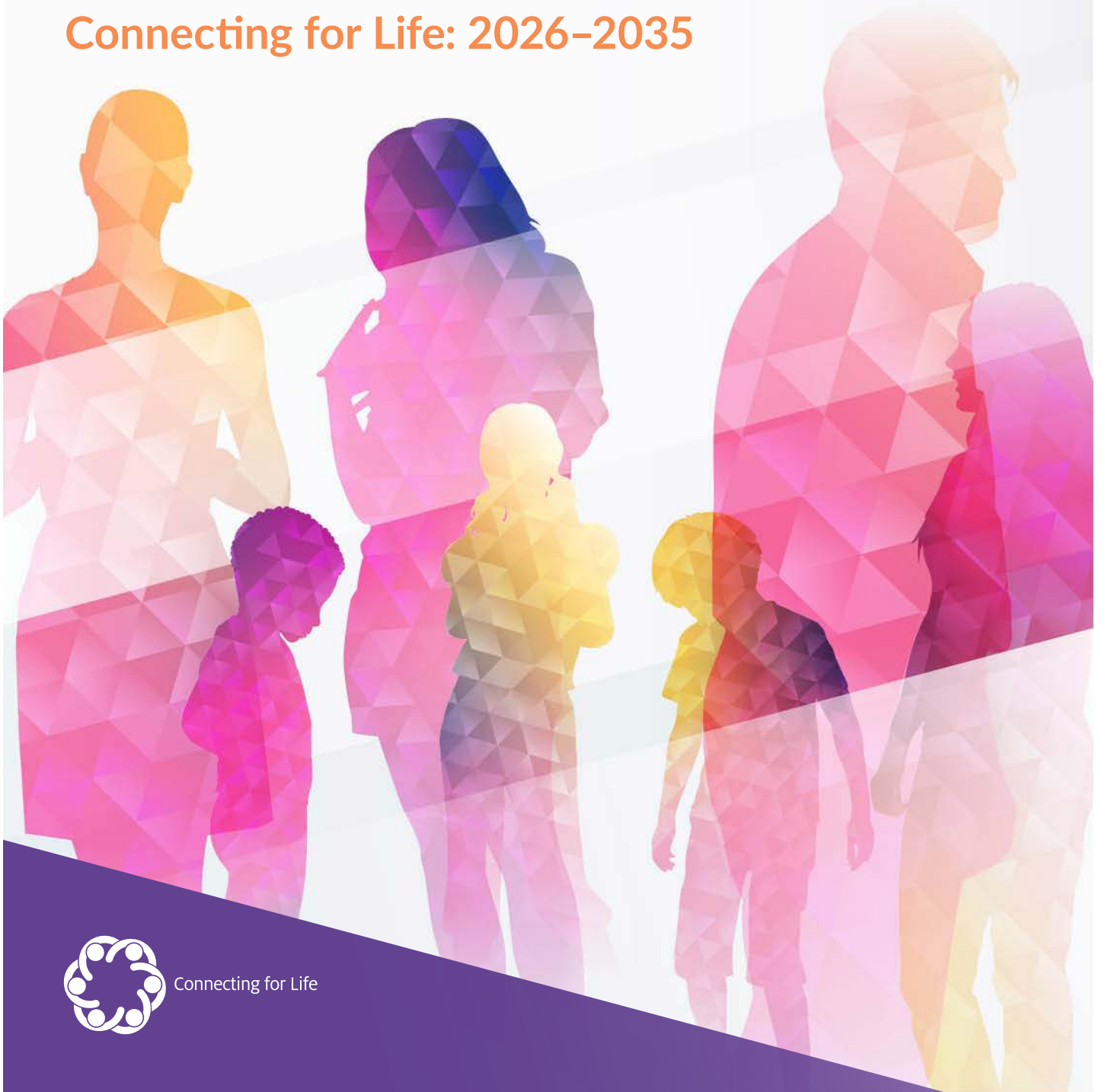




Rialtas na hÉireann
Government of Ireland

Ireland's Strategy to Reduce Suicide and Self-harm

Connecting for Life: 2026–2035



Connecting for Life

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Foreword 1: From Taoiseach Micheál Martin TD

Ba mhaith liom buíochas a ghabháil leis an Aire Sláinte, Jennifer Carroll MacNeill TD, agus leis an Aire Stáit um Shláinte Meabhrach, Mary Butler TD, as an straitéis is déanaí seo a thabhairt chun cinn atá dírithe ar an ráta féinmharaithe in Éirinn a laghdú.

I would also like to thank the many individuals who contributed to the strategy's development including international partners, the Expert Advisory Group and, in particular, those who took part in the Lived Experience Group.

The Lived Experience Group selflessly shared their very personal stories to further develop our mental health services in Ireland. The value of lived experience has provided the opportunity to have a more informed strategy and a better understanding of how to talk about suicide. Thank you on behalf of all the people who will benefit from the actions in this strategy both now and in the future.

The loss of a life to suicide is a tragedy that has impacted too many families, friends, and communities across Ireland. Each death is a devastating event and a stark reminder of the importance of prioritising mental health and wellbeing, as well as kindness and compassion, in our society.

Over the last 20 years of strategies aimed at reducing the rate of suicide in Ireland, it's positive and welcome to see that steady progress has been made. We know that men are at higher risk of suicide, and I particularly want to urge any man who might benefit from counselling to avail of it. Even one suicide is one too many. It is on this basis that we will continue to tackle this challenge head on and strive to find new and better ways to support those who need it during times of crisis.

Our new national strategy builds on the progress made under previous strategies, including *Reach Out (2005–2014)* and, more recently, *Connecting for Life (2015–2024)*. This strategy delivers on one of our strategic priorities for mental health under Sláintecare 2025+, giving us an ambitious roadmap for the next decade, including actions to seek to address the root causes of suicide and self-harm. Realising the vision of “an Ireland where far fewer lives are lost to suicide, and where communities and individuals have access to the supports and services needed to prevent suicide and respond to self-harm” will require an all-of-Government and indeed an all-island commitment.

As Taoiseach, I am deeply committed to supporting effective implementation of this strategy across Government as a collective. Together, we must create a future of hope and resilience, where everyone feels supported at a time of crisis in their lives.



Micheál Martin TD
An Taoiseach

Michael Martin

Foreword 2: From the Minister for Health, Jennifer Carroll MacNeill TD

Ireland's Strategy to Reduce Suicide and *Self-harm: Connecting for Life: 2026–2035* is a key component of the Government's commitment to improving mental health and wellbeing. By integrating mental health and suicide prevention into broader health and social care reforms we will ensure that mental health is treated with the same urgency and importance as physical health.

This strategy aligns closely with the Department of Health's priorities, including the transformative goals of Sláintecare to develop healthcare that is accessible, high-quality, and focused on achieving the highest possible standards of care for the people of Ireland when they need it, where they need it. It is also supported by Healthy Ireland, the national Framework for action to improve the health and wellbeing of everyone living in Ireland and specifically the Sláintecare Healthy Communities Programme under which we will provide enhanced suicide prevention initiatives in targeted areas.

As part of the public consultation for this strategy, people shared negative experiences of presenting to Emergency Departments in suicidal distress. As Minister for Health, I have been actively involved in improving the efficiency and quality of care in Emergency Departments and addressing unscheduled care in Ireland. I will continue to invest in staffing and infrastructure in our hospitals as well as investing in alternatives within our communities so that patients receive the best possible care.

This strategy is testament to what we can achieve when we work together. I am confident that it will deliver meaningful change for individuals, families, and communities across Ireland.



Jennifer Carroll MacNeill TD
Minister for Health

A handwritten signature in black ink that reads "Jennifer Carroll MacNeill TD".

Foreword 3: From the Minister for Mental Health, Mary Butler TD

Preventing the tragedy of suicide and ensuring that people experiencing suicidal thoughts or self-harm are supported to live happy and fulfilling lives will always be a priority for me and for the Government as a whole. It is hugely important that we keep working to reduce suicide and self-harm in Ireland and that appropriate and empathetic support is there for people in crisis and those bereaved by suicide.

With this new strategy, together with *Sharing the Vision*, our mental health policy, and the Mental Health Act 2026, we now have a comprehensive framework to fundamentally change how we view mental health in this country. National policies are a vital way of ensuring that a conscious and coherent effort is made to reduce stigma and put the person at the centre of mental health service delivery.

Since I was first appointed Minister for Mental Health in July 2020, I have worked tirelessly to ensure that supports are there for anyone who needs them, whenever this may be. Over the past two decades, suicide rates have decreased from a standardised rate of 12.9 per 100,000 in 2000, to a standardised rate of 8.6 per 100,000 in 2022. In recent years, we have also reduced the number of people presenting with self-harm to Emergency Departments.

With this new strategy we will further enhance crisis supports by developing specialist nursing teams in our hospital emergency departments and in our communities through the national roll out of Crisis Resolution Teams, Crisis Cafes and Suicide Crisis Assessment Nurse teams. I am also deeply committed to supporting the most vulnerable groups in our society and we will continue to develop targeted interventions to address the unique needs of specific communities shown by evidence to be at increased risk of suicide and self-harm. This includes targeted initiatives to support the Traveller community whom we know are disproportionately impacted by suicide. The new strategy also places a greater emphasis on the specific needs of people bereaved by suicide and contains actions to develop enhanced and compassionate bereavement and postvention supports.

This strategy is the result of a highly collaborative process, grounded in evidence and shaped by the voices of those with lived experience of suicide and self-harm. I want to express my deepest gratitude to the members of the Expert Advisory Group and the Lived Experience Reference Group, whose insights and dedication have been instrumental in shaping this strategy. I would like to thank members of the Lived Experience Reference Group, led by Joe O'Donovan, who have generously given their time and insights so that others will not suffer unnecessarily and to help promote messages of hope and recovery. I remain committed to ensuring that the voice and choice of those living with suicidal ideation, self-harm or suicide bereavement in Ireland are heard as we implement the strategy and will establish a dedicated lived experience reference group to support implementation.

Support needs to be available wherever people are, whenever they need it. The community and voluntary sector has a key role to play in supporting people in communities across the country, and I would like to acknowledge the hard work of everyone working in our voluntary mental health services to reduce suicide.

I am proud to support this strategy and its ambitious goals, including the target to reduce the rate of suicide to 7 per 100,000 or lower by 2035. I look forward to working with all stakeholders to ensure its successful implementation.



Mary Butler TD
Minister for Mental Health

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Foreword 4: From the Secretary General, Department of Health, Derek Tierney

The implementation of *Ireland's Strategy to Reduce Suicide and Self-harm Connecting for Life: 2026–2035* is something that we must do together. It's a shared responsibility and it will only succeed if the Department of Health, the HSE, and our partners in government, communities, and the voluntary sector all play their part. Each of us has a role in making sure that support and hope reach every corner of Ireland.

The Department of Health chaired the National Cross Sectoral Steering and Implementation Group for Ireland's very first all of Government suicide reduction strategy, *Connecting for Life: 2015-2024* and witnessed the importance and value of a coordinated national cross-governmental strategy. That experience showed us just how much we can achieve when we work together, and how vital it is to have a coordinated national approach. This new strategy builds on everything we learned from its predecessor and gives all Government Departments a clear mandate: work together to reduce suicide and self-harm. It is not just about policies and structures - it's about people. That is why we're placing such importance on strong governance, better use of real-time data, and making sure the voices and experiences of people affected by suicide and self-harm are at the heart of every step we take.

A new national implementation monitoring group, chaired by the Department of Health, will be established to oversee implementation of this strategy. It will be supported by the HSE National Office for Suicide Prevention, a Lived Experience Reference Group and a number of specialist sub-groups. We will also work hand in glove with the Interdepartmental Steering Group for Mental Health, which provides crucial guidance to deliver *Sharing the Vision, Pathways to Wellbeing* and this strategy. Close collaboration with the National Implementation and Monitoring Committee for *Sharing the Vision* will ensure our actions are joined up and truly make a difference for people across Ireland.

I want to assure everyone—whether you're working on the front line, supporting someone you care about, or have lived through your own experience—that the Department of Health is fully committed to making this strategy a reality. I am hopeful for the significant and positive impact it will have for individuals, families, and communities across Ireland in the years ahead.



Derek Tierney
Secretary General, Department of Health

A handwritten signature in black ink, appearing to read 'Derek Tierney' in a cursive style.

Foreword 5: From the CEO of the Health Service Executive, Anne O'Connor

I am delighted to welcome this new Suicide and Self-harm Reduction Strategy. The HSE, with the support of national and regional implementation structures, will work with the Department of Health to realise the ambitious goals set out in the strategy and I, as CEO, am committed to supporting all staff to deliver a safer, more compassionate health service for all, where mental health is prioritised.

It is a time of great opportunity and challenge for healthcare in Ireland. With Sláintecare reform we are transforming how we deliver healthcare. This move towards an integrated model presents a significant opportunity for different parts of the HSE to work together, including Public Health, Mental Health Services, Health and Wellbeing, Primary Care and Acute Hospitals. By sharing data and using evidence effectively, our services can strengthen suicide prevention efforts and ensure consistent, supportive pathways of care for people experiencing distress. Instilling a message of hope is essential and by including people with lived experience of suicide and self-harm in the development and delivery of services we will ensure that we are consistently promoting recovery.

I was proud to work both as a clinician in mental health services and later as HSE National Director for Mental Health, where I oversaw the restructuring of the National Office for Suicide Prevention (NOSP) to support the delivery of *Connecting for Life 2015-2024*. I would like to acknowledge John Meehan and the NOSP Team for the pivotal role they have played in implementing *Connecting for Life 2015-2024* and developing this new strategy.

The HSE looks forward to continuing to support this vital work both through the national structures and through the development of six regional plans and establishment of regional implementation monitoring groups.



Anne O'Connor
CEO of the Health Service Executive

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Vision, target, domains and guiding principles

Vision

An Ireland where far fewer lives are lost to suicide, and where communities and individuals have access to the supports and services needed to prevent suicide and respond to self-harm.

Target

A target of a reduction in the rate of suicide to 7 per 100,000 by 2035 has been adopted as the minimum target for this strategy.

The long-term intended benefits of the strategy are:

1	A sustained reduction in the number of people who die by suicide or probable suicide across all population groups in Ireland.
2	A reduction in the incidence, severity and repetition of self-harm.
3	A reduction in the number of people experiencing suicidal ideation.
4	People impacted by suicide and self-harm will live well and have an improved quality of life as a result of having timely access to appropriate, compassionate and quality services and supports. This includes (i) people experiencing suicidal thoughts/ ideation, (ii) people who have, or who are at risk, of self-harm, (iii) families, carers and supporters of persons at risk of suicide or who are self-harming and (iv) people impacted in the aftermath of death by suicide.
5	People in suicidal distress or with experience of self-harm feel safer in their communities and are encouraged to seek support when needed as a result of access to more targeted supports and strengthened community awareness as well as improved education, awareness, and more open and informed conversations about suicide and self-harm.
6	Improved awareness and early intervention initiatives are effective in promoting and maintaining lower suicide and self-harm risk from early years, through adolescence to young adulthood.
7	Actions are more relevant and there is enhanced accountability because the experiences of people with lived and living experience are embedded across all elements of the strategy.

Domains

The recommendations and associated actions in this strategy are arranged within five domains. The domains are specific themes or areas of focus and reflect the need for the new strategy to include both a greater focus on the root causes of suicide, and enhanced support for people in suicidal or self-harm distress or who have been bereaved by suicide.

Domain 1

Preventing suicide and self-harm, reducing stigma and addressing the social determinants.

10 Recommendations

Domain 2

Restricting access to means and methods.

6 Recommendations

Domain 3

Implementing effective responses for people in suicidal distress or with experience of self-harm.

11 Recommendations

Domain 4

Ensuring compassionate, coordinated and accessible postvention support.

