THE WINSTON CHURCHILL MEMORIAL TRUST OF AUSTRALIA

Report by Jorgen Gullestrup – 2017 Churchill Fellow

To study workplace and industry approaches to mental health and suicide prevention globally

April 2019
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Signed: Jorgen Gullestrup
Date: 5 April 2019

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1 ACKNOWLEDGEMENTS

“Never, never, in nothing great or small, large or petty, never give in except to conviction of honour and good sense. Never yield to force; never yield to the apparently overwhelming might of the enemy (Churchill 29/10/41).”

My industry has been touched by suicide, my family has been touched by suicide, I have been touched by suicide. When you have experienced the despair of suicide, the questions left behind, the regret - you learn to see suicide as an enemy that must be fought personally and communally.

I am deeply grateful for the opportunity I was given by the Winston Churchill Memorial Trust as a 2017 Fellow to travel and learn. I have worked in suicide prevention in Australia for the past 10 years, having the opportunity to meet and learn from others in the field has given me inspiration and ideas for the further work.

It has been uplifting to experience how open the people I met on my journey were around the work they were doing and how generous they were with their time. People shared ideas and their work on such a broad spectrum that in writing this report it has been very difficult to narrow the discussions down to a point where it would fit in a coherent report.

Over the past 10 years I have been fortunate enough to work for an organisation that really value people. My board of directors were immediately supportive of the idea of allowing me to participate in this fellowship. I am incredible fortunate to have great people leading me and working for me within my organisation without whom this project would not have been possible.

Packing a suitcase and disappearing for a few months was great for me – I am lucky to have a family that is supportive of my ambitions and my work. I am deeply grateful to Kanitta, Yada, Carmen, Daniel and Lars.

Finally, I thank Marg Hantz for reading this document and correcting the worst of my spelling mistakes.
2 INTRODUCTION

2.1 The project

The object of this project was to “investigate and understand approaches to workplace suicide prevention and mental health globally.”

The approved project descriptions stated:

“In this project I will investigate approaches and programs aimed at reducing suicide amongst workers in male dominated industries – particularly construction workers. I will especially investigate bottom up vs top down approaches in engaging workforces around mental health and suicide prevention. In doing this I will talk to trade unions, employers’ associations, and mental health professionals in a number of countries and seek to draw comparisons and conclusions. As a community worker at heart I will attempt to create a community of workers in the field for long term collaboration.”

The proposed itinerary was Geneva, Switzerland; Copenhagen, Denmark; London, United Kingdom; Boston, New York, Washington, Denver; Auckland and Christchurch in New Zealand.

The final itinerary approved by the trust also included Paris, France and Los Angeles, USA while the visit to New Zealand was limited to attendance at the 8th Asian Pacific Regional Conference of the International Association for Suicide Prevention in Waitangi.

In addition to the approved itinerary the project was extended to:

- Participate in the delivery of a suicide prevention workshop for social workers, crisis workers, police and student counsellors in Rønne, Denmark. This was sponsored by the organisation Stopselvmord.nu
- Deliver a seminar/round table discussion for trade unions, employer associations, workplace regulators and insurers and mental health researchers in Stockholm, Sweden. This was sponsored by AHA the Swedish labour market insurance company.
- Attend the American Association of Suicidologists 51st Annual Conference in Washington. This was sponsored by my employer – MATES in Construction (Qld/NT).
- Attend Meetings on a construction sites and with senior construction executives in Chicago, USA. This as sponsored by the Lendlease Foundation.

The project started in Paris on the 5th of March and concluded at a Waitangi on the 5th May. During this period the project was suspended for two weeks due to personal holiday.

Across this itinerary the project involved:

- 53 meetings, interviews, seminars and roundtables involving 163 individuals in 14 cities across 7 countries and three continents. A total of 73 hours of audio recordings were collected.
- Attendance in two major conferences – the American Association of Suicidologists annual conference in Washington and the International Association for Suicide Prevention Asia Pacific Conference in Waitangi.
2.2 Practical Outcomes and Dissemination

The practical implications of this project are to learn and understand the workplace as the venue for suicide prevention better. To identify the drivers and the inhibitors of effective workplace suicide prevention and mental health programs. The main body of this report will focus on the learnings from my travels however it is not my intention to stop learning after my submission of this report. While travelling I sought to draw together a community of people who had a passion around suicide prevention in the workplace.

To promote the project objective “to create a community of workers in the field for long term collaboration” I established a closed Facebook group called: “Workplace Suicide Prevention: Jorgen’s Churchill Memorial Trust Project 2018” and members of the group was recruited during the course of the project. The group was established in December 2017 and had 20 members on 5th of March when the trip commenced. Upon completion of the project the group had 105 members. Following my return to Australia I have renamed the group: “Workplace suicide prevention” inviting a broader discussion and as of the 17 February 2019 the group had 210 members discussing and exchanging information on the subject.
In this report I will draw together some of the themes I have encountered during my trip and in particular what I believe these themes will mean for my work and for workplace mental health and suicide prevention more generally. I hope my observations in this report can help to start and inform a debate around workplace impact on mental health and suicide risk as well as best practice in using the workplace as a venue for intervention.
3 DISCUSSION

3.1 Impact of Mental Ill-Health and Suicide

It is estimated that on average 20% of the population in industrialised countries will experience a diagnosable mental health condition over any 12-month period while close to 50% will have this experience over a life time. Further the OECD has estimated that mental ill-health, conservatively, impact OECD member economies by an average of 3.5% of GDP per year (OECD, 2015c).

Every 40 second a person dies by suicide worldwide. With few exceptions more men than women die by suicide in most communities. The World Health Organisation estimates that for every death by suicide 10 to 20 will make a suicide attempt where of 17% will result in a permanent disability (WHO, 2006). The OECD has calculated that the financial burden of mental illness in Australia equates to $28.6B per year – 2.2% of our GDP (OECD, 2015). The financial burden of suicidal behaviour amongst employed Australian cost the community $6.73B per year (Kinchin & Doran, 2017).

It is positive that all countries I visited on my trip had reduced suicide rates in the years from 2000 to 2016. The exception was the USA where suicide rates have increased by more than 35% over the same period. It should also be noted that Australian suicide rates in 2017 increased to 12.6 per 100,000, an increase of 3.3% since between 2000 and 2017.
The human impact of suicide on the community is significant, although exactly how significant is still unclear. One study has found that 7% of American households surveyed had been exposed to suicide and 1.1% had lost a family member to suicide in the most recent 12-month period. More conservative estimates suggest at least 10 people are significantly impacted by a suicide (Maple, Cerel, Jordan, & McKay, 2014). According to these estimates between 1.6M Australians are impacted by and 265,000 Australian lose a family member to suicide each year at worst, or more conservatively, 30,000 Australians will be significantly impacted by a suicide each year.

Each year around 200 male construction workers die by suicide. Between 2001 and 2015 around 3000 construction workers have died by suicide. Although relative risk of dying by suicide for construction workers has decreased significantly over the past 15 years it is still much higher than for other employed men in Australia (Maheen & Milner, 2015). For every construction worker lost to a fatal accident at work, six are lost to suicide (Safe Work Australia, 2017).

Between 2000 and 4000 Australian construction workers will attempt suicide each year and between 340 and 680 will incur a permanent disability following suicide attempts (Doran, Ling, Gullestrup, Swannell, & Milner, 2016). A recent analysis of 20,125 participants in the MATES in Construction program identified that 75.1% had known someone who had died or attempted suicide (King, et al., 2018).

There is increasing awareness around work related suicide. A recent WHO report estimates that more than 1/3 of all suicides globally are by ingestion of pesticides, a tool of trade for many farm workers in Asia. The same report estimated that 10.9% of Depression cases are attributable to occupational risk (Wolf, et al., 2018).

An Australian study found that seventeen per cent of suicides in Victoria were work-related. In Japan karōjisatsu – suicide due to overwork and stress has been a compensable injury since the 1980s while 23 work-related suicides were compensated between 1999 and 2004 in Korea. In France 149 work-related suicide claims were made over the 2010-2011 period (ILO, 2016, p. 8).

In the USA, Assistant Regional Administrator of the US Department of Labour Occupational Safety and Health Authority, Mr Tim Irving,¹ highlighted that the US Bureau of Labour Statistics found 6% of all workplace fatalities to be suicide, making it a leading cause of workplace fatalities in the USA (Harris, 2016). However, in many jurisdictions work related suicides are not counted. Professor Sarah Waters of Leeds University²:

> In the UK, work-related suicides are not officially monitored or recorded. In the absence of official data or evidence, public authorities and employers have been able to turn a blind eye. (Waters, 2017 (a))

### 3.2 Global Institutions

The OECD recommends an integrated approach where the mental health care system recognise the benefits of meaningful work for people living with mental health conditions, the vocational training and education system seek to improve the educational outcomes for young people living with mental health conditions and workplaces implementing policies for workplace mental health promotion and return-to-work. The organisation recommend that member and non-member states:

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¹ Meeting 35, Boston 13th April 2018. Mr Irving is the Assistant Regional Administrator of the US Department of Labour Occupational Safety and Health Authority

² Phone interview, Leeds/ Copenhagen 29th March 2018.
seek to improve their mental health care systems in order to promote mental wellbeing, prevent mental health conditions, and provide appropriate and timely services which recognise the benefits of meaningful work for people living with mental health conditions (OECD, 2015a).

The International Labour Organisation ILO has developed the SOLVE program, a train the trainer program aimed at equipping member countries to run and develop upstream interventions around the psychosocial work environment but with a focused around the individual and resilience. The ILO is also working on a convention for the prevention of workplace violence in all its forms, including mental violence, and thus targeting mental health as a workplace rights and safety issue.


1. Employers and mangers must recognise that mental health issues are legitimate work-related concerns, whatever their precipitating factors and develop policies and guidelines to address them.
2. Employers must understand disability legislation and the need to make accommodation for people with mental health disabilities
3. Employers must develop appropriate prevention and promotion policies and programmes.

From a global institutional view point it is recommended that workplaces are inclusive and actively accommodate people with lived experience of mental illness or suicidality. The workplace is further seen as a venue where individuals with mental health vulnerabilities can be reached but also that employers must actively prevent injury by providing a mentally safe workplace. Finally, that workplaces should promote help-seeking and actively work to reduce stigma.

Both employer associations and Unions globally conceded their limited engagement around mental health and suicide in the workplace. The employer association stated that while mental health was emerging as a topic of growing importance, it is also a topic where employers feel they lack practical information, training and expertise.

Unions expressed similar sentiments. Global Unions cover such a broad cross-section of working conditions and workplace mental health have a radically different meaning to a garment worker in Bangladesh who lost colleges following the Rana Plaza collapse or a seafarer isolated from friends and family for months on end, or a South African mine worker who saw colleges being gunned down during an industrial dispute. These are very different issues to issues faced by workers in industrialised countries however, as we know from the construction industry in Australia workers die by suicide for every worker dying from a workplace accident.

3.3 National Observations
There are two dominant approaches to mental ill-health and suicide; an individual and a social paradigm. The focus of interventions is often focused around these two approaches either focusing on early detection, treatment and support of individuals or examining and working on the social determinants for higher risk of mental ill-health and suicide across the population.

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3 Meeting 6, ILO Geneva 7th March 2018
4 Meeting 10, IOE Geneva 9th March 2018
5 Meeting 9, IndustriALL Geneva 9th March 2018, Meeting 20, International Seafarers Trust 4th April 2018
There was a noticeable difference in approaches to workplace mental health and suicide prevention in United Kingdom, USA and Australia where the focus is on the workplace as a venue for intervention and Sweden and France where the workplace is seen as the potential cause.

Where the workplace is primarily seen as the venue for mental health promotion and suicide prevention, employers engage with mental health and suicide prevention as a human resources issue seeking to improve productivity or as an act of corporate social responsibility. This view is highlighted on the Australian Government Funded “Heads Up” website:

Healthy workplaces promote mental health and wellbeing. They are positive and productive and get the best out of everyone in the workplace. Business that care about good mental health and wellbeing attract and keep talent because they’re great places to work. The facts are clear: as well as benefitting employees, a mentally healthy workplace is also better for your bottom line (The Mentally Healthy Workplace Alliance, 2018).

In the United Kingdom Dame Carol Black has been influential in the campaign - “time to change, let’s end mental health discrimination” - which reached more than 835 business across the UK. The focus of the campaign was to support individuals within the workplace experiencing mental ill-health. However, while business did sign up for this initiative there was a real reluctance to talk about suicide, the focus was more on resilience and positive messages acceptable to business6.

The Construction Union “Unite”7 had notice a willingness and eagerness for members to be engaged around mental health and suicide prevention in a transformative way but did not feel equipped to engage with the membership:

There needs to be some underpinning movement where people genuinely can become part of creating change (Meeting 21, Jerry Swain Construction Organiser)

The two construction initiatives I looked at in the UK “The Building Mental Health Framework”8 and “Mates in Mind”9 were focusing on providing individuals with resilience skills and knowledge around mental health avoiding the issue of workplace influences and suicide all together.

In the USA the focus was overwhelmingly on the opioid crisis. A large percentage of opioid overdoses are in the working population and a very high proportion of these deaths are amongst construction workers. The typical pathway to opioid addiction amongst the active workforce is from pain management following a workplace injury10.

Despite this direct systemic workplace link, the focus of most discussions and approaches was on the individual. Getting addicts in treatment and warnings against the dangers of opioid use in the pain management of workplace injuries. The Unions’ I spoke with in the USA were actively partnering

6 Meeting 24, National Suicide Prevention Program, Public Health England, London 6th April 2018
7 Meeting 21, Unite the Union, London 4th April 2018
8 Meeting 25, Martin Coyd, London 6th April 2018
9 Meeting 22, Mates in Mind, London 4th April 2018
10 Meetings 30 to 35, 11th to 13th April 2018 in Boston, strongly illustrated this out.
with their medical insurance providers to find alternative pain management strategies\textsuperscript{11}, others I spoke with that exactly this relationship with insurers created a conflict of interest for the unions\textsuperscript{12}.

The Construction Financial Management Association have taken the initiative to create the “Construction Industry Alliance for Suicide Prevention” where resources are provided to companies and individuals to start conversations around workplace-based suicide prevention\textsuperscript{13}. Around this framework several interventions have been build, perhaps the most noteworthy was that of the Sheet Metal, Air, Rail and Transport Workers Union (SMART Union) who is building a peer support network up within the union.

The National Action Alliance for Suicide Prevention is also providing guidance and leadership for workplace suicide prevention. A blueprint for suicide prevention in the construction industry was produced a few years back and other resources such as a “managers guide” have been produced\textsuperscript{14}.

The approach in continental Europe appeared more focused around the workplace as an active factor in mental health and suicide prevention risk with several jurisdictions investigating or setting standards for workplaces in a more traditional workplace health and safety sense.

Workplaces provide social structure and belonging, and employment is generally seen as a protective factor against suicide. However, poor psychosocial work environment can have a server impact on mental health and suicide risk (Milner & Law, 2017). The French Telecom case study\textsuperscript{15} is a powerful example of suicide as a workplace health and safety issue.

In France suicide is now recognised as a fatal work-related injury and employers have been investigated and could be prosecuted for failing to take steps to prevent it:

\emph{If a suicide happens in the workplace or in the course of work, it is automatically investigated as work related. There is a presumption that it is work-related unless the circumstances prove otherwise (Professor Waters)}\textsuperscript{16}

Sweden is a country with a good track record on public health and safety issues. For example, Sweden has the lowest traffic fatality rate in Europe after a concerted, multi-pronged strategy over several decades so effective that Sweden today has less than 260 traffic fatalities per year. In comparison Sweden has amongst the highest suicide rates in Europe with almost 1500 suicides per year\textsuperscript{17}.

