The Centre for Effective Services

Evaluation of the Implementation and Intermediate Outcomes of *Connecting for Life*, Ireland's National Strategy to Reduce Suicide

Final report

November 2025

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Regretfully, on the 10th of September 2025, Dr David Kryl passed away.

Members of the Evaluation Advisory Group

John Meehan	**(Chairperson, from February 2024)** National Office for Suicide Prevention
Prof. Stephen Platt	**(Chairperson, until January 2024)** University of Edinburgh
Prof. Ella Arensman	National Suicide Research Foundation and University College Cork
Emer Clarke	Heath Service Executive
Dr Paul Corcoran	National Suicide Research Foundation
Dr Gemma Cox	National Office for Suicide Prevention
Prof. Barbara Dooley	University College Dublin
Dr Eve Griffin	National Suicide Research Foundation
Dr Claire Hickey	Houses of the Oireachtas
Prof. Agnes Higgins	Trinity College Dublin
Dr Katerina Kavalidou	National Suicide Research Foundation and National Office for Suicide Prevention
Sally-Ann Lovejoy	Health Service Executive

Members of the Evaluation Stakeholder Group

Dr Eve Griffin	**(Chairperson)** National Suicide Research Foundation
Nicola Byrne	Shine
Derek Chambers	Health Service Executive
Moninne Griffith	BeLonG To
Dr Barry Kestell	Department of Health
Stephanie Manahan	Pieta
Mary McGrath	Health Service Executive
Sandra Taylor	Health Service Executive
Fiona Tuomey	HUGG
Sarah Woods	National Office for Suicide Prevention
Secretariat support:	Dr Gemma Cox, National Office for Suicide Prevention Dr Katerina Kavalidou, National Office for Suicide Prevention and National Suicide Research Foundation

List of acronyms

AAR – After-Action Review

AATT – Adults Accessing Talking Therapies

ADHD – Attention Deficit Hyperactivity Disorder

ASIST – Applied Suicide Intervention Skills Training

BCI – Brief Contact Intervention

BPG – Best Practice Guidance

CAMHS – Child and Adolescent Mental Health Service

CAMS – Collaborative Assessment & Management of Suicidality

CBT – Cognitive Behavioural Therapy

CES – Centre for Effective Services

CFIR – Consolidated Framework for Implementation Research

CfL - Connecting for Life

CHO – Community Healthcare Organisation

CIPC – Counselling In Primary Care

COM-B – Capability, Opportunity, Motivation – Behaviour

CSO – Central Statistics Office

CYPSC – Children and Young People's Services Committees

DBT – Dialectical Behaviour Therapy

DUMP – Disposal of Unused Medication Properly

ED – Emergency Department

FRC – Family Resource Centres

GAA – Grant Aid Agreement

GDPR – General Data Protection Regulation

GMS (card) – General Medical Services, i.e., Medical Card

GP – General Practitioner

HRB – Health Research Board

HSE – Health Service Executive

HUGG – Healing Untold Grief Groups

ICGP – Irish College of General Practitioners

IO – Intermediate Outcome

KPI – Key Performance Indicator

LE – Lived or Living Experience

LGBT – Lesbian, Gay, Bisexual, Transgender

LGBTQI+ – Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex. The plus sign symbolises many other identities included under the LGBTQI+ umbrella.

MBT – Mentalisation-Based Therapy

NCEC - National Clinical Effectiveness Committee

NCPSHI – National Clinical Programme for Self-harm and Suicide-related Ideation

NGO – Non-Governmental Organisation

NICE – National Institute for Health and Care Excellence

NOSP – National Office for Suicide Prevention

NSHPSG – National Suicide and Harm Prevention Steering Group

NSRF – National Suicide Research Foundation

QAF – Quality Assurance Framework

RE-AIM – Reach, Effectiveness, Adoption, Implementation, Maintenance

RI – Rapid Insight

ROSP – Resource Officer for Suicide Prevention

SADA – Self-Harm Assessment and Data Analysis

SAMAGH – Self-Harm Assessment and Management Programme for General Hospitals

SAOR – Support, Ask and Assess, Offer Assistance, Refer

SATS – Suicide Assessment and Treatment Service

SBLO – Suicide Bereavement Liaison Officer

SBLS – Suicide Bereavement Liaison Service

SCAN – Suicide Crisis Assessment Nurse

SLA – Service Level Agreement

STORM – Skills Training On Risk Management

WHO – World Health Organization

Glossary of terms

Agile – move quickly and easily.

Anonymous – no identification of a person or place.

Bellwether – something that indicates a trend.

Cohesive – united and working together effectively.

Coroner – an independent public official who is legally responsible for investigating sudden, violent or unexplained deaths to find out if the death is due to natural or unnatural cause.

Coronial – relating to the coroner.

Cross-sectoral – government, state agencies and NGOs working together to address a specific complex social challenge to make a better impact.

Evaluation – is an *investigation***.** It examines or studies an aspect or aspects of an intervention in detail.

Gatekeeper – a person who controls access to an organisation.

Governance – the system by which an organisation is controlled and operates, and it is held to account.

Implementation – is about putting a plan into action.

Inter-agency – occurring between agencies.

Intersectionality – refers to the ways that multiple sources of inequality, for example, gender, race, ethnicity, sexual orientation, gender identity, disability, class, and other aspects of identity, overlap and create a unique experience of discrimination for an individual or group.

Intervention – refers to a service, project, programme or policy, trying to change a problem or situation.

Literature review – a summary of evidence on a topic.

Methodology – research methods used to answer research questions.

Multifaceted – many features.

Mind map – a visual thinking technique to organise and represent information.

Narrative – a spoken or written story.

NGO – non-governmental organisations sometimes called charities.

Policy – decision and steps by government to achieve an outcome.

Postvention – activities that occur after a suicide to help reduce the risk of further suicides or suicidal behaviours and promote healing for people bereaved by suicide.

Psychosocial – connecting social decisions and mental health and wellbeing.

Qualitative – measuring the quality of something.

Quantitative – measuring the quantity of something.

Realist Evaluation – a type of theory-based evaluation that looks at the different factors at play in determining the success of an intervention or policy, and asks “What works, in what circumstances, and for whom.”

Research – involves finding new knowledge and finding out whether something works, it is about studying facts, reasons, and purpose, asking the right questions and looking for the answers (the outcomes).

Social Prescribing – a way for healthcare professionals to connect patients with non-medical support in their community to improve their health and wellbeing.

Strategy – a plan to achieve an outcome.

Synergy – cooperation between several organisations to achieve something greater by their combined efforts.

Upstream – addressing risk at an earlier stage.

Whole of society – a collaboration of individuals, government, and its agencies and NGOs to achieve a social goal.

Mental health supports

If you, or someone you know needs support, visit www.yourmentalhealth.ie – for information on how to mind your mental health, support others, or to find a support service in your area.

You can get help through:

- text HELLO to 50808 anytime day or night (24/7) to text with a trained listening volunteer
- your GP
- Emergency Department
- HSE Mental Health Services
- yourmentalhealth.ie or telephone information line 1800 111 888 - anytime day or night, for information on mental health services in your area. Mental health supports and services - HSE.ie
- Samaritans on 116 123
- Pieta House on 1800 247 247 or text HELP to 5144

Executive summary

Introduction

Connecting for Life (CfL) was Ireland's national strategy to reduce suicide from 2015 to 2020 (Department of Health, 2015) and extended to 2024 following an Interim Strategy Review in 2018 (National Office for Suicide Prevention [NOSP], 2019a).

The strategy's vision is for *"an Ireland where fewer lives are lost through suicide and where communities and individuals are empowered to improve their mental health and wellbeing"*.

CfL sets out two ambitious primary 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.

CfL's strategic framework is presented in Figure 1 in the main report. *CfL* includes 7 strategic goals, and each strategic goal has associated strategic objectives. Sixty-nine actions are specified under these objectives. The strategy also sets out 23 Intermediate Outcomes (IOs) and associated indicators for each IO.

CfL focuses on priority groups including[1]:

- Health/mental health related groups: People of all ages with mental health problems, 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 Lesbian, Gay, Bisexual, Transgender (LGBT) community, members of the Traveller community, people experiencing homelessness, people in contact with the criminal justice system (i.e., prisoners), people experiencing abuse (i.e., domestic, clerical, institutional, sexual, or physical), 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.

In total, 22 government departments and state agencies made commitments, as leads or supporting partners, to deliver on these actions. This includes the various sections of the Health Service Executive (HSE, i.e., NOSP, Primary Care, Acute Hospitals, Mental Health, Health and Wellbeing) and the Department of Health, other government departments and state agencies,

[1] The *CfL* strategy states that the list of priority groups would be reviewed regularly based on the most up-to-date evidence.

including the Department of Education and Youth, the Department of Agriculture, Food and the Marine, the Department of Justice and Equality, and the Department of Defence.[2]

In addition, 23 Non-Governmental Organisation (NGO) partners are funded by the HSE to deliver on work aligned with *CfL*'s strategic objectives. These partners play a key role in direct service delivery; research, evaluation, and evidence generation; advocacy and awareness campaigns; and in the provision of targeted, culturally sensitive, and tailored interventions for *CfL* priority groups.

The HSE NOSP is identified in the strategy as the provider of cross-sectoral implementation support, in addition to being a named lead or supporting partner on 39 *CfL* actions. At the same time, there is a parallel bottom-up approach to delivering on *CfL*'s strategic objectives, realised through local area *CfL* suicide prevention action plans aligned with the national strategy.

Implementation of *CfL* occurs through a multifaceted governance framework that includes national oversight with local community action. To this end, *CfL* has parallel national and area-level implementation structures. A full account of *CfL* governance structures is presented in Figure 2 in the main report.

Evaluation of the implementation and intermediate outcomes of *CfL*

The overarching objectives of the current evaluation are to understand the implementation of *CfL* and the extent to which it is achieving its intermediate outcomes.

The evaluation set out to answer the following questions:

- To what extent does *CfL* as a policy framework inform key stakeholders in the development of their respective suicide prevention policies and programmes?
- To what extent are *CfL*'s suicide prevention activities and strategies aligned with the evidence base and good practice?
- How well is the top-down/national implementation of the strategy working?
- How well is the bottom-up/area-level implementation of the strategy working?
- Is there an ongoing need for *CfL* as a policy intervention?
- What lessons have been learned from the implementation of *CfL* (that could improve the efficiency and effectiveness of any future associated strategies)?
- Which of *CfL*'s suicide prevention activities and individually funded projects are achieving the agreed intermediate outcomes (identified in the strategy)?

[2] Government department names at outset of strategy. Government department names have changed over the lifetime of the strategy.

Overview of methodology

The current evaluation is a mixed-methods evaluation of the implementation and Intermediate Outcomes (IOs) of the *CfL* strategy, to inform future resourcing of suicide prevention policies and activities. Our approach to the evaluation is rooted in the principles of realist evaluation, a theory-driven approach to the evaluation of complex interventions. The *CfL* strategy can be conceived of as a complex intervention, in that it contains multiple interacting components and multiple potential outcomes, that are dependent on the behaviours of those delivering and receiving intervention activities. The system within which the strategy is delivered is also inherently complex, affected by broad social, economic, and political factors. Realist evaluation is commonly used to evaluate how complex interventions achieve their outcomes. The evaluation includes both primary and secondary data sources, as described below. Other activities were also carried out as part of the evaluation process, including logic modelling and a literature review.

Primary data

Three Rapid Insight (RI) sessions were conducted online with three groups of stakeholders, (i) members of the *CfL* National Cross-Sectoral Steering and Implementation Group, (ii) representatives from NGO partners funded by NOSP to deliver on work aligned with the strategy, and (iii) HSE Resource Officers for Suicide Prevention (ROSPs) across the country responsible for coordinating area-level implementation of *CfL*. These sessions encouraged participants to share their experiences and insights on *CfL*'s implementation, lessons learned, and factors needed for sustainability.

Semi-structured interviews complemented the RI sessions, targeting both implementers and bellwether advisors. These interviews explored implementation processes, barriers, facilitators, and recommendations for future strategies. Additionally, two surveys were distributed to ROSPs and local stakeholders/implementation partners to gather quantitative data on engagement, adoption, implementation fidelity, and sustainability of the *CfL* area-level action plans.

Secondary data

Secondary data analysis of two data sources was carried out: the multiple lines of evidence document compiled by NOSP and implementers across 23 IO – containing document links, publicly available document references, websites, internal and/or progress reports etc. In addition, other publicly available background documents including *CfL* progress report (quarterly), *CfL* Annual Report, the Interim Strategy Review, and *CfL* implementation plans were reviewed and analysed.

To integrate findings, triangulation was employed, combining qualitative and quantitative data through a narrative approach. This ensured a holistic understanding of *CfL*'s implementation and progress. Finally, illustrative examples were selected from interview data to demonstrate *CfL*'s impact, highlighting challenges, actions taken, and significant changes realised. Overall, this methodology provided a comprehensive evaluation of *CfL*, offering valuable insights to inform the development of future suicide prevention strategies.

Conclusion

Assessment of the content of the *CfL* strategy

As demonstrated by the literature review carried out as part of this evaluation, *CfL* activities and interventions are broadly aligned with the evidence base and good practice (see Figure 3 in the main report). Broadly, *CfL* has encompassed many of the core components of effective suicide prevention strategy design and implementation.

The *CfL* strategy has:

- Applied a multi-component systems approach to suicide prevention – engaging government departments to work together to reduce suicide and self-harm. Through its implementation and governance structures, *CfL* has achieved a high level of buy-in across government departments. Through the *CfL* strategy, interventions have been implemented at general population level, as well as for specific high-risk and priority groups.
- Involved multiple stakeholders in cross-sectoral collaborative work – *CfL* has supported the engagement of multi-stakeholder implementation teams at local, regional, and national levels. Through it's top-down and bottom-up approach, *CfL* has ensured that suicide prevention efforts can be tailored to specific local and regional contexts and that suicide prevention remains a national priority. The involvement of NGO partners has played a vital role in the delivery of *CfL* actions.
- Increasingly endeavoured to empower and involve people with lived or living experience perspectives – in recent years, attempts have been made to empower and involve people with lived or living experience as part of *CfL*, e.g., in the development of specific resources, such as *Safe Harbour* (Forde, 2024) and in the current evaluation. However, there is a need to create space for meaningful involvement of people with lived or living experience from the outset of the next strategy, throughout its design, implementation, and evaluation. While significant achievements have been made in the area of postvention, it is noted that the *CfL* strategy set out limited actions relating to postvention.
- Applied an implementation science lens to the work – with three implementation plans published over the lifetime of *CfL* to support the implementation of the strategy, as well as local action plans. HSE NOSP also developed a monitoring system to track implementation of *CfL* actions by lead agents so barriers to implementation could be flagged.
- Included 'upstream' risk factors that affect the whole population – Social Prescribing is one example of this work.
- Ensured that prevention efforts are informed by data – While obtaining accurate and timely data on suicide, suicide attempts, and self-harm remains a challenge, progress has been made over the lifetime of the strategy. Monitoring and evaluation are embedded in the *CfL* strategy, which is outcomes focused, with two primary outcomes and 23 IOs included.

CfL actions correspond to specific suicide prevention interventions referenced in the literature on suicide prevention, i.e., means restriction, media guidelines, community-based interventions, postvention, training, psychosocial interventions, crisis interventions, mental health treatment, and stigma reduction (see Table 5 in the main report).

While it is challenging to attribute changes in suicide and self-harm data to specific interventions, evidence for restricting access to means remains stronger than other suicide prevention interventions. Evidence for psychosocial interventions remains promising. Evidence for other suicide prevention strategies remains mixed.

Multi-level interventions, which integrate multiple approaches across different settings, are most likely to impact suicide and suicidal behaviour as this approach shows significantly greater effectiveness compared to single-level interventions, highlighting the importance of a comprehensive approach in suicide prevention efforts (Hofstra, et al., 2020).

Assessment of the (top-down) cross-sectoral implementation of the *CfL* strategy

Implementation and governance structures

Ireland is described by some interviewees as *"unique"* in its approach to suicide prevention. *CfL* distinguishes Ireland with oversight structures that, in theory, ensure meaningful cross-government collaboration and implementation. These include the presence of a National Office (HSE NOSP), a Cross-Sectoral Steering and Implementation Group, Local Cross-Sectoral Implementation Structures, and the NGO group (see Figure 2 in the main report).

The strategy itself provides a roadmap for how different government departments, agencies, and NGOs engage in suicide prevention, recognising that solutions extend beyond mental health services alone. Despite challenges, strong attendance at *CfL*'s governance forums demonstrates its success in keeping suicide prevention on the national agenda.

However, challenges persist. While different sectors attend meetings and agree on actions, the extent to which commitments translate into implementation remains uncertain. Suicide prevention is acknowledged as a collective effort, but in practice, this can lead to sectors deferring responsibility to others.

Representation at national, local and regional level was identified as a particular challenge for NGOs working in the area of suicide prevention, intervention, and postvention.

There is a lack of meaningful engagement with lived or living experience voices in national policymaking for suicide prevention which should be addressed. It was also noted that participation from government departments such as the Department of Social Protection should be explored to address the social determinants of suicide.

Enablers, barriers, and context of top-down *CfL* implementation

Despite the challenges outlined in the current report, the concurrent top-down and bottom-up approaches to implementation can be considered a strength of the *CfL* strategy. This approach

ensured that suicide prevention efforts were embedded within communities at local and regional level, as well as at national level. This approach should be continued and strengthened in the next strategy.

A recurrent concern is the gap between national policy intentions and local-level implementation. *CfL* has regional implementation structures, which attempt to localise the strategy, and this was acknowledged as a strength of the strategy. On the other hand, regional variability leads to inconsistencies with some local agencies noting a lack of clear guidance on adapting national objectives. Communication across implementation structures, from national to local and regional level and across sectors at local and regional level was also highlighted as a key challenge by some groups. The absence of real-time, region-specific suicide data further complicates measuring local intervention effectiveness.

Policy crossover was highlighted as a barrier to top-down implementation, i.e., crossover between mental health policies and between mental health policies and policies for specific at-risk/priority groups. Structural barriers (e.g., siloed working, lack of funding and resources) was also perceived as significant barriers to the implementing of *CfL* actions.

Good stakeholder engagement was apparent at national level. Strong leadership has played a crucial role in maintaining suicide prevention as a national priority. This includes strong leadership at national level (Department of Health, HSE NOSP) which has kept suicide prevention high on the government's agenda. High level buy-in has supported the implementation of *CfL*.

Staff turnover was emphasised as a barrier to implementation and a need for continuity within roles was described. There was concern expressed that there may be a reduced focus on suicide prevention at a local level because of changes in leadership at regional level due to HSE restructuring.

Gaps in service provision and pathways between services were highlighted as an area for improvement, e.g., access to primary care level supports and targeted services for at-risk groups such as those experiencing addiction.

Suicide prevention is now a mainstream policy issue, with greater public and political awareness and cultural shifts within government bodies. The following issues also impacted the implementation context for *CfL* during the 10-year period that the strategy was in place:

- The COVID-19 pandemic
- A cyberattack on the HSE
- HSE restructuring and a
- National cost of living crisis.

Both the COVID-19 pandemic and the HSE cyberattack were unprecedented events and caused major disruptions to the implementation of the strategy and functioning of health and social care systems, more generally. At the time of data collection and publication of this evaluation report, the restructuring of the HSE was ongoing.

Assessment of the (bottom-up) area-level implementation of the *CfL* strategy

Implementation and governance structures and local action plans

Local implementation structures have been established since the *CfL* strategy was published. Findings suggest that these structures support implementation at a local level. However, there is a need for greater alignment between national strategy and local implementation plans, clearer responsibilities and accountability, and more cross-sectoral work. Implementation gaps at local level were identified. Local and regional implementation remains a challenge due to regional variation. Regional variability led to inconsistencies, with some local agencies noting a lack of clear guidance on adapting national objectives. More consistency is required at local level. ROSPs are embedded at community level and have a pivotal role in local implementation. Local implementation can improve efforts to reach priority groups and improve the reach of the strategy in general. While all areas prepared local action plans, only some were updated over the extended lifetime of the strategy.

Enablers and barriers of bottom-up *CfL* implementation

The *CfL* implementation and governance structures have facilitated improved communication. The need for better communication from NOSP to local level and between stakeholders was highlighted.

Local autonomy is important within broader governance structures. Concerns were raised that HSE restructuring may impact local autonomy hindering local implementer's ability to act responsively in their work. More timely availability of relevant data locally, could also improve local implementation teams' ability to respond swiftly.

Regional adaptability is necessary for local implementation as what works in one area might not work in another. Regional level suicide prevention intervention can adapt to the specific needs and demographics within an area.

Strong leadership, ownership, partnerships, and stakeholder engagement enable local implementation. Regional leadership has been more inconsistent than national leadership; however, local champions have driven effectiveness.

Challenges in stakeholder engagement were raised and staff turnover and change of structure within organisations were highlighted as particular challenges presenting a need for frequent reengagement with key stakeholders. Local government buy-in remains variable across regions. Challenges in securing consistent cross-sectoral participation remain.

While *CfL* was a long-term strategy, annual funding cycles make it difficult for some organisations to plan, invest in capacity, and sustain progress.

To what extent did *CfL* achieve its Intermediate Outcomes?

The analysis of the secondary data was structured around *CfL's* 7 strategic goals and associated IOs. The secondary data was then triangulated with the survey, interview, and RI sessions data.

Based on this triangulation an assessment was made on the extent to which IOs were achieved using a 5-colour scale:

- Green – Achieved and sustainable
- Light green – Achieved, with minor learnings/barriers/challenges
- Amber – Achieved, with 1 major learning/barrier/challenge
- Orange – Achieved, with >1 major learnings/barriers/challenges
- Red – Not achieved

The results of this process are presented in Table 4 in the main report. As can be seen, over the 10-year term that *CfL* was in place, all of the IOs were assessed as achieved to some level. Of the 23 IOs one was assessed as 'Achieved and sustainable', three were assessed as 'Achieved, with minor learnings/barriers/challenges', seventeen as 'Achieved, with one major learnings/barriers/challenges', and two as 'Achieved, with >1 major learnings/barriers/challenges'. None of the IOs were assessed as 'Not achieved'.

Unintended positive and negative outcomes

Interviewees highlighted some positive and negative unintended outcomes from the *CfL* strategy as follows:

- Over-reliance on *CfL* for funding: Some programmes expect automatic funding increases without deeper evaluation of effectiveness.
- "Strategy fatigue": After nearly a decade, some sectors are experiencing a dip in momentum.
- Governance vs. flexibility: While *CfL* has successfully created structures, some interviewees argue that formal systems can become bureaucratic and slow-moving.
- Balancing structure and adaptability: Need to maintain agility in responding to emerging challenges.
- Strong working relationships have formed: Cross-sectoral work has supported the development of strong working relationships that have enabled other work in addition to *CfL*-related work.

What can be done to improve outcomes measurement (and impact assessment) of suicide prevention activities?

A significant commitment was made to research and evaluation in *CfL*. Strategic goal 7 outlines the specific objectives, actions, and IOs relating to research, evaluation, and data. A monitoring and evaluation framework was developed by NOSP in 2018 and a collaborative research grant scheme has ensured that research and evaluation activities relating to priority groups have progressed.

While improved systems for monitoring and reporting suicide and self-harm have been developed, more robust data systems are needed to improve outcome measurement. This was a strong theme across all data sources. The following issues are noted:

- Issues with the availability of timely data on suicide and self-harm were noted throughout. Current data on suicide are not available due to time lags in the reporting of official statistics by the CSO. The current coronial system and inquest process means that obtaining statistics for recent years is difficult as suicide is often determined after an inquest process has been completed and this may take some time.
- The lack of real-time surveillance was also noted as a critical gap in data systems. Although research has been carried out to progress work in this area, real-time surveillance is required at a national level.
- Currently there is a focus on outputs rather than outcomes.
- Delays in the completion of data sharing agreements have also impacted the availability of timely suicide statistics at local implementation level.
- Research gaps in relation to priority groups.
- Suggestions to incorporate lived or living experience into evaluation processes.

Embedding continuous evaluation could also improve outcome measurement for the next suicide prevention strategy. A more robust and integrated outcomes framework was suggested.

Is there an ongoing need for a national suicide prevention strategy such as *CfL*?

CfL came to an end in 2024 and preparation for the next phase of suicide prevention in Ireland is underway. Data from RI sessions, interviews, surveys indicate that there is broad agreement that the next suicide prevention strategy should be a refinement of *CfL*.

Over the 10-year term that *CfL* was in place as the national suicide prevention strategy, progress was made on all IOs, demonstrating the importance and value of a coordinated national strategy. While work remains on the majority of IOs, this evaluation highlights the importance of having a national strategy in place to coordinate and guide suicide prevention work.

The duration of the strategy should be considered further. Some interviewees suggested a 10-year strategy with fewer, high-impact goals, structured evaluation, and stronger regional implementation under *Sláintecare*[3]. Others recommended a shorter timeframe, e.g., 5 years, with clear short-, medium-, and long-term milestones.

The scope of the strategy should be examined. It was suggested that the next suicide prevention strategy should identify a limited number of actions that would be *"genuinely transformative and have an impact on people's lives"*.

Consideration should be given to the need for and feasibility of a separate self-harm strategy. If self-harm is addressed within the next suicide prevention strategy, then actions in relation to self-harm and suicidal ideation may need to be expanded.

The findings indicate that there is cross-over with other mental health and wellbeing strategies, such as *Sharing the Vision* (Department of Health, 2020), and this needs to be addressed to ensure that ownership of actions is correctly assigned to avoid duplication of work.

[3] https://www.gov.ie/en/department-of-health/campaigns/sláintecare/

Recommendations

This evaluation has produced a set of recommendations that are intended to improve the next national suicide strategy. These recommendations reflect key messages on best practice from the literature and the views of experts, as well as the views of stakeholders involved in *CfL*.

Governance

1. Retain *CfL*'s implementation structures and governance: Building on the success of the Cross-Sectoral Steering and Implementation Group, strengthen links with NGO groups and local implementation teams.
2. Consider broadening leadership beyond Department of Health: Joint leadership of the next suicide prevention strategy, by the Department of Health alongside another government department (e.g., Department of the Taoiseach) may assist suicide prevention being increasingly seen as an issue beyond health.
3. Clarify NGO engagement: Introducing structured, rotational representation for NGOs in governance structures to ensure more diverse and representative input.
4. Strengthen local implementation structures: Adapt *CfL's* model to better reflect the needs of Ireland's new six HSE Health Regions, while ensuring locally driven implementation plans.

Scope

5. Reassess strategy scope: Avoid an overly broad, action-heavy framework, prioritising fewer, more achievable, high-impact goals. The number, scope, and breadth of actions in the next strategy should be viable to be delivered.
6. Strengthen postvention objectives: This contributes to suicide prevention as well as stigma reduction and healing for those impacted by a death by suicide.
7. Clarify self-harm as a risk factor in suicide and ensure there are specific interventions for self-harm in the policy and strategy for suicide prevention: Provide clear self-harm interventions for suicide prevention and acknowledgement of self-harm as a behaviour that may be linked to mental health issues more generally.
8. Increase focus on suicide prevention as a public health issue: Move beyond mental health to better address social determinants of suicide, stigma reduction and broader health system integration. This would allow for more preventative and population-based health initiatives.
9. Focus on priority groups: Review who are the priority groups and expand peer-led approaches. Strengthen engagement with marginalised populations.
10. Enhance focus on service accessibility: Adopt an equity-based approach that considers vulnerable populations (e.g., digitally excluded groups, youth, rural communities, older adults).

Funding

11. Maintain dedicated suicide prevention resources within the HSE: This may need particular attention during the HSE restructuring process.
12. Develop a more strategic funding model: Prevent duplication of effort amongst partners to ensure resources are allocated effectively. A more sustainable funding model is also required for NGO partners delivering front-line services.
13. Strengthen prevention and early intervention: Funding is needed for improvements in availability of primary care counselling and adequate resourcing of community teams. Resource allocation should meet the needs of changing demographics and increasing population in some areas (e.g., urban areas) and ensure services are accessible (i.e., in rural areas).

Processes

14. Engage with stakeholders at strategy development stage: For successful implementation, identify who will lead on actions and recommendations, roles for stakeholders and where overlap exists with other strategies and policies. Engagement with stakeholders who will have responsibility for actions is critical at this early stage.
15. Include a living experience perspective: The Living Experience Representative Group in this evaluation provided a unique and valuable insight during the interpretation of findings stage. Lived or living experience should be embedded into policy development, governance, and evaluation.
16. Check efficacy of communications: A refinement of communication procedures is recommended, including communication from national to regional and local levels, among stakeholders, and between governance structures.
17. Strengthen data systems, surveillance, and outcome measurement: Address real-time data gaps and improve suicide reporting methodologies to move beyond coronial determinations. Measurement of protective factors such as resilience and social connectedness is also suggested, as well as a more robust outcome framework.
18. Embed continuous evaluation: Develop a real-time impact measurement system as part of an integrated outcomes framework that tracks progress continuously. Improved data collection, encompassing both intermediate and long-term indicators, is essential for demonstrating impact and securing ongoing funding.

Section 1: Introduction

Connecting for Life, Ireland's national strategy to reduce suicide (2015-2024)

Connecting for Life (CfL) was Ireland's national strategy to reduce suicide from 2015 to 2020 (Department of Health, 2015) and extended to 2024 following an Interim Strategy Review in 2018 (National Office for Suicide Prevention [NOSP], 2019a).

The strategy's vision is for *"an Ireland where fewer lives are lost through suicide and where communities and individuals are empowered to improve their mental health and wellbeing"*. *CfL* sets out two ambitious primary outcomes:

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

CfL sets out five guiding principles:

1. *Collaboration* is central to the strategy's whole-of-society approach to suicide prevention, thereby recognising that cross-sectoral inter-agency partnership working is essential to a coordinated, cohesive approach to suicide prevention.
2. *Accountability* is key to successful strategy implementation, largely addressed through clearly defined roles, responsibility, and governance structures.
3. *Responsive* to need, demonstrated through the strategy's focus on providing person-centred, high quality, easily accessible services for all.
4. *Evidence informed and outcome focused* in both strategy design and in the strategy document's focus on supporting the implementation of evidence-based practices and ongoing research to inform practice and policy.
5. *Adaptive to change* in recognition of the need for services and structures to be agile and flexible in order to adapt to emerging trends, new evidence, and changing circumstances.

The strategy provides a comprehensive multifaceted action plan aligned with best practice in the international literature (at the time of development) and the World Health Organization's recommendations for suicide prevention strategies (WHO, 2014). The action plan revolves around 7 overarching strategic goals and 69 specific actions.

- Strategic Goal 1 Better understanding of suicidal behaviour focuses on enhancing public awareness and attitudes towards suicide, self-harm, and mental health. This includes public media, targeted awareness raising and stigma reduction campaigns. The emphasis is on increasing awareness and knowledge of suicidal behaviour.
- Strategic Goal 2 Supporting communities recognises the need to empower local communities to prevent and respond to suicidal behaviour effectively, through the implementation of cross-sectoral, multiagency, area-level action plans aligned with the national strategy. Building the capacity of community-based organisations and gatekeepers through the delivery of suicide prevention training (as part of the national training plan) is also a key action under this goal.

- Strategic Goal 3 Targeted approaches for priority/vulnerable groups focuses on providing specialised support to reduce suicidal behaviour and improve mental health for individuals at increased risk of suicide. The strategy identified 22 priority groups or groups vulnerable to suicidal behaviour.
- Strategic Goal 4 Improved access, consistency and integration of services focuses on improving the accessibility, coordination and responsiveness of services for individuals vulnerable to suicidal behaviour. This includes improved psychosocial assessment, better access to effective therapeutic interventions (e.g., Dialectical Behaviour Therapy [DBT] and Cognitive Behavioural Therapy [CBT]), and support services for families and communities bereaved by suicide.
- Strategic Goal 5 Safe and high-quality services focuses on strengthening the quality and safety of services for people vulnerable to suicide. A key action under this goal is the design and implementation of Best Practice Guidance for Suicide Prevention Services. In addition, this goal focuses on improving the response to suicidal behaviour in health and social care services, in part through the implementation of a national training plan.
- Strategic Goal 6 Reducing and restricting access to means of suicidal behaviour focuses on implementing measures to restrict access to methods commonly used in suicide.
- Strategic Goal 7 Better surveillance, evaluation and research on suicidal behaviour focuses on improving the quality and availability of data on suicidal behaviour. Thereby recognising the need for more timely and accurate data to inform local and national policy. In addition, it shows a strong commitment to increasing understanding of suicide prevention, through the evaluation of major *CfL* activities and innovative approaches to suicide prevention.

Each of the 7 strategic goals has associated strategic objectives (see Figure 1 for an illustration of *CfL*'s strategic framework). The strategy also sets out 23 Intermediate Outcomes (IOs) and associated indicators for each IO.

In total, 22 government departments and state agencies made commitments, as leads or supporting partners, to deliver on these actions. This includes the various sections of the Health Service Executive (HSE, i.e., NOSP, Primary Care, Acute Hospitals, Mental Health, Health and Wellbeing) and the Department of Health, other government departments and state agencies, including the Department of Education and Youth, the Department of Agriculture, Food and the Marine, the Department of Justice and Equality, and the Department of Defence.[4] In addition, 23 Non-Governmental Organisation (NGO) partners are funded by the HSE to deliver on work aligned with *CfL*'s strategic objectives. These partners play a key role in direct service delivery; research, evaluation, and evidence generation; advocacy and awareness campaigns; and in the provision of targeted, culturally sensitive, and tailored interventions for *CfL* priority groups.

The HSE NOSP is identified in the strategy as the provider of cross-sectoral implementation support, in addition to being a named lead or supporting partner on 39 *CfL* actions. At the same time, there is a parallel bottom-up approach to delivering on *CfL*'s strategic objectives, realised through local area *CfL* suicide prevention action plans aligned with the national strategy.

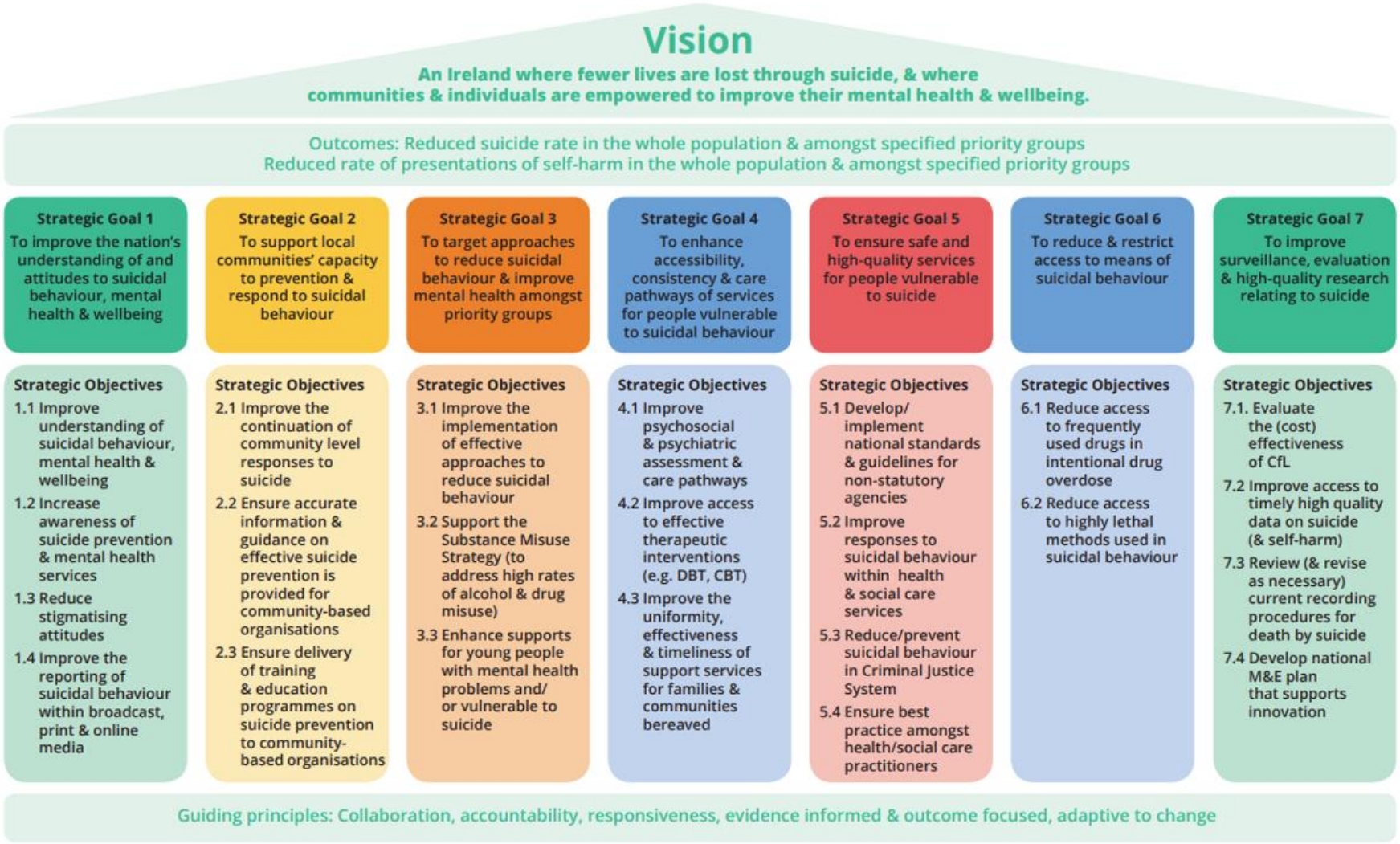
[4] Government department names at outset of strategy. Government department names have changed over the lifetime of the strategy.

CfL focuses on priority groups including[5]:

- Health/mental health related groups: People of all ages with mental health problems, 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 Lesbian, Gay, Bisexual, Transgender (LGBT) community, members of the Traveller community, people experiencing homelessness, people in contact with the criminal justice system (i.e., prisoners), people experiencing abuse (i.e., domestic, clerical, institutional, sexual, or physical), 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.

[5] The *CfL* strategy states that the list of priority groups would be reviewed regularly based on the most up-to-date evidence.

Figure 1: CfL strategic framework[6]



[6] Source: (NOSP, 2019a) – *Connecting for Life, Ireland's national strategy to reduce suicide 2015-2020 - Interim review.*

CfL implementation structures

Implementation of *CfL* occurs through a multifaceted governance framework that includes national oversight with local community action. To this end, *CfL* has parallel national and area-level implementation structures. Figure 2a shows (reading from the top down) that suicide prevention is a regular agenda item at the highest governmental level, the Cabinet Committee on Social Policy and Public Service Reform. The next key implementation structure is the *CfL* National Cross-Sectoral Steering and Implementation Group, which brings together the key partners from the health sector, various government departments, agencies, and NGOs on a quarterly basis. This group, chaired by the Department of Health, coordinates policy, plans actions, and works to ensure that the work of all partners, both statutory and NGOs, are aligned in their efforts to reduce suicide. All government department or state agencies who lead on actions set out in the strategy are represented on this group. Figure 2b provides more detail on the *CfL* implementation structures.

The HSE NOSP plays a crucial role in coordinating and driving strategy implementation. It offers support and oversight, manages the day-to-day implementation of the action plans, and acts as a liaison between the Cross-Sectoral Steering and Implementation Group and local implementation efforts. HSE NOSP led the development of a three-year *CfL* Implementation Plan (2017-20) published in January 2018; two subsequent Implementation Plans (2020-22 and 2023-24) were also published (National Office for Suicide Prevention, n.d.). HSE NOSP also provides oversight of the development, coordination, and quality assurance of comprehensive suicide prevention education and training programmes. It works closely with the NGO partners funded under *CfL* to provide a wide range of suicide prevention and mental health support and services for priority groups. It also plays a role in the coordination of national suicide bereavement supports; monitoring and evaluation; communications, resource development, and dissemination; and provision of support for local implementation of *CfL*.

