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**Suicide and the workplace – Intervention,
prevention and support for people
affected by suicide – Guide**

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Foreword

Publishing information

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- Individual capacity – Business psychologist
- Individual capacity – Clinical academic
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- Individual capacity – HR and wellbeing expert
- Individual capacity – HR specialist
- Individual capacity – Large-scale infrastructure projects
- Individual capacity – Mental health in financial services
- Individual capacity – Mental health training provider
- Individual capacity – Occupational psychologist
- Individual capacity – Practicing nurse
- Individual capacity – Public health expert
- Individual capacity – Risk management in financial services
- Individual capacity – Speaker and advocate

- Individual capacity – Specialist support provider
- Individual capacity – Trauma recovery consultant
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- National Centre for Suicide Prevention Education and Training (NCSPET)
- National Grid Electricity Transmission
- NHS Wales
- North London NHS Foundation Trust
- Public Health Agency (PHA) Northern Ireland
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- Suffolk Mind
- Survivors of Bereavement by Suicide
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As a guide, this British Standard takes the form of guidance and advisory recommendations. It is not to be quoted as if it were a specification or a code of practice.

Presentation conventions

The guidance in this document is presented in roman (i.e. upright) type. Any recommendations are expressed in sentences in which the principal auxiliary verb is “should”.

Additional commentary, explanation and general informative material is presented in smaller italic type.

Where words have alternative spellings, the preferred spelling of the *Shorter Oxford English Dictionary* is used (e.g. “organization” rather than “organisation”).

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Compliance with a British Standard cannot confer immunity from legal obligations.

In particular, attention is drawn to the following specific Acts and regulations:

- Health and Safety at Work etc. Act 1974 [1]; and
- Management of Health and Safety at Work Regulations 1999 [2].

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0 Introduction

0.1 General

This British Standard summarizes measures that organizations can take for suicide prevention, intervention and support for those affected by suicide. It provides guidance on creating and sustaining safe, supportive work environments where people can thrive and survive in life and through crises. Avoiding the human tragedy of suicide through suicide prevention strategies, systems, policies and practical actions is always preferable to responding, unprepared, to a person in crisis or to a death by suicide.

Some measures described in this British Standard are generic good practice for sustainable success within teams and organizations. Some are more specific to suicide prevention. Some might be unfamiliar or seen to be “an additional cost of doing business”. However, organizational suicide prevention programmes/initiatives can have broader business benefits as well as reducing the risk of suicide¹⁾. They are an investment to try and avoid the potentially devastating costs of preventable suicide deaths and the wide and deep ripple effect created by exposure to suicide.

Almost every workplace is affected by suicide at some point, whether through the suicide of a colleague, seeing a colleague losing a loved one to suicide, knowing someone experiencing a suicide crisis, or by witnessing a suicide or suicide attempt. Where these traumatic experiences are visible or talked about openly, the adverse impacts are more evident.

However, many organizations are not aware of the full impacts of suicide. This might be due to a lack of knowledge, understanding, confidence and/or competence in talking about suicide. These, alongside stigma and shame, prevent open discussions. This means that while suicide is relatively rare, exposure to suicide is much more common than most people realize. In fact, one in four adults have thought of taking their own life and 1 in 13 have made a suicide attempt at some point²⁾. For every death by suicide, at least 135 people are exposed and potentially impacted³⁾. This includes those who knew the person indirectly, e.g. through being a client of a provided service, a patient, or having witnessed the death. In addition, those bereaved by suicide are at a heightened risk of suicide themselves⁴⁾.

A single suicide of a colleague is a devastating experience. Commonly, managers and workers react by wanting to do everything they can to prevent further suicides. However, people can go through a wide range of reactions and emotions, including anger, grief, guilt, silence and withdrawal. Some will be more affected than others. Many will be unsure of what to do or say. Some may even feel resentful that it is not business as usual. There is no right or wrong reaction or timeframe for these emotions. Acknowledging this range of emotions and calling for understanding recognizes this complexity.

