Summary report:

MENTAL HEALTH IN THE CONSTRUCTION INDUSTRY

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FOREWORD

The construction industry is integral to the Australian economy, and at a broader level, society. Those employed in construction work hard. In fact, by and large, they are much more likely to work longer hours than other occupational groups in Australia. At the same time, the industry is vulnerable to shifts in national and international finances. Each time the Australian economy contracts, the construction industry is one of the first to feel the financial pressure. There is now a good understanding that suicide rates are elevated among construction workers. The stresses associated with construction work are likely to be one of many factors contributing to poor mental health and suicide in the industry.

The Construction Industry Mental Health Roundtable is comprised of Australian construction companies with guidance provided by MATES in Construction and beyondblue. The key goal of the Roundtable is to improve the mental wellbeing of the industry. As detailed in this report, this will not only involve reducing suicide and psychological ill health, but also improving the positive aspects of mental wellbeing. The challenges associated with meeting this goal necessitate the importance of the industry taking coordinated action to plan, implement, and evaluate targeted mental health activities.

While there are challenges ahead, the industry is well on the way to solving them. This is not only evidence in the establishment of the Roundtable itself, but also in the programs that the industry has supported to date. The Roundtable provides an opportunity to leverage and share the work undertaken to date so as to provide an industry framework that can be adopted by all workplaces irrespective of size. We hope that this report provides one of the stepping-stones along the journey.

Dr Allison Milner
March 2017

THE CONSTRUCTION INDUSTRY MENTAL HEALTH ROUNDTABLE

The Construction Industry Mental Health Roundtable was initiated by MATES in Construction and beyondblue to address problems associated with suicide and poor mental health in the industry.

The first meeting of the Roundtable was in September 2016 and involved a large number of stakeholders, including construction companies, regulators, researchers, and suicide prevention and mental health service providers. Over the course of a day, the Roundtable discussed ways to address the problem of suicide, and to improve overall mental health in the industry. An important outcome of this meeting was the development of a Mental Health Strategy Map 2016–2021, which included key milestones and ambitious outcomes for success.

The milestones for 2017 include:

- The establishment of an effective national work group and communications strategy;
- The completion of research to define a mentally healthy workplace and to identify hazards and risks for mental ill health;
- The publication of an industry mental health framework;
- Agreed guidelines for mental health in the sector;
- A strategy for full industry engagement over the next three years; and
- Mental health and wellbeing education for all apprentices in the industry.

The first milestone was completed in late 2016, culminating in three National Working Groups comprised of industry representatives, service providers and academics reporting to an overarching decision making Industry Steering Committee. These groups are:

- Sub Working Group 1: Evidence Based Research and Evaluation
- Sub Working Group 2: Industry and Training
- Sub Working Group 3: Governance and Process

The governance and process sub working group focuses on potential opportunities to include regulatory compliance within the Mental Health Framework.

The current report was commissioned to establish the evidence base and current knowledge about mental health in the industry. In greater depth, the purpose of this report is to provide the following:

- A description of the burden of suicide and the state of mental health in the industry;
- Factors influencing mental health and suicide in the industry that can be modified by the industry;
- An overview of evaluated industry-specific workplace activities for mental health;
- An overview of current guides for ‘best practice’ mental health in the workplace; and
- Provide an indication of models and tools that could help guide the Roundtable as it moves towards its goal of better mental health for the construction industry.

Each of these is covered as separate sections of the current report, with the final section providing recommendations for future activities.

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1 Evidence from the Household Income and Labour Dynamic Survey, which shows that 40% of skilled trades and technical workers work 45 hours or more a week. Data pooled over the periods 2001 to 2013.
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What is good mental health?

“... a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.”

Mental health is central to having a good life. Without it, people are likely to experience problems or distress in various aspects of their lives, including their relationships and their work lives. At the same time, problems in each of these aspects of life are likely to affect mental health. Hence, there is a reciprocal relationship between a person’s social environment and their mental health.

