Report to

An Roinn Sláinte
Department of Health

Findings from Public Consultation Events to Inform Ireland’s New Suicide Reduction Strategy

September 2025

Contents

Executive Summary

Purpose

This report presents findings from a national stakeholder consultation undertaken to support the development of Ireland's next Suicide Reduction Policy. Commissioned by the Department of Health and facilitated by Crowe, the process aimed to gather practical insights from key groups directly involved in or affected by suicide reduction efforts.

Consultation Overview

Between March 2025 and May 2025, seven workshops were held with four stakeholder groups:

- Non-Governmental Organisations (NGOs) – x1 session, 38 participants.
- People with Lived Experience (including individuals with personal experience of suicidality, those bereaved by suicide, and those who supported others in crisis) – x4 sessions, 98 participants.
- Health Service Executive (HSE) Staff – x1 session, 26 participants.
- Key Professional Stakeholders – x1 session, 33 participants.

Sessions were semi-structured and supported by Samaritans Ireland volunteers. The Mental Health Unit of the Department of Health was actively involved in workshop design, facilitation, and observation. Participants could also share additional anonymous input via Padlet—a secure virtual noticeboard used in both online and in-person sessions—enabling broader contributions, including from those less comfortable speaking in groups.

Key Themes

Insights were organised around five domains:

- **Future Priorities:** Strong support for upstream, community-based, and youth-focused interventions.
- **Gaps and Lessons:** Emergency Departments (EDs) seen as inappropriate for those in mental health crisis; follow-up and referral pathways were reported as inconsistent.
- **Policy Performance:** Connecting for Life (CfL) valued but seen as disconnected from local delivery.
- **Systemic Barriers:** Fragmented services, inequity, and poor coordination were recurring concerns.
- **Retention and Expansion:** Desire to retain CfL's intent but streamline actions and strengthen implementation.

Contribution to Policy

The findings offer grounded, stakeholder-informed perspectives to support the next phase of suicide reduction planning. They are not prescriptive but are intended as a practical and values-driven resource for policy refinement.

1 Introduction

1.1 Background

A new Suicide Reduction Strategy is currently in development, which will be informed from learnings from the current national strategy for suicide prevention Connecting for Life (CfL), emerging evidence, and information sourced from a series of public consultations. The purpose of the public consultations was to offer interested stakeholders an opportunity to provide their experience, observations, and ideas on suicide reduction in Ireland and to express what they would like to see in the new policy.

The Department of Health commissioned Crowe to design, facilitate, and report on a series of public consultation events. These events formed part of a broader consultation process, which also included an open online survey and invitation for written submissions. Participants with lived experience were primarily recruited from those who expressed an interest in taking part through the survey. The combined findings will feed into a final national report prepared by the National Suicide Research Foundation (NSRF).

This report presents a detailed analysis of feedback gathered during seven facilitated consultation workshops (three in-person and four online events) held between March and May 2025. These sessions brought together diverse participants from four key stakeholder groups:

- Non-Governmental Organisations (NGOs).
- People with lived experience.
- Health Service Executive (HSE) staff.
- Key professional stakeholders (e.g., front-line workers, educators, clinicians).

The objective of this report is to capture the real-world experience, challenges, and ideas voiced by these groups and to identify patterns, gaps, and opportunities that can inform the next phase of suicide reduction strategy in Ireland.

1.2 Policy Context

CfL is Ireland's current national strategy to reduce suicide. First launched in 2015 and extended to 2024, the strategy sets out a vision of an Ireland where fewer lives are lost through suicide, and where individuals and communities are empowered to improve their mental health and wellbeing.

CfL outlines 69 strategic actions across seven national goals, which aim to:

1. Improve the nation's understanding of and attitudes to suicidal behaviour, mental health, and wellbeing.
2. Support local communities' capacity to prevent and respond to suicidal behaviour.
3. Target approaches to reduce suicidal behaviour and improve mental health among priority groups.
4. Enhance accessibility, consistency, and care pathways of services for people vulnerable to suicidal behaviour.
5. Ensure safe and high-quality services for people vulnerable to suicide.

6. Reduce and restrict access to means of suicidal behaviour.
7. Improve surveillance, evaluation, and high-quality research relating to suicidal behaviour.

The HSE National Office for Suicide Prevention (NOSP) is responsible for coordinating the implementation of CfL. This work is delivered across multiple government departments, statutory agencies, and non-governmental organisations, supported by a National Cross-Sectoral Steering and Implementation Group, chaired by the Department of Health. On the ground, implementation is advanced through 10 Local CfL Action Plans. CfL was extended to 2024 which created a valuable opportunity to build on existing structures, deepen community-level action, and assess what further innovation, integration, or investment is required.

As Ireland moves toward the next phase of the national suicide reduction strategy, this consultation was designed to gather real-world input from a wide range of voices. By capturing the lived, operational, and strategic experience of those most involved in suicide prevention—whether in personal, professional, or organisational roles—this process ensures that the next national strategy is responsive, inclusive, and grounded in current realities.

1.3 Terms of Reference

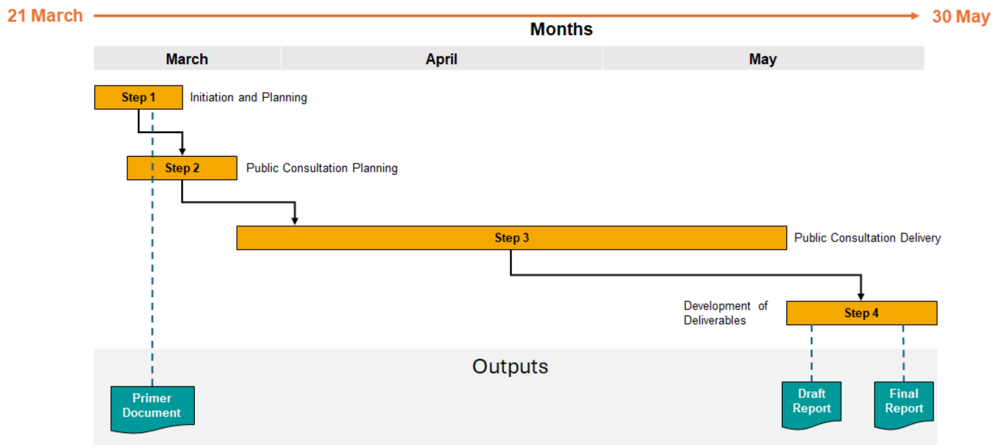
The key tasks requested by the Department were as follows:

- Design and facilitate six[1] public consultation events held to inform the new Suicide Reduction strategy which consider strategic priorities, governance, whole of Government engagement and funding options for the new policy.
- Production of a report from the in person/online consultation sessions to inform the new suicide reduction strategy.

1.4 Methodology and Workshop Schedule

1.4.1 Project Timeline

A project-level timeline was established at the outset to guide key phases of delivery, including workshop design, stakeholder engagement, facilitation, analysis, and reporting. An overview of this timeline is provided in the following diagram:



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[1] A seventh consultation event, a further online session for those with lived experience of suicide, was added to the schedule by agreement with the Department.

1.4.2 Workshop Design and Facilitation

Crowe developed an inclusive and structured facilitation approach working with staff from the Department of Health, in line with the Departments terms of reference. Workshops were co-produced with Departmental input and designed around thematic prompts tailored to each stakeholder group. A semi-structured format was used across all sessions, delivered either in-person or via secure online platforms. To support accessibility, online sessions were scheduled at varying times—including evenings and weekends—to enable maximum participation.

Experienced facilitators, rapporteurs, and note-takers supported all workshops to guide discussion and ensure the capture of meaningful insights. Department of Health staff also played an active role in facilitating breakout discussions and observing sessions to ensure alignment with policy priorities.

In recognition of sensitive and potentially distressing nature of the subject matter, trained Samaritans Ireland volunteers were present at all workshops—online and in-person—that involved people with lived experience to offer emotional support to participants during or after sessions. Signposting to relevant support services was provided at the close of each session and included in follow-up communications to participants.

1.4.3 Participant Feedback on the Consultation Process

Participants across several stakeholder groups commented positively on the format and facilitation of the workshops. Feedback highlighted the respectful and inclusive tone, the safe space for open discussion, and the structured yet flexible approach that enabled diverse perspectives to be shared.

These reflections highlight the value of a respectful, participant-led approach in enabling meaningful conversations about complex and deeply personal issues.

1.4.4 Consultation Schedule

A total of seven workshops were conducted between 28th March and 26th May 2025, involving 195 participants across all stakeholder groups. The table below outlines the consultation schedule:

Stakeholder Group	Date(s)	No. of Attendees	Format
Non-Governmental Organisations	28th March 2025	38	Online
People with lived experience	30th April 2025	19	In person
	10th May 2025	36	Online
	21st May 2025	20	Online
	26th May 2025	23	In person
HSE staff	1st May 2025	26	Online
Key professional stakeholders	7th May 2025	33	Online

1.5 Report Structure

This report presents the findings from a series of public consultation workshops held to inform Ireland's next national Suicide Reduction Policy. It is structured to provide clarity to both specialist and non-specialist audiences and to support policy decision-making with grounded, inclusive insights.

Section	Purpose
Introduction & Background	Sets out the context for the consultation process and policy development.
Methodology	Describes how the workshops were designed, conducted, and analysed.
Thematic Analysis Protocol	Outlines how data were coded, themed, and synthesised across stakeholder groups.
Findings	Presents structured results from each stakeholder group, organised by thematic domain.
Cross-Group Synthesis	Summarises patterns, divergences, and system-wide insights that cut across all stakeholder perspectives.