Stigma around suicide remains strong in society, and this stigma extends into the workplace. People struggling with thoughts of suicide, suicide behaviours or bereavement often feel shame and might fear judgment, career damage, or job loss, while workers might avoid difficult conversations due to uncertainty about how to help or worry that they might make things worse. Stigma might also be a reason why not everyone sees suicide prevention as a workplace concern. However, it is unrealistic to expect people to leave their personal struggles at home. Thoughts of suicide and suicide behaviours rarely have a single cause but are a complex interplay of different factors, some of which might be work based.

¹⁾ Further information is given in the article *Workplace interventions to prevent suicide: A scoping review* [3].

²⁾ Further information is given in the article *Adult psychiatric morbidity survey: Survey of mental health and wellbeing, England, 2023/4* [4].

³⁾ Further information is given in the article *How many people are exposed to suicide? Not six* [5].

⁴⁾ Further information is given in the article *Proportion of suicides in Denmark attributable to bereavement by the suicide of a first-degree relative or partner: Nested case-control study* [6].

Language matters, and the language used when discussing suicide in the workplace is an important tool in reducing stigma and encouraging help-seeking. Terms that reinforce negative perceptions, such as “committed suicide” implying criminality, or “successful/failed” suicide attempt, unintentionally frame suicide as an achievement or personal failure. Neutral and supportive language, such as “died by suicide” or “lived through a suicide crisis”, is more appropriate. These terms acknowledge the seriousness of suicide without judgement. Additionally, the term “suicidal” is too broad and vague. It does not distinguish between thoughts of suicide or suicide behaviours. Being able to differentiate between these allows for more tailored and appropriate responses; for example, someone experiencing thoughts of suicide might need emotional support and signposting to resources, while someone engaging in suicide behaviours might require immediate intervention. Encouraging the use of respectful language helps create a culture where workers feel safe discussing their thoughts and accessing support without fear.

This also includes the language used by an organization following a death in the workplace, where terms like “sudden death” or “suspected suicide” are appropriate until official confirmation occurs. As such, this British Standard uses “suicide” to include suspected suicide deaths.

The trauma and grief of exposure to suicide, without the appropriate support and suicide prevention measures in place⁵⁾, can have a significant adverse impact on workplace attendance, retention, performance and productivity levels. Each organization can take steps to build psychologically supportive work environments which will likely make them more conducive to suicide prevention, more supportive of those exposed to suicide, more knowledgeable and more confident in talking about suicide and in taking actions that prevent suicide.

Most people who die by suicide are of working age. Whilst the causes of suicide are often complex and multifactorial, workplaces are key settings for suicide prevention and most suicides are preventable.

As the profile of suicide and suicide prevention rises, there are also increasing risks (e.g. reputational, recruitment, retention) to organizations that are seen as unsafe or as not giving sufficient attention to suicide prevention. Organizational suicide prevention, intervention and support initiatives have the potential to make a significant and meaningful impact. This British Standard provides guidance on how to make that impact happen.

0.2 Myths around suicide, thoughts of suicide and suicide behaviours

Few people have a high level of knowledge and understanding about suicide and suicide prevention, and there are many myths and misconceptions which are detailed below. Understanding the facts can help users of this British Standard to support those affected by suicide.

Myth 1: Asking someone directly if they are thinking about suicide “plants” the idea in their head

There is no evidence that asking someone directly if they are thinking about suicide makes them more likely to act on, or increase, those thoughts. In fact, it opens up a conversation that could help the person get the help they need.

Myth 2: Those who talk about suicide are not at risk of suicide

People who die by suicide have often told someone that they do not feel life is worth living or that they feel there is no future. Some might have said they want to die. Every conversation or disclosure needs to be taken seriously⁶⁾. By talking to someone, they are likely to be reaching out for help.

⁵⁾ Further information is given in the article *Workplace interventions to prevent suicide: A scoping review* [3].

⁶⁾ Further information is given in the article *Does asking about suicide and related behaviours induce suicidal ideation? What is the evidence?* [7].

