International Journal of Vocational Education and Training

Volume 31
Number 1
Summer 2026

Chibueze Tobias Orji
Editor

Official Publication of the
International Vocational Education and Training Association
www.iveta.global

IVETA
INTERNATIONAL VOCATIONAL EDUCATION AND TRAINING ASSOCIATION

International Journal of Vocational Education and Training

Volume 31 • Number 1 • 2026

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Acute Suicide Postvention in the U.S. Construction Industry: Addressing the First 48 Hours Following Suicide

John S. Gaal

Abstract

This pilot study focuses on the need for an acute suicide postvention response in the US construction industry. This author proposes that it is necessary to rethink suicide research and prevention due to the disconnect between the three legs of the Suicide Triangle: Prevention, Intervention, and Postvention. A series of related calls, in Q3-2024, served as the impetus for this author's attempt to partially shift the construction industry's focus from suicide prevention and intervention to also include postvention care for loss/attempt survivors. It soon became clear that suicide postvention was an under-researched area of study, in general, and, more specifically, pertaining to the construction industry—not to mention the acute phase following a suicide.

By means of a mixed methods approach, the aim of this pilot study is to establish if there is a need for the construction industry to address suicide postvention. After consulting with the author's mentor, a mixed methods approach was undertaken. This included designing a three-phase process involving surveys, interviews, and a focus group that sought input from 79 stakeholders spanning 5 countries. The findings from Phase 1 (surveys) & Phase 2 (interviews) indicated a need to address the issue of suicide postvention in the construction industry—in the short term/acute phase—with trained peer supporters. A Focus Group was recruited from a sampling of participants in Phases 1 and 2 and served as Phase 3 of this study. It provided an opportunity to cross-pollinate views and set the stage for producing related article(s), guidebook(s), training(s), and a video to capture and disseminate this study's findings.

This results of this study provide evidence that the time has come for the U.S. construction industry to address the 3rd leg of the Suicide Triangle: Postvention. In so doing, the industry can link the 3 legs of the Suicide Triangle to help ensure Postvention plays a part in current Prevention and Intervention efforts.

As this was a pilot study, it involved a small sample size of participants. Therefore, one should exercise caution when extrapolating the findings presented herein.

Keywords: Postvention, Construction, Acute, Loss Survivors, Peers, Suicide Triangle

Introduction

Before the end of the 20st Century, researchers studied a variety of aspects related to job site safety in the U.S. construction industry with intentions to decrease/eliminate unsafe conditions/habits. Many of these efforts focused on the physical aspects of safety (Centers for Disease Control and Prevention, 1999). However, in the past decade, more research attention has been paid to the mental aspects of safety in construction. In 2017, the U.S. Centers of Disease Control and Prevention (CDC) reported that in 32 states—as an industrial sector—Construction ranked #2 for suicide deaths just behind Mining & Extraction (Peterson et al., 2020). While, in 2020, the U.S. Department of Health and Human services revealed that in 46 states and New York City—as an industrial sector—Construction ranked #1 for drug overdose deaths (Billock et al., 2023). Not long after, Trueblood et al. (2024), via The Center for Construction Research and Training (CPWR), published a report that indicated U.S. construction workers (16-64-years-old), in 2022, died five times greater by suicide and 17 times greater by drug overdoses than by workplace related injuries/accidents (See Figure 1).

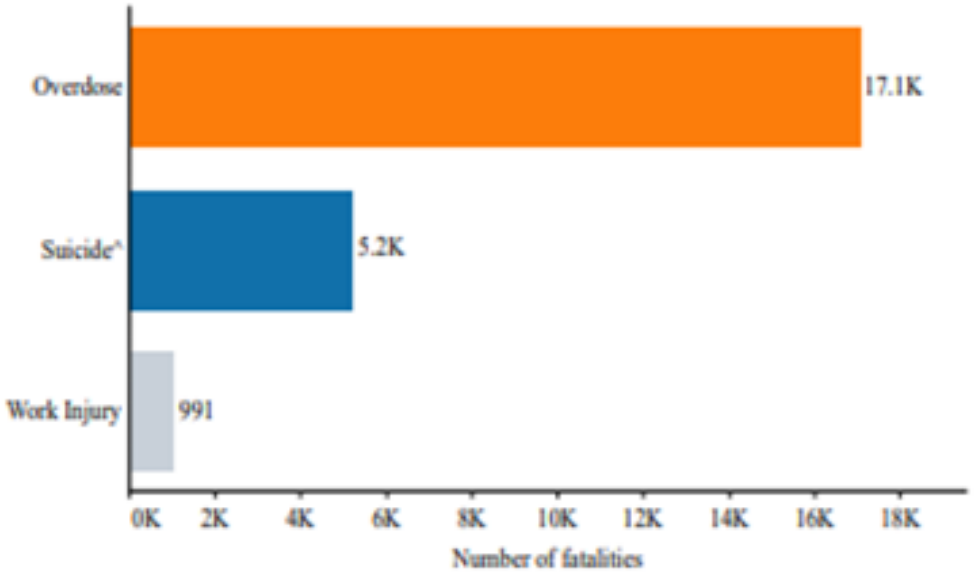

Figure 1. (Source: CPWR, 2024)

DeMarco (2025, para 8) asserts, "As mental health becomes a growing concern across industries, construction leaders are being challenged to respond with both compassion and strategy." Before the Great Recession fully receded, in the early 2010s, progressive leaders in the St. Louis construction industry began paving a path for dealing with the mental health issues in their local construction industry. While early efforts may have served as a means to address recruiting and retention issues, the major impetus resulted in moving the U.S. Occupational Safety & Health Administration's (OSHA) from their Focus Four strategy pertaining solely to the physical aspects of job safety to also include the mental aspects of safety on and off the job. As such, in 2021, days prior to the beginning of Suicide Prevention Awareness Month, Deputy Assistant Secretary of Labor, Jim Frederick, addressed the construction industry in what is now known as the "Moonshot". Herein,

he laid the groundwork for placing psychological safety in construction on the same plane as physical safety (Occupational Health and Safety Administration, 2021). Since then, efforts have been disseminated by national labor organizations, management associations, and professional societies and serve as models across the industry. However, when it comes to a strategy for dealing with suicide postvention in the construction industry, this remains an obscure matter when compared to the training and programs available for suicide prevention and intervention. In fact, AFSP launched a suicide prevention program in 2025 called Talk Saves Lives-Construction while QPRI implemented a virtual QPR-Gatekeeper suicide intervention program in 2023 addressing the construction industry. As of mid-2025, a formal program to specifically address suicide postvention in the construction industry did not exist.

