The Evaluation of Connecting for Life:

Overview and insights

Compiled by the HSE National Office for Suicide Prevention (HSE 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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Section 1: Introduction

1.1 Connecting for Life

Connecting for Life (CfL) Ireland's national strategy to reduce suicide from 2015 to 2020 (Department of Health, 2015) was extended to 2024 following an Interim Strategy Review in 2018. 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". It sets out two ambitious primary outcomes: reduced suicide rate in the whole population and among specified priority groups and reduced rate of self-harm presentations in the whole population and among specified priority groups.

CfL is grounded in five guiding principles that shape its strategic direction and implementation. At its core is a whole-of-society approach, recognising that effective suicide prevention requires coordinated collaboration across sectoral and communities. The strategy ensures accountability through clearly defined roles, responsibility, and governance structures. CfL is responsive to need, placing emphasis on person-centred, high-quality, and accessible services for all. It is also evidence-informed, and outcomes focused using research and data to guide both design and implementation. Finally it is adaptive to change, acknowledging the important of flexible in responding 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 actions):

- Strategic Goal 1 Better understanding of suicidal behaviour aims to enhancing public awareness and attitudes towards suicide, self-harm, and mental health through media campaigns, targeted awareness initiatives and stigma reduction efforts.
- Strategic Goal 2 Supporting communities emphasises the empowerment of communities to effectively prevent and response to suicidal behaviour. This is achieved through cross sectoral, multi-agency action plans aligned with the national strategy, and by building the capacity of community organisations and gatekeepers via suicide prevention training.
- Strategic Goal 3 Targeted approaches for priority/vulnerable groups focuses on providing

specialised support to individuals at increases risk of suicide (i.e., CfL 22 priority groups).

- Strategic Goal 4 Improved access, consistency and integration of services seeks to enhance the accessibility, coordination and responsiveness of services. Key actions include improved psychosocial assessment, better access to effective therapeutic interventions and support for individuals and families bereaved by suicide.
- Strategic Goal 5 Safe and high-quality services aims to strengthen the safety and quality of services for those vulnerable to suicide. This includes the development of Best Practice Guidance and improved responses within health and social care settings, supported by a national training programme.
- Strategic Goal 6 Reducing and restricting access to means focuses on measures to curb access to methods commonly used in suicide.
- Strategic Goal 7 Better surveillance, evaluation and research on suicidal behaviour priorities the improvement of data quality and availability to inform policy and practice. It demonstrates a strong commitment to evaluating major activities and advancing innovative approaches to suicide prevention.

The strategic goals and objective are supported by a set of 23 Intermediate Outcomes (IOs) with associated indicators (see Figure 1). This outcome-focused framework was considered both rare and ambitious in national suicide prevention strategies at the time of its development.

CfL is a cross-sectoral strategy, with 22 government departments and state agencies committed as lead or supporting partners. Additionally, 23 HSE-funded Non-Governmental Organisations (NGOs) contribute to service delivery, research, and advocacy under the strategy. These NGOs play a critical role in reaching vulnerable populations through culturally sensitive and targeted approaches. These vulnerable populations are identified in the strategy as priority groups for targeted interventions. Broadly speaking there are five priority groupings; health and mental health related groups (e.g., People who engage in repeated self-harm, substance misuser, people living with chronic physical conditions) minority groups (e.g., members of the LGBTQI+, Travellers), demographic cohorts (e.g., middle-aged adults, young people) suicide related groups (e.g., individuals bereaved by suicide) and occupational groups (e.g., healthcare professionals, farmers).

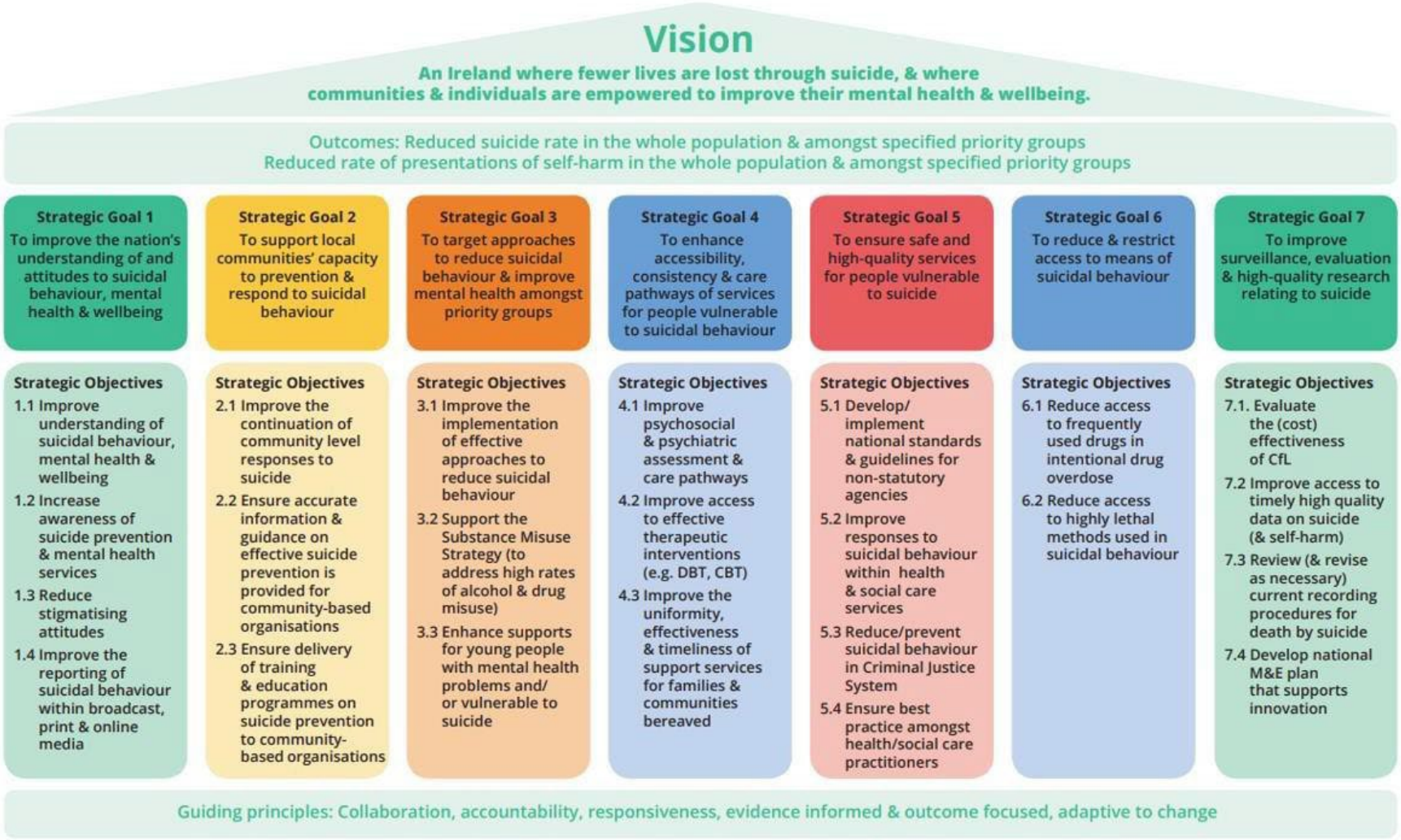
1.2 Implementation structures

CfL is implementation through a multi-level governance framework that integrates national oversight with local delivery. At the national level, suicide prevention is overseen by the Cabinet Committee on Social Policy and Public Service Reform. Strategic coordination is led by the CfL National Cross-Sectoral Steering and Implementation Group, chaired by the Department of Health, which meets quarterly, and includes all lead government departments/ agencies responsible for delivering actions under the strategy. The HSE National Office for Suicide Prevention (HSE NOSP) plays a crucial role in operationalising the strategy. It provides overarching implementation support and is directly responsible for 39 CfL actions. HSE NOSPS work is structured around eight streams; strategy co-ordination, education and training, NGO support, Local implementation support, research and evaluation, communications, bereavement support coordination, and clinical leadership. More specifically HSE NOSP provides strategic and operational oversight, manages implementation plans (2017–2020; 2020–2222, and 2023–2024) and oversees the development, coordination, and quality assurance of suicide prevention education and training programmes. In collaboration with funded NGO partners, HSE NOSP supports a broad range of suicide prevention and mental health services targeted at priority groups. Additionally it contributed to the coordination of national suicide bereavement supports, monitors and evaluates strategy [and programmatic] implementation and outcomes, manages communications and resource development, and provides guidance for local implementation activities.

At a local level, CfL is delivered through area-level action plans tailored to community needs. Initially, 17 plans were developed across nine HSE Community Health Organisation (CHO) regions. Implementation is facilitated by HSE Resource Officers for Suicide Prevention (HSE ROSPs) who work with local stakeholder groups to align national objectives and local priorities. 1.2 Implementation structures

CfL is implementation through a multi-level governance framework that integrates national

Figure 1: CfL strategic framework[1]



[1] Source: (HSE NOSP, 2019) – Connecting for Life, Ireland's national strategy to reduce suicide 2015–2020 – Interim Strategy Revier

1.3 Outcomes and evaluation focused

CfL adopts a systematic and embedded approach to evaluation, ensuring that monitoring and assessment are integral to its implementation framework. In 2017 HSE NOSP introduced a structured monitoring system to track implementation progress by lead agents via a quarterly reporting system which identifies achievements and implementation challenges. HSE NOSP publishes summary updates three times annually, supporting continuous learning and strategic alignment. In 2018, the HSE NOSP in collaboration with the CfL Evaluation Advisory Group conducted an Interim Strategy Review (National Office for Suicide Prevention, 2019). Drawing on monitoring data the review evaluated progress across all strategy actions (by lead agents) and identified key facilitators and barriers to inform future strategic priorities. It confirmed the continued relevance of CfL and its strengths in multi-sectoral coordination and commitment to evaluation. 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 HSE NOSP commission an external evaluation of CfL after 2024 focusing on measurement of progress towards intermediate outcomes and linking outcomes to implementation achievements.

In 2023 HSE NOSP issued a request for tender, through eTendering processes, for the evaluation of CfL on a national and regional basis. The overarching objectives of the evaluation were to understand the implementation of CfL and the extent to which it is achieving its intermediate outcomes. More specifically the evaluation set out to answer the following key questions:

- To what extent are CfL's suicide prevention activities and strategies aligned with the evidence base and good practice?
- To what extent did CfL achieve its intermediate outcomes?
- How well is the top-down/national CfL implementation working?
- How well is the bottom-up/area-level implementation of CfL working?
- What can be done to improve outcome measurement?
- Is there an ongoing need for a national suicide prevention strategy?

To support the delivery of the evaluation, HSE NOSP established a comprehensive governance structure following the commencement of the evaluation contract [in January 2024]. This included the convening of CfL's Evaluation Advisory Group on a quarterly basis, to provide expert guidance and to ensure the development of a credible and robust evaluation process. In

parallel, a CfL Evaluation Stakeholder Group was convened to support the evaluation team in several practical ways: facilitating access to key stakeholders, addressing barriers encountered during fieldwork, identifying and mitigating risks to delivery, and providing a structured forum for discussion with key implementation partners. The group, which met quarterly, also ensured regular reporting of progress to relevant stakeholder bodies.

Section 2: Methodology

2.1 Overall approach

This evaluation applies a mixed-methods approach to assessing the implementation and Intermediate Outcomes (IOs) of the CfL strategy, with the aim of informing future suicide prevention policies and resource allocation. Grounded in the principles of realist evaluation, a theory-driven method suited to complex interventions, the evaluation seeks to understand not only whether the strategy is effective, but how and why it achieves its intermediate outcomes. CfL is considered a complex intervention due to its multiple interacting components and multiple potential outcomes, which are dependent on the behaviours of those delivering and receiving services, as well as the broad social, economic, and political contexts. Realist evaluation focuses on three elements; the context in which the intervention occurs, the mechanisms that drive change and the resulting outcomes, whether intended to unintended. 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. Prior to the commencement of primary data collection, stakeholder mapping was carried out by HSE NOSP; this was made available to the CES for data sourcing. A summary of each data collection method is provided below; Figure 2.1 provides an overview of the evaluation methodologies.

