Collaborative Working in Suicide Prevention: An Exploration of the Relationships between the Community, Voluntary and Statutory Sectors on the Process of Developing Suicide Prevention Policy in Ireland

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Breda Friel   **October 2018**

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Abbreviations

ASIST - Applied Suicide Intervention Skills Training

CAMH – Children and Adolescent Mental Health

CMHS – Community Mental Health Services

CHO – Community Healthcare Organisations

CSO – Central Statistics Office

C&V – Community and Voluntary

DOH – Department of Health

EU – European Union

HRB – Health Review Board

HSE – Health Service Executive

IAS – Irish Association of Suicidology

IASP – International Association for Suicide Prevention

MHFA - Mental Health First Aid

MHS – Mental Health Service

NAASP – National Action Alliance for Suicide Prevention (USA)

NESC – National Economic and Social Council

NOSP- National Office for Suicide prevention

NSRF- National Suicide Research Foundation

ROI – Republic of Ireland

PSNI – Police Service of Northern Ireland

RQIA - Regulation and Quality Improvement Authority (NI)

TD – Teachta Dála (member of Dáil Éireann, lower house of Irish Parliament)

UN – United Nations

WHO – World Health Organisation

Summary

Substantive changes have occurred to the cross-sectoral consultative process in suicide prevention policy planning in Ireland (1998-2015). Findings from interview and document analysis reveal that despite improvements, there remains a need for clearly defined, transparent cross-sectoral partnership in planning suicide prevention strategy. Findings reveal that the structure and systems in which the development of strategy takes place has a significant effect on the ability of stakeholders to impact policy change. It is also evident that successful implementation of strategy requires continuous evaluation of progress, in order to inform future strategy. Improved engagement methods, alongside rolling review, can offer a more robust, distinct and well-defined method for effective cross-sectoral participation.

The findings corroborate theoretical considerations, including the need to consider the range of policy actors in the process (Buse et al, 2005), the importance of policy context and political factors including boundaries and the impact on participation in policy planning (Keck and Sikkink, 1998). The study identified the characteristics and distinctiveness of the sectors in suicide prevention, considering power, parity of esteem and impact on the policy process. The study makes a number of recommendations, the need for a whole of Oireachtas approach to strategy planning, implementing and reviewing strategy, the importance of reviewing funding structures and procedures associated with commissioning of C&V organisations to deliver actions contained in strategy. Additional themes emerged in the study, including the potential of benefit from the development of cross-department linkages promoting suicide prevention as a priority agenda item. Improved cross-departmental communication would reduce the separateness and culture of silos between Government departments and statutory agencies. The study also reveals issues about independence, representativeness, gatekeeping and advocacy by elite groups in the C&V sector and how this impacts the process of developing and implementing suicide prevention strategy in Ireland.

Chapter 1: Suicide in Ireland

Introducing the Study

Suicide has a traumatic impact on individuals, families and communities in Ireland, with recent data revealing 399 deaths by suicide in Ireland in 2016 (National Suicide Research Foundation). Whilst this rate is down on the high of 554 in 2011, it represents the tragic death of 318 males and 81 females, a profound loss for families and communities.   Preventing suicide in Ireland requires a robust, well managed and evidence based strategy. Implementation and delivery of actions to reduce suicide must represent a partnership approach and collaboration between all stakeholders. This study examines relationships between the community, voluntary and statutory sectors and how they impact the process of developing suicide prevention policy in Ireland. The study addresses a gap in the literature by focussing on suicide prevention policy process, investigating *who decides who decides* policy in Ireland?

Rationale for the study

The rationale and motivation for this study is informed by my experience as an academic, a psychotherapist, founder member and chair of a community based suicide prevention voluntary organisation in Donegal in the Republic of Ireland. As principal investigator I completed research examining the development of an accreditation model and set of standards for the C&V suicide prevention sector in Ireland (ROI). *"Quality Systems and Accreditation Standards for Voluntary Suicide Prevention Organisations in Ireland"* Friel &Gallagher (2013) was funded by the National Office for Suicide Prevention (NOSP) and commissioned by the Irish Association of Suicidology (IAS). The research articulated emerging themes associated with standards and accreditation in local, regional and national C&V suicide prevention organisations. Data revealed a number of areas for further study, including collaboration and partnership approaches to suicide prevention across sectors (statutory and voluntary), resource allocation and management of funding. Emerging themes also included cross-sectoral communication, strategic planning between the statutory and voluntary sector and need for clear data collection and statistic management measures to quantify the impact of services within and between both sectors**. C**ompleting the above research and the emergence of the aforementioned themes and questions about suicide prevention policy development and implementation resulted in the development of the research questions for this study. It prompted a reflection on the working relationships between the statutory and voluntary

sector in shaping suicide prevention strategy and if/how the relationships between the sectors impact on the suicide prevention policy process.

This study addresses a gap in the literature by focussing on suicide prevention policy process, investigating "*who decides, who decides*" policy in Ireland. It is particularly concerned with the relationship between community and voluntary sector (to be referred throughout the study as (C&V's) and statutory sectors in policy process and development, an area which has received little research attention to date in Ireland (ROI).

Aim of the Study

The aim of the study is to examine the extent to which relationships between the community, voluntary and statutory sectors impact the process of developing suicide prevention policy in Ireland. The discussion of the aim and objectives will be further developed in the methodology section (chapter 2) of this study

