The Evaluation of Connecting for Life:

A review of strategies and best practices

Compiled by the HSE National Office for Suicide Prevention (NOSP)

Based on the Evaluation of the Implementation and Intermediate Outcomes of Connecting for Life, Ireland's National Strategy to Reduce Suicide (Centre for Effective Services, 2025)

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1. Introduction

A national suicide prevention strategy provides a systematic framework for developing a comprehensive and integrated response to suicidal behaviour. It establishes the structural foundation necessary to support effective suicide prevention actions and ongoing evaluation (Platt, Arensman, & Rezaeian, 2019). For such a strategy to be impactful, it must incorporate a suite of evidence-based initiatives (United Nations, 1996). However, the success of any strategy ultimately depends on its implementation. Strategy implementation is not a linear process; rather, it is a dynamic, iterative, and complex endeavour, involving a range of activities by managers and employees to translate strategic plans into tangible outcomes and achieve strategic objectives (Yang et al., 2010, as cited in Tawse & Tabesh, 2021).

This literature review was conducted as part of the CES evaluation of the implementation and intermediate outcomes of Connecting for Life (CfL), Ireland's national suicide prevention strategy. It is presented in two parts:

A. Review of Evidence-Based Suicide Prevention Strategies

This section provides a focused update on best practices in suicide prevention, drawing on systematic reviews and meta-analyses published since the Health Research Board's (HRB) 2015 review, which informed the development of CfL (Dillon, et al., 2015). The scope is intentionally narrow, concentrating on high-quality evidence from relevant and comparable clinical contexts.

B. Rapid Review of Best Practice in Strategy Design and Implementation

The second section presents a narrative synthesis of findings from a rapid review of best practices in the design and implementation of suicide prevention strategies.

This review is being used to inform both the evaluation of CfL's implementation and intermediate outcomes, and the development of the next iteration of suicide prevention efforts in Ireland.

2. Review of 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[1]. The review concluded that the suicide prevention interventions with the strongest evidence base included restricting access to means and psychosocial interventions, such as Cognitive Behaviour Therapy (CBT) and Dialectical Behaviour Therapy (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, the current literature search, carried out as part of the overall evaluation of Connecting for Life, set out to identify relevant updates to the evidence-based studies published between 2015 and 2024. Consequently the scope of the review is intentionally narrow. Table 2.1 provides a brief description of the evidence-based suicide prevention interventions presented in this review, and the corresponding CfL action. Appendix A sets out the methodology for the literature search in more detail.

Figure 2.1 illustrates the quantity of articles retrieved in the literature search under each of the evidence-based suicide prevention intervention headings outlined in Table 1. 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) of 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

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

health treatment (n =6); training (n=4); community-based interventions (n=3); crisis intervention (n=3); and media guidelines (n=2). Articles that contain information on more than one intervention were categorised as 'multiple interventions' (n=10); Figure 2.2 shows the evidence-based interventions referred to in articles categorised as containing multiple interventions.

Table 2.1: 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.	Strategic Goal 6 - all actions
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 (including school-based interventions)	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, (including coping skills, problem-solving skills)	Examples include interventions such as CBT and DBT which are effective in enhancing coping skills and emotional regulation, and 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. Strategies to reduce stigma can include social contact, education, public awareness which may overlap with media guidelines and training strategies.	Actions 1.3.1

