Report of the Expert Advisory Group for the next suicide and self-harm reduction strategy

13 April 2026

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Foreword from the Chair of the Expert Advisory Group

It has been an honour to chair the Expert Advisory Group (EAG) for Ireland's next suicide and self-harm reduction strategy. From the first meeting, where members became acquainted and explored the scope of the work, through to the session where agreement on proposed recommendations was reached, the journey was marked by collaboration, commitment and urgency.

Early discussions focused on governance and principles, ensuring that the approach taken was inclusive and aligned with existing mental health policies. As the process evolved, evidence from the evaluation of *Connecting for Life*: 2015-2024 and the Findings of the Public Consultation were examined to help shape the priorities of the group as was feedback from meetings of the Lived Experience Group. Workshops allowed all members to debate the vision, principles, and domains of the new strategy, and subsequent meetings refined these into actionable recommendations.

While agreeing on recommendations represents a significant milestone, the work of the EAG does not end here. The group will continue its efforts in 2026, supporting the development of the implementation plan and ensuring that the recommendations translate into meaningful change.

I would like to express my deepest gratitude to each member of the EAG. Working within a tight timeframe, they brought expertise, insight and dedication to bear on complex issues. Their contributions have ensured that the recommendations are robust, evidence-informed and practical. I would like to thank them for their professionalism, for giving so generously of their time and expertise and for helping to lay the foundation for a strategy that will strengthen supports across Ireland and help to save lives

Signature

Dr Eileen Williamson

Foreword from the Chair of the Lived Experience Reference Group

I have had the privilege of working with a wonderful group of people on the Lived Experience Reference Group (LERG), brought together through the devastating tragedy of suicide and self-harm in our lives. In our group, we shared the lived experience of those who experienced suicidal and self-harm behaviour, suicide bereavement and supporting a friend or family member through suicidal or self-harm behaviour.

Between us, we have lived experience of the supports and systems in place to help those in difficulty and assist those through times of crisis. We have lived experience of where things worked well, where there are failings, and we have insights on what improvements can make a difference.

Throughout this process we wanted to be listened to, to have our thoughts and suggestions for improvements understood and taken into account in the strategy development, and that our input and that of all participants would lead to positive change and help those in need to avoid the lifelong devastation that comes with loss from suicide and the impact of self-harm. It is fair to say that our voice was heard and that the recommendations taken forward in the strategy reflect our input.

We had the opportunity to meet with Minister for Mental Health, Mary Butler, in November 2025. The Minister showed a great understanding and empathy around suicide and self-harm, demonstrating a series of actions she had taken to effect change in the lives of those vulnerable to suicide and self-harm. I want to commend the Minister for her efforts in this regard, and she reassured the LERG that she would provide the leadership necessary for the implementation of the recommendations, and we take a lot of heart from this commitment.

The input of all those who took part in the public consultation process was really important to us on the lived experience group. It helped us navigate through some really tough discussions around our lived experiences.

We received great support from the Department of Health in facilitating our engagement. It was clear there was recognition of the importance of Lived Experience to developing a

national strategy, and we ask that engagement with Lived Experience continues and becomes a cornerstone, not only of strategy development but also strategy implementation. I started this Foreword by highlighting the wonderful members of the LERG, and I want to finish by expressing my thanks to them for being so open, so giving, so sharing of their experiences, so supportive of each other throughout our meetings and so determined that positive change happens to help others avoid the lived experiences that brought this group together.

Signature

Joe O’Donovan

Statement of Compliance with the Transparency Code

The EAG conducts its activities in accordance with the criteria set out in the Transparency Code. The Chairperson has informed and secured agreement from the Expert Advisory Group regarding adherence to the Code. Material relating to the activities of the group is published online, to achieve compliance with the requirements of the Code. These include:

- Name of Chairperson together with details of his or her employing organisation;
- Names of Members together with details of their employing organisation;
- Terms of reference of the group;
- Agenda of each meeting;
- Minutes of each meeting;
- Expected timeframe for the group to conclude its work;
- Reporting arrangements.

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Dr Eileen Williamson, Chair

Introduction

The EAG was established to guide the development of Ireland's next suicide and self-harm reduction strategy. Minister for Mental Health Mary Butler appointed 22 members to this group, coming from clinical, academic, policy, and community sectors, as well as lived experience.

A parallel LERG coordinated by the National Suicide Research Foundation was established to support the EAG and ensure the inclusion of lived experience perspectives in the development of the strategy. This group worked closely with the EAG, and the Chair of the LERG sat on the EAG. Members of the LERG included individuals with experience of suicidal behaviour, suicide bereavement, self-harm and supporting others in crisis.

The EAG, in close collaboration with the LERG, 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.

Both groups have played a central role in shaping the strategy, ensuring it is informed by the latest evidence, cross-sectoral expertise, and the lived experience of those affected by suicide and self-harm.