Traditionally, mental health has been conceptualised in terms of clinical symptomatology (i.e., a disease-based model). However, there is recognition that a sole focus on a deficit model ignores the mechanistic complexity of mental health involving protective factors such as positive emotion (e.g., feelings of happiness), psychological resources such as self-esteem and mastery, and resilience (e.g., the capacity to cope with adversity). The World Health Organization recognises these positive aspects of mental health as being the foundation for well-being and effective functioning at an individual and community level across countries and cultures.

In this report, we seek to conceptualise mental health at its most holistic level, including both symptoms of poor mental health and positive aspects of mental health.

What is suicide, self-harm and suicide ideation?

Every year in Australia, over 5,000 people take their own lives. The vast majority of these cases are men. The number of suicides occurring in the population each year is far greater than the number of deaths due to traffic accidents, homicide, and other assaults. Another relevant outcome is suicide ideation (thoughts about suicide), which is associated with considerable psychological distress. Aside from this, suicide ideation is a likely predictor of later attempts and death by suicide, and thus is an important variable on which to intervene.

What do we know about the mental health of construction workers?

Suicide

The burden of suicide is estimated to affect about 8.1% of the population or 52,000 people each year, and becomes even greater when considering self-harm (and suicide attempt). Suicide is elevated in construction workers compared to other workers in Australia. This is particularly the case for labourers, where the rates are markedly above the male general population. The high rates of suicide in the construction industry underscores the importance of promoting mental wellbeing as a means of reducing suicide.

In saying this, the rates of suicide among construction workers have been dropping. Between 2001 and 2003, the rates of suicide in construction workers were over 2.3 times that of other male workers (Figure 1). Between 2011 and 2013, these rates were 1.7 that of other male workers.

Depression and anxiety

In 2014, a systematic review reported an updated review of depression and anxiety in blue-collar workers (including construction workers) across 19 studies. This report found only four studies on mental health in the construction industry, none of which were conducted in Australia. These four studies reported conflicting findings (e.g., both higher and lower prevalence of depression compared with the national prevalence of depression). Since the time the current report was written, which reviewed the literature from January 1990 to June 2012, there have been only two studies on mental health problems in the construction industry, both of which were conducted overseas. These studies report a greater prevalence of depression compared with the general Dutch population, and greater mental distress compared with the general male population of greater New England.

Positive aspects of mental health

Existing knowledge on mental health in the construction industry relates to symptomology of poor mental health. However, there is growing knowledge on the positive aspects of mental health such as subjective wellbeing, which encapsulates a number of domains including:

- Affect (i.e., positive feelings such as feelings of contentment, joy, and happiness);
- Satisfaction with different areas of life (e.g., family, fiancés, and self);
- Global life satisfaction (i.e., satisfaction with one’s past, present and future, and desire of change one’s life).

In recent years, there has been increased business interest directed towards the positive aspects of mental wellbeing. The reason for this is that, in many ways, it is more relevant to the majority of workers (considering that mental ill health affects approximately 20% of the working population). Employers have realised that promoting optimal mental health makes good business sense, as investing in strategies to promote positive aspects of mental health can prevent mental illness, thus resulting in a healthier, more engaged, and more productive workforce. In addition, positive mental wellbeing leads to greater levels of engagement with work, a higher degree of meaning from work, proactive work behaviour, and transformational leadership.

Figure 1. Age standardised suicide rates, male, construction and non-construction in Australia from 2001 and 2013. Source: MATES in Construction report on suicide.
FACTORS INFLUENCING THE MENTAL WELLBEING OF CONSTRUCTION WORKERS

The high rates of suicide in construction provide us with a strong indication that poor mental health exists amongst workers within the industry (acknowledging that we need more understanding of other aspects of mental health other than suicide and related behaviours and thoughts).

The following section focuses on the potential reasons for these high rates of suicide, with a specific focus on the factors that are able to be modified in a construction worker’s external environment. By modified, we mean those factors that could be directly targeted by prevention initiatives, and which are strongly related to mental health and suicide. These factors include:

- Work and employment conditions;
- Relationships;
- Attitudes toward help-seeking and stigma against mental ill health;
- Alcohol and drug use; and
- Sleep and physical activity.