2.2 Literature review

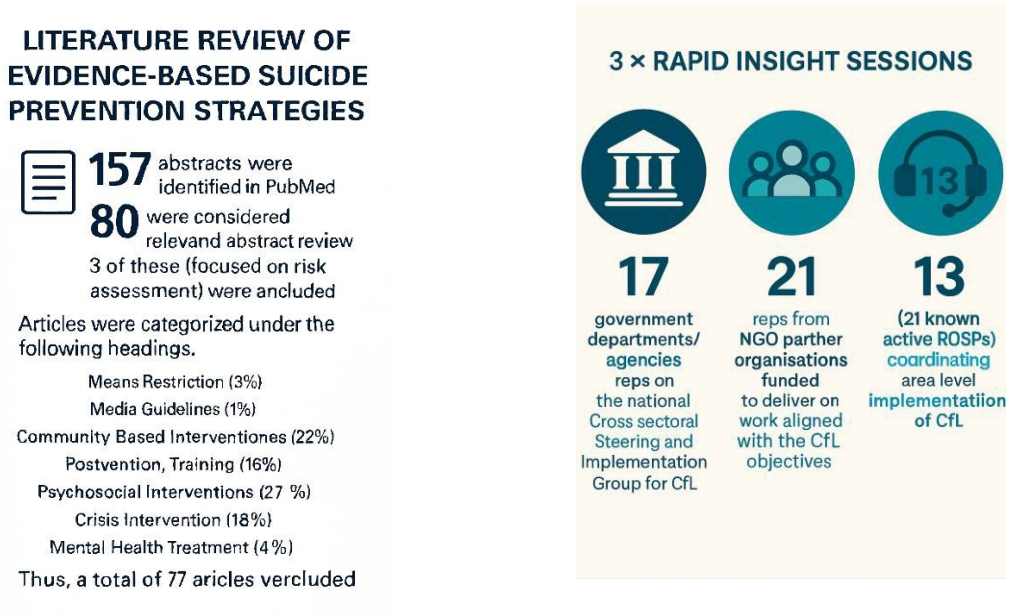
As part of this evaluation a literature review was conducted in order to help determine the extent to which CfL's activities and strategies are aligned with the evidence base and best practice. The review focused on published systematic reviews and meta-analyses on relevant evidence and best practice from appropriate and comparable clinical contexts that have been published since the Health Research Board's evidence review (Dillon et al, 2015) conducted to inform the development of CfL. Search terms were based on evidence-based interventions included in CfL and commonly cited in suicide prevention literature. Following screening and review 77 articles were identified as containing relevant evidence-based interventions. These

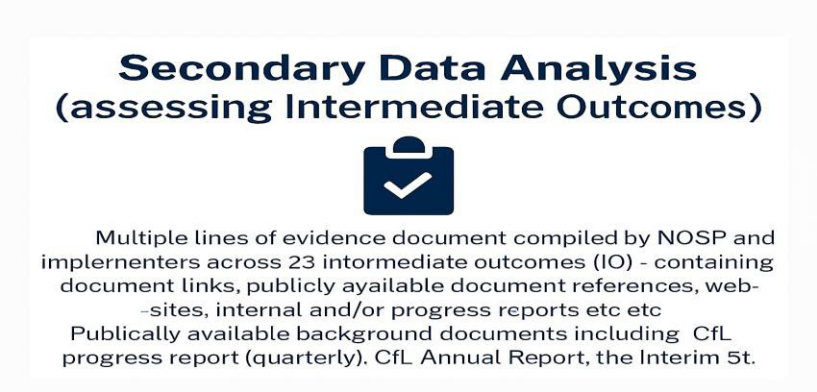
were categorised under key thematic areas; means restriction, media guidelines, community-based interventions, postvention, training, psychosocial, including coping skills, problem-solving etc., crisis intervention, mental health treatment, and stigma reduction. Articles addressing more than one intervention type were classified under 'multiple interventions'. In addition a rapid review of best practice in suicide preventing strategy design and implementation was also conduct.

2.3 Primary data collection

Primary data collection plays a crucial role in evaluation research, providing direct insights into the experience, perspectives and outcomes of those involved in, in this instance, the implementation of CfL, nationally and at an area-level. Primary data are gathered specifically for the purpose of the evaluation, thereby ensuring relevance and contextual accuracy. This section briefly summaries the methods used to collect original data, including focus groups, interviews, and surveys.

Figure 2.1: Connecting for Life Evaluation Methodologies





The Rapid Insight (RI) methodology is a structured virtual focus group approach designed to gather diverse professional perspectives, particularly amplifying less heard voices. This methodology was used to engage three CfL stakeholders groups involved in implementing the CfL strategy; representatives from the government departments and agencies (n=17), NGO partner organisations funded by HSE NOSP (n=21) and the HSE ROSPs (n=13). These online session (conducted between October and December 2024) were guided by three core questions derived from prior reviews and workshops, focusing on area for improvement, cross-sectoral implementation lessons, and factors essential for sustaining future suicide prevention efforts.

Semi-structured online interviews were conducted with national stakeholders across a range of government departments and agencies associated with CfL, complemented the RI sessions. The

interview participants included representatives from: HSE NOSP, Government departments and agencies, HSE ROSP, NGOs funded as delivery partners and subject matter experts, who act or acted, as advisors to CfL (bellwether interviews). These interviews explored topics such as implementation processes, barriers and facilitators, progress achieved by CfL , and recommendations for future strategies. A total of 30 interviews (including five bellwether interviews with subject matter expert who act/acted as advisors to CfL) were conducted between October and December 2024.

Two surveys were also created, one for HSE ROSPs and one for local stakeholders/ implementation partners. The HSE 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 HSE ROSPs). It gathered perspectives on CfL's reach, engagement, integration, and sustainability at the local level. Surveys were distributed via HSE ROSPs to implementation partners; all responses were anonymised. The surveys were open for a 5 week period across November and December 2024. They were distributed to 21 HSE ROSPs and 613 local stakeholders and implementation partners across the country.

2.4 Secondary Data Collection

Secondary data refers to information that has been collected previously for purposes other than the current evaluation. It can include administrative data/records, survey data, academic research, policy document, implementation plans etc. This type of data can be particularly useful for triangulating findings, validating primary data and enhancing the robustness of evaluation conclusions. Multiple lines of evidence refers to the use of various independent sources of data or information to evidence progress and/or achievement towards outcomes. In the context of secondary data analysis, this means drawing from different types of existing data, to build a more comprehensive and reliable picture of the subject being evaluation.
CfL identified 23 intermediate outcomes across its seven strategic goals. Each outcome has at least one corresponding indicator; however indicator data are not always available. Consequently, HSE NOSP compiled a multiple lines of evidence document with key implementation partners across the 23 intermediate outcomes. For each outcome relevant links to publicly available documents, data, websites, internal and/or progress report etc. were presented, along with a short narrative, to evidence relevant activities and achievements toward the outcome. This document was not an exhaustive presentation of the work under the

strategy, but it provided a sound foundation for the evaluators to begin to assess progress towards achieving the intermediate outcomes. The research team also reviewed other relevant documents including the CfL progress reports (published quarterly), CfL's Annual Reports, the CfL Interim Strategy Review and all the relevant CfL implementation plans. Table 2.1 presents an evaluation matrix outlining the key questions addressed in the evaluation, the methods employed and illustrative examples of the types of data gathered from each source.

2.5 Data Analysis

Qualitative interview data were thematically analysed to identify, interpret, and report patterns (or themes) across datasets, which represent beliefs, observations, and experiences that participants may share in relation to the research questions. Each dataset was analysed separately and then combined at the triangulation stage.

Triangulation in a mixed methods evaluation involves integrating multiple data sources and perspectives to enhance the understanding of the research problem. For this evaluation, an 'integration through narrative' approach was used, combining quantitative and qualitative findings, allowing for a more holistic interpretation of the intermediate outcomes (IO) IOs. Through face-to-face sessions, the evaluation team synthesised primary and secondary data to assess individuals IO's and overall progress in CfL implementation. This method help validate results, highlight complexities, and strengthen the overall analysis.

To inform the analysis of multiple lines of evidence document showing achievements under each intermediate outcome, the 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. This framework is tailored towards conceptualising and evaluating successful implementation within health services.

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

Table 2.1: Evaluation Matrix

<table>
<tr><th rowspan="2">Evaluation Questions</th><th colspan="4">Primary Data Source</th><th rowspan="2">Secondary Data Source</th></tr>
<tr><th>Literature Review</th><th>Semi-structured Interviews (n=30)</th><th>3 x Rapid Insight Sessions (n=51)</th><th>2 x Surveys (HSE ROSPs & area level implementers)</th></tr>
<tr><td>1. To what extent are CfL's activities and strategies aligned with the evidence base & best practice?</td><td>Review of 77 full text articles focused on key evidence-based suicide prevention interventions</td><td>Relevant data on, for example, best practise, and expert validation of CfL work</td><td rowspan="3">Relevant data extracted from the three RIS discussion questions:

Thinking about the implementation of CfL, from your perspectives on what could have been better?

What are your key lessons about implementing a</td><td>Relevant data, on, for example, awareness and use of evidence-based practices & perspectives on alignment in practice</td><td>Review of strategy document and supporting material (e.g., implementation plans & Interim Strategy Review).</td></tr>
<tr><td>2. How well is top-down, national CfL implementation working?</td><td rowspan="2">Rapid review of literature on best practice in strategy design & implementation</td><td>Relevant data validating evidence from literature; e.g., perspectives on implementation in practice; barriers & facilitators; clarity and consistency of national leadership</td><td>Relevant data on, for example, national leadership, implementation support</td><td rowspan="2">Review of strategy document and supporting material and relevant HSE NOSP led implementation surveys (included in the Multiple Lines of Evidence document)</td></tr>
<tr><td>3. How well is bottom-up area-level CfL implementation working?</td><td>Relevant data on, for example, perspectives on local capacity, autonomy & implementation barriers & facilitators; and example of local initiatives.</td><td>Relevant data on, for example, local adaptation; stakeholder engagement; ownership of work; perspectives on resourcing; implementation barriers & facilitators</td></tr>
</table>

4. To what extent did CfL achieve its Intermediate Outcomes (IOs)?	Rapid review & review of implementation frameworks to inform the development of evaluation criteria to assess progress towards each IO	Relevant data on, for example, progress achieved by CfL, success stories & challenges/barriers	strategy that crosses multiple agencies, sectors, and budget and accountability relationship?	Relevant data on for example, perception of success, achievements, and progress	Multiple Lines of evidence document presenting links to CfL work demonstrating progress towards each intermediate outcomes.
5. What can be done to improve outcome measurement?	Rapid review of literature to identify gaps in current measurement	Relevant data, on for example, perspectives on gaps in current outcome measurement; unexpected positive and negative outcomes & suggestions for improvement	What factors need to be in place to create a sustainable suicide prevention programme for the future?	Relevant data on for example, perspectives on gaps in current measurement & suggestions for improvement	Review of CfL monitoring and progress reports (and MIL document – IO7) to identify gaps.
6. Is there an ongoing need for a national strategy?	Review literature on evidence-based suicide prevention interventions	Relevant data on, for example, continued relevance & value of strategic goals		Relevant data, on for example, stakeholders perspectives on support for, and value of a new strategy.	Review of strategy document & supporting material

2.6 Lived or living experience representation

In an attempt to engage living experience representation in the evaluation process, the evaluation team held two on-line group discussions with a panel of Living Experience Representatives, individuals with personal experience of suicide, recruited through the National Suicide Research Foundation (NSRF), Pieta, and HUGG. The CES collaborated with these organisations to create an information document outlining the panels' purpose and process. Five representatives were recruited, with four attending both sessions. The first meeting introduced the CfL strategy and evaluation while the second on focused on reviewing early findings and gathering feedback. Insights for these discussions were transcribed and used to inform the final evaluation report.

2.7 Ethical Approval

Ethical approval for this low-risk evaluation was sought and obtained from University College Dublin's Research Ethics Committee. All data collection methods, including interviews, focus groups, surveys, and literature review, were designed to ensure informed consent, confidentiality, and voluntary participation. Participants were provided with clear information about the purpose of the evaluation, how their data would be used, and their right to withdraw at any time. Data was stored securely and anonymised where appropriate to protect participant privacy. The evaluation adhered to principles of integrity, transparency, and respect for all stakeholders involved.

Section 3: Evaluation of CfL's intermediate outcomes

3.1 Introduction

Evaluating intermediate outcomes (IOs) is a critical step in understanding the implementation progress of the strategy. IOs represent measurable indicators of change that occur prior to the achievement of long-term impacts at a population level. By assessing progress towards achieving IOs, evaluators can identify signs of effectiveness, implementation fidelity, and areas requiring adjustment. This approach provides a more nuanced understanding of how activities and outputs are contributing to desired outcomes, particularly in complex, multi-level strategies where final impacts may take time to materialise. Evaluating IOs also supports continuous learning and improvement by highlighting what is working well and where further attention may be needed.

For the purposes of this evaluation, CfL's IOs (see Figure 1) were assessed using secondary data, primarily drawing on the Multiple Lines of Evidence document provided by HSE NOSP. While the strategy document identified suggested indicators for each IO, in many instances, indicator-specific data were not systematically collected. As a result, a broader range of evidence was incorporated into the Multiple Lines of Evidence document to demonstrate progress towards the intended outcomes. The available evidence was aligned with the (intermediate) outcomes framework, supplemented by other forms of secondary data, to illustrate the extent to which IOs and their associated indicators were advanced. The data were analysed using the Implementation Outcomes Framework outlined in the methodology section above. Coding focused specifically on evidence directly relevant to the IO indicators and date form the Multiple Lines of Evidence document were 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

3.2 Progress towards intermediates outcomes

An overview of work undertaken under each CfL intermediate outcome, by strategic goal, is presented in the following section and summarised in Table 3.1.

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

Intermediate Outcomes	Rating
101.1 Improved understanding of suicidal behaviour, mental health & associated protective & risk factors	Achieved, 1 minor learning
101.2 Increased awareness of available suicide prevention /mental health services	Achieved, 1 major learning
101.3 Reduced stigmatizing attitudes	Achieved, 1 major learning
101.4 Improved media engagement and report	Achieved, 1 minor learning

Under IO1.1 improved understanding of suicidal behaviour, mental health and associated protective and risk factors, the multiple lines of evidence reviewed demonstrates that substantial and up-to-date research has been conducted to identify and understand the complex factors influencing mental health and suicidality. Much of this research focuses on specific population groups, including many of the priority groups identified in the strategy. Several studies are based on large, nationally representative samples and include peer-reviewed academic articles as well as systematic reviews. Collectively, this body of research provides a robust evidence base and offers a range of recommendations to inform future planning and policy development.