Key concepts—such as *idea units, subtheme clusters,* and *SWOT coding*—are explained within the methodology to support interpretation and transparency.

2 Thematic Analysis Protocol

2.1 Purpose

This section explains how qualitative data from the stakeholder consultation workshops were analysed and summarised. The aim of this analysis was to identify recurring issues, service gaps, and actionable insights that can inform Ireland's next national Suicide Reduction Policy.

The consultations, which included workshops with NGOs, people with lived experience, HSE staff, and key professional groups, generated a large volume of qualitative feedback. This feedback was captured as short, meaningful statements or ideas raised during discussion—referred to in this report as "idea units". Each idea unit reflects one complete thought, experience, or suggestion from a participant.

This analysis contributes to a broader evidence base that also includes a national survey and documentary review.

2.2 Workshop Design and Facilitation Approach

Each workshop followed a semi-structured format to ensure consistency while allowing for open, reflective dialogue. Discussions were guided by four broad thematic prompts, adapted for the experiences and roles of each stakeholder group. Sessions took place in both in-person and online formats, with breakout discussions supported by designated facilitators, note-takers, and rapporteurs.

The purpose of these workshops was not to reach consensus, but to surface a wide range of perspectives—especially around what is and isn't working in Ireland's current suicide prevention system.

A table in this section outlines the discussion themes used for each group (see **Appendix 1** for full prompts).

Stakeholder Group	Theme 1	Theme 2	Theme 3	Theme 4
NGOs	Policy performance and implementation	Future priorities and focus areas	What to retain/expand from *CfL*	What didn't work and why
	E.g. Extent of implementation, data use, resources	*E.g. New ideas, interagency models, training needs*	*E.g. Specific CfL goals, structure and delivery*	*E.g. service design, follow-up, gatekeeping gaps*
People with lived experience	Where mistakes have been made	Challenges and barriers to accessing support	What aspects of CfL should be retained or changed	What would you like to see in the new policy?
	E.g. Experiences as individuals, families, communities	*E.g. Support gaps, system responsiveness*	*E.g. Community engagement, cultural sensitivity, service access*	*E.g. For families, communities, services, nationally*

Stakeholder Group	Theme 1	Theme 2	Theme 3	Theme 4
HSE staff	Implementation and policy impact	Future policy priorities	Retention/expansion of CfL goals	Lessons learned from implementation
	E.g. Gaps in resourcing, outcomes, training	*E.g. Innovation, collaboration, emerging needs*	*E.g. Community supports, data, access to means*	*E.g. System bottlenecks, structural barriers*
Professional stakeholders	System failures and missed opportunities	Challenges and barriers to prevention	Effective elements of CfL to retain or scale	New directions for the next policy
	E.g. Failures in services, policy, community level	*E.g. Sector-specific and cross-sector coordination*	*E.g. Specific goals, cross-cutting initiatives*	*E.g. Community-based responses, systemic supports*

2.3 Analytical Framework

2.3.1 Overview

The analysis was structured around five core themes that align with the Suicide Reduction Strategy’s goals. These themes provide a consistent way to group and compare insights from across the different workshops:

- **Policy Performance and Legacy –** What’s worked in past suicide prevention strategies, including CfL.
- **Future Priorities and Needs –** What people want in the next strategy and what should be given with particular focus and attention.
- **Retention and Expansion** – What aspects of existing policy (like CfL) should be kept, grown, or improved such as community programmes, awareness campaigns and good practice.
- **Gaps and Lessons Learned –** Where current policy, services and systems fall short, including missed groups or failed approaches.
- **Systemic and Structural Barriers –** Broader, cross-cutting challenges that affect implementation or access (e.g., fragmented services, poor coordination).

Each idea unit was read and coded according to the most appropriate of these five themes.

2.3.2 Cross-Cutting Tags

Some issues were mentioned across many different themes. To highlight these reoccurring patterns, two cross-cutting tags were added to idea units during coding:

- **Equity and Inclusion** – Used when participants raised access challenges for underserved groups (e.g., migrants, LGBTQ+ people, rural populations, or people with disabilities).
- **Interagency and Systems Coordination** – Used for comments about poor communication or collaboration between services (e.g., HSE, GPs, NGOs and Gardaí).

These tags helped the team identify structural challenges that cut across themes and stakeholder groups—even if they were not included in the main focus of discussion.

2.3.3 SWOT Coding Lens

To support the thematic analysis process, a simple SWOT (Strengths, Weaknesses, Opportunities, Threats) coding lens was applied to each idea unit. This was not used as a separate analytical framework, but as a practical coding tool to help clarify the directionality and intent behind each comment—particularly where feedback cut across multiple themes.

Each idea unit was categorised as one of the following:

- **Strengths –** Indications of what is working well or valued (e.g., a helpful programme or supportive policy).
- **Weaknesses –** Areas identified as falling short, inconsistent, or in need of improvement.
- **Opportunities –** Suggestions for improvement, innovation, or unmet needs.
- **Threats –** Risks or pressures that could undermine suicide prevention efforts (e.g., service demand outpacing resources).

This step was required to ensure clarity and consistency in coding, especially during cross-group synthesis, where distinguishing between endorsement, critique, and recommendation helped validate the thematic categorisation. While not central to the final interpretation, the SWOT tags supported transparency in how participant inputs were classified.

2.3.4 Thematic Summarisation and Reporting Preparation

After coding, all idea units were sorted and summarised under major themes and subtheme. This involved:

- Reviewing the frequency and emphasis of issues.
- Grouping ideas with similar focus or implications.
- Writing clear, accessible summaries of what was raised.

Each stakeholder group’s findings are presented in this report using a consistent table format, followed by a brief narrative section called *Key Observations*, which distils the major takeaways and key messages.

Importantly, each group is presented on its own terms—no comparison is made between groups at this stage. This preserves the distinct voice of each cohort.

2.3.5 Cross-Group Synthesis and Comparative Insights

Once individual stakeholder findings were summarised, a cross-group synthesis was conducted to identify:

- **Shared Themes –** Repeated or reoccurring themes raised across groups.
- **Divergent Priorities –** Where perspectives differed based on lived experience or professional experience.

- **Unique Contributions –** Insights that were specific within one group (e.g. NGOs, frontline staff, or people with lived experience).

This final synthesis, presented in Section 4 of the report is intended to help identify the common threads and nuances that were interpreted as important key insights for the design a future strategy that is both system-wide and responsive.

As illustrated in the diagram below, this staged process ensured a coherent and transparent flow from initial workshop design through to final synthesis, anchoring all findings in systematically gathered and thematically coded stakeholder input.

1. Workshop Design & Data Collection

Stakeholder-specific planning; trauma-informed facilitation; thematic framework aligned to policy domains (CfL)

2. Data Collection

Facilitated workshops, Padlet inputs, and structured note-taking across lived experience, NGOs, HSE, and professionals

3. Data Coding

Idea units extracted and categorised using pre-defined codes (theme, subtheme, SWOT, cross-cutting tags)

4. Thematic Group Analysis

Findings structured under five policy domains across each stakeholder group: Future Needs | Gaps | Policy Legacy | Structural Barriers | Retention

2.4 Coding Reference Guide

Theme	Typical Subthemes
Policy Performance and Legacy	Perceived impact of CfL, effectiveness of resource allocation, successes in service delivery.
Future Priorities and Needs	Youth suicide prevention, bereavement supports, culturally tailored interventions, upstream prevention.
Retention and Expansion	Trusted programmes, community-based supports, education and awareness campaigns.
Gaps and Lessons Learned	Missed populations, lack of follow-up, policy fragmentation, data limitations.
Systemic and Structural Barriers	Governance challenges, interagency disconnect, workforce constraints, service navigation.
Cross-Cutting Tag	**Typical Applications**
Equity and Inclusion	Access issues for minority, rural, or marginalised groups; language barriers; cultural tailoring.
Interagency and Systems Coordination	Service silos, communication breakdowns, multi-sector collaboration issues.

2.5 Tools and Format

The analysis was carried out using a simple and transparent format to ensure consistency and traceability across all consultation inputs. All coding was conducted manually using Microsoft Excel. This allowed the team to systematically record and analyse each meaningful comment made by participants (referred to as “idea units”). Each row in the spreadsheet represented one idea unit. Alongside each idea, the following categories were recorded:

- Thematic domain (e.g., Future Priorities and Needs).
- Subtheme cluster (e.g., Access and Affordability).
- Stakeholder group (e.g., NGOs, HSE staff).
- SWOT label (Strength, Weakness, Opportunity, or Threat).
- Any relevant cross-cutting tags (e.g., Equity and Inclusion).

Built-in filters in Excel enabled easy sorting and comparison of ideas across groups and themes—helping the analysis team identify patterns, gaps, and common concerns. Quotes were not used verbatim; instead, findings were synthesised from facilitators’ notes to protect participants’ privacy and ensure data consistency.

2.6 Confidentiality, Ethical Principles, and Data Integration

Maintaining participant confidentiality and ethical rigour was a core component of the consultation process. As the workshops involved personal and, at times, deeply sensitive contributions, particular care was taken to ensure that no individual could be identified in any reporting.

