The Crane Report

CONSTRUCTION & NEURODIVERSITY - MENTAL HEALTH GUIDANCE

Section-4

ABSTRACT

This section explores the intersection of neurodiversity, mental health, and suicide risk in construction. Our investigation highlights how neurodivergent traits may influence susceptibility to psychological distress and examines the prevalence of unqualified advisors providing mental health guidance. The findings identify systemic vulnerabilities, emphasise the importance of professional standards, and frame the risks posed by insufficient or inappropriate support.

Anthony Hegarty MSc

DSRM Risk & Crisis Management

Section 4 – Construction & Neurodiversity

Looking Inwards

In this section, our investigation turns inward, to the construction industry's evolving efforts to include neurodiverse individuals. While well-intentioned, we ask:

- Are current neurodiverse inclusion policies inadvertently allowing individuals with unmanaged or serious psychiatric conditions into an already high-risk environment?
- Could this be quietly contributing to the suicide issue we are seeking to address?

We grouped these individuals into two broad categories:

- Those who have disclosed a formal diagnosis, and
- Those who either choose not to disclose, perhaps due to fear of stigma or job exclusion; or who have never received a diagnosis.

Not all mental health diagnoses carry the same level of suicidal risk. One study of nearly 4 million people over 11 years found that workers with certain conditions, especially personality disorders, bipolar disorder, schizophrenia, OCD, and substance use disorders, faced **significantly elevated suicide risks**. For example, personality disorders raised suicide risk by more than 7 times, and substance abuse disorders by over 4 times, even after adjusting for other health and lifestyle factors. We look at this study later in this section.

But before we turn to individual conditions and diagnostic challenges, it is important to first ask, who is guiding the industry's mental health response, and whether those voices are clinically qualified or adequately informed.

Where is the Focus?

The construction industry has made real progress in addressing mental health, particularly around stigma, awareness, and peer support. Many firms now promote mental wellbeing initiatives, provide helplines, and offer mental health first aid training.

However, despite these efforts, suicide rates in construction remain disproportionately high. While workplace stressors such as macho culture, long hours, job insecurity, and isolation are often cited, these are not unique to construction. Other industries face similar pressures without the same levels of suicide.

This points to the possibility of deeper, less visible factors at work. One area that remains underexplored is the presence of underlying, and often undiagnosed, psychiatric conditions among those entering or already working within the industry.

Despite a growing body of international data, such as the major nationwide study we reference later in this section, the industry's suicide prevention strategies appear to rarely engage with this clinical dimension in a meaningful or sustained way.

This raises a further concern: are industry leaders, particularly HR and wellbeing teams, sufficiently discerning when choosing external mental health advisors and training providers? Without due diligence around credentials and clinical expertise, it becomes easier for confident marketers and wellbeing entrepreneurs to shape the sector's mental health narrative, potentially pushing cultural campaigns while overlooking serious psychiatric risk.

So, the critical question becomes:

As the industry rightly tackles stigma and promotes wellbeing, has it neglected serious, pre-existing mental illness as a core driver of suicidal risk?

It is important to recognise the difference between mental health promotion and clinical psychiatric conditions:

Mental health initiatives

In the construction industry typically focus on reducing stigma, encouraging open conversations, promoting help-seeking behaviour, and addressing workplace stress. These are vital for culture change and early support.

Clinical mental illness

refers to diagnosable psychiatric disorders such as major depression, bipolar disorder, PTSD, schizophrenia, or personality disorders. These conditions often pre-date employment, may go undiagnosed for years, and require specialist assessment, treatment, and management.

Serious Disorders

Disorders such as bipolar disorder, borderline personality disorder, schizophrenia, and substance use disorders carry a significantly elevated risk of suicide **(up to 90% of those who die by suicide have some underlying mental health condition)**, yet they seem to seldom receive direct attention within industry training, recruitment protocols, or wellbeing strategies.

Even among major construction firms with extensive mental health programming, clinical psychiatric vulnerability often remains outside the scope of standard materials and interventions.

Construction workers face elevated rates of substance misuse, especially alcohol and opioids, with 15% estimated to suffer substance use problems. Opioid misuse alone is linked to a 75% increase in suicide attempts, and men with opioid dependence are twice as likely to die by suicide. (Opioid addiction is explained in Section-6, Construction & Drugs)

Companies like BAM, Balfour Beatty, and Wates are well-invested in mental health awareness campaigns, and have advanced programmes in peer support initiatives, to include external partnerships. But the emphasis appears to remain on stress management, general anxiety, or speaking up; not on the deeper psychiatric vulnerabilities that could pose risks, not only to the individual but to those around them on-site. This may be a result of legal sensitivity, the fear of discrimination claims, or efforts to draw a line so as not to become a quasi-healthcare provider. But it leaves a serious gap in meaningful risk assessment.

Whilst well-being programmes can provide excellent mental health literacy, they seem to rarely incorporate structured training addressing clinical psychiatric disorders, symptom-screening in recruitment, or workplace protocols.

A Widening Gap:

Provider Qualifications and Intervention Quality

The widening gap between real clinical risk and the construction industry's surface-level wellbeing responses has created fertile ground for questionable service providers. As construction companies scramble to appear proactive, some turn to consultants and companies whose credentials may not withstand scrutiny. Marketing polish often replaces clinical credibility, and feel-good campaigns can take priority over evidence-based prevention.

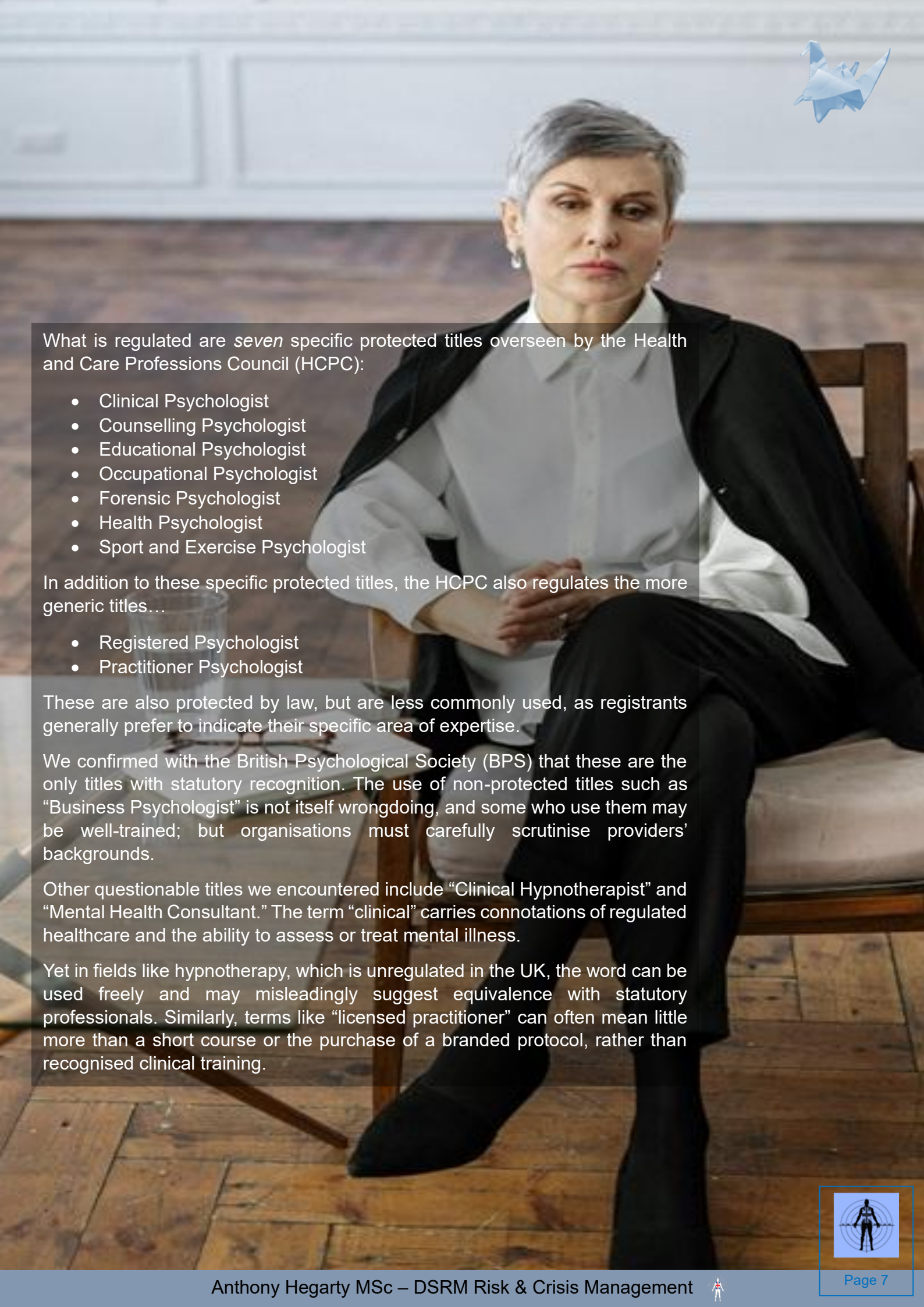
Our investigation looked into the individuals and companies shaping mental health strategies, producing training materials, and influencing how wellbeing is approached on site.

