosomatic dimensions" of work (van Horn, Taris, Schaufeli, & Schreurs, 2004, p. 366). At a basic level, occupational wellbeing is characterised by high job satisfaction and low levels of exhaustion (Klusmann, Kunter, Trautwein, Ludtke, & Baumert, 2008). Conceptualisations of occupational wellbeing often include positive and negative elements, for example, job satisfaction and stress. Historically, limited attention has been given to positive expressions of occupational wellbeing although recent evidence indicates this is changing (Nerstad, Richardsen, & Martinussen, 2010; Seppala et al., 2009). In addition to the elements described above, it is important to consider both the organisational and individual implications of a workforce experiencing occupational stress (Kendall & Muenchberger, 2009) and the subsequent impact on occupational wellbeing. Importantly, to date limited attention has been paid to workers in the construction industry (Goldenhar, Swanson, Hurrell, Ruder, & Deddens, 1998).

Existing Literature: Reasons for Compromised Wellbeing

For people employed in the construction industry there are specific characteristics of their employment which can potentially compromise occupational wellbeing. These include:

- *Project based employment:* Site-based employees are exposed to unique stressors, including work-family conflict and burnout (Lingard & Francis, 2005). For many workers in this industry, job security is threatened by the project-based nature of employment with relocation due to employment adding further stress on couples (Lingard & Sublet, 2002).

- *Irregularity of work hours:* This was a significant factor in determining the quality of marital and family life (Lingard & Sublet, 2002).
- *Gender:* There is little evidence describing women's experiences in the construction industry. Among the issues specifically affecting women in non-traditional occupations are overcompensating at work, skill under-utilisation and the stress caused by gender-based discrimination and sexual harassment (Goldenhar, et al., 1998).
- *Stressful home life:* A stressful home life has a negative impact on a worker's job performance (Lingard & Sublet, 2002).
- *Job satisfaction and remuneration:* For example, one survey of engineers found many dissatisfied with their remuneration, believing the contribution they make to society through their work ought to be more adequately recognised in their payment (Lingard, 2003; Lingard & Sublet, 2002). Furthermore, employees who perceived their employer organisation as supported both their work and family lives reported higher levels of job satisfaction (Lingard & Francis, 2005).
- *Intention to leave:* There is evidence that increased levels of cynicism and emotional exhaustion predicted an employees intention to leave the construction industry (Lingard, 2003).
- *Work/life balance:* Encouraging a better work/life balance for workers in the construction industry might involve childcare/eldercare facilities, flexitime (Lingard & Sublet, 2002) and/or rostered days off for employees (Lingard, 2003). It has been suggested that these strategies should be preferred over increasing remuneration as the latter may lead to an employee feeling trapped in their job (Lingard & Sublet, 2002).
- *Organisational factors:* Some aspects of occupational burnout are caused by organisational factors and changes at the macro (i.e., organisational) level are likely to be effective to enhance wellbeing (Lingard, 2003).

Existing Literature: Status of Suicide Prevention

In general, research recommends the implementation of the following individual and organisational interventions:

Individual

- Resilience building programs;
- Mental health promotion;
- Coping skills training;
- Counselling; and
- Creating services for employees to use when they experience work related disputes.

Organisational

- Monitoring the mental health of employees;
- Having opportunities for colleagues to discuss any worries and concerns;
- Greater support from management, such as mentoring;
- Improved working conditions such as fewer working hours, more flexible hours, increased breaks and holidays;
- Signs advising of useful support services;
- Support groups; and
- On-line support services.

Mates in Construction (MiC):

MiC is a charitable not-for-profit organisation focused on suicide prevention and good mental health and wellbeing in the building and construction industry. MiC's mission is to, using existing industry structures:

- Raise awareness – via Communication, Newsletters, Training, MATES Events;
- Develop Capacity Building – via Life Skills Toolbox, MATES in Construction, Safetalk, Asist (up-skill industry volunteers and build resilience within those at risk, e.g., apprentices);
- Provide Help – via the use of Case Managers to connect workers to practical, useful help; and
- Research – gather data, partnering with research institutions, to provide useful, insightful information back to the industry.