The following principles guided this part of the process:

- Anonymity was strictly maintained throughout the process. No names, direct quotes, or personally identifiable details were collected or published.
- Facilitator summaries, not individual submissions, formed the basis of analysis. This ensured that only synthesised, group-level feedback was included, with an emphasis on shared experiences and patterns rather than personal stories.

The process was designed and following underpinning facilitation principles that recognises the challenges and issues that may arise when facilitating groups on the topic of suicide, particularly with individuals who may have been bereaved by suicide, experienced suicidal ideation, used services, supported others, or worked on the front-line. These principles ensured the consultations were carried out appropriately, safely, and effectively.

The following facilitation approach principles were employed:

- Preparation and planning for issues, including Samaritans Ireland supports made available.
- Recognising power dynamics, use inclusive language and methods.
- Protecting the safety and well-being of the group.
- Accommodating participants’ personal circumstances such as people with mobility issues and disabilities.

- Having respect for all people and voices in the room.
- Encouraging active listening, giving appropriate space and time to group members.
- Using inclusive facilitation methods to encourage participation by all members of the group.

In both in-person and online workshops, participants also had access to a shared Padlet board—a secure virtual space where they could contribute reflections or suggestions anonymously or outside of structured discussions. This approach ensured that quieter voices or those less comfortable in group settings could still be captured.

3 Findings

3.1 Findings from People with Lived Experience

3.1.1 People with Lived Experience Consultation Overview

Between 30th April and 26th May 2025, four dedicated consultation workshops were held with individuals with lived or living experience of suicidality. Participants included people who had experienced suicidal ideation or suicide attempts, those bereaved by suicide, and individuals who had supported family members, friends, or others through crisis. While participation was based on expressions of interest through the national survey rather than purposive sampling, the resulting group was diverse spanning a range of age groups, geographic regions (rural and urban), socioeconomic backgrounds, gender identities, and cultural communities.

The analysis of the data from the consultation process followed the five thematic domains outlined in the analysis protocol, facilitating consistency and comparison across all stakeholder groups. Each workshop was conducted using a respectful, participant-centred approach that prioritised safety, consent, and appropriate support for all who participated.

Discussions centred around key system touchpoints—including help-seeking, service access, crisis intervention, and recovery—and explored perceptions of national policy and strategic direction. Participants offered deep insight into both personal experience and broader system critique. Their contributions are reflected in the table below, which presents synthesised findings by main theme and subtheme cluster. Each point in the table corresponds to recurring issues and lived experience observations that were consistently raised across multiple sessions.

Main Theme	Subtheme Cluster	Identified Issues and Dynamics
Future Priorities and Needs	Early and Upstream Support	Strong support for mental health education in schools, peer support networks, and earlier intervention models that act before crisis. Participants emphasised the value of non-clinical, relational approaches.
	Access and Affordability	Services described as patchy, expensive, or inaccessible due to long waitlists. Participants stressed that postcode and financial status often determined access to help.
	Stigma and Social Narrative	Stigma—both internal and systemic—was a major barrier to help-seeking. Participants called for cultural change, better public dialogue, and non-judgemental spaces.
Gaps and Lessons Learned	Inadequate Crisis Response	EDs were described as retraumatising and inappropriate for those in suicidal crisis. Participants cited dismissive staff and a lack of aftercare. People in crisis may be alone in EDs. Trusted family support should be alerted so that they can support their loved ones in crisis in EDs and when they leave health care settings.
	Poor Professional Responses	GPs and mental health services were sometimes perceived as invalidating or ill-equipped. Several

Main Theme	Subtheme Cluster	Identified Issues and Dynamics
		participants described feeling worse after seeking help.
	Interagency collaboration	The Garda Siochana and other front-line services should collaborate with health services so that people in crisis received a co-ordinated approach. Trusted family / friend support should be alerted when a person is found in crisis by the Garda.
Policy Performance and Legacy	Disconnect from Everyday Experience	Awareness of CfL was low. Where known, the strategy was seen as distant from day-to-day service realities, especially outside urban centres.
	Lack of Measurable Progress	Participants questioned what had changed since CfL began. They emphasised the need for greater accountability and clearer metrics for progress.
	Focus on implementation	While the goals of CfL are seen as appropriate, the participants wanted more focus on implementation so that services access and quality would improve.
Systemic and Structural Barriers	Fragmented and Confusing Pathways	Service access was described as opaque and exhausting. Participants struggled to navigate systems that felt siloed and lacking continuity. Access to therapies such as Dialectical Behaviour Therapy (DBT) were seen as useful and effective, however, gaining access to DBT is challenging particularly outside of large urban areas.
	Inequity and Underserved Groups	Marginalised communities—including migrants, LGBTQ+ individuals, Travellers, rural populations, and neurodivergent individuals—were described as consistently overlooked. Cultural, language, and communication barriers compounded access issues.
Retention and Expansion	Validity of CfL Goals and Scaling Effective Models	While rarely discussed explicitly, participants generally supported the direction of CfL but expressed concern about weak implementation. There was implicit support for expanding effective models such as DBT and peer support.

3.1.2 People with Lived Experience: Future Priorities and Needs

Participants identified the need for suicide prevention to begin far earlier in the life course. Early intervention was strongly supported, with particular emphasis on embedding emotional and mental health education within schools. This included references to building resilience, promoting wellbeing, understanding mental health, and increasing awareness of suicide specifically. Participants also supported the use of age-appropriate mental health screening and earlier, open conversations about distress beginning in childhood. These proposals reflected frustration with systems that respond only in crisis, rather than providing preventative structures that help young people recognise and manage emotional challenges before they escalate.

Peer-led support models were viewed as both effective and underused. Participants described the value of talking to someone with similar lived experience, particularly when clinical approaches felt impersonal. However, peer support was described as peripheral and inconsistently available, despite its potential to de-escalate risk and reduce reliance on emergency services.

Access to services was repeatedly described as fragmented, slow, and deeply inequitable. Delays were reported at all stages—from seeking an initial GP appointment to accessing community-based therapies. Participants highlighted challenges such as the unavailability of services in rural areas, the absence of out-of-hours care, and the financial burden associated with private mental health support. Many felt that care depended more on one's postcode or income than on need. When formal care was not available, families were often left to bridge the gap, sometimes at personal cost.

Service drop-off following major life transitions—especially after leaving school or transitioning between Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services—was identified as a major vulnerability. Participants reported that suicide risk increased when young people aged out of services and were left without structured support. These gaps were often compounded by social isolation and housing instability, particularly for neurodivergent individuals or those facing complex health issues.

Stigma remained a major barrier to accessing help. Participants described experiences of shame and judgement from professionals, the public, and themselves. In some cases, the stigma extended to families following a bereavement, limiting their willingness to seek support. Silence around suicide—especially in schools, workplaces, and healthcare—was viewed as reinforcing isolation. Many expressed concern that professionals, particularly GPs, still avoided the term “suicide” and lacked confidence in engaging with those experiencing distress. Some participants called for a national stigma-reduction campaign, comparable in visibility and impact to the Road Safety Authority's public awareness efforts—aimed at normalising conversations about suicide and promoting early help-seeking.

3.1.3 People with Lived Experience: Gaps and Lessons Learned

There was a strong consensus that EDs are fundamentally inappropriate settings for people experiencing suicidal distress. Participants described being treated dismissively or not taken seriously unless they could articulate a specific suicide plan. Triage systems were experienced as transactional and invalidating—characterised by impersonal checklists, risk assessments, and brief interactions that focused on categorising risk rather than understanding the person's emotional state. This approach often left individuals feeling unheard, dismissed, or undeserving of care. Many reported being discharged without aftercare or being left alone in clinical environments that heightened their distress. Some felt they had been “punished” for seeking help.

Outside of EDs, professional responses were similarly criticised for being inconsistent, unprepared, or overly medicalised. Short GP consultations, excessive reliance on medication, and a lack of emotional connection were commonly cited. The use of checklists and risk assessments, rather than relational or narrative-based engagement, left participants feeling unseen and unsupported.

Bereavement supports were described as deeply inadequate. Many participants shared experiences of receiving no follow-up after a suicide loss, and highlighted the absence of consistent postvention protocols or statutory support structures. This was seen as a significant oversight, particularly given the elevated suicide risk among those who are bereaved.

In addition, the coroners court process was frequently described as distressing—experienced as public, retraumatising, and overly drawn out. Participants noted the emotional toll of navigating legal procedures at an already vulnerable time, and called for more sensitive communication and support throughout the inquest process.

Critically, the system was experienced as highly fragmented. People described being bounced between services with no coordination or single point of contact. Transitions—such as from CAMHS to adult services, or between private and public providers—were marked by duplication, confusion, and dropped responsibility. Many individuals found themselves “falling through the cracks” during these handovers, exacerbating distress at already vulnerable moments. Often people left health services without care plans, next steps or supports; leaving individuals and their families and carers feeling isolated and unsupported.

The importance of interagency collaboration was also underscored. Participants called for formal protocols requiring Gardaí and other frontline responders to alert health services and trusted family / friend supports when an individual is in crisis. Many described situations where the Gardaí were the first point of contact, but no coordinated response followed. Without systems for notification and joint planning, people in crisis were too often left to navigate disconnected and unresponsive services alone.

3.1.4 People with Lived Experience: Policy Performance and Legacy

Awareness of CfL was generally low among participants. Where the strategy was known, it was often viewed as distant from daily service experiences and disconnected from local realities. In many cases, participants reported no observable improvements to care or accessibility since the strategy was introduced. This perception was especially strong in rural areas and among minority groups.