Evaluating the Evaluators

During our inquiry into the mental health response across the construction industry, we assessed a range of companies offering workplace wellbeing services. While several long-standing organisations clearly exist to provide meaningful assistance to distressed workers, we also encountered a wave of opportunistic providers whose presence raises serious concerns.

Some wellbeing providers in the construction sector have no clinical foundation at all. Their leadership teams often consist of marketers, personal trainers, or entrepreneurs with no qualifications in psychology, psychiatry, or social care. Their strength lies not in mental health intervention but in branding, with polished websites and promotional material that project more authority than their credentials justify.

We found individuals presenting themselves as "psychologists" and using unprotected titles such as "Business Psychologist" without clinical registration or statutory authority, often in ways that could appeal to senior HR leaders. In the UK, the title "psychologist" is unregulated, meaning that anyone, with or without relevant qualifications, can establish a consultancy and offer psychological services.



What is regulated are *seven* specific protected titles overseen by the Health and Care Professions Council (HCPC):

- Clinical Psychologist
- Counselling Psychologist
- Educational Psychologist
- Occupational Psychologist
- Forensic Psychologist
- Health Psychologist
- Sport and Exercise Psychologist

In addition to these specific protected titles, the HCPC also regulates the more generic titles…

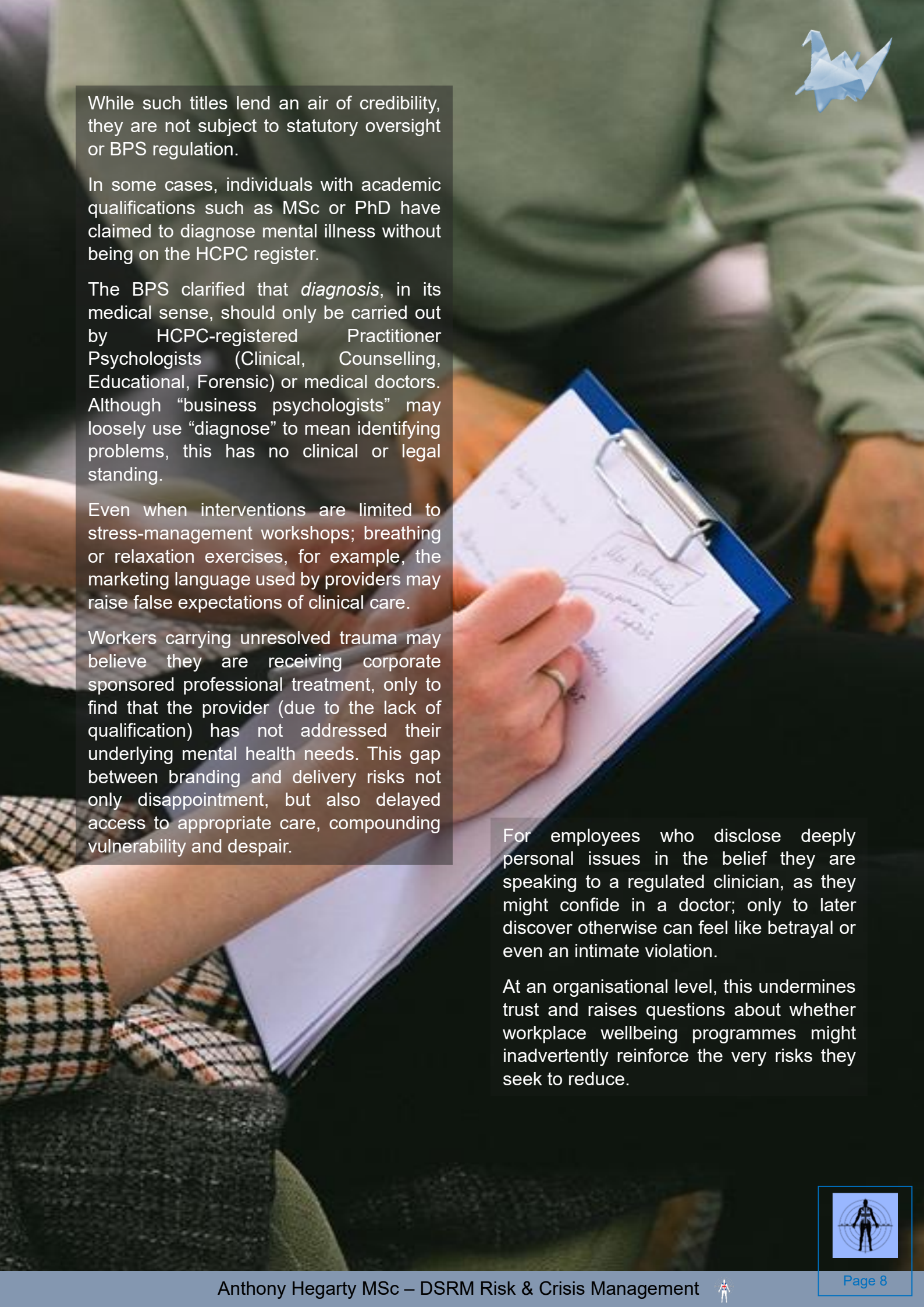
- Registered Psychologist
- Practitioner Psychologist

These are also protected by law, but are less commonly used, as registrants generally prefer to indicate their specific area of expertise.

We confirmed with the British Psychological Society (BPS) that these are the only titles with statutory recognition. The use of non-protected titles such as "Business Psychologist" is not itself wrongdoing, and some who use them may be well-trained; but organisations must carefully scrutinise providers' backgrounds.

