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RESEARCH ARTICLE OPEN ACCESS

A Qualitative Analysis of Stakeholders and Workers' Views of the Impact of a Suicide Prevention Program for the Australian Construction Industry

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ABSTRACT

Issue Addressed: In Australia, construction workers have suicide rates twice that of other male workers. The Bluehats suicide prevention program aims to address this issue. Workplace suicide prevention programs are promising due to their potential reach and ability to address industry-specific risks. However, evidence of their effectiveness is limited.

Methods: We aimed to understand more about the impact of the program and the factors influencing successful implementation through a qualitative study that comprised interviews and open-ended survey responses from 8 construction industry stakeholders, 19 workers, and 5 Incolink service delivery staff. Data were analysed using Reflexive Thematic Analysis.

Results: Participants commented on the role of the Bluehats themselves, the scope of the Bluehats program, and industry-related factors that influenced the program's impact. Whilst participants reported positive impacts of the program, key recommendations included expanding the program's reach to small businesses, rural areas, and diverse cultural groups, as well as broadening its scope to include early intervention.

Conclusions: The study emphasises the importance of a supportive work environment and industry for the success of the Bluehats program. Effective suicide prevention in the construction industry requires addressing individual, social, and systemic factors through a systems-based approach.

So What? The findings suggest that although the Bluehats program has a positive impact, an enhanced reach and scope could further improve its impact. Implementing these recommendations could lead to more effective suicide prevention in the construction industry and serve as a model for similar workplace interventions.

1 | Introduction

More than 720 000 people die by suicide every year, with most suicides occurring in people who were employed at the time of their death [1, 2]. Workplace programs hold great promise for suicide prevention, not only for their potential to reach large numbers of people in their everyday lives—to prevent

and respond to risk—but also to target industry-specific factors that confer risk or protection for suicide. Workplace suicide prevention programs have been undertaken in various workplace settings (e.g., military, police, construction, agriculture) and commonly include elements such as health promotion, education and training in risk detection and response (gatekeeper training), counselling, and support for

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staff after a personal suicide attempt or death of a colleague [3]. These elements are consistent with current best practices in suicide prevention that emphasise suicide prevention programs should combine universal, selective and indicated interventions aimed at different elements of the system for more significant reductions in suicide [4].

Despite their great promise, however, the evidence for the impacts of workplace suicide prevention programs is sparse. Hallett and colleagues' 2024 review of workplace interventions to prevent suicide identified 36 interventions across multiple industries (military, health care, construction, emergency service and others); however, fewer than half of these had been evaluated. Many of those who had been evaluated demonstrated positive impacts, including reductions in suicide rates and increases in favourable beliefs and attitudes regarding suicide and help-seeking. Very few studies had sought to understand the mechanism of impact or factors influencing implementation [5]. The available research indicates that many factors influence the impact and successful implementation of workplace suicide prevention interventions. Lack of leader buy-in, funding, and time constraints have been identified as barriers to implementation [6]. Whereas programs are aided by support from stakeholders, supportive workplace cultures, reaching all levels of workers, and responsiveness to environmental changes [3]. Hallett and colleagues conclude that more research is needed to understand the mechanisms of impact so that funds can be directed to the most effective elements [5]. Implementation research has been highlighted as a priority in suicide prevention more broadly, to help identify strategies for the successful running of all programs [7].

The construction industry is one that experiences higher rates of suicide, and therefore a higher need for workplace suicide prevention interventions.

This study complements our previous paper that explored the context and impact of the program on worker volunteers involved in delivering the program [8]. In Australia, and many other countries, construction workers have higher suicide rates than other male workers (Australian rates: 26.6/100 000 vs. 13.2/100 000) [9, 10]. Research indicates that suicide within the industry is likely influenced by a complex interplay between personal and industry-specific factors, including job instability and insecurity, low job control, transient work, long work hours, workplace injuries, masculine workplace culture, low help-seeking, and bullying [11]. Workplace cultures in male-dominated industries often perpetuate stigma, which reduces help-seeking and help-offering behaviours [12]. A recent qualitative study in the construction industry highlighted the importance of the workplace environment for program effectiveness, revealing that the work environment and culture are crucial [8].