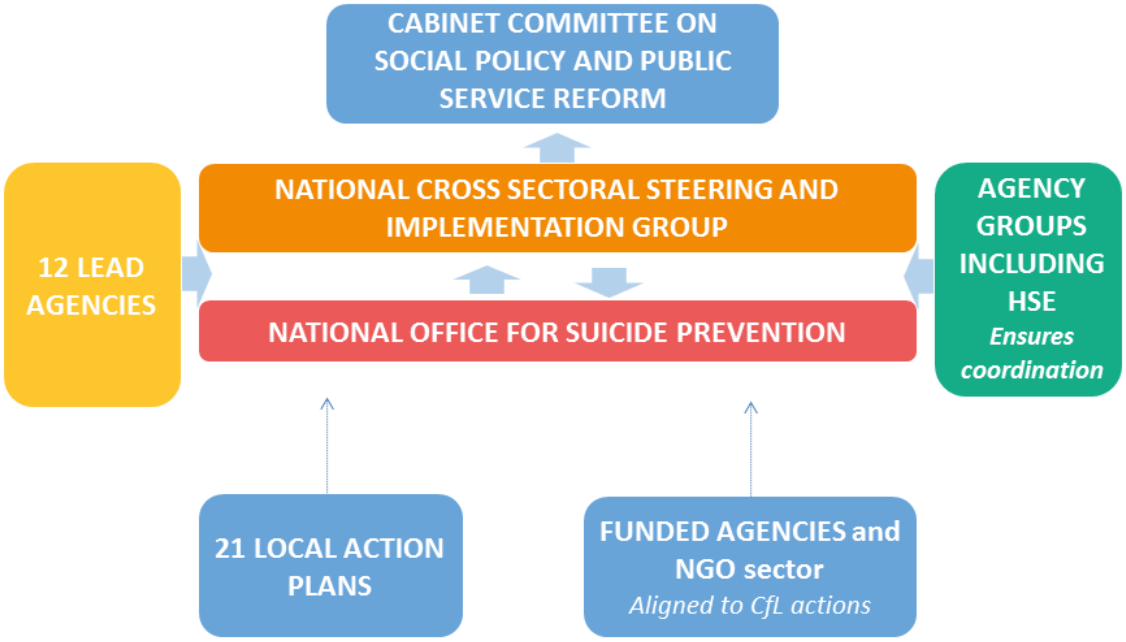
In summary the core HSE NOSP work streams are described as:

- Strategy co-ordination, which focuses on working with the 22 lead agencies.
- Education and training, which focuses on the delivery of a suite of evidence-informed training programmes.
- NGO support, which focuses on working directly with the NGO funded partners.
- Local implementation support, which focuses on working with the core network of HSE Resource Officers for Suicide Prevention (ROSPs), located around the country.
- Research and evaluation, which focuses on monitoring *CfL* implementation progress and on delivering a research and evaluation programme of work.
- Communications which support the overall communications requirements of the office.
- Coordination of national suicide bereavement supports.
- Clinical leadership, which provides clinical oversight, advice and input to relevant projects and initiatives.

The implementation of *CfL* focuses on translating the national strategic goals (and action plans) into area-level action plans (as per *CfL* action 2.1) tailored to the specific needs of the communities. Originally, 17 area-level action plans were developed across the nine HSE Community Healthcare Organisation (CHO) regions. HSE ROSPs are key facilitators and coordinators of *CfL* at the area-level. They are dedicated HSE staff members whose roles are multifaceted and critical to effective implementation of the strategy. HSE ROSPs work with local stakeholder steering groups to create and drive the implementation of area-level action plans reflecting national guidance and local realities.

Figure 2: CfL implementation structures

(a)



(b)


CABINET COMMITTEE ON SOCIAL POLICY AND PUBLIC SERVICE REFORM
(SUICIDE PREVENTION AS A REGULAR AGENDA ITEM)
PROVIDING HIGH LEVEL POLITICAL LEADERSHIP
NATIONAL CROSS SECTORAL STEERING AND IMPLEMENTATION GROUP
DRIVING POLICY, IMPLEMENTATION AND CHANGE
Chaired by Department of Health
DEPARTMENTS AND AGENCIES CENTRAL TO THE DELIVERY OF THE STRATEGY:
Dept. Health/HSE strand: Mental Health, Primary Care, Health and Wellbeing, Acute Hospitals, regulatory bodies, Healthy Ireland
Dept. Education, Dept. Justice, children's sectors (including agencies), local authorities, non-governmental organisation representatives
NATIONAL OFFICE FOR SUICIDE PREVENTION
PROVIDING CROSS SECTORAL SUPPORT FOR IMPLEMENTATION
Coordination of national implementation plans
Information, research and evaluation
Tracking of data to support evidence based approaches
Standards and guidelines
Coordination of national education and training plan
Media monitoring
Communication strategies and campaigns directing to services
LOCAL CROSS SECTORAL IMPLEMENTATION STRUCTURES FOR SUICIDE PREVENTION
RESPONSIBILITY: HSE National Mental Health Division through Community Health Organisation structures
PLANNING: Local Area Suicide Prevention Plans, linked to the Local Economic and Community Plans
SUPPORT: HSE Resource Officers for Suicide Prevention
MEMBERSHIP INCLUSIVE OF:
HSE - Community Mental Health Teams, Community Health Organisations, Primary Care and Health & Wellbeing, non-governmental organisations, Drugs and Alcohol Task Force, Gardai, education sector, Children Services Committees, Local Community Development Committees
INDIVIDUAL AGENCY IMPLEMENTATION SYSTEMS:
INCLUDING CO-ORDINATED HSE SYSTEM

Focus on outcomes and evaluation

CfL emphasises a systematic approach to evaluation and research, tracking progress and aiming for measurable improvements in suicide prevention and self-harm. The strategy explicitly refers to embedding monitoring and evaluation into the implementation process, in recognition of its role in guiding "*the on-going implementation process, with formal systems for capturing and sharing learning put in place*". To this end, in 2017 HSE NOSP developed a monitoring system to track implementation of *CfL* actions by lead agents. Each quarter leads with responsibility for *CfL* actions, report on implementation progress and flag issues that may be hindering implementation to HSE NOSP. This monitoring system uses implementation dashboards that have been informed by the literature. Dashboards are provided to each lead so they can report on milestones associated with each action and highlight any issues arising. Milestones are determined as being 'on track', 'needs attention', or 'off track' based on the agreed actions to be achieved. Based on all the information received, summary progress reports[7] were produced and published three times each year.

In addition to identifying two overarching primary outcomes, the strategy also set out 23 Intermediate Outcomes (IOs) with associated indicators, corresponding to the strategic goals and objectives. This was a rare and ambitious practice in national suicide prevention strategies at the time. The full list of IOs and associated indicators is presented in Table 3 in Section 5 of this report.

In 2018, the HSE NOSP and the *CfL* Evaluation Advisory Group undertook an Interim Strategy Review (National Office for Suicide Prevention, 2019a). The intention was to provide an assessment of advancements by examining implementation progress by strategy leads across all actions, objectives, and goals of *CfL*, and identify facilitators and barriers to implementation. It also sought to recommend strategic priorities for the subsequent period. The Interim Strategy Review asserted the ongoing relevance and importance of the strategy in addressing suicide and self-harm in Ireland. It highlighted successes in its comprehensive, multi-sectoral approach and commitment to evaluation, while also identifying critical areas for improvement, particularly around access to services, targeted support for vulnerable groups, and continued investment in data and research. The findings of the Interim Strategy Review informed the extension of the *CfL* to 2024 and subsequent implementation plans. In addition, the Interim Strategy Review recommended that:

The HSE National Office of Suicide Prevention should commission an external summative (impact) evaluation of CfL, conducted after 2024. This evaluation should focus on the measurement of progress towards principal and intermediate CfL outcomes and linkage of outcomes to implementation achievements.

[7] Progress reports are available at: https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/strategy-implementation/implementation-progress-reports/

Evaluation of the implementation and intermediate outcomes of *CfL*

In 2023 NOSP issued a request for tender for the evaluation of the implementation of *CfL* on a national and regional basis, to help understand how well *CfL* has been implemented, and to identify barriers and facilitators to implementation. A second key component of the evaluation was an examination of the extent to which *CfL's* intermediate outcomes have been achieved. Findings from both the implementation and outcomes evaluation of *CfL*, i.e., the current evaluation, will provide direction for post-*CfL* suicide prevention strategic work in Ireland. More specifically the findings will be used by NOSP, the wider HSE and the Department of Health to:

- support the identification and prioritisation of objectives for the next phase of work
- inform allocation of resources
- assist with the implementation of future suicide prevention strategies
- refine and strengthen systems for monitoring and measuring progress and outcomes.

This evaluation will also inform the work of all *CfL* implementation partners, including NGOs, HSE ROSPs, other HSE teams, and government departments.

Terms of reference for the evaluation

The overarching objectives of the current evaluation are to understand the implementation of *CfL* and the extent to which it is achieving its intermediate outcomes.

The evaluation set out to answer the following questions:

- To what extent does *CfL* as a policy framework inform key stakeholders in the development of their respective suicide prevention policies and programmes?
- To what extent are *CfL*'s suicide prevention activities and strategies aligned with the evidence base and good practice?
- How well is the top-down/national implementation of the strategy working?
- How well is the bottom-up/area-level implementation of the strategy working?
- Is there an ongoing need for *CfL* as a policy intervention?
- What lessons have been learned from the implementation of *CfL* (that could improve the efficiency and effectiveness of any future associated strategies)?
- Which of *CfL*'s suicide prevention activities and individually funded projects are achieving the agreed intermediate outcomes (identified in the strategy)?

Implementation context over the duration of the *CfL* strategy

It is important to note the following issues impacted the implementation context for *CfL* during the 10-year period that the strategy was in place:

- COVID-19 pandemic
- HSE cyberattack
- HSE restructuring and a
- national cost of living crisis.

Both the COVID-19 pandemic and the HSE cyberattack were unprecedented events and caused major disruptions to the implementation of the strategy and functioning of health and social care systems, more generally. At the time of data collection and publication of this evaluation report, the HSE restructuring was ongoing.

Section 2: Methodology

Overall approach

The current evaluation is a mixed-methods evaluation of the implementation and Intermediate Outcomes (IOs) of the *CfL* strategy, to inform future resourcing of suicide prevention policies and activities. Our approach to the evaluation is rooted in the principles of realist evaluation, a theory-driven approach to the evaluation of complex interventions. The *CfL* strategy can be conceived of as a complex intervention, in that it contains multiple interacting components and multiple potential outcomes, that are dependent on the behaviours of those delivering and receiving intervention activities. The system within which the strategy is delivered is also inherently complex, affected by broad social, economic, and political factors. Realist evaluation is commonly used to evaluate how complex interventions achieve their outcomes. A realist evaluation is not only focused on whether or not an intervention worked, but why it worked. This approach seeks to identify the many different factors that may have contributed to whether or not an intervention was successful in achieving what it set out to do. Realist evaluation is focused on:

- the ***context*** or circumstances in which the intervention was delivered,
- the ***mechanisms*** of change that led to outcomes, and
- the intended or unintended consequences (***outcomes***) of the intervention.

Mechanisms are the causes of change from an intervention. They are generated through a combination of the resources offered by an intervention and the way in which stakeholders receive and respond to the intervention. When the mechanisms interact with the specific context for the intervention, they produce outcomes. As a starting point for this evaluation, a logic modelling workshop was carried out in partnership with key *CfL* stakeholders, which took the form of an After-Action Review (AAR; further details are provided in Appendix A).

The key research questions, presented in Section 1 of this report, are concerned with the implementation of *CfL* and its IOs. In addressing these research questions, the CES evaluation team have drawn out the implementation factors that determined the mechanisms of change from the *CfL* strategy, and the national and regional contextual factors that affected how these mechanisms operated. In line with our realist approach to the evaluation, we have combined these findings with our analysis of the strategy outcomes to provide a detailed understanding of the contribution of the *CfL* strategy to suicide prevention that can inform future resourcing in this area.

Prior to the commencement of primary data collection, stakeholder mapping was carried out by HSE NOSP and this list of stakeholders was used by CES for data sourcing. A summary of each data collection method is provided in this section. Further details on the methodology are provided in Appendix A. Table 1 provides an overview of the data sources that were used to inform each of the evaluation questions.

Table 1: Matrix of data sources used to inform evaluation questions

Evaluation Questions	Literature Review	Rapid Insight Sessions (*n* = 51)	Interviews (*n* = 30)	Surveys (*n* = 186, incl. 18 ROSPs)	Secondary Data
Assess the policy content of the *CfL* strategy	●				
Assess the (top-down) cross-sectoral implementation of the *CfL* strategy		●	●		
Assess the (bottom-up) area-level implementation of the strategy		●	●	●	
To what extent are *CfL*'s suicide prevention activities and individually funded projects achieving the agreed intermediate outcomes?		●	●	●	●
What can be done to improve outcomes measurement (and impact assessment) of suicide prevention activities?		●	●	●	●
Is there an ongoing need for a national suicide prevention strategy such as *CfL*?	●	●	●	●	●

Literature review

Sources and search terms for review of evidence-based suicide prevention strategies

The literature search carried out as part of this evaluation is narrow in scope, focusing on published systematic reviews and meta-analyses, and targeted on relevant evidence and best practice from appropriate and comparable clinical contexts. The review focused on identifying relevant updates and evidence around best practice for suicide prevention that have been published since the initial development and publication of the *CfL* strategy (Department of Health, 2015). Search terms were based on evidence-based interventions included in *CfL* and commonly cited in the literature on suicide prevention (further details are provided in Appendix A).

Seventy-seven articles were deemed as containing information on evidence-based suicide prevention interventions relevant to the current evaluation, following screening and review. Articles were categorised under the following evidence-based intervention headings:

- Means restriction
- Media guidelines
- Community-based interventions
- Postvention
- Training
- Psychosocial, including coping skills, problem-solving etc.
- Crisis intervention

- Mental health treatment
- Stigma reduction.

Articles were categorised as 'multiple interventions' if findings on more than one of these interventions were included.

Primary data collection

Rapid Insight sessions

The Rapid Insight (RI) methodology is a modified type of focus group that gathers larger groups of professionals into a tightly managed, virtual forum to share system experiences and intelligence (Chandler, Darnton, & Sibley, 2023). One key benefit of RI sessions, relative to traditional focus groups, is that it empowers less heard voices, which may lead to capturing a greater diversity of experiences.

Three groups of *CfL* stakeholders were engaged to gather their insights and perspectives on the implementation of the *CfL* strategy.

- Representatives from the 22 government departments and agencies who are involved in the implementation of *CfL* actions and who are representatives on the national Cross-Sectoral Steering and Implementation Group for *CfL*. 17 participants attended.
- Representatives from the 21 different NGO partner organisations who are funded by NOSP to deliver on work aligned with the *CfL* objectives. 21 participants attended.
- HSE ROSPs (21 known active ROSPs) who work across a range of areas nationwide. 13 participants attended.

The specific questions in the RI sessions were informed by a document review and the AAR workshop:

1. Thinking about implementing the *CfL* strategy, from your perspective what could have been 'Even Better If'?
2. What are your key lessons about implementing a strategy that crosses multiple agencies, sectors, budget and accountability relationships?
3. What factors need to be in place to create a sustainable suicide prevention programme for the future?

Interviews

The CES evaluation team conducted a series of semi-structured online interviews with national stakeholders across a range of government departments and agencies associated with *CfL*. The interview participants included representatives from:

- NOSP
- Government departments and agencies
- ROSPs

- NGOs funded as delivery partners
- Subject matter experts who act, or acted, as advisors to *CfL* (bellwether interviews).

A core interview schedule was adapted to two different groups of interviewees: those with direct involvement in *CfL* implementation and those in a more advisory capacity (bellwether interviewees). More detailed interview schedules are provided in Appendix A. Interviews focused on the following topics, as appropriate:

- Implementation of *CfL* and how it worked in practice
- Implementation context for *CfL* at a national and regional level
- Perceived barriers and facilitators of *CfL* implementation
- Progress achieved by *CfL* and perceived contribution to systems change
- Unexpected positive or negative outcomes from the *CfL* strategy
- Outcomes measurement and impact assessment of *CfL*
- Concluding comments and looking to the future.

A total of 30 interviews were conducted between October and December 2024.

Surveys

Two surveys were created for this data collection, one for ROSPs and one for local stakeholders/implementation partners. The ROSP survey focused on the unique experiences, challenges, and successes encountered by them in *CfL* implementation. The local stakeholders/implementation partners survey was designed for those who actively support *CfL* initiatives but are not ROSPs. It gathered perspectives on *CfL*'s reach, engagement, integration, and sustainability at the local level.

The ROSP survey had 31 questions under the following headings:

- Demographic data
- Reach and engagement
- Adoption and integration
- Implementation and fidelity
- Maintenance and sustainability
- Additional comments and feedback.

The local stakeholders/implementation partners survey had 15 questions under the following headings:

- Challenges in agency adoption
- Implementation and fidelity

- Maintenance and sustainability
- Additional comments and feedback.

Surveys were distributed via the ROSP areas of responsibility. The ROSPs were asked to circulate the appropriate link to the questionnaire amongst the local stakeholders and implementation partners. All responses were anonymous.

The survey was open for a 5-week period across November and December 2024. It was distributed to 21 ROSPs and 613 local stakeholders and implementation partners.

Analysis

Qualitative datasets were thematically analysed to identify, interpret, and report patterns (or themes) across a dataset, which represent beliefs, observations, and experiences that participants may share in relation to the research questions. Thematic analysis is also interested in identifying differences in experiences and developing explanations for these differences.

Each dataset was analysed separately and then combined at the triangulation stage.

Rapid Insight sessions

Rapid Insight (RI) data were analysed by high-level thematic groupings, following an inductive approach (Chandler, et al., 2023). The findings are presented as a series of mind maps for each *CfL* stakeholder group. In each mind map, the central themes are placed within circles with associated sub-themes arranged around each circle.

The chat contributions were sorted into individual groupings by theme, then the groupings were compared to identify similarities and differences, prior to adding to the mind map. The individual contributions were edited for brevity to link to the identified themes within the mind map.

Interviews

A deductive interview coding framework was developed combining elements of CFIR (Consolidated Framework for Implementation Research; Damschroder, Reardon, Widerquist, & Lowery, 2022), Proctor's Outcomes for Implementation Research taxonomy (Proctor, et al., 2010), RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance; Glasgow, Vogt, & Boles, 1999), and COM-B (Capability, Opportunity, Motivation – Behaviour; Michie, van Stralen, & West, 2011). The coding framework has 8 primary categories encompassing 43 individual codes. The primary categories are:

1. Contextual factors (CFIR)
2. Cross-sectoral collaboration (CFIR)
3. Implementation processes (CFIR)
4. Intervention characteristics (CFIR)
5. Implementation outcomes (Proctor and RE-AIM)
6. Data and evidence (Proctor and RE-AIM)

7. Emerging issues and reflections (Proctor and RE-AIM)
8. COM-B informed codes.

Regular check-ins were conducted between the evaluators responsible for coding to sense-check the application of the coding framework and ensure consistency in interpretation. Any uncertainties or discrepancies that arose were referred to the wider CES evaluation team for consideration, discussion, and quality assurance. This iterative approach ensured rigor and flexibility in the analysis process, accommodating emerging insights while maintaining alignment with the evaluation objectives.

Surveys

The analysis of survey data was conducted through two main approaches: quantitative analysis of closed-ended questions and thematic analysis of open-ended or free-text responses.

For the closed-ended questions, descriptive statistics were employed to summarise the data. This included calculating measures such as frequencies, percentages, means, and standard deviations to provide a clear overview of the responses and highlight patterns and trends.

For the open-ended or free-text questions, a thematic analysis was conducted to capture the richness and depth of qualitative data. This analysis used the same coding framework as the interviews for consistency and to facilitate the data triangulation.

Secondary data

CES developed a bespoke Implementation Outcomes Framework for coding the available evidence based on the National Clinical Effectiveness Committee (NCEC)/CES Implementation Guide and Toolkit Implementation Outcomes (Department of Health, 2018), which is, in turn, based on Proctor/RE-AIM frameworks (Glasgow, et al., 1999; Proctor, et al., 2010). This framework is tailored towards conceptualising and evaluating successful implementation within health services.

There were two categories of source documents:

- A document compiled by NOSP (Multiple Lines of Evidence) that contained document links, publicly available document references, webpages, and references or observations from internal or in-progress reports and meetings.
- Publicly available background documents, including *CfL* progress reports (quarterly and annual), Interim Strategy Review, and implementation plans.

The following implementation outcomes were used for the analysis of the documents:

- **Acceptability** - The perception among stakeholders that an intervention is agreeable, palatable, or satisfactory, and leads to an improved general service experience.
- **Appropriateness/Feasibility** - The extent to which the intervention is compatible, relevant, and implementable within a given context or setting.
- **Penetration/Reach** - The degree to which the intervention is integrated into a service setting, including whether it effectively reached the target population.

- **Maintenance/Sustainability** - The extent to which the intervention will be renewed and institutionalised into the organisation/setting's ongoing operations.

An assessment of the extent to which IOs were achieved was made during the data triangulation stage using a 5-colour scale:

Green – Achieved and sustainable

Light green – Achieved, with minor learnings/barriers/challenges

Amber – Achieved, with 1 major learning/barrier/challenge

Orange – Achieved, with >1 major learnings/barriers/challenges

Red – Not achieved

Triangulation

Triangulation in a mixed methods evaluation refers to the integration of data. It is a process of using multiple methods, data sources, or perspectives to gain a more comprehensive understanding of a research problem. Triangulation methodically integrates quantitative and qualitative data to:

- maximise the strengths and minimise the flaws of each technique
- validate and reinforce the research results by providing multiple perspectives
- identify areas of discrepancies or complexities.

For the *CfL* evaluation, triangulation took place at the interpretation and reporting level using the 'integration through narrative' methodology. This methodology uses narratives to describe the quantitative and qualitative data findings, which allowed for a more holistic understanding of *CfL* implementation and progress against the IOs.

Over a series of face-to-face sessions, the CES evaluation team brought together all of the analyses against each of the individual *CfL* IOs. The combined primary and secondary data findings contributed to an overall 'assessment' of the achievement of the individual IOs. In parallel, the data were used to link together evidence of progress in the implementation of *CfL* overall.

Illustrative narratives

For this evaluation, narratives were identified to illustrate how the *CfL* strategy contributed to specific changes within services, organisations, or systems.

The selection pool consisted of interviews where participants provided the greatest amount of detail for each of the criteria below:

- the situation and particular challenges that were faced
- the actions taken
- the specific changes realised and the evidence for the change
- the significance of the change.

Follow-up interviews were carried out to expand on the content provided during the initial interview. These were written as vignettes to provide real-life examples of changes brought about within the context of the *CfL* strategy.

Evaluation governance structures

Two groups supported the CES evaluation team over the course of the evaluation. The first group, the Evaluation Advisory Group, included senior academics and researchers with expertise in suicide prevention, national suicide prevention strategy, research methodology, and evaluation. This group was in place prior to the commencement of the current evaluation.

The second group, the Evaluation Stakeholder Group, included representatives from NGOs, as well as representatives from the Department of Health and HSE with responsibility for policy development and implementation, including two ROSPs. This group was formed at the beginning of the current evaluation.

The full list of members from each group are listed in the front matter of this report (see pages v and vi). Regular meetings were help with each group over the course of the evaluation where the CES evaluation team provided updates on progress and issues arising. Both groups reviewed drafts of the current report and provided feedback. Members of both groups provided advise and support to the CES evaluation over the course of the evaluation.

The current evaluation received approval from a Research Ethics Committee.

Lived or living experience representation

The CES evaluation team conducted two on-line group discussions with a Lived or Living Experience Representatives Group to review and contribute to the final report of the *CfL* evaluation. People with lived or living experience of suicide were recruited through three of the organisations represented on the Evaluation Stakeholder Group, i.e., the National Suicide Research Foundation (NSRF), Pieta, and HUGG. A lived or living experience representation information document was produced by CES in collaboration with representatives of the three organisations and circulated to their lived or living experience representatives (see Appendix B). Those interested in participating in the *CfL* panel were asked to make initial contact with their host organisation. They were then contacted by a member of the CES evaluation team to discuss the project, to give details of the informed consent process, of supports available, and as an opportunity to ask any questions. A total of five lived or living experience representatives were recruited, four of whom attended both sessions. The initial online discussion focused on induction and on providing an overview of the *CfL* strategy and of the CES evaluation. Participants were given reading material, i.e., the presentation slides and a link to the strategy document, to consider before the next meeting. The second online discussion focused on core evaluation questions, with participants asked to comment on and 'sense check' some of the early findings from the evaluation data. This discussion was digitally transcribed and used to inform further analysis and write-up of the data.

Challenges/Limitations

The *CfL* strategy is a complex intervention, in that it contains multiple interacting components and multiple potential outcomes that are dependent on the behaviours of those delivering and receiving

intervention activities. The system within which the strategy is delivered is also inherently complex, affected by broad social, economic, and political factors. This presents an inherent challenge for the evaluation of both implementation and progress on IOs.

Other specific challenges to the evaluation of the implementation of *CfL* and progress towards its IOs include:

Determining the impact of specific interventions – Some overlap exists in the suicide prevention interventions presented in the literature review and included in the *CfL* strategy. For example, some training interventions may include attempts to reduce stigma, and some media guidelines or community-based interventions may also address stigma. Overlaps such as this create a challenge for isolating and measuring the impact of individual suicide prevention interventions.

Response rates – The response rate on the local stakeholders/implementation partners survey was low; however, for other primary data collection, response rates were good.

Section 3: Literature review

Overview

The literature review carried out for the current evaluation consists of two parts. The first section, *best practice in suicide prevention strategy design and implementation*, was compiled by NOSP. They provided the text, reference list, and an initial suggestion for the graphic. CES supplemented the NOSP material with edits for clarity, a reference search to fill in the few remaining gaps, expanding the data shown in the graphic and reformatting the graphic.

The second section of the literature review, *evidence-based suicide prevention strategies*, focused on identifying relevant updates and evidence around best practice for suicide prevention that have been published since the review carried out by the Health Research Board (HRB) on behalf of HSE NOSP in advance of the publication of *CfL* in 2015 (Dillon, Guiney, Farragher, McCarthy, & Long, 2015). It is narrow in scope, focusing on published systematic reviews and meta-analyses, and targeted on relevant evidence and best practice from appropriate and comparable clinical contexts. Specific search terms were based on the HRB review, evidence-based strategies included in *CfL*, and commonly cited in the literature on suicide prevention. PubMed was used as the search tool.

Initial search results were screened by two members of the CES evaluation team to determine eligibility for inclusion. Eligible articles then underwent a full-text review for categorisation. The findings were formatted into tables or graphics, with the support of a CES Communications Specialist, and supplemented by brief commentary.

Best practice in suicide prevention strategy design and implementation

A national suicide prevention strategy is a systematic way of developing a comprehensive and integrated national response to suicidal behaviour and a structural framework to support effective suicide prevention action and evaluation (Platt, Arensman, & Rezaeian, 2019). A well formulated national strategy must incorporate a suite of evidence-based suicide prevention strategies and initiatives (United Nations, 1996). However, success can only be guaranteed if the strategy is effectively implemented. For this document, strategy implementation is defined as a *"dynamic, iterative, and complex process"* that is comprised of various *"activities by managers and employees to turn strategic plans into reality in order to achieve strategic objectives"* [(Yang, et al., 2010, p. 165; cited in (Tawse & Tabesh, 2021)].

This section summarises the literature in relation to best practice in suicide prevention strategy design and implementation. The *CfL* strategy includes many of the elements of best practice outlined in this section. For example, *CfL* is a multi-component systems approach to suicide prevention which includes a cross-sectoral strategic approach, and these elements will be considered in the development of the next phase of suicide prevention work in Ireland.

- It is recognised that single interventions aimed at reducing suicide rates have limited impact on the complex issue of suicide prevention (United Nations, 1996). Current thinking is that multiple interventions implemented at the same time, at many levels (i.e., they

contain elements that are implemented in different health care setting or domains and by different providers) and tailored to the local community context, are likely to be the most effective way of reducing the rates of suicide (Hofstra, et al., 2020).

- This multi-component systems approach to suicide prevention combines preventative interventions ranging from those that target individuals at risk, workers who deal with suicidal crisis, and the wider community (Baker, Nicholas, Shand, Green, & Christensen, 2018); all are implemented simultaneously in a localised area.[8]

- Simultaneous implementation of these multi-component strategies/interventions needs to be facilitated by multi-stakeholder implementation teams (at a local, regional or national level as necessary). In theory such approaches to suicide prevention have synergistic potential, meaning that the effect of the combined parts of the strategies and interventions can create a stronger effect than the sum of the individual effects of the interventions (Hofstra, et al., 2020).

- There is some evidence indicating that multi-component systems approaches to suicide prevention are most effective (Baker, Nicholas, Shand, Green, & Christensen, 2018). In addition, multi-level suicide prevention interventions have been shown to be more effective than single level interventions, and further that effect size rises significantly with the number of levels involved (Hofstra, et al., 2020). Regarding the synergistic effects of multi-level interventions, the findings are at best promising, due to the low number of studies with more than one level.

- At the heart of these multi-component systems approach to suicide prevention is cross-sectoral action, that is, interventions that occur (inside and) outside the health sector but affect health outcomes (Pirkis, et al., 2023). Such an approach to suicide prevention recognises the fact that policies across a range of sectors can influence risk (of self-harm and suicide).

- This cross-sectoral action necessitates multi-sectoral collaboration – where partnerships are formed between government, NGOs, community members, citizens, and researchers (Pearce, et al., 2022a). Thus, providing a broad-based response to suicide that engages all

[8] For example, LifeSpan, developed by the Blackdog Institute in Australia focuses on simultaneous implementation of nine evidence-based interventions each addressing a different population group or issue. Briefly, the nine strategies are: improving emergency and follow-up care for those in suicidal crisis; using evidence-based treatments; better equipping primary care to identify and support people in distress; improving the competency and confidence of frontline workers to deal with suicidal crisis; partnering with schools to promote help-seeking, mental health, and resilience; engaging the community and providing opportunities to be part of the change; training the community to recognise and respond to suicidality; encouraging safe and purposeful media reporting; and improving safety and reducing access to means of suicide. Collectively, these strategies are intended to engage the whole community in the goal of suicide prevention and build capacity to identify and respond to suicide risk. The delivery of these strategies is managed at each implementation site by LifeSpan Coordinators in collaboration with the LifeSpan central team (Long, et al., 2022). Other examples of multi-component intervention models include European Alliance against Depression and Zero Suicide (European Alliance Against Depression, 2016; National Action Alliance for Suicide Prevention, 2013).

sectors including government, health care systems and providers, businesses, educational institutions, community-based organisations, family members, and friends.

- Such an approach is in line with a public health response to suicide prevention, as it recognises that suicide is both a mental health and a public health concern. Like other public health problems, suicide is affected by many influences related to individual characteristics, interpersonal relationships, the community, and the larger society (Pirkis, Dandona, Silverman, Khan, & Hawton, 2024; Sinyor, Chan, Niederkrotenthaler, Vanda, & Platt, 2024; WHO, 2014).

- In has been increasingly recognised that including people with lived or living experience is essential to multi-sectoral collaboration (Pearce, et al., 2022a; Pearce, et al., 2022b). Empowering and involving people with lived or living experience perspectives increases understanding of how to respond effectively to suicide risk and provide services and supports that best meet the needs of persons experiencing a suicidal crisis. The lived or living experience perspectives can also inform efforts to better prepare communities nationwide to respond to the aftermath of suicide and to support recovery among all who may be affected. In addition, there is also a role for lived or living perspectives in identifying and driving the necessary improvements in policies and systems.

- A national cross-sectoral strategic approach to suicide prevention should be underpinned by:

    - strong leadership and governance at the highest level of government, with clearly delineated roles and responsibility, inclusive decision-making processes, and support from policy makers;

    - oversight and coordination across the diverse sectors and stakeholder groups to ensure coherence in strategy implementation;

    - appropriate investment and funding and a recognition that people are a key strategic resource (Lorange, 1998); it is essential for organisations to effectively utilize the know-how of their employees at the right places; and

    - strong surveillance, monitoring, and evaluation mechanisms to ensure accountability, and learning, and to contribute to the evidence base.

- Multi-component systems approaches to suicide prevention are inherently complex as they involve multiple stakeholders, implementing multiple interventions in a dynamic context that is influenced by social, economic, political, and cultural factors. One way to support the work is to apply an implementation science lens to help understand 'how' interventions are being delivered and 'why' they do (or do not) work (Bauer & Kirchner, 2020). In addition, implementation science frameworks can help systematically guide how researchers plan

for, employ, adjust and measure key aspects of the strategy, such as fidelity to the plan, or adoption by partners.

- Implementation science can be integrated into the work in several ways, for example by (Gustavson, et al., 2021):

    - Establishing implementation structures that can guide teams and provide a framework on how strategies will be implemented.

    - Using implementation frameworks to help understand what and how factors are influencing strategy delivery, recognise resource needs from stakeholders, and identify appropriate strategies to overcome anticipated or unanticipated challenges to programme delivery (Nilsen, 2015). This is vital given that one of the crucial obstacles to successful implementation of a strategy is not anticipating possible nor enhancing possible benefits of factors facilitating the implementation (Nilsen, 2015).

        - Implementation frameworks[9] can be used specifically to identify and anticipate barriers to successful strategy implementation. There are several challenges to successful implementation, including for example (Platt, et al., 2019):
            - limited knowledge, capacity, or capability among partners about how to change working practices, in order to deliver interventions;
            - Ineffective planning, coordination, or collaboration between delivery partners;
            - a mismatch between inputs (resources, equipment, or personnel) and the ambition, demands, and outcomes of the strategy;
            - an unsupportive political, social, or legal environment; and
            - limited capacity to monitor implementation progress and make necessary adjustments.

        - According to the WHO (WHO, 2018), the biggest barriers to suicide prevention strategy implementation that need to be considered in more depth include, management and logistics (i.e., understanding the problem, actions, and interventions), stakeholders (i.e., leadership and management, teamwork and collaboration, legislation and policies), financial resources (i.e., budget for implementing suicide prevention), human resources, stigma, data collection, and multi-sectoral involvement.

[9] The implementation framework that *CfL* used in the Interim Strategy Review was the Consolidated Framework for Implementation Research (CFIR; Damschroder, et al., 2022). The CFIR framework is very useful when structuring results as it covers all important aspects of the implementation process (Kasal, et al., 2023).

- Identifying and applying appropriate evidence-informed implementation strategies to overcome anticipated or unanticipated challenges in strategy delivery (Bauer & Kirchner, 2020).

- Using evaluative and iterative strategies to guide how researchers plan for, employ and adjust, and measure key aspects of the delivery of the strategy, such as fidelity to the components or adoption by stakeholders that subsequently influence effectiveness.

- Conducting implementation research including gathering data on the processes involved in the delivery of an intervention, its reception, and the setting or implementation context of the intervention to help improve understanding of how and why the intervention works (Krishnamoorthy, et al., 2023). In addition, framing implementation outcomes such as acceptability, reach, adoption, fidelity, feasibility, and sustainability (Proctor, et al., 2010) as key variables in an evaluation programme of work, can increase understanding of underlying mechanisms and causal relationships in implementation processes.

- Traditionally, suicide prevention efforts have often focused on identifying and getting help for those who are at risk for suicide, but suicide prevention can also occur prior to the onset of risk to prevent the development of risk. To this end there has been increasing attention on "upstream" risk factors that affect the whole population. The upstream societal factors (or social determinants) that influence suicide risk and mental health, include adverse childhood experiences, unemployment, a lack of safe and affordable housing, and financial hardship (Pirkis, et al., 2024; Gallagher, et al., 2025).

- Moving upstream in suicide prevention involves promoting and enhancing social connections, strengthening economic supports, providing enhanced services and resources to underserved groups at elevated risk for suicidal behaviours, and devoting efforts to develop, implement, and evaluate primary suicide prevention initiatives (Iskander & Crosby, 2021). At the same time, ways to strengthen the protective factors that promote strength and resilience (the ability to endure, respond to, and recover from stress and adversity) should be identified to reduce suicide risk.

- Suicide prevention theory and research have long identified the social context as crucial to protecting individuals and populations from suicide. The social context is also crucial to understanding suicide risk especially given the evidence that suicide is socially patterned being significantly more prevalent in areas of social disadvantage compared to more affluent areas (O'Connor & Portzky, 2018). Theories of suicide suggest that social factors, such as isolation and the feeling of being a burden to others, may increase suicide risk. Opportunities to contribute, through gainful employment that pays a living wage, or by volunteering or mentoring, may help reduce suicide risk by fostering supportive relationships and a sense of meaning and purpose.

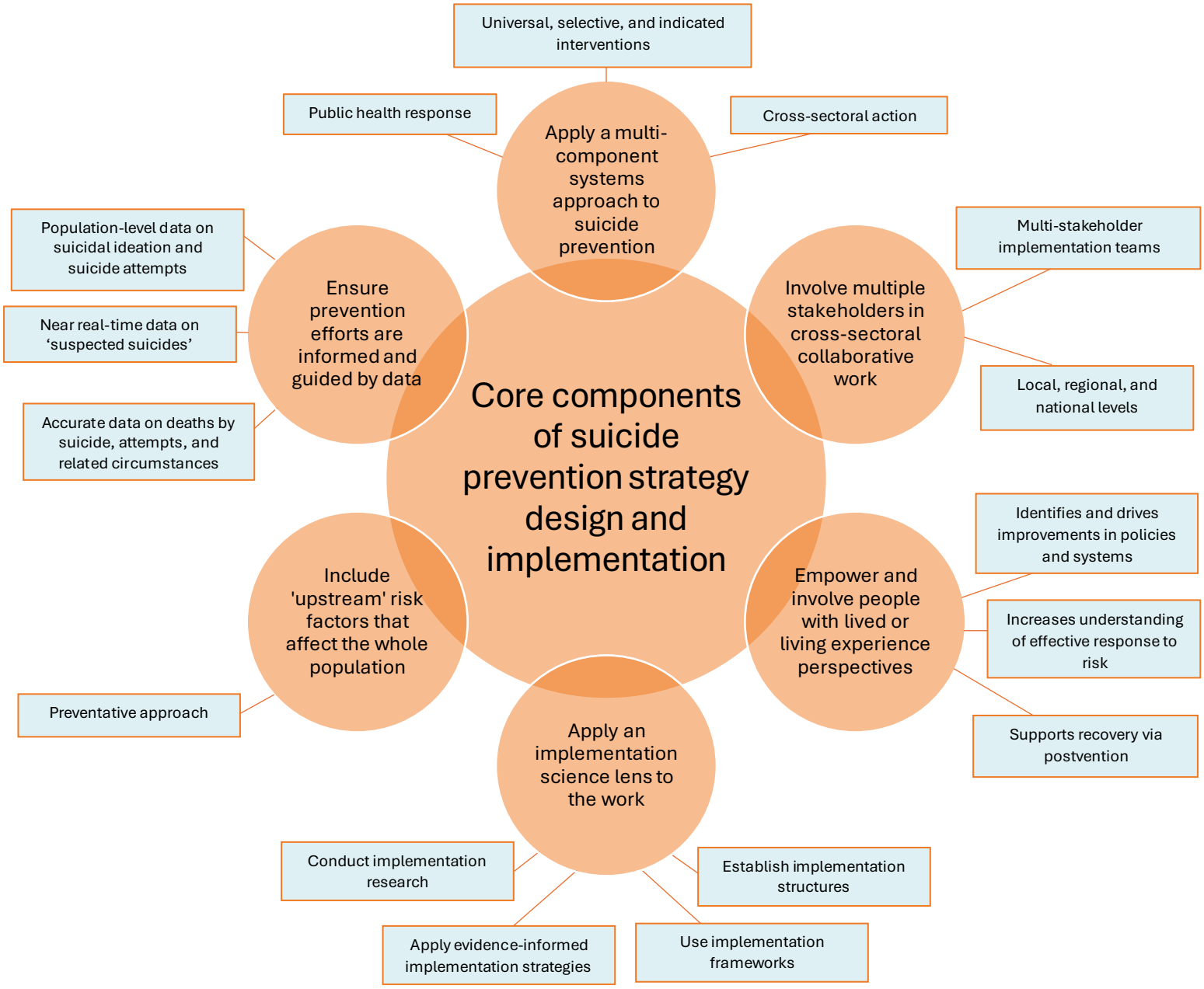
- Access to timely and accurate data on deaths by suicide, suicide attempts, and related circumstances is critical to ensure that prevention efforts are reaching those most at risk. Thus, suicide prevention efforts must be guided by timely and reliable data collected at the national, regional, and local levels monitoring trends, guiding prevention efforts, informing public policy, and assessing the effects of interventions.

