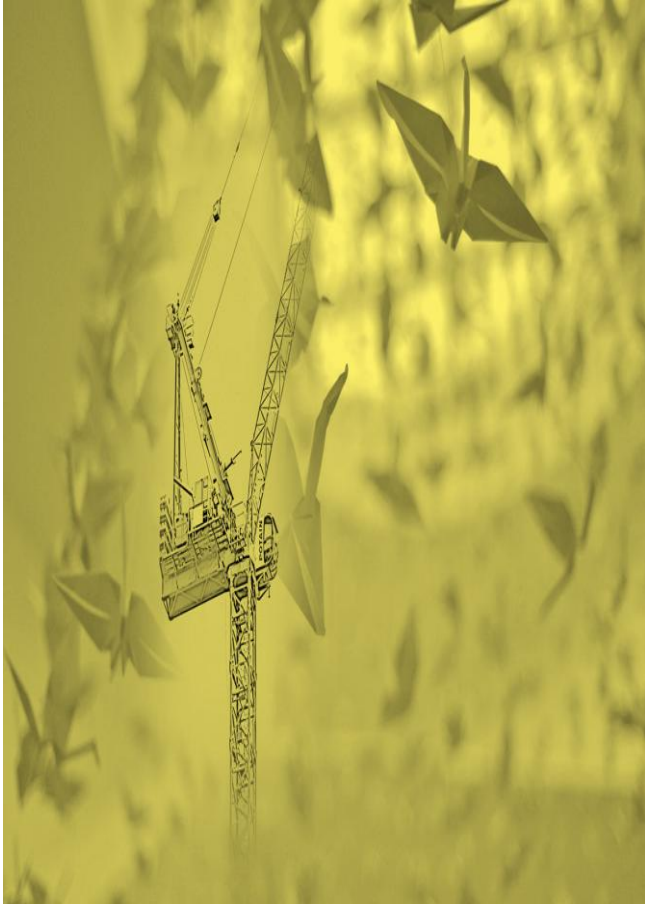


The Crane Report



CONSTRUCTION & DRUGS – RISKS & MORTALITY

Section-6

ABSTRACT

This section examines substance use within the construction industry and its intersection with mental health and suicide risk. Shifts in public perception, such as the acceptance of medical marijuana, contrast with rising risks from high-potency synthetic opioids, including fentanyl and nitazenes, exacerbated by global heroin shortages linked to the Afghan's Taliban. Reduced access to prescription opioids and chronic occupational pain contribute to addiction among construction workers, while regional patterns of drug mortality correlate closely with regional suicide rates. The investigation further highlights associations between specific substances, cocaine, marijuana, and mental health conditions, including depression, schizophrenia, and ADHD, which amplify suicide risk. Testing of construction managers revealed limited knowledge of these issues, underscoring gaps in workplace awareness and the need for targeted education and intervention.

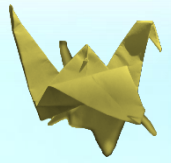
Anthony Hegarty MSc

DSRM Risk & Crisis Management

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Section 6 – Construction & Drugs – Risks & Mortality



- Construction & Drugs – Why This Section Matters
- Medical Marijuana – The Shift in Public Perception
- How do individuals in high-risk, physically demanding jobs like construction, become trapped in patterns of drug dependency?
- What is the connection between the construction worker, pain management, and the Afghanistan War?
- How do non-drug users end up addicted to heroin?
- Is there a link between heroin-related deaths and male suicides?
- Is there a deeper connection between heroin deaths and male suicide
- Are there regional patterns in UK drug poisoning deaths that could inform pre-emptive interventions?
- Do these regional drug poisoning patterns correlate with regional suicide statistics?
- What are the consequences of losing Afghanistan's heroin supply and the NHS tightening restrictions on opioid prescriptions?
 - Is fentanyl replacing heroin as a common drug for pain relief and misuse?
 - Are nitazenes a bigger threat than fentanyl?
 - Fentanyl Vs Nitazenes: What is the Difference?
 - Why do so many people take nitazenes when they pose such a risk of death?
 - Is fentanyl a threat to construction workers?
 - Why are synthetic opioids being mixed into heroin, cocaine, and other drugs?
 - Why is this relevant for the construction industry?
- What is the relationship with mental health and depression?
 - If someone just uses marijuana to relax, how can they get addicted to synthetic opioids like nitazenes?
- Do the same regional patterns that exist with drug poisonings and suicide, also exist with nitazenes?
- What are the shared risks of stimulant and depressant drug use for construction workers?
- How many cocaine deaths are due to combining it with alcohol?
- Is marijuana a depressant, and why does that matter in high-risk industries?
- What is “skunk” and how is it different from regular marijuana?
- What do schizophrenics experience?
 - Are schizophrenics attracted to the construction industry in the same way that persons with ADHD are?
 - Would a person with schizophrenia ever apply for a job in construction?
- Are there many people with ADHD working in the UK construction industry?
- Is there a link between ADHD, drug use, and suicide?
 - Are ADHD suicide patterns similar to regular suicide patterns?
 - How do we know if an ADHD death was suicide and not an accidental drug poisoning?
- Mental Health and Suicide Risk on Site
 - Do we know that mental illness is linked to suicide?
- Drug Testing in the UK Construction Industry
 - Can drug test kits trace synthetic opioids?
 - Where has drug testing succeeded?
 - Is drug testing the solution to site safety?
 - Will drug testing fix the problems?
 - Is testing realistic?
 - Will Drug Testing Reduce Suicide Risks?
- Do construction / HSE leaders have a sufficient level of knowledge on drugs?
 - The Survey Results
- Drugs' Education





Whilst our primary focus in this report is suicide within the construction industry, it is impossible to separate that issue from the rising influence of drug misuse. Substance use, whether initiated for pain relief, stress management, or recreational purposes, may have become both a coping mechanism and a contributing factor in many construction worker deaths.

In recent years, the drug landscape has shifted rapidly. The decline in Afghanistan's heroin output, the NHS crackdown on prescription opioids, and the surge in synthetic substances like fentanyl and nitazenes have created a volatile and dangerous environment for vulnerable individuals, many of whom work in physically demanding roles. At the same time, growing acceptance of marijuana has blurred perceptions of risk, especially among young people and those with underlying mental health conditions.

In this section we explore the overlap between drugs, suicide, and site safety. We also highlight how broader social, medical, and political developments, from the fallout of the Afghanistan war, to what seems to be a failure of youth protection systems, are having a direct impact on the mental health and wellbeing of the UK's construction workforce.

Our aim is not to moralise, but to inform, and to provide employers, industry bodies, and policymakers with insight into how and why drugs matter in this context, and what can be done to mitigate the risks.



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.

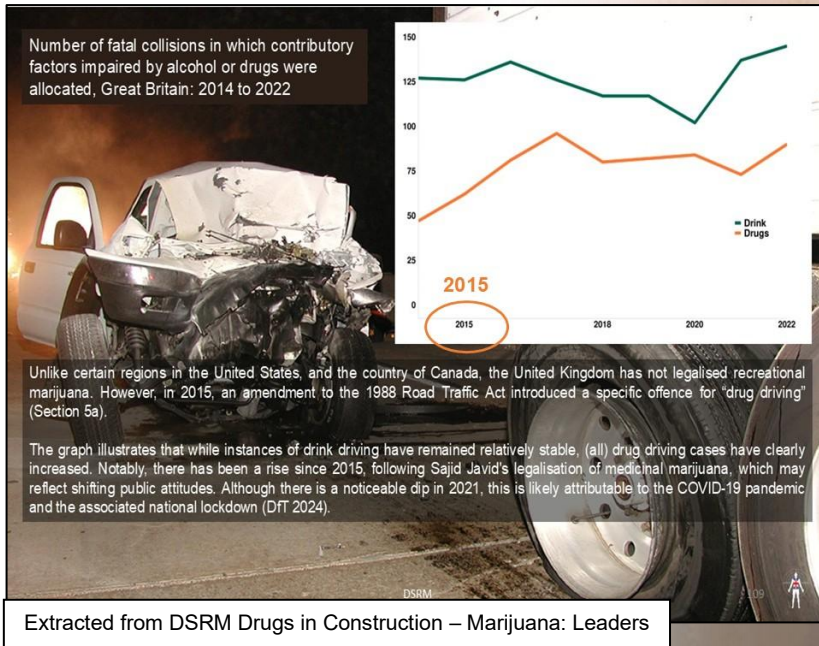


Medical Marijuana – The Shift in Public Perception



How has the legalisation of medical marijuana influenced public perceptions of the drug's safety?

In 2015, then UK Home Secretary Sajid Javid legalised medical marijuana. This may have shifted some public attitudes towards the drug being safe. The ONS graph's orange line depicts the sharp rise in fatal car accidents in which drugs were a contributory factor. The green line represents fatal accidents involving alcohol which remains relatively steady.



These developments raise important questions about how shifts in drug policy, even those limited to medical use, can influence public perception and behaviour. As legal frameworks have loosened and the language surrounding drugs has become more permissive, the line between **medical use** and **recreational abuse** appears unclear, especially in the eyes of the wider public.

The sharp increase in fatal road traffic incidents where drugs were a contributory factor should serve as a warning; *perception changes often precede policy consequences*.

With this broader context in mind, we now turn our attention to a critical question:

How do individuals in high-risk, physically demanding jobs like construction, become trapped in patterns of drug dependency?

To explain this, we need to first understand a number of geopolitical facts.



Afghanistan & the UK Construction Industry – A Perfect Storm

What is the connection between the construction worker, pain management, and the Afghanistan War?

A perfect storm has been forming that may significantly reshape drug use patterns among UK construction workers, a group already vulnerable due to chronic pain, physical labour, and inconsistent access to healthcare.

Compounding the risks, the UK's response to the U.S. opioid crisis has led to a tightening of prescription painkiller access, leaving many workers to seek alternative, and increasingly dangerous, means of relief.

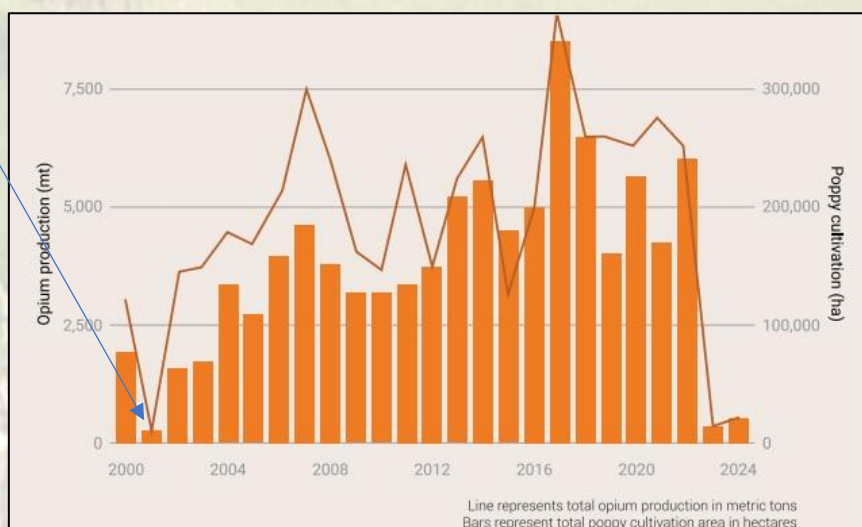
The following timeline explores the correlation between pain management needs among ageing workers, the rising heroin poisoning death toll in the 45–55 age group in England and Wales, and global events, including U.S. military operations, and Afghan opium policies.

This line graph represents Afghan opium production: 2000~2024

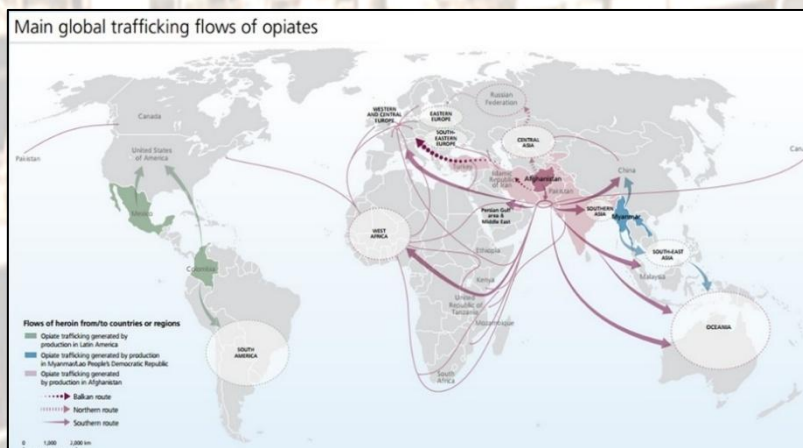
2001

→The U.S. and allied forces invade Afghanistan.

→ Initial disruption caused a steep drop in opium/heroin production.



→There is typically an **18–24 month lag** from opium harvest to UK street-level heroin availability. The 2001 invasion would impact UK supplies...

