



Briefing for Amanda Greaves

Executive interpretation

Construction's suicide burden is not explained by one variable or by an inherent weakness in workers. The strongest evidence points to an interaction among **male-dominated occupational culture, high job demands, low control, injury and pain, insecure employment, isolation, substance use, access to lethal means, and limited access to trusted help.**

Communication and leadership matter because they shape whether these pressures remain hidden, whether workers feel they belong, and whether help-seeking is treated as responsible behavior or as a liability. However, the evidence is stronger for identifying risk and protective factors than for proving that any single communication technique independently reduces suicide deaths.

The following distinction is important:

- **Evidence-based conclusion:** supported by epidemiological research, systematic reviews, evaluations, or authoritative public-health guidance.
- **Expert/practice implication:** a reasonable application of the evidence, but not itself proven to reduce suicide mortality.

1. Current statistics

United States

The most recent detailed occupation-specific CDC analysis identified construction as one of the highest-risk occupational groups:

- In 2021, construction workers had a suicide death rate of **46.1 per 100,000**, compared with **19.5 per 100,000 across all industries**—approximately 2.4 times higher. ^[1]
- The male construction-worker rate was **50.5 per 100,000**, compared with **30.0 per 100,000 for men across all industries.** ^[1]
- Construction workers represented approximately **7.4% of the workforce but 17.9% of suicide deaths with a reported industry code.** ^[1]
- Male laborers had the highest number of suicides among the construction occupations examined, while male iron and steel workers had the highest occupation-specific rate in that analysis. ^[1]

Some public-health and industry sources report more than 5,000 construction-worker suicides annually, and a CDC analysis reported an estimated **6,000 deaths in 2022.** These figures should

be presented carefully because estimates vary depending on whether the analysis includes only employed people, how “construction” is coded, and whether occupation or industry is used.^[2]^[3]

International comparisons

Comparable international data are not perfectly standardized, but the pattern is consistent:

- In Australia, male construction workers had an age-standardized suicide rate of approximately 26.6 per 100,000, compared with 13.2 per 100,000 among other male workers during 2001–2019.^[4]
- Research and industry analyses report substantially elevated construction suicide rates in the United Kingdom, with estimates approaching four times the national average, although methods differ across studies.^[5]
- The Australian MATES evaluation found that construction suicide rates fell after program implementation, but the evidence is ecological and cannot prove that MATES alone caused the decline.^[6]

Evidence-based interpretation: Construction has a disproportionately high suicide burden in several countries, particularly among men. Statistics demonstrate an occupational disparity; they do not, by themselves, establish that the industry or its culture causes suicide.

2. Root causes supported by research

Research supports a **multifactorial occupational-risk model** rather than a single “construction personality” explanation.

Work design and psychosocial demands

Frequently identified factors include:

- Long hours, fatigue, unpredictable schedules, and deadline pressure.
- Low worker control over pace, sequencing, and decisions.
- Job insecurity, temporary employment, layoffs, and fluctuating income.
- High physical demands, injury, chronic pain, and exposure to traumatic incidents.
- Remote or mobile work that separates workers from family and community.
- Competitive environments in which errors may bring shame, financial loss, or loss of employment.

NIOSH recommends treating suicide prevention as a workplace-health issue that includes access to behavioral healthcare, encouragement to seek help, referral pathways, financial and substance-use support, and a postvention plan after a suicide death.^[7]

A systematic review of construction mental-health research found that most identified stressors were psychosocial rather than purely technical or physical. The review identified work hours, workload, hazards, fatigue, job conditions, and substance use as relevant risk

factors, while reduced demands, family-friendly work, positive coping, teamwork, and stronger relationships functioned as protective factors.^[8]

Access and opportunity

Construction workers may routinely encounter or work around potentially lethal means, including firearms, medications, heights, vehicles, and heavy equipment. Familiarity with dangerous environments may also reduce fear of lethal means. This is a plausible contributor, but the relative contribution of each means is not sufficiently quantified in construction-specific research.