Philosophical Lens

The philosophical movement of post-structuralism emerged in the 1960s and 1970s (Woodward, Dixon, Jones, 2009) and challenged the precepts of structuralism, which had beforehand assumed authority and power over studies in the social sciences. The philosophical lens in this thesis situates at a boundary line, drawn between a style of work which affiliates to a post-structuralist, Foucauldian influence and the imbrication with a social constructivist approach. This assumes reality as socially constructed, based on social, historical and political processes and the study examines subjective experiences as perceived by respondents. Post-structuralists, as described by Woodward et-al (2009), offered a critique of structuralism in its reliance on centres and binary oppositions (2009). It re- examined epistemology and assumptions about how we know the world and the ontological theories or what the world consists of and how it works thereby challenging the dominant theoretical frameworks. In this study, the aim is to consider how the phenomena and process that dominate policy making is constructed and to challenge the epistemological and ontological assumptions therein. Post-structuralism established the occurrence of regimes of truth; it advanced another way of contemplating about themes that are the foundation to many studies in social sciences, including subjectivity, centre   and   margin and truth and fiction, or the taken for granted in policy making process, the subject matter of this study. In examining the

interplay of structural and opposing forces in the subject of the thesis and the complex context of suicide prevention policy process in Ireland, the approach is aimed at, not simply theorising, but critically reflecting on the social construction and meaning making in the phenomenon under scrutiny and emerging themes that may support action and change. Thus the study has an interest in themes, including subjectivity and power, informed by the work of Foucault, in policy making and informing proceedings and modification in prospective suicide prevention plans in Ireland. In regard to suicide prevention policy process the study is informed by the philosophical lens of post-structuralism thereby required to consider, as stated by Woodward, Dixon, Jones, (2009, p. 396) how "*social relations of power fix the meaning and significance of social practices, objects, and events, determining some to be self-evident, given, natural, and enduring*" in this instance linked to suicide prevention policy making in Ireland.

The context and practice of suicide prevention in Ireland has changed dramatically in the past 30 years. The sector is informed by national and international research and expertise and influenced by global developments and supranational influences such as the EU, WHO, and by changing social structures in Ireland. Suicide was decriminalised in 1993 and from that time there has developed a burgeoning community and voluntary (C&V) sector led by grassroots activism. The momentum this generated has irrevocably changed the delivery of services and development of policy to address suicide in Ireland, and with it, the relationship between C&V, government and statutory sectors working in this field.

This chapter outlines the setting for the study; reviewing data on rates and the reporting of suicide in Ireland, articulating the complexity of structures, and describing the characteristics and resourcing of the statutory and C&V suicide prevention sector. Using primary literature, reports and government documents and secondary data (Friel and Gallagher, 2013), the chapter outlines the context, informing and developing the study question raised in the introduction. This is further developed with an examination of organisational theory, power and the structures informing the development and implementation of strategy aimed at suicide prevention in Ireland.

Suicide in Ireland

The National Office of Suicide Prevention's (NOSP) definition of suicidal behaviour is 'the spectrum of activities related to suicide including suicidal thinking, self-harming behaviours not aimed at causing death and suicide attempts. The suicide rate in Ireland has increased steadily during the past twelve years, and in February 2014 the NOSP office stated that ten people die by suicide in Ireland every week. (Thejournal.ie. Feb 2014). The psychological, economic, sociological and contextual factors behind these statistics require examination in seeking an understanding and explanation of suicide in the country.

Suicide Statistics – Rates, Recording and Understanding

The collection and publication of data on suicide is the responsibility of the Central Statistics Office (CSO) and the figures are usually 1-2 years' retrospective in publication. Recent data indicates that there were 399 suicides registered in 2016, or 8.5 per 100,000. As can be seen from the table below this figure compares with 475 suicides registered in 2013 and the highest rate recorded in 2011 when there were 554 deaths from suicide in Ireland, 59 more than in 2010 and 2 more than in 2009. The previous highest number of deaths was in 2001 when there were 519 recorded suicides. The collecting and monitoring of data on death by suicide has been problematic in Ireland, with studies concluding that official suicide rates should be increased by a factor of three to arrive at a 'true' clinical rate on the 'balance of probabilities' under-reporting having resulted in a gap between the clinical, narrative and official rate (McCarthy and Walsh; Brugha and Walsh cited in Walsh, D 2008). In Ireland recorded data indicates that the most common methods of suicide in Ireland in 2011 included hanging, strangulation and suffocation (which accounted for 407 or 73.5% deaths), followed by drowning and submersion (46 or 8.3%) and self-poisoning (44 or 7.9%).

Gender Profile, Age Range and Standardisation

The data and statistical characteristics indicate particular features of suicide in Ireland. Articulating the demography of suicide is an important aspect of this study, increasing the understanding of trends among certain groups and populations. Improved awareness of the factors and trends informs approaches to suicide prevention. The evidence produced contributes to the development of strategy and the examination of

demographic trends support the development of targeted prevention and intervention activities for perceived at-risk groups, populations or geographic locations.

There is a distinct gender difference in statistics on suicide in Ireland. The data in 2015 indicates that there were 375 male suicides (approximately 83% of the total) compared with 76 female deaths by suicide. This appears to be a similar pattern to earlier years, and as an example in 2000 there were 395 male deaths from suicide in 2000 again representing over 81% of the total (486) of deaths by suicide. Standardising of the death rate from suicide in 2015 was 9.7 per 100,000. Previous data recorded 12.1 deaths per 100,000 in 2011, up from 10.9 in 2010. Male suicide rates were five times higher at 20.5 deaths per 100,000 compared with female suicide rate of 4.0 in 2011. In 2010, the rates were 20.5 for males and 4.1 for females. It is noted by CSO that in the years from 2000 to 2011, rates were generally between 4 to 5 times higher for men than for women.

When the age grouping profile of suicide data from 2011 is examined it indicates that male suicide rates were highest in the 45-64 age-group (28 per 100,000) while women were highest in the 25-44 age-group (almost 7 per 100,000) with the number of deaths from self-harm decreasing after the age of 44. Data reveals that Ireland has the 17th highest overall suicide rate in the 27 countries of the EU and the 4th highest in 15–24-year-old males according to Murphy, Kelleher and Malone (2014), who examined data derived from the World Health Organisation (2012).