- The importance of near real-time data on suicide has increasingly been recognised in detecting and responding to increases in suicide attempts and deaths by suicide, identifying emerging populations at risk, and assessing the effectiveness of suicide prevention efforts over time (Hawton & Pirkis, 2024).

- In addition, population-level suicide-related data related to suicidal thoughts, and attempts; risk factors; healthcare use; and other relevant outcomes are also critical to identifying emerging trends, planning suicide prevention efforts, and assessing progress.

The core components of suicide prevention strategy design and implementation are displayed in Figure 3.

Figure 3: Core components of suicide prevention strategy design and implementation[10]



[10] (WHO, 2014, p. 30) distinguishes between universal, selective, and indicated interventions as follows:

1. Universal prevention strategies - designed to reach an entire population in an effort to maximize health and minimize suicide risk by removing barriers to care and increasing access to help, strengthening protective processes such as social support, and altering the physical environment.
2. Selective prevention strategies - target vulnerable groups within a population based on characteristics such as age, sex, occupational status, or family history.
3. Indicated prevention strategies - target specific vulnerable individuals within the population, e.g., those displaying early signs of suicide potential or who have made a suicide attempt.

Evidence-based suicide prevention strategies

Prior to the publication of *CfL*, a literature review was carried out by the HRB (Dillon et al., 2015) to determine the international evidence base for suicide prevention strategies[11]. The review concluded that the suicide prevention interventions with the strongest evidence base included restricting access to means and psychosocial interventions, such as CBT and DBT. Screening and gatekeeping were noted as effective when followed by referral to behavioural interventions. Emergency Departments (ED) were also identified as a promising location for the delivery of suicide prevention interventions. The overall conclusion of this review was that the evidence base for suicide prevention interventions was limited.

Following on from the HRB review, a literature search was carried out to identify relevant updates to the evidence base published between 2015 and 2024.

- Full details of the literature search carried out by the CES evaluation team are provided in Appendix A of this report. A description of the evidence-based suicide prevention interventions presented in this review is provided in Table 2.
- Figure 4a illustrates the quantity of articles retrieved under each of the evidence-based suicide prevention intervention headings outlined in Table 2. Articles that contain information on more than one intervention were categorised as 'multiple interventions'.
- Figure 4b shows the evidence-based interventions referred to in articles categorised as containing multiple interventions.
- A summary of findings relating to each intervention type is provided in Appendix C. Findings from articles reporting on 'multiple interventions' are also presented in Appendix C, along with a summary of 'community-based interventions' in specific at-risk groups. Most of the articles categorised as 'community-based interventions' present findings on more than one type of intervention.

Of the 77 full text articles included, the majority were categorised as including information relating to psychosocial interventions, including problem-solving and coping skills (*n* = 21, 27%) or community-based interventions (*n* = 17, 22%). A further 15% (*n* = 12) of articles related to training and 13% (*n* = 10) reported on crisis intervention, while 12% (*n* = 9) articles reported on multiple interventions.

- A smaller number of articles focused specifically on mental health treatment (*n* = 3, 4%), means restriction (*n* = 2, 3%), postvention (*n* = 2, 3%), and media guidelines (*n* = 1, 1%).
- Nine (12%) included information on multiple interventions. Within these, information was included on the following evidence-based interventions: means restriction (*n* = 7); psychosocial (*n* = 6); mental health treatment (*n* =6); training (*n* = 4); community-based interventions (*n* = 3); crisis intervention (*n* = 3); and media guidelines (*n* = 2).

[11] The term 'intervention' will be used for the remainder of this report to distinguish between national suicide prevention strategy and more focused interventions.

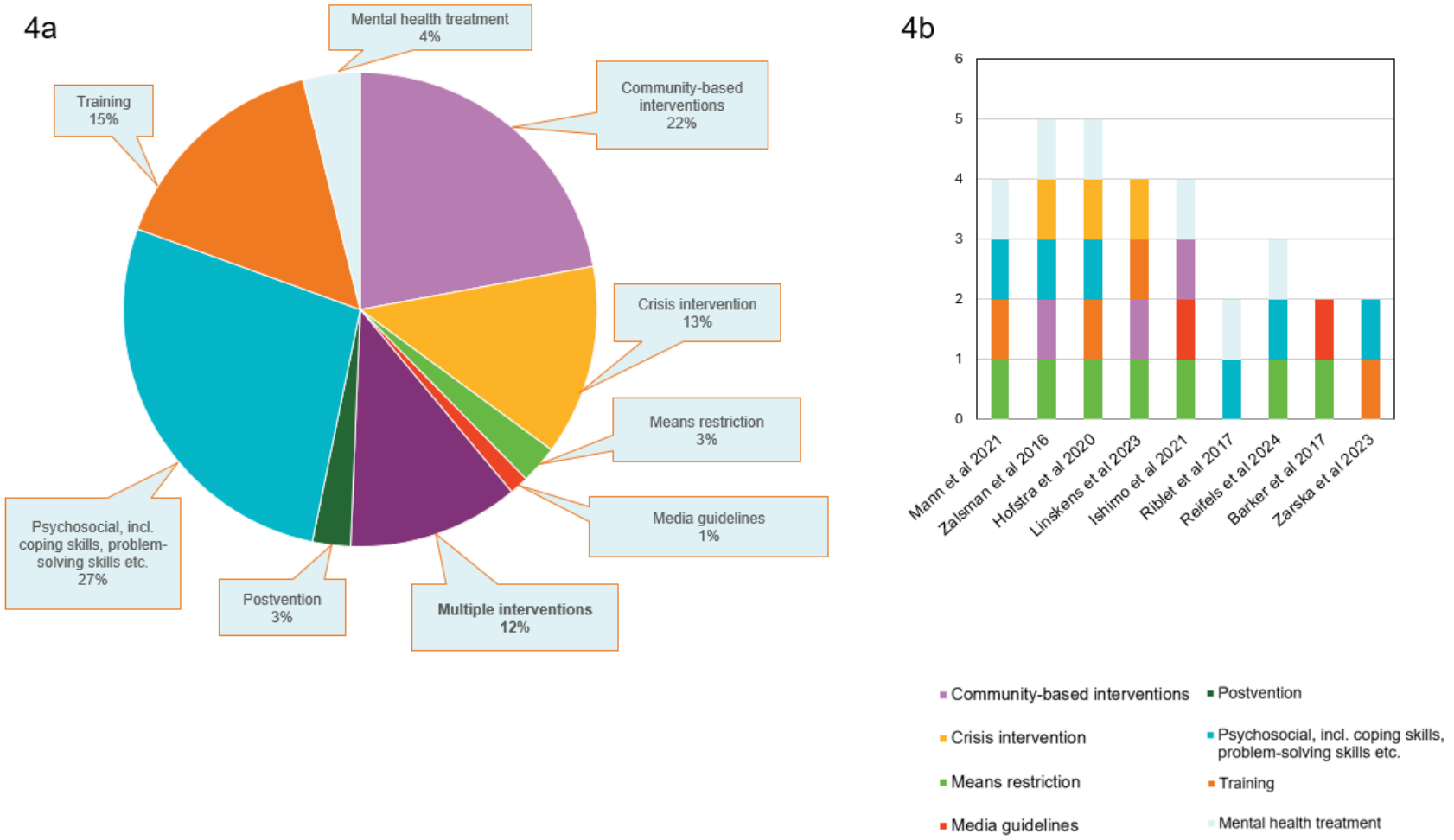
Table 2: Description of evidence-based suicide prevention interventions

Intervention	Description of intervention	Examples of corresponding *CfL* actions
Means restriction	Restricting access to common means of suicide, such as firearms, pesticides, or medications. Examples include implementing policies like safe storage practices for firearms or limiting access to lethal medications.	All 5 actions under strategic goal 6
Media guidelines	Responsible media reporting to help prevent suicide contagion by avoiding sensationalism, providing resources for help, and promoting stories of resilience and recovery.	Actions 1.4.1-1.4.4
Community-based interventions[12]	Building strong social support networks and promoting community resilience. Examples include programmes that foster connectedness, social integration, and access to mental health resources.	Actions 1.1.3, 1.1.4, 1.2.2, 1.3.1, 2.2.1-2.3.3, 3.3.1-3.3.5, 5.1.2, 5.1.3
Postvention	Support provided to affected individuals and communities following a suicide attempt or death. Postvention efforts may include counselling, education, and support groups.	Actions 4.3.1, 4.3.2
Training	Training, such as gatekeeper and General Practitioner (GP) suicide prevention training programmes, which aim to increase knowledge and enhance skills related to suicide prevention.	Actions 2.3.1, 2.3.2, 2.3.3, 3.1.5, 5.4.1-5.4.4
Psychosocial, incl. coping skills, problem-solving skills etc.	CBT and DBT are effective in enhancing coping skills and emotional regulation, which can help individuals better manage stress and suicidal thoughts.	Actions 3.3.6, 3.3.7, 4.1.3, 4.2.1, 5.1.4, 5.1.5
Crisis intervention	Crisis intervention services, including suicide hotlines, crisis centres, and mobile crisis teams, which provide immediate support to individuals in acute distress.	Actions 4.1.1, 4.1.2, 4.1.4, 4.1.5, 4.3.1
Mental health treatment	Mental health conditions, particularly depression, substance abuse, and schizophrenia, are major risk factors for suicide. Providing evidence-based treatment for these conditions, such as DBT/CBT, psychotherapy or medication, which aim to reduce suicide risk.	Actions 1.2.1, 3.2.1, 3.3.7, 5.2.1-5.2.3, 5.3.1-5.3.3
Stigma reduction	Types of stigma include self-stigma, public stigma, stigma by association, and structural discrimination.[13] Strategies to reduce stigma can include social contact, education, public awareness which may overlap with media guidelines and training strategies.	Actions 1.3.1

[12] Including school-based programmes.

[13] (Thornicroft, et al., 2022)

Figure 4: (a) Categorisation of articles identified in the literature search (b) Evidence-based suicide prevention interventions referred to in articles categorised as containing multiple interventions



Conclusion

Some overlap exists in the suicide prevention interventions presented in this review. For example, there is overlap between psychosocial interventions and mental health treatment interventions. Another example of overlap of categorisations relates to stigma reduction, such that some training interventions may include attempts to reduce stigma, and some media guidelines or community-based interventions may also address stigma. Most of the articles reporting on community-based interventions reported on more than one intervention. This overlap creates a challenge for isolating and measuring the impact of individual suicide prevention interventions.

Only a small number of articles were identified in relation to some suicide prevention interventions, for example:

- Few articles specifically focused on postvention.
- Relatively few papers focused specifically on stigma reduction. There is a potential gap in the literature in relation to stigma reduction interventions and overlap in attempts to address stigma though other interventions, e.g., training and community-based interventions.

While a greater evidence base is required to understand the impact of these interventions on suicide and suicidal behaviour, this does not discount their importance as part of a broader suicide prevention strategy. Recent research has highlighted the perceived effectiveness of components of postvention interventions (Hofmann, et al., 2024). This review highlights the importance of psychoeducation and having a structured approach to intervention and appropriate content. For example, manualised interventions, consistency, closed and homogenous groups; trained facilitators; and support from peers, group members, the community or online. A recent review has also highlighted the need for supports and signposting for bereaved persons to be delivered within the coronial service (O'Driscoll, Khan, O'Connell, Corcoran, & Griffin, 2023).

The evidence identified in the literature search is broadly similar to the findings reported by Dillon and colleagues (Dillon, et al., 2015) in advance of the publication of the *CfL* strategy. Similar findings were also reported by Tye and colleagues, more recently (Tye, et al., 2015). Evidence for restricting access to means is stronger than other suicide prevention interventions. Evidence for psychosocial interventions remains promising. Evidence for other suicide prevention strategies remains mixed and it is difficult to attribute changes in suicide or suicidal behaviour to specific interventions.

In line with Hofstra and colleagues (Hofstra, et al., 2020) suggestion, multi-level interventions, which integrate multiple approaches across different settings are most likely to impact suicide and suicidal behaviour as this approach shows significantly greater effectiveness compared to single-level interventions, highlighting the importance of a comprehensive approach in suicide prevention efforts.

Aligning with goal 7 of the *CfL* strategy, a review carried out in 2024 highlights the need for more research on priority groups identified in *CfL* (Hursztyn, et al., 2024).

Section 4: Evaluation of the implementation of *CfL*

Overview

As described in Section 2 and Appendix A, Rapid Insight (RI) sessions were carried out with three key stakeholder groups representing the Cross-Sectoral Steering and Implementation Group, NGOs, and the ROSPs. The RI sessions focused on three questions which provided participants with the opportunity to reflect on the implementation of *CfL* to identify areas for improvement, challenges in working across sectors to implement a national suicide prevention strategy, and factors which affect sustainability.

The five high-level interviews (academics, senior government officials, and policy makers in mental health and suicide prevention) provide a crucial "bellwether" perspective on *CfL*. Unlike direct implementers, these individuals offer a strategic, cross-sectoral and research-informed lens that enhances understanding of the broader impact and future direction of the strategy.

The 25 interviews with persons responsible for the implementation of *CfL* (NOSP staff, members of the Cross-Sectoral Steering and Implementation Group, Department of Health staff, HSE staff, and NGO representatives) provide insight into their experience of the implementation of *CfL* from both a national and regional perspective.

The ROSP and local implementation team survey findings add a bottom-up perspective of how the implementation of *CfL* worked in practice at a local and regional level.

The analysis presented in this section synthesises the primary data collected to identify key contributions of *CfL*, challenges and opportunities for future development. The findings are presented under headings from the implementation frameworks used in analysis (as described in Section 2 and Appendix A of this report).

Rapid Insight session and interview findings

Contextual factors

Policy and legislation

Policy duplication is an issue – There is significant duplication with other policies such as *Sharing the Vision* (Department of Health, 2020), *Stronger Together* (Health Service Executive, 2022), and policies/strategies for at-risk groups such as LGBTQI+ and the Traveller Community. This creates confusion and blurs the boundaries of responsibility for some actions.

CfL could learn from other policies and their monitoring and reporting processes – *Sharing the Vision* reports were described as more detailed and include ratings of risks. One interviewee described reporting on *Sharing the Vision* (Department of Health, 2020) as *"more transparent"*.

Opportunities for better integration of policies and cross-policy synergy are called for – Suggestions include the development of a *"formal mechanism to work across the overlapping policies in the space"*. This could take the form of a national mental health policy programme board to oversee

mental health policies and strategies or a senior governance structure that could oversee these policies to ensure alignment and prevent redundancy.

Policy gaps also exist – The lack of structured policy recognition for some areas was raised, e.g., limited actions relating to bereavement support and a lack of recognition of loneliness as a risk factor for suicide.

Legislation as a barrier – Changes in legislation need to be made with greater urgency, e.g., legislation for prescription control.

Funding and resources

Adequate funding and resources (including staffing) are required for strategy implementation – Funding and resources also need to be aligned to implement a strategy fully. There was a suggestion from some interviewees that the proportion of the health budget that is spent on suicide prevention needs to be increased significantly and that one-off funding arrangements create a sustainability challenge for the NGO sector. It was suggested that funding gaps, short-term contracts, and recruitment difficulties severely hinder the ability to implement *CfL* effectively. A lack of multi-annual funding for key programmes, makes long-term planning difficult. Recruitment challenges mean that some actions simply cannot progress, even if they are well-designed and strategically important. Workforce shortages are beyond the control of *CfL* implementation teams, limiting what can be realistically achieved. This reflects a wider issue in policy implementation; strong frameworks exist, but without stable funding and staff, even well-planned actions stall.

Funding processes for NGOs are well structured – Clear templates for Service Level Agreements (SLAs) and Grant Aid Agreements (GAAs) have been developed, ensuring NGOs operate within defined financial parameters.

However, stronger structures are required to support the distribution of funding to NGOs that work with priority groups – It was suggested that more formal structures are required to review funding requests from NGOs that are funded under *CfL* but also receive funding from elsewhere, e.g., social inclusion. Funding requests are currently not reviewed as a whole and a more formal structure is required where all funders meet to agree which actions are being supported by which department(s).

A more strategic funding model is needed to reduce duplication and ensure that resources are directed efficiently – For example, it was suggested that this is relevant for training and education with multiple organisations delivering similar initiatives without clear differentiation.

Socio-political context

Need for greater public awareness and a stronger national narrative – While *CfL* has reached professional and priority groups, some interviewees suggested that there is an opportunity to enhance *"general population engagement"* with suicide prevention, in a way similar to public health campaigns such as the FAST[14] campaign for stroke awareness.

[14] Recognising the signs of stroke quickly using the following acronym: Face drooping, Arm weakness, Speech difficulty, and Time to call emergency services.

High level buy-in

High-level buy-in and leadership are important enablers of progress – The Cross-Sectoral Steering and Implementation Group works well for keeping actions on track. Senior representatives on this group can *"nudge"* staff on actions that are not progressing. High level buy-in is important for this group to work effectively. The restructuring of the HSE may have a significant impact if leadership changes at local level.

High-level buy-in and good stakeholder engagement are clear strengths of the *CfL* strategy – Having the Cross-Sectoral Steering and Implementation Group chaired by an Assistant Secretary at the Department of Health meant that other departments *"had to attend and they stood up"*. This structure worked well, and it was suggested by interviewees that it should be retained for any future strategy.

Organisational structure and HSE restructuring

Organisational fragmentation and HSE restructuring are a concern – The fragmented structure of the HSE and its recent reorganisation (the shift to six HSE Health Regions) have created challenges in maintaining consistent, unified approaches – especially in areas like mental health promotion and training. HSE restructuring is an unknown variable that may impact roles and reporting structures, adding to uncertainty. The restructuring from CHOs to Health Regions is a risk factor which may have an impact on the implementation of any future suicide prevention strategy at national, regional, and local levels. Redistribution of funding responsibilities across HSE Health Regions was raised as a concern as this could lead to inequities, as local biases could affect how national NGOs are funded. The disbanding of the HSE's central governance structures raises fears that mental health and suicide prevention could lose their voice, potentially weakening national oversight.

Inter-organisational relationships

NGOs play a vital role – NGOs have played a vital role in delivering on *CfL* actions, particularly in addressing gaps where the HSE lacks capacity to deliver services directly. The importance of NGO involvement in suicide prevention efforts, was highlighted by one interviewee as an improvement compared to the previous national suicide prevention strategy, *Reach Out* (Health Service Executive & Department of Health, 2005), where there was less collaboration between government bodies and service providers. While NGOs are valuable facilitators of implementation, their level of accountability and outcome measurement varies, requiring stronger oversight and strategic alignment.

Strong relationships and collaboration are central to *CfL*'s success – This is particularly noted at local level. In some areas, through cross-sectoral partnerships, *CfL* has been embedded into existing structures, such as local health and well-being initiatives, inter-agency working groups, and local authority strategies.

Leadership, including leadership challenges and staff turnover

Leadership is an enabler of implementation – Including the leadership of the Cross-Sectoral Steering and Implementation Group, NOSP oversight, local and regional leadership, and high-level

buy in, e.g., engagement of the current Minister with responsibility for Mental Health and former government officials was also acknowledged.

Leadership instability slows progress – Frequent changes in leadership at the national level have disrupted continuity and slowed progress. This turnover has made it more difficult for new leaders to quickly grasp and drive the *CfL* agenda. Turnover in leadership roles can lead to the loss of *"champions"* for the work.

Staff turnover – High turnover rates in key departments (e.g., Justice, Local Government) disrupt continuity, leading to a cycle of frequently rebuilding relationships. Turnover results in a loss of institutional knowledge.

Cross-sectoral collaboration

The whole of Government approach

RI session attendees were asked: *what are your key lessons about implementing a strategy that crosses multiple agencies, sectors, budget and accountability relationships*? See Figure 5 for mind maps displaying the findings relating to this question. They are a visual summary of the text below. In each mind map, the central themes are placed within circles with associated sub -themes arranged around each circle.

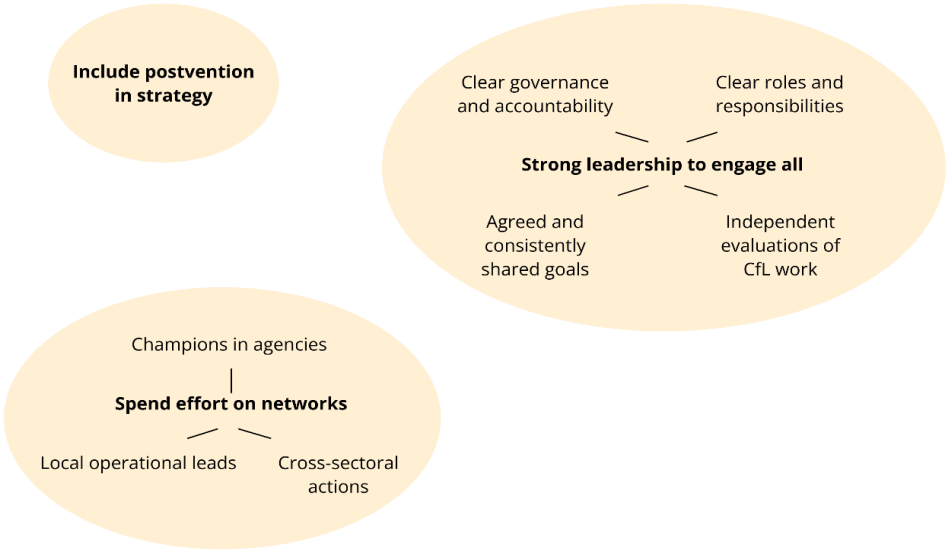
From the perspective of the Cross-Sectoral Steering and Implementation Group, the key lessons included that **strong leadership is needed to engage all** including clear governance and accountability, clear roles and responsibilities, and agreed and consistently shared goals. They also noted the need for independent evaluations of *CfL* work. This group also highlighted the **importance of establishing networks and relationships**, including champions in agencies.

The NGO Group suggested that **improved funding and human resources** are crucial for structuring implementation, planning goals, and ultimately, implementing the strategy. Human resources can help to maximise the potential of cross-sectoral partnerships. Improved funding and resources could also help to increase awareness and understanding of *CfL*.

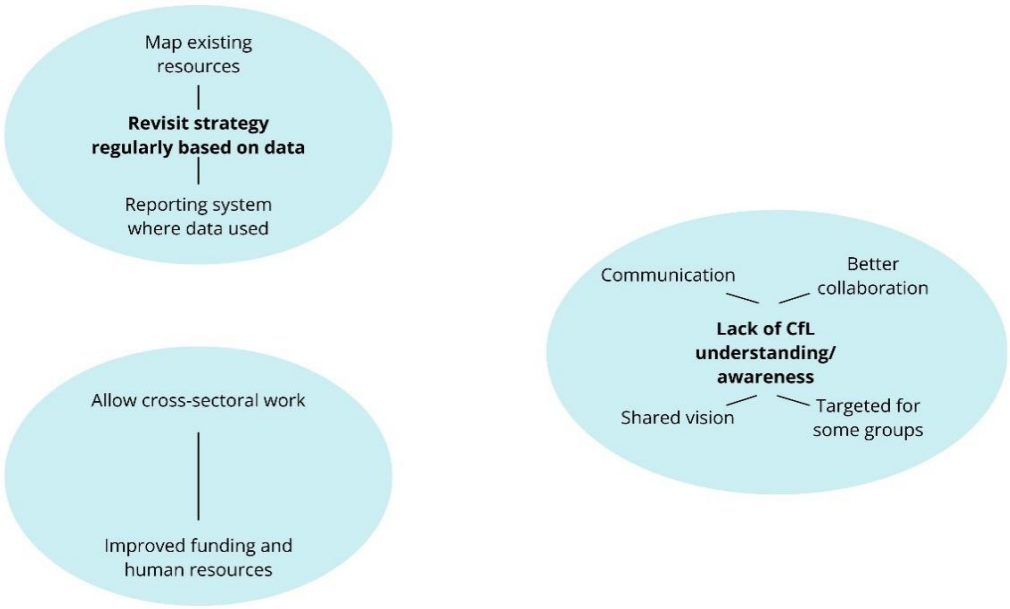
The ROSP Group suggested that the use of an **implementation approach** is important including committed leadership, active feedback loops, achievable actions, and clear monitoring and evaluation. They noted that **smaller multi-agency working groups** with a specific focus work best and these help to nurture relationships with champions. **Time is necessary**, to allow for communications and buy-in. **Robust project management structures are required** for implementation including clear roles, responsibilities, and scope; administrative support; transparent budget, with flexibility; and active NOSP involvement.

Figure 5: Mind maps of RI session responses to 'what are your key lessons about implementing a strategy that crosses multiple agencies, sectors, budget and accountability relationships?'

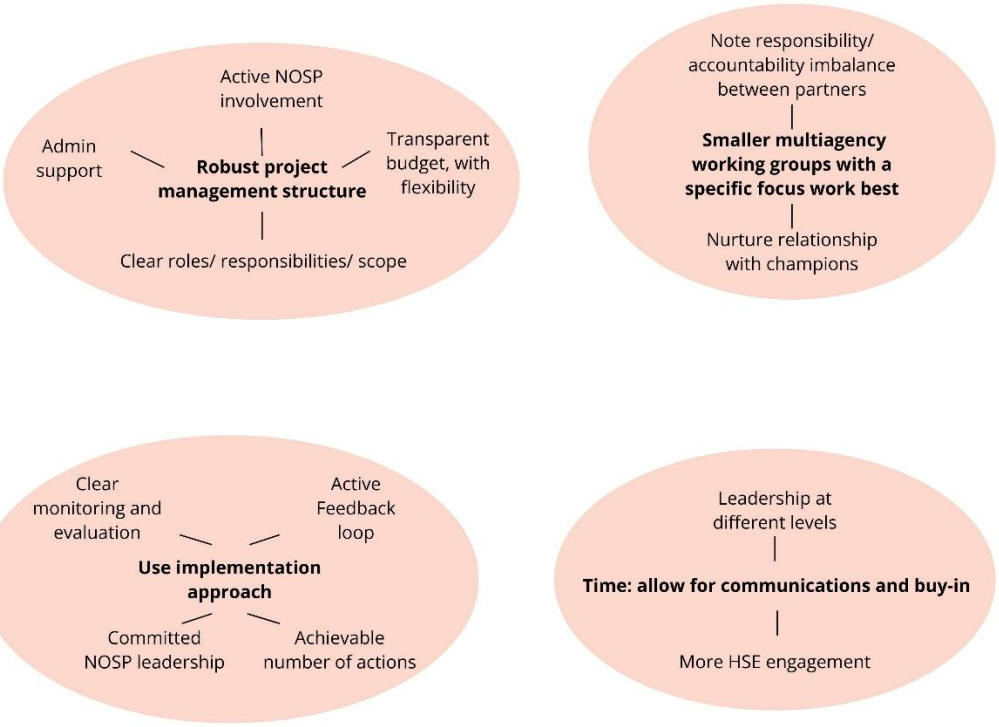
Cross-Sectoral Steering and Implementation Group Mind Map



NGOs Mind Map



ROSPs



The following points were highlighted by interviewees:

CfL's whole-of-government design is one of its key successes – *CfL* is positioned as both a HSE and national government policy, meaning that responsibility is shared across multiple departments and agencies rather than solely housed within mental health services.

Key enablers of this approach include:

- Governance structures – i.e., the Cross-Sectoral Steering and Implementation Group.
- Regional implementation – *CfL* is embedded locally through ROSPs, ensuring a bottom-up as well as top-down approach.
- Structured implementation planning – Development of a structured, phased implementation plan that aligns national priorities with local needs.

These structures have helped institutionalise suicide prevention within the broader policy landscape and provided a framework for inter-agency collaboration.

Cross-sectoral collaboration is a strength with structural weaknesses – Cross-sectoral collaboration is a core feature of *CfL* but there are some structural limitations in how it operates. In many cases, collaboration is dependent on individual motivation rather than systemic buy-in. Some interviewees highlighted successful collaborative efforts which arose from *CfL*-related work.

Other barriers to cross-sectoral collaboration include:

- Uneven buy-in across departments: While some government departments see *CfL* as central to their remit, others still perceive suicide prevention as a health sector issue, limiting meaningful engagement.
- Local government disengagement: County councils, with some notable exceptions, often do not see suicide prevention as within their responsibility, particularly when it requires financial investment (e.g., restricting access to means).
- Siloed approaches: To work, policy development, and service provision.

Stakeholder engagement

Challenges to stakeholder engagement (power, funding, and constraints) – Challenges to stakeholder engagement were noted, including the following:

- NGOs operate in a compromised position – They are both dependent on government funding and expected to advocate for policy change, creating an inherent conflict.
- Inter-agency relationships vary in effectiveness – While some collaborative structures have been successful, broader cross-sector coordination remains inconsistent. Stakeholder engagement was described as fragmented, with some agencies only participating in a tokenistic manner rather than truly embedding suicide prevention into their work.
- Monthly meetings between NOSP-funded NGOs were described as ineffective by some.

Engagement with stakeholders is different at national and local levels – From a local and regional perspective, engagement with stakeholders was described as *"functional, educational, and informative"* at national level and *"practical"* at a local level.

Engagement with stakeholders can be challenging from a local and regional perspective – A need to reinvent engagement processes frequently was described because of staff turnover and change of structure within organisations.

The voice of lived or living experience is missing – There is still a lack of meaningful engagement with lived or living experience voices in national policymaking for suicide prevention.

Securing consistent participation is challenging – From a local and regional perspective, some interviewees stated that local NGOs and community partners have been highly engaged, engagement with statutory agencies, particularly within the health service, has been more difficult. Challenges in securing consistent participation from the health service were described, with ROSPs having to go through senior leadership to encourage attendance at meetings or follow through on commitments. In contrast, NGOs and community groups have been described as more responsive and willing to engage with *CfL* initiatives.

Some NGOs may be under-represented – It was suggested that NGOs that work exclusively in the areas of suicide prevention, intervention, and postvention should be prioritised within *CfL* implementation and governance groups.

Strong stakeholder engagement and working relationships have developed – Examples include work between the NSRF and NGOs to collaborate on joint research projects.

Alignment of roles/Partnership strengths

Strong partnerships are required for local implementation to be successful – This is facilitated by strong leadership and high-level buy-in which supports implementation at a local level.

Cross-sectoral collaboration is facilitated by having structures in place to support work – For example, it was suggested that cross-sectoral work within the context of a clinical care programme works well. It is more of a challenge to work with generic services in mental health as capacity to respond is an issue.

Partnerships are important, cross-sectoral and inter-organisational, for learning and advancing work in suicide prevention – NOSP can learn from colleagues in area such as Public Health and this learning works both ways.

Implementation processes

Planning and adaptability

Adaptability is a requirement of a successful suicide prevention strategy at national level – The need for adaptability in suicide prevention strategy was raised, especially in light of COVID-19, evolving service needs, and structural changes in the HSE.

Adaptability is also important for regional implementation – Suggestions include giving NGOs and external collaborators leadership on actions to increase engagement; understanding the context and knowledge of stakeholders is important to identify those who will lead actions, i.e., leveraging existing relationships and identifying champions; and knowing what works in a region is important.

Some criticisms of *CfL*'s ability to adapt to real-world changes were raised – Some disconnect between strategy and practical service provision was noted:

- The shift to digital and online services created barriers for populations with low digital literacy.
- No major review of the strategy was undertaken in response to the pandemic, meaning some aspects of *CfL* remained outdated and not reflective of the changed service delivery landscape.

Capacity building

Training opportunities – NOSP has provided significant training opportunities for both the general population, e.g., *Let's Talk about Suicide*[15], *safeTALK* (Suicide Alertness for Everyone), and *ASIST* (Applied Suicide Intervention Skills Training), as well as training for specific professional groups like An Garda Síochána.

[15] https://traininghub.nosp.ie/

ROSPs are a key enabler of implementation at a local and regional level – Particularly in delivering training and awareness-raising activities. ROSPs play a critical role in liaising with first responders (Gardaí, paramedics, etc.), helping to embed suicide prevention awareness in frontline services.

Intervention characteristics

Complexity and feasibility

The role of training as a core strategy for suicide prevention was questioned – Some interviewees suggested that training is often easier to justify in policy terms than service provision, leading to funding imbalances where training dominates while core services remain underdeveloped.

Local implementation plans

Some disconnection between national and local level implementation exists – A lack of consistency in the composition of local implementation teams was described. Further learning across local implementation groups could be facilitated to avoid this duplication and share learning.

Local autonomy is important within broader governance structures – Concerns were raised that HSE restructuring may create bureaucratic hurdles for suicide prevention efforts. Ensuring that local implementers retain the flexibility to act swiftly and responsively will be critical to sustaining *CfL*'s impact.

Regional adaptability is necessary for local implementation – What works in one area may not necessarily work in other areas. Areas differ in terms of demographics and risk groups etc., and demographics within an area change over time, quite rapidly in some areas. National strategy is required but being able to adapt to local needs is important.

ROSPs are key to the success of local implementation of suicide prevention strategies and efforts at a local level – ROSPs are a key link to local agencies and their presence in the community is very important. They are also a key link to NOSP and the national level. The importance of ROSPs being *"embedded"* in the community is stressed by some interviewees but ROSPs need support from leadership to bring about change when they identify an issue, i.e., leaders reaching out to other persons in authority to make change happen.

Inconsistent ROSP reporting structures were noted – ROSPs report to different roles depending on their region, leading to variations in their influence and ability to advocate for suicide prevention within HSE structures.

Local implementation can improve efforts to reach priority groups (and improve the reach of the strategy in general) – For example, training to support the Traveller community alongside the Traveller Mental Health Coordinator.

NGOs can provide valuable insights in relation to local/regional needs – NGOs collect data on service users which is available at a CHO level and could provide insight into local/regional needs.

Implementation outcomes

Reach

Public awareness efforts could be more proactive – Suicide prevention should not only target at-risk groups but also the general population, equipping them with basic awareness and knowledge before a crisis occurs.

Challenges in reaching minority groups were noted – Interviewees described difficulties in engaging certain groups for postvention work and difficulty supporting some high-risk groups such as the Traveller community due to inadequate resources or staffing in other organisations, difficulty obtaining buy-in and literacy issues. A lack of support for neurodiversity was also flagged.

At-risk or high-risk groups change over time (within a region) and vary from region to region – Demographics change frequently and quickly in some regions, e.g., number of new arrivals to the country can vary from region to region and can be more concentrated in some areas.

The list of priority groups should be kept under review – This could help to increase targeted interventions for those most at risk.

Intersectionality is an important consideration for determining risk – Intersectionality was also highlighted, e.g., homelessness and addiction issues or homelessness in the Traveller community.

Engagement with other stakeholders and service providers facilitates work with hard to reach and at-risk groups – These build relationships and build capacity which improves reach and communication. Shared ownership is also important.

Clearer pathways between services are required – Deficiencies exist in service provision, e.g., where a person has addiction issues and needs primary care level counselling, barriers to service provision exist, i.e., if the mental health difficulty is not sufficiently complex but the person has addiction issues then they cannot access primary care level counselling. It was suggested that access to counselling in primary care needs to be improved going forward.

Sustainability

RI session attendees were asked: *what factors need to be in place to create a sustainable suicide prevention programme for the future*? See Figure 6 for mind maps displaying the findings relating to this question. They are a visual summary of the text below. In each mind map, the central themes are placed within circles with associated sub-themes arranged around each circle.

There was broad agreement across the Cross-Sectoral Steering and Implementation Group and ROSPs Group that **a more streamlined and concise strategy** is required for the future. The Cross-Sectoral Steering and Implementation Group emphasised the need for policy alignment, an evidence-informed approach, realistic timelines, clear language, and clear outcome indicators. ROSPs also highlighted the need for a more concise, trauma-informed strategy with fewer actions overall but more postvention actions. They suggested that suicide and self-harm should be separated and that there should be closer alignment with other strategies.

The Cross-Sectoral Steering and Implementation Group also highlighted the need for **implementation expertise** at national and local level and raised the need for **multi-year funding**

to ensure continuity planning, capacity building, and training within organisations. The NGO group highlighted the need for a **clear implementation plan** that is data-driven, allows for training, and is costed and resourced. The ROSP group noted the need to plan for implementation time.

The NGO Group stated that **better NOSP coordination** is required to support relationships building between statutory and NGO sectors and provide direction on how agencies can work together.

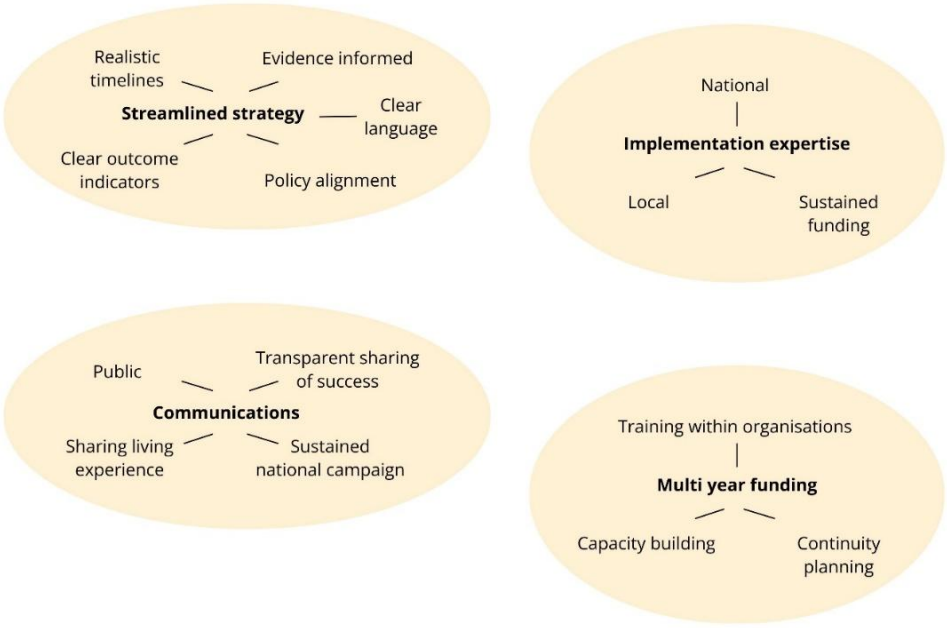
The Cross-Sectoral Steering and Implementation Group noted the need for improved **communications** including sharing lived or living experience, transparent sharing of success, public visibility, and sustained national campaigns.

The ROSP group raised the need for **additional human resources**, including administrative resources. They also noted the need for **clear governance** including strong management, clear roles and boundaries, and the incorporation of regular feedback loops.

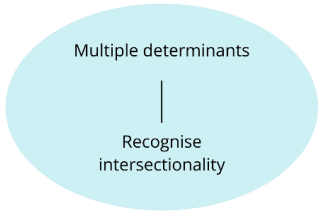
The NGO group stated that **pilot projects** should be funded properly and have transition plans in place to stop or fully implement the pilot. They also noted that **multiple determinants and intersectionality** should be recognised in relation to risk in a sustainable suicide prevention programme.

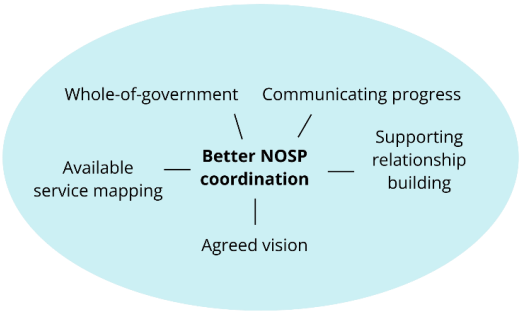
Figure 6: Mind maps of RI session responses to 'what factors need to be in place to create a sustainable suicide prevention programme for the future?'

