# The Evaluation of Connecting for Life:

## A Summary of Findings

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

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

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# Background

**Connecting for Life (CfL)** is Ireland's national strategy to reduce suicide, first launched in 2015 and extended to 2024 following a mid-term review in 2018. It sets out two core outcomes: to reduce suicide and self-harm rates both across the general population and within identified priority groups. Grounded in international best practice and World Health Organization guidelines, CfL takes a comprehensive, multi-level approach to suicide prevention. It is structured around seven strategic goals (and 69 actions) intended to:

- Improve understanding of suicidal behaviour (Strategic Goal 1),
- Empower communities to effectively prevent and respond to suicidal behaviour (Strategic Goal 2),
- Provide specialised support to individuals at increased risk of suicide i.e. priority groups (Strategic Goal 3)
- Enhance the accessibility, coordination, and responsiveness of services (Strategic Goal 4)
- Strengthen the quality and safety of services for people vulnerable to suicide. (Strategic Goal 5)
- Restrict access to highly lethal means of suicide (Strategic Goal 6)
- Improve the quality and availability of data on suicidal behaviour to inform policy and practice (Strategic Goal 7)

These strategic goals are supported by 23 Intermediate Outcomes (IOs), forming an outcome-focused framework that was considered both rare and ambitious among national suicide prevention strategies at the time of its development.

CfL is implemented through a cross-sectoral partnership involving 22 government departments and agencies, alongside 23 HSE-funded NGOs. These NGOs play a vital role in reaching vulnerable groups through culturally sensitive and targeted interventions. The HSE's National Office for Suicide Prevention (HSE NOSP) oversees implementation and is directly responsible for 39 actions. At the local level, CfL is implemented through area-level action plans developed across the nine HSE Community Health Organisation (CHO) regions. Implementation of these plans are supported by HSE Resource Officers for Suicide Prevention (ROSPs), who work with local stakeholders to align national goals with community needs.

In 2023, the HSE NOSP commissioned an implementation and intermediate outcomes evaluation of Connecting for Life (CfL). The CES was awarded the contract in January 2024.

Ethical approval for a low-risk evaluation was sought and secured via University College Dublin's' Research Ethics Committee.

# Evaluation Methodology

The evaluation applied a comprehensive multi- method approach to assess its implementation and intermediate outcomes. The methodology was designed to capture diverse perspectives, ensure robust data collection, and provide actionable insights for future suicide prevention strategies. **Figure 1** shows the primary data collection methods, i.e. 3 Rapid Insight Sessions, 30 semi structured interviews with key stakeholders and two surveys (for ROSPs and area level implementation teams). Sources of secondary data included a multiple lines of evidence documentation compiled by HSE NOSP, drawing evidence from different types of existing data sources to inform the assessment of progress towards the 23 intermediate outcomes. In addition, a comprehensive literature review of evidence based suicide prevention strategies was carried out, and a rapid review of best practice in strategy design and implementation.

Figure 1: Connecting for Life Evaluation Methodologies

## Literature Review of evidence-based suicide prevention strategies

A total of **157** abstracts were identified in PubMed

**80** were considered relevant and abstracts were reviewed

3 of these (focused on risk assessment and) were excluded

Articles were categorised under the following headings

| | |
|---|---|
| 27% | **Psychosocial interventions** |
| 22% | **Community based interventions** |
| 15% | **Training** |
| 13% | **Crisis Intervention** |
| 12% | **Multiple interventions** |
| 4% | **Mental health treatment** |
| 3% | **Means restriction** |
| 3% | **Postvention** |
| 1% | **Media guidelines** |

## 3 x Rapid Insight Sessions

**17** **Government Department/ agency reps**

on the national Cross Sectoral Steering and Implementation Group

**21** **reps from NGO partner organisations**

funded to deliver on work aligned with CfL objectives

**13** **HSE ROSPs responsible**

for coordinating area-level implementation of CfL

## Stakeholder Surveys

**Survey 1: HSE ROSPs**

**Key Themes**

- CfL Reach & Engagement
- How well is CfL known & accessed across regions
- Adoption & Integration
- Extent of CfL's integration into local services & strategies
- Implementation & fidelity
- Consistency & quality of CfL delivery across regions