In Sweden, one employer has been prosecuted following a work-related suicide. While the conviction was overturned on appeal, this was largely due to a technicality relating to the special legal status of municipal employers under Swedish law.

\textsuperscript{11} Meeting 47, Sheet Metal Occupational Health Institute Trust, Washington 23 April 2018, Meeting 48, Laborers Health and Safety Trust Washington 23 April 2018
\textsuperscript{12} Meeting 35, Professor Jack Dennerlein Boston 13 April 2018
\textsuperscript{13} Meeting 44, Construction Finance Mangers Association, Washington 21th April 2018 and Meeting 53, Calvin Beyer, Los Angeles 28th April 2018
\textsuperscript{14} Meeting 39, EDC / Action Alliance for Suicide Prevention Washington 16th April 2018, Meeting 45, Dr Sally Spencer Thomas Washington 21th April 2018
\textsuperscript{15} Described in The French Telecom Orange Case study is in Section 4 of this report.
\textsuperscript{16} Meeting 19, Professor Waters Leeds 29th March 2018
\textsuperscript{17} Meeting 25, Professor Jaervholm, Stockholm 5th April 2018
Sweden has since enacted regulations imposing an obligation on employers to intervene to balance conditions and prevent damaging stress.

*It is the first time, it is unique in the world, to require employers to be proactive around the psychosocial work environment (Meeting 26, Mr Stoetzer)*\(^{18}\).

The Swedish regulation now require employers to proactively prevent injury and harm caused by the psychosocial work environment\(^{19}\). The regulation (section 18) require employers to promote:

>a good work environment and prevent risk of ill health due to organisational and social conditions in the work environment.

### 3.4 Conclusions

Workplace mental health and suicide prevention require a comprehensive and multi-faceted intervention. The workplace is both a good venue for promoting better mental health and suicide prevention and at times causing mental ill health and even suicide.

For suicide to be recognised as potentially work-related a workable definition for work-related suicide will have to be developed. It is conceded that it may never be possible to develop an absolute definition for work-related suicide, but perhaps a threshold can be identified where further investigation is required.

To progress both mental health and suicide prevention in the workplace definitions must be agreed and base line data collected. Suicide must be accepted as potentially work related and at times the consequence of workplace mental health hazards which employers have a duty of care to manage.

Standards such as those developed in Sweden will also serve to encourage employers to develop policies and active programs monitoring the psychosocial work environment in the same manner as physical health is monitored today.

In short, workplace mental health and suicide risk should be treated as workplace hazards for which employers have a duty of care to mitigate risk, to investigate and to learn from near misses or incidents will lead to better mental health.

However, it should also be recognised that much mental ill-health and suicide risk is not work related, but that work can be a venue for intervention and support. A purely regulative and punitive approach could undermine some of the benefits of business and workplaces acting socially.

The meetings I had with employers, unions and employer associations in both Europe and the USA universally expressed a willingness to engage with worker and workplaces to improve mental health and preventing suicide.

Perhaps it is worth considering carrot as well as a stick approach, for example credits in procurement processes for public works or rebates on workers compensation insurances for such business engaging actively in workplace mental health and/or suicide prevention programs.

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\(^{18}\) Meeting 26, Stockholm 5\(^{th}\) April – Mr Ulrich Stoetzer, Medical Director, Psychology Swedish Work Environment Authority

\(^{19}\) Meeting 26, AFA Insurance Roundtable, Stockholm 5\(^{th}\) April 2018
4 CASE STUDY: FRENCH TELECOM / ORANGE

It has been difficult for me to find a structure for a report that would do justice to the broad range of experiences, perspective and approaches I had on my trip. I felt the story about workplace suicide must have a human face. The story of French Telecom was probably the story that made the greatest impression on me. It is also well positioned as a reference point for many of my other experiences on the trip as it is a story with many layers.

My travel gave me the opportunity to meet Union Delegate Pierre Gojat\textsuperscript{20} and Research Academic Danielle Linhart\textsuperscript{21} who were amongst the key drivers of the \textit{Observatory of stress and forced mobility} that brought situation within French Telecom / Orange to the public’s attention in the early 2000’s.

French Telecom / Orange was a public service utility until harmonisation within the EU opened the telecommunications market up for competition. As the company was corporatized and then privatised it was difficult to move the company culture from a “public service” to a “shareholder service” mindset:

\begin{quote}
\textit{We treated the little grandmother in the country side with the same importance as a large commercial operation – they deserved the same telecom quality. Workers saw themselves as public servants, not as the servants of the shareholders (Mr Gojat Meeting 4).}
\end{quote}

Ms Linhart recalled a conversation she had with a human resource middle manager of French Telecom at a conference around 1996:

\begin{quote}
\textit{He asked me – “what do you think my role is?” I said I did not know, and he proceeded to say – “It is to create amnesia”.

I recall a painting I saw in a museum in Sao Paulo where slaves arrived on ships from Africa. On arrival they had to walk around “the forgetting tree” – men seven times and women nine times to forget, the old memories had to go so a new reality could be created.}
\end{quote}

\textsuperscript{20} Meeting 4, Paris 6\textsuperscript{th} March. Pierre Gojat is a Union delegate for the French Managers union CFE-CGC he was one of the founders of the Observatory for stress and forced mobility.

\textsuperscript{21} Meeting 5, Paris 6\textsuperscript{th} March. Ms Danielle Linhart, Director of Research National Centre for Scientific Research (CNRS)
The way to produce corporate amnesia is to shake the coconut tree so people fall out of their habits and are prepared to start something new (Dr Linhart, Meeting 5).

A successful example of this tactic was observed in Australia during the same period. An alternate workforce was trained to replace the existing workforce at the Patrick Stevedoring operations. It would have been clear to all that training a new workforce to replace one with decades of experience would not be a viable option, but history has shown that they did manage to shake the coconut tree and a new workplace culture was created breaking a union monopoly.

However, for French Telecom’s position was more complicated. As a monopoly all workers with expertise in the field already worked for the company making an alternative workforce an unavailable option. Furthermore, the labour agreements binding the company made forced redundancies and terminations impracticable.

Technological change did mitigate the company’s situation. Moving from physical hard-wired connections to virtual electronic connections made moving a telephone landline 60 times more efficient. Switching to mobile / internet services also provided significant efficiencies and restructuring possible.

The company instituted the “Next” restructure plan with the view of cutting 22,000 jobs and change the positions of a further 14,000 workers. However, it was estimated to take 15 to 20 years to achieve this target by voluntary redundancies and natural attrition. The CEO of French Telecom Didier Lombard was quoted for saying at a board meeting:

I’ll make them leave, one way or another, through the window or out the door (Waters, 2017(c), p. 196).

This led to a policy and processes which later has been classified by the French Public Prosecutor as moral harassment – a crime punishable with up to two years in prison (CBC News, 2018):

The judicial investigation into the suicides revealed that management put in place tactics intended destabilise the working lives of the entire workforce and thereby push employees to leave the company voluntarily (Waters, 2017(c), p. 195).

The company trained approximately 4000 executives to exert maximum pressure to push workers to their limits.

Ms Linhart described the tactic as Sisyphean. The workforce was exposed to constant change and restructures. Like the Greek God ordered by Persephone to roll an immense boulder up a mountain only for the boulder to roll down again when it neared the top, rules and tasks were continually changed never allowing the workforce to feel any sense of control or ability to direct their own destiny. An internal score system was introduced where a worker who had not had significant change in a two-year period was considered as having no value to the company.

They lost reference points and confidence – they lost identity and hope. The result for many was burn out. A combination of exhaustion and a mental collapse losing purpose of work and confidence. They saw no solutions and found the situation hopeless increasing the risk of suicide (Dr Linhart, Meeting 5).
Professor Waters has studied and provided some insight into the emotions and reactions of individuals to this process. She describes the suicide of a 53-year-old technician who was redeployed from monitoring satellite communications into a call-centre. In communication to his union he stated:

You know, I could no longer bear to be in this hell, spending hours in front of a screen like a mechanical puppet faced with the determination of people who let us die like dogs. If you could speak about this or escalate it so that others know and realise what this reckless lot is prepared to do to get people to leave (Waters, 2017 (b)).

Work provides individuals with belonging and usefulness which is protective against suicide. Through work we get social connection and status in our community. It also provides structure in our daily lives (Milner & Law, 2017). Professor Waters concludes:

The suicide cases studied here demonstrate that workplace transformations can generate such intense suffering that some employees choose to take their own lives. In their letters, emails and notes suicidal individuals have sought to communicate, interpreted and define the “social meanings’ of their own self-killing (Waters, 2017 (b))

Mr Gojat explained why workers did not just leave the company during this period:

Instead of promoting massive escape [from the company] it provoked mental suffering, diseases, depression and suicide. Most of the employees were very attached to the company and servicing the public. They expected a relatively low pay in return for life employment. You are working in a high-profile public entity working for all the population. That was a moral contract which the company broke (Mr Gojat, Meeting 4).

Mr Gojat further explained:

Suicides were regular from 2007 and the trade unions knew it, but they did not know how to treat it because of its complexity and the taboo around it. Unions tended to concentrate on wages and conditions, safety and similar issues. Suicide and mental health made them uncomfortable and unsure of how to deal with it. Suicide is often seen in the realm of the personal or a health paradigm requiring doctors, psychologists and other professionals. The union found it very hard to deal with this.

A group of 10 trade unionists within French Telecom /Orange were outraged by the situation and formed a group to bring the issue to the attention of the public. The relevant trade unions were not prepared to take the matter up. So, the group decided to start a campaign around the trade unions rather than through the unions. They called the campaign the Observatory of Stress and Force Mobilities – Observe, understand, act. It was important to refer to mobility in the name of the organisation as a key tactic in discouragement from the company was to enforce mobility in the very literal meaning of the term.

Only two out of five relevant unions were prepared to support the campaign. Ironically it was the CFE-CGC – a traditionally conservative union of mid and top executives and SUD – a more militant left-wing trade union covering blue collar workers who supported the initiative.

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22 Meeting 19, Phone Interview with Professor Sarah Waters of Leeds University
Unions say Think Global, Act Local – the problem was they did not know what to do locally, how to organise around mental despair, so they tried to avoid the subject all together (Mr Gojat, Meeting 4).

The Observatory was a coalition of workers, academics and media with an interest in the subject. Initially the Observatory set out to collect data. With the help of academics such as Dr Linhart they developed and analysed questionnaires. The initial questionnaire obtained 3450 responses with 60% reporting being stressed and 15% as being distressed.

French Telecom / Orange responded to this initiative by blocking internet access to the questionnaire. When the observatory changed web address French Telecom also blocked access to the new address.

The Observatory started to develop newsletters. Initially a version for academics and one for the workers but they realised the strength in connecting the two creating an open dialog between the workforce and the academics.

With the production of survey results backed up by stories the media found an interest in the topic:

John was a technician who spend 20 years advancing to dealing with high level business clients. At a team meeting his manager told him that he now was demoted to deal with retail clients. He felt destroyed in front of his colleagues, left the meeting and went to his car to pick up a knife. He returned to the meeting and attempted to suicide in front of his colleagues. He survived after a prolonged period in hospital. His wife agreed to go on national television with me to tell his story and later when he was well enough he told his own story – it was very impactful (Mr Gojat, Meeting 4).

A turning point in the matter was when the CEO of the company appeared on TV in response to these interviews and proclaimed that he did not understand this new “fashion” of suicide in French Telecom /Orange. The CEO also said that the suicides had hurt the company as well as him personally “a bit”!

This statement created such a stir that the CEO was dismissed shortly after. The new CEO took several proactive steps to recover the situation. The systematic restructuring, reclassifications, moving and centralisation of jobs was stopped.

The company is now surveying the staff every two years. The first survey was a done while the crisis was most severe and thus provided a base line. Questions are developed in consultation with the Unions and the workforce to ensure that the questions are formulated in the language of the workers. In the initial survey 80,000 out of 100,000 surveys were returned confirming the previous findings from the Observatory’s initial work.

The French workplace health and safety inspectorate commenced an inquiry into French Telecom /Orange. During this inquiry the systematic nature of the process was exposed. Managers were provided with a manual in how to encourage employees to leave the company and even a modified version of Kubler-Ross 7 stages of grief model to illustrate the process workers would go through in deciding to leave the company.

The findings from this inquiry was provided to the French Public Prosecutor with a recommendation that up to 30 previous French Telecom employees should be prosecuted. To date seven executives
and managers have been ordered to stand trial including the former CEO, COO and HR Director (CBC News, 2018).

The story of French Telecom/Orange is dramatic and confronting. It was estimated that up to 30 suicides were connected to the restructure of French Telecom/Orange. The silver lining of this tragic story is that things have improved. France is now recognising death by suicide as the most extreme and serious result from lack of mental safety in the workplace.

After the French Telecom/Orange tragedy a wide range of companies including Renault, Peugeot, Le Poste and several utilities, banks, supermarkets and the police forces have been connected to work related suicides.

In response to these issues the French Government has set up a National Observatory of Suicide\textsuperscript{23}, the National Research Institute for Public Health do specific research into modifiable risk factors in workplace mental health\textsuperscript{24} and a unit within the Ministry of Public Health, Labour research\textsuperscript{25} is developing a specific definition for workplace suicide.

At a workplace level this has practical implications as Mr Gojat explained:

\textit{On the 12 August last year a colleague of mine died by suicide. There was a connection with work. I received a letter from the husband to point to work as a part of the reason. Under legislation this require an inquiry by the safety committee, the occupational doctor, the labour inspector and representatives of management. We have been looking into this death and are now finalising a report. We are required to ask four questions –}

1. Was working conditions at least partly influential?
2. What can be done to prevent future suicides?
3. Are there any other employees at acute risk for a similar situation?
4. What indicators can be put in place to identify similar events?

Like with any other workplace fatality the focus is not so much to apportion blame as it is to identify what can be learned to avoid future tragedies. If we cannot or are not prepared to identify work related suicides, then our ability to prevent future suicides are diminished. Suicide is complex and that compared to physical accidents it may be more difficult to apportion blame, but as a minimum we should be prepared to consider the workplace as an influence (positive as well as negative) in a person’s decision to suicide before dismissing it as entirely a private matter.

\textsuperscript{23} Meeting 1, Paris 5\textsuperscript{th} March, Observatoire National du Suicide; National Suicide Observatory
\textsuperscript{24} Meeting 2, Paris 5\textsuperscript{th} March, Dr Isabelle Neidhammer, INSERM – Institute National de la Sante et de la Recherche Medicale
\textsuperscript{25} Meeting 3, Paris 5\textsuperscript{th} March, Ministry of Public Health, Labour Research
5 OBSERVATIONS

5.1 International
I thought it to be important to discover the views and approaches of global organisations with responsibility for workplace health and safety as well as global organisations with a responsibility for mental health and suicide generally. I met with representatives of the WHO, ILO, the International Organisation of Employers, IndustriALL global union and the International Seafarers Welfare Trust.

5.1.1 World Health Organisation (WHO)

The WHO recommends a strategic and comprehensive public health approach to suicide prevention. Suicide risk is one of the health risks that affect developed countries proportionally harder than less developed countries\(^\text{26}\). WHO recommends a combination of universal, selective and indicated responses to suicide. Training of gatekeepers of workers who are likely to encounter persons at risk of suicide is recommended but also workplace program such as the program within the Montreal police force where a 79% reduction in suicide was achieved following a combination of a half day suicide prevention training course for all staff and a full day training course for supervisors and union representatives. The WHO concludes:

> Comprehensive suicide prevention programmes tailored to the culture of the work environment may be effective in improving attitudes, knowledge and behaviours and may significantly affect suicide rates (WHO, 2014, p. 39).