Figure 2.1 Categorisation of articles identified in the literature search

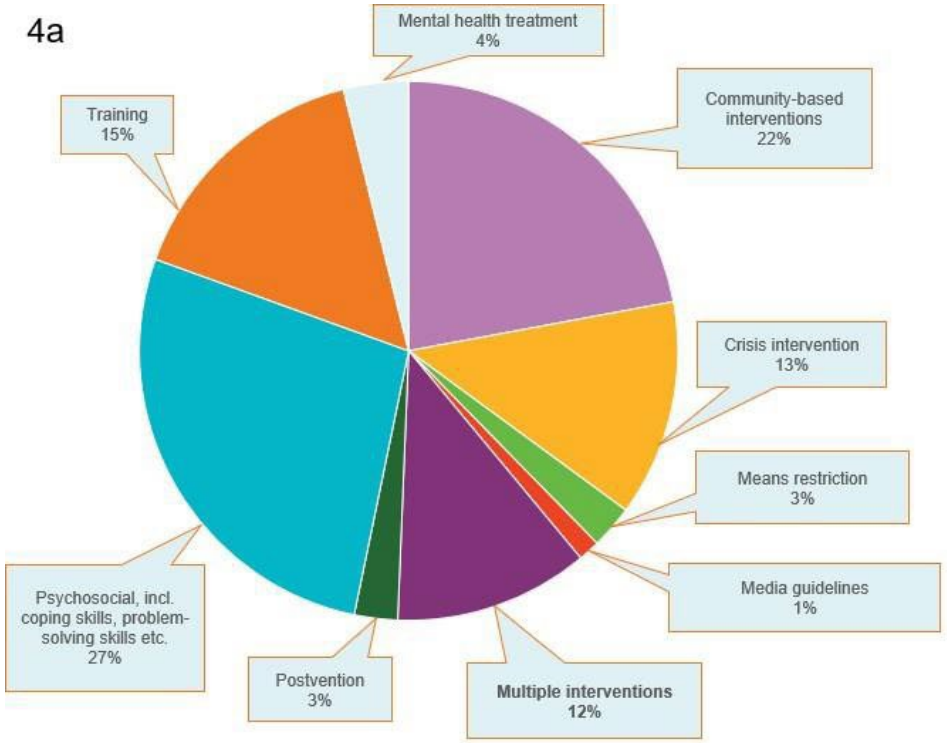
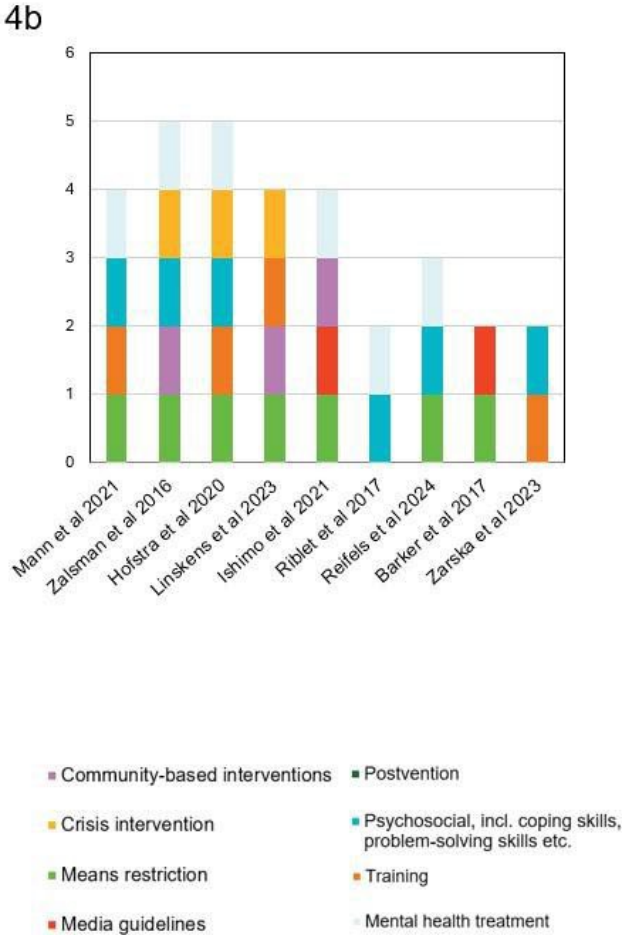


Figure 2.2 Evidence-based suicide prevention interventions referred to in articles categorised as containing multiple inter tions



Findings of the evidence review

This section presents a synthesis of evidence on the range of suicide prevention interventions reviewed. The interventions span individual, community, and systemic levels, reflecting the multifaceted nature of suicide prevention. Evidence is presented across key domains including means restriction, media guidelines, postvention, training, psychosocial and crisis interventions, mental health treatment, and stigma reduction. While some approaches demonstrate consistent effectiveness, others show promise but require further investigation to establish their impact and sustainability. The following subsections summarise the current state of evidence for each intervention type.