Although CfL’s goals were seen as conceptually sound, participants questioned the practical implementation and impact. There was limited confidence that CfL had produced measurable change, and frustration over the lack of visibility, feedback, or local engagement. Participants repeatedly called for improved communication about what the strategy aims to do and how it is being delivered in practice.

There was a strong belief that lived experience must be meaningfully embedded in both the design and evaluation of suicide prevention policy. Participants expressed concern that consultations were often tokenistic, and that service user input rarely led to concrete changes. The need for clearer mechanisms to incorporate lived experience systematically—and at all levels of policy development—was a recurring theme.

3.1.5 People with Lived Experience: Systemic and Structural Barriers

Participants described a system that was fragmented, confusing, and ill-suited to the complexity of suicide risk. Services were perceived as operating in silos, with little collaboration or continuity. There were repeated accounts of individuals being “bounced” between services, with no clear pathway or single point of accountability. The lack of a coordinated national system made it difficult to navigate care—particularly during periods of emotional distress.

Access to Dialectical Behaviour Therapy (DBT) was identified as a specific gap. While some participants had benefited from DBT, many more described being unaware of it, or unable to access it due to location, waitlists, or lack of referral. Participants felt that DBT and other evidence-based therapies should be universally available and clearly signposted by services. DBT was frequently referenced as one of the few interventions perceived to make a significant difference in reducing distress.

The experiences of marginalised groups—including migrants, Travellers, LGBTQ+ individuals, and neurodivergent people—were particularly concerning. Participants from these groups described mental health services as culturally unresponsive, difficult to access, or even causing mental harm. There was a view that suicide prevention services had not adapted to reflect Ireland’s evolving demographics, and that cultural and linguistic needs were routinely overlooked.

Participants also called for a broader understanding of suicide risk that includes social determinants such as poverty, housing insecurity, and discrimination. The current system was seen as too focused on individual pathology, without considering the structural conditions that shape distress. Individuals facing multiple disadvantages were often left without effective support, despite being at higher risk.

Finally, families were frequently left to manage complex care needs alone. Participants described situations where confidentiality was used to exclude loved ones from care planning, despite their critical support role. Families were rarely included during discharge planning or aftercare, leaving both the person in distress and their caregivers unsupported. This over-reliance on family was seen as both unfair and unsustainable—particularly where families were already struggling with grief, burnout, or trauma.

3.1.6 People with Lived Experience: Retention and Expansion

Lived experience participants focused primarily on immediate service realities and everyday experience rather than strategic or bureaucratic design, such as how best to retain and expand existing policy structures.

That said, where the goals of CfL were recognised, they were generally supported in principle. Participants did not question the overarching direction of suicide prevention policy but focused their feedback on the lack of visible progress and practical implementation. In this sense, retention of CfL’s core ambitions was implicitly endorsed—provided future iterations are delivered with greater transparency, community relevance, and follow-through. However, it was seen that the relevance of access to means was perceived as less important than access to quality services.

There was also an implicit desire for expansion—especially of access and quality of interventions that were perceived to work, such as DBT, peer support, human-based approaches and community-based alternatives to EDs. Awareness campaigns were seen as valuable, and the use of social media appropriate to age groups was seen as an opportunity to open a public discussion reducing stigma. These were seen as examples of what should be scaled and embedded more firmly in the national framework.

3.2 Findings from Non-Governmental Organisations

3.2.1 NGO Consultation Overview

A dedicated consultation workshop with representatives from non-governmental organisations (NGOs) was conducted on 28th March 2025, bringing together 38 participants from 31 different organisations. The NGOs represented a diverse range of national and community-based services, with a notable emphasis on advocacy, mental health, and frontline suicide prevention support.

The workshop discussions were structured around the five core thematic domains outlined in the analysis protocol. Participants provided insights on both past policy experiences and future needs. The following table synthesises the key findings from this group, organised into thematic subclusters. It captures the core issues, dynamics, and insights from the NGO perspective, highlighting areas of consensus and divergence when compared with other stakeholder groups.

Main Theme	Subtheme Cluster	Identified Issues and Dynamics
Future Priorities and Needs	Early & Tailored Intervention	Early intervention for homeless and youth; psychotherapy access; Men’s Sheds and other tailored community models.
	Anti-Stigma & Communication Reform	Reduce stigma (incl. among professionals); public education; reframe how suicide is discussed in society.
	Training & Capacity Building	Mandatory training for NGO staff; Mental Health First Aid; expanded gatekeeper roles beyond clinicians.
	System Navigation / No Wrong Door	Poor transitions, fragmented access points; call for universal pathways and simplified service navigation.
	Community & Trauma-Informed Approaches	Trauma-informed care; social prescribing; stepped care models rooted in community.
Gaps and Lessons Learned	ED and Crisis Services Not Appropriate	EDs often retraumatising and inappropriate settings for suicide crises; lack of compassion and inappropriate clinical response.
	Insufficient Services for Minority Communities	Services not tailored for minorities, migrants, or new communities; language and culture overlooked.
	Complex Implementation Structure	Overly complex and siloed NOSP-led structure; poor communication and follow-through.
Policy Performance and Legacy	Policy Overload & Measurement Gaps	CfL perceived as too broad and lacking clear success metrics; no interim reviews; unclear impact.
	Data and Research Deficiencies	No real-time data; Garda integration missing; limited use of existing research.

Main Theme	Subtheme Cluster	Identified Issues and Dynamics
	Awareness Gains but Limited Impact	Awareness has improved but no clear evidence of reduced suicidality; digital tools under-leveraged.
Systemic and Structural Barriers	Interagency Disconnect	NGO, HSE, Garda, GP systems not connected; poor referral pathways and data sharing.
	Funding and Role Clarity	NGOs expected to deliver frontline support without stable funding or guidance.
Retention and Expansion	Streamlined Goals and Objectives	CfL goals remain valid but need simplification; fewer actions, better interlinking, clear milestones. Better and faster implementation of less actions.

3.2.2 NGOs: Future Priorities and Needs

NGO participants called for a more comprehensive and proactive approach to suicide prevention, particularly for groups experiencing high vulnerability. Early intervention was consistently highlighted as essential, especially for populations such as homeless individuals and people exiting the prison system. Participants noted that these groups frequently face complex social and psychological risks yet remain excluded from early-stage supports. Tailored community initiatives like Men’s Sheds and accessible psychotherapy services were identified as promising interventions, but these were not consistently resourced or available.

There was also a call to reform how suicide is understood and communicated. Participants stressed the need for suicide prevention efforts to address stigma in both public and professional domains. Negative perceptions of self-harm, discomfort discussing suicide, and persistent silence in institutional settings were all identified as barriers. Communication strategies that normalise help-seeking and equip staff to engage confidently with people in distress were considered essential.

Across the NGO sector, staff capacity was a major concern. Many organisations felt under-prepared to respond to suicide risk and called for suicide prevention training to be made mandatory for NGO personnel. Stakeholders also proposed expanding gatekeeping roles to include receptionists, community workers, and pharmacists—people who often serve as first points of contact. Mental Health First Aid and similar models were seen as useful frameworks to support this broader network.

Navigation through the system was also raised as a point of frustration. Participants described a fragmented service landscape where people in distress were passed between providers with inconsistent eligibility thresholds and unclear entry points. There was strong support for a “no wrong door” approach, where all individuals presenting with distress are supported regardless of their initial access point.

A wider shift towards community-based and trauma-informed models was also strongly endorsed. Social prescribing locally delivered therapy, and stepped care models were all named as desirable approaches. These were seen not only as more humane and responsive but also as more sustainable alternatives to crisis-driven care. Participants stressed the importance of grounding services in local communities and designing them around the realities of people's lives.

3.2.3 NGOs: Gaps and Lessons Learned

NGOs reported that EDs remain poorly suited to supporting individuals in suicidal crisis. The ED environment was described as retraumatising, overstimulating, and lacking the compassion required for mental health emergencies. Participants noted that even when individuals are brought to hospital, they often leave without meaningful follow-up or safety planning. These accounts reflected deep concern that EDs, while heavily relied on, are not designed to meet the needs of suicidal individuals.

Concerns were also raised about the consistent under-resourcing of services that have proven effective. NGOs delivering trauma-informed or community-rooted interventions shared that they often operate with limited funding, despite strong demand. These resourcing challenges make it difficult to maintain continuity of care and limit the scalability of programmes known to work.

Participants were particularly concerned that many newer or more diverse communities—including migrants and ethnic minorities—are systematically overlooked. Language access, cultural relevance, and community-specific programming were frequently absent from the mainstream suicide prevention infrastructure. This lack of inclusion was seen not only as a failure of outreach but as a contributing factor to risk.

The complexity of implementation structures was also identified as a barrier. Participants described the current system as overly bureaucratic, siloed, and slow to adapt. Poor communication between agencies and rigid planning processes were cited as reasons why good ideas failed to translate into action.

Finally, participants highlighted the absence of a robust research and evaluation framework. Suicide prevention initiatives were often rolled out without clear outcome metrics or mechanisms for real-time learning. The lack of data integration with Garda systems and underuse of existing research were seen as key missed opportunities to strengthen evidence-informed policy.

3.2.4 NGOs: Policy Performance and Legacy

CfL was acknowledged by participants as having achieved some progress in raising awareness and framing suicide prevention as a national priority. However, many described the strategy as overly broad, with too many discrete actions and insufficient follow-through. The result, according to several participants, was a sense of policy fatigue, where goals were familiar but lacked tangible progress on the ground.