7 Recommendations

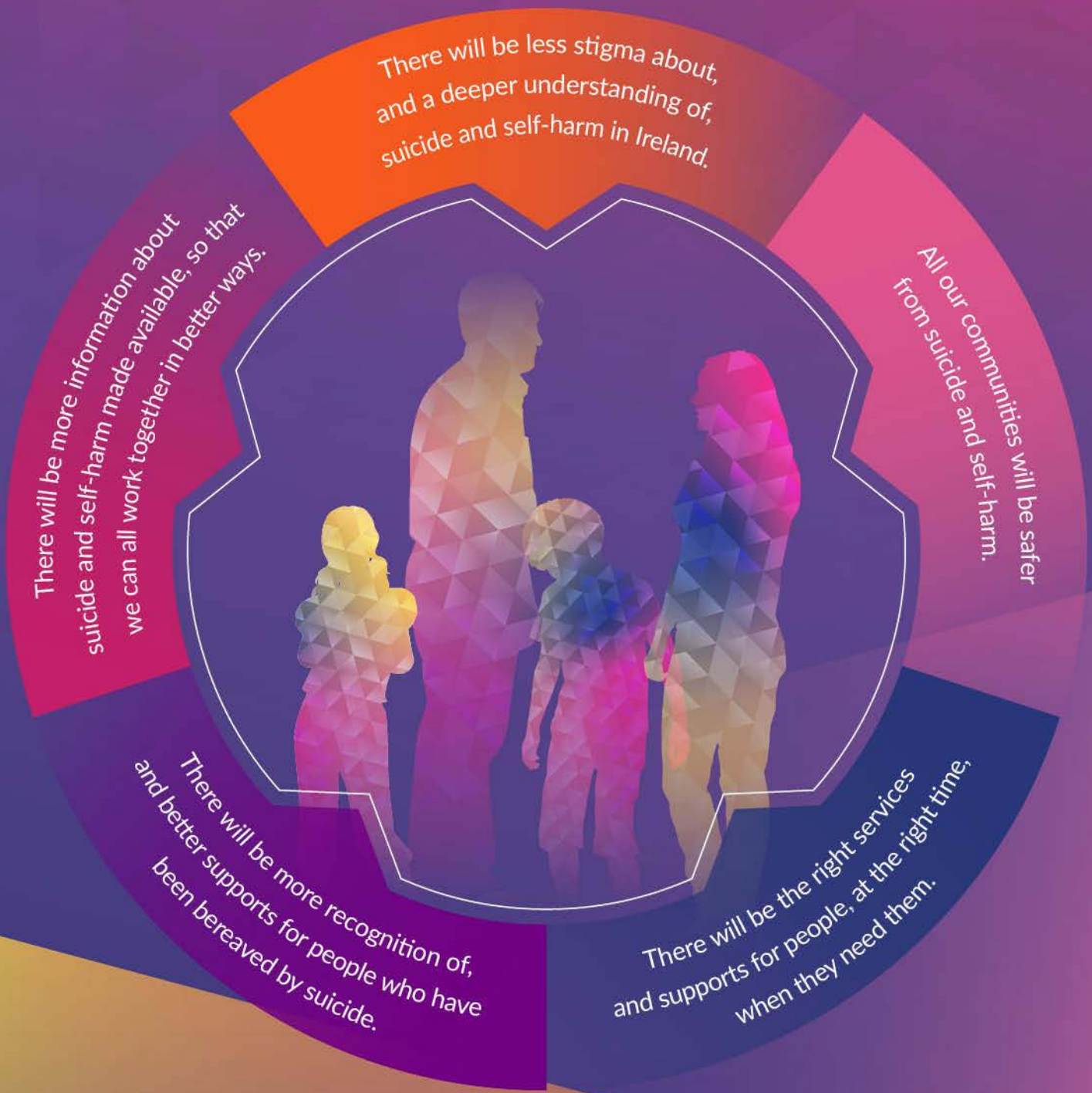
Domain 5

Establishing evidence, surveillance systems and supporting structures.

14 Recommendations

At a glance:

What this strategy will mean for us all



Guiding principles

Six guiding principles were developed to support implementation of this strategy. These build on the principles set out in [Connecting for Life, Ireland's National Strategy to Reduce Suicide 2015–2024](#).

1 Collaborative – achieve together to deliver on the strategy.

Suicide and self-harm reduction work is best undertaken with a whole-of-society approach, where individuals, communities, non-governmental organisations and government departments work collaboratively, to coordinate efforts and achieve more. This collaboration will work across multiple relevant public policies.

2 Engagement with people with lived experience.

This strategy has been shaped by people who have had suicidal thoughts, survived suicide attempts, engaged in self-harm, cared for a person in crisis, or been bereaved by suicide. While every person's journey is unique, the contributions can help build compassionate, effective and responsive suicide and self-harm reduction efforts, prevent imitative behaviour and ultimately achieve better outcomes for everyone. The strategy should be monitored and implemented in close collaboration with people with lived experience of suicide and self-harm.

3 Responsive – providing trauma informed, high-quality service responses that work with and support people to achieve goals that are meaningful and important to them.

Responses to suicidal behaviour and self-harm will be offered in a trauma informed, person-centred manner, which is recovery oriented and respects a person's choice and voice. Information on services and the services themselves must be accessible to all sections of society.

4 Evidence-informed and outcome focused – actions are targeted to needs that have been identified and based on international best-practice recommendations.

All programmes, projects and interventions will be evidence-informed and robustly evaluated. Service design, delivery and evaluation will be focused on achieving results to agreed standards and timeframes in a targeted and a cost-effective manner.

5 Flexible and adaptive to change.

Services and structures need to be able to adapt to emerging knowledge, respond to changing circumstances and be ready to adopt new and successful evidence-based initiatives, including new technologies.

6 Accountable – clear governance structures and openness in implementing the strategy.

Implementation structures will be built on accountability, competence, shared learning and openness as a means to improve quality and deliver efficient and cost-effective initiatives and services.

“The lived experience voice should be an integral part of any governmental suicide reduction strategy to ensure stakeholders are always learning and developing the most robust yet kind and compassionate system possible. We give our time willingly in the hope that others might avoid unnecessary suffering and with time, care and attention it will encourage healing and recovery in today’s complex and challenging world.”

A member of the Lived Experience Reference Group for the development of this strategy.



Sources of support

This strategy discusses suicide, self-harm and suicide bereavement. While every effort has been taken to do this safely and with sensitivity, some readers might find reading it difficult, or some of the content distressing.

Here are some ways to find support in Ireland.

- **Samaritans services are available 24 hours every day, for confidential, non-judgmental support.**
 - » Freephone 116 123 anytime day or night.
 - » Email jo@samaritans.ie.
 - » Visit www.samaritans.ie.
- **Pieta provide a range of suicide and self-harm prevention and bereavement services.**
 - » Freephone 1800 247247 anytime day or night.
 - » Text HELP to 51444 (standard message rates apply).
 - » Visit www.pieta.ie.
- **Text About It is a free, anonymous, messaging support service.**
 - » Text HELLO to 50808 anytime day or night.
 - » Visit www.textaboutit.ie, where a WhatsApp option is also available.
- **Visit www.hse.ie/grief for information on grief after bereavement or loss, how to support others, and suicide bereavement supports and services.**
- **Visit www.yourmentalhealth.ie for more information on how to mind your mental health, support others, and to find a support service in your area.**
- The Your Mental Health information line is a phone service you can call for information on mental health support and services and how to access them. Freephone 1800 111 888 anytime day or night.
- Spunout navigator is an online tool connecting you to personalised mental health information, resources and support. Visit <https://spunout.ie/navigator/>.

Terminology used in this strategy

Suicide is an action that a person takes to deliberately end their own life and that results in death.¹

A **suicide attempt** is an act in which a person harms themselves with the intention of ending their life and survives.²

Suicidal thoughts and behaviours describe the range of experiences that a person who is suicidal may be having. This range spans from having thoughts of suicide to attempting suicide. Suicidal thoughts and behaviours describe a person's experience, rather than risk.³

Suicidal distress describes the experience of unbearable emotional and psychological pain, which can be associated with thoughts or plans to end one's life as a means of escaping that unbearable pain. This experience is also referred to as **suicidal crisis**, especially when this emotional and psychological pain intensifies for a period and the person considers themselves at immediate risk of taking action to end their life.⁴

Suicide or suicidal ideation refers to thoughts, ideas, or ruminations about the possibility of ending one's life, ranging from not wanting to live or thinking that one would be better off dead (**passive ideation**) to preparing and planning to end one's life (**active ideation**).⁵

Self-harm is intentional self-poisoning or injury irrespective of the apparent purpose of the act.⁶ It is broader than, but includes, suicide attempts, due to intent. Some people may self-harm with suicidal intent or for other reasons. Both suicide and self-harm are a response to overwhelming emotional distress. For some people, self-harm is a way of coping with difficult or overwhelming feelings.

In some contexts (for example, in research) it might be necessary to be specific about whether the self-harm act in itself, was intentional or not (**intentional self-harm**).

Suicide postvention is a term that incorporates a range of organised responses after the death of a person to suicide.⁷ These responses aim to do one or more of the following: to facilitate the healing of people from the grief and distress of **suicide bereavement**; to mitigate other negative effects of exposure to suicide, and; to prevent suicide among people who are at high risk after exposure to suicide.

Lived experience includes having: experienced suicidal thoughts; engaged in self-harm; survived a suicide attempt; cared for someone through suicidal crisis, or; been bereaved by suicide.

Social determinants of health are non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. The social determinants of suicide and self-harm are these societal influences that impact on suicide and self-harm. Strongest evidence links income, social protection, unemployment and early childhood development to suicide risk.

Public health is defined as the science and art of preventing disease, prolonging life and promoting health and wellbeing, through the organised efforts of society.⁹ Health is defined by the World Health Organisation as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

A note on language

Language and terminology can play a powerful role in shaping how we understand and respond to suicide and self-harm. Words have potential to either harm or heal. They can either reinforce stigma or provide hope.

This is especially important for people and communities with lived or living experience of suicide or self-harm, or who have been bereaved. For people who might be particularly vulnerable with thoughts or plans for suicide, unintentional use of particular language or tone could increase the risk of harm to them.

People who have died by suicide should also be acknowledged and remembered – beyond the statistics – with dignity and respect when we talk about or reference them.

Here are some ways to write or talk about suicide and self-harm, that can help people feel seen, valued and safe.

- Use neutral and simple terms, such as 'die by suicide', 'died by suicide', 'death by suicide', or 'ended his/her/their own life'. The term 'committed suicide' is not used because the word 'committed' is often associated with crime (suicide in Ireland was decriminalised in 1993) or sin, neither of which is a helpful association. Use the term 'self-harm' instead of 'deliberate self-harm'. "Deliberate" can feel judgmental and oversimplifies intent.
- Use person-centred, or person-first terminology where possible. Avoid using terminology that labels a person singly by their method of death, or by their experiences. For example, 'a person who died by suicide' is preferred to describing a person as 'a suicide'. 'A person bereaved by suicide' is preferred to 'a bereaved person'. Say a 'person who self-harms' as opposed to 'a self-harmer' or 'a cutter'.
- Avoid terms that imply a death was somehow desirable or successful, for example, 'completed suicide', 'successful suicide' or 'failed suicide'. 'Suicide attempt' and 'non-fatal attempt' are more acceptable terms.
- Always avoid insensitive terms that can sensationalise suicide, for example, 'suicide epidemic', 'suicide mission' or 'suicide hotspot'. These types of terms can be harmful for people who are vulnerable themselves, or for people who have been bereaved by suicide.
- Avoid language that dismisses self-harm as a "cry for help" or trivialises its seriousness.

Media reporting

If you are a journalist or media professional covering this strategy or a suicide-related topic, consider the [Samaritans Ireland Media Guidelines for Reporting Suicide and Preventing Suicide, a resource for media professionals \(World Health Organisation\)](#) – because of the potentially harmful consequences of irresponsible reporting. In particular, the guidelines advise on terminology to use and not use, and to include links to sources of support for anyone impacted by the themes in any coverage.

1

Background, context and development of this strategy

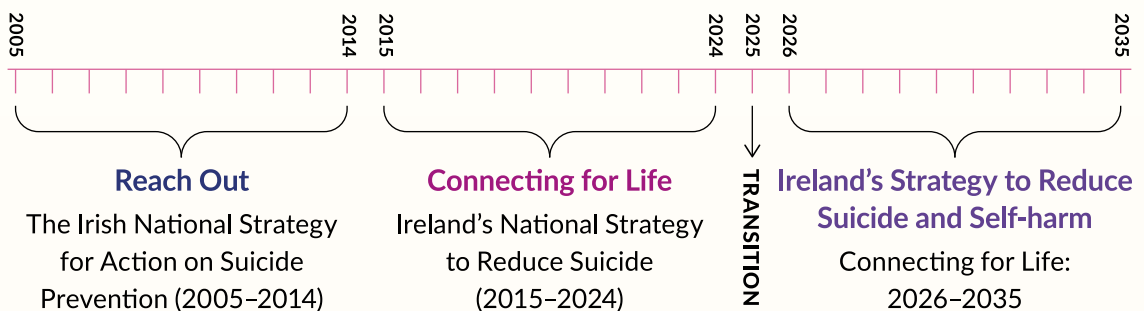


1.1 Looking back to Connecting for Life 2015–2024

This strategy is Ireland’s third system-wide, national strategic framework to reduce suicide and self-harm.

Suicide prevention in Ireland up to 2014 was informed by [Reach Out, the Irish National Strategy for Action on Suicide Prevention \(2005–2014\)](#). [Connecting for Life, Ireland's National Strategy to Reduce Suicide](#) was introduced in 2015. In 2020, Connecting for Life was extended to 2024. During the overall span of Connecting for Life 2015–2024, there were 17 local Actions Plans which were further consolidated into 10 local Action Plans in the latter stages of the strategy.

Figure 1.1: Suicide prevention strategies in Ireland, from 2005 to 2035



Implementation, monitoring and reporting of Connecting for Life 2015–2024

There were three Implementation Plans associated with Connecting for Life 2015–2024—published in 2018, 2020 and 2023. One of the strengths of Connecting for Life 2015–2024 was the introduction of a monitoring system, with quarterly implementation progress reports compiled and published. These reports assisted the [National Cross-sectoral Steering Group for Connecting for Life](#) to understand, discuss and resolve issues or barriers to progress.

The role of the HSE National Office for Suicide Prevention

The HSE National Office for Suicide Prevention (NOSP) was established to strategically lead on suicide and self-harm reduction efforts. The HSE NOSP worked with agencies with responsibility for actions under Connecting for Life and many other stakeholders to drive implementation of the national strategy. The HSE NOSP was also responsible for producing quarterly monitoring reports and leading out on an independent evaluation of Connecting for Life.

Evaluation of Connecting for Life 2015–2024

There have been two independent reviews of the implementation of Connecting for Life 2015–2024 since 2015. The [Interim Strategy Review of Connecting for Life \(2018\)](#) was an independent review of implementation progress by strategy leads. This review concluded that the strategic vision of Connecting for Life, and the seven strategic goals would remain relevant beyond 2020 and that a more concentrated, intensive and consistent implementation of the strategy beyond 2020 was required. It recommended the extension of the strategy beyond 2020, and the retention of governance and implementation structures.

A large-scale independent evaluation of the strategy was conducted in 2024 and 2025 – an [Evaluation of the Implementation and Intermediate Outcomes of Connecting for Life](#), Ireland's National Strategy to Reduce Suicide. Overall, the evaluation found that over the 10-year term of Connecting for Life 2015–2024, all of the intermediate outcomes were achieved to some level. This evaluation set out a range of recommendations, which have been considered when developing this strategy.

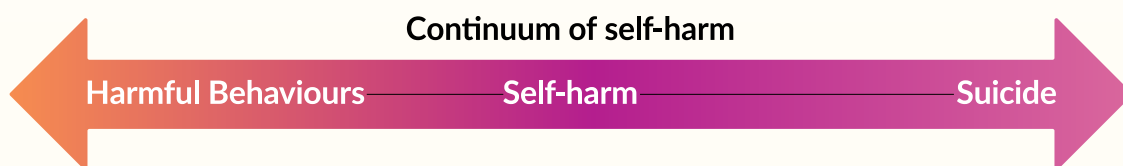
1.2 Changes since Connecting for Life 2015–2024

There have been a number of significant events and developments since Connecting for Life 2015–2024 was launched in 2015 including:

1. The relationship between suicide and self-harm

Self-harm can be seen as a range of behaviours with varying severity and intent – from self-injury without intent to die, to a suicide attempt. This is known as the 'continuum of self-harm'.