Death by Suicide 2001 – 2016 (ROI)

Table 1.1 Death rates by Suicide in Ireland (2001 – 2016)

Year	Total		Male		Female	
	No.	Rate per 100,000	No.	Rate per 100,000	No.	Rate per 100,000
2001	519	13.5	429	22.4	90	4.7
2002	478	12.2	387	19.9	91	4.6
2003	497	12.5	386	19.5	111	5.5
2004	493	12.2	406	20.2	87	4.3
2005	481	11.6	382	18.5	99	4.8
2006	460	10.9	379	17.9	81	3.8
2007	458	10.6	362	16.7	96	4.4
2008	506	11.4	386	17.5	120	5.4
2009	552	12.4	443	20	109	4.9
2010	495	11.1	405	17.9	90	3.9
2011	554	12.1	458	20.2	96	4.2
2012	541	11.8	445	19.6	96	4.1
2013	487	10.6	391	17.2	96	4.1
2014	459	10.0	368	16.1	91	3.9
2015	451	9.7	375	16.4	76	3.2
2016	399	8.5	318	13.8	81	3.4

Source (http://www.nsrf.ie/statistics/suicide, 2018)

Registering Death by Suicide in Ireland

Ireland, as a highly religious state, was slow to decriminalise suicide, with the Criminal Law (Suicide) Act being passed in 1993 (Irishstatutebook.ie, 1993). Chapter 3 will provide a retrospective discussion of the pathway toward decriminalising the act of suicide and development of policy. The recording and registration of death by suicide is an important consideration in accurately assessing data in Ireland. Recording cause of death in many cases in Ireland is relatively clear if the deceased was under the care of medical professionals who complete a Medical Certificate of the Cause of Death. In approximately 20% of all cases (5,000 to 6,000 cases annually) the cause of death may not immediately be known and these cases are referred to a Coroner. Such cases include sudden, unexplained, violent and unnatural deaths which must be reported and investigated. The role of a coroner is to be an independent office responsible under the law for completing a medico-legal investigation. The investigation may result in a post-mortem examination and inquest where the inquiry aims to establish if the death occurred as a result of natural or unnatural causes, the latter determining that an inquest is required by law. Inquests are held in approximately 30% of the cases referred to a Coroner (1,500 to 1,800) cases annually in Ireland with the death being registered through the issue of a Coroner's Certificate upon conclusion of this process. Delays in the registration and inquest process have been noted by Corcoran et al (2006) who describe the lengthy delays (12 months or more) in the national system for recording and registration of many deaths and findings (2002) that 15 % of the inquested deaths that occurred in Ireland in 2002 waited for a period of 12 months for an inquest to be held.

Classification - Form 104

The Central Statistics Office (CSO) issue Form 104 for completion by the Gardaí at the scene of sudden and unexpected deaths that may necessitate inquest. Form 104, confidential under the Statistics Act 1993, collects relevant information on the circumstances, scene and location of the death and offer opinion on the nature of the death. This aims to determine if death occurred as a result of accident, homicide, suicide or is undetermined. Data from completed 104 forms is taken into account when cause of death codes are assigned by CSO. Form 104 was developed in October 1967 and reviewed in 1998 as a result of recommendations by the Task Force on Suicide (1996-98). The review specified the need for an account of the personal and social

circumstances of the deceased. The aim of this amendment to Form 104 was to improve the statistical categorisation of suicide and increase the amount of information available to assist the classification of death. The limitations of Form 104 include the potential for under reporting of suicide due to: the subjective opinion of investigating Gardai; social and religious factors; level of family distress and other factors, such as lack of obvious evidence that may influence the determination of death away from a classification of suicide. Analysis and interpretation of rates of death by suicide in Ireland therefore requires care, as methods of suicide registration vary between district/counties, rural/urban and can be influenced by cultural attitudes. The level of proof required for a verdict or classification of suicide are also factors to be considered when comparing data.

The World Health Organization (2014) defines suicide as an act deliberately initiated and performed by a person in the full knowledge or expectation of its fatal outcome. It is recognised that global reporting of suicides rates may be inaccurate due to under-reporting in certain countries. This can be a result of stigma associated with the act of suicide, often a result of cultural and religious factors, a significant problem affecting the reporting of suicide in Ireland. For the WHO, the comparability of suicide data between countries can be affected by the methods used to investigate evidence and ascertain intent which can often be unclear. As discussed above in relation to Form 104, there may be a degree of subjectivity in the investigating, reporting and determining a person's intention of killing themselves. The range of methods used across countries can impact data collection and interpretation, being influenced by criteria used to determine how intention of death by suicide is ascertained, who is responsible for completion of the death certificate, if and to what extent a forensic investigation is completed, and the precautions for confidentiality of the cause of death. Awareness and caution is therefore necessary in data collection, interpretation and generalisability; particularly in understanding and clarifying themes and variations across countries.

Ireland, Europe and the World

National suicide prevention activities were informed by the expansion of the European and international field of suicidology and indeed, Irish developments contributed greatly to the international field of study and research. The developments influenced the work of the National Task Force, formed in 1996 to address the growing rate of suicide in Ireland. Trends in Ireland situate across a global context, offering a comparative to

international data. Being a member of the EU Ireland is also subject to European strategic efforts to reduce suicide rates across the EU member states.

Figures from the OECD (OECD.EU 2016) cite suicide as a significant cause of death in many EU member states with approximately 58,000 deaths in 2014 across all EU countries. With 32 suicides per 100 000 inhabitants, Lithuania registered the highest rate of suicide among the EU Member States. It was followed by Latvia, Hungary and Slovenia (all with 19 suicides per 100 000 inhabitants), Estonia (18), Belgium and Croatia (both 17). The rate in Ireland is 10 per 100,000. At the opposite of the scale, the lowest rates of suicide were recorded in Greece and Cyprus (both with 5 suicides per 100 000 inhabitants), Italy (6), the United Kingdom (7) and Spain and Malta (8 each). At EU level, the suicide rate stood on average at 11 deaths per 100 000 inhabitants in 2014. The same study (OECD.EU) indicate that the suicide rate in Lithuania is six times higher in men compared to female deaths, with the extremely high rates of death by suicide being correlated with a selection of factors, such as degrees of social or psychological uncertainty and anxiety, and high levels of alcohol and substance misuse, abuse and dependence. Similar trends have been discussed in Ireland regarding the differences between genders and links between economic and social uncertainty and increases in mental health difficulties.