Schedule of meetings

	Expert Advisory Group	Lived Experience Reference Group
Meeting 1	**Date:** Thurs 10 July **Time:** 3pm-4:30 **Venue:** Online **Purpose:** Introduce group. Brief group. Agree TORs.	**Date:** Mon 18 August **Time:** 11am-3pm **Venue:** Dept Health **Purpose:** Group to meet each other. Agree ways of working. Brief discussion on priorities.
Meeting 2	**Date:** Mon 1 September **Time:** 11am-2pm **Venue:** Dept Health **Purpose:** Engagement with Minister Butler. Workshop on recommendations paper from Dept Heath.	**Date:** Mon 8 September **Time:** 11am-3pm **Venue:** Dept Health **Purpose:** Workshop on updated recommendations paper from Dept Heath.
Meeting 3	**Date:** Wed 17 Sept **Time:** 2pm-3:30pm **Venue:** Online **Purpose:** Review and discuss updated version of recommendations paper and hear LERG feedback.	**Date:** Wed 24 Sept **Time:** 2:30pm-4:30pm **Venue:** Online **Purpose:** Review and discuss updated version of paper.
Meeting 4	**Date:** Wed 1 Oct **Time:** 2pm-3:30pm **Venue:** Online **Purpose:** Review and discuss updated version of recommendations paper and hear LERG feedback. Guest presentation from: Derek Chambers, HSE Policy Implementation Lead, & Oisín Murphy, Assistant Principal Officer Mental Health Policy Unit	**Date:** Wed 8 Oct **Time:** 2:30pm-4:30pm **Venue:** Online **Purpose:** Review and discuss updated version of paper. Final feedback. Guest presentation from: Poul Walsh Olesen and Emer Clarke, HSE Policy Implementation Team.
Meeting 5	**Date:** Mon 13 Oct **Time:** 11am-2pm **Venue:** Dept Health **Purpose:** Final comments and sign off on recommendations paper.	**Date:** Mon 20 Oct **Time:** 11am-3pm **Venue:** In person **Purpose:** Final review and reflection on recommendations paper. Guest presentation on strategy document content: Ciarán Austin, National Office for Suicide Prevention,
Meeting 6	**Date:** Fri 5 Dec **Time:** 11am-12.30pm **Venue:** Online **Purpose:** Update on strategy development. Final feedback on draft strategy.	**Date:** Mon 24 Nov **Time:** 2pm-3.30pm **Venue:** Online **Purpose:** Meeting with Minister Butler and review of draft strategy, including ideas for design

Membership

Expert Advisory Group

Name	Organisation
Eileen Williamson (Chair)	Former CEO, National Suicide Research Foundation
Timothy Linehan	Central Statistics Office
John Dunne	Central Statistics Office
Derek Maguire	Garda National Protective Services Bureau
Brendan Kennelly	University of Galway
Sarah Hearne	HSE Resource Officer for Suicide Prevention
Niamh Crudden	HSE Resource Officer for Suicide Prevention
Philip Dodd	Deputy Chief Medical Officer
Joe O'Donovan	Chair, Lived Experience Reference Group
Donan Kelly	HSE Child and Youth Mental Health Office
Ella Arensman	University College Cork & National Suicide Research Foundation
Eve Griffin	National Suicide Research Foundation
Sharon Eustace	Department of Education and Youth, National Educational Psychological Service
Diarmuid O'Donovan	HSE Public Health
John Meehan	HSE National Office for Suicide Prevention
Tony Canavan	HSE Regional Executive Officer
Bríd Shanahan	GP, DeepEnd
Noel Hand	Department of Social Protection
Yolande Ferguson	HSE
Amir Niazi	HSE National Clinical and Group Lead
Lisa Robson	HSE Social Inclusion
Aleisha Clarke	Department of Health
Ken Kilbride	C&V Sector Representation

Lived Experience Reference Group

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

Overview of meetings

Both the EAG and the LERG met five times in the period July to October 2025 to develop recommendations for Ireland's next suicide and self-harm reduction strategy.

Across these meetings, the groups progressed from initial briefings and agreement on governance and principles to detailed discussions on the strategy's vision, domains, and priorities. They reviewed evidence from the evaluation of *Connecting for Life*, considered the Findings from the Public Consultation, reviewed international research and evidence and worked collaboratively to develop recommendations that are both evidence-informed and grounded in lived experience. The Chair of the LERG brought feedback from the LERG to the EAG meetings. Officials from the Department of Health, Mental Health Strategy Unit attended both the EAG and LERG meetings to ensure that feedback from both groups was captured.

To help guide the discussions, the Department of Health, Mental Health Strategy Unit developed a recommendations guidance document. The document set out four proposed domains for the strategy as follows:

- Domain 1: Focussed on promotion and prevention
- Domain 2: Focussed on intervention and restricting access to means
- Domain 3: Focussed on postvention
- Domain 4: Focussed on supporting structures.

The EAG agreed with this structure but felt that the area of "restricting access to means" was a significant one and required its own domain. As such, the original domain 2 was split and five domains were agreed for the strategy.

The final meetings of the groups focused on refining proposed actions and agreeing on recommendations for the new strategy.

The work of both groups will continue in 2026, supporting the development of the implementation plan and ensuring that the recommendations are reflected therein.

The following sections provide an overview of the key themes discussed at the meetings of both groups. Detailed Agendas and Minutes of the six meetings are available at:

Discussion Themes

Vision, objectives and guiding principles

Across EAG and LERG meetings, there was broad agreement on the direction of Ireland's next national suicide and self-harm strategy. Members of both groups identified several areas where *Connecting for Life* could be strengthened, and there was a consistent focus on developing a clearer, more inclusive, and more responsive strategy.