A brief explanation of these domains of mental health can be seen below.

Work and employment conditions

Work can provide a number of tangible benefits to the mental health of an individual2,3. Figure 2, adapted from Jahoda’s (1989) model4, demonstrates some of the ways work is beneficial to a person’s mental health. Aside from providing income, the latent benefits associated with employment include providing a way for people to work towards a common goal (goal direction) and a sense of structure. Other elements that are critical to understanding the importance of employment to mental health include the provision of social contact and support from colleagues and supervisors, social status and identity, and sense of activity and purpose.

At the same time, work can be detrimental to mental health. Prolonged or excessive job stress is a risk factor for mental health problems, and accounts for 13% of depression in working men21. Evidence also suggests that job stressors (such as those discussed below) are risk factors for suicide in Australian men22.

Some of the main stress-arousing factors associated with work range from ergonomic (e.g., through repetitive physical movements), to physical and chemical (e.g., direct exposure of the sun, exposure to hazardous chemicals), to psychosocial exposures (e.g., low job control, high job demands). Of all these work exposures, psychosocial exposures have been found to be particularly detrimental to mental health. These include the following:

- Job insecurity (e.g., the perceived possibility that a person will lose their job);
- Low job control (e.g., low control over where, how, what and when work is undertaken);
- Excessive job demands (e.g., a large number of tasks that need to be undertaken and the need to do many things);
- Low rewards for work (e.g., the perception of low pay for work, and a lack of recognition from colleagues and supervisors);
- Poor working relationships with colleagues and supervisors; and
- Bullying and harassment (e.g., repeated negative behaviour, mistreatment and/or abuse at work from others within the organisation)21.

Overarching all of this, the health of construction workers is inherently tied to the wider economic environment. For example, compared to other occupations in Australia, the suicide rate among construction workers rose considerably during the 2007 global economic recession27. This suggests that construction workers are particularly vulnerable to the wider economic environment.

Relationships

Strong relationships with an intimate partner, family member, and friends can buffer people against mental health problems23,24 and, if these people do develop mental health problems, they are more likely to recover quickly25. There has also been considerable research to show that being divorced, widowed, or separated represent risk factors for male (and female) suicide26. These risk factors are important considering the increased rate of divorce in Australia (4.5%)24, and the fact that males tend to reduce the social connections they have with other males as they age24. Indeed, relationship problems have shown to play a greater role in suicide among construction workers than among the general population in Queensland (53.5% vs. 29.5%, respectively)27, with a much higher prevalence in the 15-24 year age group (75% of construction workers vs. 27.2% of general population). Some recent Australian research demonstrates the interaction of life events – such as job loss – with social relationships and mental health21. Specifically, this study showed that people with high levels of social support were more likely to be buffered from adverse life events (e.g., job loss) than those with low levels of social support. Further, as construction workers move about from job to job, they may suffer from a lack of collegial and supervisor support.

Help-seeking and stigma

The ability to seek help for a mental health problem is a key step towards recovery. Despite this, the majority of those people who suffer from common mental disorders do not seek treatment from a qualified health professional28. Males in particular, are less likely to seek help for a mental health problem29. There are a number of factors thought to be underpinning the lack of help-seeking among males30, including:

- Lack of knowledge about signs and symptoms to identify a mental health problem;
- Ignorance about how to access treatment;
- Prejudice against people who have mental illness; and
- Expectations that people with mental illness experience are discriminated against.