Participants also raised concerns about the absence of formal interim reviews or adaptive mechanisms. In the face of rising need and shifting post-pandemic realities, the static nature of CfL planning was viewed as limiting. Several NGOs expressed frustration that they could not see the impact of CfL in their daily work with at-risk individuals.

Despite these challenges, there was support for maintaining the direction of CfL, provided it is refined and operationalised more effectively. Participants called for clearer success metrics, streamlined actions, and better connection between goals, funding, and delivery. Digital innovation and public awareness efforts were acknowledged as strengths, but participants stressed that these had not yet translated into reductions in suicide risk or improved care pathways.

3.2.5 NGOs: Retention and Expansion

The core goals of CfL were supported in principle, but participants emphasised the need for simplification and sharper alignment between actions and outcomes. There was a call for reducing the number of goals, improving integration between them, and sequencing actions more strategically. NGOs noted that CfL includes too many discrete actions, making implementation fragmented and difficult to track. Simplifying and phasing these actions was viewed as essential to improving focus and delivery.

Participants recommended greater specificity in CfL's objectives and improved mechanisms for cross-sector engagement. This included clarity on timelines, clearer definitions of success, and transparent review cycles. These refinements were viewed as critical to transforming CfL from a strategic document into a tool that drives service improvement and accountability.

3.2.6 NGOs: Systemic and Structural Barriers

System fragmentation emerged as a dominant concern. NGOs described a landscape in which service providers—including the HSE, general practitioners, Gardaí, and civil society organisations—often worked in parallel, with limited coordination or data sharing. This fragmentation led to disjointed care pathways, delayed referrals, and gaps in support during critical moments of need.

Funding and role clarity were also highlighted as major systemic issues. NGOs frequently carry out core suicide prevention work—such as crisis response, family support, and bereavement services—without stable, multi-year funding. Participants described the sector as overstretched, with expectations that far exceeded available resources. This imbalance made it difficult to maintain staff, develop expertise, or plan strategically.

Participants also identified gaps in training and workforce development. There were concerns about inadequate preparation for frontline staff, as well as the lack of formal recognition for the gatekeeping role played by non-clinical personnel. Broader training across all NGO roles was viewed as necessary, along with appropriate support structures to prevent burnout.

Finally, structural barriers to collaboration within the NGO sector were flagged. Competitive funding models and project-based grants discouraged information sharing and made it difficult to sustain partnerships. Participants called for more flexible and cooperative funding mechanisms to enable a unified, sector-wide contribution to suicide prevention.

3.3 Findings from HSE Staff

3.3.1 HSE Staff Consultation Overview

A comprehensive consultation workshop was held with Health Service Executive (HSE) staff, bringing together professionals from a diverse range of roles across mental health, emergency, and community care settings. Participants were drawn from those involved in both national and regional implementation of suicide prevention policy and services, offering perspectives from operational, strategic, and frontline contexts. Discussions were structured around the five core thematic domains outlined in the analysis protocol, providing a platform for participants to reflect on the operational, policy, and structural dimensions of suicide prevention.

The table below synthesises the findings from this group, with thematic subclusters capturing key challenges and opportunities. The focus was on implementation experience, systemic coordination, and service-level realities across the national framework.

Main Theme	Subtheme Cluster	Identified Issues and Dynamics
Future Priorities and Needs	Focus on Risk & Inclusion	Men, members of the Traveller community, neurodiverse individuals; people who have addiction issues, people with housing issues and key suicide drivers.
	Youth and Digital Safety	Digital media exposure a rising concern for youth; call for tighter regulation and prevention tools.
	Data Infrastructure & Surveillance	Need real-time suicide data; include ethnic identifiers; integrate with Garda and coroner data.
	Suicide Bereavement & Community Response	Under-resourced postvention supports; regional inconsistencies; families often unsupported.
	Suicide Prevention Workforce	Call for defined and resourced suicide prevention roles (e.g. Suicide Bereavement Liaison Officers (SBLOs), Resource Officers for Suicide Prevention (ROSPs)).
Gaps and Lessons Learned	ED Inadequacy & Service Gaps	EDs not trauma-informed; unsuitable for suicide crises; long waits, low compassion.
	Inconsistent Implementation	Area-level delivery varies by leadership; structure of ROSP roles unclear or inconsistent.
	Training Gaps	Training impact not measured; staff turnover hampers continuity.
	Lived Experience	People with lived/living experience not meaningfully included in policy or design.
Policy Performance and Legacy	High-Level Strategy, Poor Grounding	CfL viewed as evidence-based, internationally strong, but disconnected from frontline.
	Some System Gains	More Resource Officers for Suicide Prevention; improved language around suicide; increased training.
Systemic and Structural Barriers	Fragmented Systems	Poor interagency coordination; different standards and buy-in across regions.
	Invisibility of Social Determinants	Suicide framed too clinically; inequality, trauma, displacement overlooked.
Retention and Expansion	Goals Still Relevant	CfL goals still seen as valid; need better targeted and phased implementation.
	Data & Means Restriction	Suicide observatories, access to means control (e.g. paracetamol) supported.
	Community Integration & Education	Need for trauma-informed schools, better training for first responders.

3.3.2 HSE Staff: Future Priorities and Needs

HSE stakeholders stressed the urgent need for suicide prevention efforts to better address risk among priority populations. Groups identified as requiring particular attention included men, neurodivergent individuals, the Travelling community, and those affected by housing instability and substance misuse. Current service responses were seen as not sufficiently tailored or inclusive, particularly where multiple risk factors intersected.

There was also concern about growing suicide risks linked to youth and online environments. Participants highlighted that social media and digital platforms increasingly influence self-harm behaviours, noting that prevention efforts must evolve to include regulation and oversight in digital spaces. Suicide education in schools was seen as crucial but needed to be age-appropriate, consistent across regions, and connected to broader mental health promotion initiatives.

Investment in a dedicated suicide prevention workforce was viewed as both a gap and an opportunity. Roles such as ROSPs and SBLOs were seen as vital but inconsistently resourced. Staff in these positions were often unclear about their remit or under-supported, which limited their capacity to provide coordinated care and postvention response.

Participants called for better support for families and communities bereaved by suicide. Postvention services were described as under-resourced, unevenly distributed, and lacking formal protocols. There was a clear recommendation to make such supports statutory and ensure a national standard that does not vary by geography or service configuration.

Additionally, the need for real-time data collection and improved suicide surveillance was flagged repeatedly. Health service staff noted that national-level data systems often lag behind frontline trends, impeding timely responses. The inclusion of ethnic identifiers and the integration of data from Gardaí and coroners were identified as essential to designing equitable and evidence-led interventions.

3.3.3 HSE Staff: Gaps and Lessons Learned

Participants identified EDs as among the least appropriate environments for people in suicidal crisis. EDs were described as medically dominated, under-resourced, and not trauma informed. Long queues, poor staff training, and a lack of designated safe spaces contributed to experiences that were frequently retraumatising for patients. The consensus was that alternative crisis care models must be developed and scaled.

Training emerged as a recurring concern, both in terms of reach and impact. While some training had increased, especially for clinicians, gaps remained across broader staff groups, including administrative, allied health, and primary care providers. The absence of mandatory suicide prevention training (such as STORM) for all healthcare workers was noted as a barrier to systemic competence. Stakeholders also called for more rigorous evaluation of training effectiveness and ongoing development opportunities to ensure consistent delivery across the system.

Post-crisis care coordination was described as patchy, particularly where team structures such as suicide response or postvention protocols were absent or unclear. Participants described a lack of standardised referral pathways and follow-up practices, which resulted in families and individuals often being left unsupported following discharge or crisis contact. This was exacerbated by variability in the implementation of ROSP roles, where some areas benefited from well-defined leadership while others lacked continuity.

More inclusion of lived experience in service planning was seen as important. Staff acknowledged that while lived experience voices were increasingly recognised rhetorically, their integration into planning and evaluation remained limited. It was noted that inclusion needed to be embedded into all stages of policy and programme design—not added retrospectively or in a tokenistic manner.

Finally, the challenge of dual diagnosis (addiction and mental health) was noted as an area where suicide prevention strategies fell short. Participants reported that services often operated in silos, resulting in people being bounced between systems or denied access based on conflicting eligibility criteria.

3.3.4 HSE Staff: Policy Performance and Legacy

HSE participants generally viewed CfL as a strategically sound and internationally credible framework. They acknowledged that CfL had contributed to suicide reduction in some areas and had raised awareness across sectors. The introduction of resource officers and suicide-specific language were seen as positive shifts.

However, concerns were expressed about a disconnect between CfL's strategic intent and operational delivery. Many frontline staff felt that the strategy lacked grounding in service realities. There was a sense that implementation mechanisms had not kept pace with the ambition of the framework, leading to frustration among those tasked with realising its goals.

Data gaps, particularly in relation to suicide surveillance and evaluation, were highlighted as limiting CfL's effectiveness. Participants also noted that the strategy failed to respond dynamically to changing risk patterns, such as increased youth suicidality linked to digital exposure. There was a call for CfL to evolve in step with societal changes and service learning.

Stigma reduction efforts were acknowledged as important but underpowered. Campaigns such as *Green Ribbon* and *Little Things* were seen as valuable starting points, yet stakeholders stressed the need for more targeted and sustained communication efforts. These campaigns should not only raise awareness but also encourage early help-seeking and reduce fear among both service users and professionals.