Other questionable titles we encountered include "Clinical Hypnotherapist" and "Mental Health Consultant." The term "clinical" carries connotations of regulated healthcare and the ability to assess or treat mental illness.

Yet in fields like hypnotherapy, which is unregulated in the UK, the word can be used freely and may misleadingly suggest equivalence with statutory professionals. Similarly, terms like "licensed practitioner" can often mean little more than a short course or the purchase of a branded protocol, rather than recognised clinical training.



While such titles lend an air of credibility, they are not subject to statutory oversight or BPS regulation.

In some cases, individuals with academic qualifications such as MSc or PhD have claimed to diagnose mental illness without being on the HCPC register.

The BPS clarified that *diagnosis*, in its medical sense, should only be carried out by HCPC-registered Practitioner Psychologists (Clinical, Counselling, Educational, Forensic) or medical doctors. Although "business psychologists" may loosely use "diagnose" to mean identifying problems, this has no clinical or legal standing.

Even when interventions are limited to stress-management workshops; breathing or relaxation exercises, for example, the marketing language used by providers may raise false expectations of clinical care.

Workers carrying unresolved trauma may believe they are receiving corporate sponsored professional treatment, only to find that the provider (due to the lack of qualification) has not addressed their underlying mental health needs. This gap between branding and delivery risks not only disappointment, but also delayed access to appropriate care, compounding vulnerability and despair.

For employees who disclose deeply personal issues in the belief they are speaking to a regulated clinician, as they might confide in a doctor; only to later discover otherwise can feel like betrayal or even an intimate violation.

At an organisational level, this undermines trust and raises questions about whether workplace wellbeing programmes might inadvertently reinforce the very risks they seek to reduce.

Even among formally qualified psychologists, due diligence remains essential. HR leaders should examine how much clinical expertise is genuinely embedded in a provider's operations, how directly qualified staff engage with clients, and whether the interventions address root causes such as stress, burnout, and trauma. Where expertise is overstated or marginal, workplace wellbeing strategies risk becoming another layer of messaging rather than a path to meaningful change.

Referencing Section-3, our media analysis of industry wellbeing videos raises further questions about the influence of provider expertise on intervention quality.

Given the revealing data on qualifications and regulatory oversight, it is reasonable to ask: why were videos that risk appearing suggestive of suicide, rather than preventive, *not flagged*? Why has guidance on the Papageno and Werther effects, well-established phenomena in suicide prevention, been largely absent? Why does the overall intervention strategy so often cast stress and normal occupational pressure as clinical pathology, creating a narrative of dysfunction rather than resilience?

Furthermore, despite the extensive "*consultations*," why does job insecurity continue to feature as a central singular causation factor in construction industry suicides, when the COVID-19 period, an era of significant job disruption, saw no significant difference in suicide numbers, and in fact in some trades the numbers fell (see Section-8).

These questions suggest that the current ecosystem of workplace wellbeing advice may prioritise appearances, or brand positioning over genuinely effective and responsible mental health intervention.

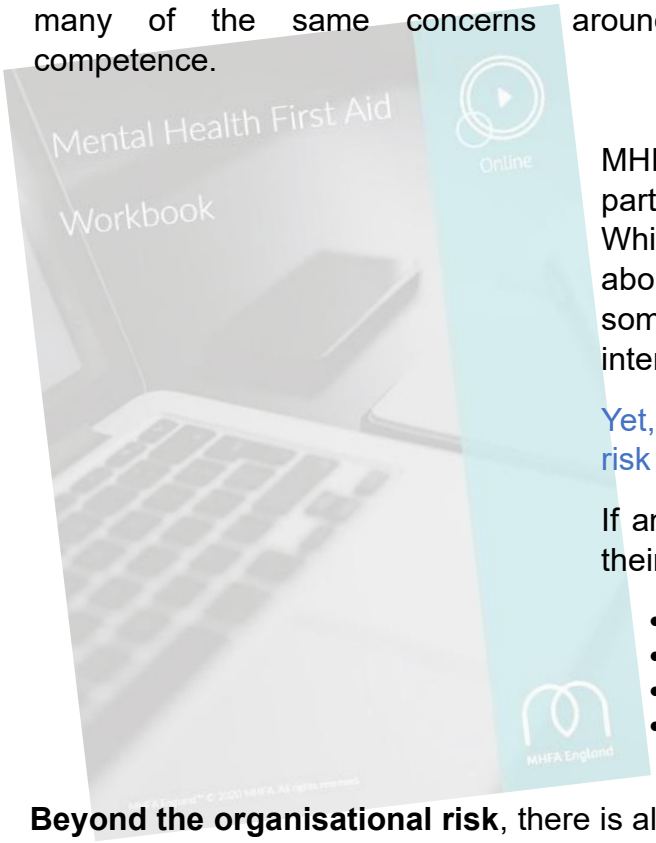
The gaps in provider qualifications are therefore not just an abstract concern; they have tangible consequences for the interventions delivered on site. Poorly conceived wellbeing videos, overly negative messaging, and a pathologised framing of everyday stress all point to a lack of clinical insight. Without the oversight of fully qualified, *regulated medical professionals*, there is a heightened risk that strategies intended to support workers may instead reinforce distress, misinterpret normal pressures as mental illness, and overlook the factors driving stress and suicide risk. In this context, the credentials and regulatory standing of those advising the industry might be directly linked to the effectiveness, and safety, of their interventions.

Providers who assemble advisory teams of verified experts in clinical health, occupational safety, and organisational psychology demonstrate greater professional oversight. However, HR leaders need to look past this and become more curious: verifying qualifications, regulatory status, and the tangible contribution a provider can realistically make…

To build an accurate picture of suicide within the construction industry, we need real stories. That is why we are inviting participation in the Stage 2 Investigation; an anonymous survey open to anyone with insights into lives lost or saved. The findings will be made publicly available to support the development of more effective intervention strategies and targeted policies.

Mental Health First Aiders (MHFA)

It was during this part of our investigation that we turned to the types of services these providers are actively promoting within the construction industry. One of the most prominent offerings is the training and placement of Mental Health First Aiders (MHFA). On the surface, these schemes appear to provide companies with a practical way to address workplace wellbeing. In reality, they also raise many of the same concerns around overstated competence.



MHFA training typically lasts two days and provides participants with basic awareness and signposting skills. While such courses can help normalise conversations about mental health, they cannot realistically qualify someone to take on responsibilities that border on clinical intervention.

Yet, by labelling participants as “first aiders,” do companies risk creating an expectation gap?

If an employee speaks with an MHFA before later taking their own life, difficult questions will follow:

- Was the support appropriate?
- Were signs missed?
- Was the first aider qualified?
- What policies or duty of care were in place?

Beyond the organisational risk, there is also the personal risk to the first-aiders themselves. Well-meaning employees can be left carrying guilt, self-blame, or even trauma when they inevitably encounter situations that exceed their training. Without “clinical” supervision or ongoing support, they are placed in a complex and potentially damaging position.

For these reasons, well-intentioned schemes like MHFA could be seen as another iteration of the same issue identified with inflated qualifications: the packaging of limited training as professional expertise. What is promoted as a safeguard may, in practice, expose both individuals and employers to new vulnerabilities.

