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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 – Mental health training provider
- Individual capacity – Occupational psychologist
- Individual capacity – Practicing nurse
- Individual capacity – Public health expert
- Individual capacity – Risk management in financial services
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- National Grid Electricity Transmission
- NHS Wales
- North London NHS Foundation Trust
- Public Health Agency (PHA) Northern Ireland
- QinetiQ
- R;pple Suicide Prevention
- Samaritans
- Society of Occupational Medicine (SOM)
- Suffolk Mind
- Survivors of Bereavement by Suicide
- Swansea University
- TfL – Transport for London
- The Charlie Waller Trust
- The Employee Assistance Professionals Association (EAPA)
- The LEARN Network
- The OLLIE Foundation
- The University of Glasgow
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Presentational 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 suicide[1)]. 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 point[2)]. For every death by suicide, at least 135 people are exposed and potentially impacted[3)]. 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 themselves[4)].

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].

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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 place[5)], 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 seriously[6)]. 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].

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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 on[7)]. 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 services[8)] 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 suicide[9)]. 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.

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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].

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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 behaviours[10)] 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].

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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.

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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

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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 themself, 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

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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.

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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.

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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 media[12)], 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].

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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.

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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;

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f) diversity, equity, inclusion and justice;

g) communication;

h) training;

i) crisis management and response plans, including response/support after a suicide;

j) individual suicide safety plans (see Annex D, **D.6**);

k) bereavement, loss and trauma;

l) absence management and return-to-work (or healthy "stay-at-work-with-support" policies);

m) mental health and wellbeing;

n) roles and responsibilities; and

o) monitoring and review.

Developing and implementing a clear policy enables managers, supervisors and workers to have open discussions about suicide prevention in the workplace and means that people in vulnerable situations receive appropriate support and timely care.

When developing the policy, the contents should include:

1) ethical considerations (see **5.3**);

2) suicide prevention measures, which should be integrated into existing policies so that they align with overall wellbeing and mental health strategies;

3) cross-references to related policies [see a) to o) above], but also performance management, sickness and absence and flexible working, to create a cohesive approach;

4) organizational procedures that enable effective implementation and review of mental health and suicide prevention policies;

5) a clear communication strategy, with all workers, managers and HR teams understanding their role in its implementation;

6) absence and attendance management policies, which should be in place and account for mental health needs and suicide prevention;

7) recruitment, training and career progression practices, which should be implemented to accommodate mental health considerations;

8) structured consultation channels, which should be established to discuss policy changes with workers;

9) clear crisis response plans, which should acknowledge that any fatality in the workplace should be investigated by the proper authorities. Apart from any life-saving actions, the scene should be undisturbed until the proper authorities arrive. The plan should also determine what support is to be given to witnesses, staff, family or friends, and how personal effects, final pay etc., are to be dealt with;

10) a nominated contact or next of kin on record to be informed in emergencies and potentially facilitate involving the person's support network when their wellbeing is at risk;

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11) clear intervention protocols and co-designed individual safety plans for situations where a worker is thinking about or engaging in suicide behaviours, including how to contact emergency services or mental health professionals and signposting to any other appropriate services and support groups. These protocols should also cover appropriate support following a worker's death by suicide, detailing the support available and the methods of communication;
12) alignment of suicide prevention policies with national and local frameworks to encourage collaboration, co-ordination, learning and shared resources with healthcare and community organizations, e.g. support awareness campaigns and engagement in sector wide initiatives;
13) details of the support to be given to staff undergoing disciplinary, performance, probation or severance proceedings, including redundancies. The potential to impact the individual's sense of identity and financial stability through the loss, or anticipated loss, of work is a key risk factor; and
14) consideration of those affected by the individual's expressed thoughts of suicide and suicide behaviours. This can include first responders, mental health champions, HR, line management, site managers, area managers, the individual's team and wider networks.

All staff should be trained to give them a general awareness of suicide prevention, with managers given additional training to cover compliance with H&S, equity and inclusion obligations. First responders should also be trained on verbal intervention and de-escalation techniques.

Integrating it with other policies and management systems, such as the emergency preparedness requirements in BS EN ISO 45001:2023+A1:2024, **8.2**, and monitoring and evaluating the impact of the policy through regular assessment, allows policies to remain effective and adaptable.

5.3 Ethical considerations

Policies and guidance on suicide prevention should address ethical issues, including:

a) confidentiality: clarity as to how individuals, or line managers, should respond to disclosures, when confidentiality can be maintained and when information might be shared (e.g. in response to an immediate risk of harm);

b) record keeping: details on how, when and where records are kept and how they are handled (e.g. manager's diary notes, HR records, etc.);

c) individual autonomy: where individuals express thoughts of suicide, the situation should be approached with sensitivity and respect, encouraging dialogue rather than imposing solutions unless there is an immediate risk of harm;

d) support: clarity on available support for the individual making the disclosure and the person(s) to whom the disclosure is being made;

e) safe conversations and best practices: such as providing a safe environment for private conversations, and approaching such conversations with empathy, open questions and respecting cultural issues where thoughts of suicide, suicide behaviours and bereavement might be taboo; and

f) people's ability to support others: recognizing the limits of supporting others without negatively impacting on themselves, people should feel able to say they are not currently able to offer support and signpost to alternative help.

5.4 Support frameworks

Support frameworks should be in place when implementing suicide prevention policies to create a comprehensive network of care that extends beyond initial interventions.

All workers should be aware of support frameworks provided by the organization or available in the community for themselves and colleagues, as well as those for service users. These should be covered in induction/onboarding, reinforced through regular refreshers and included in ongoing communications.

Information on these support frameworks should be readily available, visible and regularly updated. They might include:

a) mental health support;

b) mentoring programmes;

c) support groups, including for those bereaved by suicide and shared experiences;

d) awareness raising campaigns;

e) education on policy and procedures for at risk workers and service users;

f) Employee Assistance Programmes (EAP) or other assistance programmes;

g) counselling services;

h) signposting to resources, i.e. community, local and national services for support including for those affected by suicide; and

i) training and education programmes for managers and workers.

NOTE Guidance and support can be adapted to meet the specific needs of service users/customers.

5.5 Monitoring and evaluation

It is important to assess the impact and effectiveness of what the organization currently provides and continually review unmet needs. Annex E provides self-evaluation and internal benchmarking questions to help organizations develop a tailored suicide prevention plan, establish a baseline and identify areas for improvement. This process should include reporting, monitoring feedback, user support and referral mechanisms for service users. It enables the application of the plan-do-check-act (PDCA) cycle.

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6 Understanding suicide and prevention

6.1 General

Suicide prevention aims to stop individuals reaching a crisis where thoughts of suicide or suicide behaviours require intervention. It should be a shared responsibility across the organization, not limited to one person or department. While a single point of contact (SPOC) in HR or H&S can coordinate efforts, a collaborative approach distributes responsibility, enhances effectiveness and reduces individual burden.

Suicide prevention and promoting good mental wellbeing require organizational cultures that support workers to meet emotional needs, and support them through the kinds of life crises (see Figure 1 below) that increase the risk of thoughts of suicide or suicide behaviours.

The relationship between thoughts of suicide, suicide behaviours, self-harm and suicide is complex. While thoughts of suicide, suicide behaviours and self-harm do indicate an increased risk of suicide, the vast majority of people who experience them do not go on to die by suicide. However, they warrant a response in their own right as they cause significant distress for individuals experiencing them and those around them.

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This British Standard covers suicide prevention, intervention and support for people affected by suicide. But, in fact, it is all suicide prevention. Interventions are designed to prevent suicide deaths and supporting those affected by suicide (including those bereaved by suicide, those who've lived through suicide attempts or suicide crises, and those who had other traumatic experiences like witnessing a suicide), and is also to prevent further suicides among those traumatized by their exposure to suicide.

6.2 Support with meeting emotional needs

Workplace suicide prevention should recognize that people have emotional needs which, if unmet, might give rise to the distress which fuel thoughts of suicide. An individual safety plan (see **3.1.4** and **7.9**) should identify these needs (including those described in **4.1**), and outline actions agreed in collaboration to address them. Plans can be developed within the organization or shared if created externally. The individual's safety plan should be made known to line managers, HR, their agreed support person and potentially OH where available (see Annex D).

Workplace policy and training should seek to remove barriers to workers meeting emotional needs, including unreasonable or excessive work demands which prevent them from meeting needs outside of work (see Clause **4** for guidance on creating a supportive organizational culture).

Direct access to EAPs, familiarity with resources and available support should be included in safety planning; having established the relationships with mental health services and promoting an awareness of how support services can be accessed.

Organizations can also consider digital tools that divert a person in crisis to sources of support or distraction techniques if words related to suicide are used on company hardware and devices.

6.3 Risk factors and causes of workplace distress

Suicide is rarely caused by a single risk factor and is best understood in each individual's life circumstances. Whilst some groups are more at risk than others, suicide risk factors can affect anyone and include the examples shown in Figure 1.

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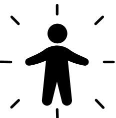
Figure 1 — *Risk factors*

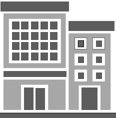
RISK FACTORS

Multiple factors often combine



PERSONAL

- Adverse childhood experiences (ACE), including neglect and abuse
- Physical or mental health conditions (existing or new, diagnosed or undiagnosed)
- Legal pressures
- Economic hardship/financial pressures
- Compulsive behaviours (e.g. gambling)
- Previous self-harm or suicide attempt
- Social isolation/loneliness
- Major or stressful life events

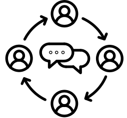


WORKPLACE

- Conflict with colleagues
- Workload demands
- Poor management practices
- Isolation including lone working
- Bullying and harassment
- Redundancy processes
- Work/life imbalance
- Organizational change
- Workplace design
- Access to means, e.g. location, firearms, toxic substances, or other methods
- Lack of access to adequate support
- Culture
- Inequality and discrimination
- Exposure to highly stressful situations, including life and death situations
- Precarious employment

RELATIONSHIPS

- Loss, e.g. relationship breakdown, divorce
- Bereavement including suicide bereavement
- Family history of suicide
- Social isolation
- Intimate partner violence, domestic abuse, sexual abuse
- Caring responsibilities
- Child access arrangements



COMMUNITY / SOCIETAL

- Stigma and discrimination, e.g. ethnicity, gender identity, sexual orientation, disability
- Access to means of suicide
- Cyberbullying and harmful online content
- Cultural pressures

NOTE Further information is given in the article Risk factors for suicide in adults: Systematic review and meta-analysis of psychological autopsy studies *[11].*

6.4 Warning signs in the workplace

Distress, from unmet emotional needs or when people are unable to cope with the life challenges, can lead to thoughts of suicide or suicide behaviours. Distress can present in different ways, which might not always be obvious, or might be hidden. Organizations should train managers and HR professionals to recognize early signs and respond appropriately.