Among the key activities of the MiC program are:

1. General Awareness Training – a 45 minute presentation that goes through taboos, myths, prevalence, warning signs to be aware of (e.g. life events, behaviour changes and emotion recognition) –1002 people received General Awareness Training between September 9 and December 2, 2011 at the Fiona Stanley site.
2. At the time of this report, 47 people at the project site have received Connector training (a 4 hour session where people are trained on how to keep a MATE safe while connecting them to help). This Connector training has SafeTALK embedded within it.
3. Two people have received ASIST training (a 2 day mental health first aid training which enables a worker to put together a safe plan for workers with suicidal thoughts) at the pilot project site.

Instrument

A survey instrument was developed incorporating the following measures:

1. Occupational wellbeing (adapted from the 2007 Wellbeing of the Professions Survey). Sub-scales are:
 - a. Collegial support
 - b. Work pressure
 - c. Occupational commitment
 - d. Intention to leave profession
 - e. Life/work balance
 - f. Wellbeing
 - g. Impact of work
 - h. Self-harm and suicidal ideation
 - i. Social wellbeing
2. The Alcohol Use Disorders Identification Test – Consumption (AUDIT-C; Bush, Kivlahan, McDonell, Fihn, & Bradley, 1998).
3. Illicit and prescription drug use test (Adapted from the Drug Use Monitoring Australia Survey)

General demographic details and workplace history was also gathered.

Methodology

Quantitative and qualitative data were collected using mixed methods via a survey and focus groups.

Quantitative data collection

Recruitment of participants was co-ordinated by the West Australian Construction, Forestry, Mining and Energy Union (CFMEU) and the builder Brookfield Multiplex. At the time of data collection, all participants were employed in construction and working at the Fiona Stanley Hospital site. A code number was assigned to each participant. All participants were asked to consent to participate in a focus group and to indicate their consent to participate in a further follow-up survey.

Participants were assigned times to attend and complete the survey in a specially designated room on the Hospital site. On arrival, an information letter was provided, explaining the project, confidentiality and the expectations of participants. Having read the letter and consented to take part in the project, participants were given the option of completing the survey independently (with assistance as required) or with the aid of a member of the research team. Upon concluding the survey, each participant was asked to consent to a follow-up survey in six months and to a focus group being conducted the following week. Participants could agree to both, either, or none. All participants were provided with information about local support services if they wished to seek help for themselves or someone they know.

Participants' personal details were only used for the purposes of co-ordinating the focus groups and distributing follow-up surveys. All information (including personal) is being stored in a secure location (locked storage facility at the Edith Cowan University). Once the research project is completed, all identifying information will be destroyed.

Qualitative data collection

Participants who expressed an interest in participating in a focus group were assigned to one of twelve groups, with an average of 5 members per group. Four members of the research team each conducted three groups. Three of the groups were also attended by an undergraduate research student.

The aim of the focus group was to explore participants' observations about suicide and self-harm in their industry and in their personal lives. In addition, participants' awareness and perceptions of services available to assist people with mental health needs were explored.

At the conclusion of the focus groups, group members were given information about available support services if they, or someone they knew, were feeling distressed. Finally, participants were offered the option of playing a game (throwing a tennis ball into an empty box with chocolate as prizes) or having a general discussion to ensure participants were prepared to return to work.

Limitations

A total of 156 individuals completed the survey and 60 participated in the focus groups. It is important to highlight that the results of this project are representative only of those employed in construction and working at the Fiona Stanley Hospital site. Therefore, the results must be interpreted with caution as they may not be representative of the total construction industry.