Figure 1.2: The continuum of self-harm¹¹



Self-harm is often described as 'a hidden phenomenon' because many incidents or acts of self-harm do not come to the attention of healthcare services or professionals. Therefore, self-harm statistics – for example, from hospital or Emergency Department attendances – do not reflect the true scale of the problem.

Suicide and self-harm have a close relationship, but not everyone who dies by suicide will have previously self-harmed, and not everyone who self-harms will go on to end their own life. While suicide represents ending a life, self-harm may represent a survival or coping strategy in response to emotional distress. However, previous self-harm is the single biggest indicator of future suicide.¹² This strategy contains specific self-harm actions and implementation structures. It aims to build a better understanding of self-harm, to reduce stigma and to provide a compassionate and person-centred response, regardless of whether suicidal intent is present or not.

2. A greater recognition of the value of lived experience

In more recent times there has been greater recognition of the importance of including the perspectives of people with lived experience of suicide and self-harm in suicide and self-harm reduction policies. Incorporating the voice of lived experience can help reduce stigma, provide hope and lead to higher quality services. The need to enhance engagement with people with lived experience was highlighted in findings from the public consultation and the evidence synthesis which supported the development of this strategy. Future plans and governance structures for the implementation of this strategy will be designed to significantly integrate lived experience throughout.

3. A better understanding of suicide bereavement

Previous strategies on suicide and self-harm in Ireland have had a limited focus on suicide postvention and suicide bereavement. However, investment, research and work in this area has progressed considerably in recent years.

Surveys in Ireland indicate that almost 70% of people know someone who has died by suicide, and 15% know someone close to them who has died by suicide.¹³ For every person who dies, it is estimated that six close family members and up to 135 people may be affected by the death.¹⁴ A more recent landmark survey of people in Ireland who have been bereaved by suicide has now established a much clearer understanding of the impact of suicide bereavement, rethinking what people who are bereaved by suicide need, and determining how services and supports can best evolve to meet their needs.¹⁵

Building on these insights and supported by an improved body of research on suicide bereavement, this strategy now places greater emphasis on support following a death by suicide. It establishes suicide bereavement as a distinct domain, containing a more comprehensive set of recommendations and actions that underscore the value of building more modern and responsive suicide postvention and bereavement approaches.

“Being bereaved by suicide is like carrying a cement block on your shoulders heading up a hill that never ends. You raise your child in the shadow of suicide, always terrified... it’s utterly exhausting. You hang on for the brighter moments and wish time away... the shadow always follows you and you fight to survive.”

A member of the Lived Experience Reference Group for the development of this strategy.



4. The impact of the COVID-19 pandemic

There is no indication of any increase in the number of people who died by suicide in Ireland during the COVID-19 pandemic. This is broadly in line with findings from international studies that found in high-income and upper-middle-income countries, the number of deaths by suicide remained largely unchanged or declined in the early months of the pandemic compared with the expected levels based on the pre-pandemic period.¹⁶

However, the pandemic undoubtedly had a significant impact on all aspects of people's lives, on society, and on our health services. It brought attention to new groups of people who were particularly vulnerable to the emergence of new mental health difficulties because of the pandemic. For others, it exacerbated pre-existing mental health problems. During the pandemic, financial support and psychosocial support and responses were put in place to ease its impact on people's day-to-day lives and on their health.

The domains, recommendations and actions in this strategy have been influenced by some of the learning from the COVID-19 pandemic.

5. Moving toward a public health approach to suicide prevention

Over the last twenty years, approaches to prevent suicide and self-harm in Ireland have shifted – away from understanding suicide as fundamentally a mental health issue, toward more multi-sectoral, whole-of-government, and system-wide ownership and responsibility.

Public health aims to build a healthier, fairer society and create the conditions in which communities can thrive. This involves reducing health inequalities, as well as wide-ranging activities, from monitoring and preventing the spread of infectious and noncommunicable diseases, ensuring access to clean water and air, green and blues places, promoting healthy behaviours, driving health system improvement, to advocating for and supporting implementation of policies that support health and well-being.²⁶

Reducing rates of suicide by 2030 is an indicator under the UN's Sustainable Development Goals. Internationally, there is growing support for also adopting a broader public health approach to preventing suicide and self-harm. This approach takes into account the complex interaction between individual experiences and wider societal influences and 'upstream' general population based suicide prevention approaches. It enables a deeper understanding of, and targeted action on, the impact of issues such as poverty, debt, addiction, homelessness, abuse, discrimination, and social isolation on a person's decision to consider suicide.⁷

In line with a public health approach, the World Health Organisations LIVE LIFE initiative for Suicide Prevention categorises suicide prevention strategies into universal, targeted, and indicated interventions, each addressing different levels of risk within a population. Many of the recommendations and actions in this strategy have been influenced by this approach.

There are also considerable opportunities for suicide and self-harm reduction efforts in closer collaboration with public health professionals and systems in Ireland. For example, in actions to establish a real-time surveillance system for deaths by suicide, to better integrate data across multiple agencies, and to collaborate on initiatives to better understand and respond to clusters of deaths by suicide and deaths in public places.

6. Greater opportunities for improving online safety

There have been significant developments in online platforms and digital technologies, and concerns around the harmful impact of them, since Connecting for Life 2015–2024.

The online space poses both risks and opportunities for suicide prevention, with targeted interventions needed to address specific harmful experiences rather than general internet or social media use. However, there are pressing questions about the negative role of Artificial Intelligence chatbots in suicide prevention, ranging from the accuracy of answers to suicide-related questions, to direct and indirect effects of Artificial Intelligence on suicide-related outcomes.

Coimisiún na Meán was established in 2023 as the independent media regulator responsible for regulating broadcasters, video-on-demand providers and online platforms established in Ireland. Their wide-reaching remit also includes supporting and developing the Irish media sector. Coimisiún na Meán's Online Safety Code ([Online Safety Code - Coimisiún na Meán](#)) addresses harmful and illegal content on video-sharing platform services (VSPS). The Code requires the general public to be protected from content by which a person promotes, encourages, or makes available knowledge of methods of self-harm or suicide.

An Online Health Taskforce was established in 2024 by the Department of Health in recognition of the growing body of evidence, from Ireland and internationally, showing the link between certain types of online activity and physical and mental health harms to children and young people. In February 2026 it delivered a final report. The report sets out a comprehensive framework to address the complex challenges facing children and young people in digital environments. This framework includes four foundational principles that establish the overarching policy direction and ten operational recommendations that provide specific, actionable measures. The operational recommendations are grouped under five categories: children and young people's rights, safety by design, critical digital literacy, enforcement and accountability, and regulatory frameworks.¹⁸

These developments – along with a greater number of other agencies and organisations that now advocate for and educate in online safety – have influenced how online safety actions in this strategy have developed. The potential for more coordinated, proactive health input into the frameworks and activities that will improve online safety – especially in the context of suicide and self-harm – is much greater now than in previous years.

7. Considering suicide prevention in changing environments¹⁹

Building the evidence base for suicide and self-harm in the context of more recent challenging times and ever-changing societal environments has been identified as requiring attention. These are areas highlighted for global attention.

- **Changing work environments.** Considering the rapid changes that have occurred in workplaces is required. These have arisen rapidly, as a result of digital and green transitions, economic recessions, and a wide range of public health emergencies, such as health crises, natural disasters, and/or political conflict and migration.
- **Financial pressures.** There are clear links between suicide and financial stress. Cost of living challenges are an important prompt for the health community to contribute to the implementation of evidence-based public health and clinical interventions that might reduce suicide rates globally.
- **Climate change.** In this context, research and public health programs should prioritise psychological support, coping mechanisms, and resilience-building strategies for people experiencing distress related to climate change concerns. Integrating mental health and suicide prevention priorities into climate change policies can enhance their effectiveness.
- **Geopolitical context.** Globally, understanding the interaction between conflict, political turmoil, and suicide prevention will require multidisciplinary efforts drawing on a range of disciplines such as political science, conflict studies, economics, international development, and health systems research.

1.3 Context for this strategy

Population growth

Ireland's population has grown significantly in recent years to 5.4 million people in April 2024. This is an average annual growth of 1.3% between 2016 and 2022, driven by a combination of natural increase and inward migration. Ireland has an ageing population, with the proportion of the population aged 65 and over increasing from 13.8% to 15.5% between 2018 and 2024. This has been driven by rising life expectancy and declining birth rates.

Geographically, the population is concentrated in urban areas, with 28.5% of the total population living in the greater Dublin area. Rural areas experience varying degrees of population density.²² Ireland's population is increasing in its diversity with increasing migrant communities.

Socio-economic disadvantage was experienced by 22% of the population in Ireland in 2022.²³ This creates persistent inequalities across various aspects of life, including employment, education, housing and health, with factors such as poverty, unemployment, and limited access to resources contributing to these inequalities. Certain communities experience higher rates of deprivation, leading to poorer health outcomes – including reduced healthy life expectancy. This disadvantage is often intergenerational, creating cycles of poverty and limited opportunity, highlighting the critical role of actions on the wider determinants of health.

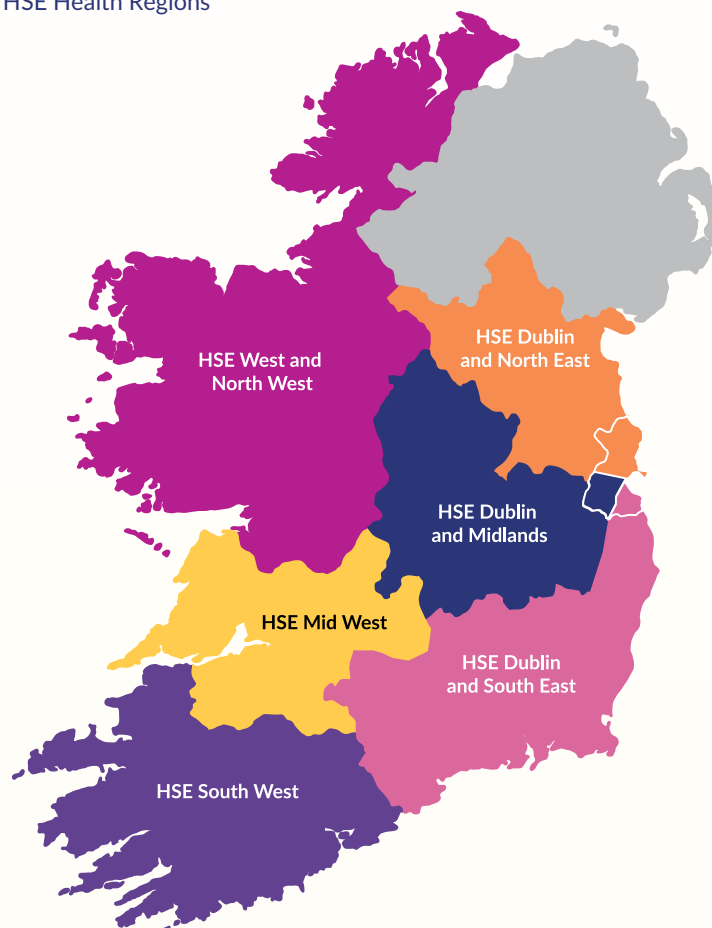
The Central Statistics Office (CSO) projects Ireland's population will grow to between 5.77 and 6.40 million by 2042 and to 5.73 to 7.01 million by 2057, depending on the migration scenario used.² These projections also show significant population aging, with the number of people aged 65 and over increasing substantially.

A reconfigured health service

Sláintecare reform is transforming how we deliver healthcare in Ireland, building towards equal access to services for every citizen based on patient need and not their ability to pay. This strategy is very much aligned to the ambition of Sláintecare to provide equal access to high quality health and social services. Under Sláintecare reform six new HSE Health Regions have been created to allow the HSE to deliver safer, better care that is planned and funded in line with local and regional health needs.

Each region is now responsible for providing both hospital and community care for people in that area – this is known as Integrated Care. Each region works towards the [Sláintecare](#) objectives of delivering the right care, in the right place, at the right time – meaning the full alignment and better integration of health and social care services within each specific region. There are particular opportunities to strengthen delivery of local suicide and self-harm reduction activity within the new HSE Health Regions.

Figure 1.3: The six HSE Health Regions



Other national policies and initiatives

This strategy is separate from – but closely connected to – a wide range of other national strategies, policies and frameworks. Most notably, this strategy aligns closely with [Sharing the Vision, a Mental Health Policy for Everyone \(2020–2030\)](#). Sharing the Vision aims to enhance the provision of mental health services and supports in Ireland across a broad continuum, from mental health promotion to specialist mental health delivery. Many of the risk factors for suicide, self-harm and poor mental health are the same. Through alignment of this strategy with Sharing the Vision, suicide prevention can be clearly embedded in mental health policy implementation and mental health service delivery across Ireland.

This strategy focuses on 48 suicide- and self-harm-specific recommendations and associated actions across five domains. However, addressing the broader upstream issues leading to poor mental health, and the wider multiple factors associated with suicide and self-harm – for different people and across different services – is equally important. As well as Sharing the Vision, the successful delivery of this strategy is reliant in part, on close collaboration and partnership working within other frameworks which have identified links with self-harm and suicide.

Relevant health sector policies and initiatives include:

- [Sláintecare. Right Care, Right Place, Right Time.](#)
- [The HSE Child and Youth Mental Health Office Action Plan \(2024–2027\).](#)
- [Stronger Together, the HSE Mental Health Promotion Plan \(2022–2027\).](#)
- [Pathways to Wellbeing, the National Mental Health Promotion Plan \(2024–2030\).](#)
- [Healthy Ireland Framework 2013-2025](#)
- [The National Traveller Health Action Plan \(2022–2027\).](#)
- [Reducing Harm, Supporting Recovery 2017-2025](#)
- [The National Mental Health Research Strategy \(2024\).](#)
- [Sharing the Vision - Digital Mental Health Strategy 2026-2030](#)
- [The Women's Health Action Plan 2024–2025, Phase 2: An Evolution in Women's Health.](#)
- [The National Men's Health Action Plan, Healthy Ireland – Men \(HI-M\) \(2024–2028\).](#)
- [National Clinical Programme for Self-Harm and Suicide-Related Ideation – Model of Care \(2022\)](#)
- [Traveller and Roma Education Strategy 2024-2030](#)

Other non-health sector policies and initiatives which specifically address suicide and/or self-harm include:

- [The National LGBTIQ+ Inclusion Strategy II \(2024–2028\)](#)
- [National Traveller and Roma Inclusion Strategy II \(2024–2028\)](#)
- [National Student Mental Health and Suicide Prevention Framework \(2020\)](#)
- [Autism Innovation Strategy \(2024\)](#)
- [Responding to Self-Harm in Schools: Guidance for School staff – Department of Education National Educational Psychology Service](#)
- [National Educational Psychological Service \(NEPS\) resources and publications](#)
- [Self-Harm Assessment and Data Analysis \(SADA\) Project – Irish Prison Service](#)
- [An Garda Síochána Human Rights Strategy \(2022–2024\)](#)
- [Local Community Safety Partnerships](#)
- [Traveller and Roma Education Strategy Plan for implementation and action 2024–2026](#)
- [Wellbeing Policy Statement and Framework for Practice – Department of Education and Youth](#)
- [HSE Public Health Strategy 2025 -2030: Achieving the best possible health for everyone in Ireland](#)
- [Young Ireland: National Policy Framework for Children and Young People 2023-2028](#)
- [A Well-being Framework for Ireland: Understanding life in Ireland](#)

1.4 How this strategy was developed

In early 2025 the Minister for Mental Health initiated the development of a new national strategy to reduce suicide in Ireland for the years 2026 to 2035. The aim was to build on the progress of Connecting for Life 2015–2024 and to develop a new strategy that was inclusive, evidence-informed and responsive to the evolving needs of people and communities.