Types of warning signs and categories are shown in Figure 2.

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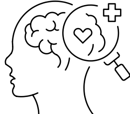
Figure 2 — *Warning signs*

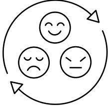
WARNING SIGNS

Not everyone shows obvious signs



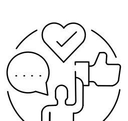
PSYCHOLOGICAL

• Inability to concentrate • Memory lapses • Negative thinking • Excessive worry • Depression • Anxiety • Feeling vague or easily distracted • Frequent conflict



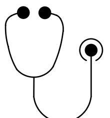
EMOTIONAL

• Tearfulness • Irritability • Anger • Mood swings • Defensiveness • Frustration • Feeling out of control • Apathy • Cynicism • Low self-esteem and confidence • Expressions of hopelessness or despair • Talk of wanting to "escape" problems • Might appear calm or outwardly happier than usual



BEHAVIOURAL

• Increased absenteeism or presenteeism (working while unwell) • Social withdrawal • Poor time management • Risk taking • Self-neglect • Increased reliance on substances • Aggression • Recklessness • Breaches of policy • Uncharacteristic lying • Poor or delayed decision making



PHYSICAL

• Unexplained illness • Weight loss or gain • Fatigue • Digestive or heart-related issues • Panic attacks • Frequent aches and pains • Poor sleep • Signs of physical exhaustion

REMEMBER: Some show NO signs — when in doubt, **ASK**

Organizations should foster an environment where workers feel safe discussing mental health concerns or personal life struggles. If a person shares that they are experiencing thoughts of suicide, or is actively planning suicide, the guidance provided in Clause **7** should be followed.

6.5 Coping strategies

6.5.1 General

Coping strategies include tools, techniques and actions which a person might take to cope when affected by stress or distress, or where events prevent them meeting needs or resolving life crises, leaving them more vulnerable to experiencing and acting upon thoughts of suicide. Suicide prevention promotes helpful coping mechanisms through education, prevention initiatives and individual safety plans. When harmful coping strategies arise, organizations should provide access to interventions for issues like trauma, addiction and self-harm. People should be supported when managing harmful coping strategies and encouraged to adopt alternative helpful ones, so as not to leave the person without the means to cope.

Coping strategies should be viewed in the context of the person's specific needs.

6.5.2 Helpful coping strategies

Identifying unmet needs and taking steps to address these, while recognizing which needs are being met, should accompany support to develop helpful coping strategies.

Key approaches include:

a) diet and exercise: a nutrient-rich diet and regular physical activity enhance mood, cognitive function and sleep, fostering resilience and reducing isolation;

b) social support: encouraging participation in social activities helps mitigate isolation and support for social skills development should be available;

c) sleep hygiene: establishing regular sleep patterns, limiting screen time and maximizing exposure to natural light support mental wellbeing. Shift workers should schedule short sleep cycles to minimize deficits; and

d) coping with own feelings: support through activities such as breathing exercises, yoga and relaxation techniques help manage or reduce distress. Cognitive skills to manage thoughts of suicide should include knowing how to recognize and challenge negative thoughts. Working with the right support can enable some people to develop those cognitive skills.

6.5.3 Harmful coping strategies

Harmful coping mechanisms could worsen mental health and impact workplace behaviour. These might include:

a) overworking: used to avoid personal struggles, social isolation or unhealthy home environments;

b) substance use: dependency or misuse of alcohol and drugs (including prescription drugs) affects concentration, productivity, relationships and workplace safety;

c) self-harm: this is sometimes used as a way of managing challenging emotions and distress (see **0.2**, Myth 4 and Myth 5);

d) caffeine dependency: overuse of coffee and energy drinks to counteract exhaustion or withdrawal symptoms;

e) gambling and financial insecurity: might lead to stress, debt and increased suicide risk; and

f) pornography use: can reinforce cycles of shame and distress, raising suicide risk.

Thoughts of suicide and suicide behaviours often arise from people having major life challenges that they are finding difficult to resolve. Coping strategies help support through periods of high stress or distress, although the underlying causes still need to be addressed.

6.6 Reducing access to means of suicide

Reducing access to means of suicide is a key pillar of suicide prevention. The availability of lethal means can significantly impact the outcome of a suicide attempt. Restricting access might delay lethal actions, provide opportunities for intervention and reduce lethality of an attempt.

Organizations should conduct workplace risk assessments to identify and mitigate suicide risks from access to means. This is influenced by the nature of their premises and/or business[13)], such as rail suicide prevention[14)]. Some occupations provide ready access to potentially lethal means – such as firearms for police and military personnel, or pharmaceutical drugs for healthcare and veterinary staff. Examples of controls to reduce risks include (but are not limited to):

a) physical restrictions: limit access to high-risk locations (e.g. rooftops, multi-storey car parks, high-rise windows and construction sites) through secure locks, barriers or restricted entry;

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13) Further information is given in the article *Access to means of suicide, occupation and the risk of suicide: A national study over 12 years of coronial data* [12].

14) More information is available at https://railsuicideprevention.co.uk/our-work/.

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b) controlled substances: implement effective safety measures for lethal substances such as pharmaceuticals, pesticides and toxic chemicals in relevant industries (e.g. healthcare, agriculture);

c) design considerations: incorporate suicide prevention into building design or retrofit where needed (e.g. remove potential ligature points, use window restrictors and install unscalable barriers); and

d) hard versus soft measures: where physical barriers are not feasible, consider alternative interventions such as surveillance, trained security, lighting, signage and mental health training for staff.

Organizations should also assess whether a contagion risk could arise, as exposure to suicide methods or locations can lead to imitation. This means that communications should not include method, location or suggest motivation(s).

Access restrictions should be balanced with inclusivity (e.g. raised barriers not limiting wheelchair user access). A proactive approach, integrating both structural and behavioural interventions, can significantly reduce suicide risks in the workplace.

NOTE Those involved in the design and fit-out of buildings are advised to assess access to means in building design, use and layout, as part of a suicide prevention strategy. Further guidance can be found in PAS 6463.

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7 Intervention

7.1 General

As described in **6.1**, suicide prevention aims to stop individuals from reaching a crisis. Intervention focuses on responding to those already experiencing thoughts of suicide or suicide behaviours.

7.2 Attitudes and values

If someone approaches a person in an organization and talks about thoughts of suicide or suicide behaviours, it will often have taken courage to do so, and they are putting a great deal of trust in that person. It is important that the person they approach responds to them appropriately. While they are not expected to be able to "solve all the problems", non-judgmental listening can help provide initial support and encourage future help-seeking.

Some people who have disclosed their thoughts of suicide have been treated in a way that has left them feeling embarrassed, guilty, frightened or stigmatized. Being made to feel like this can deter someone from engaging with any support (for guidance on effective communication, see Annex D, **D.5.4**, and for examples of helpful language, see **7.4**). It might also discourage them from telling someone else in the future.

7.3 Recognition – what a person in distress might say

Organizations should support workers in recognizing the signs of distress or clear intent as part of suicide prevention initiatives (e.g. training). By remaining observant and responsive, workers can provide support to those in need and all signs of distress (including seemingly flippant comments about taking their own life) should be taken seriously (see **6.4**). If there are concerns about someone's wellbeing, initiating a conversation can be a critical first step. Key indicators are shown in Table 2.

Table 2 — *Key indicators of distress or intent*

What we might sense	What someone might say
• Hopelessness • Worthlessness • Burdensomeness • Despair • Sadness • Depression • Anger • Agitation • Numbness • Indifference • Anxiety • Elation • At peace	• I can't take it anymore • I don't want to be here • I wish I could disappear • People would be better off without me • I don't want to wake up • I feel like a burden • I'm worthless • I'm trapped • I don't see a way out • No one cares • Soon my problems will be over
How someone might act	**Life events experienced**
• Isolation • Withdrawal • Aggression • Changes in self-care • Physical symptoms • Preoccupation with death or dying • Giving away belongings • Finalizing affairs • Visiting people to say goodbye • Making recompense • Increased use of alcohol/drugs • Risk-taking behaviours • Self-harm	• Bereavement • Job loss/redundancy • Legal troubles • Financial difficulties • Health issues/injury • Trauma • Bullying • Relationship issues/divorce • Domestic abuse • Other forms of abuse • Work pressure • Family conflict • Eviction • Perceived humiliation

A sudden shift from depression, moodiness and withdrawal to an unexpected improvement in mood might signal suicide intent. This change can occur when an individual has formulated a plan and feels relieved to have found a perceived solution to their distress. Timely intervention, combined with empathetic listening, can help guide individuals toward support and recovery.

7.4 Asking about suicide

Once signs of distress (see **6.4**) are observed, the next step is to ask directly and without judgment about thoughts of suicide; this is a critical part of effective intervention. This helps to break the silence and stigma and provides individuals with the opportunity and permission to share their experiences openly.

As highlighted in **0.2**, Myth 1, asking about thoughts of suicide does not increase the likelihood that someone will act on those thoughts. In fact, research shows it helps people express how they feel.

People often express thoughts of suicide indirectly, making comments such as "I don't care if I live or die" (see **7.3**). A general rule is: if in doubt, ask, and use clear, direct language. Figure 3 provides examples of recommended phrases, and the kinds of phrases to avoid.

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Figure 3 — *Asking about suicide; what to say, what to avoid*

HOW TO ASK

Direct questions save lives

- "Are you having thoughts of suicide?"
- "Have you had thoughts about ending your life?"
- "Are things so bad you're thinking of ending our life?"
- "I have noticed you seem low, not yourself. Do you get so low that you think of suicide?"

