NSRF
National Suicide
Research Foundation

Findings from the Public Consultation Survey to Inform Ireland's New Suicide Reduction Strategy

Report prepared for the Department of Health
August, 2025

This research has been commissioned by the Department of Health to inform the development of Ireland's New Suicide Reduction Strategy.

This report was undertaken by Grace Cully, Eve Griffin, Leigh Huggard and Isabela Troya.

The Department of Health had no influence on analysis or reporting of findings. The assessment of the anonymous survey results, analysis and write up of the report were carried out independently by NSRF researchers.

We would like to thank all the individuals that responded to the consultation survey.

We are grateful to Sofia Bettella for contributing to the design and editing of the report.

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1. Executive summary

1.1 Context and aims

This report presents the findings of a survey from the Department of Health's public consultation on the development of Ireland's new suicide reduction strategy. It follows the country's second National Suicide Prevention Strategy, *Connecting for Life* (2015–2024), which succeeded Reach Out (2005–2014), Ireland's inaugural suicide prevention strategy.

On 5th of March 2025, Minister for Mental Health Mary Butler TD launched a public consultation to support the development of Ireland's new suicide reduction strategy. The consultation aimed to gather input from individuals, communities, and organisations on progress made so far in suicide prevention and their priorities for the upcoming strategy. Special emphasis was placed on hearing from those with lived experience of suicide. Information was gathered via an online survey, open to all members of the public and organisations.

To support the development of Ireland's new suicide reduction strategy, the Department of Health commissioned the National Suicide Research Foundation (NSRF) to analyse and summarise the findings from the public consultation survey.

Separately, there were a) standalone submissions (n=25) received from individuals and organisations who wished to provide further information on the public consultation, and b) online and in-person workshops with organisations, relevant professionals and individuals with lived experience. These are summarised in two separate reports: a) NSRF report "Synthesis of Public Consultation Submissions to Inform Ireland's New Suicide Reduction Strategy", b) Crowe report "Findings from Public Consultation Events to Inform the New Suicide Reduction Strategy".

1.2 Key findings

In total, 1,895 individuals responded to the online survey. The majority of those that responded to the survey reported lived experience of suicide[1] (82%), most commonly being bereaved or impacted by suicide (68%).

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[1] Lived experience of suicide is defined in accordance with the International Association for Suicide Prevention as *having experienced suicidal thoughts, made a suicide attempt, cared for a loved one through suicidal crisis or been bereaved through suicide*. https://www.iasp.info/wp-content/uploads/Lived-Experience-Outreach-Brief-WSPD.pdf

Respondents represented all 26 counties in the Republic of Ireland. Individuals responding on behalf of an organisation represented 17% of responses, with the majority representing community, voluntary and advocacy sectors.

There was strong support for national policy to reduce suicide, with 85% of survey respondents stating they believe suicide reduction policy should be prioritised to a great extent. Survey respondents were asked to provide their perspectives on areas to prioritise for suicide reduction for the coming years. Improved access, consistency and integration of services was most ranked as the most important (33%), followed by safe and high-quality services (21%).

The last question of the survey was open-ended and analysed qualitatively. Five main themes were identified from this question, reflecting individuals' experience of suicide-related support and opportunities for improvement (see Figure 1). Several of these themes were in line with the existing strategic goals of the current national suicide prevention strategy, *Connecting for Life* (2015-2024).

Figure 1. Central themes reflecting experiences of suicide-related support opportunities for improvement derived from Question 13.

1.2.1 Ensuring accessible and high quality services

Survey respondents emphasised the importance of having accessible quality services for people experiencing mental health or suicidal crises. Reported issues raised included inadequate risk assessments, lack of timeliness in the provision of care, poor continuity of care, cost-related barriers, inadequate resourcing, accessibility, and more.

1.2.2 Enhancing care systems

The existing structure and orientation of mental health services were reported to require improvement and restructuring. Respondents frequently noted overly medicalised approaches to care, lack of alternatives to hospital emergency departments for mental health and suicide crises, lack of integration between services, lack of clear referral pathways, and lack of lived experience input in service design.

1.2.3 Targeted interventions and support

Survey respondents reported the need for targeted interventions and support for groups at heightened risk of suicide. These groups included individuals with comorbidities, substance misuse, neurodiverse individuals, young people, men, Irish Travellers, members of the LGBTIQ+ community, people living with disabilities, refugees, migrants, and family members of individuals experiencing mental health/suicidal crises. There was also a strong emphasis on the need for greater support for individuals bereaved by suicide. Although groups known to be at elevated risk of suicide, they were frequently reported as facing greater barriers to accessing mental health services. In particular, respondents noted a critical absence of specialised support, leading to inadequate access to tailored suicide prevention efforts.

1.2.4 Education and stigma reduction

Public awareness of suicide and mental health was identified as needing further attention as a step towards stigma reduction. Respondents noted stigma is a prevalent societal issue which acts as a barrier to help-seeking, being more pervasive amongst certain sociodemographic groups such as men, Irish Travellers, and in rural communities. The need for national- and local-level awareness campaigns was identified as one way to address this issue.

1.2.5 Addressing social determinants in suicide prevention

Respondents frequently emphasised that effective suicide prevention must address the social determinants of mental health and suicide. They noted that lasting progress depends not only on accessible, high-quality care but also on tackling these underlying social factors. Some of the factors reported were macro-level social issues such as housing, economic instability and social inequalities, while community and individual-level social determinants such as abuse, bullying, social media, usage and more were also reported.