One area that received a significant amount of focus was the title of the strategy. Both groups noted that while '*Connecting for Life*' is familiar to those working in suicide prevention, it has limited visibility among the wider public and across parts of the health system. Among LERG members, in particular, there was a strong feeling that the title should be transparent and clearly name suicide and self-harm. There was strong agreement that this would improve clarity, reduce stigma, and better reflect the scope of the strategy. This conflicted with the views of some EAG members who underlined the value of maintaining continuity with the '*Connecting for Life*' brand. Both groups were satisfied with the recommended final title: National Suicide and Self-Harm Reduction Strategy 2026-2035: *Connecting for Life*.

There was also significant discussion around the use of 'prevention' or 'reduction', with members recognising the importance of choosing terminology that is realistic, measurable, and aligned with international best practice, while still being accessible. Reduction was ultimately the preferred option among members.

There was similarly constructive alignment around the strategy's vision. Members agreed that the aspiration to reduce deaths by suicide remains at the heart of the strategy and supported making the wording clearer and more person-focused. A consistent theme was the need to revise the second part of the current *Connecting for Life* vision, which was seen as placing too much emphasis on individuals and communities rather than on the responsibility of services and systems. Both groups supported the adoption of a more rights-based approach and emphasised the importance of explicitly referencing self-harm.

Feedback on the principles also highlighted opportunities for strengthening the strategy. While some members felt that services do not always reflect the principle of being person-centred, the conversation was forward-looking and solution-driven. Members saw significant value in embedding lived experience more explicitly within the principles and throughout the strategy as a whole. They also emphasised the importance of continuity of care, meaningful family involvement, and clearer commitments to co-production. There was

interest in reframing *Connecting for Life* principles such as 'adaptive to change' to better reflect expectations of responsiveness and accountability.

Another major theme discussed was the need to give greater prominence in the new strategy to self-harm. Both groups noted that self-harm was not sufficiently emphasised in the previous strategy and wanted to address this. Rising rates of self-harm among younger people, especially since the pandemic, was highlighted as a key reason to strengthen early intervention and upstream prevention.

Overall, the discussions moved the groups closer to a more cohesive, people-centred, and inclusive national strategy, one that better reflects lived experience and supports a more effective national response to suicide and self-harm.

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

Across all meetings, there was strong agreement that Domain 1's focus on upstream prevention is essential. Members consistently emphasised that if Ireland is to successfully reduce suicide, the strategy must address the broader social, educational, economic, commercial and digital factors that have an impact on people's wellbeing before people reach crisis point. Members noted the significant world changes since *Connecting for Life* was published and agreed on the importance of the new strategy responding to emerging risks and exploring new opportunities for prevention.

A major focus of discussion under this domain was rising needs among children and young people. Members of the EAG noted growing levels of anxiety, earlier onset of emotional difficulties, and evidence of high-lethality self-harm among young children. Stakeholders felt there is a clear need for earlier education on self-harm, better coping skills, and specialist training for teachers and parents. Schools were viewed as of central importance but LERG members stressed the importance of not overburdening teachers. There was some support among LERG members for embedding mental health professionals in schools, extending existing wellbeing programmes, ensuring better supports for families who are supporting people who are suicidal, and ensuring families receive support after a death by suicide or self-harm incident. Some members also highlighted academic pressures and bullying (including online bullying) as specific risk factors.

Discussions on the social and commercial determinants of suicide highlighted a wide variety of important issues. Members of both groups emphasised loneliness, social isolation,

financial stress, debt practices of utility companies, gambling harms, and the influence of the alcohol industry. Members of the Traveller community, people in chronic pain, and those dealing with major health conditions were identified as groups at particularly elevated risk. The complexity of some social determinants was acknowledged, such as poverty and housing, and it was suggested that the strategy focus on targeted actions in areas where it can make a more direct impact, for example at the individual level with respect to training in financial literacy, targeting particular at risk occupational groups, as well as those experiencing isolation.

EAG members welcomed the ambition for suicide prevention to be included in all relevant government policies, noting opportunities to influence social policy, workplace practice, and frontline public services. Mental health promotion was seen as requiring dedicated staff, improved local coordination and use of linking of data to identify emerging risks.

There was enthusiasm for national stigma reduction campaigns, which directly talk about suicide and self-harm, among both the EAG and LERG members, but it was underlined that such campaigns would need to identify appropriate supports which should be sufficiently resourced.

There was strong emphasis on risk factors linked to alcohol, drugs, and access to services. Members supported universal screening for alcohol and drug issues in Emergency Departments (EDs), improved wraparound models of care, and more flexible referral pathways into mental health services. Concerns were also raised about unregulated online pharmacies and prescription medication practices.

Domain 2 - Restricting access to means and methods

Domain 2 focuses on reducing access to the means of self-harm and suicide, reflecting strong agreement among members that effective prevention necessitates reducing access to means of suicide. Members of both groups placed significant focus on this area highlighting the need to improve regulation, oversight and protective measures. Alongside calls for strengthened controls on prescription practices, online pharmacies, and access to alcohol and drugs, members also emphasised the growing impact of online harms. In particular, concerns centred on the role of social media algorithms, AI-enabled interactions, and children’s exposure to harmful content, all of which were viewed as digital pathways that can increase vulnerability and require targeted restriction and regulation.