3.3.5 HSE Staff: Retention and Expansion

There was strong consensus that the overarching goals of CfL should be retained, but with better prioritisation and implementation. Participants called for fewer, more clearly defined actions with aligned accountability and implementation structures. This would improve focus and reduce the perception of CfL as overly diffuse. Staff emphasised the need for the next iteration of suicide reduction strategy to include measurable outcomes, scheduled reviews, and defined responsibilities across sectors. The integration of suicide prevention actions into broader health, housing, and education policies was also suggested to ensure more coherent system-wide implementation.

Greater emphasis on trauma-informed environments—especially in education and primary care—was recommended as part of CfL's evolution. Participants also stressed that implementation plans should be regionally adaptable, while maintaining consistency in core standards and expectations.

3.3.6 *HSE Staff: Systemic and Structural Barriers*

Fragmentation of suicide prevention infrastructure was described as a major barrier to progress. Participants highlighted that referral pathways, leadership structures, and service availability often differed dramatically across regions, depending on local leadership or historical investment. This variation led to inconsistent care, staff confusion, and gaps in accountability.

The absence of coordinated interagency protocols further contributed to service inefficiency. HSE staff noted challenges in working with Gardaí, education providers, and NGOs, especially in areas lacking formal communication channels or joint working agreements. Leadership continuity and cross-sector accountability were flagged as key levers for addressing this issue.

Participants were also concerned that suicide prevention strategy remains overly clinical in its framing, with insufficient attention paid to social determinants such as poverty, trauma, or displacement. This was seen as a structural blind spot—limiting the effectiveness of interventions that focus solely on individual pathology. A more balanced approach that integrates social and systemic risk factors into both service design and policy was recommended.

3.4 Findings from Professional Groups

3.4.1 *Professional Group Consultation Overview*

A dedicated consultation session was held with a range of professional group stakeholders recruited via survey, including clinicians, allied health professionals, primary care representatives, educators, ambulance staff, and frontline mental health personnel. The workshop brought together 33 participants from varied regional and national contexts, many with deep experience across suicide prevention, mental health crisis response, and service leadership.

Structured around the five thematic domains in the analysis protocol, participants shared detailed insights into gaps in service delivery, the realities of care pathways, and opportunities for innovation. The discussion was shaped by both professional observations and operational experience, with strong emphasis on the need for more trauma-informed, collaborative, and person-centred approaches. The table below synthesises the findings from this group.

Main Theme	Subtheme Cluster	Identified Issues and Dynamics
Future Priorities and Needs	Therapeutic Crisis Alternatives	Need for calm, specialised 24/7 spaces for suicidal individuals.
	Human Connection	Support systems should prioritise empathy and storytelling.
	Neurodiversity and Inclusion	Services lack training and structures to support neurodivergent individuals.
Gaps and Lessons Learned	Crisis Care Pathways	Overreliance on EDs creates traumatic and inappropriate experiences for those in crisis.

Main Theme	Subtheme Cluster	Identified Issues and Dynamics
	Training and Competency	Inadequately trained practitioners are unprepared for suicide-related cases.
	Workforce Capacity	Suicide Crisis Assessment Nurses (SCAN) nurses feel under-equipped; services need to meet people where they are.
	Complex Needs and Dual Diagnosis	Addiction and mental health are not integrated; services push people away.
	CAMHS and Referral Failures	GPs struggle as CAMHS rejects too many referrals, including for suicidal children.
Policy Performance and Legacy	Implementation Failures	Lack of resourcing undermined policy outcomes for vulnerable families.
	Data Quality and Timeliness	Delayed, inaccurate suicide data hinders responsiveness.
	Lived Experience	Policy design lacks sufficient input from people with lived experience.
	Lack of Implementation	CfL lacks an implementation plan, timeline, or dedicated budget.
Systemic and Structural Barriers	Marginalisation and Model Design	Services failed to accommodate marginalised groups and used exclusive models.
	Social Determinants	CfL neglects upstream factors such as housing, poverty, and violence.
	Stigma in Communities	Stigma within families and schools limits open dialogue about suicide.
	Professional Hierarchies	Mental health services are constrained by psychiatric hierarchies.
	Service Mismatch	No stepped care model results in people receiving the wrong level of care.
Retention and Expansion	Therapeutic Gaps	CfL references talking therapies without resourcing psychotherapy or professionals.
	Public Engagement and Visibility	Public unaware of CfL; it lacks visibility and brand recognition.

3.4.2 Future Priorities and Needs

Professional groups consistently called for suicide prevention strategies that are therapeutic, inclusive, and person-centred. There was a strong emphasis on the need for dedicated, non-clinical, mental health crisis alternatives to EDs. These environments should be trauma-informed, calm, and staffed by professionals trained specifically in suicide-related distress, available 24/7 and integrated into broader care systems.

The role of empathy, connection, and storytelling was viewed as essential to effective support. Many practitioners described the current model as overly transactional and urged a shift toward relational care models that prioritise trust-building, continuity, and lived experience-informed practice.

Greater attention to neurodivergent individuals was seen as long overdue. Services were widely regarded as lacking in both training and structure to accommodate neurodiverse people in crisis. The need for neuroaffirmative approaches and specialised teams was highlighted, with emphasis on tailored care pathways and culturally competent staff development.

3.4.3 Gaps and Lessons Learned

Participants described a system that still funnels individuals in mental health crisis into EDs, despite long-standing consensus that these are inappropriate settings. EDs were characterised as dehumanising and clinically unsuited to psychological distress. The absence of therapeutic alternatives was cited as a critical gap, with calls for alternative crisis hubs or safe spaces rooted in trauma-informed care.

Workforce capacity and readiness emerged as key challenges. SCAN nurses and frontline responders were described as under-equipped to meet demand. Practitioners reported insufficient training and preparation, especially around complex suicide-related presentations, and noted high levels of stress and professional burnout.

A lack of systemic support for dual diagnosis was also flagged. Addiction and mental health were treated in siloed systems, with individuals often excluded from either due to co-existing needs. This was viewed as one of the most pressing systemic failings, given the prevalence of dual diagnosis in suicide risk populations.

Child and adolescent services—particularly CAMHS referral processes—were repeatedly highlighted as a bottleneck. Participants noted that GPs struggled to access timely supports for suicidal young people, with many referrals being rejected. This left frontline professionals without alternatives, contributing to risk escalation and service disengagement.

Finally, training and competency standards were seen as inconsistent across the system. While suicide prevention training exists, its implementation was viewed as ad hoc and poorly evaluated. Practitioners called for mandatory, evidence-based training for all clinical and non-clinical staff involved in suicide-related care.

3.4.4 Policy Performance and Legacy

Participants described CfL as a well-conceived but under-implemented framework. While its intent and structure were broadly supported, the lack of resourcing, timeline, and practical delivery plans left many professionals feeling frustrated and unsupported. This implementation gap undermined confidence in the strategy's ability to drive change.

There were also concerns about delayed and incomplete data. Professionals described the current suicide surveillance infrastructure as reactive rather than proactive, with delays in coroner data and limited granularity on demographics and risk patterns. These data gaps limited the ability to respond quickly to emerging needs or identify systemic failures.

Lack of inclusion of lived experience from CfL’s design and implementation was seen as a weakness. While lived experience is increasingly referenced in national discourse, participants reported that it was not systematically embedded in planning, evaluation, or service design. This disconnect was viewed as reducing the policy’s relevance and effectiveness.

Despite these critiques, some progress was acknowledged—particularly the increased use of appropriate language and the development of specialist roles. However, participants stressed that these gains were not yet system-wide, and must be supported through broader investment in coordination, staffing, and training.

3.4.5 Retention and Expansion

There was broad agreement that CfL's existing goals remained valid, but that its implementation must be refocused. Practitioners recommended streamlining CfL to include fewer, clearer goals, each supported by measurable targets and defined cross-sector responsibilities.

The gap between strategic vision and resource allocation was seen as particularly problematic in the area of psychotherapy. Although CfL references therapeutic supports, there remains a lack of resourcing for psychotherapy and trained therapists within the public system. This disconnect contributed to long wait times and inappropriate referrals, with services unable to deliver the model of care outlined in policy.

There was also concern that CfL lacked public visibility and resonance. While health professionals are familiar with the strategy, the general public remains largely unaware. Rebranding efforts and awareness campaigns were recommended to increase public understanding of CfL's purpose and strengthen its role in stigma reduction.

3.4.6 Systemic and Structural Barriers

Professional stakeholders identified multiple structural and cultural barriers to effective suicide prevention. Chief among these was the dominance of psychiatric hierarchies, which were seen to inhibit recovery-oriented models of care. Participants called for greater empowerment of community and multidisciplinary professionals, and for care models that are human-centred and flexible over diagnosis and control.

Stigma remained an entrenched barrier, both in public and institutional contexts. Cultural silence around suicide, especially within families and schools, continued to limit early disclosure and help-seeking. Participants stressed that public campaigns—while helpful—had not shifted this stigma sufficiently and must be strengthened with targeted engagement and structural change.

In terms of care design, participants highlighted the lack of a stepped care model, leading to service mismatch. Many people received care that was either too intensive or too minimal for their needs, resulting in poor outcomes, repeat crises, or disengagement. This inefficiency was linked to broader system fragmentation and limited coordination across providers.

Finally, the system's failure to incorporate social determinants of suicide—including housing, poverty, and violence—was seen as a core policy omission. Suicide prevention efforts were still perceived as overly medicalised, without sufficient integration of the broader life circumstances that shape distress and despair.