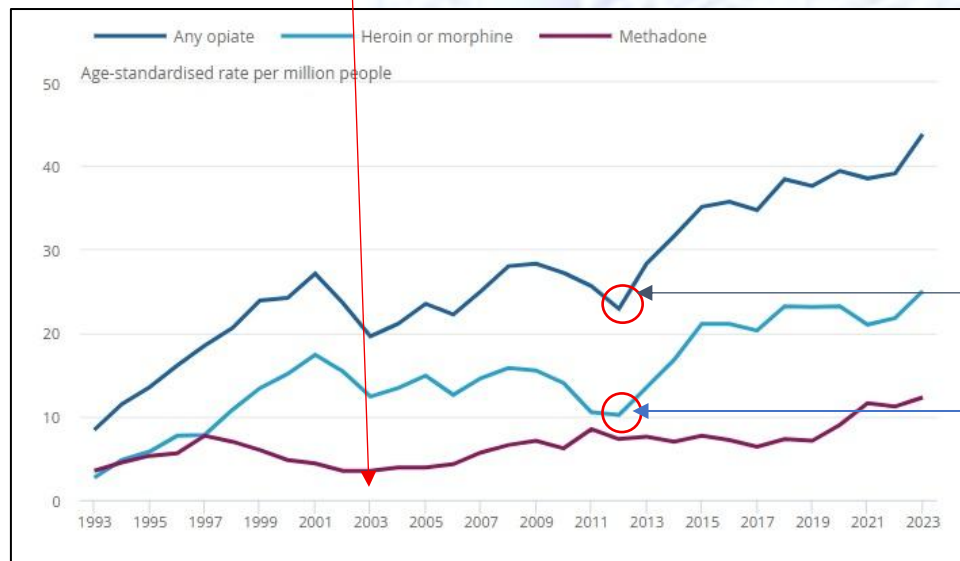




2001
~2003

→ By 2003, England & Wales recorded a **sharp fall in heroin-related deaths**, consistent with earlier 2001 disruption in supply (*caused by the Afghan invasion*).

2004
~2009



- Heroin production in Afghanistan rebounds, partly as local warlords are supported to maintain regional stability.
- Heroin-related deaths in England & Wales rise steadily during this period.

2009

- U.S. President Obama announces a military surge of 30,000 additional troops, increasing total to ~100,000.
- Heroin production in Afghanistan drops sharply in 2009, likely due to renewed military disruption in poppy-growing regions.

2011

- Approximately two years later, England & Wales record a second sharp drop in heroin-related deaths, mirroring the 2009 production dip. (C)

Post-2011

- Heroin production rises again as conflict dynamics change, foreign forces begin to withdraw, and US surge ends.
- From 2013 onwards, UK heroin deaths begin a consistent upward trend.

2021

England & Wales data show the highest mortality group for heroin poisoning is the 45–55-year-old demographic, often long-time manual workers with unresolved injuries: persons born in the 1970s.

Age group at death	2016	2017	2018	2019	2020	2021
15-19	8.9	9.7	13.1	12	11.6	12.8
20-24	28.4	27.9	38.7	30.1	27.7	32.4
25-29	58.3	50.8	60.2	52.1	44.2	45.9
30-34	80.1	72.3	84.8	80	81.1	78.6
35-39	116	103.4	113.3	113.6	111.1	114.2
40-44	121.4	114.5	134.3	126.4	129.6	127
45-49	96.2	93.3	118.1	114.4	134.9	135.6
50-54	61.5	68.1	73.2	88.4	97.5	99.9
55-59	40.8	38	51.2	52.7	63.5	64.7
60-64	31.1	33.1	32.2	40.5	32.4	34.3
65-69	18	21.8	20.6	17.5	22.3	28
70-74	7.9	9	9.7	13.9	11.7	12.3
75-79	11.5	15	8.6	10.6	9.3	6.7
80-84	9.8	11	16.1	5.9	11.7	9.7
85+	15.6	17.4	13.1	18.9	16.8	16.3

Source: ONS





Recent Developments and New Risks (2023 Onward)

2023

- U.S. military withdrawal finalised. Taliban regain control of Afghanistan.
- Nationwide ban on opium cultivation imposed by Taliban.
- Global heroin supply drops by 90%, according to UNODC estimates.

2023

Parallel Trend – NHS Prescription Policy

- In response to the U.S. opioid crisis, UK tightens opioid prescription practices.
- 450,000 fewer opioid prescriptions issued by 2023, leaving many chronic pain patients without support.

Knock-on
Effect

- Risks of patients denied painkillers turning to informal sources (friends, etc.).
- When that fails, many search on-line and drift to heroin as a substitute, a pathway especially observed in middle-class users and older manual labourers, including construction workers.

NHS
England

Commissioning Get involved

News

Opioid prescriptions cut by almost half a million in four years as NHS continues crackdown

2 March 2023

General practice Pharmacy

GPs and pharmacists have helped cut opioid prescriptions in England by 450,000 in under four years, latest data shows, as the NHS today unveils a new action plan to crack down on the overuse of potentially-addictive medicines.

The [new framework for local health and care providers](#) aims to further reduce inappropriate prescribing of high-strength painkillers and other addiction-causing medicines, like opioids and benzodiazepines, where they may no longer be the most clinically appropriate treatment for patients – and in some cases can become harmful without intervention.

Afghan authorities destroy opium crops as Taliban soldiers look on.

NHS England report cutting opioid prescriptions by 450,000.





Pain or High?

How do non-drug users end up addicted to heroin?

Addiction does not always begin with criminal behaviour or deliberate misuse. In physically demanding industries like construction, a common route into opioid dependency starts with a legitimate injury, a shoulder or back problem, for example.



A doctor prescribes strong painkillers, such as codeine or morphine, which not only reduce physical discomfort but also produce a subtle mood elevation. As tolerance develops, the initial effect fades.

When prescriptions are reduced or stopped, the pain may be gone, but the individual begins to feel emotionally flat or depressed, an early withdrawal symptom that may go unrecognised as such. Seeking to recapture the original sense of wellbeing, some turn to black market alternatives like heroin. Today, that path is more dangerous than ever, with heroin increasingly laced with synthetic opioids, as you will read of later in this section. A single illicit dose can lead to overdose or poisoning death.

As a part of this investigation, we spoke with multiple construction workers who use illicit drugs for pain management. However, they did not see themselves as “drug users,” despite this being one of the fastest-growing addiction pathways facing high-risk labour sectors today.





Drug Mortalities & Suicides – a Coincidence?

Is there a link between heroin-related deaths and male suicides?

In 2021, the 45–49-year-old age group, *common among long-serving construction workers*, recorded the **highest heroin-related mortality** in England and Wales. This age bracket also appears in the **highest (45-54-year-old) male suicide** demographic. It is important to note that “drug poisoning deaths” are recorded separately from “suicides.”

However, we have found that these are not necessarily two separate crises; they are often one and the same, simply labelled differently.

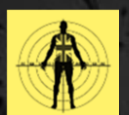
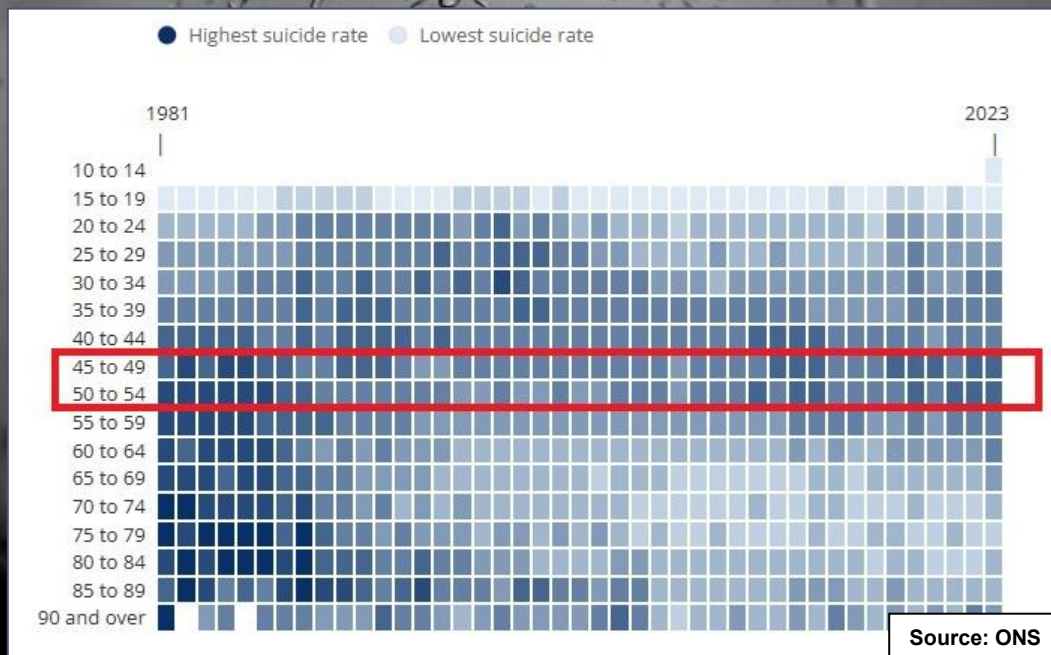
Heroin related deaths.

45-49 largest group: 2021.

Age group at death	2016	2017	2018	2019	2020	2021
15-19	8.9	9.7	13.1	12	11.6	12.8
20-24	28.4	27.9	38.7	30.1	27.7	32.4
25-29	58.3	50.8	60.2	52.1	44.2	45.9
30-34	80.1	72.3	84.8	80	81.1	78.6
35-39	116	103.4	113.3	113.6	111.1	114.2
40-44	121.4	114.5	134.3	126.4	129.6	127
45-49	96.2	93.3	118.1	114.4	134.9	135.6
50-54	61.5	68.1	73.2	88.4	97.5	99.9
55-59	40.8	38	51.2	52.7	63.5	64.7
60-64	31.1	33.1	32.2	40.5	32.4	34.3
65-69	18	21.8	20.6	17.5	22.3	28
70-74	7.9	9	9.7	13.9	11.7	12.3
75-79	11.5	15	8.6	10.6	9.3	6.7
80-84	9.8	11	16.1	5.9	11.7	9.7
85+	15.6	17.4	13.1	18.9	16.8	16.3

Source: ONS

Suicides, male & female – largest group, 45-54-years

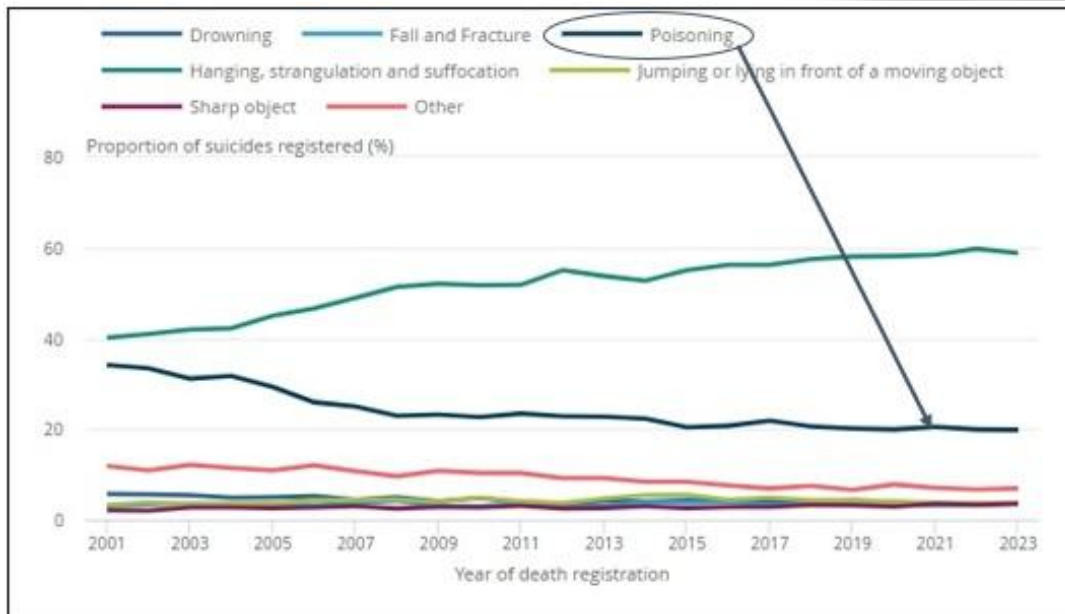




Is there a deeper connection between heroin deaths and male suicide, beyond coincidence?

We investigated suicide methodology.

We found drug poisoning is the second most common way to die by suicide.



This is why it is imperative for first responders to fully understand the death scene (See Section-1) and to be sure that it is a “**suicide scene**” and not an “**accidental death scene**,” or vice-versa. This often requires a deep-dive investigation into the deceased’s life, not simply observations on the death scene.

This survey is about those who survived

[Start Survey - 5 minutes needed](#)

This survey is about those we have lost

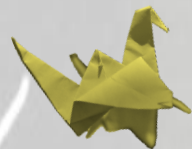
[Start Survey - 15 or 20 minutes needed](#)



Whether the death is a suicide or accidental death cannot be determined by this report alone. This can only be established once actual personal experience data is collated and analysed. We have therefore created an [anonymous survey](#) for those who have lost friends & loved ones so we can explore the lead up to the death moment. Such data will greatly enhance the ability to intervene and save lives.

NOTE: When we investigated ADHD suicides, we found a disruption to regular suicide methodology. We report on this later in this section.