In brief, suicide prevention mainly focuses on issues related to statistics and awareness such as risk factors and protective factors; suicide intervention is basically what someone (gatekeeper) does when they see/hear a person in crisis; and suicide postvention is the care provided to survivors after a suicide or suicide attempt has taken place. Since 2017, after the suicide death of this author's oldest son, the gap between prevention/intervention and postvention became clearer. The author's own personal experience with a lack of emergency outreach for postvention assistance was further entrenched in 2021 and 2024. In 2021, an industry colleague reached out to share that he just lost his 21-year-old son hours earlier to suicide and was seeking support. And, in the third quarter of 2024, the author took eight similar suicide calls over a 12 week period. All nine of these callers were seeking assistance immediately after they just lost their loved ones. This period is referred to as the acute phase: the first 48-72 hours following the death. The aforementioned rash of calls convinced the author that the time for a change was now, with respect to suicide postvention services as it pertains to the U.S. construction industry, in general, but with a focus on the acute phase. However, designing and developing a program that delivers such services requires people trained to fill that need. Being a Certified Peer Specialist in the state of Missouri for many years, the author proposed that trained Peer Supporters could be positioned to serve as a resource for suicide loss survivors, like the nine encountered in 2021 and 2024.

By identifying the aforementioned gap in services/programs, this author proposed the following research questions:

1. Should the U.S. construction industry address the aftermath of suicides?
2. Is there a need for a postvention program that focuses on the acute phase?
3. If so, might a Peer Supporters serve this need?

With these questions in mind, the author sought the guidance of a mentor and two subject matter experts (SME) to assist in the design, development, and implementation of a multi-phase pilot study that consisted of surveys, interviews, and a focus group seeking input from industry-related stakeholders.

Literature Review

Suicide Prevention

Regarding the first leg of the Suicide Triangle, a brief overview will provide general context pertaining to the topic of suicide prevention in the U.S. As per The Ness Center (n.d.), there are a few milestones worth mentioning:

1. in 1968, the American Association for Suicidology was founded to advance suicide prevention research and advocacy;
2. in 1987, the American Foundation for Suicide Prevention (AFSP) was founded as the first national non-profit dedicated to suicide prevention;
3. in 1999, the U.S. Surgeon General's 'Call to Action to Prevent Suicide' formally recognized suicide as a public health problem. This led to the development of a National Strategy for Suicide Prevention that was issued in 2001. This document addressed both Prevention and Intervention. However, it did not mention Postvention until its third edition in 2024, as follows: Strategic Direction 1: Community Based Suicide Prevention: Conduct postvention and support people with suicide-centered lived experience. Its goal is to provide postvention after suicide deaths and support for people with suicide-centered lived experience (U.S. Department of Health and Human Services, p.34).

With respect to suicide prevention in the workplace, Milner, et al. (2015, p. 35) proclaimed, "Very few workplace suicide prevention initiatives had been evaluated in terms of effectiveness…" However, they noted that there were citable examples of prevention activities in a few occupations and non-school workplace settings, including but not limited to the armed forces, police, farming, and construction. In the meta-analysis performed by Milner et al., they identified 212 such initiatives but upon further review narrowed their pool down to 13. Four of these prevention programs utilized training for buddies or gatekeepers: Working Minds: U.S.A., Mates in Construction: Australia, IncoLink: Australia, and ASIST: Canada. And, two of these four focused specifically on the construction industry (Mates and IncoLink). Findings included the importance of union support, having a multi-faceted approach that ensures those at risk can be identified and treated in a timely manner, and employers' concerns over the extent of which it is their responsibility to implement suicide prevention programs.

King et al. (2025, p. 2) asserted, "The Construction industry is one that experiences higher rates of suicide, and therefore a higher need for workplace suicide prevention interventions." In the King et al. analysis of the IncoLink program mentioned above, they attempted to understand the factors that influenced a successful of a suicide prevention program. This model launched the Bluehats Suicide Prevention program in 2018. It involves providing General Awareness Sessions (GAS) to all workers on the job site (i.e., recognizing suicide and mental health concerns in themselves and others). Afterwards, those trained are asked if they would like to be Bluehats. This requires training to become peer supporters with the promise of ongoing support from IncoLink. The GAS program has reached over 7000 workers which includes 300 Bluehats. Surveys and interviews served as the means to gather data from 'Bluehat workers', management, and other industry stakeholders. Findings included understanding the importance of the role the workplace plays in the broader

context of industry and society, opportunities to improve the Bluehat program (i.e., additional delivery formats, improvements to diversity and language issues), and providing more education to foster increased industry commitment.

