Connecting for Life

Ireland's National Strategy to Reduce Suicide 2015-2020

hi Healthy Ireland

An Roinn Sláinte
DEPARTMENT OF HEALTH

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

National Office for Suicide Prevention

Connecting for Life is Ireland's National Strategy to reduce suicide (2015-2020). The development of the strategy was a collaborative and inclusive process. Some of the most important contributions to the development of 'Connecting for Life' came from our public consultation process. We received 272 submissions from people and organisations, which included members of the general public, people who have used our services and their families, professional bodies and community interests and organisations.

" Everyone has a role to play in suicide prevention."

Submission reference number: 54

" All I ask for is a system of care that gives sufferers and their loved ones the best possible chance of survival and recovery."

Submission reference number: 134

Contents

Foreword iii

Introduction iv

Acknowledgements vi

Reducing Suicide in Ireland 2015-2020 ix

Executive Summary x

Section 1: Context for Suicide Prevention in Ireland 1

1.1 Suicide and self-harm in Ireland 2

1.2 Economic and social issues in Ireland and the impact on suicide 6

1.3 Suicide prevention in Ireland up to 2014 7

1.4 Policy context for suicide prevention 9

1.5 Policy coordination and a whole-of-government approach 10

Section 2: Development of the Strategy 13

2.1 Planning groups 14

2.2 Engagement process 15

Section 3: Evidence Base for the Strategy 17

3.1 An evidence-informed approach 18

3.2 Learning from *Reach Out* 18

3.3 Data on protective and risk factors and groups vulnerable to suicide 20

3.4 Evidence for suicide prevention, knowledge and awareness 22

3.5 International research evidence relating to the formulation of national suicide prevention strategies 24

3.6 Issues emerging from the planning process 26

Section 4: Overview of the Strategy 27

4.1 Vision 28

4.2 Outcomes 28

4.3 Guiding principles and themes 28

4.4 Strategic goals and objectives 29

Section 5: Implementation and Evaluation of the Strategy 35
5.1 The approach to implementation 36
5.2 Action plan to achieve goals and objectives 37
5.3 Implementation structures and roles 54
5.4 Resourcing the strategy 59
5.5 Communications plan 60
5.6 Measurement of outcomes 61
5.7 Integrative evaluation: process and outcomes 67

Appendices
Appendix 1: Abbreviations 70
Appendix 2: Key terms and definitions 72
Appendix 3: Suicide and self-harm in Ireland 75
Appendix 4: Irish policies with relevance to suicide prevention 82
Appendix 5: Membership of advisory groups 91
Appendix 6: Protective and risk factors for suicide 95
Appendix 7: Engagement that took place as part of the strategy process 101
Appendix 8: Government commitments 105

References 124

List of tables

Table 1: Methods of suicide in Ireland, 2007-2012 4
Table 2: Methods of self-harm in Ireland, 2007-2012 6
Table 3: Key learning points from Reach Out 19
Table 4: Individual, socio-cultural and situational risk factors 21
Table 5: International research on evidence for suicide prevention 25
Table 6: Implementation structures 56
Table 7: Agreed indicators and data variables for measurement of principal outcomes (POs) 62

List of figures

Figure 1: Suicide rate per 100,000 for males and females, 2010 2
Figure 2: Suicide rate per 100,000 for males and females aged 15 to 19 years by geographic region, 2010 3
Figure 3: Suicide rate per 100,000 by gender, 2001-2014 4
Figure 4: Summary of the full strategy development process 14
Figure 5: Implementation Structure 55

FOREWORD

Suicide prevention is everybody's concern. This national strategy sets out what we must do as a government and society to protect and save lives over the next five years.

The strategy is all about connection, the ties that bind. We know that connections to family, friends and community protect us from isolation. Connected services mean that more people can get the right help at the right time in the right place.

Since suicide is a 'whole-of-society' issue, we're taking a 'whole-of-government' approach. In framing the policies that shape the delivery of services to those who need them, strong connections must be embedded to ensure effectiveness and the provision of that all important human chain of support.

The challenge of reducing suicide rates demands a comprehensive response and will involve all stakeholders. This strategy outlines how all of us together can help to reduce suicide in Ireland. As a nation we must not alone become mindful, but minding of ourselves and those around us.

We, each of us, have just one life. We must 'mind' it and celebrate it. With this national strategy to prevent suicide we can. I hope it will bring peace, comfort and hope to lives and life in Ireland.

Enda Kenny TD
Taoiseach

INTRODUCTION

Connecting for Life is founded on the suicide prevention work that has taken place in Ireland over the past ten years as part of *Reach Out*, the Government's previous strategy to reduce suicide. Since then, there have been significant developments in the areas of research, policy and service delivery relating to suicide prevention, including:

- National and international research into suicidal behaviours and an improved understanding of the evidence base for suicide prevention.
- A stronger and far-reaching working relationship with a wide range of non-statutory and community partners, underpinned by a focus on hope, belief, recovery and commitment.
- A range of public policies within and beyond the health services that either deal directly with suicide prevention or have the potential to impact positively in terms of reducing suicidal behaviour and improving the wellbeing of the population.
- Increased public awareness of suicide prevention and mental health.

The planning process for *Connecting for Life* involved the engagement of a broad range of statutory, non-statutory and community stakeholders, identifying agreed strategic priorities, setting clear goals and objectives; it is underpinned by strong political leadership and commitment. The focus on engagement in the strategy development process has created a strong community of people and agencies ready to lead the implementation of *Connecting for Life*.

Connecting for Life involves preventive and awareness-raising work with the population as a whole, supportive work with local communities and targeted approaches to priority groups. The strategy proposes high-quality standards of practice across service delivery areas, and an underpinning evaluation and research framework. This wide reach presents unique implementation challenges. The whole-of-government, multi-agency, inter-professional, expert-by-experience, local/national focuses will involve multiple stakeholders across and between levels of government and governance.

While we need to focus on providing support to people who are in crisis, have attempted suicide or bereaved through suicide, we also need to remember that suicide prevention needs to address universal approaches such as building resilience among young people, reducing alcohol use within the population and delivering health promotion programmes to at risk populations

Implementing *Connecting for Life* will challenge all individuals and agencies and collectively allow everyone's strengths to evolve. *Connecting for Life* will aim to connect these and use these evolving strengths to form a major force for change in suicide prevention in Ireland.

Solid building blocks are already in place, as was evident throughout the implementation of *Reach Out*, particularly in relation to the developing evidence base and the range of services available to the public. However, gaps in services remain. Significant issues around timely access to services and early identification of risk are to be resolved and resourced.

Connecting for Life places huge value on the necessary collaborative partnerships and the rich learning that has and will continue to take place. This is essential and brings its own challenges. The range of suicide prevention services has developed significantly over the past decade and it is only by pooling expertise and resources and working together in a spirit of real cooperation that we can continue the great work already started in this area.

The implementation structure envisaged to deliver this strategy will assist in maintaining momentum and support, within a spirit of mutual respect and a united and focused platform of quality services for our community.

Kathleen Lynch TD
Minister of State for Primary Care,
Social Care and Mental Health

ACKNOWLEDGEMENTS

The development of *Connecting for Life* was a truly collaborative and inclusive process. I would like to thank everyone who participated in the development of this strategy. As shown in the listings below, this includes representatives from a very large number of statutory and non-statutory/community organisations working in the area of suicide prevention. It also includes individuals and families affected by suicide.

In particular, I would like to say a sincere thank you to:

The chairperson and members of the Strategy Planning Oversight Group – for their leadership in driving the development of the strategy.

The participants of each of the five advisory groups who gave generously of their time, energy and expertise. The insights from the non-statutory sector contributed enormously.

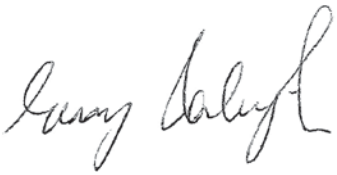
The staff team of the National Office for Suicide Prevention, who worked diligently to support this process, in particular Susan Kenny, Lead for Strategic Planning and Implementation, who played a central role in the development of this strategy and also Hugh Duane, Project Assistant.

The staff of HSE Mental Health Division and the Department of Health who supported the work, in particular Yvonne O'Neill and Colm Desmond who worked closely with NOSP in the planning process.

Prof. Steve Platt of the University of Edinburgh and Prof. Ella Arensman of the National Suicide Research Foundation, who provided valuable academic input relating to the international and Irish contexts.

Rita Burtenshaw of Burtenshaw Kenny Associates who provided external facilitation and process support.

And most especially, I thank the individuals and bereaved families who contributed to the public consultation process. They shared painful experiences and insightful reflections on the impact of suicide and the services and interventions that are needed for individuals, families and communities. These inputs were invaluable in maintaining our focus on the overall goal – to develop a strategy to reduce the incidence of suicide in Ireland.



Gerry Raleigh
Director, National Office for Suicide Prevention
June 2015

Members of the Strategic Planning Oversight Group

Kieran Ryan (Chair)	Irish College of General Practitioners
Prof. Ella Arensman	National Suicide Research Foundation
Dr. Tony Bates	Headstrong
Kirsten Connolly	HSE Communications
Colm Desmond	Department of Health
Fergal Fox	HSE Health and Wellbeing Division
Patricia Gilheaney	Mental Health Commission
Cate Hartigan	HSE Health and Wellbeing Division
Hugh Kane	GENIO
Susan Kenny	HSE National Office for Suicide Prevention
Prof. Kevin Malone	Irish College of Psychiatry
Patrick McGowan	HSE Service-Family Member and Carer Engagement
Owen Metcalfe	Institute Public Health
Stephen Mulvany	HSE Mental Health Division
Brian Murphy	HSE Primary Care Division
Kate O'Flaherty	Department of Health
Gerry Raleigh	HSE National Office for Suicide Prevention
Martin Rogan	HSE Mental Health Division
Dr. Matthew Sadlier	HSE Mental Health Division
Sandra Walsh	Department of Health
Dr. Margo Wrigley	HSE National Clinical Lead Mental Health Services

Membership of the Advisory Groups

Representatives of the following organisations contributed through membership of five advisory groups:

3Ts
Alcohol Action Ireland
Aware
BeLongTo
Bodywhys
Carer Engagement Representative Console
Cycle Against Suicide
Department of Children and Youth Affairs
Department of Education and Skills
Department of Health
Gaelic Athletic Association
Gay and Lesbian Equality Network
GENIO
Headstrong
Health Research Board
HSE Clinical Programmes
HSE Communications Department
HSE Health and Wellbeing
HSE Mental Health Division (Psychiatry and Psychology)
HSE Nursing and Midwifery Planning and Development
HSE Primary Care
HSE Resource Officers for Suicide Prevention

HSE Public Health
HSE Quality and Patient Safety
HSE Social Inclusion
Irish Association of Suicidology
Irish College of General Practitioners
Institute of Public Health
Irish College of Psychiatry
Irish Society for the Prevention of Cruelty to Children
Living Links
Men's Health Research Group IT Carlow
Mental Health Commission
Mental Health Ireland
Mental Health Reform
MOJO - South County Dublin Partnership
National Suicide Research Foundation
Pieta House
Psychiatric Nurses Association
Queen's University
ReachOut.com
Rehab Group
Samaritans
See Change
SpunOut.ie
Suicide or Survive
The Family Centre, Castlebar

Government departments and national agencies that made commitments as part of the strategy:

- Department of An Taoiseach
  - Central Statistics Office
- Department of Agriculture, Food and the Marine
- Department of Children and Youth Affairs
  - TUSLA Child and Family Agency
- Department of Communications, Energy and Natural Resources
  - Broadcasting Authority of Ireland
  - Press Council of Ireland
  - Press Ombudsman Office
- Department of Defence
- Department of Education and Skills
  - Higher Education Authority
  - National Education Welfare Service
  - National Educational Psychological Service
- Department of Environment, Community and Local Government
  - Local Authorities
- Department of Health
  - HSE Acute Hospitals
  - HSE Estates
  - HSE Health and Wellbeing
  - HSE Mental Health
  - HSE Primary Care
  - National Office for Suicide Prevention
- Department of Jobs, Enterprise and Innovation
  - Health and Safety Authority
- Department of Justice and Equality
  - An Garda Síochána
  - Coroners' Offices
  - Irish Prison Service
  - The Probation Service
- Department of Social Protection
- Department of Transport, Tourism and Sport
  - Irish Sports Council

Connecting for Life

Ireland's National Strategy to Reduce Suicide 2015-2020

VISION

An Ireland where fewer lives are lost through suicide, and where communities and individuals are empowered to improve their mental health and wellbeing.

GOALS

1. Better understanding of suicidal behaviour
2. Supporting communities to prevent and respond to suicidal behaviour
3. Targeted approaches for those vulnerable to suicide
4. Improved access, consistency and integration of services
5. Safe and high quality services
6. Reduce access to means
7. Better data and research

OUTCOMES

Reduced suicide rate in the whole population and amongst specified priority groups

Reduced rate of presentations of self-harm in the whole population and amongst specified priority groups

IMPLEMENTATION

Action plan to achieve goals and objectives

Cabinet Committee on Social Policy and Public Service Reform
National Cross-Sectoral Steering and Implementation Group
National Office for Suicide Prevention
Local Cross-Sectoral Implementation Structures
Individual Agency and Implementation Systems

Resource and Communication

Outcome and Evaluation Frameworks

EXECUTIVE SUMMARY

SECTION 1 – Context for Suicide Prevention in Ireland

In communities across Ireland, suicide generates feelings of grief, apprehension and concern. For every Irish person who dies by suicide, many others attempt to end their lives, and many more suffer the despair that leads them to consider suicide. Historically as a nation we have struggled to talk openly about suicide and how it impacts on us. However, our national conversation is growing and we are becoming better at discussing and addressing issues relating to our mental health. It is essential that we maintain the momentum. *Connecting for Life* is a whole-of-society strategy to co-ordinate and focus our national effort to reduce the loss of life by suicide.

Suicide is a complex problem. Addressing suicidal behaviour means supporting people in many different ways and requires a coordinated effort across many different sectors and levels of society. *Connecting for Life* is designed to co-ordinate and focus the efforts of a broad range of government departments, state agencies, non-statutory organisations and local communities in suicide prevention.

Usually no single cause or risk factor is sufficient to explain a suicidal act. Most commonly, several risk factors act cumulatively to increase an individual's vulnerability to suicidal behaviour, and risk factors interplay in different ways for different populations, groups and individuals.

In Ireland, one in four people will use a mental health service at some stage of their lives. Research shows a strong link between mental health difficulties and death by suicide. In high-income countries, mental health problems are present in up to 90% of people who die by suicide.

As of 2010, the alcohol consumption rate for Ireland was one of the highest in Europe. The Irish rate increased by 24% between 1980 and 2010, whereas the average alcohol consumption in Europe decreased by an average of 15%. Alcohol and other substance use disorders are found in 25-50% of all suicides.

Research shows a link between economic factors such as social deprivation, homelessness and poverty and suicidal behaviour. The recent economic recession in Ireland has also impacted on the delivery of public services and the continuity of care for vulnerable people.

Despite Central Statistics Office (CSO) data showing that between 2007 and 2011 there was an increase in the suicide rate in Ireland, specifically among men, recent figures point to a reduction in the rate of suicide. Self-harm rates also appear to be falling, but young people remain at elevated risk of self-harm and while Ireland's overall suicide rate is not high by international comparison, we have the 4th highest suicide rate in the 15-19 age group across 31 European countries.

Linking in with mental health and wellbeing policies such as A Vision for Change and Healthy Ireland is key to the work outlined in *Connecting for Life*, but the broad focus of the strategy means a wider range of Government

strategies and policies can also contribute; for example, men's health policies, policies for young people and policies aimed at marginalised groups such as members of the Traveller community and prisoners. In addition, general Government programmes in the Education, Children's, Justice and other sectors, can also assist in suicide prevention as part of their general implementation.

SECTION 2 – Development of the Strategy

The development of *Connecting for Life* began in 2014 with the appointment of a strategic planning oversight group and five supporting advisory groups covering the areas of research, policy, practice, engagement and communications / media. The development of the strategy was led by the Department of Health and the National Office for Suicide Prevention. Membership of the advisory groups was drawn from a broad base of expertise including clinicians, researchers, policy makers, government departments, community leaders, non-statutory partners and those affected by suicide. Each advisory group reviewed evidence and in some cases commissioned new material within its area of expertise.

A wide-ranging consultation and engagement process was undertaken to capture the voices and opinions of a range of stakeholders, including service providers, the general public, people affected by suicide, government departments and state bodies. 272 submissions were received from individuals and organisations and meetings were held with non-statutory partners working in the area of suicide. The Department of Health held bilateral discussions with other government departments and agencies with a view to building cross-sectoral commitment to the strategy.

SECTION 3 – Evidence Base for the Strategy

Effective suicide prevention strategies must be rooted in robust data about the risk and protective factors affecting particular population groups. Identifying what groups are vulnerable to suicidal behaviour and trying to identify what puts them at risk and what can help to protect them is essential in designing effective responses.

During the development process a wide range of evidence and data was examined. This included:

- An examination of key learning points from *Reach Out*
- 272 written submissions arising from the public consultation, of which 120 were personal accounts from people directly affected by depression and those who had lost people close to them by suicide
- Research on risk and protective factors for suicide
- Central Statistics Office material

- National Registry of Deliberate Self-Harm research reports, including National Registry of Deliberate Self-Harm Report 2013
- A Policy Paper on Suicide Prevention – *A review of national and international policy approaches to suicide prevention*, commissioned by HSE NOSP
- A review of the evidence base for interventions for suicide prevention by the Health Research Board (HRB) *Suicide Prevention: An evidence review*, commissioned by HSE NOSP
- International evidence about key elements in effective suicide prevention strategies
- Evidence on social media and social marketing strategies, language and stigma reduction and media reporting issues and interventions
- The WHO 2014 Report *Preventing suicide: A global imperative*
- Review of training linked to *Reach Out*, commissioned by HSE NOSP.

Arising from analysis, groups for whom there is evidence of vulnerability to and increased risk of suicidal behaviour are listed below. This list of priority groups will be reviewed regularly based on the most up to date evidence.

- Health/mental health related groups: People with mental health problems of all ages, those who have engaged in repeated acts of self-harm, people with alcohol and drug problems and people with chronic physical health conditions.
- Minority groups: Members of the LGBT community, members of the Traveller community, people who are homeless, people who come in contact with the criminal justice system (e.g. prisoners), people who have experienced domestic, clerical, institutional, sexual or physical abuse, asylum seekers, refugees, migrants and sex workers.
- Demographic cohorts: Middle aged men and women, young people and economically disadvantaged people.
- Suicide related: People bereaved by suicide.
- Occupational groups: Healthcare professionals, professionals working in isolation, e.g. veterinarians, farmers.

The National Office for Suicide Prevention (NOSP) commissioned a Health Research Board (HRB) review of research into the effectiveness of various suicide prevention strategies. While the HRB identified those interventions that show the most promise to reduce suicide in Ireland, the review found that the body of evidence on suicide prevention programmes was limited. However, the evidence would point to a combination of targeted interventions having an impact on suicide prevention.

Research evidence indicated that *Connecting for Life* should:

- Co-ordinate across all sectors of government and society
- Be culturally specific
- Be evidence informed and needs based
- Be focused on both whole-population and targeted interventions

SECTION 4 – Overview of the Strategy

Connecting for Life sets out a vision of an Ireland where fewer lives are lost through suicide, and where communities and individuals are empowered to improve their mental health and wellbeing.

This vision is to be realised through seven goals:

1. Better understanding of suicidal behaviour
2. Supporting communities to prevent and respond to suicide behaviour
3. Targeted approaches for those vulnerable to suicide
4. Improved access, consistency and integration of services
5. Safe and high-quality services
6. Reduce access to means
7. Better data and research

The defined outcomes of the strategy are:

- Reduced suicide rate in the whole population and amongst specified priority groups
- Reduced rate of presentations of self-harm in the whole population and amongst specified priority groups

Each goal is based on the achievement of a set of supporting objectives.

Goal 1: To improve the nation's understanding of and attitudes to suicidal behaviour, mental health and wellbeing

1.1	Improve population-wide understanding of suicidal behaviour, mental health and wellbeing, and associated risk and protective factors.
1.2	Increase awareness of available suicide prevention and mental health services.
1.3	Reduce stigmatising attitudes to mental health and suicidal behaviour at population level and within priority groups.
1.4	Engage and work collaboratively with the media in relation to media guidelines, tools and training programmes to improve the reporting of suicidal behaviour within broadcast, print and online media.

Goal 2: To support local communities' capacity to prevent and respond to suicidal behaviour

2.1	Improve the continuation of community level responses to suicide through planned, multi-agency approaches.
2.2	Ensure that accurate information and guidance on effective suicide prevention are provided for community-based organisations (e.g. family resource centres, sporting organisations).
2.3	Ensure the provision and delivery of training and education programmes on suicide prevention to community-based organisations.

Goal 3: To target approaches to reduce suicidal behaviour and improve mental health among priority groups

3.1	Improve the implementation of effective approaches to reducing suicidal behaviour among priority groups.
3.2	Support, in relation to suicide prevention, the Substance Misuse Strategy, to address the high rate of alcohol and drug misuse.
3.3	Enhance the supports for young people with mental health problems or vulnerable to suicide.

Goal 4: To enhance accessibility, consistency and care pathways of services for people vulnerable to suicidal behaviour

4.1 Improve psychosocial and psychiatric assessment and care pathways for people vulnerable to suicidal behaviour.

4.2 Improve access to effective therapeutic interventions (e.g. counselling, DBT, CBT) for people vulnerable to suicide.

4.3 Improve the uniformity, effectiveness and timeliness of support services to families and communities bereaved by suicide.

Goal 5: To ensure safe and high-quality services for people vulnerable to suicide

5.1 Develop and implement national standards and guidelines for statutory and non-statutory organisations contributing to suicide prevention.

5.2 Improve the response to suicidal behaviour within health and social care services, with an initial focus on incidents within mental health services..

5.3 Reduce and prevent suicidal behaviour in the criminal justice system.

5.4 Ensure best practice among health and social care practitioners through (a) the implementation of clinical guidelines on self-harm and (b) the delivery of accredited education programmes on suicide prevention.

Goal 6: To reduce and restrict access to means of suicidal behaviour

6.1 Reduce access to frequently used drugs in intentional drug overdose.

6.2 Reduce access to highly lethal methods used in suicidal behaviour.

Goal 7: To improve surveillance, evaluation and high-quality research relating to suicidal behaviour

7.1 Evaluate the effectiveness and cost-effectiveness of *Connecting for Life*.

7.2 Improve access to timely and high-quality data on suicide and self-harm.

7.3 Review (and, if necessary, revise) current recording procedures for death by suicide.

7.4 Develop a national research and evaluation plan that supports innovation aimed at early identification of suicide risk, assessment, intervention and prevention.

SECTION 5 – Implementation and Evaluation of the Strategy

Implementation of *Connecting for Life* will be a complex process because it is a cross-cutting, whole-of-society strategy, which requires consistent co-operation and communication between relevant stakeholders.

An implementation plan with clear roles and responsibilities, robust monitoring and accountability structures and resourcing, to support and drive action across all stakeholder organisations will be integral to this process. This will include a detailed plan with a series of actions specified to achieve each objective within each goal, with a leading agency and key partners identified for each action. A communications plan and a resource plan will also support implementation of the strategy.

Implementation of *Connecting for Life* will be through the following key implementation structures:

- Cabinet Committee on Social Policy and Public Service Reform – Suicide prevention as a regular agenda item
- National Cross-Sectoral Steering and Implementation Group – with representation from the health sector, government departments, agencies and NGOs
- The National Office for Suicide Prevention (NOSP) will provide cross-sectoral support for implementation
- Local Cross-Sectoral Implementation Structures – to produce local area plans and community-level response reflecting national actions
- Individual Agency Implementation Systems – Including a co-ordinated HSE system

The Cabinet Committee on Social Policy & Public Service Reform will monitor overall progress on implementation.

Primary outcomes

At the core of *Connecting for Life* is an outcomes focus – a vision that measurable improvements be made in relation to the incidence of suicide and self-harm. The implementation plan sets out agreed primary indicators and data variables to allow the primary outcomes (reduced rates of suicide and self-harm presentations) to be measured and tracked over time.

Secondary outcomes

As well as the two primary outcomes, *Connecting for Life* will also track its progress against a range of secondary and intermediate outcomes, which are influenced by suicide prevention efforts in the shorter term and can provide

preliminary evidence that *Connecting for Life* is on course to achieve its long-term goal of reducing the rate of suicide; for example, more responsible reporting of suicidal behaviour in the media, increased numbers of people accessing appropriate support and services, increased public understanding of suicidal behaviour, mental health and wellbeing.

Process evaluation

Systematic evaluation of the interventions proposed as part of *Connecting for Life* will be needed to define best approaches in the Irish context. In addition to measurement of primary and secondary outcomes, evaluation of *Connecting for Life* will include process evaluation. This allows changes that may impact negatively on the implementation of planned actions or suicide rates, such as an economic downturn or lack of commitment to the process by stakeholders, to be identified, meaning that the elements contributing to the success or failure of the strategy can be better understood.

The strategy is supported by a number of reports which are available at www.nosp.ie

Connecting for Life is Ireland's National Strategy to reduce suicide (2015-2020). The development of the strategy was a collaborative and inclusive process. Some of the most important contributions to the development of 'Connecting for Life' came from our public consultation process. We received 272 submissions from people and organisations, which included members of the general public, people who have used our services and their families, professional bodies and community interests and organisations.

"Heading into the clinic, in a bit of a heap and feeling very low on a couple of occasions, a smiling and empathetic face is what I wanted to greet me."

Submission reference number: 63

"Depression is like being stuck down a well. Everyone is looking down shouting: 'DO THIS, DO THAT, HERE, THIS WILL GET YOU OUT OF THE WELL...' but you cannot get out of the well."

Submission reference number: 113

"As young people move towards the virtual world for information and support, health care professionals and parents alike need to be informed to be able to offer the best intervention, and, in the long term, prevention."

Submission Reference Number: 156

"The message needs to be given that alcohol can affect one's mind to the extent that totally irrational and unexplained actions (such as a suicide attempt) can arise when under the influence of this powerful drug."

Submission Reference Number: 157

1

Context for Suicide Prevention in Ireland

In communities across Ireland, suicide generates feelings of grief, apprehension and concern. For every Irish person who dies by suicide, many others attempt to end their lives, and many more suffer the despair that leads them to consider suicide. Historically as a nation we have struggled to talk openly about suicide and how it impacts on us. However, our national conversation is growing and we are becoming better at discussing and addressing issues relating to our mental health. It is essential that we maintain the momentum. *Connecting for Life* is a whole-of-society strategy to co-ordinate and focus our national effort to reduce the loss of life by suicide.

This section sets out the research context for future suicide prevention. It includes:

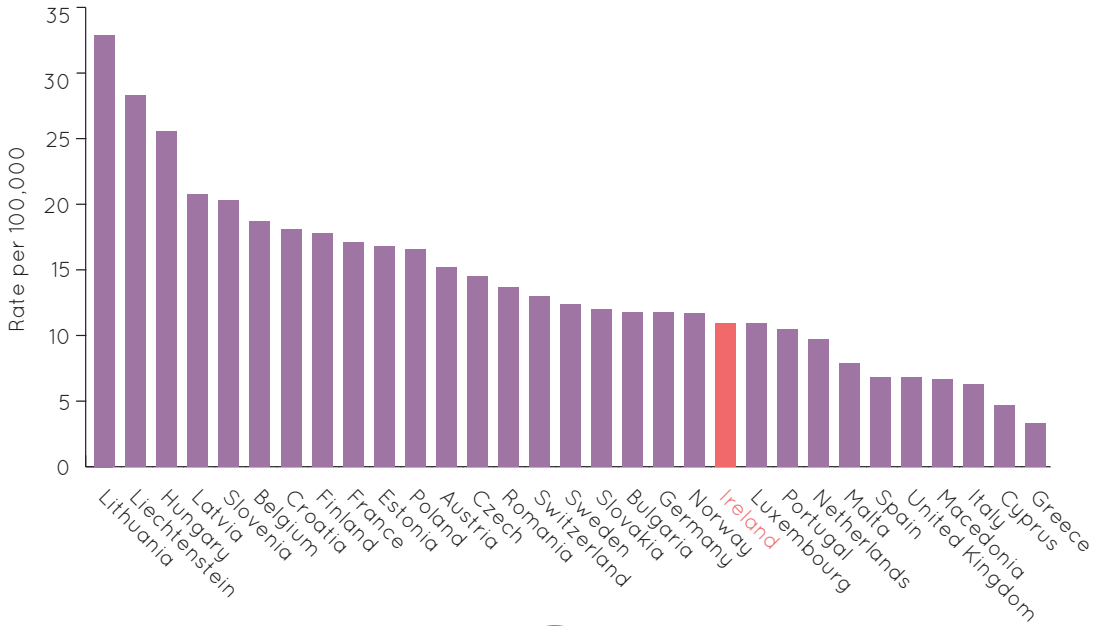
- An analysis of suicide and self-harm patterns in Ireland;
- Identification of economic and social factors that increase the risk of suicidal behaviour;
- An overview of the previous suicide prevention strategy;
- The efficacy of different types of suicide policy interventions;
- The requirement for a whole-of-government approach to suicide prevention.

1.1 Suicide and self-harm in Ireland

1.1.1 Suicide

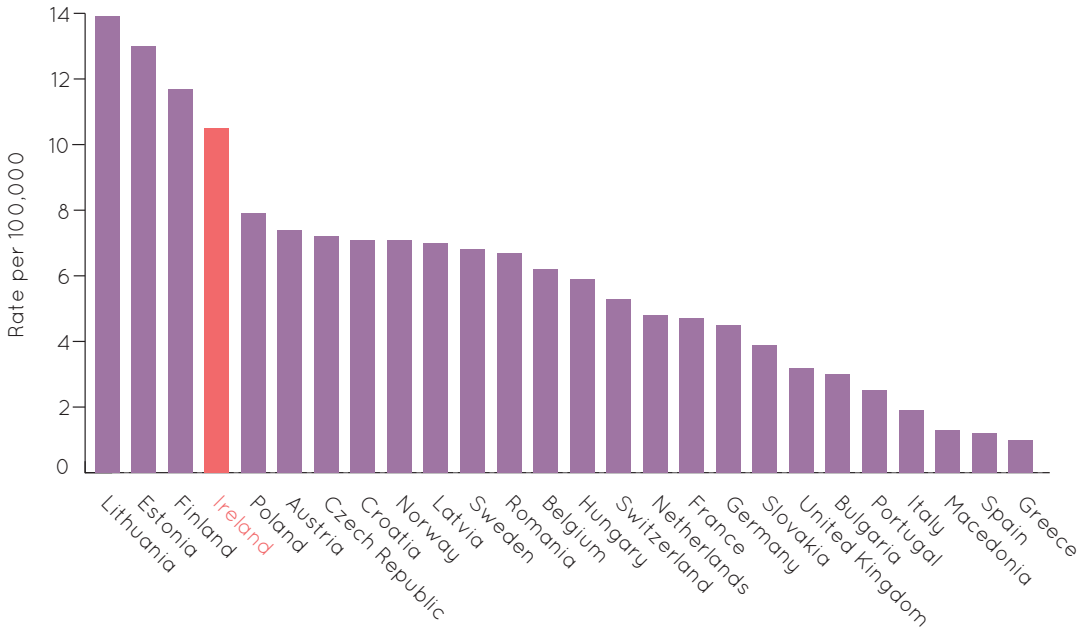
Ireland's overall suicide rate is not high by European comparison. Looking at the total rate of suicide for men and women of all ages in Ireland, the rate in 2010 was 10.9 per 100,000 of the population, the 11th lowest rate of suicide among the 31 European countries for which data was recorded (Figure 1) (1). The highest rate was found in Lithuania (32.9 per 100,000 of the population) and the lowest in Greece (3.3 per 100,000 of the population) (1).