2.1 Means restriction

There is consistent evidence supporting the effectiveness of restricting access to lethal means as an effective suicide prevention intervention. More specifically findings support the restriction of access to poisons as a means of reducing suicide (Lim, et al., 2021). There is also 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, et al 2024).

2.2 Media guidelines

Media reporting plays a significant role in shaping public perceptions of suicide. Niederkrotenthaler et al. (2022) found that exposure to media stories focused on hope and recovery was associated with a small decrease in suicidal ideation among intervention groups. Their findings suggest that positive narratives can contribute to suicide prevention (the Papageno Effect) and support the development of media guidelines that promote responsible reporting of suicide-related content.

2.3 Postvention

Linde et al. (2017) 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. Andriessen et al. (2019) report some evidence for the effectiveness of general interventions for

uncomplicated grief and a gap in the literature with regards to complicated grief. Linde et al. (2017) highlight the unique challenges faced by the suicide bereaved, such as feelings of guilt, shame, and stigmatisation, which can complicate the grieving process and increase the risk of developing complicated grief. This paper underscore the need for tailored interventions to address the specific needs of those bereaved by suicide and for more robust evaluation research in the area.

2.4 Training

Twelve studies focused on training interventions across healthcare, education and community settings. These included training for nurses (Richard, et al., 2023; Dabkowski & Porter, 2021; Ferguson, et al., 2018; Ferguson, et al., 2020), GPs (Milner, et al., 2017), healthcare settings (Dillon, et al., 2020), educators (Pistone, et al., 2019), as well as gatekeeper training (Holmes, et al., 2021; Morton, et al., 2021; Nasir, et al., 2016; Yonemoto, et al., 2019; Torok, et al., 2019). A recent NOSP commissioned 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 this 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.

2.5 Psychosocial intervention

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 Cognitive Behaviour Therapy (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 Dialectical Behaviour Therapy (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, et al 2023).

2.6 Crisis intervention

Evidence for crisis interventions is mixed. Balasa, et al., (2023) found no significant impact of emergency department-based youth interventions on suicide attempts or ideation. However, telehealth platforms have shown promise in reducing suicidal thoughts and behaviours (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, et al., 2022; Marshall, et al., 2023). Caring Contacts and follow-up communications were also shown to have a protective effect against suicide attempts (Katsivarda, et al., 2021; Skopp, et al., 2023).

2.7 Mental health treatment

Findings in this area are also mixed. Evidence supports the effectiveness of Collaborative Assessment and Management of Suicidality (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). Brief Contact Interventions (BCIs), particularly those extending beyond 12 months, are associated with reduced risk of suicide re-attempts (Azizi et al., 2023). Focusing on Substance Use Disorder, Padmanathan et al. (2020) reported limited evidence for interventions targeting individuals with substance use disorders.

2.8 Stigma reduction

While none of the reviewed studies focused exclusively on stigma reduction, elements of stigma were addressed within broader training and community-based interventions. The evidence suggests that stigma reduction may be a secondary benefit of other strategies, but dedicated research is needed to evaluate its direct impact on suicide prevention. Oexle and colleagues have distinguished between attitudes toward individuals affected by suicidality (suicide stigma) and attitudes toward the act of suicide itself (suicide normalisation) and suggested that future research should identify strategies to improve attitudes towards persons affected by suicidality that avoid normalisation (Oexle et al., 2022).