Dr Alexandra Fleishman\(^\text{27}\) pointed out that the WHO is an organisation of member countries and that the WHO focus therefore is strategy and advice around national programs. However, the power of local communities, particularly around suicide prevention have led the WHO to start work on community development kits to allow local communities to take direct action and through that influence national policy (WHO, 2016):

> A great example of bottom up approaches in suicide prevention is that of Else and Jerry Weyrauch from the USA. They lost their daughter to suicide and became active in one state but eventually were an important part in creating a national movement for suicide prevention (Dr Fleishman meeting 6).

The WHO produced a resource book on workplace suicide prevention in 2006. Dr Fleishman agreed that the resource we in need of updating. In particular it is interesting that this guide puts all

\(^{26}\) While most suicides occur in developing countries (75%) suicide rates – in particular male suicide rates – are higher in developed countries.

\(^{27}\) Meeting 6, Geneva 7\(^{\text{th}}\) March 2018
responsibility on employers and what the employers should do for staff, and less so on what staff can do for each other. The guide recommends that (WHO, 2006):

1. Employers and managers must recognise that mental health issues are a legitimate work-related concern, whatever their precipitating factors and develop policies and guidelines to address them.
2. Employers must understand disability legislation and the need to make accommodation for people with mental health disabilities.
3. Employers must develop appropriate prevention and promotion policies and programmes.

Perhaps not surprisingly the WHO focus on a public health combined with an illness treatment approach to suicide and mental health and the workplace is a venue where such activities can take place.

5.1.2 International Labour Organisation (ILO)

The ILO have developed the SOLVE program which focus on the prevention of psychosocial risk and promotion of health and well-being at work through policy design and action. SOLVE encourage upstream interventions in the psychosocial work environment with a focus on the individual dealing with issues such as alcohol and drugs, violence, HIV and AIDS, smoking, nutrition, physical activity, sleep and economic stress. However, the program does not deal with suicide directly in terms of suicide prevention in the workplace (ILO, 2012).

In my discussions with Ms Manal Azzi and Mr Franklin Muchiri at the International Labor Organisation (ILO) we discussed the difficulty in having suicide recognised and accepted as a workplace issue. Ms Azzi highlighted the importance of establishing a causal link between suicide and the workplace:

“As soon as it is a workplace issue there is a liability on employers. Suicide is difficult because it is influenced by a broad range of factors. The question is how do we deal with employers collaboratively when we in effect are accusing them of creating the problem we want their help in dealing with? (Ms Azzi meeting 8)”

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28 Meeting 8, Geneva 9th March 2018
The tension Ms Azzi highlighted lies in the complex and interdisciplinary nature of suicide – there are no simple explanations for individual suicides as well as for suicide as a community problem. Suicide is biopsychosocial with a solid overlay of stigma.

The ILO is working on a convention on workplace violence which will include mental violence and through that mental health in the workplace. This process will take around four years but is expected to create an increase interest in research around the topics covered in the convention. It is expected the convention is ready for ratification by June 2019. There is particularly high interest in this convention from developing countries.

Traditional Occupational Health and Safety systems and risk assessments are heavily biased towards physical safety and the ILO is currently focusing on adapting and provide guidance in changing these procedures so they become more sensitive to psychosocial risks.

The complexity of workplace mental health is almost overwhelming particularly from the perspective of a global organisation such as the ILO. Different sectors have specific issues from female hospitality workers experiencing sexual harassment to the isolation experienced by seafarers. Different cultures have different understanding and stigma around mental health issues. There are gender issues as well as the interplay between personal and workplace issues.

In our discussion Mr Muchiri highlighted how ILO conventions, tools and policies had to be general enough to be universally applicable and yet specific enough to be useful.

This was further explained by Ms Azzi:

“We are so global that we cannot always enter into the depth of the problem. We serve developing countries which have nothing like MATES in Construction. We cover workers who die from heat stress, migrant workers not even covered by workplace safety legislation, workers who die at work and are not even found until 20 days later. Workers to whom the concept of mental safety is completely foreign. The ILO needs to cover the wide spectrum.”

In developing countries, it makes sense to address workplace mental health as a productivity issue using health economic arguments around absenteeism, presenteeism, staff retention and attraction has been the main drivers of the debate. In short, sophisticated and smart employers will create a mentally healthy work environment because it makes financial sense (The Mentally Healthy Workplace Alliance, 2018).

It should be noted that it is not always possible to make credible health economic arguments – it is harder to make such arguments for itinerant or project based workforces such as construction workers for example. Further the example from French Telecom / Orange above illustrate a case where a mentally unhealthy workplace was seen to be of more value to the business.

5.1.3 Global Unions and Employer Associations

The tension in accepting mental health and suicide prevention as a workplace issues was well illustrated in meeting with global employer and employee organisations. While in different stages of development around the topic they were all struggling with the complexity of the issues.
IndustriALL is a global union representing 50 million workers in 140 industrialised as well as developing countries across the mining, energy and manufacturing sectors. I met Mr Brian Kohler who is the Director for Health and Safety at the meeting was also Mr Shane Choshane of the South African National Union of Miners. This meeting was an illustration of the difficulty in dealing with the issue of mental health and workplace suicide through global frameworks.

Mr Kohler recalled being amongst the first western union officials on the scene following the Rana Plaza building collapse in Bangladesh. He recalled the smell of rotting flesh from the unrecovered bodies and long suffered nightmares picturing the women and young girls who was killed in that disaster while Mr Shane Choshane, South African National Union of Miners, recalled the shooting deaths of 34 workers during the Marikana strike in South Africa saying “workers are just expected to continue in the same environment as if nothing happened.”

Issues of this magnitude are hard to understand from an industrialised workforce perspective. It is therefore understandable that issues such as mental health is not at the top of the health and safety agenda of unions dealing with such brutal realities. It provided very practical examples of the issues raised in discussions with the ILO. Mr Kohler explained the dilemma very honestly:

“We are conscious of the issue of mental health but at least in IndustriALL we are not doing much. My guess is that very few affiliates are doing much about it. IndustriALL has not provided much leadership as we simply do not have the resources to do much more than physical health and safety at this stage (Mr Kohler Meeting 9).”

The International Transport Federation (ITF) represent 20 million workers across 146 countries. ITF seafaring members covered by collective agreements each contributes $250 per year towards various welfare initiatives. Part of these funds are distributed though the Seafarers Welfare Trust. I met Lucy Cooper, Program Manager with the trust during my visit. Lucy visited Australia with her colleague Dr Asif Altaf ITF Global HIV and wellbeing co-ordinator in February 2018, so the meeting allowed me to build on previous discussions.
I also had previous knowledge of mental health and suicide as an issue amongst seafarers through my brother, Chair of the International Seafarers Welfare and Assistance Network (ISWAN) Per Gullestrup and I met with the Executive Director of ISWAN Roger Harris during a visit to London in July 2017. ISWAN has a broad membership of seafaring related welfare, employer and union organisations and is partly funded by the Seafarers Welfare Trust as a support service for seafarers.

The Seafarers Welfare Trust the ITF is aiming to develop a comprehensive policy and intervention around mental health, wellbeing and suicide prevention. Ms Cooper pointed to the complexity of such interventions. While many seafarers work in small workplaces such as cargo ships, other seafarers’ workplaces are very large such as cruise ships. Most workplaces are multinational and multicultural with a strong sense of hierarchy.

*Calenture* – was described as long ago as 1771 as an at times mental disease caused by prolonged periods at sea causing a delusion that the sea was the green fields of home giving the seafarer an irresistible wish to be reunited with land and home (Macleod, 1983). *Calenture* is not recognised in the current psychiatric literature as a mental disorder and perhaps today it is used to describe suicide at sea.

*Calenture* was pointed out to me in my discussions with my brother, Per Gullestrup, he was concerned about the number of seafarers “lost at sea” many of which he thought could be suicides. Ms Cooper also explained that the trusts current focus in part came from affiliates being concerned about *Calenture*, particularly in the Asian subcontinent.

The Seafarers Welfare Trust is currently commissioning several projects around mental health and suicide amongst seafarers. Recently the Trust and the ITF launched the award winning MARI-WELL project, a three-module welfare distance education program for seafarers covering:

- Module 1: international regulations, conventions, codes, and seafarers’ rights
- Module 2: psycho-social and occupational health relating to seafarers
- Module 3: crew & resource management and land-based seafarer welfare

The trust is also looking to commission two peer support pilot projects, one focusing on the cruise ship industry delivered through an affiliate member union and one delivered through a major

shipping company focusing on the cargo shipping industry. The trust has also commissioned a major research project of mental health and suicide across the industry.

Ms Cooper highlighted the importance of projects longer term being integrated with other welfare initiatives both industry based such as ISWAN but also resources available in the seafarer’s local communities in port and at home.

“If we have a welfare mandate, then these projects must be tied into the overall wellbeing offering. There is a spectrum of need – and whatever intervention introduced must be committed to a specific spectrum of need and must consider how individuals are channelled to the right type of support (Ms Cooper Meeting 20).

The International Organisation of Employers (IOE) is the largest network of the private sector in the world representing 153 national employer organisations across 143 countries. The organisation sees its role as the global voice of business have a heavy focus on assisting and informing its members regarding the activities of the International Labour Organisation and providing general representation of business interests in international forums.

I met Mr Pierre Vincensini Adviser at the International Organisation of Employers.32 to discuss global employer perspectives on mental health and workplace suicide. Mr Vincensini highlighted that mental wellbeing was firmly on the agenda of many larger corporations:

“Mental health is an emerging topic of growing importance and is more and more on the agenda of our Global Occupational Safety and Health (GOSH) network meetings, where the overall objective is to raise awareness and share best practice. However, it is a topic where our members, employers and mangers, often feel they lack practical information, appropriate training and expertise. But when I think of it I do not think we have ever discussed suicide. That is quite strange, as it is linked with mental health. (Mr Vincensini Meeting 10)"

Like several other interviewees Mr Vincensini pointed to the complexity around mental health as a barrier in dealing effectively with the matter as a workplace issue: “When it comes to mental health injuries it seems a lot harder to link them to a particular event of practice.”

32 Meeting 10, Geneva 9th March 2018
The IOE produced a Fact Sheet for Business: Mental Health and Neurological Disorders in 2013 pointing to this complexity but also sees business as a potential agent for improving community health in this area:

- Psychosocial wellbeing is a productivity issue
- The workplace is an important venue for information, education and support
- Early intervention can prevent further deterioration
- Workplace information can support communities
- There are business opportunities in providing mental welfare initiatives
- Even where mental wellbeing issues does not have a direct impact on a business it may well be a secondary threat or opportunity to the business.

The fact sheet goes on to point out that:

“currently there is not a great understanding of work-related mental and neurological ill health, beyond the discussions about work-related stress and psychosocial wellbeing. Developments in technology, monitoring techniques, understanding of science and cultural acceptance will shift knowledge, perceptions and responsibilities...

Employers need to take a business decision about the appropriateness of intervention and management. The legal obligations for employers to have responsibilities for psychosocial well-being are shifting and are dependent on their recognition and the practicalities of management. (International Organisation of Employers, 2013)”

5.2 Europe

5.2.1 France

My main reason for visiting France was to understand the circumstances around French Telecom / Orange better. I had five meetings organised over two days in Paris. I have described the meetings with Pierre Gojat33 Union delegate with French Telecom / Orange and Dr Danielle Linhart34 Director of Research National Centre for Scientific Research (CNRS) in detail during the case study above. While the French Telecom / Orange tragedy has been very influential in suicide prevention in France I will focus on other aspects in this section.

The National Observatory of Suicide Risk35 was established in 2013 and employ approximately 50 staff. The observatories’ primary role is to document current knowledge around suicide more so than focusing on specific interventions. However, information provided by the observatory can and is often used as the evidence base for interventions. Although suicide rates has fallen in France over the past 30 years, awareness of the issue has increased dramatically over the recent years. Perhaps especially due to the tragedy in French Telecom / Orange being so extreme that it could not be ignored.

33 Meeting 4, Paris 6th March 2018
34 Meeting 5, Paris 6th March 2018
35 Meeting 1, Paris 5th March 2018
In term of workplace perspectives there is increased recognition of “burnout” and other work-related psychological disorders as occupational diseases although mental health related conditions are still a very small proportion of all compensable work injuries in France. The observatory is particularly concerned about suicide rates amongst both guards and inmates in the correctional facilities, hospital and health staff and agricultural workers.

INSERM is the National Research Institute for Public Health and Dr Isabelle Neidhammer is part of unit 1085 researching physical and psychological health in the workplace. The focus of Dr Neidhammer’s work is the modifiable factors in mental health specifically as they apply to the workplace. As an epidemiologist she is focusing on large data sets looking for patterns and connections that can inform the healthiest relationship between individuals, organisations and structures.

Perhaps the focus in not surprising in the light of French Telecom/ Orange:

_We seek to identify associations between work factors and mental health. We are interested in workplace factors because employers have a responsibility to mitigate risk and employers are amenable to effect change (Dr Neidhammer Meeting 2)._ 

The work of Dr Isabelle Neidhammer and the National Observatory of Suicide in part inform the work of the French Public Health Agency which looks are preventative measures from a range of perspectives.

Christine Chan-chee is an epidemiologist looking at mental health and indicators of suicide in the general population. A major concern is that despite having a national policy for suicide prevention

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36 Meeting 2, Paris 5th March 2018
37 Meeting 3, Paris 5th March 2018
with a broad range of interventions and suicide rates falling since the 1990s, France still have amongst the highest suicide rates in Western Europe (21/100,000 for men, 7/100,000 for women being 1.6% of all deaths nationally). However, the nature of the coroners’ system in France made the reporting of suicide very imprecise and varying greatly between regions.

Ms Audrey Sitbon is working on an inventory of mental health promotions in occupational health to assist the sharing and dissemination of programs across industry. The focus is not only the negative impacts of work but also the positive influence on mental health of work. Ms Sitbon pointed to certain European Union guidelines around the psychosocial work environment (such as the EU Strategic Framework on health and safety at work 2014-2020) as well as a International Labour Organisations convention on Workplace health and safety which specifically define the term health to “not merely meaning the absence of disease or infirmity; it also includes the physical and mental elements affecting health which are directly related to safety and hygiene at work.”

Ms Laetitia Chareyre works on communication with the public around various public health campaigns. She described the response plan by the Ministry of Agriculture to reduce suicide amongst French farmers. Using the existing structures of a Mutual Benefit Fund (CCMSA) and partnering with a charity (SOS Amitie) a support line is promoted to farmers buying into and using existing networks.

Ms Virgnie Gigonzac is working on policy around psychosocial factors, distress and illness relating to work. The project is specifically looking at suicide rates across different occupations and economic sectors seeking to identify the highest risk groups for specific intervention. Secondly the project is seeking to uncover potential work-related suicide for further analysis seeking to identify how work may increase the risk of suicide. Her initial analysis identified agriculture, food production, manufacturing and construction as the highest risk economic sectors for suicide for men and manufacturing, and agriculture being the highest risk economic sectors for women.

Ms Gigonzac said:

*A difficulty in the study include a lack for a validated definition of work related suicide. Indicators of a work-related suicide is:*

- Suicides occurring at or on the way to the place of work.
- Where the person has indicated work stress in suicide notes or conversations with others before the suicide.
- Use of a working tool in the suicidal act
- Suicide in workwear when the person was not due to work
Suicide by employees of a company experiencing economic difficulties (Ms Gigonzac Meeting 3)

Much of this information is not routinely collected as part of the coroner’s process making research of work-related suicide very difficult.

5.2.2 Switzerland
In Switzerland I met Mr Nicolas Rufner, General Secretary and Mr Marc Radler Assistant General Secretary from the Construction Employer Association (Fédération des Métiers du Bâtiment- FMB)\(^\text{38}\) in French speaking Geneva and Ms Christine Michell Workplace Health and Safety Secretary of UNIA\(^\text{39}\) in German speaking Bern.