Figure 1: Suicide rate per 100,000 for males and females, 2010 (1)



However, in Ireland, the suicide rates among young males and females are relatively high in comparison to international rates for young people. Taking females and males aged 15-19 years together, the rate was 10.5 per 100,000 of the population, the 4th highest suicide rate in this age group across the 31 European countries studied (Figure 2). The highest rate was found in Lithuania (13.9 per 100,000 of the population) and the lowest in Greece (1 per 100,000 of the population).

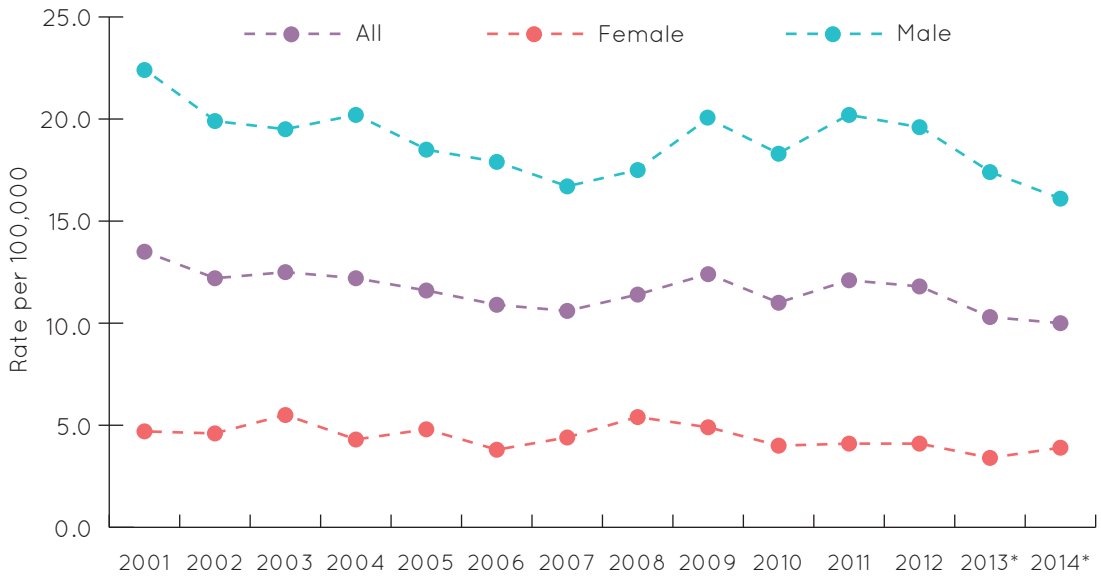
Figure 2: Suicide rate per 100,000 for males and females aged 15 to 19 years by geographic region, 2010 (2)



Between the years 2007 and 2011, particularly since the onset of the economic recession in 2008, there was an increase in the suicide rate in Ireland, specifically among men. The overall increase in suicide in Ireland between these years can be wholly attributed to an increase in the male rate of suicide (3).

In 2012, 82.3% of all those who died by suicide were men, with the highest rate of suicide among 45 to 54 year old men. The lowest rate for male suicide in 2012 was in the 65+ age group. The highest rate for female suicide in 2012 was also in the 45 to 54 age group, and the lowest rate for female suicide in 2012 was also in the 65+ age group (3).

Figure 3: Suicide rate per 100,000 by gender, 2001-2014 (3)



Note: Figures for 2013 and 2014 are provisional and subject to change

Table 1 below outlines the main methods involved in suicide in Ireland based on CSO data for the years 2007 and 2012. The method of hanging is the most frequently used method by both males and females (74% and 60% respectively), followed by drowning, which is involved in 18% of female and 9% of male suicides.) Restricting access to these methods of suicide is a major challenge. Therefore, this requires prioritisation in the 2015-2020 strategy in terms of further exploring feasible and effective public health approaches towards these methods.

Table 1: Methods of suicide in Ireland, 2007-2012 (3)

	Male		Female	
	N	(%)	N	(%)
Overdose	102	(4%)	87	(14%)
Poisoning	57	(2%)	13	(2%)
Hanging	1,842	(74%)	362	(60%)
Drowning	231	(9%)	107	(18%)
Firearms	144	(6%)	<10	(1%)
Cutting	37	(1%)	11	(2%)
Other	86	(3%)	21	(3%)

1.1.2 Self-harm

Suicide involves death through a deliberate and lethal form of self-harm. The term self-harm is used to cover various methods by which people harm themselves non-fatally. Varying degrees of suicidal attempt can be present at the time of self-harm; sometimes there may not be any suicidal attempt, although an increased risk of further suicidal behaviour is associated with all self-harm. Research has shown that people who engage in self-harm are at increased risk of dying by suicide compared to those who do not engage in self-harm (4). Among people who engage in highly lethal acts of self-harm, subsequent risk of suicide is highest, with fatality rates over 70% (4, 5).

Data from 122,743 self-harm presentations to hospitals in Ireland from 2003 to 2013 held by the National Registry of Deliberate Self-Harm (NRDSH) showed that the rate of use of highly lethal methods of self-harm has increased significantly since 2004, with the greatest increase among those aged 15-29 years (6).

Self-harm very often forms a repeat behaviour pattern. The strongest risk factor for the occurrence of an incident of self-harm is a history of multiple previous acts of self-harm. This is reflected in the NRDSH's finding that among patients with a history of five or more previous acts of self-harm, 82% engaged in a repeated act of non-fatal self-harm in the three months following a self-harm presentation to hospital (7, 8). Another study found that the estimated one-year rate of non-fatal self-harm repetition is 16% (9).

More recent data suggests a stabilisation and modest fall in suicide and self-harm rates. The 2012 Central Statistics Office (CSO) figures indicate that there were 541 deaths by suicide that year (3). This represents a decreasing trend from 2011 figures. Provisional data from 2013 and 2014 suggests a further decreasing trend. Since 2010 there has been a 12% decrease in the overall rate of self-harm presentations to accident and emergency departments. However, this figure is still 6% higher than rates for 2007, before the economic recession (7).

Table 2 outlines the main methods of self-harm in Ireland. Overdose is the main method of self-harm in both males and females (64% and 77% respectively). The second most frequently used method of self-harm is cutting, which is seen in 26% of male presentations and 20% of female presentations.

Table 2: Methods of self-harm in Ireland, 2007-2012 (7)

	Male		Female	
	N	(%)	N	(%)
Overdose	20,919	(64%)	29,475	(77%)
Poisoning	719	(2%)	564	(2%)
Hanging	2,576	(8%)	1,113	(3%)
Drowning	1,201	(4%)	773	(2%)
Cutting	8,585	(26%)	7,526	(20%)
Other	1,672	(5%)	1,161	(3%)

More detailed information on suicide and self-harm is available in Appendix 3 and from the *Report of the Research Advisory Group* (10), which was completed as part of the process to develop *Connecting for Life*.

1.2 Economic and social issues in Ireland and the impact on suicide

Research indicates a significant association between economic factors and the prevalence of suicidal behaviour (11). The increasing rates of suicide during the recent economic downturn are a matter of national concern. The fact that suicidal behaviour occurs frequently among people who are socially excluded is a call to action we must act upon. The economic challenges that we have faced in recent years have underscored significant social challenges, among them poverty, homelessness, social deprivation, alcohol and drug misuse, and financial difficulty. Economic considerations have impacted on the delivery of public services and continuity of care for vulnerable people.

Research also shows a strong link between mental health difficulties and death by suicide. In high-income countries, mental health problems are present in up to 90% of people who die by suicide (12). In Ireland, one in four people will use a mental health service at some stage of their lives (13).

While depression and substance use disorders are relatively common, most people suffering from them will not display suicidal behaviour. However, people dying by suicide or making suicide attempts may have significant psychiatric co morbidity. Suicide risk varies with the type of disorder. The most common disorders associated with suicidal behaviour are depression and alcohol use disorders (14).

In September 2014, there were over 18,866 active cases of young people (0-18 years) attending HSE Child and Adolescent Mental Health Services (CAMHS). In 33% of cases, the reason for referral to CAMHS included suicidal ideation or self-harm (15).

As of 2010, the alcohol consumption rate for Ireland was one of the highest in Europe, averaging at 11.9 litres per adult person. Between the period 1980 to 2010, the average alcohol consumption in Europe decreased by an average of 15%, while consumption in Ireland over that period increased by 24% (16). Alcohol and other substance use disorders are found in 25-50% of all suicides (17). Acknowledging the issue of alcohol misuse in Ireland will be one of the essential elements to the successful implementation of *Connecting for Life*.

Other groups of people are also at increased risk of suicidal behaviour. These include people bereaved by suicide, particular demographic cohorts and certain minority groups.

The evidence about the interplay of risk and protective factors relating to suicidal behaviour is explored in more detail in Section 3.

1.3 Suicide prevention in Ireland up to 2014

Suicide prevention in Ireland up to 2014 was guided by *Reach Out*, the first national suicide prevention strategy. The National Office for Suicide Prevention (NOSP) was set up in 2005 within the HSE to oversee the implementation, monitoring and coordination of *Reach Out*. NOSP is a core part of the HSE National Mental Health Division, providing strong alignment with mental health promotion and specialist mental health services delivery as appropriate. In order to be effective it relies on strong working relationships with HSE Health and Wellbeing, HSE Primary Care and other HSE divisions, as well as with statutory, non-statutory and community partners.

Reach Out brought a focus on suicide prevention work and guided activities in this area in Ireland from 2005 to 2014. *Reach Out* set out a vision and guiding principles for suicide prevention in Ireland. It outlined 96 actions and identified lead agencies. These actions fell within the remits of over 80 agencies and departments, not including the organisations funded by the HSE NOSP to deliver many of the actions, working in collaboration with HSE Resource Officers for Suicide Prevention. A total of 34 organisations (mainly non-statutory organisations), were funded by the NOSP in 2014 alone.

The HSE NOSP reviewed progress against *Reach Out* objectives over the course of the strategy and presented annual reports to the House of the Oireachtas. Some of the key achievements of *Reach Out* over its lifespan are highlighted overleaf:

Supporting individuals, families and communities

- **Increased support for local and national groups and organisations** to respond at all levels: prevention, intervention and postvention. The financial allocation available to HSE NOSP increased nearly threefold between 2012 and 2014.
- **Expansion of telephone crisis and support lines** and enhanced signposting to the most appropriate services.
- **A range of counselling services** including crisis counselling, bereavement counselling and online counselling and supports provided by statutory and non-statutory organisations.
- **Development of a range of web-based information** and support, including YourMentalHealth.ie and online platforms for young people.
- **Increased targeting of groups vulnerable to suicide** including LGBT groups, members of the Traveller community and those impacted by the economic crisis.

Improved service delivery

- **Wide availability and uptake of suicide-prevention training**, including more than 30,000 people trained in ASIST and 20,000 trained in SafeTALK in communities across Ireland.
- **Innovative practices introduced**, including SCAN (Suicide Crisis Assessment Nursing service), a National Dialectical Behavioural Therapy Programme and Cognitive Behaviour Therapy programmes.
- **Increased standardisation of approach for service delivery**, through dissemination of guidelines and protocols to communities and families, schools, sporting organisations and workplaces, among others.

Building evidence and monitoring suicidal behaviour

- **Improved knowledge and evidence base** relating to suicide risk and prevention and self-harm.
- **The National Registry of Deliberate Self-Harm** contributing to research, policy and practice through regular reports from the Registry.
- **The Suicide Support and Information System** researching and reporting on proactive supports required for people bereaved through suicide.

Improving awareness and understanding

- **Increased awareness-raising** with our partners and colleagues about mental health and suicide. Development of the "Little Things", "Your Mental Health", "Let Someone Know" and "PleaseTALK" campaigns.
- **Improved reporting of suicide in the media** and updating of media guidelines.

Since the launch of *Reach Out* the services available to people in emotional distress have increased, in terms of availability, access and quality. This is reflected in increased uptake of such services.

The high level of public awareness of and support for non-statutory suicide prevention organisations, together with statutory services, reflects an increased sense of common purpose. This is essential in effectively addressing the challenge of reducing suicidal behaviour in Ireland.

1.4 Policy context for suicide prevention

Policy on suicide prevention guides the delivery and implementation of services. Central to suicide prevention work is the need for evidence-based policies and synergies between and across different areas of policy and practice.

Types of policy interventions

Policy recommendations from the World Health Organisation (WHO) (18) and best practice approaches from other countries show that national suicide prevention strategies that incorporate both universal, population-based policies and interventions for priority groups can play a major role in reducing suicide rates.

Broadly speaking there are three types of policy interventions that address suicide prevention:

(a) **Universal interventions:** these are broad-based policies that directly or indirectly address suicide prevention across the whole population, aimed at improving the health and wellbeing, social and economic inclusion and safety of the population.

(b) **Selective interventions:** these are interventions that address specific individuals and groups that are vulnerable to suicide, and include the risks associated with alcohol and drugs, as well as specific interventions aimed at the training and awareness of front-line responders, for example, professionals who come into contact with vulnerable groups in hospitals and schools.

(c) **Indicated interventions:** these are more targeted interventions that focus on specific individuals and groups that have a high risk of suicide because of severe mental health problems and suicidal behaviour.

These three types of interventions underpin *Connecting for Life*. They emphasise different policy approaches aimed at improving the overall health and wellbeing of the population, reaching individuals and groups vulnerable to suicide, and in providing targeted treatment and programmes for groups most vulnerable.

Best practice approaches

In Ireland and internationally suicide prevention policies have been shown to benefit from a number of factors. These include:

- Identification of multiple risk factors, acknowledging that while mental health problems are a key risk factor, socio-economic and cultural issues are highly relevant both in relation to underlying trends in Irish society and the economic and social impact of the recent economic crisis.
- Interagency participation and engagement with a wide range of stakeholders (for example, government departments, local authorities, educational providers, non-statutory and community organisations, service users and the social partners).
- Involvement of stakeholders from key delivery organisations (for example, health service providers, An Garda Síochána, prisons, non-statutory and community organisations, sports and religious organisations). The lived experience of service users is paramount in the learning from this engagement.

Connecting for Life seeks to identify policy that can create joined up thinking across government departments, between individuals, communities, service providers and people with lived experience.

1.5 Policy coordination and a whole-of-government approach

There is strong international evidence relating to the importance of coordinated whole-of-government and whole-of-society policy frameworks on suicide prevention, including World Health Organisation recommendations (18, 19), the International Association for Suicide Prevention (20) and the United Nations (21). HSE NOSP's review of national policies that directly and indirectly impact on suicide prevention (22) also shows the importance of embedding a multi-sectoral approach to suicide prevention across government. A key dimension of this is to promote policy approaches that are visible, responsive and coordinated so that all government departments can play an active role in suicide prevention.

This broad-based, collaborative approach is necessary in order to effectively address the multiple protective and risk factors that inform policy developments on suicide prevention. Practical and achievable outcomes will first need to connect current overarching government policies on mental health and wellbeing. For example, this means taking account of and coordinating a diverse range of policies, including services and supports for children and young people, a greater emphasis on socio-economic factors, and taking into account the role of primary and community care in providing coordinated service responses to address issues such as discharge from mental health settings.

Although mental health and wellbeing services play a major role in suicide prevention, the risk factors for suicidal behaviour are broad and complex, thus a wider range of government strategies and policies can contribute to suicide prevention. Some of these strategies and policies provide explicit commitments to suicide prevention; others impact on prevention and play a role in reducing the risk factors associated with suicide.

Connecting for Life will depend on the effective delivery of a broad range of health and social policies and strategies including:

- A Vision for Change: Report of the Expert Group on Mental Health Policy 2006 (23)
- Better Outcomes, Brighter Futures: the National Policy Framework for Children and Young People 2014-2020 (24)
- Healthy Ireland – A Framework for Improved Health and Wellbeing 2013-2025 (25)
- The National Drugs Strategy 2009-2016, Report of the National Substance Misuse Strategy Steering Group and the HSE National Drugs Rehabilitation Framework (26)

Other strategies and policies have a role in reducing risks and preventing suicide. Examples include:

- Department of Children and Youth Affairs – National Youth Strategy 2015-2020 (27)
- Department of Education and Skills – A Framework for Junior Cycle (28)
- Department of Education and Skills – National Strategy for Higher Education to 2030 (29)
- Department of Education and Skills Action Plan on Bullying – Report of the Anti-bullying Working Group to the Minister for Education and Skills (30)
- Department of Environment, Community and Local Government's Putting People First Action Programme for Effective Local Government (31)
- Department of Foreign Affairs and Trade – Global Irish: Ireland's Diaspora Policy 2015 (32)
- Department of Health and Children's Report of the National Substance Misuse Strategy Steering Group 2012 (33)
- Department of Social Protection: Guidance and Support for Staff Dealing with Distressed Customers or Suicide Threats in the Workplace (34)
- Health Service Executive's National Drugs Rehabilitation Framework 2009-2016 (35)
- Health Service Executive's The Health Promotion Strategic Framework 2011 (36)

- Inclusion Ireland's National Disability Strategy (37)
- Irish Prison Service Three Year Strategic Plan 2012-2015 (38)
- National Action Plan for Social Inclusion 2007-2016 (39)
- National Intercultural Health Strategy 2008-2012 (40)
- National Men's Health Policy 2008-2013, currently being reviewed (41)
- National Positive Ageing Strategy 2013 (42)
- National Strategy on Domestic, Sexual and Gender-based Violence 2010-2014 (43)
- Policy and Strategic Plan on Suicide Prevention – Irish Water Safety (44)
- The Way Home – A strategy to address adult homelessness in Ireland 2008- 2013 (45)
- Traveller Health: A National Strategy 2002-2005 (46)

A full list and details of these and other policies and strategies that are relevant to suicide prevention can be found in Appendix 4 and in the *Policy Paper on Suicide Prevention: A review of national and international policy approaches to suicide prevention* (22), which was commissioned as part of the process to develop *Connecting for Life*. The report can be downloaded from **www.nosp.ie**.

Connecting for Life is Ireland's National Strategy to reduce suicide (2015-2020). The development of the strategy was a collaborative and inclusive process. Some of the most important contributions to the development of 'Connecting for Life' came from our public consultation process. We received 272 submissions from people and organisations, which included members of the general public, people who have used our services and their families, professional bodies and community interests and organisations.

" Every problem has a solution but isolation is the enemy of reason and solutions."

Submission reference number: 79

" People suffering form mental illness should have an advocate, whether a trusted family member or friend who is educated in the person's illness."

Submission reference number: 90

2

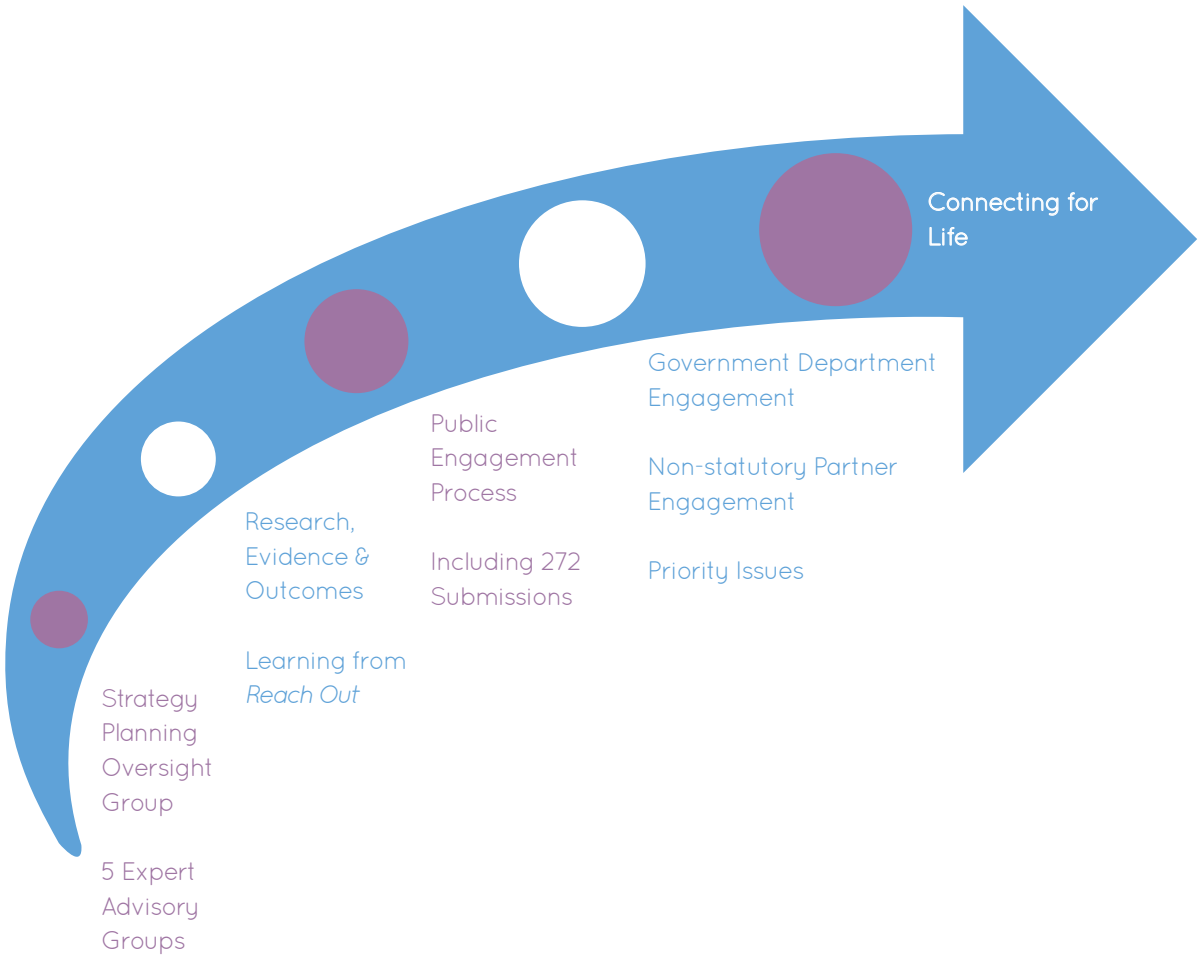
Development of the Strategy

2.1 Planning groups

Early in 2014, Kathleen Lynch T.D., Minister for Primary Care, Social Care and Mental Health, commissioned the development of a new national strategy to reduce suicide in Ireland for the period 2015 to 2020. The goal was to deliver a realistic, ambitious and challenging suicide prevention strategy, building on a foundation of partnership and drawing upon the wealth of expertise available, involving government departments, national agencies and non-statutory partner organisations. The strategy also set out with an outcomes focus, with a vision that measurable improvements be made in relation to the incidence of suicide and self-harm, against which the impact of the strategy and its component parts could be evaluated in the future. Strong emphasis was placed on the need to deliver a whole-of-government and whole-of-society strategy and to listen to the voice of the community and service users, maximising public involvement.

This section summarises the steps in the development of the strategy, including the planning group structure, the public engagement process and the cross-sectoral collaboration that took place.

Figure 4: Summary of the full strategy development process



A Strategic Planning Oversight Group was formed to take responsibility for the process and the outcomes. Five advisory groups were set up to offer advice and to assist in developing the evidence base for the strategy:

- Research
- Policy
- Practice
- Engagement
- Communications/media

Membership of the advisory groups was drawn from a broad base of expertise including clinicians, researchers, policy makers, government departments, community leaders, non-statutory partners and those affected by suicide.

Each advisory group reviewed evidence and in some cases commissioned new material within its area of expertise. Each group also produced a report detailing its findings and recommendations. These are integrated into the evidence for and formulation of this strategy. The reports from each working group as well as the commissioned reports are available at **www.nosp.ie**.

2.2 Engagement process

In 2014, the Department of Health and the HSE undertook a public consultation to ensure that everyone in Ireland had the opportunity to share their views and recommendations for *Connecting for Life*.

2.2.1 Public engagement

The public consultation revealed a wealth of interest and experience, both personal and academic, amongst members of the public and stakeholders working in the area of mental health. It gave an extensive number of people in Ireland the opportunity to have their say in the formation of the strategy, with the media advertisements reaching 62% of all adults in Ireland. The engagement process received 272 submissions from individuals and organisations. This included submissions from members of the general public, including service and family service users, professional bodies and community interest groups and organisations. These submissions helped to inform the development of *Connecting for Life*. For more information on the public engagement process and for a full list of organisations that contributed, see Appendix 7 and the *Report of the Engagement Advisory Group* (10).

2.2.2 Non-statutory partner engagement

Non-statutory partners were involved in the Strategic Planning Oversight Group and the advisory groups. The planning process also included a series of meetings with non-statutory partners working in the area of suicide prevention to review the public submissions and recommend objectives and outcomes for the formulation of *Connecting for Life*.

2.2.3 Whole-of-government engagement

Connecting for Life was developed in collaboration with government departments and national agencies in addition to the non-statutory partners. The Department of Health held bi-lateral discussions with six departments, and three agencies. There was detailed bilateral engagement with three other departments and the Press Ombudsman. *Connecting for Life* was reviewed on two occasions in the cross-departmental Senior Official Group, chaired by Department of An Taoiseach, and presented to the Cabinet Committee on Social Policy and Public Service Reform on 30th March 2015. Details of the commitments which government departments and national agencies made as part of the strategy can be found in Appendix 8.

Connecting for Life is Ireland's National Strategy to reduce suicide (2015-2020). The development of the strategy was a collaborative and inclusive process. Some of the most important contributions to the development of 'Connecting for Life' came from our public consultation process. We received 272 submissions from people and organisations, which included members of the general public, people who have used our services and their families, professional bodies and community interests and organisations.

" An understanding of the social determinants that affect a Traveller's health would be useful in all mental health staff and a move away from concentrating on solely lifestyle factors."

Submission reference number: 101

" I realise the importance of 'hard' evidence but I really hope the issuing of this information and the engagement with the media will broaden and become more humane, once the new framework is issued."

Submission reference number: 155

3

Evidence Base for the Strategy

Connecting for Life takes an evidence-informed approach to suicide prevention, to ensure the proposed aims, objectives and interventions deliver real and measurable benefits in a cost-efficient way. This section describes the sources of evidence that were drawn upon in formulating the strategy and highlights some of the key data that informed *Connecting for Life*.

3.1 An evidence-informed approach

During the development process a huge range of evidence and data was examined by the advisory groups. This included:

- An examination of key learning points from *Reach Out*
- 272 written submissions arising from the public consultation, of which 120 were personal accounts from people directly affected by depression and those who had lost people close to them by suicide
- Research on risk and protective factors for suicide (19)
- Central Statistics Office material (3)
- National Registry of Deliberate Self-Harm research reports, including National Registry of Deliberate Self-Harm Report 2013 (6, 7)
- *A Policy Paper on Suicide Prevention – A review of national and international policy approaches to suicide prevention,* commissioned by HSE NOSP (22)
- A review of the evidence base for interventions for suicide prevention by the Health Research Board (HRB) *Suicide Prevention: An evidence review, 2014* commissioned by HSE NOSP (47)
- International evidence about key elements in effective suicide prevention strategies (19)
- Evidence on social media and social marketing strategies, language and stigma reduction and media reporting issues and interventions
- The WHO 2014 Report *Preventing suicide: A global imperative* (19)
- Review of training linked to *Reach Out*, commissioned by HSE NOSP

3.2 Learning from *Reach Out*

A starting point for the development process and an important source of evidence for *Connecting for Life* was an internal assessment of *Reach Out*, the first Irish suicide prevention strategy, which was carried out by HSE NOSP in 2014. This outlined a set of key learning points from *Reach Out*, relevant to the development of a future suicide prevention strategy. These are summarised in Table 3.

Table 3: Key learning points from *Reach Out*

Area	For consideration in strategy development
Planning and monitoring in an interagency environment	Formalise mechanisms for planning and reporting with all bodies with responsibility for delivering *Connecting for Life* Strengthen the co-ordination with intersecting HSE and governmental strategies
Information systems and evaluation framework	Consider an outcomes-based evaluation framework for *Connecting for Life* Strengthen and align the data systems to support data-driven surveillance and the evaluation framework
Administrative location	Consider the most appropriate executive structure as part of the implementation structure of *Connecting for Life*
Identification of related policies	Define the HSE NOSP's policy role in supporting the co-ordination, delivery and evaluation of a whole-government approach to suicide prevention
Regional structures	Plan a comprehensive regional approach to the implementation of *Connecting for Life* including regional plans, staffing and structures and monitoring framework
Research	Commission a review of relevant research and formulate a national research strategy as part of *Connecting for Life*
Care pathways for suicide prevention	Continue to strengthen the integrated service pathways across the country Implement the National Clinical Care Programme for self-harm in emergency departments Ensure the funding strategy supports service pathways Continue to develop service standards and accreditation Embed actions under HSE and other state agency service plans as relevant
Guidelines and materials	Ensure guidelines and materials are disseminated, available and evaluated
Pilots and mainstream integration	Establish clearer pathways for accessing and scaling up or mainstreaming successful pilots Devolve self-sustaining suicide prevention activities into other HSE Divisions and state agencies
Communications	Integrate the existing HSE NOSP Communications Strategy into *Connecting for Life*
Training	Integrate the outcomes from the training needs analysis into *Connecting for Life* Ensure an emphasis on staff and stakeholders most in contact with people who are at increased risk of suicide
Increase stakeholder engagement	Expand engagement in some areas including: faith communities, agencies addressing sexual and domestic violence, agencies working with disadvantaged families and communities
Funding and resources	Build adequate resourcing (staffing and funding) into the implementation of *Connecting for Life*

3.3 Data on protective and risk factors and groups vulnerable to suicide

Effective suicide prevention strategies must be rooted in robust data about the risk and protective factors affecting particular population groups. Identifying what groups are vulnerable to suicidal behaviour and trying to identify what puts them at risk and what can help to protect them is essential in designing effective responses. The Research Advisory group reviewed the available Irish and international evidence in relation to risk and protective factors to identify priority groups and potential priority groups vulnerable to suicide in Ireland. Some of the key findings are outlined below.