Industry-specific suicide prevention programs have been developed for the Australian construction sector, notably by Incolink and MATES in Construction, which operate in different states in Australia. Both programs offer training and a peer-support suicide prevention program for the industry. Research regarding these two programs for the construction

industry has been featured in 13 peer-reviewed articles (12 on the MATES program and one on the Incolink program) [8, 13]. Research on the impacts of the MATES program has primarily focused on implications for peer supporters, with improvements in mental health and suicide prevention literacy, helping intentions, and reduced stigma observed. However, evidence is lacking about longer-term outcomes for peer supporters and impacts on suicide behaviour for those they support [13]. So far in this research, there has been little information about factors impacting the successful implementation of suicide prevention programs in the industry.

In this study, we aimed to gain a deeper understanding of the factors influencing the impact and successful implementation of suicide prevention programs in the construction industry. To achieve this, we collaborated with Incolink to explore the implementation of their Bluehats program. The project was funded by [funder]. Incolink is Australia's oldest and largest manager of redundancy entitlements for commercial building and construction workers. They have been operating in Victoria since 1988, in Tasmania since 2013, and have recently begun operating in South Australia. They have over 84 000 members across commercial building, construction, plumbing, transport, mechanical services, and manufacturing. In addition to their insurance offerings to the industry, they also provide a range of wellbeing and support services, including training and career advisors; COVID testing, flu vaccinations, and health checks onsite; counselling support by phone, online, and in-person; critical incident and onsite crisis support; and Bluehats Suicide Prevention (described below) (www.incolink.org.au/wellbeing-support-services).

The Bluehats Suicide Prevention Program was rolled out in 2018 in response to concerns about the suicide rate among construction workers. This program provides onsite training for workers via General Awareness Sessions (GAS) that aim to improve awareness of suicide, recognise signs of poor mental health in themselves or others, and provide self-help tools and information about how to seek help. Participants at GAS are then asked if they would like to become Bluehats, who provide onsite peer support to workers with suicide or mental health concerns (indicated intervention) and referral to Incolink clinical services and other community services when required. Bluehats volunteers receive further training (one full day) and ongoing support from Incolink.

Incolink has reached over 7000 workers with GAS and supports over 300 Bluehats. In our prior study, we interviewed Bluehats to identify the capabilities (knowledge, skills and abilities, attitudes and self-efficacy), opportunities, and motivation that influence their support behaviour in the construction industry [7]. In the current study, we aimed to understand more about the impact of the program and the factors influencing implementation through interviews and surveys with industry stakeholders, industry workers, and Incolink staff. Our research questions were: What has been the impact of Bluehats on the industry, and what factors facilitate or hinder the potential impact and implementation of the program? The research findings could be used to identify opportunities for program improvements and further knowledge about the

successful implementation of workplace suicide prevention interventions.

2 | Method

2.1 | Procedure

Ethical approval was gained from the Monash University Human Research Ethics Committee (ID. 29386). For workers, Incolink distributed an online survey to all construction workers on their member mailing list and via their social media accounts (Facebook, LinkedIn) on behalf of the researchers. Interested workers clicked on a website link to the researchers' site, where they were presented with the explanatory statement and consent form. Consenting workers completed an online survey hosted on Qualtrics. The survey included demographic questions and open-ended questions that the researchers designed to understand workers' views on the impact and implementation of the Bluehats program. They included the following: 'What difference do you think Bluehats is making for the industry?', 'How could Bluehats be better?', 'What gets in the way of people getting help from a Bluehat?' and 'What helps people to feel comfortable to get help from a Bluehat?'. At the end of the survey, worker participants were asked to provide their email addresses and phone numbers if they were interested in participating in an interview. The researchers then made contact to invite them to an interview and provided a link to the online explanatory statement and consent form. There was no reimbursement for the survey. Workers who participated in an interview received a \$50 voucher. Workers were excluded if they were a Bluehat.

Industry representatives (e.g., employers, unions, legislative bodies) and Incolink staff were invited by Incolink to participate in an interview with the research team. Incolink invited all staff and all stakeholders who were involved in the Bluehats program. There were no exclusion criteria for staff and stakeholders. If they agreed, Incolink provided the researchers with their contact details. The researchers then contacted and invited them to participate and provided a link to the online explanatory statement and consent form. This recruitment ended when Incolink reported that they had exhausted all recruitment options (i.e., they had invited all staff and stakeholders).