Abbreviations

ADHD: Attention Deficit Hyperactivity Disorder

CAHMS: Child and Adolescent Mental Health Services

ED: Emergency Department

CFL: Connecting for Life

DOH: Department of Health

GP: General Practitioner

HSE: Health Services Executive

LE: Lived /Living Experience

LGBTQ+: Lesbian, Gay, Bisexual, Transgender, and Queer

NOSP: National Office for Suicide Prevention

NSRF: National Suicide Research Foundation

SCAN: Suicide Crisis Assessment Nurse

TD: Teachta Dála

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2. Methodology

2.1 Structure of the public consultation process

The public consultation survey on suicide reduction in Ireland was developed by the Department of Health in consultation with the NSRF and reviewed by two members of the NSRF's Lived Experience Panel. The Department of Health opened the anonymous online survey for six weeks, from March 5 to April 18, 2025. Members of the public, groups, and organisations were invited to share feedback, experiences, and evidence relating to suicide reduction in Ireland, with the purpose of informing the new strategy. The anonymous survey was conducted online, using EUSurvey.

Survey questions

The survey included 13 questions with a mix of multiple choice, Likert-type, and open-ended questions (see Appendix 1). The survey included demographic, experiential, and opinion-based questions focused on suicide prevention, lived experience, service access, and priorities for national policy planning. The last question (Q13) was open-ended, relating to the experience of suicide-related support and opportunities for improvement. At the end of the survey, respondents were asked to leave their contact details if they wished to be invited to take part in the online or in-person consultation which are presented in a separate report prepared which are summarised in the Crowe report "Findings from Public Consultation Events to Inform the New Suicide Reduction Strategy". Standalone submissions (n=25) to complement the public consultation survey were also received from individuals and organisations who wished to provide further information on the public consultation which are not presented in this report and are summarised in the National Suicide Research Foundation report “Synthesis of Public Consultation Submissions to Inform Ireland’s New Suicide Reduction Strategy".

Lived Experience

In this report, we defined Lived Experience of suicide in accordance with the International Association for Suicide Prevention as “having experienced suicidal thoughts, made a suicide attempt, cared for a loved one through suicidal crisis or been bereaved through suicide”. Three, not mutually exclusive options of Lived Experience were provided in the survey:

- Personal lived experience of self-harm or thoughts of suicide
- Lived experience supporting a loved one with self-harm or thoughts of suicide
- Bereaved or impacted by suicide.

2.2 Data analysis

Survey responses were gathered by staff members of the Mental Health Unit in the Department of Health and were subsequently shared with the research team in the NSRF. Quantitative data were analysed using Stata and descriptive statistics were presented graphically and in text. Approximately 16% of respondents did not complete the sociodemographic information but did provide their perspectives on suicide reduction in Ireland. All responses were included in the analyses and results are presented based on available data for each variable. The survey collected professional role and organisation in open text format. Content analysis was performed in Microsoft Excel on responses to these items to develop groupings of professions and organisation type. Canva and SAGA GIS software were used to develop graphics. NVivo 14 was used to manage qualitative data (Q13).

Section five of this report presents the demographic and experiential characteristics of survey respondents in frequency format, from a combination of close-ended and open text questions (Q1-8).

Section six presents respondents' attitudes and familiarity with suicide reduction policy. A mixed-methods approach was used in the reporting of this section, where quantitative closed-ended questions (Q9-12) are supplemented with quotes captured by the Q13 open-ended question, with the purpose of further contextualising these responses.

Section seven presents the themes which were generated from survey answers to the single open-ended question (Q13). The six steps of thematic analysis were followed, involving (1) familiarisation with the data by reading all transcripts, (2) development of initial codes, and (3) collation of codes into themes. Finally, (4) themes were reviewed for internal consistency and against the original data before they (5) were finalised and named for (6) writing of the report. All qualitative data were coded by Leigh Huggard (LH). Isabela Troya (IT) independently coded 12% of the qualitative survey data (approximately 232 responses). IT and LH compared their coding, and no major differences were identified. IT and Grace Cully (GC) reviewed the content of all themes, and the three researchers collaboratively named the final themes and prepared summaries. A final researcher, Eve Griffin (EG), reviewed the theme summaries to ensure analytic rigour, consistency, and clarity in interpretation.

3. Characteristics of survey respondents

In total, **1,895 individuals** participated in the survey. More than two-thirds of respondents were women (70%), 28% were men, 1% were non-binary and a further 1% identified as other gender or did not want to disclose their gender.