The Global Health Observatory (GHO) estimated (who.int/gho/mental_health/suicide_rates) that there were 793 000 suicide deaths in 2016 as indicated by data, with ingestion of pesticide, hanging and firearms among the most common methods of suicide globally. The rate indicates an annual global age-standardized suicide rate of 10.5 per 100 000 population or one person every 40 seconds. Suicide is a sensitive subject, illegal in some countries and WHO estimates (who.int/en/news-room/fact-sheets/detail/suicide) the likelihood of under-reporting. In countries with satisfactory registration data, suicide may often, as observed in Ireland, be classified as accidental or some other cause, therefore in countries without reliable registration of deaths, suicides simply die uncounted and without recording. Suicide occurs throughout the lifespan, is the second leading cause of death among 15-29 year olds globally and is a global phenomenon. The same WHO data states that 79% of suicides occurred in low- and middle-income countries in 2016 and suicide accounted for 1.4% of all deaths worldwide. International suicide prevention evidence is discussed in chapter 5 of this study, however in setting the context of Irish policy making it is noteworthy that WHO cites the need for effective, evidence-based

interventions, implemented at a number of levels, including population, sub-population and with individuals aimed at preventing suicide and suicide attempts in a global context.

Suicide is a serious public health problem; however, suicides are preventable with timely, evidence-based and often low-cost interventions. For national responses to be effective, a comprehensive multi-sector suicide prevention strategy is needed

Behind the Statistics

The range of factors that contribute to increased risk of suicide are documented and considered in detail in further chapters of this study. An association is frequently correlated between suicide, mental ill-health and depression, alcohol and/or drug misuse and abuse (Dillon et al. HRB, 2015). In considering "what works" in suicide prevention evidence supports a range of schemes and methods, including reducing access to means for those at risk, education, early intervention and recognition of emotional, psychological and social problems together with the provision of effective and efficiently managed treatments and support. The recommendations from the National Task Force (1998) included increased supports for high-risk groups and families, training for Gardai and health professionals as an important element of suicide prevention campaigning, this having been confirmed in recent studies (Arensman et al, 2013). Ireland, as a highly religious and historically insular, largely rural nation experienced a high degree of stigma around mental ill-health and efforts are still needed to remove the stigma associated with seeking care (OECD, 2014).

Studies (van Gool and Pearson, 2014) have revealed clear indication of a link between unfavourable and deteriorating economic recession and increasing rates of suicide, data indicating a rise in deaths from 2008, associated with the economic and banking crisis and across a number of European countries. This is evident in the statistics above from Ireland and resulted in a high degree of community concern about deaths by suicide across the country.

Catalano et al. (cited in van Gool and Pearson 2014) suggest three broad mechanisms by which macroeconomic conditions can influence individual behaviours that, in turn, have an impact on health. These are (1) stress; (2) effect budgeting; and (3) frustration-aggression. Whilst there is evidence of the impact of austerity and worsening economic conditions on health outcomes (Ruhm 2000; Marmot 2002; Bezruchka, 2009; Miller et

al., 2009; and Stevens et al., 2011, cited in van Gool and Pearson, 2014), there is also theory to suggest and predict the opposite, a return to community and strengthening of social bonds. Suicide mortality was shown to rise when unemployment goes up (Ruhm, 2000) and as can be seen in the above table, death by suicide was found to increase in Ireland from 2008 – 2012 when austerity impacted the country with the banking crisis, sharp increase in unemployment and general economic downturn. Arensman and Corcoran found that between the years 1996–2006 in Ireland the suicide rates remained stable even though unemployment rates dropped from 12 to 4 % and that the suicide rate of unemployed males increased (2013).

Across Europe, as indicated above, the increased rate was mainly concentrated in male populations (Chang et al., 2013) and as with Irish data, the trend did not continue,, with Irelands rate reaching its highest recorded number of deaths in 2011 (554). Rates of suicide have been reducing from 2012 (541) to 2015 (451) and a recording of 399 deaths in 2016.

Factors associated with a changing demographic in Ireland must be considered when examining the trends and rates of suicide. Demographic changes include rates of migration/emigration particularly from those groups (male, age profile) with possible higher risk profile; this may skew the profile and context. The changing awareness about mental health and increased public profile of suicide prevention activities is an important consideration in examining reduced rates of suicide. Finally, improved social and economic factors, with evidence of positive economic upturn occurring in Ireland from 2012 may have a bearing on the health and well-being across populations, subsequently leading to reduction in suicide.

In the six-year period from 2007 (328) to 2013 (532) Greece witnessed the total number of deaths by suicide rising substantially, amounting to over 60% of an increase. This indicates that suicide rates can be impacted by factors associated with economic uncertainty. It is evident that the EU and its member nations must monitor developments and economic progress to ensure a prompt and coordinated response to the service needs of high-risk populations, such as those affected by unemployment, psychiatric and emotional ill-health issues.

Addressing the Problem- the Statutory Sector

Connecting for Life, Ireland's national strategy for suicide prevention (2015 – 2020), is managed and implemented by the National Office for Suicide Prevention (NOSP). NOSP is based within the Mental Health Division of the Health Service Executive (HSE) and collaborates with strategic partners and government departments, including education and justice among others in implementing the actions associated with the strategy. It is the body tasked with co-ordinating suicide prevention strategy in Ireland and holds an operating budget of €11.87 million (2015). The cross-sectoral engagement, consultation and relationships in the process of reviewing, agenda setting and planning suicide prevention policy is the consideration of this study. The stated aim, for the review of Ireland's national suicide prevention strategy was to have an evidence informed action plan for suicide prevention in Ireland and Connecting for Life was launched in 2015 as a whole of government approach to achieving the outcomes associated with the plan.

The Department of Health and NOSP, as the statutory, or public health agency tasked with preventing suicide, can provide, fund, commission and purchase services from across statutory, non-governmental and voluntary sectors. As with many public sector departments, it can also be tasked with and involved in regulation, research and training among its range of functions. In providing services, the statutory sector can be a competitor, a partner of private sector and community or voluntary sectors and non-governmental groups. It can be complex if the statutory or public sector also holds a regulatory or standards and quality assurance responsibility. In completing such commissioning of services and regulatory actions, the statutory sector may rely on knowledge and information, outputs and outcomes of practice from the sectors it is overseeing and indeed funding. In addition, health issues such as suicide, the focus of this study, are often emotive and high profile and there can be a demand from the public for responses and actions.