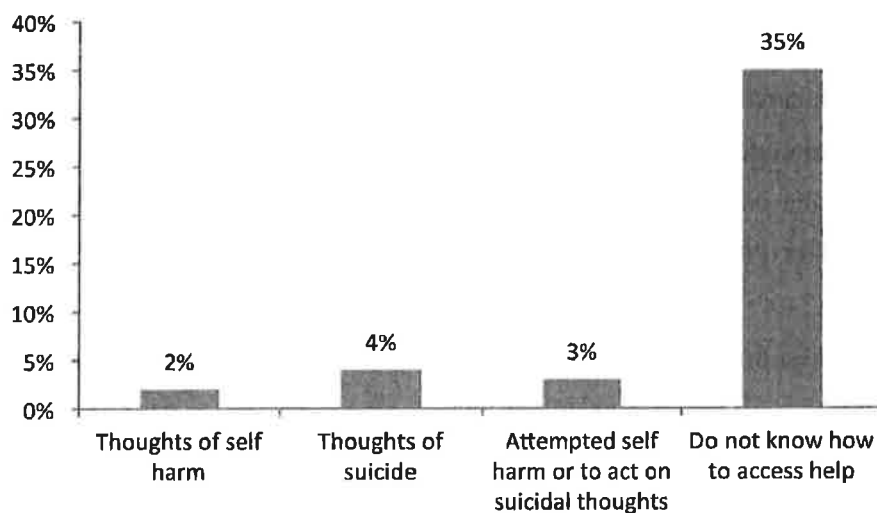
Quantitative Results

The majority of respondents were male (94%), with an average age 35 years, lived in the metropolitan area (98%), married or have a partner (84%). Twenty-eight percent had a trade (the most common being plumbers, electricians, carpenters and ceiling fixers) and 27% had completed year 10, 43% belonged to the CFMEU and 35% did not belong to a union.

Respondents had been working an average of 15 years in the construction industry, worked weekends (89%) on average 35 times a year where it was part of their weekly roster (57%), and were earning more than \$90,000 p.a. (50%). Forty-four percent indicated that they had sustained workplace injuries during their career, the most common being back injuries, broken bones, cuts, and injuries to eyes.

Two percent of respondents reported having thoughts of self-harm in the past four weeks (1% a little of the time and 1% some of the time) and 4% of respondents reported thoughts of

suicide in the previous four weeks (2% a little of the time; 1% some of the time; 1% most of the time). The majority of respondents (97%) reported not having self-harmed or tried to act on suicidal thoughts in the past four weeks. Sixty-five percent of respondents believed if they had thoughts of self-harm/suicide they would know how to access help with 39% of respondents likely/very likely to seek help from a health professional if they were depressed. A further 17% indicated they were undecided as to whether they would seek help if they were depressed (25% were unlikely and 20% very unlikely to seek professional help).



Predictors of thoughts of self-harm, thoughts of suicide and acting on thoughts of self-harm and suicide

The risk factors associated with thoughts of self-harm and suicide, and acting on thoughts of self-harm and suicide which have been examined include: age; gender; region; injured at work; illicit drug use; hazardous and harmful alcohol use; mental health; and work pressure/demands. Protective factors examined include: life/work balance; collegial support; support mechanisms; and social wellbeing. Age was included as a covariate in all statistical models. Gender and region were not significant predictors and were excluded from all the models.

Odds ratio's refer to the ratio of the odds of an event occurring in the exposed group versus the unexposed group. For example, the likelihood of having thoughts of self-harm given the person was injured at work versus not injured at work.

*An odds ratio of 1 implies that the event is equally likely in both groups.

*An odds ratio greater than one implies that the event is more likely in the first group.

*An odds ratio less than one implies that the event is less likely in the first group.

Poor mental health and work pressure were significant predictors of thoughts of self-harm and suicide. Respondents with poorer mental health were more likely (OR=1.2) to have thoughts of self-harm and suicide than those with better mental health. Respondents who reported feeling under pressure at work were also more likely to report thoughts of self-harm (OR=1.6) and suicide (OR=1.4) than those who felt under less pressure at work.