Suicide Intervention

Regarding the second leg of the Suicide Triangle, suicide intervention is often referred to as suicide prevention intervention. This mixing of 'legs' may be cause for some confusion with the general public but a brief explanation of how and why this works follows. With suicide being recognized as a national public health issue, Quinnette (2007) noted, in general, gatekeepers are properly trained to recognize and refer persons identified to be potentially at risk of suicide. To clarify, the recognizing of warning signs—awareness—emanates from the prevention domain while the ability to properly refer someone in need—taking action—stems from the intervention domain. As such, gatekeepers must be knowledgeable in both prevention and intervention domains. Since 1995, Quinnette is credited with developing the 60-90-minute training program called QPR: Question, Persuade, Refer, that has been utilized in more than 40 countries. Quinnette's goal was to "Conceptually link QPR to CPR—a well-known, universal intervention for emergent medical crises that can be executed by trained lay persons" (2007, p. 5). Quinnette asserts, "It is up to those in an already existing and strategic relationship with the suicidal person to observe this journey and to make an effort to interrupt it with helpful, hopeful intervention." It is important to note that the QPR Institute developed QPR programs focusing on a variety of high-risk population including the Construction Industry in 2023 and, more specifically, for Iron Workers in 2025.

While QPR serves the purpose of training large groups of people, a more intense version of suicide intervention was developed in the mid-1980s, in Canada, known as Applied Suicide Intervention Skills Training (ASIST). In Evans and Price (2013, p. 214), according to Living Works, "The program is a two-day workshop aiming to help 'caregivers' (gatekeepers) feel more comfortable and competent in helping to prevent the immediate risk of suicide." These researchers explored influences that moved gatekeepers to intervene with at-risk individuals via 305 surveys and 94 follow up interviews involving workers at various levels and types of large and small organizations. Upon analysis of the data, Evans and Price identified the following two approaches:

1. organizations that were committed to training most of their employees;
2. organizations that identified small pockets of employees to attend training.

Evans and Price (2013, p. 215) posited, "These approaches were largely determined by the discourse espoused by the organization regarding suicide and its recognition of a 'collective responsibility' for intervention." To this end, three influences were ascertained:

1. ASIST democratized intervention—prior to training, many employees were not sure about the legality of intervening with at-risk individuals;
2. Leveraging opportunities—interventions increased when those in need were provided a safe space and interacted with an empathetic and trusted gatekeeper;

3. Enhancing the experience—providing help should not be the domain of one employee. As such, gatekeepers can provide support to one another and reduce emotional strain while improving future interventions.

Suicide Postvention

Postvention is often referred to as after-care or, in other words, what do we do after a suicide incident—whether it was an attempt or death. This is the third leg of the Suicide Triangle and is considered an under-developed area of study. In fact, a recent Google inquiry revealed the following, with respect to total PubMed articles available:

1. Prevention: ~38500
2. Intervention: ~21000
3. Postvention: ~1200

Causer et al. (2022, p. 1) state, "Suicide affects the physical and psychological health of the bereaved and, when compared to other causes of sudden death, those bereaved by suicide report higher levels of rejection, shame, stigma, and a need to conceal the method of death." By definition, bereavement is the period of mourning following the loss of a loved one. It is important to note that some people bereaved by suicide are also considered at risk of suicide. Furthermore, Causer et al. suggest that while effective postvention has been shown to improve mental health and grief-related outcomes, guidance is limited and often not evidence-based. Accordingly, Causer et al. performed an integrative review of 17 related articles—10 from peer reviewed (PR) journals and seven from professional organizations (PO)—by means of thematic analysis. The PR focused on the following occupations: police, fire, armed services, health care, and higher education. While the PO offered general and specific industry guidance in the form of tool kits, guidebooks, etc. A few highlights require mentioning. The first is organizational unpreparedness to address a suicide death in the workplace which places the onus on individuals to seek support while leaving some staff angry and confused. The second is the need to train leaders to positively impact work culture without placing undue pressure on managers who often function in an under-resourced system. The third is the role stigma plays. Causer et al. (2022, p. 15) declare, "It leads to inadequate postvention since, if an organization cannot talk about suicide, it cannot properly support those impacted by it." The fourth worth noting is, "Currently, workplaces do not provide the time and support required by employees to undertake the emotional work that arises following a colleague suicide" (Causer et al., 2022, p.15). The fifth is that postvention guidance needs acknowledge managers face competing needs: supporting their workers while running a business. Finally, consideration should be given to developing a postvention team that includes members from both inside and outside the organization.

While, historically, most consider Edwin Schneidman the Father of Suicidology, one of Schneidman's mentees, Dr. Frank Campbell is recognized by many as the contemporary Godfather of Suicide Postvention. Campbell et al. (2004, p., p. 30) stated, "Postvention services have historically been

delivered via a passive model, requiring survivors of the suicide death of a loved one to learn about the available resources in some indirect way and often by sheer chance." In 1997, a Baton Rouge based pilot program replaced the aforementioned passive model with an active postvention model that became known as the Local Outreach to Suicide Survivors (LOSS) program. LOSS team members are trained in responding to the scene of the suicide, crime scene procedures, bloodborne pathogens, and supportive counseling. The team includes para-professional volunteers (with lived experience) who—as close to the time of death as possible—reach out to survivors in order to provide support and resources. Worth mentioning is the fact that it takes time to build trust with the First Responders (police, fire, and medical examiners) on the scene to gain access to the loss survivors. It is important to note that Campbell et al. (2004) found that when LOSS Teams reach out soon after the suicide death—proactively vs reactively—loss survivors seek assistance in less than two months vs ~4.5 years for those who do not receive survivor assistance.

The Tragedy Assistance Program for Survivors (TAPS) model, per Ruocco et al. (2022) was developed—in 1994—for survivors by survivors and has brought comfort, hope, and healing to more than 90,000 survivors in the past +25 years. Ruocco et al. (2022, p. 1898) noted that around 2008, it "…became apparent that specialized programing for suicide loss survivors was increasing." In fact, new survivors began asking for assistance beyond the scope provided by the military while longer term survivors reached out because they felt stuck or alone in their grief. The TAPS model provides a three-phase template:

1. Stabilization immediately after a suicide death
   *With the intention of mitigating risks and promoting healing

2. Offer guidance on how to navigate grieving
   *Integrating grief in one's life constructively since grief is a process that lasts a lifetime

3. Establishing a pathway toward post traumatic growth.
   *Offers opportunities for survivors to make meaning from their loss and, thus, re-channel their grief into instruments of good.