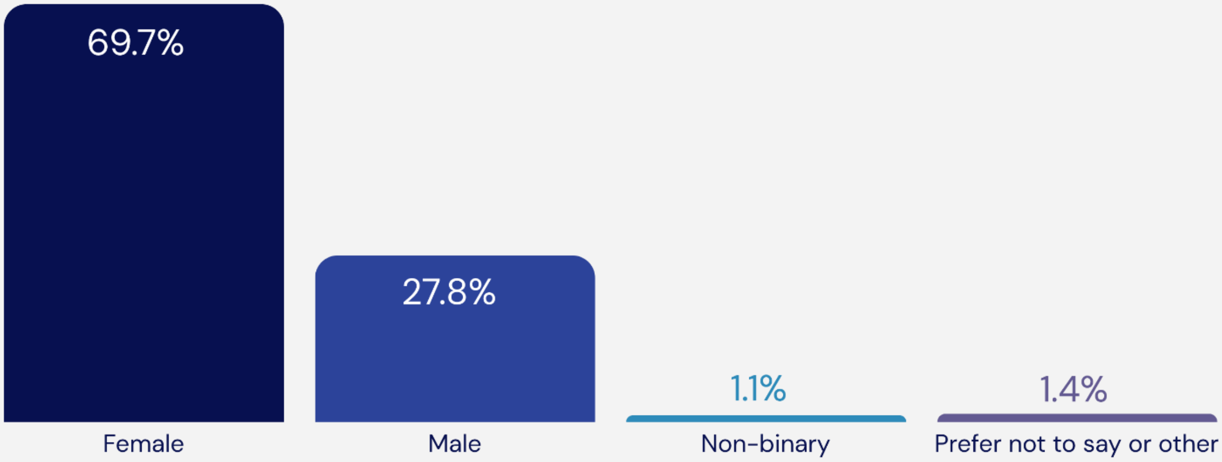

Figure 2. Gender of survey respondents (N=1,619)

The age of respondents ranged from under 18 years of age to over 80 years. Over half of the respondents (55%) were aged between 40 and 59 years.

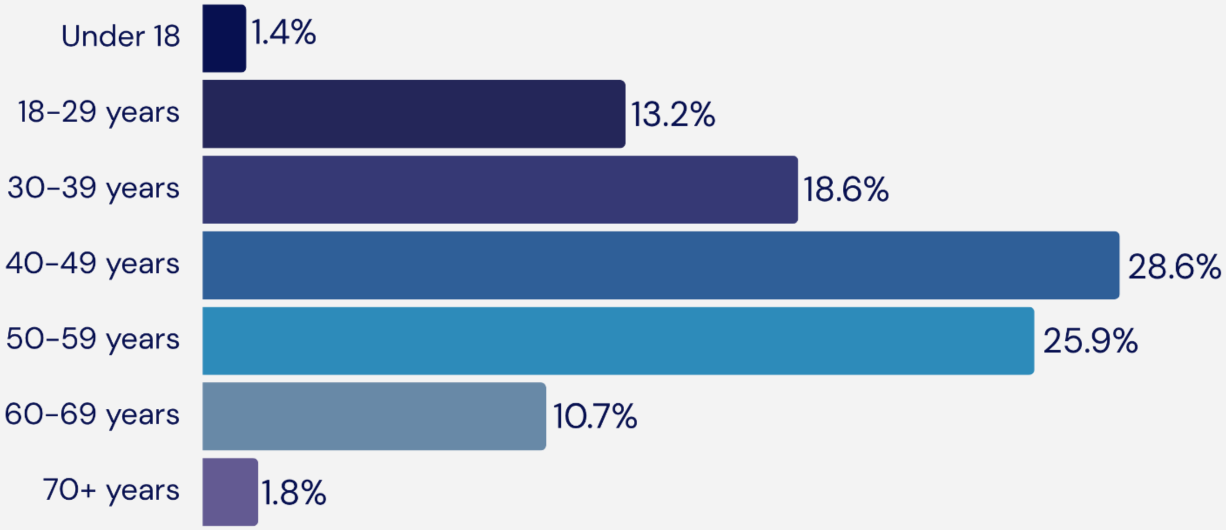

Figure 3. Age of survey respondents (N=1,617)

A total of 1,617 respondents provided information on their ethnicity. Most respondents reported their ethnicity as White Irish (90%), while 5% were from a white background other than Irish, and 1% of respondents identified as (Irish) Asian. Fewer than 1% of respondents reported other ethnicities, including mixed background, (Irish) Black, Irish Traveller, and Roma.

There was participation from residents in all counties across Ireland. The most common area of residence was Dublin (28%), followed by Cork (9%) and Galway (6%). A minority were residing outside of Ireland (1%), including Northern Ireland as the survey was not restricted to Irish residents, in recognition of the potential interest and relevant lived experience among individuals in Northern Ireland and the Irish diaspora.