Table 1: Risk factors of thoughts of self harm, thoughts of suicide and attempted self-harm or suicide⁺.

	Thoughts of self-harm	Thoughts of suicide	Attempted self-harm or suicide
Injured at work	-	2.8(0.5,16.9)	1.1(0.1,8.3)
Illicit drugs	-	3.3(0.5,21.7)	0.5(0.1,5.9)
Hazardous and harmful alcohol use	0.5(0.1,5.6)	0.4(0.1,2.6)	0.2(0.1,1.8)
Mental Health	1.2(1.1,1.4)*	1.2(1.1,1.4)*	0.9(0.7,1.2)
Work pressure	1.6(1.1,2.5)*	1.4(1.1,1.9)*	1.1(0.8, 1.6)

⁺Demographic factor age was entered into all models

*significant at p<0.05

Respondents who reported greater collegial support (OR=0.8) and who felt people such as supervisors, work colleagues, partner, family and friends were willing to listen to their personal problems (OR=0.3) had lower odds of thoughts of suicide than those with less collegial support and fewer people willing to listen to their personal problems.

Table 2: Protective factors of thoughts of self harm, thoughts of suicide and attempted self-harm or suicide⁺.

	Thoughts of self-harm	Thoughts of suicide	Attempted self-harm or suicide
Work/life balance	0.7(0.5,1.1)	0.8(0.6,1.0)	0.9(0.6,1.2)
Collegial support	0.9(0.7,1.1)	0.8(0.7,0.9)*	1.0(0.7,1.3)
Support mechanisms ⁺⁺			
Support	0.6(0.2,2.1)	0.6(0.3,1.5)	2.6(0.5,14.7)
Discuss	0.5(0.1,2.2)	0.8(0.3,2.1)	6.7(0.6,82.0)
Rely	0.5(0.1,1.7)	0.8(0.3,2.0)	1.1(0.3,3.9)
Listen	0.2(0.0,1.1)	0.3(0.1,0.9)*	3.4(0.4,27.4)
Well being	0.8(0.5,1.2)	1.0(0.7,1.4)	1.7(1.0,2.8)

⁺Demographic factor age was entered into all models

⁺⁺All support mechanisms were entered into one model

*significant at $p < 0.05$

Qualitative Results

Occupational issues

Participants' responses generally indicated a perception that mental health, suicide, self-harm or drug and alcohol use issues were not more prevalent in the construction industry than in other industries. It was suggested that this may relate to several factors, such as, occupational satisfaction. In terms of identifying people with any of the concerns previously mentioned, the majority of respondents believed that it would depend on their relationship with the person. That is, the closer the relationship, the more likely it would be that an issue would be identified. The level of relationship was also commonly reported in assessing how to help the individual concerned.

Recognising the signs of a mental health issue

Respondents indicated that they would recognise the signs if someone were dealing with a mental health issue. Others said it would depend on how well they knew the person, stating that they would feel confident in recognising the signs if they had known the individual for a period of time. Others recognised that they would have difficulty recognising if someone was dealing with a mental health issue given their lack of experience in this area.

Those who said they would recognise the signs were asked to identify the signs that would indicate to them that someone was suffering from a mental health issue. Overwhelmingly participants stated that a change in personality or attitude would indicate that the person may be suffering from some mental health issues. For example, a person may be experiencing a mental health problem (e.g., stress, depression or anxiety) if they were cranky, quieter and/or more withdrawn than normal and if they were making mistakes in their work. Importantly, the inability to recognise change was explained due to a lack of signs that indicate mental health issues, and because change occurs gradually and so is difficult to notice.

The most common course of action indicated was to speak to the individual; however participants were concerned about the individual's reaction and were concerned about prying into the individual's business. Importantly, intervention was discussed as more likely if the individual was putting themselves or others at risk due to unsafe work practices. In this circumstance participants indicated that they would be more likely to speak to the individual and/or a supervisor.