The evidence reviewed also demonstrates a clear and intentional policy direction, reflected in national frameworks such as the national mental health promotion plan and the integration of an opt-in suicide prevention module into the Healthy Ireland Survey. These developments signal a growing recognition of the importance of mental health at a population level and a commitment to embedding mental health awareness within broader public health. While the Healthy Ireland Survey has the potential to generate valuable population-level insights into mental health and suicide prevention, its voluntary nature presents limitations in terms of representativeness, which affects the generalisability of findings. In parallel, the evidence indicates that the HSE's Mental Health Literacy campaign, grounded in research, has helped increase public awareness and engagement. Its

growing digital presence, particularly via the website, reflects rising public interest in mental health information and support. This progress suggests a positive shift toward normalising mental health conversations and improving the public's ability to recognise and respond to mental health issues.

Under IO 101.2 increased awareness of available support services the evidence reviewed indicates a notable increase in public engagement with mental health resources, e.g., traffic to **yourmentalhealth.ie** rose significantly throughout 2024, with marked spikes during campaign periods. This suggests that targeted communications are effective in driving awareness and interest in available support services. The CfL 2023 Directory for GPs (Health Service Executive, 2023) is another key resource designed to support general practitioners in identifying and referring patients to appropriate quality assured mental health services. While there is evidence that this directory is available online, there is currently no data on how frequently the directly has been downloaded or accessed. Overall the evidence points to growing awareness and engagement with support services, particularly among the general public. However, further monitoring and evaluation of resource usage, especially among key stakeholders like GP's, would strengthen understanding of how these tools are begin utilised in practice.

Under the IO 101.3 reduced stigmatising attitudes to mental health, self-harm, and suicide a range of national initiatives, and research efforts have been undertaken to address stigma in Ireland. The Green Ribbon campaign, led by Shine (through SeeChange) is a prominent annual anti-stigma initiative. It is supported by resources such as an anti-stigma guide (Shine, 2020) and booklet (Shine, 2020) and has achieved broad reach, distributing 600,000 ribbons and engaging with the public through events and social media. However its perceived effectiveness is mixed; only 29% of those aware of the campaign rated it as very or extremely effective (Shine, 2023, p. 19). Research by the Samaritans further highlights the persistent impact of stigma on help-seeking behaviour. While survey data indicated growing public awareness and a willingness to change language around mental health, stigma remains deeply entrenched. These findings underscore the need for a more systematic and sustained approach to anti-stigma efforts, including mandatory training, improved data collection and the integration of wellbeing programmes in schools. Furthermore, targeted research into self-stigma among priority groups, such as LGBTQI+ individuals, and travellers, underscores the need for tailored interventions to improve mental health outcomes and reduce barriers to support. Related, research has highlighted the impact of self-stigma on mental health and help-seeking among marginalised groups. These studies consistently call for culturally sensitive, targeted interventions and additional resources to reduce stigma and improve access to support. Despite progress through national campaigns, self-stigma remains a major barrier, requiring both broad public engagement and community-informed strategies.

Under IO1.4 improvement in the reporting of suicidal behaviour in broadcasting, print and online media evidence shows a well-established infrastructure supporting responsible media coverage of suicide and mental ill-health in Ireland. Media guidelines developed by Samaritans Ireland (2021), along with resources such as the Samaritans' Online Excellence Programme, are readily available to journalists. Training opportunities are also provided by Headline (the national programme delivered by Shine and funded by HSE NOSP), which promotes responsible reporting and representation. Headline also conducts extensive media monitoring, responds to issues identified, and contributes to global initiatives, while its Media Awards recognise excellence in reporting. An evaluation of Headline's monitoring activities recommended focusing on guideline breaches and limiting in-depth analysis to periodic samples, a recommendation that has since been implemented. At a policy level, HSE NOSP has supported the enactment of the Online Safety and Media Regulation Bill and the establishment of An Coimisiún na Meán (Media Commission) in 2023, further strengthening the regulatory framework. Additionally, research by NSRF (McTernan & Ryan, 2023) provides a literature review aimed at defining harmful online content related to suicide and self-harm, offering a foundation for future planning and regulation. 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.

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

Intermediate Outcomes	Rating
I02.1 Continued improvement of community-level responses to suicide through multi-agency approaches	Achieved, 1 major learning
102.2 Accurate info. & guidance on effective suicide prevention provided for community organisations	Achieved, 1 major learning
102.3 Training and education programmes on suicide prevention to community-based organisations	Achieved & sustainable

Under IO2.1 continued improvement of community-level responses to suicide through multi-agency approaches, a key indicator is the availability of local CfL action (and implementation) plans, aligned with the national strategy, designed to guide and improve community responses. At the time of writing, eleven HSE regions had published Action Plans, with six extending to 2024. Implementation surveys from 2018 and 2019 conducted by HSE NOSP, show generally positive stakeholder views on CfL area level implementation, though concerns were noted around leadership, communication, and

funding. Despite these challenges, a wide range of evidence-informed strategies are being used, and the 2022 Innovation Project highlighted twelve locally developed interventions as particularly innovative. Planning and progress tracking are supported by three national CfL Implementation Plans (2017–2024), each outlining milestones for developing, revising, and reviewing CfL Local Action Plans, including a formal review process in the 2020–2022 plan.

Under IO2.2 accurate Information and Guidance on Effective Suicide Prevention Provided for Community-Based Organisations the evidence reviewed included three guidance documents: Developing a Community Response to Suicide (National Office for Suicide Prevention, 2021), Suicide Prevention in the Community (O'Sullivan & Tiernan, 2023), and Responding to a Person in Suicidal Distress (National Office for Suicide Prevention, 2024). 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.

Under IO2.3 Training and Education Programmes on Suicide Prevention to Community-Based Organisations the evidence reviewed included a suite of training programmes for community organisations funded by HSE NOSP (National Office for Suicide Prevention, 2024), the CfL National Education and Training Plan (National Office for Suicide Prevention, 2025), the CfL Training Quality Assurance Framework (QAF) (National Office for Suicide Prevention, 2021), 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, 2024) (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. 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 HSE 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 Outcomes	Rating
I03.1 Improved implementation of approaches to reduced suicidal behaviour among priority groups	Achieved, 1 major learning
103.2 Support the Substance Misuse Strategy to address the high rates of drug/alcohol misuse	Achieved, >1 major learning
103.3 Enhanced supports for young people with mental health problems or vulnerable to suicide	Achieved, 1 minor learning

Under IO3.1 improved implementation of effective approaches to reduce suicidal behaviour among priority groups named in strategy evidence reviewed includes the pilot implementation of CAMHS Hubs, which provide brief, intensive mental health interventions for children and young people. These hubs operate across five learning sites and are guided by an evidence-based Model of Care (see IO4.2). Further evidence highlights a wide range of HSE NOSP-funded training programmes delivered to community organisations (see IO2.3), and interventions provided by a range of NGOs targeting priority groups. According to HSE NOSP's 2022 annual report, over 50% of its budget supports mental health and suicide prevention services delivered by NGOs. These organisations report extensive reach and deliver tailored interventions to groups such as LGBTQI+ individuals, people experiencing homelessness, Travellers and Roma, men in the construction industry, students, and those bereaved by suicide. Amongst CfL lead agents best practice interventions focused on professions who may come into contact with vulnerable people 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.

Under IO3.2 support provided to the Substance Misuse Strategy, to address the high rates of alcohol & drug misuse the main evidence available was related to the roll-out of programmes aimed at early intervention & prevention of alcohol & drug misuse, more specifically to the implementation of SAOR (Support, Ask and Assess, Offer Assistance, Refer) 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 reporting, 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 available indicates that the roll out of SAOR is ongoing.

Under IO3.3 enhanced supports for young people with mental health problems or vulnerable to suicide the evidence reviewed includes the 2022 evaluation of the Counselling in Primary Care (CIPC) Service. CIPC offers time-limited counselling to GMS card holders aged 18 years and over experiencing mild to moderate psychological and emotional difficulties. The evaluation report highlighted identified high levels of user satisfaction and found the service effective in addressing presenting issues (CIPC National Research Group, p. 7). Approximately, 150,000 people had been referred to CIPC across all HSE Community Health Areas. However, challenges remain, including long waiting times and the exclusion of non-GMS card holders (p.19). No data are available on service uptake, specifically by young people. Additional evidence highlights the role of HSE-funded NGO partners, Jigsaw and Pieta, in providing primary care-level mental health supports for young people. Jigsaw, the National Centre for Youth Mental Health, offers online and in-person services to those aged 12–25. In 2024, it reported delivering 45,376 in-person appointments (Jigsaw, 2024). Pieta provides nationwide support for individuals experiencing suicidal thoughts, self-harm, or bereavement by suicide, across all age groups. Its current five-year plan notes rising demand from children and young people and outlines prevention initiatives such as the Amber Flag programme for schools (Pieta, 2024, p. 12).

Related, the evidence reviewed also shows that a whole-school approach to wellbeing is supported by national frameworks like Health Promoting Schools, Healthy Ireland, and School Self-Evaluation (SSE). Key documents, including the 2018 Wellbeing Policy Statement, National Educational Psychological Services (NEPS) guidance, and the 2024 Cineáltas action plan, form a coherent policy foundation. Schools were expected to embed a Wellbeing Promotion Process by 2023, and by 2025, initiate a wellbeing review cycle, supported by inspector advisory visits. Despite COVID-19 disruptions, alignment across policies and guidance remains strong.

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

Intermediate Outcomes	Rating
I04.1 Improved psychosocial & psychiatrist assessment & care pathways for people vulnerable to suicide	Achieved, 1 major learning
104.2 Improved access to effective therapeutic interventions for people vulnerable to suicide	Achieved, 1 major learning
104.3 Improved uniformity, effectiveness & timeliness of support services to those bereaved by suicide	Achieved, 1 major learning

Under IO4.1 improved Psychosocial and Psychiatric Assessment and Care Pathways the evidence reviewed focused on the SCAN (Suicide Crisis Assessment Nurse) service and the National Clinical Programme for Self-harm and Suicide-related Ideation (NCPSHI), which places specialist nurses in hospital emergency departments (EDs). Both services are positively regarded by service users, with evidence indicating they contribute meaningfully to the quality of care delivery. However, several implementation challenges were identified. For SCAN, concerns include limited supervision and restricted reach, currently serving only 20% of the population (College of Psychiatrists of Ireland, 2022). For NCPSHI, barriers include the lack of designated assessment rooms and weak collaboration between ED and liaison psychiatry staff. Despite these challenges, both services are supported by key resources: the 2022 NCPSHI Model of Care and the SCAN Operational Guidance (College of Psychiatrists of Ireland, 2022; HSE National Clinical & Integrated Care Programmes, 2024). As of the latest data, NCPSHI is operational in 24 of 26 adult EDs and one children's hospital (Cully et al., 2023). The 2025 NSRF PRISM Policy Brief recommends establishing a national coordination team to support evidence-based implementation and highlights the inconsistent availability of timely follow-up care from community services as an ongoing issue (National Suicide Research Foundation, 2025). Overall, the evidence suggests that substantial research and guidance are available to inform planning and standardise service provision.

In addition, the evidence shows that various GP training initiatives have been rolled out under CfL. These include the HSE NOSP/Irish College of General Practitioners (ICGP) programme Connecting with People, monthly ICGP webinars, and suicide prevention training for GP trainees in Sligo (2023). HSE NOSP estimates that 591 GPs have completed Connecting with People training, which is currently being evaluated by the NSRF to inform future planning. There is also evidence of ongoing collaboration with ICGP to support the future rollout of STORM training for GPs.

Under IO4.2 improved access to effective therapeutic intervention for people vulnerable to suicide the evidence reviewed highlights several key developments aimed at improving access to therapeutic interventions for individuals vulnerable to suicide. Central to this progress are three evidence-based Models of Care, each developed collaboratively and incorporating lived experience or service user input

- Model of Care for Adults Accessing Talking Therapies (AATT) (HSE Mental Health Service, 2021)
- Model of Care for Dual Diagnosis (National Clinical Programme for Dual Diagnosis Working Group, 2023)
- Model of Care for CAMHS Hubs (Butler & Hardiman, 2023)

The AATT Model is currently being rolled out on a phased basis across selected Community Healthcare Organisations and is under evaluation by the National Suicide Research Foundation (NSRF). The CAMHS Hub Model is being piloted at five learning sites. The Dual Diagnosis Model recommends the establishment of 12 Adult Dual Diagnosis teams across the nine CHOs, though implementation data is not yet available. All three Models of Care include strategies for implementation and sustainability.

Additional therapeutic supports include the HSE National DBT Programme, delivered by a dedicated training team established in 2021. In 2024, 14 mental health teams were actively delivering Dialectical Behaviour Therapy (DBT) (Joyce et al., 2024). In addition, the Collaborative Assessment and Management of Suicidality (CAMS) model is also being expanded. This evidence-based therapeutic framework complements existing mental health interventions, though data on the scale of its expansion is currently unavailable. Further evidence highlights the activation of over 4,000 licences for online Cognitive Behavioural Therapy (CBT), accessible via referrals from GPs, primary care psychology, CIPC, and Jigsaw. In addition, HSE NOSP funds NGOs to deliver therapeutic interventions to priority groups, further broadening access to tailored supports.