Myth 3: It is always obvious when someone is experiencing thoughts of suicide

Some people might show lots of signs, while others display only a few – or even none which are obvious. The challenge is that those around them miss, dismiss or avoid them.

Most people have never been taught the warning signs, and guidance on how to spot potential signs is given in 7.3.

It is always best to ask directly.

Myth 4: Suicide behaviour and self-harm is “just attention seeking”

This myth has no place in the workplace. It reinforces very unhelpful stigma around suicide and self-harm. Some people do disclose self-harm as a means of seeking support, because they might find it difficult to express what they are feeling verbally. This is not simply “attention-seeking” behaviour so much as a communication of a need for help. The person needs support, but the right support, in the right way. The response is very important in setting the tone for future help-seeking.

Myth 5: All people who self-harm are trying to end their life

For most people, self-harm is a coping mechanism. Rather than trying to end their life, people self-harm to manage their distress and carry on⁷⁾. However, for some people, self-harm might be related to thoughts of suicide or a clear desire to end their life, and is a suicide attempt.

Myth 6: Suicide and self-harm happen in certain groups, or especially those who are in contact with mental health services (“it won’t affect me”)

Suicide can affect anyone, at any time.

Although suicide is more common in men (particularly middle-aged men), as well as those with mental health conditions, and self-harm is more common in young people, particularly females, it is not exclusive to those groups. It can, and does, occur in all ages, abilities, sexes, genders, cultures, socio-economic groups and ethnicities. Most people who die by suicide are not known to mental health services⁸⁾ and many mental health conditions are unrecognized or not diagnosed.

Suicide can affect any workplace and any worker in that workplace.

Myth 7: Men don’t seek help for thoughts of suicide and self-harm or suicide behaviours

Some evidence suggests that men in general tend to cope with distress differently from women. Men might seem aggressive rather than sad, and want to do something active rather than talk about their feelings. Men actually do increasingly seek help prior to death by suicide⁹⁾. It is possible that responses to men in distress are different from responses to women in distress. It is important to address this imbalance.

Myth 8: People bereaved by suicide do not want to talk about the person who has died

Although they might find it hard to talk about their loss, bereaved people might still want to share their memories of the person they lost and to celebrate their life. They need appropriate listening and support to enable them to talk about their loss and grief.

⁷⁾ Further information is given in Chapter 4 of *Adult psychiatric morbidity survey: Survey of mental health and wellbeing, England, 2023/4* [4].

⁸⁾ Further information is given in the article *Annual report 2025: UK patient and general population data 2012-2022* [8].

⁹⁾ Further information is given in the article *Contacts with primary and secondary healthcare prior to suicide: Case-control whole-population-based study using person-level linked routine data in Wales, UK, 2000-2017* [9].

Myth 9: There's a set period within which to grieve a loved one lost to suicide

Bereavement is personal, and every experience is unique. Bereaved people often do not simply “move on” or “get over” the death of a loved one. A traumatic loss like a suicide can have a lifetime impact.

Myth 10: Only family or friends of someone who has died by suicide are impacted by their death

Anyone can be bereaved or experience strong reactions to a death by suicide. They might be emotionally affected by the loss, regardless of the nature of their relationship. People might identify or look up to the person who has died, they might have had previous personal experiences of suicide bereavement or behaviours¹⁰⁾ or be a first responder or a witness to the suicide or suicide attempt.

0.3 Questions that this British Standard can help to address

[Table 1](#) identifies specific subclauses and annexes that address important questions in this topic.

Table 1 — *Examples of questions that this British Standard addresses*

Question	Subclause/annex
What is a supportive workplace culture?	4.1
What are the ethical considerations?	5.3
What are the causes of workplace distress?	6.3
How do I reduce access to means of suicide?	6.6
How do I recognize the signs of suicide?	7.3
How do I ask about suicide?	7.4
What about confidentiality when someone talks to me about suicide?	7.5
What can an organization do following the suicide death of a colleague?	7.4 to 7.8
What are HR's responsibilities and what are a line manager's responsibilities?	Annex B and Annex D
How do I support a colleague's return to work after a suicide attempt?	Annex B , B.7
What practical things can an organization do for suicide prevention?	Annex D
How do I create an individual's safety plan?	7.9 and Annex D

¹⁰⁾ Further information is given in the article *How many people are exposed to suicide? Not six* [5].