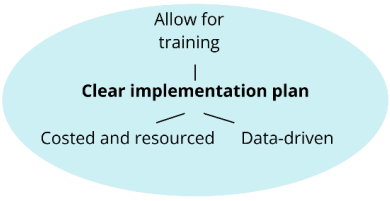
Cross-Sectoral Steering and Implementation Group

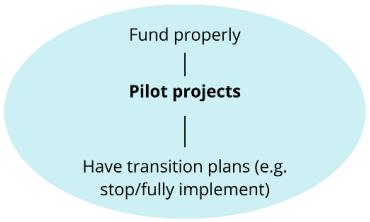


NGOs

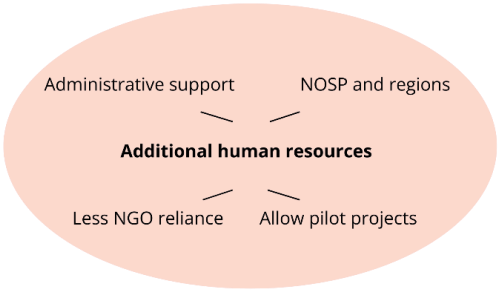

Multiple determinants
Recognise intersectionality

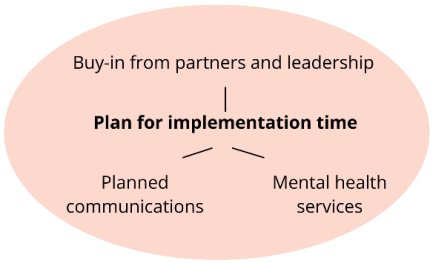

Whole-of-government
Communicating progress
Available service mapping
Better NOSP coordination
Supporting relationship building
Agreed vision

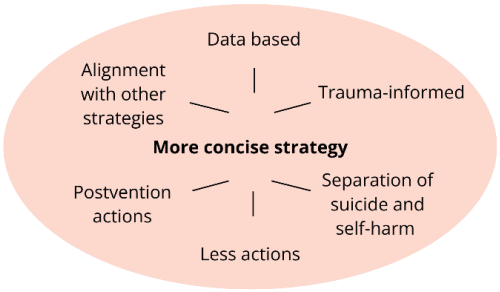

Allow for training
Clear implementation plan
Costed and resourced
Data-driven

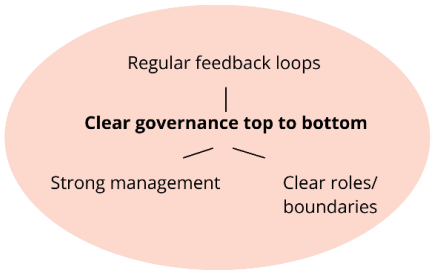

Fund properly
Pilot projects
Have transition plans (e.g. stop/fully implement)

ROSPs


Administrative support
NOSP and regions
Additional human resources
Less NGO reliance
Allow pilot projects


Buy-in from partners and leadership
Plan for implementation time
Planned communications
Mental health services


Data based
Alignment with other strategies
Trauma-informed
More concise strategy
Postvention actions
Separation of suicide and self-harm
Less actions


Regular feedback loops
Clear governance top to bottom
Strong management
Clear roles/ boundaries

Interviewees raised the following issues relating to sustainability:

Funding and resources are required to ensure sustainability – One off funding arrangements create a sustainability challenge for NGOs.

HSE restructuring creates a sustainability challenge – Long-term sustainability is an issue, particularly with uncertainty around the HSE restructuring and its impact on funding and governance structures.

A broader Public Health approach may enhance sustainability – Transitioning suicide prevention from a primarily mental health focus to a broader public health approach may help address stigma and improve long-term sustainability.

Awareness of *CfL* supports reach and sustainability – *CfL* identity, communications, presence online, showcasing of partnerships.

Data and evidence

Data systems

Issues with current data systems act as a barrier to research and evaluation efforts – The coronial system was cited by multiple interviewees as problematic and the time lag in availability of suicide data due to inquest processes was also raised. Reliance on outdated Central Statistics Office (CSO) data, which lags by several years, makes it difficult to assess whether *CfL* has reduced suicide rates.

Gaps in data sharing agreements impact the availability of data – While efforts have been made to put data sharing agreements in place with key stakeholders, such as An Garda Síochána, challenges exist, and the process of agreement is slow.

Real-time data is lacking – There is the lack of a robust, real-time, comprehensive surveillance data infrastructure to guide decision-making in suicide prevention. It was suggested that this is vital to a Public Health approach to suicide prevention. From a local and regional perspective, the lack of real-time data makes it difficult to monitor trends, respond to incidents, and address misinformation. The availability of real-time monitoring systems would allow for more timely interventions and informed decision-making. The lack of real-time, high-quality data on suicide rates makes it difficult to track implementation progress and impact.

Measurement focuses on outputs rather than outcomes – Current evaluation practices track activities (e.g., training delivered, campaigns run) rather than long-term impact on suicide rates or help-seeking behaviours.

More robust and varied outcome measurement is suggested – This could include qualitative data, such as focus groups, and data on positive mental health, resilience, and social connectedness.

Outcomes framework and performance metrics – Intermediate and high-level indicators (e.g., suicide rates and self-harm trends), are not well integrated into regular quarterly reporting. The lack of a robust, continuous outcomes framework hampers the ability to clearly demonstrate progress and attract further investment.

Despite challenges, progress has been made in some areas – Including the National Self-Harm Registry[16] and the Irish Probable Suicide Deaths Study[17].

Evidence-based decision making

Data gaps exist – This limits the ability to identify and support some high-risk groups.

Research and evaluation remain underfunded – Despite efforts to integrate evaluation from the outset, it was suggested that the budget for monitoring and evaluation remains minimal, limiting long-term impact assessment.

Successful research partnerships have been established – The Collaborative Research Grant Scheme has been a key success, fostering partnerships between NGOs, academics, and policymakers.

Difficulty in attributing success to specific actions – It was acknowledged that while suicide rates may decline, it is challenging to draw a direct causal link between this and specific *CfL* actions. This complexity, inherent to suicide prevention strategies, makes impact assessment difficult.

Emerging issues and critical reflections

Strengths

Ireland is *"unique"* in its approach to suicide prevention – From an international perspective, Ireland is a good example of efforts to reduce suicide through the advancement of the national strategy and the presence of a dedicated suicide prevention office. *CfL* was described as a globally unique, whole-of-government approach to suicide prevention, with a structured governance model, cross-sectoral collaboration, and a dual accountability system between the HSE and the Department of Health. NOSP was described as one of the most effective agencies within the health sector, and its proactive role in socialising the strategy, ensuring stakeholders understand their roles, and maintaining momentum for implementation was described.

Strong cross-government and cross-sectoral collaboration – *CfL* has successfully fostered cooperation across government agencies, including An Garda Síochána, Department of Justice, and the Irish Prison Service.

Local implementation, NGOs, and ROSPs have enabled implementation – Multi-agency groups, including regulators, NGOs, and health services, have enabled a flexible and responsive implementation approach. NGOs and ROSPs play a vital role in *CfL* implementation, particularly in training and frontline engagement. When well-supported, ROSPs are deeply embedded in communities and play a crucial role in local suicide prevention work.

Clear implementation structure and accountability exist – The way *CfL* structures its actions, clear, well-defined, and with specific ownership, has been key to its effectiveness.

Improvements have been made in research and evaluation – The Evaluation Advisory Group was described as invaluable, providing external expertise that has guided research and monitoring

[16] https://www.nsrf.ie/registry/

[17] https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/ipsds.html

efforts. The Collaborative Research Grant Scheme has yielded tangible outcomes, including new research on suicide among farmers, prisoners, and other high-risk groups.

Strengths of *CfL* initiatives – For example, *CfL*'s suicide bereavement initiatives, including the publication of *Safe Harbour* (Forde, 2024), the *National Suicide Bereavement Guide* (National Office for Suicide Prevention, 2021), targeted grief training, a GP awareness campaign, and comprehensive training programmes developed under *CfL*, e.g., *Let's Talk About Suicide*[18]. Small meaningful shifts in service delivery were also described such as funding for Suicide Crisis Assessment Nurses (SCAN) to work with Traveller communities based on data-driven advocacy. Community-based mental health promotion was also highlighted as a key success, including social prescribing and local authority partnerships.

Areas for improvement

RI session attendees were asked: *'thinking about implementing the CfL strategy, from your perspective what could have been 'Even Better If'?'*. See Figure 7 for mind maps displaying the findings relating to this question. They are a visual summary of the text below. In each mind map, the central themes are placed within circles with associated sub-themes arranged around each circle.

The Cross-Sectoral Steering and Implementation Group stated that the *CfL* strategy would be 'even better if' there was a **greater emphasis on operational collaboration and organisation**, including improved alignment between national strategy and local implementation plans; more cross-sectoral work; clearer responsibilities and accountability; and more oversight of shared Key Performance Indicators (KPIs). They also stated that *CfL* would be 'even better if' **communication was improved**, including increasing public engagement and having funding to support this and increasing the use of digital communication including social media. **Including lived or living experience from the beginning** of the strategy and throughout implementation was also noted as a potential avenue for improvement.

The NGO Group suggested that *CfL* would be 'even better if' there was **better coordination** from national level to NGOs, between government departments, between NGO partners, and inter-agency, and if **NOSP meetings were more focused**, focusing on relevant actions and including in-person meetings or events. They also noted **communications** as an issue, both between stakeholders and with the public, and suggested that more **focus on priority groups**, such as prisoners, LGBTQI+, and the Traveller community, is warranted for *CfL* to be even better. Their suggestions include more funding, specifically for vulnerable groups. The NGO Group also noted the need for **better funding arrangements** including longer term or multi-year funding.

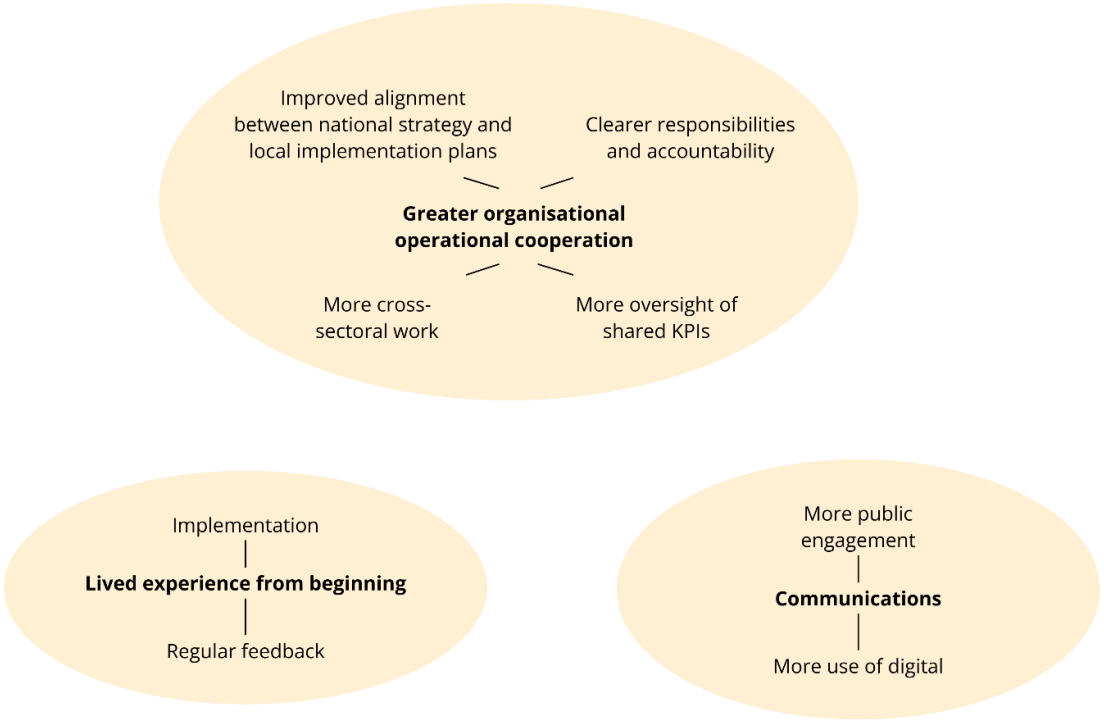
The ROSP Group suggested that *CfL* would be 'even better if' there was **clearer national and local governance** including, links to other HSE strategies, better feedback and learning loops, and smaller, more focused steering groups. The ROSP Group suggested that improvements could be made by including **more implementation work from the outset and before strategy launch** including clearer KPIs and clearer development of local plans and guidelines. They stated that *CfL* would be 'even better if' **better data on suicide** were available including social determinants. The

[18] https://traininghub.nosp.ie/

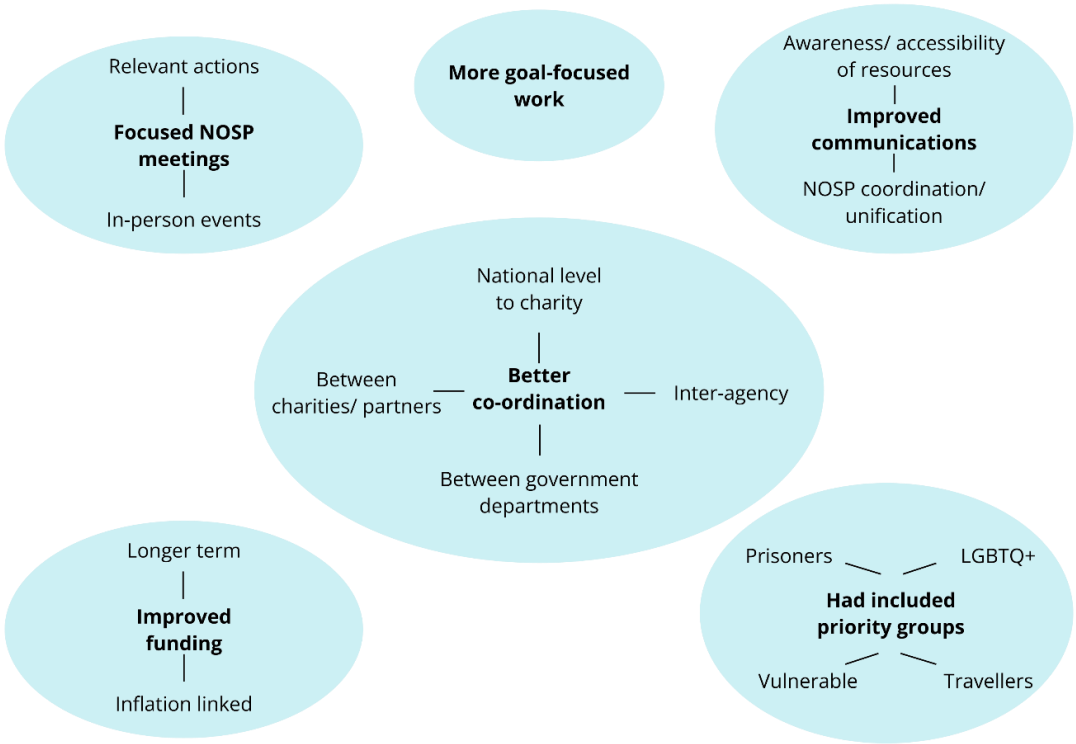
desire for **better communication from NOSP to the local level** was also raised and **better funding for pilot projects**. Finally, they suggested that *CfL* would be better if the **strategy was more focused** and considered local needs and had better inclusion of groups representing priority groups.

Figure 7: Mind maps of RI session responses to 'thinking about implementing the CfL strategy, from your perspective what could have been 'Even Better If'?'

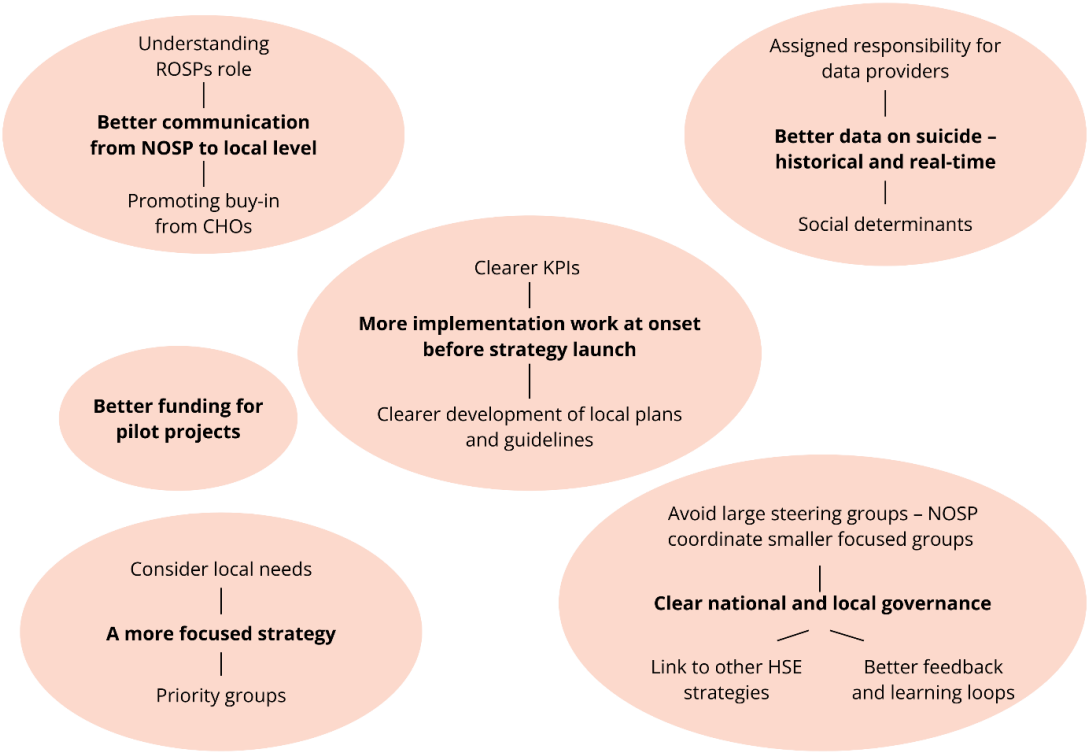
Cross-Sectoral Steering and Implementation Group



NGOs


Relevant actions
Focused NOSP meetings
In-person events
More goal-focused work
Awareness/ accessibility of resources
Improved communications
NOSP coordination/ unification
National level to charity
Between charities/ partners
Better co-ordination
Inter-agency
Between government departments
Longer term
Improved funding
Inflation linked
Prisoners
LGBTQ+
Had included priority groups
Vulnerable
Travellers

ROSPs


Understanding ROSPs role
Better communication from NOSP to local level
Promoting buy-in from CHOs
Assigned responsibility for data providers
Better data on suicide – historical and real-time
Social determinants
Clearer KPIs
More implementation work at onset before strategy launch
Clearer development of local plans and guidelines
Better funding for pilot projects
Consider local needs
A more focused strategy
Priority groups
Avoid large steering groups – NOSP coordinate smaller focused groups
Clear national and local governance
Link to other HSE strategies
Better feedback and learning loops

Interviewees raised the following issues:

Inter-departmental engagement remains inconsistent – This hinders strategy implementation.

A broader focus is required – Suicide was described as a *"societal problem"* rather than a mental health issue. The need to transition suicide prevention from a primarily mental health focus to a broader public health approach was suggested to help address stigma and improve long-term sustainability. Existing Public Health systems and expertise have potential to complement the work being carried out by NOSP and their partners – surveillance systems and mapping platforms such as Health Atlas can easily map areas in terms of deprivation etc. and could be utilised by NOSP as the basis of a complementary system for suicide surveillance. Public Health shares an interest with NOSP in vulnerable groups.

Gaps in strategic scope – *CfL* has not sufficiently incorporated upstream determinants of suicide – most notably, financial stress. The absence of key departments, such as the Department of Social Protection, in the strategic framework is seen as a systemic weakness that limits the strategy's comprehensiveness.

At a national level, there is room for improvement in reporting and monitoring – a) It was suggested that the NGO Group meetings could be improved by adding a quarterly CEO only group. Reporting from the Cross-Sectoral Steering and Implementation Group back to NGO representatives could also be improved with clearer communication and updates. It was suggested that ROSPs should be included in NGO Group meetings. b) In relation to reporting and monitoring activities, consistency in reporting on quarterly reports is required. Some interviewees suggested that reporting is done in a *"bottom-up"* way with implementers reporting on what they have done rather than what they set out to do and metrics that were agreed in advance. c) Communication to cross-sectoral collaborators could be improved by clearer communication from NOSP about important events.

At a local and regional level, more consistency is required – a) At local level, implementation and monitoring groups are organised in an ad hoc way, e.g., some are steering groups, some are implementation groups, and they are chaired by people with different roles. The focus can change depending on who is chairing the group and who is in attendance. b) Increase understanding of available services – e.g., the role of the Suicide Bereavement Liaison Officer (SBLO) is misunderstood in some areas.

Lived or living experience involvement is absent – People with lived or living experience of suicide have not yet had a parallel structure for engagement in *CfL*, this is seen as a gap that needs to be addressed in the next strategy.

Systemic weaknesses exist – Access to therapeutic supports, such as counselling, were described as weaknesses at a systems level. Funding and resources are required to address gaps in mental health service provision.

In some areas, local government buy-in remains weak – Again, this hinders strategy implementation.

Real-time data collection is a major gap – Improvements in surveillance and real-time data collection are required.

Future directions and strategic priorities for the next suicide prevention strategy

In general, interviewees advocated for a refreshed suicide prevention strategy, rather than a complete overhaul. Interviewees advocated for a more focused and realistic strategy, with some recommending a 10-year plan with fewer, high-impact goals, structured evaluation, and stronger regional implementation under *Sláintecare*[19]. Others recommended a shorter timeframe, e.g., 5 years, with clear short-, medium, and long-term milestones to maintain momentum. Maintaining cross-sectoral governance, embedding lived or living experience in decision-making, and ensuring suicide prevention is not deprioritised in health system reforms are critical concerns for the future of suicide prevention strategy in Ireland.

Survey findings

An overview of key findings from the ROSP and local implementation team surveys are outlined below. Further detailed findings from the ROSP survey are presented in Appendix D.

Regional participation and engagement

- **Findings:** There are disparities in regional participation in both surveys. For local stakeholders and implementation partners, CHO 1 (20.24%), CHO 2 (17.26%), and CHO 8 (14.88%) had the highest representation, while CHO 3 (2.98%) and CHO 9 (5.36%) were lower. ROSPs showed a relatively even distribution.
- **Implication:** These patterns suggest varying levels of regional engagement with *CfL* activities, potentially reflecting differences in leadership support, resource availability, or local priorities.

Stakeholder involvement

- **Findings:** Both surveys highlighted varying levels of stakeholder engagement. For ROSPs, stakeholders like Local Authorities, An Garda Síochána, and NGOs showed moderate to high involvement, while minority groups and individuals with lived or living experience were less engaged. In the local stakeholders and implementation partners survey, community and statutory health sectors dominated (39.29% each), with less representation from NGO (11.9%) and education sectors (9.52%).
- **Implication:** As above, potentially reflecting differences in leadership support, resource availability, or priorities. Free-text responses from both surveys emphasised the limited roles and structures available for meaningful engagement of individuals with lived or living experience.

Barriers to adoption and implementation

- **Findings:** Common barriers across both surveys include insufficient resources, competing priorities, and lack of leadership support. ROSPs cited limited resources (83.33%), lack of leadership support (77.78%), and competing priorities (66.67%) as key barriers. Local stakeholders and implementation partners reported similar challenges, with insufficient resources (44.1%) and dependencies on national decisions (27.33%) as top barriers.

[19] https://www.gov.ie/en/department-of-health/campaigns/sláintecare/

- **Implication:** Resource constraints and fostering leadership buy-in may need to be considered for improving implementation.

Clarity and use of implementation plans

- **Findings:** While most local stakeholders and implementation partners found *CfL* implementation plans clear (60.67%), only 18% rated them as very clear. ROSPs reported occasional adherence to plans, with some adaptations for local contexts.
- **Implication:** Considering the presentation of implementation plans could improve understanding and adherence.

Support for implementation

- **Findings:** Support from local HSE *CfL* teams was rated as *"as expected"* by most local stakeholders/implementation partners (55.33%), with 32.67% noting support exceeded expectations. ROSPs reported mixed satisfaction with NOSP and line management support.
- **Implication:** Enhancing administrative support and clarifying the roles of NOSP and line managers may need to be considered.

Sustainability challenges

- **Findings:** Both groups expressed concerns about the long-term sustainability of *CfL* actions, citing limited resources, leadership turnover, and lack of formal sustainability plans. ROSPs reported limited resources (83.33%) and lack of capacity (77.78%) as major sustainability barriers, with only 5.56% reporting full incorporation of *CfL* actions into routine practice. Local stakeholders/implementation partners showed moderate sustainability readiness, with 57.33% feeling well-prepared.
- **Implication:** Funding and resources should be addressed to insure sustainability of *CfL* actions.

Examples of successful integration

- **Findings:** Successful integration examples include strong inter-agency collaborations, community-led initiatives, and embedding *CfL* actions into routine practices. ROSPs highlighted community-based suicide prevention training, integration into Children and Young People's Services Committees (CYPSC) activities, and strong NGO partnerships. Local stakeholders/implementation partners reported successes such as community-led Green Ribbon campaigns, targeted outreach for marginalised groups (e.g., Travellers, LGBTQI+ youth), and cross-sectoral training initiatives.
- **Implication:** Sharing success stories can be considered to spread best practices and encourage wider adoption of effective approaches.

Lessons learned and future priorities

- **Findings:** Both groups identified key lessons, including the importance of structured inter-agency coordination, proactive communication, and consistent leadership support. ROSPs emphasised leadership stability, administrative support, and inter-agency coordination, while local stakeholders and implementation partners focused on structured collaboration, proactive communication, and recognition of local

champions. Future stated priorities include expanding youth mental health services, enhancing training, and improving data systems.

Additional findings:

The open-ended responses from both the ROSPs and local stakeholders/implementation partners surveys provide additional information that enrich and contextualise the quantitative data. Some points and areas of alignment and divergence identified are listed below.

1. **Involvement of people with lived or living experience:**
    - Both surveys highlighted the limited yet growing involvement of individuals with lived or living experience. In the ROSP responses, this was noted as a **missed opportunity**, with recommendations to establish **advisory roles** and **peer support positions** within implementation teams.
    - Local stakeholders/implementation partners provided examples of initiatives where people with lived or living experience contributed meaningfully, such as **health and wellbeing events in local libraries** that integrated voices of lived or living experience to enhance authenticity and community connection.
2. **Sustainability challenges:**
    - ROSPs emphasised the **lack of administrative support**, **inconsistent leadership**, and **over-reliance on short-term funding** as key threats to sustainability.
    - Local stakeholders/implementation partners echoed concerns about leadership turnover, absence of formal sustainability plans, and **uncertainty due to structural changes** in the health service impacting long-term *CfL* continuity.
3. **Cross-sectoral collaboration:**
    - Both groups cited **barriers in cross-sectoral engagement**. ROSPs noted **fragmented data systems** and inconsistent stakeholder roles as limiting factors.
    - Local stakeholders/implementation partners suggested that strong **community-led partnerships** helped overcome collaboration barriers, with examples of **inter-agency projects targeting marginalised groups**.
4. **Successful integration examples:**
    - ROSPs highlighted the integration of suicide prevention training into CYPSC activities, partnerships with NGOs, and successful pilots like **social prescribing programmes**.
    - Local stakeholders and implementation partners shared **creative grassroots initiatives** facilitated by local *CfL* ROSPs.

Alignment across surveys

- **Resource constraints:** Both surveys consistently point to insufficient resources as the most significant barrier.
- **Leadership and sustainability:** Both groups express concern over inconsistent leadership support and lack of formal sustainability structures.

- **Stakeholder engagement:** There is mutual acknowledgment of gaps in engaging key groups.

Points of divergence

- **Strategic vs. operational Focus:**
    - **ROSPs** tend to focus on **system-level issues**, such as policy alignment, data infrastructure, and high-level leadership gaps.
    - **Local stakeholders and implementation partners** emphasise **day-to-day operational challenges**, including staff turnover, administrative support gaps, and the need for practical tools for frontline implementation.
- **Use of data:**
    - **ROSPs** are more focused on **strategic monitoring and national data gaps**, such as the absence of a suicide surveillance system.
    - **Local stakeholders and implementation partners** discuss **practical data applications**, like using local feedback to adjust community programmes and training schedules.

Section 5: Evaluation of the intermediate outcomes

The *CfL's* strategic framework is structured around 7 strategic goals, and the two principal outcomes for the strategy are a reduced suicide rate in the whole population and amongst specified priority groups, and a reduced rate of presentations of self-harm in the whole population and amongst specified priority groups. The authors identify challenges in measuring these principal outcomes directly including the low baseline suicide rate at the time of publication and the potential impact of changes in data collection; the possible impact of external factors outside the remit of the strategy; and the long timeframes between some interventions and outcomes. They propose that the measurement of outcomes be refined through the use of an outcome's framework comprised of intermediate outcomes (IOs) (and associated indicators) which are *"more directly influenced by suicide prevention efforts, and can be measured to provide preliminary evidence of the effectiveness of a suicide prevention programme or strategy in the shorter term"* (National Office for Suicide Prevention, 2015, p. 63). See the *CfL* outcomes framework in Table 3 below.

Table 3: CFL Intermediate Outcomes framework

Strategic Goal 1 To improve the nations understanding of, & attitude to suicide, mental health and wellbeing	
Intermediate Outcomes (IOs)	**Indicators**
IO1.1 Improved population-wide understanding of suicidal behaviour, mental health & wellbeing, and associated protective & risk factors. **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 priority groups.**	• Knowledge & awareness about support services • Understanding of protective & risk factors for suicide & self-harm • Understanding of mental health & wellbeing • Stigmatising attitudes towards mental ill-health, self-harm & suicide • Self-stigma (priority groups)
IO1.4 Engagement with media in relation to media guidelines, tools and training programmes & improvement in the reporting of suicidal behaviour within broadcasting, print & online media.	• Poor reporting (does not adhere to guidelines) • Positive reporting (adherence to guidelines)
Strategic Goal 2 To support communities' capacity to prevent & respond to suicidal behaviour	
IO2.1 Continued improvement of community-level responses to suicide through planned multi-agency approaches	• Local action plan available to enhance community responses to suicidal behaviour
IO2.2 Accurate information & guidance on effective suicide prevention are provided for community-based organisations (e.g. Family Resource Centres, Sports Organisations).	• Community organisations access to, & substantive knowledge on guidelines, protocols & training on effective suicide prevention interventions
IO2.3 Training and education programmes on suicide prevention to community-based organisations	• Availability of relevant training & education programme to community organisations • Delivery of relevant training & education programmes to community organisations

Strategic Goal 3 To target approached to reduce suicidal behaviour & improve mental health among priority groups	
IO3.1 Improve implementation of effective approaches to reduce suicidal behaviour among priority groups	• Best practice interventions (based on systematic review of evidence) • Interventions that are not evidence-informed & not evaluated
IO3.2 Support provided to the Substance Misuse Strategy, to address the high rates of alcohol & drug misuse	• (Continued) roll-out of programmes aimed at early intervention & prevention of alcohol & 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/centre of education adopting a whole-school approach to health & wellbeing in line with the Health Promoting School, Health Ireland & School Self-evaluation frameworks
Strategic Goal 4 - To enhance accessibility, consistency & care pathways of services for people vulnerable to suicidal behaviour	
IO4.1 Improved psychosocial & psychiatric assessment & care pathways for people vulnerable to suicidal behaviour	• Availability of crisis nurses in primary & secondary care settings • GPs trained to manage suicidal ideation/behaviour in primary care setting
IO4.2 Improved access to effective therapeutic intervention 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 & timeliness of support services to families & communities bereaved by suicide	• Systematic approach to offer of timely & effective support to families bereaved by suicide • Timely & effective support offered to families bereaved by suicide
Strategic Goal 5 - To ensure safe & high-quality services for people vulnerable to suicide	
IO5.1 Develop and implement national standards and guidelines for statutory and non-statutory organisations contributing to suicide prevention.	• Quality standards for suicide prevention programmes provided by statutory & non-statutory services • Implementation of quality standards
IO5.2 Improved response to suicidal behaviour within health & social care services (initial focus on incidents within mental health services)	• Development & effective implementation of uniform procedure to respond to suicidal behaviour in MH services • Development & implementation of uniform procedure to respond to suicidal behaviour in other health care services
IO5.3 Reduction in & prevention of suicidal behaviour in the criminal justice system	• Self-harm & suicide incidence in prison (adults) & children detention schools (minors)
IO5.4 Best practice among health & social care practitioners through (a) the implementation of clinical guidelines on self-harm and (b) the delivery of accredited education programmes on suicide prevention within the National Training Plan.	• 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	
IO6.1 Reduced access to frequently used drugs in intentional drug overdose	• Potentially risky prescribing practices (including number of tables 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 (proportions) of suicide deaths by highly lethal methods
Strategic Goal 7 - To improve surveillance, evaluation & high-quality research relating to suicidal behaviour	
IO7.1 Improve access to timely & high-quality data on suicidal behaviour	• Availability & timeliness of key data on suicide & self-harm • Effectiveness & timeliness of dissemination of key data on suicide & 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 national plan that supports research innovation aimed at early identification of suicide risk, assessment intervention& prevention	• National plan supporting research & innovation
IO7.4 Evaluation of the effectiveness of *Connecting for Life*[20]	• Development and publication of a comprehensive evaluation plan • Commissioning of evaluation studies • Successful implementation of evaluation studies • Publicly available report(s) on findings of evaluation studies

For the purposes of this evaluation the IOs and associated indicators were evaluated using secondary data provided by NOSP. This data was aligned to the *CfL* outcomes framework, with other forms of secondary data provided as evidence of the extent to which IOs and associated indicators were progressed. The secondary data provided included document links, publicly available document references, webpages, and references/observations from internal or in-progress reports (see Appendix E for the published evidence provided for each strategic goal). This data was analysed using the implementation outcomes framework described in the methodology section above with coding focused on the evidence directly relevant to the IO indicators.

The analysis of the secondary data is summarised for each of the 7 strategic goals in the following sections.

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

Intermediate Outcome 1.1 *Improved population-wide understanding of suicidal behaviour, mental health & wellbeing, and associated protective & risk factors.*

Under the indicator *Understanding Protective and Risk Factors,* evidence reviewed indicates that significant and current research has been undertaken to identify and understand the various and complex factors that influence mental health and suicidality (see Appendix E). Much of the research focuses on specific population groups including many of the priority groups identified in the *CfL* strategy document. Research on the social determinants of health is also highlighted. Some of the research presented is based on large samples and has a national reach. It includes peer-

[20] This IO includes cost-effectiveness in the *CfL* strategy document; however, cost-effectiveness is outside the scope of the current evaluation.

reviewed academic articles and a systematic review of the literature. The research presented provides an evidence base and makes various recommendations for future planning.

Under the indicator *Understanding Mental Health and Wellbeing* evidence was presented that the current mental health promotion policy framework provides a strategic direction for mental health promotion (Health Service Executive, 2022; Department of Health, 2024). The evidence reviewed also indicates that the inclusion of a module on suicide prevention in the Healthy Ireland Survey provides data on suicidality at a population level which aims to improve understanding on the prevalence and exposure to suicide. The survey is conducted annually with a representative sample of the population aged 15 and older, although the suicide awareness module is voluntary, with a minority of respondents completing it, and the results cannot be taken as representative of the wider population (Ipsos B&A, 2024). The HSE Mental Health Literacy campaign has been developed under the auspices of the HSE Mental Health Communications Campaigns Working Group (convened in 2019), and its development was informed by commissioned research. The evidence reviewed indicates significant increases in engagement with the campaign's website, yourmentalhealth.ie, suggesting that the campaign is increasing public awareness of mental health and wellbeing (National Office for Suicide Prevention, 2024a, p. 12).

Intermediate Outcome 1.2 *Increased awareness of available suicide prevention and mental health services.*[21]

Under the indicator *Knowledge and awareness about support services,* evidence reviewed shows that there has been significant and increasing traffic on yourmentalhealth.ie in 2024, with spikes in traffic during campaign bursts (National Office for Suicide Prevention, 2024a, p. 12). The *CfL* 2023 Directory for GPs (Health Service Executive, 2023) is available online and easily accessible, supporting GPs and their practices to avail of the information they need to refer patients to appropriate services. However, while there is evidence that this directory is available online, we do not have details of the number of times the Directory has been downloaded.

Intermediate Outcome 1.3 *Reduced stigmatising attitudes to mental health and suicidal behaviour at population level and within priority groups.*

Under the indicator *Stigmatizing Attitudes Towards Mental Ill-Health, Self-Harm, and Suicide,* a national anti-stigma campaign (the annual Green Ribbon campaign) and programmes under SeeChange, were delivered by Shine (2024). An anti-stigma guide (Shine, 2020a), booklet (Shine, 2020b), and research (Samaritans Ireland, 2023) are also available.

Evidence for the perceived effectiveness of the Green Ribbon campaign is contained in research conducted by Amárach Research for the 2023 Green Ribbon Impact Report. It found mixed feelings in the general population about the campaign's effectiveness in raising awareness about mental health stigma. Among those aware of the campaign, 29% reported it as very or extremely effective, while 31% felt it was not or slightly effective (Shine, 2023a, p. 19).

More broadly the evidence reviewed suggests that stigmatizing attitudes continue to be present in the wider population, although the wider population is aware of mental health stigma and

[21] Note that IO1.1 *Improved understanding of and attitude to suicide, mental health and wellbeing*, particularly indicator (2) *Understanding of mental health and wellbeing* is also relevant to this IO.

theoretically prepared to make changes. For example, a 2022 national survey found there was widespread agreement about the language used to describe mental health matters, and that 83% of respondents indicated they are prepared to change the way they talk about mental health (Amárach Research, 2022). However, the 2023 Samaritans research found a theoretical willingness to support those who self-harm but that roughly six in ten respondents reported that when faced with real-life scenarios they do not act in supportive ways (Samaritans Ireland, 2023).

The evidence reviewed shows that the See Change resources are available to support implementation, bearing in mind the limitation of findings discussed above. In addition, the 2023 Samaritans research made a number of recommendations in relation to future resources required to reduce stigma including the need for a 'whole of government approach', clear pathways to report, mandatory training for health and social care professionals and other employees, adherence to the Samaritans' media guidelines, accurate data, ongoing research, and mandatory wellbeing programmes in schools' (p. 6). This suggests that additional resources may be required.

The reach of the Green Ribbon campaign seems extensive as reported in the Green Ribbon Impact Report 2023. It is a national, month-long campaign and includes events, social media campaigns, and aims to support workplaces, organisations and the public to have conversations about mental health with over 600,000 green ribbons distributed. Findings from Amárach Research in this report give details on awareness of the Green Ribbon campaign including that overall, 24% of Irish adults were aware of the campaign (Shine, 2023a, p. 19).

Under the indicator *Self-Stigma (Priority Groups)* research concerned with understanding self-stigma amongst the priority groups LGBTQI+ people, people living in IPAS accommodation, at risk groups of middle-aged men, Travellers, and LGBTQI+ Traveller and Roma people, is available (See Appendix E). A number of the studies make recommendations around addressing mental health stigma and its impact on help-seeking behaviour, indicating that additional resources were needed to address stigma.

Intermediate Outcome 1.4 *Engagement with media in relation to media guidelines, tools and training programmes & improvement in the reporting of suicidal behaviour within broadcasting, print & online media.*

Under the indicators *Poor Reporting (Does Not Adhere to Guidelines)* and *Positive Reporting (Adheres to Guidelines)* the evidence shows that media guidelines (Samaritans Ireland, 2021) and other resources are available to the media, including the Samaritans 'Online Excellence Programme' (Samaritans, n.d.). There are also training opportunities for media practitioners run by Headline (the national programme for responsible reporting and representations of mental ill health delivered by Shine and funded by HSE NOSP). The *CfL* quarterly implementation progress reports for 2024 record a media event "Safe and Sensitive Reporting of Suicide" delivered with partners, including roundtable on previous day (Connecting for Life, n.d.).