Under IO4.3 improved uniformity, effectiveness & timeliness of support services to families and communities bereaved by suicide the evidence reviewed highlights ongoing challenges and progress in providing timely and effective support to individuals and families bereaved by suicide. A 2022 national survey found that 57% of respondents affected by suicide waited more than one month to access bereavement support and reported various barriers to accessing services in their area

(O'Connell et al., 2022). Key services supporting this outcome include Pieta's Suicide Bereavement Liaison Service (SBLS) and HUGG's peer support groups. Both are valued by service users and providers. SBLS operates nationwide, but challenges include unclear role definitions, staff retention, burnout risk, and inconsistent referral pathways. Users also reported limited awareness of peer support and difficulties accessing SBLS (O'Brien et al., 2023). Suicide Bereavement Liaison Officers (SBLOs) noted variation in community engagement across CHOs and challenges in reaching marginalised groups and allied services. In 2024, HUGG ran 20 support groups, offering both online and in-person formats. Participants described the groups as safe spaces that fostered belonging and hope (Griffin et al., 2023).

A systematic approach is supported by the 2020 CfL document, "Improving suicide bereavement supports in Ireland" which outlines ten action areas and includes resources such as a mapping of supports, literature review, best practice guidance, and a communications guide (HSE NOSP, 2020). Additional resources include support guides for bereaved individuals (HSE NOSP, 2024), workplaces (McGuinness & Skehan, 2021), and young people and families (Forde, 2024). A National Suicide Bereavement Support Coordinator was appointed in 2022 and made full-time in 2024. Planning and monitoring are supported by a 2023 SBLS review, which produced a Logic Model and recommended improvements to the Salesforce data system (O'Brien et al., 2023). Pieta and HUGG also report regularly through Connecting for Life quarterly progress updates.

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

Intermediate Outcomes	Rating
I05.1 Develop & implement national standards & guidelines for statutory & NGOs	Achieved, 1 major learning
I05.2 Improved response to suicidal behaviour within health & social care services	Achieved, 1 major learning
I05.3 Reduction in & prevention of suicidal behaviour in the criminal justice system	Achieved, 1 major learning
105.4 Best practice among health & social care practitioners via clinical guidelines & training	Achieved, 1 major learning

Under IO5.1 develop and implement national standards and guidelines for statutory and non-statutory organisations contributing to suicide prevention , a best practice guidance(BPG) document was published by HSE NOSP in 2019. Co-produced with NGOs, the guidance is aligned

with national frameworks on mental health and healthcare quality and is based on a self-assessment model. The BPG is implemented voluntarily by stakeholders (as opposed to a compulsory 'standards' framework, which would require as inspection system). An evaluation of the BPG found that the quality standards were comprehensive and aligned with CfL. Following the evaluation, the BPG was aligned with the HSE Service Level Agreement process, strengthening oversight and monitoring for funded NGOs. Additionally, the role of the Charities Regulator was acknowledged in ensuring compliance with legal and governance standards (Charities Regulator, 2018).

Under IO5.2 improved response to suicidal behaviour within health and social care services the evidence reviewed pointed towards efforts to promote a uniform procedure to respond to suicidal behaviour through the 2020 HSE Incident Management Framework which provides general guidance on complying with statutory and HSE requirements in relation to managing incidents (Office of the Chief Clinical Officer, 2020). In addition, HSE 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. In addition, the NSRF 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.

Under IO5.3 reduction and prevention of suicidal behaviour in prison (adults) and children detention schools (minors), a key initiative is the Self-Harm Assessment and Data Analysis (SADA) project which plays a central role in monitoring and addressing suicidal behaviour within Irish custodial settings. The project provides comprehensive annual data on suicidal behaviour across all twelve Irish adult prisons. SADA data offers detailed insights into the incidence and profile of self-harm in prison environments, identifying both individual and contextual risk factors, as well as patterns of repeat self-harm. This evidence base is used by the Irish Prison Service's National Suicide and Harm Prevention Steering Group (NSHPSG) to inform targeted prevention and response measures within the Irish Prison Service, contributing to a more proactive and data-driven approach to harm reduction (Irish Prison Service, 2018; 2020; 2021). A peer-reviewed study published in 2023 analysed longitudinal data from the SADA project 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). This finding underscores the importance of sustained monitoring and intervention, while also highlighting the need for continued innovation in prevention strategies.

Under IO5.4 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 the evidence reviewed highlighted a number of key developments. Operational guidance documents were developed for health practitioners in emergency departments and for Specialist Clinical Assessment Nurses (SCANs) to support the implementation of the National Clinical Programme for the Self-Harm and Suicide-related Ideation (NCPSHI) Model of Care (HSE, 2024; College of Psychiatrists of Ireland, 2022). These resources aim to standardise care and improve outcomes for individuals presenting with self-harm or suicidal ideation. In terms of education, several initiatives have been introduced:

- STORM Training, an accredited programme in self-harm and suicide prevention, was delivered to 109 participants in 2024 by the HSE and STORM UK (Storm Skills Training,).
- The NSRF developed a pilot suicide prevention module for third-level curricula, currently being tested with 200 students. A future evaluation will assess its impact on knowledge, competence, and student feedback (NSRF, n.d.).
- The Self-Harm Assessment and Management Programme for General Hospitals Programme (SAMAGH) provides advanced training for hospital staff in managing high-risk self-harm cases. Developed through an evidence-based protocol, it is proposed for rollout across all 27 public hospitals (Arensman et al., 2020).

These developments reflect a coordinated effort to strengthen clinical practice and build capacity among frontline professionals in suicide prevention.

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

Intermediate Outcomes	Rating
I06.1 Restrict access to frequently used drugs in intention drug overdose	Achieved, 1 major learning
I06.2 Reduce access to highly lethal methods used in suicidal behaviour	Achieved, >1 major learning

Under I06.1 restrict access to frequently used drugs in intention overdose the evidence reviewed shows that focus has been on improving prescribing practices by limiting the quantity of tablets dispensed, ensuring regular reviews of repeat prescriptions, and encouraging the use of lower-lethality alternatives where possible. A key initiative in this space is the Preventing Paracetamol-Related Drug Overdose Working Group, established in 2021. This multiagency group has led a national pharmacy information campaign and supports ongoing surveillance through the National Suicide Research Foundation. Complementing this work is the Department of Health's national DUMP (Disposal of Unused Medication Properly) scheme, funded under budget 2025 and currently in development. Its impact will be assessed through the HRB funded RESTRICT (Reducing intentional overdose: a mixed methods study of means restriction interventions) mixed methods research project led by University College Cork.

Meanwhile the 2025 Report of the Multiagency Working Group on Overprescribing of Benzodiazepines, Z Drugs and Gabapentinoids in Ireland highlights progress including a downward trend in some data on prescribing and regulatory updates to the Misuse of Drugs regulations introducing additional controls, and subsequent PSI and Medical Council guidelines and tools developed for GPs and Pharmacists. The report also points to areas needing attention: better access to counselling services, stronger public and professional education, improved data transparency, especially for private prescriptions, and consideration of tighter controls on drugs like Pregabalin and Gabapentin. Together with ongoing research and surveillance, these efforts are shaping a more informed and proactive approach to reducing international overdose in Ireland.

Under I06.2 reduce access to highly lethal methods used in suicidal behaviour focus has been on strengthening efforts to prevent suicide in public places. HSE NOSP developed the Suicide in

Public Places: A Best Practice Toolkit (2025), in collaboration with a multi-agency advisory group, to supports public bodies in identifying and addressing high-risk locations. At the time of writing, one Health Impact Assessment had been completed using the toolkit, with another underway. At the same time, the Samaritans has ongoing engagement with Irish Rail and UK Network Rail to share best practices and restrict access to high-risk locations. As to whether there has been a reduction in the numbers (proportions) of suicide deaths by highly lethal methods, published data from the CSO and the IPSDS does not show the overall proportion of deaths by highly lethal methods. Analyses of 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 evidence points to meaningful progress in suicide prevention through environmental design, inter-agency collaboration, and targeted research.

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

Intermediate Outcomes	Rating
IO7.1 Improved access to timely & high quality data on suicidal behaviour	Achieved, 1 major learning
IO7.2 Current recording procedures for suicide deaths in Ireland reviewed	Achieved, 1 major learning
IO7.3 National plan that supports research innovation aimed at early identification	Achieved, 1 major learning
IO7.4 Evaluation of the effectiveness of Connecting for Life	Achieved, 1 major learning

Under IO7.1 improved access to timely and high-quality data on suicidal behaviour the evidence reviewed showed that efforts under CfL to improve access to timely and high-quality data on suicidal behaviour are reflected across key data categories: population-level data, self-harm presentations, suicide mortality, deaths in mental health services, and near real-time suicide data. At a population level data, the suicide prevention model was added to the annual Healthy Ireland (HI) Survey (see IO1.1 for more details) which helps improve understanding of suicide prevalence and exposure. For self-harm data, the HSE NOSP-funded National Self-Harm Registry (NSHR), active since 2000, tracks presentations to emergency departments nationwide. Outputs include annual reports, regional data for HSE ROSPs and implementation teams, infographics, and academic publications. In addition, increased capacity in the NCPSHI has helped facilitate the availability of data.

Regarding suicide mortality data, the Irish Probable Suicide Deaths Study (IPSDS), a collaboration between HSE NOSP, HRB, and Irish Coroners, has resulted in a comprehensive 6-year dataset (2015–2020) of coroner and research determined suicide. Outputs include national and CHO-level reports and academic articles. Building on this, the Health Research Board (HRB) are implementing a National Probable Suicide Monitoring System based on the IPSDS framework. In mental health services, the NSRF is leading a project to merge HSE and Mental Health Commission datasets to better understand suicides occurring within these settings. While outputs are pending, two reports are in draft and will inform future strategic planning. To enable near real-time monitoring the NSRF developed the Suicide Observatory, which collects suspected suicide data from Cork Coroners and the HSE Patient Mortality Register. This supports early identification of clusters, emerging methods, and locations of concern, and informs timely responses and policy planning. An evaluation and scalability assessment of the Observatory is underway. Finally, HSE NOSP is also working with the Garda Victim Liaison Office to establish a joint protocol and data-sharing agreement to facilitate near-real-time data collection. While not yet finalised, this initiative aims to further strengthen interagency collaboration and data access.

Under IO7.2 review current recording procedures for suicide in Ireland, the CSO Suicide Mortality Statistics Liaison Group, which include representatives from the CSO and the NSRF, meets twice yearly and aims to improve suicide statistics and dissemination. Additional work under this action includes the IPSDS Study which collected data on coroner and research determined suicides in Ireland (2015–2020). Given its broad inclusion criteria, it recorded more deaths included in official CSO statistics. Analysis of the IPSDS data shows that the current coronial system may be underestimating the number of reported suicides (in 2015–2018)– primarily due to no verdict being formally recorded. 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 an increase in the number of reported suicides (Indecon International Research Economists, 2024). However the HRB's National Probable Suicide Monitoring System is including both coroner and research determined suicides.

Under IO7.3 develop a national plan supporting research since 2020, the national research plan under CfL has been delivered through a Collaborative Research Grant Scheme, supporting research aligned with CfL priority groups. Eleven projects were funded and featured in a Book of Abstracts (2021), with briefing papers published in 2023. Topics included homelessness, substance use and mental ill-health, ADHD, Traveller men, acute mental health care, bullying, bereavement, ED

presentations, sex workers, first responders, parents of adolescents who self-harm, and farmers. Outputs also included conference presentations and journal articles. It is unclear whether the scheme will continue to receive funding. A scoping review by Hursztyn et al. (2024), commissioned by the Higher Education Authority with HSE NOSP support, reviewed 629 studies from 2015–2023. Conducted under the C-SSHRI network, it assessed the current state of suicide and self-harm research across Ireland and Northern Ireland and recommended further research on CfL priority and other at-risk groups. Together, these initiatives reflect a growing, structured approach to suicide prevention research, grounded in collaboration and aligned with national priorities.

Under the IO7.4 commissioning of evaluation studies the evidence reviewed showed a broad and expanding programme of work. Since 2020, 18 evaluation studies have been completed, covering a wide geographic spread. The evaluations also span a diverse range of target groups. This body of work includes five evaluations authored by the National Suicide Research Foundation (NSRF), two in collaboration with University College Cork, and eight commissioned to external agencies, including consultants and one university, all funded by HSE NOSP. The scale and diversity of this evaluation activity demonstrate a strong commitment to evidence-informed implementation and continuous learning. Preceding this, a comprehensive research synthesis was conducted by the Centre for Effective Services (CES) in 2021. Reviewing 31 commissioned studies from the first phase of Connecting for Life, the CES aligned findings with strategic goals and priority groups. In addition, an interim strategy evaluation was also completed in 2019 by the CfL Evaluation Advisory Group, assessing progress on key actions and offering recommendations for future development. Further expanding the evidence base, a scoping review of suicide and self-harm research in Ireland and Northern Ireland (2015–2023) was commissioned by the Higher Education Authority with HSE NOSP support (Hursztyn et al., 2024), as referenced under IO7.3. All evaluations referenced above are publicly accessible, reinforcing transparency and knowledge sharing.