- "You're not thinking of doing anything silly, are you?"
- "We're not talking about anything serious, are we?"
- Anything vague, euphemistic or dismissive of the seriousness of the person's thoughts.

The exact words matter less than asking a clear, compassionate question.

When asking these recommended questions, those helping should maintain a calm empathetic tone, so the person in distress feels supported, not judged, dismissed or infantilized.

Euphemisms, leading questions or vague language should be avoided, such as "You're not thinking of doing anything silly, are you?" These phrases downplay the seriousness of the person's thoughts and creates a barrier to honest disclosure. Direct language normalizes the conversation, reduces stigma and shows the person that discussing suicide is not taboo. Normalization helps individuals feel less isolated, as they might realize that others care about their wellbeing and are prepared to listen. This approach provides a sense of relief and hope, as many people in crisis fear being misunderstood or dismissed.

Asking clearly about suicide demonstrates that the topic is safe to discuss, which could be the first step toward accessing appropriate support. By approaching the conversation with openness and compassion, professionals and laypersons alike can create a safe space that encourages honesty and connection, paving the way for effective intervention and individual safety planning.

If a person is asked and they say they are not having such thoughts, it is worth following up with a statement such as "If anything changes, please do feel able to talk to me about it".

7.5 Confidentiality

Confidentiality cannot be guaranteed when someone discloses thoughts of suicide to a colleague or manager (see **5.3**). If a worker requests a confidential conversation, they should be informed that information will be shared sensitively if there is a risk to their safety, in line with the organization's policies. Organizations should provide clear guidance on who managers and workers should contact in such instances (e.g. HR, a senior manager or OH services if available). Further policy and ethics guidance is provided in Clause **5**.

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It is better to be open with a person in crisis about the limits of confidentiality, stressing that their health, safety and welfare is paramount, and that there are obligations with regards to the sharing of information; explaining who will be told and what will be shared helps maintain trust, which is easily lost, and slow to rebuild.

Their agreement should be gained, where possible, but information can be shared without their consent if policies require it. Informed consent is preferred, and underpins privacy and data protection laws and policies, but if there is a threat to life then a duty of care supersedes the duty of confidentiality.

7.6 Thoughts of suicide: how to respond

Effective suicide intervention requires active listening and clear, compassionate communication. Creating a safe, supportive space encourages people to share their feelings and explore what help might be available. Those responding should take disclosures seriously, remain calm and avoid making assumptions. Responders should be open and honest about the limits of confidentiality (see **5.3** and **7.5**). While supporting others, it is also important to manage personal wellbeing without letting emotions affect the response.

The use of empathetic, straightforward language builds trust and helps individuals to feel heard and supported. In the initial conversations, Table 3 provides some examples of clear, compassionate approaches and empathetic language.

Table 3 — *Examples of helpful and unhelpful behaviours and communications*

Helpful	Unhelpful
• Asking appropriate questions • Reflecting back what you have heard • Summarizing key points • Paying attention to body language, not fidgeting, maintaining eye contact, open and calm body posture • Noticing their tone of voice and body language • A calm and confident tone can be reassuring • Allowing silence can be supportive and enable time for gathering thoughts • Positively validating emotions, accepting their reality with compassion Examples of clear, compassionate and empathetic language are: • “It sounds like you are going through a really tough time right now”; • “It’s OK to feel this way”; • “I can’t imagine how painful this must be for you”; • “I care about you, and I want to help”; • “You are not alone in this”; • “I’m here to listen, no matter what”; or • “It’s understandable you feel this way given what you are describing”.	• Talking about your own experiences; this undermines theirs • Using “why” or “at least” in questioning, this can appear accusatory and patronizing • Making assumptions; or saying “I know”, or “I understand” • Minimizing their experience or comparing it to that of others In communications, using language that might elicit feelings of guilt or shame, such as: • “What about your family”; • “People care about you”; • “How would they feel”; or • “Think how your friends and family will feel”.

Active listening is key to effective intervention. Demonstrating empathy through reflective listening, summarizing key points and validating emotions encourages openness and trust. Responders should be non-judgmental and use non-verbal cues, such as eye contact and body language, to reinforce attentiveness and care. Interruptions and offering immediate solutions should be avoided; instead, focus on their narrative, acknowledge their feelings and gently encourage expression. This fosters connection and empowers them to seek help and safety.

Once a rapport with the person has been established, they can be asked whether they have made a plan and have access to the means to end their life.

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7.7 Suicide concerns or crises: how to respond

Suicide intervention focuses on immediate safety and support until professional help is available. It requires a calm and structured approach, whether someone is at imminent risk or has disclosed their thoughts of suicide. Disclosure is a key warning sign, and it should always be taken seriously.

While suicide crises are often “temporary”, the person in distress might not recognize this. Suicide crises can arise from both shorter-term, immediate stressors, or events that have accumulated over time. People experiencing thoughts of suicide might not be able to identify alternative ways to stop their feelings of distress other than suicide. Timely intervention can be life-saving. Key principles are shown in Figure 4.

Figure 4 — *Responding to a person in distress*

Steps in intervention should include:

a) recognizing signs of distress and identifying when someone is thinking of suicide or demonstrating suicide behaviours (see **7.3**);

b) checking for safety and always asking: “Is it safe for me to continue? Are we both safe right now?” and never using physical intervention in high-risk situations;

c) removing access to means, if appropriate (see **6.6**);

d) engaging with empathy, listening actively and non-judgementally, staying calm and showing genuine care; and

e) seeking professional support for the person in distress;

Follow up activities should include:

1) creating an individual safety plan for the person (see Annex D, **D.6**); and

2) supporting helpers (those who intervene also need care and resources).

Above all, safety comes first.

7.8 Suicide behaviours: how to respond to immediate danger

When someone is at immediate risk, taking action should be swift.

Assessing danger involves evaluating risk factors such as whether the individual has a specific plan, access to means and a timeline. A well-defined method with immediate access poses a higher risk than vague thoughts, without a plan.

Reducing access to means (see **6.6**) lowers immediate danger. Securing medications, firearms or ligature points and restricting site access can prevent impulsive actions. Trusted individuals can help monitor and provide support. By assessing risk and limiting access to means, organizations can create a safer environment and facilitate further intervention.

See Figure 5 for the immediate steps to take when responding to a person in crisis.

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Figure 5 — *Responding to a person in crisis*

Stay CALM Be DIRECT LISTEN actively Show CARE FOLLOW UP

IMMEDIATE STEPS

Stay calm	Don't leave alone	Call 999	Remove means	Get help
Your response matters	Stay with them	If immediate danger	If safe to do so	Professional support

7.9 Individual safety planning

Organizations should encourage and support the creation of, or adaptation of existing, individual safety plans. They are essential for those in crisis and beneficial for anyone struggling. They involve a collaborative process that reduces risk[15)], fosters connection and empowers individuals in crisis (see Annex D, **D.6**, for an example individual safety plan). Benefits include:

a) gaining permission to stay safe: engaging the person in an open conversation and securing their commitment to safety reinforces trust and motivation;

b) reducing isolation: identifying supportive people and establishing regular check-ins can help counter loneliness. Crisis helplines and peer groups offer additional support;

c) managing distress: encouraging comforting activities and exploring therapeutic options can alleviate emotional pain;

d) dismantling suicide plans: identifying and restricting access to means, with the support of trusted individuals, enhances safety;

e) learning from past behaviours: understanding triggers and effective and ineffective coping strategies help tailor the plan;

f) addressing substance use: exploring alcohol or drug use and signposting to support services can reduce risk;

g) connecting to appropriate professional support: signposting to professional care fosters long-term recovery; and

h) understanding when to use the individual safety plan: based on previous experiences, triggers and early warning signs including emotions.

By fostering collaboration, securing the individual's agreement to safety and addressing their unique needs, an individual safety plan becomes a powerful tool. It reduces immediate risks while building hope, resilience and a pathway towards recovery.

[15)] Further information is given in the article *Safety planning-type interventions for suicide prevention: Meta-analysis* [13].

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7.10 Individual self-care

Everyone taking time for reflection, seeking supervision or peer support and engaging in activities that promote physical and mental wellbeing can help sustain the ability to support oneself and others.

By prioritizing self-care and addressing their own unmet needs (see **6.5**), individuals can protect their physical and mental health and remain effective in their roles. This practice also serves as a preventive measure, safeguarding wellbeing to allow continued support for others to be provided with empathy and focus. Caring for oneself is not selfish but a necessary aspect of providing effective assistance to others.

7.11 Organizational self-care

The design of work significantly impacts worker engagement, motivation and mental health. Organizations should assess workplace environments to identify and address psychosocial hazards that might contribute to suicide risk. This includes evaluating how work is structured, its social and physical aspects and addressing unmet needs within the organization, while promoting supportive measures as detailed in Clause **4**. Undertaking an internal review and looking for opportunities for continual improvement is essential.

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8 Support for people affected by suicide – family, friends, colleagues, and the wider community

8.1 Audience

Some workers might be affected by suicide loss (bereaved by or exposed to) in their lives outside work, requiring individual approaches, while some might be affected by suicide loss (bereaved by or exposed to) by the suicide of a colleague, requiring community response and individual approaches. Others might be at risk of being affected by suicide as part of their public facing work.

This clause focuses on the important perspective of suicide bereavement.

It should be acknowledged, however, that there are many other ways in which people are affected by suicide, including personal experience of a suicide crisis or knowing someone who has lived through a suicide crisis or witnessing a suicide attempt. All of these experiences can be highly traumatic and those affected need appropriate support. Those living through a suicide attempt are one of the highest risk groups for a further suicide attempt (see Annex B, **B.7**, for steps that might be taken to provide support after a suicide attempt).

Formal support services or resources for people witnessing a suicide or suicide attempt are still rare; however, *First hand: Making sense of lasting memories and emotions after the suicide of someone you didn't know* [14] gives guidance and advice for those who have experienced such an event.

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8.2 Context

8.2.1 Prevalence of suicide bereavement

One in five people experience suicide loss over their lifetime[16]. This means that many colleagues might have experienced suicide loss of relatives or friends but might not disclose this due to the taboo around death and the stigma associated with suicide.