Similar factors, such as shame and stigma, have shown to predict help-seeking for suicidality2. A recent cross-country study suggests that negative attitudes towards help-seeking predicted professional (e.g., from a doctor) and informal (e.g.,
The ability to seek help for a mental health problem is a key step towards recovery. Despite this, the majority of those who suffer from common mental disorders do not seek treatment from a qualified health professional. Males in particular, are less likely to seek help for a mental health problem. There are a number of factors thought to be underpinning the lack of help-seeking among males, including:

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Similar factors, such as shame and stigma, have shown to predict help-seeking for suicidality. A recent cross-country study suggests that negative attitudes towards help-seeking predicted professional (e.g., from a doctor) and informal (e.g., from a friend) help-seeking intentions. Research from Australia confirms these findings and suggests that greater knowledge and awareness of the signs and symptoms of suicidality are associated with increased likelihood of help-seeking. This suggests that suicide knowledge and attitudes play an important role in facilitating the help-seeking process for suicide and should be carefully considered in the development of mental health programs.

**Alcohol and drug use**

The use of alcohol and drugs heighten pre-existing vulnerabilities towards mental illnesses and suicide. As such, more construction workers dying from suicide report alcohol related problems than the general population (25.4% vs. 17.4%), respectively, though noting that these differences were not significant, particularly among the 15–24 year age group. Men may also use alcohol and other drugs as a form of self-medication for poor mental health. Thus, these are important risk factors. Unfortunately, alcohol and drug use appears to be common among construction workers. Data from the 2007 National Drug Strategy Household Survey (NDSS) reports that 10.6% of construction workers had used alcohol at work, while 13.5% had used drugs. Approximately 6% of construction workers had worked while under the influence of alcohol and 4.8% had worked while under the influence of drugs. Key predictors of alcohol and drug use include being a younger male, and being single, separated, widowed or divorced. This may suggest that alcohol and drugs are used to cope with other life stressors, culminating in greater risk of mental health problems.

**Sleep and physical activity**

Tenure in the construction industry is associated with fatigue. Being physically active and getting adequate sleep are recognised protective factors for mental health. The beneficial effects of such factors have been found in clinical populations suffering from mental health problems, and in the general population. The reasons that these factors are thought to be protective are likely connected to the fact they provide respite and promote healthy chemical flows to the brain. The intersection of risk factors – future questions

Many of the factors discussed above are inter-related, which underlines the multidimensional nature of mental health and suicide. For example, poor working circumstances may lead to greater use of alcohol, which may increase the risk of suicide. Similarly, relationship breakdown may lead to lack of sleep, exercise, and problems at work. The challenge for those in the industry is to identify which of the risk factors presented above are the most feasible and worthwhile to intervene on. It is also necessary to consider any risk factors that might be missing from this picture and which might also be able to be addressed in mental health programs in the construction sector.

**Method**

A systematic literature search was undertaken to identify and assess the findings and methodological rigor of relevant studies. Articles were included in the review if they examined male blue-collar workers. Articles were excluded if they examined workers in the forestry/agricultural industry because these are structurally very different from construction work in terms of the organisation of work, examined white-collar workers, and were published after January 2012 (which was when the last review was published in the area). Searches were conducted using electronic databases: CINAHL, Cochrane Library, PubMed, PsycInfo, Informit, and Scopus. Searches combined relevant MeSH and other database thesaurus headings, Boolean terms, and keywords. The main search terms used were:

- “intervention” OR “program” OR “trial” OR “therapy” OR “treatment” OR “support” OR “prevent”
- “self$harm” OR suicid* OR attempted suicid* OR parasuicid* OR “intentional$self$harm” OR “mental$health” OR “wellbeing” OR “suicidal$behavior” OR “blue$collar” OR white$collar

A reviewer screened each article title and abstract for relevance. In addition, all previous reviews in the area were examined by two reviewers to identify relevant articles.
The search strategy produced one randomised controlled trial (RCT) in Dutch construction workers. Twelve studies were identified through all previous reviews in the area. All these studies are included in the qualitative synthesis.

**Summary of the programs**

We briefly provide an overview of the program and its results, as well as the characteristics of the occupational groups. More detail on each of these programs can be seen in Table 1.