4 Cross-Group Synthesis and Comparative Insights

4.1 Overview

This section presents a cross-stakeholder synthesis of the thematic findings derived from the four consultation streams:

- People with lived experience.
- NGOs.
- HSE staff.
- Key professionals.

Using the five core policy domains as an organising framework—Future Priorities and Needs; Gaps and Lessons Learned; Policy Performance and Legacy; Retention and Expansion; and Systemic and Structural Barriers—this section identifies areas of thematic convergence, divergence, and distinctive insight.

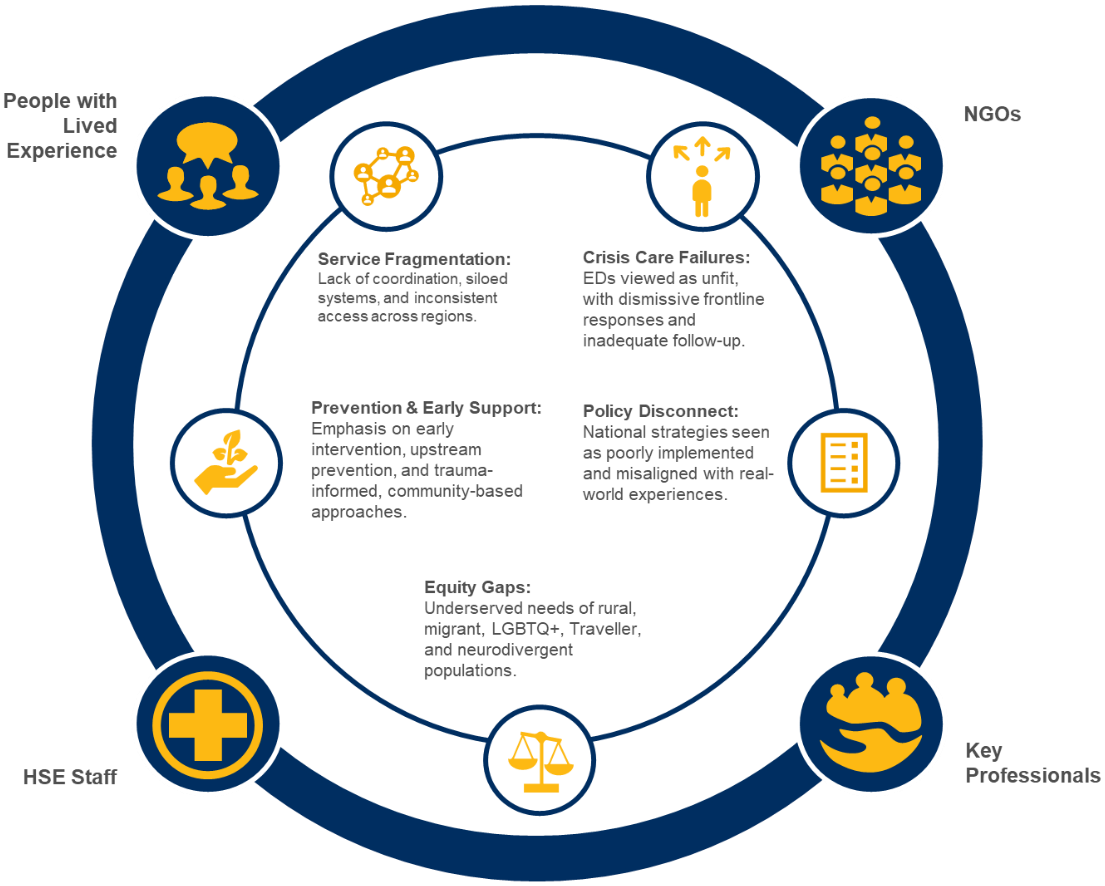
It offers a system-level perspective on the challenges and opportunities facing suicide prevention efforts in Ireland. In doing so, it highlights both the common ground that exists across different stakeholder groups and the unique priorities that shape each group's view of policy, practice, and service delivery.

4.2 Shared Themes Across Stakeholder Groups

Theme	Shared Subthemes	Summary of Cross-Group Insights
Future Priorities and Needs	Early intervention; upstream prevention; community and trauma-informed approaches	All groups called for a fundamental shift in focus—from reactive models to prevention. There was widespread endorsement of mental health education in schools, relational supports like peer and community-based care, and services that build capacity before crisis occurs. More awareness campaigns were seen as a priority. Youth-specific interventions, school supports, emotional literacy, and non-clinical engagement pathways were emphasised.
Gaps and Lessons Learned	ED inappropriateness; dismissive frontline responses; lack of follow-up	There was consistent consensus that EDs are structurally inappropriate to support people in suicidal crisis. Participants across all groups described them as dehumanising, retraumatising, and misaligned with the needs of those in distress. GPs and frontline providers were often viewed as ill-equipped, and post-crisis support was described as variable, fragmented, or entirely absent.
Policy Performance and Legacy	Disconnect between national policy and lived experience; limited visibility of CfL	CfL was generally regarded as well-intentioned but poorly implemented. Stakeholders across all sectors noted that its impact had not been meaningfully felt on the ground, especially outside major urban centres. The strategy was viewed as abstract and disconnected from service realities. There were strong calls for clearer communication, measurable progress indicators, and greater policy transparency.

Theme	Shared Subthemes	Summary of Cross-Group Insights
Systemic and Structural Barriers	Fragmented services; lack of coordination; inequitable access	Service fragmentation was universally identified as a barrier. Participants described systems that were siloed, difficult to navigate, and highly dependent on individual or geographic factors. A recurring frustration was the absence of consistent referral pathways and the lack of inter-agency protocols. These challenges were seen to disproportionately affect people in rural areas, as well as marginalised communities.
Equity and Inclusion *(Cross-Cutting)*	Gaps for rural, migrant, LGBTQ+, Traveller, and neurodivergent groups	Across all stakeholder groups, specific concern was raised about those who remain systematically underserved. These include people with disabilities, members of the Travelling community, neurodivergent individuals, migrants, and people experiencing housing or addiction issues. There was widespread recognition that suicide reduction efforts must be tailored, culturally appropriate, and designed with diverse voices at the centre.

The graphic below visually synthesises these shared insights, highlighting the core themes and cross-cutting challenges identified across all stakeholder groups.



Service Fragmentation: Lack of coordination, siloed systems, and inconsistent access across regions.

Crisis Care Failures: EDs viewed as unfit, with dismissive frontline responses and inadequate follow-up.

Prevention & Early Support: Emphasis on early intervention, upstream prevention, and trauma-informed, community-based approaches.

Policy Disconnect: National strategies seen as poorly implemented and misaligned with real-world experiences.

Equity Gaps: Underserved needs of rural, migrant, LGBTQ+, Traveller, and neurodivergent populations.

4.3 Divergent Priorities Across Groups

Despite shared critique of the current system, each stakeholder group brought unique perspectives informed by their lived, operational, or professional experience. These differences shaped how problems were framed, and which solutions were prioritised.

Group	Distinctive Emphases
People with Lived Experience	This group emphasised emotional safety, relational care, and dignity. Participants prioritised peer-led, human responses over medicalised or risk-assessed interventions. Their engagement with national strategy was minimal, reflecting either low awareness or a perceived disconnect from daily life. Their core insights centred on stigma, emotional neglect, and the nature of current help-seeking experiences. They also strongly voiced the need for open, national-level conversations about suicide—criticising the perceived silence from Government—and called for a public awareness campaign on the scale of the Road Safety Authority to challenge stigma and normalise help-seeking.
NGOs	NGO representatives were strongly focused on systemic structure and operational design. They called for simplified policy frameworks, measurable objectives, and stable funding models. Frustration was expressed at the disconnect between frontline delivery and NOSP-led architecture, as well as the tendency to outsource core prevention functions to underfunded NGOs.
HSE Staff	Health Service staff placed greater emphasis on formal implementation mechanisms, such as structured roles, surveillance infrastructure, and workforce capacity. Concerns were raised about inconsistent application of CfL across regions, the absence of statutory postvention services, and the disconnect between national strategy and local enablement. Data quality and interagency integration were recurring priorities.
Key Professionals	Professionals from clinical and educational sectors identified diagnostic silos, unintegrated pathways, and inadequate training as critical points of failure. Particular attention was given to system mismatches—for example, the overreliance on EDs in CAMHS referral systems, and the lack of care for neurodivergent and dual diagnosis populations. Participants also highlighted the need to reform psychiatric hierarchies and introduce stepped care models.

4.4 Unique Contributions by Stakeholder Group

Each group also brought distinct perspectives shaped by their specific roles and experiences—whether as people directly affected, frontline workers, policy staff, or service leaders.

Group	Unique Insights
People with Lived Experience	Participants shared deeply personal accounts of harm in the system. EDs were described as appropriate, and professionals as emotionally disengaged. This group offered powerful critiques of current service culture, including the over-medicalisation of care and the exclusion of families / friends' support. DBT was one of the few interventions described as effective but often inaccessible.
NGOs	This group provided detailed analysis of systemic inefficiencies within the suicide reduction landscape. They raised concerns about implementation structures under NOSP, and the lack of interim reviews or feedback loops

Group	Unique Insights
	within CfL. The sector called for mandatory training, decentralised community models, and interlinked action plans with funding clarity.
HSE Staff	HSE contributors outlined structural reforms needed at the national level, including standardisation of ROSP roles, real-time suicide data, and the integration of bereavement services into statutory provision. They offered practical reflections on cross-sector coordination and called for clearer accountability mechanisms to support the implementation of policy into practice.
Key Professionals	This group uniquely identified the CAMHS referral pathways and highlighted failures in cross-service compatibility for individuals with dual diagnoses. They emphasised the need to dismantle rigid professional hierarchies and incorporate lived experience and social determinants into every level of design and delivery. Their input strongly supported operational reform, particularly in crisis care environments.