Resourcing Suicide Prevention in Ireland

This research is focused on cross-sectoral relationships and the impact on suicide prevention policy process. It is useful to examine funding protocols and decision making procedures in the assessment, management and awarding of resources in the National Office for Suicide Prevention (NOSP) as funding is an important feature in

cross-sectoral relationship. There are a number of sources of funding available to organisations involved in suicide prevention, intervention and postvention and as stated above, evidence across the C&V sector suggests a diminution of resources and increased competition for the same due to changes in the national economy.

NOSP reported a budget of €11.87 million in 2015, an increase of approximately 20% on 2014. Annual reports stated that €5.3 million was distributed to 32 service providers, community and non-profit organisations. Annual reports from 2006 - 2014 and the most recent publication 2015, were examined to assess patterns and changes in funding during the life cycle of Reach Out Policy (2005-2014) and Connecting for Life (2015-2020). Understanding budget allocation, priority areas for funding, criteria and procedures employed in screening, scrutinising prioritising, decision making and awarding of funding highlights a significant factor at the centre of cross sectoral relations, namely the issue of funding and its influence on dynamics between those actors involved in policy making. In Connecting for Life there has been a noticeable shift in the managing of funding for the implementation of the strategy with actions and objectives are implemented through the establishment of strategic partnerships with primarily national organisations and specified group of government departments, NGO, family resource centres, sporting organisations and targeted groups.

Policy Review

This study examines the retrospective and contemporary policy making process to articulate the cross-sectoral engagement and consultation with a particular emphasis on the participation and inclusion of the C&V sector in reviewing Reach Out and developing the Connecting for Life strategy. Ireland's Reach Out strategy (2005-2014) had reached the end of its lifespan in 2014 and the review was conducted with the National Office (NOSP) lead agency in developing Connecting for Life (2015 – 2020). A process of consultation and planning for a new national plan, the language and terminology changing to "strategy" and "actions" was launched. A stated aim was to develop an evidence informed "action plan" for suicide prevention in Ireland. The history and development of strategy in Ireland is examined further in Chapter 3 of this study and situated in an international policy context with an examination of how Irish strategy is informed and shaped by developments in other countries, the UN and WHO in Chapter 5.

Suicide prevention funding in Ireland is derived by organisations from a number of sources. Some C&V organisations solely rely on fundraising, whilst others rely on a mix of Government and statutory sector funding, other funding bodies and fundraising. Funding from NOSP must be linked directly to actions from the "Connecting for Life" (2015-2020) since the strategy was produced and launched by the NOSP in 2015.

The study examined annual reports from NOSP, which outlined the resourcing of organisations from Government sources. Resourcing is also available through NGO and EU and philanthropic sources. The sector also relies on fundraising including charitable gift tax exemptions. Understanding the relationship between the sectors in the development of suicide prevention policy is predicated upon establishing clarity about the power dynamics and impact in funded relationships, a theme addressed at length in Chapter 4.

Irelands Community and Voluntary (C&V) Suicide Prevention Sector

The Irish Non Profit Exchange estimated in 2010 that the generic non-profit sector in Ireland comprised approximately 11,700 organisations across a wide range of activities, with an estimated 100,000 employees and as many as five times more volunteers. The Irish Non-profit Knowledge Exchange (INKEx) project calculated the not for profit sector as a strong contributor to the gross domestic product in Ireland, with a contribution of approximately 3.25% of the total of €130 billion of GNP in 2010 (The Wheel, 2014).

There has been a significant drop in funding across the community and voluntary sector in Ireland, estimated at between 11-25% from 2009 to 2012. At the same time organisations report an increased demand for services, some as much as 63.5% (Wheel, 2014). 44% of those surveyed have dropped services as a result of funding restrictions. The implications for community and voluntary organisations of a reduced funding stream, with increased demand for services impacts the delivery and provision of services across many sections of the community in Ireland.

The size of Ireland's not for profit suicide prevention sector is difficult to estimate, as there is no registration system for organisations and the sector has, to date, not been accurately mapped. Many groups are registered with statutory agencies for funding purposes only and it is through such databases that this study gathers data on existing numbers of voluntary and community organisations. In 2011 the Irish Association of Suicidology (IAS) estimated that there may be as many as 350 voluntary and

community suicide prevention organisations in Ireland. There is a sense that duplication of services is a problem. John Connolly states "In the voluntary field there is a tremendous amount of duplication of effort and people like to do good work. When there is a tragedy, instead of finding out what is there, people go out and set up a new voluntary organisation," (Mayo News, 2013). This study uses information on registration in official databases to estimate the number of existing C&V organisations providing services or support related to suicide prevention.

The reasons for the burgeoning C&V suicide prevention sector are varied and will be discussed further in this chapter and in the study; however, a number of emerging themes for the increased number of local, regional and national organisations, include the perception (from the interviewees in this study) in the community that:

- services don't exist in statutory mental health provision,
- services may exist but are not known about and are difficult to access,
- services may be unavailable,
- means tested or exclusively reserved for medical card holders, thus excluding large proportion of the population,
- many existing services are subject to extensive waiting times.

Findings from Suicide in Ireland Survey (2003-2008) suggest that support services, from statutory agencies, are perceived as disconnected from local communities resulting in anger, mistrust and a polarising effect between C&V and statutory agencies (Malone, 2010). The survey concluded that any successful suicide prevention strategy required an inclusive approach between sectors as voluntary community agencies were considered frequently "best placed to lead local suicide response efforts" (Malone, 2010). For the purposes of this study the author considers national organisations as those offering services across 26 counties, regional organisations are those which offer services across one or more counties and local organisations are those with services across a limited local geographic area or townland.

C&V organisations consist of a diverse and disparate range of national and regional institutions to small local community groups. Whilst many adhere to and are regulated against high standards of governance through a range of bodies, there exists too, a multitude of unregulated community groups, predominately run by volunteers and unpaid staff.