The Shine Annual Report for 2024 notes that:

- 339 attendees were recorded at workshops (Shine).
- 23 student workshops on suicide reporting guidelines across 13 universities (Shine, 2025).

Headline provides extensive media monitoring and acts on issues found, runs Media Awards, and inputs into global initiatives on media and mental health (Shine, 2024). The *CfL* quarterly implementation progress reports indicate significant reach for monitoring activities.

An evaluation of Headline's monitoring activities recommended focusing on guideline breaches and limiting in-depth media analysis to periodic samples (Flynn, 2017). The information forwarded by NOSP indicates that this has been done. It also highlights that NOSP has worked on the enactment of the Online Safety and Media Regulation Bill and the establishment of the Media Commission (An Coimisiún na Meán)' in 2023.

Research available to inform planning includes a NSRF literature review which aims to propose clearly defined descriptions of harmful online material related to suicide and self-harm (McTernan & Ryan, 2023).

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

Intermediate Outcome 2.1 *Continued improvement of community-level responses to suicide through multi-agency approaches.*

Under the indicator *Local action plan available to enhance community responses to suicidal behaviour* evidence reviewed includes *CfL* Local Action Plan webpages, NOSP reports on surveys of stakeholders involved in area-level (Duane & Cox, 2019) and national (Duane & Cox, 2018) implementation structures, *CfL* Implementation Plans (National Office for Suicide Prevention, n.d.), and a 2022 report on the *CfL* Innovation Project (Aboutface Consulting, 2022).

Eleven areas provide links to Local Action Plans on the *CfL* website, covering all HSE geographical regions. Six of the areas provide links to plans up to 2024 (Connecting for Life, n.d.).

The 2018 and 2019 survey reports indicate largely positive attitudes towards the *CfL* implementation strategies and structures among stakeholders involved in *CfL* implementation at area and national level. These reports also highlighted some less positive attitudes towards specific areas, including that a minority (20%) felt that there were not clear 'champions of work' (Duane & Cox, 2019, p. 3) and that less than half (45%) recognised the ROSP Learning Community of Practice as playing an instrumental part in driving implementation (Duane & Cox, 2018, p. 6). A minority of stakeholders (32% in 2018 and 25% in 2019) also felt that communication was 'somewhat effective' or that they were 'not at all' or only 'somewhat' consulted. The 2019 survey found that stakeholders in the local level oversight and working groups had concerns about the level of funding available for implementation of *CfL* (76% and 59% respectively) (Duane & Cox, 2019, p. 1).

The 2018 and 2019 survey reports found that a broad range of evidence-informed implementation strategies were used to drive *CfL* at area-level and nationally. The 2022 report on the *CfL* Innovation Project presents twelve interventions from across the *CfL* Local Action Plans that were judged by

the project steering group to be 'innovative' implementation interventions (Aboutface Consulting, 2022).

The evidence that there is a system in place to inform planning and track changes over time includes the three national level *CfL* Implementation Plans published covering the period from 2017 to 2024. Each plan contained milestones relating to the development and implementation of the Local Action Plans, including a milestone relating to the revision of local plans and to a report on the review of local plans in the 2020-2022 Implementation Plan (National Office for Suicide Prevention, n.d.).

Intermediate Outcome 2.2 *Accurate Information and Guidance on Effective Suicide Prevention Provided for Community-Based Organisations*

Under the indicator *Community organisations' access to, & substantive knowledge on guidelines, protocols & training on effective suicide prevention interventions,* there were three guidance documents: Developing a Community Response to Suicide (National Office for Suicide Prevention, 2021a), Suicide Prevention in the Community (O'Sullivan & Tiernan, 2023), and Responding to a Person in Suicidal Distress (National Office for Suicide Prevention, 2024b). Development included extensive stakeholder consultation. They are available to all community-based organisations and are tailored respectively at developing an inter-agency Community Response Plan, guidance on suicide prevention in the community, and guidance for public-facing staff and volunteers on interacting with people who present in distress or at risk of suicide and self-harm.

Intermediate Outcome 2.3 *Training and Education Programmes on Suicide Prevention to Community-Based Organisations*

Evidence reviewed for the indicators *Availability of relevant training & education programmes to community organisations* and *Delivery of relevant training & education programmes to community organisations* includes a suite of training programmes for community organisations funded by NOSP (National Office for Suicide Prevention, 2024c), the *CfL* National Education and Training Plan (National Office for Suicide Prevention, 2025a), the *CfL* Training Quality Assurance Framework (QAF) (National Office for Suicide Prevention, 2021b), details of the HSE Social Prescribing Framework (HSE Healthy Ireland, 2025), links to the HSE Health and Wellbeing online programmes (HSE Health and Wellbeing, n.d.) and the *CfL* quarterly implementation progress reports (Connecting for Life).

Training programmes provided under *CfL* include: *safeTALK*, *ASIST*, Suicide Bereavement workshops, *Skills Training On Risk Management* (STORM), and *Let's Talk about Suicide* (National Office for Suicide Prevention, 2024c) (National Office for Suicide Prevention, 2025). There are also free online training resources (HSE Health and Wellbeing, n.d.) (HSE Healthy Ireland, 2025).

The *CfL* quarterly implementation progress reports give details of the various training programmes provided and numbers attending. The numbers demonstrate there has been significant national reach, and the various training programmes have been attended by tens of thousands of people. The *CfL* monitoring system also provides a system to track changes over time and provide ongoing feedback.

Training quality assurance and planning are supported by the *CfL* National Education and Training Plan 2025 and the *CfL* Training QAF. The National Education and Training Plan 2025, providing a

framework for continuous improvement in NOSP training by mandating monitoring, reporting and evaluation.

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

Intermediate Outcome 3.1 *Improve implementation of effective approaches to reduce suicidal behaviour among priority groups*

The indicators *Best practice interventions (based on systematic review of evidence)* and *Interventions that are not evidence-informed and not evaluated* refer to interventions targeted at the priority groups identified in *CfL* (Department of Health, 2015). These are:

- Health and 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.

Evidence reviewed includes interventions provided through HSE Child and Adolescent Mental Health Service (CAMHS) Hubs. CAMHS Hubs are currently operating on a pilot basis across five pilot learning sites and provide brief, intensive, mental health interventions to children, young people, and their families. They are guided by the evidence-based CAMHS Model of Care (see IO 4.2 for details of the CAMHS Model of Care). In addition, the evidence points to the suite of training programmes delivered to community organisations that are funded by NOSP (see IO 2.3 for details of these training programmes).

Other evidence provided relevant to these indicators includes evidence-based interventions and evidence-informed practices funded by NOSP and provided through a range of NGOs (see Appendix E). The 2022 NOSP annual report states that over 50% of its budget is allocated to supporting mental health and suicide prevention provided by NGOs and that consideration is given to 'research, evidence, standards and best practice' in assessing funding applications through the HSE SLA process. The report highlights self-reported activity from funded organisations indicating extensive and diverse reach (National Office for Suicide Prevention, 2022, pp. 40-52). These organisations target interventions at a number of priority groups including mental health related groups, LGBTQI+ people, people attending homeless services, people attending community

development organisations, people from the Traveller and Roma communities, men working in the construction industry, people bereaved by suicide, and students.

Amongst *CfL* lead agents best practice interventions include:

- Increased awareness of suicidal prevention and support throughout the Department of Social Protection by ensuring access for all staff who wish to avail of *safeTALK*.
- Incorporation of suicide awareness and prevention strategies amongst members of the Defence Forces.
- Incorporation of suicide awareness and prevention strategies into Gardaí training.

Intermediate Outcome 3.2 *Support provided to the Substance Misuse Strategy, to address the high rates of alcohol & drug misuse*

Under the indicator (*Continued) roll-out of programmes aimed at early intervention & prevention of alcohol & drug misuse* the evidence provided related to the roll out of the SAOR (Support, Ask and Assess, Offer Assistance, Refer) programme by the HSE. SAOR is an evidence-based framework for the delivery of screening around alcohol and other drug use (with reference to suicide and self-harm related behaviour if appropriate) and brief interventions within a broad range of settings (O'Shea, Goff, & Armstrong, 2017).

The 2017 report on the delivery of SAOR II found sustained expansion and delivery of SAOR training nationwide, including the ongoing recruitment of staff in each CHO area and implementation of 'Train the Trainer' models. At the time of publication over 3,500 frontline staff had been trained across mental health, criminal justice, and community settings (O'Shea, et al., p. 16). The authors conclude that the SAOR II framework is embedded in national training and policy and bolstered by partnerships between key organisations such as the HSE and the National Social Inclusion Office (p. 96). The information forwarded by NOSP indicates that the roll out of SAOR is ongoing.

There was no evidence forwarded relating to other programmes relevant to this indicator.

Intermediate Outcome 3.3 *Enhanced supports for young people with mental health problems or vulnerable to suicide*.

Evidence reviewed under the indicator *Enhanced availability in primary care to early intervention psychological supports including counselling* includes the 2022 evaluation of the Counselling in Primary Care (CIPC) Service. CIPC provides time-limited counselling to people over 18 years who are GMS card holders and who are experiencing mild to moderate psychological and emotional difficulties. The 2022 evaluation identified high levels of service user satisfaction and found that the counselling provided was effective in addressing the problems people presented to a significant degree (CIPC National Research Group, p. 7). The review found that CIPC was available in each HSE Community Health Area and that by the end of 2021 almost 150,000 people had been referred to the service (p. 4). Difficulties identified around accessing the service include long waiting times, and exclusion of non-GMS card holders (p. 19). There was no data available on the extent to which the service was accessed by young people specifically.

The information forwarded by NOSP also pointed to the services provided by the NGOs Jigsaw and Pieta at primary care level for young people. These NGOs receive funding through the HSE and

provide diverse services with a national reach. Jigsaw is the National Centre for Youth Mental Health and provides mental health supports (online and in-person) to children and young people aged 12 to 25. Their annual report states the service provided mental health support to thousands of young people nationally, with 45,376 in-person appointments offered (Jigsaw, 2024). Pieta also has a national reach and provides services to people who experience thoughts of suicide, engage in self-harm, or are bereaved by suicide, across all age-groups. Its current five-year plan indicates increasing demand for its services from children and young people. It also highlights education/prevention interventions that target young people including their Amber Flag programme for schools and other education institutions (Pieta, 2024, p. 12).

Under the indicator *Schools/centres of education adopting a whole-school approach to health & wellbeing in line with the Health Promoting School, Healthy Ireland & School Self-evaluation (SSE) frameworks,* the evidence reviewed includes: the Department of Education 2018 Wellbeing Policy Statement and Framework for Practice, two National Educational Psychological Service guidance documents on developing student support teams and on responding to self-harm in schools, and a Department of Education 2024 review of the 2013 action plan on bullying/development of an updated (Cineáltas) action plan (see Appendix E).

These policy and guidance documents have national reach in that they apply to all schools and centres for education[22]. There is also evidence that the policy and guidance documents form a coherent policy framework to support a whole school approach and to support school self-evaluation in this context. The 2018 Wellbeing policy document promotes a whole-school approach to wellbeing and requires schools to have embedded a School Self-Evaluation Wellbeing Promotion Process by 2023 (Department of Education and Skills, 2018, p. 1). The NEPS guidance documents advocate that schools draw on the 2018 Wellbeing Policy Statement and Framework and for a whole school approach to implementation. Similarly, the 2024 report on bullying action plans situates its work under the 'overarching framework' provided by the Wellbeing policy document. The review of the 2013 bullying actions found, although school self-evaluation was curtailed due to the COVID-19 pandemic, schools are required to use the SSE process to initiate a wellbeing promotion review and development cycle by 2025 and inspectors carry out advisory visits on a regular basis to support this process (Department of Education, 2024, p. 26).

[22] The 2019 Wellbeing Policy Statement and Framework for Practice defines schools and centres for education as 'primary and post primary schools, including special schools, and alternative education settings such as Youthreach, Community Training Centres, Hospital Schools, High Support Special Schools and Youth Encounter Projects' (Department of Education and Skills, 2018, p. 3).

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

Intermediate Outcome 4.1 *Improved Psychosocial and Psychiatric Assessment and Care Pathways*

The evidence reviewed for the indicator *Availability of crisis nurses in primary & secondary care settings* relates to the SCAN service and the National Clinical Programme for Self-harm and Suicide-related Ideation (NCPSHI) hospital-based nurses.

The evidence indicates that the SCAN service is valued by service providers and users and that both the SCAN and NCPSHI service have a positive impact on care provided (College of Psychiatrists of Ireland, 2022) (Griffin, et al., 2021) (Cully, et al., 2023). Issues identified include levels of supervision for SCANs. Lack of designated assessment room, and poor collaborative relationships between ED and liaison psychiatry staff are identified as barriers for the implementation of the NCPSHI (College of Psychiatrists of Ireland, 2022) (National Suicide Research Foundation, 2025). Key resources to support implementation include the 2022 NCPSHI Model of Care and SCAN Operational Guidance (College of Psychiatrists of Ireland, 2022) (HSE National Clinical & Integrated Care Programmes, 2024).

The reach of the SCAN service is limited (20% of population) (College of Psychiatrists of Ireland, 2022). The NCPSHI is operational in 24 of 26 adult EDs and one children's hospital (Cully, et al., 2023).

Key findings from the 2025 NSRF **PR**oviding **I**mproved care for **S**elf-har**M** (PRISM) Policy Brief recommend resourcing of a national team to coordinate evidence-based implementation and point to the varied availability of timely next care from community providers as an ongoing challenge (National Suicide Research Foundation, 2025).

The evidence reviewed indicates that there is substantial research available to inform planning, and that the 2022 Model of Care and the SCAN Operational Guidance are available as supports to standardise and inform service provision (See Appendix E).

The evidence reviewed for the indicator *GPs trained to manage suicidal ideation/behaviour in primary care settings* shows there is different training aimed at GPs under *CfL* including the NOSP/Irish College of General Practitioners training 'Connecting with People', Irish College of General Practitioners (ICGP) monthly webinars, and suicide prevention training to trainee GPs in Sligo (in 2023).

Correspondence from NOSP estimates that 591 GPs attended the 'Connecting with People' training. There is ongoing evaluation by the NRSF of this training, which will be available to inform planning when completed (National Suicide Research Foundation, n.d.). The information provided by NOSP noted that they are currently working with the ICGP to inform the future rollout of the STORM training for GPs.

Intermediate Outcome 4.2 *Improved access to effective therapeutic intervention for people vulnerable to suicide*

The evidence reviewed for the indicators *Availability of effective therapeutic interventions for people vulnerable to suicide* and *Systematic approach to offer therapeutic interventions to eligible persons* shows three evidence-based, collaboratively produced, Models of Care available (all three refer to either lived or living experience or service user involvement in their development), namely: the 2021 Model of Care for Adults Accessing Talking Therapies (AATT), the 2023 Model of Care for Dual Diagnosis, and the 2023 Model of Care for CAMHS Hubs (HSE Mental Health Service, 2021) (National Clinical Programme for Dual Diagnosis Working Group, 2023) (Butler & Hardiman, 2023). The AATT Model of Care is currently being evaluated by the NSRF and being rolled out on a phased basis 'across some Community Healthcare Organisations' (National Suicide Research Foundation, n.d.) and the CAMHS Hub Model of Care is being piloted across five learning sites (CAMHS Hubs, n.d.). The Dual Diagnosis Model of Care recommends 12 Adult Dual Diagnosis teams across the 9 CHOs. There was no data available of the extent to which this has been implemented.

There are references within all three Models of Care to strategies to plan for implementation and sustainability. The 2023 Model of Care for CAMHS Hubs is informed by an implementation science approach and the document refers to a process that includes evaluation, review, sustain and upscale stages (Butler & Hardiman, 2023, p. 15). The 2021 AATT Model of Care recommends that each CHO complete a mapping strategy which 'should result in a development plan' (HSE Mental Health Service, 2021, p. 36). The 2023 Model of Care for Dual Diagnosis gives details of an evaluation framework (National Clinical Programme for Dual Diagnosis Working Group, 2023, p. 108) .

The HSE National DBT programmes is rolled out by their training team (established in 2021) to mental health teams, with 14 teams delivering the programme in 2024 (Joyce, et al., 2024a).

The information forwarded by NOSP notes the expansion of the Collaborative Assessment & Management of Suicidality (CAMS) model. This is an evidence-based therapeutic framework designed to work with pre-existing mental health interventions. Data on the extent of the expansion was not available.

The information forwarded by NOSP notes that over 4000 licences for the delivery of online CBT through referral from GPs, primary care psychology, CIPC and Jigsaw have been activated. The provision of therapeutic interventions to priority groups by NGOs and funded by NOSP is also noted.

Intermediate Outcome 4.3 *Improved uniformity, effectiveness & timeliness of support services to families and communities bereaved by suicide*

In 2022, 57% of respondents to a national survey on people affected by suicide in Ireland reported waiting more than one month to access suicide bereavement support and reported a number of issues in relation to accessing suicide bereavement support in their areas (O'Connell, et al., 2022).

Much of the evidence reviewed for the indicators *Timely and effective support offered to families bereaved by suicide* and *Systematic approach to offer timely and effective support to families bereaved by suicide* relates to Pieta's national Suicide Bereavement Liaison Service (SBLS), a

support service provided by SBL Officers (SBLOs), and HUGG's peer support service for suicide bereaved adults.

The evidence shows that service users and service providers value and find effective the SBLS and the HUGG peer support services. The SBLS service is provided across all counties. Challenges such as role definition, risk of burnout, staff retention, and the need for consistent referral pathways have been identified by SBLS service providers. Service users highlighted challenges including limited awareness of peer support services, and issues around accessing SBLS supports (O'Brien, Ní Dhálaigh, & Corcoran, 2023).

Evidence also indicates the SBLOs reported engagement with the community varied across CHOs and described difficulties in engaging with marginalised communities and in engaging with other allied services (O'Brien, et al., 2023).

In 2024, HUGG provided 20 support groups across Ireland, offering both online and in person attendance. Participants in support groups identified the groups as creating a safe space and providing a sense of belonging and hope (Griffin, et al., 2023).

The 2020 *CfL Improving suicide bereavement supports in Ireland* document identified ten action areas to inform future developments. The document also listed a number of resources to support a systematic approach. These include a mapping of supports completed in 2018/2019, a literature review on suicide bereavement support published in 2019, and a best practice guidance and a HSE communications guide, both published in 2019 (National Office for Suicide Prevention, 2020, p. 19)

The evidence reviewed shows support guides have been developed under *CfL* for people bereaved by suicide (National Office for Suicide Prevention, 2024d), responding to grief in the workplace (McGuinness & Skehan, 2021), and for young people and their families (Forde, 2024). An additional resource is the appointment of a National Suicide Bereavement Support Coordinator in 2022 (full-time since 2024). The information provided by NOSP noted that an additional resource to support implementation is the appointment of a National Suicide Bereavement Support Coordinator in 2022 (full-time since 2024).

There is a system in place to inform planning and track changes over time, including a 2023 review of the SBLS which led to the production of a Logic Model to guide future evaluation and recommended a review of the current Salesforce system (O'Brien, et al., 2023). HUGG and Pieta report through the *CfL* quarterly implementation progress reports.

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

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

Under the indicators *Quality standards for suicide prevention programmes provided by statutory and non-statutory services* and *Implementation of quality standards,* a best practice guidance (BPG) document for suicide prevention services was published by NOSP in 2019. This BPG applies to both statutory and non-statutory organisations and is based on a self-assessment approach. The BPG was co-produced with NGOs and is aligned with the national frameworks on mental health

and healthcare quality. It includes an adapted version of the Guidance Assessment Improvement Tool (GAIT) to facilitate self-audit and to track changes over time (National Office for Suicide Prevention, 2019). The BPG is implemented voluntarily by stakeholders (as opposed to a compulsory 'standards' framework, which would require as inspection system) (Centre for Effective Services, 2021a, p. 22).

An evaluation of the BPG found that the quality standards were comprehensive, in line with *CfL,* and that NGOs and stakeholders were largely committed to their implementation. The evaluation also noted that larger organisations integrated the quality guidance more fully, while some smaller organisations struggled to engage with the entire framework within their resources. Enhanced IT support, more streamlined assessment tools, and implementation support (particularly for smaller organisations) were also recommended (Centre for Effective Services, 2021b).

Following this evaluation, a decision was taken to align the BPG with the HSE Service Level Agreement process which provides an oversight and monitoring function for funded NGOs. In addition, the role of the Charity Regulator in relation to ensuring that charities adhere to legal and governance standards was recognised (Charities Regulator, 2018).

Intermediate Outcome 5.2 *Improved response to suicidal behaviour within health and social care services (initial focus on incidents within mental health services)*

Under the indicators *Development and effective implementation of uniform procedure to respond to suicidal behaviour in mental health services* and *Development and effective implementation of uniform procedure to respond to suicidal behaviour in other health care services,* the 2020 HSE Incident Management Framework is available to all HSE services and provides general guidance on complying with statutory and HSE requirements in relation to managing incidents (Office of the Chief Clinical Officer, 2020). In addition, NOSP (supported by a multi-agency working group) has published a guidance document aimed at staff in community mental health services provided or funded by the HSE. This guidance document is aligned with the Incident Management Framework and aims to promote a standardised, culturally sensitive, and informed response to deaths reported as suspected suicide within community mental health settings. The document specifies that the procedures do not cover deaths by suspected suicide of inpatients or residents in mental healthcare facilities (National Office for Suicide Prevention, 2024e).

The National Suicide Research Foundation has secured ethical approval for a feasibility study on the development of a new National Probable Suicide (in mental health services) Register, and an agency is contracted to develop a guidance document for suicide self-harm, awareness, assessment and response in health services.

Intermediate Outcome 5.3 *Reduction in and prevention of suicidal behaviour in the criminal justice system*

Under the indicator *Self-harm and suicide incidence in prison (adults) and children detention schools (minors),* the Self-Harm Assessment and Data Analysis (SADA) project is coordinated by the multi-agency National Suicide and Harm Prevention Steering Group (NSHPSG). The project provides comprehensive data on suicidal behaviour in all twelve Irish prisons (adults). The data is reported on annually and provides information on the incidence and profile of self-harm within

prison settings, identifies individual and context-specific risk factors relating to self-harm, and identifies patterns of repeat self-harm. The information is monitored by the NSHPSG to inform prevention and response measures in the prison service (Irish Prison Service, 2018) (Irish Prison Service, 2020) (Irish Prison Service, 2021).

A 2023 peer-reviewed article analysed the SADA project data and found that the rate of self-harm in Irish prisons has remained stable over the past two decades and is approximately one-third lower than in England and Wales (McTernan, et al., 2023, p. 571).

Intermediate Outcome 5.4 *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 training within the National Training Plan*

Under the indicator *The implementation of clinical guidelines on self-harm,* there are operational guidance documents developed for health practitioners in emergency departments and for SCANs, and that these were developed to facilitate implementation of the National Clinical Programme for the Self-harm and Suicide-related Ideation (NCPSHI) Model of Care (HSE National Clinical & Integrated Care Programmes, 2024a) (HSE National Clinical & Integrated Care Programmes, 2024b) (College of Psychiatrists of Ireland, 2022). The SCAN operational guidance and the NCPSHI Model of Care are discussed under Strategic Goal 4.

Under the indicator *Delivery of accredited education programmes on suicide training within the National Training Plan,* the evidence reviewed describes a number of education initiatives aimed at health and social care practitioners.

STORM is an accredited self-harm and suicide prevention training (Storm Skills Training, n.d.). In 2024 this training was delivered either by the HSE directly, or online through STORM UK, to 109 participants.

A module on suicide prevention by the NSRF for incorporation into relevant third-level curricula is in pilot phase. This module was developed through a review of existing training resources and consultations with health and social care academics to shape an interdisciplinary approach to suicide prevention education. It is currently being piloted with 200 health and social care students and the NSRF proposes a future evaluation phase incorporating quantitative surveys and qualitative focus groups to assess students' knowledge acquisition, competence in suicide prevention, and feedback on content (National Suicide Research Foundation, n.d.).

Finally, NOSP noted the development and evaluation of the Self-Harm Assessment and Management Programme for General Hospitals (SAMAGH). This is an advanced training programme designed to improve the assessment, management, and support of high-risk self-harm patients in a hospital setting. The 2020 SAMAGH study protocol outlines the evidence-based development of the training and the protocol for ongoing evaluation. It is proposed that the training be delivered in health-care practitioners across all 27 public hospitals in Ireland (Arensman, et al., 2020).

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

Intermediate Outcome 6.1 *Reduce access to frequently used drugs in intentional drug overdose*

Under the indicator *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)* the work of the multiagency Preventing Paracetamol-Related Drug Overdose Working Group (convened in 2021) is evidence-based and includes a national pharmacy information campaign and ongoing surveillance work (National Suicide Research Foundation) (Connecting for Life, 2023). The Department of Health's national DUMP (Disposal of Unused Medication Properly) scheme received funding under budget 2025 and is currently under development. The DUMP scheme is to be evaluated under the HRB funded *Reducing intentional overdose: a mixed methods study of means restriction interventions* (RESTRICT) research (University College Cork, n.d.).

Evidence presented on other research relevant to this indicator includes an academic article describing a protocol for future research using multi-indicator analysis in the Irish context, and academic articles on drug overdose among young people in Ireland using National Self-harm Registry data (, et al., 2023) (Daly, et al., 2021) (Daly, et al., 2020).

The 2025 Report of the Multiagency Working Group on *Overprescribing of Benzodiazepines, Z Drugs and Gabapentinoids in Ireland* recognises a positive downward trend in some data on prescribing and describes updates in 2017 to the Misuse of Drugs regulations introducing additional controls, and subsequent PSI and Medical Council guidelines and tools developed for GPs and Pharmacists (Multiagency Working Group on Overprescribing, 2025, pp. 8-9). Recommendations at the end of this report indicate areas where the authors feel there is still work to be done. These include improved service delivery (lack of publicly funded counselling services); improved education (need for further education initiatives for doctors, pharmacists and the public, including a public information campaign to highlight dangers); advancing transparency in prescribing practices (they recommend a central repository of data and highlight that a particular issue is the lack of data on private patients); and they that consideration be given to including Pregabalin and Gabapentin in the Controlled Drugs List (Multiagency Working Group on Overprescribing, 2025, pp. 42-43).

The Department of Health is currently reviewing the recommendations of the Multiagency Working Group on Overprescribing report. Other research available to inform future planning includes the NSRF RESTRICT research referred to above, which aims to provide an understanding of intentional overdose in Ireland and to inform future measures to restrict access to drugs, and a protocol for research using multi-indicator analysis developed by academics for the Irish context (University College Cork, n.d.) (, et al., 2023).

Intermediate Outcome 6.2 *Reduced access to highly lethal methods used in suicidal behaviour*

Under the indicator *Suicide proofing of locations of concern,* the evidence reviewed shows that the 'Suicide in Public Places: A best practice toolkit 2025' has been developed by NOSP in partnership with a multi-agency project advisory group and is a resource for public bodies, agencies, or stakeholders responsible for public places in Ireland (National Office for Suicide Prevention, 2025b). Feedback from NOSP notes that one Health Impact Assessments has been conducted and one is in progress on locations of concern using this resource.

The Samaritans' working group to restrict access to frequently used high-risk locations and liaise with Irish-rail and UK Network Rail on best practice, is on-going.

Under the indicator *Reduced number (proportions) of suicide deaths by highly lethal methods* statistics from the Central Statistics Office and the Irish Probable Suicide Deaths Study were forwarded. These give the percentage of deaths cross-tabulated by method and gender for the years 2015 to 2020 (comparing the percentage of males and females who died by each method for each year). The data does not show the overall proportion of deaths by highly lethal methods.

An academic article which analyses the presentations of self-harm in Irish hospitals from 2007 to 2019, concludes that over this period there was an increase in self-harm by hanging and drowning, highest among adolescents and young adults (White, Corcoran, Griffin, Arensman, & Barrett, 2024).

The analysis of primary population level outcomes or impact data is outside the scope of this evaluation.

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

Intermediate Outcome 7.1 *Improved access to timely and high-quality data on suicidal behaviour*

Under the indicators *Availability & timeliness of key data on suicide & self-harm* and *Effectiveness & timeliness of dissemination of key data on suicide & self-harm,* evidence was categorised by type of data.

Under the category population level data, the inclusion of a module on suicide prevention in the Healthy Ireland (HI) Survey aims to improve understanding on the prevalence and exposure to suicide. The Survey is conducted annually with a representative sample of the population aged 15 and older, although the suicide awareness module is voluntary, with a minority of respondents completing it, and the results cannot be taken as representative of the wider population (Ipsos B&A, 2024). The NOSP and the NSRF have been approved by the Department of Health to access and conduct more in-depth analysis on this data (National Office for Suicide Prevention, 2024a).

Under the category self-harm data from hospital emergency departments, the NOSP funded National Self-Harm Registry (NSHR), established in 2000, records and reports on the number of self-harm presentations to hospital EDs across the country each year (The National Self-Harm Registry Ireland, n.d.). Outputs from the registry include an infographic on the website with the latest available data, National Self-Harm Registry Ireland Annual Reports, and reports providing data at regional level for ROSPs and implementation teams (Joyce, et al., 2024b). In addition, there have been eleven NSHR academic articles published. The registry data has also been used to inform academic articles published as part of the NCPSHI (see Appendix E).

Under the category suicide mortality data, suicide statistics are published by the Central Statistics Office annually following the Coronial investigation, inquest and registration processes. The decision as to whether someone has died by suicide is a legal determination made by Coroners. There is generally a time lag of approximately two years in the published data (Prevention, n.d.). Evidence also shows that a multiagency (NOSP, HRB, Irish Coroners) Irish Probable Suicide Deaths Study (IPSDS) was initiated in 2016. Under this study six years of data on

coroner determined and research determined suicides were collated (2015-2020) with the aim of understanding characteristics of people who have died by probable suicide, to identify risk factors, and to inform planning. Outputs from the study include the published IPSDS 4-year report (2015-2018) and IPSDS Supplementary CHO level reports and academic articles (see Appendix E) (Irish Probable Suicide Deaths Study, n.d.). NOSP Annual Report notes that work is underway to establish a new system to reestablish data collection on 'probable suicides' based on the IPSDS framework and to be called the National Probable Suicide Monitoring System (National Office for Suicide Prevention, 2024a).

Under the category deaths in mental health services there is an ongoing NSRF project with the aim of merging HSE and Mental Health Commission datasets to learn about the circumstances surrounding deaths by suicide in mental health services (National Suicide Research Foundation, National Suicide Research Foundation). Outputs from this project are not yet available. Two reports are drafted for sign off and will inform a strategic work plan to improve access to data in the future. An HSE Death in Mental Health Services Guide for Staff was published in 2024 (Health Service Executive, 2024)

Under the category near real time mortality data, the Suicide and Self-Harm Observatory was developed by the NSRF to obtain data in real time, on suspected suicide cases from the Coroners of County Cork and the HSE Patient Mortality Register. This data can be used for the early identification of emerging suicide clusters, new methods amenable to means restriction measures and locations of concern, as well as timely responses to bereaved individuals, evidence-based policy planning and targeted service provision (National Suicide Research Foundation, n.d.). Outputs from the work of the Observatory include 4 academic articles published in 2022 (see Appendix E). In 2024 NOSP issued a Request for Tender to evaluate the Observatory and to undertake a scalability assessment, which is currently underway.

NOSP has worked with the Garda Victim Liaison Office on developing a joint working protocol and Memorandum of Understanding which will include a data sharing agreement (National Office for Suicide Prevention, 2024a). This protocol is not yet in place.

Intermediate Outcome 7.2 *Current recording procedures for suicide deaths in Ireland reviewed (and, if necessary, revised)*

Under the indicator *Review of current recording procedures,* the CSO Suicide Mortality Statistics Liaison Group was initiated in 2014 and includes representatives from the CSO and the NSRF. The group meets twice yearly and aims to improve suicide statistics and dissemination (CSO Suicide Mortality Statistics Liaison Group, n.d.).

Other evidence related to this indicator is the Irish Probable Suicide Deaths Study (IPSDS). Study aims include to improve understanding of the characteristics of people who die by suicide (Irish Probable Suicide Deaths Study, n.d.). The IPSDS four-year report is based on data from completed coronial files from 2015 to 2018. It uses a broader definition of suicide than the coroner (which requires a 'beyond reasonable doubt' verdict) i.e. it includes 'more likely than not' deaths. Consequently, the study has analysed more deaths than normally included in official CSO statistics. Limitations of the study identified by the authors include the time-lagged nature of data.

In addition, the current coronial system may be underestimating the number of reported suicides. A HUGG commissioned report on changing the burden of proof for a legal determination of death by suicide in Ireland argues that change would lead to an estimated 20 to 25% increase in the number of reported suicides (Indecon International Research Economists, 2024).

Intermediate Outcome 7.3 *Development of a national plan that supports research innovation aimed at early identification of suicide risk, assessment, intervention and prevention*

Under the indicator *National plan supporting research and innovation,* since 2020 the national research plan has taken the form of a collaborative grant scheme. Under this scheme eleven successful research projects were published in a Book of Abstracts in 2021, and related briefing papers were published in 2023. The research is described as focusing on the priority groups identified in *CfL*. The briefing papers include research on people experiencing homelessness, substance use and mental ill-health, adults with Attention Deficit Hyperactivity Disorder (ADHD), Traveller men affected by suicide, people experiencing suicidality in an Adult Acute Mental Healthcare Unit, young people experiencing bullying, people bereaved by suicide, people presenting to ED departments, sex workers, first responders and other mental healthcare professionals, parents of adolescents who self-harm, and Farmers (Grant Scheme for Collaborative Research Projects, n.d.). Other outputs from the Collaborative Research Grant Scheme include conference presentations and journal articles from the research teams (see Appendix E). There was no indication in the evidence reviewed if the Collaborative Research Grant Scheme is funded to continue.

The scoping review *Suicide and self-harm studies by researchers in Ireland and Northern Ireland during 2015-2023* (Hursztyn, et al., 2024) looked at 629 published primary and secondary data sources. The review was part of the work of the C-SSHRI (Connecting Suicide and Self-Harm Researchers on the Island of Ireland) network. It refers to progressing the work of *CfL* by identifying '...the current status on research relating to suicidal behaviour in Ireland, as well as to capture the extent of this research since *CfL* and PL2 were initiated' (p. 6). The authors make a number of recommendations including the need for further research on several priority groups highlighted in *CfL* and other at-risk groups (p. 18).

Intermediate Outcome 7.4 *Evaluation of the effectiveness of Connecting for Life*[23]

Under the indicator *Development and publication of comprehensive evaluation plan,* the 2018 Connecting for Life Monitoring and Evaluation Framework sets out the evaluation approach applied by NOSP and proposed monitoring and evaluation strategies aligned to *CfL* strategic goals (Cox, 2018).

Under the indicators *Commissioning of evaluation studies* and *Successful implementation of evaluation studies,* the interim strategy evaluation commissioned by NOSP and conducted by the *CfL* Evaluation Advisory Group. It examined the extent to which key actions in the strategy were achieved and made recommendations for future development (National Office for Suicide Prevention, 2019).

[23] This IO includes cost-effectiveness in the *CfL* strategy document; however, cost-effectiveness is outside the scope of the current evaluation.

A review of the research was carried out under *CfL* (Centre for Effective Services, 2021c). This review considered commissioned research and evaluations and produced a synthesis of findings. Thirty-one reports were reviewed, categorised by type, and aligned with the goals, objectives, and priority groups to inform future policy and practice. Recommendations included the 'development of a research and evaluation plan, aligned with the goals, objectives and priorities outlined within Connecting for Life, to facilitate research and evaluation activity across all groups and objectives' (Centre for Effective Services, 2021c).

A total of 18 evaluation studies completed since 2020 were reviewed (see Appendix E). Five were authored by NSRF (2 in collaboration with UCC) ranging in date from 2022 to 'currently underway'. Eight were commissioned to external agencies (consultants and one university) and funded by NOSP ranging in date from 2020 to 2022. The information also referred to the establishment of the HSE National DBT training and its ongoing evaluation (funded by NOSP) and 3 academic articles relevant to the DBT team (see Appendix E).

Geographical areas covered in evaluations include the Southeast Community Health Care, CHO 7 (Kildare/Wicklow), Ballyfermot community, Dublin and Mid-west, North Dublin Suicide Assessment and Treatment Service (SATS). Other indicators of reach include that the studies included veterinary professionals, adults attending HUGG support groups, GPs attending training, 9 NGOs who attended training, representatives from 17 NGOs, 12 social prescribing projects, all ROSPS, across 17 Local Plans.

The scoping review *Suicide and self-harm studies by researchers in Ireland and Northern Ireland during 2015-2023* (Hursztyn, et al., 2024) was also considered. It was commissioned by the Higher Education Authority with support from NOSP (see IO7.3 above for more detail).

Under the indicator *Publicly available report(s) on findings of evaluation studies* the evidence shows that all of the evaluation studies described above are publicly available.

Assessment of the Intermediate Outcomes

The secondary data presented above was triangulated with the survey, interview, and RI sessions data. Based on this triangulation an assessment was made on the extent to which each IO were achieved using a 5-colour scale:

- Green – Achieved and sustainable
- Light green – Achieved, with minor learnings/barriers/challenges
- Amber – Achieved, with 1 major learning/barrier/challenge
- Orange – Achieved, with >1 major learnings/barriers/challenges
- Red – Not achieved

The results of this process are presented in Table 4 below.

Table 4: Assessment of CFL Intermediate Outcomes

Strategic Goal 1 To improve the nations understanding of, & attitude to suicide, mental health and wellbeing.		
Intermediate Outcomes (IOs)		**Rating**
IO1.1	**Improved population-wide understanding of suicidal behaviour, mental health & wellbeing, and associated protective & risk factors**.	Light Green
Overview of IO1.1 Much of the evidence reviewed indicates that significant and current research at stakeholder level has been undertaken to identify and understand the various and complex factors that influence mental health and suicidality. A population level increase in engagement with mental health issues is evidenced (HSE Mental Health Literacy Campaign). Primary data indicated the need for better public-facing engagement and deeper public understanding.		
IO1.2	**Increased awareness of available suicide prevention and mental health services.**	Amber
Overview of IO1.2 Evidence to support progress on this IO is weaker. A population level increase in engagement with mental health issues is evidenced (HSE Mental Health Literacy Campaign). Primary data indicated the need for better public-facing engagement and deeper public understanding. A specific barrier relating to marginalised groups is noted.		
IO1.3	**Reduced stigmatising attitudes to mental health and suicidal behaviour at population level and within priority groups.**	Amber
Overview of IO1.3 Significant work has progressed to address stigma, including a national campaign and the development of resources, as well as research on priority groups. Evidence indicates mixed perceptions of effectiveness and limited awareness of the campaign.		
IO1.4	**Engagement with media in relation to media guidelines, tools and training programmes & improvement in the reporting of suicidal behaviour within broadcasting, print & online media.**	Light Green
Overview of IO1.4 Guidelines and other resources are available to the media. Media training is available , and monitoring seems to have significant reach and sustainability. There is evidence that research and evaluation has been used to inform planning and address issues identified.		
Strategic Goal 2 To support communities' capacity to prevent & respond to suicidal behaviour		
IO2.1	**Continued improvement of community-level responses to suicide through planned multi-agency approaches**	Amber
Overview of IO2.1 Innovation and local implementation strengths are evident; however, challenges identified include the need for improved communication, and a perception of the need for more funding and resources. Staff turnover was identified as an issue, including changes in leadership. While all areas prepared		

local action plans, only some were updated over the extended lifetime of the strategy. Disconnection between national strategy and local implementation was identified in the primary data.		
IO2.2	**Accurate information & guidance on effective suicide prevention are provided for community-based organisations (e.g. Family Resource Centres, Sports Organisations).**	**Amber**
Overview of IO2.2 Three collaboratively produced Guidance Documents are available to all community-based organisations. There was no data available on the extent to which these have been accessed.		
IO2.3	**Training and education programmes on suicide prevention to community-based organisations**	**Green**
Overview of IO2.3 Comprehensive training programmes developed under *CfL* are a strength of the strategy. A suite of training programmes is available and these programmes have been delivered reaching thousands (for example, there are 16,000 people trained annually in suicide and self-harm prevention programmes). Quality assurance and planning is evident from documents provided. Sustainability is dependent on future funding.		
Strategic Goal 3 To target approached to reduce suicidal behaviour & improve mental health among priority groups		
IO3.1	**Improve implementation of effective approaches to reduce suicidal behaviour among priority groups**	**Amber**
Overview of IO3.1 There has been significant funding of NGOs which support priority groups. A suite of training is available to community-based organisations as evidenced under IO2.3, and there have been awareness raising and education initiatives with *CfL* lead agents. Primary data indicated that engagement with priority groups remains fragmented and is often driven by NGOs or community groups rather than embedded in public services. Concerns about sustainability were raised.		
IO3.2	**Support provided to the Substance Misuse Strategy, to address the high rates of alcohol & drug misuse**	**Orange**
Overview of IO3.2 Sustained expansion and delivery of SAOR training nationwide is evident. There was no evidence relating to other programmes relevant to this indicator in the secondary data. Findings from primary data recognise substance misuse as a core suicide risk factor but indicate it is poorly integrated into *CfL* planning or activity. Challenges identified include a siloed policy landscape and service provision.		
IO3.3	**Enhanced supports for young people with mental health problems or vulnerable to suicide**	**Light Green**
Overview of IO3.3 Significant work by NGOs that support young people was highlighted. Data indicate that engagement with young people is often driven by NGOs or community groups rather than embedded in public services. Primary data identified progress including stronger engagement and signposting; however, overreliance on underfunded services and a lack of clear pathways were also highlighted. Wellbeing is evident as a priority within schools and is embedded as a requirement of the School Self-evaluation process by 2025.		