Once interview participants had provided their consent, the researchers contacted consenting participants to schedule an interview time. Interviews were conducted and recorded (with participant consent) via Zoom between 15 September 2021 and 11 November 2022 by either KK or SL from the research team at Monash University. Each interview took approximately 30 min. Interviews were transcribed and participants were provided with the opportunity to review the transcription, but no participants did so.

Questions were semi-structured and designed by the researchers to explore views on the impacts and implementation of the Bluehats program. Questions were broadly phrased to ask for their thoughts about the impact on the industry, what helps the program work well, what gets in the way of the program working well, and how it could be improved. Questions were

asked in an iterative process across the interviews, exploring topics raised by early participants with subsequent participants. Staff and stakeholder participants did not receive reimbursement.

As two researchers undertook the interviews, the reflective processes were undertaken jointly. After each interview, the researcher discussed the interview with the second researcher (and vice versa). Together, they explored their responses to the participant and interview content, their role in influencing the interview, and their thoughts about how to conduct the following interview. The two interviewers reviewed the worker survey data together, discussing personal responses to the content and the influence of personal beliefs and biases on the meaning of the text responses. Their positionality as female academics interviewing mostly male construction workers was explored for its impact on the interviews and on the development of the themes and meaning making.

2.2 | Participants

Thirty-three workers consented to participate, of which 20 (87.9%) completed the online survey. Of these, five workers expressed an interest in an interview; however, only one participated, as four were ineligible (they were trained Bluehats (2) or had no interaction with Bluehats (2)). Of the 20 workers, 19 were male, with a mean age of 42.7 years (range: 23–60 years). Work role demographics (20 survey, one interview and survey) are shown in Table 1.

Tabulated in-depth demographics are not shown for the 13 representatives or staff, given the potential for this information to inadvertently identify individuals within this smaller group of participants. Industry representatives were from large building businesses, industry superannuation and insurance companies (8), and Incolink staff providing counselling and/or training sessions to the industry (5).

TABLE 1 | Worker participant demographics.

Demographic	<i>N</i> = 20
Years in industry (years, %)	
20+	9
11–19	5
6–10	5
0–5	2
Occupation (<i>n</i> , %)	
Manager	9
Professional	4
Technician or trades worker	4
Apprentice technician or trades worker	1
Clerical or administrative workers	1
Machinery operator or driver	1
Health and safety representative	1

2.3 | Data Analysis

KK undertook Reflexive Thematic Analysis using an inductive orientation to develop themes across the interviews and survey data, pooling all responses [14]. After reading all the transcripts of the interviews and all the survey responses, they generated codes representing salient points made by each participant. KK then developed overarching themes and subthemes that described the codes. They then imported all the data into NVivo [15] and coded interview and survey data to the themes and subthemes, reviewing and refining the themes throughout this process. Each theme was then defined and named to reflect the content within. KK kept a reflective journal throughout the analysis to record the process by which themes were developed. Exemplar quotes for each theme and subtheme were located, with particular attention paid to representing workers and stakeholders. KK and SL then discussed the final themes and exemplar quotes in an extension of the joint reflective process undertaken during the interviews.

3 | Results

Overall, all three participant groups were generally optimistic about the impact of the Bluehats program for the industry, and its potential for future positive impact. As shown in Table 2, they also spoke about three main factors that they felt influenced the impact of the Bluehats program: the Bluehats themselves, the scope of the Bluehats program, and industry-related factors. Analysis indicated that the responses of industry representatives and Incolink staff were relatively similar. Still, there was a significant risk that participants could be inadvertently identified via personal idioms, given the small sample size (particularly for staff). The potential loss of nuance in combining the

TABLE 2 | Theme map of factors influencing program success.

1st level themes	2nd level themes
The Bluehats	Trustworthy and non-judgemental listening
	Relatable role models
	The correct people
	Work roles
Scope of the Bluehats program	Broader social context
	Awareness and trust of the program
	Reach of the program
Industry-related factors	Crisis response vs. early intervention
	Negative attitudes towards mental health
	Competing demands of productivity and money
	Education for increased industry commitment
	Shifting workforce

quotes from these groups was considered against the risk of participant identification if the groups were quoted separately. The potential for identification was deemed too high, so the quotes from these two groups were combined, collectively referred to as ‘stakeholders’.