Suicide and self-harm

When asked whether suicide and self-harm were an issue in the industry, participants stated that they were not aware of it, that they had only been exposed to relevant information recently (as a result of the research initiative) and were surprised to learn that construction workers were considered a high risk group. As with mental health issues and drug and alcohol use, participants felt that suicide and self-harm was no more common in the construction industry in comparison to other industries: *"we face the same life stresses, mortgage, family. Don't think this industry attracts any other mental demographic"* (Focus Group [F/G] 6).

It was suggested that risk of suicide and self-harm was due to a combination of work and personal stressors. Although many did not believe that there was an increased risk of suicide and self-harm in the construction industry, when asked what factors may contribute, participants gave these responses:

- Stress and pressure from management;
- Long hours and a lack of work/life balance; and
- Lack of job security and financial pressure which increases stress within the family.

Recognising a person at risk of self-harm or suicide

Participants were asked whether they would be able to identify the signs that indicated some one was at risk of suicide. Overwhelmingly, participants indicated that there were no signs that an individual was going to attempt to take his/her own life. There was a common perception that suicide was impulsive, and that if someone intended to take his/her life successfully they would exhibit no signs and would not discuss it. Participants indicated that self-harm and discussions about suicide were cries for help.

Responding to the situation

Participants indicated an overall lack of confidence in dealing with a situation if they did become concerned about an individual's risk of suicide. Participants expressed that their response would depend on the relationship between the participant and the person concerned. Most commonly it was reported that the participant would talk to the individual and try to get someone else involved such as a family member or friend. Concerns around taking action included:

- Not feeling like they're in a position to take action;
- Fear that given a lack of training they could do more harm;
- Inability to broach the subject if it is not raised by the individual themselves /fear of incorrectly assuming that there is an issue when there is not; and
- Concern about intruding on privacy and causing conflict.

What stops people from asking for help/seeking support?

Focus group participants were asked what stops people from asking for help. The most common response was that men prefer to deal with issues on their own. Pride was discussed within a number of focus groups: "*can't say they have a problem coz it's not manly*" (F/G 5) and participants discussed the stigma and embarrassment that surrounded seeking help. A lack of awareness about mental health issues and what supports are available was a further barrier to seeking help.

Respondents in a number of focus groups stated that men are unwilling to discuss issues such as mental illness, self-harm and suicide, or to ask for help when issues arise. This theme was evident in participant responses: *“Got the whole pride thing as well. Some people think they can take it all on themselves- don’t want to tell anyone, want to fix it themselves so no one knows”* (F/G 8). Participants also noted that there is an expectation that *“if you ask someone how they are going we are programmed to say good. We are not programmed to say I’m not riding too hot today. If we said how we really feel they’d be no suicides”* (F/G 6).

What could be done to increase the likelihood that people seek help?

The large majority of groups discussed the need to increase awareness of mental health issues and the support services that are available to those who might be experiencing a mental health issue. This was recognised as serving a twofold purpose- to ensure that those in need of assistance know where and how to access it and to reduce the stigma associated with mental health issues.

Recommendations

The results of this study provide insight into the key issues related to self-harm and suicide in a sample of construction workers. The data contained in this report will be used, in collaboration with Mates in Construction WA, to develop and enhance self-harm and suicide programs as part of the 1Life WA State Suicide Prevention Strategy.

Appendix 1 – Additional Quantitative Results

Collegial support: The majority of respondents agreed or strongly agreed employees are supportive of one another within a professional context. Respondents felt they could rely on people they work with to lend them a hand if they needed it (96%), they could rely on colleagues to follow through on things they say or do (95%), colleagues were friendly and sociable (98%), civil and supportive (94%), and favourably influenced their attitude towards work (88%); and there was little friction between work colleagues (87%).