**Occupational groups examined**

Three studies have investigated the efficacy of the MATES In Construction program in the Australian construction industry. Another study was set in Dutch construction workers, and one was conducted with construction workers in Finland. Five other studies examined the effects of programs for workers in manufacturing, two in maintenance occupations, and one in public transportation. Two others were based in an electricity and gas company. These industries and companies were based in Japan, France, Britain, United Kingdom, and the United States of America.

Two other programs addressing suicide and mental health in the Australian setting were conducted by OzHelp Foundation and IncoLink. However, these did not provide outcomes for mental health and suicide. Evaluation of these two programs can be found in a previous review.

**Study design**

Nine studies were randomised control trials (RCTs; three of which examined construction workers), two were non-randomised control trials, and two were case-control studies. Follow-up periods of these studies ranged between three months and three years. Two other studies represented an observation ecological design. The OzHelp Foundation, IncoLink, and one other MATES In Construction papers were process evaluations.

**Results**

The programs included the following: (i) targeted advice from a physical therapist to reduce physical workload and fatigue, as well as empowerment training (6-month program); and (ii) consultation and personalised feedback from occupational medical staff (6-month program). Programs examined in workers of other industries include a combination of programs to reduce and manage stress, health promotion and smoking cessation, increasing group task identity and promoting group autonomy, improving work environments and job processes, counselling, and psychosocial skills training. Martin et al. represented the MATES In Construction multimodal program involving a number of components such as General Awareness Training provided to all construction workers on site, Connector training for volunteers to help an at-risk worker access help, field and case officers, and a telephone support line. The OzHelp Foundation and IncoLink programs also provided onsite training and training to apprentices.

**Mental health outcomes measured**

One observation ecological study assessed suicide. The 10-item Depression Scale (DEPS) was administered to assess depressive symptoms in one RCT examining construction workers, with the 12-item Short Form Survey (SF-12) being used to assess mental health status in the other RCT examining construction workers. The 20-item Zung’s Self-rating Depression Scale (SDS; to assess depression), 80-item State-Trait Anxiety Inventory (STAI; to assess state-trait anxiety, anger, depression, and curiosity), and a telephone support line. The OzHelp Foundation, IncoLink, and one other MATES In Construction papers were process evaluations.
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<th>STUDY</th>
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| Martin et al. (2016) | Australia | Ecological design | Construction workers in Queensland versus Australia | MATES in construction, a multi-modal suicide prevention program comprising of general awareness training, connector and ASTR workers to be present on site, case workers, and emergency telephone hotline. | Suicide rates | • Age adjusted male suicide rate in the Queensland Construction Industry decreased 7.9% for the years 2008–2012 compared with 2003–2007.  
• Suicide among construction workers in Queensland, where MATES in Construction was established, was lower than other states and territories (where the program was either absent or newly established). |
| Tamela et al. (2008) | Finland | Case-control RCT | Construction (49% of total sample), repair, service, maintenance, industrial installations, and communications network workers with high risk of sickness absence. | Program group (N=209) and control group (N=209). | DEPS | • No significant group difference in self-reported depression.  
• Depression tended to be more present for control group at 12 months. |
| Oude Hengel et al. (2013) | Netherlands | Clustered RCT | Construction workers | Baseline: Program group (N=112) and control group (N=110);  
6-month followup: Program group (N=95) and control group (N=93);  
12-month followup: Program group (N=95) and control group (N=108). | 6-month program involving targeted recommendations on how to reduce physical workload and fatigue by physical therapist and interactive empowerment training | SF-12 | • No significant effect of the program on mental health status between the program and control group. |
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<th>STUDY</th>
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| Murphy et al. (1984) | USA     | Case-control RCT.             | Highway maintenance workers | 10-day company-based stress management program. | BSI, STAI | - Significant decrease in BSI from pretesting to followup for all groups.  
- Significant decrease in STAI from pretesting to followup for all groups. |
| Kawakami et al. (1997) | Japan   | Non-randomised case-control.   | Electric company workers | 1 year stress reduction program implemented by supervisors. | Zung's SDS | - Depression scores significantly decreased over time for program group (significant depression score x time interaction for males, but not for females).  
- No significant change in depression score for control group over time. |
| Guppy & Marsden (1997) | Britain | Pretest/posttest design.       | Public transportation workers (N=104; 96% males). | Company-based alcohol program for employees with alcohol programs including basic monitoring and counselling. | GHQ-12 | Significant decrease in GHQ-12 score. |
| Maes et al. (1998) | Netherlands | Quasi-experimental pretest/posttest case-control design. | Manufacturing workers | Company-based program targeting lifestyle and work environment involving concurrent health promotion program (smoking cessation and physical activity) and psychosocial skills training. In addition, establishment of a consultative committee (involving employees, managers and researchers) to discuss organisational change. | Symptom Checklist-90 (Dutch version) | No significant program effect in mental health symptoms (e.g., anxiety, somatic complaints, sleep problems) for both groups. |
| Kawakami et al. (1999) | Japan   | Case-control RCT.             | Manufacturing workers | Individualised mailed advice reducing stress, blood pressure, serum lipids, and sick leave. | GHQ-12 | No Significant interaction on GHQ scores. |
| Peters & Carlson (1999) | USA     | Case-control RCT.             | Maintenance workers | 10-week multimodal program including stress management training, educational workshop, counselling, self-directed health promotion. | STPI | - Significant treatment effect over time for program group.  
- Significant difference between pretest and posttest. |
**WHAT DO WE KNOW TO BE BEST PRACTICE?**