The C&V sector witnessed the consequences of poor regulation and accountability in 2016 with the investigation into the activities and financial irregularities of Console, a national suicide postvention organisation. The organisation had been awarded funding by the HSE of €252,114 in 2012, increasing it to €598,557 in 2013 and €855,227 in 2014 with the investigation raising questions about regulation accountability and governance across the sector, matters addressed in "Quality Systems and Accreditation Standards for Voluntary Suicide Prevention Organisations in Ireland" (Friel and Gallagher, 2013). This research was completed by this author, submitted to the IAS and NOSP in 2013 and the findings informed the research questions in this present study.

The development of the Sectors

The size, practices and development of the rapidly changing suicide prevention third sector is difficult to capture as the sector consists of an estimated 350 organisations (IAS, 2012) ranging in size from small local groups to large national organisations. As a consequence of social change, economic and austerity factors the C&V sectors continues to experience changes associated with reduced funding and an apparent change in how funding is allocated by NOSP and other agencies. The characteristics and practice in the C&V suicide sector was examined in "Quality Systems and Accreditation Standards for Voluntary Suicide Prevention Organisations in Ireland" (Friel and Gallagher, 2013), The research offered findings and produced reflections and recommendations on the development of standards and accreditation for the suicide prevention third sector in Ireland. Data afforded a snapshot across the C&V sector, the disparate and diversity of activity was portrayed and emerging themes affecting the sector were articulated. The responses were such that they raised for this author an interest in cross-sectoral relationships in suicide prevention in Ireland and informed and influenced the questions for this study. The responses which formed the data for the study were from groups and organisations founded from 1966 – 2009 with 45% of them local, 15% regional and 40% national headquarter organisations. The sample revealed the non-profit sector providing prevention activities as the most significant area of activity. More than half of the organisations stated their practice across 13 different types of user groups and some were specific to individuals whose mental health had been affected by the economic downturn, self-harm and unemployment, gender or eating disorders. Data also indicated intervention activities, some training related, as a significant activity in the sector. For some respondents postvention was considered a specialist skill, with lesser activity recorded in the sample and the findings would raise

questions about availability of services and help seeking capacity for those bereaved through suicide (Friel and Gallagher, 2013).

The community and voluntary sector is complex, comprising a wide range of organisations working across a variety of activities. Regardless of size, they are groups started and managed by paid or unpaid members and are not externally controlled. Part of the complexity emerges because of the relationships between statutory sector and C&V and within the voluntary sector itself. Cross-sectoral relationships are further complicated by the funder/funded relationship between C&V and statutory agencies. This raises the characteristics of independence for the sector around voice, purpose and action (Baring Foundation cited in Ketola and Hughes, 2016). In order to elucidate the relational nature of independence differently, Ketola and Hughes devised a framework comprising four responses in organisations that highlight and contribute to challenges around independence. These can impact the ability to retain independence and include:

- Agent organisations, those which fulfil or operate delivering services on behalf of government.
- Competitor organisations, that don't trust or collaborate with others, prioritising resource led relationships with government
- Mimicker organisations that behave increasingly like public agencies they sought to replace
- Reticent organisations that moderate their critical appraisal of government, sometimes due to threats about funding. (Ketola and Hughes, 2016)

Policy informed practice in C&V

Findings from "Quality Systems and Accreditation Standards for Voluntary Suicide Prevention Organisations in Ireland" (Friel and Gallagher, 2013), indicated that the national strategy informed the activities of those C&V organizations successfully securing public funding through NOSP and statutory government departments. This led to the development of programmes directly informed by the objectives in the Reach Out strategy. There was an absence of alignment between the national strategy and established vision and mission statements in other organizations, this being more evident in smaller, local groups. Whilst many described knowledge of the national strategy, their work in the community was not driven by or informed by strategy content. Factors that explain this included a perception within C&V that organisations

deliver programmes in a responsive manner, with an ability to meet emerging need promptly and with flexibility, unlike the statutory sector services which were perceived to have a lower and slower response pace to need and emerging themes for stakeholders and service users. There was a perception that the statutory and public sector departments are technocratic, rigid or fixed and procedural.

Service Users: Who is accessing Services?

The participant organisations (Friel and Gallagher 2013) reported offering services to a range of groups including: families classified as 'at risk'; rural and isolated individuals; Travellers; unemployed; LGBTQ groups; and those with mental health issues. The findings raised questions about organisation expertise and capacity in the suicide prevention sector. It questioned how effective can organisations can be if they are over extended. The findings revealed considerations about organisations setting of priorities and clarifying their level of functioning within the parameters of capacity, skill and resources (including finance, energy, time and vision).

An Example:

Table 1.2 Relative competencies of National and Local C&V Organisations
Organisation A is a large National Organisation concerned with suicide prevention.
Organisation B a small, local C&V organisation concerned with suicide prevention.

Competence		Organisation A	Organisation B
		National	Local
Governance		Yes - High	Yes – Low
Funding	State funded	Yes	No
	Funded by other body	No	No
	Fundraising	Yes	Yes
Capacity		Yes	No
Energy		No	Yes
Vision		No	Yes
Expertise	Counselling	Yes	No
	Signposting	Yes	Yes
Paid officers		Yes	No
Volunteers		Yes	Yes
Local knowledge		No	Yes

Capacity, Governance and Boundaries

The 2013 research revealed that 60% of the primary C&V activity is suicide prevention, including counselling; education and positive mental health programmes; listening ear and support groups, offered using a range of methods, such as face to face; telephone and online delivery. Education and training is offered in a range of settings while the response data indicates an increase in virtual support activities. This may be indicative of who responded to the survey and interview but it appears to be a significant growth area in suicide prevention in Ireland. There emerges a portrait of a community and voluntary sector comprising of organisations crossing across boundaries with each other competitively, due to diminishing resources and sometimes engaging in areas of other professions, range of identities and activities. It also emerged that there are indications that the community and voluntary sector is loosely structured, weakly systemized, split and of many branches and parts.