Continuing the focus on cross-sectoral collaboration – which was central to Connecting for Life 2015–2024 – insights and experiences were sought from other government departments to inform the design and delivery of a system-wide consultation.

During this strategy's development it was important to ensure the central involvement of people with lived experience of suicide. Their insights, perspectives and leadership were integral to shaping the direction, priorities and tone of the new strategy. This commitment to lived experience was reflected in the design of the public consultation process and in the composition of advisory groups.

The development of this new strategy was grounded in meaningful public and stakeholder engagement, cross-sectoral collaboration and learning from both national experience and international best practice. This has ensured that the strategy reflects the realities of people impacted by suicide and is better positioned to deliver compassionate, coordinated and effective responses.

Figure 1.4: The development of this strategy during 2025 and 2026



Public consultation

The public consultation for input to this strategy was open from March to May 2025. It was designed to ensure that the voices of people impacted by suicide – including individuals, families, communities and frontline professionals – were central to shaping the new strategy. The Department of Health received 1,895 responses to a national online survey, developed in partnership with the National Suicide Research Foundation.

The survey captured responses from all 26 counties, with 17% submitted on behalf of organisations, primarily from the community, voluntary and advocacy sectors. A majority of people reported lived experience of suicide.

People who responded to the survey were also invited to express their interest in continuing their participation in the consultation process, by attending additional live consultation sessions.

Additional standalone submissions were received from a number of non-governmental organisations and smaller meetings were held with other representative organisations – including those supporting people in direct provision, minority ethnic communities and people bereaved by suicide.

Three reports were published in September 2025 on gov.ie, presenting the findings of each aspect of the consultation.

- [Findings from the Public Consultation Survey to Inform Ireland's New Suicide Reduction Strategy.](#)
- [Synthesis of Public Consultation Submissions to Inform Ireland's New Suicide Reduction Strategy.](#)
- [Findings from Public Consultation Events to Inform Ireland's New Suicide Reduction Strategy.](#)

International engagement

In parallel with the public consultation, the Department of Health engaged with international counterparts (for example, in Scotland and Australia) to learn from their suicide prevention strategies. These engagements provided valuable insights which were considered during this strategy's development. It is important that this strategy reflects both global best practice and the unique needs of Irish society.

Evidence synthesis

The Department of Health also commissioned an evidence synthesis ([Evidence synthesis to inform Ireland's next suicide reduction strategy. National Suicide Research Foundation, 2025](#)) to bring together recent evidence on interventions for suicide prevention, and risk and protective factors for suicide and self-harm. The review prioritised high-quality reviews published within the past ten years on these topics and research relevant to the Irish context.

Expert Advisory Group

Following the public consultation process, Minister for Mental Health Mary Butler appointed 22 members to an Expert Advisory Group to guide the development of this strategy. This group comprised members representing clinical, academic, policy and community sectors. Members of this group are listed in Appendix 1.

Lived Experience Reference Group

A parallel Lived Experience Reference Group worked closely with the Expert Advisory Group. This group ensured that lived experience was central to the development of this strategy. Members included people with experience of suicidal behaviour, self-harm, suicide bereavement, and supporting others in crisis.

The Expert Advisory Group, in consultation with the Lived Experience Reference Group, was asked to develop a set of recommendations for the new strategy and to ensure that the strategy was developed based on the latest evidence, cross-sectoral expertise and the lived experience of those affected by suicide and self-harm. The report of the Expert Advisory Group can be found here at gov.ie.

Whole-of-government engagement

The development of this strategy was also supported by a whole-of-government approach, recognising that effective suicide prevention requires coordinated action across multiple sectors. The Department of Health engaged with a range of government departments and national agencies to discuss and refine proposed actions, ensuring alignment with existing policy frameworks and securing agreement on roles and responsibilities.

This collaborative process helped to build shared ownership of the strategy and reinforced the commitment of departments and agencies to its implementation. Engagement through other existing interdepartmental structures further supported agreement, accountability and integration across government.

2

Suicide and self-harm in Ireland



2.1 Data on suicide and self-harm

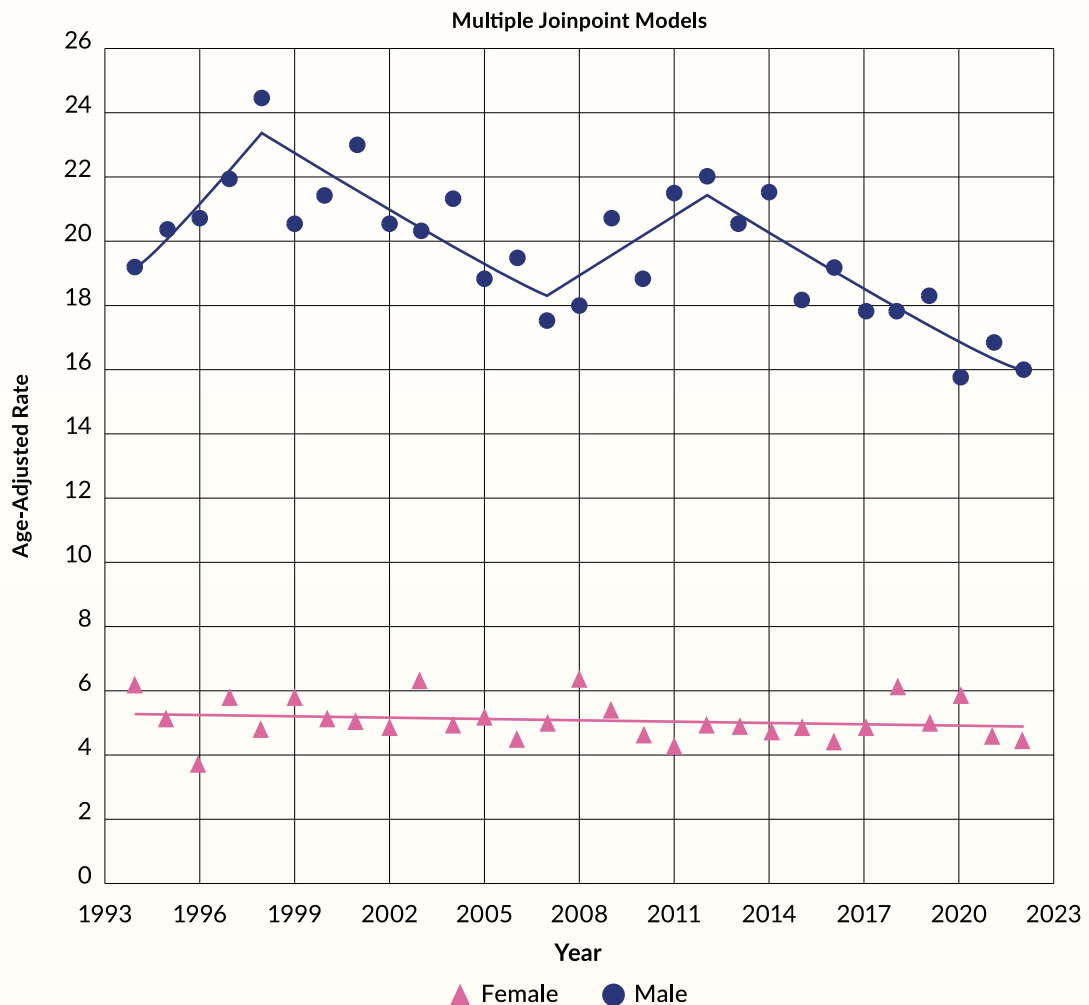
Deaths by suicide in Ireland

The rate of suicide in Ireland has declined in recent years. According to the Central Statistics Office (CSO), the standardised rate per 100,000 in 2000 was 12.9. By 2022, the rate was approximately 8.6. This is a decrease of 33.3%, which compares favourably with an OECD (Organisation for Economic Co-operation and Development) wide decrease of 29% between 2003 and 2023.

In 2002, the population was 3.9m people; it is now over 5.1m people and the number of people who die by suicide each year has consistently remained around the same number. While this progress is welcome, approximately 500 lives are tragically lost to suicide in our country each year and an estimated 60,000 people are impacted by suicide bereavement each year. People who are bereaved by suicide experience impacts on their mental and physical health that can be long lasting. They are also at increased risk of suicidal thoughts and behaviours.²⁵

In Ireland and internationally, men are significantly more likely to die by suicide than women. However, women have consistently higher rates of self-harm and non-fatal suicide attempts. The decision as to whether someone has died by suicide is a legal determination made by Coroners. Following the Coronial investigation, inquest and registration processes, the CSO publishes national mortality data, including data on deaths by suicide.

Figure 2.1: Male (blue) and Female (pink) suicide rates in Ireland, 1994–2022 (age standardised rates for all age groups) with linear trends estimated by joinpoint regression. Analysis completed by the Department of Health and National Suicide Research Foundation in collaboration with the Central Statistics Office.



It is important to look at suicide trends over a relatively long period of time, rather than focusing on increases or decreases year-on-year, and the number of deaths by suicide is best compared using age standardised rates, to adjust for underlying population size. The rate per 100,000 people is used, with 'age standardised rates' taking account of differences in age structure of populations, so comparisons can be made with greater confidence. As presented in Figure 2.1:

- Looking at the entire period from 1994 to 2022, suicide rates among men showed a slight overall decline, dropping by about 0.6% per year on average. For women, the trend also suggests a very small yearly decrease of around 0.3%, but the data does not allow us to say with confidence that this was a genuine change.
- From 1994 to 1998, male suicide rates increased by about 5% each year. Then, between 1998 and 2007, the rates began to fall by nearly 3% annually. However, during the economic recession from 2007 to 2012, the trend reversed, and rates rose again by about 3% per year.

- After 2012, the trend reversed and the rate declined by just over 3% each year up to 2022.
- For women, the pattern was quite different. Overall, the trend stayed mostly stable, with only a very small annual decrease of about 0.3%, which was not statistically significant.

Suicide among Travellers

The suicide rate within the Irish Traveller Community is estimated to be much higher than the general population. According to the CSO, over the period 2019 to 2023, nearly 10% of deaths among those who self-reported as White Irish Traveller was due to suicide, compared to 1% for people who self-reported as White Irish or 2% for all other ethnic groups.

International comparisons of suicide

Eurostat provides some comparisons of rates of suicide among European countries and the OECD (Organisation for Economic Co-operation and Development) provides some global comparisons. Eurostat data from 2022 shows Ireland's overall rate as 8.75 per 100,000 people, making it 11th lowest of 27 EU countries included. This is an improvement from 12th lowest in 2021. Eurostat comparison data looking at suicide rates for people aged 15-19 from 2022 shows Ireland's rate as 6.79 per 100,000 people, making it 9th highest of the 27 EU countries included. This has decreased from 2nd highest in 2016 and 9th highest in 2020.

The OECD Health Statistics 2025 indicated that Ireland has a lower rate of suicide than the OECD average. Suicide rates were 9 per 100,000 population in Ireland, compared to the OECD average of 11 deaths per 100,000 population. However, figures should be interpreted with care as suicide registration methods vary between countries and over time.

Irish self-harm data

There were a total of 12,621 self-harm presentations made to hospitals in Ireland in 2024 by 9,436 people. Research suggests that the approximate yearly cost of hospital treatment and initial aftercare for hospital-presenting self-harm in Ireland is €26.5m.²⁷ The [National Self-harm Registry Ireland Annual Report 2024](#) shows that self-harm rates are decreasing, and rates of self-harm in 2024 were 5 per cent lower than in 2023 and 19 per cent lower than the peak rate recorded in 2010. However, concern has been raised about increasing rates of self-harm in children and adolescents in recent years.

The National Self-Harm Registry Ireland records and reports information about self-harm presentations to hospital Emergency Departments across the country. The Registry is operated by the National Suicide Research Foundation (NSRF) and is funded by the HSE National Office for Suicide Prevention (NOSP). The Registry details the number of self-harm presentations each year. It shows which groups in the country make the most presentations, when the presentations happen, what type of self-harm is involved, and which areas have the highest rates. By providing this information, the Registry helps to inform the improvement of services for people who self-harm and prevention efforts.

Figure 2.2: Male (blue) and Female (pink) self-harm rates in Ireland, 2007-2024 (age standardised rates for all age groups) with linear trends estimated by joinpoint regression. (Source: National Self-harm Registry Ireland). Analysis completed by the Department of Health and National Suicide Research Foundation.

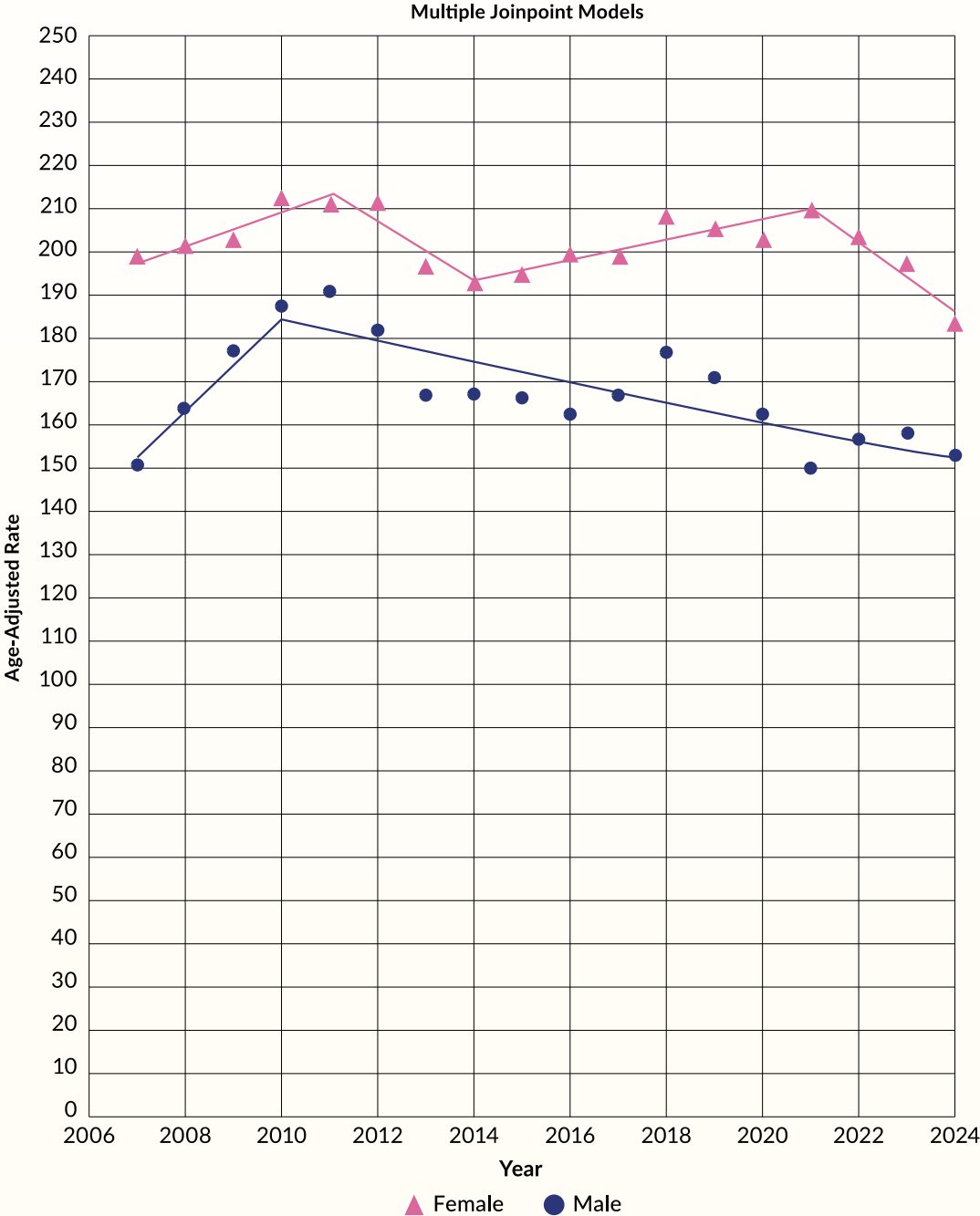


Figure 2.2 shows self-harm rates in Ireland for males and females from 2007 to 2024. The figure shows two distinct periods of linear trends for self-harm rates among males:

- **2007–2010:** Rates increased **rapidly**, with an annual rise of **6.38%**, which may reflect the impact of the economic recession during this period.
- **2010–2024:** Rates experienced a **steady and consistent decline**, decreasing by about **1.33% per year**, with no clear evidence of reversal during the COVID-19 pandemic.