Employer Vulnerabilities

We then turned our attention to litigation in France, which we felt could be replicated in the UK…

Case Study: France Télécom (now Orange)

Between 2006 and 2009, France Télécom undertook a major restructuring programme, aiming to cut 22,000 jobs. During this period, at least 19 employees died by suicide, with several explicitly attributing their actions to unbearable work-related stress and management practices. In a landmark 2019 ruling, a French court found the company and several top executives guilty of institutional moral harassment.

Former CEO Didier Lombard received a one-year prison sentence (eight months suspended) and a €15,000 fine. The company itself was fined €75,000 and ordered to pay damages to victims' families. This was the first time a major French corporation had been criminally convicted for such an offence, establishing a precedent that toxic workplace environments can be judged as criminally negligent.

Whilst France Télécom's liability arose from creating a toxic and harassing work environment during mass layoffs, the parallel for UK construction companies lies in the potential risks of internal mental health schemes: even well-intentioned programmes like Mental Health First Aid can create *expectations of care* and expose organisations to legal and ethical responsibility if they are inadequately implemented.

It does appear that UK construction industry policies have been developed "in good faith" and in line with "wider industry practice," presumably supported by legal counsel and insurance. However, where misrepresented qualifications are involved (*perhaps in the training of those First-Aiders*), companies could face litigation if a worker were to die by suicide after interacting with a company-appointed mental health representative.

Our investigation demonstrates the ways in which providers package expertise, and how *well-meaning interventions*, such as MHFA schemes, can create real risks for both employees and employers. The France Télécom case starkly illustrates the consequences when organisations step into new spaces without sufficient oversight. Structural pressures can escalate into both human tragedy, and legal liability.

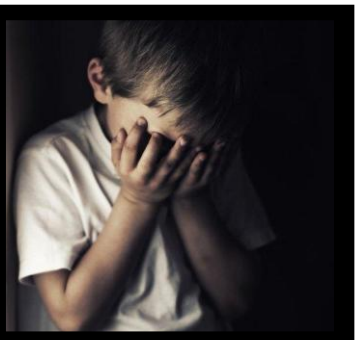
Yet, even with robust policies in place, the picture remains incomplete. Mental health challenges in construction do not emerge solely from the workplace; they are **shaped by a complex interplay of personal history, psychological predispositions, and prior experiences**.

To understand the full spectrum of risk, we needed to look beyond organisational practices to the **individual workers themselves,** which took us to the question;

- Where does the responsibility of the construction industry truly begin (*and end*), when it comes to addressing suicide and mental health?

One striking insight from our data (Section-8) is that **scaffolders face the highest suicide risk** within the industry. But unlike bricklayers or plasterers, their work appears *less* dictated by deadlines, suggesting that the pressures driving the risk are not purely task-related.

Instead, factors such as physically demanding conditions, exposure to height and weather, irregular schedules, and relative isolation, appear to **combine with personal vulnerabilities**, creating a *uniquely* hazardous environment.



And here we remind you of "Jake" (Executive Summary Section), the construction worker who took his own life due to historic criminal acts committed against him when he was a child; the case which brought DSRM into this project.

Should the construction industry have programmes about managing historic cases of child sexual abuse, or even school bullying? As tragic as these issues are, at what point do they become the responsibility of the industry?

This led our investigation to neurodiversity, and the hidden risks on site, exploring how factors present *before employment,* can interact with the demanding conditions of construction work, sometimes with devastating consequences.

Neurodiversity, & Hidden Risks on Site

In construction, particularly at the unskilled or entry level, workers often operate in physically punishing, unpredictable conditions. Early mornings, cold weather, dangerous heights, repetitive labour, poor nutrition, and limited job security.

For some, it may be routine. For others, a strong work ethic passed down through family. But for many, especially those with difficult upbringings, **minimal education, or undiagnosed mental health conditions**, the answer can sometimes be more complex, and may be rooted in a blend of psychological wiring, impulsivity, the pursuit of stimulation, and the quiet hope for structure or belonging.

But to understand the darker side of construction mental health, we needed to consider the mental illnesses that often remain undiagnosed, or emerge later in life, **and how they link to suicide.**

A 2025 study published in **Molecular Psychiatry** used South Korea's universal health insurance data, covering a population of over 50 million people, to investigate **suicide risk across mental disorders**. Drawing from 3.95 million adults tracked over nearly 11 years, it produced **one of the most robust mental health suicide risk analyses in the world**.

The data came from the National Health Insurance Sharing Service (NHISS), which includes hospital, outpatient, pharmaceutical, and health screening records. With 70% of the population participating in one of the world's largest early intervention health programmes, this study offers rare clarity on which mental disorders carry the highest suicide risk. Adjusted hazard ratios (aHRs) were calculated to isolate the risk from each disorder independently.

Mental Disorder	Adjusted Suicide Risk (aHR)	Interpretation
Personality Disorder	7.69	Individuals had ~7.69x greater suicide risk *than those without mental illness.*
Bipolar Disorder	6.05	Suicide risk 6× higher.
Schizophrenia Spectrum Disorders	5.91	Strongly elevated risk, consistent with previous studies.
Obsessive–Compulsive Disorder	4.66	Not typically seen as high-risk, but ranks above substance use here.
Substance Use Disorder	4.53	Consistent with global findings on addiction and impulsivity.
Alcohol Use Disorder	4.43	Aligned closely with substance use disorder.
Post-Traumatic Stress Disorder	3.37	Strong association, especially among younger adults.
Depressive Disorder	2.98	Nearly triple the suicide risk.
Anxiety Disorder	2.66	Moderate increase.
Insomnia	2.62	Often overlooked in suicide prevention efforts.
Eating Disorder	1.95	Fewer cases in this cohort, but still elevated.

Note: These hazard ratios are "adjusted," meaning they represent the independent risk of suicide associated with each disorder, after accounting for other variables.

While the Korean cohort study provides one of the most comprehensive and statistically controlled analyses of suicide risk by diagnosis to date, it was important for our investigation to view these findings within a broader global context. **Patterns of elevated suicide risk** among certain mental disorders, particularly personality disorders, bipolar disorder, and schizophrenia, have been consistently observed in multiple international studies across the UK, Europe, Australia, and North America.

Comparing these international data points not only reinforced the Korean study's findings, but also highlighted the universality of certain vulnerabilities, regardless of healthcare system or culture.

International Comparisons

Multiple global studies affirm the same hierarchy of suicide risk across mental health conditions, particularly in high-income countries:

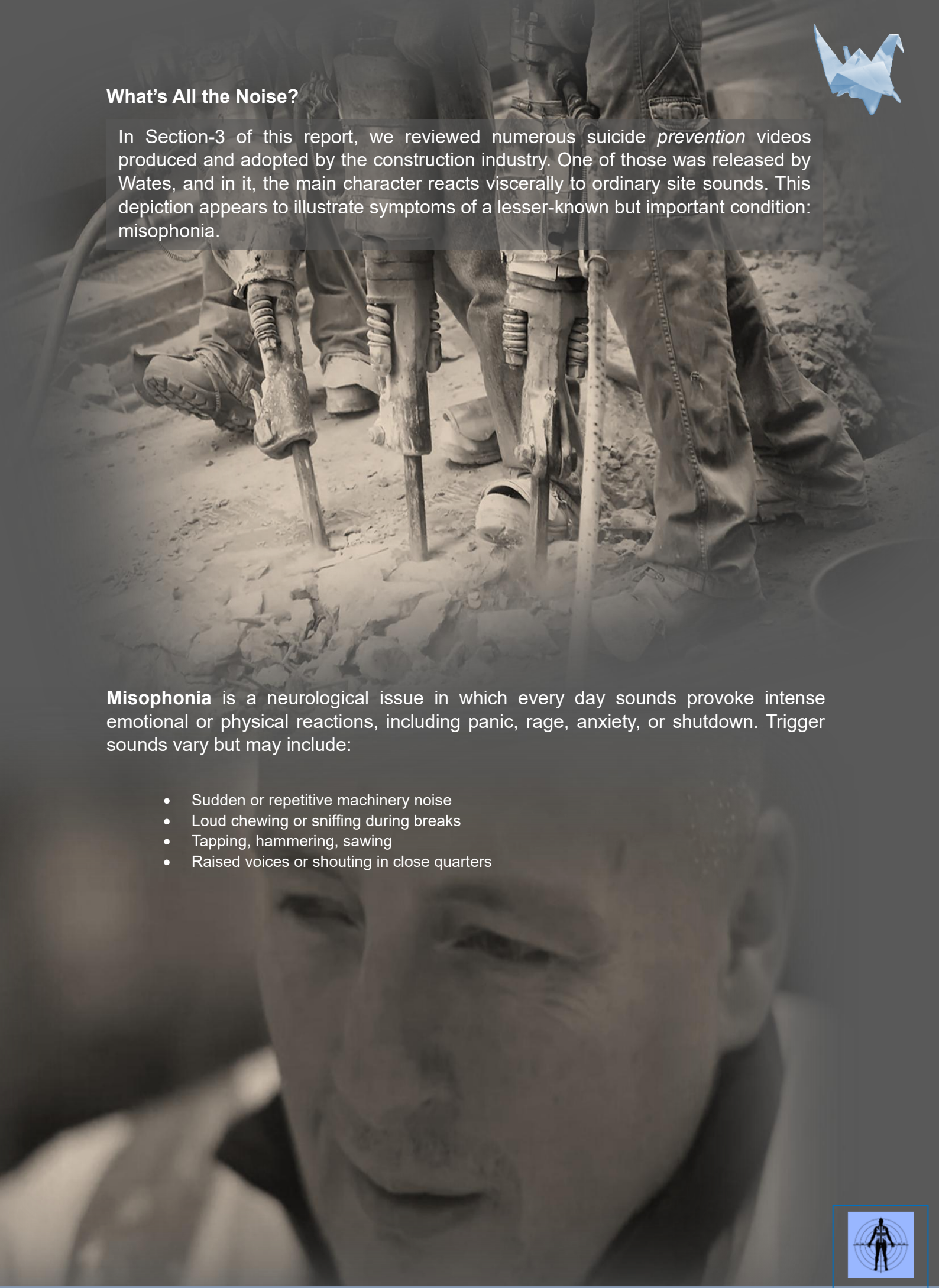
Disorder	Korean aHR	Global Suicide Risk Estimate (Approx.)	
Personality Disorder	7.69×	Up to 45× risk; ~10% mortality in borderline PD (BPD).	Harris & Barraclough, 1997; Paris, 2002
Bipolar Disorder	6.05×	11–12× suicide risk; 34% attempt rate.	Nordentoft et al., 2011; Pompili et al., 2013
Schizophrenia	5.91×	10–13% lifetime suicide risk globally; 15–20× increased risk.	Palmer et al., 2005; Chesney et al., 2014
Depression	2.98×	Around 8–9× risk in some Western studies.	Hawton et al., 2013; Cavanagh et al., 2003
Substance Use	4.53×	Typically, 6–15× depending on substance and setting.	Wilcox et al., 2004; Darke et al., 2010
OCD/PTSD/Anxiety	2.5–4.5×	Often under-recognized, but elevated in both Korea and globally.	Bernert et al., 2014; Angelakis et al., 2015

These international findings come from meta-reviews across North America, Europe, and Australia, showing broadly consistent patterns in how certain disorders dramatically elevate suicide risk, especially borderline personality disorder, bipolar disorder, and schizophrenia.

"Internationally, borderline personality disorder shows **the highest suicide risk**, about 45 times increased, with around 10% mortality, surpassing even the Korean cohort's 7.69× aHR, which accounts for confounders. Bipolar disorder also consistently poses an 11–12× higher risk, with a third of individuals making at least one suicide attempt. Schizophrenia, depression, and other disorders carry elevated, but comparatively lower, risks, aligning with the study's aHRs."

What's All the Noise?

In Section-3 of this report, we reviewed numerous suicide *prevention* videos produced and adopted by the construction industry. One of those was released by Wates, and in it, the main character reacts viscerally to ordinary site sounds. This depiction appears to illustrate symptoms of a lesser-known but important condition: misophonia.



Misophonia is a neurological issue in which every day sounds provoke intense emotional or physical reactions, including panic, rage, anxiety, or shutdown. Trigger sounds vary but may include:

- Sudden or repetitive machinery noise
- Loud chewing or sniffing during breaks
- Tapping, hammering, sawing
- Raised voices or shouting in close quarters

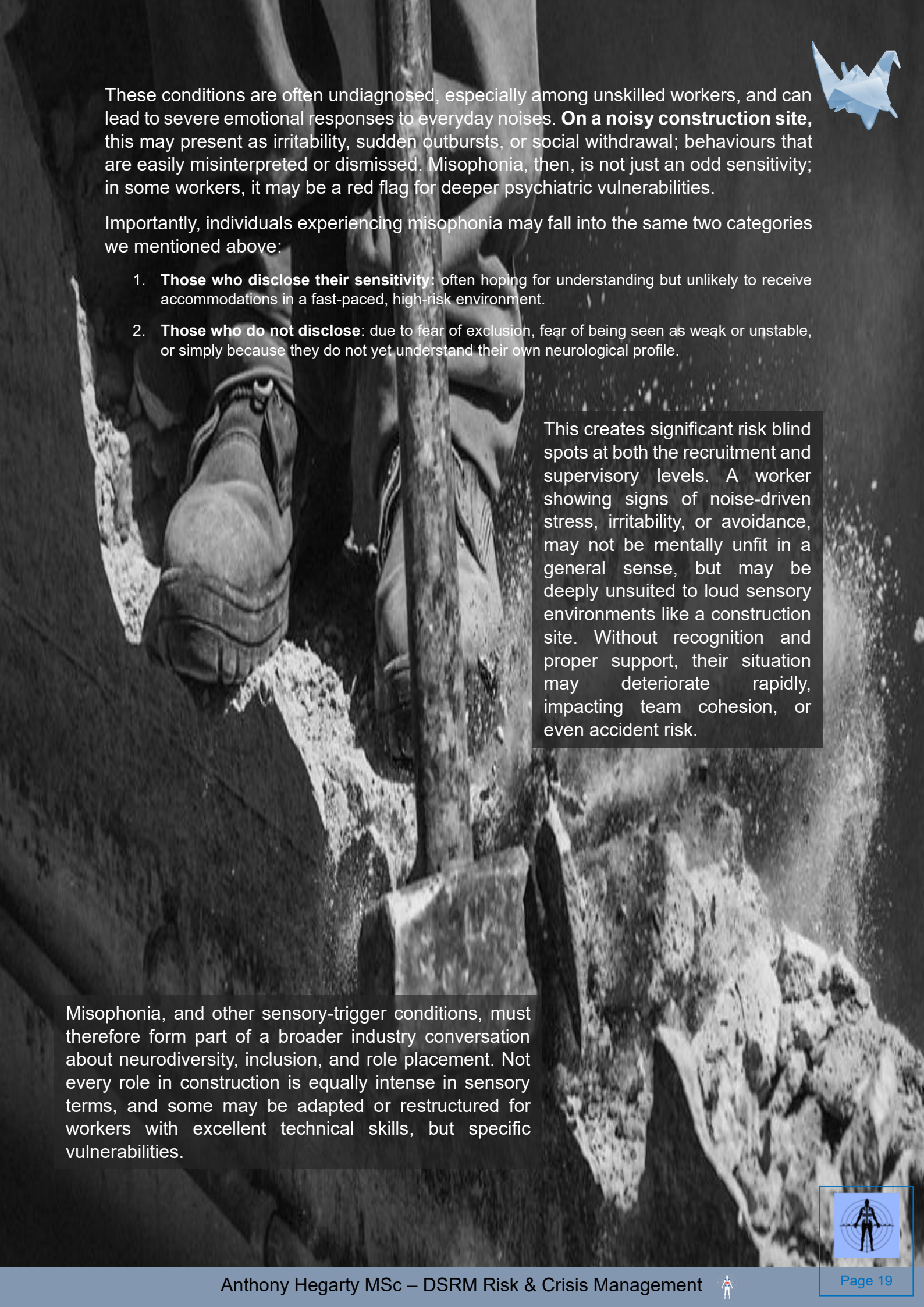
Despite the serious potential outcomes of this condition, particularly in the case of construction sites, misophonia is not a condition currently recognised by the DSM5 (Diagnostical Statistical Manual 5), the leading authority on mental health conditions published by the American Psychological Association, nor is it included within the International Classification of Diseases (ICD).