2.9 Multicomponent interventions

Evidence increasingly supports the effectiveness of integrated multicomponent approaches to suicide prevention. In a number of the multicomponent studies reviewed restricting access to lethal means, such as firearms, pesticides, and physical barriers, consistently emerges as one of the most effective strategies for reducing suicide rates (Zalsman et al., 2016; Ishimo et al., 2021; Barker et al., 2017; Linskens et al., 2023). While in clinical settings, training for emergency department providers, safety planning, and follow-up contact have demonstrated benefits in reducing repeat suicide attempts (Zarska et al., 2023). Similarly, the WHO's brief intervention and contact programme has shown significant impact (Riblet et al., 2017), while other clinical approaches like CBT have yielded less consistent results. School-based programmes, particularly those focused on awareness and social-emotional learning, appear to be effective in reducing suicidal ideation and attempts among adolescents (Zalsman et al., 2016; Sultan et al., 2021). However, their impact on actual suicide deaths remains uncertain. Despite the promise of some interventions, others, such as gatekeeper training, public awareness campaigns, crisis hotlines, and media guidelines, show inconsistent or insufficient evidence across studies (Mann et al., 2021; Linskens et al., 2023; Sultan et al., 2021). This underscores the need for further research, particularly in challenging contexts like disasters and public health emergencies (Reifels et al., 2024). Appendix B provides a summary of each of the relevant papers reviewed. Overall, the evidence suggests that suicide prevention is most effective when it is comprehensive, context-sensitive, and evidence-informed, with a strong emphasis on reducing access to means as part of a multifaceted approach integrating interventions across multiple sectors.

2.10 Community-based interventions for at-risk groups

Suicide risk is shaped by a complex interplay of individual, social, cultural, and structural factors. As such, interventions must be tailored to the specific needs, contexts, and lived experiences of different communities. This includes ensuring cultural appropriateness, engaging with lived experience, and adopting multi-level, multi-sectoral approaches that reflect the realities of those most at risk. Many promising interventions have been developed for specific population groups, such as Indigenous communities, occupational groups, older adults, students, and young people in care, but the effectiveness of these programmes often depends on how well they are adapted to context, delivered with fidelity, and supported by robust evaluation frameworks. The following section synthesises findings from recent reviews on studies that explore suicide prevention interventions across a range of community and institutional settings. It highlights the importance of

culturally sensitive design, the role of lived experience, and the need for continued research and evaluation to strengthen the evidence base and guide future strategy development.

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 experience mentoring, and tailoring programmes to effectively reach the targeted audience (Dabkowski, et al 2022). Leske et al., 2020 state that the limited evidence available for Indigenous communities supports the use of multi-level, multi-sectoral interventions.

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. However 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, et al 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, et al 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, et al 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 are yet to be determined (Witt, et al., 2019).

Older people

One review reports no effect of interventions to reduce suicidal behaviour and ideation (Chauliac, et al, 2020) while another reports some effective interventions for older people but highlights the need for more research (Okolie, et al 2017).

School and university communities

Gijzen, et al., (2022) suggest that while school-based programmes have small but significant effects on 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 et al., (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 et al, (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, et al, (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, et al 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, et al, 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[2] (Pedrola-Pons, et al 2024).

In summary the findings from this review broadly align with earlier evidence syntheses conducted prior to the publication of the Connecting for Life (CfL) strategy (Dillon et al., 2015; Tye et al., 2015). Table 2.2 provides a summary of the evidence for key suicide prevention strategies. Consistent with these earlier reviews, evidence supporting means restriction remains the strongest among suicide prevention strategies, while psychosocial interventions continue to show promise. However, evidence for other approaches remains mixed, and it is often difficult to attribute changes in suicide rates or suicidal behaviour to specific interventions.

[2] Third generation therapies refer to a group of psychological treatments that build upon behavioral therapy by emphasising mindfulness, acceptance, and context, rather than solely focusing on changing negative thoughts.