Work pressure: The majority of respondents reported that they agreed or strongly agreed to the degree to which the pressures of work and time urgency dominate the work environment. Respondents felt that there was constant pressure to keep working (83%) and that there was always an urgency about work (68%). However the majority of respondents do not find it that is was difficult to keep up with workload (77%). They reported that they do not often have to work extra hours (68%) and felt there is enough time to complete professional development (64%).

Occupational commitment: The majority of respondents reported that they agreed or strongly agreed to the positive level of emotional attachment to their occupation. Respondents did not regret entering their line of work (92%) but were proud to be in their line of work (95%). They identified with (94%) and were enthusiastic about their occupation (90%), they liked the job they were in (93%) and the job was important to their self-image (55%).

Intention to leave profession: The majority of respondents agreed or strongly agreed they have plans to stay within the profession: 83% are not actively looking for a new job; 23% often think about quitting; and 15% will probably look for a new job outside their profession in the next year.

Life/work balance: The majority of respondents agreed or strongly agreed that their work responsibilities allow enough time for family/friends (62%) and recreational activities (60%); there is enough support at work to maintain a healthy work/life balance (74%); and they feel they have achieved an appropriate work/life balance (61%).

Wellbeing: The minority of respondents indicated that they felt due to their work they were often unable to get to sleep (11%) or did not want to get up in the morning (26%). However the majority of respondents felt emotionally (16%) or physically (38%) drained from work.

Impact of work: The majority of respondents felt the demands of their work had a positive impact on their work performance (79%), and felt that work had a positive impact on their physical (64%) and social wellbeing (60%).

Social wellbeing: In terms of intimate relationships, 65% reported that their work has a positive impact on their current intimate relationship and 54% felt their work had a positive impact on their previous intimate relationships.

Alcohol and drug use: Four percent of respondents reported never consuming a drink containing alcohol, 10% consume monthly or less, 15% consume two-four times a month, 42% consume two-three times a week, and 30% consume four or more times a week. On a typical day when drinking, 39% reported consuming one or two drinks, 31% three or four drinks and 16% drink five to six drinks. Fifteen percent of respondents reported drinking at least six drinks on a typical day. Only seven percent report never binge drinking, 20% report binge drinking less than monthly, 32% report binge drinking monthly, 38% report binge drinking 2-3 times a week and 3% report binge drinking four or more times a week. Twenty-eight percent have been under the influence of alcohol at least once or twice at work, with 1% reporting being under the influence quite a few times. The majority of respondents (58%) thought alcohol was a problem amongst their co-workers. According to the Audit-C scale, 81% of respondents are classified as having hazardous and harmful alcohol use.

Forty-four percent of respondents reported using an illicit substance in the previous 12 months. One third of respondents reported using cannabis, 16% cocaine, 0% heroin, 28% amphetamines, 28% ecstasy, 8% hallucinogens and 1% inhalents. The majority of respondents who used illicit drugs, used cannabis, cocaine, amphetamines and hallucinogens only occasionally. However of those who used ecstasy, 39% reported daily use, 36% reported weekly use, 7% reported monthly use and 18% reported occasional use.

Illicit drugs were used primarily for recreation (cannabis 43%, cocaine 36%, amphetamines 46% and ecstasy 49%), with a large proportion of respondents using cannabis (39%), cocaine

(28%) and ecstasy (38%) to help them relax. Forty-four percent of those using cannabis and 38% of those using amphetamines used the drug to have fun. Five respondents have taken more than the recommended dosage or used their prescription medication for non-medicinal purposes. Fifty-one percent of respondents think illicit drug use or taking excessive doses of prescription medication is a problem amongst co-workers.

Support mechanisms: The majority of respondents have support to make their work life easier and reported being able to discuss their problems at work with their partner (61% and 60% respectively), family (68% and 70% respectively) and friends (69% and 72% respectively). Respondents also feel they can obtain practical advice, information or assistance when things get tough at work from their partner (58%), family (70%) and friends (73%). Family (80%), friends (75%) and partners (68%) were the most willing to listen to personal problems followed by work colleagues (64%) and immediate supervisors (59%).