Every suicide death affects individuals across a social network, estimated to be as many as 135 people[17] and potentially many more given the reach of social media [16]. With approximately 6 417 suicide deaths per year (2012 to 2022) in the UK [8], and 7 555 in the UK in 2023, including registrations[18], an estimated 865 000 to 950 000 people are exposed to suicide annually.

The economic impact of suicide in the UK, including emergency services, healthcare services, lost productivity (deceased and family), coronial/legal costs, plus intangibles, has been estimated at £1.46 million per suicide, using 2022 data; the overall UK financial impact of suicides therefore approaches £10 billion per year [17].

8.2.2 Impact of suicide bereavement

Suicide loss impacts people in diverse ways, affecting mental health, social functioning (at work, in education and in relationships) and personal views about suicide.

Grief after suicide is particularly difficult because of the additional burden of stigma, self-blame, guilt, responsibility, shame, hopelessness and severe psychological distress. Some people experience prolonged grief and/or grief complicated by psychiatric symptoms. They might meet criteria for complicated grief, prolonged grief disorder, persistent complex bereavement disorder, or depression. Their grief might not be openly acknowledged or socially validated (also termed disenfranchised grief). Research shows that suicide-bereaved people are at greater risk of depression and post-traumatic stress disorder than people bereaved by other causes. They are also more likely to drop out of education or work and are at a greater risk of suicide and self-harm but are less likely to receive support.

People who experience other forms of sudden, violent, unexpected or otherwise traumatic loss (e.g. miscarriage, loss of a young child, murder) are also at heightened risk of suicide and need appropriate support. Suicide bereavement support should be part of a broader suite of support services and policies for bereaved workers.

8.3 Sources of support

A range of suicide bereavement support organizations operate across the UK, predominantly in the voluntary sector. People bereaved by suicide often do not feel worthy of support.

One way to combat stigma and encourage help-seeking is by sharing information about suicide bereavement support organizations, emphasizing that anyone affected by the loss could consider contacting them. Since those bereaved by suicide are often in shock and unable to process information about help-seeking immediately, providing written information, including links to sources of support, shows them that support is available at any stage. Organizations should also be familiar with local suicide bereavement support services (commissioned by their local authority) and their contact information. Table 4 lists a number of suicide bereavement support organizations in the UK.

[16] Further information is given in the article *Prevalence of exposure to suicide: A meta-analysis of population-based studies* [15].
[17] Further information is given in the article *How many people are exposed to suicide? Not six* [5].
[18] Information available at https://www.samaritans.org/about-samaritans/research-policy/suicide-facts-and-figures/latest-suicide-data/.

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Table 4 — *Suicide bereavement support organizations in the UK*

Government funded:	**Website:**
NHS England	https://www.england.nhs.uk
NHS Wales	https://www.nhs.wales
NHS Scotland	https://www.scot.nhs.uk
NHS Northern Ireland	https://online.hscni.net
Charities:	**Website**:
Canmore Trust	https://thecanmoretrust.co.uk
AtaLoss	https://www.ataloss.org
Support After Suicide Partnership	https://supportaftersuicide.org.uk
Suicide&co	https://suicideandco.squarespace.com
Survivors of Bereavement by Suicide (SoBS)	https://uksobs.com
Cruse Scotland	https://www.crusescotland.org.uk
Papyrus	https://www.papyrus-uk.org
Privately funded:	**Website**:
British Association of Counselling and Psychotherapy (BACP)	https://www.bacp.co.uk
National Counselling & Psychotherapy Society (NCPS)	https://ncps.com
Pink Therapy	https://pinktherapy.com

NOTE This is not an exhaustive list. There are many organizations, such as the Good Grief Trust, that list and signpost to many more organizations, so finding the right resource can be tailored to individual needs and made specific to particular sectors, occupations etc.

8.4 Grief after suicide loss

Grief is a dynamic process and affects people in different ways, depending on their relationship to the deceased, their culture, their religion, their past experience of loss and their coping skills. Some cultures grieve openly, whilst in others (including the UK) there is more of a taboo around death. People vary in their needs for emotional and/or practical support.

It is important to be thoughtful about the language used around suicide as outlined throughout this British Standard. Further guidance on ways to communicate about suicide is provided by Mindframe[19].

Many people bereaved by suicide might be sensitive to questioning that implies that more could have been done to help the person who died, or to speculation about the reasons for the suicide. They might also feel stigmatized where people avoid talking about the loss. The person's bereavement should be acknowledged and offering practical help is often valued.

8.5 Communicating with those affected by suicide

Asking detailed questions about the death can feel intrusive because it might be perceived as collecting information to share with others. It is important to let the person talk about the person they have lost in their own time. Offering solutions is not helpful.

Many bereaved people feel under pressure to have "moved on". They might feel that others are uncomfortable about their grief and should not talk about the person who has died any more. However, grief fluctuates over time and there is no set time at which people "recover" from a loss.

Guidance on how to communicate with someone bereaved by suicide is available via HospiceUK's Dying Matters campaign[20] and Support after Suicide Partnership's *Finding the words: How to support someone who has been bereaved and affected by suicide* [18].

[19] Available at https://mindframe.org.au/suicide/communicating-about-suicide/language.
[20] Available at https://learn.mywishes.co.uk/wp-content/uploads/2019/09/dyingmatters.org_sites_default_files_files_Leaflet-12_WEB.pdf.

It is important to focus on the positive aspects of the deceased person's life rather than their death. Asking colleagues about important aspects of their life and showing willingness to share memories of the person who died, particularly around anniversaries, is good practice.

8.6 Responsiveness

Every organization should have a procedure in place to support:

a) a worker bereaved by suicide;

b) workers and site staff after a suspected suicide;

c) workers and site staff after a suspected suicide on site; and

d) workers witnessing a suicide or suicide attempt.

The guidance in this sub-clause covers points b) and c).

There are a number of online resources that organizations can learn from and adapt to fit the needs of their own settings. These include guidance for:

1) universities: Responding to a suicide: Advice for universities[21];

2) workplaces: Grief in the workplace responding to suicide: A guide for employers[22] or Crisis management in the event of a suicide: A postvention toolkit for employers[23];

3) NHS staff: Postvention guidance: Supporting NHS staff after the death by suicide of a colleague[24]; and

4) NHS workers: NHS worker suicide: A postvention toolkit to help manage the impact and provide support[25].

In the event that a worker dies by a suspected suicide, a senior member of the HR team, having details of the nominated contact or next of kin, should contact them to express condolences and to offer practical support. This might include collecting the person's belongings and arranging a time to return them while being sensitive to, and guided by, the family. Thought should be given as to presentation. Packaging up the items carefully and including a thoughtful message, perhaps signed by other workers who knew the person, communicates how much they were valued. Requirements for time off work for the registration of the loss, other compassionate leave, any sick leave for associated illness should be given. HR should prevent systems triggering automated email requests to the individual requiring action at a time when they are struggling to cope with the immediate aftermath of their losses.

The incident team (see Annex B, **B.5**) should be aware of:

i) the deceased's local social network might be extensive, and potentially hard to identify;

ii) the deceased person may be known to workers in neighbouring organizations, in shops and cafes surrounding the workplace, as well as to site staff (e.g. reception or cleaning staff);

iii) communications to those who might have known the deceased person should be done sensitively, e.g. if a client contacted the company to speak to the person;

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21) Available at https://www.universitiesuk.ac.uk/what-we-do/policy-and-research/publications/features/suicide-safer-universities/responding-suicide-advice-universities.

22) Available at https://hospicefoundation.ie/our-supports-services/bereavement-loss-hub/grief-in-the-workplace/responding-to-suicide-a-guide-for-employers/.

23) Available at https://hub.supportaftersuicide.org.uk/resource/crisis-management-in-the-event-of-a-suicide-a-postvention-toolkit-for-employers/.

24) Available at https://www.nhsconfed.org/publications/ (A postvention toolkit to help manage the impact and provide support).

25) Available at https://www.surrey.ac.uk/sites/default/files/2024-09/postvention-guidance.pdf.

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iv) any staff sharing the news of the person's death should be done with thought to the impact on the other person. One approach is to use condolence cards including contact details of bereavement support organizations; and

v) communications should only include detail of cause/means of death if agreed with the deceased person's nominated contact or next of kin, but this detail is not necessary in all communications.

There is no "one-size-fits-all" approach to supporting someone after suicide bereavement, due to variations in relationships, closeness, context and timeline. Likewise, the approaches to support vary depending on the organizational structure. Any differing approaches for managers, peers, colleagues, team members, direct reports, etc., should be identified. Even if the loss was external to the organization, how people interact with a bereaved colleague depends on the exact relationship to the bereaved individual and should be accounted for in the action plan.

Many people who experience suicide loss report struggling with their social interactions and work roles after their loss. Managers can consider what reasonable adjustments they can make to support the bereaved person in the aftermath of the loss, as outlined in **8.7** to **8.10**.

8.7 Ability to function in the organizational environment

Some people bereaved by suicide may seem to function as usual at work, perhaps even with greater energy than before. This can be misleading and suggest they are coping much better than they are. Others might find focus and concentration overwhelmingly difficult and find previously routine tasks challenging to complete.

The need for leave varies greatly and, at any stage, a return to work never signifies that those bereaved by suicide have "moved on"– the impacts are often protracted and lifelong.

8.8 Practical implications for individuals dealing with suicide loss

Practical implications might include taking time out for dealing with wills/probate, recovery of possessions, closing of accounts, seeking information from healthcare professionals/systems regarding the care those they lost had received and organizing memorial events.

A key factor is preparing for the funeral, the day of the funeral and the subsequent emotional impact. Depending on the situation, there might be significant financial impacts due to funeral costs, travel, accommodation and even repatriation (where a loved one has died abroad).

An aspect many of those bereaved by suicide find challenging is the inquest process, which might be prolonged and can be re-traumatizing. There are resources available from INQUEST[26)] to help guide those bereaved by suicide through the inquest process, for example, where the loss was state-related (refer also to Table 4). In the longer term, as anniversaries of the death or other significant dates such as birthdays approach, the person bereaved by suicide may require additional support.