Table 2.2 Summary of evidence for key suicide prevention strategies

Intervention Area	Effectiveness	Evidence Summary
Restricting Access to Lethal Means	✓✓ Strong Evidence	Consistently shown to reduce suicide rates (e.g., firearms, pesticides, barriers).
Multi-Level & Integrated Approaches	✓✓ Strong Evidence	More effective than single interventions; especially recommended for Indigenous communities.
Mental Health Treatment	✓✓ Strong Evidence	Access to timely, quality care is critical; shown to reduce suicide risk.
Clinical Interventions (Safety Planning, Follow-up)	○ Moderate Evidence	Effective in reducing repeat attempts; some variability across settings.
Psychosocial Interventions (e.g., coping skills, problem-solving)	○ Moderate Evidence	Promising results in building resilience and reducing suicidal ideation.
School-Based Programmes	○ Moderate Evidence	Small but significant effects; Reduce ideation and attempts; impact on suicide deaths remains uncertain; more research needed.
University-Based Programmes	○ Moderate Evidence	Targeted interventions show promise; universal programmes need further evaluation.
Stigma Reduction	○ Moderate Evidence	Can improve help-seeking and reduces isolation; culturally tailored approaches important; evidence is growing but still
Postvention (support after suicide)	○ Moderate Evidence	Helps reduce suicide risk among the bereaved; increasingly recognised as essential.
Indigenous Communities	○ Moderate Evidence	Culturally tailored, community-based, multi-level interventions show promise.
Occupational Groups (e.g., police, military, construction)	○ Moderate Evidence	Some tailored programmes show benefit; formal evaluation and research still needed.
Young People in Care	○ Moderate Evidence	Youth-focused therapies reduce ideation; adult-focused gatekeeper training improves knowledge.
Gatekeeper Training	✗ Inconsistent Evidence	Mixed results; some promise in occupational settings but overall evidence is limited; further research needed to confirm effectiveness.
Public Awareness Campaigns	✗ Inconsistent	Limited and variable impact; not consistently

	Evidence	linked to reduced suicide rates.
Crisis Hotlines	✗ Inconsistent Evidence	Widely used but evidence of effectiveness is mixed.
Media Guidelines	✗ Inconsistent Evidence	Some positive outcomes, but overall evidence is limited.
Older People	✗ Inconsistent Evidence	Mixed findings; some interventions show promise but overall evidence is limited.

3. Review of Best Practice in Strategy Design and Implementation

A national suicide prevention strategy establishes a structured framework for creating a coordinated and comprehensive approach to addressing suicidal behaviour. It serves as the foundational infrastructure that enables effective prevention efforts and continuous evaluation (Platt, et al 2019). As illustrated, to be effective, such a strategy must incorporate a suite of evidence-based suicide prevention initiatives (United Nations, 1996). However, success depends not only on the strategy's design but also on its implementation. In this context, implementation is understood as a "dynamic, iterative, and complex process" involving a range of activities by managers and employees to translate strategic plans into reality and achieve strategic objectives (Yang et al., 2010, as cited in Tawse & Tabesh, 2021). This section summarises the literature on best practice in suicide prevention strategy design and implementation. Many of the elements identified as best practice are reflected in the Connecting for Life (CfL) strategy, which adopts a multi-component systems approach and a cross-sectoral strategic framework. These elements will be central to the development of the next phase of suicide prevention work in Ireland.

Findings of the rapid review

3.1 Multi-component systems approach

Evidence suggests that single interventions aimed at reducing suicide rates have limited impact due to the complexity of suicidal behaviour (United Nations, 1996). As seen in the previous section (2.2.9), current evidence supports the use of multiple, simultaneous interventions implemented across various levels, such as healthcare settings, community domains, and by diverse providers, and tailored to local contexts (Hofstra et al., 2020). This multi-component systems approach integrates preventative interventions usually targeting: individuals at risk, professionals responding to suicidal crises and the wider community. These multi-component interventions are implemented concurrently within a defined geographic area (Baker, et al., 2018). Therefore, effective implementation requires multi-stakeholder teams operating at local, regional, or national levels to coordinate and sustain efforts. Theoretically, such approaches have synergistic potential, meaning the combined effect of multiple interventions may exceed the sum of their individual impacts (Hofstra et al., 2020). Empirical evidence supports the effectiveness of multi-component strategies, with multi-level interventions shown to outperform single-level ones. Moreover, the effect size increases with the number of levels involved. However, while findings on synergistic effects are promising, they remain tentative due to the limited number of studies involving multi-level designs.