Professional, Semi-Professional and Volunteer

This present study is interested in the quality that characterises professions and the distinctions in the C&V sector. Abbott (1988) describes the concept of abstraction, explained as the strategies professions engage in to establish ownership and position, power and control over a particular field or situation, often a reaction designed to aid professional survival in a competitive environment. The C&V sector encompasses a range of organisations at national, regional and local level, some with high level of governance and some less formally structured. They range from professional, semi-professional or run entirely by volunteers and there exists within the sector many and varied types of skills and levels of expertise. This was an important theme which emerged in survey and interview data (Friel and Gallagher, 2013), namely the recognition and expectation that all organisations would adhere to formal standards of professional behavior raising the question about standards and how/who would set them, how they would be managed and measured question of trust/mistrust emerging across the sectors in how to manage themes such as accreditation in C&V suicide prevention sector (Friel and Gallagher, 2013).

The 2013 study revealed that the C&V sector face competing demands, raising issues about capacity time management, workloads and in delivering services. This is an important feature in smaller local groups that may be reliant on volunteers and where a

crisis can arise as finances constrict and there is a pressure to rationalize services. Governance emerged as a significant theme. Some organizations appeared unprepared for competition, particularly smaller voluntary groups that indicated less confidence around accreditation issues. Data protection, as an essential governance requirement was addressed satisfactorily by 60% of respondents and other areas including, health and safety, public liability, child protection (57.9%) and social media policies were areas given a high level of consideration.

Organisations and Identity

It is important to consider the dynamics of organisations and the formulation of organisational identities in both the C&V and statutory sector. It is against this backdrop that policy review and policy review themes emerge and in which the process occurs. Organisations are created and populated by humans, with the values, ethos, culture, identity and methods of operation are shaped by the people within. This is explained and articulated by the bounded rationality concept in punctuated equilibrium theory, discussed in Chapter 4 of this thesis. Organisations evolve; they can deliberately change, and can also get embedded in a pattern of operation. Stacey (2005) states "patterns of human interaction produce further patterns of interaction". Organisations are influenced be the way people behave, by individuals' identities and anxieties and peoples' capacity, and as a consequence, organisational capacity for change to the taken for granted ways of doing what they do.

The suicide prevention C&V sector in Ireland comprises a wide variety of organisations, established in response, and at times reaction to a number of factors, as Roberts (1994:32) writes

> *"Many organisations are set up as alternatives to other, more traditional ones, by someone disaffected by personal or professional experience or other settings. However, identity based on being alternative, superior, by some ethical or humanitarian criterion tends to stifle internal debate. Doubts and disagreements are projected fuelling intergroup conflict."*

Managing boundaries in the C&V sector can be difficult as volunteers may themselves have been impacted by the issue of suicide, often drawn to activism as a result of the death of someone close to them. The complexity of negotiating boundaries in such situations and ensuring that organizations and individuals are not overstretched can be difficult, as stress and difficulties can be commonplace, especially in circumstances where resources diminish thus restricting service provision and sometimes impacting on

service users with the highest need. Cross-sectoral practices consist of "bringing more than one profession together and creating new and adapted professional processes and practices" (Cracknell et al, 2009). In reviewing the context of suicide prevention in Ireland there emerges an uncomfortable edge to the relationship between the sectors in practice and policy making processes; that interface between C&V and statutory agencies that formed the exploratory hypothesis for this study.

A groups' identity is linked to defining its primary task and its purpose (Rice, 1963 cited in Roberts). In organisations that are caring, identity and tasks are often linked to ideals and ideology. Personal meaning in the practice tends to be closely aligned to an ideal underlying the choice of working methods. Anxiety can be evoked if ideals and practice are challenged or questioned, and instead of space to reflect on what is most appropriate for there is often "polarisation about right or wrong". (Roberts, 1994, p.114)

As stated above, the motivation for individual activism and involvement in suicide prevention can be linked to experience of suicide in the family or community. The personal meaning of involvement can result in strong personal commitment, caring for others, with a strong motivation for change, in a suicide prevention context that is slow to change and respond. This is an important feature of the C&V sector, as Roberts (1994) succinctly articulated. As people become involved in practice, they established a sense of meaning, as strong sense of identity and a community of practice, especially when this is associated with an emotive subject such as suicide prevention.

The C&V suicide prevention sector is part of a wider market environment, outlined above as the third sector, and contributing, as stated in a speech in Buncrana by President Higgins (2014) to economic development that is socially embedded, and that offers a glimpse of a reconnected economy and society. The economy and society are profoundly embedded in one another and the basis Irelands recovery from austerity must take account of the social capital generated through C&V sector activity meeting the increased need of citizens in a time of decrease in government spending.

The examination of policy process is interested in the degree of engagement and cross-sectoral consultation in the making of suicide prevention strategy and if/how relationships between C&V and Statutory sector impact on suicide prevention policy process. It is hoped that an improved understanding of the characteristics of the

principal sectors can inform and if necessary, change how strategy is made, influence who determines the content of policy and strategy, the drivers for it and as a consequence determine improved effectiveness and implementation through the activities of the statutory and C&V sectors therein. This raises the question about who or what organisations or sections of sectors are outside of the discourse or inside the discourse in policy making, where does power lie in the policy making process and if the statutory sector has more power and the C&V sector less power in this regard. The exploratory hypothesis in this thesis, namely "who decides who decides suicide prevention policy in Ireland" was influenced, as stated by emerging themes in aforementioned, "Quality Systems and Accreditation Standards for Voluntary Suicide Prevention Organisations in Ireland" (Friel and Gallagher, 2013). The particular theme that resulted in the development of this study was an interest in how cross-sectoral relationships shape and influence the discourse, knowledge and process of policy review and policy making. Cross-sectoral relationships require developing the conversation and enquiry that occurs between sectors aimed toward the development of a shared language and a common understanding of knowledge and skills required to support improved outcomes for suicide prevention strategy in Ireland. The collaborative process between disciplines results in the development of a professional community and the conversation taking place between different professions and occurs in what is described as the "third space" (Zeichner, 2010; Bhabha, 1994).