Strategic Goal 4 - To enhance accessibility, consistency & care pathways of services for people vulnerable to suicidal behaviour		
IO4.1	**Improved psychosocial & psychiatric assessment & care pathways for people vulnerable to suicidal behaviour**	**Amber**
Overview of IO4.1 Data indicates that the SCAN service and the National Clinical Care Programme for Self-harm and Suicide-related Ideation (NCPSHI) are valued and have a positive impact on care provided. The reach of the SCAN service is limited. Challenges for the NCPSHI include the need for national coordination of implementation and variable availability of follow-on care. A key strength is the availability of the model of care and operational guidance to support standardised best practice. Secondary data also shows evidence of significant numbers of GPs trained to manage suicidal ideation/behaviour in primary care setting with ongoing efforts to train trainee GPs. A remaining challenge is the rollout of STORM training to GPs.		
IO4.2	**Improved access to effective therapeutic intervention for people vulnerable to suicide**	**Amber**
Overview of IO4.2 Three evidence-based, collaboratively produced models of care targeted at vulnerable groups are developed. One model is currently in pilot phase, one is being rolled out (and evaluated), and no data were available on the extent to which the third model is implemented. Progress is evident for a coordinated rollout of training by the National Dialectical Behaviour Therapy training team. Data on the extent of the expansion of the CAMS model was not available. Progress in provision of online CBT through licensing to primary care and NGO providers is strong. Primary data identified inconsistencies in provision across regions and referral pathways between services (NGO and statutory) as a structural challenge.		
IO4.3	**Improved uniformity, effectiveness & timeliness of support services to families & communities bereaved by suicide**	**Amber**
Overview of IO4.3 Data indicates that the SBLS and HUGG services are valued. Gaps in reach were identified, including difficulty supporting marginalised/hard-to reach groups. Service provider challenges such as role definition, staff turnover, risk of burnout, and the need for consistent referral pathways were noted, as well as variability in cross-sectoral working across CHOs. Limited awareness of peer support among service users, variability in the availability of services on a regional level and wait times for service provision were highlighted. The appointment of a National Suicide Bereavement Support Coordinator is a positive support for implementation as well as the development of relevant resources/guides for people bereaved by suicide. Primary data acknowledge that postvention work has significantly improved under CfL despite what was perceived as a limited focus on postvention in *CfL*.		
Strategic Goal 5 - To ensure safe & high-quality services for people vulnerable to suicide		
IO5.1	**Develop and implement national standards and guidelines for statutory and non-statutory organisations contributing to suicide prevention.**	**Amber**
Overview of IO5.1 Secondary data show that a best practice guidance document is available to both statutory and non-statutory agencies. An independent evaluation shows that the guidelines are comprehensive and in line with *CfL*. The evaluation found that smaller organisations struggled to engage with the entire framework because of resource restrictions. A limitation is that the implementation of the guidelines is voluntary; however, the best practice guidance is now aligned with the HSE SLA process.		

IO5.2	**Improved response to suicidal behaviour within health & social care services (initial focus on incidents within mental health services)**	**Amber**
Overview of IO5.2 Limited secondary data available to support progress on this IO. Secondary data does show that NOSP has published a guidance document aimed at staff in community mental health services. This document is aligned with the HSE Incident Management Framework and aims to promote a standardised, culturally sensitive, and informed response to deaths reported as suspected suicide. The document specifies that the procedures do not cover deaths by suspected suicide of inpatients or residents in mental healthcare facilities. In addition, and as described under IO4.1 a key strength of the SCAN service and Clinical Care Programme for Self-harm and Suicide-related Ideation (NCPSHI) is the availability of the model of care and operational guidance to support standardised best practice and significant numbers of GPs trained to manage suicidal ideation/behaviour in primary care setting.		
IO5.3	**Reduction in & prevention of suicidal behaviour in the criminal justice system**	**Amber**
Overview of IO5.3 Significant progress has been made in adult prison settings, including research, prevention and response measures, as evidenced in both primary and secondary data. No secondary data provided on children in detention schools, and this did not emerge as a theme in the primary data.		
IO5.4	**Best practice among health & social care practitioners through (a) the implementation of clinical guidelines on self-harm and (b) the delivery of accredited education programmes on suicide prevention within the National Training Plan.**	**Amber**
Overview of IO5.4 Secondary data relates to the availability of clinical guidelines for SCAN and the NCPSHI and on accredited training programmes. In addition the secondary data indicates that the SAMAGH guidelines for hospital staff are currently being evaluated. Primary data indicate some gaps in awareness of what guidelines are in place. One of the accredited training programmes highlighted in the secondary data (STORM) is currently being delivered by the HSE. A module on suicide prevention is currently being piloted with health and social care students. Training to community-based organisations is seen as a key strength of *CfL* as outlined in IO2.3.		
Strategic Goal 6 - To reduce and restrict access to means of suicide		
IO6.1	**Reduced access to frequently used drugs in intentional drug overdose**	**Amber**
Overview of IO6.1 Both secondary and primary data noted significant progress in restricting access to paracetamol. A second initiative, the DUMP scheme, is in development. The 2025 Report of the Multiagency Working Group on *Overprescribing of Benzodiazepines, Z Drugs and Gabapentinoids in Ireland* made a number of recommendations and it is intended that these will inform future planning. Recommendations in this report indicate areas for improvement, including increased availability of publicly funded counselling services, improved education for professionals and the public, and the need for better quality data. Other resources to support future planning include the HRB RESTRICT study, a mixed methods study of means restriction interventions.		
IO6.2	**Reduced access to highly lethal methods used in suicidal behaviour**	**Orange**
Overview of IO6.2 'Suicide in Public Places: A best practice toolkit 2025' has been developed by HSE NOSP in partnership with a multi-agency project advisory group and is a resource for public bodies, agencies, or stakeholders responsible for public places in Ireland. Feedback from NOSP indicates that one HIA has been		

completed based on this resource and that one is in progress. Primary data revealed variation in approaches to suicide-proofing of locations of concern at local level. Key barriers identified include the level of engagement from local stakeholders and ownership of actions. Enablers include good partnership and leadership. The lack of a national means restriction strategy was noted.

There was limited and/or time-lagged data for the second indicator (i.e. *Reduced number (proportions) of suicide deaths by highly lethal methods*). The secondary data relates to statistics from the CSO and IPSDS and does not show the overall proportion of deaths by highly lethal methods. The analysis of primary population level outcomes or impact data is outside the scope of this evaluation. The other source of secondary data under the second indicator is an academic article which analyses the presentation of self-harm in Irish hospitals from 2007 to 2019. The authors conclude that over this period there was an increase in self-harm by hanging and drowning.

Strategic Goal 7 - To improve surveillance, evaluation & high-quality research relating to suicidal behaviour		
IO7.1	**Improve access to timely & high-quality data on suicidal behaviour**	**Amber**

Overview of IO7.1

Data highlights the time lag in the availability of data via the CSO and coronial system. The coronial system relies on a legal definition of "beyond reasonable doubt" and may underestimate the number of deaths by suicide. Work is underway to establish a new system of data collection to reflect probable deaths by suicide, based on the IPSDS, this will take the form of a monitoring system. Primary and secondary data indicate that data sharing agreements between key stakeholders are not yet finalised and this has an impact at local level. Both primary and secondary data identified the limited availability of real-time data as an issue. A pilot programme to improve the monitoring of near real-time data is developed in one geographical area and a scalability assessment is currently underway. Progress has been made on new systems for monitoring and reporting developed or in development, i.e., the National Self-harm Registry and the inclusion of suicidality in the Healthy Ireland Survey. An ongoing project with the aim of merging HSE and Mental Health Commission datasets to learn about the circumstances surrounding deaths by suicide in mental health services is underway.

IO7.2	**Current recording procedures for suicide deaths in Ireland reviewed (and if necessary revised)**	**Amber**

Overview of IO7.2

The secondary data show that current recording procedures have been reviewed. Work is underway to establish a new system of data collection to reflect probable deaths by suicide, based on the IPSDS, this will take the form of a monitoring system. Work has progressed on a Memorandum of Understanding between key stakeholders, which includes a data sharing agreement, but this is not yet in place. Primary data indicated a lack of timely data and a limited understanding of formal recording procedures by some groups.

IO7.3	**Development of national plan that supports research innovation aimed at early identification of suicide risk, assessment intervention& prevention**	**Amber**

Overview of IO7.3

A national plan is in place, which has taken the form of a collaborative grant scheme. The research funded under this scheme has focused on a range of priority groups. There was no evidence in the secondary data to indicate if the collaborative research grant scheme is funded to continue, therefore sustainability may be an issue. Successful research partnerships have been established under this scheme, fostering partnerships between NGOs, academics, and policymakers. A recent scoping review recommends further research on several priority groups highlighted in *CfL* and other at-risk groups. This point is also reflected in the primary data.

IO7.4	**Evaluation of the effectiveness of Connecting for Life**	**Amber**

Overview of IO7.4

A monitoring and evaluation framework was developed by NOSP in 2018. In addition, the secondary data included details of 18 evaluations commissioned, demonstrating significant reach. Secondary data also included a 2021 synthesis of evaluation findings and the 2019 *CfL* Interim Review. The 2021 synthesis recommended a closer alignment with *CfL* goals, objectives, and priorities. All the reports referred to are publicly available. A recent scoping review recommends further research on several priority groups highlighted in *CfL* and other at-risk groups. This point is also reflected in the primary data. Primary data acknowledges the importance of independent evaluations. The need to embed evaluation processes from the outset was highlighted as was a perception of the need to move towards measuring longer term impact and outcomes rather than outputs.

Section 6: Illustrative narratives

Overview

This section provides two examples of how the *CfL* strategy helped to bring about positive changes. For each narrative, a description of the situation and particular challenges that were faced is presented, the actions taken are described, as well as the specific changes realised and any evidence for the change. The significance of the change is also described.

Example 1: Safe Harbour – A ground-breaking resource for families bereaved by suicide

Responding to a direct community-identified need, staff at NOSP collaborated with CHO 7, the Irish Childhood Bereavement Network, and others to develop *Safe Harbour* (Forde, 2024), an illustrated book for children bereaved by suicide. A number of requests were made by parents whose partner had died by suicide to the local ROSP for resources to help them navigate this situation with their children. These requests initiated the development of a resource for Irish families. Prior to the publication of *Safe Harbour*, no similar resource existed for families that had experienced a suicide bereavement, leaving families to consult resources from other countries such as the UK and USA.

Safe Harbour[24] was launched in June 2024. The book, written by Patricia Forde and illustrated by visual artist Bronagh Lee, is written from the perspective of a child whose parent has died by suicide. Through the story and illustrations, the child explains what the loss was like for them. A guide was also developed for parents and carers to support their use of the book and empower them when having difficult conversations with their child.

This work aligns with some of the core components of suicide prevention strategy design and implementation outlined earlier in this report (see Section 3, Figure 3). This includes, empowering and involving people with lived or living experience perspectives and supporting postvention work. HSE NOSP and *CfL* have helped to support the development of *Safe Harbour* in a number of ways.

Funding and resources were provided by HSE NOSP through *CfL*: By providing funding and resources, including staff with clinical, communications, and bereavement expertise, *CfL* supported the development of *Safe Harbour*.

Postvention work was included within the strategy's objectives and actions: The development of *Safe Harbour* falls within the objectives and actions of the *CfL* strategy. Specifically, objective 4.3 which aims to improve the uniformity, effectiveness and timeliness of support services to families and communities bereaved by suicide. Having specific objectives and actions relating to bereavement supports outlined in the *CfL* strategy has helped to keep the development of postvention supports on the agenda at a senior level, e.g., through the Cross-Sectoral Steering and Implementation Group.

[24] All resources relating to *Safe Harbour* are available at: https://www.childhoodbereavement.ie/safeharbour/

Safe Harbour addresses the needs of a priority group, as identified in the _CfL_ strategy: *Safe Harbour* is designed to support the needs of those who are suicide related, i.e., bereaved by suicide, a priority group identified in the *CfL* strategy.

Partnership strengths helped to progress this work and stakeholder engagement was strong: A variety of stakeholders were involved in the development of *Safe Harbour*, including those with clinical expertise and those with lived or living experience. The need for *Safe Harbour* was identified at local/regional level and strong links and partnerships between local and national level helped to progress its development. An advisory group with representatives from NOSP and NGOs, including Barnardos, HUGG, and Pieta, supported this work. Other contributors included individuals with clinical and publishing expertise.[25] Existing relationships established through *CfL*, and associated collaborations and governance structures, helped to progress this work and collaborators were willing to support the work from the outset. A high level of commitment to the work helped to ensure its completion and success.

The voice of lived or living experience was included: The development of *Safe Harbour* was heavily informed by persons who had lived or living experience of bereavement by suicide. The involvement of those with lived or living experience was crucial to the development of this book and their insight was invaluable.

Safe Harbour took 3 years to develop but was an immediate success, with 2,000 copies distributed within the first 2 and a half months. This has increased to over 3,000 requests to date. *Safe Harbour* has filled a critical gap in bereavement support for young children. While the original intended audience was parents and carers, requests for the book have also come from a variety of professionals, including (but not limited to), play therapists, psychotherapists, social workers, An Garda Síochána, school principals, and priests. Reaching these professionals was a welcome and positive unintended outcome of this work expanding the awareness and reach of the resource.

Safe Harbour is an example of how direct engagement with affected families led to a high-impact resource that will continue to support grieving children and families nationwide. Since its initial development, a second version of *Safe Harbour* has been published, i.e., a version in which the child's mother dies. In the original version, the child's father dies. An audiobook[26], a podcast series[27], and activities for children[28] are also available. The book has been translated into Irish and a Braille version is now available. *Safe Harbour* has also received international attention and interest highlighting the pioneering nature of this resource.

[25] A full list of contributors is available at: https://www.childhoodbereavement.ie/safeharbour/acknowledgements/
[26] https://www.childhoodbereavement.ie/safeharbour/audio/
[27] https://www.childhoodbereavement.ie/safeharbour/podcasts/
[28] https://www.childhoodbereavement.ie/safeharbour/calming-exercises/

Example 2: Social Prescribing – From a small-scale initiative to a national network

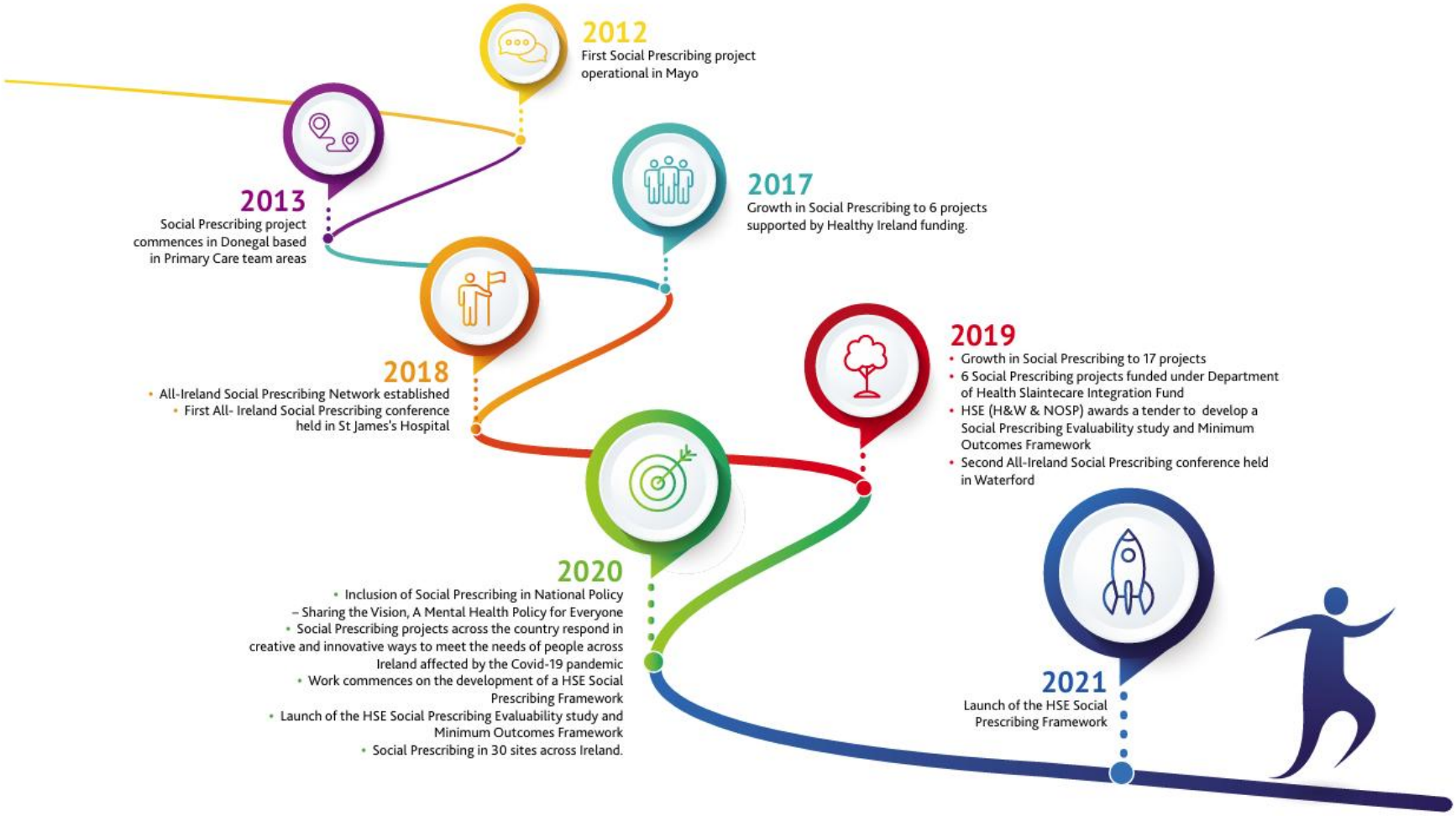
Social Prescribing connects people with community-based activities to support mental health and wellbeing. According to the Social Prescribing Framework published by the HSE (Health Service Executive, 2021), Social Prescribing is for people over the age of 18 years including (but not exclusively) those:

- with one or more long-term conditions
- who need support with their mental health
- who are lonely or isolated
- who are frequent GP/ED attendees and may benefit from other social supports outside of clinical services
- who have complex social needs which affect their health and wellbeing.

Referrals, either from a professional or self-referrals, are made to a link worker who connects the individual to community groups or organisations that can support their health and wellbeing. The individual's transition to the sources of support is assisted by the link worker and a follow-up and review procedure typically takes place after transition.

Social Prescribing has grown significantly in recent years. Initially, only a few pilot services were funded, but now there are 48[29] Social Prescribing services operating across the country. The Social Prescribing Framework (HSE, 2021) provides an overview of the development of this initiative as shown overleaf:[30]

[29] Due to expand to 52 Social Prescribing services soon.
[30] Source: (HSE, 2021) – *Social Prescribing Framework*.


2012
First Social Prescribing project operational in Mayo
2013
Social Prescribing project commences in Donegal based in Primary Care team areas
2017
Growth in Social Prescribing to 6 projects supported by Healthy Ireland funding.
2018
• All-Ireland Social Prescribing Network established
• First All- Ireland Social Prescribing conference held in St James's Hospital
2019
• Growth in Social Prescribing to 17 projects
• 6 Social Prescribing projects funded under Department of Health Slaintecare Integration Fund
• HSE (H&W & NOSP) awards a tender to develop a Social Prescribing Evaluability study and Minimum Outcomes Framework
• Second All-Ireland Social Prescribing conference held in Waterford
2020
• Inclusion of Social Prescribing in National Policy – Sharing the Vision, A Mental Health Policy for Everyone
• Social Prescribing projects across the country respond in creative and innovative ways to meet the needs of people across Ireland affected by the Covid-19 pandemic
• Work commences on the development of a HSE Social Prescribing Framework
• Launch of the HSE Social Prescribing Evaluability study and Minimum Outcomes Framework
• Social Prescribing in 30 sites across Ireland.
2021
Launch of the HSE Social Prescribing Framework

Social Prescribing aims to address social determinants of mental health. This aligns with one of the core components of suicide prevention strategy design and implementation outlined earlier in this report (See Section 3, Figure 3). That is, including 'upstream' risk factors that affect the whole population, i.e., a preventative approach.

HSE NOSP and the *CfL* strategy have helped to support Social Prescribing is a number of ways.

Social Prescribing is monitored under *CfL*'s governance structures: Updates on Social Prescribing are submitted to the Cross-Sectoral Steering and Implementation Group as part of the quarterly reporting system for *CfL* under action 2.3.3[31]. This helps to ensure that Social Prescribing is visible and kept on the agenda with senior decision makers.

Funding and support for funding has been provided: HSE NOSP provided funding for the initial implementation of Social Prescribing and the inclusion of Social Prescribing within the remit of the *CfL* strategy has enabled the growth of Social Prescribing in Ireland.

Partnership strengths and stakeholder engagement: Strong partnerships exist between the Department of Health, HSE Health and Wellbeing, HSE NOSP, Family Resource Centres, Local Development Companies, and other *CfL* stakeholders, e.g., NGOs, which support work at a national level as well as at regional and local levels.

Evaluation support: HSE NOSP has supported work towards evaluating Social Prescribing, including an evaluability study which was carried out in 2019-2020 to assess the extent to which Social Prescribing can be reliably evaluated (Health Service Executive, 2020). A Minimum Data Outcomes Framework for Social Prescribing services in Ireland was developed as part of this research. This work was commissioned by HSE Health and Wellbeing, HSE NOSP, and the Department of Health.

Social prescribing offers a preventative, community-based approach to mental health by linking individuals to non-clinical supports such as creative arts, exercise, and volunteering. Expanding this model helps reduce reliance on crisis services and promotes mental wellbeing at an early stage.

There is strong ambition to expand Social Prescribing further and address geographic as well as other barriers to accessing the service. A key challenge is ensuring sufficient resources to meet the increasing demand for these services. Being named in the *CfL* strategy helped establish legitimacy for Social Prescribing, making it easier to advocate for sustained funding and expansion.

Boader shifts in public health policy also contributed to the growth of Social Prescribing. Other government strategies and initiatives, such as *Sláintecare*[32] and *Healthy Ireland*[33], and mental health policies, such as *Sharing the Vision* (Department of Health, 2020), have also significantly helped to support the expansion of Social Prescribing. Having Social Prescribing named in these strategies has also helped to keep development of Social Prescribing on-track.

[31] Action 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.

[32] https://www.gov.ie/en/department-of-health/campaigns/sláintecare/

[33] https://www.hse.ie/eng/about/who/healthwellbeing/healthy-ireland/

Section 7: Conclusion

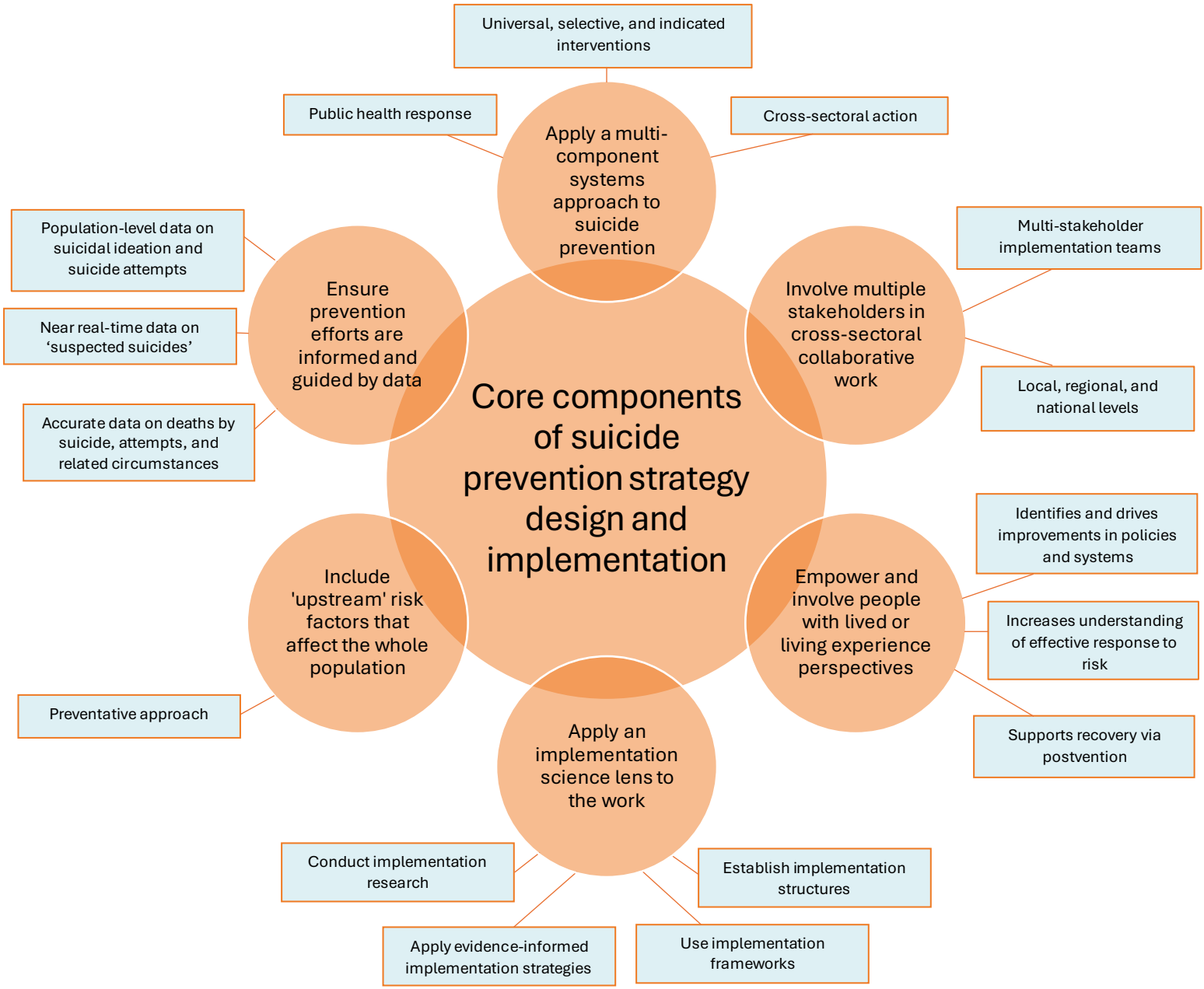
Assessment of the content of the *CfL* strategy

As demonstrated by the literature review carried out as part of this evaluation, *CfL* activities and interventions are broadly aligned with the evidence base and good practice (see Figure 3 from Section 3 of this report, presented again overleaf). Broadly, *CfL* has encompassed many of the core components of effective suicide prevention strategy design and implementation as outlined in Figure 3.

The *CfL* strategy has:

- Applied a multi-component systems approach to suicide prevention – engaging government departments to work together to reduce suicide and self-harm. Through its implementation and governance structures, *CfL* has achieved a high level of buy-in across government departments. Through the *CfL* strategy, interventions have been implemented at general population level, as well as for specific high-risk and priority groups.
- Involved multiple stakeholders in cross-sectoral collaborative work – *CfL* has supported the engagement of multi-stakeholder implementation teams at local, regional, and national levels. Through it's top-down and bottom-up approach, *CfL* has ensured that suicide prevention efforts can be tailored to specific local and regional contexts and that suicide prevention remains a national priority. The involvement of NGO partners has played a vital role in the delivery of *CfL* actions.
- Increasingly endeavoured to empower and involve people with lived or living experience perspectives – in recent years, attempts have been made to empower and involve people with lived or living experience as part of *CfL*, e.g., in the development of specific resources, such as *Safe Harbour* (Forde, 2024) and *Let's Talk About Suicide*, and in the current evaluation. However, there is a need to create space for meaningful involvement of people with lived or living experience from the outset of the next strategy, throughout its design, implementation, and evaluation. While significant achievements have been made in the area of postvention, it is noted that the *CfL* strategy set out limited actions relating to postvention.
- Applied an implementation science lens to the work – with three implementation plans published over the lifetime of *CfL* to support the implementation of the strategy, as well as local action plans. HSE NOSP also developed a monitoring system to track implementation of *CfL* actions by lead agents so barriers to implementation could be flagged.
- Included 'upstream' risk factors that affect the whole population – Social Prescribing is one example of this work.
- Ensured that prevention efforts are informed by data – While obtaining accurate and timely data on suicide, suicide attempts, and self-harm remains a challenge, progress has been made over the lifetime of the strategy. Monitoring and evaluation are embedded in the *CfL* strategy, which is outcomes focused, with two primary outcomes and 23 Intermediate Outcomes (IOs) included.

Figure 3 (also presented earlier in Section 3 of this report): Core components of suicide prevention strategy design and implementation[34]



[34] (WHO, 2014, p. 30) distinguishes between universal, selective, and indicated interventions as follows:

4. Universal prevention strategies - designed to reach an entire population in an effort to maximize health and minimize suicide risk by removing barriers to care and increasing access to help, strengthening protective processes such as social support, and altering the physical environment.
5. Selective prevention strategies - target vulnerable groups within a population based on characteristics such as age, sex, occupational status, or family history.
6. Indicated prevention strategies - target specific vulnerable individuals within the population, e.g., those displaying early signs of suicide potential or who have made a suicide attempt.

Table 5 below is an abridged version of Table 2, presented previously in Section 3. Table 5 highlights how *CfL* actions correspond to specific suicide prevention interventions reviewed in Section 3.

Table 5: Evidence-based suicide prevention interventions and associated CfL actions

Intervention	Examples of corresponding *CfL* actions
Means restriction	All 5 actions under strategic goal 6
Media guidelines	Actions 1.4.1-1.4.4
Community-based interventions[35]	Actions 1.1.3, 1.1.4, 1.2.2, 1.3.1, 2.2.1-2.3.3, 3.3.1-3.3.5, 5.1.2, 5.1.3
Postvention	Actions 4.3.1, 4.3.2
Training	Actions 2.3.1, 2.3.2, 2.3.3, 3.1.5, 5.4.1-5.4.4
Psychosocial, incl. coping skills, problem-solving skills etc.	Actions 3.3.6, 3.3.7, 4.1.3, 4.2.1, 5.1.4, 5.1.5
Crisis intervention	Actions 4.1.1, 4.1.2, 4.1.4, 4.1.5, 4.3.1
Mental health treatment	Actions 1.2.1, 3.2.1, 3.3.7, 5.2.1-5.2.3, 5.3.1-5.3.3
Stigma reduction	Actions 1.3.1

While it is challenging to attribute changes in suicide and self-harm data to specific interventions, evidence for restricting access to means remains stronger than other suicide prevention interventions. Evidence for psychosocial interventions remains promising. Evidence for other suicide prevention strategies remains mixed.

In line with Hofstra and colleagues (Hofstra, et al., 2020) suggestion, multi-level interventions, which integrate multiple approaches across different settings are most likely to impact suicide and suicidal behaviour as this approach shows significantly greater effectiveness compared to single-level interventions, highlighting the importance of a comprehensive approach in suicide prevention efforts.

Assessment of the (top-down) cross-sectoral implementation of the *CfL* strategy

Implementation and governance structures

Ireland is described by some interviewees as *"unique"* in its approach to suicide prevention. *CfL* distinguishes Ireland with oversight structures that, in theory, ensure meaningful cross-government collaboration and implementation. These include the presence of a National Office (HSE NOSP), a

[35] Including school-based programmes.

Cross-Sectoral Steering and Implementation Group, Local Cross-Sectoral Implementation Structures, and the NGO group (see Figure 2).

The strategy itself provides a roadmap for how different government departments, agencies, and NGOs engage in suicide prevention, recognising that solutions extend beyond mental health services alone. Despite challenges, strong attendance at *CfL*'s governance forums demonstrates its success in keeping suicide prevention on the national agenda.

However, challenges persist. While different sectors attend meetings and agree on actions, the extent to which commitments translate into implementation remains uncertain. Suicide prevention is acknowledged as a collective effort, but in practice, this can lead to sectors deferring responsibility to others.

Representation at national, local and regional level was identified as a particular challenge for NGOs working in the area of suicide prevention, intervention, and postvention.

There is a lack of meaningful engagement with lived or living experience voices in national policymaking for suicide prevention which should be addressed. It was also noted that participation from government departments such as the Department of Social Protection should be explored to address the social determinants of suicide.

Enablers, barriers, and context of top-down *CfL* implementation

Despite the challenges outlined in the current report, the concurrent top-down and bottom-up approaches to implementation can be considered a strength of the *CfL* strategy. This approach ensured that suicide prevention efforts were embedded within communities at local and regional level, as well as at national level. This approach should be continued and strengthened in the next strategy.

A recurrent concern is the gap between national policy intentions and local-level implementation. *CfL* has regional implementation structures, which attempt to localise the strategy, and this was acknowledged as a strength of the strategy. On the other hand, regional variability leads to inconsistencies with some local agencies noting a lack of clear guidance on adapting national objectives. Communication across implementation structures, from national to local and regional level and across sectors at local and regional level was also highlighted as a key challenge by some groups. The absence of real-time, region-specific suicide data further complicates measuring local intervention effectiveness.

Policy crossover was highlighted as a barrier to top-down implementation, i.e., crossover between mental health policies and between mental health policies and policies for specific at-risk/priority groups. Structural barriers (e.g., siloed working, lack of funding and resources) was also perceived as significant barriers to the implementing of *CfL* actions.

Good stakeholder engagement was apparent at national level. Strong leadership has played a crucial role in maintaining suicide prevention as a national priority. This includes strong leadership at national level (Department of Health, HSE NOSP) which has kept suicide prevention high on the government's agenda. High level buy-in has supported the implementation of *CfL*.

Staff turnover was emphasised as a barrier to implementation and a need for continuity within roles was described. There was concern expressed that there may be a reduced focus on suicide prevention at a local level because of changes in leadership at regional level due to HSE restructuring.

Gaps in service provision and pathways between services were highlighted as an area for improvement, e.g., access to primary care level supports and targeted services for at-risk groups such as those experiencing addiction.

Suicide prevention is now a mainstream policy issue, with greater public and political awareness and cultural shifts within government bodies. The following issues also impacted the implementation context for *CfL* during the 10-year period that the strategy was in place:

- The COVID-19 pandemic
- A cyberattack on the HSE
- HSE restructuring and a
- National cost of living crisis.

Both the COVID-19 pandemic and the HSE cyberattack were unprecedented events and caused major disruptions to the implementation of the strategy and functioning of health and social care systems, more generally. At the time of data collection and publication of this evaluation report, the restructuring of the HSE was ongoing.

Assessment of the (bottom-up) area-level implementation of the *CfL* strategy

Implementation and governance structures and local action plans

Local implementation structures have been established since the *CfL* strategy was published. Findings suggest that these structures support implementation at a local level. However, there is a need for greater alignment between national strategy and local implementation plans, clearer responsibilities and accountability, and more cross-sectoral work. Implementation gaps at local level were identified. Local and regional implementation remains a challenge due to regional variation. Regional variability led to inconsistencies, with some local agencies noting a lack of clear guidance on adapting national objectives. More consistency is required at local level. ROSPs are embedded at community level and have a pivotal role in local implementation. Local implementation can improve efforts to reach priority groups and improve the reach of the strategy in general. While all areas prepared local action plans, only some were updated over the extended lifetime of the strategy.

Enablers and barriers of bottom-up *CfL* implementation

The *CfL* implementation and governance structures have facilitated improved communication. The need for better communication from NOSP to local level and between stakeholders was highlighted.

Local autonomy is important within broader governance structures. Concerns were raised that HSE restructuring may impact local autonomy hindering local implementer's ability to act responsively

in their work. More timely availability of relevant data locally, could also improve local implementation teams' ability to respond swiftly.

Regional adaptability is necessary for local implementation as what works in one area might not work in another. Regional level suicide prevention intervention can adapt to the specific needs and demographics within an area.

Strong leadership, ownership, partnerships, and stakeholder engagement enable local implementation. Regional leadership has been more inconsistent than national leadership; however, local champions have driven effectiveness.

Challenges in stakeholder engagement were raised and staff turnover and change of structure within organisations were highlighted as particular challenges presenting a need for frequent reengagement with key stakeholders. Local government buy-in remains variable across regions. Challenges in securing consistent cross-sectoral participation remain.

While *CfL* was a long-term strategy, annual funding cycles make it difficult for some organisations to plan, invest in capacity, and sustain progress.

To what extent did *CfL* achieve its intermediate outcomes?

As outlined in the methodology section, the analysis of the secondary data was structured around *CfL's* 7 strategic goals and associated IOs. The secondary data was then triangulated with the survey, interview, and RI sessions data. Based on this triangulation an assessment was made on the extent to which IOs were achieved using a 5-colour scale:

- Green – Achieved and sustainable
- Light green – Achieved, with minor learnings/barriers/challenges
- Amber – Achieved, with 1 major learning/barrier/challenge
- Orange – Achieved, with >1 major learnings/barriers/challenges
- Red – Not achieved

The results of this process are presented in Table 4 above. As can be seen, over the 10-year term that *CfL* was in place, all of the IOs were assessed as achieved to some level. Of the IOs one was assessed as 'Achieved and sustainable', three were assessed as 'Achieved, with minor learnings/barriers/challenges', seventeen as 'Achieved, with one major learnings/barriers/challenges', and two as 'Achieved, with >1 major learnings/barriers/challenges'. None of the IOs were assessed as 'Not achieved'.

Unintended positive and negative outcomes

Interviewees highlighted some positive and negative unintended outcomes from the *CfL* strategy as follows:

- Over-reliance on *CfL* for funding: Some programmes expect automatic funding increases without deeper evaluation of effectiveness.
- "Strategy fatigue": After nearly a decade, some sectors are experiencing a dip in momentum.

- Governance vs. flexibility: While *CfL* has successfully created structures, some interviewees argue that formal systems can become bureaucratic and slow-moving.
- Balancing structure and adaptability: Need to maintain agility in responding to emerging challenges.
- Strong working relationships have formed: Cross-sectoral work has supported the development of strong working relationships that have enabled other work in addition to *CfL*-related work.

What can be done to improve outcomes measurement (and impact assessment) of suicide prevention activities?

A significant commitment was made to research and evaluation in *CfL*. Strategic goal 7 outlines the specific objectives, actions, and IOs relating to research, evaluation, and data. A monitoring and evaluation framework was developed by NOSP in 2018 and a collaborative research grant scheme has ensured that research and evaluation activities relating to priority groups have progressed.