1 Scope

This British Standard gives guidance to organizations on prevention, intervention and support for people affected by suicide.

It covers policies and systematic prevention and intervention practices for workers and other people in contact with the organization (e.g. service users, customers, suppliers, contractors, partners) who might be experiencing thoughts of suicide and suicide behaviours, or supporting someone who is, might be, or might know someone who has been affected by suicide.

Informed by relevant data, research and lived experience, it describes the types of processes that can be implemented, and the ways to monitor and adjust those measures to maintain their effectiveness and impact. It also highlights where specialist advice might be needed.

It provides guidance on sensitive and responsible communications, including with those affected by suicide, and on ways to support them.

This British Standard is applicable to all organizations, regardless of size and type, and inclusive of:

- the public sector (e.g. educational and academic institutions, police services, NHS, local and central government, prisons, armed forces);
- the voluntary, community, faith and social enterprise sector, (e.g. charities, faith settings, independent education providers, housing associations, youth groups, clubs); and

NOTE This sector might also be known as the third sector.

- business and commercial sectors (e.g. construction, financial services, call centre environments and includes freelancers and contractors).

This British Standard is applicable to all workers, but of particular use to managers, human resources (HR) teams, health and safety (H&S) teams and occupational health (OH) teams, as well as those in organizational health and wellbeing, diversity and inclusion, learning and development and organizational development teams. It is also of use to those who are responsible for managing performance, workload, mental health and wellbeing and work environments.

This British Standard does not cover:

- situations where statutory responsibilities, such as safeguarding, apply; and
- medical guidance or clinical options outside of the workplace (but includes reference to relevant sources where such information is available).

2 Normative references

There are no normative references in this document.¹¹⁾

3 Terms, definitions and abbreviated terms

3.1 Terms and definitions

For the purposes of this document, the following terms and definitions apply.

3.1.1 access to means

the level of availability of methods used to die by suicide

NOTE The degree to which certain means are lethal and their ease of access, can significantly impact the outcome of a suicide attempt. Restricting access might delay the suicidal individual, provide opportunities for intervention and reduce the lethality of an attempt.

¹¹⁾ Documents that are referred to solely in an informative manner are listed in the Bibliography.

3.1.2 affected by suicide

people experiencing thoughts of suicide or suicide behaviours, their colleagues and those who are in contact with them as part of their work; those bereaved or affected by the suicide of a colleague or person they know, including where the contact occurs as part of their work; and those who witness a suicide or suicide attempt

3.1.3 anxiety

emotional state which can affect both thinking and physical health and often occurs in response to an actual or perceived threat to health, life or general wellbeing

3.1.4 depression

persistent feelings of sadness, low mood, or hopelessness, loss of interest in activities previously enjoyed, for at least two weeks

NOTE Symptoms include feelings of apathy, tiredness or worthlessness, trouble sleeping or eating, and finding it hard to concentrate. Some people have thoughts of suicide. Depression is a risk factor for suicide behaviours.

3.1.5 individual safety plan

personalized plan, outlining coping strategies, support contacts and emergency steps to help an individual manage thoughts of suicide and/or suicide behaviours and stay safe

3.1.6 intervention

action taken at the individual, group or organizational level to prevent, respond to or support those at risk of, or who have, thoughts of suicide or suicide behaviours

3.1.7 line manager

person responsible for overseeing the performance and development of workers within an organization, including team leaders or those with leadership responsibilities

3.1.8 mental health

psychological state, on a spectrum of good to bad, affecting an individual's ability to cope with usual or unforeseen disappointments and stresses in life, and to work productively, maintain healthy relationships and contribute to their community

NOTE It encompasses emotional, psychological and social wellbeing, influencing how people think, feel and act, fulfil their potential and have a sense of self-worth.