**Survey 2: CfL Local Stakeholders/ Implementers**

**Key Themes**

- Challenges in agency adoption
- Barriers to uptake with local partners
- Implementation & fidelity
- Local delivery practices & adherence to implementation plans
- Maintenance & sustainability

## Stakeholder Insights on CfL Implementation

**25x** **Implementer interviews**

with for example HSE NOSP, government lead agents, NGO partners, HSE ROSPs etc

**Themes**

- Implementation in practice
- Context (national & regional)
- Barriers & facilitators
- Progress & systems change
- Unexpected outcomes
- Measurement & impact

**5x** **Bellwether interviews**

with academic advisors, decision makers, policy advisory

**Themes**

- National strategy implementation
- CfL reflections
- Barriers & facilitators
- Unexpected outcomes
- Impact assessment of CfL
- Future vision

## Secondary Data Analysis

**(assessing CfL's Intermediate Outcomes)**

**A multiple lines of evidence document was compiled by HSE NOSP and implementers across 23 intermediate outcomes (IO).**

It contained relevant outputs, data, published papers/ reports, links to websites, internal and/or progress report etc.

In addition, the evaluators review publically available documents including CfL Implementation Plans and Annual Reports.

# Evaluation Findings

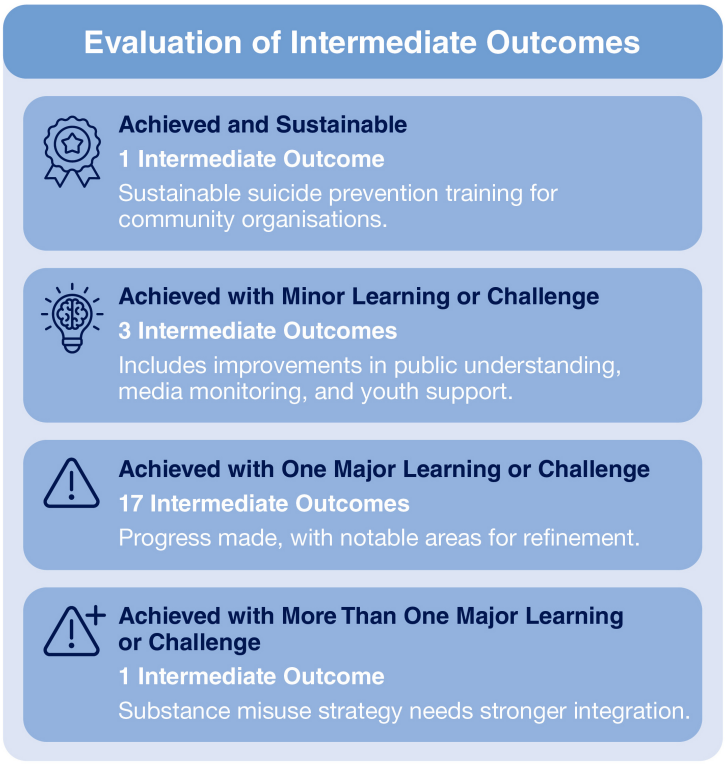
## 1. To what extent are CfL's suicide prevention activities and strategies aligned with the evidence base and good practice?

The (separate published) literature review conducted as part of this evaluation confirms that Connecting for Life (CfL) is aligns with international evidence and best practice. Key CfL strategies such as restricting access to means, gatekeeper training, and psychosocial supports, are consistent with the evidence base, athough attribution of impact remains complex. Importantly, CfL supports a multi-level approaches to suicide prevention, combining strategies across a range of settings. Such an approach is shown, in the literature, to be significantly more effective than single-level approaches, underscoring the importance of a comprehensive, integrated response.