Are there regional patterns in UK drug poisoning deaths that could inform pre-emptive interventions?

Regional Drug Deaths – a Pattern Emerges

We looked at one more set of data relative to location. This set of graphs provides us with the rates of drug poisoning deaths from 1993 to 2023.

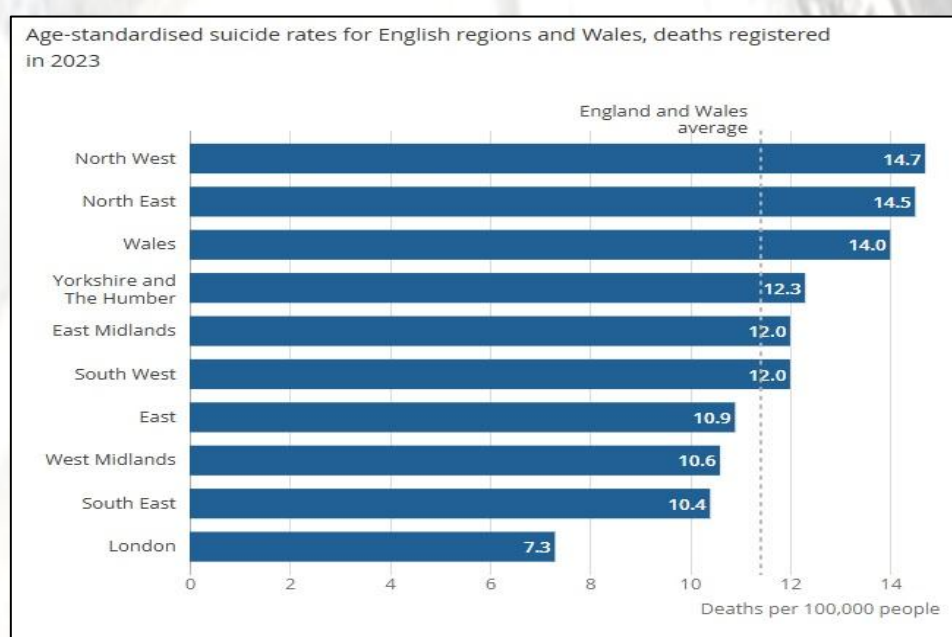
This (*all drug*) mortality data shows a clear **North South divide**.
Not Suicides!

We attribute the lower London numbers, and its satellites across the South & East to better established supply lines and quality controls.



Do these regional drug poisoning patterns correlate with regional suicide statistics?

We looked at the regional suicide data and found a distinct pattern emerges, as it appears to correlate with the regional drug poisoning data.





What are the consequences of losing Afghanistan's heroin supply and the NHS tightening restrictions on opioid prescriptions?

Unintended Consequences

At first glance, a reduction in the global heroin supply might seem like a positive development. However, when combined with the NHS's tightening of opioid pain management prescriptions, the unintended consequence is that thousands are left searching for alternatives, some in genuine need of pain relief, others simply trying to manage withdrawal (*from prescription painkillers or recreational drugs*).

This dual pressure;

- reduced legal access to painkillers, and
- the sharp decline in the illicit back-up heroin

...is likely increasingly pushing vulnerable individuals, including construction workers, **toward higher-risk synthetic substitutes such as fentanyl.**

Is fentanyl replacing heroin as a common drug for pain relief and misuse?

While fentanyl has dominated headlines in the United States since 2015–2016, where it quickly surpassed heroin and prescription opioids in overdose & poisoning deaths, its rise in the UK has been quieter, but no less concerning. **The first confirmed UK deaths involving fentanyl were reported in 2017.** Since then, and especially as heroin supplies contract globally, synthetic opioids have begun to gain traction, posing a growing but still under-recognised threat across British industries.

United States (Ground Zero for the Fentanyl Crisis)

2013~2015	U.S. authorities begin reporting a sharp rise in overdose deaths involving synthetic opioids, mainly illicit fentanyl.
2016	The U.S. Centers for Disease Control and Prevention (CDC) declares fentanyl a key driver of a “third wave” of the opioid crisis (following prescription opioids and heroin).
2017	Fentanyl surpasses heroin and prescription opioids as the leading cause of opioid deaths in the U.S.
2020~2023	Fentanyl becomes involved in over 70% of opioid deaths in the U.S., and is increasingly mixed into counterfeit pills and other drugs.

United Kingdom

2017	The first UK warning notices about illicit fentanyl analogues appear following a cluster of deaths in Yorkshire linked to heroin laced with fentanyl.
2018–2019	UK police and coroners begin reporting sporadic fentanyl-related deaths, mostly through contaminated heroin or counterfeit pills.
2020s	Concerns increase, but numbers remain low compared to North America — though experts warn the UK is likely “only a few years behind” the U.S. curve.
2023~2024	Media reports and health briefings begin identifying fentanyl and synthetic opioids as a rising threat, especially as global heroin supply tightens.





Nitazenes

Are nitazenes a bigger threat than fentanyl?

We looked at competing substances and found that fentanyl may have already been overtaken by an even more lethal class of ultra-potent synthetics, known as *nitazenes*. Originally developed in the 1950s but never approved for medical use, nitazenes have now entered the UK drug market, **showing up in heroin, counterfeit painkillers, and even cocaine!**

Their extreme potency, often several hundred times stronger than heroin, **makes accidental overdose far more likely, even for experienced users**, which can easily be misinterpreted as suicide, *particularly if the deceased was known or believed to have been depressed.*

Fentanyl Vs Nitazenes: What is the Difference?

Feature	Fentanyl	Nitazenes
Origin	Developed as a medical painkiller	Created in the 1950s; never approved
Potency	50–100× stronger than morphine	Up to 300–500× stronger than heroin
First UK cases	2017 (heroin contaminated)	2021–2022 (rapid rise in street drugs)
Appearance	White powder or liquid; easy to miss	Similar; often found in counterfeit pills
Detection	Detectable with updated field kits	Harder to detect; not always screened
UK deaths (2023–24)	Rising slowly; still limited	179 confirmed deaths (June 2023–May 2024)





Why do so many people take nitazenes when they pose such a risk of death?

Deaths often occur when **unsuspecting users** believe they are purchasing a drug they are “used to,” *such as* heroin for pain management / withdrawal, or cocaine or marijuana for recreational use; yet they are often being laced / cut with the synthetics like nitazenes.

The ONS provides fentanyl mortality data based on the regions of England & Wales, and in the case of nitazenes, for England only.

	England & Wales		England
2017	Fentanyl without heroin/morphine	Fentanyl with heroin/morphine	England Deaths involving Nitazenes June 2023 to May 2024
North East	3	1	3
North West	9	3	12
Yorkshire and the Humber	12	5	25
London	5	0	18
East Midlands	4	1	29
East of England	6	0	33
West Midlands	2	0	21
South East	14	0	16
South West	3	3	22
England Total	58	13	179
Wales Total	3	0	
Sub-Total	61	13	179
Total	74		Total 179

It is worth noting that fentanyl-related deaths in the UK have typically been recorded with some detail, distinguishing cases where fentanyl was **mixed with heroin** from those where it was taken alone or in combination with other drugs.

By contrast, current reporting on nitazenes-related deaths, including the 179 fatalities recorded between June 2023 and May 2024, does not yet distinguish whether these deaths involved nitazenes alone, or in combination with heroin, cocaine, or other substances. This limits the ability to directly compare the two substances and may understate the wider risks posed by cross-contamination in the illicit drug supply.

Is fentanyl a threat to construction workers?

But while fentanyl marked the first major wave of synthetic opioid concern, recent data suggest that its role has already diminished. According to figures from the Office for Health Improvement and Disparities, between June 2023 and May 2024 there were no confirmed fatalities involving illicit fentanyl alone; **every synthetic opioid death during this period involved nitazenes-class drugs.**

Fentanyl-related deaths peaked in 2017 at 74 recorded cases in England and Wales, but have remained rare ever since. We therefore believe that the threat has now evolved: nitazenes, not fentanyl, have become the primary synthetic danger in the UK drug landscape, potentially replacing heroin as the go-to painkiller.



Why are synthetic opioids being mixed into heroin, cocaine, and other drugs?



Profitability	Synthetic opioids like fentanyl and nitazenes are cheap to produce in labs. Just a few grammes can replace much larger quantities of heroin, making it easier to smuggle and more profitable per dose.
Potency = Stretching Supply	Dealers mix synthetics into heroin to boost potency, especially when it has already been cut, or supply is tight (as is currently the case due to the Taliban's 2023 opium ban). This lets them dilute the product and maintain a 'hit' while stretching their stash.
Dependency and Repeat Business	Synthetic opioids are more addictive, keeping users coming back more often, even as risk of overdose increases. Some users unknowingly develop tolerance to fentanyl or nitazenes, making detox harder and relapse more likely.
Unwitting Use = High Fatality Risk	Cocaine, ketamine, and even vapes are increasingly being cross-contaminated with synthetic opioids, often without the user's knowledge. This is especially deadly for non-opioid users like recreational cocaine users, they have no tolerance, and just one contaminated line or pill can kill.

Why is this relevant for the construction industry?

- Drug use/abuse is “*not unheard of*” within the UK construction industry...
- ...A construction worker using cocaine recreationally at the weekend, or even misusing painkillers, could unknowingly ingest nitazenes.
- **These compounds are not reliably detected in standard drug screens.**
- The shift from heroin to synthetics is not just about addiction, it dramatically increases the risk of sudden overdose, even in casual or first-time users.

Tom's Dangerous Weekend: A Methamphetamine-Induced Disaster

Tom spent the weekend on a methamphetamine bender with his mates, staying awake for nearly 48 hours with non-stop drugs, loud music, and vodka. By Monday morning, still high, he arrived at the construction site in his dump truck, feeling confident and energised.

As the day went on, the drugs wore off, and exhaustion hit hard. His vision blurred, and he struggled to keep his eyes open. While driving, he momentarily dozed off, losing control of the truck. It overturned, spilling its load across the road.

Emergency services arrived to find Tom dazed and barely coherent. Although no one was seriously injured, the accident caused major delays and costly damage. His reckless decision to work after a drug-fuelled weekend put everyone at risk.

Extracted from DSRM – Drugs & Construction

DSRM 20





Leading to Depression

From Dependency to Despair: The Overlap with Mental Health and Suicide

What is the relationship with mental health and depression?

We spoke with multiple construction workers, especially older workers living with pain, debt, and or isolation, and found the use of heroin or painkillers has *not* always been about getting high; **it is about coping**. But as heroin becomes scarce and synthetic opioids like fentanyl or nitazenes increasingly flood the supply chains, that coping mechanism turns deadly.

These ultra-potent synthetics are often taken unknowingly, and their effects, blackouts, memory loss, paranoia, or sudden withdrawal, can deepen existing mental health struggles, including **depression, anxiety, and hopelessness**. Many users may not realise they are ingesting synthetic opioids until they have already developed dependence, or suffer a near-fatal overdose.

If someone just uses marijuana to relax, how can they get addicted to synthetic opioids like nitazenes?

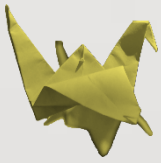
A regular weekend user of marijuana for example, could become addicted to synthetic opioids if the marijuana batch has been so laced. This is often an intentional ploy by the supplier to create an addict, and as such, a long-term customer.

In this context, **the line between accidental poisoning and suicide is often indistinguishable**. A worker self-medicating to survive the week may not be intending to die, but with these drugs, a single misjudged dose, or contaminated pill, can have the same result. And in some cases, especially where physical pain and emotional distress co-exist, a fatal dose may be taken deliberately, **although without the intention to die**.



Fentanyl, also known as fent
tion with a rapid onset



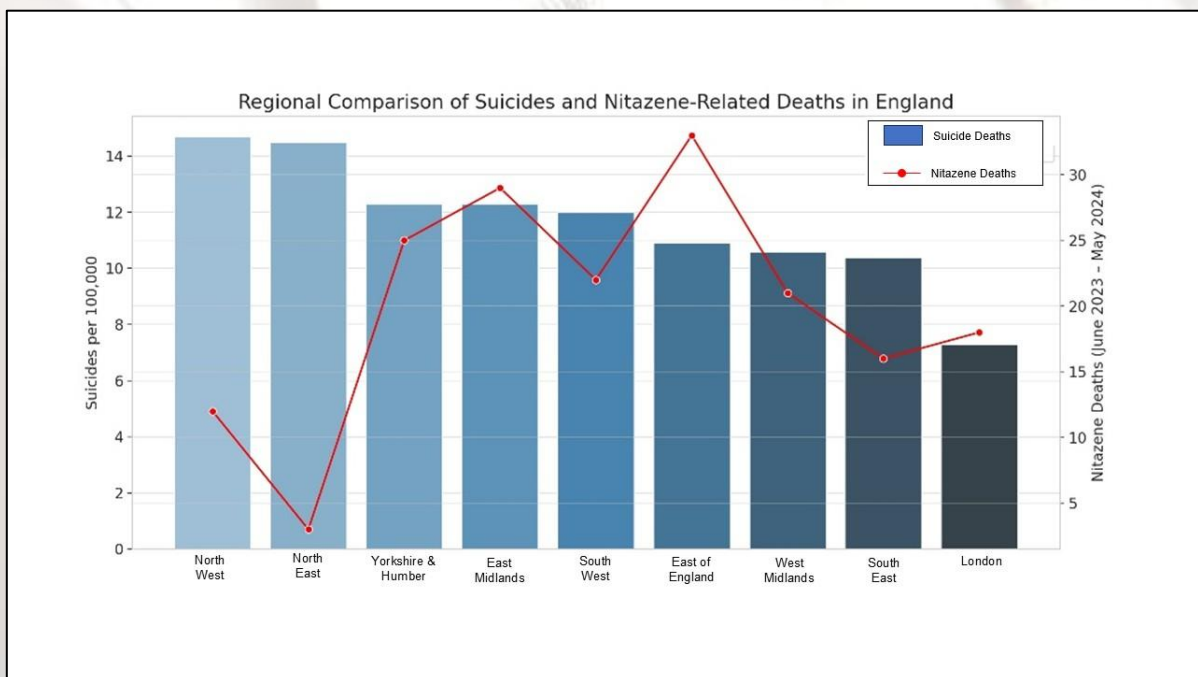


Do the same regional patterns that exist with drug poisonings and suicide, also exist with nitazenes?