This might be because misophonia lacks clear diagnostic criteria and is seen as a neurological processing issue, as oppose to a psychological condition.

The Wates video presents this condition rather well, but it would be difficult to state that the issue was caused by the main character's job.

Indeed, what actually causes the disorder is not currently well understood.

However, it is commonly found in individuals with high-risk mental illnesses such as OCD, anxiety disorders, depression, and borderline personality disorder, all of which feature prominently in both the Korean and international suicide risk data.



These conditions are often undiagnosed, especially among unskilled workers, and can lead to severe emotional responses to everyday noises. **On a noisy construction site,** this may present as irritability, sudden outbursts, or social withdrawal; behaviours that are easily misinterpreted or dismissed. Misophonia, then, is not just an odd sensitivity; in some workers, it may be a red flag for deeper psychiatric vulnerabilities.

Importantly, individuals experiencing misophonia may fall into the same two categories we mentioned above:

1. **Those who disclose their sensitivity:** often hoping for understanding but unlikely to receive accommodations in a fast-paced, high-risk environment.
2. **Those who do not disclose**: due to fear of exclusion, fear of being seen as weak or unstable, or simply because they do not yet understand their own neurological profile.

This creates significant risk blind spots at both the recruitment and supervisory levels. A worker showing signs of noise-driven stress, irritability, or avoidance, may not be mentally unfit in a general sense, but may be deeply unsuited to loud sensory environments like a construction site. Without recognition and proper support, their situation may deteriorate rapidly, impacting team cohesion, or even accident risk.

Misophonia, and other sensory-trigger conditions, must therefore form part of a broader industry conversation about neurodiversity, inclusion, and role placement. Not every role in construction is equally intense in sensory terms, and some may be adapted or restructured for workers with excellent technical skills, but specific vulnerabilities.

Schizophrenia, Suicide Risk & the Prison Pipeline

- Suicide risk among people with schizophrenia is:
  - Nearly 6× higher (aHR 5.91) in the Korean national study
  - 15–20× higher in international research
  - With a 10–13% lifetime suicide rate
- Schizophrenia often emerges in men from their early to mid-twenties, ages which might overlap with construction recruitment demographics.
- The condition tends to emerge in women from their late-twenties to early thirties. Women can experience a second onset which could be linked to their menopausal stage.
- The condition is also strongly linked to early marijuana use, further explored in this report's Section-6, Construction & Drugs.
- Individuals with schizophrenia are significantly overrepresented in UK prison populations, often due to the criminalisation of untreated symptoms such as paranoia, delusions, aggression, or erratic behaviour.
- As the construction industry recruits from prison populations to address labour shortages, there is a heightened need for robust mental health screening and support mechanisms, especially on high-risk, high-stress sites (See Section-5, Recruitment: The Prison Estate).

Schizophrenia

Schizophrenia is one of the most serious psychiatric conditions linked to suicide. The Korean study reported an adjusted suicide risk nearly 6 times higher (aHR 5.91) than in the general population.

International studies have estimated the suicide risk in schizophrenia to be between 15–20 times higher, with a 10–13% lifetime suicide mortality rate, meaning around 1 in 10 individuals with schizophrenia will ultimately die by suicide. While misophonia is not a recognised feature of schizophrenia, the early stages of the illness (*schizophrenia*) often involve heightened sensory sensitivity, including distress around sound.

This is particularly relevant when recruiting from within the UK prison estate, as explored in the next, Section-5 (The Prison Estate), of this report. Multiple studies have shown that individuals with schizophrenia are significantly overrepresented in prison populations, often due to the criminalisation of untreated or poorly managed symptoms such as paranoia, impulsivity, or erratic behaviour.

We return to schizophrenia in greater detail later in this report, in Section-6, Construction & Drugs, cannabis use and drug-related mental illness, due to its well-established link with early marijuana use, particularly in adolescence.

What motivates an unskilled worker to enter the construction industry?

Alongside this, we must also consider the motivations of **unskilled workers** (the largest suicide cohort, *in raw data terms*) who are drawn to the construction sector.

What compels someone with no formal training or trade, to rise at 5:30a.m. on a cold, dark, January morning for a job that is physically punishing, inconsistent, and often poorly paid, when other unskilled options exist?

Understanding these drivers is critical if we are to accurately assess the psychological landscape of the modern construction workforce.

What compels someone with no formal training or trade, to rise at 5:30a.m. on a cold, dark, January morning for a job that is physically punishing, inconsistent, and often poorly paid, when other unskilled options exist?

To build an accurate picture of suicide within the construction industry, we need real stories. That is why we are inviting participation in the Stage 2 Investigation; an anonymous survey open to anyone with insights into lives lost or saved. The findings will be made publicly available to support the development of more effective intervention strategies and targeted policies.

For many neurodiverse individuals, particularly those diagnosed with ADHD or autism spectrum conditions, construction may feel less like a job choice and more like a natural progression. In childhood, structured building activities, such as Lego, Meccano, or digital design games like Minecraft, are commonly used by therapists and educators to foster focus, improve executive functioning, and channel excess energy or repetitive behaviours into constructive outcomes.

These activities reward visual thinking, problem-solving, and tactile engagement; traits often pronounced in neurodivergent children.

Not all, however, arrive at construction by way of diagnosis or structured therapy. Many individuals with undiagnosed ADHD never encountered Lego-based interventions or clinical support, yet they too seem often drawn to building work.

The reasons lie in the core traits of ADHD itself: a preference for active, hands-on tasks; the need for immediate feedback and visible progress; and the relief of working in an environment that rewards practical skill over academic conformity.

For these individuals, construction provides a form of belonging and achievement that was often absent in traditional educational or occupational pathways.