3.2 Cross sectoral collaborative working

Central to the multi-component systems approach to suicide prevention is cross-sectoral action; that is interventions that occur both within and beyond the health sector but influence health outcomes (Pirkis et al., 2023). This approach acknowledges that policies across diverse sectors (e.g., education, employment, housing, justice) can significantly affect the risk of self-harm and suicide. Integrating suicide prevention into broader policy domains enhances the strategy's reach and sustainability. Effective cross-sectoral action, in turn, requires multi-sectoral collaboration involving partnerships between government bodies, NGOs, community organisations, researchers, and citizens (Pearce et al., 2022a). This broad-based response ensures that suicide prevention efforts are inclusive and community-driven, engaging stakeholders across government and policy-making institutions, health care systems and providers, educational institutions, community-based organisations, families, friends, and individuals with lived experience. This multi-sectoral, systems-based approach aligns with a public health perspective on suicide prevention. Recognising that

suicide is influenced by a complex interplay of factors at the individual, interpersonal, community, and societal levels and addressing these factors requires coordinated action across sectors and disciplines (Pirkis et al., 2024; Sinyor et al., 2024).

3.3 Applying an implementation science lens

Multi-component systems approaches to suicide prevention are inherently complex. As discussed, they involve numerous stakeholders and interventions operating within dynamic social, economic, political, and cultural contexts. To navigate this complexity and enhance the effectiveness of strategy delivery, implementation science offers a valuable set of tools and frameworks that help explain how and why interventions succeed or fail (Bauer & Kirchner, 2020). It provides structured guidance for planning, executing, and evaluating strategies, ensuring that they are not only well-designed but also effectively implemented.

Implementation science can be integrated into the work in several ways, for example by establishing clear implementation structures to guide teams and coordinate activities (Gustafson, et al., 2021). Using implementation frameworks, such as those described by Nilsen (2015) can help identify influencing factors, assess resource needs, and anticipate potential barriers. These frameworks also support the selection and application of evidence-informed strategies to overcome both anticipated and unanticipated challenges in strategy delivery (Bauer & Kirchner, 2020). An example of this approach is the use of the Consolidated Framework for Implementation Research (CFIR) in the Connecting for Life Interim Strategy Review. CFIR enables a structured analysis of implementation processes and outcomes, helping to ensure that strategies are delivered with fidelity and adopted effectively by stakeholders (Damschroder et al., 2022). Implementation science also encourages the use of evaluative and iterative methods to guide how researchers plan for, employ, adjust, and measure key aspects of strategy delivery. These include assessing fidelity to core components and monitoring stakeholder adoption, both of which influence overall effectiveness. In addition, conducting implementation research, which involves gathering data on the processes of intervention delivery, its reception, and the context in which it is implemented, can improve understanding of how and why interventions work (Krishnamoorthy et al., 2023). Framing implementation outcomes such as acceptability, reach, adoption, fidelity, feasibility, and sustainability as key variables within an evaluation programme can further enhance understanding

of the mechanisms and causal relationships that underpin successful implementation (Proctor et al., 2010). These outcomes provide insight into not only whether an intervention works, but also how it works, for whom, and under what conditions.

Despite careful planning, several common barriers can hinder successful implementation. These include limited capacity or knowledge among partners to change working practices, poor coordination and collaboration, mismatches between available resources and strategic ambitions, and unsupportive political or legal environments (Platt et al., 2019; WHO, 2018). Additional challenges include inadequate monitoring systems, stigma, insufficient data, and a lack of multi-sectoral involvement. Addressing these barriers requires proactive planning, meaningful stakeholder engagement, and a commitment to continuous learning. By applying an implementation science lens, suicide prevention strategies can be more responsive, adaptive, and impactful, ultimately improving outcomes for individuals and communities.

3.4 Inclusion of lived and living experience

Increasingly, the inclusion of people with lived and living experience is recognised as essential to effective multi-sectoral collaboration (Pearce et al., 2022a; 2022b). A recent scoping review examined 42 Australian studies on lived experience participation in suicide prevention (2016–2023) and found wide variation in how such participation was defined, implemented, and reported (Purdon et al., 2025). The authors highlighted a need for standardised definitions, transparent reporting, and stronger ethical and safety practices to ensure meaningful, safe, and reciprocal involvement, concluding that while the field is expanding, it remains methodologically immature and requires gradual, evidence-informed improvement. Empowering and involving people with lived and living experience perspectives improves 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 and 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 and living perspectives in identifying and driving the necessary improvements in policies and systems.