Table 3.1 Assessment of CfL Intermediate Outcomes

Goal 1 To improve the nations understanding of, & attitude to suicide, mental health and wellbeing	
IO1.1 Improved population-wide understanding of suicidal behaviour, mental health & wellbeing, and associated protective & risk factors. The evidence reviewed showed significant stakeholder-level research into the complex factors influencing mental health and suicidality. Public engagement with mental health is increasing, as seen in initiatives like the HSE Mental Health Literacy Campaign. Primary data indicates the need for better public-facing engagement and deeper public understanding.	**Achieved, 1 minor learning/ challenge**
IO1.2 Increased awareness of available suicide prevention and mental health services. Evidence to support progress on this IO is weaker. A population level increase in engagement with mental health issues is evident (JHSE Mental Health Literacy Campaign). Primary data points to a need for clearer public communication and deeper understanding, especially among marginalised groups.	**Achieved, 1 major learning/ challenge**
IO1.3 Reduced stigmatising attitudes to mental health and suicidal behaviour at population level and within priority groups. Significant work has progressed to address stigma, including an annual national (Green Ribbon) 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.	**Achieved, 1 major learning/ challenge**
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. Guidelines and other resources are available to the media. Media training is available and media monitoring (via Headline) seems to have significant reach and sustainability. There is evidence that research and evaluation has been used to inform planning and address issues identified.	**Achieved, 1 minor learning/ challenge**

Strategic Goal 2 To support communities'	
IO2.1 Continued improvement of community-level responses to suicide through planned multi-agency approaches. Innovation and local implementation were evident strengths. However, challenges included poor communication, perceived gaps in funding and resources, and staff turnover—including leadership changes. While all areas developed local action plans, only some were updated during the extended strategy period. Primary data also highlighted a disconnect between the national strategy and local implementation.	**Achieved,** 1 major learning/ challenge
IO2.2 Accurate information & guidance on effective suicide prevention are provided for community-based organisations Three collaboratively produced Guidance Documents are available to all community-based organisations. However, there was no data available on the extent to which these have been accessed, and/or their effectiveness.	**Achieved,** **1** major learning/ challenge
IO2.3 Training and education programmes on suicide prevention to community-based organisations. Comprehensive training programmes implemented under CfL are a key strength.. A wide suite of programmes is available, reaching thousands annually; for example, 16,000 people are trained each year in suicide and self-harm prevention. Quality assurance and planning are evident. Sustainability is however dependent on future funding.	**Achieved,** & sustainable

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 NGOs supporting priority groups received substantial funding. Community organisations have access to training (102.3), and there have been awareness raising and education initiatives with CfL lead agents. However engagement with priority groups remains fragmented and largely driven by NGOs with limited integration into public services. Sustainability concerns were noted.	**Achieved,** **1** major learning/ challenge
IO3.2 Support provided to the Substance Misuse Strategy, to address the high rates of alcohol & drug misuse Support for the Substance Misuse Strategy is evident through the sustained national rollout of SAOR training However, no secondary data was found on other relevant programmes. Primary data highlights substance misuse as a key suicide risk factor, yet it remains poorly integrated into CfL planning and activity. Challenges include siloed policies and fragmented service provision.	**Achieved,** >1 major learning / challenge

IO3.3 Enhanced supports for young people with mental health problems or vulnerable to suicide NGO-led support for young people was a notable strength. Data shows that engagement is often driven by NGOs or community groups, with limited integration into public services. Primary data highlights progress in engagement and signposting, but also notes overreliance on underfunded services and unclear pathways. Wellbeing is a recognised priority in schools and is embedded in the School Self-Evaluation process.	**Achieved,** 1 minor learning/ challenge

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 Data shows the NCPSHI and the SCAN service are valued and positively impact care. However, SCAN's reach is currently limited. NCPSHI faces challenges including inconsistent follow-on care and a lack of national coordination. A key strength is the availability of a standardised model of care and operational guidance. Secondary data shows many GPs have been trained to manage suicidal ideation, with ongoing efforts targeting trainees. The rollout of STORM training remains a challenge.	**Achieved, 1 major learning/ challenge**
IO4.2 Improved access to effective therapeutic intervention for people vulnerable to suicide Three evidence-based models of care for vulnerable groups have been developed. One is in pilot, one is being rolled out and evaluated, and no data is available on the third. National DBT training shows coordinated progress, but data on CAMS expansion is lacking. Online CBT provision through licensed access for primary care and NGOs is strong, though primary data highlights regional inconsistencies and unclear referral pathways between statutory and NGO services.	**Achieved, 1 major learning/ challenge**
IO4.3 Improved uniformity, effectiveness & timeliness of support services to families & communities bereaved by suicide Data indicates that the SBLS and HUGG services are valued, though gaps in reach remain, particularly for marginalised groups. Challenges include role clarity, staff turnover, burnout risk, inconsistent referral pathways, and variable cross-sectoral collaboration across CHOs. Peer support awareness is limited, and service availability and wait times vary regionally. The appointment of a National Suicide Bereavement Support Coordinator and development of resources are positive steps. Primary data indicates postvention has improved under CfL, despite perceptions of limited strategic focus.	**Achieved, 1 major learning/ challenge**

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. Best practice guidance is available to both statutory and non-statutory agencies. An independent evaluation found the guidelines comprehensive and aligned with CfL. However, smaller organisations struggled to engage fully due to limited resources. A limitation is that implementation remains voluntary, though the guidance is now aligned with the HSE Service Level Agreement process.	**Achieved, 1 major learning/ challenge**
IO5.2 Improved response to suicidal behaviour within health & social care services (initial focus on incidents within mental health services) Limited secondary data were available to support progress on this IO. HSE NOSP has published guidance for staff in community mental health services, aligned with the HSE Incident Management Framework, promoting a standardised, culturally sensitive response to suspected suicide deaths. As noted under IO4.1, a key strength of the SCAN service and NCPSHI is the availability of a standardised model of care and operational guidance, along with significant GP training in managing suicidal ideation. However, data on STORM training rollout remains limited.	**Achieved, 1 major learning/ challenge**
IO5.3 Reduction in & prevention of suicidal behaviour in the criminal justice system 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.	**Achieved, 1 major learning/ challenge**
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. Secondary data highlights the availability of clinical guidelines for SCAN, NCPSHI and accredited training programmes. SAMAGH guidelines for hospital staff are under evaluation. Primary data reveals gaps in awareness of existing guidelines. STORM training is being delivered by the HSE and a suicide prevention module is currently being piloted with health and social care students. Training for community-based organisations remains a key strength of CfL (IO2.3)	**Achieved, 1 major learning/ challenge**

Strategic Goal 6 To reduce and restrict access to means of suicide	
IO6.1 Reduced access to frequently used drugs in intentional drug overdose. Both secondary and primary data noted significant progress in restricting access to paracetamol. The DUMP scheme, is in development. The 2025 Report of the Multiagency Working Group on Overprescribing of Benzodiazepines, Z Drugs and Gabapentinoids in Ireland outlines recommendations to inform future planning including improved access to publicly funded counselling, improved education for professionals and the public, and enhanced data quality. The HRB RESTRICT study also provides valuable evidence to support future means restriction efforts	**Achieved, 1 major learning/ challenge**
IO6.2 Reduced access to highly lethal methods used in suicidal behaviour The 'Suicide in Public Places: Best Practice Toolkit 2025' was developed by HSE NOSP with a multi-agency group. One HIA has been completed using the toolkit, with another underway. Primary data shows varied local approaches to suicide-proofing, with barriers including stakeholder engagement and unclear ownership, and enablers such as strong partnerships. The lack of a national means restriction strategy was noted. Data for the second indicator—reducing suicide deaths by highly lethal methods—is limited and outdated. An academic study (2007–2019) reports increased self-harm by hanging and drowning.	**Achieved, 1 major learning/ challenge**

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 Evidence highlights the lag in suicide data. Both primary and secondary data indicates that the lack of near real-time data is an issue affecting local coordination. Efforts to address this thought data-sharing agreements between key stakeholders are not yet finalised. A pilot project accessing near real-time data via coroners (the Suicide Observatory) has been underway in two areas, with scalability being assessed. Other related development include the HRB's new National Probable Suicide Monitoring System (NPSMS), based on IPSDS, which collects data on probable suicide. Data from the Healthy Ireland Survey was also noted, and an ongoing project to merge HSE and Mental Health Commission datasets to better understand suicide in mental health services. Overall, while system improvements are progressing, delays, limited real-time access, and coordination challenges remain.	**Achieved, 1 major learning/ challenge**

IO7.2 Current recording procedures for suicide deaths in Ireland reviewed (and if necessary revised) The secondary data show that current recording procedures have been reviewed. The new HRB system of coronial data collection (NPSMS) based on the IPSDS, is being implemented. Primary data indicated a lack of timely data and a limited understanding of formal recording procedures by some groups.	**Achieved, 1 major learning/ challenge**
IO7.3 Development of national plan that supports research innovation aimed at early identification of suicide risk, assessment intervention& prevention A national plan is in place through a collaborative research grant scheme, which has funded studies focused on priority groups. While successful partnerships between NGOs, academics, and policymakers have emerged from this scheme, there is no evidence of continued funding, raising concerns about sustainability. A recent scoping review and primary data highlight the need for further research on CfL priority groups and other at-risk populations. Overall, the research framework shows promise, but long-term sustainability and coverage of emerging needs remain uncertain.	**Achieved, 1 major learning/ challenge**
107.4 Evaluation of effectiveness of Connecting for Life A CfL monitoring and evaluation framework for the overarching strategy was developed by HSE NOSP in 2018. . Key related evaluation outputs include the 2019 CfL Interim Strategy Review and this evaluation of CfL's implementation and intermediate outcomes. In addition, a research review and synthesis of externally commissioned work carried out under the first half of CfL was undertaken (published in 2021); 31 publicly available evaluation report were reviewed. Since 2020 a further 18 evaluations have been commissioned. A recent scoping review and primary data highlight the need for further research on CfL priority and at-risk groups. Overall, while evaluation activity has been substantial, future efforts should prioritise sustainability, strategic alignment, and outcome-focused measurement.	**Achieved, 1 major learning/ challenge**

Section 4: Evaluation of CfL's implementation

4.1 Overview

Evaluating implementation is essential to understanding a strategy's effectiveness in practice. It reveals how well intended actions are delivered, identifies barriers and enablers, and ensures that outcomes are interpreted in the context of real-world delivery. The analysis presented in this section synthesises the primary data collected. That is the data collected from the Rapid Insight (RI) sessions carried out with three key stakeholder groups: representatives for the Cross-Sectoral Steering and Implementation Group, NGO partner organisations, and the HSE ROSPs. The 25 interviews with persons responsible for implementation of CfL (HSE NOSP staff, members of the Cross-Sectoral Steering and Implementation Group, Department of Health staff, HSE staff, and NGO representatives) and the two stakeholder surveys (i.e., with HSE ROSPs and local implementation teams). The findings are presented under headings from the implementation frameworks used in analysis.

4.2 Contextual factors

Contextual factors play a critical role in shaping how a strategy is implemented and experienced. These include organisational capacity, leadership, policy alignment, and socio-political climate. Analysis of the Rapid Insight sessions and interview data revealed several critical insights across a number of domains. This are detailed below and summarised in Table 4.1. A recurring concern was the duplication of policy efforts, particularly due to overlapping strategies such as Sharing the Vision (Department of Health, 2020), Stronger Together (HSE, 2022), and targeted policies for at-risk groups (e.g., LGBTQI+ and the Traveller Community). These overlaps has created confusion around roles and responsibilities, weakening the coherence of suicide prevention efforts. Interviewees recommended clearer monitoring and accountability mechanisms for CfL, similar to Sharing the Vision, which includes risk ratings and structured reporting. There was a strong call for better integration across mental health policies, with suggestions for a formal oversight structure to coordinate across strategies. Despite the breadth of existing policy, gaps remain, particularly in bereavement support and addressing loneliness, a known suicide risk factor. Legislative delays, such as in prescription control reform, were also seen as barriers to progress.

Funding, staffing, and resource allocation also emerged as key themes. Effective implementation of

CfL requires not only adequate financial support but also sustained staffing. Interviewees stressed the need for a greater share of the health budget to be directed toward suicide prevention. Reliance on one-off funding undermines sustainability, particularly for NGOs facing short-term contracts and recruitment challenges. The lack of multi-annual funding limits long-term planning, and workforce shortages, thereby prevent progress on even well-designed actions. This reflects a broader issue in policy implementation: strong frameworks exist, but without stable funding and staffing, delivery stalls. While NGO funding processes are well structured, there is a need for a more coordinated model to reduce duplication and ensure efficient resource use. Currently, funding requests are not reviewed collectively; a formal structure is needed where funders align on which actions are supported by which departments.

The social-political context also influences CfL's effectiveness. While the strategy has successfully engaged professional and priority groups, some interviewees suggested that there is an opportunity to enhance "general population engagement" with suicide prevention. A major campaign, akin to the FAST campaign for stroke awareness, was proposed as a way to communicate key suicide prevention messages to the public more effectively. Leadership and governance structures were identified as both strengths and vulnerabilities. The Cross-Sectoral Steering and Implementation Group was praised for maintaining momentum and accountability, particularly due to the high-level leadership including the involvement of an Assistant Secretary from the Department of Health. This structure ensured departmental engagement and senior representatives on this group can "nudge" staff on actions that are not progressing. It was seen as a model worth retaining in future strategies. However, leadership instability, both nationally and locally, was a noted barrier to progress.