3.3.1 Profiling priority groups in Ireland

Ireland's overall suicide rate is among the lowest in the OECD, however, particular demographic groups have consistently been shown by both national and international research evidence to have increased risk of suicidal behaviour. To inform *Connecting for Life*, CSO suicide statistics and data from the National Registry of Deliberate Self-harm, as well as research on the incidence of suicide in various population groups were examined to profile the groups most vulnerable to suicide in Ireland. These include people with mental health problems of all ages, people with alcohol and drug problems, people bereaved by suicide, members of the LGBT and Traveller communities, people who are homeless, healthcare professionals and prisoners.

There are other groups with potentially increased risk of suicidal behaviour where the research evidence is either less consistent or limited. These include asylum seekers, refugees, migrants, sex workers and people with a chronic illness or disability. Further research is required for these groups. These priority groups may change over time.

There is significant overlap between many of the groups, and it is important to note that even within a group where there is increased risk only a minority will engage in suicidal behaviour. Over the lifetime of *Connecting for Life*, other population groups may emerge as particularly vulnerable to suicide. This list of priority groups will be reviewed regularly based on the most up to date evidence.

3.3.2 Profiling risk and protective factors for suicide

Risk factors

Suicidal behaviour is complex. Usually no single cause or risk factor is sufficient to explain a suicidal act. Most commonly, several risk factors act cumulatively to increase an individual's vulnerability to suicidal behaviour and risk factors interplay in different ways for different population groups and individuals. International research has identified some common risk factors at individual, socio-cultural and situational levels. These are shown in Table 4.

Table 4: Individual, socio-cultural and situational risk factors (18)

Individual	Socio-cultural	Situational
• Previous suicide attempt • Mental health problem • Alcohol or drug misuse • Hopelessness • Sense of isolation • Lack of social support • Aggressive tendencies • Impulsivity • History of trauma or abuse • Acute emotional distress • Major physical or chronic illnesses and chronic pain • Family history of suicide • Neurobiological factors	• Stigma associated with help-seeking behaviour • Barriers to accessing health care, mental health services and substance abuse treatment • Certain cultural and religious beliefs (e.g. the belief that suicide is a noble resolution of a personal dilemma) • Exposure to suicidal behaviour, e.g. through the media, and influence of others who have died by suicide	• Job and financial losses • Relational or social losses • Easy access to lethal means • Local clusters of suicide that have a contagious influence • Stressful life events

Many of these risk factors have been identified as significant in the Irish context, with different risk factors affecting different population groups in different ways. A review of Irish studies also found specific risk factors for different populations such as young people, unemployed people and marginalised groups like men living in rural communities, members of the Traveller Community and survivors of institutional sex abuse (48-51). The complex interplay of factors, which seem to exacerbate the risk for individuals, is not yet fully understood. Refer to Appendix 6 for further information on internationally recognised risk factors.

Protective factors

While many interventions are geared towards the reduction of risk factors in suicide prevention, it is equally important to consider and strengthen the factors that have been shown to increase resilience and protect against suicidal behaviour. Research conducted by the World Health Organisation's *Preventing Suicide, A global imperative* (19) demonstrates that strong personal relationships, religious or spiritual beliefs and a lifestyle practice of positive coping strategies and wellbeing are protective factors against the risk of suicide.

Strong personal relationships

Suicidal behaviour increases when people experience relationship conflict, loss or discord. Equally, maintaining healthy close relationships can increase individual resilience and act as a protective factor against the risk of suicide. The individual's closest social circle – partners, family members, peers, friends and significant others – have the most influence and can be supportive in times of crisis. In particular, resilience gained from this support mitigates the suicide risk associated with childhood trauma (52). Relationships are especially protective for adolescents and the elderly, who have a higher level of dependency.

Religious or spiritual beliefs

Faith itself may be a protective factor since it typically provides a structured belief system and can advocate for behaviour that can be considered physically and mentally beneficial (53). Many religious and cultural beliefs and behaviours may also contribute towards stigma related to suicide due to their moral stances on suicide, which can discourage help-seeking behaviours. The protective value of religion and spirituality may occur from providing access to a socially cohesive and supportive community with a shared set of values. Many religious groups also prohibit suicide risk factors such as alcohol use. While religion and spiritual beliefs may offer some protection against suicide, this depends on specific cultural and contextual practices and interpretations.

Lifestyle practice of positive coping strategies and wellbeing

Personal wellbeing and effective positive coping strategies protect against suicide (54). An optimistic outlook, emotional stability and a developed self-identity assist in coping with life's complications. Good self-esteem, self-efficacy and effective problem solving-skills, which include the ability to seek help when needed, can mitigate the impact of stressors and childhood adversities (55). Willingness to seek help for mental health problems may in particular be determined by personal attitudes. Due to the fact that mental health problems are widely stigmatised, people (and especially males) may be reluctant to seek help. Those who are unlikely to seek help can compound their mental health problems, increasing the risk of suicide that may otherwise have been prevented through early intervention. Healthy lifestyle choices which promote mental and physical wellbeing include regular exercise and sport, sleeping well, a healthy diet, consideration of the impact on health of alcohol and drugs, talking about problems, healthy relationships and social contact and effective management of stress (56, 57).

3.4 Evidence for suicide prevention, knowledge and awareness

In 2014, the Health Research Board were asked by the National Office of Suicide Prevention to examine the evidence base for suicide prevention to establish to which suicide prevention interventions were successful in reducing suicidal behaviour including suicidal ideation, self-harm, suicide attempts or death by suicide. The interventions that were effective in reducing suicide behaviours are as follows: means restriction, cognitive behavioural therapy and dialectic behavioural therapy. Emergency departments are settings for the delivery of suicide prevention interventions that show promise. Tele-mental health and

web-based interventions have only emerged recently so there is not enough evidence to comment on the success. Screening and gatekeeping were effective when followed by referral to behavioural interventions. Overall the review found the body of evidence on suicide prevention interventions to be limited. This does not mean that interventions are ineffective, but that there is little evidence of their effect in published papers. In order to prove an intervention works it needs to be tested. In addition, the NOSP examined the research on knowledge and awareness interventions and found that a number of these interventions show promise. This research has important implications for the work carried out as part of *Connecting for Life* in that systematic evaluation of interventions will be needed to define best approaches in the Irish context.

Taken together, the review of all literature indicated that the following interventions are effective or show promise:

- Promote public awareness with regard to issues of mental wellbeing, suicidal behaviour, the consequences of stress and effective crisis management.
- Enable early identification, assessment, treatment and referral to professional care of people vulnerable to suicidal behaviour.
- Maintain a comprehensive training programme for identified first responders and frontline healthcare staff (e.g. Gardaí, emergency department staff, educators, mental health professionals).
- Promote responsible reporting of suicidal behaviour by media outlets.
- Promote increased access to comprehensive services, including mental health services and emergency departments, for those vulnerable to, or affected by, suicidal behaviour.
- Provide supportive and rehabilitative services to people affected by suicide/suicidal behaviour.
- Support the provision of therapeutic approaches such as dialectical behavioural therapy and cognitive behavioural therapy to defined population groups, e.g. those who repeatedly self-harm.
- Reduce the availability, accessibility, and attractiveness of the means for suicidal behaviour.
- Support the establishment of an integrated data-collection system, which serves to identify at-risk groups, individuals, and situations.
- Allow screening for suicide risk among groups vulnerable to suicide.
- Improve healthcare services targeting people vulnerable to suicide, including improvements in inpatient and outpatient aftercare available to people who have attempted suicide.
- Support a whole-school approach to mental health promotion.

Evidence is also emerging relating to the potential benefit of online supports and services to people who have mental health problems or are vulnerable to suicide.

Connecting for Life has taken these findings into account in both the design of its goals, objectives and actions and its implementation and evaluation mechanisms.

3.5 International research evidence relating to the formulation of national suicide prevention strategies

Since the development of *Reach Out* in 2005, the evidence base around suicidal behaviour has evolved and some shifts in understanding relating to the best approaches to suicide prevention have occurred. In developing *Connecting for Life*, an analysis of the evidence about what works internationally in suicide prevention was conducted. The key elements from this analysis are outlined in Table 5.

Connecting for Life is Ireland's National Strategy to reduce suicide (2015-2020). The development of the strategy was a collaborative and inclusive process. Some of the most important contributions to the development of 'Connecting for Life' came from our public consultation process. We received 272 submissions from people and organisations, which included members of the general public, people who have used our services and their families, professional bodies and community interests and organisations.

"Education and training for mental health professionals must be developed in a collaborative integrated manner throughout services."

Submission reference number: 265

"There needs to be a national integrated approach, starting from a young age, ideally in pre-school/ primary school settings, building communication skills, resilience and coping."

Submission reference number: 132

Table 5: International research on evidence for suicide prevention (19)

Element	Detail of what works
Cross-sectoral coordination and segregation	In order to be effective, national suicide prevention strategies require cross-sectoral coordination, evaluation, multidisciplinary approaches, political support and ownership across multiple sectors in society. Strategies must be comprehensive, integrated and synergistic, as no single intervention has been found to reduce suicide rates. (21)
Culturally specific	National strategies need to be culturally specific, as no universal strategy will be effective in every country.
Evidence-informed	National suicide prevention strategies have an evidence-informed vision, a plan and set of actions. For health policy or health strategy formulation to be robust it needs to be evidence based, by drawing on research and epidemiological evidence, and the voice of service users, families and communities (22).
Needs based	Suicide prevention strategies need to take account of the way different factors affect different demographic and population groups, with an emphasis on the most vulnerable who are in the greatest need of suicide prevention efforts (18). Addressing the different risk factors for different sections of the population means devising prevention strategies at different levels and targeted to specific needs.
Whole population and targeted approaches	Effective interventions are likely to include prevention strategies at the general population level, such as promoting mental health or reducing access to the means of suicide, prevention strategies for certain vulnerable sub-populations, such as interventions for particular groups or training for gatekeepers, and prevention strategies at the individual level, such as support for those with mental health or substance abuse disorders (18). *Connecting for Life* will particularly address priority groups known to have an elevated risk of suicidal behaviour.

3.6 Issues emerging from the planning process

The use of a broad evidence base in the development of *Connecting for Life* reflects the complexity inherent in devising inclusive and comprehensive suicide prevention strategies. However, clear themes and approaches did emerge from the evidence base, and there was much overlap between the insights and recommendations of stakeholders, the research and statistical evidence and the recommendations of the advisory groups. The following issues emerged consistently across the planning process:

- The requirement of partnership and a whole-of-society approach from Government, service pathways, through to co-ordinated community action.
- The need for strong leadership, governance, accountability and clear implementation structures.
- The need for early intervention (at primary care level) and improved access to excellent clinical services secured by national service standard.
- Recognition that targeted approaches are required for some groups.
- The need for promotion of good mental health across the population with an emphasis on safe communication strategies and media reporting.
- The potential for the availability of online and smartphone services.
- The need to use evidence from research and evaluations to make decisions.

Connecting for Life is Ireland's National Strategy to reduce suicide (2015-2020). The development of the strategy was a collaborative and inclusive process. Some of the most important contributions to the development of 'Connecting for Life' came from our public consultation process. We received 272 submissions from people and organisations, which included members of the general public, people who have used our services and their families, professional bodies and community interests and organisations.

"We believe is it vitally important that mental health and suicide prevention groups and organisations work in partnership, together."

Submission reference number: 142

4

Overview of the Strategy

This section outlines the vision for the strategy, the main outcomes and the guiding principles. Within this section the main goals are listed, along with the objectives for each of these. The detailed actions and lead agencies are set out in Section 5 – Implementation.

4.1 Vision

An Ireland where fewer lives are lost through suicide, and where communities and individuals are empowered to improve their mental health and wellbeing.

4.2 Outcomes

The two primary outcomes from this strategy are:

1. Reduced suicide rate in the whole population and amongst specified priority groups.
2. Reduced rate of presentations of self-harm in the whole population and amongst specified priority groups.

The agreed indicators and data variables for measurement of achievement of these primary outcomes are presented in Section 5.

A set of 23 intermediate outcomes is presented in Section 5, in addition to considerations relating to evaluation of process factors.

4.3 Guiding principles and themes

This strategy is based around five guiding principles:

1. **Collaborative – Achieve together to deliver our goals**
   Suicide prevention work is best undertaken with a whole-of-society approach, where individuals, non-statutory organisations, government departments and communities work collaboratively, to coordinate efforts and achieve more.
2. **Accountable – Clear governance structures and openness in implementing the strategy**
   Implementation structures must be built on accountability, competence and openness as a means to improve quality, and deliver efficient and cost-effective initiatives and services.
3. **Responsive – Providing high-quality service responses that work with and support people to achieve goals that are meaningful and important to them**
   Our response to suicidal behaviour must be offered in a person-centred manner, which respects the individual's choices. Information on services and the services themselves must be accessible to all sections of society.

4. **Evidence-informed and outcome focused – Action targeted to identified need and based on international best-practice recommendations**
   All strategies, projects and interventions must be evidence-informed, robustly evaluated and contribute to the outcomes. Service design, delivery and evaluation should be focused on achieving results to agreed standards and timeframes in a targeted and a cost-effective manner.
5. **Adaptive to change – responsive to new and emerging circumstances**
   Services and structures need to be able to adapt to emerging thinking, respond to changing circumstances and be ready to adopt new and successful evidence-based initiatives, including new technologies.

4.4 Strategic goals and objectives

The seven goals of *Connecting for Life* are:

1. To improve the nation's understanding of and attitudes to suicidal behaviour, mental health and wellbeing.
2. To support local communities' capacity to prevent and respond to suicidal behaviour.
3. To target approaches to reduce suicidal behaviour and improve mental health among priority groups.
4. To enhance accessibility, consistency and care pathways of services for people vulnerable to suicidal behaviour.
5. To ensure safe and high-quality services for people vulnerable to suicide
6. To reduce and restrict access to means of suicidal behaviour.
7. To improve surveillance, evaluation and high-quality research relating to suicidal behaviour.

Each goal is detailed with its associated objectives. The actions, lead agencies and partner agencies supporting each action are listed in the detailed implementation plan in Section 5. This plan will be the foundation of the implementation process, which will support and inform the work on an on-going basis throughout the duration of the strategy. It will be revised on a regular basis, drawing on the learning from the reality of putting the plan into practice.

Goal 1: To improve the nation's understanding of, and attitudes to, suicidal behaviour, mental health and wellbeing

While there is a growing national dialogue around mental health and wellbeing, people in Ireland remain hesitant to talk openly about their own mental health, and misperceptions about suicidal behaviour persist. The language relating to suicide and mental health is often stigmatising or misleading. Inadequate or ill-informed media reporting can add to this problem. Mental health problems are a major risk factor for suicide. By working with people and organisations across society, including the media, we can achieve a greater understanding of suicide and the factors that protect and improve our mental health and reduce stigma.

Goal 1: To improve the nation's understanding of, and attitudes to, suicidal behaviour, mental health and wellbeing	
Objectives	
1.1	Improve population-wide understanding of suicidal behaviour, mental health and wellbeing, and associated risk and protective factors.
1.2	Increase awareness of available suicide prevention and mental health services.
1.3	Reduce stigmatising attitudes to mental health and suicidal behaviour at population level and within priority groups.
1.4	Engage and work collaboratively with the media in relation to media guidelines, tools and training programmes to improve the reporting of suicidal behaviour within broadcast, print and online media.

Connecting for Life is Ireland's National Strategy to reduce suicide (2015-2020). The development of the strategy was a collaborative and inclusive process. Some of the most important contributions to the development of 'Connecting for Life' came from our public consultation process. We received 272 submissions from people and organisations, which included members of the general public, people who have used our services and their families, professional bodies and community interests and organisations.

" Research into the applicability of internationally proposed models of suicide prevention to the Irish context must be prioritised and inform the development of any framework."

Submission reference number: 272

Goal 2: To support local communities' capacity to prevent and respond to suicidal behaviour

Well-structured and co-ordinated community-based initiatives can translate into protective benefits for families and individuals, which contribute to reduced risk of suicidal behaviour. An empowered community can respond to the needs of its members and protect them in difficult times and can sustain these positive effects over time. The work of and partnership formed amongst HSE Resource Officers for Suicide Prevention and non-statutory organisations is crucial in ensuring this goal is met.

Goal 2: To support local communities' capacity to prevent and respond to suicidal behaviour	
Objectives	
2.1	Improve the continuation of community level responses to suicide through planned, multi-agency approaches.
2.2	Ensure that accurate information and guidance on effective suicide prevention are provided for community-based organisations (e.g. family resource centres, sporting organisations).
2.3	Ensure the provision and delivery of training and education programmes on suicide prevention to community-based organisations.

Goal 3: To target approaches to reduce suicidal behaviour and improve mental health among priority groups

While Ireland's overall suicide rate is among the lowest in the OECD, particular demographic groups have consistently been shown by both national and international research evidence to have increased risk of suicidal behaviour. These include young people aged 15-24, people with mental health problems of all ages, people with alcohol and drug problems, people bereaved by suicide and prisoners.

There are other groups with potentially increased vulnerability to suicidal behaviour where the research evidence is either less consistent or limited. These include asylum seekers, refugees, migrants, sex workers and people with chronic illness or disability. Further research is required for these groups. These risk groups may change over time. While there is significant overlap between many of the groups, it is important to note that even within a group where there is increased risk, only a minority will engage in suicidal behaviour.

Groups for whom there is evidence of vulnerability to and increased risk of suicidal behaviour are listed below. This list of priority groups will be reviewed regularly based on the most up to date evidence.

- **Health/mental health related groups:** People with mental health problems of all ages, those who have engaged in repeated acts of self-harm, people with alcohol and drug problems and people with chronic physical health conditions.
- **Minority groups:** Members of the LGBT community, members of the Traveller community, people who are homeless, people who come in contact with the criminal justice system (e.g. prisoners), people who have experienced domestic, clerical, institutional, sexual or physical abuse, asylum seekers, refugees, migrants and sex workers.
- **Demographic cohorts:** Middle aged men and women, young people and economically disadvantaged people.
- **Suicide related:** People bereaved by suicide.
- **Occupational groups:** Healthcare professionals, professionals working in isolation, e.g. veterinarians, farmers.

Goal 3: To target approaches to reduce suicidal behaviour and improve mental health among priority groups	
Objectives	
3.1	Improve the implementation of effective approaches to reducing suicidal behaviour among priority groups.
3.2	Support, in relation to suicide prevention, the Substance Misuse Strategy, to address the high rate of alcohol and drug misuse.
3.3	Enhance the supports for young people with mental health problems or vulnerable to suicide.

Goal 4: To enhance accessibility, consistency and care pathways of services for people vulnerable to suicidal behaviour

A person vulnerable to suicidal behaviour requires easy access to a continuum of support in accordance with his or her needs at a particular time – from a sensitive response to a disclosure of distress to crisis management or appropriate referral, psychotherapeutic interventions or longer-term support. Transition points between services need to operate under widely understood protocols, ensuring the person is guided through a supportive network of assistance and that the work of statutory and non-statutory service providers enhance and complement each other. In some geographical areas there are clusters of services and supports for certain groups, while in other areas there are service gaps. What is more, the response to the person in distress may vary according to the type and location of the service. The foundations of a sustained approach to preventing and reducing suicide and (especially repeated) self-harm are consistently available services and integrated care pathways, across both statutory and non-statutory services.

Goal 4: To enhance accessibility, consistency and care pathways of services for people vulnerable to suicidal behaviour	
Objectives	
4.1	Improve psychosocial and psychiatric assessment and care pathways for people vulnerable to suicidal behaviour.
4.2	Improve access to effective therapeutic interventions (e.g. counselling, DBT, CBT) for people vulnerable to suicide.
4.3	Improve the uniformity, effectiveness and timeliness of support services to families and communities bereaved by suicide.

Goal 5: To ensure safe and high-quality services for people vulnerable to suicide

Supporting people through a time of distress can be difficult work; therefore, agencies need to have good-practice guidelines, clear care protocols, appropriate training and supervision mechanisms. By ensuring the quality and standard of both statutory and funded non-statutory health and social care services and strong governance and accountability structures, service users and providers are protected and the professionalism and safety of the service response are enhanced. All services must promote an ambition for recovery, restoring the individual's independence built on self-worth and self-belief.

Goal 5: To ensure safe and high-quality services for people vulnerable to suicide	
Objectives	
5.1	Develop and implement national standards and guidelines for statutory and non-statutory organisations contributing to suicide prevention.
5.2	Improve the response to suicidal behaviour within health and social care services, with an initial focus on incidents within mental health services.
5.3	Reduce and prevent suicidal behaviour in the criminal justice system.
5.4	Ensure best practice among health and social care practitioners through (a) the implementation of clinical guidelines on self-harm and (b) the delivery of accredited education programmes on suicide prevention.

Goal 6: To reduce and restrict access to means of suicidal behaviour

Restricting, where practicable, access to means of suicidal behaviour has been consistently shown to be effective in reducing suicidal behaviour across countries and settings. Implementation of strategies to restrict means can occur at national level, via legislation and regulations, and at local level, for example by improving safety at locations where people frequently attempt or complete suicide. This also includes exploring additional interventions for the most frequently used methods of suicide within the Irish context.

Goal 6: To reduce and restrict access to means of suicidal behaviour	
Objectives	
6.1	Reduce access to frequently used drugs in intentional drug overdose.
6.2	Reduce access to highly lethal methods used in suicidal behaviour.

Goal 7: To improve surveillance, evaluation and high quality research relating to suicidal behaviour

Responsive, cost-efficient and effective suicide prevention services depend on the widespread availability of robust data – data on the types of services and interventions that are effective in reducing or preventing suicidal behaviour, on the groups most vulnerable to suicidal behaviour; on trends in suicidal behaviour in the country; and on key risk and protective factors. Improving the quality of the evidence base for suicidal behaviour and suicide prevention in the Irish context, having real-time and better integrated data surveillance systems for suicidal behaviour as well as accelerating the transfer of research findings into practice are fundamental to the success of *Connecting for Life* and other suicide prevention policies and practices.

Goal 7: To improve surveillance, evaluation and high quality research relating to suicidal behaviour	
Objectives	
7.1	Evaluate the effectiveness and cost-effectiveness of *Connecting for Life*.
7.2	Improve access to timely and high-quality data on suicide and self-harm.
7.3	Review (and, if necessary, revise) current recording procedures for death by suicide.
7.4	Develop a national research and evaluation plan that supports innovation aimed at early identification of suicide risk, assessment, intervention and prevention.

5

Implementation and Evaluation of the Strategy

The following section outlines the approach, structures and processes for implementing *Connecting for Life*:

- The approach to implementation
- A detailed action plan including lead and supporting partners with responsibility for delivery
- Detailed implementation structures with clear roles and accountability
- A resource framework to ensure development and delivery of the necessary responses and services
- A communications framework, tailoring communications to all audiences
- An outcomes framework including primary outcomes and intermediate potential outcomes, as well as consideration of process outcomes

5.1 The approach to implementation

Connecting for Life is much more than a vision. It provides a detailed and clear plan to achieve each of the goals it proposes, with defined actions and a lead agency and key partners in place for each individual action. This action plan will be supported by robust implementation and governance structures and resourcing and communications frameworks. Monitoring and evaluation will be embedded into the implementation process, with an accompanying outcomes framework in place, which will allow progress to be tracked and the impact of the strategy to be objectively measured against baseline indicators.

In keeping with the evidence-informed approach of *Connecting for Life*, its implementation will be guided by the learning from and research into effective policies, practices and approaches. This is known as implementation science. It will be based on the knowledge that best practice in terms of policy and services is necessary but not sufficient to effect change in practice and policy: effective implementation is also needed.

Effective implementation occurs in four incremental stages, each requiring different conditions and activities. These stages of implementation are exploring and preparing, planning and resourcing, implementing and operationalising and full implementation, or business as usual, where the proposed actions are mainstreamed and fully operational.

The implementation process for *Connecting for Life* is particularly complex because it is a cross-cutting, whole-of-society strategy, which requires consistent co-operation and communication between relevant stakeholders. In this context, the following will build on the planning process and guide the implementation of *Connecting for Life*:

- *Connecting for Life* will be seen as a clear strategic priority of government and will have **strong, visible leadership** from senior public officials and key departments
- The **leadership team** driving implementation of the strategy will be **cross-sectoral**, reflecting the whole-of-government nature of *Connecting for Life*
- All **stakeholders** on whose involvement and co-operation success depends will be involved in implementation
- Those tasked with implementing – **the implementation teams** – will have the expertise and 'boundary spanning' skills to support a whole-of-government initiative
- **Service delivery personnel** and professionals will be brought into the planning process from the start
- All **roles** and **responsibilities** will be clearly delineated
- There will be ongoing **monitoring and evaluation** of the implementation of the strategy to guide the on-going implementation process, with **formal systems** for capturing and sharing learning put in place
- The **resources** for implementation and the extent of shared accountabilities for budgets will be clear

5.2 Action plan to achieve goals and objectives

The action plan sets out the objectives to support each strategic goal. The component actions for achievement of each objective are listed, together with specification of the lead and other key partners for delivery.

Connecting for Life is Ireland's National Strategy to reduce suicide (2015-2020). The development of the strategy was a collaborative and inclusive process. Some of the most important contributions to the development of 'Connecting for Life' came from our public consultation process. We received 272 submissions from people and organisations, which included members of the general public, people who have used our services and their families, professional bodies and community interests and organisations.

" Mental health professionals, GPs, youth workers, social workers etc are often the first point of call for people with mental illness, and they need to be fit for purpose."

Submission reference number: 83

Strategic Goal 1: To improve the nation's understanding of, and attitudes to, suicidal behaviour, mental health and wellbeing

1. To improve the nation's understanding of, and attitudes to, suicidal behaviour, mental health and wellbeing			
Objective	**Action**	**Lead**	**Key Partners**
1.1 Improve population-wide understanding of suicidal behaviour, mental health and wellbeing, and associated protective and risk factors.	1.1.1 Measure how people currently understand suicidal behaviour, mental health and wellbeing and set targets for improved understanding.	NOSP	DOH
	1.1.2 Develop and implement a national mental health and wellbeing promotion plan.	HSE H&W, DOH HI	NOSP, HSE MH
	1.1.3 Deliver co-ordinated communication campaigns (such as LittleThings, 2014) for the promotion of mental health and wellbeing among the whole population with a focus on protective health behaviours and consistent signposting to relevant support services.	HSE MH	HSE H&W, DOD, Non-statutory partners, NOSP
	1.1.4 Build the link between alcohol/drug misuse and suicidal behaviour into all communication campaigns.	HSE PC	HSE H&W, NOSP, DOH
	1.1.5 Promoting physical activity as a protective factor for mental health through the National Physical Activity Plan.	DOH HI DTTAS	Non-statutory partners
1.2 Increase awareness of available suicide prevention and mental health services.	1.2.1 Deliver accessible information on all mental health services and access/referral mechanisms and make the information available online at YourMentalHealth.ie.	HSE MH	NOSP
	1.2.2 Deliver targeted campaigns to improve awareness of appropriate support services to priority groups.	HSE MH	NOSP, Non-statutory partners

continued

1. To improve the nation's understanding of, and attitudes to, suicidal behaviour, mental health and wellbeing			
Objective	**Action**	**Lead**	**Key Partners**
1.3 Reduce stigmatising attitudes to mental health and suicidal behaviour at population level and within priority groups.	**1.3.1** Deliver campaigns that reduce stigma to those with mental health difficulties and suicidal behaviour in the whole population and self-stigma among priority groups.	NOSP	HSE MH, Youth sector, Non-statutory partners
1.4 Engage and work collaboratively with the media in relation to media guidelines, tools and training programmes to improve the reporting of suicidal behaviour within broadcast, print and online media.	**1.4.1** Engage with online platforms to encourage best practice in reporting around suicidal behaviour, so as to encourage a safer online environment in this area.	DCENR	NOSP, Non-statutory partners
	1.4.2 Broadcasting Authority of Ireland will apply and monitor its Code of Programme Standards, including Principle 3 - Protection from Harm, which references self-harm and suicide, so as to ensure responsible coverage around these issues in the broadcast media.	DCENR	Broadcasting Authority of Ireland
	1.4.3 The Press Council will amend its code of practice to include a principle on responsible reporting of suicide.	Press Council of Ireland	
	1.4.4 Monitor media reporting of suicide, and engage with the media in relation to adherence to guidelines on media reporting.	NOSP	

Strategic Goal 2: To support local communities' capacity to prevent and respond to suicidal behaviour

2. To support local communities' capacity to prevent and respond to suicidal behaviour			
Objective	**Action**	**Lead**	**Key Partners**
2.1 Improve the continuation of community level responses to suicide through planned multi-agency approaches.	**2.1.1** Implement consistent, multi-agency suicide prevention action plans to enhance communities' capacity to respond to suicidal behaviours, emerging suicide clusters and murder suicide. The plans will be the responsibility of HSE Mental Health Division and aligned with HSE Community Health Organisations structure, Local Economic and Community Plans and Children and Young People's Services Committee's (CYPSC) county plans.	HSE MH	DECLG, LA, HSE: PC H&W, CHOs, Acute Hospitals, Non-statutory partners, NOSP
2.2 Ensure that accurate information and guidance on effective suicide prevention are provided for community-based organisations (e.g. Family Resource Centres, Sporting Organisations).	**2.2.1** Provide community-based organisations with guidelines, protocols and training on effective suicide prevention.	NOSP	Non-statutory partners
2.3 Ensure the provision and delivery of training and education programmes on suicide prevention to community-based organisations.	**2.3.1** Develop a Training and Education Plan for community based training (as part of the National Training Plan) building on the Review of Training completed by NOSP in 2014.	NOSP	Non-statutory partners

continued

2. To support local communities' capacity to prevent and respond to suicidal behaviour			
Objective	**Action**	**Lead**	**Key Partners**
2.3 Ensure the provision and delivery of training programmes on suicide prevention to community-based organisations.	**2.3.2** Deliver training and awareness programmes in line with the National Training Plan prioritising professionals and volunteers across community-based organisations, particularly those who come into regular contact with people who are vulnerable to suicide.	NOSP	Non-statutory partners
	2.3.3 Deliver a range of mental health promoting programmes in community, health and education settings aimed at improving the mental health of the whole population and priority groups.	HSE H&W	HSE MH, DOH

Connecting for Life is Ireland's National Strategy to reduce suicide (2015-2020). The development of the strategy was a collaborative and inclusive process. Some of the most important contributions to the development of 'Connecting for Life' came from our public consultation process. We received 272 submissions from people and organisations, which included members of the general public, people who have used our services and their families, professional bodies and community interests and organisations.