3.5 Upstream societal factors

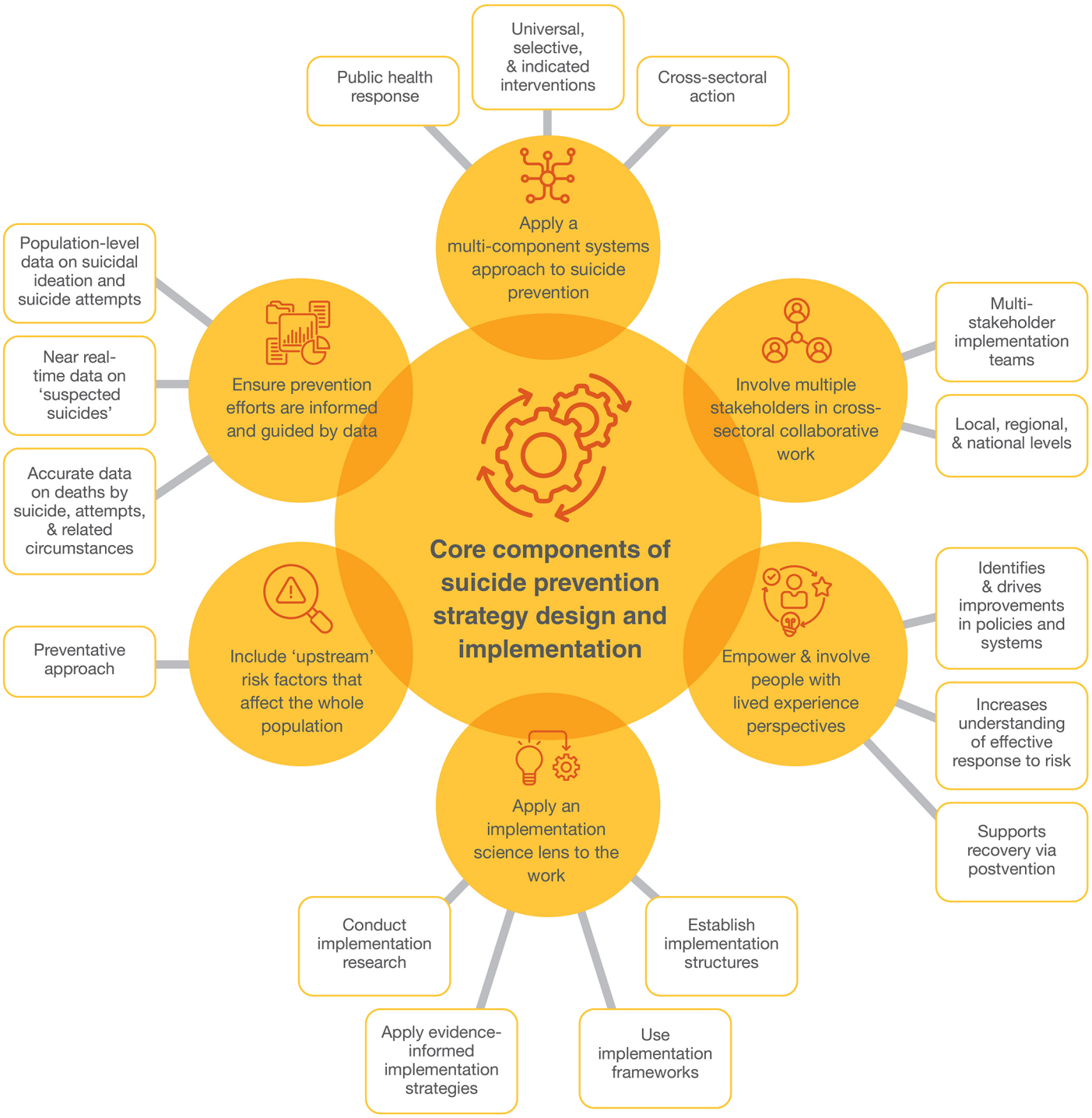
Traditionally, suicide prevention efforts have focused on identifying individuals at risk and connecting them with appropriate support. However, there is growing recognition of the need to intervene before the onset of risk, by addressing upstream societal factors that influence mental health and suicide risk across the population. These include adverse childhood experiences, unemployment, lack of safe and affordable housing, and financial hardship (Pirkis et al., 2024; Gallagher et al., 2025). Moving upstream involves promoting social connectedness, strengthening economic supports, expanding services for underserved groups, and developing primary prevention initiatives (Iskander & Crosby, 2021). It also requires identifying and reinforcing protective factors, such as resilience, purpose, and supportive relationships that help individuals endure and recover from adversity. Suicide prevention theory and research have long emphasised the importance of social context in both risk and protection. Suicide is socially patterned, with higher prevalence in areas of disadvantage compared to more affluent communities (O'Connor & Portzky, 2018). Feelings of isolation and burdensomeness are known to increase suicide risk, while opportunities to contribute, through employment, volunteering, or mentoring, can foster meaning and reduce vulnerability.