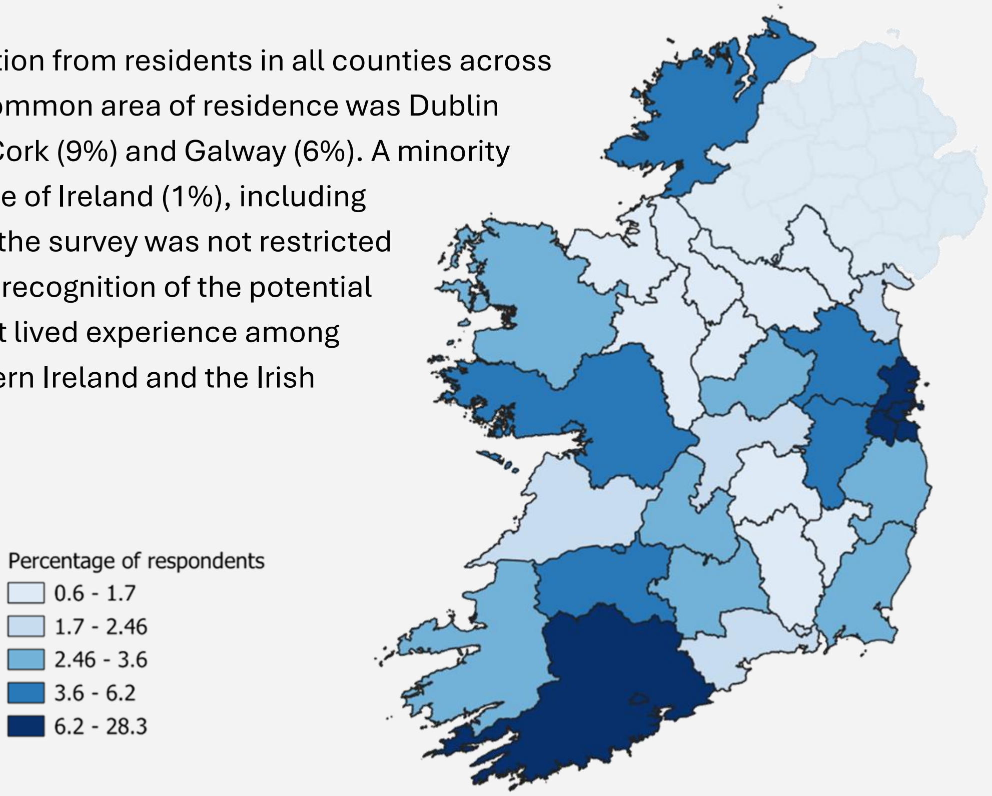

Figure 4. Percentage of respondents represented according to county of residence (N=1,623)

Four in five respondents (84%) reported lived experience of suicide. Of these, 68% had been bereaved or impacted by suicide, while 28% reported having personal experience of self-harm or thoughts of suicide and 27% reported experience supporting a loved one. Of those reporting lived experience, most (62%) reported one of these types of experiences, while 24% reported two types and 14% reported all three.

84%
n=1,592

Reported lived experience of suicide

Figure 5. Nature of lived experience of suicide (N=1,592)

Respondents most commonly reported that they completed the survey on their own behalf (82%), rather than on behalf of an organisation (17%), while a minority indicated that they provided both their personal and organisational perspectives (1%). Of those who were responding on behalf of their organisation, more than half were based in community, voluntary or advocacy organisations (55%), almost one-quarter represented health services or associated professional bodies (23%), 12% were based in education and research settings, and a final 10% represented other statutory bodies which did not include health services.

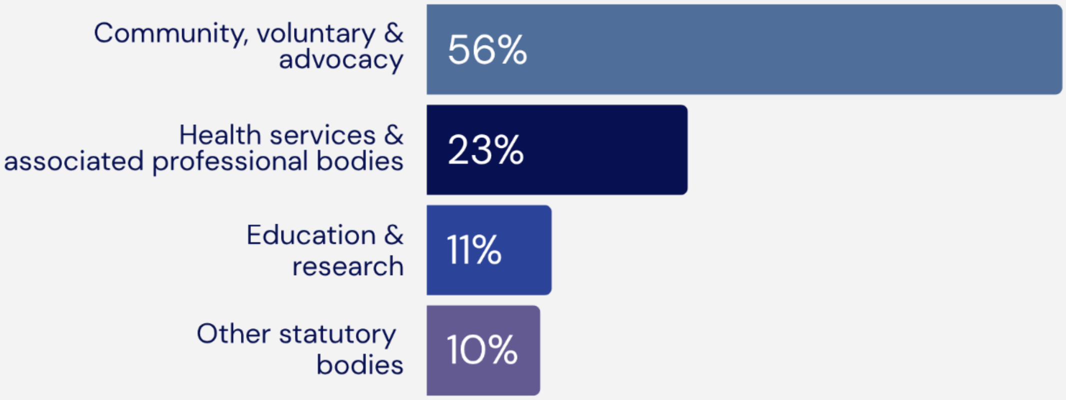

Figure 6. Organisations represented among those responding on behalf of an organisation (N=322)

Most respondents indicated that suicide prevention was relevant to their professional role, with 66% reporting that it was either somewhat or of great relevance to their role. An additional 18% stated it was slightly relevant to their role, while 14% reported no relevance. Among those who indicated a strong degree of relevance (somewhat or to a great extent), the largest group were mental health professionals (30%), followed by professionals in social care, community / youth / suicide prevention services (20%). This was followed by healthcare professionals (15%), educators and researchers (15%), individuals in administrative and managerial roles (12%), Members of An Garda Síochána and first responders (4%), and students (4%).

Figure 7. Professions of respondents who reported at least some degree of professional relevance of suicide prevention to their role (N=722)

4. Perspectives on suicide reduction in Ireland

The following section summarises responses to the final questions of the survey, which focused on perspectives regarding suicide reduction policy in Ireland. These questions explored respondents' attitudes and familiarity with suicide prevention, as well as their perspectives on suicide prevention activities to date, and on priority areas for future suicide reduction policy through multiple-choice and ranking formats.

4.1 Attitudes and familiarity with suicide reduction policy

In response to the question "how much of a priority is a suicide reduction policy?", almost three in four respondents reported *to a great extent* (72%), with 7% reporting that is a priority *to some extent*, and 5% responding *very little* or *not at all*, and the remainder of individuals indicated that they were not sure (16%).

Whilst more than one-third of respondents were familiar with *Connecting for Life*, Ireland's current national suicide reduction strategy (36%), the majority were not aware of the strategy (63%) out of a total of 1,880 respondents.