We also investigated how nitazenes were taking hold across the UK supply chains, to compare regions?



When we looked at these on a regional level, we found the overlap between suicide rates and nitazene-related drug deaths is not exact, but regional groupings suggest a worrying trend. Areas such as [Yorkshire & Humber](#), [the East Midlands](#), [South West](#), and [the East of England](#), show **both elevated suicide rates and high nitazene mortality**.



Why are there fewer nitazene deaths in the north of England, yet this report previously stated that these regions have higher drug poisoning deaths?

Our analyses suggest that heroin availability in regions like the North West may be stabilised by long-standing trafficking routes involving organised crime groups with links to Pakistan or Iran.

Could heroin supply rise again despite the Taliban's opium ban?

If Taliban supply routes remain disrupted, such networks within the UK could expand their influence, creating further risk in high-construction, high-suicide regions. This should be monitored as part of future regional risk assessments.

However, heroin production is labour intensive and thus costly, whereas synthetic drugs are lower cost and can be produced within small spaces.



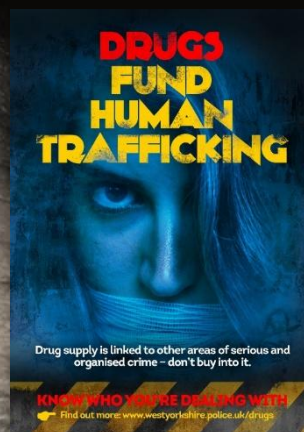


Unintended Consequences

Are there any identifiable trends with UK based heroin traffickers?

Globally, many drug trafficking organisations have shifted towards human trafficking, attracted by higher profit margins, lower detection risks, and lighter penalties. However, in the UK, increased public and media scrutiny on grooming gangs may influence a reversion to traditional drug markets, including heroin, as a lower-profile criminal enterprise.

In 2019 the [West Yorkshire Police](#) reported on a link between these two serious crime types.



Despite the lower levels of nitazenes in these northern regions, we have found that when taken as a whole, the data suggest that wherever high-risk substances gain a foothold, there is an elevated risk of suicide, raising risks further in physically and mentally demanding sectors like construction.

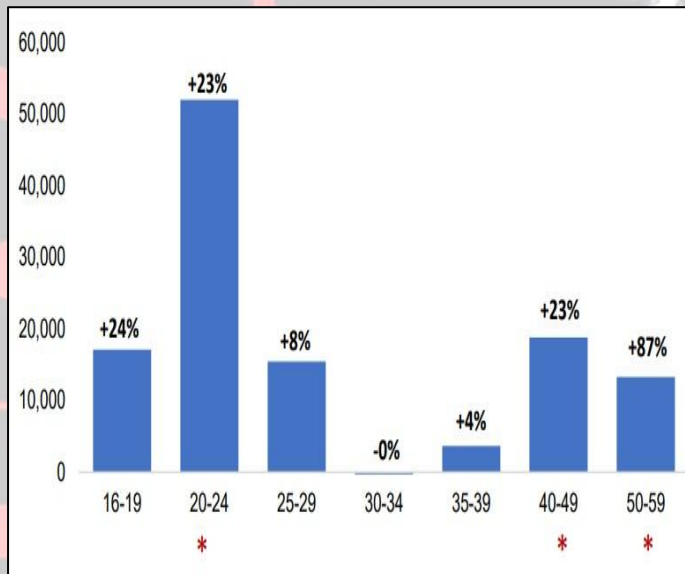




Cocaine

What are the shared risks of stimulant and depressant drug use for construction workers?

Cocaine, is the second most abused drug in the UK after cannabis, and was linked to 857 deaths registered in 2022, marking the 11th consecutive annual rise. The primary users are younger: the most common age group is 20 to 24 years old, according to both 2019 user data and 2022 ONS cocaine mortality statistics. **The typical profile of a cocaine-related death is a young, white male manual worker earning between £20,000 and £29,000 per year.**



One might reasonably conclude that opioid-related deaths are more often associated with older men who may have begun with genuine physical needs, whereas cocaine-related deaths tend to involve younger men, possibly engaged in recreational use. There does however appear to be an emerging trend of older people using this stimulant drug. This may be due to the shortage of heroin supplies, and or its broad availability and low cost.

Cocaine causes death through various mechanisms, central to which are cardiovascular & neurological complications.

Mixing a stimulant drug like cocaine with a depressant like alcohol, not only places enormous strain on the cardiovascular system, it creates an increase in impulsivity potentially leading the user to act in ways they might not have otherwise done.

Impact 2: The Cardiovascular System

Cocaine	Crack Cocaine	Methamphetamine
Increased heart rate / Increased blood pressure	Increased heart rate / Increased blood pressure	Increased heart rate / Increased blood pressure

The main short-term effect of stimulant drugs is that everything increases:

- Breathing rate
- Heart rate
- Temperature
- Blood pressure

Some users of stimulant drugs consume alcohol at the same time, sometimes in the belief the drugs will prevent them from getting drunk. Alcohol however is a depressant and does *not* complement the stimulant's impact upon the heart.

Whilst the stimulants cause the heart rate / cardiovascular system to speed up, the depressant (in this case alcohol) causes it to slow down. These two opposing forces place enormous strain upon the heart.

Extracted from DSRM – Drugs & Construction

We found that social patterns amongst the typical cocaine user profile suggest a prevalence of joint cocaine and alcohol consumption, however, UK mortality data on this comorbidity is limited.

NOTE: Later in this report we disclose our survey results of drug knowledge among construction and HSE leaders. You will learn that 9.1% of the 815 respondents to a question on mixing cocaine with alcohol, incorrectly chose answers that suggest perceived benefits of combining the two, a dangerous misunderstanding.





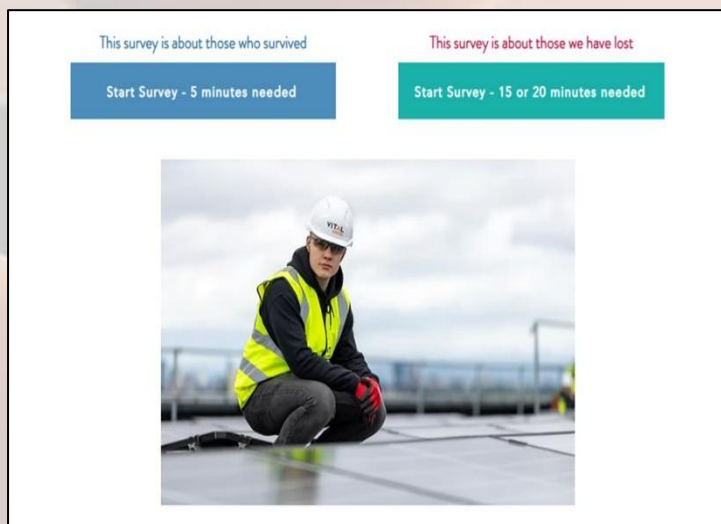
How many cocaine deaths are due to combining it with alcohol?

ONS Limitations

Current ONS data does not isolate the number of cocaine deaths involving alcohol, but international studies in the US, Canada, and Australia show this combination is a common and lethal mix. The absence of this data in UK reporting should be addressed in future studies.

We found...

- **United States:** The CDC has reported that up to 20% of cocaine-related deaths involve concurrent alcohol use. (2024)
- **Canada:** Provincial coroner reports have noted a frequent presence of alcohol in toxicology findings for cocaine-related fatalities, particularly among young men. (2024)
- **Australia:** Research by the National Drug and Alcohol Research Centre (NDARC) has found that more than one-third of cocaine overdose deaths also involve alcohol. (2022)

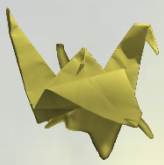


Due to the limitations of this investigation, we are unable to determine how many construction industry deaths involved cocaine or other substances, whether alone or in combination with alcohol. To address this gap, we refer throughout this report to the [Stage 2 Investigation](#), which invites individuals who have lost a friend or family member to suicide (where the deceased was employed in the construction industry) to complete an **anonymous** online survey. The aim is to build a more detailed and personal picture of the factors that may be contributing to these deaths.

But while drugs such as heroin, fentanyl, and nitazenes are **depressants**, and cocaine is a **stimulant**; both drug types intersect with one common factor...

...they both lead to depression and suicidal ideation.





Marijuana

Is marijuana a depressant, and why does that matter in high-risk industries?

Marijuana, produces depressant, stimulant, and hallucinogenic effects. It is also closely linked with psychosis and as such we devote this next section to marijuana and its **high-risks for the construction industry**.

We can usually classify drugs into three groups; stimulants, depressants, and hallucinogens.

Stimulants: Stimulants increase brain activity by enhancing the release of neurotransmitters like dopamine and norepinephrine. These chemicals boost alertness, attention, and energy levels, making the user feel more awake and focused.



Hallucinogens: Hallucinogens alter perception, mood, and cognitive processes by disrupting normal communication between neurotransmitter systems, particularly serotonin. They can cause profound changes in sensory perception, thought processes, and emotions, often leading to visual and auditory hallucinations.

Depressants: Depressants decrease brain activity by enhancing the effect of the neurotransmitter gamma-aminobutyric acid (GABA). This results in a calming effect, reducing anxiety, and inducing sedation or sleep. Depressants can impair cognitive and motor functions, and excessive use can lead to dependence, overdose, and severe withdrawal symptoms.

Extracted from DSRM –
Drugs & Construction

In a 2024 collaboration study between the University of Bath, Kings College London, and University College London, published in the [European Archives of Psychiatry and Clinical Neuroscience](#), 80% of adolescents had negative experiences from marijuana.

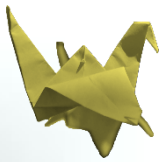
Is marijuana a bigger threat to younger people (*the future workforce*) than to adults?

A major threat is that teenagers, whose brains are still in their developmental stages, are unlikely to be informed about the future risks to their mental health, particularly if they have existing underlying mental health issues they are unaware of, such as schizophrenia.

Schizophrenia does not generally become noticeable:

- in men until their early to mid-twenties, *and*
- in females, until their late-twenties to early thirties.





Schizophrenia

This delayed onset is one reason schizophrenia often goes undiagnosed in teenagers and young adults, particularly in males. Yet this age group is also the most likely to experiment with marijuana, unaware of the longer-term risks. Of particular concern is Skunk, a high-THC variant of cannabis strongly linked to early-onset psychosis.

Skunk

What is “skunk” and how is it different from regular marijuana?

A major knowledge gap on what potency level of marijuana is being sold / consumed appears to exist. We understand that the marijuana largely available today is not that smoked by anti-Vietnam war protesters in the 1960s; but the high-potency Skunk type.

Police seizures (London, Kent, Derbyshire, Merseyside & Sussex) reported on their seizures:

- 2016 – 94% Skunk
- 2008 – 85% Skunk
- 2005 – 51% Skunk

Skunk is *not* a “type” of marijuana, but is a label associated with high potency strains of the drug with a THC (Tetrahydrocannabinol) content ranging from 15% to 30%. THC is the psychoactive ingredient of marijuana.



Yale University
School of Medicine

Not Your Grandmother's Marijuana:

Rising THC Concentrations in Cannabis Can Pose Devastating Health Risks





What do schizophrenics experience?

Those with schizophrenia may experience auditory hallucinations, paranoia, or disorganised thinking, which can compromise concentration, coordination, and risk awareness. These individuals may also self-medicate with cannabis or other drugs to manage symptoms, creating a cycle of increased psychosis, dependency, and social isolation. As a result, schizophrenia should be recognised as **a key mental health factor when considering both drug misuse and suicide in construction settings.**

The Lancet Psychiatry

Do people with schizophrenia commit suicide?

Research published in the March 2019 issue of the Lancet Psychiatry, found that smoking the more potent, 'skunk-like' cannabis, increases your risk of serious mental illness.

They estimated that around one in 10 new cases of psychosis, may be associated with strong cannabis, based on their study of European cities and towns.

This suggests that those who were regular users of high-strength (Skunk) marijuana during their adolescent years are more exposed to schizophrenia.