3.1 | The Bluehats

The Bluehats themselves were described as key to the program’s impacts. Participants stated that Bluehats who were passionate, relatable, and skilled at building relationships were most likely to impact the industry positively. The following factors were seen as key to making a Bluehat successful in their ability to support their colleagues.

Against a backdrop of mental health stigma in the industry, **trust and non-judgemental listening** were seen as crucial. Trust was built through connection with workers through daily casual interactions where the Bluehat took time to get to know each worker:

They’ll build a relationship around the site and engage with other workers through casual conversation and probably find ways to talk about mental health and how people are going with their mental health through more casual conversations.

(stakeholder/staff)

Trust was then further earned through a track record of confidentiality and non-judgemental listening:

■ Being able to freely converse without judgement

(worker)

Bluehats earned respect as **relatable role models** when there was a sense of shared experiences as colleagues between Bluehats and other workers. This shared experience meant that workers felt the Bluehats would understand them. Sometimes Bluehats deepened the connection by sharing some of their own experiences with personal struggles:

The person under the Bluehat has to already be a trusting personality that can relate to the people talking to them

(worker)

Have some people that have lived the experience and are willing to go and talk to people about – not the suicide thoughts, but it could be similar to my journey and stuff like that. So, getting real-life people that have been through different scenarios

(stakeholder/staff)

In contrast, a few participants were concerned that life experience might get in the way of providing support in that sometimes Bluehats might centre their own experience in conversations, or that this may create bias:

Sometimes, I think they're actually the worst person because you've got to hold space for people. You can't tell your own story, and you can't project your own – it's unconscious bias or your own experience of the world

(stakeholder/staff)

Given the importance of these nuanced personal qualities, many participants discussed the importance of **selecting and training the 'correct people'** with the appropriate pre-existing personal attributes and skills. Participants commented that these qualities can be hard to teach and that Bluehats were often those who already acted as informal supporters to colleagues—the ones people already trusted for help and support. For many, becoming a Bluehat formalised an informal role. There was some concern that not all Bluehats were suited to the role.

My question is always going to be: is someone wearing a blue hat, just by virtue of the fact that they've got a blue hat, going to be the go-to person or the right person or the most equipped person to be dealing with a myriad of issues that we see on site?

(stakeholder/staff)

Building on the idea of the 'right person', participants also commented on how **work roles** sometimes helped and sometimes hindered Bluehats in their roles. Participants noted that many Bluehats held health and safety or union roles and that, in many ways, this was ideal – given their position of trust and commitment to work wellbeing. People in these roles were sometimes seen as ideal candidates for a Bluehats role:

I think they're seen as people who are pretty courageous and who somebody can go to for help

(stakeholder/staff)

However, one of the workers raised concerns about managers or health and safety representatives acting as Bluehats – with the potential for role confusion, blurred boundaries, or misuse of power in the workplace. Workers spoke about how they were sometimes sceptical of these Bluehats' motivations and agendas, and whether they were acting in their own interest.

I think sometimes I felt like the person I'm speaking to is – my welfare isn't their priority, and they're looking for... an opportunity to grab what you're saying, whether it's a physical safety, wellbeing, whatever – this is not all the time – but pick on what you're saying, or to see if what you're saying can be politicised or be mobilised

(worker)

There were also some concerns that perhaps the Bluehats program was not seen as relatable and trusted by some people. In particular, there were concerns raised that perhaps work needed to be done to ensure that the program appealed to people from

different language and cultural backgrounds—noting that some workers also experienced language barriers.

Well, I think straight away, they need to – they actually need to appeal to people from different backgrounds. That's number one, right

(stakeholder/staff)

Suggestions to address this concern included encouraging the recruitment and training of Bluehats from different cultural backgrounds and providing awareness-raising materials in various languages.

There's basically people from around the world, and probably particularly they're – those cultures I mentioned maybe – probably need some assistance in that area to encourage contractors to train their people as Bluehats

(stakeholder/staff)

So maybe it's just a case of development of posters would be a good start, the CaLD posters, different languages, 'Bluehats program, this is what it is. We encourage you to do this'

(stakeholder/staff)

Participants appreciated the personal challenges that Bluehats might experience because of their role. They reflected the heaviness that could come with the responsibility—particularly for those 'right people'—those who were already acting in informal helpers at work, who naturally built connection and trust through daily interactions, and were listening to workers' problems regularly. They were concerned about the impact on individual Bluehats and saw a critical need to support them through further training from Incolink and debriefing with Incolink and peers. Some participants felt that Incolink could be doing more to support Bluehats by providing more skills training and personal support.