8.9 Dealing with media enquiries

The incident plan (see Annex B, **B.5**) should identify a single point of contact for the media, in the event of media enquiries. They should communicate with the family as to their preferences. Any information provided to the media should focus on the positive aspects of the life of the deceased person rather than details of their death. If the family agree to disclose the cause/means of death, the journalists should be reminded that any media coverage should include sources of support for people affected by these issues[27)]. Messaging should be consistent, along with an awareness that media interest might be somewhat driven by the profile of both the person lost and the organization, in conjunction with the method and/or location of the suspected suicide.

26) Available at https://www.inquest.org.uk/.
27) Available at https://www.samaritans.org/about-samaritans/media-guidelines/10-top-tips-reporting-suicide/.

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8.10 Examples of existing resources

Below is a non-exhaustive list of online resources, toolkits and mobile apps.

a) Samaritans[28].

b) Suicide Prevention Scotland[29].

c) Irish Hospice Foundation[30].

d) Irish Childhood Bereavement Network[31].

e) Stay Alive app[32].

f) Hub of Hope app[33].

NOTE 1 Points e) and f) above both have websites, as well as apps available for download to mobile devices.

NOTE 2 Refer to Table 4 for further resources.

[28] Available at https://www.samaritans.org/.
[29] Available at http://www.suicideprevention.scot/.
[30] Available at https://hospicefoundation.ie/our-supports-services/bereavement-loss-hub/.
[31] Available at https://www.childhoodbereavement.ie/safeharbour/.
[32] Available at https://prevent-suicide.org.uk/stay-alive-app-grassroots-suicide-prevention/.
[33] Available at https://hubofhope.co.uk/.

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Annex A (informative)
Principles for commissioning suicide prevention training

When commissioning suicide prevention training, the following principles can help organizations to select the training package that best suits their requirements. Approaches can be informed by relevant data, research and lived experience.

a) Trauma-informed practice

This is training designed and delivered with an understanding of trauma, creating a safe and supportive environment for learners. It mitigates the potential emotional impact on learners and includes strategies for managing distress. It also limits personal disclosure to protect learners' wellbeing and ability to learn.

b) Externally recognized content

Training programmes that meet external recognized standards. These can provide assurance of content integrity and alignment with best practices.

c) Qualified trainers

Engaging trainers who are qualified and experienced in teaching, mental health and suicide prevention ensures training is delivered effectively and sensitively, and fosters learner confidence. Organizations can ask training providers about their trainer selection criteria.

d) Evidence-based curriculum

Content that is grounded in the latest research and evidence incorporates proven strategies and interventions and reflects current best practices. Organizations can evaluate training programmes to assess effectiveness, relevance and impact; for example, if the curriculum adheres to scientific standards and demonstrates real-world applicability and measurable outcomes. Evidence-based, independently evaluated training provides learners with reliable, actionable tools and techniques while assuring organizations of credibility and success.

e) Informed by lived experience

Listening to and learning from people with lived experience of suicide is now a core part of training and development programmes, both indirectly through insights as a part of the research and evidence base, and directly through training delivered or co-delivered by those with lived experience. Combining research, case studies and first-hand accounts helps ensure training is grounded in diverse lived experiences.

f) Focus on practical skills

In this type of training, learners are equipped with clear, actionable skills that can be immediately applied, such as recognizing signs, initiating supportive conversations and developing individual safety plans and note-taking.

f) Participant support

Organizations prioritize the emotional wellbeing of learners by providing access to support resources, debriefing opportunities and guidance on self-care during and after the training.

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g) Sensitivity to culture, neurodiversity and context

Training is tailored to meet the cultural and contextual needs of the organization and the populations it serves, including, for example, neurodivergence and those in specific ethnic groups, to maintain inclusivity and accessibility. It should include understanding the intersection of many factors, including, but not limited to, diversity, inclusion and mental health challenges

h) Sustainability and continuous development

This is where pathways for ongoing learning and development are provided, such as refresher courses or advanced modules, to sustain and build on learners' skills over time.

Annex B (informative) Toolkit for human resources

B.1 Conversations with workers

Asking questions about wellbeing is a simple tool to help workers who might be struggling with their mental health or a stressful challenge in their work or life. Through conversations with their manager or HR, workers can talk about any problems they might be facing at work and together they can agree on plans to support wellbeing, coping and productivity. This might involve making small changes to their work, such as adjusting their workload or taking more breaks. The goal is to support the worker and keep them happy, healthy and productive at work.

Conversations that focus on what the worker can do and not what they cannot do can make a positive experience for the worker. It is important that conversations are worker led with an offer for the worker to have support at the meeting, e.g. from a person trained in suicide prevention from the organization.

When managing conversations, it is important:

a) to hold the conversation in a private environment without interruptions;

b) to confirm that the conversation is confidential, but advise that any specific concerns that could risk the safety of anyone will need to be reported to occupational health, their line manager or other members of the HR department;

c) to use active listening;

d) to use open and non-judgemental questions to guide the conversation (along with necessary closed questions such as “Are you having thoughts of suicide?”);

e) to show understanding, an open mind and compassion;

f) that personal opinions are not shared;

g) to be careful in sharing the personal experiences of others, as these can significantly differ from those of the worker being spoken to;

h) to use a personalized approach, where possible, as everyone is different;

i) to talk in a calm manner while maintaining appropriate eye contact. The worker’s communication style and preferences are to be taken into account;

j) to not rush the conversation and to focus attention on the worker. Where possible, help them to come up with their own solutions;

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k) to discuss preferred coping strategies and working patterns. It is important not to make assumptions on which options would be best, as experiences vary; and

l) to never, under any circumstances, apply a diagnostic label to a worker who is struggling.

For possible adjustments, see **7.4**.

NOTE It is advised that the organization and worker discuss whether the worker's difficulties might temporarily affect their ability to do their role safely or expose others to harm; for example, within safety-critical roles or in roles where mental health management policies are likely to apply due to the nature of the work undertaken (such as driving and work in the rail, oil and gas or construction industries, access to means which can be used for suicide, e.g. scaffolding, chemicals, knives, medicines).

The following questions could be used to gain an understanding of the situation, support and adjustments required:

1) "What mental health condition, self-harm or substance use, if any, do you or have you experienced?"

2) "What are the difficulties or issues you experience?"

3) "Do your difficulties stay the same or do they fluctuate depending on the time of day or situation?"

4) "How does this impact on your daily activities?"

5) "How does this impact on your abilities to carry out your role?"

6) "What adjustments would allow you to work effectively?"

7) "Does anyone already know about your difficulties, or would it be helpful to inform someone else in the organization about how to support you?"

8) "Do you notice any warning signs, and how can we work together when they appear to support you?"

9) "If you do need time off work, how do you wish to be contacted and how frequently?"

10) "How can the organization support you in attending any health appointments?"

Possible ways to conclude the conversation include the following.

i) If the worker discusses any difficulties, ask whether they are getting adequate support from their GP or whether they want their manager or HR to contact their GP on their behalf, and confirm whether a specific occupational health (OH) report is necessary.

ii) Signpost to support organizations for mental health, self-harm or substance use or organizations which support in a time of crisis, e.g. Samaritans.

iii) Encourage the worker to use the wellbeing material and resources provided by the organization.

iv) Where necessary, confirm actions agreed with a specific timeframe – this might involve multiple stakeholders, including the employer, worker, HR, H&S, OH, or operational managers.

v) Where there is a risk to the individual, inform them of what needs to be reported to the appropriate people and what can be confidential.

vi) Where an individual safety plan is required, refer to Annex D, **D.6**.

vii) Schedule a follow-up meeting while making it clear that the worker can speak to you at any time in advance of this.

viii) Offer a mentor support from a member of HR or a person suitably trained in suicide prevention for the worker to be able to discuss any mental health scenarios which might occur or reoccur after the initial meeting.

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B.2 Note-taking

When documenting interactions with individuals experiencing thoughts of suicide or suicide behaviours, it is important to document only what is necessary and factual. Only keep notes that are objective, concise and relevant, whilst avoiding the use of speculation, diagnostic language or unnecessary details.

Key guidance for note-taking is as follows.

a) Purpose and necessity: that information is only recorded when necessary, i.e. to provide appropriate support or escalate concerns in line with organizational procedures.

b) Accuracy and objectivity: documenting what was said or observed, rather than interpretations or assumptions, and with neutral, non-judgemental language.

c) Data minimization: including only essential personal data, such as name and relevant details.

d) Security and access control: storing records securely (and encrypted, if digital), restricting access only to authorized personnel on a need-to-know basis.

e) Consent: recording information only if justifiable, e.g. it has legitimate interest or vital interest. This involves obtaining explicit consent from the individual concerned, where possible and appropriate.

f) Retention and disposal: establishing clear retention periods for notes and having a means of secure deletion/destruction when they are no longer needed.

It is advisable for organizations to provide staff training on note-taking good practices so that organizational confidentiality and ethical obligations are met when handling sensitive information.

NOTE Information regarding data protection, use and access is available from the Information Commissioner's Office[34)].

B.3 Crisis management

Any suspected suicide which occurs at the organization's premises or at work is a crisis and needs to be treated as such. Refer to **5.2** for guidance on the contents of policies and procedures and how they can be cross-referenced with other policies.

They can be installed alongside other emergency preparedness management procedures and policies within the H&S management system as detailed in BS EN ISO 45001.

B.4 Policies

It is advised that policies put in place to cover sexual harassment, equal opportunities and treatment, and health and safety of the workers are reviewed to adequately cover suicide prevention. However, other HR policies, e.g. redundancy, disciplinary or garden leave, suspension, performance and probation processes when activated, might cause a worker to suddenly have thoughts of suicide. The following considerations are useful when handling these situations.

a) How might this affect the worker regarding financial and family commitments?

b) How might this affect the worker and the HR team's mental health?

c) What support can be offered to the affected worker if they start to have thoughts of suicide or is it more appropriate to signpost external organizations who can support them, e.g. Samaritans?

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34) Available at https://ico.org.uk/.

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d) Can the organization manage the situation in a caring and considerate manner which understands that the affected worker might feel that they have failed in some manner?

e) Is the right person carrying out the interviews so that they are independent of any previous conflicts which might have occurred between them and the worker?

f) Who can the affected worker speak to openly about the situation they are going through, especially if they do not have any family?