The digital environment emerged as a growing area of concern. Members of both groups described online harms, particularly those related to social media algorithms and AI, as particularly problematic and in need of urgent attention. Members of the EAG called for stronger regulation, clearer accountability for technology companies, and policies on mobile phone use in schools. Opportunities were also identified by LERG members, including partnering with influencers and improving local relevance of content warnings on streaming platforms.

Concerns were also raised about unregulated online pharmacies and prescription medication practices.

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

Across the meetings, there was strong agreement that Domain 3 must focus on building a system of care that is integrated, compassionate, timely, and easy to access, particularly during moments of suicidal crisis. Members broadly supported the direction of the domain, and the aim to deliver meaningful, practical improvements for people who need help, especially those navigating complex issues and suicidal crisis.

A central theme was the need for early intervention, particularly in childhood. Members noted emerging initiatives such as the piloting of counselling and wellbeing supports in primary schools and they emphasised that early supports can reduce crises later in life. It was suggested that there should be a shift towards defined care pathways that include identification of support need, intervention, follow-up and not just support at the point of acute distress.

The need for a single, streamlined referral pathway was repeatedly highlighted. It was suggested that, currently, people experiencing suicidal thoughts may face fragmented services, unclear access points, and inconsistent follow-up. Both EAG and LERG members noted that continuity of care can be inadequate. Families also reported a lack of transparency after a death by suicide, with some suggesting that cases involving contact with mental health services should be reviewed to ensure accountability and learning.

There was consensus that Ireland must significantly expand alternatives to EDs which were described as overstretched, often not therapeutic, and unable to provide the calm, compassionate environments needed for people in suicide crises. The expansion of SCAN

nurses, Crisis Resolution Teams, and community-based crisis services was widely supported, with members of both groups urging wider rollout and nationwide consistency.

Members also called for better integration with primary care centres and non-clinical community services, including the not-for-profit sector, welfare offices, and community welfare officers who often support people in distress.

Members noted that access to psychological therapies remains a challenge. Stakeholders described long waits for Cognitive Behavioural and Dialectical Behaviour therapies and a disconnect between psychotherapy and psychiatry, despite strong evidence for the value of talk therapy. Members emphasised that dual diagnosis services remain insufficient.

Throughout discussions, members stressed that services must be trauma-informed, co-produced, person-centred, rights-based, and aligned with Ireland's national mental health policy, *Sharing the Vision*, while avoiding duplication of existing efforts. They also highlighted the importance of compassion, as an important aspect of improving service quality, and the need to recognise addiction as both a coping mechanism and a driver of suicidality.

There was strong emphasis on risk factors linked to alcohol, drugs and access to services. Members supported universal screening for alcohol and drug issues in EDs, improved wraparound models of care, and more flexible referral pathways into mental health services.

Members of the LERG emphasised the need to establish timely, robust procedures for the evaluation of new and emerging therapies and treatments, with the explicit aim of enabling their efficient and rapid implementation.

Finally, stakeholders emphasised that improving services also requires attention to workforce shortages, sustainable resourcing, and practical delivery. Effective implementation, rather than new concepts, was seen as the critical challenge.

Domain 4 - Ensuring compassionate, coordinated and accessible support after a death by suicide

Across discussions, there was strong agreement around the importance of supporting individuals, families, and communities after a death by suicide, ensuring ethical and responsible media practice, and strengthening the systems that respond to clusters and bereavement.

A central theme was the pressing need for a more structured, proactive and coordinated response following a death by suicide. Members of the EAG highlighted how the current notification pathways are often unclear and inconsistent, leading to delays in outreach and gaps in support. LERG members emphasised the importance of ensuring that every bereaved family receives timely contact from an appropriate service, supported by a clear national protocol. The coronial process emerged as a significant point of distress for families, with delays, lack of communication, and the courtroom setting all contributing to stress for the bereaved. EAG members agreed that families need dedicated support before and after inquests, as well as standardised information and compassionate communication from all professionals involved.

The need for a nationally coordinated bereavement support system was strongly emphasised by both the EAG and LERG members. In the Public Consultation many bereaved people reported poor experiences of care and a reliance on NGOs that are not always evaluated or integrated into statutory services. There was widespread support for expanding the Suicide Bereavement Liaison Service and peer postvention supports, with several members calling for a dedicated statutory service for suicide bereavement. Tailored supports for ethnic minority communities and specialist training for professionals including teachers, Gardaí, clergy, housing officers and first responders were identified as essential. Members also highlighted the importance of providing support for those indirectly affected, including witnesses, frontline workers and wider school or community groups.

Children and young people were highlighted repeatedly as requiring specialised, ongoing support after a death by suicide. Members noted how childhood bereavement can have long-term, evolving impacts and that services must be able to support children over time as their needs develop. Schools were identified as safe and trusted spaces where supports could be delivered, with it being suggested that more access to therapy services is needed for some children and young people.

Another strong theme was the role of the media and the digital environment. Members stressed the need for ethical reporting following suicide, noting that journalists contacting families too soon is inappropriate and harmful. While traditional media practice has improved, online spaces remain a major concern. Members called for stronger regulation of algorithms, greater oversight of digital content, and awareness of online and social clusters, where exposure can lead to imitative behaviour. It was suggested that families may also need guidance about risks linked to funerals, memorials and social media.

Data sharing and evaluation were seen as crucial enablers. Faster identification of deaths by probable suicide would allow earlier responses to emerging clusters. Members also highlighted gaps in evidence about what types of bereavement supports work best, especially for men, and called for regular evaluation and clear standards.