The aforementioned phases are not intended to be linear as issues may arise later on which allows phases to be revisited out of sequence. According to Ruocco et al. (2020, p. 1899), "The model provides guidance on how to navigate an adaptive journey of grieving and establishes a pathway toward intentional posttraumatic growth." Specifically, Ruocco et al. (2020, p. 1905) proclaim, "…it is critical during the Stabilization phase to ask clearly and directly about suicide risk and then connect survivors to appropriate resources." Peers with lived experience connect with loss survivors which assists in normalizing emotions, validates the need to seek additional care, and serves as an important form of suicide prevention. To this end, TAPS utilizes both thoroughly trained peers and licensed professionals to deliver care to survivors. Finally, Ruocco et al. (2020, p. 1906) stress, "The TAPS Suicide Postvention Model is broadly applicable to anyone grieving the loss of a loved one to suicide and is applicable to other traumatic events."

The literature review above provides an overview of what is offered in all three aspects of the Suicide Triangle. Some of the common themes between suicide prevention, intervention, and postvention are highlighted below:

1. Training in each area may be available but not always based in evidence.
2. Training is being tailored to specific organizations, occupations, and special interest groups.
3. Caregivers, Bluehats, para-professionals, in other words, peer supporters, must be willing and available, trusted, and offer resources.
4. Aspects of suicide prevention, intervention, and postvention are interlinked.

While the work of evidence-based training and trained peers in other industry sectors are supported, when it comes to literature focusing on suicide postvention in the U.S. construction industry that specifically targets providing assistance to loss survivors during the acute phase—the first 48 to 72 hours following a suicide death—a gap in research appears to exist. However, if one is able to bridge the divide between occupations, the evidence-based TAPS model could serve as the basis to leverage the use of trained peers in the acute phase in the construction industry. This pilot study attempts to help fill that gap.

Notes: Appendix A provides additional information on industry-based programs, etc. relevant to workplace postvention. Appendix B offers background gathered from the author's related research tour in June 2025.

Methods

This research was based on a mixed-methods approach that consists of surveys, interviews, and a Focus Group. It was designed in three phases, as follows:

Phase 1: Surveys

Phase 2: Interviews

Phase 3: Focus Group

Surveys

With respect to the survey phase, 70 participants were recruited via email invitations based on convenience sampling. The author utilized his +40 years in the construction industry to identify potential candidates for this portion of the pilot study. The backgrounds of these people ranged from construction industry professionals (white- and blue-collar), consultants, First Responders, and researchers/practitioners. Upon completing the literature review, the author developed a questionnaire consisting of 34 questions. Questions were designed to obtain stakeholders' input on the Suicide Triangle and their views on the need/desire to create an industry Postvention program with a focus on timing and delivery issues. In order to obtain face validity, the author worked with his mentor in an iterative manner—Dr. Hatton—who provided guidance regarding content and context. The aforementioned email consisted of a brief overview of the proposed study, timelines, and an opportunity to obtain informed consent. Sixty-four participants opted-in

to complete the online survey hosted by SurveyMonkey. The survey included close-ended and open-ended questions regarding demographics, professional background, personal/professional awareness of the topic, training approaches, and another opportunity to obtain informed consent. The survey was designed to allow participants—who were not comfortable or supportive of the Postvention concept—opportunities to exit without completing the 34 questions and without negative repercussions for doing so. At the end of the survey, participants were provided space to comment, make suggestions, share ideas, etc. Note: The survey tool was available for two weeks (Nov-Dec 2024).

Interviews

Upon analyzing the survey data, the author shared a written report of the findings with Dr. Hatton. After making minor adjustments based on his mentor's edits, the author was advised to move on to Phase 2: Interviews. At this point, the author reached out to enlist two Subject Matter Experts (SME) with deeper backgrounds in qualitative research techniques and/or mental health. Both Luke Steinke, PhD (Eastern Illinois University: EIU) and Bryan Zoran, CEBS (International Foundation of Employee Benefit Plans: IFEBP) agreed to assist on this portion of the pilot study. With their guidance and input, the author designed an interview instrument in MS Word. This tool took into account constructive comments from the end of the aforementioned survey. There were 14 General interview questions that all participants were asked—one of which involved informed consent. Depending on how one self-identified, s/he would be asked an additional series of specific questions (typically 2-4) related to each of the five categories selected: Loss Survivor, Attempt Survivor, Construction Professional, First Responder, and Researcher/Practitioner. It is important to note that one participant could be asked 17 to 25 questions depending on the categories s/he selected above. In order to obtain face validity, the author worked with the two SMEs and Dr. Hatton in an iterative manner. All of which provided guidance regarding content and context. A recruiting email was sent to 22 potential participants describing the overall project and the interview process. Potential candidates were selected via a convenience sample based on referrals from the survey participants and attempted to maintain a balance in the aforementioned categories. Information was provided to these candidates regarding consent, privacy, and self-care. Fifteen (15) interview candidates opted-in. Once a potential participant agreed, a one-hour online semi-structured interview was scheduled typically weeks in advance. All interviews were recorded and transcribed in Teams (14) or Zoom (1). Each participant was sent a copy of the transcription for editing and/or clarifications. Afterwards, the author collated and then deidentified the 15 interviews for thematic analysis in parallel with one SME: Luke Steinke (LS). After which, these two reviewed the aggregated interview data utilizing a Reflexive Thematic Analysis framework: coding data, identifying patterns, and generating initial themes. The second step involved sharing each other's findings for review and comments. Followed by the third step of jointly revisiting and revising themes. Once agreement was obtained, each researcher utilized an Artificial Intelligence (AI) tool—LS (Claude) and the author (Gemini)—for the sake of separately comparing their findings to AI's findings. Upon further discussion, minor edits were made. The fourth step involved sending a draft of these findings to the second SME, Bryan Zoran (BZ) for his input. Upon receiving BZ's comments, the author edited the draft. In the fifth step, the author forwarded the aforementioned revised draft to Dr. Hatton for comments. Once feedback was received from Dr. Hatton, a final report pertaining to the interview phase was produced.