Organisational fragmentation resulting from HSE restructuring was a concern. The transition from Community Healthcare Organisations (CHOs) to six Health Regions has created challenges in maintaining consistent, unified approaches, especially in areas like mental health promotion and training. There were fears that this restructuring may impact the implementation of any future suicide prevention strategy at national, regional, and local levels. The redistribution of funding responsibilities across HSE Health Regions has introduced additional uncertainty. This reorganisation risks fragmenting the work, as local biases could affect how national NGOs are funded. The disbanding of the HSE's central governance structures raises concerns that mental health and suicide prevention could lose their voice, potentially weakening national oversight.

The role of NGOs was consistently highlighted as vital to CfL's success. NGOs have filled critical service gaps where the HSE lacks capacity; their involvement marks a significant improvement over the previous national suicide prevention strategy, Reach Out which featured less collaboration. However, the variability in NGO accountability and outcome measurement underscored the need for stronger oversight and strategic alignment. At a local level, strong inter-organisational relationships and collaborative structures have enables CfL to be embedded within broader health and wellbeing initiatives, demonstrating the value of cross-sectoral partnership in advancing suicide prevention efforts.

Table 4.1 Contextual factors – Summary table

Domain	Key Insights	Challenges	Recommendations
Policy & Legislation	Overlapping strategies causing duplication of effort, lack of clarity in roles & responsibilities	Duplication of policy efforts weakening cohesion; despite policies gaps remain e.g., in bereavement support & loneliness; legislative barriers	Establish formal oversight mechanism for mental health policies; more transparent monitoring & accountability mechanisms; better policy integration
Funding & Resources	Need for sustained funding and staffing	One-off funding undermines sustainability; causes recruitment issues; lack of multi-annual planning	Strategic funding model; coordinated reviews; reduce duplication
Socio-Political Context	Good engagement with priority groups (via NGOs)	Limited general population engagement	Enhance general public engagement; National awareness campaign (e.g., FAST model)
High-Level Buy-In	Strong leadership via Cross-Sectoral Group	Leadership instability	Retain high-level governance structure
HSE Restructuring	Transition to Health Regions	Fragmentation; funding uncertainty; loss of central governance	Safeguard national oversight; mitigate regional bias
Inter-Organisational relationships	NGOs fill service gaps; improved collaboration	Variable accountability; outcome measurement gaps	Strengthen oversight; better alignment of NGO efforts with strategy

4.3 Implementation processes

Implementation processes refer to the specific activities, structures, and mechanisms through which a strategy is put into practice. In the analysis a number of implementation processes were identified. These are presented in detail below and summarised in Table 4.2 and include cross-sectoral collaboration, stakeholder engagement, training and capacity building, and monitoring and evaluation. These processes are critical to achieving the intended outcomes and are often influenced by contextual factors such as organisational culture, leadership, and available resources.

4.3.1 Cross-sectoral collaboration

The implementation of CfL across multiple agencies, sectors, and governance structures has revealed valuable lessons in cross-sectoral collaboration & stakeholder engagement. Participants in Rapid Insight sessions emphasised the importance of strong leadership, clear governance, defined roles, and shared goals. The Cross-Sectoral Steering and Implementation Group was highlighted as a key enabler, providing a framework for accountability and momentum. Independent evaluations and the cultivation of networks, including agency champions, were also seen as essential to sustaining collaboration. NGO representatives stressed the need for adequate funding and human resources to support planning, implementation and partnership development. These resources were also considered vital for raising awareness of CfL. Meanwhile HSE ROSPs advocated for a structured approach to implementation, underpinned by committed leadership, active feedback loops, achievable actions, and robust monitoring and evaluation. Smaller multi-agency working groups were found to foster stronger relationships and more effective collaboration.

Interviewees consistently identified CfL's whole-of-government design as one of its key strengths. By positioning CfL as both a HSE and national government policy, responsibility is shared across departments and agencies, rather than being confined to mental health services. This approach is supported by governance structures such as the Cross-Sectoral Steering Group, regional implementation coordinated by HSE ROSPs, and structured planning that aligns national priorities with local needs. These elements have helped institutionalise suicide prevention within the broader policy landscape.

However, while cross-sectoral collaboration is a core feature of CfL, structural limitations persist. In many cases, collaboration depends on individual motivation rather than systemic commitment. Uneven buy-in across government departments remains a challenge; some view suicide prevention as central to their remit, while others still see it as a health sector issue. Local government engagement is also inconsistent, particularly when financial investment is required, such as in restricting access to means. Siloed approaches to policy development and service provision further hinder collaboration. Stakeholder engagement faces several challenges, including power dynamics, funding dependencies, and structural constraints. NGOs often operate in a compromised position, reliant on government funding while expected to advocate for policy change. Inter-agency relationships vary in effectiveness, and some agencies participate only in a tokenistic manner. Monthly meetings between HSE NOSP-funded NGOs were described by some as ineffective.

4.3.2 Stakeholder engagement

Stakeholder engagement differs at a national and local levels. National engagement is often "functional, educational and informative", while local engagement tends to be more "practical". However, frequent reinvention of engagement processes is required due to staff turnover and organisational restructuring. A notable gap remains in the meaningful inclusion of lived or living experience voices in national policymaking. Securing consistent participation is particularly challenging within statutory agencies. While local NGOs and community partners are often highly engaged, health service representatives are less consistently involved. HSE ROSPs frequently need to escalate to senior leadership to ensure attendance and follow-through. In contrast, NGOs and community groups are generally more responsive and committed to CfL initiatives. It was also noted that NGOs working exclusively in suicide prevention, intervention, and postvention should be prioritised within CfL's governance structures. Despite these challenges, strong stakeholder engagement and working relationships have developed in some areas. For example, collaboration between the National Suicide Research Foundation (NSRF) and NGOs has led to joint research projects, demonstrating the potential of cross-sectoral partnerships. Successful local implementation relies on strong leadership and high-level buy-in, supported by structures that facilitate cross-sectoral work. While collaboration within clinical care programmes is effective, working with generic mental health services remains more difficult due to capacity constraints. Cross-sectoral and inter-organisational partnerships are essential for learning and advancing suicide prevention efforts. HSE NOSP could benefit from mutual learning with colleagues in areas such as Public Health.

4.3.3 Capacity building and training

Capacity building was identified as a cornerstone of CfL's success. HSE NOSP has delivered extensive training opportunities for both the general public and professional groups, including Gardaí and paramedics. HSE ROSPs play a vital role in liaising with first responders, delivering these initiatives and embedding suicide prevention awareness in frontline services. However, while training is widely recognised as a core suicide prevention strategy, some interviewees questioned its dominance in policy and funding decisions. They noted that suicide prevention training is often easier to justify than direct service provision, which can result in funding imbalances where training is well-resourced but core services remain underdeveloped.

4.3.4 Data and Evaluation

Effective suicide prevention relies heavily on timely, high-quality data and robust evaluation systems. However, current data infrastructure presents significant barriers. Interviewees highlighted the limitations of the coronial system and the lengthy inquest process, resulting in lagged national suicide data. Thus, reliance on Central Statistics Office (CSO) data hampers the ability to assess the impact of suicide prevention measures, particularly in tracking suicide rates. Efforts to establish data-sharing agreements with key stakeholders, such as An Garda Síochána, have been slow, limiting access to critical information. A major gap identified is the absence of a near real-time surveillance system. This lack of timely data restricts the ability to monitor trends, respond to incidents, and counter misinformation, especially at local and regional levels. Near real-time data is essential for guiding public health approaches and enabling rapid, informed interventions. Interviewees also highlighted the fact that current programme evaluation practices tend to focus on outputs (e.g., number of trainings or campaigns) rather than outcomes, such as changes in help-seeking behaviours. Interviewees recommended expanding outcome measurement to include qualitative data (from focus groups for example), and indicators of positive mental health, resilience, and social connectedness. The absence of a continuous outcome framework and integration of intermediate and high-level indicators into regular reporting was noted.

Despite these challenges, progress has been made. The National Self-Harm Registry in tandem with the NCPSHI, and the National Probable Suicide Monitoring System (NPSMS), based on the Irish Probable Suicide Deaths Study (IPSDS) are important steps forward. Additionally, the Collaborative

Research Grant Scheme has successfully fostered partnerships between NGOs, academics, and policymakers, supporting evidence-based decision-making. Nonetheless, data gaps persist, particularly in identifying and supporting high-risk groups. Research and (programme) evaluation remain underfunded, limiting long-term impact assessment. Interviewees also acknowledged the complexity of attributing changes in suicide rates directly to CfL actions, which complicates impact evaluation.

Table 4.2 Implementation processes – Summary Table

Domain	Key Insights	Challenges	Recommendations
Governance & Leadership	Whole-of-government approach; strong steering structures (Cross-Sectoral Group, HSE ROSPs)	Leadership instability; reliance on individual motivation for collaboration	Strengthen systemic leadership; retain high-level governance structures
Collaboration Structures	Multi-agency working groups foster relationships; structured planning aligns national and local priorities	Uneven departmental buy-in; local government disengagement; siloed approaches	Formalise collaboration mechanisms; improve inter-agency accountability
Capacity Building & training	HSE NOSP provides extensive training; HSE ROSPs engage frontline services	Limited capacity in generic mental health services	Expand training reach; strengthen HSE ROSP support; share learning across sectors
	Training is a core strategy but may be over-prioritised compared to service provision	Imbalance in funding; underdevelopment of core services	Rebalance funding to support both training and direct service provision
Data systems	Real-time data essential for timely intervention and public health response; Some progress made (e.g IPSDS & newly established NPSMS)	Delays due to coronial system; CSO data is lagged; lack of real-time infrastructure; Limited integration of data systems into broader evaluation frameworks	Develop a national real-time suicide surveillance system; improve data timeliness; Build on existing registries; align with CfL monitoring systems

Monitoring and evaluation	Current programme evaluation focus on outputs, not outcomes	Lack of outcome tracking; limited integration of performance metrics	Expand outcome measures (e.g., resilience, help-seeking); embed indicators in reporting
Evidence-Based Decision-Making	Collaborative research partnerships are effective	Underfunded evaluation; limited data on high-risk groups	Increase funding for research and evaluation; improve data on vulnerable populations
	Attribution of impact to CfL actions is complex	Difficulty linking suicide rate changes to specific interventions	Use mixed-methods evaluation; focus on contribution rather than attribution

4.4 Intervention characteristics

Intervention characteristics refer to the features of a strategy that influence how easily it can be implemented. They are key to strategy evaluation because they help explain variation in uptake and effectiveness across different settings. Adaptability and flexibility under CfL emerged as a key themes in stakeholder feedback. A disconnect at the local level between the national strategy and local delivery was noted, particularly in the inconsistent composition of local implementation teams. Interviewees emphasised the importance of local autonomy within broader governance structures, and suggested that greater opportunities for shared learning across regions could reduce duplication and improve coherence. Concerns were raised about the potential impact of the ongoing HSE restructuring, which may introduce bureaucratic hurdles that hinder suicide prevention efforts. Maintaining flexibility for local implementers to respond swiftly and effectively to emerging needs is critical to sustaining CfL's impact. Regional adaptability was also highlighted with interviewees noting that what works in one area may not be suitable for another, due to differences in demographics, risk profiles, and evolving community needs. While a national strategy provides necessary direction, the ability to tailor interventions to local contexts is vital.

HSE ROSPs were consistently identified as key enablers of local implementation. Their embedded presence in communities allows them to build relationships with local agencies and act as a bridge between national strategy and local action. However, HSE ROSPs require support from leadership to effect change, particularly when they identify issues that need escalation to senior decision-makers.

Inconsistencies in HSE ROSP reporting structures were also noted. Depending on the region, HSE ROSPs report to different roles within the HSE, which affects their influence and ability to advocate for suicide prevention within the system.

Local implementation was seen as a way to improve reach to priority groups. For example, targeted training for the Traveller community, delivered in collaboration with the Traveller Mental Health Coordinator, was cited as a successful initiative. NGOs were also recognised for their valuable insights into local and regional needs. Many collect service user data at the Community Healthcare Organisation (CHO) level, which could be better utilised to inform local planning and strategy refinement.

Adaptability remains a critical factor in successful implementation. The strategy must respond to evolving service needs, structural changes within the HSE, and external events such as the COVID-19 pandemic. Regional implementation also requires flexibility, including empowering NGOs and external collaborators to lead actions. Understanding local contexts and leveraging existing relationships is key to identifying champions and tailoring actions to regional needs. Some criticisms were raised regarding CfL's adaptability. The shift to digital services created barriers for populations with low digital literacy, and the lack of a major strategy review following the pandemic left some aspects outdated and misaligned with current service delivery models.

Table 4.3 Intervention Characteristics – Summary Table

Domain	Key Insights	Challenges	Recommendations
Local Implementation	Tailoring interventions to local contexts improves relevance and impact.	Regional differences in demographics and needs; limited flexibility to respond to emerging issues.	Empower local implementers; maintain flexibility to adapt actions to local contexts.
HSE ROSPs	HSE ROSPs are key enablers due to their community presence and bridging role.	Inconsistent reporting structures; limited influence without leadership support.	Standardise reporting lines; strengthen leadership backing to support HSE ROSP advocacy.
NGO Contributions	NGOs provide valuable local insights and data	Limited integration of NGO data into planning	Use NGO data to inform regional planning and strategy refinement

Adaptability	Strategy must evolve with service needs, structural changes, and external events.	Digital shift excluded some populations; lack of post-pandemic review left elements outdated.	Conduct regular strategy reviews; ensure inclusive service models that reflect current realities.
System-Level Factors	HSE restructuring may impact implementation capacity and responsiveness.	Risk of increased bureaucracy and reduced agility in suicide prevention efforts.	Safeguard local flexibility; streamline governance to support timely and effective action.