The programs discussed above provide an overview of what activities have been undertaken in the industry and the extent to which these could be considered as effective in relation to mental health and suicide. However, this does not mean that these programs are necessarily the best the industry could implement. Indeed, when measured against the ‘best practice’ approaches discussed below, there are a number of ways in which the programs operating in the industry could be enhanced.

Based on a substantial amount of research, there have been a number of guidelines developed to help guide best practice strategies for addressing mental health at work. These include the following:

- **The Mentally Healthy Workplace Alliance through the Heads Up initiative and Working well: An organisational approach to preventing psychological injury at work** (Superfriend) [16]; and **WHMIS 2015 general training (Can/CGA)”** (Canada and the Canadian Standards Association) [17];
- **Mental health policies and programmes in the workplace** (New South Wales and the Black Dog Institute and (National Mental Health Commission));
- **Provide mental health and suicide prevention literacy**
- **Mental health policies and programmes in the workplace** (New South Wales and the Black Dog Institute and (National Mental Health Commission));
- **Facilitate early intervention and treatment**

While all of these guidelines have slightly different foci, they all share common principles regarding a vision of workplace mental health. These principles can be seen in Figure 4 over the page, and a brief explanation is provided below. For further detail, we would suggest looking at the guidelines themselves.

Reducing exposure to harmful exposures in the workplace

Harmful exposures in the workplace can be ergonomic, physical, chemical, or psychological (as discussed above). A best practice approach would involve addressing these at each level of the industry, from the top-level, to specific companies, workers, and individual managers and workers.

Promote positive aspects of mental health

Work can bring a number of tangible and positive benefits to a person’s life. There is growing public and academic recognition of the potential benefits of enhancing the positive aspects of employment. Some ways in which this could be done would be to consider the different ways in which work could be meaningful, or to highlight positive aspects of work, such as social support from colleagues.

Provide mental health and suicide prevention literacy

There is now good evidence that greater awareness and education about mental health problems can facilitate help-seeking behaviour. Because of this, providing awareness and education is an important component of an integrated program approach.

Facilitate early intervention and treatment

This recommendation follows on from literacy, and refers to the presence of clear pathways through which workers with mental health problems can be identified and provided with appropriate care. This could be achieved by ensuring that there are workers on construction sites that are able to help identify colleagues who are experiencing mental health issues.
who need support and refer them onto appropriate professional services. In particular, programs to increase and facilitate help offering could target individuals with poor help-seeking and may help to break down stigma.