4.2 Suicide prevention activities to date

Respondents were asked to reflect on the extent to which suicide prevention has been addressed by recent and current policy and resources in Ireland. More than one-third (36%) indicated to *some* or *a great extent*, while 58% responded *very little* or *not at all*, and the remaining 6% were unsure.

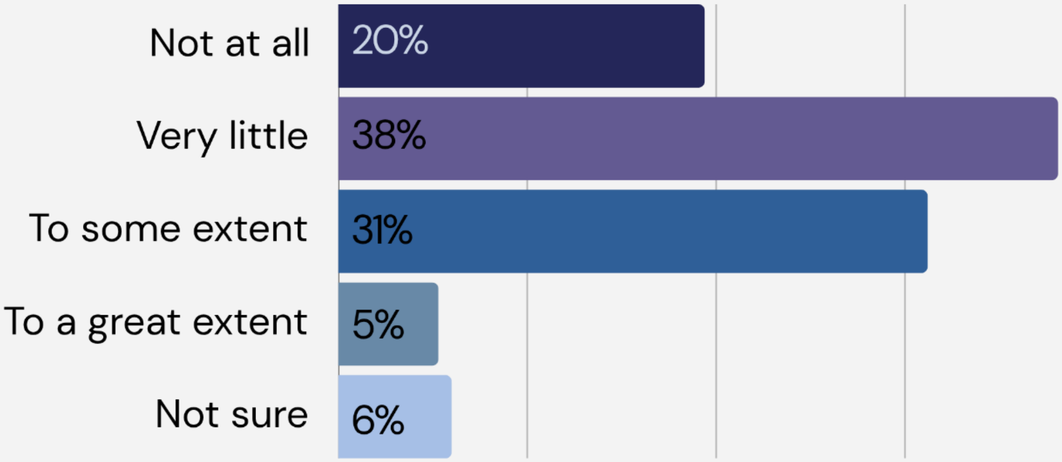

Figure 8. How much of a priority is a suicide reduction policy? (N=1,883)

4.3 Priority areas for future suicide reduction policy

Respondents were asked to provide their perspectives on areas to prioritise for suicide reduction for the coming years. These areas reflected the seven goals of *Connecting for Life*. Of those who ranked the areas from one to seven (n= 1,542), *Improved access, consistency and integration of services* was most frequently ranked as the most important (33%), followed by *safe and high-quality services* (21%), and *targeted approaches for those vulnerable to suicide* (16%), *better understanding of suicidal behaviour* (14%), *supporting communities to prevent and respond to suicide behaviour* (11%), *better data and research* (3%) and *reduce access to means* (3%). This prioritisation is in line with the open text responses (Q13), in which many respondents frequently reflected an urgent need for improved access to mental healthcare.

> ***"I believe prevention is the best path. I think there is already an understanding of the causes that lead to suicide at some levels, but the causes are not sufficiently attended to. I think that mental health needs to be a priority in policy making."***

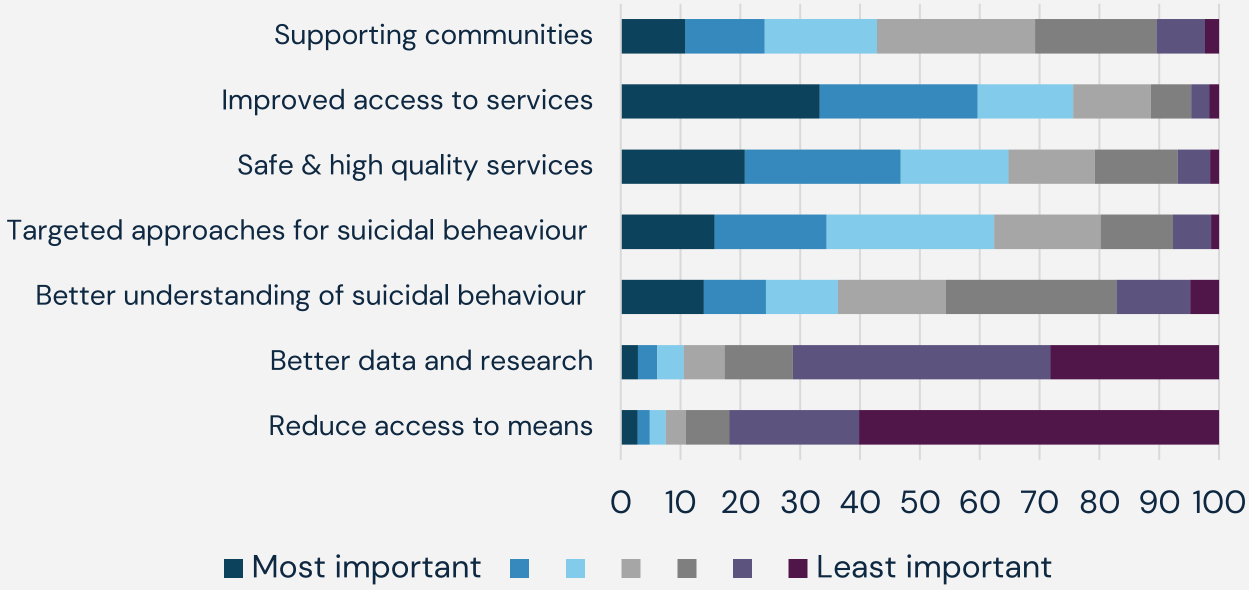

Figure 9. What are the most important priorities for suicide reduction? (N=1,542)

Some respondents specifically commented on the challenge of ranking the relative importance of the priorities, noting that areas related to the immediate provision of support or intervention for individuals vulnerable to suicide had to be ranked as most important due to the urgency of the current situation, but that this did not diminish the importance of other priorities with less of an immediate impact, such as better data and research.