Notes: There was no crossover of participants between Phases 1 and 2. The interviews took place over a four-week span (May 2025). See Appendix C for discussions with Global Thought Leaders beyond the interview process.

Focus Group

After making minor adjustments to the interview's findings—based on his mentor's edits—the author was advised to move on to Phase 3: Focus Group. The goal of this phase was to allow a sampling of participants from Phases 1 and 2 the opportunity to jointly examine the findings from the first two phases of this pilot project and, then, work in small groups to set the course for future actions. Recruiting potential candidates for this phase consisted of a convenience sample; it targeted participants from—in and around—the Greater St. Louis area. Eighteen (18) candidates were sent emails explaining the third phase of the pilot project's process: Focus Group. Twelve (12) responded and eight (8) showed up for a scheduled two-hour Focus Group session. Note: One of the participants allowed for the Focus Group meeting to take place at his office's meeting rooms. All participants signed in before the session began and this document included an informed consent notice. After reviewing the highlights from the findings in Phases 1 and 2, the room was then divided into two groups of four each to ensure a good mix of viewpoints from those in attendance (i.e., personal and professional backgrounds, loss survivors, labor v management, survey participant v interview participant, etc.). Directions were provided by the author to groups 1 and 2: four stations, 10 minutes per station, etc. Groups were instructed to enter each station and address/brainstorm the ideas around the identified theme for that specific station, based on their backgrounds, while acknowledging the results from this pilot study's survey and interview data just shared. Furthermore, when they entered a given station that the other group just exited, they could validate the other group's input with a check mark while still adding to their own input to that list. The topics at each station were based on the highlights from the literature review and key findings from Phases 1 and 2 and checked for face validity by LS. Each Station's topic was assigned, as follows:

Station 1: End Products

Station 2: Targeted Audiences

Station 3: What's Missing?

Station 4: Name It

Near the end of the Focus Group session, each group was provided an opportunity to share their input/insights regarding this exercise. The author drafted a report of the proceedings and shared it with the two aforementioned SMEs for input. Upon editing, a report was forwarded to Dr. Hatton for her inspection and comments. This focus group session was two hours long (August 28, 2025).

Note: Ethical approval for this pilot project was gained from Warnborough College's Institutional Review Board (WCI-1201).

Findings

Surveys and Interviews

The findings below will focus on the three aforementioned research questions:

1. Should the U.S. construction industry address the aftermath of suicides?
2. Is there a need for a postvention program that focuses on the acute phase?
3. If so, might a Peer Supporters serve this need?

With respect to research question 1 (RQ1): Should the U.S. construction industry address the aftermath of suicides? Both survey participants (SP) and interview participants (IP) indicated a very high need for the construction industry to intervene after a workplace suicide, with 95% of SP expressing that "the industry has an opportunity to act" and, from a thematic perspective, 100% of the IP pointing out that "the industry needed to take action."

Regarding RQ2: Is there a need for a postvention program that focuses on the acute phase? Both SP and IP demonstrated a moderately high need for a postvention program in the construction industry, with 77% of SP indicating that "the industry should focus on the short term" and, from a thematic perspective, 73% of the IP insisting that "the emphasis should be in the 0-24 hour timeframe."

With respect to RQ3: If so, might a peer support program serve as this model? While the SP indicated a high need (81%) to consider a peer support model to deliver postvention services in the construction industry but only "if trained", from a thematic perspective, only 47% of the IP stated a moderate need "due to shared experience."

Notes: From a demographic standpoint, the survey participants consisted of 36% females and 64% males while the interview participants consisted 53% females and 47% males. Some or all data pertaining to the surveys and interviews are available upon a reasonable request within the constraints of ethical clearance.

Focus Group

Following is a thematic overview of topics from both groups' input at the aforementioned four stations.

With respect to Station 1 (End Products), Group 2 identified seven items of which Group 1 agreed to all seven but added another five distinct items to consider. From a thematic perspective, both groups agreed that developing training programs for the field and office workers as well as a Train-the-Trainer program for Industry Specific Certified Peer Supporters were necessary as soon as possible. In addition, recommendations were made to produce articles and promotional activities to raise the awareness regarding the need for addressing suicide postvention in the construction industry with a focus on the acute phase. This links to the need for addressing the acute phase of postvention (Campbell et al. 2004) as well as the need to do so with trained peers in the literature (Ruocco et al. 2020) as well as findings regarding peer support (RQ2; RQ3) from the SP and IP in the previous section.

Regarding Station 2 (Targeted Audiences), Group 2 identified 13 items of which Group 1 agreed to all 13 but added a drawing to depict a concise web of these connections. From a thematic perspective, both groups agreed that the outreach of postvention services should include family, friends, co-workers (white- and blue-collar), unions, employers/managers/staff, management associations, schools, and First Responders. This links to the need to address postvention in the workplace in the literature (Causer et al., 2022) as well as findings regarding the need to address postvention in the construction industry (RQ1) from the SP and IP in the previous section.