Finally, some members raised the need to address complex areas such as familicide, recognising the multi-layered and distinctive nature of these incidents and the need for a coordinated national response.

Domain 5 - Establishing evidence, surveillance systems and supporting structures

Across all group discussions, there was strong agreement that Domain 5 is a critical foundation for the entire strategy. EAG and LERG members consistently underlined that robust data, high-quality research, and effective monitoring systems are essential to understanding suicide patterns, identifying risk, informing action and evaluating impact.

A recurring theme was the need for timely, accurate and linked datasets. Participants stressed that Ireland's current suicide-related data systems remain fragmented, slow, and limited by gaps in coverage. Members noted that many relevant datasets are not linked, making it difficult to identify emerging high-risk groups, to respond quickly to clusters or to analyse inequalities. There was widespread agreement on the need for improved data linkage across health, policing, social protection and other systems, while also ensuring compliance with the provisions of the General Data Protection Regulations. Members highlighted how current systems do not adequately capture data on ethnicity, priority groups, or marginalised groups, undermining the ability to measure and address inequalities at national and regional levels.

Improving the timeliness of official suicide statistics was seen as an urgent priority. Long delays associated with coronial processes currently hamper timely support for bereaved families. Several members recommended changes to coronial processes to allow the early sharing of provisional causes of death. Others proposed drawing on additional datasets, such as those held by the Department of Social Protection, which could then be linked with existing datasets to enhance early detection of trends.

Concerns about underreporting and inconsistencies in determining deaths by suicide were noted. Similar challenges were identified within self-harm surveillance, with strong support among LERG members for expanding the National Self-Harm Registry beyond hospital

settings to capture presentations to General Practitioners, minor injury clinics, psychologists, and other community providers. It was suggested that Emergency Department presentations of self-harm were likely a significant under-representation of overall self-harm incidents. Members also suggested including suicidal ideation as a registry category, recognising that thoughts of suicide often precede behaviour but are currently invisible in national data.

The importance of research, evaluation and learning systems was another central theme. Members called for greater emphasis on implementation research, understanding what works, for whom and in what context, and ensuring that research findings lead to sustained change. Regular evaluation of interventions, services and peer-support models was viewed as essential, and LERG members stressed the need for clearer communication to avoid insensitive or unclear language in reporting.

Finally, both the LERG and the EAG emphasised that effective implementation requires strong regional structures. While the HSE, and specifically the National Office for Suicide Prevention (NOSP), nationally have a vital leadership role, members stressed that Ireland's six new health regions present both opportunities and risks. A balance must be struck between national consistency and regional flexibility, with equitable resourcing, clear monitoring mechanisms, and culturally sensitive approaches across diverse communities.

Workshops to develop outcomes

A subgroup comprised of members of the EAG and LERG was established to develop outcomes for the strategy. The group met three times in November.

Recommendations

A total of 49 recommendations across the five domains were agreed by the EAG, in collaboration with the LERG. These are set out below. It should be noted that in the final strategy recommendation 1.2 was incorporated into recommendations 5.7 and 5.13.

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

1.2 Addressing risk factors	The HSE National Office for Suicide Prevention should continue to invest in research into specific risk factors[1] linked to suicide and self-harm. The HSE National Office for Suicide Prevention should also work with relevant statutory bodies to fund community and voluntary organisations to deliver suicide prevention activity to address risk factors based on the evidence.
1.3 Addressing risk factors	The HSE National Office for Suicide Prevention in collaboration with other parts of the HSE working in the areas of social inclusion and disability should develop targeted and appropriate suicide prevention information and training to provide appropriate support to vulnerable people within the community including Travellers, people facing substance use disorder, people who are homeless, neurodiverse people and the LGBTQI Community.
1.4 Addressing risk factors: alcohol and drugs	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.
1.5 Addressing risk factors: gambling	The Department of Health, HSE (Clinical Programme for Dual Diagnosis) and Department of Justice should 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. 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.

1.6 Addressing risk factors: online activity	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.
1.7 Implementing Healthy Ireland and the settings approach	The Department of Health should ensure the ongoing implementation of Healthy Ireland to improve overall health outcomes. Healthy Ireland and the HSE National Office for Suicide Prevention 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.
1.8 Improving mental health and wellbeing outcomes: Targeted Supports (Sláintecare Healthy Communities)	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.
1.9 Supporting children and young people	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.

1.10 Improving Mental Health and Wellbeing Outcomes: Universal Supports	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.
1.11 Reducing stigma associated with suicide and self-harm	The HSE National Office for Suicide Prevention 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.

Recommendations: Domain 2 – Restricting access to means and methods

2.1 Medications and chemicals used in intentional overdose	Informed by surveillance data, the Department of Health and Health and Safety Authority (together with other Government Departments and Agencies involved in the regulation of substances in Ireland) should continue to restrict the use of medications and chemicals used in intentional overdose.
2.2 Preventing death in public places	The Department of Transport, the LGMA, the Department of Health (Healthy Ireland) and the Office of Public Works should continue to work with the HSE National Office for Suicide Prevention, relevant agencies and local authorities to implement evidence informed initiatives to prevent suicide attempts and death by suicide in public places.