4.5 Synthesis Implications for Policy Development

Taken together, the findings from this cross-stakeholder synthesis present a clear mandate for transformation in Ireland’s approach to suicide prevention. While differing in tone and emphasis, each group outlined critical weaknesses in the current system and articulated clear principles for future strategy.

- **Proactive and upstream** – investing in education, relational care, and early intervention to reduce crisis-level need.
- **Person-centred and relational** – replacing transactional, checklist-based models with approaches that prioritise empathy, human connection, and cultural responsiveness.
- **Operationally aligned and accountable** – with clearly defined roles, data systems, and cross-sector implementation plans that reflect real-world service environments.
- **Equity-driven** – explicitly including diverse voices and embedding inclusion as a foundational principle, not an add-on.

Stakeholders across all groups expressed a readiness to engage with a reformed policy environment—one that is grounded in lived realities, responsive to feedback, and resourced for impact.

5 Conclusion

This consultation process has generated a comprehensive, multi-perspective account of Ireland’s current suicide reduction landscape. Drawing on the insights of people with lived and living experience, non-governmental organisations, health service staff, and professional stakeholders, the findings present a sobering but constructive narrative of system-wide failures and opportunities.

5.1 Policy Intention vs. Service Reality

Across all groups, participants spoke of a misalignment between policy intent and lived service experience. While the CfL strategy was widely acknowledged as well-conceived—evidence-based and internationally aligned—there was common that implementation has not matched intent. For many, CfL was not tangibly felt in daily interactions with services.

5.2 A Call for Prevention Over Crisis Response

There was a strong, shared theme across all cohorts: Ireland must shift from a crisis-led to a preventative, community-based model. This includes investing in mental health education, peer support, and early intervention, but also addressing upstream risk factors—poverty, trauma, housing instability, and social exclusion—as essential components of prevention, not side issues.

5.3 Need for Inclusion of Lived Experience

The need for inclusion of those with lived experience emerged as a cross-cutting topic. The call was for co-production from the outset, embedding lived experience in design, implementation, and evaluation.

5.4 EDs as Inappropriate Setting

The inappropriateness of EDs as safe, appropriate spaces for people in mental health crisis was one of the most urgent and repeated themes. Participants described EDs as overwhelming, invalidating, and in some cases harmful for people in mental health crisis. Alternatives—therapeutic crisis centres, peer-led spaces, trauma-informed hubs—were not only supported but seen as essential.

5.5 NGOs: Critical but Under-resourced

NGOs were seen as critical in suicide reduction yet remain under-resourced. Their work is constrained by short-term funding, unclear integration points into health systems, and expectations to fill service gaps without adequate support. Sector fatigue and frustration were clearly expressed. Some participants, particularly those with lived experience, were critical of NGOs delivering services they felt should be the responsibility of the State.

5.6 System Constraints within the HSE

HSE staff expressed readiness for reform, but also acknowledged major constraints—workforce shortages, poor inter-system integration, and importantly the absence of real-time data. Without these foundations, it was felt that service improvement is difficult to sustain.

5.7 Over-Medicalised Models and Gaps in Care

Professional groups critiqued the clinical hierarchies that offer over-medicalised models rather than human-based support. There were calls for stepped care models, human-based services, and relationship training—particularly for those working with dual diagnosis, neurodivergent individuals, and youth in transition.

5.8 From Operational Reform to Cultural Shift

A common theme pointed to the need for a cultural shift as well as operational reform. It was seen the suicide reduction entails a cultural and ethical shift: treating people not as problems to be managed, but as rights-holders, community members, and experts in their own lives.

5.9 The Next Suicide Reduction Strategy

It was seen that the next Suicide Reduction Strategy must address trauma, enable joined-up delivery, and pursue accountability across services and sectors. It should involve lived experience, be human-centric and deliver with visibility and credibility.

5.10 Closing Reflection

In closing, these insights offer a view on how to achieve a more inclusive and sustainable suicide strategy. They reflect shared challenges, aspirations, and practical ideas for change. It was seen that suicide reduction is not the task of any one service—it is relational, involves complex solutions, compassion, and is deeply human.

Appendix 1 – Group Facilitator Guide

Lived Experience Workshop Plan

Initial introductions:
Each participant to briefly introduce themselves and note the names
Have the group select a rapporteur who will report back on the discussion

Theme 1: Where have mistakes been made and how should this change for the future? (20 minutes)
Prompts/questions for driving discussion:
In services
In the Community
In Ireland and Society
In Government Policy

Theme 2: What challenges and barriers have you experienced? (20 minutes)
Prompts/questions for driving discussion:
Where are the biggest challenges and barriers for support for you?
What would help address these challenges and barriers?

Theme 3: What aspects of the previous suicide policy (Connecting for Life) do you want to see retained and/or expanded over the coming years? (20 minutes)
Prompts/questions for driving discussion (Connecting for Life Goals):
Goal 1: Better understanding
Goal 2: Supporting Communities
Goal 3: Targeted approaches
Goal 4: Access to services
Goal 5: Quality services
Goal 6: Access to means
Goal 7 Data and research

Theme 4: What else would you like to see in a new policy? (20 minutes)
Prompts/questions for driving discussion:
For families
For different communities
Improvements that have been made

NGOs Workshop Plan

Initial introductions:
Each participant to briefly introduce themselves and note the names
Have the group select a rapporteur who will report back on the discussion

Theme 1: How well do you think suicide prevention has been addressed by recent and current policy and resources in Ireland? (20 minutes)
Prompts/questions for driving discussion:
Extent of implementation of existing policy?
Impact of existing policy on suicide in Ireland?
Resource availability?
Challenges to implementation?

Theme 2: What are the priorities for suicide reduction for the coming years? What would you like to see in a new policy? (20 minutes)
Prompts/questions for driving discussion:
Are these different from previous priorities?
Innovative ideas?
Learning from elsewhere?
Areas of focus?

Theme 3: What aspects of the previous suicide policy (Connecting for Life) do you want to see retained and/or expanded over the coming years? (20 minutes)
Prompts/questions for driving discussion (Connecting for Life Goals):
Goal 1: Better understanding
Goal 2: Supporting Communities
Goal 3: Targeted approaches
Goal 5: Quality services
Goal 6: Access to means
Goal 7 Data and research

Goal 4: Access to services
Theme 4: What did not work as it was intended, where were there gaps, and how should this change for the future? (20 minutes) Prompts/questions for driving discussion (from the consultation process online): Service delivery? Training? Individual risk factors? Addressing societal factors? Postvention?

HSE Staff Workshop Plan
Initial introductions: Each participant to briefly introduce themselves and note the names Have the group select a rapporteur who will report back on the discussion
Theme 1: How well do you think suicide prevention has been addressed by recent and current policy and resources in Ireland? (20 minutes) Prompts/questions for driving discussion: Extent of implementation of existing policy? Impact of existing policy on suicide in Ireland? Resource availability? Challenges to implementation?
Theme 2: What are the priorities for suicide reduction for the coming years? What would you like to see in a new policy? (20 minutes) Prompts/questions for driving discussion: Are these different from previous priorities? Innovative ideas? Learning from elsewhere? Areas of focus?
Theme 3: What aspects of the previous suicide policy (Connecting for Life) do you want to see retained and/or expanded over the coming years? (20 minutes) Prompts/questions for driving discussion (Connecting for Life Goals): Goal 1: Better understanding Goal 2: Supporting Communities Goal 3: Targeted approaches Goal 4: Access to services Goal 5: Quality services Goal 6: Access to means Goal 7 Data and research
Theme 4: What did not work as it was intended, where were there gaps, and how should this change for the future? 20 minutes) Prompts/questions for driving discussion (from the consultation process online): Service delivery? Training? Individual risk factors? Addressing societal factors? Postvention?

Key Professionals Workshop Plan

Initial introductions:
Each participant to briefly introduce themselves and note the names
Identify a Rapporteur who will report back to the Plenary Session on the 3/4 key points you have discussed

Theme 1: Where have mistakes been made and how should this change for the future? (20 minutes)
Prompts/questions for driving discussion:
In services
In the Community
In Ireland and Society
In Government Policy

Theme 2: How well do you think suicide prevention has been addressed in Ireland? What challenges and barriers have you experienced? (20 minutes)
Prompts/questions for driving discussion:
Where are the biggest challenges and barriers for support for you
What would help address these challenges and barriers

Theme 3: What aspects of the previous suicide policy (Connecting for Life) do you want to see retained and/or expanded over the coming years? (20 minutes)
Prompts/questions for driving discussion (Connecting for Life Goals):
Goal 1: Better understanding
Goal 2: Supporting Communities
Goal 3: Targeted approaches
Goal 4: Access to services
Goal 5: Quality services
Goal 6: Access to means
Goal 7 Data and research

Theme 4: What else would you like to see in a new policy? (20 minutes)
Prompts/questions for driving discussion:
For families
For different communities
Improvements that have been made