With respect to Station 3 (What's missing?), Group 1 identified 2 items of which Group 2 agreed to both but added 14 more items. From a thematic perspective, both groups agreed that the outreach of postvention services should include family, friends, co-workers (white- and blue-collar), First Responders, schools, unions, and management associations but provided an opportunity to think beyond the details so far presented. While not directly related to RQ1, RQ2, or RQ3, this station allowed for focus group participants to reflect on and discuss related issues of personal concern as well as details regarding the potential for customizing an existing evidence-based program from another sector for this industry, funding, rollout, and program sustainability. This station focused on the future operational needs related to this pilot study.

Regarding Station 4 (Name It), Group 1 identified seven items of which Group 2 did not agree to any of those items. However, they added five more items. From a thematic perspective, both groups did include a few suggestions that touched on life and living in the proposed program titles. While not directly related to RQ1, RQ2, or RQ3, this station allowed for focus group participants to reflect on and discuss an important aspect of marketing: branding. As such, LOSS and TAPS are examples of catchy titles (Campbell et al. 2004; Ruocco et al. 2020).

Notes: From a demographic standpoint, the focus group participants consisted of 13% females and 87% males. Some or all data pertaining to the focus group are available upon a reasonable request within the constraints of ethical clearance.

Discussion

The analysis of the data from the surveys, interviews, and focus group pertaining to the three research questions provides support for moving ahead with implementing a program that addresses suicide postvention in the U.S. construction industry. The work of Causer et al. (2022) suggests that if management does not act after a workplace related suicide, a vacuum exists and can cause fear and anger among staff. Without proper guidance from leadership, this can be cause for a spike in 'suicide contagion' related deaths affiliated with the recent suicide loss. Herein, family, friends, or employees already struggling with mental health issues may move towards carrying out their own suicide. In addition, the findings in this pilot study's RQ1 further substantiate the need to address the need for a postvention program in the construction industry. A related theme and comment from the interview process worth noting is as follows, Action: "I would say the industry has more than an opportunity to act…I would say they have an obligation."

While a holistic postvention program, like TAPS addresses the entire postvention eco-system, this pilot study seeks to more precisely focus on the acute phase of postvention in the construction industry—as TAPS refers to as the Stabilization phase (Ruocco, 2020). To this end, Campbell

et al.'s (2004) observation that people who receive immediate peer support, after a suicide death of a loved one, tend to seek therapy in less than 60 days as opposed to more than four years for those who do not. In so doing, this serves as a protective factor and, thus establishes a connection between the three legs of the Suicide Triangle. In doing so, postvention becomes prevention! In addition, the findings in this pilot study's RQ2 support the need to focus on the acute phase of postvention in the construction industry. A related theme and comment from the interview process worth noting is as follows, Emphasis on the 0-24 hour timeframe: "I think touchpoints need to happen within the first 24 hours."

While results for RQ3 appear not to be as fully supported as in RQ1 and RQ2, they do reveal a high to moderately high support for imploring the use of peers to deliver postvention support services. It is important to note that while peers play a large role in both the Bluehats and TAPS postvention programs, a mix of trained peers and other related professionals round out intervention and postvention teams, respectively (King et al. 2025; Ruocco, 2020). There are two related themes and comments from the interview process worth noting is as follows, Shared experience/ Understanding: "There's just no substitute for someone who gets it and has been there."; and Immediate support/Presence: "I think if you've got a properly trained peer support program, it can be far more immediate and far more effective than even a mental health professional."

Conclusion

With annual suicide rates in the U.S. nearing the 50,000-mark, and in light of the crisis within the construction industry, this author set out to explore how to better address the acute phase of suicide postvention in this industry—especially in light of the fact this sector is losing >1 worker to suicide approximately every 2 hours—each day, every day of the year! Guidance and input were sought by an array of subject matter experts across 5 countries. Each step of this process was overseen by the author's mentor—who over the past several decades has obtained a steeped academic and professional background in mental health counseling. By undertaking a mixed-methods approach, this author was able to tweak each following phase with lessons learned from the previous phase.

The 100% (64/64) return rate of Phase 1 Surveys indicated that the participants were interested in this under-researched topic. Key findings addressed the 3 research questions pertaining to need, timing, and method of delivery. Wrap-up comments from this phase assisted the author in sculpting the Interview instrument in Phase 2 with the assistance of two SMEs having backgrounds in qualitative methods and mental health. This allowed (15) participants to identify in more than one category and, thus, provide more robust discussions than the Survey instrument. As such, these findings helped in the development of the Phase 3 Focus Group. In an attempt to cross pollinate findings between the first two phases, a balanced mix of participants were invited to participate in a 2-hour (in-person) session with the intention of laying out a 'road map' of End Products. As a result, this article serves as the first step in a long journey over the next year, wherein, guidebooks and training will be developed for specific audiences (rank & file field/office workers vs Peer Specialists) as well as a training video strategically housed on a local university's website to reach the masses.

By incorporating the following findings from this pilot study:

1. Take action now to address suicide postvention in the construction industry;
2. Focus on the acute phase following an attempt or death; and
3. Utilize trained Peer Specialists to fill this void;

this author argues that postvention efforts undertaken will assist in completing the suicide triangle connections between prevention and intervention. Thus, allowing for a more comprehensive and un-siloed approach to addressing the suicide crisis—specifically in the acute phase in the aftermath of a suicide death. Regardless of the industrial sector—military, healthcare, or construction—it is time to acknowledge that Postvention is Prevention (Be Connected Program, 2025). To this end, McDonnell et al. (2020, p. 356) proclaim, "The development of evidenced-based suicide bereavement training is in its infancy but is a key aspect of suicide prevention, requiring postvention policies worldwide to support it."