> ***"The above ranking is very difficult for example – Data and research is essential but so also is the prevention and response and this being resourced. Better understanding of the causes is paramount as we will keep getting it wrong if we do not understand the root cause."***

5. Experience of suicide-related support and opportunities for improvement

The final part of this report presents insights into experiences of suicide-related support and suggestions for improvement, drawn from the last open-ended survey question: “The Department of Health really wants to hear from people with lived experience of suicide. Have you had an experience where you think things could have been better?”.

Responses to this question were independently reviewed to extract key themes and insights. This analysis resulted in the identification of five central themes that are summarised in Figure 1.

Figure 1. Central themes reflecting experiences of suicide-related support opportunities for improvement derived from Question 13

1. Ensuring accessible high quality care

Survey respondents emphasised the need for improved accessibility and quality of services for people experiencing mental health or suicidal crises. Concerns raised included inadequate risk assessments, lack of timeliness, poor continuity of care, cost-related barriers, inadequate resourcing, accessibility, and more.

> ***"It is incredibly difficult to access high quality resources when in crisis and at risk of suicide. I had a friend who was turned away at a hospital when they were suicidal, and myself and a relative of mine were waiting months for help with our mental health difficulties in the public system before having to fork out money to get private healthcare. The public mental health unit in my area was at capacity and couldn't take my referral…"***

Many respondents felt that there was a lack of adequate risk assessments being undertaken by professionals, and people with lived experience commonly reported that they or their family members were "*dismissed*" and not taken seriously when in crisis. Respondents also called for more compassionate approaches to care, through a "*trauma-informed and person-centred*" lens. A common suggestion to address this issue was to ensure all relevant healthcare professionals undergo appropriate training to improve crisis recognition and facilitate safer, more accessible, quality care. The importance of cultural awareness training, particularly for at-risk groups such as Travellers, was also reported by several organisations. Another suggestion was to increase family involvement in care, particularly for individuals with complex needs.

> ***"From my experience in my work, so many students are turned down by organisations because they don't meet the threshold of acting on suicidal thoughts rather than taking them into the service because they have suicidal thoughts."***

The sentiment that *"people are only given support when it's too late"* was frequently mentioned. Respondents felt that early intervention should be prioritised, and that there was a lack of accessible care for those without a diagnosis or not yet in crisis. The need for greater continuity of care, post-crisis support, and frequent check-ins were also identified.

Appropriate care options following primary care and emergency department presentations were viewed as lacking.

> ***"Follow-up care after a crisis remains inconsistent. Post-crisis care must be a priority, including rapid referrals & clear pathways."***

Respondents felt that there wasn't enough resourcing being designated to mental health services. In particular, there were calls for greater funding to resource community-level care, multidisciplinary care, counselling, availability of inpatient beds, and child and adolescent mental health services (CAMHS) and other services targeting individuals aged under 18 years. In addition to state health services, charities and voluntary organisations providing care were described as under-resourced, leading to long waiting lists and limited counselling sessions. A lack of adequate staffing across services was also identified as a significant issue, leading to staff burnout, blame culture, and retention issues.

> ***"A majority of services are overwhelmed under funded in regards to mental health support. These delays in waiting lists mean people aren't getting the help when they need to."***

Respondents commonly described existing services as inaccessible. Cost barriers, particularly a lack of access to affordable counselling, were identified as a notable issue. Moreover, individuals that disclosed living in rural areas expressed particular difficulty in accessing services, reporting frustration with inconsistencies in service provision across the county. Overall, there was a call for more equitable access to care for all members of society.

> ***"It should not be the case that only those who can afford to pay get quality care."***

2. Enhancing care systems

In addition to a need for more accessible, high-quality services, respondents identified several issues with the structure and orientation of existing services. Survey respondents specifically reported concerns with current overly medicalised approaches to care, lack of alternatives to emergency services for mental health and suicide crises, lack of integration between services, lack of clear referral pathways, and lack of lived experience input in service design.

Respondents noted that existing approaches to mental healthcare rely on a medical model, characterised by an overreliance on medication and lack of adequate therapeutic or holistic approaches to care. Respondents advocated for greater provision of talking therapies, trauma-informed care, occupational therapy, peer support programmes, and integrative multidisciplinary approaches.

> ***"HSE adult mental health services are overly medicalised, staff in the teams are often focused on medicating 'biological illness' and are devoted to this aim. However, they fail to adopt more effective and evidence based approaches to mental health care."***

The emergency department (ED) was frequently identified as an unsuitable place to present with a mental health or suicidal crisis. The need for a targeted out-of-hours crisis service was commonly identified, and respondents noted that understaffing, limited availably of mental health professionals, and lack of access to mental health beds make the ED an unsuitable environment for those without coexisting medical needs.

> ***"The system is on its knees in ED … We cannot continue to work in the current system. I do not think the solution lies in ED – it lies it alternate pathways that avoid ED to be made available for those with no coexisting medical needs."***

Respondents pointed to the necessity for greater integration and collaboration between existing services, often perceiving current services as being "*disjointed*". Several noted a particular lack of integration between crisis services and community-based aftercare. Respondents reported the need for greater overall provision of community care, and clearer, more appropriate referral pathways. Others suggested that counselling sessions and other services provided by charities and voluntary organisations should be incorporated as part of the public health system.