Selection versus exposure

It is not established that construction workers enter the industry because they possess particular psychological characteristics that increase suicide risk. A more defensible interpretation is that some workers may be **selected into or retained in environments that reward stoicism while exposing them to chronic stress, pain, insecurity, and isolation.**

3. Psychological factors in construction

The psychological profile is not unique in a biological sense, but the work environment can produce a distinctive combination of pressures:

- **Identity tied to competence:** A worker's value may be strongly connected to being reliable, physically capable, and able to solve problems.
- **Threat to status:** Injury, financial difficulty, mental distress, or inability to keep up may be experienced as personal failure rather than a health issue.
- **High tolerance for danger:** Workers accustomed to managing physical risk may normalize emotional risk and delay care.
- **Accumulated strain:** Repeated pain, sleep disruption, near misses, conflict, and financial uncertainty can erode coping over time.
- **Rapid transitions:** Moving between projects, crews, employers, or locations can interrupt relationships and support systems.

These factors should be treated as **contextual vulnerabilities**, not diagnostic characteristics of construction workers. Evidence specifically linking each factor to suicide deaths is less developed than evidence linking them to distress, stigma, poor sleep, substance use, or help-seeking barriers.

4. Business and organizational factors

Business practices can either amplify or reduce risk.

Risk-amplifying conditions

- Production targets that consistently override rest, recovery, and safety.
- Chronic understaffing and excessive overtime.
- Supervisors promoted for technical skill without training in people management.
- Punitive responses to mistakes, injury, disclosure, or requests for time off.
- Fragmented subcontracting and unclear responsibility for worker wellbeing.
- EAPs that are technically available but difficult to access, poorly trusted, or unavailable outside office hours.
- Layoffs, delayed pay, debt, and inconsistent employment.
- No procedure for responding after a suicide attempt, death, or traumatic incident.

Protective organizational conditions

NIOSH and CDC guidance emphasizes environments that foster **communication, belonging, connectedness, respect, help-seeking, access to care, and appropriate crisis response.**^{[9] [7]}

Work can itself be protective when it provides meaning, social contact, structure, and financial security. The goal is therefore not merely to remove workers from stressful jobs; it is to make work more predictable, humane, connected, and responsive.^[10]

Practice implication: Owners should measure psychological health using the same seriousness applied to physical safety: identify hazards, assign responsibility, document corrective action, and review outcomes.

5. Leadership behaviors

Behaviors associated with higher risk

These behaviors are not proven to cause suicide directly, but they plausibly increase risk by reducing psychological safety and help-seeking:

- Public humiliation, ridicule, yelling, or “toughen up” responses.
- Treating distress as lack of commitment.
- Rewarding excessive hours and constant availability.
- Ignoring bullying, harassment, discrimination, or unsafe work.
- Making mental-health disclosure appear career-limiting.
- Using confidentiality threats or casually sharing personal information.
- Asking about wellbeing only after performance deteriorates.

Behaviors associated with lower risk

- Consistently modeling that asking for help is compatible with competence.
- Conducting brief, private, routine check-ins—not only crisis conversations.
- Responding to disclosure with calm concern, listening, and practical next steps.
- Ensuring supervisors know how to connect workers with professional help.
- Giving workers meaningful control where feasible.
- Addressing workload, fatigue, conflict, and job insecurity as management issues.
- Following through when workers raise concerns.

Evidence-based conclusion: Leadership and organizational climate are important protective-environment mechanisms, but construction-specific causal trials of individual leadership behaviors remain limited. **Expert opinion:** The most credible leadership strategy is to combine relational trust with concrete changes to workload, access, and job design; supportive language alone is insufficient.

6. Communication patterns

Healthier workplaces tend to replace one-off awareness campaigns with repeated, ordinary conversations.

More protective patterns

- “How are you doing?” followed by enough time to listen.
- Direct but nonjudgmental questions when behavior changes.
- Toolbox talks that include stress, sleep, substance use, and help-seeking.
- Clear language such as, “You will not be punished for telling us you need help.”
- Private escalation routes that bypass an unsafe supervisor.
- Closed-loop communication: concerns are acknowledged, acted upon, and reported back.
- Plain-language crisis information posted where workers actually gather.
- Conversations that focus on safety and support rather than diagnosing coworkers.