FMB is an employer association targeting French speaking employers in the building and construction industry. The association has approximately 1400 firms with most being small employers. The association works as an umbrella organisation for a number of specific trade organisations and is part of a network of similar umbrella organisations across Switzerland.

The associations focus was strongly on physical safety. They have established a safety display on premise to provide training and information to apprentices focusing on key physical safety issues:

“\textit{In the construction industry we do not see much burnout or stress. The most common cause for people being unable to work is accidents. The industry will occasionally take part in campaigns, but this is voluntary. For example, the Geneva Canton decided to start a campaign focusing on harassment and several employers volunteered to participate- but it was not an obligation (Mr Radler Meeting 7).}\n
Mr Rufner and Mr Radler, acknowledged that issues such as harassment and burnout had a workplace base but saw most mental health issues as having a base in the personal realm that therefore fell outside the responsibility of employers.

\(^{38}\) Meeting 7, Geneva 7\textsuperscript{th} March 2018  
\(^{39}\) Meeting 11, Bern 8\textsuperscript{th} March 2018
Ms Michel pointed to an increase casualisation of the workforce as a significant influencer on workplace stress. She acknowledged that suicide had not been an issue the union had focused on to date.

Workplace violence is an issue where workers kill each other rather than themselves. There are also extreme cases for example I recall Polish domestic workers who have taken their own life following pressure around their work visas – but these were extreme cases (Ms Michel Meeting 11).

The union has had a number of campaigns around workplace stress and focused on the high tempo and deadline pressures in the construction industry with Switzerland having the longest working hours in Europe (42 hours) plus additional overtime. Highly flexible hours meant that workers worked longer in summer and less in winter.

Surveys of the workforce had revealed that one third of the workforce often or very often feel stressed and more than one third felt so tired by the end of the workday that they were not able to recover before the start of the following work day.

Ms Michel did not agree with the proposition raised by Mr Radler that mental health generally was in the private realm. She pointed to high levels of stigma around mental health and therefore the union had adopted the term of psychosocial health to stress the social aspect of it.

The labour inspectorate says you can manage the psychosocial risk just as well as physical safety. But there is still most focus on physical work environment particularly in the blue-collar areas.

A difficulty is that psychosocial and physical work environment is generally the responsibility of two different structures in the industry – psychosocial falls under human resources while physical safety is under workplace health and safety.

5.2.3 Denmark
In Denmark I had the benefit of meeting both researchers such as Associate Professor Annette Erlangsen of the Danish Institute for Suicide Prevention\(^{40}\) and Dr Send Aage Madsen of the National Hospital, Department for Psychology, Pedagogic and Social work\(^{41}\) but also a broad cross-section of

\(^{40}\) Meeting 20, Copenhagen 15 March 2018
\(^{41}\) Meeting 23, Copenhagen 23 March 2018
trade unions and employer associations. I also had an opportunity to participate as a trainer in an Applied Suicide Intervention Skills Training workshop for 20 workers employed in social institutions and the police force on a small regional Danish island.

Every Dane has a Central Personal Register (CPR) number which is used in all interaction with government, health and tax interactions. This registration provides prime opportunity for population-based research linking various aspects of a person life such as health and employment history. According to this data it is possible to calculate and measure mental health and suicide rates right down to a single employer.

In our discussion Professor Erlangsen pointed to Danish research by Esben Agerbo and others looking at suicide rates across 55 different occupations. With the exception of Nursing and Medical Doctors the highest risk occupations are lower skilled manual occupations such as elementary occupations, plant and machine operators, bricklayers, drivers and mobile plant operators, painters, cooks and construction/maintenance workers (Agerbo, Gunnell, Bonde, Mortensen, & Nordentoft, 2007).

The study looked at occupation and then sought to control for and compare with socio-economic, demographic and psychiatric differences. It is clear that suicide risk varies significantly between occupations. It is clear that occupations (except for Doctors and Nurses) with higher rates of suicide also have higher rates of socio-economic factors and psychiatric disorders generally associated with higher suicide rates.

A limitation of our analysis is that we cannot determine whether elevated suicide risk associated with particular occupations arise as a result of the characteristics of the jobs, the people who take up the jobs or a combination of the two (Agerbo, Gunnell, Bonde, Mortensen, & Nordentoft, 2007, p. 1136).

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42 Meeting 19, Copenhagen 14 March retail, office, food production, rail and metal unions, Meeting 21, Copenhagen 19 March cross section of Construction Unions and Employer Associations, Meeting 24 Copenhagen 27 March FOA Union of Government Employed Workers

43 Workshop Meeting 18, Rønne 12 & 13 March 2018
Thus, this research raises similar issues as those raised in Switzerland between the workplace as a cause of poor mental health and suicide. Similar sentiment was raised in several other meetings I had in Denmark.

Professor Erlangsen said while it is possible to research further in the causation issues and particularly deeper analysis within occupation to her knowledge it has not been done yet. She highlighted a limitation in that Denmark experience approximately 620 suicides per year which means the number of suicides in particular occupations may too low for meaningful research on a year by year basis.

Denmark is a signatory of the WHO suicide reduction target, but Denmark does not have a coordinated national suicide prevention plan. There was national action plan until 2004 but since then the focus has been on a psychiatric action plan dealing with mental illness issues as the primary strategy to reduce suicide. Professor Erlangsen felt that a renewed suicide prevention action plan would be required to coordinate and prioritise suicide prevention activities nationally.

Dr Svend Aage Madsen is the chief psychologist at the Danish National Hospital (Rigshospitalet). He has a specific interest in men’s health and understand various masculine roles. Although Danish men die from suicide at twice the rates of Danish women, men are less likely to receive support and treatment for mental health disorders (in Denmark in 2015 22,876 men and 60,196 women were referred to a psychologist). In general men are less likely to engage in help seeking for both mental and physical conditions. Dr Madsen has a specific interest in the indicators and warning signs for male mental health problems and suicide ideation.

Dr Madsen has researched men in the workplace to understand how they express their distress and pain. He finds it important to inform the community about the indicators for male distress and men often are not aware themselves about the depts of despair. Better information may assist others to offer help and refer men in distress to services.

“Many men have the thought that if I can be left in peace then I will feel better – they do not see those closest to them as a resource but perhaps more as a burden.

As researchers we can provide the evidence-based information about the types of behaviour and signs of distress, but we need to collaborate with business and communities to translate
this knowledge to the specifics contexts where men find themselves (Dr Madsen, Meeting 23).”

He is currently working with the Danish Union 3F (Un and semi-skilled workers Union), Esbjerg Local Authorities and Employers on a project aimed at getting long term unemployed young men into employment in traditional male dominated workplaces. He said:

“The Union was a key partner here. For example, scaffolders have a strong internal culture and camaraderie. We needed to convince them that they needed to take hand on these perhaps slightly different young workers coming into their group. This inclusion not only supported the young workers but also provided diversity and through that enriched the workgroup.”

Dr Madsen has also worked with 3F around a project called “alone with mental health” targeting those workers who are isolated from the work community due to unemployment, injury or illness. They have provided training to the frontline staff within the Union to highlight the importance of including men who otherwise might be isolated from the collective in activities.

HK (the Danish Retail and Officer Workers Union) organised a mini-conference for members of the LO (National Confederation of Trade Unions) to discuss suicide prevention in the workplace. The 17 participants came from a broad range of unions and occupational groups. I provided an overview of my work in Australia to the participants followed by a discussion about the relevance of suicide prevention to trade unionism.

While HK has been proactive around raising awareness of the psychosocial work environment the issue of suicide was rarely discussed. None of the participating unions had policies or processes in place around suicide prevention internally in their unions or from their members. Several participants disclosed experiences where members had either been at risk of suicide or had died by suicide. The examples ranged from supporting members on the phone, supporting families following work related suicides and negotiation of settlement to the representative form the Danish Railway Workers Union where exposure to suicide from the public was common experiences:

“In my union we have experienced some situations that made it relevant for us to be here today. It was not situations that happened at work, but members have died by suicide and referred to stress and bullying from supervisors at work in suicide notes”

“I only enrolled in this workshop yesterday because a Union delegate called me last week who had talked to a member who had had her employment terminated as happens from time to time. She finished her conversation with the union delegates with the words to the
effect that there was no reason for here to be here anymore. It really stressed the delegate, I tried to advise him, but I felt I needed to know more.”

“I am a social worker and I advise members who have been injured at work. It is not uncommon for these workers to talk about despair and that they don’t want to be here anymore. I spoke to one member who had already loaded his hunting rifle – we talked and he was ok but I don’t feel I know what to do in those situations.”

In common for the participants was that they were looking for structures and tools they could use to better support members and colleagues experiencing despair or distress. They felt an insecurity in identifying and understanding boundaries for the unions and their personal role. Several participants raised concern that the culture on many workplaces are such that workers would feel it difficult to disclose thoughts of suicide or mental distress.

Figure 20 Meeting 21 Employer and Union representatives from the building industry

The BAT Kartel (construction union cartel) organised a round table discussion with employers, unions and researchers relevant to the building and construction industry in Denmark. Lack of regulation and legislation in the areas of mental health and wellbeing was identified as a major barrier for improvement. Søren Schytte from Blik og Rørarbejder forbundet (Plumbers’ Union) said:

“In Norway they have legislated for minimum standards of dongers – 17 square meters with own toilet and shower. I was in Norway 20 years ago and we had 5 square meters with common toilet and bath – it was squalor – when they build Storebælts Broen (a major bridge project) these were the sheds they used in Denmark, we are far behind. This is just an illustration of how welfare is looked at in the building and construction industry.”

Lene Christiansen National Secretary of Dansk El-Forbund (Electrical workers union) was not sure that suicide was a major issue within her membership, it was not an issue that had been noticed and discussed however she also said that mental health-based workplace injuries were hopelessly underreported:

“It is so difficult to get a case for psychological injury recognised that we are reluctant to push people that way. The people who experiencing psychological injury may already be fragile so to put them through that system is cruel and wrong, so perhaps that allows us to say psychological injury in not a significant problem in our industry. Often the advice we give is to cut your losses and find another job, not because it is ok, but out of care for the individual worker.”

Both employers and unions agreed that there was not much focus on workplace mental health and even less suicide in the Danish building and construction industry. Both sides saw that most focus
was on the risk of physical injury. The difficulty in having psychosocial work injuries recognised leads to less focus on the matter, and lower injury levels leads to less attention being given to the problem.

I had separate discussions with the national leadership team of Blik og Ror Arbejderforbundet (Plumbers Union) where the uniqueness of employment in the Danish building and construction industry was discussed. Employment in Denmark in construction is often on “accord” (a special system of piece rates) and in that system workers form part of a “sjak”, a set group of workers working with a high level of autonomy as a team under a collective agreement with an employer. They felt that the specific unity within this team could be protective44. This idea of autonomy and internal support within the work group is the basis for the MATES in Construction program but it was also raised in several meetings in the USA.

Finally, I had opportunity to meet Jens Nielsen National Secretary of FOA (Danish Union of Public Employees). FOA were in the final stages of negotiations of new collective agreements and Mr Nielsen was preparing for the lockout of 450,000 workers due to start only a few days later, I was therefore deeply grateful for him finding time to meet me.

Similarly, to previous meetings Mr Nielsen pointed to the Danish workplace health and safety legislation as not being conducive to improving mental health and safety in the workplace:

“Our workplace legislation is not that sharp, it could be much sharper. In Denmark employers are required to ensure the workplace is healthy and safe while for example Swedish workplace health and safety legislation require employers to prove they have done what is reasonable to prevent illness caused by the workplace.

Mr Nielsen highlighted that the mental health area is contested between employers and unions with employers making a strong link to “KRAM Faktorer” (Diet, Smoking, Alcohol and Exercise) and therefore pointing to lifestyle links. He could see opportunities in introducing suicide prevention as a “no fault” issue – simply focusing on the workplace as the venue for rather than the cause of suicide, that way employer participation became corporate social responsibility rather than an admission of guilt.

44 Meeting 16, Copenhagen 19th March 2018
5.2.4  Sweden

I went to Sweden at the invitation of AFA Insurance. AFA insurance is an organisation owned by Sweden’s labour market parties. The company insure employees within the private sector, municipalities and county councils. The purpose of this visit was to provide a presentation around the work done in the Australian building and construction industry.

Sweden experience almost 1500 suicides each year. The Swedish suicide rates are amongst the highest in western Europe. This is perhaps surprising given Sweden’s very good record on other public health and safety parameters. For example, with less than 260 traffic fatalities per year Sweden has 4.5 suicides per traffic fatality compared to approximately 2 suicides per traffic fatality in Australia45.

I met Professor of public health and clinical medicine at Umeå University, Bengt Jarvholm. He leads the unit of Occupational and Environmental Medicine. Professor Jarvholm is specifically interested in the risk of cancer and respiratory diseases but he also looks at insurance medicine more broadly. He is currently working on studies of workers who his leaving work early due to injury and illness to understand how this impact their life post work.

While there is no known data about suicide risk amongst Swedish construction workers generally, Professor Jarvholm has done research into suicide amongst electricians, glass and wood workers. He found that the risk of suicide amongst these trades were lower than average (Jarvholm & Stenberg, 2002).

Professor Jarvholm explained that suicide is not commonly discussed as a workplace health and safety issue in Sweden although workplace bullying (a risk factor for work related suicide) is increasingly being discussed. The term “krænkende særbehandling” (humiliating/violating special treatment) was part of one case of work-related suicide decided by the courts.

In the case of Lasse Persson, a social worker with the Krokom Council workplace bullying and unreasonable management action was alleged to have led to his suicide. In the period leading up to his suicide Mr Person involved in an interpersonal dispute with his supervisor.

The district court found that the council had been negligent in its duty to prevent occupational illness and injury. The case had a number of procedural complications due to Mr Persson being employed by a public rather than a private enterprise employer. The court had no jurisdiction to deal with the main protagonist in the dispute, the supervisor (due to the council being a public

45 Meeting 25, Stockholm 5th April 2018
employer), but did find two managers guilty of breaches of the workplace health and safety legislation leading to the death of Mr Persson. The High Court agreed with facts discovered by the lower court but did not find that it was sufficiently proven that the actions of these managers caused the suicide (Persson, 2014; Arnoth, 2016).

It is likely the High Court would have found differently if the situation had arisen in a private business as the main protagonist could have been charged. It is also noteworthy that the Swedish law changed on 31 March 2016 now requiring employers to intervene to balance conditions to prevent stress such as reducing overtime, work pressures, pace and breaks, interpersonal disputes and staff turnover (Swedish Work Environment Authority, 2015).

Another risk factor increasingly being discussed in Sweden is burnout. This is particularly relevant to female dominated industries46.

The female dominated industries include local authorities, childcare, government jobs such as hospitals. Industries where there often are large amounts of unpaid overtime. While construction work often is on accord, physically hard at a high tempo, the accord system in construction industry provide a high level of autonomy for construction workers which can mitigate against burnout (Professor Jarvholm Meeting 25).

The AFA had gathered 16 representatives of unions, employer associations and government regulators discussing mental health and suicide prevention for a discussion around workplace suicide prevention and mental health. It was interesting that despite Sweden having work leading legislation around the psychosocial work environment many participants felt they were behind the world in terms of dealing with suicide in the workplace.

I challenged the group with comments from trade unions in Denmark who referred to the situation being more progressive in Sweden around mental health in the workplace. Ulrich Stoetzer from the Swedish Work Environment Authority said:

I would hope they are referring to our provisions on the psychosocial work environment because it is the first time, it is unique in the world, to require employers to be proactive around the psychosocial work environment. It is about being proactive and prevent things from happening, not trying to intervene when someone is already injured or thinking about suicide.