It is key to remember that during these situations, the worker is likely to be feeling emotional and might feel a perceived loss of standing or reputation and/or that their values and beliefs are being challenged, and as such, all interviews and communications to them about this needs to be handled with the appropriate understanding and compassion.

It is also key to note that the people completing the interviews, e.g. HR, the line manager, might also feel emotional around the situation, especially if they do not personally agree with the course of action which the organization is taking. Therefore, support and a debriefing session after the event might be required.

B.5 Sample checklist of responses required after a workplace or colleague suicide

A plan of action for the incident (following the example considerations shown in Table B.1) enables appropriate and consistent steps to be taken. The incident team involved might vary depending on organization size and dynamics but could also be a single individual. Regardless of team size, it is important to have a named individual responsible for overseeing and managing the implementation of the incident handling, who can do so with sensitivity and empathy. Those involved, including themselves, might be directly impacted by the suicide loss. As such, potential issues such as trauma and guilt, and the need for appropriate self-care, might arise.

Table B.1 is an illustrative series of steps that can be taken and, while it can be used as a starting point, it is advised that each organization develops one pertinent to its unique structure and workforce (links to example published documents with existing checklists can be found in Clause **8**). While the initial actions can be taken in order, i.e. establishing the facts first and assessing those impacted, later actions are very likely to overlap or occur in parallel.

B.6 Checklist following the loss of a colleague to suicide

Table B.1 shows a series of actions to be taken following notification of a suicide (or a suspected suicide), communications within the organization, interactions to be had with the family of the deceased person and support for workers.

Table B.1 — *Checklist following the loss of a colleague to suicide*

Action	Considerations/steps
a) Initial steps following notification of a suicide (or suspected suicide)	
Establish the facts	Undertake the recording of only factual and accurate details of the person lost, and circumstances of the incident, to mitigate misinformation and rumours. This includes involvement of the emergency services where the suicide was on-site. If a note was left, it is likely to be retained by the police which can be confirmed to the next of kin if they were not already aware. If the incident was outside the workplace, capture the details of the informant and confirm what can be shared. Be considerate of any cultural/diversity aspects. In some circumstances, the incident might not be declared as a suicide immediately or even until the inquest is held. In some circumstances, family members might not wish the term suicide to be used. How the incident is described and communicated needs to be tailored accordingly and designed to mitigate speculation.
Assess and triage those affected	Determination of those impacted involves confirming social contacts, i.e. colleagues or external parties (suppliers, contractors, clients etc.) as well as family members, and gaining a sense of the closeness of their interactions, as this is likely to influence the impact on each individual. Anyone who might have witnessed the suicide (or suspected suicide) and/or discovered the deceased is very likely to require support.
b) Communication within the organization	
Confirm the communication strategy	Prior creation of a flowchart and templates (for consistency and to make sure nothing is missed) might assist this process. Several individuals might be involved in the communication strategy, but implementation carried out by a named individual is best practice. It is important to understand when and how the nominated contact or next of kin will be/have been informed – if it was via the emergency services, establish what was communicated to them, how and by whom. Communicating at an individual level and tailoring it based on the relationship to the deceased person is more appropriate; in some instances, this might need to be on a group basis involving family/carers. Providing sources of support to the nominated contact or next of kin in writing is an important step, including support available within the workplace (EAP, mental health champions) and those available externally (NHS primary care and voluntary sector) that are known to be current. It is important that misinformation through the "rumour mill" (including social media) is minimized and its perpetuation discouraged. As such, the strategy covers the immediate notification of the incident but also the long-term sharing of information, e.g. funeral arrangements or any memorial events. It is good practice that an appropriate named individual checks with the family whether they would appreciate colleagues attending any memorial service or whether they would prefer to mark this privately. Colleagues might also wish to share their memories and feelings regarding the deceased person.
Communicate the facts to the workplace	Keep all communications with the workplace factual but warm and empathetic, and, if practicable, delivered in person (or verbally if individuals are remote). Other means (e.g. email) might be necessary in large organizations but, again, have these come from a named individual and with contact details provided and an offer to talk extended?
Response to media enquiries	See 8.9.

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Table B.1 — *Checklist following the loss of a colleague to suicide (continued)*

Action	Considerations/steps
c) Interactions with the family of the deceased person	
Communication	Family members are best supported by a person from the organization (chosen from HR, H&S or a manager of the deceased) and this choice may be led by their preferences for someone previously known to them. An important element of this is that the organization is responsive to family requests for information (even if legally limited on what can be shared).
Personal possessions	As soon as possible, pending any formal investigations, return personal possessions to the family but in a thoughtful manner and in discussion with the family, i.e. not in a generic file box. The organization and/or individuals might wish to include, for example, a condolence card(s).
Funeral arrangements	It is proper that organizational representation at the funeral is in keeping with the wishes of the family, e.g. attendance by a senior manager might be appropriate to represent the organization but co-worker(s) might be better received (or a combination thereof). Provision of flowers and/or donation to a charity also need to be in line with family wishes.
Memorials	The desire to gather, honour and grieve after a suspected suicide is a natural response. While floral tributes, vigils and memorials can offer comfort, they might also draw attention to a work-based site of death and, for vulnerable individuals or those who identify with the deceased person, risk romanticizing the death and increasing the “cognitive availability” of suicide. Organizations might wish to discourage site-specific tributes and instead suggest alternative forms of remembrance, such as memorial books or services in neutral locations. If physical memorials are used, limiting their duration (e.g. two weeks) might help reduce any potential harm. Any decisions should be handled sensitively and communicated clearly so that the death is acknowledged respectfully (and in keeping with deaths from other causes) and without increasing risk or stigma.
HR systems	Where a colleague has died by a suspected suicide, it is important that the family is not additionally burdened (to the greatest extent possible) regarding impersonal communications around payroll, benefits, etc. In resolving these sensitively, HR can minimize administrative burdens on the bereaved. Where a colleague has lost a loved one, and has requested sick leave, HR can also access alternative means of getting information, other than directly contacting them, e.g. speaking to their line manager, reviewing HR records.
d) Interactions with workers	
Support	Following the initial notification, staff can be further supported with regularly reminders of the resources available to them (EAP, mental health advocates, NHS and charities). Depending on the relationship to the deceased, individual support plans might be required, including allowances for time off work. Future events might trigger additional support requirements, e.g. the funeral, the inquest (especially if called to give evidence), birthdays, the anniversary and organization events such as team-building and social gatherings. Acknowledge and provide feedback to those that have given personal support to those affected.

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Table B.1 — *Checklist following the loss of a colleague to suicide (continued)*

Action	Considerations/steps
Establish any prior known issues or risks	Whilst it is important that any serious untoward incident (SUI) investigation is not seen to be looking to apportion blame, it is also important that the organization assesses all relevant prior information regarding the deceased (contact with manager(s), HR, EAP, etc.). In conjunction with the circumstances of the death, this information can inform policy or procedural changes that could mitigate risk of future deaths.
Increased risk of suicide	In general, those bereaved by suicide are at greater risk of suicide themselves. In the specific context of a workplace and/or job role, there is a risk that a suicide could induce thoughts of suicide in the bereaved, potentially leading to other suicides. Organizations need to be aware of this risk and take steps to mitigate it via contact, support and, where appropriate, restriction of access to means.
Return to work	If staff members require time off following the loss of a colleague, or where the suicide was of a colleague’s family member, in both instances their return to work requires sensitive planning. Expectations of “business as usual” are not appropriate and allowances for staff members to adapt to their new circumstances and process their trauma are good practice.
Memorialization and anniversaries	To honour the deceased, breakdown taboos and mitigate stigma, organizations can formally recognize losses to suicide. Encouraging staff to participate in activities that celebrate the life of a lost colleague (or family member) might help them both acknowledge and foster sharing of their feelings and needs. These might occur at work or informally. Workers may wish to donate to/volunteer for a charity in the name of a lost colleague.
Practicalities	Where a colleague has died, sensitively deal with practical aspects such as reallocation of a workspace, work materials, work responsibilities, email access and monitoring of their incoming communications etc.
e) Capture lessons and develop into best practice	
Ongoing activities	It is important that the steps taken above are evaluated for their perceived impact and modified iteratively where indicated. This improves current and future support provision and allows for consistent delivery of that support where perceived to be beneficial.
Continual process improvement	Feedback from staff, families, the incident team plus changes in law and information sharing from other organizations, new research findings, etc., might all give cause for the handling of suicide bereavement to be modified. It is advisable to assess procedures after each incident but also on a recurring basis or when significant new information becomes available.

B.7 Checklist following the return to work of a colleague after a suicide attempt

Table B.2 shows actions to be taken following the return of a colleague to work after a suicide attempt to provide support and help them re-engage with their colleagues and the organization. Refer to the questions detailed in **B.1** to help structure their return.

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Table B.2 — *Considerations following the return of a colleague after a suicide attempt*

Action	Consideration/steps
Establish welfare	Undertake a return-to-work interview in a safe space chosen by the worker, which may be outside the workplace and in a public or private area. If the attempt was within the workplace, then establish if they feel able to return to the same location. Invite the colleague to bring a trusted person (this might need to be family member or friend) to the interview, if they need further emotional support.
Assess what support is already in place	After the attempt, the colleague is likely to have support around them from therapists or their doctor, as well as family and friends. It is important for them not to lose that support during working hours. Therefore, establish if they need to be able to contact them, to see them during breaks or if time off is required for them to attend appointments. Understand if they have received any medication from their doctor to support them during this time and how this might affect their return to work and their usual work activities (e.g. use of heavy machinery).
Understand if they are still at risk	Ask the colleague, if appropriate, to provide a letter from their therapist (or other professional supporting them) to understand if they are still at risk of thoughts of suicide, and if they are recommending any support which needs to be provided. If this is the case, then provide what is recommended.
Maintain confidentiality	It is paramount that the colleague manages who is informed about the attempt and how this is communicated. Discuss this with them and understand if there is anyone that they work with who already knows about the attempt. Explain the company policy around maintaining their safety and whether they might need to inform others if there is still a risk of suicide. Agree on what, if anything, will be communicated to colleagues (especially their immediate team members) regarding their absence and return to work.
Establish a return-to-work plan	Establish a return-to-work plan with their trusted person and consider what reasonable adjustments are required. This might be a phased plan where they only return on light duties or part time for an agreed period of time. However, they might also wish to return to full normal duties. Where uniforms/dress codes are in place, then consider if this might expose the colleague to questions if scars are visible (e.g. exposed arms). Consider the privacy of covering scars around the arms or neck and allow them dispensation against any company requirements. If they are required to travel and be away from family and friends or are a lone/remote worker, then it might be appropriate to allow them to travel with others or have technological solutions installed for lone working that require them to check in with people at a set frequency. This might also include working from home and using technology for online meetings rather than travelling. Refer to stressors in Annex C, Table C.1, for areas to consider, dependent on role.
Establish an ongoing wellbeing support plan	Establish what ongoing support is required and the frequency/location of meetings. This might need to be with HR or their line manager but could also be with occupational health if available. Consider if the colleague only wants to have discussions with the same person and organize meetings accordingly. Within these meetings, consider their feelings and how they are engaging back into the organization as well as how they feel that they are performing. Discuss if any further support could be provided or is needed. When establishing the plan, understand what the duration of the plan might be. This needs to be as short or long as required and discuss what does good look like as to when to reduce or remove the support.