You've got to have people supporting the Bluehats as well. So, because if they're dealing with people who are thinking about suicide or, even worse, committing suicide, what's the impact on the Bluehats? (stakeholder/staff)

They need more advanced training

(worker)

Having some kind of ongoing skill session that they could be engaged in would be really good... I think if you could get a bunch of Bluehats together regularly, talking about, 'Hey, what's your experience been out there?', 'What's working? What's not working? What's been difficult?' I think that sort of thing could be really helpful for men in the industry

(stakeholder/staff)

3.2 | Scope of the Bluehats Program

Participants were mindful of the limits of the program to make an impact within the **broader social context** of the program within a male-focussed large industry. They talked about how negative attitudes in the industry towards talking about personal problems or asking for help were symptomatic of a much larger issue outside the industry:

For a little program, it's a big ask because this is society-wide, it's just so much more accentuated in a male-dominated industry (stakeholder/staff)

Participants described little tolerance of mental health concerns in the industry:

Sometimes, you actually can't physically do the job. But with a mental injury, it's probably seen as – you've still got your hands and your legs and you can still get along and do the work, so just get along, get on with it and do it
(stakeholder/staff)

Given the prevalence of negative attitudes towards mental health in the industry and society generally, continued efforts to **raise awareness about mental health and trust in the Bluehats program** was described as pivotal to its success. Worker participants mentioned that a lack of awareness of the program or not knowing where to find a Bluehat was a barrier to people seeking help and to the impact of the program.

The more presence there is onsite, the more awareness there is [about] what Bluehats means, the more accepting – the more people use the services and talk
(stakeholder/staff)

Regular follow-ups to keep momentum going
(worker)

However, a couple of participants feared that the program had 'lost traction' during the Covid pandemic due to the inability of Incolink to be on work sites during lockdowns and a refocus on activities such as Covid-testing and vaccinations:

COVID's come along and all of a sudden, it's stagnated for the last two years
(stakeholder/staff)

Participants suggested a need to reinvigorate the program with more awareness-raising activities.

I would stick with the basic principles of the initiative, however, a refreshed model [is needed] that shows it hasn't aged, such as continuing advertising and awareness of the program constantly to keep it at the forefront of workers and employers at a site level
(stakeholder/staff)

Participants described how worker trust in Incolink was crucial to its ability to support workers.

I think they're a trusted organisation, and I think they know they have adequate tools, resources and skilled people to help people. So that definitely goes a long way, supported by other stakeholders as well, and big businesses and companies and that. So their reputation and their trust factor is high
(stakeholder/staff)

They explained how different aspects of Incolink's program can work together to support worker wellbeing. For example, a call to make an insurance claim following a job loss or physical injury can translate into a referral for counselling. However, there were concerns that some workers were not fully aware of the services available to them, and that greater awareness of these services could benefit workers. For example:

Knowing that mental health is covered under your illness protection and you can take time off to get yourself better
(worker)

Services for their families... if someone has Incolink's number and they put it up in their house, their partner could be going to counselling
(stakeholder/staff)

One stakeholder/staff participant spoke about Incolink's role in facilitating industry stakeholder conversations about mental health—bringing together employers, unions, and government to think about how to address more significant systemic issues (such as long working hours) that influence worker health and mental health.

When asked for suggestions on program improvement, participants' suggestions reflected the strengths they had described in the program and ways these could be extended to reach and support more workers. They discussed the need for improved program reach, prevention, and early intervention, as well as ideas for changes to the training. Most of these comments came from stakeholders or staff.

Participants discussed the need to expand the program's reach beyond city areas, to smaller builders, and among subcontractors.

I've been in Vic[toria] for three years on various sites, and I've not yet met [a Bluehat]
(worker)

They're predominantly in the city and just the outskirts. I haven't seen them in suburbs. I don't know why... it's not a compulsory thing. So, the smaller builders, you won't have it. They won't be on their sites
(stakeholder/staff)

Some suggested this problem could be overcome by mandating the presence of a Bluehat on every site. Though, as described earlier, participants also acknowledged tensions between productivity and Bluehats' activities, particularly for smaller builders, and also concerns around not getting the 'right people' if some are forced to become Bluehats.