Around 10% of schizophrenics will die by suicide within 10 years of diagnosis, and a further 15% will make unsuccessful attempts.



This survey is about those who survived

Start Survey - 5 minutes needed

This survey is about those we have lost

Start Survey - 15 or 20 minutes needed



How many construction suicides have been committed by persons struggling with schizophrenia? Did they consume marijuana as teenagers?

If we wish to build a true picture of the shape of suicides within this industry, then we need true stories, and we ask therefore for participation in the [Stage 2 Investigation](#). The survey is anonymous and we will make the results available publicly. This will enable industry leaders to create better intervention policies, and help also families and friends to intervene.





Are schizophrenics attracted to the construction industry in the same way that persons with ADHD are?

In Section-4 we explained how those with ADHD might be attracted to work in the construction industry. However, persons with schizophrenia would **usually avoid** (construction) jobs *which are*:

Stress sensitive	Construction sites are noisy, unpredictable, socially intense, and sometimes confrontational, all of which can be difficult for people with schizophrenia, especially if they experience hallucinations, delusions, or social anxiety.
Cognitive and sensory challenging	• Schizophrenics can struggle with executive function (planning, task switching), memory, and sensory processing, which can be taxed on a busy, dynamic site. • High noise and constant movement can worsen symptoms.
Safety-critical	Construction requires strong situational awareness and safety compliance. If a person's symptoms are active (e.g., paranoia or disordered thinking), this can pose real risk to themselves or others.

There is no specific list of jobs for schizophrenics, but they might be more content in positions that are:

- Low stress, and structured
- Creative and solitary
- IT related

However, individuals with schizophrenia, especially in the early or undiagnosed phase, might be unaware of how their condition interacts with environmental stressors.

- They may seek construction employment due to economic pressure or social expectations.
- They may gravitate toward unskilled labour roles simply because these are the most accessible, including construction site labouring, clean-up, delivery, or security guard work.

They are not necessarily choosing construction because it suits their condition (*as is possible with ADHD*), but because it is what is available, and that can **create a dangerous mismatch** between individual needs and job environment.

As such, upon entering the disorganised environment of a construction site, a person with schizophrenia could experience negative emotions due to:

Sensory Emotions		Negative Responses
Unpredictable schedules	These sensory emotions listed <u>on the left</u> , could trigger any of the negative responses listed <u>on the right</u> .	Paranoia
Loud, chaotic environments		Auditory hallucinations
Unstructured social dynamics		Panic or withdrawal
Few private spaces to decompress		Feelings of failure or entrapment
Peer pressure, rough humour, or confrontation (consider the macho-culture)		Fear of stigma if they disclose symptoms – intensifying the attack





Is there a Suicide Risk for schizophrenics under these conditions?

Yes. This kind of occupational mismatch can contribute to suicidal ideation or crisis, particularly when:

- The individual feels they cannot cope, but cannot leave (financial or familial pressure).
- They begin to doubt their own sanity or feel like a burden.
- They internalise failure, especially in a macho environment where vulnerability is not safe.
- They lack diagnosis, medication, or support to help interpret what is happening.

Suicide risk is highest when:

loss of control + isolation + mental health crisis = (high potential for suicide)

This combination is very plausible in the construction setting.

What about those coming out of prison and entering the construction industry, are they likely to be schizophrenic?



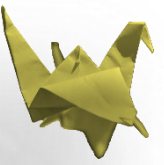
Schizophrenics do tend to be overrepresented in the prison population, and when recruiting from across that estate, the construction industry will need to ensure the correct level of risk assessments are in place. We would refer you back to Section-5 for more details.

Would a person with schizophrenia ever apply for a job in construction?

While individuals with schizophrenia are generally not well-suited to the unpredictable, high-stimulus environments like construction sites, economic necessity or lack of diagnosis may lead them to take **unskilled site roles**. In these cases, the mismatch between the individual's neurological needs and the realities of site work can result in rapid destabilisation, emotional withdrawal, and in some cases, **suicidal ideation, and realisation**.

The risk is particularly acute when the individual has no diagnosis, no support, and no realistic pathway to escape the environment safely. With few exceptions, construction sites, as currently structured, offer little in the way of support or accommodation for these vulnerable workers.





Why are schizophrenics drawn towards marijuana and other drugs?

Such individuals, (especially those undiagnosed), feeling trapped, can often be drawn to marijuana due to their stress loads.

This offers them:

Short-term relief	The drug can soothe anxiety, & create a sense of detachment from the environment
Peer influence	On construction sites, marijuana may have become socially normalised, especially among younger or lower-tier workers, making access easy.
Self-medication	They may sense something is wrong internally (paranoia, voices, racing thoughts) but lack a diagnosis, so they take what is immediately available.

Under high stress, individuals with undiagnosed schizophrenia turning to cannabis, will often be unaware that it directly worsens their condition. While marijuana may initially offer a sense of calm or escape, it quickly amplifies psychotic symptoms, destabilises mood, and **increases the risk of suicide**, especially with high-THC strains such as skunk.

In the high-pressure environment of a construction site, this can accelerate a spiral from internal distress to emotional breakdown and, **in some cases, suicide**.





ADHD & MARIJUANA

Are there many people with ADHD working in the UK construction industry?

We found there is increasing discussion around the possibility that undiagnosed ADHD may be more common in the UK construction workforce than previously recognised. Individuals with ADHD often struggle with emotional regulation, impulsivity, risk-taking, and poor long-term planning, all of which can increase vulnerability to drug misuse and suicide. Research also shows that the heightened suicide risk in ADHD is particularly linked to psychiatric comorbidities such as depression, substance misuse, and trauma-related disorders, which frequently co-occur with ADHD and amplify the dangers.

In the workplace, these challenges can manifest as difficulties with consistency, focus, or communication, particularly when instructions are ambiguous or when workers fear ridicule for asking questions. Construction work, with its fast pace, physicality, and short-term contracts, can be attractive to individuals who struggle in more rigid environments. However, this also creates risk, particularly where pressure, fatigue, or site conflict is involved.

Why are ADHD people drawn towards marijuana?

In the earlier Section-4 we mentioned that those with ADHD brains produce lower levels of dopamine and as such can be drawn to drugs like marijuana to cope with issues of anxiety and depression.

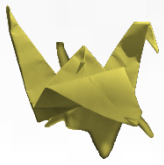
What are the risks of using marijuana with ADHD medications?

For those being treated with stimulants such as methylphenidate or amphetamines, risks increase when these drugs are mixed with marijuana, alcohol, or synthetic opioids. Stimulants can sometimes mask the level of intoxication from depressants, leading to overuse, or they may create a severe “crash” effect when the substances wear off. ADHD medications may also interact unpredictably with illicit substances, heightening the risk of overdose, psychotic episodes, or impulsive decision-making.

Importantly, ADHD already carries elevated risks of substance misuse and suicidal behaviour, and these are significantly magnified when psychiatric comorbidities are present. The overlap of ADHD, stimulant medication, and marijuana use is therefore recognised as a high-risk combination, particularly in industries like construction where:

- Self-medication appears to be common
- Workers may not disclose mental health or drug use
- There is limited oversight or *professional* mental health support





When mixing ADHD drugs with marijuana, how is one's mood affected?

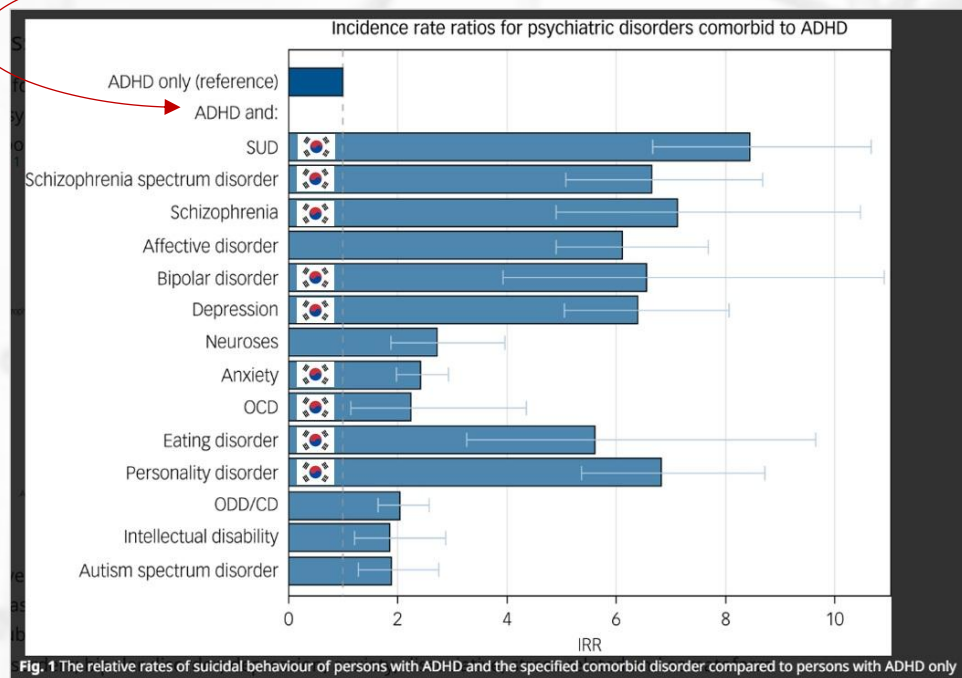
Mixing stimulants with cannabis can worsen mood swings, cognitive confusion, and impulsivity, especially as tolerance builds. The situation is not helped by the increasing prevalence of the high-strength skunk cannabis.

These combined effects increase the risk of suicidal ideation, particularly during comedown or withdrawal periods.

Is there a link between ADHD, drug use, and suicide?

ADHD medication appears to increase suicide risk, especially in the presence of comorbid substance use, so this link into construction is both timely and credible...

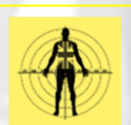
We found a 2019 Danish study, published by the [Mental Health Centre Copenhagen](#), demonstrating the **link between ADHD and a significantly elevated rate of suicidal behaviour** where comorbidity existed. **Substance Use Disorder (SUD)** (*which is also the term applied to marijuana, rather than addiction*) was the leading comorbid condition.



This graph shows the relative rates of suicidal behaviour of persons with ADHD & co-morbidities.

We extracted this graph from the original paper and added a Korean flag to highlight where earlier research from [Korea](#) that we cited in Section-4, reported elevated suicide risks relative to specific mental illnesses.

The findings of this Danish study are supported not only by the Korean study, but also by Swedish research into 38,000 ADHD patients, we review on the next page...



A Swedish national cohort study, published in [JAMA Psychiatry](#) (2014), followed nearly 38,000 individuals diagnosed with ADHD between 2006 and 2009. The researchers examined associations between ADHD, medication status, and suicide-related events. **Substance Use Disorder** is shown to be the leading comorbidity condition.

Table 1. Distribution of Study Variables Among Probands With ADHD and Matched Control Participants, and ORs for ADHD Associated With Each Comorbid Disorder			
Study Variable	No. (%)		OR (95% CI)
	Probands With ADHD (n = 51 707)	Control Participants (n = 258 535)	
Comorbid disorder			
Substance use disorder	7296 (14.1)	4230 (1.6)	11.07 (10.61-11.55)
Depression	6615 (13.3)	3558 (1.4)	13.02 (12.42-13.65)
Anxiety	4077 (9.5)	3033 (1.2)	10.53 (9.86-11.14)
Conduct disorder	2421 (4.7)	383 (0.2)	34.41 (30.75-38.50)
Bipolar disorder	1731 (3.4)	420 (0.2)	22.98 (20.51-25.75)
Borderline personality disorder	1147 (2.2)	170 (0.1)	31.06 (26.23-36.78)
Schizophrenia	384 (0.7)	220 (0.1)	9.79 (7.75-10.89)
Antisocial personality disorder	348 (0.7)	42 (0.02)	42.97 (30.65-58.56)
Suicide			
Attempted	4875 (9.4)	3356 (1.3)	8.46 (8.07-8.87)
Completed	113 (0.2)	47 (0.02)	12.22 (8.67-17.22)
Family education level ^a			
Elementary	4899 (9.5)	18 898 (7.3)	
Secondary	28 675 (55.4)	117 826 (45.6)	
Higher	17 312 (33.5)	118 917 (46.0)	
Missing data	821 (1.6)	2894 (1.1)	
Age at suicide, mean, y			
Attempted	21	20	
Completed	26	24	
Suicide method			
Attempted suicide			Attempted
Hanging or suffocation	93 (1.9)	40 (1.2)	
Poisoning	3374 (69.2)	1635 (48.7)	
Sharp object	434 (8.9)	211 (6.3)	
Other	974 (20.0)	1470 (43.8)	
Completed suicide			Completed
Hanging or strangulation	40 (35.4)	18 (38.3)	
Poisoning	46 (40.7)	13 (27.7)	
Firearms	0	3 (6.3)	
Other	27 (23.9)	13 (27.7)	

Suicide Method

Are ADHD suicide patterns similar to regular suicide patterns?

We believe the Swedish study **revealed an important insight relevant to construction environments**, where drug use and emotional instability often go unrecognised. Among individuals with ADHD, 79.1% of suicide attempts and 56.5% of completed suicides involved poisoning, while hanging, typically the most common method in UK ONS data, accounted for only 23.9% of deaths.