The figure shows multiple changes in self-harm rates for females:

- **2007–2011:** Rates showed a **moderate increase (+1.94% annually)**, possibly influenced by recession-related stressors.
- **2011–2014:** Rates declined, dropping by **3.20% per year**.
- **2014–2021:** Rates began a **gradual increase**, up by **1.16% annually**.
- **2021–2024:** Rates declined, decreasing by **3.90% per year**.

2.2 Evidence on risk and protective factors related to suicide and self-harm

To support the development of this strategy, the Department of Health commissioned the National Suicide Research Foundation to complete an evidence synthesis to inform Ireland's next suicide reduction strategy of the up-to-date evidence base for suicide prevention in the last 10 years, focusing on risk and protective factors, and interventions.

From this evidence synthesis, there is evidence for risk and protective factors from both international (umbrella) reviews and national studies. The evidence points to the need for targeted responses for high-risk groups, including those experiencing multiple forms of adversity across home, school, and peer contexts. Adolescents exposed to cumulative adversity are at significantly higher risk of self-harm and suicide attempts, underscoring the importance of early identification and support.

Figure 2.3: Risk factors for suicide and self-harm

Level	Risk factors	Examples
Individual	Mental health disorders	Depression, anxiety, bipolar disorder, Post Traumatic Stress Disorder.
	Substance use	Alcohol, drugs, smoking and medications.
	Sleep disorders	Poor sleep quality, parasomnia.
	History of self-harm or suicide attempts	Particularly the use of more lethal means.
	Gender and sexuality	Higher suicide rates in males, higher self-harm levels in females, elevated risk in people who are LGBTQI+.
	Age	Higher self-harm rates in young people under the age of 25, higher suicide rates in adults over the age of 65.
	Physical health problems	Chronic illnesses, cancer diagnosis and traumatic brain injury.
Relationship	Bullying	Traditional and cyberbullying.
	Family and relationship factors	Divorce, poor relationships, being single and living alone.
	Exposure to family mental illness or suicide	
	Intimate partner violence	
	Dating violence, trauma and relationship breakups	Significantly associated with self-harm in young people.

Level	Risk factors	Examples
Community	Abuse and adverse experiences (particularly during childhood)	Emotional, physical, sexual abuse, neglect and childhood maltreatment.
	Displacement	Refugees, asylum seekers.
	School-related adversity	School disengagement, truancy, academic pressure.
	Ethnic disparities	Higher rates among Irish Travellers due to many factors including marginalisation and experience of racism/prejudice.
	Barriers to accessing healthcare	For example in rural areas.
	Being in prison	Particularly where there are relational factors such as difficulties with family, staff, or fellow prisoners.
Societal	Socioeconomic disadvantage	Unemployment, financial stress, debt, insecure housing/homelessness and lower levels of education.
	Media and internet exposure	Sensationalised media and online content related to suicide.
	Social fragmentation	Especially in urban or deprived areas.
	Occupational risk	Machine operator, services and sales workers, skilled agricultural, forestry, and fishery workers.
	Access to means	

Figure 2.4: Protective factors for suicide and self-harm

Level	Protective factors	Examples
Individual	Good sleep hygiene Personal resilience Religious affiliation	
Relationship	Caregiver resilience Living with family	Especially during the COVID-19 pandemic. Among farmers and agricultural workers.
Community	School connectedness Community resources	Crisis hotlines, school-based programs.
Societal	Social protection policies Restricting access to means	Unemployment benefits, retirement benefits and tax credits. Codeine sales restrictions.

Individual factors

Individual-level factors are the most common risk and protective factors. There is strong evidence of risk associated with various mental health disorders, having a history of self-harm or suicide attempt, substance use, sleep disturbances, physical health conditions (such as cancer), being LGBTQI+, and abuse/adverse experiences.

Being female is associated with a greater risk of self-harm across several studies, and being male is associated with elevated suicide risk amongst other studies. Younger and older people are also identified as being at-risk across several of the national studies. Individual-level protective factors include strong school connectedness, good sleep hygiene, and broader social policies that reduce economic and structural vulnerabilities.

Relationship factors

For relational factors, bullying emerges as a strong risk factor. Others – such as adverse family environments and interpersonal issues – are also associated with increased risk, while caregiver resilience may act as a protective factor.

Community factors

For community factors, school-related adversity was a significant risk factor. Displacement is also considered to be a risk factor amongst refugees. Ethnicity-based disparities among Irish Travellers are associated with elevated risk.

Societal factors

Societal risk factors include a range of socioeconomic factors, such as socioeconomic disadvantage, deprivation and insecure housing and employment. Protective factors include unemployment benefits and social protection reforms. Sensationalised or biased media coverage is associated with increased risk. The evidence synthesis notes an absence of reporting on risk and protective factors at the health systems level, limiting the ability to draw definitive conclusions.

Vulnerable communities

The evidence highlights specific groups of people shown to be at greater risk of suicide and self-harm. Vulnerable communities include: people from the Traveller Community; Neurodivergent people; people who are LGBTQI+; people with substance misuse issues; International Protected Applicants, beneficiaries of temporary protection and refugees; peri-natal women; victims/survivors of domestic, sexual and gender based violence; people experiencing homelessness; and people with chronic illnesses. Vulnerable communities will be identified using robust, real-time surveillance data, including data on ethnicity, and the groups identified will be set out in the strategy's implementation plans.

2.3 The social determinants of suicide and self-harm

Suicide is shaped by a complex interplay of individual vulnerabilities and broader social, economic and environmental conditions. The community and societal risk factors above can be considered as 'social determinants of suicide and self-harm'. The evidence synthesis notes that there is limited evidence on interventions that single these social determinants, likely due to the emerging nature of this area of research. Greater attention is needed to policies targeting the social determinants of suicide such as income protection, housing stability and employment conditions. Findings from both the evidence synthesis and public consultation emphasise the importance of upstream, universal measures in addition to targeted, individual-level interventions. Attention to commercial determinants, such as regulation of alcohol, gambling, firearms, and pharmaceutical industries, is also important. These insights are considered within the domains and actions in this strategy.

2.4 Evidence on interventions for suicide and self-harm prevention

There is mixed evidence to support the effectiveness of different types of interventions for self-harm and suicide.

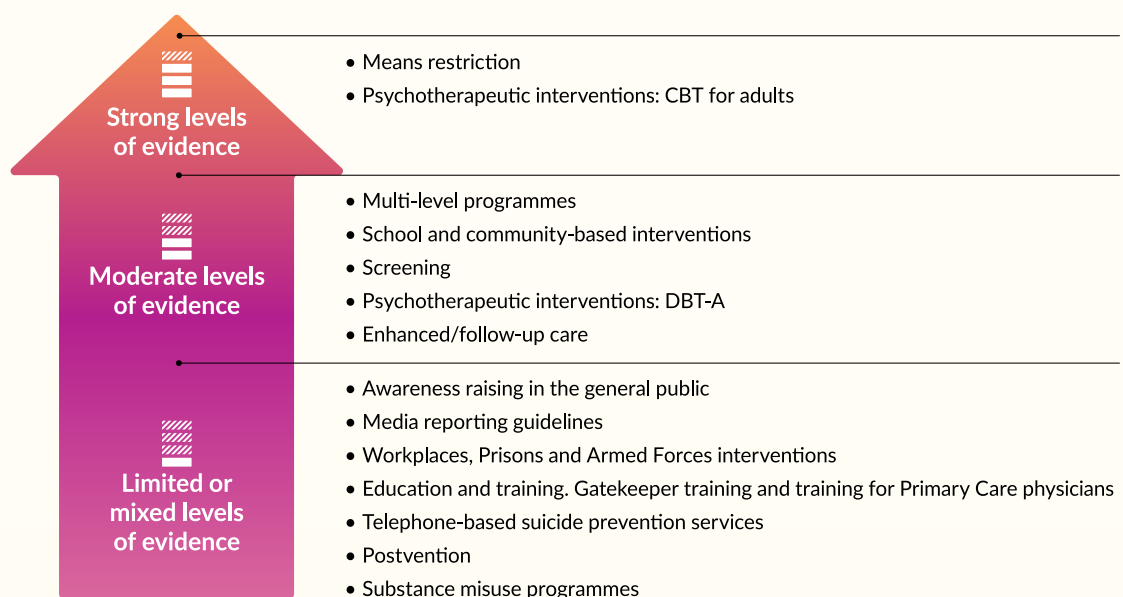
There is good evidence to support interventions such as: means restriction; setting based interventions in schools and communities; substance misuse interventions; gatekeeper training; telephone-based services; postvention strategies; screening programmes; psychotherapeutic interventions; and enhanced follow-up care. Means restriction and Cognitive Behaviour Therapy (CBT) for adults (psychotherapeutic intervention) have the strongest levels of evidence.

There are moderate levels of evidence for the following interventions: multilevel programmes; school and community-based interventions; screening; enhanced follow up care; and Dialectical Behaviour Therapy (DBT) for adolescents.

There are limited levels of evidence for: awareness raising; media reporting; workplace, prison, and armed forces interventions; education and training; telephone-based services; postvention; and substance misuse programmes.

Despite the different levels of evidence, suicide prevention requires the implementation of a combination of evidence-based interventions. The World Health Organisation (WHO) emphasises that the greatest impact is achieved when measures are implemented together. The WHO's Live Life approach underlines this through its core cross-cutting pillars. In addition to contributing independently, interventions such as limiting access to the means of suicide, interacting with the media for responsible reporting, fostering protective factors through awareness-raising and capacity-building in community and workplace settings, and ensuring early identification, assessment, management and follow-up should be implemented together, as different components interact to produce additional benefits.

Figure 2.5: Levels of evidence for self-harm and suicide related interventions.



3

Strategy and action plan



3.1 Domains, recommendations and actions

Domains

The recommendations and associated actions in this strategy are arranged within five domains. The domains are specific themes or areas of focus and reflect the need for the new strategy to include both enhanced 'up-stream' activity and enhanced 'postvention' activity.

Domain 1	Domain 2	Domain 3	Domain 4	Domain 5
Preventing suicide and self-harm, reducing stigma and addressing the social determinants.	Restricting access to means and methods.	Implementing effective responses for people in suicidal distress or with experience of self-harm.	Ensuring compassionate, coordinated and accessible postvention support.	Establishing evidence, surveillance systems and supporting structures.

Recommendations

Each domain has a series of recommendations, developed by the Expert Advisory Group in close collaboration with the Lived Experience Reference Group. When developing the recommendations, these groups drew on the findings of the public consultation, evidence synthesis and emerging findings from the evaluation of Connecting for Life 2015–2024, as well as their own lived experience.

Actions

Each recommendation has a corresponding action (or actions) which describes the commitment by the lead agency to fulfil the recommendation. The Department of Health developed the actions in collaboration with relevant stakeholders or action owners.

Objectives

Each domain also has a number of strategic objectives. These are clear, specific and measurable goals that the strategy aims to achieve within that particular domain.

Outcomes

As well as the overarching outcomes, each domain also has a set of outcomes. These are the changes or differences the actions will lead to in the short- or long-term. They are considered realistic and measurable benefits of the strategy, developed by the Department together with a sub group of members of the Expert Advisory Group and the Lived Experience Reference Group.

Domain 1

Preventing suicide and self-harm, reducing stigma and addressing the social determinants

Objectives

- Address the social and commercial risk factors and individual risk factors associated with suicide and self-harm, and the impact of government policy on these.
- Embed mental health promotion and suicide and self-harm reduction into broader health and wellbeing policies and initiatives.
- Reduce stigma associated with self-harm and suicide.

About this domain

Domain 1 reflects the suicide prevention activity needed to prevent people reaching crisis point. It promotes a whole-of-government approach, asking government departments to assess the impact of their policies on suicide and self-harm – particularly in relation to economic decisions, public health responses, and humanitarian events.

A public health approach to suicide and self-harm reduction recognises the important influence of social determinants. This means looking at the risk factors for suicide and self-harm from a societal point of view. People who took part in the public consultation for this strategy emphasised that lasting progress means tackling these underlying social factors, and ensuring accessible, high-quality care. This domain addresses a wide range of social and commercial risk factors including, disadvantage, gambling harms, alcohol and drug misuse, and online activity. It also considers individual risk factors and targeted suicide and self-harm prevention programmes. Enhanced surveillance and research will further improve understanding of these societal and individual risk factors over the lifetime of the strategy.

This domain also supports the implementation of the National Mental Health Promotion Plan, Pathways to Wellbeing. It aligns with other national programmes such as Healthy Ireland where suicide and self-harm reduction is embedded into broader health and wellbeing initiatives. These are across settings such as workplaces, prisons, farms, colleges and sporting bodies, and across areas of disadvantage.

The reduction of stigma associated with suicide and self-harm is a core focus of this domain, aiming to shift public attitudes and institutional practices through education, awareness and campaigns informed by lived experience. This is important because stigma associated with suicide and self-harm remains a barrier for people getting support and treatment. This stigma can affect people who might be in distress, and also people and communities bereaved by suicide. The stigma reduction activity under this domain will form part of a coherent stigma reduction programme, as set out in the Sharing the Vision policy.

During the public consultation for this strategy, participants identified the need for suicide prevention to begin far earlier in the life course. This domain also considers the vital role of schools in emotional and mental health education, and the need for complementary initiatives for parents and out-of-school settings.

“Stigma can wrongly place shame on people experiencing unbearable emotional pain, increasing isolation and discouraging help-seeking. Reducing stigma is essential to lowering suicide risk.”

A member of the Lived Experience Reference Group for the development of this strategy.



Domain 1 – Preventing suicide and self-harm, reducing stigma and addressing the social determinants.

Outcomes

- A suicide and self-harm stigma reduction programme is developed and implemented. It aligns with other mental health programmes and has a clear data infrastructure to monitor its impact.
- Health and wellbeing services and approaches are clearly integrated with mental health services including those that support suicide reduction.
- Relevant population approaches are aligned to social and commercial determinants (e.g., alcohol/drug abuse, gambling, social media, online material) and risk factors and are informed and aligned to suicide and self-harm reduction approaches.

1.1 Incorporating suicide prevention in all relevant policies to address the social determinants of suicide and self-harm

Recommendation:

To address the social, economic, and environmental factors contributing to suicide and self-harm, all government departments should consider the impact that relevant policies/programmes/legislation under their remit may have on suicide or self-harm. As part of this, a suicide prevention impact assessment should be carried out. Particular attention should be paid to economic policies and responses to public health challenges and humanitarian events. Consideration should also be given to linking suicide and self-harm reduction to performance and equality budgeting.

Action:

Develop guidance for incorporating suicide prevention into the Government programme development and policy making process.

Lead:

- Department of Health

Action:

Assess relevant policies, plans and programmes for their impact or potential impact on the groups most at risk of suicide. If there is a potentially negative impact identified, take steps to mitigate the risk of suicide.

Lead:

- Department of Health

Other partners:

- Department of Agriculture, Food and the Marine
- Department of Children, Disability and Equality, Department of Climate, Energy and the Environment
- Department of Culture, Communications and Sport
- Department of Defence, Department of Education and Youth
- Department of Enterprise, Tourism and Employment
- Department of Finance, Department of Foreign Affairs and Trade
- Department of Further and Higher Education, Research, Innovation and Science
- Department of Health
- Department of Housing, Local Government and Heritage
- Department of Justice, Home Affairs and Migration
- Department of Public Expenditure, Infrastructure, Public Service Reform and Digitalisation
- Department of Social Protection
- Department of An Taoiseach
- Department of Transport

1.1 Incorporating suicide prevention in all relevant policies to address the social determinants of suicide and self-harm

Action:

Continue to consider suicide prevention in the development of relevant national policies, plans and programmes for people who are at an increased risk of suicide or self-harm.