If you've got a company of 10 people, [you] might not have the time or space for it
(stakeholder/staff)

Suggestions were made to **focus on prevention and early intervention**.

This is probably the one probably downside of Bluehats. Suicide prevention is – can be at the point of where it's gone too far already, and I'd like to see more focus on the upstream
(stakeholder/staff)

Not everyone's thinking about suicide, but if you can get to them before those stages of trying to fix some of their problems, they might not even get towards that stage
(stakeholder/staff)

Participants suggested a need for a focus on other factors that can compound to increase suicide risk, including alcohol and substance use, financial pressures, poor sleep, and stress.

If you put [factors like financial pressures, poor sleep, alcohol and substance use] in isolation, they're probably not going to make you go down a certain direction. But when you start getting out of balance and there's three, four, five of them contributing together, that's when challenges can happen
(stakeholder/staff)

Participants had ideas for how the training program itself could be improved. For the GAS (brief training provided to all workers), many of the suggestions were ideas to reduce the burden on the worksite, including providing multiple training sessions over days or even weeks—rather than all on 1 day; keeping a register of who has attended so workers are not attending multiple times across different work sites; reducing the length of the training; not forcing all workers to complete the training.

Maybe it doesn't need to be an hour, and we need to engage more people through a 15-min program because it's better for us to hit 200 people with 15 min than three people with an hour
(stakeholder/staff)

Other suggestions were about how to increase the impact of the training, including sharing of stories from people with lived experience for greater impact; and more interactive, less classroom-like experiences. Suggestions for the training for

Bluehats included combining the GAS and Bluehats training into one session and providing more opportunities to practice learnt skills.

It's like learning to kick a football. If you've never done that before or something like that, you've got to drop the ball 100 times on your foot before you get some idea of what you're supposed to be doing
(stakeholder/staff)

3.3 | Industry-Related Factors

Aside from the need for the 'right person' in the Bluehat role who is supported by Incolink, participants spoke more broadly about a range of industry-related factors that they perceived to influence the impact of the Bluehats program. They spoke about how these industry-related factors could impede an individual Bluehat's ability to have an impact within a work site, or even prevent the implementation of the program at a site.

Participants spoke about how **negative attitudes towards mental health in the industry** translated into a lack of prioritisation of the Bluehats program.

Some noted that sometimes there is not a genuine effort from employers to address poor mental health and a lack of knowledge about, or perhaps concern for, worker mental health.

A lot of companies participate in Bluehats, Incolink, to 'tick a box' and appear as though they're supportive of mental health but don't actually change work practices or culture. It's, unfortunately lip service in some places
(worker)

Don't work them into the ground doing 60+ hour weeks and then wonder why there's a mental health crisis
(worker)

Participants spoke about how stigma against poor mental health acted as a barrier to people accessing support from Bluehats. Many workers mentioned a fear of judgement or embarrassment. So even if a relatable and trustworthy Bluehat was present on a work site, workers might still not talk to them for fear of 'other people finding out about their problems' or 'losing their job due to their problems' (worker).

When you see the guy wearing the blue hat. It's just that stigma of having workers actually going and talking. That seems to be the problem. Everyone knows what that guy does in the corner, but it's actually getting there to him. That's the real problem
(stakeholder/staff)

It was also noted that Bluehats could feel this stigma, which could reduce their motivation, and this might stop them from operating as a Bluehat:

They're immersed in this culture of stigma. And so there might be times when a Bluehat doesn't want to wear his blue hat because he doesn't want people to know he's a Bluehat. Or he doesn't mind people knowing he's a Bluehat, but he doesn't want to advertise is overtly

(stakeholder/staff)

Participants reported that there had been significant improvements in attitudes towards mental health in recent years, particularly for younger workers, and since the COVID-19 pandemic. Although participants feared that the pandemic had caused a loss of momentum for the program (as described earlier), it seems that change occurred within the pandemic for workers in relation to some of the targets of the program, namely improving attitudes to, and awareness of, mental health.