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It important to understand that if they feel unable to return to work in the same capacity as before the attempt and can no longer fulfil their duties, even with reasonable adjustment and support, then it might be necessary to discuss alternative options including resignation or termination of contract by mutual consent. If this is the case, then this needs to be completed in a sensitive manner and with the right support, as outlined in **B.4**.

Annex C (informative) Roles and stressors at work

Environments that engender openness, promote feelings of importance, purpose and belonging can elevate mental health and in turn minimize an individual's likelihood of experiencing thoughts of suicide. Conversely, environments and organizational structures riddled with stressors, disorganization and silence surrounding the importance of mental health can exacerbate distress and have a significant impact on thoughts of suicide.

Throughout life, individuals experience a variety of environments, two of the most prominent being work and home. All environments place a variety of demands on an individual, known as stressors, which can impact their mental health and in turn thoughts of suicide. Although environments are distinct, what happens in one environment can impact an individual's thoughts, feelings and behaviours in another, and therefore it is important for organizations to consider this when preventing poor mental health and thoughts of suicide at work. General stressors are present in all occupational environments (in addition to those that are role/sector/organization-specific) and organizations are advised to minimize and mitigate their impact where possible.

Table C.1 details the variety of stressors that individuals can experience working in a range of sectors and roles. This list is not exhaustive but features some of the more prominent stressors associated with each job type. Having an awareness of the potential for these stressors to negatively impact individuals can help organizations to have structures in place to support them.

NOTE Not all stressors listed might be present for all roles within each job type.

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Table C.1 — *Examples of stressors at work*

Role	Stressors
Stressors general to any role might be:	
General occupational stressors for all roles	Job security, deadlines, lack of autonomy, bad management practices, workplace relationships, role changes, uncertainty about the future, travel, working hours (including shift patterns) and pay, working conditions and environment, nature of the role and exposure to stressful situations, level of responsibility, tight deadlines and pressure to meet KPIs, risk of legal repercussions, pressure to maintain up to date knowledge.
Stressors for specific roles might be:	
Physical roles requiring travel without consistent access to facilities, e.g. police officer, postal worker, electrician, construction worker	Tight deadlines, high safety standards, physical discomfort, long/unsociable working hours, discomfort due to excessive heat or cold, uncertainly of working days due to weather, isolation from family and friends and loneliness, costs of staying away from home.
Static roles, e.g. cashier, security guard, call centre worker, stockbroker	Client behaviour, monitoring of communications, environmental uncertainly, time of the year/shop foot traffic (Christmas, Black Friday, back-to-school), noise levels/ overstimulation, exposure to previous stressful situations, e.g. robbery/abuse, national/local government pressures.
Highly physical roles, e.g. carer, warehouse operative, catering staff, manufacturing staff, oil rig workers	Physical discomfort, long/unsociable working hours, quotas, pressure to comply with standards and regulations, behaviours of service users/clients, pressure of unannounced audits.
Lone working roles requiring travel, e.g. sales, auditors, drivers, transport industry (air crew, bus drivers, train drivers), sole traders	Long working/unsociable hours, isolation from family and friends and loneliness, client behaviour, costs of staying away from home, exposure to previous stressful situations, e.g. previous suicides.
Roles which work on the land, e.g. arable farmers, livestock farmers, growers	Financial pressures, long working/unsociable hours, isolation from family and friends and loneliness, dependency on weather, protestors and activists, pressure to comply with animal welfare/crop standards, climate change, soil health, media pressures, meeting the needs for food or commodity security, pressure to protect and restore the biodiversity of the land.
Roles which are in the public eye, e.g. politicians, actors, presenters, models, social media influencers, reality personalities, sport players, musicians, chief executive officers, board directors	Public scrutiny, lack/invasion of privacy, behaviour of the public and media, social media, pressure to perform, peer pressure, trust, welfare requirements for children and elderly, pressure to maintain a certain perceived physical appearance.
Role dealing with vulnerable groups, e.g. teachers, childcare workers, healthcare professionals, homeless charities, emergency services, crisis non-governmental organizations	Pressure of government targets/regulatory bodies, vulnerable group behaviours, inability to switch off, pressure of unannounced audits, immediate medical/welfare impact, risk to harm to self, abuse from family and friends.

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Annex D (informative) Toolkit for line management

*COMMENTARY ON ANNEX **D***

It is acknowledged that some of the content in this British Standard is repeated in this annex; however, this annex is designed to be a synopsis of the key recommendations for line managers to use in an emergency.

D.1 Understanding suicide and the role of managers in prevention

Line managers play a pivotal role in worker suicide prevention, as 69% of workers state that their managers significantly impact their mental health, equally as much as their partners and more than their doctors or therapists [19].

This toolkit aims to educate and assist line managers and colleagues to reduce suicide risk by outlining the core components for suicide awareness and prevention.

These areas of knowledge need to be reviewed and understood by a line manager to enable effective support of staff in understanding suicide and its prevention.

D.2 Building knowledge of fundamentals

D.2.1 Key statistics

Virtually every workplace is affected by suicide, at some point and in some way.

a) Every suicide death affects individuals across a social network, estimated to be as many as 135 people[35)].

b) With approximately 6 417 suicide deaths per year (2012 to 2022) in the UK [8], and 7 555 in the UK in 2023[36)], an estimated 865 000 to 950 000 people are exposed to suicide annually.

c) The economic impact of suicide in the UK has been estimated at £1.46 million per suicide [including emergency services, healthcare services, lost productivity (deceased and family)], coronial/legal costs, plus intangibles; using 2022 data [17].

For a summary of statistics on how exposure to suicide is much more common than believed, see **0.1**.

D.2.2 Myths and facts

See **0.2** for common myths that surround the topic of suicide and what the reality is for each of them. In particular, Myth 1 to Myth 3 aim to alleviate the potential worries a person might have if speaking to someone who has expressed, or who might express, their thoughts of suicide.

D.2.3 Support frameworks

Line managers are advised to maintain familiarity with existing support frameworks, policies and processes. These elements establish a comprehensive care and support infrastructure that goes beyond initial prevention and intervention, facilitating recovery and assistance for individuals at risk. Managers that are knowledgeable about both organizational and community support resources can make this information easily accessible.

35) Further information is given in the article *How many people are exposed to suicide? Not six* [5].
36) Information available at https://www.samaritans.org/about-samaritans/research-policy/suicide-facts-and-figures/latest-suicide-data/.

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The following is a sample checklist.

a) Support frameworks within the workplace might include:
   1) mental health support;
   2) mentoring programmes;
   3) support groups;
   4) awareness raising campaigns;
   5) education on policy and procedures for at risk staff;
   6) EAPs;
   7) counselling service;
   8) external resources available, i.e. community, local and national services for support; and
   9) training and education programmes (see Annex A).

b) Policy and processes might include:
   1) equal employment opportunity policy;
   2) performance evaluation process, including probation;
   3) knowledge of staff trained in suicide prevention;
   4) harassment and bullying policy;
   5) workplace health and safety policy;
   6) remote work and flexible work policy;
   7) compensation and benefits policy.
   8) ethics and confidentiality;
   9) an organizational risk assessment of the hazards and risks present in the organization;
   10) complaints, disputes, grievances and appeals procedures;
   11) organizational action planning;
   12) diversity, equity, inclusion and justice;
   13) communication;
   14) training;
   15) crisis management and response plans, including response after suicide;
   16) individual suicide safety plans (see Annex D, **D.6**);
   17) bereavement, loss and trauma;
   18) absence management and return-to-work (or healthy "stay-at-work-with-support" policies);
   19) mental health and wellbeing; and
   20) monitoring and review.

D.3 Identifying risk factors

Understanding the factors that increase suicide risk helps its prevention. The causes of suicide are complex, with no single explanation. Risk factors are dynamic and vary throughout an individual's life, differing from person to person.

See Figure 2 for examples of what those factors might include.

D.4 Recognizing warning signs

Suicide is a complex issue with no singular cause for why an individual might contemplate or die by suicide. This complexity complicates the understanding of who could be affected and the identification of warning signs, if any. However, there are common behaviours and communication patterns that can indicate someone is struggling (see Figure 3). Unmet emotional needs can lead to distress, which can manifest in subtle ways, potentially resulting in thoughts of suicide or suicide behaviours. Managers need to be aware and able to recognize warning signs and respond effectively.

D.5 Approach and communication

D.5.1 General

Effective suicide intervention requires active listening and clear, compassionate communication. This is key to creating a safe, supportive space encouraging individuals to share their feelings and explore help options.

D.5.2 When to respond

A response is required in the following situations:

a) if you have a gut feeling that someone is not OK;

b) when there are clear signs of distress; and

c) immediate risk to life and crisis situation.

D.5.3 How to respond safely

Once signs of distress have been observed, then asking about thoughts of suicide directly and without judgment is the next step and a critical component of effective intervention.

It helps to break the silence and stigma surrounding thoughts of suicide and provides individuals with the opportunity and permission to share their experiences openly.

Use of empathetic, straightforward language builds trust and helps individuals to feel heard and supported. Asking clearly about suicide demonstrates that the topic is safe to discuss.