Provide return to work and ongoing support

Return to work can be a challenging time for workers who have experienced mental health problems. This process can be eased by ensuring that workers returning to work enter into a supportive environment that is free of stigma. This last principle of ‘ongoing support’ also refers to bereavement support in the case that a worker loses an employee to suicide (or another type of death on site).

Facilitate early intervention and treatment

Moving ahead, we recommend that the industry considers its key priorities for mental health programs, and then develop appropriate programs to address these priorities. This could begin with an internal review of current strategies and actions being undertaken to improve workplace mental wellbeing by companies within the industry. This would provide a compliment to the published best practice referred to above and be specific to the Australian context.

Provide mental health and suicide prevention literacy

The reason for this is that programs assessing suicide may have a different emphasis than programs that aim to improve the overall psychosocial quality of work in the industry. In saying this, if the industry decides on best practice approach (as described above), then we would argue that this would address a number of mental health outcomes, including suicide, positive mental health, and symptoms of depression and anxiety.

FINDINGS & RECOMMENDATIONS

The purpose of this report was to provide a summary of information regarding:

- What is already known about mental health and suicide in the industry; and
- The main modifiable factors influencing the mental health of construction workers.

The report also provided information on the following:

- The type of mental health programs conducted in the industry, and the extent to which these have been effective in reducing mental health problems and suicide; and
- Best practice recommendations for mental health at work.

The main findings from this report are the following:

1. There is limited knowledge about mental health in the construction industry (including both ‘symptomology’ as well as the positive aspects of mental health, such as wellbeing), but comparatively good information on suicide.

2. The factors influencing the mental health of construction workers are likely to comprise a range of background socio-economic factors, as well as those embedded in working environments, a person’s social life, and individual lifestyle and behaviours. However, as this information is extrapolated from a range of studies not necessarily conducted in the construction industry, there is a need for a better assessment of these factors.

3. There have been relatively few systematic and evaluated programs to address mental health and suicide in the construction industry.

4. Best practice recommendations for how the industry could move forward, would be to:
   - Reduce harmful exposures at work (including reducing stigma);
   - Promote positive aspects of mental health;
   - Provide mental health and suicide prevention literacy;
   - Facilitate early intervention and treatment; and
   - Provide return to work and ongoing support.

Moving ahead, we recommend that the industry considers its key priorities for mental health programs, and then develop appropriate programs to address these priorities. This could begin with an internal review of current strategies and actions being undertaken to improve workplace mental wellbeing by companies within the industry. This would provide a compliment to the published best practice referred to above and be specific to the Australian context.

A best practice approach would require engagement and buy in across the industry. Following on from this, best practice would require different activities at every level of the industry. At the industry level, this might involve the development of standards and protocols. At the company level, best practice could involve policy reform and staff training. Worksites could think about different ways to enhance work, while simultaneously addressing risk factors.

Once these industry-approved approaches are developed, we would suggest the establishment of benchmarks and desired goals and outcomes. There are a number of standard assessment tools that may be useful in the process, including:

- Guarding minds at work[79];
- The Copenhagen Psychosocial Questionnaire (COPSOQ)[80];
- The mentally healthy workplace alliance resources (Heads Up)[81];
- People at Work (SafeWork Queensland)[82];
• The Australian Workplace Barometer (Safe Work Australia)\(^\text{15}\); and
• The audit tools released by the Canadian Mental Health Commission\(^\text{41}\).

A number of these tools have been provided in the appendix of this report.

In terms of overall goals or targets, the industry might consider the following:
• A reduction in the suicide rate of construction workers (based on what might be considered as feasible from past intervention efforts in the area);
• An overall improvement in mental wellbeing of construction workers;
• A decrease in psychological distress and mental health of construction workers; and
• An overall improvement in the psychosocial characteristics of working conditions.

The first step to achieving these goals would be reach consensus on what can actually be feasibly changed in the industry in terms of its policy, practice, and overall culture. Following on from this, the industry can move forward to develop, implement, and evaluate activities. With this engagement, we are sure that the industry can achieve great things for construction and contribute to an improvement and enhancement of workers’ lives.

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