In closing, the author recognizes the limitations regarding this pilot study that is focused on acute suicide postvention in the U.S. construction industry. In order to obtain more data to support generalizing findings, it will be necessary for further research into this topic which includes more diversity in people, sectors within the industry, and geographic locations. While more recent efforts have been made to address postvention in this industry (i.e., AFSP's After a Suicide Toolkit, Vital Cog's Postvention Guidance, and MATES' Response Training Program), this original work is focused on the hours/days vs weeks, months, or years following a suicide incident. Why? Because loss survivors tend to be in shock and disbelief and need immediate support in order to help stabilize the space around themselves, loved ones, and co-workers, etc. so as to more immediately prevent suicide contagion while gradually and compassionately guiding survivors towards the grieving and post-traumatic growth phases of suicide postvention. As such, the TAPS (military) postvention model can serve as the framework for the U.S. construction industry to adopt and address this current unmet need.

Acknowledgements

The author wishes to thank those kind people who shared their time and talents to bring this research project from concept to reality. First and foremost, Dr. Pamela Hatton was an important asset in providing guidance throughout the entire process. In addition, the author tips his hat to Luke Steinke, PhD and Bryan Zoran, CEBS who both served as SMEs and readers at critical stages of this three phase process. To all of the survey and interview participants, your insights, thoughtfulness, and kindness will be shared in various formats to assist others. To the global thought leaders, I am grateful and hope to return the generosity in the not too distant future. Finally, to the author's loving wife and children, the past +9 years have taught us many lessons—most of all, how our resilience can benefit others by turning tragedy into triumph!

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APPENDIX A

Mates in Mind (General Workplaces)

Post-Suicide Response Guide and Continuum of Survivorship.

This UK-based charity provides frameworks for businesses to manage trauma and identify how varying levels of exposure affect employees.

- Preventative Focus: Enables mental health support before crisis points occur through industry partnerships.
- Survivorship Levels: Categorizes impact from "Suicide Exposed" (aware) to "Suicide Bereaved" (intense, long-term grief).
- Response Tools: Prepares businesses for the traumatic event of a suicide to ensure effective change.

For more information:

Mates in Mind (2025). Post-suicide response guide. https://www.matesinmind.org/media/uhij1f3p/post-suicide-response-guide.pdf

K-12 Schools

Program: After a Suicide: A Toolkit for Schools

A comprehensive guide providing practical tools and reliable information to help schools protect students and return to their educational mission.

- Stigma Reduction: Recommends treating all student deaths equally to avoid reinforcing negative stigmas surrounding suicide.
- Contagion Management: Focuses on avoiding the glamorization of death while acknowledging adolescent resilience and coping capacity.
- Holistic Approach: Accounts for cultural differences and recognizes that suicide often stems from multiple complex causes.

For more information:

American Foundation for Suicide Prevention and Suicide Prevention and Resource Center. (2018). After a suicide: A toolkit for schools (2nd edition). https://sprc.org/wp-content/uploads/2022/12/AfteraSuicideToolkitforSchools-3.pdf

Veterinarians

VetLife Postvention Support

A Scotland-based program combining public health, crisis management, and peer experience to support the veterinary community.

- Peer Engagement: Highlights that active engagement with usual support mechanisms is most critical in the first month.
- Core Support: Relies on active, non-judgmental listening and empathy to help colleagues navigate the professional realm.
- Communication: Stresses the need for clear, honest, and flexible communication following a workplace suicide.

For more information:

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APPENDIX B: Research Tour

Since the author has been intensely studying the spectrum of Suicide Prevention/Intervention/Postvention topics for nearly a decade, he has had opportunities to learn from some of the leading experts in the Suicidology field. Often these connections were made via follow-up emails after participating in related webinars. One such encounter was with Dr Susie Bennett via the Karolinska Instituet's platform. Days prior to her defending her doctoral dissertation, she presented on the topic of "Why men die by suicide" in the late fall, a few years ago. Susie opened the door to a variety of other researchers in this space for the author. This led to the author visiting Scotland and England in early June 2025 for training, research, and presenting opportunities.

One such contact was Dr. John Whitebrook at the University of West London. He lost his 24-year-old son to suicide years ago and has been researching the topic of postvention for men. Dr. Whitebrook invited the author to a suicide researchers' conference in Glasgow, Scotland on June 2-3, 2025. This two-day event was hosted by Professor Rory O'Connor—a leading Suicide Prevention researcher. At this event, the author was introduced to Dr. Rosie Allister. Dr. Allister is a veterinarian by trade who went on to become a suicide researcher.

Another contact made was with Dr. John Gibson via Dr Bennett. Dr. Gibson is located in Dunblane, Scotland. He lost his 24-year-old son to suicide a few years ago as well. His family created The Canmore Trust (TCT) in honor of their son, Cameron, who was also a veterinarian. Among other services, TCT is a charity that offers Postvention trainings for the general public and workplace. Dr. Gibson invited the author to attend their two-day training for Workplace Postvention on June 4-5, 2025.

From there, the author went to Canterbury, England to address a group of stakeholders at Canterbury Cathedral hosted by Warnborough College. Efforts were made months in advance to invite a variety of Suicide Prevention organizations (i.e., Samaritans, Mates in Mind, St John Ambulance, Lighthouse Construction Industry Charity), in the near-London area, to participate. Herein, the author presented findings from Phase 1 of this pilot study.

APPENDIX C: Discussions with Global Thought Leaders

During the author's journey to obtain answers to the three research questions proposed in this study's Introduction, a number of names kept re-appearing as more connections were made during the Literature Review process. The author via email, upon consent, arranged one-on-one Teams recorded discussions—each lasted approximately one-hour. Below are brief summaries captured following the Focus Group phase.