4.5 Implementation Outcomes: Reach and Sustainability

The data presented here focus on two key implementation outcomes. Firstly reach, the extent to which CfL work has reached it intended audiences and/or sectors. Secondly CfL's potential for long-term sustainability. The findings provide insight into how well the strategy has been embedded in practice.

Regarding reach, efforts to raise public awareness around suicide prevention were seen as needing a more proactive and inclusive approach. While current strategies focus on at-risk groups, interviewees emphasised the importance of equipping the general population with basic knowledge before a crisis occurs. Reaching minority and high-risk groups, such as the Traveller community, neurodiverse individuals, and those facing intersectional challenges like homelessness and addiction, remains difficult due to resource gaps, literacy barriers, and inconsistent stakeholder engagement. Demographic shifts and regional differences mean that priority groups vary over time and location. Interviewees recommended keeping the list of priority groups under regular review and improving collaboration with other service providers to enhance reach and build capacity. Clearer service pathways, especially for individuals with co-occurring needs (e.g., addiction and mental health), were also identified as a priority.

On sustainability, stakeholders across groups agreed that future suicide prevention efforts require a more streamlined, trauma-informed strategy with fewer but more targeted actions. Key elements for sustainability include policy alignment, realistic timelines, clear outcome indicators, and multi-year funding. Interviewees stressed the need for strong governance, improved coordination between statutory and NGO sectors, and better integration of lived experience voices. Challenges to sustainability include short-term funding arrangements, leadership turnover, and uncertainty

caused by HSE restructuring. A broader public health approach was suggested to reduce stigma and improve long-term viability. Visibility and communication, such as showcasing CfL partnerships and maintaining a strong online presence, were also seen as essential to sustainability.

Table 4.4 Implementation Outcomes Summary

Domain	Key Insights	Challenges	Recommendations
Reach	Public awareness should include general population, not just at-risk groups	Limited engagement with minority groups; literacy barriers; changing demographics	Broaden outreach; regularly review priority groups; improve stakeholder collaboration
	Intersectionality influences risk (e.g., homelessness + addiction)	Lack of tailored support for complex needs	Recognise and address intersectional vulnerabilities
	Service pathways need to be clearer and more inclusive	Barriers to accessing counselling for co-occurring issues	Improve access to primary care counselling; streamline referral pathways
	Collaboration with other services improves reach	Inconsistent engagement across sectors	Strengthen partnerships and shared ownership
Sustainability	A streamlined, trauma-informed strategy is needed	Overly complex strategies; lack of postvention focus	Simplify strategy; separate suicide and self-harm; align with other policies
	Multi-year funding and implementation planning are essential	Short-term funding; leadership turnover; HSE restructuring	Secure long-term funding; build implementation capacity; plan for continuity
	Strong governance and coordination improve outcomes	Unclear roles; weak HSE NOSP coordination; lack of feedback loops	Clarify governance

4.6 Emerging issues and critical reflections

This section presents key findings from the data, highlighting both areas of strength and opportunities for reflection. The strengths illustrate where the strategy has been effectively implemented, alongside these, critical reflections offer insight into challenges encountered, limitations in approach, and areas requiring further attention or adaptation.

4.6.1 Strengths

Ireland's approach to suicide prevention was widely recognised by stakeholders as distinctive and exemplary from an international perspective. The national strategy was described as a globally unique, whole-of-government initiative. The fact that it is supported by a structured governance model, cross-sectoral collaboration, and a dual accountability framework between the Health Service Executive (HSE) and the Department of Health was noted by many as a key strength. The presence of a dedicated suicide prevention office, the HSE NOSP, was considered to further reinforce this approach. HSE NOSP was described as one of the most effective agencies within the health sector, playing a proactive role in promoting the strategy, clarifying stakeholder responsibilities, and sustaining implementation momentum.

Analysis shows that CfL has successfully fostered meaningful cooperation across a range of government departments and agencies, including An Garda Síochána, the Department of Justice, and the Irish Prison Service. This collaborative ethos has been central to the strategy's reach and effectiveness. Implementation at the local level has been enabled through multi-agency groups comprising NGOs, statutory sector representatives and health services. HSE ROSPs and NGOs are particularly vital to CfL's success, especially in delivering training and engaging with frontline services. When adequately supported, HSE ROSPs are deeply embedded in their communities and play a pivotal role in local suicide prevention efforts. The strategy benefits from a well-defined implementation framework, with clearly structured actions and designated ownership. This clarity has been instrumental in driving progress and ensuring accountability across all levels. Significant improvements have also been made in research and evaluation. The Evaluation Advisory Group has provided invaluable external expertise, guiding the development of robust monitoring and research mechanisms. The Collaborative Research Grant Scheme has produced tangible outcomes, including new studies focused on suicide among high-risk groups such as farmers and prisoners.

CfL has introduced a range of impactful initiatives, particularly in the area of suicide bereavement. These include the publication of Safe Harbour (Forde, 2024), the National Suicide Bereavement Guide (HSE NOSP, 2021), targeted grief training, a GP awareness campaign, and comprehensive training programmes such as Let's Talk About Suicide. Small but meaningful shifts in service delivery have also been noted, such as the deployment of Suicide Crisis Assessment Nurses (SCAN) to work with Traveller communities, an initiative driven by data-informed advocacy. Community-based mental health promotion has emerged as another key success, with social prescribing and partnerships with local authorities playing a central role.

Table 4.5 CfL Strengths and reflections Summary

Domain	Key Insights	Challenges	Recommendations
National Strategy & Governance	Internationally recognised whole-of-government approach; dual accountability (HSE & Dept. of Health); strong HSE NOSP role.	Sustaining long-term momentum and cross-departmental commitment.	Continue reinforcing governance structures and ensure sustained political and institutional support.
Cross-Government Collaboration	Effective partnerships with An Garda Síochána, Dept. of Justice, Irish Prison Service.	Coordination across diverse agencies can be complex and resource-intensive.	Strengthen inter-agency protocols and shared accountability mechanisms.
Local Implementation	HSE ROSPs and NGOs are central to community engagement and training; flexible multi-agency structures.	Variable support and resourcing for HSE ROSPs; uneven local capacity.	Ensure consistent funding and support for HSE ROSPs; build local capacity through targeted investment.
Implementation Structure	Clear ownership and action plans enhance accountability and delivery.	Risk of fragmentation if roles or responsibilities are unclear.	Maintain clarity in roles and responsibilities; regularly review implementation plans.
Research & Evaluation	Evaluation Advisory Group and Collaborative Research Grant Scheme have produced valuable insights.	Need for ongoing, targeted research in emerging and high-risk areas.	Expand research funding and focus on under-represented groups and emerging trends.
Suicide Bereavement Initiatives	Resources like Safe Harbour, bereavement guides, grief training, and GP campaigns are impactful.	Ensuring equitable access to bereavement supports across regions.	Scale up bereavement supports nationally;

4.6.2 Areas for improvement

Stakeholders identified several areas where CfL could be strengthened. A recurring theme was the need for improved operational collaboration and clearer alignment between national strategy and local implementation. This includes better coordination across sectors, clearer roles and responsibilities, and enhanced oversight of shared Key Performance Indicators (KPIs). Communication was also highlighted as a key area for improvement, both internally among stakeholders and externally with the public. Suggestions included increased use of digital platforms, more public engagement, and dedicated funding to support communication efforts. The inclusion of lived experience was noted as a critical gap. Stakeholders felt that people with lived or living experience of suicide should be involved from the outset and throughout implementation. NGOs called for better coordination between national structures and local partners, more focused HSE NOSP meetings, and stronger attention to priority groups such as prisoners, LGBTQI+ individuals, and the Traveller community. Funding was a consistent concern, with calls for more targeted investment and longer-term funding arrangements. HSE ROSPs emphasised the need for clearer governance at both national and local levels, better integration with other HSE strategies, and stronger feedback loops. They also highlighted the importance of having clear KPIs and local implementation plans before strategy launch. Access to better suicide-related data, including social determinants, was seen as essential for more effective planning and evaluation.

Interviewees pointed to inconsistent inter-departmental engagement and a narrow framing of suicide as primarily a mental health issue. A broader public health approach was recommended to address stigma and improve sustainability. Existing public health tools, such as Health Atlas, could support suicide surveillance and mapping of deprivation. Strategic gaps were also noted, particularly the lack of focus on upstream determinants like financial stress and the absence of key departments such as Social Protection. Monitoring and reporting practices were seen as inconsistent, with suggestions to improve communication between steering groups and NGOs, include HSE ROSPs in NGO meetings, and ensure reporting aligns with pre-agreed metrics. At the local level, implementation structures vary widely, leading to inconsistent focus and leadership.

Misunderstandings about roles, such as that of the Suicide Bereavement Liaison Officer (SBLO), were also noted. Finally, systemic weaknesses persist, including limited access to therapeutic supports and weak local government buy-in in some areas. The absence of real-time data collection was identified as a major gap, with stakeholders calling for improved surveillance systems to support timely and targeted interventions.

Table 4.6 Areas of improvement summary

Domain	Key Insights	Challenges	Recommendations
Strategy & Governance	Strong national framework and leadership through HSE NOSP	Misalignment between national strategy and local plans; unclear roles and KPIs	Improve operational coordination; clarify responsibilities and shared KPIs across all levels
Communication	Commitment to stakeholder engagement	Limited public engagement; weak internal communication; underuse of digital platforms	Invest in public-facing campaigns; enhance digital communication; improve stakeholder updates
Inclusion of Lived Experience	Recognition of its value.	Absence of structured involvement of people with lived/living experience	Establish formal mechanisms for lived experience input from strategy design through to implementation
Cross-Sectoral Collaboration	Multi-agency involvement	Inconsistent inter-departmental engagement; lack of key departments (e.g., Social Protection)	Strengthen cross-sectoral governance; include missing departments to address upstream determinants
NGO & HSE ROSP Engagement	Active role in implementation and training	Poor coordination; unfocused meetings; lack of inclusion in decision-making	Improve meeting structure and relevance; include HSE ROSPs in NGO forums; enhance feedback loops.
Funding & Resources	Targeted initiatives supported	Short-term funding; insufficient resources for vulnerable groups and pilot projects	Provide multi-year funding; p

4.7 Future directions

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. 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.

4.8 Survey findings

Finally, Table 4.7 summarises the key findings from the HSE ROSP and local implementation teams surveys. The survey responses revealed several key insights into the implementation of CfL. It is however worth noting that regional engagement varied, with some CHOs showing stronger survey participation than others, potentially reflecting differences in leadership and resources. Stakeholder involvement in the survey was also uneven, with statutory bodies more engaged than minority groups or individuals with lived experience. In brief, analysis of the survey data shows common implementation barriers including insufficient resources, competing priorities, and limited leadership support. While CfL implementation plans were generally seen as clear, they were not consistently understood or followed. Support from HSE NOSP and line managers received mixed reviews, and concerns about long-term sustainability of the work were widespread, particularly due to short-term funding and leadership turnover. Despite these challenges, successful integration examples were noted, including community-led initiatives and strong inter-agency collaborations. Lessons learned emphasised the importance of structured coordination, proactive communication, and consistent leadership. Future priorities include expanding youth mental health services, improving training, and strengthening data systems. Greater inclusion of lived experience voices and better alignment between strategic and operational efforts were also identified as areas for improvement.

It must be noted that differences in focus emerged between HSE ROSPs and local stakeholders. HSE ROSPs tend to concentrate on strategic, system-level issues such as policy alignment, data infrastructure, and gaps in national leadership. In contrast, local stakeholders and implementation

partners are more concerned with operational challenges, including staff turnover, limited administrative support, and the need for practical tools to support frontline delivery. Similarly, views on data use diverge. HSE ROSPs emphasise national-level monitoring and the absence of a comprehensive suicide surveillance system. Meanwhile, local partners focus on applying data in practical ways, such as using community feedback to adjust programmes and training schedules, highlighting the need for tools that support responsive, on-the-ground implementation.

Table 4.7 HSE ROSP/Local Implementer Survey Findings – Summary

Domains	Key findings	Implications/Consideration
Barriers to Implementation	Common barriers: insufficient resources, competing priorities, lack of leadership support	Improved resource allocation and leadership buy-in may be needed to improve implementation
CfL Implementation Plans	Majority found plans clear, but few rated them as very clear; HSE ROSPs adapted plans locally	Consider presentation of implementation plans to improve understanding /adherence
Support for Implementation	Mixed satisfaction with HSE NOSP and line manager support; most rated local HSE support as expected	Improve administrative support and clarify roles/responsibilities of HSE NOSP may be needed
Sustainability Challenges	Concerns over long-term sustainability of CfL action; reliance on short-term funding; leadership turnover	Develop formal sustainability plans; secure long-term funding and leadership stability
Successful Integration	Examples include CYPSC partnerships, NGO collaboration, community-led campaigns	Share success stories & best practices to encourage wider adoption and replication
Lessons & Future Priorities	Emphasis on inter-agency coordination, communication, and leadership stability	Consider prioritising youth mental health, training expansion, and improved data systems
Lived Experience Involvement	Engagement is growing but remains limited; some successful local initiatives noted	Establish advisory roles and peer support positions within implementation teams
Cross-Sectoral Collaboration	Barriers include fragmented data systems and unclear stakeholder	Strengthen data infrastructure and clarify stakeholder roles to support collaboration

	roles; community-led efforts help	
Strategic vs Operational Focus	HSE ROSPs focus on system-level issues; stakeholders on operational challenges	Align strategic and operational planning; bridge national-local gaps
Use of Data	HSE ROSPs seek national data systems; stakeholders use local feedback for programme refinement	Develop national suicide surveillance system; support local data use for continuous improvement

Section 5: Conclusion

The evaluation of Connecting for Life's implementation and intermediate outcomes was designed to address a series of key questions. This section presents a summary of the overall findings by systematically responding to each of these evaluation questions.