2.3 Addressing specific means	The Department of Justice, Home Affairs and Migration, Department of Defence and Department of Health (supported by the HSE National Office for Suicide Prevention) should continue to work together to promote awareness of death by suicide by firearms and promote adherence to legislation among relevant stakeholders.
2.4 Addressing specific methods	The HSE National Office for Suicide Prevention should establish a programme to determine evidence-based interventions to prevent self-harm and death by suicide by hanging outside of care settings. 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.
2.5 Addressing online harm and harnessing the benefits of technology	Coimisiún na Meán and other relevant partners, informed by the HSE National Office for Suicide Prevention, 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.
2.6 Promoting responsible media reporting and portrayal	The HSE National Office for Suicide Prevention, 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.

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

3.1 Making the most of every interaction	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 National Office for Suicide Prevention 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.
3.2 Workforce training and development	All Government Departments and agencies with frontline staff should work with the Department of Health and HSE National Office for Suicide Prevention to implement evidence-based training, guidance and protocols on self-harm and suicide to create a safe public sector environment.
3.3 Building capacity within the health sector	Building on progress made under *Connecting for Life* 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.
3.4 Building capacity within the Community	Building on progress made under Connecting for Life, the HSE National Office for Suicide Prevention should continue to deliver evidence based suicide and self-harm training programmes to the community. These should be supported by appropriate resources and guidance.
3.5 Building capacity within schools	The HSE (NOSP and Child and Youth Mental Health Office) 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.
3.6 Providing culturally appropriate services and targeted interventions	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 S*haring 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-harm[2].
3.7 Offering alternative care pathways and evidence based interventions	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.
3.8 Ensuring an integrated response to crisis	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.

[2] This recommendation relies on robust real time surveillance data which also captures ethnicity. At-risk communities include: Irish Travellers; Neurodivergent people; the LGBTIQ+ community; people facing substance use disorder; and International Protected Applicants, beneficiaries of temporary protection and refugees; peri-natal women; and people with chronic illnesses.

3.9 Enhancing support within Emergency Departments	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.
3.10 Enhancing community support	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.
3.11 Responding to self-harm clusters	The HSE National Office for Suicide Prevention together with the HSE Health Regions (including, HSE Resource Officers for Suicide Prevention) should develop and implement guidance to respond to self-harm clusters. This should take account of different settings, collaborating with relevant partners as appropriate.

Recommendations: Domain 4 – Ensuring compassionate, coordinated and accessible support postvention support

4.1 Enhancing suicide bereavement support	Building on progress made under Connecting for Life, the HSE National Office for Suicide Prevention should develop and implement a national framework for bereavement support which includes universal access to free postvention supports and dedicated tailored supports for specific groups disproportionally 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.

4.2 Developing suicide bereavement education	The HSE National Office for Suicide Prevention should further develop a programme of work to increase awareness of grief associated with suicide bereavement. The HSE National Office for Suicide Prevention 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.
4.3 Providing support in the immediate aftermath	To ensure a joined up response in the immediate period following a death by probable suicide, the HSE National Office for Suicide Prevention and National Office for Community Safety should work with key partners (including, first responders, emergency services, hospitals, HSE Mental Health Services, 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.
4.4 Providing support around an inquest	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 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.
4.5 Addressing the burden of proof	The Department of Justice, Home Affairs and Migration should consider changing the burden of proof for a legal determination of death by suicide to 'on the balance of probabilities'. The Department of Health, Central Statistics Office and HSE National Office for Suicide Prevention should support this through evidence of the implications of and feasibility of changing the burden of proof.

4.6 Providing support for service providers	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.
4.7 Responding to clusters of suicide	The HSE National Office for Suicide Prevention 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.

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

5.1 Improving official suicide mortality data in Ireland (Post-inquest data)	The Department of Health, the Central Statistics Office, the 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, regional level data, ongoing communication and publication of more detailed datasets.
5.2 Enhancing our understanding of probable suicide (Post-inquest data)	The Department of Health 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.
5.3 Establishing a real time surveillance system (Pre-inquest data)	The HSE National Office for Suicide Prevention/ROSPs, HSE Public Health 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 Regions.
5.4 Establishing a monitoring system for deaths of mental health service users (Pre-inquest data)	In line with Sharing the Vision, the HSE (HSE Mental Health Office and HSE Quality and Patient Safety should establish a national register of deaths by probable suicide in mental 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.
5.5 Developing integrated data	The Department of Health, HSE Public Health, HSE National Office for Suicide Prevention and Central Statistics Office should work together to develop an integrated data repository for all pre and post inquest data related to suicide.
5.6 Improving self-harm data in Ireland	Data on self-harm presentations to Emergency Departments should continue to be collected and analysed. The HSE National Office for Suicide Prevention and the National Clinical Programme for self-harm and suicidal ideation 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 Regions and identifying key risk factors.
5.7 Developing supportive research	A strategic approach to research should be taken which is lived experience informed and considers accessibility. It should support actions across all domains.
5.8 Establishing implementation structures	National implementation structures should include: ● Cabinet Committee ● The Interdepartmental Mental health Steering Group ● An 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: ● 6 x regional implementation monitoring groups ● Specialist sub-groups at an IHA level (to include lived experience) ● Integration with other structures such as Community Safety Partnerships and Healthy Ireland.
5.9 Incorporating the voice of lived experience	The Department of Health and HSE National Office for Suicide Prevention 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.
5.10 Addressing self-harm	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.
5.11 Establishing monitoring and evaluation processes	The Department of Health and HSE National Office for Suicide Prevention 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.