As these children grow into adults, the act of building has been found to transform from play into a purposeful mission.

The construction industry, with its clear tasks, tangible outcomes, and a sense of satisfaction upon completion, can offer a reward structure that mirrors the reinforcement they once found in childhood clinical play sessions or, in the case of undiagnosed individuals, what they naturally sought out in everyday activity.

Could this help answer the earlier question:

What compels someone with no formal training or trade to rise at 5:30a.m. on a cold, January morning for a job that is physically punishing, inconsistent, and often poorly paid, when other unskilled options exist?

Where the mid-stage construction site might appear chaotic to most, to the individuals we are discussing it can feel like a controlled and absorbing environment, not unlike the learning spaces they experienced in therapy, or instinctively created for themselves.

This helps to explain why construction attracts a disproportionate number of neurodiverse individuals, including many with underlying mental health vulnerabilities.

Upstream Approach

What might start out as a positive pathway to success, could be cut short by the stressors common to construction, such as noise, disruption of routine, and inconsistent job opportunities.

By understanding these early pull factors, more balanced responses can be developed; identifying and supporting those at risk, whilst at the same time not transitioning the construction site into a frontline mental health service provider.

But there are critical points that leaders will need to consider:

- What is ideal in theory, *and*
- What is realistic in practice?

The goal should not be to medicalise the workplace, nor to shift responsibility onto site managers for complex psychiatric care. But understanding who is drawn into the industry, and why, helps to move upstream in the approach. Before better support systems can be developed, the vulnerabilities some workers bring with them on day one must be understood.

Downstream Risks

In the 2025 Korean national cohort study we have cited, ADHD did not appear among the psychiatric disorders with the highest suicide or mortality risk, unlike conditions such as bipolar disorder, schizophrenia spectrum disorders, or personality disorders. This absence partly reflects that, when ADHD is formally diagnosed and treated, it may present a comparatively lower hazard than more severe or psychotic illnesses.

However, it also reflects methodological blind spots: the study relied on insurance claims, meaning undiagnosed adults with ADHD were not captured, and ADHD's risks are often overshadowed by comorbid depression, substance use, or personality disorders.

Yet undiagnosed or untreated ADHD can carry serious downstream risks. Individuals with ADHD often experience chronic frustration, social rejection, impulsivity, and poor emotional regulation, all known risk factors for suicidal ideation. Korean survey-based research, not restricted to clinical diagnoses, has shown that ADHD symptoms, particularly inattention, are linked to elevated suicidal thoughts, underscoring the danger of underdiagnosis.

A further complication is neurochemistry. Reduced dopamine activity is a core feature of ADHD, and many individuals, diagnosed or not, turn to substances that provide short-term dopamine boosts, including marijuana, alcohol, nicotine, or stimulants such as cocaine and methamphetamine. While these may offer momentary relief, they tend to worsen long-term instability and raise suicide risk. For those prescribed ADHD medication, combining stimulants with recreational substances can produce highly unpredictable and dangerous effects, particularly in relation to mood crashes and impulsivity.

We explore these combined risks in more depth in Section-6, Construction & Drugs.

Prevalence:

According to NICE (National Institute for Health & Care Excellence) (2024) the global prevalence of ADHD in children is around 5%; and in adults in the UK at 3% – 4%. These numbers are supported by ADHD UK.

	Population (ONS)	Percentage	ADHD Population*
UK	68,265,200	100%	2,955,895
England	57,690,300	84.5%	2,498,000
Wales	5,490,100	8%	237,722
Scotland	3,164,400	4.6%	137,019
Northern Ireland	1,920,400	2.8%	83,154

* England's ADHD population number NHS England's ADHD Estimate. Devolved Nations population numbers are a simple extrapolation by ADHD UK based on total nation size.

To gain a picture of the number of ADHD adults within the workforce selection pool we extrapolated the adult figures – adults & young adults. If we are to accept that these individuals could be naturally drawn to the construction industry, then it is only right that we should consider the risks relative to suicide.

	Total Adults (18 & above)	Young Adults 18 - 24
England	1,875,000	265,000
Wales	178,433	25,218
Scotland	102,845	14,535
Northern Ireland	62,414	8,821
UK	2,218,692	313,574

We also looked at the child numbers to project an image of **future suicide risks…**

	Children under 5	Children 5~17 (up to 18th birthday)	Total children (0~18)
England	147,000	476,000	623,000
Wales	13,989	45,298	59,287
Scotland	8,063	26,109	34,172
Northern Ireland	4,893	15,845	20,738
UK	173,945	563,252	737,197

The latest UK figures from ADHD UK show that over 737,000 children aged 0–17 are currently diagnosed with ADHD, a number that reflects not only growing awareness but also a **future workforce dynamic that cannot be ignored**. Compounding these threats is the natural draw to drugs like marijuana, particularly as a teenager, which further heighten the risks, particularly to schizophrenia. We address this in Section-6 of this report.

Whilst not all those individuals affected by ADHD will enter construction, the industry's reliance on physical labour, practical skills, and tolerance for alternative learning styles means it is likely to remain attractive to neurodiverse individuals, including those with ADHD. There is also an assumption here that these children have been correctly diagnosed.

In this sense, today's childhood diagnosis rates represent tomorrow's occupational safety challenge.

If support systems, awareness training, and risk mitigation strategies are not in place, the industry could see a surge in preventable incidents linked to impulsivity, poor risk assessment, self-medication, and mental health breakdowns, to include suicide.

HOWEVER: Despite the official ADHD prevalence figures published by the NHS and ADHD UK, we questioned how reliable these numbers really are, particularly after uncovering cases where unqualified individuals were making clinical diagnoses.

We found research published in the Canadian Medical Association Journal (2012) which also questioned the veracity of ADHD diagnoses. A population study of nearly one million schoolchildren in British Columbia found that those born in December, the youngest in the school year, were up to 70% more likely to be diagnosed and medicated for ADHD, than those born in January, the oldest in the cohort.