Dr. Rosie Allister was the keynote speaker at a suicide research conference at the University of Glasgow on June 3, 2025. She did not participate in Phase 1 or 2 of this study. Her story intrigued the author as she essentially researched, designed, developed, and launched a Postvention project for veterinarians in 2009. The author shared this study's findings that focused on research questions 1-3 from Phase 1 and Phase 2 with Dr. Allister. And, followed up by asking for her guidance in preparing End Products. Here are some suggested highlights:

1. Structured peer support was helpful in her work
2. Training for volunteers covers three 2.5-hour modules spread over time to provide reflection
3. Help must be available immediately
4. Use the 'paired' model for visits
5. Be flexible
6. Be ready for 'grief' responses
7. Be aware of 'space' where person died
8. If you provide Critical Incident Response, you may trigger PTSD
   *Use licensed mental health professionals
9. Listen vs Fix
10. Look for those 'missed' out and with elevated risks
11. Do not assume who 'needs' help
12. Consider uneven burden (impact) based on staff positions
13. Management needs to set up Postvention team before an incident
14. Have a low threshold for employees seeking help

Dr Carla Stumpf Patton is the Senior Director of TAPS, a researcher, and loss survivor. She did participate in Phase 1 of this study. Her doctoral work in the early 2010s contributed to the development of the military's TAPS Suicide Postvention program. The author shared this study's findings that focused on research questions 1-3 from Phase 1 and Phase 2 with Dr. Stumpf Patton. And, followed up by asking for her guidance in preparing End Products. Here are some suggested highlights:

1. TAPS is not linear or in stages—it is meant to be fluid
2. When to provide assistance: The sooner the better
3. Third Phase: Post Traumatic Growth is on a spectrum based on each person
4. Leading with peers builds trust
5. By offering services you may close the gap and reduce risks
6. Don't give up
7. Ask: Focus on 'micro' needs
8. Develop a guidebook and toolkit
9. Be mindful of burnout and self-care

Dr. Anna Mueller is a professor, sociology researcher, and author. She did not participate in Phase 1 or 2 of this study. Her recent co-authored book, Life under pressure, intrigued the author because it addressed K-12 suicides but, more importantly, completed the suicide triangle mentioned earlier. The author shared this study's findings that focused on research questions 1-3 from Phase 1 and Phase 2 with Dr. Mueller. And, followed up by asking for her guidance in preparing End Products. Here are some suggested highlights:

1. Tailor the End Products to the context of participants
2. Don't treat suicide as taboo

   *Talk about it

   *Don't promote myths

   *Offer onsite help
3. Utilize trained peer supporters
4. Grief takes a toll—It reshapes us
5. Consider 'safer' memorializations
6. Avoid too much sharing (details)
7. Respect grieving family's privacy but allow space to discuss suicide

8. Develop & distribute a one-pager

   *What is Postvention

   *Why it matters

   *What can you do to assist

Dr. Rory O'Connor is a professor, researcher, and author. He did not participate in Phase 1 or 2 of this study. His book, When it is darkest, discusses factors that lead people to consider suicide (thoughts vs behaviors) and was recommended by two of the three researchers mentioned above. The author shared this study's findings that focused on research questions 1-3 from Phase 1 and Phase 2 with Dr. O'Connor. And, followed up by asking for his guidance in preparing End Products. Here are some suggested highlights:

1. Best mode of delivery is co-created with all stakeholders
2. Content should be developed based on evidence, evaluated to 'do no harm', reviewed and tweaked
3. Consider how proper support will be in place
4. First 24 hours will require professional assistance
5. Embed sensitivity and compassion in training
6. Start small and adopt continuous improvement approach
7. Look at other models
8. Be mindful of self-care

Dr. Sharon McDonnell is a researcher, trainer, and consultant who led the 4-year PABBS (Postvention Assisting those Bereaved by Suicide) research study at the University of Manchester (England) and then translated those findings into evidence-based training. She did not participate in Phase 1 or 2 of this study. The author shared this study's findings that focused on research questions 1-3 from Phase 1 and Phase 2 with Dr McDonnell. And, followed up by asking for her guidance in preparing End Products. Here are some suggested highlights:

1. With everything bad in life, there is some good
2. Post-traumatic growth allows us to make meaning out of something that is meaningless
3. Without proper training we do nothing or say the wrong things
4. It is important to develop guidelines for employees in the workplace but we need additional guidelines for managers

5. It is powerful that:

    a. you are bereaved by suicide

    b. you are from the construction industry

6. Industry peers are valuable vs trained ‘professionals’ without related-experiences

7. Dig into the construction deaths’ data: Falls may sometimes be intentional

8. Consult the newly created British Standards Institution: BS 30480(2025) for addressing suicides in the workplace (prevention/intervention/postvention)

Nicholas Thompson is the CEO of MATES in Queensland, Australia and a PhD student who played a key part in the development of the MATES (postvention) Respond Training Program. He did not participate in Phase 1 or 2 of this study. The author shared this study’s findings that focused on research questions 1-3 from Phase 1 and Phase 2 with Mr. Thompson. And, followed up by asking for his guidance in preparing End Products. Here are some suggested highlights:

1. Program must be flexible as needs for each person differ

2. When it comes to construction, Peer Support is most effective approach

3. Peer Supporters (Responders) must take a variety of training courses to help ensure Mental Health literacy (i.e., safeTALK, PFA, ASIST, etc.)

4. A need for more ‘practice’ conversations to better prepare Responders for reality

5. Important to provide assistance to Responders after the event (i.e., self-care, etc.)

6. Access to Mental Health professionals for clinical matters whether they are immediate or long term for survivors and/or Responders

For more information:

Biggs, A., Townsend, K., Loudoun, R., Robertson, A., Mason, J., Maple, M., Lacey, J., & Thompson, N. (2024). Towards as evidenced-based critical incidents and suicides response program in Australian construction. Buildings, 14(2797), 1-27. https://doi.org/10.3390/buildings14092797