According to Sweden's National Centre for Suicide Research & Prevention of Mental Health, hanging remains the most common method of suicide for men, and for both sexes combined. Female only suicides tend to show more poisonings.

This pattern may suggest that some proportion of the ADHD poisonings were impulsive or even accidental, rather than planned suicides.

How do we know if an ADHD death was suicide and not an accidental drug poisoning?

In high-risk workplace environments like construction, where ADHD often goes undiagnosed and drug use does occur, **the line between accidental overdose and intentional self-harm can become dangerously indistinct**. As highlighted earlier in this report (Section-1), thorough death scene analysis is essential to understanding **whether a worker died by suicide or by unintentional poisoning**.

Given the findings of the Swedish study which suggests ADHD persons are inclined to use drugs for suicide, the actual scale and nature of risk in this population may be misunderstood, and underestimated.



Why did ADHD not appear on the Korean cohort study cited in Section-4?

As noted in Section-4, ADHD did not emerge as a significant factor in the 2025 Korean insurance-claims' cohort. This absence should not be misinterpreted as evidence of safety. Rather, it reflects methodological limitations, only formally diagnosed cases were included, leaving many adults with undiagnosed ADHD uncounted, while comorbid conditions such as depression, substance use, and personality disorders exert greater statistical weight.

When undiagnosed, ADHD still carries significant vulnerabilities. Symptoms such as impulsivity, emotional dysregulation, and social rejection are well-established risk factors for suicidal ideation. Korean *survey*-based studies, which capture individuals outside of the health-insurance system, have confirmed that ADHD symptoms, particularly inattention, are associated with higher rates of suicidal thoughts.

The overlap with substance use is especially relevant in construction. Reduced dopamine activity often drives individuals toward alcohol, nicotine, cannabis, or illicit stimulants. In an industry where such substances are accessible and possibly culturally embedded, a cycle of dependency and heightened emotional instability could be created. When combined with prescribed stimulant medication, these patterns can produce unpredictable and dangerous effects, including rapid mood crashes and increased impulsivity.

Clarifying whether a death was accidental or intentional also has a compassionate value, helping families and colleagues understand what truly happened. In cases where impulsive or confused actions led to an unintentional overdose, recognising this distinction can alleviate misplaced guilt, ease the burden of unanswered questions, and reduce the trauma of blame.



Mental Health and Suicide Risk on Site



Do we know that mental illness is linked to suicide?

Both ADHD and schizophrenia are linked to elevated suicide risk, particularly in environments where individuals feel isolated, stigmatised, or unsupported. In construction, where employment is often transient, managerial oversight is limited, and mental health literacy is low, this creates a dangerous gap.

Workers facing social disconnection, substance misuse, or unmanaged mental illness may be more likely to engage in risk-taking behaviour, or to see **suicide as a means of escape**. For employers, recognising these patterns is not just a matter of compassion, it is a question of site safety, team cohesion, and possibly a legal duty of care.





Drug Testing in the UK Construction Industry:

DSRM is not involved in drug testing.

Whilst this report is focused primarily on suicide within the construction industry, it is important to acknowledge the significant overlap between **mental health, substance misuse, and workplace safety**. Drug and alcohol abuse not only contribute to increased suicide risk but also compromise on-site safety through impaired judgment, reduced coordination, and slower reaction times. In this session, we examine the effectiveness of workplace drug-testing programmes, as they may influence both on-site safety outcomes and off-site behaviours linked to mental health and substance misuse.

We looked at the approach to drug abuse in the industry...

Is drug-testing mandatory in the construction industry?

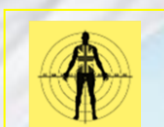
Reports on the extent of drug use and abuse in the construction industry are mixed. However, several publications have highlighted concerns about the relationship between drug abuse and site safety. Whilst drug-testing does exist, it is not mandatory within the construction industry.

Do all major industries conduct drug testing?

If we compare with several other industries which often intersect with construction; Oil & Gas, Rail, and Aviation, we see quite a different approach to the issue...



Drug Testing			
Industry	Legal Requirement	Scope of Testing	Reason/Trigger
Rail	Yes (Transport and Works Act)	Safety-critical roles	Public safety; criminal liability if impaired while on duty
Oil & Gas	Yes (OGUK & maritime law)	Compulsory offshore; strongly encouraged onshore	Safety, explosion risk, international maritime regulation
Aviation	Yes (Civil Aviation Authority)	• Pilots, • Air traffic controllers • Maintenance crew	Civil Aviation Authority (CAA) and international standards
Construction	No	Inconsistent: only ~9% subject to random testing	Industry discretion; no regulatory obligation

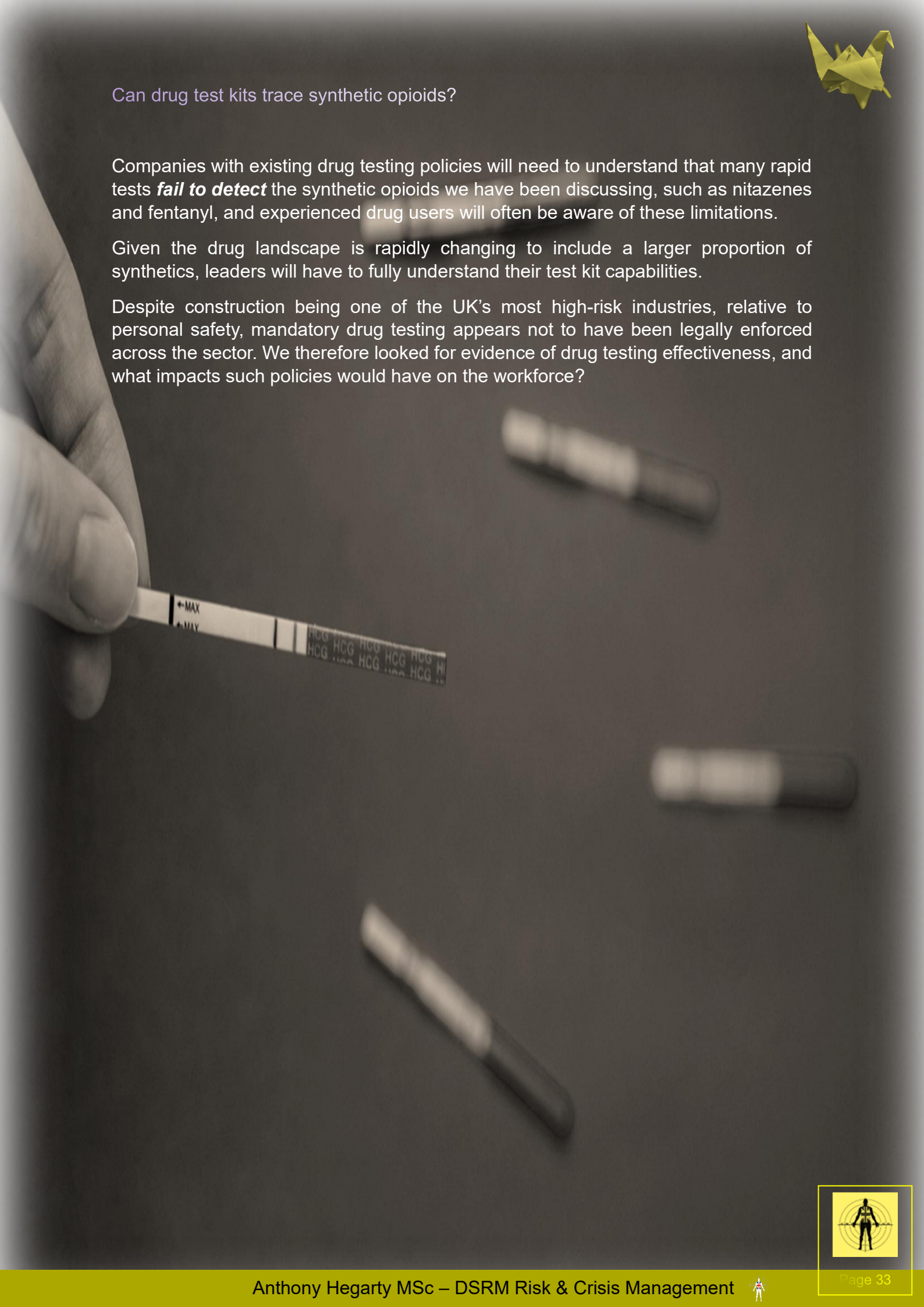


Can drug test kits trace synthetic opioids?

Companies with existing drug testing policies will need to understand that many rapid tests **fail to detect** the synthetic opioids we have been discussing, such as nitazenes and fentanyl, and experienced drug users will often be aware of these limitations.

Given the drug landscape is rapidly changing to include a larger proportion of synthetics, leaders will have to fully understand their test kit capabilities.

Despite construction being one of the UK's most high-risk industries, relative to personal safety, mandatory drug testing appears not to have been legally enforced across the sector. We therefore looked for evidence of drug testing effectiveness, and what impacts such policies would have on the workforce?





Where has drug testing succeeded?



The [Independent](#) newspaper reported in December 2019 that **Network Rail had banned 12 train drivers over an 18-month period** due to failed drug or alcohol tests, a clear example of enforcement action helping to remove impaired individuals from safety-critical roles before an incident occurred.

In the offshore oil and gas sector, drug testing is built into medical fitness assessments, and [8.2% of failed offshore certifications in 2019](#) were attributed to drug misuse.

But **we found that the most robust outcome data comes from the United States**, where mandatory testing is applied consistently across key transport sectors. One major U.S. rail operator recorded a [90% reduction in accidents caused by human error](#) after introducing drug testing.

In aviation, U.S. employees who tested positive were found to be [three times more likely to be involved in workplace incidents](#). These findings, though drawn from international sources, strongly support the rationale behind the UK's own testing policies in high-risk sectors, and **raise legitimate concerns about why such protections have not been extended to construction.**

Several reasons might contribute to an explanation for this:

Absence of Centralised Regulations

- Unlike the Rail, Oil & Gas, & Aviation industries, the UK Construction Industry has no central safety legislation requiring drug testing.
- HSWA (1974) requires employers to manage risks, but does not specify drugs' testing...
- In 2021, during a **DSRM** re-examination of the [2015 Alton Towers Smiler ride crash](#), we contacted the Health and Safety Executive (HSE) to ask whether drug use had been considered. HSE confirmed it had not explored this line of inquiry, stating that drug-related matters fall under police jurisdiction. This underscores a regulatory gap in how potential impairment is investigated following serious workplace incidents.

Fragmented Industry

Despite the considerable size of the UK construction industry, most companies are small firms and sub-contractors, and as such lack the resources or incentive to implement testing.

Low Visibility of High-Risk Synthetics (e.g. fentanyl, nitazenes)

- Synthetic opioids have been seen to be a problem for the US, not the UK, and certainly not a construction-specific one.
- Testing kits often exclude synthetics, *so employers do not appear to be anticipating the potential scale of the incoming threat.*





US Construction Companies Testing Review

Workplace drug testing in the US construction industry has shown a measurable impact on safety outcomes. In a landmark study conducted by [Cornell University](#), 405 construction companies were surveyed, with 71 providing data on injury rates before and after implementing drug-testing programmes. The results indicated a strong association between testing and improved safety performance:

- Companies that implemented drug-testing programmes saw a **51% reduction in injury rates**, from 8.92 to 4.36 injuries per 200,000 work-hours.
- In contrast, companies that did not implement testing experienced only a **14% reduction** over the same period.
- Firms with drug-testing also reported an **11.4% average reduction** in their workers' compensation experience-rating modification factors, reducing overall insurance liability and cost exposure.
- The study concluded that "drug-testing programmes, if properly implemented, can significantly reduce workplace injuries and associated costs in the construction sector."

DSRM is *not* involved in drug testing.

Does this confirm that drug testing works?

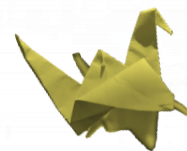
Of the 71 participant contractor companies, 31 of them provided complete pre- and post-intervention injury rates. Of these 31:

- 21 reported reductions in injuries
- 1 reported no change
- 9 reported an increase in injury rates after implementing drug testing

The increase in accidents will be surprising to some. We are unable to explain this, but provide here several possible explanations:

False Sense of Safety (Testing = Problem Solved)	• May have introduced testing, then reduced other safety measures – over-relying on drug-testing to reduce risks. • Tests may have created complacency among management or supervisors.
Poor Implementation	• Misunderstood ("<i>They're trying to catch us out</i>") • Resisted (actively or passively). • Undermined by poor procedures (e.g. infrequent testing, inconsistent follow-up).
Low Morale & Distrust	• Workers may have felt they are being targeted or humiliated by testing, eroding trust & reducing teamwork / communication. • Psychological stress linked to workplace surveillance and job insecurity may itself increase accident risk (tiredness, distraction, errors).
No Complementary Safety Changes	• In the absence of a broader safety culture shift, drug testing may have no meaningful impact, or worse, divert attention from root causes (e.g. fatigue, poor planning, unsafe machinery). • Testing alone does not change behaviours, attitudes, or environment.
Coincidental or driven by unrelated factors	• Bad weather seasons • Labour shortages • Sudden contract pressures or deadlines





Drug Testing “Alone” May *not* be Sufficient

Is drug testing the solution to site safety?