3.1.9 organization

person or group of people that has its own functions with responsibilities, authorities and relationships to achieve its objectives

NOTE The concept of an organization includes, but is not limited to, sole-trader, company, corporation, firm, enterprise, authority, partnership, charity or institution, or part or combination thereof, whether incorporated or not, public or private.

[SOURCE: [BS EN ISO 45001:2023+A1:2024](#), 3.1, modified – Note 2 has been removed]

3.1.10 service user

external users of the services, products, outputs, information or resources of an organization, including those who may be referred to as customers, consumers or clients

3.1.11 self-harm

intentional self-injury or self-poisoning regardless of motivation or suicide intent

NOTE Individuals might not always have a clear understanding of their motivations or intent, some might be ambivalent about whether they want to live or die. Motivations and intent might change.

3.1.12 stigma

negative attitudes or beliefs directed toward individuals or groups or felt by the person themselves, based on perceived differences or characteristics

3.1.13 stress

natural response to a perceived threat, demand or pressure which can be physical, emotional or mental, occurring when they exceed the ability to cope and meet needs, whether temporarily or over time

3.1.14 support after a suicide

organized response and support provided after a suicide has occurred, immediate and longer term, for those affected (bereaved or exposed) aiming to minimize distress, promote healing, and reduce risks of thoughts of suicide, suicide behaviours and imitation

NOTE This is also referred to as "postvention".

3.1.15 trauma

emotional response to an experience that is deeply distressing or disturbing, including both short or longer-term impacts that can be conscious or subconscious

3.1.16 wellbeing

fulfilment of physical, mental, social and cognitive needs

[SOURCE: [BS ISO 45003:2021](#), 3.2, modified – term changed from "wellbeing at work" to "wellbeing", "and expectation of a worker related to their work" removed from the definition and the Notes removed]

3.1.17 worker

colleague performing work or work-related activities under the remit of the organization, including employees, volunteers, freelancers, agency and temporary staff and contractors

3.1.18 workplace

place under the remit of the organization where a person needs to be or to go for work purposes

[SOURCE: [BS EN ISO 45001:2023+A1:2024](#), 3.6, modified – "control" changed to "remit" and the Note removed]

3.2 Abbreviated terms

For the purposes of this document, the following abbreviated terms apply.

EAP	Employee Assistance Programme
GP	general practitioner
H&S	health and safety
HR	human resources
LGBTQIA+	lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other sexual and gender identities (such as pansexual, non-binary or genderqueer)
NHS	National Health Service
OH	occupational health

4 Organizational culture and meeting worker and service user needs

4.1 Organizational culture

Organizational cultures that allow workers and/or service users to meet psychological needs in healthy ways make a significant contribution to preventing suicide and enabling workers and/or service users to ask for support if they are experiencing thoughts of suicide. Emotional needs include:

- a) security and feeling physically, psychologically and financially safe;
- b) autonomy and having a reasonable degree of control over work demands;
- c) community and relationships, including outside of work time;
- d) feeling valued and included;
- e) learning and developing competence at work; and
- f) work which has a clear purpose and is meaningful.

Organizations should be aware of when events and factors in the workplace prevent workers and/or service users from meeting their needs. These events and factors can include:

- 1) financial hardship;
- 2) excessive workplace demands;
- 3) unfair criticism and devaluing of work;
- 4) uncertainty during and following restructures, redundancies and changes in leadership, working processes or how an organization operates;
- 5) bullying and harassment;
- 6) relationship breakdown in and outside of work, including with children;
- 7) bereavements;
- 8) social isolation and exclusion; and
- 9) ill health and long-term health conditions.

When unmet needs give rise to distress and thoughts of suicide, organizations should support workers to remove workplace barriers to meeting emotional needs and enable access to external support, including:

- i) debt management and financial support agencies;
- ii) bereavement support;
- iii) counselling or other relevant appointments;
- iv) substance use agencies;
- v) domestic abuse and violence agencies; and
- vi) family mediation and parental support.