46 Meeting 25, Stockholm 5th April 2018
Regulations have been issued by the Swedish Work Environment Authority pursuant to Section 18 of the Swedish Work Environment Ordinance for the “purpose of promoting a good work environment and prevent risk of ill health due to organisational and social conditions in the work environment.” The provisions apply to all activities where an employee perform work for an employer.

Under this legislation employers are required to ensure workers are not provided with unhealthy workloads, ensure working hours do not lead to ill health particularly when scheduling shift work, nightwork, split shifts, overtime, long workhours and changing workhours. Finally, the employer must ensure that victimisation is not accepted in their operation and must counteract conditions in the work environment that could lead to victimization (Swedish Work Environment Authority, 2015).

Several participants said that they were missing data highlighting the high-risk groups in an occupational context to target intervention and effort while other commented that while they do have discussion around mental health and wellbeing in the workplace suicide was rarely discussed as a workplace issue.

_We have rules now around mental health in the workplace, but the focus is still a systems driven approach. From management to the workforce through policy and procedures. We need the tools to ask the simple question: How are you going? in a meaningful way. We do need a bottom up approach._

5.2.5 United Kingdom

Part of Public Health England’s role is to advise and support the actions taken by local government, National Health Service (NHS) and the public. The NHS is the world’s largest single-payer healthcare system providing health care for legal English residents. I met Dr Helen Garnham National Program Director of Public Mental Health at Public Health England in London 47.

Mental health and suicide prevention is a devolved responsibility in the United Kingdom and local government are responsible for developing local suicide prevention action plans. The intention of these plans is to create a network across the community including the health system, local authority, community sector, workplaces, schools and universities.

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47 Meeting 23, London 6th April 2018
Dr Garnham pointed out that local government often lack resources to do this work at a high level and as the NHS is a major funder in the area intervention and plans are often very focused on the medical health system.

There are strong similarities between the Australian system where 31 Primary Health Networks (PHNs) are responsible for commissioning suicide prevention services locally. Likewise, the PHNs are very medical system focused and only recently have Australia started to seriously discuss some form of national office for suicide prevention to advice this effort.

Dr Garnham explained that Public Health England strongly advocated that resilience and/or treatment is not the full answer to suicide in the community or in the workplace. It is much broader and more complex including the social environment. This advocacy is getting some traction with the Government recently committing 25M Pounds towards more upstream suicide prevention interventions a project led by the NHS but done collaboratively with Public Health England and the community sector.

In terms of workplaces there are increasing focus on mental health but a lot less discussion about work-related suicide or suicide within the workforce generally. With Dame Carol Black and Martin Coyd 48, Dr Garnham has been part of the “time to change, let’s end mental health discrimination” campaign where more than 835 business, more than 80 of these from the construction industry, have taken a pledge to change how the business and its people think and act about mental health in the workplace and to make sure that employees who are facing these problems feel supported. Participating business will work with the campaign to develop an action plan to get employees talking about mental health (Time to Change, 2018).

“The focus was very much on mental health, at the time no one was prepared to go there with suicide. However, in my role with Public Health England I worked with The Prince’s Responsible Business Network to develop business tools helping business manage mental health, suicide prevention and postvention in the workplace and the community around the workplace (Dr Garnham Meeting 24).

The Prince’s Responsible Business Network is a business-led membership organisation where members pledge to work towards being the best they can both as individual business and collectively as a business community (The Prince’s Responsible Business Network, 2018; Business in the Community, 2016; Business in the Community, 2017(a); Business in the Community, 2017(b)).

I think we are going through a journey and I think we are a bit behind and I think it is maybe because we have not yet had a French Telecom situation, we have much less interventionist government, and I don’t think we would necessarily know if we did have a French Telecom situation (Dr Garnham Meeting 24).

48 Meeting 24, London 6th April 2018
This concern was backed up in my interview with Professor Sarah Waters of Leeds University\textsuperscript{49} who said:

\textit{In France if a suicide happens in the workplace or in the course of work it is automatically investigated as work related. There is a presumption that it is work-related unless the circumstances prove otherwise. In the UK the Health and Safety Executive sets out that all deaths to workers and non-workers, with the exception of suicides, must be reported if they arise from a work-related accident. Even if a suicide happens in the workplace it is presumed to be an individuals and voluntary act (Meeting 19 Professor Sarah Waters).}

Both Dr Garnham and Professor Sarah Waters pointed to the coroner’s system as problematic in getting accurate and consistent data around suicide generally and work-related suicide in particular. While a death is investigated by a coroner in the United Kingdom (and Australia) the French system is based on a team working together, discussing and coming to a joint conclusion around a cause of death. However, my meetings with the National Suicide Observatory\textsuperscript{50} highlighted that they also saw there being problems with consistency in the French system.

Professor Waters highlighted that there has only been one case in the UK where a company has been held liable for suicide where more than 100 companies in France has been held liable for work related suicides.

Sarah Waters is Professor of French Studies at the University of Leeds and have written several articles on work related suicide due to her research around workplace suicide in France (Waters, 2017 (a); Waters, 2017 (b); Waters, 2017(c); Waters, Karanikolos, & McKee, When Work Kills, 2016).

Unions in the United Kingdom anecdotally experience higher levels of work related suicides, but Professor Waters argues that these suicides are brushed under the carpet. Due to the gap in British workplace health and safety legislation there is no investigation following a suicide and this can result in other workers being exposed to the same mental health risks in the workplace.

The only successful case of prosecution was a worker from Vaxhaull Motors when a worker died by suicide following a workplace accident causing him severe injury. The courts found it reasonably foreseeable that such physical injury could lead to suicide and ruled his family entitled to compensation under the 1976 Fatal Accidents Act. This can be contrasted by the suicide in the workplace by a British Telecom worker. Although the court found he had been under sustained work pressure leading up to the suicide it was found that it would not be in the public interest to investigate further (Waters, 2017 (a)).

\textsuperscript{49} Meeting 19, Phone Interview 29\textsuperscript{th} March 2018
\textsuperscript{50} Meeting 1, Paris 5\textsuperscript{th} March 2018
She contrasts this with France where Peugeot was found liable for a suicide in the workplace because the company had failed to do a psychosocial impact investigation prior to introducing a significant work restructure.

Figure 26 Meeting 21 Unite the Union Jerry Swain, Susan Murray, Rob Miguel

Unite the union is Britain’s biggest union with 1.42 million members across 20 industry sectors. I met National Health and Safety Adviser Susan Murray, National Officer for Construction and Regional Officer Rob Miguel.

Susan Murray said that mental ill health and stress is an issue raised across all the union’s 20 industry sectors. In response to this Union has established a mental health taskforce chaired by the Educational Director, but also including Unite General Secretary Gail Cartmail, to formulate the Union’s response to these increasing concerns but also to provide some tools for activists.

National construction officer Jerry Swain highlighted that there are green shoots around this area where activists increasingly want to get involved but find it difficult to know how.

We need to work out how to engage them, what tools we can give them. There needs to be some underpinning movement where people genuinely can become part of creating change. We need to find out how we can stimulate this interest and turn it into activity (Meeting 21, Jerry Swain).

Mr Swain identified the importance of Unions becoming clear on their role and proactive in setting the agenda for better mental health in the workplace. He was concerned that if Unions failed to do this the only roles left for the workers to fill in the agenda would be those roles allocated to the workers by the employers. This will rarely be the roles that can drive systemic change.

The British Trade Union Council have launched a guide to suicide prevention for trade union activists (TUC, 2017). The guide point activists to consider works negative impacts on workers mental health as well as insuring that the workplace has support structures to help identifying and helping those in the workplace experiencing poor mental health. The guide also identify that Union representatives often can be the point of contact for members in the workplace experiencing mental stress and how they may assist such workers getting in contact with appropriate professional help.

In the construction area Unite has commenced work with several contractors in the industry around mental safety. They are working with Martin Coyd51 and Mace Construction:

If we get the model right we can work together between the client, the contractor and the Union. It will not work if it comes from the top “you will tell me if you are depressed, you

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51 Meeting 24, London 6th April 2018
Susan Murry pointed to the need for authenticity when talking to workers. She pointed to tool box talk videos made by the NHS Scotland using construction workers talking about their mental health to start conversations (https://www.youtube.com/watch?v=ABKuz8BCh8).

In January 2017 the British Prime Minister, Theresa May, commissioned Stevenson Farmer to conduct a review “into how employers can better support all individuals currently in employment including those with mental ill health or poor well-being to remain in and thrive through work (Stevenson & Farmer, 2017)”. The report calls for all organisation in the United Kingdom to adopt a series of core standards:

- Produce, implement and communicate a mental health at work plan
- Develop mental health awareness among employees
- Encourage open conversations about mental health and the support available when employees are struggling
- Provide employees with good working conditions and ensure they have a healthy work life balance and opportunities for development
- Promote effective people management through line managers and supervisors
- Routinely monitor employee mental health and wellbeing.

Martin Coyd highlighted that every working day two British construction workers die by suicide. This is a risk ratio of 15 suicides for every workplace fatality in the industry. He has been a passionate advocate for using the workplace to provide better mental health and wellbeing in the construction industry.

Most recently he has been part of developing the Building Mental Health Framework as a vehicle to promote uptake and acceptance of the six core standards promoted through the Stevenson / Farmer review. Business sign up to a charter to provide three levels of mental health training on sites.

Workers who have received 45 minutes of training in awareness around mental health will wear a bronze sticker on the back of their hardhats.

Supervisors and line managers will receive 3 hours of training and will wear a silver sticker on their hardhat while workers receiving two-day training will have a gold sticker on their hard hat. There
are no training particularly mandated for these stickers but any training performed under the policy will be recognised on all sites.

This approach will allow individual business to customise and corporatize the program offerings. This level of flexibility is necessary in the United Kingdom:

Workers hate that there are different programs on different sites but it is necessary to have this flexibility because business are very tribal in the United Kingdom (Meeting 24, Martin Coyd).

The initiative can draw on £500,000 from the Government to train 150 additional mental health first aid trainers for the industry as well as £65 for each worker doing the 3-hour training modules.

The initiative will not build any infrastructure but will rely on existing structures.

I met with Mr Kevin Meyer who is a director of the Construction based mental health organisation Mates in Mind. The objective of MATES in mind is to provide clear information to employers on the available support and guidance for addressing mental health and wellbeing within their organisations.

The organisation was established by the British Safety Council in collaboration with Mind and Mental Health First Aid. Masted in Mind provides a three-level training program on sites being 45 minutes general awareness for the general workforce, a half day course aimed at line managers and supervisors. Finally, they provide a two-day Mental Health First Aid training course for key personnel on site.

Mates in Mind was established to provide a consistent approach to mental health across the British construction industry:

It would be best to have some communality in approach across the industry, so we can get better impact but also to avoid “sheep dipping” worker in the industry with different programs as the move through the industry (Meeting 22, Kevin Meyer).

Mates in Mind took some inspiration from MATES in Construction in Australia but felt it would be a mistake to simply import a copy of the MATES in Construction program in the United Kingdom. It was felt that the UK market would be more receptive to a broader mental health and wellbeing
program than a suicide prevention program, echoing the remarks by Dr Garnham of Public Health England.

The Mates in Mind model relies on external organisations to deliver on the ground training such as Mind and Mental Health First Aid. The British Safety Council is also providing extensive safety training on sites and could provide onsite mental health training as well. Mates in Mind facilitate the training and expect a small contribution based on delivered training.

Mates in Mind does not provide any support directly to workers but rely on direct connections to the existing mental health system in the United Kingdom. The business model is to build a strong brand around good mental health intervention and selling this brand for social capital. They want to create a quality loop between development, delivery, evaluation and back to redevelopment of the training model funded through industry partners.

5.3 United States

5.3.1 Lendlease

Lendlease is a global company founded by Dick Dusseldorp in Australia. It is built on the idea that:

Companies must start justifying their worth to society, with greater emphasis placed on environmental and social impact rather than straight Economics (Dick Dusseldorp, 1973)

Lendlease have developed a view around workplace health and safety including mental safety as well as physical safety. In 2014 the company created a Global Mental Health Peer Group to look at its global operations and propose policies and initiatives to extend the safety agenda beyond physical safety. The company has developed a four-pronged mental health approach focusing on:

1. Education / Awareness
2. Early Intervention
3. Active Intervention and

Over past years I have worked extensively with Lendlease in Australia and in 2016 I was commissioned to test the MATES in Construction idea on the Lendlease Elephant and Castle project in London, a major urban development project.

Figure 29 Edmund McCombs, Director of Community Engagement and Head of the Lendlease Foundation US and Eleni Reed Head of Sustainability
Through contact with the Lendlease Americus Director of Community Engagement and the Head of the Lendlease Foundation in the USA, Mr Edmund McCombs I had the opportunity to meet and discuss mental health and suicide prevention with senior leaders in the business across the US. I visited Lendlease offices in New York, Boston, Washington, Chicago, Los Angeles as well as a phone interview with the General Manager of Private / Public partnerships Ben Symons based in Nashville., Tennessee.

Lendlease have global minimum requirements around mental wellbeing. Knowing well how Lendlease work with these requirements in Australia as well as my exposure to the European operations made it interesting to observe how such requirements was implemented across a country as diverse and large as the USA. The minimum requirements include:

- Establishing an Employee Assistance Program with independent counselling and support lines available for those feeling stress or living with other mental illnesses;
- Providing general awareness programs appropriate to roles and relationships with the business;
- Training employees to identify signs of poor mental health in colleagues and contractors; and
- Training employees to intervene and direct individuals showing signs of mental health issues to appropriate professional support.

From a National USA perspective, I spoke to Andrew Council, Managing Director of Construction and James Mooney, Head of Environment, Health and Safety. We discussed the difficulties in implementing standards across a country as vast and varied as the USA. While some rules are national through the Occupational Safety and Health Administration (OSHA – US Department of Labour) most regulation is state based and, in some cases, even city based. Some states are “Union” states where labour is provided through agreements with trade unions while other states are “right to work” states where labour is generally not organised. Increasingly they were seeing a mix where some states are organised through unions and others are not – often decided through the developer.

Mr Mooney explained that while mental wellbeing was often brought up in conversation across the industry very little was happening at a practical level to the best of his knowledge. The trade unions in the USA have less national organisation and discipline than what is experienced in Australia.
Ralph Esposito heads up construction in the eastern region of the Americus. He provided interesting insight and thoughts around how mental health and suicide prevention programs could work in a US market. He said:

*We don’t hear so much about suicide and mental ill health as we hear about accidents in the industry. However arguably suicide could have a larger impact on the works in the industry. It is clearly a very noble and worthy area to explore, but getting started will be kind of the hard part (Meeting 29 – Ralph Exposito).*

Often suicide rates are higher in lower socioeconomic areas and populations. Mr Esposito pointed out that construction workers in the US are fairly well compensated with engineers earning as much as $700,000 per year while a builder’s labourer could earn $140-170,000 per year. It should however also be recognised, as pointed out by Andrew Council, that working conditions for onsite workers can be tough – for New York for example working on buildings 90 storeys in the air in temperatures of -20 degrees or worse.

Mr Esposito also pointed to some potential cultural differences in the US construction industry. Workers can be very tribal within their respective crafts. Running a program out across a project could cause back lash whereas a program focusing on a particular craft – perhaps organised through a union would be much more likely to be acceptable. Project managers like Lendlease employ relatively few on sites with most labour supplied in New York is done through agreements with respective craft unions.

“I think it would be best if the Union was running programs like this. Attrition is 10% to 12% so over 5 years I could turn over half my staff. But if you are a plumber you are a plumber from you are 16 to when you are 65 years of age – that is where you belong, that is your family. So, aligning it with their unions makes a lot of sense (Ralph Exposito, Meeting 29).
The discussion with Lendlease in Massachusetts was framed around an industry meeting held the previous day (dealt with below) and how Lendlease best could play a progressive part in an industry approach.