What is clear from the above data is that some construction companies saw injury rates go down after introducing drug testing, but another did not, and some even got worse. This suggests that **simply adding a drug-testing policy without changing anything else does not guarantee better outcomes.**

What Should Be Included Alongside Testing?

Training: Educate workers & supervisors	• Why testing is done (safety, <i>not punishment</i>). • How drug misuse affects performance and decision-making. • How substances impair judgement, reaction time, and coordination. • What to do if someone needs help.
Support: Real solutions for those who test positive	• Access to counselling or rehabilitation (Employee Assistance Programmes). • Return-to-work policies that prioritise recovery. • Confidentiality protections to reduce fear of dismissal.
Data-Driven Monitoring: Track results, not just tests	• Are injuries decreasing? • Are the same subcontractors repeatedly testing positive? • Is drug use shifting (e.g. more synthetics)?

Striking the Right Balance: Testing Without Threat

Does drug testing intimidate workers?

Drug and alcohol testing policies in construction must strike a careful balance. For many workers, particularly those who developed substance dependencies because of attempting to manage pain, drug testing can feel less like a safety tool and more like a threat. A programme that is perceived as punitive risks driving the problem underground, **increasing concealment rather than promoting support.**

The objective should *not* be to "catch offenders" but to create a culture where safety, recovery, and dignity are prioritised. This raises valid questions:

- Should tests be mandatory or optional?
- Should they be random, or scheduled in advance?

Innovative approaches could include:

- Voluntary daily testing with small incentives (*e.g. coffee vouchers, cinema tickets*) to normalise participation and reward openness.
- Pattern monitoring of workers who occasionally test or consistently avoid testing, not for punishment, but for engagement, conversation, and support.
- Clear boundaries and communication: random testing may still be necessary for high-risk roles, but its purpose should be transparent and its process fair.



Will drug testing fix the problems?

A meaningful drug testing programme in construction should be part of a wider mental health and injury recovery framework, *not* a standalone tool. When implemented with empathy, consistency, and structure, **testing becomes a point of contact, not a point of conflict.**

Testing Approach	Outcome	Worker Response	Culture Created
Punitive, zero-tolerance	Fear of dismissal	Avoidance, denial, concealment	Suspicion, blame, silence
Support-first model (with clear policy)	Early identification + pathway to support	Increased disclosure and willingness to engage	Trust, openness, shared responsibility
Random testing without explanation	Sporadic deterrence	Confusion, resentment, inconsistent compliance	Mixed signals, short-term fear-based control
Voluntary daily testing with small rewards	Normalisation of testing and routine engagement	Higher participation, early issue detection	Proactive safety culture, shared accountability
Fixed-date testing	Opportunity to "game the system"	Temporary abstinence before test	Superficial compliance, not lasting change

Would a voluntary testing system lead to drug users avoiding tests?

A concern with voluntary testing might be that those most at risk, particularly individuals struggling with substance abuse, will opt out, making early detection impossible. However, **this very pattern of avoidance can itself become a signal.**

In well-designed voluntary programmes:

- Participation is tracked over time, not judged in isolation.
- Workers who consistently avoid testing, test only around key dates (e.g. site inspections), or stop testing after previously participating, are flagged for discreet supportive follow-up.
- This "pattern intelligence" allows supervisors or safety leads to detect potential emerging risks without coercion or confrontation.

Additionally:

- When most of the team tests regularly, non-participation becomes more visible, allowing for soft engagement before problems escalate.
- Voluntary testing with small incentives help to normalise testing and makes opting out a deviation from the norm. Incentive ideas might include...

Gift cards	Sporting events	Classes and courses (think B-Plans: Section-9))
Box of biscuits	Paid time off	Nominated charity donation





The Costs' Considerations / Limitations

Is testing realistic?

We recognise that voluntary drug testing incentive programmes will largely remain the preserve of larger construction companies. The cost of such programmes can be offset in part through reduced accident rates, lower absenteeism, and long-term reputational gains. Once established among the major players, smaller subcontractors may follow suit, even if in scaled-down forms, especially when safety compliance and subcontractor vetting begin to favour companies that participate in such schemes.

Will Drug Testing Reduce Suicide Risks?

What we have learned so far suggests that many suicides in the construction industry stem from personal issues outside of work. **Drugs are often used as a coping mechanism, for both physical pain and mental health challenges.** But the cycle can be self-destructive: **those experiencing depression from recreational drug use may turn to even more drugs in an attempt to cope, deepening their decline.**

As noted earlier, individuals with underlying mental health conditions such as ADHD may be more vulnerable to drug misuse. Others, such as workers recruited from the prison system, may conceal long-term drug dependencies, particularly those with theft convictions, a group also at heightened suicide risk, possibly due to addiction-driven behaviour.

In this context, a well-structured drug testing programme, supported by clear explanations and training, could serve as an early intervention tool, encouraging those affected to come forward and seek help before reaching crisis point, they may not even see coming.



Whilst we understand [Barratt Homes](#) conducts random drug testing, we were unable to identify any UK construction companies currently operating a voluntary drug testing policy.

There are, of course, practical exceptions; for example, roles involving heavy plant or machinery may rightly demand more enforced approaches due to the safety-critical nature of the work.

But developing successful drug policies is largely dependent on the level of knowledge / understanding that leaders have of drugs themselves...





Do construction / HSE leaders have a sufficient level of knowledge on drugs?

If we were to imply that **drugs could be contributing to the suicide rates** within the construction industry, then we wanted to examine the level of knowledge about drugs within leadership roles. We did this by joining multiple construction industry groups on LinkedIn and placing multiple weekly polls / quizzes on drugs. Members of these groups hold largely supervisory, management or senior leadership positions.

While the number of survey responses represents only a fraction of the total membership, the 4,255 responses gathered over a 10-week period still offer valuable insight, and highlight a concerning lack of awareness around the dangers of drugs in the construction industry.

It is also worth noting that while many respondents were based in the UK, participation was not limited to the UK alone.

We asked 10 drug-related questions relevant to the construction sector in each group. The results are outlined below.

LinkedIn Groups

[Linking Construction](#)

[HSE People](#)

[Construction Environment Health & Safety](#)

[Construction Who's Who](#)

[Civil Engineering & Construction](#)

[Construction Safety Group](#)

[OSHA Discussion & Support
\(Occupational Safety / EHS / HSE\)](#)

[Middle East Construction Who's Who](#)

[Construction & Project Managers](#)

Here we provide an **overview of the ten questions asked**, and the responses.

Quiz	Question Topic	Correct Answer	% Correct	% Incorrect	Key Insight
1	Alcohol + Cocaine	Major stress on the heart	90.9%	9.1%	All incorrect answers reflected positive misconceptions .
2	Cannabis & Mental Health	A combination of the above	67.8%	32.2%	Many leaned toward single-solution thinking .
3	Marijuana & Lung Disease Detection	Masks symptoms	69.3%	30.7%	Significant belief in health benefits or neutrality .
4	Cocaine in Construction	Anxiety risk	83.7%	16.3%	Some believed in productivity enhancement .
5	ADHD & Marijuana	Low dopamine levels	26.4%	73.6%	Most believed in functional benefits — major myth.
6	Heroin & Brain Impact	Damages white matter	48.3%	51.7%	Misunderstood short-term vs long-term impact .
7	Psychedelics on Site	All of the above	90.6%	9.4%	Most understood multi-layered danger .
8	LSD & Drug Testing	Symptoms from historic use	7.8%	92.2%	Massive misunderstanding — most believed LSD cannot be traced .
9	Cocaine & Gas Explosion	Cocaine kills smell	67.6%	32.4%	Many blamed poor training , not hidden sensory loss.
10	Marijuana & Addiction Terminology	Psychological dependence	50.2%	49.8%	Deep confusion over addiction vs dependence .

We now provide a more detailed analysis of each question & answer...





= Correct response.

= Incorrect response.

1. What happens if you drink alcohol (a depressant) while also consuming cocaine (a stimulant)?

Key Insights

Major stress on the heart. 741

Reduces risk of hangover. 19

Enhances focus & control. 39

Prevents drunkenness. 16

Participants 815

Correct response 741 → 90.9%

Incorrect response 74 → 9.1%

While only 9.1% got it wrong, all of them chose answers that suggest perceived benefits of combining alcohol and cocaine, a dangerous misunderstanding. That makes this minority statistically small but educationally significant, particularly in a workplace or safety training context.

2. The links between marijuana use and mental illness are well-established, particularly if usage began during teenage years. What should be done?

Key Insights

Comprehensive Drugs Education 61

Random Drug Testing 32

Clear Penalties for Drug Abuse 20

A Combination of the Above 238

Participants 351

Correct response 238 → 67.8%

Incorrect response 113 → 32.2%

Roughly 1 in 3 participants (32.2%) selected only one response as the appropriate solution, reflecting a tendency to favour partial or single-track approaches (education, testing, or penalties in isolation).

This suggests a potential underestimation of the need for multi-faceted intervention when dealing with cannabis and adolescent mental health risks.

3. How can marijuana use impact the early detection of work-related lung diseases in construction worker?

Key Insights

It masks symptoms coughing/shortness of breath), delaying diagnosis. 192

It improves lung health by reducing inflammation permanently. 26

It prevents lung diseases by acting as a natural air purifier. 18

There is no impact—marijuana use and lung health are unrelated. 41

Participants 277

Correct response 192 → 69.3%

Incorrect response 85 → 30.7%

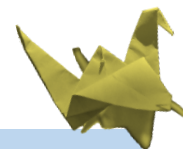
Over 30% of respondents either believed marijuana has no impact on lung health or that it benefits lung function — both medically unsupported and dangerous assumptions.

Notably:

- 15.6% (44 votes) selected answers implying positive respiratory effects (air purification or inflammation reduction).
- 14.8% (41 votes) thought marijuana and lung health were unrelated.

This reflects a significant knowledge gap in how cannabis use can obscure serious occupational illnesses, particularly in high-risk sectors like construction where early detection is vital.



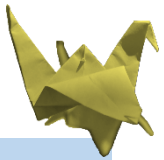


4. People with ADHD brains can be attracted to marijuana because...		Key Insights
They have low dopamine levels.	84	Nearly 3 out of 4 participants chose functionally appealing, but incorrect explanations for ADHD–marijuana use. • 88 (27.7%) thought marijuana helps concentration, a misconception often repeated in ADHD circles. • 88 (27.7%) believed it blocks distractions. • 58 (18.2%) said it calms job-site noise. Each response reflects functional or self-medicating justifications, and shows a gap in understanding the neurochemical roots of ADHD vulnerability to substance use, specifically the dopamine-deficiency link.
Marijuana helps concentration.	88	
It blocks out distractions.	88	
It calms the noise of the site.	58	
Participants	318	
Correct response	84 → 26.4%	
Incorrect response	234 → 73.6%	

5. The UK is the world's second-largest consumer of cocaine. In construction, which of the following is a key risk associated with cocaine use?		Key Insights
Increase Energy = Output HIGH	45	While the majority (83.7%) understood the mental health risks, 16.3% chose answers that: • glorified the effects ("Energy = Output HIGH", "Alertness = Risks LOW") • denied impacts ("No significant impact"). This means: • 14.2% (64 votes) saw perceived workplace benefits of cocaine, reinforcing a dangerous myth, especially in a productivity-driven industry like construction. • A further 2% (9 votes) dismissed cocaine as harmless, a red flag for safety culture.
Improves Alertness = Risks LOW	19	
Mental Health = Anxiety HIGH	376	
No significant impact	9	
Participants	449	
Correct response	376 → 83.7%	
Incorrect response	73 → 16.3%	

6. Heroin impacts the brain by...?		Key Insights
Boosting grey matter.	21	This was a split-field result, with just under half of respondents identifying the correct neurological damage caused by heroin. More specifically: • 39.4% (80 votes) believed heroin enhances dopamine, a common oversimplification. While opioids do temporarily increase dopamine, the correct concern here was structural brain damage (white matter). • The rest (~12.3%) either had misplaced optimism ("boosting grey matter") or saw it as a stress reliever ("allowing downtime"). This highlights: • A knowledge gap between short-term effects (euphoria/dopamine surge) vs. long-term harm (white matter damage). • The need to reframe drug education around invisible but lasting neurological consequences — not just overdose and addiction.
Damaging white matter.	98	
Enhancing dopamine.	80	
Allowing downtime.	4	
Participants	203	
Correct response	98 → 48.3%	
Incorrect response	105 → 51.7%	





7. Psychedelics like LSD and Magic Mushrooms are making a comeback. Why is the side effect belief, 'I can fly,' a serious risk in construction?

Key Insights

Fall-from-height risk increase.	36
Impairs judgment on scaffold.	8
May go unnoticed by coworkers.	4
All of the Above.	462

Participants 510

Correct response 462 → 90.6%

Incorrect response 48 → 9.4%

This was a strong result, with over 90% of participants understanding that the risks from psychedelics in construction are multi-layered, not isolated.

Of the 9.4% who got it wrong, each selected only one aspect of the threat, showing:

- Some awareness of partial risk, but a lack of full context, which is critical in safety-sensitive environments like construction.