A general rule is: if in doubt, ask, and use clear, direct language, such as the examples shown in Table 3.

Approach the conversation with openness and compassion; it can create a safe space that encourages honesty and connection, paving the way for effective intervention and safety planning.

D.5.4 Principles of active listening and effective communication

Confidentiality cannot be guaranteed when a worker discloses thoughts of suicide to a colleague or manager. If a worker requests confidentiality, it is important to make them aware that information might need to be shared sensitively, if their safety is at risk.

It is the responsibility of HR to provide clear guidance on communication protocols for disclosures of thoughts of suicide or suicide behaviours. Proper handling of the situation is therefore achieved when managers maintain familiarity with these procedures. Examples of behaviours and communications that could help, or hinder, the conversation, are shown in Table 4.

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D.6 Creating an individual safety plan

An individual safety plan (an example is provided in Table D.1) is designed to help individuals identify coping strategies, support networks and professional resources. It is good practice to complete it collaboratively with a manager, HR representative or a trusted colleague, and to treat it with confidentiality and sensitivity and reviewed as appropriate.

Table D.1 — *Example individual safety plan*

My Suicide Safety Plan (fill in the sections that apply to you):	
1	Gaining permission to stay safe (Can we agree on a plan to help keep you safe? What steps feel manageable for you?)
2	Recognizing warning signs (What thoughts, feelings, or situations indicate you might need extra support?)
3	Reducing isolation (Who can you regularly check in with for support? This could be a trusted colleague, friend, or crisis helpline.) • Name: • Contact: • Name: • Contact: • National helpline: • Contact:
4	Managing distress (What activities or strategies help you feel better? Are there therapeutic options you would consider? Who can help?)
5	Dismantling suicide plans (Are there specific steps we can take together to reduce access to means and increase your safety? Who can help?)
6	Learning from past behaviours (What has helped in the past? What has not worked? Who could help?)
7	Addressing substance use (Does alcohol or drug use impact how you feel? Would you like support in managing this? Who can help?)
8	Connecting to professional support (Who are the professionals or services that can support you?) • GP: • Contact: • Mental health professional: • Contact: • Employee (worker) Assistance Programme: • Contact: • Specialist support service: • Contact:
9	Emergency steps and crisis plan (What should be done if you are in immediate crisis? Who needs to be contacted? Who can help?)
10	Final agreement We agree to use this plan to help you stay safe and seek support when needed. • Name: • Date: • Manager/support person: • Date:
This plan is to be reviewed regularly and updated as needed. If you are in immediate danger or require urgent support, seek emergency assistance.	

Other resources that are helpful for safety planning are listed in **8.10**.

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D.7 Crisis response

Assessing danger involves evaluating risk factors such as a specific plan, access to means and a timeline. A well-defined method with immediate access poses a higher risk than vague thoughts without a plan.

As a manager it is important to know and understand what risks are present in order to mitigate and manage (e.g. physical restrictions, controlled substances or location risk).

If the person is at immediate risk, the best approach is for the manager to act swiftly, and to make use of the organization's crisis response protocol, including the specific actions and communication pathways to be followed, as shown in Figure D.1. The individual's safety is the priority.

Figure D.1 — *Steps to take in a crisis*

D.8 Support after a suicide

D.8.1 General

Some members of the workforce might experience suicide loss beyond their working lives, some might experience the suicide of a member of the workforce.

Grief after suicide is particularly difficult because of the additional burden of stigma, self-blame, guilt, responsibility, shame, hopelessness and severe psychological distress. It is a dynamic process and different for every individual.

It is a line manager's role to understand the procedures HR has in place to support:

a) a worker bereaved by suicide;

b) workers and site staff after the suicide of a colleague; and

c) workers and site staff after the suicide of a colleague, customer or visitor on site.

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D.8.2 Actions for managers following a workplace suicide

Actions for managers include the following.

a) Understand the procedures and process for handling the suicide in the workplace.

b) Confirm the communication strategy, who and how information is to be communicated to necessary parties and individuals.

c) Be thoughtful about the language used around suicide and do not use terms such as "a successful suicide attempt" or a "failed suicide attempt" communicated within and outside of the workplace.

d) Address the impacts of a suicide within the workplace with sensitivity and care.

D.8.3 Self-care for managers

Managing situations involving suicide or suicide behaviour in the workplace can be emotionally taxing, leading to increased stress and distress for managers. It is imperative that organizations implement measures to support their managers who are offering support to workers in order to protect their own mental health, such as seeking supervision, accessing counselling services (see Table 4) and prioritizing time for reflection and self-care activities. By enhancing their own emotional resilience, managers can provide more effective support to their colleagues and foster a healthier workplace environment.

Annex E (informative) Suicide prevention self-evaluation and benchmarking questions

Continual improvement, systemic action and learning needs organizational self-evaluation. This process gathers necessary data, monitors progress, identifies key gaps, challenges thinking, drives change, raises ambition and provides momentum.

The questions in Table E.1 to Table E.3 support organizations in collecting the data needed to conduct an organizational risk assessment, benchmarking and action planning to drive coordinated continual improvement for suicide prevention efforts within an organization.

Monitoring and evaluation processes enable the effectiveness of suicide prevention initiatives to be assessed. By establishing clear metrics, using diverse data collection methods, engaging stakeholders and committing to continuous improvement efforts, organizations can enhance the impact of their programmes. Regular reviews help to identify successful practices and areas that need enhancement, ultimately leading to more effective and sustainable suicide prevention strategies.

In the early stages of development of suicide prevention approaches, some organizations might find some of the questions harder to answer or might lack the required data, systems or policies to answer affirmatively. Over time however, it allows key data to be collected, gaps in systems and policies filled and evaluation processes to evolve. The degree of challenge and "stretch" might change. It remains important to ask the key questions regularly to monitor progress and inform new actions.

Organizations relatively new to suicide prevention might initially worry about asking some of these questions, notably asking workers in (confidential or anonymized) surveys about thoughts of suicide or suicide behaviours but may to become more comfortable with asking them over time.

Table E.1 lists questions pertaining to existing organizational procedures and systems.

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Table E.1 — *Existing organizational procedures and systems*

Question no.	Self-evaluation questions
Q1	What data, if any, is present on suicides, suspected suicides, suicide attempts and self-harm among those who work in or with the organization?
Q2	What steps, if any, are being taken to collect such data so the problem can be monitored and managed?
Q3	What systems or processes, if any, are in place to investigate suicide deaths among those who work in or with the organization to learn lessons and help prevent further suicides?
Q4	Is there data from surveys of the workers on what percentage have had thoughts of suicide, made plans to end their life or made a suicide attempt or self-harm? If present, is this data monitored and used to shape suicide prevention strategies and plans, suicide education programmes and support for people who have experienced a suicide crisis, lost someone to suicide, or been affected in some way?
Q5	What suicide prevention strategies and plans, if any, are in place for those who work in or with the organization?
Q6	What support does the organization provide for workers who have been affected by suicide?
Q7	Is there data from surveys of the workers on what percentage have had mental health issues, self-harmed or experienced substance use (alcohol, drugs) that needed treatment or support in the past 12 months? If present, is this data monitored and used to feed into wellbeing and suicide prevention strategies, plans and policies?
Q8	What hard data on mental health, self-harm and substance use and their impact does the organization routinely collect?
Q9	What mental health or substance use strategies and plans, if any, does the organization have in place, or are currently being developed, or being planned, or being updated?
Q10	What percentage of managers and workers have had mental health awareness training?
Q11	What percentage of managers and workers have had suicide prevention training?

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Table E.2 lists questions concerning known suicide risk factors.

Table E.2 — *Self-evaluation questions concerning support for known suicide risk factors*

Question no.	Self-evaluation questions
Q1	What support, if any, is available for people working in or with the organization who experience loss or a traumatic event?
Q2	What mental health support, if any, is available for people working in or with the organization who have a permanent physical health condition or chronic physical illness?
Q3	What support, if any, is available for people working in or with the organization who have an ongoing mental health condition or mental illness?
Q4	What support, if any, is available for people working in or with the organization who are the primary carer for a child, disabled child, disabled adult, family member with a permanent physical health condition or chronic physical illness, or older family member who is frail or with declining health?
Q5	What support, if any, is available for people working in or with the organization who are neurodivergent?
Q6	What support, if any, is available for people working in or with the organization who are struggling financially?
Q7	What support, if any, is available for people working in or with the organization who are having personal relationship issues?
Q8	What support, if any, is available for people working in or with the organization who are experiencing domestic abuse or domestic violence?
Q9	What support, if any, is available for people working in or with the organization who are struggling with substance use (e.g. alcohol, drugs), gambling or sex addiction?
Q10	What support, if any, is available for people working in or with the organization who live alone, have no family or friends or social support network?
Q11	What support, if any, is available for people working in or with the organization who are exposed to online bullying, controlling or coercive behaviour or human trafficking?
Q12	What support, if any, is available for people working in or with the organization who are experiencing mental health issues, and possibly thoughts of suicide, as a result of bullying, discrimination, injustice, prejudice, not being included, not being believed, not being understood, or in any way thinking or feeling that the workplace is not psychologically safe?
Q13	What support, if any, is available for staff undergoing performance, disciplinary or severance proceedings including redundancies?
Q14	What support, if any, is available for staff who self-harm?
Q15	What support, if any, is available for staff undergoing relationship breakdown?

Table E.3 lists questions concerning actions the organization has already taken.

Table E.3 — *Action-oriented questions*

Question no.	Self-evaluation questions
Q1	What steps has the organization taken, and what is being planned, to make sure the working environment in all its forms (centrally located offices, factories or sites, other sites or meeting spaces, working remotely, working from home) is mentally healthy and psychologically safe for all those who work in or with the organization?
Q2	Has the organization discussed with all workers the steps it can take to reduce known suicide risk factors for all workers?
Q3	What steps has the organization taken, and what is being planned, to try and prevent all preventable suicides and to prevent suicide crises from being experienced by those who work in or with the organization?
Q4	Which issues, causes of suicide crises, or contributory factors for suicide is the organization currently focusing on, if any?
Q5	What steps, if any, has the organization taken to restrict access to means of suicide?

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