" If new plans, ideas and actions were rolled out in local communities at the same time as nationally, the impact would be far greater and therefore more success in raising awareness and prevention."

Submission reference number: 102

Strategic Goal 3: To target approaches to reduce suicidal behaviour and improve mental health among priority groups

3. To target approaches to reduce suicidal behaviour and improve mental health among priority groups			
Objective	**Action**	**Lead**	**Key Partners**
3.1 Improve the implementation of effective approaches to reducing suicidal behaviour among priority groups.	**3.1.1** Integrate suicide prevention into the development of relevant national policies, plans and programmes for people who are at an increased risk of suicide or self-harm. *See Appendix 8 for exact wording on this action by each government department and agency.*	DAFM, DOH, DJE, DSP, DCYA/ TUSLA, DECLG, DOD, DTTAS	IPS, Garda Síochána, NEWS, ISC, NOSP
	3.1.2 Develop and implement a range of agency and inter-agency operational protocols (including protocols for sharing information and protocols in respect of young people) to assist organisations to work collaboratively in relation to suicide prevention and the management of critical incidents.	NOSP, HSE: Acute Hospitals, PC,MH, IPS/An Garda Síochána, Non-statutory partners	DAFM, DOH, DJE, DSP, DES, DCYA/ TUSLA, DOD
	3.1.3 Develop and deliver targeted initiatives and services at Primary Care level for priority groups.	HSE PC	NOSP
	3.1.4 Evaluate as appropriate targeted initiatives and/ or services for priority groups.	NOSP	

continued

3. To target approaches to reduce suicidal behaviour and improve mental health among priority groups			
Objective	**Action**	**Lead**	**Key Partners**
3.1 Improve the implementation of effective approaches to reducing suicidal behaviour among priority groups.	**3.1.5** Provide and sustain training to health and social care professionals, including frontline mental health service staff and primary care health providers. This training will improve recognition of, and response to, suicide risk and suicidal behaviour among people vulnerable to suicide.	NOSP	HSE PC, MH, Acute Hospitals
	3.1.6 Continue the development of mental health promotion programmes with and for priority groups, including the youth sector.	HSE H&W	HSE MH, NOSP, Youth sector, Non-statutory partners
3.2 Support, in relation to suicide prevention, the Substance Misuse Strategy to address the high rate of alcohol and drug misuse.	**3.2.1** Continue the roll out of programmes aimed at early intervention and prevention of alcohol and drug misuse in conjunction with HSE Primary Care.	HSE PC	HSE H&W, DOH
3.3 Enhance the supports for young people with mental health problems or vulnerable to suicide.	**3.3.1** Support the implementation of the relevant guidelines for mental health promotion and suicide prevention across primary and post primary schools, and the development of guidelines for Centres of Education.	DES	TUSLA, HSE H&W, NOSP

continued

3. To target approaches to reduce suicidal behaviour and improve mental health among priority groups			
Objective	**Action**	**Lead**	**Key Partners**
3.3 Enhance the supports for young people with mental health problems or vulnerable to suicide.	**3.3.2** Guide and encourage the implementation of the relevant policies and plans in schools, including support for development of Student Support Teams and for the management of critical incidents.	DES	NEPS, HSE H&W, NOSP
	3.3.3 Work with the HSE to develop national guidance for higher education institutions in relation to suicide risk and critical incident response, thereby helping to address any gaps which may exist in the prevention of suicide in higher education.	HEA	NOSP
	3.3.4 Implement the National Anti-bullying Action Plan including online and homophobic bullying.	DES	HSE H&W, NOSP
	3.3.5 Support all schools to implement a new Wellbeing programme, which will encompass SPHE, CSPE and PE, in Junior Cycle and encourage schools to deliver an SPHE programme (including RSE and mental health awareness) at Senior Cycle.	DES	HSE H&W DCYA/ TUSLA, DOH HI
	3.3.6 Deliver early intervention and psychological support service for young people at primary care level.	HSE PC	HSE MH

continued

3. To target approaches to reduce suicidal behaviour and improve mental health among priority groups			
Objective	**Action**	**Lead**	**Key Partners**
	3.3.7 Deliver early intervention and psychological support service for young people at secondary care level, including CAMHS.	HSE MH	

Strategic Goal 4: To enhance accessibility, consistency and care pathways of services for people vulnerable to suicidal behaviour

4. To enhance accessibility, consistency and care pathways of services for people vulnerable to suicidal behaviour			
Objective	**Action**	**Lead**	**Key Partners**
4.1 Improve psychosocial and psychiatric assessment and care pathways for people vulnerable to suicidal behaviour.	4.1.1 Provide a co-ordinated, uniform and quality assured 24/7 service and deliver pathways of care from primary to secondary mental health services for all those in need of specialist mental health services.	HSE MH	HSE: PC, Acute Hospitals, DECLG, Non-statutory partners
	4.1.2 Provide a co-ordinated, uniform and quality assured service and deliver pathways of care for those with co-morbid addiction and mental health difficulties.	HSE MH	HSE: PC, Acute Hospitals, Non-statutory partners

continued

4. To enhance accessibility, consistency and care pathways of services for people vulnerable to suicidal behaviour			
Objective	**Action**	**Lead**	**Key Partners**
4.1 Improve psychosocial and psychiatric assessment and care pathways for people vulnerable to suicidal behaviour.	**4.1.3** Ensure that those in the criminal justice system have continued access to appropriate information and treatment in prisons and while under Probation services in the community. The Irish Prison Service and the HSE National Forensic Mental Health Service will complete an agreed memorandum of understanding on improved links through the NFMHS Prison In-reach Service and the Probabtion Service will engage with the HSE on maintaining and developing access to community psychiatric services.	DJE	IPS, Probation Service, HSE MH
	4.1.4 Deliver a uniform assessment approach across the health services, in accordance with existing and recognised guidelines for people who have self-harmed or are at risk of suicide.	HSE MH	HSE Acute Hospitals
	4.1.5 Deliver a comprehensive approach to managing self-harm presentations through the HSE Clincal Care Programme for the assessment and management of patients presenting with self-harm to emergency departments.	HSE MH	HSE Acute Hospitals

continued

4. To enhance accessibility, consistency and care pathways of services for people vulnerable to suicidal behaviour			
Objective	**Action**	**Lead**	**Key Partners**
4.2 Improve access to effective therapeutic interventions (e.g. counselling, DBT, CBT) for people vulnerable to suicide.	**4.2.1** Deliver accessible, uniform, evidence based psychological interventions, including counselling, for mental health problems at both primary and secondary care levels.	HSE: MH, PC	NOSP, Non-statutory partners
4.3 Improve the uniformity, effectiveness and timeliness of support services to families and communities bereaved by suicide.	**4.3.1** Deliver enhanced bereavement support services to families and communities that are known to mental health services and affected by suicide.	HSE MH	NOSP, Non-statutory partners
	4.3.2 Commission and evaluate bereavement support services.	NOSP	HSE: PC, CHOs

Strategic Goal 5: To ensure safe and high quality services for people vulnerable to suicide

5. To ensure safe and high quality services for people vulnerable to suicide			
Objective	**Action**	**Lead**	**Key Partners**
5.1 Develop and implement national standards and guidelines for statutory and non-statutory organisations contributing to suicide prevention.	**5.1.1** Develop quality standards for suicide prevention services provided by statutory and non-statutory organisations, and implement the standards through an appropriate structure.	NOSP	Non-statutory partners
	5.1.2 Continue to promote a whole school approach to student guidance/ counselling within each post primary school.	DES	TUSLA, HSE H&W, NOSP

continued

5. To ensure safe and high quality services for people vulnerable to suicide			
Objective	**Action**	**Lead**	**Key Partners**
	5.1.3 Provide support and resources for the implementation of the Department's curriculum and programmes in the promotion of wellbeing in the school community. Facilitate access to appropriate mental health and suicide prevention training for teachers, e.g. through summer courses and the Education Centre network. In this regard, the support services will work collaboratively and liaise, as appropriate, with Government agencies.	DES	HSE H&W
5.1 Improve access to effective therapeutic interventions (e.g. counselling, DBT, CBT) for people vulnerable to suicide.	**5.1.4** Conduct a statutory consultation process and (in the context of wider policy development on the regulation of health and social care professionals) decide on the feasibility of designating by regulation the profession(s) of counsellor and psychotherapist.	DOH	
	5.1.5 Disseminate information on effective suicide prevention responses through the development and promotion of repositories of evidence-based tools, resources, guidelines and protocols.	NOSP, DJE	

continued

5. To ensure safe and high quality services for people vulnerable to suicide			
Objective	**Action**	**Lead**	**Key Partners**
5.2 Improve the response to suicidal behaviour within health and social care services, with an initial focus on incidents within mental health services.	**5.2.1** Develop and deliver a uniform procedure to respond to suicidal behaviour across mental health services.	HSE MH	HSE: PC, Acute Hospitals
	5.2.2 Strengthen the data systems to report and learn from investigations and reviews on child protection and deaths of children in care in order to review the profile of need and requisite service response to vulnerable young people who are in the care of the state or known to TUSLA.	DCYA/ TUSLA	
	5.2.3 Implement a system of service review, based on incidents of suicide and suicidal behaviour, within HSE mental health services (and those known to the mental health service) and develop responsive practice models.	HSE MH	
5.3 Reduce and prevent suicidal behaviour in the criminal justice system.	**5.3.1** Through the Death in Custody/Suicide Prevention Group in each prison, identify lessons learned, oversee the implementation of the corrective action plan, and carry out periodic audits.	DJE	Chaired by Senior Governor in each prison
	5.3.2 Ensure compliance with the relevant policies through regular audit and implementation of audit recommendations.	DJE	IPS

continued

5. To ensure safe and high quality services for people vulnerable to suicide			
Objective	**Action**	**Lead**	**Key Partners**
5.3 Reduce and prevent suicidal behaviour in the criminal justice system.	**5.3.3** Implement the IPS Prisoner Release Policy, to ensure care, treatment and information is provided, including identifying the appropriate mental health services in each area for those leaving prison. This will include appropriate links with the community mental health services.	DJE	HSE MH, PC
5.4 Ensure best practice among health and social care practitioners through (a) the implementation of clinical guidelines on self-harm and (b) the delivery of accredited education programmes on suicide prevention.	**5.4.1** Develop a National Training Plan, building on the NOSP Review of Training.	NOSP	Wide range of statutory and non-statutory organisations who deliver training programmes
	5.4.2 Deliver training in suicide prevention to staff in government departments and agencies who are likely to come into contact with people who are vulnerable to/at risk of suicidal behaviour.	DAFM, DOH, DJE/IPS, DSP, DES, DCYA/ TUSLA, HSA, DOD, DECLG, LA	NOSP
	5.4.3 Support professional regulatory bodies to develop and deliver accredited, competency based education on suicide prevention to health professionals.	DOH	A range of professional bodies
	5.4.4 Recommend the incorporation of suicide prevention training as part of undergraduate curriculum of the relevant professions.	Academic oversight structures	

continued

5. To ensure safe and high quality services for people vulnerable to suicide			
Objective	**Action**	**Lead**	**Key Partners**
	5.4.5 Support the National Clinical Effectiveness Agenda and implement national clinical guidelines in line with NCEC requirements.	DOH	HSE MH, NOSP

Strategic Goal 6: To reduce and restrict access to means of suicidal behaviour

6. To reduce and restrict access to means of suicidal behaviour			
Objective	**Action**	**Lead**	**Key Partners**
6.1 Reduce access to frequently used drugs in intentional drug overdose.	**6.1.1** Work with professional groups to reduce the inappropriate prescribing of medicines commonly used in intentional overdose, including benzodiazepines and SSRIs.	DOH	
	6.1.2 Continue improvements in adherence to the legislation limiting access to paracetamol through raising awareness amongst retailers and the public and the use of point of sale systems.	DOH	

continued

6. To reduce and restrict access to means of suicidal behaviour			
Objective	**Action**	**Lead**	**Key Partners**
6.2 Reduce access to highly lethal methods used in suicidal behaviour.	**6.2.1** Local Authorities will be requested to consider, develop and implement measures where practical to restrict access to identified locations and settings where people are at risk of engaging in suicidal behaviour, and assist generally in reducing risk factors in public locations.	LA	DECLG, NOSP
	6.2.2 Implement a strategy to improve environmental safety within the HSE mental health services (e.g. ligature audits).	HSE MH	HSE Estates
	6.2.3 Ensure that access to ligature points in cells is minimised and that this issue is given ongoing attention, particularly in the planning of all new prisons.	DJE	IPS

Strategic Goal 7: To improve surveillance, evaluation and high quality research relating to suicidal behaviour

7. To improve surveillance, evaluation and high quality research relating to suicidal behaviour			
Objective	**Action**	**Lead**	**Key Partners**
7.1 Evaluate the effectiveness and cost-effectiveness of *Connecting for Life*.	**7.1.1** Conduct proportionate evaluations of all major activities conducted under the aegis of *Connecting for Life*; disseminate findings and share lessons learned with programme practitioners and partners.	NOSP	
7.2 Improve access to timely and high quality data on suicide and self-harm.	**7.2.1** Develop capacity for observation and information gathering on those at risk of or vulnerable to suicide and self-harm. This includes children/young people in the child welfare/protection sector and places of detention, including prisons.	DJE DCYA/ TUSLA	IPS, Coroners' Offices (in the context of the recording of deaths), CSO, NSRF
	7.2.2 Collate and report on incidences of suicide through current and expanded health surveillance systems over the life of *Connecting for Life*.	HSE MH	
	7.2.3 Collect, analyse and disseminate high quality data on suicide and self-harm and ensure adequate access to and understanding of the data among those working in suicide prevention across all sectors.	NOSP	DOH, NSRF DJE/IPS, DCYA/ TUSLA
7.3 Review (and, if necessary, revise) current recording procedures for death by suicide.	**7.3.1** The Justice and Health sectors will engage with the Coroners, Garda Síochána, NOSP, CSO and research bodies in relation to deaths in custody, and recording of deaths by suicide and open verdicts, to further refine the basis of suicide statistics.	DJE	DOH, NOSP, Coroners' Offices, Garda Síochána, CSO, Research Bodies

continued

7. To improve surveillance, evaluation and high quality research relating to suicidal behaviour			
Objective	**Action**	**Lead**	**Key Partners**
7.4 Develop a national research and evaluation plan that supports innovation and is aimed at early identification of suicide risk, assessment, intervention and prevention.	**7.4.1** Support research on risk and protective factors for suicidal behaviour in groups with an increased risk (or potential increased risk) of suicide behaviour (*see Strategic Goal 3*).	NOSP	DOH
	7.4.2 Support the co-ordination and streamlining of research completed by third-level institutions.	HEA	NOSP
	7.4.3 Develop working partnerships with centres of expertise to support evaluation and research, knowledge transfer and implementation support between researchers, policy makers and service providers.	NOSP	
	7.4.4 Evaluate innovative approaches to suicide prevention including online service provision and targeted approaches for appropriate priority groups.	NOSP	Third-level Institutions

5.3 Implementation structures and roles

Connecting for Life depends in a fundamental way on co-ordination across government departments and agencies. Formal accountability, budgetary management, capacity development and evaluation structures, with clearly delineated roles and responsibilities, are central requirements for effective implementation. These provide communication channels for stakeholders, to allow practical constraints and also opportunities for a policy or strategy to be identified and addressed, as well as increasing service integration.

For government strategies with a relatively short timeframe, having solid implementation structures in place facilitates valuable monitoring of activities and puts a clear decision-making process in place, which helps avoid decisions being made hastily, without clarifying accountability and implications.

There are five key implementation structures for *Connecting for Life* as shown in Figure 5 below.

These five structures represent the different stakeholder groups involved in delivery. They provide forums for engagement, facilitate monitoring and clear decision-making and are designed to make best use of existing structures to ensure efficient working.

Figure 5: Implementation structure

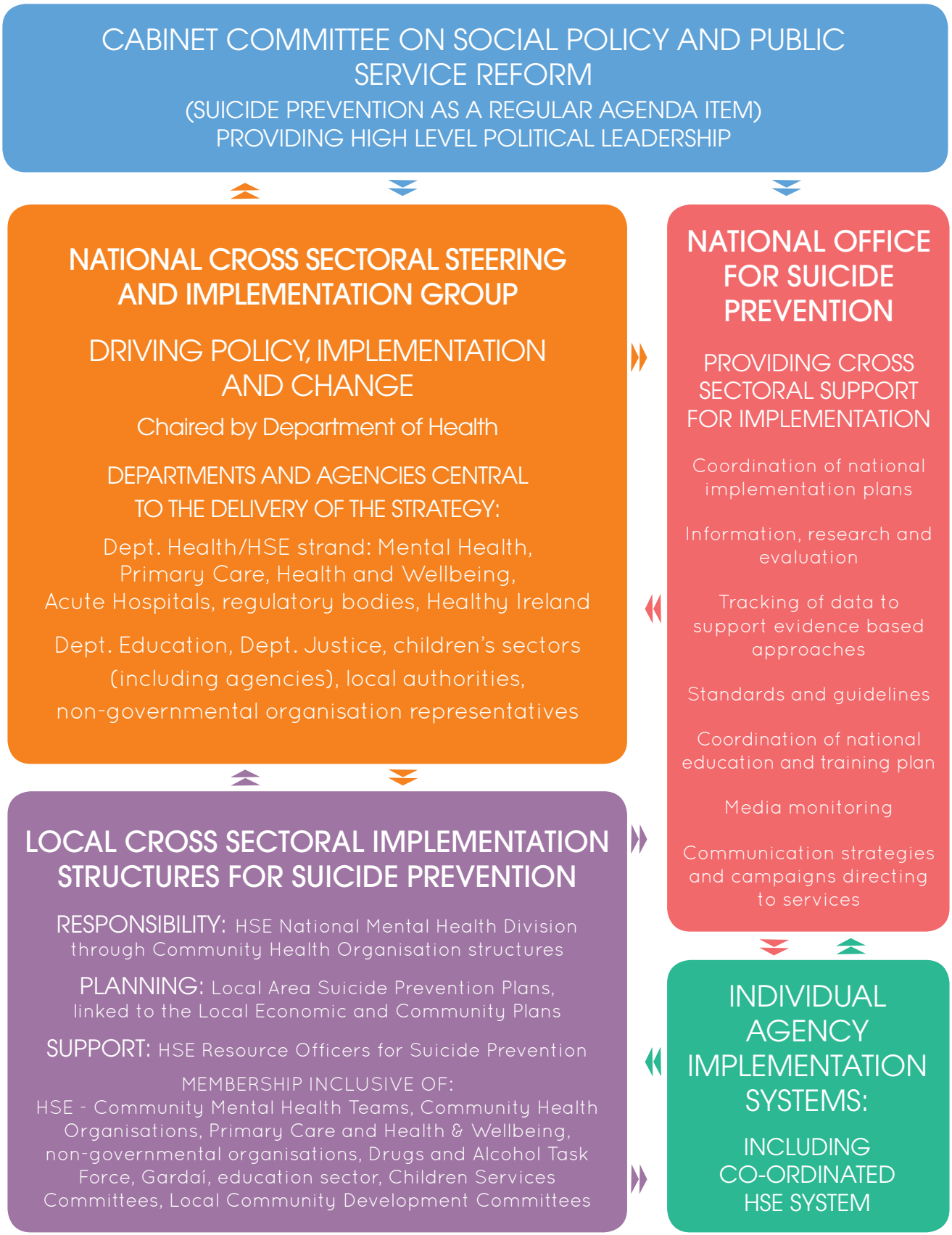


Table 6: Implementation structures

Structure	Membership	Role
Cabinet Committee on Social Policy and Public Service Reform – Suicide prevention as a regular agenda item	• Taoiseach (Chair) • Tánaiste and Minister for Social Protection • Minister for Public Expenditure and Reform • Minister for Finance • Minister for Justice and Equality • Minister for Agriculture, Food and the Marine • Minister for Defence • Minister for Children and Youth Affairs • Minister for Health • Minister for Education and Skills • Minister for the Environment, Community and Local Government • Minister of State (Primary Care, Mental Health and Disability) • Minister of State (Skills, Research and Innovation) • Minister of State (Housing, Planning and Co-ordination of the Construction 2020 Strategy) • Minister of State (Office of Public Works, Public Procurement and International Banking (including International Financial Services Centre)) • Minister of State (Employment, Community and Social Support) • Minister of State (New Communities, Culture and Equality)	• High-level political leadership • Setting and communicating expectations • Accountability to Government

continued

Structure	Membership	Role
National Cross-sectoral Steering and Implementation Group – Driving policy, implementation and change	• Senior officials of key departments key to the delivery of the strategy • Senior officials from statutory and NGO agencies with implementation roles • Chaired by the Department of Health	• Senior leadership • Joint governance of the strategy • Accountability • High-level implementation planning (including priority setting, staffing allocations) • Budgetary planning • Addressing national blockages to implementation
National Office for Suicide Prevention – Providing cross-sectoral support for implementation	• Director and staff of the NOSP • National Implementation Groups including: Research and Training	• Coordination of national implementation plans • Information, research and evaluation • Tracking of data to support evidence based approaches • Standards and guidelines • Coordination of national training and education plans • Media Monitoring • Communication strategies and campaigns directing to services
Local Cross-Sectoral Implementation Structures for Suicide Prevention – Planning and local support	RESPONSIBILITY: HSE National Mental Health Division through Community Health Organisation structures MEMBERSHIP AND SUPPORT: • HSE Resource Officers for Suicide Prevention (ROSP) • Senior and middle management from key service delivery agencies (statutory and NGO) • Service user representation • Family/carer representative • Families bereaved by suicide	• Joined-up management of delivery of actions, within the implementation planning framework • Detailed implementation planning/timelines • Capacity building • Reporting

continued

Structure	Membership	Role
Individual Agency Implementation Systems – Including a coordinated HSE system	• Management and staff within service delivery agencies	• Within agencies responsibility for specific actions, including coordinated HSE system • Accountability for specific actions/ timelines and resources

The implementation structure and processes will connect to the infrastructure for whole-of-government projects that forms part of the Government's 2014 *Civil Service Renewal Plan: A Vision and Three Year Action Plan for the Civil Service*, through which priority projects are driven by the Civil Service Management Board.

5.3.1 Local implementation structures

At a local level *Connecting for Life* will require cross-sectoral implementation structures. There are a range of suicide prevention structures and plans supported by the HSE Resource Officers for Suicide Prevention currently in place. For example, five local action plans are in place at county level in the HSE Community Health Care Organisation covering Wexford, Waterford, Carlow, Kilkenny and South Tipperary. This approach is aligned with the Local Area Plans and the Local Community Development Committees (LCDC). The model brings the five structures together into one regional grouping and is supported by the HSE Resource Officers for Suicide Prevention.

Connect Donegal was developed in parallel with the development of *Connecting for Life*. The 'Connect Donegal' model involved the establishment of a multi-agency planning group to address suicide in Donegal. Membership of the group was drawn from HSE services, Donegal County Council, GPs, Coroner Service, Gardaí, education sector, TUSLA, youth and community organisations, bereaved families and local media. The group undertook a significant public consultation and developed a Suicide Prevention Action Plan Resource Manual to support the development of local plans in other counties. The manual includes all resources and tools developed and used in developing *Connect Donegal* and the lessons learned through the process.

These models will be assessed as part of the development of implementation structures, with a view to capturing and mainstreaming good practice models.

5.4 Resourcing the strategy

Connecting for Life takes a whole-of-government approach, where the coordination and integration of the relevant goals and actions can generate outcomes that may not be otherwise achievable working in isolation. This provides for more effective service delivery and more efficient use of resources.

The discussions with government departments and agencies in the development of the strategy included agreement that the actions should encompass both improved use of existing resources and identification of resource requirements that may emerge for key programmes or sectors during implementation.

The resource requirements of the strategy depend on the type of action proposed, as outlined below:

- Improved integration of suicide prevention in policy development or engagement across agencies for shared guidelines and protocols, as well as training development – the overall focus is on how we do our work and these measures should be largely resource neutral.
- Continued communications initiatives and community planning initiatives. Minimal additional resources may be required to support local structures.
- More significant service provision and delivery of training actions. Agencies may reconfigure existing resources to better respond to the needs of those with suicidal behaviour and/or may seek additional resources through the government budget processes for enhanced prevention/early intervention services (for example, mental health promotion plans and primary care psychological supports, and specialist services, such as secondary care CAMHS, out-of-hours mental health services, treatment services in prisons, etc.)

There are considerable existing resources in the current investment in service provision across all the sectors; however, as part of the implementation further considerations may be required on the refocusing of services to prioritise early identification and treatment of those at risk of suicidal behaviour and those affected by suicide.

The HSE NOSP, as outlined earlier, performed a high-level governance and monitoring role for the previous suicide prevention strategy *Reach Out*, including allocating funding to approximately 40 organisations relevant to suicide prevention and general counselling from the overall budget for mental health services. Coordinating and monitoring the implementation of *Connecting for Life* will require enhanced programme management and research and evaluation capacity in the HSE NOSP. The HSE NOSP will therefore have to be adequately enabled and resourced to undertake these new functions.

5.5 Communications plan

Achieving the outcomes set out in *Connecting for Life* will be a complex and challenging undertaking.

Evidence and experience from around the world clearly shows that to create measurable improvements takes the involvement of the whole community, the whole-of-government, and all of society working in unison. A communications framework and coordinated communications action plan has a central and supportive role to play in that positive change.

Being clear – about the strategy, the action plan, the priorities and staging of the implementation plan, and specific roles within all of these – is an essential enabler of success. We will create a communications plan to help to inform and support the people, communities, teams and services who will be working to implement the strategy.

Mobilising the many services and organisations involved in suicide prevention to become powerful leaders and ambassadors for our common cause is a significant challenge. Building capacity, channels, networks and confidence for communications activity among the teams connected to the strategy's implementation will support and enhance the quality and impact of their work. It will help to promote hope and ongoing learning and participation. For example, the overall HSE's unique reach across the population means that NOSP, its teams and its health messages have a significant supportive influence on the health decisions made. A communications plan will be created to illustrate how we can use our influence to support the strategy.

Supporting partnerships

The successful implementation of the strategy across all sectors, including the health services, will rely on partnership. This is clear from the experiences and evidence gathered from many international settings and programmes of work in this area. While we have a rich, existing network of partners within the health system, across Government, and throughout society, the scale of the strategy is challenging and will require high-level support and leadership. Effective communications at every level will be one of the important enabling supports to all who are and will be participating in the programmes for change. The communications plan will set out how the partnerships and projects will be supported by better communications.

Mark and identity

Connecting for Life will come with a new and engaging brand identity, which will be created to endorse and link all the initiatives that support and are part of the strategy. The communications plan will support and define the roll-out of the strategy's brand identity and value within the health services, government departments and its funded agencies. It will outline how that brand can be used by all the projects and partners to celebrate their activities, signal their participation, and support the strategy's overall goals.

Behaviour change and inspiration

The communications plan will work to promote healthy behaviours and behaviour change by generating messages and health education campaigns aimed at people and communities. The plan will include a social marketing campaign to help deliver real changes in the lives and lifestyles of people living, learning and working in Ireland. We will encourage and support more people to make positive choices for themselves, their families and their communities.

5.6 Measurement of outcomes

Connecting for Life focuses on outcomes, measuring improvements in the principal outcomes along with identifying and measuring a range of intermediate outcomes.

Principal outcomes

1. Reduced suicide rate in the whole population and amongst specified priority groups.
2. Reduced rate of presentations of self-harm in the whole population and amongst specified priority groups.

Setting a target for reduced suicide rates is challenging because the baseline suicide rate is low. This means small changes such as improvements in data collection can have a major impact on the rate. Also, external factors outside the remit of this strategy, such as economic conditions, can impact on the rate. Additionally, given the long timeframes between some interventions and outcomes (for example, interventions that involve building resilience), the long-term outcomes from programmes cannot be measured without longitudinal studies. However, the WHO 2014 target of a 10% reduction by 2020 has been adopted as the minimum target for this strategy.

The outcomes framework proposed relates to the research and evaluation plan in goal 7 in that it relies on the availability or the development of robust and timely data on services and interventions that are effective in reducing or preventing suicidal behaviour. The outcomes, indicators and data sources will be further refined and developed with the relevant stakeholders during implementation to support meaningful monitoring and evaluation of delivery and to inform new or continued funding priorities. This detailed planning will involve consideration of approaches to identification of suitable data and data sources, including scoping the resources and timeframes required to gather the necessary data and prioritise what can be collected and reported for the duration of the strategy. This would also include the timing and frequency of reporting of indicators, where some may be quarterly, annually or phased at points during the lifetime of the strategy.

Table 7: Agreed indicators and data variables for measurement of principal outcomes (POs)

Outcomes	Indicators	Data	Data source(s)
01 Reduced suicide rate 01.1 in whole population 01.2 in priority groups (where data is available)	Standardised annual incidence of intentional self-harm deaths ('definite suicide'): overall and by each of the following comparison groups: gender, age group, socio economic status (individual/area level) Male self-harm rate as proxy for male suicide rate [See Note 1 below]	Deaths coded 'intentional self-harm' (ICD10) A&E male admissions for self-harm (proxy) As a proportion of: census/ population estimates	CSO /National Registry of Deliberate Self-harm
02 Reduced rate of A&E-presentations for self-harm 02.1 in whole population 02.2 in priority groups (where data is available)	Standardised annual A&E self-harm rates: overall and by each of the following comparison groups: gender, age group, socio economic status (individual/area level) Episodes (events) and persons Self-harm rates using highly lethal methods Proportion of persons readmitted to A&E following self-harm in subsequent 12 months: overall; by sex; by sex and age-group. (Annual cohorts) Proportion of persons admitted to A&E following self-harm who have had previous such admissions: overall and by each of the following comparison groups: gender, age group, socio economic status (individual/ area level - (annual cohorts)	A&E admissions for self-harm As a proportion of: census/ population estimates	National Registry of Deliberate Self-harm

Note 1: Given the delay in the release of suicide mortality data by the CSO, consideration will be given to the use of a valid proxy measure for one of the strategy's principal outcomes, which is available on a more timely basis. There is evidence of a temporal association between the rate of hospital presentations for self-harm among males and the rate of completed suicide (intentional self-harm) among males in Ireland, and national data on self-harm from the Irish National Registry of Deliberate Self-harm are available considerably in advance of data on suicide. In the context of this strategy, changes in male self-harm rates may therefore be considered a valid and useful proxy measure for changes in male suicide rates.

Note 2: Current data sources will be utilised and/or further developed in finalising these indicators.

The key outcome indicator in most evaluations of suicide prevention programmes is the change in suicide incidence. However, the rate of suicide is a long-term outcome indicator and should not be the sole outcome indicator used to determine the effectiveness of a suicide prevention strategy or programme (18, 58, 59). Intermediate outcomes, which are more directly influenced by suicide prevention efforts, can be measured to provide preliminary evidence of the effectiveness of a suicide prevention programme or strategy in the shorter term (60).