5.12 Ensuring ongoing funding	There should be an all of Government commitment to investing in suicide prevention and an annual report to capture investment in suicide prevention across the civil service and public sector. The Department of Health should continue to request to increase investment in supporting implementation of the new strategy through the annual estimates process.
5.13 Developing an NGO framework	The HSE National Office for Suicide Prevention 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.
5.14 Developing a communications plan	The Department of Health and HSE National Office for Suicide Prevention 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).

Appendix 1

Terms of Reference for the Expert Advisory Group and the Lived Experience Reference Group.

1. Expert Advisory Group TOR

Expert Advisory Group for next Suicide Reduction Policy:

Terms of Reference

Department of Health, Mental Health Unit

Background

The Irish Government's approach to suicide prevention, intervention and postvention is set out in the *Connecting for Life* policy. It provides a comprehensive plan, based on the best international evidence, for how we can reduce levels of suicide in our country. *Connecting for Life* was launched in 2015 and came to an end in 2024. *Connecting for Life* is currently being evaluated to assess how well the different parts of the plan have worked. A final report is due in September 2025. At the same time, the Department of Health Mental Health Unit has begun working on a successor policy, which builds on the successes of the current one and takes account of new evidence. This policy is due to be completed by the end of 2025. The new policy will set out Government's approach to suicide reduction from 2026 onwards.

A public consultation process to inform the development of the next suicide reduction strategy was launched at the start of March and concluded at the end of May. This process has included 1,890 submissions from members of the public, seven in-person/online sessions with over 200 people and many more consultation meetings with specific interest groups. The next stage of the process is the establishment of an Expert Policy Advisory Group and a Lived Experience Reference Group to make recommendations for the next policy.

Role

The role of the group is to provide expert advice to the Department of Health on the development of the new Suicide Reduction Policy.

Outputs

The anticipated outputs of the Group will be:

1. Conduct review of informing documents. Namely, evidence review, report on public consultation and key considerations document drafted by the Department of Health Mental Health Strategy Unit.

2. Collaborate with the Suicide Reduction Policy Lived Experience Reference Group (to be established via the National Suicide Research Foundation's Lived Experience panel), to ensure that the recommendations of the Expert Advisory Group reflect the voice of Lived Experience.

3. Advise on development of outcomes framework for new policy.

4. Support inter-agency/cross Departmental engagement.

5. Advise on the development of the final policy document and implementation plan.

Deliverables

1. Report containing recommendations for Ireland's next suicide reduction policy, developed in consultation with the Lived Experience Reference Group.
2. Document outlining recommendations for the development of outcomes framework for the new policy.

Timeframe

The Reference Group will run from July 2025 until March 2026. The meetings will be a mix of in-person and online meetings. A schedule of meetings will be established by the Chair. It is anticipated that the majority of meetings will take place between the start of July 2025 and mid-October 2025, which is when the report is due.

- Group appointed: June 2025
- First briefing meeting: Early July 2025
- All final documentation sent: August 2025
- Second Meeting: Start of Sept 2025
- Report to be sent to DoH: Mid-October 2025
- Group remains in place until March 2026 to provide advice on final policy development and implementation plan development

Secretariat

Secretarial support to the Group will be provided by the Department of Health Mental Health Strategy Unit.

Ways of Working

Group Membership

The Advisory Group will have approximately 22 members. Members will be appointed by the Minister for Mental Health and will represent a diverse range of

perspectives in suicide prevention, intervention and postvention. Lived experience involvement in the Advisory Group will be crucial to ensuring that the recommendations of the group meet the needs of those the policy aims to serve. A separate Lived Experience Reference Group will work in parallel with the Advisory Group and the Chair of that group will be a member of the Advisory Group. Additional experts may be added as required.

The group will be chaired by Dr Eileen Williamson, former CEO of the National Suicide Research Foundation, who will oversee the work of the group.

Group Model

The group will have a tightly focused work programme and organise this work through four meetings taking place between the start of August and mid-October 2025. An agenda and pre-reading materials will be circulated in advance of each meeting.

- Group Aim: To guide the development of the new suicide reduction strategy.
- Function: To collaborate, advise, review and make recommendations in relation to the development of the new suicide reduction strategy.
- Role of Chairperson:
    - To promote the aims of the group and facilitate the process of work.
    - To mediate differences of opinions.
    - To be cognisant of the various viewpoints of all those represented on the group and to allow for these to be equally expressed at meetings.
    - To represent and communicate the outputs of the group to senior stakeholders and external stakeholders where appropriate.
    - Should the Chair become unavailable for whatever reason, the Department of Health will request that a suitably qualified alternative member of the group take over as Chair.
- Role of Expert Advisory Group Members:
    - To collaborate, advise, review and make recommendations as appropriate in relation to the development and delivery of the new suicide reduction strategy.
    - To commit to objective and timely completion of deliverables.
    - To attend meetings and participate accordingly.
    - To contribute to the analysis and development of the work.
    - To critically review, analyse, and interpret drafts of the work.
    - To agree to be accountable for the work.
- Role of Secretariat:
    - To support the group to achieve their objectives.
    - To manage the process so that the work is coordinated and cohesive.
    - To manage internal DOH coordination in relation to the programme of work.