This quiz reinforces the importance of promoting broad situational awareness around drug-induced behaviours, particularly in high-risk zones like scaffolding.

8. You have top-tier drug test kits. A worker, took LSD; wants to fly from the scaffold. Later, he is tested. But no trace of drugs. Why?

Key Insights

He drank lots of water with it.	41
LSD balanced out by alcohol.	27
Symptoms from historic use.	31
Test kits cannot trace LSD.	298

Participants 397

Correct response 31 → 7.8%

Incorrect response 366 → 92.2%

Just 7.8% correctly identified historic LSD use as the source of lingering symptoms.

Instead:

- 75.1% (298 votes) mistakenly believed LSD cannot be traced, a popular myth that underestimates detection capabilities of some advanced kits.
- Others blamed water dilution (10.3%) or interaction with alcohol (6.8%).

This result highlights a widespread misunderstanding of LSD's long-term psychological risks. Flashbacks, hallucinations, and disassociation can occur long after use, without any detectable substance remaining in the body. This makes such symptoms invisible to drug tests but still dangerous, especially in high-risk environments like scaffolding.

NOTE: Passing a drug test does not always mean a worker is safe to be on-site.

9. A builder lit a cigarette on-site, triggering a gas explosion. He had been a long-term cocaine user. What caused him to miss the gas leak?

Key Insights

Poor training.	178
Blocked nose from a cold.	12
Fatigue.	27
Cocaine kills sense of smell.	453

Participants 670

Correct response 453 → 67.6%

Incorrect response 217 → 32.4%

While a strong majority (67.6%) identified anosmia (loss of smell) from chronic cocaine use as the key factor, nearly 1 in 3 respondents blamed:

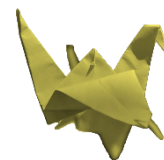
- Training deficits (26.6%)
- Fatigue or minor illness (5.8%)

This highlights a major point for site safety culture:

Even well-trained, seemingly alert workers may still lack critical senses, in this case, smell, due to long-term drug use. This creates hidden vulnerabilities in hazardous environments, particularly where gas leaks or chemical vapours are involved.

It is a powerful example of how undetected long-term drug effects can lead to catastrophic outcomes, and a reminder that drug history matters, not just the day-of impairment.





10. Addiction is a term NOT generally used for marijuana because...		Key Insights
It is non-addictive.	48	Here we see considerable confusion over marijuana's addictive potential and classification. • 18.1% believed cannabis is non-addictive. • 17.7% claimed there is no withdrawal, despite well-documented symptoms: irritability, insomnia, & cravings. • 14% incorrectly tied addiction to method of use, e.g., injection, showing a poor understanding of addiction mechanics.
Dependence is psychological.	133	
It is not injected.	37	
There is no withdrawal.	47	
Participants	265	
Correct response	133 → 50.2%	
Incorrect response	132 → 49.8%	

The Survey Results

The results of these surveys highlight a clear need for enhanced and targeted drug awareness training within the construction sector. While many participants demonstrated a solid grasp of certain risks, serious misconceptions persist, especially around cannabis, LSD, and the long-term neurological effects of various substances.

These misunderstandings are not just academic; they obscure the very real ways that drug use can alter brain chemistry, reduce emotional resilience, and contribute to anxiety, depression, and ultimately **suicidal ideation**. In a sector already battling high suicide rates, overlooking the link between drug misuse and mental health outcomes is a critical gap.

Fortunately, several training providers offer drug programmes tailored to construction environments, with some beginning to address these deeper risks. Investing in such training is not simply about compliance or safety, it is a proactive step toward preventing the hidden psychological harms that too often lead to tragic outcomes.





1. CITB – [Substance Misuse Awareness Module](#)

Overview:

CITB, the industry's leading training authority, offers a **Substance Misuse Awareness** course aimed at supervisors and operatives. It provides an overview of the effects of alcohol and drugs on health and safety, signs of misuse, and employer responsibilities.

Strengths:

- Nationally recognised standard
- Often integrated with other mandatory HSE training
- Suitable for toolbox talks or safety stand-down days

Limitations:

- Largely compliance-focused
- Tends to consist of links to external information sites
- Limited psychological depth (e.g., no ADHD, suicide, or long-term effects)

citb Levy, grants and funding Courses and qualifications Standards and de

Home > Standards and delivering training > Health and safety publications and support materials >

B: Health and welfare

- B01: Management of health
- B02: Welfare facilities
- B03: Stress and mental health at work
- B04: Drugs and alcohol

B04: Drugs and alcohol

- 4.1 On average, 350,000 people are admitted to hospital every year as a result of alcohol. For further information visit the [Drinkaware website](#).
- 4.2 For the latest statistics on alcohol-related deaths, visit the [Government website](#).
- 4.4 A document detailing drug misuse and statistics can be found on the [Office for National Statistics website](#).
- 4.5 For up-to-date A to Z lists of drugs and currently-used slang terms, as well as free impartial information, advice and guidance on all of the different drugs available and their effects on people, visit the [Talk to Frank website](#).
- 4.6 Visit the [Drinkaware website](#) for an alcohol unit calculator.
- 4.6 For an employers' guide to alcohol at work visit the [HSE website](#).
- 4.8.2 Employer associations, solicitors and professional bodies (such as Alcohol Change UK, Phoenix Futures or DrugWise) can advise and help develop a workplace alcohol and drugs policy.

- [Alcohol Change UK](#)
- [Phoenix Futures](#)
- [DrugWise](#)





2. The Lighthouse Construction Industry Charity – [Wellbeing Academy](#)

Overview:

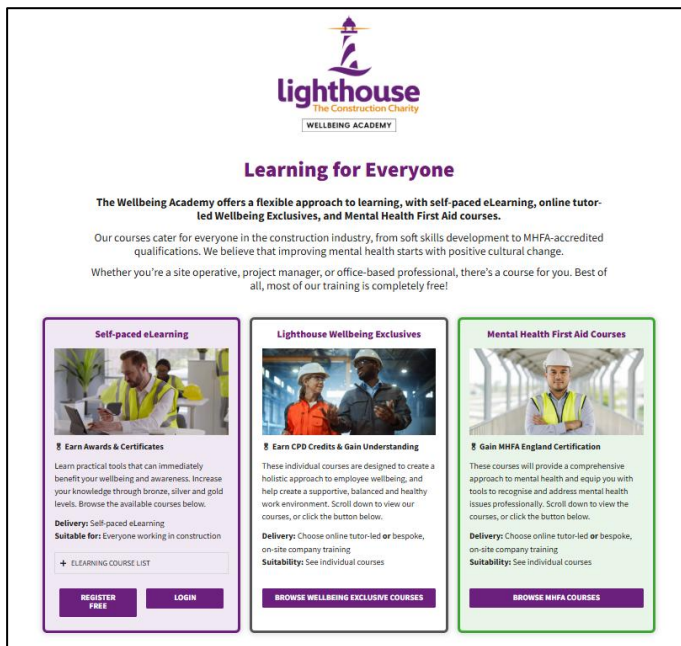
Lighthouse Club offers **free training and support services** through its Wellbeing Academy, focusing on mental health, addiction, and emotional wellbeing. Courses include “Understanding Addiction” and “Drugs and Alcohol – Starting the Conversation.”

Strengths:

- Charitable access — free to workers
- Addresses stigma and encourages early help-seeking
- Strong integration of lived-experience case studies

Limitations:

- Not industry-mandated
- Less technical focus on site-specific risks (e.g. impairment and hazard interaction)



The screenshot shows the Lighthouse Wellbeing Academy website. At the top is the Lighthouse logo with the tagline 'The Construction Charity' and 'WELLBEING ACADEMY'. Below this is the heading 'Learning for Everyone'. A paragraph states: 'The Wellbeing Academy offers a flexible approach to learning, with self-paced eLearning, online tutor-led Wellbeing Exclusives, and Mental Health First Aid courses. Our courses cater for everyone in the construction industry, from soft skills development to MHFA-accredited qualifications. We believe that improving mental health starts with positive cultural change. Whether you're a site operative, project manager, or office-based professional, there's a course for you. Best of all, most of our training is completely free!'

There are three main course categories:

- Self-paced eLearning:** Earn Awards & Certificates. Learn practical tools that can immediately benefit your wellbeing and awareness. Increase your knowledge through bronze, silver and gold levels. Browse the available courses below. Delivery: Self-paced eLearning. Suitable for: Everyone working in construction. Includes a 'REGISTER FREE' and 'LOGIN' button.
- Lighthouse Wellbeing Exclusives:** Earn CPD Credits & Gain Understanding. These individual courses are designed to create a holistic approach to employee wellbeing, and help create a supportive, balanced and healthy work environment. Scroll down to view our courses, or click the button below. Delivery: Choose online tutor-led or bespoke, on-site company training. Suitability: See individual courses. Includes a 'BROWSE WELLBEING EXCLUSIVE COURSES' button.
- Mental Health First Aid Courses:** Gain MHFA England Certification. These courses will provide a comprehensive approach to mental health and equip you with tools to recognise and address mental health issues professionally. Scroll down to view the courses, or click the button below. Delivery: Choose online tutor-led or bespoke, on-site company training. Suitability: See individual courses. Includes a 'BROWSE MHFA COURSES' button.



The screenshot shows a course page for 'Taking Control: Drugs & Alcohol'. It features an image of various pills and a bottle. The title is 'Taking Control: Drugs & Alcohol' and it is described as an 'Online tutor-led course (1 hour)'. Below this is a 'DESCRIPTION' section. The text states: 'Suitable for: Everyone working in construction. This course will explore the physical and mental effects of drugs and alcohol, the importance of regular employee testing for organisations, and the consequences of a positive test on both work and home life.' At the bottom is a 'BOOK FREE COURSE' button.





3. DSRM Risk & Crisis Management – [Drugs In Construction](#)

Overview:

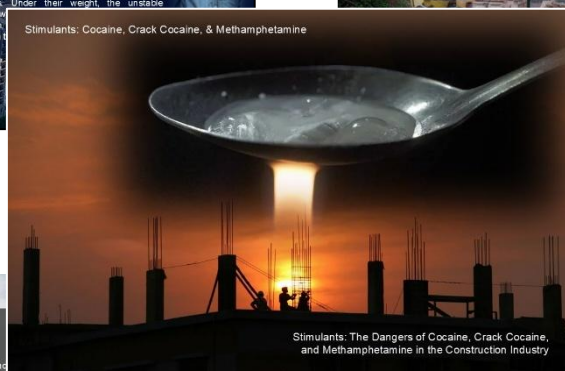
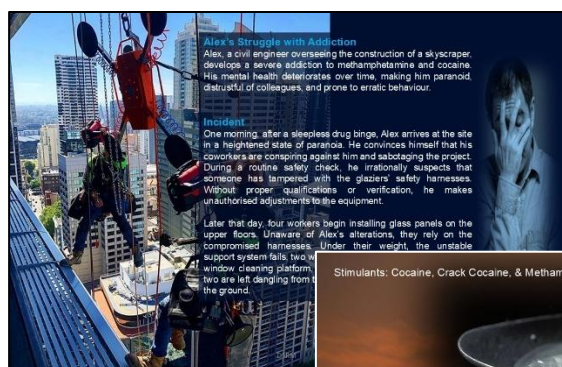
DSRM offers a specialised training course focusing on the **real-world impact of drug use within construction**, including site safety, psychological dependency, and emerging drug trends. Modules cover stimulants, cannabis, psychedelics, prescription drug misuse, ADHD, and the suicide risk connection.

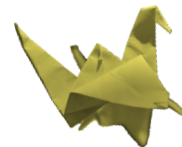
Strengths:

- Built specifically around construction-site scenarios
- Deep dive into drugs' cognitive and safety impacts
- Materials regularly updated
- Offers corporate branding & customisation on modules
- Delivered online through **automated presentations** with annual in-person workshop sessions
- Includes modules for teenage kids of participants
- Leadership modules for advanced learning

Limitations:

- Considerable history in corporate, police & government training, but newer to the construction landscape compared to other groups mentioned
- Course delivers its own completion records - Not yet linked to industry-wide certifications





4. Building Mental Health – [Industry Framework & Resources](#)

Overview:

An industry-wide initiative created by construction leaders to **embed mental health support** into every level of site life. Offers free downloadable toolbox talks, mental health first aid support, and awareness videos (including substance misuse elements).

Strengths:

- Highly collaborative approach across the industry
- Encourages **senior leadership involvement**
- Good for kickstarting conversations and cultural change

Limitations:

- Lacks formal assessment or certification
- Drug content is limited — primarily focused on stress, anxiety, and suicide

	
Building Mental Health framework	5 Steps to building a successful mental health culture
	
Free adaptable Tool Box Talk	Mental Health First Aid Training



Section Conclusion

This part of our investigation showed that drug use in the construction industry cannot be separated from wider social and economic forces. We found that shifting perceptions, inadequate medical alternatives, and the influx of synthetic substances have combined to deepen risks of dependency, depression, and suicide.

We also found that whilst drug testing alone cannot resolve the problems, leadership knowledge remains limited. What is required is a more informed and proactive approach, one that recognises the complexity of these issues and responds with education, support, and accountability across the sector.





Investigation Stage 2 / Stage 3 - We Request Your Support

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](https://www.dsrmrisk.com/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.