Frequently used intermediate outcomes following education and awareness programmes include changes in knowledge, attitudes and help-seeking behaviour and treatment referral and antidepressant prescription rates (61, 62).

When evaluating targeted interventions, such as screening and treatment programmes for individuals who have engaged in non-fatal suicidal behaviour, changes in mental health indicators, including depression severity, self-esteem and hopelessness, can be considered intermediate outcomes (60). Studies have reported reductions in suicide rates following positive and significant changes in intermediate outcomes, such as reduced suicide rates following increased prescribing of antidepressants (63-64).

On this basis, intermediate outcomes and indicators have been identified corresponding to the strategic goals and objectives of *Connecting for Life*. These are outlined in the table below.

Strategic Goal 1: To improve the nation's understanding of, and attitudes to, suicide, mental health and wellbeing

Intermediate outcome (IO)s	Indicators
IO1.1 Improved population-wide understanding of suicidal behaviour, mental health and wellbeing, and associated protective and risk factors.	Knowledge and awareness about support services Understanding of protective and risk factors for suicide and self-harm Understanding of mental health and wellbeing Stigmatising attitudes towards mental ill-health, self-harm and suicide Self-stigma (priority groups)
IO1.2 Increased awareness of available suicide prevention and mental health services.	
IO1.3 Reduced stigmatising attitudes to mental health and suicidal behaviour at population level and within selected priority groups.	
IO1.4 Engagement with the media in relation to media guidelines, tools and training programmes and improvement in the reporting of suicidal behaviour within broadcast, print and online media.	Poor reporting (does not adhere to guidelines) Positive reporting (adheres to guidelines)

The current #Littlethings campaign, YourMentalHealth.ie can support the outcomes and indicators, as well as funding for current SeeChange and Red C surveys of public opinion.

Strategic Goal 2: To support local communities' capacity to prevent and respond to suicide

Intermediate outcomes (IOs)	Indicators
IO2.1 Continued improvement of community-level responses to suicide through multi-agency approaches.	Local action plan available to enhance community response to suicidal behaviour
IO2.2 Accurate information and guidance on effective suicide prevention interventions provided for community-based organisations.	Community organisations' access to, and substantive knowledge of, guidelines, protocols and training on effective suicide prevention interventions
IO2.3 Training and education programmes on suicide prevention provided and delivered to community-based organisations.	Availability of relevant training and education programmes to community organisations Delivery of relevant training and education programmes to community organisations

Strategic Goal 3: To target approaches to reduce suicidal behaviour and improve mental health among priority groups

Intermediate outcomes (IOs)	Indicators
IO3.1 Improved implementation of effective approaches to reducing suicidal behaviour among priority groups.	Best practice interventions (based on systematic review of evidence) Interventions that are not evidence-informed and not evaluated
IO3.2 Support provided to the Substance Misuse Strategy, to address the high rate of alcohol and drug misuse.	(Continued) roll-out of programmes aimed at early intervention and prevention of alcohol and drug misuse

IO3.3 Enhanced supports for young people with mental health problems or vulnerable to suicide.	Enhanced availability in primary care to early intervention psychological supports, including counselling Schools and centres of education adopting a whole-school approach to health and wellbeing in line with the Health Promoting School, Healthy Ireland and School Self-evaluation frameworks

Strategic Goal 4: To enhance accessibility, consistency and care pathways of services for people vulnerable to suicidal behaviour

Intermediate outcomes (IOs)	Indicators
IO4.1 Improved psychosocial and psychiatric assessment and care pathways for people vulnerable to suicidal behaviour.	Availability of crisis nurses in primary and secondary care settings GPs trained to manage suicidal ideation/behaviour in primary care setting
IO4.2 Improved access to effective therapeutic interventions (e.g. DBT, CBT) for people vulnerable to suicide.	Availability of effective therapeutic interventions for persons who have self-harmed or attempted suicide Systematic approach to offer therapeutic interventions to eligible persons
IO4.3 Improved uniformity, effectiveness and timeliness of support services to families and communities bereaved by suicide.	Systematic approach to offer of timely and effective support to families bereaved by suicide Timely and effective support offered to families bereaved by suicide

Strategic Goal 5: To ensure safe and high-quality services for people vulnerable to suicide

Intermediate outcomes (IOs)	Indicators
IO5.1 Development and implementation of national standards and guidelines for statutory and non-statutory organisations contributing to suicide prevention.	Quality standards for suicide prevention programmes provided by statutory and non-statutory services Implementation of quality standards
IO5.2 Improved response to suicidal behaviour within health and social care services, with an initial focus on incidents within mental health services.	Development and effective implementation of uniform procedure to respond to suicidal behaviour in mental health services Development and effective implementation of uniform procedure to respond to suicidal behaviour in other health and care services
IO5.3 Reduction in and prevention of suicidal behaviour in the criminal justice system.	Self-harm and suicide incidence in prisons (adults) and children detention schools (minors)
IO5.4 Best practice among health and social care practitioners ensured through (a) the implementation of clinical guidelines on self-harm and (b) the delivery of accredited education programmes on suicide prevention.	Implementation of clinical guidelines on self-harm Delivery of accredited education programmes on suicide prevention

Strategic Goal 6: To reduce and restrict access to means of suicide

Intermediate outcomes	Indicators
IO6.1 Reduced access to frequently used drugs in intentional drug overdose.	Potentially risky prescribing practices (including number of tablets provided in a single prescription; repeat prescriptions without review; failure to switch to lower-lethality medication where available)
IO6.2 Reduced access to highly lethal methods used in suicidal behaviour.	Suicide-proofing of locations of concern Reduced number (proportion) of suicide deaths by highly lethal methods

Strategic Goal 7: To improve surveillance, evaluation and high-quality research relating to suicidal behaviour

Intermediate outcomes (IOs)	Indicators
IO7.1 Improved access to timely and high-quality data on suicidal behaviour.	Availability and timeliness of key data on suicide and self-harm Effectiveness and timeliness of dissemination of key data on suicide and self-harm
IO7.2 Current recording procedures for suicide deaths in Ireland reviewed (and, if necessary, revised).	Review of current recording procedures
IO7.3 Development of a national plan that supports research innovation aimed at early identification of suicide risk, assessment, intervention and prevention.	National plan supporting research and innovation
IO7.4 Evaluation of the effectiveness and cost-effectiveness of *Connecting for Life*.	Development and publication of comprehensive evaluation plan Commissioning of evaluation studies Successful implementation of evaluation studies Publicly available report(s) on findings of evaluation studies

5.7 Integrative evaluation: process and outcomes

In addition to the measurement of principal and intermediate outcomes, evaluation of this strategy will include assessment of process variables. This focus on both process and outcomes is consistent with the principles of programme evaluation (65, 66).

Process evaluation facilitates an assessment of changes that occur during the timeframe of a strategy, such as reduced commitment from key stakeholders or changes in environmental contexts (for example, significant economic changes at national level), which may impact negatively on the implementation of planned actions or may impact on suicide levels (67, 68). This will involve assessment of the activities undertaken and of the causal pathways from inputs and activities to outcomes

Connecting for Life is Ireland's National Strategy to reduce suicide (2015-2020). The development of the strategy was a collaborative and inclusive process. Some of the most important contributions to the development of 'Connecting for Life' came from our public consultation process. We received 272 submissions from people and organisations, which included members of the general public, people who have used our services and their families, professional bodies and community interests and organisations.

"The alcohol situation in this county is out of control, particularly with the very young."

Submission reference number: 5

"I think there needs to be inclusion of family members (or significant people in the patient's life) in adult services. Those who see the patient more often can read body language better."

Submission reference number: 6

"The issue of bullying has to be recognised and tackled to prevent more lives being taken needlessly."

Submission reference number: 163

Appendices

Appendix 1: Abbreviations

A&E	Accident and Emergency
ASIST	Applied Suicide Intervention Skills Training
CAMHS	Child and Adolescent Mental Health Service
CHOs	Community Health Organisations
CSCs	Close Supervision Centres
CSO	Central Statistics Office
CSPE	Civic, Social and Political Education
CYPSCs	Children and Young People's Services Committees
DAFM	Department of Agriculture, Food and the Marine
DCENR	Department of Communications, Energy and Natural Resources
DCYA	Department of Children and Youth Affairs
DECLG	Department of Environment, Community and Local Government
DES	Department of Education and Skills
DOH	Department of Health
DJE	Department of Justice and Equality
DOD	Department of Defence
DSP	Department of Social Protection
DTTAS	Department of Transport, Tourism and Sport
GP	General Practitioner
H&W	Health and Wellbeing
HEA	Higher Education Authority
HSA	Health and Safety Authority
HI	Healthy Ireland
HRB	Health Research Board
HSE NOSP	HSE National Office for Suicide Prevention
HSE ROSP	HSE Resource Officers for Suicide Prevention
HSE	Health Service Executive
ICD	International Classification of Diseases
ICGP	Irish College of General Practitioners
IO	Intermediate Outcome
IPS	Irish Prison Service
ISC	Irish Sports Council
LA	Local Authorities
LGBT	Lesbian, Gay, Bisexual and Transgender
MH	Mental Health
NCEC	National Clinical Effectiveness Committee
NEWS	National Educational Welfare Service

NGOs	Non Governmental Organisations
NRDSH	National Registry of Deliberate Self-harm
NSRF	National Suicide Research Foundation
OECD	Organisation for Economic Co-operation and Development
PC	Primary Care
PO	Principal Outcome
PE	Physical Education
RSE	Relationship and Sexuality Education
SOCs	Safety Observation Cells
SPHE	Social, Personal and Health Education
SSRIs	Selective Serotonin Reuptake Inhibitors
WHO	World Health Organisation

Appendix 2: Key terms and definitions

Families/friends/communities bereaved by suicide

People who have been impacted, directly or indirectly, when someone has died by suicide.

HSE mental health services

The HSE provides a wide range of community and hospital based mental health services in Ireland. HSE mental health services are delivered through specialist mental health teams from childhood to old age.

Incidence of self-harm/Self-harm rates

In 2013, a third successive decrease in the rate of hospital-treated self-harm in Ireland was recorded. The rate of self-harm in 2013 was 199 per 100,000 (182 and 217 per 100,000 for men and women, respectively). However this rate is still 6% higher than the pre-recession rate in 2007. The highest rate of self-harm is among young people, in particular women aged 15-19 years and men aged 20-24 years (7).

Marginalised groups

Marginalised groups are people who are, or consider themselves, excluded or marginalised from access to participate in activities which are considered the norm for other people in society.

Mental health and wellbeing

Mental health is defined as a state of wellbeing in which the individual realises his or her own potential, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community (69).

Mental health problems

Refers to a wide range of mental health conditions that affect mental health and impact on mood, thinking and behaviour.

Mental health promotion

Mental health promotion aims to promote positive mental health among the population and those who are at risk of experiencing mental health problems. This is a strategic approach, working in coordination with a wide group of agencies and individuals, that can enable people at risk in general to change their behaviour for the better by getting skills and knowledge that enable them to cope with life's difficulties and specific disorders (70).

Murder suicide

Murder suicide is murder followed by the suicide of a perpetrator within one week (71).

Non-statutory and community organisations

Community, voluntary and non-statutory services, organisations and groups.

People/groups who are vulnerable to suicide

People/groups who experience more of the risk factors of suicide.

People at acute risk of suicide/self-harm

People who are at high risk of suicide or self-harm. This may include frequent, intense and enduring thoughts of suicide or self-harm, specific plans or high distress (72).

People/groups who are vulnerable to self-harm

People/groups who are more susceptible than other people/groups to the possibility of self-harm.

Primary care services

Primary care means all of the health or social care services in communities, outside of a hospital setting.

Priority groups

In *Connecting for Life*, priority groups refer to the population groups identified as vulnerable to suicide in Ireland. Over the lifetime of the Strategy, other population groups may emerge as particularly vulnerable to suicide.

Protective and risk factors

In general, risk factors increase the likelihood that suicidal behaviour will develop, whereas protective factors reduce this likelihood (73). In relation to mental health, protective factors include secure family attachments, having one supportive adult during early years, positive early childhood experiences, good physical health, and positive sense of self, effective life and coping skills. Risk factors include physical illness or disability, family history of psychiatric problems, family history of suicide, low self-esteem, social status, childhood neglect.

Reducing suicide/Reducing self-harm

Reducing suicide, or self-harm, means lowering the number of deaths by suicide or the number of self-harm incidents.

Resilience

Resilience is the ability to cope with adverse, or challenging, circumstances (74).

Responding to a suicide attempt

Response, or intervention, to support someone who attempts suicide.

Responding when someone has died by suicide/Postvention

Responding to suicide refers to the response, or intervention, to support relatives, friends and communities after someone dies by suicide.

Self-harm

Self-harm describes the various methods by which people harm themselves. Varying degrees of suicidal intent can be present and sometimes there may not be any suicidal intent, although an increased risk of further suicidal behaviour is associated with all self-harm.

Service user

Person who uses the mental health services.

Social exclusion

Social exclusion refers to being unable to participate in society because of a lack of access to resources that are normally available to the general population. It can refer to both individuals, and communities in a broader framework, with linked problems such as low incomes, poor housing, high-crime environments and family problems (75).

Stigma reduction

Stigma reduction refers to the process of minimising negative beliefs associated with different types of mental health problems. It brings about a positive change in public attitudes and behaviour towards people with mental health problems (76).

Suicide/die by suicide

Suicide is death resulting from an intentional, self-inflicted act (77).

Suicide attempt/attempted suicide/someone who has attempted suicide

A suicide attempt means any non-fatal suicidal behaviour, when someone has the intent to take their own life.

Suicidal behaviour

Suicidal behaviour refers to a range of behaviours that include planning for suicide, attempting suicide and suicide itself (19). For the purpose of this Strategy, the term suicidal behaviour also refers to self-harm. (*See above for a full definition of self-harm.*)

Suicide cluster

A suicide cluster refers to a number of unexpected suicide or attempted suicides that occur closer together in space and time than one would normally expect in any given community (78, 79).

Suicide mortality/Suicide rates

There were 541 deaths by suicide in Ireland in 2012 (the most recent year where finalised data is available), representing a rate of 11.8% per 100,000 population (3). 800,000 people (19) die by suicide worldwide every year.

Suicide prevention/Help prevent suicide

Suicide prevention aims to diminish the risk and rates of suicide. It may not be possible to eliminate entirely the risk of suicide but it is possible to reduce this risk.

Targeted approach

Embedded in a whole population approach and focuses on 1) identifying the smaller number of people who are vulnerable to suicide/self-harm and 2) putting in place appropriate interventions.

Whole-population approach

A whole-population approach focuses on suicide prevention for all members of society. It aims to reduce suicidal behaviour by addressing the risk and protective factors at individual, family, community and societal levels.

Appendix 3: Suicide and self-harm in Ireland

A note relating to the data presented:

The CSO provides mortality data in two forms: (i) year of registration data and (ii) year of occurrence data. In this report, we focus on 'year of occurrence' data, as this information is more comprehensive and allows for year-on-year comparison. At the time of writing, 2012 is the most recent 'year of occurrence' data available. Data for 2013 and 2014 is also included, but this is provisional, due to the data-collection process in Ireland.

The CSO publishes national mortality data, including data on deaths by suicide. It is likely that a proportion of the deaths classified as undetermined are also deaths by suicide, but it is not possible to estimate this at present (3).

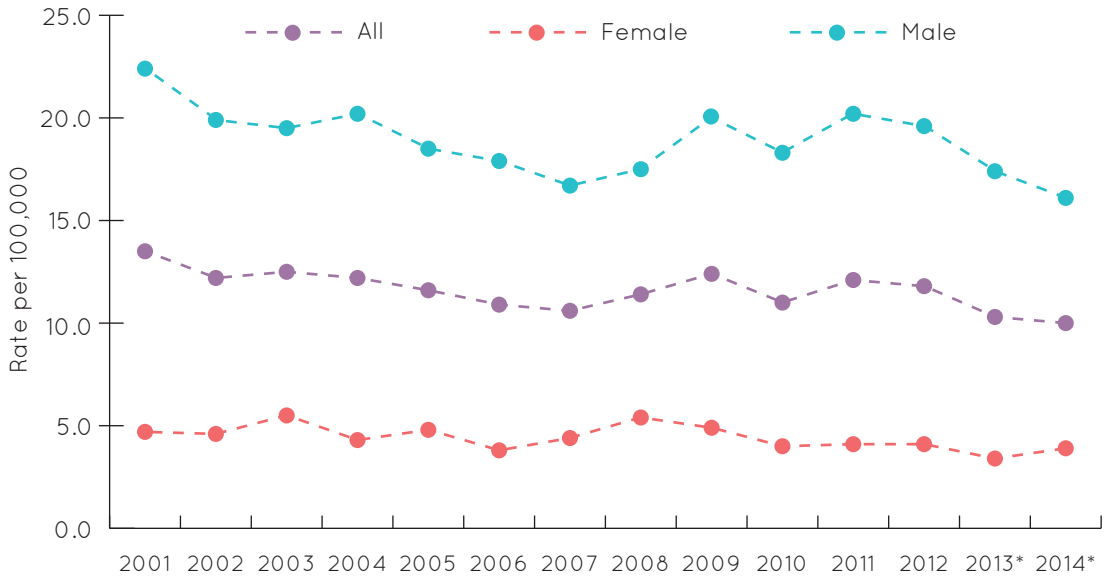
Self-harm statistics in Ireland are gathered by the National Registry of Deliberate Self-harm (NRDSH). This records information on persons who present to hospital emergency departments after an episode of deliberate self-harm. Self-harm statistics are included in this review, while self-harm is associated with an increased risk of suicide, and so interventions to reduce suicide tend to address the issue of self-harm (19). Also, the self-harm statistics include cases that may be a proxy indicator of suicidal ideation, such as intentional drug overdose cases. Such cases were the most common form of self-harm according to NRDSH figures, accounting for 67% of cases (7).

Incidence of suicide in Ireland, 2004-2014

There were 541 deaths by suicide in Ireland in 2012, representing a rate of 11.8 per 100,000. 445 (82.3%) of these were men (3). This high male-to-female ratio is a constant feature of deaths by suicide over the years, as can be seen in the figure below.

Since 2007, particularly since the onset of the economic recession in Ireland in 2008, there has been an increase in the suicide rate in Ireland. The increase observed between 2007 and 2012 can be wholly attributed to an increase in the male rate of suicide. More recently, data from 2012, 2013 and 2014 suggest a levelling-off of this rise. However, this pattern should be interpreted with some caution as data for 2013 and 2014 is still provisional.

Suicide rate per 100,000 by gender, 2001-2014 (3)



Note: Figures for 2013 and 2014 are provisional and subject to change

Numbers and rates of suicide and other causes of death, 2004-2014 (3)

	Suicide		Undetermined		Deaths by external causes		All deaths	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
2014*								
Males	368	16.1	46	2.0	1088	47.7	14863	652.0
Females	91	3.9	16	0.7	472	20.3	14232	610.8
Total	459	10.0	62	1.3	1560	33.8	29095	631.2
2013*								
Males	396	17.4	43	1.9	1110	48.8	15211	669.0
Females	79	3.4	22	0.9	397	17.1	14809	638.5
Total	475	10.3	65	1.4	1507	32.8	30020	653.6
2012								
Males	445	19.6	36	1.6	1142	50.3	14945	658.5
Females	96	4.1	18	0.8	435	18.8	14241	614.9
Total	541	11.8	54	1.2	1577	34.4	29186	636.5
2011								
Males	458	20.2	40	1.8	1211	53.3	14492	637.7
Females	96	4.1	27	1.2	482	20.8	13964	603.1
Total	554	12.1	67	1.5	1693	36.9	28456	620.2
2010								
Males	405	18.3	54	2.4	1198	54.1	14334	646.8
Females	90	4.0	29	1.3	462	20.5	13627	604.4
Total	495	11.1	83	1.9	1600	37.1	27961	625.4

	Suicide		Undetermined		Deaths by external causes		All deaths	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
2009								
Males	443	20.0	52	2.3	1236	55.7	14727	664.1
Females	109	4.9	22	1.0	490	21.9	13653	609.1
Total	552	12.2	74	1.7	1726	38.7	28380	636.4
2008								
Males	386	17.5	64	2.9	1215	55.1	14457	655.3
Females	120	5.4	19	0.9	506	22.8	13817	623.6
Total	506	11.4	83	1.9	1721	38.9	28274	639.8
2007								
Males	362	16.7	87	4.0	1252	57.7	14391	662.8
Females	96	4.4	32	1.5	507	23.4	13726	633.1
Total	458	10.6	119	2.7	1759	40.5	28117	648.0
2006								
Males	379	17.9	68	3.2	1180	55.6	14065	688.5
Females	81	3.8	16	0.8	484	22.8	13883	655.3
Total	460	10.8	82	1.9	1664	39.2	28488	671.9
2005								
Males	382	18.5	93	4.5	1239	60.1	14412	699.0
Females	99	4.8	41	2.0	506	24.4	13848	668.3
Total	481	11.6	134	3.2	1745	42.2	28260	683.6
2004								
Males	406	20.2	60	3.0	1127	56.0	14801	735.9
Females	87	4.3	21	1.0	467	23.0	13864	682.1
Total	493	12.2	81	2.0	1594	39.4	28665	708.9

** Figures for 2013 and 2014 are provisional and subject to change*

*** All rates are crude, based on 100,000 population*

Rates of suicide in Ireland by gender and age, 2001-2014

The majority of people who die by suicide in Ireland are male. In 2012, 82.3% of those who died were males. The highest rate was among 45-54 year old males, at 32.3 per 100,000 population. The lowest rate for male suicide in 2012 was in the 65+ age group. Similarly, the lowest rate for female suicide in 2012 was also in the 65+ age group. The highest rate for female suicide in 2012 was 7.1 per 100,000 in the 45-54 year old age group. Provisional rates for 2013 show a stabilisation or decrease of suicide across all age-groups, except in the 45-54 year female age group (3).

Male suicide rates per 100,000 population (3)

	All	15-24	25-34	35-44	45-54	55-64	65+
2001	22.4	27.7	37.2	29.9	28.6	26.5	17.2
2002	19.9	27.6	34.4	22.2	22.8	23.1	16.9
2003	19.5	29.5	22.7	30.6	23.3	24.3	14.0
2004	20.2	27.1	28.0	28.5	29.4	22.9	13.2
2005	18.5	25.6	26.8	24.9	25.8	21.6	10.4
2006	17.9	27.5	23.5	21.4	24.1	21.1	14.2
2007	16.7	23.7	23.5	19.5	20.9	16.6	17.6
2008	17.5	22.2	25.3	22.7	24.6	21.2	13.1
2009	20.0	24.4	26.6	31.5	26.6	26.9	13.7
2010	18.3	27.2	20.3	29.7	28.9	23.3	8.1
2011	20.2	26.8	27.1	28.1	32.3	25.0	13.8
2012	19.2	21.1	25.1	27.7	32.3	28.3	14.7
2013*	17.4	17.2	24.3	21.9	29.0	27.5	13.8
2014*	16.1	16.7	19.5	21.7	30.6	20.1	14.8

** Figures for 2013 and 2014 are provisional and subject to change*

Female suicide rates per 100,000 population (3)

	All	15-24	25-34	35-44	45-54	55-64	65+
2001	4.7	5.1	4.4	6.8	8.5	10.7	1.6
2002	4.6	4.7	6.8	5.3	8.0	6.3	3.2
2003	5.5	5.0	6.0	7.0	9.5	9.9	5.2
2004	4.3	2.9	5.2	6.5	7.7	7.4	3.5
2005	4.8	6.4	6.8	4.3	7.5	6.2	4.3
2006	3.8	5.1	3.6	4.6	6.2	6.5	2.7
2007	4.4	4.8	5.1	6.4	9.4	5.3	2.2
2008	5.4	8.1	4.6	6.5	9.2	8.4	5.6
2009	4.9	4.1	5.3	7.9	7.2	6.8	5.1
2010	4.0	4.0	4.6	5.4	6.0	8.4	2.5
2011	4.1	5.5	7.0	6.1	5.8	5.2	1.2
2012	4.5	5.8	5.3	6.0	7.1	5.6	1.3
2013*	3.4	3.8	4.9	4.5	7.4	3.4	1.6
2014*	3.9	4.7	6.7	5.5	5.6	3.7	2.9

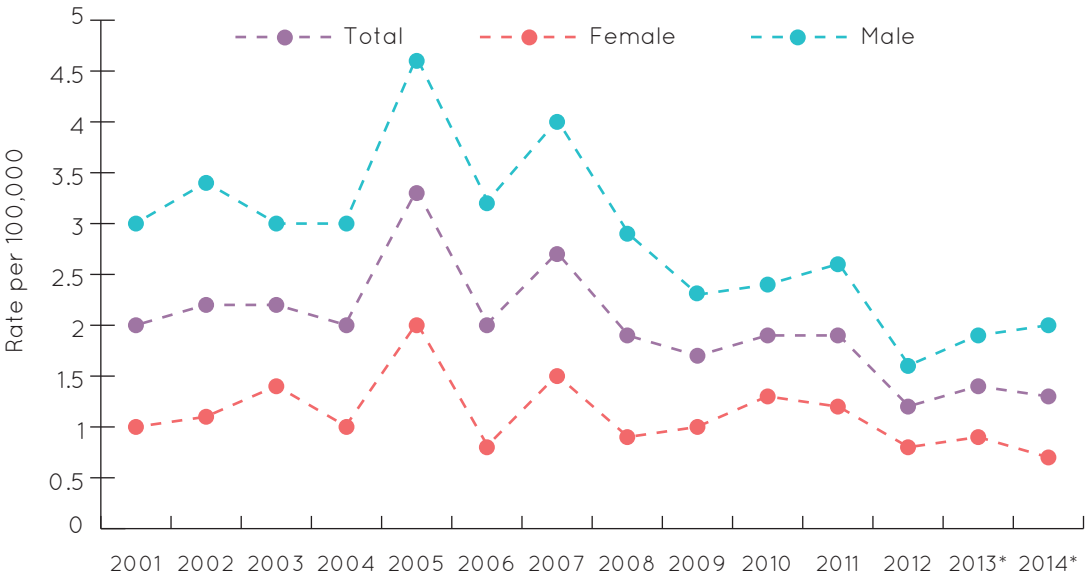
** Figures for 2013 and 2014 are provisional and subject to change*

Deaths of undetermined intent

There are indications that deaths of undetermined intent may include 'hidden' cases of suicide. However, it is not yet clear which proportion of undetermined deaths involve probable suicide cases.

The figure below shows an overview of undetermined deaths per 100,000 by gender and total confirmed rates for Ireland, 2001-2014.

Rates of undetermined deaths per 100,000 by gender and total rates for Ireland, 2001-2014 (3)



** Figures for 2013 and 2014 are provisional and subject to change*

Incidence of self-harm in Ireland

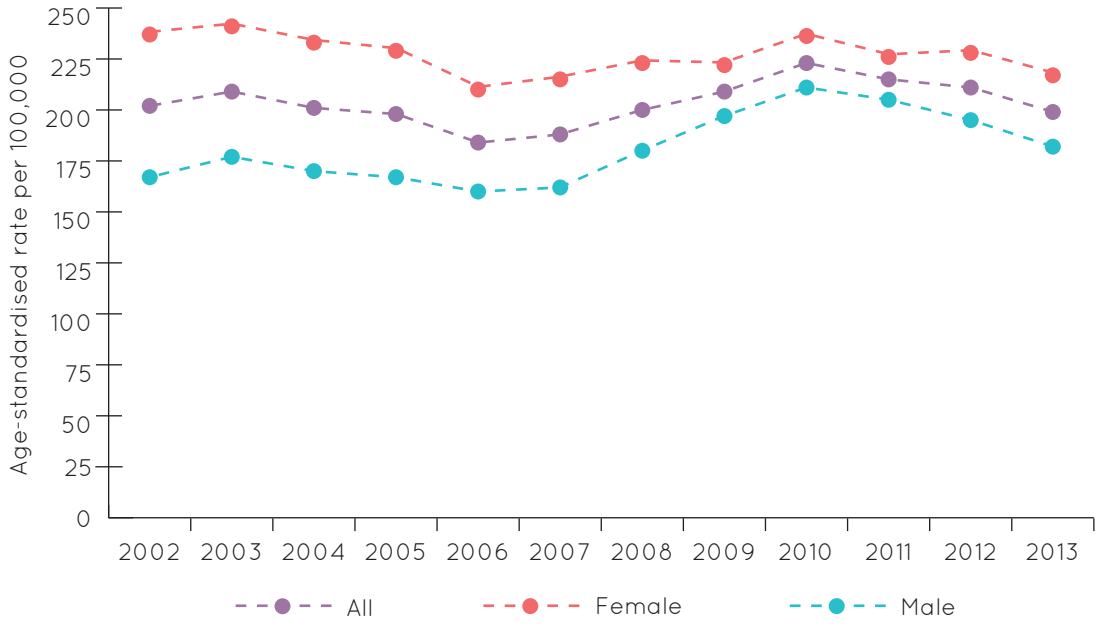
Self-harm includes the various methods by which people deliberately harm themselves. The Irish statistics presented here are collated by The National Registry of Deliberate Self-harm, based on data collected on persons presenting to hospital emergency departments as a result of self-harm. Since 2006, all general hospital and paediatric hospital emergency departments in Ireland have contributed to the Registry.

Trends in self-harm by gender in Ireland, 2002-2013

In 2011 and 2012 there were two successive decreases in the annual Irish rate of persons presenting to hospital as a result of self-harm in 2011 and 2012 (-4% and -2% respectively). The age-standardised rate of hospital-treated self-harm in 2013 was 199 per 100,000, 6% lower than the equivalent rate in 2012 (211 per 100,000). However, despite these decreases, the rate in 2013 was still 6% higher than in 2007, the year before the economic recession (6, 7).

Between 2007 and 2010 there was an increasing trend in the rate of self-harm in Ireland, with a 20% increase overall during this period. The largest increase was seen among men, where the rate went from 162 per 100,000 to 211 per 100,000 (+30%). There was a less pronounced increase in the female rate during this period, with a 10% increase observed. While overall the female rate of self-harm in Ireland is consistently higher than to the male rate, this period has also seen the gender gap narrowing, with 2010 recording the smallest difference between these rates (10%) (6, 7).

Rates of self-harm by gender and overall, 2002-2013 (6, 7)



Rates of self-harm by gender and age

The highest rate of self-harm is in the younger age brackets. In 2013 the highest rate for women was among 15-19 year-olds. This rate implies that one in every 162 girls in this age group presented to hospital in 2013 as a consequence of self-harm. The highest rate for men was among 20-24 year-olds or one in every 196 men. The incidence of self-harm gradually decreased with increasing age in men. This was the case to a lesser extent in women as their rate remained stable, across the 30-49 year age range (7).