Partner:

- Department of Rural Community Development and the Gaeltacht

1.2 Addressing risk factors

Recommendation:

The HSE should develop targeted and appropriate suicide prevention information and training to provide appropriate support to vulnerable people within the community including Travellers, people with substance misuse issues, people who are homeless, prisoners, neurodivergent people and LGBTQI+. Regional suicide prevention plans should take account of specific demographic groups and communities of concern in their regions.

Action:

Develop targeted and appropriate suicide prevention information and training to provide appropriate support to specific at risk groups including Travellers, people with substance misuse issues, people who are homeless, prisoners, neurodivergent people and LGBTQI+.

Lead:

- HSE
- Irish Prison Service

Action:

Take account of specific demographic groups and communities of concern when developing regional plans.

Lead:

- HSE

1.3 Addressing risk factors: alcohol and drugs

Recommendation:

This strategy should support the implementation of the new National Drugs Strategy and support Healthy Ireland and the HSE Alcohol Programme to prevent alcohol harms.

Action:

Integrate with the new National Drugs Strategy and the efforts of Healthy Ireland and the HSE Alcohol Programme to prevent alcohol harms to support joint working where the strategies/programmes crossover.

Lead:

- Department of Health
- HSE

1.4 Addressing risk factors: gambling

Recommendation:

The Department of Health, HSE (Clinical Programme for Dual Diagnosis) and Department of Justice, Home Affairs and Migration should ensure that protections are provided for those who are most vulnerable to harmful gambling (particularly children and young people) and that there is treatment available for those who need it. The Gambling Regulatory Authority of Ireland should use social impact funding to support treatment, education and awareness. They should also allocate a proportion of funding for research into gambling and self-harm and suicide.

1.4 Addressing risk factors: gambling

Action:

Ensure that protections are there for those who are most vulnerable to harmful gambling (particularly children and young people) and that there is treatment available for those who need it. Use social impact funding to support treatment, education and awareness. Allocate a proportion of funding for research into gambling and self-harm and suicide.

Lead:

- The Department of Health
- HSE
- Department of Justice, Home Affairs and Migration

1.5 Addressing risk factors: online activity

Recommendation:

To address any link between online activity and physical and mental health harms including anxiety, sleep deprivation, eating disorders, self-harm and suicide, the Department of Health should work with Coimisiún na Meán and other partners to develop and implement an action plan for public health.

Action:

Develop and implement an action plan, from a public health perspective, to address harms caused by certain types of online activity.

Lead:

- Department of Health

1.6 Implementing Healthy Ireland and the settings approach

Recommendation:

The Department of Health should ensure the ongoing implementation of Healthy Ireland to improve overall health outcomes. Healthy Ireland and the HSE should ensure that suicide prevention approaches are incorporated into Healthy Ireland programmes including for, workplaces, sporting bodies, schools, college campuses, farming communities and prisons. It is also important to ensure there is co-ordination between this strategy and Healthy Ireland at all levels of implementation.

Action:

Support the ongoing implementation of Healthy Ireland to improve overall health outcomes.

Lead:

- Department of Health

Action:

Ensure that suicide prevention approaches are incorporated into Healthy Ireland programmes including for, workplaces, sporting bodies, schools, college campuses, farming communities and prisons.

Lead:

- Department of Health
- HSE
- Irish Prison Service

Action:

Work with Local Authorities to ensure there is co-ordination between this strategy and Healthy Ireland at all levels of implementation.

Lead:

- HSE

1.7 Improving mental health and wellbeing outcomes: Targeted supports (Sláintecare Healthy Communities)

Recommendation:

The Department of Health and Local Authorities should integrate specific suicide prevention programmes within mental health and wellbeing supports delivered across Sláintecare Healthy Communities sites. This should be based on data and evidence of need.

1.7 Improving mental health and wellbeing outcomes: Targeted supports (Sláintecare Healthy Communities)

Action:

Integrate specific suicide prevention programmes within mental health and wellbeing supports delivered across Sláintecare Healthy Communities sites. Engage with relevant stakeholders, including the National Office for Community Safety and Local Community Safety Partnerships.

Lead:

- Department of Health
- Local Authorities
- Local Government Management Agency (LGMA)

1.8 Supporting children and young people

Recommendation:

The Department of Education and Youth should continue to build emotional and mental health education into the primary and post-primary curricula. This should include building resilience, bullying prevention, supporting transition, promoting wellbeing, understanding mental health, teaching coping and problem solving and help seeking skills.

The HSE, in collaboration with other partners, should support this with complementary initiatives for parents and for the out of school setting for children and young people.

The Department of Further and Higher Education, Research, Innovation and Science should continue to implement the Higher Education Authority's Student Mental and Suicide Prevention Framework and should develop a similar framework for the Further Education and Training Sector.

Action:

Continue to build emotional and mental health education into the primary and post-primary curricula. This includes building resilience, bullying prevention, supporting transition, promoting wellbeing, understanding mental health, teaching coping and problem solving and help seeking skills. Continue to implement the actions contained in Cineáltas, the whole education approach to preventing and addressing bullying behaviour. Continue to implement a whole school approach to wellbeing promotion as per actions in the Department's Wellbeing Policy and Framework for Practice. Continue to implement the strategies set out in the Traveller and Roma Education Strategy Plan for implementation and action 2024–2026 and Traveller and Roma Education Strategy 2024–2030 (TRES).

Lead:

- Department of Education and Youth

Action:

Develop initiatives for parents and for the out of school setting for children and young people.

Lead:

- HSE

Action:

Implement the Higher Education Authority's Student Mental and Suicide Prevention Framework across Higher Education Institutions and explore the feasibility of a suicide prevention framework specifically for Further Education and Training.

Lead:

- Department of Further and Higher Education, Research, Innovation and Science

1.9 Improving mental health and wellbeing: Universal supports

Recommendation:

The Department of Health should implement the National Mental Health Promotion Plan, *Pathways to Wellbeing*, and deliver supports at individual and community level across the home environment, schools, community and workplaces.

The HSE should develop a common understanding of upstream suicide prevention by ensuring a comprehensive approach with joined up messaging, signposting, training and services across mental health promotion, mental health services and suicide prevention, both nationally and at a regional level.

Action:

Implement the National Mental Health Promotion Plan, *Pathways to Wellbeing*.

Lead:

- Department of Health

Action:

Develop and implement an integrated national and regional framework for upstream suicide prevention that aligns mental health promotion, mental health services and suicide-prevention activity. This will include coordinated messaging, shared signposting pathways, aligned training programmes and standardised service guidance to support consistent delivery across all settings.

Lead:

- HSE

1.10 Reducing stigma associated with suicide and self-harm

Recommendation:

The HSE should develop a suicide and self-harm stigma reduction programme which includes, suicide and self-harm literacy, skills, awareness and knowledge improvement initiatives. Part of the programme should focus on a public campaign which speaks directly about suicide and self-harm. It should be informed by evidence and lived experience. This should also consider key target audiences shown by the evidence to be at increased risk of suicide.

Action:

Develop a suicide stigma reduction programme which includes literacy, skills, awareness and knowledge improvement initiatives, informed by evidence and lived experience. Develop targeted initiatives for those shown by the evidence to be at increased risk of suicide.

Lead:

- HSE

Action:

Develop a self-harm stigma reduction programme which includes literacy, skills, awareness and knowledge improvement initiatives, informed by evidence and lived experience. Develop targeted initiatives for those shown by the evidence to be at increased risk of self-harm.

Lead:

- HSE

Domain 2

Restricting access to means and methods

Objectives

- Control access means of suicide and self-harm and deter access to methods of suicide and self-harm.
- Protect the public from harmful online content.

About this domain

Domain 2 focuses on reducing access to the tools and environments associated with self-harm and suicide. Means restriction is the most robustly supported intervention for suicide prevention across all evidence sources. The evidence synthesis which informed this strategy concluded that means restriction is effective, scalable and it can be implemented through policy, environmental design and regulation.

This domain highlights the importance of continued efforts to limit the availability of medications and chemicals frequently used in intentional overdose. Public spaces are also a focus, with collaboration across sectors to implement evidence-informed initiatives that reduce the risk of suicide attempts and deaths in these areas.

This domain also considers deaths by suicide by firearms and hanging. Within care environments, ongoing surveillance, incident reviews and ligature audits are emphasised as key tools for minimising risk.

Domain 2 is closely linked to Domain 5 because surveillance data and evidence-based practices are essential to identifying locations or methods of concern and in putting successful interventions in place.

This domain acknowledges the need to protect the public from harmful online content that promotes self-harm or suicide and calls for future-oriented planning to address technological advances in this area. It promotes responsible media reporting and encourages the development of positive narratives around mental health and suicide prevention within the media and arts sectors.

Domain 2 – Restricting access to means and methods

Outcomes

- It is more difficult for people to access means that is most often used in suicide or self-harm.
- Government departments and services collaborate to develop clear protocols on means safety.
- Fewer people die by specific lethal methods that are most frequently used.
- There is better media reporting (including via public representatives/figures) of suicide and self-harm.
- Reduced visibility and spread of harmful or suicide-promoting content online.
- Better data on, and monitoring of, the means and methods so emerging risks can be reacted to quickly.
- People within care facilities with suicidal ideation are kept safe.
- Improved safety measures at public locations where people may be at higher risk of suicidal behaviour, including places where access, height or isolation could increase vulnerability.

2.1 Medications and substances used in intentional overdose

Recommendation:

Informed by surveillance data, the Department of Health (together with other Government Departments and agencies involved in the regulation of substances in Ireland) should continue to restrict the use of medications and substances frequently used in intentional overdose.

Action:

Continue to restrict the use of medications and substances used in intentional overdose.

Lead:

- Department of Health

2.2 Preventing deaths by suicide in public places

Recommendation:

The Department of Transport, the Local Government Management Agency (LGMA), the Department of Health (Healthy Ireland) and the Office of Public Works should continue to work with the HSE, relevant agencies and local authorities to implement evidence informed initiatives to prevent suicide attempts and deaths by suicide in public places.

Action:

Implement evidence informed initiatives to prevent suicide attempts and deaths by suicide in public places.

Lead:

- Department of Transport
- Local Authorities
- Local Government Management Agency
- Department of Health
- Office of Public Works
- HSE

2.3 Addressing specific means

Recommendation:

The Department of Justice, Home Affairs and Migration, Department of Defence and Department of Health should continue to work together to promote awareness of death by suicide by firearms and promote adherence to legislation among relevant stakeholders.

Action:

Promote awareness of death by suicide by firearms and promote adherence to legislation among relevant stakeholders.

Lead:

- Department of Justice, Home Affairs and Migration
- Department of Defence
- Department of Health

2.4 Addressing specific methods

Recommendation:

The HSE should establish a programme to determine evidence-based interventions to prevent self-harm and death by suicide by hanging within residential and public environments.

The HSE and Irish Prison Service should continue to minimise risks within their facilities through surveillance, implementation of recommendations from incident reviews and ligature audits.

Action:

Establish a programme to determine and implement evidence-based interventions to prevent death by suicide by hanging within residential and public environments.

Lead:

- HSE

Action:

Continue to minimise risks within mental health and prison facilities through surveillance, implementation of recommendations from incident reviews and ligature audits.

Lead:

- HSE
- Irish Prison Service

2.5 Addressing online harm and harnessing the benefits of technology

Recommendation:

Coimisiún na Meán and other relevant partners, supported by the HSE, should protect the public from online and AI related harm caused by content/technology which promotes self-harm or suicide. Consideration should also be given to identifying opportunities to apply digital innovation safely and effectively to suicide prevention activity. Given the rapid evolution of technology, it is important that activity includes horizon planning and proactive partnering with the sector.

Action:

Develop and implement a programme of work that aims to minimise, and protect people from, harm from services and content which promote or encourage suicide or self-harm.

Lead:

- Coimisiún na Meán
- HSE

2.6 Promoting responsible media reporting and portrayal

Recommendation:

The HSE, Coimisiún na Meán, the Press Council, NGO partners and the Arts Council should develop a programme of work which promotes responsible media reporting of suicide and self-harm within the media and arts sectors and supports the industry to develop positive narratives.

Action:

Develop a programme of work which promotes responsible media reporting of suicide within the media and arts sectors. Develop a programme of work which promotes responsible media reporting of self-harm within the media and arts sectors.

Lead:

- Coimisiún na Meán
- HSE
- The Department of Culture, Communications and Sport

Domain 3

Implementing effective responses for people in suicidal distress or with experience of self-harm

Objectives

- Provide effective support and treatment to people suicidal crisis and people who have self-harmed.
- Provide targeted support and treatment for vulnerable communities.
- Ensure that professionals and community members have the skills to support people in suicidal distress.

About this domain

Domain 3 emphasises the importance of equipping professionals and communities with the skills and resources needed to respond effectively to people in distress. It considers evidence-based interventions for people who have self-harmed, are experiencing suicidal ideation and/or are in crisis. The domain considers universal, targeted and indicated interventions.

This domain focuses on integrating mental health, self-harm, and suicide prevention content into brief intervention programmes for health and social care professionals, and ongoing upskilling in how to identify risk and signpost to support. In this domain, frontline staff across sectors will receive evidence-based training. The domain emphasises the importance of ensuring there is appropriate infrastructure to support trained individuals in services such as mental health, maternity, disability, addiction and primary care.

In this domain, community-based training programmes will be expanded and supported with resources and guidance. Schools are identified as key settings for intervention, with continued efforts to build staff capacity, develop support structures, and establish referral pathways for students affected by self-harm, suicidal behaviour or bereavement.

A trauma informed approach is central to service delivery, with a focus on cultural appropriateness and targeted interventions for communities at increased risk. These communities will be identified through surveillance data and described in the implementation plans for this strategy. A particularly important aspect of this domain – from the lived experience perspective – is enhanced access to therapeutic (for example talk therapies) and non-therapeutic evidence-based interventions, supported by individualised care planning.

A comprehensive crisis response framework is proposed in this domain, integrating services across hospital, emergency, justice and community settings. During the public consultation for this strategy, people emphasised the need for improvements to Emergency Departments and the need for alternatives to Emergency Departments for people in crisis. In this domain, Emergency Departments will provide empathetic, trauma-informed assessments and appropriate spaces for mental health support. Community-based crisis responses will be developed and connected to statutory services, and guidance will be developed to respond to self-harm clusters in collaboration with relevant partners.

“It is important to foster a hopeful and supportive approach to living well with mental illness”.

A member of the Lived Experience Reference Group for the development of this strategy.



Domain 3 – Implementing effective responses for people in suicidal distress or with experience of self-harm.

Outcomes

- Frontline health or social care workers, public servants and community workers are able to confidently identify and compassionately respond to self-harm and suicide.
- Communities are more empowered to respond as they will have taken part in training which supports open and informed conversations about suicide and self-harm and supports them to signpost people to the appropriate supports available.
- Schools and other educational settings intervene early, support distressed students and connect them to services.
- Whenever and wherever a person presents in distress to a HSE or HSE-funded mental health service they receive a trauma-informed psychosocial assessment and an appropriate evidence-based and individualised care plan that supports seamless transition between services through a person's recovery journey.
- Local organisations and communities are supported to recognise and respond where appropriate to self-harm clusters.

3.1 Making the most of every interaction

Recommendation:

To enhance support and signposting at key interactions points, the HSE together with supporting health sector partners should incorporate mental health, self-harm and suicide prevention content into brief intervention programmes for health and social care professionals. The HSE should continue to work with key professional bodies to ensure ongoing upskilling of health and mental health professionals in responding to self-harm and suicide risk and signposting to further support.

Action:

Incorporate mental health, self-harm and suicide prevention content into brief intervention programmes for health and social care professionals.