> ***"Services across the statutory and non-statutory sector are fragmented and service users are falling through the gaps with no clear referral process or handover between services. We need better integration and collaboration across the sector led by a single authority in suicide reduction. As the HSE is undergoing significant restructuring, this is a unique opportunity to develop and implement suicide service reform."***

The importance of including the voices of individuals with lived experience in service and policy design was also noted. Respondents reflected that given the unique insights that come from lived experience, services should be tailed to meet the needs and challenges of those they aim to support.

> ***"Individuals who have walked the path of mental health challenges, survivors of a suicide loss, or attempted suicide, must not only be heard, but meaningfully included in the design, delivery, and evaluation of services and policies."***

Respondents also acknowledged the success of many existing services and reported the importance of further expansion and roll-out of these services. Notable examples included clinical programmes, Suicide Crisis Assessment Nurse (SCAN) service, community support cafes, and home-based treatment teams.

> ***"The SCAN service is exceptional and we would hope this could be continued and even developed further. We would love to see the potential for direct referral into the SCAN service from recognised (approved) community & voluntary organisations."***

3. Targeted interventions and support

Survey respondents identified the need for targeted interventions and support for a range of groups at greater risk of suicide. The importance of ensuring equitable access to care for all members of society – regardless of their co-existing needs or sociodemographic background – was also emphasised.

Despite being considered at higher risk of suicide, clinical groups and individuals with comorbidities and substance use frequently reported being excluded from mental health services. Respondents identified a lack of designated support for these issues, leaving an absence of accessible and targeted suicide prevention strategies.

> ***“There is a huge issue with how drug and alcohol use is treated in suicide prevention. Too often, people are turned away from crisis services because of co-occurring substance use, even though it's a key risk factor for suicide. SCAN (Suicide Crisis Assessment Nurses) teams and dual diagnosis supports need to be standard. Complexity should never be a barrier to care.”***

There was also an identified lack of awareness and tailored care for neurodiverse individuals, with many reporting a lack of services equipped to address issues associated with autism, ADHD, and other types of neurodiversity.

> ***“In my clinical role I experienced first hand the way in which neurodiverse individuals often received a service that was not tailored to their needs and in some cases exacerbated the distress they were experiencing.”***

A wide array of other at-risk groups requiring targeted supports were identified, with commonly mentioned groups including young people, men, Irish Travellers, members of the LGBTIQ+ community, people living with disabilities, and family members of individuals experiencing mental health/suicidal crises. A frequent suggestion was the development of services tailored to members of these groups – for instance, implementing school-based counselling for young people, and targeted community-based supports.

> ***“Targeted, evidence-based mental health supports for high-risk groups including Travellers, LGBTQ+, refugees, older adults, and people living with disabilities. These groups face unique challenges. Services should reflect the diversity of communities, in who they serve and who they employ. Culturally competent, inclusive staffing is key to building trust and engagement.”***

There was a strong emphasis on the need for greater support for individuals bereaved by suicide, who were also identified as an at-risk group. Respondents noted a lack of postvention, and bereavement supports. Automatic signposting for bereaved individuals was frequently suggested.

> ***“Suicide grief is unique, complex and non-linear. Services to support those who have been bereaved by suicide are limited due to severe under-funding. Resources such as Safe Harbour were particularly welcomed, and continued investment in resources and services […] and support groups is needed.”***

4. Education and stigma reduction

Respondents emphasised the need for greater public awareness of suicide and mental health. They emphasised the importance of stigma reduction, and people with lived experience noted that stigma is still a prevalent societal issue and major barrier to help-seeking. Some noted that stigma was particularly pervasive for certain sociodemographic groups, such as amongst men, Travellers, and in rural communities. Respondents called for the development and expansion of year-round anti-stigma and awareness campaigns, both at national and local level.

> ***"There is also a need for a targeted, compassionate national campaign to reduce stigma. Stigma, shame, and silence are still huge barriers to people seeking help or even naming their pain. The campaign must be informed by those with lived experience and must address the different ways stigma manifests—across age, gender, culture, and geography."***

Another common suggestion was the implementation of training and educational courses for schools, workplaces, and communities. In addition to raising awareness and reducing the stigma associated with mental health and suicidal ideation, respondents suggested that these courses should aim to equip individuals with skills to improve mental health, wellbeing, and resilience.

> ***"It's clear to me now that suicide prevention and mental health education should be integrated into schools, starting from a young age. This early intervention could have equipped me with the tools to understand my emotions, cope with grief, and reach out for help, rather than resorting to self-destructive behaviours …. These topics should be introduced in an age-appropriate way so that children can develop a healthy understanding of their emotions and how to manage them. Primary school is the time when children begin to form a foundational understanding of the world around them, including their emotional health. If we can normalize discussions about mental health at this stage, we can create a culture where children feel empowered to express their emotions and seek help without fear of judgment."***

Emphasis was also placed on the value of peer support networks and other community activities in bringing people together to promote awareness, reduce stigma, and create *"environments where people can find connection, purpose, and understanding"*. In addition to resourcing new initiatives, such as walking clubs and community coffee mornings, further roll-out of existing initiatives such as men's sheds, crisis cafes, and local peer networks were commonly suggested.