The construction market had been relatively buoyant over the previous years. There was a general mood to try to progress initiatives around addiction, mental health and suicide prevention.

Particularly opioid addiction was frequently discussed. The industry also had problems attracting younger workers with the average age of workers being well past 45.

The discussion touched on some of the unique aspects of the US health care system that could be exacerbating the problems.

Mr Edmund McCombs reported that Lendlease conduct a biannual workplace health insights study across the business globally and found it remarkable that in the Americus responses specifically avoided using mental health terms apart from stress. He suggested that this could be due to the close link between employment and access to health care in the US so workers may be reluctant to disclose concerns they feel could jeopardise their insurance cover.

Opioid use is seen as a major issue. This could be due to Boston being seen as a “health care state” where high quality care is available and therefore attracting individuals in need of such care. Lendlease has a system of drug testing at time of employment and following any accidents. They did not observe particularly high number of positive results. Workers who had declared medical prescriptions is not seen as positive tests, but it could also be that people self-select not to work on a site with testing.
Stephen Conley, Principal in Charge of Lendlease in Washington/ Maryland / Northern Virginia. He has been with the company for 34 years and was somewhat taken back with the issue of suicide being raised in a workplace context.

“I am not aware of suicide ever having been an issue on our jobs. About 15 years ago a member of the public died by suicide on one of the jobs, but it was completely unrelated."

He explained that Lendlease since this incidence have stepped security up on the jobs significantly so it has become more difficult to access the jobs with better fences and security surveillance by third party security companies.

Maryland is a right to work state meaning that Lendlease only has done one union project agreement with most jobs being a combination of unionised and non-unionised workers.

The office is progressively rolling Mental Health First Aid training out across the business with the hope of decreasing stigma and increasing help seeking within the business.

The Lendlease US Communities and Infrastructure group is somewhat different to most other parts of the Lendlease US business. The group specialises in private public partnerships with the US military where the perform construction work on military bases. The group employ approximately 130 staff directly and between 500 and 1000 contractors at any time.

Typically, the group will work on a particular base building a project over a few years and thereafter have a facilities maintenance contract for a further 20 or 30 years.

Ben Symons was the General Manager of project manager of the Lendlease US Community and Infrastructure business (In August 2018 he was appointed General Manager of Lendlease in the Los Angeles Area).

The nature of the work of the group makes it difficult to make an impact on local cultures and market in the same way as a regionally based Lendlease business. Typically, the group engage local contractors for the period of the project and do not have the same longer term relationships with these contractors.

The group adhere to the Lendlease global standards in training key employees in Mental Health First Aid. Mr Symons is an Australian who worked for the Australian business for 10 years before moving to the USA on 2010. He could therefore offer perspectives on cultural similarities and differences.

*There are a lot of similarities between US and Australia in that the construction industry is very “blokey” – there is a certain pride and toughness in what we do and a resistance to anything that is emotional. Perhaps the American worker is more attuned to having support structures. Having a therapist have less of a stigma attached to it over here.*
The nature of the work in the Communities and Infrastructure business, working closely with the military, means the business employs a high proportion of ex-military staff. Given the high profile of mental health within the military this may also mean that workers are more prepared to consider support around mental health.

From Lendlease in Chicago I meet COO Jeffrey Arfsten, General Manager / Senior Vice President Bert Brandt and Field Operations Director for EH&S Kevin Zesch. While Lendlease in Chicago were participating in the corporate Lendlease projects of training Mental Health First Aid officers for sites they conceded that they were not aware of suicide as an issue relevant to workplaces in the construction industry.

They identified that a meaningful approach would be across industry as blue-collar workers tended to move through the industry. We had some discussion about running initiatives “on the clock” (during paid working hours) and they highlighted that although they at times did have push back from contractors, they made it clear that on important safety issues this approach was necessary to ensure universal attendance.

Much of the discussion focused on the aging of the industry with relatively few young workers entering the industry. The more traditional entry to the industry through trade union sponsored training was now supplemented by vocational schools particularly targeting minority communities. Unions would support these schools as a pathway into the industry, but enrolments were falling. Many young workers left the industry during the GFC and older workers retired early leading to a severe skills crisis at present.

One of the highlights of my trip was the opportunity to meet Bob “Chappy” Dinkins, an Environment, health and safety manager with Lendlease on their Van Buren street, Chicago project. An electrician by trade, Chappy has his own lived experience of suicide and has chosen to make sense of his loss by helping others. It serves the function as chaplain on his worksite as well as for a number of other organisations.
Chappy took me around his site and introduced me to several site managers and workers. The encounter highlighted the similarity between people in Australia and the US. He continually pointed to the strong connection between physical and mental safety on sites.

“I make a point of telling people when they come to site that they can come to me with any safety problems they find on site, but also that they can come to me as a chaplain if they are struggling with their mental health. If you are struggling it may be difficult to focus and it is dangerous to be on a construction site if you cannot focus, both for you but also everybody else on site.”

He pointed to the strong union culture in Chicago as a potential enabler of initiatives such as MATES in Construction. While individual unions may have pride in their unique crafts, when it comes to safety they have each other’s back.

Chappy was very enthusiastic about a peer driven program such as MATES in Construction. He said:

“When we talk to people in their workplace, as site worker to site worker, we are in familiar surroundings following common rules. As soon as you walk into a therapist’s room it is no longer the same – we are no longer equal. (Chappy)

Los Angeles Vice President and General Manager Mike Concannon shared the trauma felt by the organisation when a worker died by suicide in the job three days after starting. The impact on the organisation was profound and it has motivated him to focus on mental health within the business unit.

Similar to the discussion in Chicago and other Lendlease operations mental health is to be seen closely connected to general workplace health and safety.

“Howver, I see Lendlease focus on mental health and community work generally as a differentiating advantage of Lendlease. I am engaged in community work privately and feel good about working for an organisation prepared to give back to the community. (Mr Concannon, Meeting 52)

He is engaged in community work privately and sees focus on mental health as one of the differentiating advantages of Lendlease. We need it to be ok to go through a difficult time, a time where people must feel supported and valued. He sees mental health as closely connected with workplace health and safety.
Mr Concannon saw an industry approach to mental health and suicide prevention as advantageous and was prepared to put the Los Angeles business unit forward as a place to pilot such initiatives.

Following my return from the US I have been informed that Lendleas is piloting a major intervention program on their sites loosely modelled on the MATES in Construction approach where key site workers have been trained in Applied Suicide Intervention Skills Training (16 hours intervention training), a broader group trained in safeTALK (4 hours alertness training) while all workers on sites will be trained in suicideTALK (1 hours awareness training). The training is delivered through the Canadian based social enterprise Livingworks. Livingworks is the philosophical base for MATES in Construction and I was able to make connections between Livingworks and Lendlease during my US visit.

Lendlease is also sponsoring an industry discussion in LA to discuss the pilot program undertaken and provide energy towards a broader industry intervention. Finally Lendlease Americas has as the first General Contractor in the industry joined the Construction Industry Alliance for Suicide Prevention.

5.3.2 Trade Unions

The relationship between business and unions in the USA is somewhat different to that in Australia. Union’s enter into contracts with business to supply labour on certain terms and conditions. In some states construction project agreements are reached with a range of unions on behalf of the developer while other states have placed restrictions on freedom of contract between business and unions. Generally, it seemed to be a collaborative approach where employers in unionised states/business would point to the Unions as the most appropriate avenue for intervention around mental health and suicide prevention.

The labour unions differentiate themselves from non-union labour by having a strong focus on training and skill amongst the workforce and Unions generally run training facilities as well as labour hiring halls.

A key function of trade unions is to manage pension and welfare plans for their members. In USA most access to health services and health insurance is through employment schemes such as those provided by Unions or employers.

I met Jamie Becker, director of health promotion at the Laborers Health and Safety Fund of North America (LHSF) in Washington. The Laborers Health and Safety Fund of North America was established to improve the safety and welfare of labourers and to improve profitability of unionised business. The fund is governed by a board of trustees consisting of equal union and business
representatives. The fund consists of several divisions/Departments including an Administrative, Accounting, Occupational Safety and Health, Research, Communication and IT.

The Fund is situated within the Laborers International Union of North America’s (LIUNA), a union representing 500,000 workers across North America. The Union is organised across 44 districts and more than 400 local unions.

The decentralised nature of the Union though their local unions has made a coordinated approach to issues such as mental health and opioid abuse complex. Most union services are provided through the locals. The union has 95 different health plans with varying levels of benefits and conditions. The intermittent nature of employment in the construction industry, particularly amongst the un- and semiskilled workforce ad a further complication which has led several locals to introduce a “smoothing fund“ to extend coverage while workers are out of work. It is likely that workers are un-reluctant to disclose mental health issues as such issues potentially could limit coverage as pre-existing conditions.

From the LSHF point of view the insurance systems does provide data for research and understanding of issues across industry. In the context of the opioid use debate in the USA the LSHF has been able to access prescription pattern data across the various insurance plans and though that been able to monitor opioid prescriptions. They can intervene when over prescription seem to occur and/or develop alternative pain management options as well as recommending less addictive and problematic pharmaceutical solutions.

The LSHF has concerns around the reactions to the opioid discussion, as the data show while opioid prescriptions have fallen, overdoses have increased suggesting that substitution with unprescribed medication including heroine is occurring. It was also noted that the evidence still pointed to alcohol abuse being a more significant and widespread problem.

Ms Becker expressed some concerns regarding on site testing for drugs as testing failed to deal with underlying causes and could also lead so substitution for drugs that may be harder to detect but more harmful.

Figure 38 Ms Ambrose, United Association of Journeymen Plumbers

The United Association of journeymen plumbers, gas fitters, steam fitter and steam fitter’s helpers of the US and Canada (UA) was founded in 1889. Today the union has more than 320,000 members across more than 325 locals across Canada and the USA. The UA also have a partnership with the Australian Plumbing Trades Employees Union and the Irish Technical, Engineering, Electrical Union.

I met with Cheryl Ambrose Health, Safety and Environment Director and Patrick Kellett the General Secretary / Treasurer of the Union.
Like the Labourers International the union is highly decentralised with each local having separate insurance plans. The UA has a centralised training system where the union train trainers in each local to deliver the Union trade and safety programs in a consistent manner. The Union’s 2000 affiliated trainers meet each year and receive training in the US program – 5 modules of 40 hours delivered over five years.

“A colleague from my previous workplace contacted me. He is a senior manager and felt he had to administrate a drug and alcohol test to an employee who also happened to be a close friend. We discussed it, and rather than doing it formally he went to the friends house and spoke to him and his wife. He said, if this continues you will lose your job and I will have to be the person who fire you. They arranged to get him into treatment for his alcohol problem. The result was much better than if it had been done formally with a drug and alcohol test, he kept his job, he kept his friend and he got help. That is the strength of peer support.” (Ms Ambrose, Meeting 42)

There is not a lot of focus on wellness of mental health within the union. While several locals have EAP services in their insurance plans the benefit is often buried in the policy so not even the Union business manager knows about it. A survey amongst union locals showed that 60-70% of them either did not have or were not aware they had access to EAP services.

Shawn Nehiley, business agent with Ironworkers Local 7 in Boston. shared his own powerful story with me. It would not do it justice to paraphrase it, so I have transcribed his story below:

I was 18 years old and I got hurt at work. The first thing they did was to give me a prescription of Oxycodone – I had a back injury. The insurance company tells me go to occupational therapy, I do that for six months. Now try shots in your back. Ok that does not work, that’s another six months I am on pain medication. I am just speaking from personal experience. I am already addicted to pain medication and I need 600 hours every six month, so my wife and my two boys can have medical insurance.

When I had my injury, I couldn’t walk. I lay on my floor for weeks, I could not go out. As soon as I could stand I would go to work to make my hours for insurance.
Now I finally get an MRI, I have two herniated disks and I need an operation. Now they could have given me an MRI straight up, found out what was wrong, and have it fixed, but instead they put me on pain meds for a year and a half stringing me along.

I didn’t get the MRI because it was too expensive – but it wasn’t cheaper for me to get addicted on pain medication – four detox later – it definitely was not cheaper.

Before I could have my operation, I needed to get my 600 hours for insurance because I would have four months off after the operation. That is the stress that the guys get.

It is the individual guy out there concerned about doing his hours to make insurance, to feed his kids I am worried about. And that is the biggest stress on the individual.

You get hooked and next you run your friends out, you run your family out, you run everyone around you out and you are all alone and you feel others will be better off without you.

I have too many prayer cards on my wall, too many colleagues have taken their own life – this has to stop.

Figure 40 Frank Callahan, President, Massachusetts Building Trades Council

Frank Callahan, President of the Massachusetts Building Trades Council represents 75,000 Union members in the State of Massachusetts. The construction unions combined spend more than 49 million dollars per year.

There is fertile ground for a Union based mental health and suicide prevention program in Massachusetts. Painters union has introduced a peer support model that has been very successful and have invited other Unions to join. While there are disputes between workers and employers there is also a strong collaboration on a day to day basis particularly around supply of well-trained labour to the industry.

The Unions are running training around drug and alcohol as well as financial management, so it is not a stretch to include mental health and suicide prevention. It is about getting the timing right, the time where employers are prepared to take the issue on and when there are financial resources available for a program.

5.3.3 Sheet Metal Workers Union SMART MAP Program
The International Association of Sheet Metal, Air, Rail and Transportation Workers has around 220,000 members across 174 local unions in North America. The Association was formed in an amalgamation between Sheet Metal workers and Air, Rail and Transportation workers.
The Sheet Metal Occupational Health Institute Trust (SMOHIT), a trust originally established by the SMART Union to support and inform members who had been exposed to asbestos, but now providing training and advice to the Union across a range of health and safety issues including mental health.

Randall Krocka is the Director for Health and Safety and Administrator of SMOHIT. A sheet metal worker with 25 years worksite experience followed by 10 years as Financial Secretary- Treasurer, Business Representative at the Unions Local 18 in Wisconsin. I had the pleasure of seeing him present the Union’s work to the American Association of Suicidology (AAS) conference as well as meeting him for a one on one interview.

The origin of the Union’s national mental health program was a Philadelphian man called Bobby Bonds who established a Union Members Assistance Coordinator (UMAC). From 2014 the UMAC program was changed to the SMART MAP (Members Assistance Program) with a change in focus from a coordinator to a peer support program with a greater emphasis on rank and file member involvement in the program.

Members are encouraged to participate, particularly individuals with high credibility within the industry, the members that others will trust. The Union seek to establish a Union wide network of SMART MAP trained members. Most locals are using hiring halls and the number of contractors in each area is limited so members may be reluctant to talk to someone locally about their issues as addiction and mental health issues are stigmatised and they may fear it could impact on their employment prospects, so they may be more likely to talk to someone from another area.

The concept was reasonably simple Mr Krocka explained. When a member was having difficulty, it would be natural for them to turn to another union member for support so the union took on the role to train union members to become peer supporters.

*Don’t walk away from a brother or sister who is hurting. Learn and reach out and become part of the solution. Remember that, “People don’t care what you know, until they know that you care”. (SMART, 2014).*

After four years of the program Mr Krocka feels the program is still a bit short of it’s full potential:

*I don’t think we are reaping what we thought we would at this stage. We have been doing this for four years – the buy-in has not been as great as we would have hoped. Perhaps our business managers in the locals are saying: “We already have this EAP through our insurance*
Perhaps Mr Krocka reflect the comments made by Mr Irving the Massachusetts Assistant Regional Administrator of the US Department of Labour Occupational Safety and Health Authority (mentioned below) when he expressed concern that the time for intervention might not be right yet. He was concerned that stigma was rife and that the case for workplace involvement in the crisis was not yet accepted.