Less protective patterns

- Humor that shames vulnerability.
- Euphemisms that make suicide impossible to discuss.
- “If you can work, you can cope.”
- Treating every problem as an individual resilience deficit.
- Publicly identifying workers as mentally ill.
- Offering a hotline without changing the conditions producing distress.

NIOSH specifically recommends promoting help-seeking, assessing and referring workers to mental-health, substance-use, and financial services, and preparing for post-suicide response.

7. Role of emotional intelligence

Emotional intelligence can be useful, but it should not be presented as a standalone suicide-prevention intervention.

In practice, EI includes:

- Recognizing changes in one's own emotional state.
- Accurately noticing distress in others.
- Regulating anger, shame, and impulsive reactions.
- Showing empathy without taking over.
- Communicating difficult information respectfully.
- Building trust across trades, shifts, and organizational levels.

A peer-reviewed review of emotional intelligence, leadership, and teams found recurring associations between EI-related capabilities, leadership behavior, team relationships, and team functioning.^[11]

Evidence-based conclusion: EI is relevant to leadership quality, relationship climate, conflict management, and help-seeking conversations. There is not yet strong evidence that EI training alone reduces construction suicide rates.

Expert/practice implication: EI training is most defensible when embedded in supervisor development and paired with organizational changes. A foreperson who listens skillfully but cannot alter dangerous hours, bullying, or impossible deadlines has limited preventive power.

8. Mental-health stigma in trades

Stigma is a central mechanism because it can delay disclosure and treatment.

A study of 264 commercial construction workers found that mental-health stigma was significantly associated with psychological distress and impaired sleep. Interviews and focus groups described masculine norms, job insecurity, and workplace culture as contributors to stigma; the authors identified peer support and improved HR practices as promising responses.^[12]

Common stigma beliefs include:

- “A strong worker handles problems alone.”
- “A diagnosis will threaten my job.”
- “Talking will make me a target.”
- “Mental health is an office-worker issue.”
- “Treatment means I cannot be trusted around equipment.”

The solution is not simply to tell workers that stigma is wrong. Companies must make help-seeking **safe in practice** through confidentiality, non-retaliation, accessible care, supervisor

accountability, and visible examples of respected leaders using support appropriately.

9. Isolation, masculinity, financial stress, and substance use

Isolation

Remote projects, travel, long commutes, seasonal work, and fragmented crews can weaken family and peer connection. Isolation is especially concerning when combined with poor sleep, relationship breakdown, or lack of continuity between projects. ^[13]

Masculinity

Norms of toughness, self-reliance, emotional control, and risk tolerance can discourage help-seeking. Masculinity is not itself a cause of suicide; the risk arises when narrow norms are enforced through ridicule, exclusion, or employment consequences.

Financial stress

Construction workers may face variable income, debt, insecure contracts, layoffs, compensation disputes, and pressure to work through injury. Financial counseling and predictable employment practices are therefore relevant components of prevention, not peripheral benefits.

Substance use

Alcohol and other substances may be used to manage pain, stress, sleep problems, or social pressure. Substance use can increase impulsivity, worsen depression and sleep, intensify family and financial problems, and increase access-related risk. Construction-specific research supports an association between stigma and distress, while the exact causal pathway between substance use and suicide requires more rigorous study. ^[8] ^[12]

10. Programs with measurable success

MATES in Construction

MATES is a prominent Australian, industry-based, multimodal program involving general awareness training, peer “connectors,” case management, and crisis support.

A review found evidence of improvements in:

- Suicide-prevention literacy.
- Helping intentions.
- Mental-health literacy.
- Stigma-related outcomes.
- Some indicators of suicide risk.

Ecological evaluations reported a relative reduction in suicide behavior and a decline in Queensland construction suicide rates after implementation compared with earlier periods. However, those studies cannot fully separate program effects from broader social or economic changes.^[6]

Important caution about implementation

A later cluster-randomized evaluation of a MATES adaptation in manufacturing found no statistically significant improvement over control sites in the primary outcome, and implementation was incomplete.^[14]

This does not prove that MATES is ineffective in construction. It does show that:

1. Training programs can fail when implementation is weak.
2. Improvements in literacy or intentions do not automatically produce fewer suicide deaths.
3. Program evaluation must measure reach, fidelity, actual help-seeking, distress, attempts, and mortality where feasible.