During the time of the economic recession in Ireland from 2008-2013, changes in the rate of self-harm were observed across certain age groups. During this period for men the greatest increase in the self-harm rate was for middle-aged men (aged 45-54), where an increase of 11% was seen. For women, the increase was greatest among those aged 15-24 years (12%) and for those aged 45-64 years (7%). Thus, while the self-harm rates remain highest among young people, middle-aged groups saw the most significant increase in recent years (6,7).

Repetition of self-harm, 2013

Repeated self-harm is a significant risk factor for suicide. Therefore, those who present with repeat acts of self-harm are a significant target group for suicide prevention. Appropriate aftercare is critical in reducing rates of subsequent suicide in this population cohort.

Of the total number of presentations made to emergency departments in Ireland in 2013 more than one in five (2,289, 21.0%) were due to repeat acts of self-harm. This rate is similar to that reported in 2012, which is higher than the proportion of acts accounted for by repetition in the years 2010 and 2011 (19.9 and 19.5% respectively) (6, 7).

Of the 8,772 individuals treated for self-harm in 2013, 1,211 (13.8%) made at least one repeat presentation to hospital during the calendar year. This proportion has been consistent over the last ten years and is slightly lower than the rate recorded in 2012 (14.5%) (6, 7).

Appendix 4: Irish policies with relevance to suicide prevention

Department of Health: physical and mental health and wellbeing			
Department of Health	2001	Quality and Fairness: A Health System for You	The National Health Strategy *Quality and Fairness: A Health System for You* is the defining document on health policy in Ireland. It describes a vision of health services and defines the actions necessary to achieve this. It recognises the need to update and modernise health services, including mental health services.
Department of Health and Children	2006	A Vision for Change: Report of the Expert Group on Mental Health Policy	National strategy on mental health, with specific sections on suicide prevention within the whole population and with regard to people with mental health problems.
Department of Health	2013-2025	Healthy Ireland – A Framework for Improved Health and Wellbeing, 2013-2025	The Healthy Ireland Framework is a 'whole-of-government' and 'whole-of-society' framework for action to improve health and wellbeing across the population and the life course, address the social determinants of health more effectively and reduce health inequalities.
Department of Health and Children	2009-2016	The National Drugs Strategy 2009-2016	National framework for reducing drug misuse; highlights the role of alcohol in suicide and self-harm and recommends a wide range of interventions and a continued partnership approach. The Strategy contains five pillars: supply reduction, prevention, treatment, rehabilitation and research, which are dovetailed into the provisions of the EU Drugs Action Plan 2009-2012.
Department of Health and Children	2012	Report of the National Substance Misuse Strategy Steering Group	The report recommends an integrated approach to substance misuse, integrating policy responses to alcohol use and misuse and to the misuse of other substances. It implements the recommendations on alcohol with the National Drugs Strategy 2009–2016 into a single policy response.

continued

Department of Health	2013	National Positive Ageing Strategy	The Strategy addresses the broader determinants of health, covering a wide range of priority areas such as healthy ageing, health and social services, carers, employment and retirement, education and lifelong learning, volunteering, cultural and social participation, transport, financial security, housing, safety and security, and elder abuse.
Department of Health and Children/ Health Service Executive	2008	National Strategy for Service User Involvement in the Irish Health Service	The Strategy aims to promote active service user involvement to enable health services to anticipate problems, avoid complaints, develop appropriate and effective service provision and it guarantees that service users will be at the centre of quality and safety in service provision.
Department of Health and Children	2001	Primary Care Strategy: A New Direction	The Strategy aims to implement primary care as the first and on-going point of contact with the health and personal social services, through an inter-disciplinary team approach.
Department of Health and Children	2002	Traveller Health: A National Strategy 2002-2005	Although the timeframe for the Strategy has elapsed, it remains an important guiding document for the provision of Traveller focused health services and involvement of the Traveller community. Provisions related to Traveller health were subsequently included in the HSE National Intercultural Health Strategy.
Department of Health and Children	2008	National Men's Health Policy 2008-2013	This policy is directed to policy makers, service providers, health and allied health professionals, and the community and voluntary sector. It provides recommendations and an evidence base for tackling men's health by addressing the social determinants of health, health promotion, community development and gender inequality.

continued

Health Services Executive: physical and mental health and wellbeing			
Health Service Executive	2009-2016	National Drugs Rehabilitation Framework	The Framework aims to enhance the provision of rehabilitation services to current and former drug users by creating integrated care pathways, based on four steps: initial contact for screening and referral; initial assessment and identification of appropriate service; comprehensive assessment; implementation of the care plan to support an individual rehabilitation pathway.
Health Service Executive (Office of the Nursing and Midwifery Services Director)	2012	A Vision for Psychiatric/ Mental Health Nursing	Sets out a formal strategy for psychiatric/mental health nursing in Ireland, which outlines a vision for the profession for the next 10-20 years. The document supports a cultural shift to a values-based system of care, which promotes the recovery approach, service user and carer outcomes, improved service quality and effective team working, and on the basis that service users are central to management and delivery of service in line with the implementation of *A Vision for Change*.
HSE Nursing and Midwifery Planning and Development Unit (HSE South) and National Suicide Research Foundation	2006	Accident and Emergency Nursing Assessment of Deliberate Self-harm.	Guidelines for the assessment of self-harm in Accident and Emergency nursing.
Health Service Executive, Galway	2012	Suicide Prevention in the Community: A practical guide.	HSE draft standards and guidelines for community organisations on responding to suicide.

continued

Health Service Executive, Console and the National Bereavement Support Service	2014	National Quality Standards for the Provision of Suicide Bereavement Services: A Practical Resource	The National Quality Standards cover four levels: information, support, counselling and psychotherapy services, and provide guidance at each level.
Health Service Executive	2009	LGBT Health – towards meeting the healthcare needs of lesbian, gay, bisexual and transgender people	Reviews literature and policy to show the high incidence of suicide risk amongst the LGBT population – recommendations include a national LGBT Health Strategy and a continued focus to suicide prevention under NOSP funding, for community organisations such as BeLongTo.
Health Service Executive National Women's Council of Ireland	2012	Equal but Different – A framework for integrating gender equality in Health Service Executive policy, planning and service delivery	An integrated framework for the provision of gender-sensitive health services set within the broader social determinants of health. It contains guidelines and recommendations for gender impact assessment, training, policy making and service provision.
Health Service Executive	2010	Health Inequalities Framework	This framework addresses health inequalities across a range of population groups and recommends actions to address inequalities through the social determinants of health.
Health Service Executive	2008	National Intercultural Health Strategy 2008-2012	National strategy covering all minority ethnic groups (including Travellers and refugees/asylum seekers) with recommendations for implementation of inter-sectoral collaboration, awareness and tools to promote inter-culturalism and anti-racism, community participation, partnership working and learning and support for staff.

continued

Health Service Executive and Family Resources Centres	2012	Suicide Prevention Code of Practice for Family Resources Centres	Guidelines and best practice for Family Resource Centres in addressing suicide prevention (developed by HSE (Galway, Mayo and Roscommon) and 13 Family Resource Centres from Mayo and Galway).
National Office for Suicide Prevention			
Health Service Executive National Suicide Review Group and Department of Health and Children	2005	*Reach Out:* National Strategy for Action on Suicide Prevention	National cross-departmental strategy on suicide prevention.
National Office for Suicide Prevention	2012	National Guidelines for the Assessment and Management of Patients Presenting to Irish Emergency Departments following self-harm	Guidelines for assessment and management of people who self-harm for staff working in Emergency Departments.
National Office for Suicide Prevention	2009	You Are Not Alone: Help and advice on coping with the death of someone close.	Practical resources, advice and information for people bereaved.
Education			
Department of Education and Skills (National Educational Psychological Service)	2014	Student Support Teams in Post-Primary Schools: A Guide to Establishing a Team or Reviewing an Existing Team	Guidance on establishing or reviewing student support teams in post-primary schools, for all students and students with additional support needs.

continued

Department of Education and Skills (National Educational Psychological Service)	2013	Wellbeing in Post-Primary Schools: Guidelines for Mental Health Promotion and Suicide Prevention	Guidance on providing support for students on mental health and wellbeing. Provides a framework for a) School support for ALL providing a whole-school approach to mental health and suicide prevention b) School support for some by focusing on early identification of young people or groups who are at risk and c) School support for a few by providing support young people with more complex needs related to mental and emotional wellbeing. The guidelines cover good practice approaches and health promotion activities that can contribute to suicide prevention.
Department of Education and Skills	2013	Action Plan on Bullying – report of the anti-bullying working group to the Minister for Education and Skills	Actions to promote anti-bullying policies and practices in schools, with a particular emphasis on homophobic bullying. Actions cover: a positive school culture and climate; school-wide approach; effective leadership; a shared understanding of what bullying is and its impact; anti-bullying policies; recording of reported bullying behaviour; education and training; prevention awareness-raising; and evidence-based intervention strategies. This led to specific Bullying Procedures for Primary and Post-primary Schools (Circular 045/2013).
Department of Education and Skills	2005	Delivering Equality of Opportunity in Schools (DEIS): The Action Plan for Educational Inclusion in Schools	The action plan promotes educational inclusion in schools with a focus on literacy and numeracy from an early stage; strong links between the home, school and community; strong links between schools working co-operatively; and added value from links between education and other services. Specific actions are included on early school leaving and tackling educational disadvantage.

continued

Children and Youth Affairs			
Department of Children and Youth Affairs	2014	Better Outcomes, Brighter Futures: The National Policy Framework for Children and Young People 2014-2020 See briefing note on the policy here.	National framework for the development and implementation of policy and services for children and young people. It highlights specific concerns about the increase in youth suicide and self-harm. As a cross-departmental strategy it brings together all government departments, agencies, statutory services and the voluntary and community sectors. Specific outcomes identified for children and young people include: active and healthy, with positive physical and mental wellbeing; achieving their full potential in all areas of learning and development; safe and protected from harm; economic security and opportunity; connected, respected and contributing to their world.
Department of Children and Youth Affairs	2011	Children First: National Guidance for the Protection and Welfare of Children	Promotes national guidelines for the protection and welfare of children, with a specific focus on the role of the Child and Family Support Agency in relation to family support and child protection services. It includes an implementation programme, training and audit of compliance and impact to ensure national application of best practice. See also: Children First Sectoral Implementation Plan.
Department of Children and Youth Affairs	2015-2020	National Youth Strategy 2015-2020	The aim of the National Youth Strategy is to enable all young people to realise their maximum potential, by respecting their rights and hearing their voices, while protecting and supporting them as they transition from childhood to adulthood.
Social Protection			
Department of Social Protection	2007	National Action Plan for Social Inclusion 2007-2016	Wide ranging strategy to reduce social exclusion, with specific goals focused on ensuring children reach their potential; reducing homelessness; supporting working age people and people with

continued

Social Protection *(continued)*			
			disabilities to increase employment and participation; supports to enable older people to maintain a comfortable and high-quality standard of living; and building viable and sustainable communities, improving the lives of people living in disadvantaged areas and building social capital.
Department of Social Protection	undated	Guidance and Support for Staff Dealing with Distressed Customers or Suicide Threats In the Workplace	The document provides staff with guidance and practical steps to deal with an individual who is distressed and/or expressing suicidal thoughts; includes a reporting template.
Justice and Equality			
COSC/ Department of Justice and Equality	2010	National Strategy on Domestic, Sexual and Gender-based Violence	The Strategy is based on a model of primary intervention (prevention, recognising and understanding), secondary intervention (reporting, responding, referring) and policy outcome oversight. The objective is to promote sustainable interventions to prevent and effectively respond to domestic, sexual and gender-based violence.
Irish Prison Service	2012	Irish Prison Service Strategic Plan 2012-2015	The Strategic Plan gives a strong focus to mental health and support services for prisoners with mental health problems. No specific mention is made of suicide prevention or policy in this regard, although the focus given to mental health through the Psychology Service (Care and Rehabilitation Directorate of the Irish Prison Service) is relevant to prevention.
Foreign Affairs and Trade			
Department of Foreign Affairs and Trade	2015	Global Irish: Ireland's Diaspora Policy	This is the first clear statement of Government of Ireland policy on the diaspora which recognises that Ireland has a unique and important relationship with its diaspora that must be nurtured and developed.

continued

Other (statutory)			
Irish Water Safety	undated	Policy and Strategic Plan on Suicide Prevention	Strategy on suicide prevention linked to strategic priorities of Irish Water Safety.
Other (non-statutory)			
Irish Medical Organisation	2009	Position Statement on Suicide Prevention	The statement gives a specific focus to young males and suicide, alcohol misuse and suicide, role of suicide prevention strategies, treatment approaches, awareness and education. Recommendations are made regarding a general population approach, targeted approach, responding to suicide and information and research.
Irish Association of Suicidology/ Samaritans	2013	Media Guidelines for Reporting Suicide	The guidelines provide information and data about suicide in Ireland, address media myths about suicide, copycat suicide and social contagion, murder suicide, and how the media can help with reporting tips. The guidelines also cover: role of new media, working with bereaved individuals, families and communities.
National Youth Council of Ireland	2009	Health Position Paper	The paper has a specific focus on suicide and mental health of young people, with recommendations and guidelines for youth services.
Console/ Irish Hospice Foundation	2012	Breaking the Silence in the Workplace	Resources and guidelines for workplaces and employers on responding to suicide in the workplace.
European Child Safety Alliance	2014	National Action to Address Child Intentional Injury 2014 – Report of the European Child Safety Alliance	The Report examines the policy measures in place to address intentional injury to children in over 25 Member States, and is currently being considered in the Department of Health.

Appendix 5: Membership of advisory groups

Membership of the six advisory groups was as follows:

Strategy Planning and Oversight group

Group Member	Organisation
Kieran Ryan (Chair)	Irish College of General Practitioners
Prof Ella Arensman (Vice Chair of Research Group)	National Suicide Research Foundation
Dr Tony Bates	Headstrong
Kirsten Connolly (Chair of Communications Group)	HSE Communications
Colm Desmond (Chair of Policy Group)	Department of Health
Fergal Fox	HSE Health and Wellbeing Division
Patricia Gilheaney (Chair of Practice Group)	CEO Mental Health Commission
Cate Hartigan	HSE Health and Wellbeing Division
Hugh Kane (Chair of Engagement Group)	GENIO
Susan Kenny (Strategy Development Lead)	HSE NOSP
Prof Kevin Malone	Irish College of Psychiatry
Patrick McGowan	HSE Service-Family Member and Carer Engagement
Owen Metcalfe (Chair of Research Group)	Institute Public Health
Stephen Mulvany	HSE Mental Health Division
Brian Murphy	HSE Primary Care Division
Kate O'Flaherty	Department of Health
Gerry Raleigh (Director NOSP)	HSE NOSP
Martin Rogan[1]	HSE Mental Health Division
Dr Matthew Sadlier	HSE Mental Health Division
Sandra Walsh	Department of Health
Dr Margo Wrigley	HSE National Clinical Lead Mental Health Services

[1] Martin Rogan retired in August 2014

Writing group members

Susan Kenny (Chair)	HSE NOSP
Hugh Duane	HSE NOSP
Anna Lally	HSE NOSP
Martin Rogan	HSE Mental Health Division
Eileen Williamson	NSRF
Rachel Wright	Samaritans

Engagement group members

Hugh Kane (Chair)	GENIO
Lise Alford	3Ts
Margaret Casey	Living Links
Kahlil Coyle	HSE NOSP
Ray Darcy	Today FM
Pearse Finegan	Irish College of General Practitioners
Paula Forrest	HSE NOSP
Elaine Geraghty	ReachOut.com
Orla Howard	GLEN / HSE NOSP
Susan Kenny	HSE NOSP
Roisin Lowry	HSE Health and Wellbeing Directorate
Shari McDaid	Mental Health Reform
Patrick McGowan	HSE Service-Family Member and Carer Engagement
Caroline McGuigan	Suicide or Survive
Carol Anne Milton	Living Links
Anne O'Donnell	Department of Children and Youth Affairs
Colin Regan	GAA
Sandra Walsh	Department of Health

Policy group members

Colm Desmond (Chair)	Department of Health
Odhran Allen	GLEN
Orla Barry	Mental Health Ireland
Brid Casey	HSE NOSP
Derek Chambers	ReachOut.com
Suzanne Costello	Alcohol Action Ireland
Margaret Grogan	Department of Education and Skills
Jacinta Hastings	Bodywhys
Susan Kenny	HSE NOSP
Anne O'Donnell	Department of Children and Youth Affairs
Ronan Toomey	Department of Health
Sandra Walsh	Department of Health
Rachel Wright	Samaritans

Practice group members

Patricia Gilheaney (Chair)	Mental Health Commission
Ciaran Austin	Console
Kieran Brady	Pieta House
Margaret Brennan	HSE Quality and Patient Safety in Mental Health Directorate
Catherine Brogan	Samaritans
Dr Justin Brophy	HSE Mental Health Services
Michael Byrne	HSE Psychology
Bernie Carroll	HSE NOSP
Aisling Culhane	Psychiatric Nurses Association
Eithne Cusack	HSE Office of the Nursing and Midwifery Services
Dr Brendan Doody	HSE Mental Health Services
Joseph Duffy	Headstrong
Cathal Kearney	The Family Centre
Susan Kenny	HSE NOSP
Paula Lawlor	Suicide or Survive
Derek McDonnell	South County Dublin Partnership
Fenella Murphy	ReachOut.com
Anne Sheridan	HSE Health and Wellbeing Directorate

Communications group members

Kirsten Connolly (Chair)	HSE Communications
Paul Bailey	Department of Health
Jim Breen	Cycle Against Suicide
Mary Cannon	Irish Association of Suicidology
David Carroll	BeLonG To
Dr John Connolly	Irish Association of Suicidology
Kahlil Coyle	HSE NOSP
Elaine Geraghty	ReachOut.com
Dr Claire Hayes	Aware
Seamus Hempenstall	Department of Health
Susan Kenny	HSE NOSP
Denise Keogh	Department of Health
Anna Lally	HSE NOSP
Sorcha Lowry	See Change
Michelle Merrigan	HSE Communications
Angie O'Brien	HSE
Garreth Phelan	HSE Health and Wellbeing Directorate
Ian Power	SpunOut.ie
Margie Roe	ISPCC
Collette Ryan	Rehab
Enda Saul	HSE Communications
Eileen Williamson	National Suicide Research Foundation
Rachel Wright	Samaritans

Research group members

Owen Metcalfe (Chair)	Institute of Public Health
Prof Ella Arensman	National Suicide Research Foundation
Dr Daniel Flynn	HSE
Dr Claire Hayes	Aware
Susan Kenny	HSE NOSP
Dr Teresa Maguire	Health Research Board
Declan McKeown	HSE
Prof Siobhan O'Neill	Queen's University, Belfast
Dr Noel Richardson	HSE
Dr Paul Surgenor	Pieta House

Appendix 6: Protective and risk factors for suicide

(Adapted from the World Health Organisation's Preventing Suicide, A Global Imperative (19))

Health system and societal risk factors

Barriers to accessing health care

Suicide risk increases significantly with comorbidity, so timely and effective access to health care is essential to reducing the risk of suicide (80). However, health systems in many countries are complex or limited in resources; navigating these systems is a challenge for people with low health literacy in general and low mental literacy in particular (81). Stigma associated with seeking help for suicide attempts and mental health problems further compounds the difficulty, leading to inappropriate access to care and to higher suicide risk.

Access to means

Access to the means of suicide is a major risk factor for suicide. Direct access or proximity to means (including pesticides, firearms, heights, railway tracks, poisons, medications, sources of carbon monoxide such as car exhausts or charcoal, and other hypoxic and poisonous gases) increases the risk of suicide. The availability of and preference for specific means of suicide also depend on geographical and cultural contexts (82).

Inappropriate media reporting and social media use

Inappropriate media reporting practices can sensationalise and glamourise suicide and increase the risk of "copycat" suicides (imitation of suicides) among vulnerable people. Media practices are inappropriate when they gratuitously cover celebrity suicides, report unusual methods of suicide or suicide clusters, show pictures or information about the method used, or normalise suicide as an acceptable response to crisis or adversity.

Exposure to models of suicide has been shown to increase the risk of suicidal behaviour in vulnerable individuals (83-85). There are increasing concerns about the supplementary role that the internet and social media are playing in suicide communications. The internet is now a leading source of information about suicide and contains readily accessible sites that can be inappropriate in their portrayal of suicide (86). Internet sites and social media have been implicated in both inciting and facilitating suicidal behaviour. Private individuals can also readily broadcast uncensored suicidal acts and information, which can be easily accessed through both media.

Stigma associated with help-seeking behaviour

Stigma against seeking help for suicidal behaviours, mental health problems, substance abuse or other emotional stressors continues to exist in many societies and can be a substantial barrier to people receiving help that they need. Stigma can also discourage the friends and families of vulnerable people from providing them with the support they might need or even from acknowledging their situation. Stigma plays a key role in the resistance to change and to the implementation of suicide prevention responses.

Community and relationship risk factors

The communities that people live in have an important association with suicide risk factors. Worldwide, different cultural, religious, legal and historical factors have shaped the status and understanding of suicide, leading to the identification of a wide range of community factors that influence suicide risk. A person's immediate relationships with family, close friends and significant others can also have an impact on suicidal behaviour. Some of the key factors related to these areas are described below.

Disaster, war and conflict

Experiences of natural disaster, war and civil conflict can increase the risk of suicide because of the destructive impacts they have on social wellbeing, health, housing, employment and financial security. Paradoxically, suicide rates may decline during and immediately after a disaster or conflict, but this varies between different groups of people. The immediate decline may be due to the emergent needs for intensified social cohesion. Overall, there seems to be no clear direction in suicide mortality following natural disasters, as different studies show different patterns (87).

Stresses of acculturation and dislocation

The stresses of acculturation and dislocation represent a significant suicide risk that has an impact on a number of vulnerable groups, including indigenous peoples, asylum-seekers, refugees, persons in detention centres, internally displaced people, and newly arrived migrants.

Suicide is prevalent among indigenous peoples: native American Indians in the USA, First Nations and Inuits in Canada, Australian aboriginals, and aboriginal Maori in New Zealand all have rates of suicide that are much higher than those of the rest of the population (88, 89). This is especially true for young people, and young males in particular, who constitute some of the most vulnerable groups in the world (90). Suicidal behaviour is also increased among native and aboriginal communities undergoing transition (91). Among indigenous groups, territorial, political and economic autonomy are often infringed and native culture and language negated. These circumstances can generate feelings of depression, isolation and discrimination, accompanied by resentment and mistrust of state-affiliated social and healthcare services, especially if these services are not delivered in culturally appropriate ways.

Discrimination

Discrimination against subgroups within the population may be ongoing, endemic and systemic. This can lead to the continued experience of stressful life events such as loss of freedom, rejection, stigmatisation and violence that may evoke suicidal behaviour.

Some examples of linkages between discrimination and suicide include:

- People who are imprisoned or detained (92)
- People who identify themselves as lesbian, gay, bisexual, transgender and intersex (93)
- People who are affected by bullying, cyberbullying and peer victimization (94)
- Refugees, asylum-seekers and migrants (95)

Trauma or abuse

Trauma or abuse increases emotional stresses and may trigger depression and suicidal behaviour in people who are already vulnerable. Psychological stressors associated with suicide can arise from different types of trauma (including torture, particularly in asylum-seekers and refugees), disciplinary or legal crises, financial problems, academic or work-related problems, and bullying (96). In addition, young people who have experienced childhood and family adversity (physical violence, sexual or emotional abuse, neglect, maltreatment, family violence, parental separation or divorce, institutional or welfare care) have a much higher risk of suicide than others (97). The effects of adverse childhood factors tend to be interrelated and correlated, and act cumulatively to increase risks of mental health problems and suicide (98).

Sense of isolation and lack of social support

Isolation occurs when a person feels disconnected from his or her closest social circle: partners, family members, peers, friends and significant others. Isolation is often coupled with depression and feelings of loneliness and despair. A sense of isolation can often occur when a person has a negative life event or other psychological stress and fails to share this with someone else. Compounded with other factors, this can lead to an increase in risk for suicidal behaviour – particularly for older persons living alone, since social isolation and loneliness are important contributing factors for suicide (91).

Suicidal behaviour often occurs as a response to personal psychological stress in a social context where sources of support are lacking, and may reflect a wider absence of wellbeing and cohesion. Social cohesion is the fabric that binds people at multiple levels in a society – individuals, families, schools, neighbourhoods, local communities, cultural groups and society as a whole. People who share close, personal and enduring relationships and values typically have a sense of purpose, security and connectedness (54, 55).

Relationship conflict, discord or loss

Relationship conflict (e.g. separation), discord (e.g. child custody disputes) or loss (e.g. death of a partner) can cause grief and situational psychological stress, and are all associated with increased risk of suicide (99). Unhealthy relationships can also be a risk factor. Violence, including sexual violence, against women is a common occurrence and is often committed by an intimate partner; intimate partner violence is associated with an increase in suicide attempts and suicide risk. Globally 35% of women have experienced physical and/or sexual violence by an intimate partner or sexual violence by a non-partner (100, 101).

Individual risk factors

Risk of suicide can be influenced by individual vulnerability or resilience. Individual risk factors relate to the likelihood of a person developing suicidal behaviour.

Previous suicide attempt

By far the strongest indicator for future suicide risk is one or more prior suicide attempts (102). Even one year after a suicide attempt, risk of suicide and premature death from other causes remains high (103).

Mental health problems

In high-income countries, mental health problems are present in up to 90% of people who die by suicide (12), and among the 10% without clear diagnoses, psychiatric symptoms resemble those of people who die by suicide. However, mental health problems seem to be less prevalent (around 60%) among those who die by suicide in some Asian countries, as shown in studies from China and India (104, 105).

The risk factor should be approached with some caution. Depression, substance use disorders and antisocial behaviours are relatively common and most people suffering from them will not display suicidal behaviour. However, people dying by suicide or making suicide attempts may have a significant psychiatric comorbidity. Suicide risk varies with the type of disorder, and the most common disorders associated with suicidal behaviour are depression and alcohol use disorders. The lifetime risk of suicide is estimated to be 4% in patients with mood disorders (14), 6% in people with eating disorders (106), 7% in people with alcohol dependence (17). 8% in people with bipolar disorder (107, 108) and 5% in people with schizophrenia (109). Importantly, the risk of suicidal behaviour increases with comorbidity; individuals with more than one mental health problem have significantly higher risks (12).

Harmful use of alcohol and other substances

All substance use disorders increase the risk of suicide (110). Alcohol and other substances use disorders are found in 25 – 50% of all suicides (17), and suicide risk is further increased if alcohol or substance use is comorbid with other psychiatric disorders. Of all deaths from suicide, 22% can be attributed to the use of alcohol, which means that every fifth suicide would not occur if alcohol were not consumed in the population (111). Dependence on other substances, including cannabis, heroin or nicotine, is also a risk factor for suicide (112).

Job or financial loss

Losing a job, home foreclosure and financial uncertainty lead to an increase in the risk of suicide through comorbidity with other risk factors such as depression, anxiety, violence and the harmful use of alcohol (67). Consequently economic recessions, as they relate to cases of individual adversity through job or financial loss, can be associated with individual suicide risk (113).

Hopelessness

Hopelessness, as a cognitive aspect of psychological functioning, has often been used as an indicator of suicidal risk when coupled with mental health problem or prior suicide attempts (114). The three major aspects of hopelessness relate to a person's feelings about the future, loss of motivation and expectations. Hopelessness can often be understood by the presence of thoughts such as "things will never get better" and "I do not see things improving", and in most cases is accompanied by depression (115).

Chronic pain and illness

Chronic pain and illness are important risk factors for suicidal behaviour. Suicidal behaviour has been found to be 2-3 times higher in those with chronic pain compared to the general population (116). All illnesses that are associated with pain, physical disability, neurodevelopment impairment and distress increase the risk of suicide (117). These include cancer, diabetes and HIV/AIDS.

Family history of suicide

Suicide by a family or community member can be a particularly disruptive influence on a person's life. Losing someone close to you is devastating for most people; in addition to grief, the nature of the death can cause stress, guilt, shame, anger, anxiety and distress to family members and loved ones. Family dynamics may change, usual sources of support may be disrupted, and stigma can hinder help-seeking and inhibit others from offering support (118). Suicide of a family member or loved one may lower the threshold of suicide for someone grieving (119). For all these reasons, those who are affected or bereaved by suicide have themselves an increased risk of suicide or mental health problem (120).

Genetic and biological factors

Genetic or developmental alterations in a number of neurobiological systems are associated with suicidal behaviour. For instance, low levels of serotonin are associated with serious suicide attempts in patients with mood disorders, schizophrenia and personality disorders. A family history of suicide is a strong risk factor for suicide and suicide attempt (121).

It is important to note that the risk factors listed are far from exhaustive. Many others exist that may be classified and categorised differently. Risk factors can contribute to suicidal behaviours directly but can also contribute indirectly by influencing individual susceptibility to mental health problems.

What protects people from the risks of suicide?

In contrast to risk factors, protective factors guard people against the risk of suicide. While many interventions are geared towards the reduction of risk factors in suicide prevention, it is equally important to consider and strengthen factors that have been shown to increase resilience and connectedness and that protect against suicidal behaviour. Resilience has a buffering effect on suicide risk; for persons who are highly resilient the association between the risk of suicide and suicidal behaviour is diminished (122). Some protective factors counter specific risk factors while others protect individuals against a number of different suicide risk factors.

The main protective factors for suicide are highlighted in Section 3 of *Connecting for Life*.

Appendix 7: Engagement that took place as part of the strategy process

In 2014, the DOH and HSE undertook a public consultation to ensure that everyone in Ireland had the opportunity to share their views and recommendations for *Connecting for Life*. The engagement process aimed to encourage widespread participation from the public and from stakeholders, professional bodies, Government Departments and statutory organisations working in this area. The process included public call for submissions, targeted engagement with stakeholders, review of public submissions and focus groups. It also involved consideration of learnings from earlier public consultations.

Public call for submissions

- An "Open Call" notice appeared in the daily and Sunday national newspapers. The notice called for submissions from any member of the public or organisation interested in contributing to the strategy.
- Publicity around the call was supported by a PR and social media campaign.
- The submission notice was broadcast by email to the HSE staff database, with 45,000 recipients.
- 120 submissions were received from members of the general public and 34 submissions from HSE staff.

Targeted engagement with stakeholders

- Stakeholder organisations and professional bodies, with an interest in suicide prevention and mental health, were contacted directly about the engagement process.
- The public call for submissions was shared through the NGO digital newsletter, Activelink, which has 13,000 subscribers.
- The submission call was also publicised widely on the NOSP and stakeholders' websites.
- This activity generated submissions from 118 organisations and professional bodies.