CfL also reflects core best practice strategy design principles identified through the rapid review of literature, including a systems-based, cross-sectoral approach to implementation and strong governance. CfL stakeholder engagement is embedded nationally and locally, with NGOs playing a key role and individuals with lived experience beginning to be included in programmes of work. Guided by implementation science, CfL has developed national implementation plans, undertaken implementation surveys and has an established implementation monitoring system. CfL is evidence-informed and committed to continuous improvement. However, future strategies should involve more meaningful lived experience engagement throughout all stages, from design, through to implementation and evaluation.

## 2. To what extent did CfL achieve its Intermediate Outcomes?

The analysis of the secondary data (including the Multiple Lines of Evidence document) was structured around CfL's 7 Strategic Goals and associated 23 Intermediate Outcomes (IOs). The secondary data was then triangulated with the survey, interviews, and Rapid Insight sessions data. Based on this triangulation an assessment was made on the extent to which each IO was achieved across a 5-point scale (Achieved and sustainable; Achieved with minor learning; Achieved with 1 major learning; Achieved with more than 1 major learning; Not Achieved). Over the 10-year lifespan of CfL all IOs were achieved to some extent. Below summarises the finding of the assessment.




## 3. How well is the (top-down) national implementation of the strategy working?

The Cabinet Committee on Social Policy and Public Service Reform oversees national implementation of CfL. The National Cross-Sectoral Steering and Implementation Group chaired by the Department of Health, provides strategic leadership and the HSE's National Office for Suicide Prevention (HSE NOSP) leads out on strategy implementation.

Ireland's approach to suicide prevention is seen as distinctive or "*unique*", characterised by a whole-of-government initiation. A key strength of this approach is the positioning of CfL as both a HSE and a national government policy. This dual positioning ensures that responsibility for suicide prevention is shared across departments and agencies, rather than being confined solely to mental health service. CfL's robust oversight structures facilitate cross-government collaboration. Strategy implementation is supported effectively by the national office, HSE NOSP, and guided by the Cross-Sectoral Steering and Implementation Group which was praised for maintaining momentum and accountability, particularly due to the involvement of high level leadership, including senior officials from the Department of Health.

In addition, the strategy itself was thought to provide a clear framework for multi-agency engagement and stakeholder participation. CfL has fostered meaning collaboration across a range of government departments and agencies. NGO partners are considered vital to

implementation nationally (and locally), particularly in addressing gaps where the HSE lacks capacity to deliver services. However, it was noted that NGOs can operate in a compromised position, as both dependent on government funding and advocates for policy change, creating an inherent conflict.

Challenges to implementation were also identified (see **Table 1**). While cross-sectoral commitments are made, implementation is inconsistent, and responsibility is often deferred. NGOs face difficulties with representation at all levels, and lived experience voices are under-represented in policymaking. Engagement from departments like Social Protection is limited, hindering efforts to address social determinants of suicide. Policy overlap and siloed working, along with funding and resource constraints, can obstruct effective implementation. In addition restructuring in the HSE emerged as a contextual factor. More specifically the disbanding of the HSE's central governance structures raised concerns that mental health and suicide prevention could lose their voice, potentially weakening national oversight.

Table 1 National challenges in Implementing *Connecting for Life*

| **Domain** | **Challenge** |
|---|---|
| Alignment | Cross-sectoral commitments often do not translate into concrete action |
| Implementation Gaps | Suicide prevention seen as collective, shared ownership means responsibility is diffused, which can result in sectors deferring action |
| NGO Representation | NGOs struggle for consistent involvement at all levels (i.e. national, regional, and local levels) |
| Lived Experience Engagement | Voices of those with lived/living experience are not meaningfully included in policymaking |
| Departmental gaps | Limited involvement from key departments (e.g., Social Protection) |
| Policy Crossover | Overlap between mental health and priority group policies hinders clarity |
| Structural Barriers | Siloed working, funding constraints, and resource limitations |

## 4. How well is the (bottom-up) area-level implementation of the strategy working?

At an area-level, CfL is delivered through action plans tailored to community needs. Implementation is facilitated by the ROSPs who work with local stakeholder groups to align national objectives and local priorities. Both the area-level action plans and the local

implementation structures are considered essential to delivering the strategy effectively at an area level. The ROSPs emerged as pivotal enablers of local and regional implementation. Their presence within communities is considered vital, particularly in liaising with first responders and embedding suicide prevention awareness across frontline services. ROSPs also serve as a crucial link between local implementation efforts and HSE NOSP, helping to ensure coherence between national and local implementation.