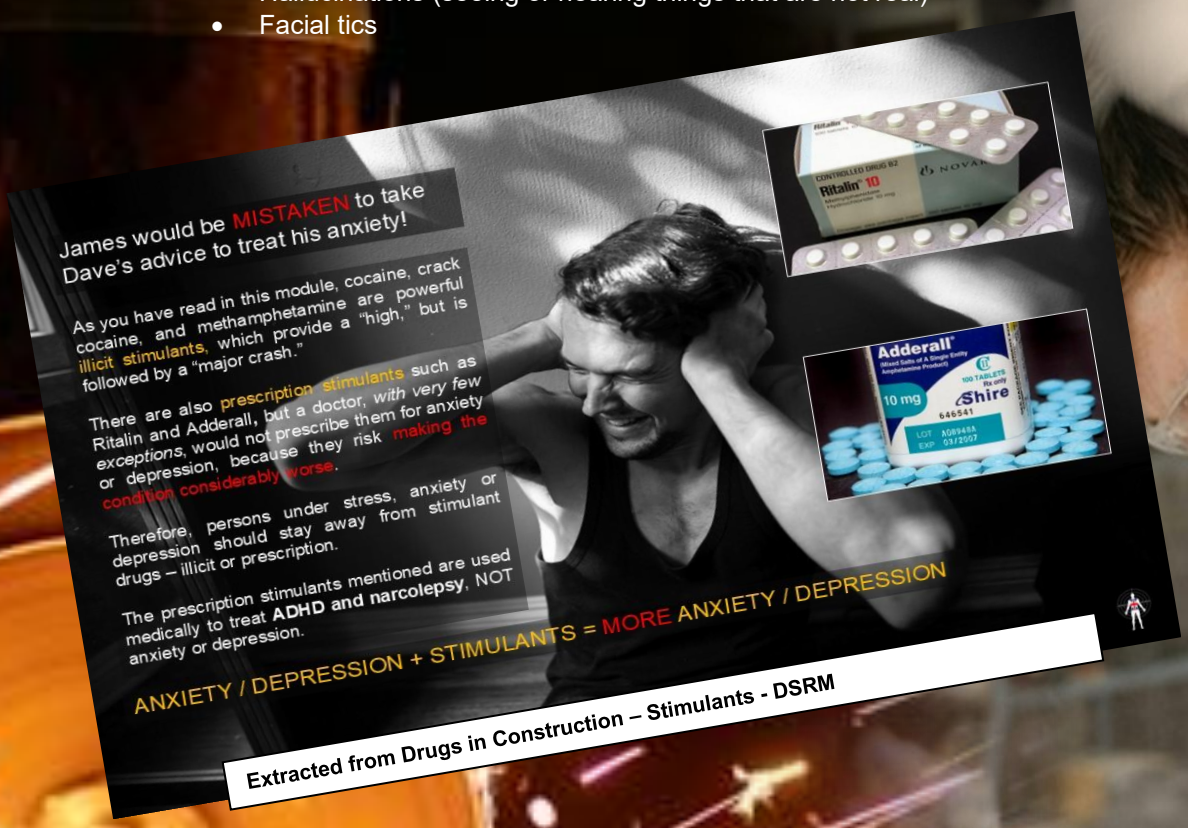
This suggests that what was often being labelled a disorder, may in fact have reflected normal age-related immaturity.

We found another (2018) study published in the Journal of Child Psychology confirmed this "**relative age effect**," through a meta-analysis of 19 studies across 13 countries, showing consistently higher risks of the youngest children in the classrooms being diagnosed with, *and medicated for*, ADHD.

Methylphenidate is the stimulant drug most prescribed for ADHD under common brand names - Ritalin, Concerta, Delmosart, Equasym, and Medikinet.

Side effects of Methylphenidate include:

- Mood / personality changes (aggression, depression, anxiety)
- Palpitations
- Hallucinations (seeing or hearing things that are not real)
- Facial tics



While large firms can train for and create roles for workers with ADHD, autism, or similar conditions, most of the UK construction industry is made up of small subcontractors, and sole traders. They…:

…seldom have HR qualified staff.

…need to compete in a crowded space, so tight margins and no interest in such roles.

…work in volatile project pipelines, leading to job insecurity, intensifying mental strain.

…rely on close-knit crews; those with mental health issues told to "just get on with it" or leave.

…unlike larger companies, they do not see mental health as their role.

In practice even if a worker discloses a condition, many employers are simply not equipped to tailor placements or manage nuanced mental health needs, not out of neglect, but due to structural limitations.

Where Are the Suicides?

We also had to be realistic as to where construction industry suicides are most likely to occur. Data linking suicides to employer size is not widely available. However, it appears that suicides are more prevalent amongst smaller firms, tradesmen, and subcontractors, than those university educated white-collar managers in the larger construction companies.

What is more, those smaller outfits are highly unlikely to have risk management HR protocols in place to identify mentally challenged individuals applying for jobs.

According to ONS Occupational Suicide (raw) Data, the highest actual suicides exist amongst:

- Low skilled male construction workers
- Ground workers, plasterers, bricklayers, scaffolders etc.

ONS England & Wales	2022	2023	2024
Construction & building trades n.e.c.	74	95	102
Carpenters & joiners	59	76	72
Plumbers, heating & ventilating installers &repairers	41	45	42
Painters & decorators	39	38	42
Roofers, roof tilers & slaters	29	28	38
Construction operatives n.e.c.	23	26	30
Bricklayers	19	23	28
Scaffolders, stagers, & riggers	19	22	25
Plasterers	15	20	24
Floorers & wall tilers	13	11	17
Glaziers, window fabricators & fitters	13	10	7
Road construction operatives	11	9	7
Electrical & electronic trades n.e.c.	8	5	4
Steel erectors	7	5	4
Construction & building trades supervisors	1	4	4
Rail construction & maintenance operatives	1	2	3
Totals	372	419	449

For a more accurate presentation of the data, please see:
Section-8, Data Analysis

Construction workers who are self-employed and more likely to be involved in smaller projects such as house extensions, loft conversions, and wall construction are more vulnerable to:

- Isolation
- Fear of reputational damage (if they admit to struggling)
- Irregular income
- Absence of sick pay / job security / HR protections

Findings Summary –
Neurodiversity and Mental Health Vulnerabilities in Construction

Our investigation into the mental health landscape of the UK construction industry reveals a concerning disparity between well-publicised corporate wellbeing initiatives and the lived experiences of those working in the most precarious and physically demanding roles. Suicide rates remain disproportionately high among low-skilled workers, sole traders, and subcontractors, groups that typically operate without the protections of formal employment, job security, or access to structured support systems. These individuals are often isolated, under financial pressure, and unlikely to engage with mainstream campaigns or corporate wellbeing resources.

At the same time, many large construction firms are actively promoting mental health strategies centred on peer support schemes, awareness events, and onsite wellbeing hubs. While these efforts signal a positive cultural shift, there is a growing visibility gap: the further down the employment chain one goes, the less likely it is that workers will benefit from these initiatives. For many, these high-profile efforts are simply out of reach, and may even reinforce a sense of exclusion.

Section Conclusion

While this section has highlighted some serious concerns regarding the provision of mental health support, including the potential misuse of clinical authority by loosely defined or unregulated advisors, and the challenges faced by neurodiverse individuals, these risks can be further amplified when the workforce includes individuals previously incarcerated within the prison estate.

In the following section-5, we turn our attention to the recruitment of workers from the prison estate, examining how, *recidivism, existing patterns of tool theft, and the heightened suicide risk among this population*, intersect with the structural and occupational vulnerabilities already discussed. By exploring these dynamics, we aim to understand how the integration of previously incarcerated individuals may compound, or interact with, the stressors and safety considerations identified in this section, and, may be contributing to the suicide data.

Roadmap of the Investigation

Stage 1 – Desk-Based Investigation

Analysis of existing literature, statistics, international models, cultural influences, and industry narratives. (*This document*.)

Stage 2 – Survey of Experiences

In an online survey we are asking you to promote across the sector, designed to capture personal testimonies: what contributed to lives lost, and what brought others back from the brink. https://www.dsrmrisk.com/survey

Stage 3 – Industry Collaboration

Structured dialogues with construction firms, unions, and industry bodies to explore their views on root causes and the adequacy of current responses. We invite your input, thoughts, ideas, and what you see as solutions…***just a few lines*** - "*What do you think is the problem?*" (This phase is currently running in parallel with Stage 2)

Please send your thoughts to: contact@dsrmrisk.com (Anonymous is Okay)

Stage 4 – Expanded Data

Incorporation of data from Scotland and Northern Ireland (*not currently included in official ONS reporting*), alongside further refinement of UK-wide analysis.

Together, these stages aim to provide both evidence and lived experience, enabling a clearer understanding of risk and more effective prevention strategies.

Stage 4 will be the Final Crane Report.