Review of the public submissions

- Members of the Engagement Advisory Group along with the NOSP staff read each submission. The data was categorised into 12 key themes.
- The NOSP invited personnel from the stakeholder organisations and members from the advisory groups for the Strategy to participate in a day-long stakeholder workshop aimed at reviewing the key points and themes emerging from the submissions.
- Participants developed a potential set of objectives and outcomes that would inform the Strategy from the submissions.

Focus groups

- In order to ensure that all stakeholders were comprehensively consulted, the Engagement group analysed the submissions and recommended that a small number of focus groups be held as an additional step to the engagement process.
- The target groups for these focus groups were people who had attempted suicide and their families, along with GPs. Three focus group sessions were held and the feedback from each group was documented and added to the engagement material informing the Advisory Groups and Writing Group.

Learning from earlier public consultations

- The NOSP collated learnings from a number of other consultation processes relevant to the development of the strategy.
- This included learning from:
  - 'Tell Us What you Think' Workshops
  - Recommendations from the 2012 NOSP Forum
  - Dáil na n'Óg Young People's Input on Mental Health
  - The Donegal Suicide Prevention Action Plan 2014.

Informing the strategy

The public consultation revealed a wealth of interest and experience, both personal and academic, amongst members of the public and stakeholders working in the area of mental health. It gave an extensive number of people in Ireland the opportunity to have their say in the formation of *Connecting for Life*, with the media advertisements reaching 62% of all adults in Ireland.

The engagement process received 272 submissions from individuals and organisations. This included submissions from members of the general public (including service and families of service users); professional bodies; community interest groups and organisations. These submissions helped to inform the development of *Connecting for Life*.

The following organisations contributed to the strategy development engagement process:

Organisations who contributed to the planning process	
3Ts	Galway Diocesan Youth Service
Acquired Brain Injury Ireland	Galway Mayo Institute of Technology
Alcohol Action Ireland	Gay and Lesbian Equality Network
All Hallows College	Graffiti Theatre Company
Aware	Greenwich and Bexley Community Hospice, London
Ballaghaderreen Mental Health Association	GROW
Ballinasloe Day Hospital	Headstrong
Ballyfermot/Chapelizod Partnership Local Employment Service	Health Research Board
BeLonG To	Hope House Addiction Treatment Centre
Be Well	Inform Psychological Services
Bodywhys	Institute of Guidance Counsellors
Bray Area Partnership	Insight Counselling
Bully Prevention Network Midlands	Institute of Technology, Carlow
Castlebar Counselling and Therapy Centre	Irish Association of Creative Arts Therapists
Church of the Immaculate Conception, Clonakilty, Co. Cork	Irish Association of Relationship Mentors
Clondalkin Travellers Development Group	Irish Association of Suicidology
College of Psychiatrists of Ireland	Irish College of General Practitioners
Console	Irish Creamery and Milk Suppliers Association
Cork Counselling Services	Irish Farmers Association
Crisis Pregnancy Programme	Irish Institute of Naturopathic Medicine
D10 Be Well Forum	Irish Medical Organisation
Day by Day support services OLAGOLA	Irish Rural Link
DEPAUL Ireland	Irish Society for the Prevention of Cruelty to Children
Donal Walsh #LiveLife Foundation	Irish Water Safety
Dual Diagnosis Ireland	Johnstown Therapy Centre
EMT Carlow/Kilkenny Mental Health Services	Limerick Institute of Technology
Exchange House	Louth Child and Adolescence Mental Health Service Team
Family Centre, Castlebar	Mayo Dialectical Behavior Therapy Service
Family Therapy Association	Meath Primary Healthcare Project for Travellers
Foróige	Men's Health Forum in Ireland
Gaelic Athletic Association	

continued

Organisations who contributed to the planning process *(continued)*

Men's Human Rights Ireland
Men's Sheds Association of Ireland
Mental Health Ireland
Mental Health Reform
Mind Your Mind
Mojo programme – South Dublin County Partnership
Mymind
National Centre for Guidance in Education
National Social Inclusion Office
National Suicide Research Foundation
National University of Ireland, Galway
National Youth Council of Ireland
NINA for Life Suicide Awareness
Nurture
O'Shea's Funeral Home Ltd
Pavee Point
Pieta House
Positive Mental Health
Positive Performance Consulting
Preparing For Life North Side Partnership
Psychiatric Nurses Association
Public Health Agency
Raidió Teilifís Éireann
ReachOut.com
Rehab Group
Roscommon LEADER Partnership
Samaritans
Save our Sons and Daughters
Shine Online
Shine, Headline, See Change
Simon Communities of Ireland
SouthWest Counselling Service
SpunOut.ie
St Canices Church, Finglas
St Patrick's Mental Health Service
St Vincent's University Hospital
Suicide and Survivors of Clerical Sexual Abuse
Suicide or Survive
Tabor Lodge, Cork
The Gaiety School of Acting
The Men's Development Network
Today FM
Touched by Suicide Group
Transgender Equality Network Ireland
Traveller Counselling Service
Trinity College Dublin
Tuam Family Services
Turn 2 Me
Union of Students in Ireland
University College Dublin
University of Limerick
Uturn/Anti-suicide, Wexford
Westport Family Resource Centre
Wicklow Primary Health Care Project
Young Social Innovators
Youth Work Ireland
Youthreach, Knocknaheeny, Cork

Appendix 8: Government commitments

The tables to follow set out commitments by government departments and agencies, with specification of role as one of:

- Lead agency
- Supporting partner, or
- Contributing to action

The tables also include a specification action number to which each commitment links.

HSE Health and Wellbeing – Commitments List	Role	Action
Develop and implement a national mental health and wellbeing promotion plan.	Lead	1.1.2
Deliver co-ordinated social marketing campaigns (such as LittleThings, 2014) for the promotion of good mental health and wellbeing among the whole population with a focus on protective health behaviours and consistent sign-posting to relevant support services.	Supporting partner	1.1.3
Build the link between alcohol/drug misuse and suicidal behaviour into all communication campaigns.	Supporting partner	1.1.4
Implement uniform, multi-agency suicide prevention action plans and align them with HSE Community Health Organisations and Local Economic and Community Plans and Children & Young People's Services Committee's (CYPSC) county plans.	Supporting partner	2.1.1
Deliver a range of mental health promoting programmes in community, health and education settings aimed at improving the mental health of the whole population and priority groups.	Lead	2.3.3
Continue the development of mental health promotion programmes with and for priority groups, including the youth sector.	Lead	3.1.6
Continue the roll-out of programmes aimed at early intervention and prevention of alcohol and drug misuse in conjunction with HSE Primary Care.	Supporting partner	3.2.1
Support the implementation of the relevant guidelines for mental health promotion and suicide prevention across primary and post primary schools, and the development of guidelines for Centres of Education.	Supporting partner	3.3.1
Guide and encourage the implementation of the relevant policies and plans in schools, including support for development of Student Support Teams and for the management of critical incidents.	Supporting partner	3.3.2

continued

HSE Health and Wellbeing – Commitments List	Role	Action
Implement the National Anti-bullying Action Plan including online and homophobic bullying.	Supporting partner	3.3.4
Support all schools to implement a new Wellbeing programme, which will encompass SPHE, CSPE and PE, in Junior Cycle; and encourage schools to deliver an SPHE programme (including RSE and mental health awareness) at Senior Cycle.	Supporting partner	3.3.5
Continue to promote a whole-school approach to student guidance/counselling within each post primary school.	Supporting partner	5.1.2
Provide support and resources for the implementation of the Department's curriculum and programmes in the promotion of wellbeing in the school community. Facilitate access to appropriate mental health and suicide prevention training for teachers, e.g. through summer courses and the Education Centre network. In this regard, the support services will work collaboratively and liaise, as appropriate, with Government agencies.	Supporting partner	5.1.3

HSE NOSP – Commitments List	Role	Action
Measure how people currently understand suicidal behaviour, mental health and wellbeing and set targets for improved understanding.	Lead	1.1.1
Develop and implement a national mental health and wellbeing promotion plan.	Supporting partner	1.1.2
Deliver co-ordinated communication campaigns (such as LittleThings, 2014) for the promotion of mental health and wellbeing among the whole population with a focus on protective health behaviours and consistent signposting to relevant support services.	Supporting partner	1.1.3
Build the link between alcohol/drug misuse and suicidal behaviour into all communication campaigns.	Supporting partner	1.1.4
Deliver accessible information on all mental health services and access/referral mechanisms – make available online, including at YourMentalHealth.ie	Supporting partner	1.2.1
Deliver targeted campaigns to improve awareness of appropriate support services to priority groups.	Supporting partner	1.2.2
Deliver campaigns that reduce stigma towards mental health problems and suicidal behaviour in the whole population and self-stigma among priority groups.	Lead	1.3.1
Engage with online platforms to encourage best practice in reporting around suicidal behaviour, so as to encourage a safer online environment in this area.	Supporting partner	1.4.1

continued

HSE NOSP Commitments List	Role	Action
Monitor media reporting of suicide, and engage with the media in relation to adherence to guidelines on media reporting.	Lead	1.4.4
Implement consistent, multi-agency suicide prevention action plans to enhance communities' capacity to respond to suicidal behaviours, emerging suicide clusters and murder suicide. The plans will be the responsibility of HSE Community Health Organisations and aligned with Local Economic and Community Plans and Children and Young People's Services Committee's (CYPSC) county plans.	Supporting partner	2.1.1
Provide community-based organisations with guidelines, protocols and training on effective suicide prevention.	Lead	2.2.1
Develop National Training and Education Plans, building on the Strategic Review of Training completed by HSE NOSP in 2014.	Lead	2.3.1
Deliver training and awareness programmes in line with the National Training Plan, prioritising professionals and volunteers across community-based organisations, particularly those who come into regular contact with people who are vulnerable to suicide.	Lead	2.3.2
Integrate suicide prevention into the development of relevant national policies, plans and programmes relevant to people who are at an increased risk of suicide or self-harm.	Supporting partner	3.1.1
Develop and implement a range of agency protocols and inter-agency protocols (including protocols for sharing information) to assist organisations to work collaboratively in relation to suicide prevention and the management of critical incidents.	Lead	3.1.2
Develop and deliver targeted initiatives and services at primary care level for priority groups.	Supporting partner	3.1.3
Evaluate as appropriate targeted initiatives and/or services for priority groups.	Lead	3.1.4
Provide and sustain training to health and social care professionals, including frontline mental health service staff. This training will improve recognition of, and response to, suicide risk and suicidal behaviour among people vulnerable to suicide.	Lead	3.1.5
Continue the development of mental health promotion programmes with and for priority groups, including the youth sector.	Supporting partner	3.1.6

continued

HSE NOSP Commitments List *(continued)*	Role	Action
Support the implementation of the relevant guidelines for mental health promotion and suicide prevention across primary and post primary schools, and the development of guidelines for Centres of Education.	Supporting partner	3.3.1
Guide and encourage the implementation of the relevant policies and plans in schools, including support for development of Student Support Teams and for the management of critical incidents.	Supporting partner	3.3.2
Work with the HSE to develop national guidance for higher education institutions in relation to suicide-risk and critical-incident response, thereby helping to address any gaps which may exist in the prevention of suicide in higher education.	Supporting partner	3.3.3
Implement the National Anti-bullying Action Plan including online and homophobic bullying.	Supporting partner	3.3.4
Deliver accessible, uniform, evidence based psychological interventions, including counselling for mental health problems at both primary and secondary care levels.	Supporting partner	4.2.1
Commission and evaluate bereavement support services.	Lead	4.3.2
Develop quality standards for suicide prevention services provided by statutory and non-statutory organisations, and implement the standards through an appropriate structure.	Lead	5.1.1
Continue to promote a whole-school approach to student guidance/counselling within each post-primary school.	Supporting partner	5.1.2
Disseminate information on effective suicide prevention responses through the development and promotion of repositories of evidence-based tools, resources, guidelines and protocols.	Lead	5.1.5
Develop a National Training Plan, building on the NOSP Review of Training.	Lead	5.4.1
Deliver training in suicide prevention to staff involved in the delivery of relevant services and to staff in government departments and agencies likely to come into contact with people who are vulnerable to/at risk of suicidal behaviour.	Supporting partner	5.4.2
Support the National Clinical Effectiveness Agenda and implement national clinical guidelines, in line with NCEC requirements.	Supporting partner	5.4.5

continued

HSE NOSP Commitments List *(continued)*	Role	Action
Local Authorities will be requested to consider, develop and implement measures where practical to restrict access to identified locations and settings where people are at risk of engaging in suicidal behaviour, and assist generally in reducing risk factors in public locations.	Supporting partner	6.2.1
Conduct proportionate evaluations of all major activities conducted under the aegis of *Connecting for Life*; disseminate findings and share lessons learned with programme practitioners and partners.	Lead	7.1.1
Collect, analyse and disseminate high quality data on suicide and self-harm. and ensure adequate access to, and understanding of the data among those working in suicide prevention across all sectors.	Lead	7.2.3
The Justice and Health sectors will engage with the Coroners, Garda Síochána, NOSP, CSO and research bodies in relation to deaths in custody, and recording of deaths by suicide and open verdicts, to further refine the basis of suicide statistics.	Supporting partner	7.3.1
Support research on risk and protective factors for suicidal behaviour in groups with an increased risk (or potential increased risk) of suicide behaviour (*see Strategic Goal 3*).	Lead	7.4.1
Support the co-ordination and streamlining of research completed by third-level institutions.	Supporting partner	7.4.2
Develop working partnerships with centres of expertise to support evaluation and research, knowledge transfer and implementation support between researchers, policy makers and service providers.	Lead	7.4.3
Evaluate innovate approaches to suicide prevention including online service provision and targeted approaches for appropriate priority groups.	Lead	7.4.4

HSE Mental Health – Commitments List	Role	Action
Develop and implement a national mental health promotion plan.	Supporting partner	1.1.2
Deliver co-ordinated communication campaigns (such as LittleThings, 2014) for the promotion of mental health and wellbeing among the whole population with a focus on protective health behaviours and consistent sign-posting to relevant support services.	Lead	1.1.3
Deliver accessible information on all mental health services and access/referral mechanisms – make available online including at YourMentalHealth.ie.	Lead	1.2.1

continued

HSE Mental Health – Commitments List *(continued)*	Role	Action
Deliver targeted campaigns to improve awareness of appropriate support services to priority groups.	Lead	1.2.2
Deliver campaigns that reduce stigma towards mental problems and suicidal behaviour in the whole population and self-stigma among priority groups.	Supporting partner	1.3.1
Implement consistent, multi-agency suicide prevention action plans to enhance communities' capacity to respond to suicidal behaviours, emerging suicide clusters and murder suicide. The plans will be the responsibility of HSE Community Health Organisations and aligned with Local Economic and Community Plans and Children and Young People's Services Committee's (CYPSC) county plans.	Lead	2.1.1
Deliver a range of mental health promoting programmes in community, health and education settings aimed at improving the mental health of the whole population and priority groups.	Supporting partner	2.3.3
Develop and implement a range of agency and inter-agency protocols (including protocols for sharing information) to assist organisations to work collaboratively in relation to suicide prevention and the management of critical incidents.	Lead	3.1.2
Provide and sustain training to health and social care professionals, including frontline mental health service staff. This training will improve recognition of, and response to, suicide risk and suicidal behaviour among people vulnerable to suicide.	Supporting partner	3.1.5
Continue the development of mental health promotion work with priority groups, including the youth sector.	Supporting partner	3.1.6
Deliver early intervention and psychological support service for young people at primary care level.	Supporting partner	3.3.6
Deliver early intervention and psychological support service for young people at secondary care level; including CAMHS.	Lead	3.3.7
Provide a co-ordinated, uniform and quality-assured 24/7 service for those in emotional distress and deliver pathways of care for all people including those with addiction problems from primary to secondary care mental health services.	Lead	4.1.1
Provide a co-ordinated, uniform and quality assured service and deliver pathways of care for those with co-morbid addiction and mental health difficulties.	Lead	4.1.2

continued

HSE Mental Health – Commitments List *(continued)*	Role	Action
Ensure that those in the criminal justice system have continued access to appropriate information and treatment in prisons and while under Probation Services in the community. The Irish Prison Service and the HSE National Forensic Mental Health Service will complete an agreed memorandum of understanding on improved links through the NFMHS Prison In-reach Service and the Probation Service will engage with the HSE on maintaining and developing access to community psychiatric services.	Supporting partner	4.1.3
Deliver a uniform assessment approach across the mental health services, in accordance with existing and recognised guidelines for people who have self-harmed or are at risk of suicide.	Lead	4.1.4
Deliver a comprehensive approach to managing self-harm presentations through the HSE Clincal Care Programme for the assessment and management of patients presenting with self-harm to emergency departments.	Lead	4.1.5
Deliver accessible, uniform, evidence based psychological interventions including counselling for mental health problems at both primary and secondary care levels.	Lead	4.2.1
Deliver enhanced bereavement support services to families and communities affected by the suicide of those people known to mental health services.	Lead	4.3.1
Develop and deliver a uniform procedure to respond to suicidal behaviour across mental health services.	Lead	5.2.1
Implement a system of service review, based on incidents of suicide and suicidal behaviour, within HSE mental health services and those known to the mental health service and develop responsive practice models.	Lead	5.2.3
Implement the IPS Prisoner Release Policy, to ensure care, treatment and information is provided, including identifying the appropriate mental health services in each area for those leaving prison. This will include appropriate links with the community mental health services.	Supporting partner	5.3.3
Support the National Clinical Effectiveness Agenda and implement national clinical guidelines, in line with NCEC requirements.	Supporting partner	5.4.5
Implement a strategy to improve environmental safety within the HSE Mental Health Services (e.g. ligature audits).	Lead	6.2.2
Collate and report on incidences of suicide through current and expanded health surveillance systems over the life of *Connecting for Life*.	Lead	7.2.2

HSE Primary Care – Commitments List	Role	Action
Build the link between alcohol/drug misuse and suicidal behaviour into all communication campaigns.	Lead	1.1.4
Implement consistent, multi-agency suicide prevention action plans to enhance communities' capacity to respond to suicidal behaviours, emerging suicide clusters and murder suicide. The plans will be the responsibility of HSE Mental Health Division and aligned with HSE Community Health Organisations structure and Local Economic and Community Plans, Children and Young People's Services Committee's (CYPSC) county plans.	Supporting partner	2.1.1
Develop and implement a range of agency protocols and inter-agency protocols (including protocols for sharing information) to assist organisations to work collaboratively in relation to suicide prevention and the management of critical incidents.	Lead	3.1.2
Develop and deliver targeted initiatives and services at primary care level for priority groups.	Lead	3.1.3
Provide and sustain training to health and social care professionals, including frontline mental health service staff and primary care health providers. This training will improve recognition of, and response to, suicide risk and suicidal behaviour among people vulnerable to suicide.	Supporting partner	3.1.5
Continue the roll-out of programmes aimed at early intervention and prevention of alcohol and drug misuse in conjunction with HSE Primary Care.	Lead	3.2.1
Deliver early intervention and psychological support service for young people at primary care level.	Lead	3.3.6
Provide a co-ordinated, uniform and quality assured 24/7 service for those in emotional distress and deliver pathways of care for all people, including those with addiction problems, from primary to secondary mental health services.	Supporting partner	4.1.1
Provide a co-ordinated, uniform and quality assured service and deliver pathways of care for those with co-morbid addiction and mental health difficulties.	Supporting partner	4.1.2
Deliver accessible, uniform, evidence based psychological interventions including counselling for mental health problems at both primary and secondary care levels.	Lead	4.2.1

continued

HSE Primary Care – Commitments List *(continued)*	Role	Action
Commission and evaluate bereavement support services.	Supporting partner	4.3.2
Develop and deliver a uniform procedure to respond to suicidal behaviour across mental health services.	Supporting partner	5.2.1
Implement the IPS Prisoner Release Policy, to ensure care, treatment and information is provided, including identifying the appropriate mental health services in each area for those leaving prison. This will include appropriate links with the community mental health services.	Supporting partner	5.3.3

HSE Acute Hospitals – Commitments List	Role	Action
Implement consistent, multi-agency suicide prevention action plans to enhance communities' capacity to respond to suicidal behaviours, emerging suicide clusters and murder suicide. The plans will be the responsibility of HSE Mental Health Division and aligned with HSE Community Health Organisations structure and Local Economic and Community Plans, Children and Young People's Services Committee's (CYPSC) county plans.	Supporting partner	2.1.1
Develop and implement a range of agency protocols and inter-agency protocols (including protocols for sharing information and protocols in respect of young people) to assist organisations to work collaboratively in relation to suicide prevention and the management of critical incidents.	Lead	3.1.2
Provide and sustain training to health and social care professionals, including frontline Mental Health Service staff and Primary Care Health Providers. This training will improve recognition of, and response to, suicide risk and suicidal behaviour among people vulnerable to suicide.	Supporting partner	3.1.5
Provide a co-ordinated, uniform and quality assured 24/7 service and deliver uniform pathways of care from primary to secondary mental health services for all those in need of specialist mental health services.	Supporting partner	4.1.1
Provide a co-ordinated, uniform and quality assured service and deliver uniform pathways of care for those with co-morbid addiction and mental health difficulties.	Supporting partner	4.1.2
Deliver a uniform assessment approach across the health services, in accordance with existing and recognised guidelines for people who have self-harmed or are at risk of suicide.	Supporting partner	4.1.4

continued

HSE Acute Hospitals – Commitments List *(continued)*	Role	Action
Deliver a comprehensive approach to managing self-harm presentations through the HSE Clincal Care Programme for the assessment and management of patients presenting with self-harm to emergency departments.	Supporting partner	4.1.5
Develop and deliver a uniform procedure to respond to suicidal behaviour across Mental Health Services.	Supporting partner	5.2.1

HSE Estates – Commitments List	Role	Action
Implement a strategy to improve environmental safety within the HSE mental health services (e.g. ligature audits).	Supporting partner	6.2.2

HSE Community Health Organisations (CHOS) – Commitments List	Role	Action
Implement consistent, multi-agency suicide prevention action plans to enhance communities' capacity to respond to suicidal behaviours, emerging suicide clusters and murder suicide. The plans will be the responsibility of HSE Mental Health Division and aligned with HSE Community Health Organisations structure and Local Economic and Community Plans, Children and Young People's Services Committee's (CYPSC) county plans.	Supporting partner	2.1.1
Commission and evaluate bereavement support services.	Supporting partner	4.3.2

Department of Education and Skills – Commitments List	Role	Action
Develop national interagency protocols to assist the interaction of the school community with HSE services and TUSLA in regard to children exhibiting suicidal tendencies and to assist in the management of critical incidents.	Supporting partner	3.1.2
Support the implementation of the relevant guidelines for mental health promotion and suicide prevention across primary and post primary schools, and the development of guidelines for Centres of Education.	Lead	3.3.1
Guide and encourage the implementation of the relevant policies and plans in schools, including support for development of Student Support Teams and for the management of critical incidents.	Lead	3.3.2
Implement the National Anti-bullying Action Plan including online and homophobic bullying.	Lead	3.3.4

continued

Department of Education and Skills – Commitments List *(continued)*	Role	Action
Support all schools to implement a new Wellbeing programme, which will encompass SPHE, CSPE and PE, in Junior Cycle; and encourage schools to deliver an SPHE programme (including RSE and mental health awareness) at Senior Cycle.	Lead	3.3.5
Review SPHE and RSE, Best Practice Guidelines for Primary and Post Primary Schools (circulars 0023/2010 and 0022/2010), which relate to inputs, interventions, and programmes provided by external agents/non-school staff to support implementation of the Social Personal and Health Education curriculum.	Lead	3.3.5
Continue to promote a whole school approach to student guidance/counselling within each post primary school.	Lead	5.1.2
Provide support and resources for the implementation of the Department's curriculum and programmes in the promotion of wellbeing in the school community. Facilitate access to appropriate mental health and suicide prevention training for teachers, e.g. through summer courses and the Education Centre network. In this regard, the support services will work collaboratively and liaise, as appropriate, with Government agencies.	Lead	5.1.3, 5.4.2

Department of Agriculture, Food and the Marine – Commitments List	Role	Action
Integrate suicide prevention into relevant national policies and programmes for people that are at an increased risk of suicide within the agriculture sector.	Lead	3.1.1
Develop, with the assistance of NOSP, protocols for Department of Agriculture and agency staff who may come into contact with people who are vulnerable to/at risk of suicidal behaviour.	Supporting partner	3.1.2
Deliver suicide prevention training to frontline staff who are likely to come into contact with people who are vulnerable to/at risk of suicidal behaviour.	Lead	5.4.2

Department of Health – Commitments List	Role	Action
Measure how people currently understand suicidal behaviour, mental health and wellbeing and set targets for improved understanding.	Supporting partner	1.1.1
Develop and implement a national mental health and wellbeing promotion plan.	Lead	1.1.2

continued

Department of Health – Commitments List *(continued)*	Role	Action
Build the link between alcohol/drug misuse and suicidal behaviour into all communication campaigns.	Supporting partner	1.1.4
Promoting physical activity as a protective factor for mental health through the National Physical Activity Plan.	Lead	1.1.5
Deliver a range of mental health promoting programmes in community, health and education settings aimed at improving the mental health of the whole population and priority groups.	Supporting partner	2.3.3
Integrate suicide prevention into the development of relevant national policies, plans and programmes for people who are at an increased risk of suicide or self-harm.	Lead	3.1.1
Examine information sharing with families for mental health service users in the context of the review of the Mental Health Act.	Supporting partner	3.1.2
Continue the roll out of programmes aimed at early intervention and prevention of alcohol and drug misuse in conjunction with HSE Primary Care.	Supporting partner	3.2.1
Support all schools to implement a new Wellbeing programme, which will encompass SPHE, CSPE and PE, in Junior Cycle; and encourage schools to deliver an SPHE programme (including RSE and mental health awareness) at Senior Cycle.	Supporting partner	3.3.5
Conduct a statutory consultation process and (in the context of wider policy development on the regulation of heath & social care professionals) decide on the feasibility of designating by regulation the profession(s) of counsellor and psychotherapist.	Lead	5.1.4
Deliver training in suicide prevention to staff involved in the delivery of relevant services and to staff in government departments and agencies likely to come into contact with people who are vulnerable to/at risk of suicidal behaviour.	Lead	5.4.2
Support professional regulatory bodies to develop and deliver accredited competency based education on suicide prevention to health professionals.	Lead	5.4.3
Support the National Clinical Effectiveness Agenda and implement national clinical guidelines in line with NCEC requirements.	Lead	5.4.5
Work with professional groups to reduce the inappropriate prescribing of medicines commonly used in intentional overdose, including benzodiazepines and SSRIs.	Lead	6.1.1

continued

Department of Health – Commitments List *(continued)*	Role	Action
Continue improvements in adherence to the legislation limiting access to paracetamol through raising awareness amongst retailers and the public and the use of point of sale systems.	Lead	6.1.2
Collect, analyse and disseminate high quality data on suicide and self-harm and ensure adequate access to, and understanding of the data among those working in suicide prevention across all sectors.	Supporting partner	7.2.3
The Justice and Health sectors will engage with the Coroners, Garda Síochána, NOSP, CSO and research bodies in relation to deaths in custody, and recording of deaths by suicide and open verdicts, to further refine the basis of suicide statistics.	Supporting partner	7.3.1
Support research on risk and protective factors for suicidal behaviour in groups with an increased risk (or potential increased risk) of suicidal behaviour (*see Strategic Goal 3*).	Supporting partner	7.4.1

Department of Communications, Energy and Natural Resources – Commitments List	Role	Action
The Department of Communications, Energy and Natural Resources will engage with online platforms to encourage best practice in reporting around suicidal behaviour, so as to encourage a safer online environment in this area.	Lead	1.4.1
Broadcasting Authority of Ireland will apply and monitor its Code of Programme Standards including Principle 3 - Protection from Harm, which references self-harm and suicide, so as to ensure responsible coverage around these issues in the broadcast media.	Lead	1.4.2

Press Council of Ireland – Commitments List	Role	Action
In the reporting of suicide, excessive detail of the means of suicide should be avoided.	Lead	1.4.3

Department of Environment, Community and Local Government– Commitments List	Role	Action
HSE Community Health Organisations will engage with Local Community Development Committees to develop and implement uniform, multi-agency suicide prevention action plans aligned with the community elements of the Local Economic and Community Plans and Children and Young People's Services Committee's (CYPSC) county plans.	Supporting partner	2.1.1

continued

Department of Environment, Community and Local Government– Commitments List *(continued)*	Role	Action
Integrate suicide prevention into the development of relevant national policies, plans and programmes relevant to people who are at an increased risk of suicide or self-harm.	Lead	3.1.1
Through the Implementation Plan on the State's Response to Homelessness (2014 to 2016), the Department of the Environment, Community and Local Government will seek to ensure that Homelessness Action Teams (HATs) countrywide have access to and are supported by Community Mental Health Teams (CMHTs) so that the needs of vulnerable or at-risk people are taken into account.	Supporting partner	4.1.1
Suicide prevention training to be made available to local authority and agency frontline staff who are likely to come into contact with people who are vulnerable to/at risk of suicidal behaviour.	Lead	5.4.2
Local Authorities will be requested to consider, develop and implement measures where practical to restrict access to identified locations and settings where people are at risk of engaging in suicidal behaviour, and assist generally in reducing risk factors in public locations.	Supporting partner	6.2.1

Local Authorities – Commitments List	Role	Action
HSE Community Health Organisations will engage with Local Community Development Committees to develop and implement uniform, multi-agency suicide prevention action plans aligned with the community elements of the Local Economic & Community Plans.	Supporting partner	2.1.1
Suicide prevention training to be made available to local authority and agency frontline staff who are likely to come into contact with people who are vulnerable to/at risk of suicidal behaviour.	Lead	5.4.2
Local Authorities will be requested to consider, develop and implement measures where practical to restrict access to identified locations and settings where people are at risk of engaging in suicidal behaviour, and assist generally in reducing risk factors in public locations.	Lead	6.2.1