Gatekeeper and awareness training

Gatekeeper training can improve confidence and knowledge, and preliminary MATES research reports positive shifts in beliefs and suicide-prevention literacy, particularly among younger workers. Evidence is insufficient to claim that brief gatekeeper training alone reduces suicide mortality.^[15]

Employer-based comprehensive approaches

The most evidence-consistent model combines:

- A protective organizational climate.
- Supervisor and peer training.
- Confidential professional care.
- Substance-use and financial support.
- Fatigue and workload controls.
- Means-safety procedures.
- Crisis response and postvention.

This aligns with CDC and NIOSH recommendations, but construction-specific randomized evidence for the complete package remains limited.^{[9] [7]}

11. Research gaps

The field still needs:

- Better national surveillance linking occupation, industry, employment status, subcontracting, and project conditions.

- Prospective studies that measure exposure to long hours, insecurity, pain, bullying, isolation, and leadership climate before suicidal outcomes occur.
- Construction-specific randomized or stepped-wedge trials of comprehensive programs.
- Evidence on which communication behaviors change actual help-seeking rather than only attitudes.
- Studies of subcontractors, temporary workers, migrants, women, LGBTQ+ workers, apprentices, older workers, and nonunion workers.
- Better evaluation of supervisors and forepersons, who often carry substantial pressure while also serving as the first point of contact.
- Research on firearms and other lethal-means safety that respects worker autonomy and local law.
- Cost-effectiveness evidence for small contractors.
- Studies of postvention, including effects on coworkers after a suicide death.
- Longitudinal evidence concerning EI, psychological safety, and psychosocial safety climate.

A major methodological limitation is that many existing studies are cross-sectional, self-reported, ecological, or conducted among workers who participated voluntarily. Associations should not be described as proof of causation.

12. Practical recommendations for company owners

First 30 days

1. Name suicide prevention as a health-and-safety responsibility owned by senior leadership.
2. Publish a confidential, non-retaliation policy for seeking mental-health or substance-use help.
3. Provide 24/7 crisis pathways, including **988 in the United States**, local emergency services, and an accessible EAP or equivalent.
4. Train supervisors to recognize warning signs, listen, ask directly about immediate safety, and connect workers with professional help.
5. Post resources in jobsite trailers, break areas, payroll communications, onboarding materials, and toolbox talks.

Next 90 days

6. Audit overtime, fatigue, travel, layoffs, pay uncertainty, injury management, and supervisor conduct.
7. Establish brief, routine check-ins for crews and private escalation routes that do not depend solely on the immediate foreperson.
8. Create a peer-support system with clear boundaries: peers listen and connect; they do not provide therapy or promise secrecy when someone is in immediate danger.

9. Add financial counseling, substance-use treatment, pain-management pathways, and return-to-work support.
10. Build a written suicide-attempt and postvention plan with clinical and legal advice.

Ongoing management

11. Track leading indicators: psychological-safety scores, resource awareness, wait times for care, absenteeism, turnover, overtime, injury-related pain, and supervisor training completion.
12. Track outcomes carefully and confidentially: help-seeking, referrals completed, distress, substance-use concerns, attempts, and deaths.
13. Hold leaders accountable for behaviors that undermine safety—humiliation, bullying, retaliation, and chronic disregard of fatigue.
14. Evaluate interventions rather than assuming that attendance at training equals success.
15. Use worker participation: ask crews what would make help-seeking safer, then visibly act on the answers.

Suggested message for leaders

“You do not have to prove your strength by handling a serious problem alone. Raising a concern about yourself or a coworker is a safety action. We will respond privately, respectfully, and with practical support.”

That message is most credible when company policies, workload decisions, supervisor behavior, and access to care consistently reinforce it.

Bottom line: The strongest prevention strategy is not a motivational campaign or a single mental-health seminar. It is a sustained **systems approach** that combines psychologically safe leadership, ordinary conversations, peer connection, professional care, substance-use and financial support, fatigue control, and measurable organizational accountability.

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