3.6 Data informed prevention efforts

To ensure that prevention efforts are responsive and targeted, access to timely and accurate data is essential. This includes data on deaths by suicide, suicide attempts, and related circumstances, collected at national, regional, and local levels. Such data are critical for monitoring trends, guiding prevention efforts, informing public policy, and evaluating the impact of interventions. The importance of near real-time data has increasingly been recognised for its role in detecting temporal clusters in suicide attempts or deaths, identifying emerging at-risk populations, and assessing the effectiveness of suicide prevention strategies over time (Hawton & Pirkis, 2024). In addition, population-level data on suicidal thoughts, behaviours, healthcare use, and associated risk factors are vital for identifying trends and planning future interventions.

The core components of suicide prevention strategy design and implementation are summarised in Figure 3.1.

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



4. Summary

Some overlap exists among the suicide prevention interventions reviewed in this document, which presents challenges in isolating and measuring the impact of individual strategies. For instance, psychosocial interventions often intersect with mental health treatments, while stigma reduction efforts may be embedded within training programmes, media guidelines, or broader community-based initiatives. Many community-based interventions encompass multiple components, further complicating attribution of outcomes to specific elements. In addition, certain intervention types are underrepresented in the literature. Few studies focus exclusively on postvention, and relatively few address stigma reduction as a standalone strategy. This suggests a potential gap in the evidence base, despite indications that stigma is often targeted indirectly through other interventions. Importantly, the limited number of studies does not diminish the relevance of these approaches within a comprehensive suicide prevention framework. For example, recent research has highlighted the perceived effectiveness of postvention components, such as psychoeducation, structured and manualised interventions, peer and community support, and the role of trained facilitators (Hofmann et al., 2024). There is also growing recognition of the need for bereavement supports within coronial services (O'Driscoll et al., 2023).

Nonetheless the findings from this review broadly align with earlier evidence syntheses conducted prior to the publication of the Connecting for Life (CfL) strategy (Dillon et al., 2015; Tye et al., 2015). Consistent with these earlier reviews, evidence supporting means restriction remains the strongest among suicide prevention strategies, while psychosocial interventions continue to show promise. However, evidence for other approaches remains mixed, and it is often difficult to attribute changes in suicide rates or suicidal behaviour to specific interventions.

The rapid review highlights that effective suicide prevention requires a multi-component, systems-based approach that integrates diverse, simultaneous interventions across sectors and settings. Single interventions are insufficient given the complexity of suicidal behaviour; instead, coordinated efforts involving healthcare, community, and policy domains are essential. Cross-sectoral collaboration, including the active involvement of people with lived and living experience, enhances the reach, relevance, and sustainability of strategies. Implementation science provides critical tools for navigating the complexity of delivery, offering frameworks to guide planning, execution, and evaluation. Addressing upstream societal factors, such as economic hardship, housing insecurity, and social isolation, is vital for long-term impact. Ultimately, responsive, data-informed, and inclusive strategies that engage stakeholders at all levels are key to reducing suicide risk and promoting mental health across populations.

Appendix A

Methodology

Sources

A search of PubMed3was 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 criteria4

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

[3] https://pubmed.ncbi.nlm.nih.gov/
[4] 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).

- 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.

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 (NICE, 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 1. Articles were categorised as 'multiple interventions' if findings on more than one of the interventions identified in Table 1 were included.

Appendix B

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) – 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.

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