Department of Justice and Equality – Commitments List	Role	Action
Integrate suicide prevention into relevant national policies and programmes for those that are at an increased risk of dying by suicide within the justice and prison sectors.	Lead	3.1.1
Develop and implement protocols to assist the sharing of information, where appropriate, in respect of people who are vulnerable to suicide within the justice and prison sectors, taking account of medical confidentiality and data protection requirements.	Supporting partner	3.1.2
Agencies in the justice sector will ensure that those in the criminal justice system have continued access to appropriate information and treatment in both prisons and the Probation Service, and in An Garda Síochána. The Irish Prison Service and the HSE National Forensic Mental Health Service will complete an agreed memorandum of understanding on improved links through the NFMHS Prison In-reach Service, and the Probation Services will engage with the HSE on maintaining and developing acce ss to community psychiatric services.	Lead	4.1.3
Develop and disseminate evidence-based shared resources, in relation to mental health and suicide prevention across the criminal justice system.	Lead	5.1.5
Through the Death in Custody/Suicide Prevention Group in each prison, identify lessons learned, oversee the implementation of the corrective action plan, and carry out periodic audits.	Lead	5.3.1
Ensure appropriate use of SOCs and CSCs, and compliance with the relevant policies by the way of regular audit and implementation of audit recommendations.	Lead	5.3.2
Implement the IPS Prisoner Release Policy, to ensure care, treatment and information is provided to those in the criminal justice system, including identifying the appropriate mental health services in each area for those leaving prison. This will include appropriate links with the community mental health services for those with mental health needs on release from prison.	Lead	5.3.3
Deliver training in suicide prevention to frontline staff who are likely to come into contact with people who are vulnerable to/at risk of suicidal behaviour.	Lead	5.4.2
The IPS will ensure that access to ligature points in cells in minimised and that this issue is given ongoing attention, particularly in the planning of all new prisons.	Lead	6.2.3

continued

Department of Justice and Equality – Commitments List *(continued)*	Role	Action
Agencies in the justice sector will develop their capacity for observation and information-gathering on people at risk/vulnerable to suicide and self-harm in prisons and places of detention.	Lead	7.2.1
Collect, analyse and disseminate high-quality data on suicide and self-harm and ensure adequate access to, and understanding of the data among those working in suicide prevention across all sectors.	Supporting partner	7.2.3
The Justice and Health sectors will engage with the Coroners, Garda Síochána, NOSP, CSO and research bodies in relation to deaths in custody, and recording of deaths by suicide and open verdicts, to further refine the basis of suicide statistics.	Lead	7.3.1

Department of Children and Youth Affairs/Tusla – Commitments List	Role	Action
Integrate suicide prevention into relevant national policies and programmes for those that are of an increased risk of suicide within DCYA-TUSLA. (e.g. within the National Youth Strategy).	Lead	3.1.1
Operational policies and procedures for TUSLA services to children and young people (family support, welfare and protection, alternative care and education welfare) will incorporate suicide prevention issues in respect of vulnerable children and young people and their families.	Lead	3.1.1
Develop and implement protocols to assist the sharing of information, where appropriate, in respect of young people who are vulnerable to suicide.	Supporting partner	3.1.2
Support schools in adopting a whole-school approach to health and wellbeing in line with the Health Promoting School, Healthy Ireland and School Self-Evaluation frameworks.	Supporting partner	3.3.1, 3.3.5, 5.1.2
Strengthen the data systems to report and learn from investigations and reviews on child protection and deaths of children in care in order to review the profile of need and requisite service response to vulnerable young people who are in the care of the state or known to TUSLA.	Lead	5.2.2
Deliver suicide prevention training to people who are working within the child protection services.	Lead	5.4.2
Agencies in the child welfare and protection sector will develop their capacity for observation and information gathering on people at risk/vulnerable to suicide and self-harm.	Lead	7.2.1

continued

Department of Children and Youth Affairs/Tusla – Commitments List *(continued)*	Role	Action
Gather and disseminate data, which could form the basis for research to further increase understanding and preventive action within the child welfare and protection sector.	Supporting partner	7.2.3

Department of Social Protection – Commitments List	Role	Action
Government departments and state agencies will take consideration of suicide prevention and, where appropriate integrate it, in the development of relevant national policies, plans and programmes which deal with people who are vulnerable or at risk of suicide or self-harm.	Lead	3.1.1
Develop and implement protocols, in consultation with NOSP, to assist DSP staff who are likely to come into contact with people who are vulnerable to/at risk of suicide.	Supporting partner	3.1.2
Continue to deliver training in suicide prevention to frontline DSP staff who come into contact with people who are vulnerable to/at risk of suicidal behaviour.	Lead	5.4.2

Department of Defence – Commitments List	Role	Action
Deliver co-ordinated, targeted communication campaigns that promote mental health and wellbeing, and awareness of support services among personnel in the Defence Forces to reduce the stigma associated with mental ill-health, suicidal behaviour and self-harm.	Supporting partner	1.1.3
Integrate suicide prevention principles into relevant national Department of Defence policies and programmes, which cover persons in the Defence Forces who are vulnerable/at risk of suicide.	Lead	3.1.1
Develop guidelines, protocols and training on (i) effective suicide prevention interventions and (ii) uniform response procedures to suicidal behaviour, including response to bereaved families.	Supporting partner	3.1.2
Continue to deliver suicide prevention training to personnel dealing with persons who are vulnerable/ at risk of suicide within the Defence Forces [Personnel Support Service].	Lead	5.4.2

Health and Safety Authority – Commitments List	Role	Action
To develop guidance, training and support to workplaces in relation to suicide prevention and critical incidence in collaboration with NOSP.	Lead	5.4.2

Department of Transport, Tourism and Sport – Commitments List	Role	Action
Promoting physical activity as a protective factor for mental health through the National Physical Activity Plan.	Lead	1.1.5
Integrate suicide prevention into relevant Sports policies and programmes for those who are vulnerable and at increased risk of suicide within the sporting community.	Lead	3.1.1
To develop guidance, training and support to workplaces in relation to suicide prevention and critical incidence in collaboration with NOSP	Lead	5.4.2

Higher Education Authority – Commitments List	Role	Action
Work with the HSE to develop national guidance for higher education institutions in relation to suicide-risk and critical-incident response, thereby helping to address any gaps which may exist in the prevention of suicide in higher education.	Lead	3.3.3
Support the co-ordination and streamlining of research completed by third-level institutions.	Lead	7.4.2
Encourage the coordination of suicide-prevention initiatives and research across the higher education sector.	Lead	7.4.2

References

1. Eurostat (2014) *Death due to suicide by sex*. Availavble at: http://epp.eurostat.ec.europa.eu/tgm/table.do?tab=table&init=1&language=en&pcode=tps00122&plugin=12014.
2. Eurostat (2014) *Suicide death rate, by age group – Total (15 to 19 year olds)*. Available at: http://epp.eurostat.ec.europa.eu/tgm/table.do?tab=table&init=1&language=en&pcode=tsdph240&plugin=1
3. CSO. *Suicide Statistics* (2014) http://www.cso.ie/en/releasesandpublications/er/ss/suicidestatistics2011/2014.
4. Bergen, H., Hawton, K., Waters, K., Ness, J., Cooper, J., Steeg, S. *et al.* (2012) 'How do methods of non-fatal self-harm relate to eventual suicide?', *Journal of Affective Disorders*, 136(3):526-33.
5. Gunnell, D., Bennewith, O., Peters, T.J., House, A., Hawton, K. (2005) 'The epidemiology and management of self-harm amongst adults in England,' *Journal of Public Health*, 27(1):67-73.
6. Griffin, E., Arensman, E., Wall, A., Corcoran, P., Perry, I. (2012) *National Registry of Deliberate Self-Harm*, Annual Report: National Suicide Research Foundation, Cork.
7. Griffin, E., Arensman, E., Corcoran, P., Wall, A., Williamson, E., Perry, I. (2014) *National Registry of Deliberate Self-harm Ireland Annual Report 2013*. Available at: http://nsrf.ie/wp-content/uploads/reports/NSRF%20Registry%20Web.pdf
8. Perry, I., Corcoran, P., Fitzgerald, A., Keeley, H.S., Reulbach, U., Arensman, E. (2012) 'The incidence and repetition of hospital-treated deliberate self-harm: findings from the world's first national registry.' PLoS One. 7(e31663).
9. Carroll, R., Metcalfe, C., Gunnell, D. (2014) 'Hospital management of self-harm patients and risk of repetition: Systematic review and meta-analysis', *Journal of Affective Disorders*, 168:476-83.
10. NOSP (2014) *Report of the Research Advisory Group*. www.nosp.ie
11. Arensman, E., Wall, A., McAuliffe, C., Corcoran, P., Williamson, E., McCarthy, J., Perry, I. J. (2013) *Second Report of the Suicide Support and Information Systems*. Cork
12. Cavanagh, J. T., Carson, A.J., Sharpe, M., Lawrie, S.M. (2003) 'Psychological autopsy studies of suicide: a systematic review', *Psychological Medicine*. 33(3):395-405.
13. HSE Mental Health Services (2013) Available at: http://www.hse.ie/eng/services/list/4/Mental_Health_Services/
14. Bostwick, J. M., Pankratz, V. S. (2000) 'Affective disorders and suicide risk: a re-examination', *The American Journal of Psychiatry*, 157(12):1925-32.
15. HSE (2014) *Fifth Annual Child and Adolescent Mental Health Service Report* Available at: https://www.iasw.ie/attachments/6c0a78b4-25ea-44e3-bb40-145e638543ca.PDF
16. OECD Health Data (2012) Frequently Requested Data http://stats.oecd.org/index.aspx?DataSetCode%3DHEALTH_STAT2012.
17. Schneider, B. (2009) *Substance use disorders and risk for completed suicide.* Archives of Suicide Research: Official Journal of the International Academy for Suicide Research. 13(4):303-16.
18. WHO (2012) *Public Health Action for the Prevention of Suicide: A Framework.* Available at: http://www.who.int/mental_health/publications/prevention_suicide_2012/en/: WHO, Geneva.
19. WHO (2014) Preventing suicide: A global imperative. Available at: http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/Geneva: WHO, Geneva.
20. International Association for Suicide Prevention (2015) Available at: https://www.iasp.info/
21. United Nations (1996)
22. NOSP (2014) Policy Paper on Suicide Prevention: A review of national and international policy approaches to suicide prevention. www.nosp.ie
23. Department of Health and Children (2006) *A Vision for Change* Report of the

Expert Group on Mental Health Policy. Available at: http://www.hse.ie/eng/services/publications/Mentalhealth/Mental_Health_-_A_Vision_for_Change.pdf

24. Department of Children and Youth Affairs (2014) *Better Outcomes, Brighter Futures: The National Policy Framework for Children and Young People, 2014 - 2020*. Available at: http://dcya.gov.ie/documents/cypp_framework/BetterOutcomesBetterFutureReport.pdf
25. Department of Health and Children (2013) *Healthy Ireland - A Framework for Improved Health and Wellbeing 2013-2025*. Available at: http://health.gov.ie/wp-content/uploads/2014/03/HealthyIrelandBrochureWA2.pdf
26. Department of Health and Children (2009) *The National Drugs Strategy 2009-2016* http://www.dohc.ie/publications/pdf/nds_2009-16.pdf?direct=1
27. Department of Children and Youth Affairs (2015) *The National Youth Strategy*. Dublin.
28. Department of Education and Skills (2012) *A Framework for Junior Cycle*. Available at: http://www.education.ie/en/Publications/Policy-Reports/A-Framework-for-Junior-Cycle-Full-Report.pdf
29. Department of Education and Skills (2011) *National Strategy for Higher Education to 2030*. Available at: http://www.hea.ie/sites/default/files/national_strategy_for_higher_education_2030.pdf
30. Department of Education and Skills (2013) *Action Plan on Bullying: Report of the Anti-bullying Working Group to the Minister for Education and Skills*. Available at: http://www.education.ie/en/Publications/Education-Reports/Action-Plan-On-Bullying-2013.pdf
31. Department of Environment, Community and Local Government (2012) *Putting People First Action Programme for Effective Local Government*. Available at: http://www.environ.ie/en/PublicationsDocuments/FileDownLoad,31309,en.pdf
32. Department of Foreign Affairs and Trade (2015) *Global Irish: Ireland's Diaspora Policy*. Available at: https://www.dfa.ie/media/globalirish/Diaspora-Report.pdf
33. Department of Health and Children (2012) *Report of the National Substance Misuse Strategy Steering Group*. Available at: http://alcoholireland.ie/download/reports/strategies_to_reduce_harmful_alcohol_use/Steering-Group-Report-on-a-National-Substance-Misuse-Strategy-7-Feb-11(2).pdf
34. Department of Social Protection (2013) *Guidance and Support for Staff Dealing with Distressed Customers or Suicide Threats in the Workplace*.
35. Health Service Executive (2010) *National Drugs Rehabilitation Framework*. Available at: http://www.drugsandalcohol.ie/12388/1/DCRGA_Strategy_2009-2016.pdf
36. Health Service Executive (2011) *The Health Promotion Strategic Framework*. Available at: http://www.healthpromotion.ie/hp-files/docs/HPSF_HSE.pdf
37. Inclusion Ireland. *National Disability Strategy* http://www.justice.ie/en/JELR/NDS_ImplementationPlan_FINAL.pdf/Files/NDS_ImplementationPlan_FINAL.pdf
38. Irish Prison Service (2012) *Three Year Strategic Plan 2012-2015*. Available at: http://www.drugsandalcohol.ie/17473/1/ips_three_year_strategic_plan.pdf
39. Department of Social Protection (2007) *National Action Plan for Social Inclusion 2007-2016*. Available at: http://www.socialinclusion.ie/documents/NAPinclusionReportPDF.pdf
40. Health Service Executive (2008) *National Interculture Health Strategy 2007-2012*. HSE, Dublin.
41. Department of Health and Children (2008) *National Men's Health Policy 2008-2013* Available at: http://www.mhfi.org/menshealthpolicy.pdf
42. Department of Health and Children (2013) *National Positive Ageing Strategy*. Available at: http://health.gov.ie/wp-content/uploads/2014/03/National_Positive_Ageing_Strategy_English.pdf
43. Department of Justice, Equality and Law Reform (2010) *National Strategy on Domestic, Sexual and Gender-Based Violence* Available at: http://www.cosc.ie/en/COSC/Final%20Electronic%20NS%20Ex%20Summary%205%20March.pdf/Files/Final%20Electronic%20NS%20Ex%20Summary%205%20March.pdf

44. Irish Water Safety. *Policy and Strategic Plan on Suicide Prevention – Irish Water Safety.* Available at: http://www.iws.ie/_fileupload/about/Documents/Irish%20Water%20Safety%20-%20Suicide%20and%20Self%20Harm%20Intervention%20Policy.pdf.
45. Department of the Environment, Heritage and Local Government (2008) *The Way Home: A Strategy to Address Adult Homelessness in Ireland 2008 – 2013.* Available at: http://www.environ.ie/en/Publications/DevelopmentandHousing/Housing/FileDownLoad,18192,en.pdf
46. Department of Health and Children (2002) *Traveller Health: A National Strategy 2002-2005.* Available at: http://www.southsidetravellers.com/traveller_healthstratpdf.pdf
47. NOSP (2014) *Suicide Prevention: An evidence review by the Health Research Board.* www.nosp.ie
48. UCD (2010) *All-Ireland Traveller Health Study*. Available at: https://www.ucd.ie/t4cms/AITHS_SUMMARY.pdf
49. O'Riordan, M., Arensman, E. (2007) *Institutional child sexual abuse and suicidal behaviour: Outcomes of a literature review, consultation meetings and a qualitative study.* National Suicide Research Foundation.
50. Cleary, A., Feeney, M., Macken-Walsh, A. (2012) *Pain and distress in rural Ireland. A qualitative study of suicidal behaviour among men in rural areas.*
51. Dooley, B., Fitzgerald, A. (2012) *Headstrong My World Survey*. National Study of Youth Mental Health. Dublin.
52. Sarchiapone, M., Mandelli, L., Iosue, M., Andrisano, C., Roy, A. (2011) 'Controlling access to suicide means', *Public Health*. 8(12):4550-62.
53. VanPraag, H. (2009) 'The role of religion in suicide prevention'. In Wasserman, C. Oxford *Textbook of Suicidology and Suicide Prevention: a Global Perspective*. Oxford: Oxford University Press; 7-12.
54. Sisask, M., Varnik, A., Kolves, K., Konstabel, K., Wasserman, D. (2008) 'Subjective psychological wellbeing (WHO-5) in assessment of the severity of suicide attempt', *Nordic Journal of Psychiatry*. 62(6):431-5.
55. Luthar, S.S. (2003) *Resilience and vulnerability: adaption in the context of childhood adversities.* Cambridge: Cambridge University Press.
56. Davidson, C.L., Babson, K.A., Bonn-Miller, M.O., Souter, T., Vannoy, S. (2013) 'The impact of exercise on suicide risk: examining pathways through depression, PTSD, and sleep in an inpatient sample of veterans', *Suicide and Life-threatening Behavior*, 43(3):279-89.
57. Sarchiapone, M., Mandelli, L., Carli, V., Iosue, M., Wasserman, C., Hadlaczky, G. *et al* (2014) 'Hours of sleep in adolescents and its association with anxiety, emotional concerns and suicidal ideation'. *Sleep Med*, 15(2):248-54.
58. D'Orio, B., Garlow, S.J. (2004) Suicide prevention: a vital national public health issue. Journal of health and human services administration. 123-41.
59. Gunnell, D., Frankel, S. (1994) 'Prevention of suicide: aspirations and evidence,' *British Medical Journal*, 308(6938):1227-33.
60. Scott, A., Guo, B. (2012) *For which strategies of suicide prevention is there evidence of effectiveness.* HEN Synthesis Report Copenhagen: World Health Organization Regional Office for Europe.
61. Hegerl, U., Wittenburg, L., Arensman, E., Van Audenhove, C., Coyne, J.C., McDaid, D. *et al* (2009) 'Optimizing Suicide Prevention Programs and Their Implementation in Europe (OSPI Europe): an evidence-based multi-level approach', *BMC Public Health*, 9(1):428.
62. Mann, J.J., Apter, A., Bertolote, J., Beautrais, A., Currier, D., Haas, A. *et al* (2005) 'Suicide prevention strategies: a systematic review,' *Jama*, 294(16):2064-74.
63. Henriksson, S., Isacsson, G. (2006) 'Increased antidepressant use and fewer suicides in Jämtland county, Sweden, after a primary care educational programme on the treatment of depression', *Acta Psychiatrica Scandinavica,* 114(3):159-67.

64. Szanto, K., Mulsant, B.H., Houck, P.R., Dew, M. A., Dombrovski, A., Pollock, B.G. *et al* (2007) 'Emergence, persistence, and resolution of suicidal ideation during treatment of depression in old age', *Journal of affective disorders*, 98(1):153-61.
65. Centers for Disease Control and Prevention (2008) *Introduction to Process Evaluation in Tobacco Use Prevention and Control.* Atlanta (GA): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.
66. Centers for Disease Control and Prevention (2011) *Developing an effective evaluation plan*. Atlanta (GA).
67. Chang, S.S., Stuckler, D., Yip, P., Gunnell, D. (2013) 'Impact of 2008 global economic crisis on suicide: time trend study in 54 countries', *BMJ* (Clinical research ed), 347.
68. McDaid, D., Quaglio, G., de Campos, A. C., Dario, C., Van Woensel, L., Karapiperis. T. *et al* (2013) 'Health protection in times of economic crisis: challenges and opportunities for Europe,' *Journal of Public Health Policy*, 34(4):489-501.
69. WHO (2014) *Mental Health: a State of Wellbeing*. Available at: http://www.who.int/features/factfiles/mental_health/en/2014
70. Nolan, P., Badger, F. (2002) Promoting collaboration in primary mental health care. Available at: http://trove.nla.gov.au/work/33476437?q=+&versionId=411381452002
71. Campanelli, C., Gilson, T. (2002) 'Murder-suicide in New Hampshire, 1995-2000', *The American Journal of Forensic Medicine and Pathology*, 23(3):248-51.
72. Rudd, M. (2006) *The assessment and management of suicidality.* USA: Professional Resource Press.
73. Commonwealth Department of Health and Aged Care (2000) *A National Framework for Palliative Care Service Development*. National Palliative Care Strategy, Canberra.
74. Department of Education and Skills (2013) *Health Service Executive, Department of Health - Wellbeing in Post Primary School Guidelines* Available at: http://www.nosp.ie/Well_Being_PP_Schools_Guidelines.pdf
75. Office for Social Inclusion (2014) Available at: http://socialinclusion.ie/2014.
76. See Change (2014) http://www.seechange.ie/why-is-a-stigma-reduction-programme-important/2014.
77. Scottish Government. (2013) Suicide Prevention Strategy 2013 – 2016. http://www.scotland.gov.uk/Resource/0043/00439429.pdf
78. Haw,C., Hawton,K., Niedzwiedz,C., Platt,S. (2013) Suicide clusters: a review of risk factors and mechanisms. Suicide and Life-Threatening Behaviour. 43(1):97-108.
79. Gould,M.S., Wallenstein,S., Kleinman,M. (1990) Time-space clustering of teenage suicide. American Journal of Epidemiology. 131(1):71-8.
80. Cho,J., Lee,W.J., Moon,K.T., Suh,M., Sohn,J., Ha,K.H. et al.(2013) Medical care utilization during 1 year prior to death in suicides motivated by physical illnesses. J Prev Med Public Health. 46(3):147-54.
81. WHO (2013) *Health Literacy: the solid facts.* Copenhagen: World Health Organization Regional Office for Europe. Available at: http://www.euro.who.int/date/assets/pdffile/0008/190655/e96854.pdf2013
82. Ajdacic-Gross, V., Weiss, M. G., Ring, M., Hepp, U., Bopp, M., Gutzwiller, F. *et al* (2008) Methods of suicide: international suicide patterns derived from the WHO mortality database. 86(9):726-32.
83. Niederkrotenthaler, T., Fu, K. W., Yip, P. S. F., Fong, D. Y. T., Stack, S., Cheng, Q. *et al* (2012) 'Changes in suicide rates following media reports on celebrity suicide: a meta-analysis', *Journal of Epidemiology and Community Health*, 66(11):1037-42.
84. Sisask, K., Vani, A. (2012) 'Media roles in suicide prevention: a systematic review', *International Journal of Environment Public Health*, 9:123-38.
85. Diane, K., Hawton, K., Singaravelu, V., Stewart, A., Simkin, S., Montgomery, P. (2013) 'The power of the web: a systematic review of studies of the influence of the internet on self-harm and suicide in young people', PlosONE. 8(10):e77555.
86. Westerlund, M., Hadlaczky, G., Wasserman, D. (2012) 'The representation of suicide on the Internet: implications for clinicians', *Journal of Medical Internet Research*, 14(5):e122.

87. Kolves, K., Kolves, K. E., De Leo, D. (2013) 'Natural disasters and suicidal behaviours: a systematic literature review', *Journal of Affective Disorders*, 146(1):1-14.
88. Fortune, S., Hawton, K. (2007) 'Culture and mental disorders: suicidal behaviour'. In: Bhugra, D., Bhui, K. editors. *Textbook of Cultural Psychiatry*. Cambridge: Cambridge University Press; 255-71
89. Oliver, L.N., Peters, P.A., Kohen, D.E. (2012) *Mortality rates among children and teenagers living in Inuit Nunangat, 1994 to 2008*. Ottawa: Statistics Canada.
90. Goldston, D. B., Molock, S. D., Whitbeck, L. B., Murakami, J. L., Zayas, L. H., Hall, G. C. N. (2008) 'Cultural considerations in adolescent suicide prevention and psychosocial treatment', *American Journal of Psychology*, 63(1):14-31.
91. Casiano, H., Katz, L. Y., Globerman, D., Sareen, J. (2013) 'Suicide and deliberate self-injurious behaviour in juvenile correctional facilities: a review', *Journal of Child and Adolescent Psychiatry*, 22(2):118-24.
92. Fazel, S., Grann, M., Kling, B., Hawton, K. (2011) 'Prison suicide in 12 countries: an ecological study of 861 suicides during 2003-2007', *Social Psychiatry and Psychiatric Epidemiology,* 46(3):191-5.
93. Haas, A. P., Eliason, M., Mays, V. M., Mathy, R. M., Cochran, S. D., D'Augelli, A.R. *et al* (2011) 'Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: review and recommendations', *Journal of Homosexuality,* 58(1):10-51.
94. Brunstein, K., Klomek, A., Sourander, A., Gould, M. (2010) 'The association of suicide and bullying in childhood to young adulthood: a review of cross-sectional and longitudinal research findings', *Canadian Journal of Psychiatry, Revue Canadienne de Psychiatrie*, 55(5):282-8.
95. Kalt, A., Hossain, M., Kiss, L., Zimmerman, C. (2013) 'Asylum seekers, violence and health: a systematic review of research in high income host countries', *American Journal of Public Health*, 103(3):30-42.
96. Foster, T. (2011) 'Adverse life events proximal to adult suicide: a synthesis of findings from psychological autopsy studies', *Archives of Suicide Research: Official Journal of the International Academy for Suicide Research*, 15(1):1-15.
97. Johnson, J. G., Cohen, P., Gould, M. S., Kasen, S., Brown, J., Brook, J. S. (2002) 'Childhood adversities, interpersonal difficulties, and risk for suicide attempts during late adolescence and early adulthood', *Journal of Psychiatry*, 59(8):741-9.
98. Ben-Efraim, Y. J., Wasserman, D., Wasserman, J., Sokolowski, M. (2013) 'Family-based study of HTR2A in suicide attempts: observed gene, gene [times] environment and parent-of-origin associations' *Journal of Psychiatry,* 18(7):758-66.
99. Kposowa, A.J. (2003) 'Divorce and suicide risk', *Journal of Epidemiology and Community Health*, 57(12):993.
100. WHO (2013) Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva;World Health Organisation. Available at: http://www.who.int/reproductivehealth/publications/violence/9789241564625/en
101. Garcia-Moreno, C., Jansen, H. A., Ellsberg, M., Heise, L., Watts, C. H. (2006) 'Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence', *Lancet*, 368(9543):1260-9.
102. Yoshimasu, K., Kiyohara, C., Miyashita, K. (2008) 'Suicidal risk factors and completed suicide: meta-analyses based on psychological autopsy studies. *Environmental Health and Preventive Medicine*, 13(5):243-56.
103. Beautrais, A. L. (2003) 'Subsequent mortality in medically serious suicide attempts: a 5-year follow-up', T*he Australian and New Zealand Journal of Psychiatry,* 37(5):595-9.
104. Phillips, M.R., Yang, G., Zhang, Y., Wang, L., Ji, H., Zhou, M. (2002) 'Risk factors for suicide in China: a national case-control psychological autopsy study' *Lancet,* 360(9347):1728-36.

105. Radhakrishnan, R., Andrade, C. (2012) 'Suicide: An Indian perspective', *Indian Journal of Psychiatry*, 54(4):304-19.
106. Kostro, K., Lerman, J. B., Attia, A. (2014) 'The current status of suicide and self-injury in eating disorders: a narrative review', *Journal of Eating Disorders,* (2):19.
107. Hawton, K. L., Sutton, L., Haw, C., Sinclair, J., Harriss, L. (2005) 'Suicide and attempted suicide in bipolar disorder: a systematic review of risk factors', *Journal of Clinical Psychiatry*, 66(6):693-704.
108. Nordentoft, M., Mortensen, P. B., Pedersen, C. B. (2011) 'Absolute risk of suicide after first hospital contact in mental disorder', *Journal of Psychiatry,* 68(10):1058-64.
109. Palmer,B.A., Pankratz,V.S., Bostwick,J.M. (2005) 'The lifetime risk of suicide in schizophrenia: a reexamination', *Journal of Psychiatry,* 62(3):247-53.
110. Beautrais, A. L., Joyce, P. R., Mulder, R. T., Fergusson, D. M., Deavoll, B. J., Nightingale, S.K. (1996) 'Prevalence and comorbidity of mental disorders in persons making serious suicide attempts: a case-control study', *The American Journal of Psychiatry,* 153(8):1009-14.
111. WHO (2014) Global status report on alcohol and health 2014 Geneva: World Health Organisation. Available at: http://www.who.int/substanceabuse/publications/globalalcoholreport/en/
112. Bohnert, K. M., Ilgen, M. A., McCarthy, J. F., Ignacio, R. V., Blow, F. C., Katz, I. R. (2014) Tobacco use disorder and the risk of suicide mortality', *Addiction* (Abingdon, England), 109(1):155-62.
113. Stuckler, D., Basu, S. (2013) *The Body Economic: Recession, budget battles, and the politics of life and death*. London: Penguin Press.
114. O'Connor, R. C., Nock, M. K. (2014) 'The psychology of suicidal behaviour' *Lancet Psychiatry,* 1(1):73-85.
115. Beck, A. T., Brown, G., Berchick, R. J., Stewart, B .L., Steer, R .A. (1990) 'Relationship between hopelessness and ultimate suicide: a replication with psychiatric outpatients', *The American Journal of Psychiatry,* 147(2):190-5.
116. Tang, N. K., Crane, C. (2006) 'Suicidality in chronic pain: a review of the prevalence, risk factors and psychological links', *Psychological Medicine,* 36(5):575-86.
117. Stengar, E. (2009) Somatic diseases and suicidal behaviour. Oxford: In: Wasserman, D., Wasserman, C., editors. *Oxford Textbook of Suicidology and Suicide Prevention: a Global Perspective*. Oxford: Oxford University Press [293-9].
118. Jordan, J. R., McIntosh, J. L. (2011) *Grief after suicide: understanding the consequences and caring for the survivors* (Series in Death, Dying, and Bereavement). New York (NY): Routledge.
119. Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., Joiner, T. E. (2010) 'The interpersonal theory of suicide', *Psychological Review*, 117(2):575-600.
120. Qin, P., Agerbo, E., Mortensen, P. B. (2002) 'Suicide risk in relation to family history of completed suicide and psychiatric disorders: a nested case-control study based on longitudinal registers', *The Lancet,* 360(9340):1126-30.
121. Mann, J.J., Currier, D.M. (2010) Stress, genetics and epigenetic effects on the neurobiology of suicidal behavior and depression. European psychiatry: The Journal of the Association of European Psychiatrists. 25(5):268-71.
122. Johnson, J., Wood, A. M., Gooding, P., Taylor, P. J., Tarrier, N. (2011) 'Resilience to suicidality: the buffering hypothesis', *Clinical Psychology Review*, 31(4):563-91.

Connecting for Life is Ireland's National Strategy to reduce suicide (2015-2020). The development of the strategy was a collaborative and inclusive process. Some of the most important contributions to the development of 'Connecting for Life' came from our public consultation process. We received 272 submissions from people and organisations, which included members of the general public, people who have used our services and their families, professional bodies and community interests and organisations.

"May I thank you for your invitation to respond – it matters so much to me."

Submission reference number: 3

"There is always hope, look for help."

Submission reference number: 29

"I want people who suffer with anxiety and depression to know that tomorrow brings hope."

Submission reference number: 84

"Promote public discourse on mental health, with a particular focus on dispelling myths and reducing attending stigma."

Submission reference number: 121

"(Suicide) is not a single Agency issue so therefore requires a multi agency response."

Submission reference number: 149

Department of Health
Hawkins House
Hawkins Street
Dublin 2
Ireland
Tel: +353 (0)1 635 4000
www.doh.ie

Design by www.penhouse.ie