I think it's changing a lot more these days. You know younger folk don't have problems with crying or telling their mates they love them or talking about their problem... but there's still a lot of people out there that think there's shame behind it and will hide from it, and don't want to talk to people about it

(stakeholder/staff)

We're beginning to see it break through, and I think COVID had a pretty big impact on that as well; the fact that everybody has kind of gone, "Oh my God, I am so stressed about so many things, I need to talk to someone"

(stakeholder/staff)

Despite these positive changes in the industry in relation to mental health attitudes and awareness, participants spoke about the **competing demands of productivity and money**. Stakeholder and staff participants spoke about the pressures on employers to complete jobs on time.

Got to get a job done, get it done by a certain time. If [they] don't get it done by a certain time, then there's penalties in place

(stakeholder/staff)

They've been under a lot of pressure at the moment... I think it's hard on them as well... they've got their own businesses, family, mortgages...

(stakeholder/staff)

Participants spoke about the tension between lost productivity due to worker mental health challenges and the lost productivity due to the time needed for the Bluehats program—with productivity often prioritised.

They can't afford to have people off [for Bluehats activities], but at the same time we can't afford to

have – losing your staff because you couldn't give someone 15 min to go out there and help someone. Someone commits suicide, or something happens to their mental health, and there's – that then affects everyone else around them

(stakeholder/staff)

Bluehats can be looked at as both an asset and as a liability because they stop people from being productive; they engage in taking people aside and talking to them, and there's a lot of pressure in the industry to keep going, keep working, keep producing, time, time, time...

(stakeholder/staff)

Worker participants also spoke about competing pressures from demanding work schedules which could 'be seen as not working if you stop and talk to someone' (worker).

Participants noted these tensions were particularly pertinent for smaller builders who relied on small numbers of staff to complete work jobs and might not have the same dedicated resources for worker health and safety.

[Large businesses] have got their safety managers and their health and safety management systems, and they're a lot more advanced and sophisticated than your Joe Blow builder down the road that's just a family business or doesn't employ that many people

(stakeholder/staff)

Conversely, many participants described workplaces that supported mental health and the Bluehats program, thus enabling the program to have more positive impacts. In some instances, as workplaces increased their own wellbeing activities and initiatives, the need for the program lessened.

I think four years ago, we probably relied on Bluehats to tick our box, but I think now most companies are – I won't just say 'larger companies', companies that are proactive wouldn't rely solely on Bluehats to be ticking their box now. They'd have other mechanisms in place to help it. But it still has a place in our industry as well

(stakeholder/staff)

Educating employers was raised by many to **increase the industry's commitment** to the mental health of workers and the Bluehats program. Participants spoke highly of the program and wished for it to be more widely implemented. There was a sense from participants that if all employers and managers could see the benefits, as they saw them, then they would implement it, and more workers would benefit:

Showing actually how many people have come to the service or whatever, or if there's any way to evaluate

what that interaction – how that interaction equated to higher productivity or savings by them not being off work, or something like that, I think would really hit the mark for employers

(stakeholder/staff)

Workers also expressed a desire for people in management roles to engage in training (general mental health or Bluehats training) for their potential to bring about changes to working conditions and culture:

Someone that identifies themselves more as a unionist, they're pretty well across health and safety, even in the wellbeing sense, I think... it's just a shame that it's usually these men and women that do the Bluehats training rather than management. They're the ones that need that training (worker)

Influence senior managers to provide healthier balanced work environments for their workers

(worker)

The **shifting workforce** was described as a critical factor that challenged the impact of Bluehats. It is common for workers to move between multiple worksites within the industry, such that there are often many different workers at worksites each day. Employers talked about how difficult it was to create positive culture change around mental health and trust with individual workers within a shifting workforce. As mentioned earlier, the 'right' people to be Bluehats were those that were naturally skilled in building trust and connection through daily interaction. However, this connection was reportedly hard to build with a shifting workforce.

We have 300 people. I can influence them 300 people because they work for us every day. When you go out onto a construction site, 90 percent of the people are transient. They're here for a week. They're here for a month. They're here for three months. And then off they go to the next. So as you start building that relationship and the trust, their job's finished. They're off

(stakeholder/staff)