However, engaging members and training is part of breaking down the stigma, so it is important Unions such as SMART are proactive in the area. The current iteration of the program was developed by Chris Carlough, Director of Education for SMART. Over the first four years of the program 400 peer support workers have been trained, but the ambition is to have a SMART MAP trained peer supporter on every job (Procter, 2018).

A barrier to attending the training for union members is loss of pay. While the local union branch may reimburse travel and attendance cost, few would compensate the member for lost work time. Mr Krocka explained that the unions were looking at ways for the Union to support members who wanted to be SMART MAP trained. One way would be to utilise the Union’s SASMI stabilisation program, a program established to support workers for periods of un- or under-employment.

The SMART MAP program is a priority of the Union nationally. Most of the Union’s health plans nationally have Employee Assistance Programs included, but the utilisation is very low. There are still significant stigma barriers to break down.

We have seen too many of our guys falling prey to this – not being as productive, not being as happy as they could – we are Union – we are about looking out for each other – we would do it if they are down on their luck and need groceries so why not for mental health. (Mr Krocka, Meeting 47)

The union have introduced a national support line. It was initially introduced to deal with specific trauma experienced by members, but it is advertised widely now but the call rates to the line are still very low.

However slowly, through information, posters and hard hat stickers the issue of mental health and suicide prevention is being placed before the membership as an issue they must relate to and take onboard.

The Union is seeking to train their apprentice instructors in the SMART MAP training with a view to these trainers supporting and sharing knowledge with the apprentices being trained by the union. The apprentices already trust the trainers, so it is a natural connection. This is a deliberate strategy engaging the younger generation trade workers to change the culture within the trade – to make it clear to them that it is ok to ask for help.

The SMART union is collaborating with other unions through the Opioid Crisis Task Force. However, the cause of the opioid crisis is structural – it is part of the way health care is provided in America. It is a system driven by vast economic interest all spending big on lobbying and promotion of their interest. Pharmaceutical is funding political campaigns and promote prescriptions of opioids.

Mr Krocka pointed me to a recent television advertisement featuring a construction worker who was being prescribed opioids following a back injury. It became another opportunity for a sale where the
pharmaceutical company had “invented” the diagnosis of OIC (Opioid Induced Constipation) for which the advert suggested a prescription of their brand of drug.\textsuperscript{52}

Despite there being significant comorbidity between addiction and suicidality Mr Krocka, in his address to the AAS conference, pointed out that only 11\% of addicts get treatment. Increasing rehabilitation for addiction is a major suicide prevention measure. To do this the industry needs to deal with the stigma associated with addiction.

\textit{Someone is working away and hurt his back and get hooked on opioids – that does not make him a bad person. It makes him a person we need to wrap our arms around and offer to support. We cannot accept that contractors say, now this is no longer the guy we want – we as a union want to take care of everybody.}

The SMART union has taken on a major problem and set itself ambitious targets. Their focus on using Union structures and the solidarity amongst the members as a major driver seems as a practical application of much of the feedback I received from both employers and mental health experts on my trip.

5.3.4 Massachusetts: A conversation on innovation

While in Boston I participated in a roundtable discussion organised by Franklin Cook of the Mass Men project and Lauren Dustin Coordinator of the Mystic Valley Public Health Coalition to discuss suicide prevention and opioid abuse in the building and construction trades.

The purpose of the meeting was to:

\textit{Promote dialogue amongst key leaders – and to explore ideas and actions – in order to lay the foundation for collaboration and innovation that takes the fight against suicide and opioid misuse in the building trades in Massachusetts to a new level of success.}

Participation in the meeting spanned Government, Unions, Contractors, Safety Regulators, Insurance companies and researchers.

The background to the roundtable was a combination of research showing construction workers generally having amongst the highest suicide rates in the United Stated (Peterson, et al., 2018) and that a quarter of all opioid deaths were related to the building and construction industry in Massachusetts, six times the average for all workers (Massachusetts Department of Public Health, Occupational Health Surveillance Program, 2018).

\textsuperscript{52} https://www.ispot.tv/ad/AejS/movantik-franks-moment
While the problem was relatively obvious, the solution was more complex. The US system of private health provided though work was in part highlighted as problematic. Health insurance is provided through employment and needs to be maintained through continuous employment. Falling out of insurance may result in future coverage being denied or limited due to pre-existing conditions such as musculoskeletal injuries in part caused by work.

In the Unionised part of the construction industry health insurance is provided through the Union and often have “smoothing provisions” where insurance cover is maintained for a period after ceasing work. However, workers will need to maintain enough hours to continue cover leading to workers using opioid pain killers to be able to manage work despite injury.

Mr Irving is the Assistant Regional Administrator of the US Department of Labour Occupational Safety and Health Authority expressed concern that the time for intervention might not be right yet. He was concerned that stigma was rife and that the case for employment involvement in the crisis was not yet accepted.

I first did my OSHA (Occupational and Health Administration) training 1995 – people asked: “why do you want to be a safety guy?” They could not find enough people to fill the class. I was one of the first fulltime safety officer in town. We must make people want to get involved. I do not want to sound to negative – but we need to be realistic. There is hardly anyone who is not affected at some level. The owners are going to want to invest, but we need to get it right. I am pushing but I am asked what the connection with OSHA is. We must make it obvious.

The need to make participation in an intervention desirable or even imperative was discussed with some length. An unidentified meeting participant expressed it as follows:

Culture is a top down issue – it is the powerful who control it. It has to be paired with organisational buy in. There is lack of incentives for employers to get onboard. It doesn’t matter how nicely it is wrapped but it is economic in nature. How do we do that in a circumstance where most will die outside the employer’s responsibility – at no cost to the employer, it will be hard to get this level of organisational buy-in. How do we get this financial aspect in – without it, it will not work.

Professor Jack Dennerlein of the Northeastern University Institute for Work and Health saw opportunity as the industry in Boston was buoyant and labour at a premium but that interventions were to be focused on prevention:

“there is an opportunity in the intersection of the increased suicide risk and opioid crisis, but if we focus too much on opioids it can be come politically difficult. We need to look at the industry culture, how we look at people. What can we use in the whole work environment, what do we know about pain, how do we look at latent work injuries – the lower back pain – how do we look at work wear, what can be done about the whole person? (Professor Dennerlein)

In response to Jack Dennerlein’s comments it was pointed out that the source of knowledge already was within the industry. Franklin Cook, coordinator of MassMen acknowledge that despite the scale of the suicide and opioid crisis, many more people recovered than did not – they must be part of the solution, exactly what it was that allowed them to recover and thrive was really important information.
A key to getting industry acceptance was the need to break down stigma and get engagement. To this end the MATES in Construction program was discussed at some length. Another (un-identified) participant said:

“I remember seeing your (Jorgen Gulstrup’s) presentation about MATES in Construction at IASP (International Association of Suicide Prevention) in Oslo a number of years ago. There was one thing that stuck in my mind – something important. It was about the Connectors, and how being a connector had status in the industry. The people who help and Connect people, they are valued in the workplace. That is a key tool in breaking down stigma. That is the cultural change we are looking for.”

As a follow-up to the roundtable I was invited to participate in a smaller discussion of key stakeholders including Kelly Cunningham, Director of Suicide Prevention Massachusetts Department of Public Health, Shamera Simpson and Michele Lee from the American Foundation for Suicide Prevention, Tim Irving or the US Labour Department of Occupational Safety and Health Administration, Nao Trieu the Project leader of the Construction Worker Health program at Northeastern University, Emily Sparer Research Associate at Harvard University, Lauren Murphy Assistant Clinical Professor at Northeastern University and Professor Jack Dennerlein of Northeastern University.

It was an open exchange of information seeking to find opportunity to collaborate around mental health and suicide prevention in the Construction industry.

Professor Dennerlein has been researching workplace health amongst construction workers for the past 13-14 years and learned that mental health is a great concern within the workforce:

Stress is constantly coming up. Being exposed to hazardous conditions is a stress. You must look at the risk factors or we will continue to injure people – therefore simple resilience training is not enough. How does the overall work environment affect outcomes – For example what motivation will a foundry worker have to stop smoking if hazardous fumes are not generally dealt with in the workplace. Interventions must be comprehensive and it is not enough to create a resilient workforce we must create a resilient workplace.

Tim Irving is the assistant regional administrator of OSHA based in Boston MA. He points to the fact that OSHAs primary role is to enforce federal laws around safety and health. However only laws that
exist can be enforced but OSHA also have a loud and influential voice in setting occupational safety and health policies and initiatives across industries.

The US Bureau of Labor Statistics provide statistics for suicide for the 17 US states wherein workplace suicides are counted and work-related suicides are the most common cause of workplace deaths in Massachusetts. A suicide death is considered to be work related if it happens at work or it is directly related to work.

As an example, I recall the incidence of a crane operator who lost a load off the crane. The load fell and killed two co-workers on site. Two days later the crane operator died by suicide. This is a death classified as a work-related suicide.

In regard to the construction industry Mr Irwin points to the opioid crisis as significant but also the fact that gun ownership is particularly high amongst Massachusetts construction workers with 50% having a gun in the home.

Harvard research associate Emily Sparer is running the “all the right moves project” focusing on total worker health on construction sites. They provide 15-minute tool box talks daily over six weeks. The program has demonstrated improvements in diet, productivity and reduction in lower back pain amongst the workforce. It has so far been trailed on 18 sites.

The experience from this work was similar to that identified by Lendlease in their global workplace health survey (Mr McCombs Meeting 27) that US workers are reluctant to engage in mental health or illness discussions but are open to discussing stress. A complication of the program has been the rapid change in workforce on typical construction sites with a one month half-life of workers on typical sites.

5.3.5 CFMA Construction Industry Alliance for Suicide Prevention

The Construction Financial Management Association (CFMA) is a not for profit organisation dedicated to serve the educational needs of the construction industry’s financial professionals. The association has 8600 members across general contractors, specialty subcontractors, heavy and highway contractors, construction management firms and industry suppliers across all sectors of the construction industry. The association has 96 chapters in the USA and two in Canada. The association runs a large number of seminars, webcasts and training courses for the continued professional development of their membership.

I met the Association’s President and Chief Executive Officer, Stuart Binstock, at the American Association of Suicidology conference in Washington:

How the CFMA got involved in Mental Health and Suicide Prevention is an interesting story. It was a member, Calvin Beyer, who offered to write an article about mental health and suicide prevention in our member magazine about 2½ years ago. Now - our members are accountants - so much focus is on standards and software packages, so this was outside what we normally would write about, but when we saw the response to the topic on our member social media platform, we realised that this was an issue we really had to be involved in (Mr Binstock Meeting 44).
Following the article, the largest chapter of CFMA in Phoenix Arizona organised a suicide prevention summit. Between 100 and 150 people turned up to talk about their experiences and discuss ways to make a difference. It was clear that what resonated with the membership was that the issue was personal.

The CFMA also placed mental illness on their conference agenda in 2016 but it was realised that it is an industry wide issue and it is best tackled across the industry. This realisation led to the creation of the Construction Industry Alliance for Suicide Prevention (www.preventconstructionsuicide.com). This alliance has now grown to more than 94 members across industry associations, unions, mental health organisations and contractors.

The alliance is not intended as an intervention program, but as a resource and a venue for sharing of resources across the industry. Since the creation of the alliance more than a dozen local summits have been organised where industry leaders have gathered to develop local plans and networks recognising that it will be at a local level a difference is made.

Part of the work that needs to be done through the alliance is the development of business reasons for engaging in mental health and suicide prevention.

“For businesses it is not that complex, the primary task is to run successful business so that is the narrative mental health and suicide prevention must fit – it has to be good for the bottom line if it is to make sense. It is an argument that can be made, after all human resources are the most important resource for the industry – it is a good fit for CFMA. Perhaps we need to define mental health and suicide as a risk in a similar way to workplace safety is seen as a risk that must be managed (Stuart Binstock - Interview)”

Like many others I spoke to, in the US the unions were identified as key partners in any suicide prevention program. Mr Binstock said that a key to success for the Construction Industry Suicide Prevention Alliance would be participation from the unions. Around this particular area of corporation, it was perhaps problematic that union density is falling in the US like in most of the western world. Mr Binstock estimated that the construction industry was 70% unionised in the 1970s while the rates now well below 30%53.

Mr Binstock noted that perhaps it was a combination of a growing gap in pay between unionised and non-unionised workers while the unions monopoly on skilled workers is disintegrating in part due to

technology but also due to union workers taking non-union jobs in times of low labour requirements.

The CFMA is hoping to organise a strategic planning meeting for the coalition in Washington DC (and in fact did so on the 25th September 2018). Getting wider industry support particularly from the Unions at a national level, but also to discuss how the coalition will be resourced in the longer term. Some ideas being discussed within the coalition is to seek funding from the Federal Occupational Safety and Health Agency and to develop nationally consistent training packaged for suicide prevention and mental health awareness for the industry to pick up and use.

Calvin Beyer is a safety professional working for a regional hot mix asphalt producer and paving contractor based near Seattle in Washington State. His primary role has been to build and expand on the safety culture within the organisation, but he noticed that much of the focus has been on physical safety. He has embedded mental health, suicide prevention and addiction recovery into his employer’s safety and risk culture.

He has been involved in the National Action Alliance for Suicide Prevention workplace stream, written numerous articles on the subject, and collaborated with Sally Spencer-Thomas on the construction industry blueprint for suicide prevention. He was recognized by Engineering News-Record as a 2016 Newsmaker for his work with suicide prevention.

Mental health can be highly stigmatised. Some time ago he raised the issue of mental health and suicide at a company leadership conference:

A senior manager said: “that thing could never happen here because we are a family company”, but not long time later it did happen. Someone did die by suicide and suddenly I found me and other leaders talking to the widow, convincing the insurance company to pay up and supporting the family – it could happen here – it can happen everywhere.

The paving industry in the Pacific Northwest regional is seasonal, and workers go off to other industries or accept a furlough in the off season. This can raise issues with interrupted insurance cover. It can therefore be problematic for workers to get a mental health diagnosis as it can affect future health cover. A peer to peer program is perhaps more important in the USA than Australia due to the private nature of health care in the USA.

Mr Beyer is an advocate for effective Employee Assistance Programs (EAP). There is the need to normalise the use of these programs, people can access an EAP program for such a wide range of reasons that are not necessarily due to diagnosable mental health conditions, so it is a “soft way” to get people engage with a mental health care giver.

The contractor Mr Beyer works for is a unionised contractor having agreements with three national unions across 17 locals and many of these locals have different insurance plans and EAP providers.

When I talk with the Unions I often ask – Do you offer employee assistance programs to your members? If so, do they know and how do they know? Typically, they will say the phone number is on the back of their insurance card – I say, let’s see it – often it is not, but even if it is I say let’s try it. We try and could be on hold for up to 45 minutes and even if you get through it can be a three week wait to see someone.

So, for us as a company, we cannot just talk to our staff and give them a phone number – there are many different phone numbers – we had an EAP for our administrative staff, but the Unionised employees need to call their own providers. So, we worked with our benefit broker and we
integrated our union employees into the existing EAP. We have developed an app to help with this but it is still complex. We are making inroads into providing real access to comprehensive care and services available through the EAP. Importantly, we worked with the EAP administration to coordinate referrals for our union members to in-network providers for their specific insurance program.

Mr Beyer is of the strong belief that the next important step for mental health and suicide prevention in the construction industry is peer driven. He points to workers being the real experts in the field:

*If you ask 25 human resource directors to identify barriers to workplace suicide prevention they will say: We shouldn’t really do this, there are privacy issues, legal implications and it is risky as it is the clinician’s sphere. 25 safety professionals will point to the lack of a regulatory framework, lack of mandate and that there is already so much to do that they can’t really handle any more. 25 workers would just tell you what needs to be done. This is where it is handy to have a blueprint to work to (Mr Beyer Meeting 53).*

In terms of establishing an industry wide program Mr Beyer pointed to the fragmentised nature of the mental health and suicide prevention sector in the US. The approach is either clinical or proprietary programs that can be adopted for business for a price. He is excited by a private-public partnership in Washington State called the Safer Homes Coalition which is bringing diverse groups together on suicide prevention initiatives, including giving away locking devices for medications and firearms to reduce access to lethal means. He is championing incorporating large employers from various industries participate in the coalition into a combined Safety Homes and Safer Workplaces Coalition.