To what extent are CfL's suicide prevention activities and strategies aligned with the evidence base and good practice?

The literature review conducted as part of this evaluation, published separately, demonstrates that that CfL's activities and interventions are broadly aligned with the existing evidence base and recognised good practice. The evidence-based suicide prevention interventions identified are largely consistent with those reviewed and reported by Dillon and colleagues (2015), which informed the development of the strategy. Figure 5.1 summarises the key evidence-based suicide prevention strategies identified in the literature review, alongside the corresponding CfL actions. While it remains challenging to directly attribute changes in suicide and self-harm rates to specific interventions, international evidence continues to show that restricting access to (highly lethal) means is among the most effective strategies. Psychosocial interventions also show promising results, although evidence for other approaches remain mixed. Importantly, multi-level interventions, combining various strategies across different settings, are significantly more effective in reducing suicide behaviour than single-level approaches, highlighting the important of a comprehensive, integrated response.

Figure 5.2 presents the core components of best practice in suicide prevention strategy design and implementation, identified through a rapid review of relevant literature. CfL incorporates many of

these design elements. Crucially, it adopts a multi-component systems approach, engaging government department in a coordinated effort to reduce suicide and self-harm. Through its implementation and governance structures, CfL has secures strong buy-in across departments, enabling the delivery of targeted interventions both at a population level and for vulnerable priority groups. CfL has also prioritised stakeholder engagement through cross-sectoral collaboration at local, regional, and national levels. It's combined top-down and bottom-up approach ensures that suicide prevention efforts are responsive to local needs while maintaining a coherent national strategic response. NGO partners are central to delivery, and recent efforts have increased involvement of people with lived experience, contributing to initiatives like Safe Harbour and participating in evaluations. However, future strategies should embed more meaningful involvement throughout all stages i.e., strategy design, implementation, and evaluation. Guided by an implementation science framework, CfL has published three implementation plans and developed local action plans. A monitoring system to tracks implementation progress can help identify barriers. Despite challenges in accessing timely and accurate data, CfL remains data-informed, with embedded monitoring and evaluation processes supporting continuous improvement.

Table 5.1 Evidence-based suicide prevention interventions

Means Restriction

- Limiting access to common means of suicide, such as hanging, drowning, firearms, or medications. This includes policies like safe storage practices or restricting access to lethal substances. This is the focus of all five action under CfL Strategic Goal 6 aimed at reducing and resrict access to means of suicide.

Media Guidelines

- Promoting responsible media reporting to prevent suicide contagion. This includes avoiding sensationalism, offering help resources, and highlighting stories of resilience and recovery. This is the focus of four actions under CfL Strategic Goal 1 (1.4.1-1.4.4) aimed at improving the reporting of suicidal behaviour within broadcast, print and online media

Community-based interventions

- Strengthening social support networks and community resilience through programmes that promote connectedness, social integration, and access to mental health resources. This is the focus of all five actions under CfL Strategic Goal 2 aimed at supporting local community capacity to prevent and respond to suicidal behaviour (largely through the implementation of multi-agency area-level suicide prevention action plans)

Postvention

- Providing support to individuals and communities after a suicide attempt or death. This includes counselling, education, and support groups. This is the focus of key actions under CfL Strategic Goal 4 (4.3.1 & 4.3.2) aimed at improving the uniformity, effectiveness and timeliness of support services to families and communities bereaved by suicide.

Training

- Delivering evidence based training programmes to gatekeepers and GP to enhance knowledge and skills in suicide prevention. This is the focus of multiple CfL actions across a range of strategic goals aimed at upskilling community-based organisaitons (CfL 2.3), health and social care professionals (CfL 3.1), government departments and agencies likely to come into contact with vulnerable people (CfL 5.4.2) and undergraduates of relevant professional (CfL 5.4.4).

Psychosocial interventions

- Enhancing coping and problem-solving skills through therapies like CBT and DBT, which help individuals manage stress and suicidal thoughts. This is the focus of multiple CfL actions across a range of strategic goals including the delivery of services for young people at a primary (CfL 3.3.6) and seconday (CfL 3.3.7) care level; improved psychosocial and psychiatric assessment and care pathways (CfL 4.1) and access to effective therapeutic interventions (CfL 4.2.1)

Crisis Intervention

- Crisis intervention services, including suicide hotlines, crisis centres and mobile crisis teams, which provide immediate support to individuals in acute distress. This is the focus of most actions under CfL Strategic Goal 4 which aims to enhance accessibility, consistency and care pathways for people vulnerable to suicidal behaviour.

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, is crucial. This is the focus of much of the work under CfL Strategic Goal 3 (including actions targeting alcohol and drug misuse (CfL 3.2.1), services for young people (CfL 3.3.7)) and Strategic Goal 5 which aims to ensure safe and high quality services for people vulnerable to sucide

Stigma reduction

- Types of stigma inlcude 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. This is the focus of CfL action 1.3.1 which aims to deliver campaigns that reduce stigma to those with mental health difficutlies within the general population and among priority groups.

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

To what extent did CfL achieve its intermediate outcomes?

To assess the extent to which CfL has achieved its intermediate outcomes, HSE NOSP compiled a multiple lines of evidence document which combined different types of data/information to evidence progress. Analysis of the secondary data presented in the multiple lines of evidence document was structured around CfL's 7 strategic goals and associated intermediate outcomes (IOs). The secondary data was then triangulated with the primary data collected specifically for the evaluation survey, i.e., interview, Rapid Insight and survey 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 the intermediate outcomes (IOs) assessment are presented in Table 3.1. In summary, over the 10-year lifespan of CfL, all IOs were achieved to some extent. More specifically

- **1 IO** (IO2.3) was rated **"**Achieved and sustainable" reflecting strong national delivery of suicide prevention training to community organisation's and gatekeepers, with sustainability dependent on continued funding.
- **3 IOs** (IO1.1, IO1.4, IO3.3) were rated "Achieved, with minor learning or challenge"**,** including improvements in public understanding of suicide, media monitoring (via Headline) and support for vulnerable young people.
- **17 IOs** were rated "Achieved, with one major learning or challenge" indicating progress with areas for refinement.
- **1 IO** (IO3.2) was rated "Achieved, with more than one major learning or challenge"**,** highlighting the need for stronger integration of substance misuse into suicide prevention planning.

Importantly, **no IOs were rated "Not achieved,"** demonstrating broad progress across all of the strategy's objectives.

How well is the top-down/national implementation of the strategy working?

Ireland is described by some interviewees as "unique" in its approach to suicide prevention. CfL is positioned as both a Health Service Executive (HSE) initiative and a cross-sectoral national government policy. This dual positioning ensures that responsibility for suicide prevention is shared across multiple departments and agencies, rather than being housed solely within mental health services. This whole-of-government design is widely recognised as one of CfL's key successes.

CfL's national oversight structures are central to enabling meaningful cross-government collaboration and effective implementation. These include the National Office (HSE NOSP), and the Cross-Sectoral Steering and Implementation Group, chaired by a senior leader from the Department of Health. HSE NOSP was described by interviewees as one of the most effective agencies within the health sector. Its proactive role in promoting the strategy, clarifying stakeholder responsibilities, and maintaining momentum was particularly noted. The Cross-Sectoral Steering and Implementation Group plays a vital role in keeping actions on track. Strong attendance and active participation in this governance forum, coupled with committed leadership from HSE NOSP and the Department of Health, have helped ensure that suicide prevention remains high on the national agenda. Leadership at the national level has been crucial in sustaining suicide prevention as a government priority.

In addition, the CfL strategy provides a clear roadmap for how different government departments, agencies, and NGOs engage in suicide prevention. Stakeholder engagement at the national level was described as strong, with NGOs playing a vital role in delivering CfL actions both nationally and locally. In particular, NGOs help address service gaps where the HSE lacks capacity to deliver directly. However, a challenge was noted in the position NGOs occupy. While they are highly engaged and essential to implementation, they operate in a compromised space, dependent on government funding while also expected to advocate for policy change. This dual role creates an inherent tension that can complicate their engagement.

Other challenges persist; CfL's cross-sectoral collaboration is both a strength with structural weaknesses. 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. A lack of meaningful engagement with lived or living experience voices in national policymaking for suicide prevention was noted; this 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. Policy crossover was also 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) were also perceived as posing significant challenges to the implementation of CfL.

How well is the bottom-up/area-level implementation of the strategy working?

Since the launch of CfL local implementation structures have been established to support delivery at an area level. These structures have made a positive contribution to local implementation, particularly through the development of local action plans and the integration of HSE ROSPs within communities. HSE ROSPs are key enablers of the strategy, playing a pivotal role in tailoring suicide prevention efforts to local needs and extending the strategy's reach, especially among priority groups. When well-supported HSE ROSPs are deeply embedded in communities and play a crucial role in local suicide prevention work.

Strong relationships and collaboration are central to CfL's success, particularly at the local level. In some areas, CfL has been embedded into existing structures through cross-sectoral partnerships, including local health and well-being initiatives, interagency working groups, and local authority strategies. HSE ROSPs also play an essential role in securing the engagement of local NGOs, community partners, and first responders. Their work helps embed suicide prevention awareness within frontline services and ensures that the strategy is responsive to local contexts. As such, when well-supported HSE ROSPs are deeply embedded in communities and play a crucial role in local suicide prevention work.

Local implementation efforts have also strengthened the strategy's ability to reach priority groups. NGOs play a particularly important role in this regard, helping to fill gaps where the HSE lacks

capacity to deliver services directly. While local implement of suicide prevention strategies has been largely successful, several challenges remain. A recurring concern is the gap between national policy intentions and local-level implementation. While CfL's regional structures aim to localise the strategy, an acknowledged strength, regional variation has led to inconsistencies. Some local agencies reported a lack of clear guidance on how to adapt national objectives to their specific contexts, highlighting the need for greater alignment between national strategy and local plans, clearer roles and accountability, and stronger cross-sectoral collaboration.

Communication across implementation structures, from national to regional and local levels, and between sectors, was frequently cited as a challenge. Although CfL's governance structures have improved communication overall, stakeholders emphasised the need for more consistent and timely communication from HSE NOSP to local implementation teams. The absence of real-time, region-specific suicide data further complicates efforts to respond swiftly to emerging needs. Local autonomy within broader governance frameworks is essential for responsive implementation. Concerns were raised that ongoing HSE restructuring was not only creating funding uncertainties, but may undermine this autonomy, potentially limiting the ability of local implementers to act adaptively. Timely access to relevant local data was also identified as a key enabler of effective implementation. Regional adaptability is crucial, as interventions must reflect the unique needs and demographics of each area. While national leadership has remained consistent, regional leadership has been more variable. In many cases, local champions have played a vital role in driving progress. However, stakeholder engagement has faced challenges, particularly due to staff turnover and organisational restructuring, which necessitate frequent re-engagement with key partners. Local government buy-in also varies across regions, and securing consistent cross-sectoral participation remains difficult. Although CfL is a long-term strategy, annual funding cycles have created uncertainty for some organisations, making it difficult to plan, build capacity, and sustain momentum.

Despite these challenges, the concurrent top-down and bottom-up implementation approach is a core strength of CfL. It has ensured that suicide prevention efforts are embedded within communities while maintaining national coherence. Based on the findings of this evaluation, this dual approach should be continued and strengthened in the next iteration of the strategy.

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

CfL has demonstrated a strong and sustained commitment to research and evaluation, as outlined in Strategic Goal 7, which sets out clear objectives, actions, and indicators in this area. A structure implementing system established in 2017 tracked progress by lead agents. In line with best practice an Interim Strategy Review was conducted in 2018 (based on data for the monitoring system) and as recommended, an implementation and intermediate outcomes evaluation was commissioned in 2023. In addition, in 2018, HSE NOSP developed a monitoring and evaluation framework, while a collaborative research grant scheme has supported progress in research focused on CfL's priority groups. While improved systems for monitoring and reporting suicide and self-harm (e.g IPSDS and the subsequent NPSMS) have been developed, more robust data systems are needed to improve outcome measurement.

Across all data sources, several issues were consistently highlighted. These include delays in accessing current suicide data due to time lags in official reporting and the coronial inquest process, which can take years to complete. The absence of real-time surveillance was identified as a critical gap, despite some progress in this area (e.g., the Cork & Kerry Suicide Observatory). Delays in finalising data-sharing agreements have further hindered access to timely suicide statistics at the local level. Additionally, programme evaluations carried out under the strategy tend to focus on outputs rather than outcomes and research gaps persist in relation to priority groups. There were also suggestions to incorporate lived and living experience more meaningfully into evaluation processes. Developing a more integrated outcomes framework and embedding it into the work were seen as essential steps for improving future suicide prevention strategies. In summary, while CfL has made significant progress in building a research and evaluation infrastructure, future efforts must address data delays, strengthen real-time surveillance, improve stakeholder coordination, and shift toward more inclusive and outcome-focused evaluation practices.

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 and 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. 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 could 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.

Section 6: 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.

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