While improved systems for monitoring and reporting suicide and self-harm have been developed, more robust data systems are needed to improve outcome measurement. This was a strong theme across all data sources. The following issues are noted:

- Issues with the availability of timely data on suicide and self-harm were noted throughout. Current data on suicide are not available due to time lags in the reporting of official statistics by the CSO. The current coronial system and inquest process means that obtaining statistics for recent years is difficult as suicide is often determined after an inquest process has been completed and this may take some time.
- The lack of real-time surveillance was also noted as a critical gap in data systems. Although research has been carried out to progress work in this area, real-time surveillance is required at a national level.
- Currently there is a focus on outputs rather than outcomes.
- Delays in the completion of data sharing agreements have also impacted the availability of timely suicide statistics at local implementation level.
- Research gaps in relation to priority groups.
- Suggestions to incorporate lived or living experience into evaluation processes.

Embedding continuous evaluation could also improve outcome measurement for the next suicide prevention strategy. A more robust and integrated outcomes framework was suggested.

Is there an ongoing need for a national suicide prevention strategy such as *CfL*?

CfL came to an end in 2024 and preparation for the next phase of suicide prevention in Ireland is underway. Data from RI sessions, interviews, surveys indicate that there is broad agreement that the next suicide prevention strategy should be a refinement of *CfL*.

Over the 10-year term that *CfL* was in place as the national suicide prevention strategy, progress was made on all IOs, demonstrating the importance and value of a coordinated national strategy.

While work remains on the majority of IOs, this evaluation highlights the importance of having a national strategy in place to coordinate and guide suicide prevention work.

The duration of the strategy should be considered further. Some interviewees suggested a 10-year strategy with fewer, high-impact goals, structured evaluation, and stronger regional implementation under *Sláintecare*[36]. Others recommended a shorter timeframe, e.g., 5 years, with clear short-, medium-, and long-term milestones.

The scope of the strategy should be examined. It was suggested that the next suicide prevention strategy should identify a limited number of actions that would be *"genuinely transformative and have an impact on people's lives"*.

Consideration should be given to the need for and feasibility of a separate self-harm strategy. If self-harm is addressed within the next suicide prevention strategy, then actions in relation to self-harm and suicidal ideation may need to be expanded.

The findings indicate that there is cross-over with other mental health and wellbeing strategies, such as *Sharing the Vision* (Department of Health, 2020), and this needs to be addressed to ensure that ownership of actions is correctly assigned to avoid duplication of work.

[36] https://www.gov.ie/en/department-of-health/campaigns/sláintecare/

Section 8: Recommendations

This evaluation has produced a set of recommendations that are intended to improve the next national suicide prevention strategy. These recommendations reflect key messages on best practice from the literature and the views of experts, as well as the views of stakeholders involved in *CfL*.

Governance

1. Retain *CfL*'s implementation structures and governance: Building on the success of the Cross-Sectoral Steering and Implementation Group, strengthen links with NGO groups and local implementation teams.
2. Consider broadening leadership beyond Department of Health: Joint leadership of the next suicide prevention strategy, by the Department of Health alongside another government department (e.g., Department of the Taoiseach) may assist suicide prevention being increasingly seen as an issue beyond health.
3. Clarify NGO engagement: Introducing structured, rotational representation for NGOs in governance structures to ensure more diverse and representative input.
4. Strengthen local implementation structures: Adapt *CfL's* model to better reflect the needs of Ireland's new six HSE Health Regions, while ensuring locally driven implementation plans.

Scope

5. Reassess strategy scope: Avoid an overly broad, action-heavy framework, prioritising fewer, more achievable, high-impact goals. The number, scope, and breadth of actions in the next strategy should be viable to be delivered.
6. Strengthen postvention objectives: This contributes to suicide prevention as well as stigma reduction and healing for those impacted by a death by suicide.
7. Clarify self-harm as a risk factor in suicide and ensure there are specific interventions for self-harm in the policy and strategy for suicide prevention: Provide clear self-harm interventions for suicide prevention and acknowledgement of self-harm as a behaviour that may be linked to mental health issues more generally.
8. Increase focus on suicide prevention as a public health issue: Move beyond mental health to better address social determinants of suicide, stigma reduction and broader health system integration. This would allow for more preventative and population-based health initiatives.
9. Focus on priority groups: Review who the priority groups will be for the new strategy and expand peer-led approaches. Strengthen engagement with marginalised populations.

10. Enhance focus on service accessibility: Adopt an equity-based approach that considers vulnerable populations (e.g., digitally excluded groups, youth, rural communities, older adults).

Funding

11. Maintain dedicated suicide prevention resources within the HSE: This may need particular attention during the HSE restructuring process.
12. Develop a more strategic funding model: Prevent duplication of effort amongst partners to ensure resources are allocated effectively. A more sustainable funding model is also required for NGO partners delivering front-line services.
13. Strengthen prevention and early intervention: Funding is needed for improvements in availability of primary care counselling and adequate resourcing of community teams. Resource allocation should meet the needs of changing demographics and increasing population in some areas (e.g., urban areas) and ensure services are accessible (i.e., in rural areas).

Processes

14. Engage with stakeholders at strategy development stage: For successful implementation, identify who will lead on actions and recommendations, roles for stakeholders and where overlap exists with other strategies and policies. Engagement with stakeholders who will have responsibility for actions is critical at this early stage.
15. Include a lived or living experience perspective: The Living Experience Representative Group in this evaluation provided a unique and valuable insight during the interpretation of findings stage. Lived or living experience should be embedded into policy development, governance, and evaluation.
16. Check efficacy of communications: A refinement of communication procedures is recommended, including communication from national to regional and local levels, among stakeholders, and between governance structures.
17. Strengthen data systems, surveillance, and outcome measurement: Address real-time data gaps and improve suicide reporting methodologies to move beyond coronial determinations. Measurement of protective factors such as resilience and social connectedness is also suggested, as well as a more robust outcome framework.
18. Embed continuous evaluation: Develop a real-time impact measurement system as part of an integrated outcomes framework that tracks progress continuously. Improved data collection, encompassing both intermediate and long-term indicators, is essential for demonstrating impact and securing ongoing funding.

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Appendix A: Detailed methodology

Logic modelling

Logic models are visual representations or diagrams that illustrate how a program or intervention is intended to work. A key methodological consideration is that logic models are intended as preparatory work to be developed before a strategy in order to inform it. There was no available logic model associated with the original development of *CfL*, so this evaluation developed a **retrospective** articulation of how and why *CfL* was expected to bring about the desired outcomes for suicide prevention.

Retrospective logic modelling is challenging due to:

1. Change of staff – original assumptions and context is missing
2. Passage of time – memories are affected
3. Retrospective bias – stakeholders can describe only the final agreed strategy contents.

Due to these challenges, a retrospective logic model will be an approximation of the original intent. To provide the *CfL* retrospective logic model, two data sources were used: a workshop and document review from the origins of *CfL*. The After-Action Review (AAR) methodology was used to frame a workshop. AAR is a facilitated discussion that prompts reflections on how successful a policy/strategy was at achieving its aim by comparing what actually happened with what was intended. The output from the logic modelling process is presented in Figure 8.

Workshop

A workshop was planned as the first stage of the logic modelling process (retrospective). The AAR methodology was used to frame the workshop. AAR is a facilitated discussion that prompts reflections on how successful a policy/strategy was at achieving its aim by comparing what actually happened with what was intended.

The participant list was provided by NOSP, while invitations were sent and managed by CES. The workshop was held in the Board Room at Stewarts Hospital, Palmerstown, Dublin 20 on 12th June 2024.

The workshop was planned for 3 hours to allow for joining, introduction, breaks, and lunch.

Invitees were chosen on the basis of being involved with *CfL* planning and delivery at a senior level and included representatives from the HSE NOSP Management Team, HSE Mental Health, Department of Health, NSRF, ROSPs, other NOSP staff, NGOs, and other HSE staff.

In advance of the workshop (10th June 2024), confirmed participants received an email with attachments describing the *CfL* IOs and logic model headings to help prepare them for participation.

At the workshop, participants were to be divided into sub-groups of 7-8 people. CES researchers provided facilitation for each sub-group.

The workshop revisited the IOs in order to establish a common understanding of the activity by asking the following questions:

- What did you set out to achieve?
- What actually happened?
- What worked well? Why?
- What could have been improved? How?
- What would you do differently next time?

Both groups sequentially discussed each of the IOs in strategic goals 1 and 2, to allow comparison between the groups, followed by split discussions about IOs 3, 4, 5 and, IOs 6 and 7, respectively.

Document review

The data captured at the workshop was augmented with findings from external documentation. This document review informed identification of the starting point of *CfL*, the interventions/ activities and projects that were used and why, the resources and inputs that were required, and the intended outcomes as they were captured prior to the launch of *CfL* in 2015.

Documents included *CfL*-associated publicly accessible policy documents, alongside reports or policy documents related to the predecessor to *CfL*.

The documents were scanned for references to inputs, outputs, and outcomes, as defined by:

- 'inputs' - meaning named activities to be undertaken
- 'outputs' - meaning the direct, causal results of the inputs
- 'outcomes' - meaning the measurable changes that can be attributed the outputs.

As this evaluation is focused on the implementation of the *CfL* strategy, rather than the impact on society, the logic models do not present population-level 'impacts'.

Figure 8: Logic modelling output

Literature review

Sources

A search of PubMed[37] was carried out to identify relevant literature. Additional publications identified by the Evaluation Advisory Group and supplied to the CES evaluation team were considered for inclusion.

PubMed query

The following query was used to search PubMed on 1st July 2024:
("suicide"[MeSH Terms] AND "prevention"[Title/Abstract] AND ("intervention"[Title/Abstract] OR "means restriction"[Title/Abstract] OR "media guidelines"[Title/Abstract] OR "community based interventions"[Title/Abstract] OR "postvention"[Title/Abstract] OR "training"[Title/Abstract] OR "coping skills"[Title/Abstract] OR "problem solving skills"[Title/Abstract] OR "psychosocial"[Title/Abstract] OR "crisis intervention"[Title/Abstract] OR "mental health treatment"[Title/Abstract] OR "risk assessment"[Title/Abstract] OR "stigma reduction"[Title/Abstract]))

Filters

The following filters were applied to the PubMed search:
Meta-Analysis, Systematic Review, English, from 2015/1 - 2024/6

Inclusion and exclusion criteria[38]

The following inclusion and exclusion criteria were applied during screening and review.

Inclusion criteria

- Articles that include a systematic review, review, or meta-analysis of a suicide prevention intervention or interventions
- Articles where the outcome measured includes suicide and/or suicidal behaviour (suicidal ideation, self-harm) as a primary outcome
- Articles published between January 2015 and June 2024
- Publications in English language.

Exclusion criteria

- Single studies on suicide prevention
- Reviews of pharmacotherapy interventions
- Reviews of risk/protective factors, at-risk populations, and suicide methods that did not assess which interventions worked but used their findings to make recommendations for what could/should work
- Reviews of interventions that had suicide/suicidal behaviours as one of their secondary outcomes
- Reviews that did not include primary studies (i.e., reviews of reviews).

Screening and categorisation of articles

- A total of 157 abstracts were identified in PubMed. Titles and abstracts were screened by two members of the CES evaluation team with each reviewer screening half of the abstracts. Abstracts were marked as 'discuss' where it was unclear if they met the inclusion criteria for the review. Following discussion, if it was still unclear if the article was relevant, it was included for full text review.

[37] https://pubmed.ncbi.nlm.nih.gov/

[38] These criteria are based on the criteria applied in a review carried out by the HRB on behalf of the HSE's NOSP in advance of the publication of *CfL* (Dillon, Guiney, Farragher, McCarthy, & Long, 2015).

- Following title and abstract screening, 91 full texts were reviewed, 80 of which were deemed as containing information on evidence-based suicide prevention interventions relevant to the current evaluation. Three of these articles, which focused on risk assessment, were excluded as a result of recent changes to the National Institute for Health and Care Excellence (NICE) guidelines which advise against the use of risk assessment tools and scales for the prediction of suicide and the repetition of self-harm (National Institute for Health and Care Excellence, 2022). Again, two members of the CES evaluation team reviewed the full texts, each reading and extracting information from half of the full texts. Articles were discussed as necessary. Articles were categorised under the evidence-based intervention headings outlined in Table 2. Articles were categorised as 'multiple interventions' if findings on more than one of the interventions identified in Table 2 were included.[39]

Primary data collection

Rapid Insight sessions

The RI methodology is a modified type of focus group that gathers larger groups of professionals into a tightly managed, virtual forum to share system experiences and intelligence (Chandler, et al., 2023). One key benefit of RI sessions, relative to traditional focus groups, is that it empowers less heard voices, which may lead to capturing a greater diversity of experiences.

Three groups of *CfL* stakeholders were engaged to gather their insights and perspectives on the implementation of the *CfL* strategy. Participant lists were provided by NOSP and confirmed between CES and NOSP to avoid duplicate invitations.

- Representatives from the 22 government departments and agencies who are involved in the implementation of *CfL* actions and who are representatives on the national Cross Sectoral Steering Group for *CfL*. 17 participants attended.
- Representatives from the 21 different NGO partner organisations who are funded by NOSP to deliver on work aligned with the *CfL* objectives. 21 participants attended.
- HSE ROSPs (21 known active ROSPs) who work across a range of areas nationwide. 13 participants attended.

Three weeks before the first RI session, a participant information sheet describing the activity was sent to invitees of the three groups through NOSP. An email was sent to participants two weeks prior to the session informing them of the upcoming meeting invitation. Invitations to the RI sessions were manged by CES to ensure that the data was captured and stored securely in accordance with General Data Protection Regulations (GDPR). All RI sessions were run through MS Teams, with a CES staff member ready to handle technical issues.

[39] At title and abstract review stage, a minor adjustment was made to the inclusion criteria. For articles categorised as 'training', the primary outcomes most often related to changes in knowledge, attitudes, beliefs etc., rather than suicide and/or suicidal behaviour (suicidal ideation, self-harm). The inclusion criteria were adjusted to ensure that relevant articles reporting on training were not excluded.

On the day, RI sessions followed a common structure over 45-60 minutes:

- a clear description of the activity
- obtaining consent for recording
- objectives and participant
- expectations
- a warm-up task
- the main data-gathering section, with each question running through:
    - question presentation
    - two minutes silence to gather thoughts
    - data capture through the chat function
    - immediate impressions by two CES observers.

Each session was hosted by a senior member of the CES evaluation team.

There were three questions, and the format included immediate feedback on the participants' contribution by CES observers to stimulate further thinking and contributions.

The specific questions in the RI sessions were informed by a document review and the AAR workshop:

1. Thinking about implementing the *CfL* strategy, from your perspective what could have been 'Even Better If'?
2. What are your key lessons about implementing a strategy that crosses multiple agencies, sectors, budget and accountability relationships?
3. What factors need to be in place to create a sustainable suicide prevention programme for the future?

For those who had an issue with entering data into the chat function during a RI session, we provided the opportunity to respond to the same questions through Microsoft Forms.

The chat and video recording were saved for analysis. The chat had identifying information removed to preserve anonymity and avoid analytical bias.

The outputs of the RI sessions were visually presented by mind maps that show linkages between themes. The RI data also contributed to the data triangulation stage.

Interviews

The CES evaluation team conducted a series of semi-structured online interviews with national stakeholders across a range of government departments and agencies associated with *CfL*. CES worked with NOSP to identify the interview participants. Specifically, individual interviews were conducted with representatives from:

- The NOSP Management Team
- Government departments and agencies
- ROSPs
- Community and Voluntary Sector organisations and NGOs funded as delivery partners
- Subject matter experts who act, or acted, as advisors to *CfL* (bellwether interviews).

A core interview schedule was informed by implementation science taxonomies and frameworks, including RE-AIM (Glasgow, et al., 1999), Proctor's Outcomes (Proctor, et al., 2010), CFIR (Damschroder, et al., 2022), and COM-B (Michie, et al., 2011) as well as by a document review and the AAR workshop. This approach allowed for an in-depth exploration of the key dimensions of *CfL* implementation, such as stakeholder engagement, integration of suicide prevention actions, implementation fidelity, and sustainability planning.

This was then adapted to two different groups of interviewees: those with direct involvement in *CfL* implementation and those in a more advisory capacity (bellwethers).

The implementation interviewee schedule included 8 core questions, and 21 prompts for the interviews to elicit further details, across the following topics:

- Implementation of *CfL* and how it worked in practice
- Implementation context for *CfL* at a national and regional level
- Perceived barriers and facilitators of *CfL* implementation
- Progress achieved by *CfL* and perceived contribution to systems change
- Unexpected positive or negative outcomes from the *CfL* strategy
- Outcomes measurement and impact assessment of *CfL*
- Concluding comments and looking to the future.

The bellwether interviewee schedule included 7 core questions, and 13 prompts for the interviews to elicit further details, across the following topics:

- Implementation of national suicide prevention strategies
- Implementation of *CfL*
- Perceived barriers and facilitators of *CfL* implementation
- Unexpected positive or negative outcomes from the *CfL* strategy
- Outcomes measurement and impact assessment of *CfL*
- Concluding comments and looking to the future.

The interview schedules were reviewed by the NOSP Management Team and were shared with the Evaluation Advisory Group and Evaluation Stakeholder Group for feedback.

All participants received an information leaflet in advance of their participation in an interview and were asked to read and sign an informed consent form before taking part. Consent forms were collected through email.

The interviews were scheduled by CES for 1-hour slots using Microsoft Teams and were conducted by either one or two evaluation team members. On one occasion, two interviewees were interviewed together because they had a similar role in their work on *CfL*. All interviews were recorded, with the transcriptions saved separately and anonymised.

In total, 30 interviews were conducted between October and December 2024.

Surveys

Two surveys were created for this data collection, one for ROSPs and one for local stakeholders/implementation partners. The ROSP survey focused on the unique experiences, challenges, and successes encountered by them in *CfL* implementation. The local stakeholders/implementation partners survey was designed for those who actively support *CfL* initiatives but are not ROSPs. It gathered perspectives on *CfL*'s reach, engagement, integration, and sustainability at the local level.

The ROSP survey had 31 questions under the following headings:

- Demographic data
- Reach and engagement
- Adoption and integration
- Implementation and fidelity
- Maintenance and sustainability
- Additional comments and feedback.

The local stakeholders/implementation partners survey had 15 questions under the following headings:

- Challenges in agency adoption
- Implementation and fidelity
- Maintenance and sustainability
- Additional comments and feedback.

Surveys were distributed via the following ROSP areas of responsibility:

- Cavan, Monaghan
- Carlow, Kilkenny, South Tipperary, Waterford, Wexford
- Galway, Mayo, Roscommon
- Sligo, Leitrim

- Donegal
- Galway, Mayo, Roscommon
- Limerick, Clare, North Tipperary
- Cork
- Kerry
- Dublin South East, Dublin South, Wicklow
- Kildare, West Wicklow
- West Dublin, Dublin South City, Dublin South West, Dublin South
- Laois/Offaly, Longford/Westmeath, Louth/Meath.

The surveys were informed by implementation science taxonomies and frameworks, including RE-AIM (Glasgow, et al., 1999) and CFIR (Damschroder, et al., 2022), as well as by a document review and the AAR workshop. This approach allowed for a comprehensive exploration of the key dimensions of *CfL* implementation, such as stakeholder engagement, integration of suicide prevention actions, implementation fidelity, and sustainability planning.

The design process involved consultation with key stakeholders to ensure the surveys were fit for purpose. Feedback was gathered through discussions with the *CfL* Evaluation Advisory Group, ROSPs, action leads and members of steering and working groups during targeted review sessions. These consultations helped refine survey content and structure to reflect the diverse perspectives and experiences of those involved in *CfL* implementation.

Drafts were iteratively revised based on this feedback, with final versions incorporating a balance of closed and open questions to reflect the *CfL* IOs. The finalised drafts were then shared for broader stakeholder review and validation before distribution.

After publishing the surveys using SurveyMonkey, the CES evaluation team piloted the ROSP survey with four former ROSPs, through contact details provided by NOSP. The purpose of the pilot was to test the wording and flow of questions within the survey, as well as accessibility. Internal CES testing for technical issues across different platforms was conducted simultaneously. We finalised the survey based on feedback received during the pilot.

Survey participants were informed of the survey by a 'newscast' email from the NOSP Management Team, provided by the CES evaluation team. CES then provided the survey link and an accompanying email to NOSP who distributed it to the ROSPs, who acted as gatekeepers so that no individual contact details of organisation representatives were seen by CES. The ROSPs were asked to circulate the appropriate link to the questionnaire amongst the local stakeholders/implementation partners.

The survey was open for a 5-week period across November and December 2024. It was distributed to 21 ROSPs and 613 local stakeholders/implementation partners.

All responses were anonymous.

Analysis

Qualitative datasets were analysed using thematic analysis. This method of analysis is used to identify, interpret, and report patterns (or themes) across a dataset, which represent beliefs, observations, and experiences that participants may share in relation to the research questions. Thematic analysis is also interested in identifying differences in experiences and developing explanations for these differences.

MAXQDA qualitative analysis software was used to manage the analysis of the qualitative data. In line with the realist approach to this evaluation, a key feature of the data analysis was also to describe the relationships in the data between context, mechanisms, and outcomes (for example by analysing participants' explanations for how specific outcomes came about).

Each dataset was analysed separately and then combined in the triangulation stage.

Rapid Insight sessions

RI data were analysed by high-level thematic groupings, following an inductive approach.

At an in-person session, CES researchers separated the chat contributions into individual units and two researchers per RI session separately grouped the contributions by high-level themes.

Next, the groupings were compared to identify similarities and differences. The similar groupings were placed into an initial mind-map structure. The groupings with different interpretations were discussed to come to agreement on them, prior to adding to the mind-map.

The individual contributions were edited for brevity to link to the identified themes within the mind-map.

Interviews

The interview coding framework combined elements of CFIR (Damschroder, et al., 2022), Proctor's Outcomes for Implementation Research taxonomy (Proctor, et al., 2010), RE-AIM (Glasgow, et al., 1999), and COM-B (Michie, et al., 2011). These codes were applied to structure the coding of transcripts and subsequent thematic analysis. The coding framework has 8 primary categories encompassing 43 individual codes. The primary categories are:

9. Contextual factors (CFIR)
10. Cross-sectoral collaboration (CFIR)
11. Implementation processes (CFIR)
12. Intervention characteristics (CFIR)
13. Implementation outcomes (Proctor and RE-AIM)
14. Data and evidence (Proctor and RE-AIM)
15. Emerging issues and reflections (Proctor and RE-AIM)
16. COM-B informed codes.

To ensure consistency and reliability in applying the coding framework, two evaluators jointly coded an initial sample of 2–3 interview transcripts. This process allowed for testing and calibration of the coding framework and enable adjustments or refinements as needed. Once the framework was validated, the evaluators each independently coded half of the remaining transcripts.

Regular check-ins were conducted between the evaluators to sense-check the application of the coding framework and ensure consistency in interpretation. Any uncertainties or discrepancies that arose were referred to the wider CES evaluation team for consideration, discussion, and quality assurance. This iterative approach ensured rigor and flexibility in the analysis process, accommodating emerging insights while maintaining alignment with the evaluation objectives.

Surveys

The analysis of survey data was conducted through two main approaches: quantitative analysis of closed-ended questions and thematic analysis of open-ended or free-text responses.

For the closed-ended questions, descriptive statistics were employed to summarise the data. This included calculating measures such as frequencies, percentages, means, and standard deviations to provide a clear overview of the responses and highlight patterns and trends. Microsoft Excel was used for this analysis.

For the open-ended or free-text questions, a thematic analysis was conducted to capture the richness and depth of qualitative data. This analysis used the same coding framework as the interviews for consistency and to facilitate the data triangulation.

The findings from the thematic analysis were used to complement and contextualise the quantitative results, providing a more comprehensive understanding of stakeholders' experiences with the implementation of the *CfL* strategy.

Secondary data

CES has developed an Implementation Outcomes Framework, bespoke to the *CfL* evaluation, for coding the available evidence. The framework is based on the NCEC/CES Implementation Guide and Toolkit Implementation Outcomes (Department of Health, NCEC Implementation Guide and Toolkit, 2018), which is, in turn, based on Proctor/RE-AIM frameworks (Glasgow, Vogt, & Boles, 1999; Proctor, et al., 2010). This framework is tailored towards conceptualising and evaluating successful implementation within health services.

Source documents

There are two broad categories of evidence:

- A document compiled by the NOSP Management Team (Multiple Lines of Evidence) that contains document links, publicly available document references, webpages, references/observations from internal or in-progress reports, and references/observations from meetings.
- Publicly available background documents, including *CfL* progress reports (quarterly and annual), Interim Strategy Review, and implementation plans.

Process

- Evidence sources were downloaded and imported into MAXQDA software.
    - Sources that could not be located or referenced internal documents were compiled and sent to NOSP for provision (if available).
- Evidence content was coded to the Implementation Outcomes Framework. The IOs from this framework that have been selected as most relevant for this evaluation are:
    - **Acceptability** - The perception among stakeholders that an intervention is agreeable, palatable, or satisfactory, and leads to an improved general service experience.
    - **Appropriateness/Feasibility** - The extent to which the intervention is compatible, relevant, and implementable within a given context or setting.
    - **Penetration/Reach** - The degree to which the intervention is integrated into a service setting, including whether it effectively reached the target population.
    - **Maintenance/Sustainability** - The extent to which the intervention will be renewed and institutionalised into the organisation/setting's ongoing operations.
- Coding focused on evidence directly relevant to the IO indicators; that is, the evidence was **not** summarised as a whole.
- Two CES evaluation team members coded the evidence in two phases:
    - Preliminary coding
    - Review of coding to eliminate duplications or anomalies.
- The data were exported to Microsoft Excel, where the source evidence was labelled horizontally, and the codes were labelled vertically.
- On the far right of the summary table, overview columns were created where the coder summarised how the reviewed evidence relates to the IO indicator and a senior CES staff member reviewed for accuracy.
- An assessment of the extent to which IOs were achieved was made during the data triangulation stage using a 5-colour scale:
    - Green – Achieved and sustainable
    - Light green – Achieved, with minor learnings/barriers/challenges
    - Amber – Achieved, with 1 major learning/barrier/challenge
    - Orange – Achieved, with >1 major learnings/barriers/challenges
    - Red – Not achieved.

Quality Assurance

- For all IOs, two CES evaluation team members coded the evidence in two phases:

- Preliminary coding
- Review of coding to eliminate duplications or anomalies.
- A senior CES staff member read the summary tables to assess if the overviews were consistent and robust.

- In piloting the first two IOs (1 more straightforward, 1 more complicated):
  - The two coders collated their experience of applying the Implementation Outcomes Framework
  - The experiences were then discussed among the CES evaluation team and refinements suggested.

Appendix B: Lived or Living Experience Representatives Group information document

The Centre for Effective Services
www.effectiveservices.org

About the Centre for Effective Services

CES is a not-for-profit, intermediary organisation that works to connect policy, practice, and research. Our purpose is to improve the lives of people by supporting the implementation of excellent public services through evidence-informed policy and practice in Ireland and Northern Ireland. CES works with government departments and service providers to design, develop, implement, and evaluate public policies and services.

CES works in areas such as education, health, justice, children and young people and social services. Our team provides expertise, support and services for public policy and services. We support service providers and policy makers in delivering improved outcomes and value for people living in our communities.

Our work is informed by our values – collaboration, creativity, evidence, equity and learning. For more information about CES, visit www.effectiveservices.org

About Connecting for Life

Connecting for Life (*CfL*) (https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/) is Ireland's National Strategy to Reduce Suicide. The strategy focuses on the primary and secondary prevention of suicidal behaviour and addresses a broad range of risk and protective factors. There are 69 actions under seven strategic goals; 22 government departments/ agencies have made commitments as lead and/or supporting partners to deliver on these actions; (currently) 21 non-governmental organisation (NGO) partners are funded by HSE NOSP to deliver on work aligned with *CfL*'s strategic objectives.

The current *CfL* strategy ended in 2024. An evaluation of the implementation of the strategy on a national and regional basis was commissioned to help HSE NOSP understand all aspects of the delivery of *CfL*, especially the barriers and facilitators to effective implementation. The findings from both the implementation and intermediate outcomes evaluation of *CfL* will be used by the

HSE NOSP, the wider HSE and the Department of Health to provide direction for post-*CfL* suicide prevention strategy and operations in Ireland.

What is Lived or Living Experience?

Lived or Living Experience (LE) informed research is research carried out 'with' or 'by' members of the public with lived or living experience rather than 'to', 'about' or 'for' them.

Why does this project need LE?

CES needs LE input into the *Connecting for Life* evaluation:

- To ensure that our evaluation is influenced by principals of citizenship, accountability, and transparency.
- To ensure that our evaluation is acceptable, accessible, sensitive, and representative of the perspectives of people with lived or living experience.
- To facilitate open and collaborative dialogue between the people with lived or living experience and CES researchers.

How do we want to involve LE?

CES would like to have LE Representatives on a panel to review and contribute to the final report of the *CfL* evaluation. We would also like some LE Representatives to write a commentary on the final report for wider publication.

Who can become a LE Representative on our panel?

CES welcomes LE Representatives from all backgrounds, from people varying levels of lived or living experience of suicide, self-harm, and mental illnesses. You do not need to be a mental health professional or researcher. Being an LE Representative is open to anyone with lived or living experience.

People we invite to become a LE Representative include, but is not limited to:

- People with personal lived or living experience of suicide (at least 3 years since your loved one's death), self-harm, or mental illness.
- Family members (including parents), carers, friends, colleagues, or healthcare/allied professionals of people with lived or living experience of suicide self-harm or mental illness.
- Members of advocacy or patient groups representing persons with lived or living experiences of suicide, self-harm, or mental illness.

The LE panel is open to individuals aged 18 years and over. We welcome people of all and no genders, people of all ethnic and socioeconomic backgrounds and of all abilities, based on the island of Ireland. Access to a computer and WIFI and the ability to use or have assistance to use a computer is currently necessary.

What will the LE representatives do?

After receiving your expression of interest, you will be contacted by a researcher from CES to discuss the project, to give details of consent and supports available, and to give you an opportunity to ask any questions.

If you decide to become an LE Representative, you will be asked to provide your insight and input into the final evaluation of *CfL*. This involves looking at the data that has been collected by the CES evaluation team and contributing to the discussion of what it may mean.

Our meeting and co-design work will take place online. For LE Representatives who may not be familiar with working online, CES can offer support or even gather your insight on a phone call or by other means.

As a LE Representative with lived or living experience, we will **not ask you to provide details of your own lived or living experience**. Furthermore, as a LE Representative you will not be a subject of any research itself. We appreciate that you will have valuable insight into suicide prevention, and we are interested in your perspectives.

How much time will I need to become a LE Representative?

For the *CfL* evaluation, it is expected that LE Representatives will meet with the CES evaluation team a maximum of 3 times, as shown in the table below (suggested dates). Prior to each meeting, LE Representatives will be provided with reading material to prepare for contributing to the discussion.

The total maximum number of expected hours for each LE Representative will be no more than 12 hours. All LE Representatives will be compensated for their time spent attending meetings and taking part in panel work, at a rate of €25 per hour. This will be paid in One4All vouchers, which can be agreed with LE Representatives in advance.

Meetings	Date	Approximate hours
Induction meeting with LE reviewers		1.5
Group discussion with LE reviewers to input into draft of the report		2 (with break)
Commentary meeting with LE reviewers (optional)	TBC	2 (with break)

Appendix C: Literature review findings

Findings relating to specific suicide prevention interventions

The findings relating to each of the nine evidence-based suicide prevention interventions are outlined below.

Means restriction – Findings support the restriction of access to poisons as a means of reducing suicide (Lim, Buckley, Chitty, Moles, & Cairns, 2021), and evidence for reduced number of suicides by jumping, following the installation of physical barriers and fencing at frequently used sites such as bridges and cliffs, as well as measures like road closures that limit access to these sites (Okolie, et al., 2020). Further, a recent publication on public health approaches to suicide prevention, highlights the importance of reducing access to means (Hawton, Knipe, & Pirkis, 2024).

Media guidelines – Examining media stories of hope and recovery, Niederkrotenthaler and colleagues (Niederkrotenthaler, et al., 2022) report a small decrease in suicidal ideation among the intervention group. They propose that their research provides new evidence about narratives for suicide prevention which may relate to media guidelines for the reporting of suicide-related information.

Community-based interventions[40] – Of the 17 articles categorised as 'community-based interventions', 16 referred to specific communities and typically reviewed more than one evidence-based intervention, e.g., indigenous communities, occupational and educational communities etc. These findings are presented in a separate section below. The remaining article concluded that arts-based programmes may be a useful component of interventions designed to decrease suicidal risk and behaviours (Sonke, et al., 2021).

Postvention – Linde and colleagues reviewed seven intervention studies, primarily focusing on cognitive-behavioural approaches, bereavement groups, and writing therapy. The findings suggest that while some interventions, particularly bereavement groups and writing therapy, show promise in reducing grief intensity, the overall quality of evidence is limited due to methodological weaknesses in the studies (Linde, Treml, Steinig, Nagl, & Kersting, 2017). Andriessen and colleagues report some evidence for the effectiveness of general interventions for uncomplicated grief and a gap in the literature with regards to complicated grief (Andriessen, et al., 2019). Linde et al. (2017) highlight the unique challenges faced by this group, such as feelings of guilt, shame, and stigmatisation, which can complicate the grieving process and increase the risk of developing complicated grief. These paper underscores the need for tailored interventions to address the specific needs of those bereaved by suicide and call for more robust research in this area (Andriessen, et al., 2019; Linde, et al., 2017).

Training – Twelve articles were identified which focused on training for nurses (Richard, et al., 2023; Dabkowski & Porter, 2021; Ferguson, et al., 2018; Ferguson, et al., 2020), GPs (Milner, et al., 2017),

[40] For this review, we have included any community-based strategy under 'community-based interventions'. This includes some groups which may be deemed to be at higher risk of suicide and/or suicidal behaviour, e.g., certain occupations, school and university communities, indigenous communities, prisoners etc.

healthcare settings (Dillon, et al., 2020), educational settings (Pistone, Beckman, Eriksson, Lagerlöf, & Sager, 2019), as well as gatekeeper training (Holmes, Clacy, Hermens, & Lagopoulos, 2021; Morton, et al., 2021; Nasir, et al., 2016; Yonemoto, Kawashima, Endo, & Yamada, 2019; Torok, Calear, Smart, Nicolopoulos, & Wong, 2019). A recent review concluded that gatekeeper training is effective in improving knowledge, skills, self-efficacy, and likelihood to intervene in crisis situations; however, the review notes that the evidence to support changes in attitudes and gatekeeper behaviour is mixed (Collins, 2021). The findings of the articles identified in the systematic search broadly echo these findings with studies generally reporting changes in self-efficacy, skills, knowledge, and attitudes in the short term, with less consistent evidence for longer-term sustainability of outcomes, and changes in behaviour or patient outcomes, e.g., suicide or suicidal behaviour.

Psychosocial, including problem-solving skills, coping skills etc. – Twenty-one articles were identified. Evidence for the impact of psychosocial interventions is summarised in a Cochrane review of interventions for self-harm (Witt, et al., 2021). The authors suggest that psychosocial therapy based on CBT approaches may result in fewer individuals repeating self-harm at longer follow-up time points but note that the quality of evidence in their review was low. They suggest that further development of Mentalisation-Based Therapy (MBT) is warranted, and DBT may also lead to a reduction in the frequency of self-harm. Further, one article included a meta-analysis and demonstrated an inverse relationship between problem-solving skills and suicidal ideation, attempts, and suicide death (Darvishi, Farhadi, Azmi-Nae, & Poorolajal, 2023).

Crisis intervention – Evidence for crisis intervention methods varied. Balasa and colleagues found no support for the impact of emergency department-based youth suicide prevention interventions on reducing suicide attempts or suicidal ideation (Balasa, et al., 2023). Four articles reported on telehealth platforms stating that the effectiveness of these interventions varied, with some demonstrating significant benefits, in reducing suicidal thoughts, suicide rates, and re-attempts (Kreuze, et al., 2017; Sullivan, et al., 2022; Shoib, et al., 2024; Gryglewicz, et al., 2024). Some support for direct telephone interventions was also observed (Baldaçara, et al., 2023) and findings also provide some support for Safety Planning Intervention as a feasible and acceptable intervention, associated with improvements in suicide behaviour, suicidal ideation, reductions in hospitalisations, and better treatment engagement (Ferguson, Rhodes, Loughhead, McIntyre, & Procter, 2022; Marshall, et al., 2023). Caring Contacts and follow-up communications were also shown to have a protective effect against suicide attempts (Katsivarda, Assimakopoulos, & Jelastopulu, 2021; Skopp, et al., 2023).

Mental health treatment – With a focus on Substance Use Disorder, one article reports a lack of evidence for successful interventions to reduce self-harm and suicide in this risk group (Padmanathan, et al., 2020). Findings support the effectiveness of CAMS for reducing suicidal ideation; however, no differences were reported for suicide attempts, self- harm, other suicide-related correlates, or cost effectiveness (Swift, Trusty, & Penix, 2021). Findings indicate that Brief Contact Interventions (BCIs), especially when extended beyond 12 months, are associated with a significant reduction in the likelihood of re-attempting suicide (Azizi, et al., 2023).

Stigma reduction – None of the reviewed papers focused specifically on stigma reduction. Some overlap exists with training and community-based interventions which aim to address stigma as one component of a broader intervention.

Findings from articles reporting on multiple suicide prevention interventions

Mann et al. (2021) – While some interventions, like training GPs and means restriction, show strong evidence for reducing suicide rates, other approaches such as gatekeeper training and internet-based interventions require further investigation.

Zalsman et al. (2016) – The review finds strengthened evidence for the effectiveness of restricting access to lethal means, such as firearms and pesticides, in preventing suicide; highlights the effectiveness of school-based awareness programmes in reducing suicide attempts and ideation; and notes insufficient evidence for some approaches, such as primary care screening and media guidelines.

Hofstra et al. (2020) – Findings suggest that multi-level interventions, which integrate multiple approaches across different settings, show significantly greater effectiveness compared to single-level interventions, highlighting the importance of a comprehensive approach in suicide prevention efforts.

Linskens et al. (2023) – Interventions that reduce access to means, implement organisational policies and culture in workplace settings, e.g., police and military, and screen for depression within the community may reduce suicide deaths. The effectiveness of other strategies, such as public awareness campaigns, crisis lines, and gatekeeper training, remains unclear due to inconsistent evidence.

Ishimo et al. (2021) – The findings highlight that physical barriers and some law reforms are particularly effective in reducing suicide mortality, while other interventions show mixed results.

Riblet et al. (2017) – Results highlight that while the WHO brief intervention and contact programme significantly reduces the odds of suicide, other interventions like CBT did not show statistically significant effects in reducing suicide rates.

Reifels et al. (2024) – The findings indicate that while some interventions show potential effectiveness, the overall quality of the evidence is variable, and there is a need for further research to better understand which interventions are most effective in challenging contexts, such as disasters and public health emergencies.

Barker et al. (2017) – Focus on physical barriers and improved media guidelines to reduce incidents of rail-related suicides. The review finds that these interventions, particularly platform screen doors, have been effective in significantly reducing suicide attempts and fatalities. However, the effectiveness of blue lights and suicide pits is less clear.

Zarska et al. (2023) – Findings support the benefit of training for ED providers which has been shown to improve knowledge, attitudes, and skills. Support is also shown for safety planning and follow-up contact to reduce repeat suicide attempts.

Sultan et al. (2021)[41] – Reducing access to lethal means, implementing organisational policies and culture in police workplace settings, and screening for depression in the community may reduce suicide deaths. The evidence for other standalone interventions, e.g., housing stabilisation programmes, public awareness and education campaigns, crisis hotlines, and gatekeeper training is uncertain. Identifies the European Alliance Against Depression as a promising multi-strategy intervention but evidence was inconsistent for community-based multi-strategy interventions. In high school students, social-emotional learning programmes, gatekeeper training, and screening may reduce suicide attempts but the effects on suicide deaths remains uncertain.