- To ensure senior decision makers have appropriate and timely outputs.
- To draft all outputs as directed by the Group as required.
- To provide administrative support including scheduling meetings, logistics support, minute taking and action tracking, circulating meeting materials.

Protocols

Should there be differences in opinion, or an inability for the group to come to a consensus, the Chair will seek to achieve a compromise position and/or the item will be remitted to a future meeting.

Remuneration, Travel and Subsistence

In accordance with the ‘One Person One Salary’ principle, there is no remuneration for the work of Expert Advisory Group members, efforts by members are greatly appreciated as valuable contributions to public service. Support in terms of travel and expenses is applicable in line with the most recent and relevant circulars. Please contact the secretariat if you require further details.

2. Lived Experience Reference Group TOR

Suicide Reduction Strategy
Lived Experience Reference Group:
Terms of Reference

Background

The Irish Government's approach to suicide prevention, intervention and postvention (support after a tragedy has occurred) is set out in the *Connecting for Life* policy. It provides a comprehensive plan, based on the best international evidence, for how we can reduce levels of suicide in our country. *Connecting for Life* was launched in 2015 and came to an end in 2024. *Connecting for Life* is currently being evaluated to assess how well the different parts of the plan have worked. At the same time, the Department of Health Mental Health Unit has begun working on a successor policy, which builds on the successes of the current one and takes account of new evidence. This policy is due to be completed by the end of 2025. The new policy will set out Government's approach to suicide reduction from 2026 onwards.

A public consultation process to inform the development of the next suicide reduction strategy was launched at the start of March and concluded at the end of May. This process has included 1,890 submissions from members of the public, seven in-person/online sessions with over 200 people and many more consultation meetings with specific interest groups. A thematic report from this process will be produced by the National Suicide Research Foundation. The next stage of the process is the establishment of an Expert Policy Advisory Group and a Lived Experience Reference Group to make recommendations for the next policy.

Role

The role of the Lived Experience Reference Group is to provide advice from a lived experience perspective to the Department of Health on the development of the new Suicide Reduction strategy. The Reference Group will run from August 2025 until March 2026 and will have at least eight members with a range of lived experience, including, experience of suicidal behaviour (i.e. thought about ending your life or attempted to do so), experience of suicide bereavement or experience of supporting a friend or family loved member through suicidal behaviour.

The Reference Group will be chaired by a facilitator with relevant expertise as well as lived experience of suicide. The Chair will also sit on the Expert Policy Advisory Group.

Specifically, the group will:

1. Review informing documents. Namely, evidence review, report on public consultation and key considerations document drafted by the Mental Strategy Health Unit.

2. Support the Expert Policy Advisory Group to produce a report for the Department of Health with recommendations for Ireland's next suicide reduction policy.

3. Advise on development of outcomes framework for new policy.

4. Support inter-agency/cross Departmental engagement.

5. Advise on the development of the final policy document and implementation plan.

Timeframe

The Lived Experience Reference Group will meet at least six times over the period August to March 2026, with more regular meetings between August and October, which is when the report with recommendations for the next policy will be developed. The timeframe is as follows:

- Chair and group members appointed: July 2025
- First meeting: 27 August 2025
- Subsequent meetings: 8 September 2025, 24 September 2025, 8 October 2025, 20 October 2025.
- Report to be sent to DoH: Mid-October 2025
- Group remains in place until March 2026 to provide advice on final policy development and implementation plan development

Secretariat

Secretarial support to the Group will be provided by the Department of Health Mental Health Strategy Unit.

Ways of Working

- Role of Chairperson:
    - To promote the aims of the group and facilitate the process of work.
    - To mediate differences of opinions.
    - To be cognisant of the various viewpoints of all those represented on the group and to allow for these to be equally expressed at meetings.
    - To represent and communicate the views of the group to the Expert Advisory Group.
    - Should the Chair become unavailable for whatever reason, the Department of Health will request that a suitably qualified alternative member of the group take over as Chair.

- Role of LERG members
    - To collaborate, advise, review and make recommendations as appropriate in relation to the development and delivery of the new suicide reduction strategy.
    - To commit to objective and timely completion of deliverables.
    - To attend meetings and participate accordingly.
    - To contribute to the analysis and development of the work.
    - To critically review, analyse, and interpret drafts of the work.
    - To communicate respectfully and engage with others' input in a considerate manner.

- Role of Secretariat:
    - To support the group to achieve their objectives.
    - To manage the process so that the work is coordinated and cohesive.
    - To manage internal DOH coordination in relation to the programme of work.

- To ensure senior decision makers have appropriate and timely outputs.
- To draft all outputs as directed by the Group as required.
- To provide administrative support including scheduling meetings, logistics support, minute taking and action tracking, circulating meeting materials.

Support for Members

The National Suicide Research Foundation (NSRF) will support the establishment and operation of the Reference Group, utilising the infrastructure of the NSRF Lived Experience Panel. All members of the Reference Group will be inducted using the structures and procedures of the NSRF Lived Experience Panel, including formalising the contribution agreement, confidentiality plans and safety and wellbeing plans, as well as briefing on the existing *Connecting for Life* policy and policy making process.

The NSRF will also provide support to the group during the lifetime of the group. This includes providing regular check-ins regarding experiences of participation and additional support needs. All members, including the chair, will have access to the NSRF's Employee Assistance Programme (EAP) for the duration of their participation in the project, and for up to six months after.