4.2 Practical actions to promote organizational culture

To meet the needs of workers and/or service users, and to reflect individual needs, organizations should:

- a) assign a named senior leader responsible for suicide prevention, with a clearly defined strategy, measurable practical actions and accountability for implementation;
- b) provide training in suicide awareness and prevention for all with access to the necessary resources (see [Annex A](#));
- c) maintain familiarity amongst human resources (HR) and management teams with workplace mental health policies and intervention strategies (see [Annex B](#));
- d) adhere to clear and consistent workplace procedures;
- e) foster and promote a culture that does not accept humiliating or degrading treatment, that challenges stigmatizing language or views about mental health difficulties or suicide and promotes the use of appropriate language and empathy for feelings and concerns;
- f) encourage awareness and open discussions about mental health and suicide prevention to foster a culture of understanding and support, including through all modes of communication, and encourage sharing stories of coming through a crisis;
- g) train line managers, and build their confidence and skill, in holding supportive conversations and providing resources and signposting;
- h) train workers on how to identify unmet needs in those around them, recognize warning signs (see [6.4](#) and [7.3](#)) and take proactive steps to intervene and direct workers and/or service users towards appropriate support;
- i) provide access to private check-ins with managers or other suitable persons, in a safe space, where concerns can be discussed without stigma;
- j) provide workers with access to educational resources and self-help tools to manage stress, anxiety, dependencies and thoughts of suicide. There should be clear signposting to internal and external support services; and
- k) where practical, have access to organization-wide mental health support, including talking therapies, and encourage workers to make use of it.

NOTE While psychological needs are universal, workers might face unique challenges with meeting needs for cultural, personal or psychological reasons; for example, some workers might experience heightened mental health risks due to isolation, ethnicity, gender, sexual orientation or religious background.

4.3 Creating supportive workplace communities

Everyone is different. People's individual experiences, beliefs and values shape them. As such, no two people are the same. Certain values and beliefs might not be openly shared or acknowledged in the workplace, if there is a concern the organization might regard them as private matters or potential weaknesses. However, when people feel that their beliefs and values are being threatened, it can negatively impact their emotions, thoughts and behaviour.

The following actions can promote a supportive and trusted workplace culture.

- a) **Inclusivity:** create an inclusive organizational culture that recognizes diversity of experience, openly challenges any mental health and suicide stigma and does not tolerate dismissing or disbelieving suicide experiences, shaming, bullying or inappropriate joking.
- b) **Cultural curiosity:** foster and promote interest in and the desire to learn about, understand and appreciate diverse beliefs, practices and perspectives, including those relating to mental health and suicide behaviours.

- c) Compassion: encourage open and supportive conversations, allowing workers to discuss their thoughts and feelings.
- d) Recognize warning signs: educate workers to identify behavioural changes linked to distress, thoughts of suicide and suicide behaviours (see 7.3) and foster a culture of empathy and proactive, timely intervention.
- e) Proactively address workplace stressors: recognize that different workers face unique stressors based on cultural, personal, organizational or social factors (see Annex C). Support and adjust work responsibilities for any workers with thoughts of suicide and suicide behaviours so that they can thrive and feel valued at work (see B.7).
- f) Flexible work practices: for example, adjusted start/end time and office attendance, communication and messaging channels and modifying roles.
- g) Manage workload and pressure: actively manage workloads and pressures so that stressors associated with thoughts of suicide and suicide behaviours are reduced.
- h) Training across the organization: in particular, provide line managers with relevant training, skills and competencies so they can recognize distress, hold supportive conversations, provide resources and help workers access professional help where needed (see Annex D).
- i) Advocacy: appoint and train suicide prevention advocates with the necessary knowledge and resources (see Annex A). Advocates should understand the intersection of diversity, inclusion and mental health challenges.
- j) Leadership accountability: clearly define the senior leadership's role in implementing suicide prevention initiatives and assign a dedicated advocate to drive awareness and support strategies across the organization.
- k) Embed worker wellbeing: suicide risk is known to be higher during disciplinary, dismissal or redundancy procedures. Support should be provided by an impartial person. Worker wellbeing should be at the centre of these procedures.
- l) Access to resources: provide workers with education and self-help tools to manage stress, anxiety and thoughts of suicide. Consider wellbeing support plans across the organization. Offer clear access to internal and external support services.
- m) Policy and procedure awareness: maintain HR and management teams' familiarity with workplace mental health policies and intervention strategies.
- n) Peer support networks: support workers in establishing informal peer support groups to create safe spaces for workers to share experiences and learn wellbeing strategies.