Findings relating to specific community-based interventions or at-risk groups

Indigenous communities – Grande and colleagues identified two studies that showed promise in reducing suicide risk in Indigenous adolescents aged 10 to 19 years using interventions that were tailored to be culturally appropriate (Grande, et al., 2022). A scoping review of community-based suicide prevention programmes aimed at adults in rural and regional Australia examined a range of interventions aimed at increasing education and reducing stigma around suicide. The paper highlights the importance of culturally appropriate services, the inclusion of lived or living experience mentoring, and tailoring programmes to effectively reach the targeted audience (Dabkowski, Porter, Barbagallo, Prokopiv, & Jackson, 2022). Leske and colleagues state that the limited evidence available for Indigenous communities supports the use of multi-level, multi-sectoral interventions (Leske, et al., 2020).

Occupational communities – Findings indicate that while some workplace suicide prevention programmes, particularly those tailored to high-risk occupations such as police, army personnel, and construction workers, show beneficial effects, many of these initiatives have not been formally evaluated and further research is needed to develop, implement, and evaluate workplace-specific suicide prevention programmes (Milner, Page, Spencer-Thomas, & Lamotagne, 2015). Rostami and colleagues highlight the effectiveness of interventions such as CBT in reducing suicidal ideation and behaviours in military personnel but note that community-based initiatives face challenges in demonstrating consistent effectiveness (Rostami, Rahmati-Najarkolaei, Salesi, & Azad, 2022). Findings also support programmes for emergency and protective service employees, particularly those that include awareness training, gatekeeper training, and crisis intervention which may result in reduced suicide rates (Witt, Milner, Allisey, Davenport, & LaMontagne, 2017). Finally, a review which focused on medical students as an at-risk group notes that effects of universal interventions on suicidal ideation and behaviour remain to be determined (Witt, et al., 2019).

Older people – One review reports no effect of interventions to reduce suicidal behaviour and ideation (Chauliac, Leaune, Gardette, Poulet, & Duclos, 2020) while another reports some effective interventions for older people but with a need for more research (Okolie, Dennis, Simon, & John, 2017).

School and university communities – Gijzen and colleagues (Gijzen, Rasing, Creemers, Engels, & Smit, 2022) suggest that while school-based programmes have small but significant effects on

[41] Additional review identified by the *CfL* Evaluation Advisory Group.

reducing suicidal ideation and behaviours, there is considerable heterogeneity in their effectiveness, and more research is needed to confirm these results and explore long-term impacts. Walsh and colleagues (Walsh, Herring, & McMahon, 2023) state that nearly half of the studies in their review of post-primary suicide prevention interventions reported reductions in post-intervention suicidal thoughts and behaviours, and five of the seven trials evaluating effectiveness of interventions using pre- and post-intervention measures reported a significant decrease in suicidal thoughts and behaviours over time. Wolitzky-Taylor and colleagues (Wolitzky-Taylor, LeBeau, Perez, & Gong-Guy, 2020) reviewed universal and targeted programmes on university campuses. They report evidence of increases in knowledge, and skills and self-efficacy to address suicide risk through gatekeeper interventions. Evidence of reductions in suicidal ideation and behaviours was observed across targeted suicide prevention programs for at-risk students. Relatively few papers in this review focused on reducing suicidal thoughts and behaviours. Breet and colleagues (Breet, Matooane, Tomlinson, & Bantjes, 2021) highlight the need for more systemic interventions for school and university communities. Findings also highlight the importance of culturally sensitive approaches and the need for further research to ensure the effectiveness of self-harm programmes when applied in different settings (Liljedahl, Hellner, Pettersson, & Ghaderi, 2023).

Young people in care – Findings from a review focusing on young people involved in child protection systems found evidence that youth-focused interventions, such as emotional intelligence therapy, led to reductions in suicidal thoughts (suicidal ideation), and adult-focused interventions, i.e., gatekeeper training, led to increases in knowledge, skills, and behaviours for suicide prevention. Only one of the youth-focused studies in this review evaluated the impact of the intervention in terms of suicide attempts but found no reduction (Russell, Trew, & Higgins, 2021).

Prison settings – Findings support the efficacy of intervention programmes on self-injury behaviour and the use of CBT to reduce suicidal ideation, as well as other third-generation therapies as interventions (Pedrola-Pons, Sanchez-Carro, Pemau, Garcia-Ramos, & De la Torre-Luque, 2024).

Considerations/Limitations

- The literature search carried out as part of the current evaluation was performed in one database, PubMed, and supplemented by relevant literature identified by the Evaluation Advisory Group. Although a search strategy was devised and inclusion and exclusion criteria were established, this is not a systematic review and may not have identified all the relevant literature on this topic.

- An adjustment was made to the inclusion criteria for articles categorised as 'training'. In these articles, the primary outcomes most often related to changes in knowledge, attitudes, beliefs etc., rather than suicide and/or suicidal behaviour (suicidal ideation, self-harm). The inclusion criteria were broadened, specifically the outcome measures criterion, to ensure that relevant articles reporting on training were not excluded. Due to the small number of articles retrieved for some of the evidence-based suicide prevention strategies, a small number of scoping reviews that were identified in the systematic search were also included in the findings.

Appendix D: Detailed survey findings

Findings from the survey of ROSPs

(18 respondents – 85.7% response rate)

Analysis of closed-ended questions

Note: Q1 and Q2 responses omitted to retain anonymity.

Q3: Engagement of key stakeholders

- **Local Authorities/Local Community Development Committees**: **33.33% (6)** rated them as fully involved, while **38.89% (7)** rated them as moderately involved. Minimal involvement was noted by **27.78% (5)**.
- **An Garda Síochána**: Equal distribution across involvement levels, with **33.33% (6)** for minimally, moderately, and fully involved.
- **Education and Training Boards**: **38.89% (7)** rated them as either moderately or fully involved, with **22.22% (4)** noting minimal involvement.
- **Schools**: Higher non-involvement (**27.78% (5)**), minimal and full involvement levels were equally rated (**27.78% (5)**).

Q4: How actively involved are NGOs?

- NGOs showed significant involvement: **50% (9 respondents)** indicated moderate involvement, and **38.89% (7)** indicated full involvement. Only **11.11% (2)** rated them as minimally involved.

Q5: How actively involved are the following HSE departments?

- **HSE Mental Health** showed the highest engagement, with **55.56% (10)** rating full involvement.
- **HSE Primary Care** had **33.33% (6)** each for full and moderate involvement, but **38.89% (7)** noted minimal involvement.
- **HSE Acute Hospitals** showed lower involvement, with **41.18% (7)** reporting minimal involvement and none reporting full involvement.

Q6: Engagement of specific stakeholders

- **People bereaved by suicide**: Engagement was primarily minimal (**44.44%, 8**) or moderate (**38.89%, 7**).
- **People with lived or living experience of mental health difficulties**: **50% (9)** reported minimal involvement.

- **People from minority groups**: Higher levels of full involvement (**38.89%, 7**) were noted compared to other stakeholder groups.

Q7: Barriers to engagement

- **Human Resources** (staffing, capacity, skills) was the most common barrier (**88.89%, 16**).
- Other barriers included **Lack of awareness (66.67%, 12)** and **Perceived relevance (55.56%, 10)**.

Q8: Adoption by lead agencies

- Adoption was highest in **Social Services (e.g., Tusla, CYPSC, FRCs)**, with **70.59% (12)** reporting moderate and **29.41% (5)** full adoption.
- Adoption was lowest in the **Education Sector**, with **11.11% (2)** reporting no adoption.

Q9: Challenges in agency adoption

- **Lack of leadership support** was the most common challenge (**77.78%, 14**), followed by **Insufficient resources (72.22%, 13)** and **Competing priorities (66.67%, 12)**.

Q10: Use of *CfL* guidelines

- Most respondents found the guidelines either **clear (55.56%, 10)** or **somewhat unclear (27.78%, 5)**. Only **16.67% (3)** found them very clear.

Q11: Support for implementation

- **NOSP Support**: Most respondents (**83.33%, 15**) rated support as "as expected," with a weighted average score of 2.78.
- **Line Manager Support**: Responses were more varied, with **33.33% (6)** each reporting "as expected" or "exceeded expectations."

Q12: Adherence to *CfL* plan

- Most respondents (**50%, 9**) reported that the plan was "mostly followed," with **44.44% (8)** noting it was "always followed."

Q13: Adaptations to *CfL* strategies

- Most respondents (**55.56%, 10**) indicated making minor adaptations, with **27.78% (5)** reporting no adaptations.

Q14: Barriers to fidelity

- The most cited barriers were **Limited resources (83.33%, 15)** and **Lack of capacity (77.78%, 14)**.

Q15: Monitoring tools

- Monitoring systems were largely rated as **very useful (44.44%, 8)** or **somewhat useful (33.33%, 6)**.

Q16: Frequency of monitoring

- Most respondents (**77.78%, 14**) reported quarterly monitoring of CfL implementation.

Q17: Use of monitoring data

- **38.89% (7)** reported that monitoring data was "regularly used," and an equal proportion noted "occasionally used."

Q18: Ongoing integration into practice

- *CfL* actions were **mostly incorporated (66.67%, 12)**, with only **5.56% (1)** indicating full incorporation.

Q19: Long-term resource availability

- Confidence in resource availability was moderate, with **55.56% (10)** reporting they were "somewhat confident."

Q20: Leadership commitment

- Leadership commitment was rated as **very committed (44.44%, 8)** or **somewhat committed (44.44%, 8)**.

Q21: Sustainability planning

- **50% (9)** noted there was no formal sustainability plan in place, and **33.33% (6)** were unsure

Analysis of closed-ended questions

1. Stakeholder engagement and involvement

- **Questions:** Q3 (Engagement of key stakeholders), Q4 (NGOs involvement), Q6 (Specific stakeholder groups), Q7 (Barriers to engagement).
- **Key themes:**
    - **Variability in engagement:** While NGOs and Local Authorities are moderately to fully engaged, groups such as schools and people with lived or living experience of mental health difficulties show lower levels of involvement.
    - **Barriers highlighted:** Human resources and awareness challenges were consistently identified as barriers, potentially explaining variations in engagement levels.

2. Agency adoption and implementation fidelity

- **Questions:** Q8 (Adoption by lead agencies), Q9 (Challenges in adoption), Q14 (Barriers to fidelity), Q18 (Ongoing integration into practice).
- **Key themes:**
    - **Adoption patterns:** Adoption levels are highest among social services (e.g., Tusla, CYPSC), but areas like the justice and education sectors show more minimal or moderate adoption.
    - **Barriers to fidelity:** Limited resources and lack of capacity appear to impact both adoption and the consistent integration of *CfL* actions into practice.

3. Implementation support and leadership commitment

- **Questions:** Q11 (Support for implementation), Q20 (Leadership commitment), Q21 (Sustainability planning).
- **Key themes:**
    - **Support variations:** NOSP support meets expectations, but support from line managers and leadership is more variable, with some reporting below expectations.
    - **Leadership gaps in sustainability:** Despite reported leadership commitment, 50% of respondents noted the absence of a formal sustainability plan, signalling potential misalignment.

4. Monitoring and use of data

- **Questions:** Q15 (Monitoring tools), Q16 (Frequency of monitoring), Q17 (Use of monitoring data).
- **Key themes:**
    - **Monitoring practices:** Most respondents monitor quarterly, with systems rated as useful or very useful.
    - **Data utilisation:** Monitoring data is being used occasionally or regularly, suggesting room for more systematic use.

5. Implementation challenges and adaptations

- **Questions:** Q7 (Barriers to engagement), Q9 (Challenges in adoption), Q13 (Adaptations to CfL strategies), Q14 (Barriers to fidelity).
- **Key themes:**
    - **Consistent challenges:** Limited resources, human capacity, and competing priorities were recurrent barriers across questions.
    - **Adaptation patterns:** Most respondents reported minor adaptations to fit local contexts, suggesting a proactive but constrained approach to overcoming challenges.

6. Guidance, clarity, and consistency

- **Questions:** Q10 (Use of guidelines), Q12 (Adherence to *CfL* plan).
- **Key themes:**
    - **Mixed clarity:** Guidelines were largely seen as clear, yet adherence to the plan was only rated as "mostly followed" by 50%.

Key issues

1. Stakeholder engagement and involvement

- **Quantitative findings:**
- NGOs are well-engaged, with **50% reporting moderate involvement** and **38.89% reporting full involvement**.
- Schools and specific groups such as those bereaved by suicide show less consistent involvement, with higher levels of minimal or no engagement.
- Barriers identified include **Human Resources (88.89%)**, **Lack of awareness (66.67%)**, and **Perceived relevance (55.56%)**.
- **Open-ended responses:**
- Several NGOs are noted to be fully involved in governance structures and training. However, others remain only moderately or minimally involved.
- Specific challenges include cultural barriers, logistical issues (e.g., transportation), and competing priorities for HSE Mental Health Services.
- One respondent highlighted, *"competing priorities for HSE Mental Health Services hinder engagement"*.

2. Agency adoption and implementation fidelity

- **Quantitative findings:**
- Social Services (e.g., Tusla, CYPSC) demonstrate the highest levels of adoption, with **70.59% reporting moderate adoption** and **29.41% reporting full adoption**.
- Barriers to adoption include **Lack of leadership support (77.78%)** and **Insufficient resources (72.22%)**.
- Minor adaptations to *CfL* strategies were reported by **55.56%**, aligning with attempts to tailor actions to local needs.
- **Open-ended responses:**
- Agency adoption varies widely, with some agencies like CYPSCs and FRCs being "very supportive," while others struggle due to the lack of mandates or dependencies on national-level decisions.

- Examples of adaptations include restructuring implementation groups to smaller, task-focused teams and aligning local engagement efforts with *CfL* actions.
- Barriers to fidelity include *"resistance to change and lack of capacity"* and *"inconsistent leadership"*.

3. Implementation support and leadership commitment

- **Quantitative findings:**
- NOSP support was rated "as expected" by **83.33%** of respondents, but line manager support was more variable, with **33.33% noting support exceeded expectations** and **27.78% noting it was below expectations**.
- Leadership commitment was evenly split between "very committed" (**44.44%**) and "somewhat committed" (**44.44%**), with **50% reporting no sustainability plan**.
- **Open-ended responses:**
- Several respondents noted the lack of clear leadership commitments and administrative support as major challenges.
- Sustainability opportunities include embedding *CfL* actions into routine practices and leveraging strong partnerships built through *CfL* initiatives.

4. Monitoring and use of data

- **Quantitative findings:**
- Monitoring systems were rated as "useful" (**44.44%**) or "very useful" (**33.33%**), and **77.78% of respondents** reported quarterly reviews of progress.
- Data usage was relatively high, with **38.89% reporting regular use** and an equal proportion reporting occasional use.
- **Open-ended responses:**
- A key limitation identified was the absence of a suicide surveillance system, which hampers the ability to address clusters or trends.
- Respondents emphasised the importance of clear monitoring and reporting systems to support implementation.

5. Challenges and opportunities for sustainability

- **Quantitative findings:**
- Primary challenges to sustainability include **Limited resources (83.33%)** and **Lack of capacity (77.78%)**.
- Opportunities include strong partnerships and embedding *CfL* actions into *"business as usual"* practices.

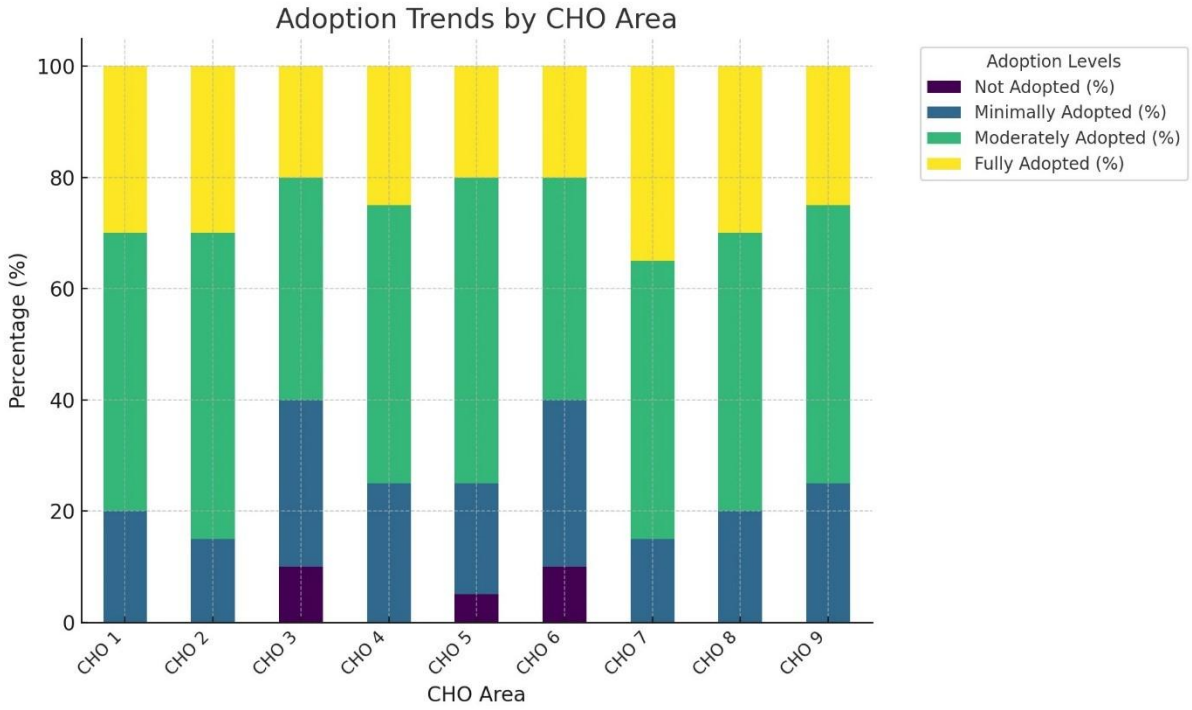
- **Open-ended responses:**
  - Challenges include long-term funding gaps, lack of administrative support, and leadership inconsistencies.
  - Opportunities include leveraging multi-agency collaborations and integrating *CfL* actions into routine workflows.
  - One respondent noted, *"embedding CfL actions into 'business as usual' practices has proven effective".*

6. Lessons learned and suggestions for improvement

- **Open-ended responses:**
  - Lessons learned emphasise the importance of relationship building, smaller task-focused groups, and clear monitoring systems.
  - Suggestions for improvement include increased awareness of suicide prevention supports, simplifying action plans, and investing in administrative support.

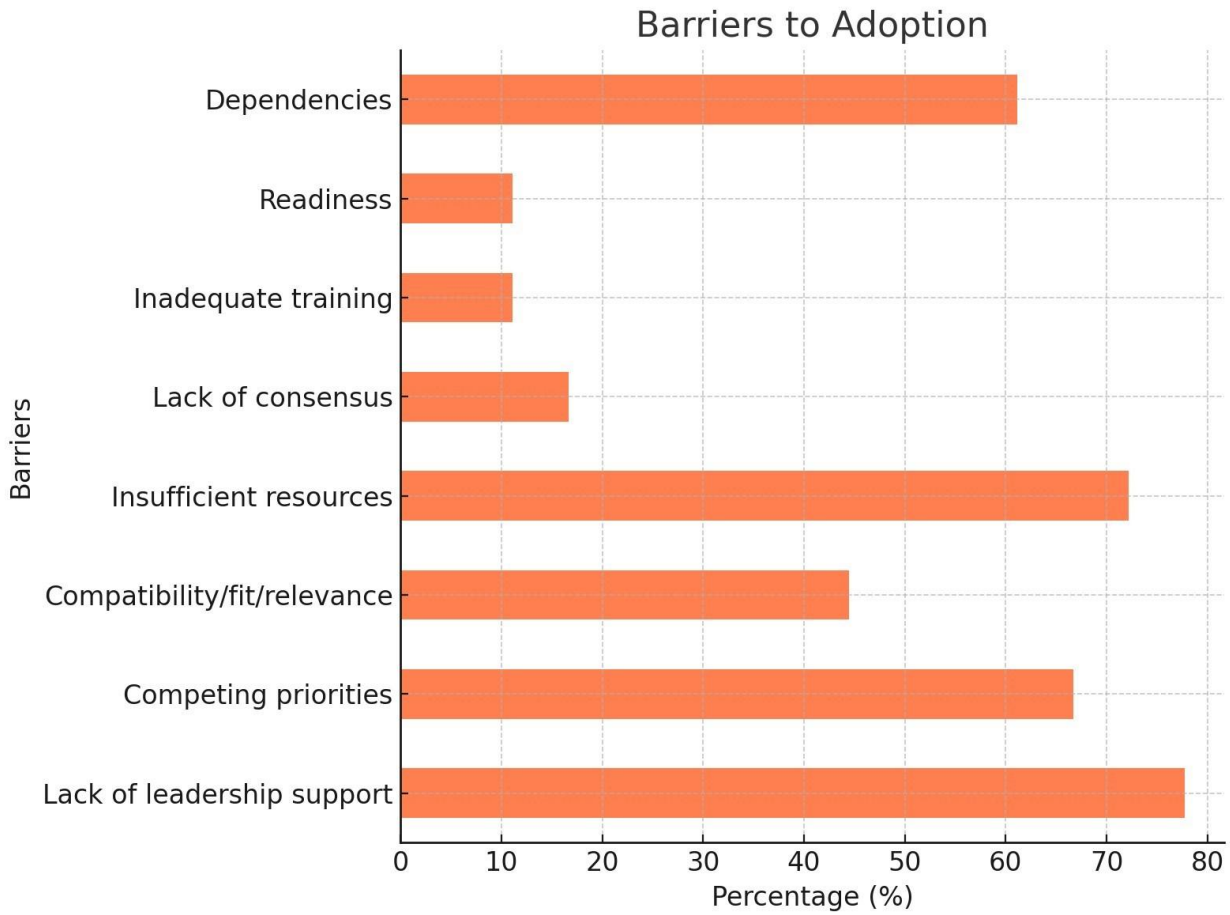
7. Key priorities post-*CfL*

- **Open-ended responses:**
  - Priorities include building community awareness, creating a digital hub for *CfL* resources, and enhancing postvention supports.
  - Respondents highlighted the importance of sustaining suicide prevention initiatives beyond *CfL*'s current framework.



Adoption trends: The chart visualises adoption trends across CHO areas, displaying the percentage of actions categorised as "Not Adopted," "Minimally Adopted," "Moderately Adopted," and "Fully Adopted" within each CHO. It highlights variability in adoption levels, with some CHOs showing higher percentages of full adoption while others lean more heavily towards moderate or minimal adoption.

Stakeholder engagement levels: This stacked bar chart shows the distribution of engagement levels across various stakeholders (e.g., Local Authorities, NGOs). It highlights differences in involvement, with NGOs and FRCs showing higher levels of full or moderate engagement compared to schools.



Barriers to adoption: This horizontal bar chart highlights the most significant barriers to adoption, with lack of leadership support, insufficient resources, and competing priorities being the most common challenges.

Sustainability challenges: This horizontal bar chart outlines the key challenges to sustaining *CfL* initiatives, with limited resources and lack of capacity as the most prominent issues.

Appendix E: Evidence of progress on intermediate outcomes provided by NOSP

Strategic Goal 1 To improve the nations understanding of, & attitude to suicide, mental health and wellbeing.		
Intermediate Outcomes (IOs)	**Indicator**	**Bibliography**
IO1.1 Improved population-wide understanding of suicidal behaviour, mental health & wellbeing, and associated protective & risk factors.	**Understanding of protective & risk factors for suicide & self-harm**	**Griffin, E., Arensman, E., Perry, I. J., et al.** (n.d.). Suicide risk following hospital attendance with self-harm: A national cohort study in Ireland. *[Journal title, if published]*. Retrieved from https://www.drugsandalcohol.ie/41273/ **Health Service Executive (HSE) National Office for Suicide Prevention (NOSP).** (2020). *Collaborative research grant scheme: Insights into suicidality in CfL priority groups*. Retrieved from https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/grant-scheme-for-collaborative-research-projects.html **Higgins, A., et al.** (2016). *LGBTIreland study: Mental health and wellbeing of LGBTQI+ people in Ireland*. Dublin: GLEN and BeLonG To. Retrieved from https://beinglgbtqi.ie/ **National Suicide Research Foundation (NSRF).** (2023). *Risk and protective factors for self-harm in adolescents and young adults: An umbrella review of systematic reviews*. *Journal of Psychiatric Research, 168*, 353–380. https://doi.org/10.1016/j.jpsychires.2023.10.017 **National Suicide Research Foundation (NSRF).** (2024). *Social determinants of suicide: An umbrella review*. Retrieved from https://www.nsrf.ie/ https://www.medrxiv.org/content/10.1101/2024.08.09.24311718v2 **National Suicide Research Foundation (NSRF).** (n.d.). *Advancing early detection of suicide? A national study examining socio-demographic factors, antecedent stressors and long-term history of self-harm*. Retrieved from https://www.nsrf.ie/ **National Suicide Research Foundation (NSRF).** (n.d.). *Probable suicide among men in farming- and agricultural-related occupations in the Republic of Ireland: Exploring coronial data*. *Journal of Agromedicine*. (Under review) **Planet Youth Ireland, National University of Ireland Galway, National Suicide Research Foundation, & Health Research Board.** (2022). *Informing youth suicide prevention and mental health promotion through secondary analysis of the Planet Youth datasets* [Research project]. Retrieved from https://www.universityofgalway.ie/ **Silke, C., McMahon, J., O'Connor, C., & Dooley, B.** (2024). Examining the relationship between adversity and suicidality and self-harm in Irish adolescents from 2020 to 2022. *Journal of Affective Disorders, 349*, 234–243. https://www.sciencedirect.com/science/article/abs/pii/S0165032723015355?via%3Dihub **Silke, C., O'Connor, C., & McMahon, J.** (2024). *Adolescent mental health & adversity: Profiles & trends in the West of Ireland from 2018–2022*. National University of Ireland Galway. Retrieved from https://www.universityofgalway.ie/

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IO1.3 Reduced stigmatising attitudes to mental health and suicidal behaviour at population level and within priority groups.		**Barry, M. M., & Villani, J.** (2021). *A qualitative study of the perceptions of mental health among the Traveller community in Ireland*. Health Promotion International, 36(5), 1450–1462. https://doi.org/10.1093/heapro/daab009 **Department of Children, Equality, Disability, Integration and Youth.** (2023, September 12). *LGBTI+ people living in International Protection Accommodation Services (IPAS) accommodation: Best practices & lived experiences*. https://www.gov.ie/en/department-of-children-equality-disability-integration-and-youth/publications/lgbti-people-living-in-international-protection-accommodation-services-ipas-accommodation-best-practices-lived-experiences/ **Department of Children, Equality, Disability, Integration and Youth.** (2023, September 12). *Minister O'Gorman launches new report on LGBTI+ people living in International Protection accommodation*. https://www.gov.ie/en/press-release/58de8-minister-ogorman-launches-new-report-on-lgbti-people-living-in-international-protection-accommodation/ **Higgins, A., Downes, C., O'Sullivan, K., de Vries, J., Molloy, R., Monahan, M., Keogh, B., Doyle, L., Begley, T., & Corcoran, P.** (2024). *Being LGBTQI+ in Ireland: The national study on the mental health and wellbeing of the LGBTQI+ communities in Ireland*. Trinity College Dublin. https://beinglgbtqi.ie/ **Men's Health Forum in Ireland (MHFI).** (2018). *Middle-aged men and suicide in Ireland*. National Centre for Men's Health, IT Carlow. Retrieved from https://mhfi.org/news/820-launch-of-middle-aged-men-and-suicide-in-ireland-report.html

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IO1.4 Engagement with media in relation to media guidelines, tools and training programmes & improvement in the reporting of suicidal behaviour within broadcasting, print & online media.	**Poor reporting (does not adhere to guidelines)** **Positive reporting (adherence to guidelines)**	Department of Health. (2024, September 12). *Minister Butler addresses Promoting Safe and Sensitive Media Reporting of Suicide and Self-harm Conference in Dublin*. https://www.gov.ie/en/press-release/78b71-minister-butler-addresses-promoting-safe-and-sensitive-media-reporting-of-suicide-and-self-harm-conference-in-dublin/ Department of Health. (2024, September 10). *Minister Mary Butler marks World Suicide Prevention Day 2024*. https://www.gov.ie/en/press-release/a5f83-minister-mary-butler-marks-world-suicide-prevention-day-2024/ HSE National Office for Suicide Prevention (NOSP). (2023, September 12). *The Harmful Impact of Online Content – a Literature Review*. https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/the-harmful-impact-of-online-content-a-literature-review.html Samaritans Ireland. (2021, February 23). *Media Guidelines for Reporting Suicide*. https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/samaritans-ireland-media-guidelines-for-reporting-suicide.html Shine. (2024, April 17). *Winners of the 2024 Mental Health Media Awards announced*. https://www.shine.ie/blog/winners-of-the-2024-mental-health-media-awards-announced Shine. (n.d.). *Headline – Ireland's national programme for responsible reporting and representation of mental ill health*. https://headline.ie/

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IO2.2 Accurate information & guidance on effective suicide prevention are provided for community-based organisations (e.g. Family Resource Centres, Sports Organisations).	**Community organisations access to, & substantive knowledge on guidelines, protocols & training on effective suicide prevention interventions**	Health Service Executive (HSE) National Office for Suicide Prevention (NOSP). (2021, September 15). *Developing a community response to suicide*. Health Service Executive. Retrieved from https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/community-response-to-suicide.pdf Health Service Executive (HSE) National Office for Suicide Prevention (NOSP). (2023, April 17). *Suicide prevention in the community: Connecting, communicating, caring – A practical guide*. Health Service Executive. Retrieved from https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/suicide-prevention-in-the-community.pdf Health Service Executive (HSE) National Office for Suicide Prevention (NOSP). (2024, May 29). *Responding to a person in suicidal distress: A guidance document*. Health Service Executive. Retrieved from https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/responding-to-a-person-in-suicidal-distress-2024.pdf

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Strategic Goal 6. To reduce and restrict access to means of suicide		
Intermediate Outcomes (IOs)	**Indicators**	**Bibliography**
IO6.1 Reduced access to frequently used drugs in international drug overdose	**Potentially risky prescribing practices (including number of tables provided in a single prescription, repeat prescriptions without review, failure to switch to lower lethality medication where available)**	**National Suicide Research Foundation**. (n.d.). *Working group: Preventing paracetamol-related intentional drug overdose*. https://www.nsrf.ie/strategic-research-clusters/restricting-access-to-lethal-means/working-group-preventing-paracetamol-related-intention-drug-overdose/ **Daly, C., Griffin, E., McMahon, E., Corcoran, P., Webb, R. T., Witt, K., Ashcroft, D. M., & Arensman, E**. (2020). Repeat self-harm following hospital-presenting intentional drug overdose among young people—a national registry study. *International Journal of Environmental Research and Public Health, 17*(17), 6159–6175. https://doi.org/10.3390/ijerph17176159 **Daly, C., Griffin, E., McMahon, E., Corcoran, P., Webb, R. T., Ashcroft, D. M., & Arensman, E**. (2021). Paracetamol-related intentional drug overdose among young people: A national registry study of characteristics, incidence and trends, 2007–2018. *Society and Psychiatry and Psychiatric Epidemiology, 56*(5), 773–781. https://doi.org/10.1007/s00127-020-01981-y **Birchall, E., Perry, I. J., Corcoran, P., Daly, C., & Griffin, E**. (2021). The impact of guidance on the supply of codeine-containing products on their use in intentional drug overdose. *European Journal of Public Health, 31*(4), 853–858. https://doi.org/10.1093/eurpub/ckab082 **Daly, C., Griffin, E., Corcoran, P., Webb, R. T., Ashcroft, D. M., Perry, I. J., & Arensman, E**. (2020). A national case fatality study of drugs taken in intentional drug overdose. *International Journal of Drug Policy, 76*, 102609. https://www.drugsandalcohol.ie/31526/ **National Suicide Research Foundation**. (2023). *Prescription drugs with potential for misuse: Protocol for a multi-indicator analysis of supply detection and the associated health burden in Ireland between 2010 and 2020*. https://bmjopen.bmj.com/content/13/3/e069665.long **Health Research Board**. (2023). *RESTRICT – Reducing intentional overdose: A mixed methods study of means restriction interventions* [Grant awarded to C. Daly]. https://www.ucc.ie/en/news/2023/hrb-invests-19-million-in-ucc-research-to-address-emerging-health-challenges.html **Multiagency Working Group on Over Prescribing**. (2025). *Examining the overprescribing of benzodiazepines, z drugs and gabapentinoids in Ireland* [Report]. Medical Council. https://www.drugsandalcohol.ie/42740/

<table>
<tr><td rowspan="2">IO6.2 Reduced access to highly lethal methods used in suicidal behaviour</td><td>Suicide-proofing of locations of concern</td><td>Health Service Executive National Office for Suicide Prevention. (2025). Preventing suicide in public places: A best practice toolkit. https://www.hse.ie/eng/services/list/4/mental-health-services/nosp/resources/preventing-suicide-public-places.pdf</td></tr>
<tr><td>Reduced number (proportions) of suicide deaths by highly lethal methods</td><td>There is conflicting evidence regarding reductions in the number of suicide deaths by highly lethal methods. Note the data are lagged.
• CSO data shows % of deaths by method & gender
<table><tr><th></th><th>2016</th><th>2017</th><th>2018</th><th>2019</th><th>2020</th></tr><tr><td>Male poisoning deaths</td><td>60%</td><td>69%</td><td>74%</td><td>41%</td><td>64%</td></tr><tr><td>Female poisoning deaths</td><td>40%</td><td>31%</td><td>26%</td><td>59%</td><td>36%</td></tr><tr><td>Male hanging deaths</td><td>83%</td><td>82%</td><td>78%</td><td>78%</td><td>80%</td></tr><tr><td>Female hanging deaths</td><td>17%</td><td>18%</td><td>22%</td><td>22%</td><td>20%</td></tr></table>Source: Central Statistics Office
• IPSDS data shows % of deaths by method & gender
<table><tr><th></th><th>2015</th><th>2016</th><th>2017</th><th>2018</th><th>2019</th><th>2020</th></tr><tr><td>Male poisoning deaths</td><td>61%</td><td>57%</td><td>67%</td><td>41%</td><td>59%</td><td>50%</td></tr><tr><td>Female poisoning deaths</td><td>39%</td><td>43%</td><td>33%</td><td>59%</td><td>41%</td><td>50%</td></tr><tr><td>Male hanging deaths</td><td>82%</td><td>81%</td><td>78%</td><td>79%</td><td>79%</td><td>72%</td></tr><tr><td>Female hanging deaths</td><td>18%</td><td>19%</td><td>22%</td><td>21%</td><td>21%</td><td>28%</td></tr></table>Sources: HSE NOSP- IPSDS

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</table>

Strategic Goal 7 - To improve surveillance, evaluation & high-quality research relating to suicidal behaviour		
Intermediate Outcomes	**Indicators**	**Bibliography**
IO7.1 Improve access to timely & high-quality data on suicidal behaviour	**Availability & timeliness of key data on suicide & self-harm** **Effectiveness & timeliness of dissemination of key data on suicide & self-harm**	Department of Health. (2023). *Healthy Ireland Survey, 2021* [Dataset]. Version 1. Irish Social Science Data Archive. https://hse.aws.openrepository.com/bitstream/handle/10147/630778/206555_260f3b84-bf78-41a2-91d7-f14c7c03d99f.pdf?sequence=1&isAllowed=y Ipsos B&A. (2023). *Healthy Ireland survey 2023 – Summary report*. Department of Health. https://www.drugsandalcohol.ie/39977/ *National Self-Harm Registry Ireland: Annual reports and publications*. Retrieved from https://www.nsrf.ie/self-harm-registry/registry-reports-and-publications/ National Suicide Research Foundation. (n.d.). *Journal articles*. https://www.nsrf.ie/registry/journal-articles/ National Suicide Research Foundation. (2021). *CHO Area 1 self-harm data 2021*. https://www.nsrf.ie/wp-content/uploads/2021/04/CHO_1_2021_FINAL1.pdf Troya, M. I., Corcoran, P., Arensman, E., & Kavalidou, K. (2024). Patterns of hospital presenting suicide-related ideation in older adults before and during COVID-19: Findings from a national clinical service in Ireland 2018–2021. *Archives of Suicide Research, 28*(4), 1368–1379. https://doi.org/10.1080/13811118.2024.2307882 Wilson, M., Byrne, S. J., Fisher, K., Seidler, Z. E., & Kavalidou, K. (2023, October 4). Profiling 22,151 male presentations to emergency departments for suicidal ideation or self-harm in Ireland. *Preprint*. https://osf.io/preprints/psyarxiv/64qkc_v1 Kavalidou, K., Zortea, T. C., Griffin, E., & Troya, M. I. (2023). Profile of people attending emergency departments with thoughts of self-harm and suicide: A descriptive study of a nurse-led programme in Ireland. *International Journal of Mental Health Nursing, 32*(4), 1102–1111. https://doi.org/10.1111/inm.13146 Kavalidou, K., Daly, C., McTernan, N., & Corcoran, P. (2023). Presentations of self-harm and suicide-related ideation among the Irish Traveller indigenous population to hospital emergency departments: Evidence from the National Clinical Programme for self-harm. *Social Psychiatry and Psychiatric Epidemiology, 58*(6), 883–891. https://doi.org/10.1007/s00127-023-02439-7 Maguire, E., Kavalidou, K., Bannan, N., Doherty, A., & Jeffers, A. (2023). Substance use and self-harm emergency department presentations during COVID-19: Evidence from a National Clinical Programme for Self-Harm. *Irish Journal of Psychological Medicine, 40*(3), 424–429. https://doi.org/10.1017/ipm.2022.36 Suicide Mortality data: The CSO-Suicide Mortality Statistics Liaison Group Cox, G., Munnelly, A., Rochford, S., & Kavalidou, K. (2022). *Irish probable suicide deaths study (IPSDS) 2015–2018*. Health Service Executive.

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IO7.2 Current recording procedures	**Review of current**	O'Toole, R. (2024). *Impact of changes in burden of proof on recorded rate of suicide in Ireland*. HUGG. https://www.drugsandalcohol.ie/41576/

for suicide deaths in Ireland reviewed (and if necessary revised)	**recording procedures**	
IO7.3 Development of national plan that supports research innovation aimed at early identification of suicide risk, assessment intervention& prevention	**National Plan supporting research & innovation**	Health Service Executive. (2021). *Grant scheme for collaborative research projects: Book of abstracts, 2021 and 2022*. National Office for Suicide Prevention. https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/research-grant-scheme-abstracts.pdf McLoughlin, A., Sadath, A., McMahon, E., Kavalidou, K., & Malone, K. (2022). Associations between humiliation, shame, self-harm and suicidal behaviours among adolescents and young adults: A systematic review protocol. *PLOS ONE, 17*(11), e0278122. https://doi.org/10.1371/journal.pone.0278122
	Commissioning of evaluation studies	Health Service Executive. (2021). *Review of Connecting for Life research*. National Office for Suicide Prevention. https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/review-of-connecting-for-life-research.html National Office for Suicide Prevention. (2019). *Connecting for Life interim strategy review*. National Office for Suicide Prevention. https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/connecting-for-life-interim-strategy-review.pdf
	(iii) Successful implementation of evaluation studies	Since the Interim Strategy Review the following evaluation has been commissioned and managed by NOSP; Health Service Executive. (2020). *Rapid assessment and community response to suicide and suspected suicide in Dublin South: Executive summary*. National Office for Suicide Prevention. https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/rapid-assessment-summary.pdf
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CES Dublin Office

27 Fitzwilliam Street Upper,

Dublin 2,

D02 TP23

office@effectiveservices.org

CES Belfast Office

9a James Street South,

Belfast,

BT2 8DN

nioffice@effectiveservices.org

www.effectiveservices.org

LinkedIn | YouTube | Twitter

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