ROSPs play a key role in engaging local NGOs and community partners in the work, thereby reinforcing the importance of being embedded within the community. These strong relationships and collaborations fostered with NGOs and other community partners is central to CfL success. It was noted that NGOs have been highly engaged in the area level implementation of CfL.

The experiences of ROSPs coordinating the implementation of CfL at an area level highlight the value of applying an implementation framework that includes committed leadership, active feedback loops, achievable actions, and clear monitoring and evaluation processes. Robust project management structures, with clearly defined roles and responsibilities, administrative support, flexible budgeting, and active HSE NOSP involvement, were identified as critical to successful implementation of CfL at an area level. However, local implementation of *the strategy has* faced several persistent challenges over the years. These are summaries below in **Table 2.** Key issues include inconsistent alignment between the national strategy and local CfL action plans, unclear roles and accountability, and regional variation resulting in uneven implementation. In addition organisational fragmentation resulting for HSE restructuring was a concern.

Table 2. Local Challenges in Implementing *Connecting for Life*

| **Domain** | **Challenge** |
|---|---|
| Alignment | Inconsistent alignment between national strategy and local plans; unclear accountability |
| Regional Variation | Uneven implementation which can lead to inconsistencies; lack of clear guidance for adapting national strategy (and objectives) to local context |
| Cross-Sectoral Work | Variability in local government buy-in across regions; limits collaboration |
| Communication | Communication gaps between HSE NOSP and area level implementation structures; weak stakeholder coordination |
| Governance | HSE restructuring may affect local autonomy and responsiveness |

| Domain | Challenge |
|---|---|
| Data Access | More timely availability of relevant data locally, could improve local implementation teams' ability to respond swiftly |
| Leadership | Inconsistent regional leadership; reliance on local champions |
| Stakeholder Engagement | Staff turnover; organisational changes; need for frequent re-engagement |
| Funding | Annual funding cycles hinder long-term planning and capacity building |

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

*CfL* demonstrates a strong commitment to research and evaluation, guided by Strategic Goal 7. A structured implementation system was established in 2017, followed by an Interim Strategy Review in 2018 and a comprehensive evaluation in 2023. HSE NOSP also developed a monitoring framework and supported targeted research through a Collaborative Research Grant Scheme.

While progress has been made in improving data systems, such as the establishment of the Health Research Board's National Probable Suicide Monitoring System (NPSMS), based on the IPSDS (2015–2020) and the inclusions of a suicide module in the Health Ireland Survey, significant challenges remain. These include the lagged nature of official data on suicide, a lack of near real-time surveillance data at a national level, and slow data-sharing processes. Moreover, programme evaluations under CfL have tended to focus more on outputs rather than outcomes, with persistent gaps in research on priority groups. Greater inclusion of lived experience and a shift toward integrated, outcome-focused evaluation are essential for future strategies.

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

With CfL ending in 2024, preparations are underway for Ireland's next suicide prevention strategy. Evaluation findings show strong support for refining CfL, which made progress across all objectives and demonstrated the value of a coordinated national approach to suicide prevention.

Key considerations for the new strategy include its duration, with views split between a 10-year plan focused on fewer, high-impact goals and a 5-year plan with clear milestones, and its scope, which should prioritise transformative actions that make a real difference. The strategy must also address the role of self-harm more specifically, either through a dedicated approach or by expanding existing actions within the suicide prevention framework. Finally, alignment with other relevant strategies, such as Sharing the Vision, is essential to ensure clear ownership and avoid duplication of work.

# Evaluation Recommendations

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| **Governance** | 1. Retain CfL's implementation structures and governance: Building on the success of the Cross-Sectoral Steering & 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). |

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| **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). |
| **Process** | 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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