Some workers might experience heightened risks due to workplace isolation or lack of representation, e.g. individuals from ethnic minorities, autistic people, or LGBTQIA+ individuals. Difference and cultural traditions should be celebrated within the organization. Workplaces should cater to all workers, including toilet/changing facilities that are appropriate to sex and gender identity.

External crises (e.g. national or personal events or emergencies) can impact mental wellbeing, thoughts of suicide and suicide behaviours, and require flexible support. Examples of these include the suspected suicide of a celebrity with whom a particular workforce identify and that is widely reported in the media¹²⁾, or relationship breakdown.

By fostering an inclusive culture that embeds positive mental health and suicide prevention, organizations can create a supportive, adaptable and mentally healthy workplace. Ways for an organization to carry out a self-evaluation of their existing culture and readiness to respond to a suicide crisis are given in Annex E.

¹²⁾ Further information is given in the article *Association between suicide reporting in the media and suicide: Systematic review and meta-analysis* [10].

4.4 Organizational structures

Organizational structures vary by sector, function and size, and can influence workers' ability to disclose mental health concerns and access support. The fear of job loss, missed opportunities and damaged trust can deter individuals from disclosing thoughts of suicide, while managers and colleagues might struggle with guilt or self-blame following the death of a colleague. Regardless of structural differences, organizations have a moral and ethical duty to support those struggling with their mental health. Promotion of good mental health and suicide prevention should be proactive, allowing for timely intervention and action when needed.

Organizations have a duty of care to their workers such that the likelihood of a worker becoming unwell in, or through, their work is minimized. This should be facilitated by providing a safe workplace environment and access to mental health resources, so that workers feel supported and valued. Health and safety considerations should extend beyond accidents and injuries to include worker wellbeing.

NOTE Attention is drawn to the Health and Safety at Work etc. Act 1974 [1]. Courts are increasingly accepting that many aspects of work, including accidents, bullying, lack of supervision and pace of work, can impact both physical and mental wellbeing.

Regardless of their size or structure, organizations should safeguard workers' psychological health and wellbeing and provide a safe work environment.

Organizations can also consider their impact on the work environments of organizations they work with, such as commissioned voluntary organizations, sub-contractors in construction, and suppliers, and encourage embedding suicide awareness and support toolkits.

5 Strategy, policy, implementation and monitoring

5.1 General

Organizations can approach suicide prevention through a co-ordinated framework of strategy, policies, implementation plans and monitoring.

A strategy describes the organization's vision and demonstrates its commitment to it. There can be more than one, but they should be sponsored by senior management, have established accountability and clear resource allocation. They should be integrated into existing management systems for maximum impact.

Policies translate the strategy into specific principles, procedures and responsibilities, detailing how it will be executed. Multiple policies may support the same strategy. Implementation plans set timelines and structures for delivering the overall strategy and associated policies.

Monitoring helps organizations assess the effectiveness of their strategy, policies and plans, enabling actions to be taken to ensure allocated resources are sufficient, progress is made and that the strategy, policies and plans remain effective.

5.2 Policy

The suicide prevention policy should include, and also be cross-referenced in, other policies to be effective. These cover:

- a) ethics and confidentiality;
- b) consultation with workers;
- c) an organizational risk assessment of the hazards and risks present in the organization;
- d) complaints, disputes, grievances and appeals procedures;
- e) organizational action planning;