> ***"I would like to see an emphasis placed on emotionally supportive centres – for example social clubs, community workers, drop in and outreach centres – I think it would be very beneficial for people to feel a part of a 'family' in a community sense rather than a literal sense. I think the community might help educate and support each other in emotional regulations and processing styles."***

Lastly, respondents reported the potential value of implementing awareness training and support for a range of professionals likely to encounter people with suicidal ideation or bereaved family members, such as healthcare professionals, Members of An Garda Síochána, first responders, railway workers, prison staff, and teachers. Suggested topics for training courses included mental health first aid, sensitivity training, crisis response, and awareness. The importance of cultural awareness training for at-risk groups such as Travellers and Roma people was also reported. Further roll-out of existing courses related to suicide prevention was frequently suggested.

> ***"Guards need more training, not just learning about the mental health act. Many guards I have spoken to have told me that they don't know how to respond other than get the person to hospital for assessment. [Self-harm training] should be mandatory training for the gardai."***

5. Addressing social determinants in suicide prevention

Survey participants emphasised that effective suicide prevention efforts must address the social determinants of mental health and suicide, noting that lasting progress requires tackling these underlying social factors in addition to ensuring accessible, high-quality care.

> ***"Factors like poverty, unemployment, discrimination, lack of access to education and housing, and social isolation create systemic stressors that erode resilience and exacerbate mental health challenges. By understanding and addressing these underlying social inequities, Ireland can develop more comprehensive and impactful prevention actions in our next suicide prevention/reduction strategy that target the root causes of despair, build stronger community support systems, and ultimately reduce the incidence of suicide."***

Macro-level social issues such as lack of housing, economic instability, and social inequalities were commonly mentioned by respondents, with many calling for the implementation of governmental policies to address these issues.

> ***"Concern that society is evolving in ways that increase suicidality, particularly among younger people and vulnerable populations. Economic insecurity, housing instability, climate anxiety, and harmful social media content are compounding mental distress. The link between social determinants of health and suicide risk is well-established but not meaningfully addressed in policy or practice. Suicide prevention strategies need to take these wider factors into account—not just individual-level interventions."***

Others emphasised the importance of also addressing community- and individual-level social determinants, such as abuse, bullying, social media usage, and more.

> ***"Online bullying is a growing issue, especially among young people, and can be a trigger for suicidal distress. The new strategy must include strong protections, reporting mechanisms, and education around digital safety, online empathy, and support for those affected."***

6. Appendices

Appendix 1. Survey questions

1. **Are you responding to this survey on behalf of an organisation/group/network?**
   - yes
   - no

   If you answered Yes above, what is the name of the organisation/group/network?

   Response: open text

2. **How relevant is suicide prevention to your area of work?**
   - 1 = Not at all
   - 2 = Slightly
   - 3 = Somewhat
   - 4 = To a great extent
3. **What is your profession?**

   Response: open text

4. **Do you have lived experience of suicide?**

   - yes
   - no
5. **Gender**
   - Male
   - Female
   - Non-binary
   - Other
   - Prefer not to say

   If you responded 'Other' above , please specify here.
   Response: open text

6. Ethnicity

- White - Irish
- White - Irish Traveller
- Roma
- Any other White background
- Black or Black Irish - African
- Black or Black Irish - Any other Black background
- Asian or Asian Irish - Chinese
- Asian or Asian Irish - Indian/Pakistani/Bangladeshi
- Asian or Asian Irish - any other Asian background
- Arab
- Other including mixed background
- Prefer not to say

Q7. What is your age-group?

- Under 18
- 18-29 years
- 30-39 years
- 40-49 years
- 50-59 years
- 60-69 years
- 70-79 years
- 80+ years

Q8. Where do you live?

- Carlow
- Cavan
- Clare
- Cork
- Donegal
- Dublin
- Galway
- Kerry
- Kildare
- Kilkenny
- Laois
- Leitrim
- Limerick
- Longford
- Louth
- Mayo
- Meath
- Monaghan
- Offaly
- Roscommon
- Sligo
- Tipperary
- Waterford
- Westmeath
- Wexford
- Wicklow
- Northern Ireland
- Outside of Ireland

Q9. Have you heard of Connecting for Life, Ireland's current national suicide reduction strategy?

- Yes
- No

Q10. How much of a priority is a suicide reduction policy?

- 1 = Not at all
- 2 = Very little
- 3 = To some extent
- 4 = To a great extent
- 5 = Not sure

Q11. How well do you think suicide prevention has been addressed by recent and current policy and resources in Ireland?

- 1 = Not at all
- 2 = Very little
- 3 = To some extent
- 4 = To a great extent
- 5 = Not sure

Q12. In your opinion, what are the most important priorities for suicide reduction for the coming years (please assign a number ranking to each item, with 1 = most important and 7 = least important)

	Ranking order
Better understanding of the causes and nature of suicidal behaviour.	
Supporting communities to prevent and respond to suicidal behaviour.	
Targeted approaches for those vulnerable to suicide.	
Improved access, consistency and integration of services.	
Safe and high-quality services.	
Reduce access to means of suicide (this can include greater control over access to	
medications/drugs/firearms).	
Better data and research.	

Q13. The Department of Health really wants to hear from people with lived experience of suicide. Have you had an experience where you think things could have been better?

Response: open text