Job training: One-third of respondents (33%) believed the training they received prepared them adequately to deal with work-related stress while 36% did not believe they were adequately prepared through job training.

Appendix 2 – Additional qualitative results

Occupational issues

When asked of the positive and negative aspects of working in the construction industry a number of issues were identified. Positive aspects of employment, as identified by participants, included: remuneration, starting and finishing the work day comparatively earlier than other industries, camaraderie amongst workers and the sense of achievement which accompanied their work. Pressure to meet deadlines, the lack of job security and expectation to work overtime and Saturdays were commonly expressed by workers as negative aspects of working in construction. Additionally, a number of job characteristics were identified as both positive and negative; the physicality of the work was considered by some as positive, while others emphasised the danger inherent in the work. Characteristics of participants' employment (company, size of the site, union/non-union) were also seen to impact the desirability of working in construction, with employment in well-regarded companies on larger, union-covered sites being seen as ideal. It is interesting to note that differences in responses were observed between the various trades represented in the focus groups. For example, job security was considered problematic for unskilled tradespeople more than it was for skilled tradespeople.

Perceptions of mental health issues

When asked whether mental health issues (i.e., depression, anxiety and stress) are a problem in the construction industry, it was suggested that these issues were no more a problem in construction than other industries. Participants in two focus groups believed mental health issues were more prevalent in the construction industry. Factors identified as increasing the incidence of mental health concerns included:

- Fly In-Fly Out (FIFO) work;
- Pressure to meet deadlines;
- Lack of job security;
- Long hours and the effect this had on family and work/life balance;
- Lack of consistent income/fluctuating income (very high to low/ non-existent) and reliance on credit; and
- A combination of factors including work stress, mortgage stress, family stress.

Responding to a situation where a mental health issue is recognised

In terms of confidence in taking action if they did recognise signs of mental health issues, the majority stated that their confidence in dealing with the issue would depend on how well they knew the individual. The closer the relationship, the more confident participants felt in saying something to the individual. Participants stated that they would feel less confident in saying something if they did not know the individual well. Participants indicated apprehension in taking action in case they had misinterpreted the individual's behaviour to indicate a problem when in fact no problem was present, and also stated that they were not skilled to talk to individuals about mental health issues.

Recognising a person at risk of self-harm or suicide

A minority of participants indicated that they might be able to detect whether someone was at risk of self-harm, stating that it would depend on how well they knew the individual. Similarly to discussion around identifying when a person is experiencing mental health problems, it was suggested that a change in behaviour or mood might indicate risk of suicide.

Drug and alcohol use

Drug and/or alcohol use was indicated to be somewhat of a problem. As with perceptions regarding mental health issues, it was generally believed that drug and alcohol consumption in the construction industry was no different to that in other industries. Further, the majority of participants believed consumption to be restricted to the weekend and thus was not affecting users' work. Perceptions, however, were far from uniform; responses within just one single focus group ranged from "*haven't seen much of that [drug use], alcohol maybe*" (F/G 10) to "*I've seen guys hitting up in the car park*" (F/G 10). Where drug and alcohol consumption was considered higher than in other industries, participants suggested that the relatively high income of workers and a culture of using drugs or alcohol to relax after work, were contributing factors.

Support

When asked about sources of support that they had available to them, the majority of respondents indicated informal support mechanisms such as family, friends, and supervisors.

Participants were able to identify a number of formal support options:

- Doctor;
- Site nurse;
- Union;
- Psychologist; and
- Beyondblue/help lines.

With regard to the union-based counselling service, the majority were aware of the service. However, there was some suggestion that the advertisement of these services may not be sufficient; *“No one pays attention to a piece of paper stuck on a wall”* [in reference to the promotional posts on site noticeboards] (F/G 3).

Participants generally reported that it was unlikely that a person would seek help, and there was an unwillingness to suggest formal supports to people around them. In terms of personal use, formal supports were considered to be an option of last resort, following contact with family or friends.

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