Mr Beyer points to MATES in Construction as an example of an industry program developed for, and by the construction industry. A collaboration rather than a competitive approach is required which perhaps is best done in collaboration between a general contractor and some relevant unions.

Sally Spencer Thomas has been working in workplace mental health and suicide prevention for the past 10 years. Following her visit to MATES in Construction in Australia 2014 she has been advocating for suicide prevention within the building and construction industry:

*One lessons I have learned is that a comprehensive and sustained approach is required. One campaign or one training course will dissipate fairly fast. Current thinking is to dovetail mental health and suicide prevention messaging into places where workplace health and safety is already happening (Ms Spencer Thomas Meeting 45).*
CFMA and SMART is the real green shoots for suicide prevention within the US construction industry. They are so important as leads and examples. It is problematic that the initiatives are still not evaluated, this needs to be done as soon as practicable, so the programs can be replicated.

When working with the construction industry the power of peer support and lived experience is evident. Most workplace programs are top down emerging from the mental health sector and do not use a lot of lived experience, but as a trainer in the SMART Union program it is clear that most of the people trained in the program comes to the program with their own lived experience.

It is important to have leaders who have survived and recovered from suicide to create hope. Stories of grief gets our hearts, but stories of survival give us hope. Programs based on peers and lived experience are also particularly important in the construction industry where there is such a strong identity as construction workers generally and along craft lines in particularly. Programs needs to be by me, about me and for me – it emerged from people like me it was born off us.

Like in so many other discussions I had stigma featured as a major issue. In the US culture stress is worn as a badge of honour – the more stressed you are the more important you are. Discussions about mental health is generally about “those people” not me. Dr Spenser Thomas was clear that construction workers need to use the language of suicide and mental health in order to decrease the stigma in the industry.

It is also important to understand and use the existing industry structures in program development. Dr Spenser Thomas said:

*I was working with one of our contractors and I asked; Where does safety show up? And he said; Toolbox talks. It would be an easy lift to create a few tool box talks to be delivered on site. Another contact point would be when workers came in to renew their benefits, doing their insurance paper work at the union office, but this is an intimate moment. This is the point, we need to imbed messaging into ordinary events, so it can be sustained over time.*

Programs needs to be broad upstream, midstream and downstream. While resilience is ok it is important also to understand risk factors such as working conditions and job security. Specific risk groups within workplaces also need focus and how events impact on individuals need to be considered:

*Workers are often the forgotten grievers, so when we talk about suicide we are talking about their buddy. We are talking about how we look after our own. When we talk to management the focus is often more outward facing about how we look to the world, our competitors an customer so it is a different conversation. How do we attract and retain the best staff?*

5.3.6 Mental Health, Suicide Prevention sector and Universities
The American Association of Suicidology (ASS) was founded in 1968 by Edwin Shneidman, a leading figure in modern suicidology. The association’s focus was initially crisis centres and they have established a certification system for crisis centres and crisis workers. Today ASS is a member-based organization with 1,100 individual and 150 organizational members.

Colleen Creighton has been the Executive Director since June 2017 and leads a team of six staff. She identified similar issues to those experienced in Australia with siloes within the suicide prevention sector limiting the collaboration across disciplines such as clinical, research, and community work.

David Covington is the President Elect of ASS and also a driving force behind the current Zero Suicide in Health Care movement. Mr. Covington pointed to a need for a shift within the US suicide prevention sector.

> When I started my career, I would have said that suicide is almost a symptom of the disease, but as I have understood the more complex context of society, we may be missing the importance contribution and connectedness to society for these individuals.

It is not either illness or social context but both, treatment and interventions are done in a community context, so the sector must be better at understanding how community and treatment interact.

He pointed to the importance of connection in suicide prevention pointing to the fact that society punish people by taking them out of their community context and how children often rather want to be treated badly than being ignored.

The focus of suicide prevention should change from trying to predict suicide for clinical treatment purposes towards broader community-based interventions focusing on social context and connectedness.
The Education Development Centre (EDC) is a global not for profit organisation with 1200 employees managing programs to a value of $160M per year. In the USA EDC focus on productive health, suicide prevention and quality education. In suicide prevention EDC focus on the social conditions in prevention suicide. The workplace is currently the focus as a prime intervention space.

I met Jerry Reed Senior Vice President for practice leadership in Suicide Prevention, Violence and Injury Prevention, Elly Stout Director of the Suicide Prevention Resource Centre and Jason Padgett Operations Director.

Mr Reed pointed to the fact that despite all efforts US suicide rates are increasing as a opioid and alcohol related deaths. This group fatalities can be grouped as deaths of despair with pain as a common denominator.

The construction industry has amongst the highest suicide rate in the USA. This is also the industry with the highest levels of opioid addiction. Construction work is often pain generating and prescriptions to manage this pain can be the start of a disintegrating spiral.

While there has been a tendency to medicalise suicide in the USA focusing on diagnosis and treatment, there is a need to also adopting an environmental approach. There is a need to ask what it is about the nature of an industry that create an environment likely to provoke psychological pain.

There is also a need to recognise that men often do not seek help and the sector has not been good at reaching men effectively. More than 50% of people who die by suicide have not seen a mental health professional. Suicide prevention programs need to find these people and this is where the workplace is becoming paramount from EDC’s perspective. They are looking seriously at workplaces and how do we engage with them in a meaningful way creating better pathways to care. Developing policies, training supervisors and reaching workers must be a priority and new and more innovative programs are required.

EDC is working on a program with partners to put together a program that focuses on training and giving an opportunity for those interested in screening, a crisis line and some technical assistance to the company to support the workforce. However, the construction industry has been hard to engage.

When discussing the MATES in Construction model in a US context it was identified that it would be very difficult to replicate the MATES in Construction charitable funding model. There are industry models, but they are generally driven top down and rely on employer funding, Mr Reed was not aware of any scalable programs in the US construction industry at present.
US Military has taken an organisational approach and taken the issue on in a systemic way but it was pointed out that there are some concerns amongst junior officers to speak as they think it could be detrimental to their career, although Ely Stout pointed to the fact that while there are real consequences for speaking up, it is the best we had and it is getting better as stigma is decreased. It is possible to change business from the top down.

This view of detrimental consequences for speaking up within the military was supported by Matt Miller, Associate Director of Harvard Injury Control Research Centre who points out that the seminal Knox studies of the US Airforce suicide prevention initiatives were skewed (Knox, Litts, Talcott, Feig, & Caine, 2003; Knox, et al., 2010):

*The problem with the study – they only looked at death amongst people in active duty. They discharged people who were problematic, so they removed people who were at higher risk from the program (Interview with Professor Miller).*

This could at least on the surface suggest that the concerns of junior officers could be based on actual experiences.

Professor Miller is particularly interested in the link between access to lethal means of suicide within occupations. He points to differences in the preferred methods of suicide between men and women being reflected in higher suicide rates for men than women in most places globally except rural regions of China where the method preferred by women, ingestion of pesticides, has high lethality resulting in women having suicide rates equal to or higher than men.

A point worth studying is suicide rates amongst the police force in America where police officers take the service firearm home after work and jurisdictions where police officers would leave the firearm at the police station after work. Presuming it is possible to control for differential in other risk factors it would be an important indicator of the importance of access to means for the rate of suicide within a population.
Harvard Centre for Work, Health and Wellbeing and the Institute of Urban Health Research at Northeastern University is collaborating around the development of workplace intervention programs.

Working collectively between the Harvard Centre for Work, Health and Wellbeing and the “Institute of Urban Health Research at Northeastern University (now the Institute of Urban Health Research and Practice) they seek to combine the disciplines of physical therapy with health sciences and sociology on a project on improving mental health and wellbeing amongst construction workers and in particular understanding the role of work and working conditions for mental health. The research aims at testing employer and site-based interventions looking at work organisation and other psychosocial factors that could contribute to the industry’s high levels of substance use and poor mental health outcomes.

I met Director Gloria Sorensen, Advisor Greg Wagner, researcher Susan Peters and Professor Jack Dennerlein at Harvard University and Sociologist and Director Professor Alisa Lincoln and Senior Researcher Mara Ellyon at the Northeastern University.

At Harvard we spoke about the impact of wellbeing on mental and physical health and in particular how workers are given a voice around their own wellbeing in the workplace. Professor Dennerlein said from the work done to date it is clear that works are worried about each other and do care about collegial mental health problems or substance abuse but they may find it difficult to act on their concern.

When programs focusing on ergonomics and diet is run in the workplace lower back and overall health improves but it rarely last. There is a need to change some of the psychosocial factors in the workplace to drive better and lasting outcome. It needs to be integrated in the industry as opposed to specific programs run in the workplace.

It is difficult to get even 15 minutes over several days for wellbeing programs in construction workplaces so many of the psychosocial issues experienced in the industry are imbedded in the industry systems, culture and stigma. From that part an industry approach would be desirable but perhaps unrealistic in a US context.

At Northeastern University I spoke to Sociologist and Director Professor Alisa Lincoln and Senior Researcher Mara Ellyon.

The project they are working on works from the US National Institute for Occupational Safety and Health (NIOSH) advocacy for integrated approach to occupational safety and health with a focused on promoting worker health and well-being (Lee, et al., 2016). The intention is to identify the upstream stressors and understand how they intersect with other factors such as gender. They expect to identify what factors are protective and health promoting. Identify what the drivers for
good outcomes are in the workplace such as the natural leaders and the power of the work group. In short, the Northeastern University team is attempting to understand what is required to embed healthy behaviours in a work community.

Professor Alisa Lincoln explained:

It is the relationships, cultural norms and behaviours in the workplace that when they are working well it can be protective, but when they breakdown or are not working well can be destructive. The power dynamics are coming out in our research – apprentices, foremen, general safety managers etc – but our process is determined by the access we are given, so yes, it is top down.

Professor Lincoln had experience with the Australian mental health system through a collaboration with University of Adelaide. The US system is very different. In the US the largest provider of mental health services and treatment is the LA County jail.

When asked about the trade unions as drivers of industry based mental health and suicide prevention programs Professor Lincoln cautioned that it could be a doubled edged sword. While Unions do have a cross industry connection with the workforce it must also be remembered that the Unions are key risk managers for the health insurance industry due to the unique US health system of occupational coverage.

It will also be difficult to have a strong public health focus on mental health and suicide prevention programs in the US. The system has built on incentives to have as many health (diagnosis) codes as possible. As each code gets more access to support. So, part of these system level factors changes outcomes. Medicalising issues. If you need to talk to someone you need to take on the label otherwise the insurance will not pay.
6 PROGRAM OF VISITS

Paris (France)

5th March:
1. Observatoire National du Suicide – Department of Health, National Suicide Observatory
2. Institute National de la santé et de la recherche médicale, INSERM – National Research institute for public health – Interview – Dr Isabelle Neidhammer

6th March:
4. Telecom Orange – Case Study / Interview – Pierre Gojat (Union Delegate)
5. Centre National de la Recherche Scientifique (National Centre for Scientific Research)–
   Interview – Research Director Danielle Linhart

Geneva (Switzerland)

7th March
6. World Health Organisation – Interview – Dr Alexandra Fleishman
7. Fédération des Métiers du Bâtiment (FMB ) -Construction Employer Association

9th March
8. International Labour Organisation
9. IndustriALL (Global Union)
10. International Organisation of Employers

Bern (Switzerland)

8th March
11. Unia (Swiss Trade Union) – Interview – Ms Michelle Christine

Rønne (Denmark)

12th and 13th March
12. ASIS Workshop – Workshop – 20 participants across social institution and police

Copenhagen (Denmark)

14th March
13. HK (Danish Retail and Office workers Union) – Mini-conference – 17 participants from
   Unions across retail, office, food production, rail and metal workers

15th March
14. Danish Research Institute for Suicide Prevention – Interview – Associate Professor Annette
   Erlangsen

19th March
15. BAT Kartellet (Building, Civil and Wood council of Unions) – Round table discussion – 11 participants (excl of writer) from across both employers, unions, research and regulators in the building and construction industry.
16. Blik og Rørarbejder Forbundet (National Plumbers and Pipefitters Union)

22nd March

17. Rigshospitalet, Klinik for Psykologi, Pædagogik og Socialrådgivning (National Hospital, Department for Psychology, Pedagogic and Social work) – Interview – Professor Svend Aage Madsen (Specialist in Psychology and men’s health)

27th March

18. FOA (Forening af Offentligt Ansatte – Union of Government Employees)

London (United Kingdom)

29th March

19. University of Leeds – Phone Interview – Professor Sarah Waters

4th April

20. International Seafarers Trust / International Transport Federation (Global Union) – Interview – Ms Lucy Cooper, Project manager
21. Unite the Union (UK Trade Union)

6th April

22. Mates in Mind – Interview – Mr Kevin Meyer Director
23. Public Health, Health Improvement Directorate – Interview – Dr Helen Garnham National Program Director

Stockholm (Sweden)

5th April

25. Umeaa University – Interview – Professor Bengt Jaervholm
26. AFA Insurance (Swedish Bi-partisan workers compensation insurer) – Seminar / Roundtable

New York (USA)

9th April

27. Lendlease Sustainability Team / Foundation
28. Lendlease Americus Construction Management
29. Lendlease – Interview – Ralph Exposito, President Construction Americus

Boston (USA)

11th April

30. Harvard Centre for Work, Health, and Wellbeing

12th April
31. Northeastern University Mental Health for Construction Workers Project
32. Harvard University Department of Epidemiology – Interview – Professor Matthew Miller
33. Construction Industry Roundtable; Meeting of minds

13th April
34. Lendlease Boston Construction team
35. Northeastern University – Meeting – 8 participants from Northeastern University, US Labour Department (OSHA), American Foundation for Suicide Prevention university, Workplace regulator, American Foundation for Suicide Prevention, Harvard University

Washington (USA)

16th April
36. Lendlease – Interview - Stephen Conley Principal in Charge, Washington/Maryland
37. Lendlease – Phone Interview - Ben Symons General Manager at Lendlease (US) Public Partnerships (Based in Dallas Texas)

17th April
38. American Association of Suicidologists – Interview – Colleen Creighton, Executive Director
39. Education Development Centre / Action Alliance for Suicide Prevention

18th April
40. Livingworks
41. QPR

19th April
42. United Association of Plumbers and Pipefitters

20th April
43. Livingworks

21st April
44. CFMA – Interview – Mr Stuart Binstock, Executive Director
45. Dr Sally Thomas Spencer – Interview

22nd April
46. American Association of Suicidologists / Zero Suicide in Health Care – Interview – Dr Dave Covington, President

23rd April
47. Sheet Metal Occupational Health Institute Trust (SMOHIT) – Interview - Randall A Krocka, Administrator
48. Laborers Health and Safety Fund – Interview - Jamie Becker, Director Health Promotion

Chicago (USA)

25th April
49. W Van Buren Construction – Site visit – Bob “Chappy” Dinkins
50. Lendlease Chicago Office

**Denver 26th April (USA)**

26th April

51. University of Colorado Boulder – Interview – Dr Stefanie K Johnson

**Los Angeles 27th and 28th April (USA)**

27th April

52. Lendlease

28th April

53. The Construction Industry Coalition for Suicide Prevention

**Waitangi 2nd to 5th May (New Zealand)**

54. Participation in the International Association for Suicide Prevention Asia Pacific Regional Conference
7 BIBLIOGRAPHY


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