Lead:

- HSE

Action:

Work with key professional, training and regulatory bodies to ensure ongoing upskilling of health and mental health professionals in responding to self-harm and suicide risk and signposting to further support.

Lead:

- HSE

3.2 Workforce training and development

Recommendation:

All Government Departments and agencies with frontline staff should work with the Department of Health and HSE to implement evidence-based training, guidance and protocols on self-harm and suicide to create a safe public sector environment.

Action:

Implement evidence-based training, guidance and protocols on self-harm and suicide for relevant staff.

Lead:

- Department of Health

Other partners:

- Department of Agriculture, Food and the Marine
- Department of Children
- Disability and Equality/Tusla
- Department of Climate, Energy and the Environment
- Department of Culture, Communications and Sport
- Department of Defence/Defence Forces
- Department of Education and Youth
- Department of Enterprise, Tourism and Employment
- Department of Finance
- Department of Foreign Affairs and Trade
- Department of Further and Higher Education, Research, Innovation and Science
- Department of Health
- Department of Housing, Local Government and Heritage
- Department of Justice, Home Affairs and Migration/An Garda Síochána/ Irish Prison Service/Probation Service
- Department of Public Expenditure, Infrastructure, Public Service Reform and Digitalisation,
- Department of Rural and Community Development and the Gaeltacht
- Department of Social Protection
- Department of the Taoiseach, Department of Transport

3.3 Building capacity among health and social care professionals

Recommendation:

Building on progress made under *Connecting for Life 2015-2024* Goal 4, the HSE should develop a national suicide prevention and self-harm capacity building programme to enhance the skills of health and social care professionals to consistently respond to self-harm and suicidal behaviour. The strategy should ensure that there is appropriate infrastructure to support those who have been trained across different settings. It should pay particular attention to areas such as mental health services, maternity services, disability services, social inclusion services, addiction services and primary care.

Action:

Develop a national suicide prevention capacity building programme to enhance the skills of health and social care professionals to respond consistently and compassionately to suicidal behaviour.

Lead:

- Department of Health
- HSE

Action:

Develop a national understanding self-harm capacity building programme to enhance the skills of health and social care professionals to respond consistently and compassionately to suicidal behaviour.

Lead:

- HSE

3.4 Building capacity within the community

Recommendation:

Building on progress made under Connecting for Life, the HSE should continue to deliver evidence-based suicide and self-harm training programmes to the community. These should be supported by appropriate resources and guidance.

Action:

Deliver evidence-based suicide prevention training programmes to the community, supported by appropriate resources and guidance.
Deliver evidence-based self-harm awareness training programmes to the community, supported by appropriate resources and guidance.

Lead:

- HSE

3.5 Building capacity within schools

Recommendation:

The HSE and the Department of Education and Youth should continue to work together to support schools responding to suicide or self-harm. This includes continuing to build the capacity of (primary, post-primary and special) school staff through training, the development of resources, support structures in schools and referral pathways to support students in relation to self-harm, suicidal behaviour and suicide bereavement.

Action:

Support schools responding to suicide or self-harm. Build the capacity of (primary, post-primary and special) school staff through training, the development of resources, support structures in schools and referral pathways to support students in relation to self-harm, suicidal behaviour and suicide bereavement.

Lead:

- HSE
- Department of Education and Youth

3.6 Providing culturally appropriate services and targeted interventions

Recommendation:

The HSE should ensure that its mental health services and services which it funds under this strategy are trauma informed or in the process of becoming trauma informed. HSE Mental Health Services should be culturally appropriate in line with *Sharing the Vision*. There should be targeted interventions in order to address the unique needs of specific communities shown by evidence to be at increased risk of suicide and self-harm¹.

Action:

Ensure HSE Mental Health Services and HSE-funded mental health services are trauma informed or in the process of becoming trauma informed and culturally appropriate. Develop targeted interventions to address the unique needs of specific communities shown by evidence to be at increased risk of suicide and self-harm.

Lead:

- HSE

1. This recommendation relies on robust real time surveillance data which also captures ethnicity. Further information on vulnerable communities is set out on p.39 of this document.

3.7 Offering alternative care pathways and evidence-based interventions

Recommendation:

The HSE should support a consolidated approach to therapeutic and non-therapeutic interventions for suicide and self-harm, to ensure that appropriate evidence-based, non-pharmacological interventions are available throughout the country. The HSE should establish a clear process to support routine outcomes measurement, review and make decisions on expanding existing interventions and supporting new and emerging therapies/treatment for self-harm and suicide. A substitute care plan should be place when a person does not respond to medical treatment, especially if there is a history of suicide attempts.

Action:

Develop a process to ensure that appropriate evidence-based, non-pharmacological interventions are available throughout the country and a mechanism for making decisions on expanding existing interventions and supporting new and emerging therapies/treatment for self-harm and suicide.

Lead:

- HSE

Action:

Ensure consistent use of co-produced individualised recovery care plans for all users of specialist mental health services.

Lead:

- HSE

3.8 Ensuring an integrated response to crisis

Recommendation:

In line with Sharing the Vision, the HSE should develop an overarching service delivery framework, which would set out an end-to-end crisis response pathway including how the different service components integrate and complement each other. This would include services provided in a hospital setting and those provided by the National Ambulance Service, An Garda Síochána, the Fire Service, the Irish Prison Service, HSE Mental Health Services, HSE-funded NGOs and those under the remit of the Department of Justice, Home Affairs and Migration, Local Authorities or Department of Social Protection. It may also highlight the need for new service components.

Action:

Develop and implement an integrated crisis response pathway.

Lead:

- HSE
- Department of Justice, Home Affairs and Migration
- Local Authorities
- Local Government Management Agency
- Department of Social Protection

3.9 Enhancing support within Emergency Departments

Recommendation:

In line with Sharing the Vision, the HSE should ensure that all people who present to Emergency Departments in suicidal distress or after self-harming receive a trauma informed empathetic biopsychosocial assessment with appropriate referral/handover, safety planning and follow up at any time. Emergency Departments should ensure that mental health assessment rooms are provided and maintained as appropriate spaces whereby support can be provided to someone experiencing acute mental distress.

Action:

Ensure that all people who present to Emergency Departments in suicidal distress or after self-harming receive a trauma informed, empathetic biopsychosocial assessment with appropriate referral/handover, safety planning and follow up at any time. Ensure that mental health assessment rooms are provided and maintained as appropriate spaces whereby support can be provided to someone experiencing acute mental distress. Improve waiting areas for people in suicidal distress and consider developing separate waiting areas. Place specialist nursing teams in Emergency Departments out-of-hours to support people in crisis and continue to develop out-of-hours liaison mental health services for all age groups.

Lead:

- HSE

3.10 Enhancing community support

Recommendation:

The HSE should develop evidence-based, integrated crisis responses within the community to support people who are in suicidal distress or have self-harmed and those who are supporting them. This should include focus on primary care and community settings. These should be connected to crisis services provided by other statutory services (for example those under the aegis of Justice or Social Protection) and HSE-funded organisations.

Action:

Develop and implement evidence-based, integrated crisis responses within the community to support people who are in suicidal distress or have self-harmed and those who are supporting them.

Lead:

- HSE
- Department of Justice, Home Affairs and Migration
- Department of Social Protection

3.11 Responding to self-harm clusters

Recommendation:

The HSE should develop and implement guidance to respond to self-harm clusters. This should take account of different settings, collaborating with relevant partners as appropriate.

Action:

Develop and implement guidance to respond to self-harm clusters. This will take account of different settings, collaborating with relevant partners as appropriate.

Lead:

- HSE

Domain 4

Ensuring compassionate, coordinated and accessible postvention support

Objectives

- Provide compassionate postvention and bereavement support for people bereaved by suicide.
- Respond to suicide clusters in a way which reduces trauma and risk of imitative behaviour.
- Consider revising the burden of proof for determining deaths by suicide.

About this domain

In the Healthy Ireland 2024 survey, 69% of Irish adults reported having known someone who died by suicide. 38% of bereaved adults reported thoughts of self-harm or suicide as a direct result of their bereavement. Among young adults, this figure was 58%. The evidence synthesis carried out to inform this strategy found that, despite widespread recognition of the impacts of suicide bereavement, evidence for effective postvention strategies is limited. The Public Consultation findings also placed a strong emphasis on the need for greater support for people bereaved by suicide.

Domain 4 focuses on ensuring compassionate, coordinated, and accessible support for people and communities affected by suicide. A national framework for bereavement support will be developed and implemented, to ensure universal access to free suicide bereavement services, with tailored supports for groups disproportionately impacted. Awareness of the unique grief associated with suicide bereavement will be actively promoted, and all settings – particularly those involving young people – must be equipped to support people bereaved by suicide. This domain also includes the development of a clear notification pathway to ensure timely and proactive support following a death by suicide. This involves collaboration across emergency services, healthcare providers, community organisations, and other relevant sectors to ensure consistent signposting and compassionate engagement.

During the in-person public consultation for this strategy, the coroner's court process was often described as distressing, and this domain addresses the need to significantly reform the Coroner Service in Ireland. As part of this reform, consideration will be given to revising the burden of proof for determining deaths by suicide. This will be supported by evidence on its implications and feasibility.

In this domain, national guidance will be strengthened to address suicide clusters and imitative behaviour, with regional teams leading the development of interagency plans to monitor and respond to community impacts.

“Losing someone to suicide shatters your sense of self and forces you to search for meaning in the wreckage. Contributing to this strategy has been part of my own meaning-making, a small step toward closure in the face of something that can never fully be resolved. By facing the darkness within myself, I have learned to sit with the pain of others. My hope is simple – that what I have lived through might help spare someone else from the same suffering.”

A member of the Lived Experience Reference Group for the development of this strategy.



Domain 4 – Ensuring compassionate, coordinated and accessible postvention support

Outcomes

- A National Suicide Bereavement Framework/Model of Care is designed and implemented to ensure that people have access to free, timely, quality, trauma-informed and culturally appropriate suicide bereavement services within their community that is in line with their level of need at any point in time.
- There are more open conversations across society with those bereaved after a death by suicide.
- Appropriate education and training on postvention supports is developed for both people delivering services as well as for the population as a whole.
- A standardised, evidence-based approach to responding to suicide clusters is developed and implemented. This prevents further death in communities in a timely and compassionate way.
- Government departments and state agencies work collaboratively to develop a clear rationale which considers the reasons, implications and feasibility of changing the burden of proof for legal determination of death by suicide to 'beyond a reasonable doubt'.

4.1 Enhancing suicide bereavement support

Recommendation:

Building on progress made under *Connecting for Life 2015-2024*, the HSE should develop and implement a national framework for bereavement support which includes access to postvention supports and dedicated tailored supports for specific groups disproportionately impacted by suicide. The supports should not be limited to the initial period following a death by suicide and should include services provided by and funded by the State. It should also specify training and resourcing needs.

Action:

Develop and implement a national framework for bereavement support which includes universal access to free postvention supports and dedicated tailored supports for specific groups disproportionately impacted by suicide.

Lead:

- HSE

4.2 Developing suicide bereavement education

Recommendation:

The HSE should further develop a programme of work to increase awareness of grief associated with suicide bereavement. The HSE should also build the capacity of all settings to support people, particularly young people, bereaved by suicide. Settings include schools, workplaces, sports clubs and specialist services.

Action:

Develop and implement a programme of work to increase awareness of grief associated with suicide bereavement. Build the capacity of all settings to support people, particularly young people, bereaved by suicide.

Lead:

- HSE

4.3 Providing support in the immediate aftermath

Recommendation:

To ensure a joined up response in the immediate period following a death by probable suicide, the HSE should work with key partners (including, first responders, emergency services, hospitals, funeral directors, faith leaders, GPs, NGOs and bodies under the Department of Justice, Home Affairs and Migration and Department of Social Protection) to develop a clear notification pathway and a proactive approach to support and signposting.

Action:

Develop and implement a clear notification pathway and a proactive approach to support and signposting in the immediate period following a death by suicide.

Lead:

- HSE
- Department of Justice, Home Affairs and Migration
- Department of Social Protection

4.4 Providing support around an inquest

Recommendation:

The Department of Justice, Home Affairs and Migration should develop a National Coroner Service to ensure a standardised approach to inquests throughout the country. This should include educating staff in relation to trauma informed practice and enhancing communications to prepare bereaved family members for the inquest. The Coroner Service should also ensure that there is appropriate 'signposting' to appropriate bereavement support. As part of reforming the Coroner Service, the Department of Justice, Home Affairs and Migration should engage with organisations such as Coimisiún na Meán and the Press Council/Ombudsman in relation to updating their guidelines to ensure that they appropriately cater for the reporting of Coroner inquests.

Action:

Ensure a standardised approach to inquests throughout the country through the development of a National Coroner Service. This will include educating staff in relation to trauma informed practice and enhancing communications to prepare bereaved family members for the inquest. Ensure that there is appropriate 'signposting' to appropriate bereavement support. Promote responsible media reporting of Coroner inquests.

Lead:

- Department of Justice, Home Affairs and Migration

4.5 Addressing the burden of proof

Recommendation:

The Department of Justice, Home Affairs and Migration should consider changing the burden of proof for a legal determination of death by suicide to 'balance of probabilities'. The Department of Health, Central Statistics Office and HSE should support this review through evidence of the implications of and feasibility of changing the burden of proof.

Action:

Consider changing the burden of proof for a legal determination of death by suicide to 'balance of probabilities'.

Lead:

- Department of Justice, Home Affairs and Migration

Action:

Develop an evidence review of the implications of and feasibility of changing the burden of proof.

Lead:

- Department of Health
- Central Statistics Office
- HSE

4.6 Providing support for service providers

Recommendation:

The Health and Justice sectors (for example, HSE National Ambulance Service, Irish Prison Service, An Garda Síochána and Fire Service) should ensure that there is specific support for service providers to ensure the unique needs of professionals and volunteers responding to a death by suicide are met. This should include support around participation in inquests and consider capacity building in specialist expertise for prolonged grief related to multiple losses to suicide or murder-suicide.

Action:

Put specific support in place for service providers to ensure the unique needs of professionals and volunteers responding to a death by suicide are met.

Lead:

- HSE
- Department of Justice, Home Affairs and Migration

4.7 Responding to clusters of suicide

Recommendation:

The HSE should further develop national guidance to respond to clusters and imitative behaviour. HSE Regional Executive Officers should support the development and implementation of interagency plans to monitor and respond to emerging suicide clusters or deaths by suicide which have an overwhelming impact on the community.

Action:

Develop and maintain national guidance to respond to clusters and imitative behaviour. Develop and implement interagency regional plans to monitor and respond to emerging suicide clusters or deaths by suicide which have an overwhelming impact on the community.

Lead:

- HSE

Domain 5

Establishing evidence, surveillance systems and supporting structures

Objectives

- Provide foundational supports for strategy implementation including data systems, research, governance and funding.
- Develop a real-time surveillance system for deaths by probable suicide.

About this domain

Domain 5 considers the supporting structures needed for this strategy and focuses on building the systems, data infrastructure, and governance needed to support its effective implementation. This domain focuses on agencies working together to improve the timeliness and quality of official suicide mortality data, including data linkage initiatives, regional-level insights, and the publication of more detailed datasets. A monitoring system will be established, producing annual reports based on coronial files but using a broader definition than official statistics.

A key initiative in this domain is the establishment of a real-time surveillance system for deaths by probable suicide, supported by clear communication protocols across HSE Health Regions. This is an essential part of effective suicide prevention and key to ensuring bereaved families and communities receive timely and appropriate support. Similarly, HSE Mental Health Services will develop a national register of probable deaths by suicide of service users, with improved incident reviews and clear communication with families.

Data collection on self-harm presentations to Emergency Departments will continue under this domain, with efforts to expand this into community care settings. This data will be actively used to identify risk factors and inform regional responses.

A strategic, lived experience-informed approach to research will be adopted to support actions across all domains.