4 | Discussion

This study reports on interviews and surveys conducted with construction industry stakeholders, industry workers, and service delivery staff (Incolink) to understand more about the impact of the Bluehats suicide prevention program and the factors influencing its impact. Participants described the positive impacts of Bluehats and the critical value of the Bluehats themselves but were also mindful of the limited potential for impacts on a society-wide issue within an industry that is sometimes unsupportive of mental health. Participants noted a loss of momentum for the program over the COVID-19 pandemic, but also corresponding increases in awareness and acceptability of mental health concerns due to the pressure

on individuals from the pandemic. This phenomenon has also been noted as a potentially positive impact of the pandemic in other countries [16]. However, our participants highlighted the need for increased awareness-raising activities and the presence of Incolink in the industry to reinvigorate the Bluehats program. Participants spoke about a need to improve the program's reach, particularly to small businesses, rural locations, and people of diverse languages and cultures. Participants also talked about the possibility of increasing the program's scope to include prevention and early intervention—to focus on other factors that can compound to create suicide risk, including alcohol and substance use, financial pressures, poor sleep, and stress.

Our study draws attention to the context of the Bluehats program. Our previous interview study with Bluehats [7] indicated that although many individual Bluehats had the capability and motivation to support work colleagues, they sometimes lacked the opportunity. This supportive working environment allowed time and space for Bluehat conversation. Our findings further highlight the role of the environment of the workplace and the larger context of industry and society. Our participants described the most effective Bluehats as those who build trust and connection through daily contact with workers, but also how this can be thwarted by social and systemic issues. For example, stigma remains a pervasive challenge in male-dominated workplaces, contributing to reluctance to seek help and engage with mental health interventions [12]. Our findings align with recommendations for systems-based suicide prevention approaches that implement interventions tailored to the local community context and aimed at different system elements for maximum impact [17, 18]. Our work also extends the research conducted on the MATES in Construction program (operating in different states in Australia), highlighting the need for a cross-sectoral collaborative approach to suicide prevention in the construction industry [13]. Attending to all these issues is often beyond the realm of feasibility for most individual programs. System-based suicide prevention programs require considerable resourcing of time and money, which means that they are sometimes not delivered as intended despite best efforts [7].

Employers and service providers have the unenviable task of having to choose which suicide prevention intervention strategies to undertake within the constraints of time and money. Unfortunately, with few evaluations of workplace suicide prevention programs, there is little guiding evidence for service providers to help them with these decisions [3, 12]. In many instances of suicide prevention, decisions to implement programs are often not based on evidence. However, they are instead based on policy priorities, funding opportunities, innovation potential, or the ethos of care [8]. The contribution of the community and people with lived experience in decision-making regarding suicide prevention has also been increasingly recognised for its potential to increase program impacts [19]. Our study has identified several strategies that could potentially improve the Bluehats program.

Our study has some limitations that should be considered when interpreting our findings. Self-selection bias may have limited our study [20]. Our participants may have held either strongly

favourable or unfavourable views of the program, or may have over- or underrepresented some groups of people. All workers, staff, and stakeholders were invited to participate, and we did not undertake any purposive sampling. Despite these efforts, the sample was relatively small. Consistent with Reflexive Thematic Analysis, we did not aim to generate representative findings. Instead, we have undertaken steps to achieve rigour in representing the views of our participants [14]. Our participants provided insights and suggestions for program improvements for Bluehats that should be considered within their context within the industry. Future evaluation of any improvements based on these recommendations could establish the utility of the improvements for program success.

Future Bluehats' program improvements would benefit from using an implementation science framework to help systematically implement and evaluate program changes to identify key drivers of success. Implementing frameworks, such as the Consolidated Framework for Implementation Research [21], in future research could help capture strategies to drive success for the Victorian construction industry [7].

5 | Conclusion

Our study provides much-needed learnings for the implementation of workplace suicide prevention programs in the construction industry and beyond. Participants were mostly confident that the Bluehats program could make a positive contribution to suicide prevention and highlighted opportunities to improve its implementation in the unique context of the Victorian construction industry. Participants discussed how the impact of the Bluehats program was influenced by the program itself, its scope, and industry-related factors. Participants also discussed possibilities for expanding the program's reach, providing more education to foster increased industry commitment, and focusing on prevention and early intervention. Incolink will now use our findings to improve the Bluehats program. Using an implementation science framework to evaluate program improvements can help identify effective strategies and contribute to the evidence base for workplace suicide prevention more broadly. Overall, our study highlights the importance of workplace suicide prevention interventions that attend to individual, industry, and systemic factors.

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Ethics Statement

Ethical approval was gained from the Monash University Human Research Ethics Committee (ID: 29386).

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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