- Ongoing monitoring and evaluation will be embedded into strategy implementation.
- A comprehensive communications plan to support the implementation of the strategy will be developed.
- National and regional implementation structures will be established to drive delivery of the strategy.
- The voice of those with lived experience will be incorporated into every level of implementation.
- A specialist group on self-harm will be formed to guide relevant actions.
- Investment in suicide prevention across the public sector will be tracked annually.
- A framework for commissioning and evaluating services – that are delivered by non-governmental organisations and are funded as part of the strategy – will be created.

Domain 5 – Establishing evidence, surveillance systems and supporting structures.

Outcomes

- The timely collection and reporting of high quality and comprehensive data across systems is possible.
- Policies, services and allocation of resources for suicide and self-harm prevention are evidence-informed and subject to evaluation.
- Efforts to reduce suicide and self-harm are informed by research and a programme of research is developed and delivered upon.
- The experiences of people with lived and living experience are embedded across all elements of the strategy.
- Robust and strengthened cross-sectoral and cross-governmental oversight is defined with appropriate delegation of authority and accountability to deliver the strategy recommendations.
- There is ongoing investment from across government to support full implementation of the strategy.

5.1 Improving official suicide mortality data in Ireland (post-inquest data)

Recommendation:

The Department of Health, the Central Statistics Office, Coroners and the HSE should continue to work together to develop a system to improve the timeliness of official suicide mortality data. This should include support for ongoing data linkage initiatives, ongoing communication, increasing geographical granularity and publication of more detailed datasets.

Action:

Develop a system to improve the timeliness of official suicide mortality data. This will include support for ongoing data linkage initiatives, ongoing communication and publication of more detailed datasets.

Lead:

- Department of Health
- Department of An Taoiseach
- Department of Justice, Home Affairs and Migration
- Central Statistics Office
- HSE

Action:

Produce enhanced regional level data.

Lead:

- HSE

5.2 Enhancing our understanding of probable suicide (post-inquest data)

Recommendation:

The Department of Health with the Health Research Board should maintain the probable suicide monitoring system and produce annual reports on the characteristics of those who died by probable suicide based on completed coronial investigation files but using a broader definition of suicide than what is used in official mortality statistics.

Action:

Maintain the probable suicide monitoring system and produce annual reports on the characteristics of those who died by probable suicide.

Lead:

- Department of Health

5.3 Establishing a real time surveillance system (pre-inquest data)

Recommendation:

The HSE with the support of An Garda Síochána and Coroners should establish a real time surveillance system for deaths by probable suicide, including communication protocols with HSE Health Regions.

Action:

Establish a real time surveillance system for deaths by probable suicide that includes communication protocols for HSE Health Regions.

Lead:

- HSE
- Department of Justice, Home Affairs and Migration

5.4 Establishing a monitoring system for deaths of mental health service users (pre-inquest data)

Recommendation:

In line with Sharing the Vision, the HSE should establish a national register of deaths by probable suicide in HSE Mental Health Services and other relevant health services in Ireland. This should be linked to incident reviews, clear communication with families, support for staff and include a mechanism for incorporating learning into service improvement.

Action:

Establish a national register for deaths by probable suicide in HSE Mental Health Services in Ireland.

Lead:

- HSE

5.5 Developing integrated data

Recommendation:

The Department of Health, HSE and Central Statistics Office should work together to develop an integrated data repository for all pre- and post-inquest data related to suicide.

Action:

Develop an integrated data repository for all pre- and post-inquest data.

Lead:

- Department of Health
- HSE
- Central Statistics Office

5.6 Improving self-harm data

Recommendation:

Data on self-harm presentations to Emergency Departments should continue to be collected and analysed. The HSE should assess the possibility of extending self-harm data collection to care settings within the community. Particular attention should be paid to use of the data, communicating data to the HSE Health Regions and identifying key risk factors.

Action:

Collect, analyse and publish data on self-harm presentations to Emergency Departments. Assess the possibility of extending self-harm data collection to health care settings within the community.

Lead:

- HSE

5.7 Developing supportive research

Recommendation:

A strategic approach to research should be taken which is lived experience informed and considers accessibility. It should support actions across all domains.

Action:

Develop a strategic research plan which is lived experience informed and considers accessibility.

Lead:

- Department of Health
- HSE

Action:

Develop a research plan to improve understanding of specific risk factors linked to suicide and self-harm.

Lead:

- Department of Health
- HSE

5.8 Establishing implementation structures

Recommendation:

National implementation structures should include:

- Cabinet Committee
- The Interdepartmental Mental health Steering Group
- A national steering and implementation monitoring group
- Specialist sub groups
- A HSE implementation structure aligned to Sharing the Vision.

Six regional implementation plans should be developed and regional implementation structures should include:

- Six regional steering and implementation monitoring groups.
- Specialist sub-groups at Integrated Healthcare Area (IHA) levels (to include lived experience).
- Integration with other structures such as Local Community Safety Partnerships, Local Community Development Committees, Children and Young People's Services Committees and Healthy Ireland.

Action:

Design and establish national and regional implementation structures for this strategy.

Lead:

- Department of Health
- Other Government Departments
- HSE

5.9 Incorporating the voice of lived experience

Recommendation:

The Department of Health and HSE should develop a plan to ensure that the voice of people with experience of suicidal behaviour and/or self-harm, experience of suicide bereavement and experience of supporting a friend or family member through suicidal behaviour and/or is incorporated into all levels of strategy implementation.

Action:

Develop a plan to ensure that the voice of people with experience of suicidal behaviour and/or self-harm, experience of suicide bereavement and experience of supporting a friend or family member through suicidal behaviour and/or is incorporated into all levels of strategy implementation.

Lead:

- Department of Health
- HSE

5.10 Addressing self-harm

Recommendation:

A structure should be established to support all the specific self-harm actions within the strategy. This should include people with lived experience of self-harm specifically.

Action:

Establish a specialist group on self-harm as part of the implementation structure.

Lead:

- Department of Health
- HSE

5.11 Establishing monitoring and evaluation processes

Recommendation:

The Department of Health and HSE should develop a process for ongoing monitoring and evaluation throughout the lifetime of the strategy. This should include consideration of regional plans. Economic evaluation should also be considered.

Action:

Develop a process for ongoing monitoring and evaluation (including economic evaluation) throughout the lifetime of the strategy. This will include consideration of regional plans.

Lead:

- Department of Health
- HSE

5.12 Ensuring ongoing funding

Recommendation:

The Department of Health should commit to sustained investment in the implementation of this strategy through the annual estimates process, underpinned by fully costed implementation plans for each implementation period to identify and secure the resources required.

Action:

Develop an annual report to capture investment in suicide prevention across the civil service and public sector.

Lead:

- Department of Health

Action:

Continue to request to increase investment in supporting implementation of this strategy through the annual estimates process.

Lead:

- Department of Health

5.13 Developing an NGO framework

Recommendation:

The HSE National Office for Suicide Prevention (NOSP) and the HSE National Mental Health Office, together with other relevant Government Departments and agencies, should develop a framework for commissioning and evaluating services from the NGO sector which align to outcomes in the strategy. This should be developed in partnership with the NGO sector.

Action:

Develop a framework for commissioning and evaluating services from the NGO sector which align to outcomes in the strategy.

Lead:

- HSE

Action:

Develop a funding framework for community and voluntary organisations to deliver suicide prevention activity to address risk factors based on the evidence.

Lead:

- HSE

5.14 Developing a communications plan

Recommendation:

The Department of Health and HSE should develop a communications plan that will look at all aspects of communication under the strategy. This includes communication between strategy personnel at all levels including Sharing the Vision, Healthy Ireland, Pathways to Wellbeing etc. It should also include how communication is done across all levels of implementation and look at infrastructure (e.g., address the streamlining of where information is held, such as on the hse.ie).

Action:

Develop a communications plan for the strategy.

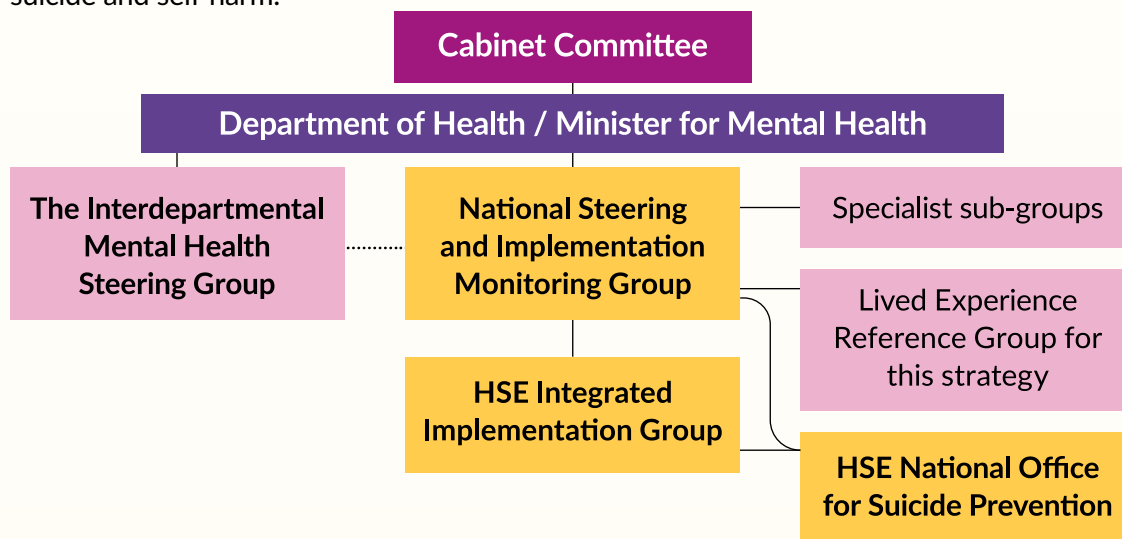
Lead:

- Department of Health
- HSE

3.2 How this strategy will be implemented

National governance and implementation

The strategy is accountable (via the Minister for Health and Minister for Mental Health) to Cabinet. A national implementation monitoring group, chaired by the Department of Health, will be established to oversee implementation of this strategy. It will be supported by a Lived Experience Reference Group and a number of specialist sub-groups. Details of the role of membership of the groups and the terms of reference will be set out in the implementation plans. This strategy is closely aligned to Ireland's national mental health policy *Sharing the Vision* and the national mental health promotion plan *Pathways to Wellbeing*. The Interdepartmental Steering Group for Mental Health was established to advance mental health as a policy priority across a number of Government Departments. It provides strategic guidance and leadership to deliver on the whole-of-government commitments in *Sharing the Vision*, *Pathways to Wellbeing* and this strategy to reduce suicide and self-harm.

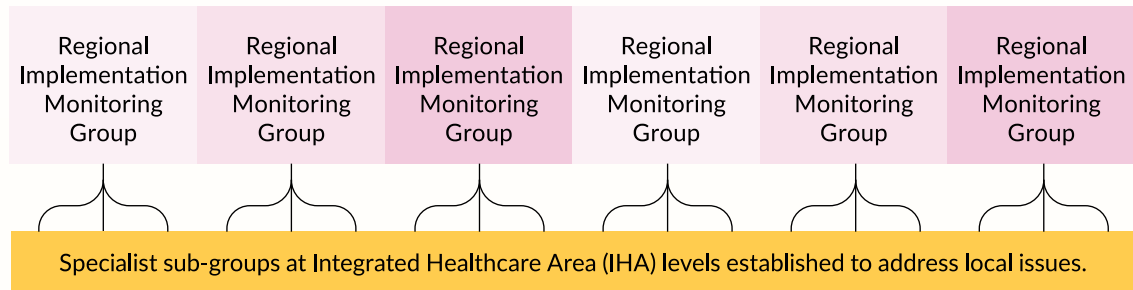


The HSE National Office for Suicide Prevention (NOSP)

The HSE National Office for Suicide Prevention (NOSP) will play a key role in coordinating the implementation of this strategy. As well as leading out on and supporting many of the actions within the strategy, the office will also be responsible for supporting implementation structures and establishing a monitoring system for the strategy.

Regional implementation

Six regional implementation structures and six regional plans will be developed in line with the national implementation plans. Specialist sub-groups will be formed at Integrated Healthcare Area (IHA) levels, to include lived experience representation. Integration with other structures such as Community Safety Partnerships and Healthy Ireland structures is important.



Implementation plans

Three implementation plans will be developed for this strategy. These plans will set out details of how the actions will be implemented during particular periods.

The implementation periods are:

- Implementation period 1: 2026–2028 (3 years)
- Implementation period 2: 2029–2032 (4 years)
- Implementation period 3: 2033–2035 (3 years)

3.3 Monitoring and evaluation

This strategy has 48 recommendations and associated actions. A monitoring system will be developed that builds on the system introduced for Connecting for Life 2015–2024. This system will include a Steering Group and a reporting system. It will provide visibility of implementation progress of all actions. Lead agencies responsible for actions will provide regular updates, anticipated to be every three months, on key milestones and activities associated with actions. Implementation progress reports will be compiled and published. These reports will assist the National Steering and Implementation Monitoring Group to understand, discuss and resolve issues or barriers to progress.

A comprehensive outcomes framework will be developed for this strategy. This will include indicators which are the specific, measurable metrics used to track progress toward meeting the target and long-term intended benefits set out on page five of this strategy.

Two independent evaluations will be commissioned – by the Department of Health – at a mid-point and toward the end of this strategy. These process evaluations will focus on the extent to which programmes of activity achieve objectives, with a focus on relevance, effectiveness, efficiency, management and information systems, and lessons. Careful consideration will also be given (as part of the development of the implementation plans) to interventions within the strategy that are particularly suitable for in-depth data driven impact evaluations.

Appendix 1

Members of the Expert Advisory Group

Organisation/Area	Representative
Chair	Dr Eileen Williamson
Coroner Society	James J Kelly – President
Academic Expert	Prof Ella Arensman – Head of University College Cork School of Public Health, Research Professor School of Public Health and Chief Scientist, National Suicide Research Foundation.
National Suicide Research Foundation	Dr Eve Griffin – Chief Executive Officer
Department of Health: Public Health/Sharing the Vision	Prof Philip Dodd – Deputy Chief Medical Officer and Mental Health Policy Specialist
Department of Education: National Educational Psychological Service	Sharon Eustace – Assistant Director
HSE Child and Youth Mental Health Office	Donan Kelly – Assistant National Director
Executive Clinical Director	Dr Yolande Ferguson – Dublin South Central Mental Health Services
An Garda Síochána	Detective Superintendent Derek Maguire – Garda National Protective Services Bureau
HSE National Office for Suicide Prevention	John Meehan – Assistant National Director
HSE Regional Health Area Representative	Tony Canavan – Regional Executive Officer, HSE West North West
HSE Resource Officers for Suicide Prevention	Niamh Crudden Sarah Hearne
Health Economist	Brendan Kennelly – Senior Lecturer and Health Economist, University of Galway
Lived Experience Panel	Joe O'Donovan – Chair
HSE Clinical Programmes	Dr Amir Niazi – National Clinical Advisor and Group Lead for Mental Health
HSE Social Inclusion	Lisa Robson – General Manager (Acting) Social Inclusion
Department of Health: Health and Wellbeing	Dr Aleisha Clarke – Assistant Principal

Organisation/Area	Representative
Primary Care Representative	Dr Bríd Shanahan – Deep End Ireland
HSE Public Health	Prof Diarmuid O'Donovan – Director of National Health Improvement
Central Statistics Office	John Dunne – Head of Division for Health and Cohesion Tim Linehan – Head of Division for Life Events and Demography
Department of Social Protection	Noel Hand – Principal, Community Welfare Service
Voluntary and community sector representative	Ken Kilbride

Members of the Lived Experience Reference Group

Joe O'Donovan, Chair
Phyllis Conway
Marina Healy
Mairead Steele
Seán Kinsella
Carrie O'Brien
Aoife Byrne
Pauline Talbot
Stephen Donnelly
Mark Creegan
Tasha Lanigan

Secretariat and Policy Development Team

Sarah Woods
Niamh Richardson-Dunn
Barry Kestell
Robert Murphy (July–December 2025)
Siobhán Hargis
Philip Dodd

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