Cross-sectoral engagement and collaboration can necessitate a change to the, often taken for granted, way of doing things and as Senge (2006) discussed this requires organisations where people continually expand their ability to create the results they would like and where new patterns of thought and practice are nurtured. This concept is one in which cross discipline and cross-sectoral engagement offers collective goals and where people are continually learning to see the whole together.

This articulates how individual and organisational identity can become very closely intertwined and defined. In the community and voluntary sector, due to limited capacity, there is often restricted opportunity for reflection and for organisational learning and growth. The statutory sector is perceived as rigid, bureaucratic and slow to embrace change or new opportunities for the development of communities of practice, shared expertise and expanding capacity across disciplines and sectors. This can create issues of mistrust and a reluctance to engage and collaborate between sectors. The

result is a perception in the C&V sector that tokenism exists in the consultative exercises and limited parity of esteem in the policy process.

Knowledge and Evidence in Suicide Prevention Policy Process

Further in the study there is an examination of Irelands' suicide prevention strategy in an international context, an important consideration that enhances an understanding of the knowledge base and evidence of what works in suicide prevention. The evidence base is derived from studies, research and policy review emerging through a network of global suicidology research and practice. There exist a number of national and international research networks, including the Irish National Suicide Research Foundation (NSRF), Irish Association of Suicidology (IAS), American Association of Suicidology (AAS) and International Association of Suicidology and Practice (IASP) among others. The contribution of a range of national and international groups to the review and development of strategy in Ireland will be discussed further in this study. This chapter raises an interesting area for consideration, namely how the body of knowledge and academic research processes informs the evidence base and practice across the suicide prevention sectors in Ireland. The Connecting for Life strategy, and resources attached to its implementation, are predicated upon an evidence based approach in the delivery of actions within the strategy.

Themes about quality standards of assurance, transparency and accountability are important in this study. The process of how decisions are made, and by whom is considered as it relates to determining the knowledge and evidence that informs practice and the content of strategy.   It is useful therefore to articulate if service users, the C&V or statutory sector are the epistemological agents in determining suicide prevention practices and what works across the disparate range of communities and affected groups. The influences and determinants of dominant knowledge culture in suicidology are an important consideration in this study. This therefore considers the extent to which knowledge culture is within (endogenous) or exogenous (without) the statutory, C&V sector and indeed national or international knowledge culture in suicide prevention. Foucault (cited in Rabinow 1991) describes this as the genealogy of a regime of veridiction, the constitution of a particular truth on the basis of law or jurisdiction and finding its privileged expression in the discourse, the set of rules, the agreed truth in which the law (policy) is formulated. In this case the jurisdiction of suicide prevention is within the state and its associated sector, resource management and policy making,

discourse and knowledge exchange establishes a power basis and can result in a veridiction, or agreed truth as opposed to an objective truth, in the subject of suicide prevention and this is based on a taken for granted world view. Pears (1972) outlines the subjectivity of what is and is not knowledge and Blackler (1995) defines knowing as five types: mediated, situated, provisional, pragmatic and contested. Each type of knowing informs practice and knowledge and in discussing such themes it increases awareness of the subtlety and complexity of the subject, yet it improves an understanding of the varying perceptions of need and the differing practices that can exist in and across the suicide prevention sectors in Ireland.

Boundaries

The boundary crossing between C&V and statutory sector is an important aspect in understanding suicide prevention policy process. The sectors meet at a point that is symbiotic, the state requires the C&V to meet delivery objectives arising from policy, the state is also funder and the C&V depend on NOSP and statutory sector to access resources. The boundary between the suicide prevention sectors has an explicit and implicit inequality due to financial resource management by the statutory sector. This reflects a challenging and problematic feature in cross-sectoral relationships and policy process, namely the representation of different views on the contested boundaries between the two sectors. There exist differing views on claims of equality between sectors, reflective of the unique characteristics of each sector's identity. This highlights interesting themes in the study because of the complexity, the symbiosis and subtlety of modern societal boundaries in public and C&V institutions (Benhabib, 2005; Lave and Wenger, 1991)

Conclusion

> "(…) it is not that state services should ever be seen as competitors with self-reliant community initiatives: a partnership between both is essential to the thriving of our economy and society." President Higgins, 2014

President Higgins was speaking at the launch of a C&V social enterprise in 2014 where he articulated his vision of cross-sectoral relationships and partnership between the state and third sector in delivering services to the community. With the suicide rate at 399 (2016), having risen to a high of 552 in 2011, it is important to examine strategic efforts to reduce the rate in Ireland and there remains much to be done in this regard. In recent

years Ireland has been experiencing the profound impact and consequences of unprecedented economic recession and journey toward recovery. As a result of austerity, from 2009 there has been an increase in demand for services and decrease in government funding at a time when the rate of death by suicide has been impacted in Ireland, and indeed across Europe, due to economic downturn.

The nation has changed dramatically in the past thirty years, influenced by changing social structures, global and EU influences, with the period from the decriminalisation of suicide in 1993 witnessing a growth in C&V suicide prevention grass root and community activism creating a momentum and changing irrevocably the relationship between the C&V, government and statutory sectors in the delivery of services and development of policy to address suicide in Ireland.

This chapter has reviewed data on the rates and the reporting of suicide in Ireland, it has described the sectors and structures, outlining the characteristics, complexity and resourcing of statutory and C&V suicide prevention sectors in Ireland. Primary literature, reports and secondary sources (Friel and Gallagher, 2013) have been used to critically consider the structure and dynamic between the sectors. The chapter outlined the context, informing and developing the study question, revealing a portrait of a C&V sector loosely structured, weakly systemized, split and of many branches and parts. It comprises of organisations crossing boundaries with each other competitively, due to diminishing resources and sometimes engaging in areas of other professions activities. It also indicates that the community and voluntary sector is eclectic, diverse and responsive, operating against a backdrop of reduced resources and limited capacity but with high levels of commitment to reduce rates of death by suicide in the community.

In launching the new strategy in 2015, a stated aim was a whole of government approach to suicide prevention and this study considers the political landscape and role of the political parties in chapter 3 of this study. Connecting for Life is being implemented through investing resources in developing an approved strategic partnership approach with an array of specific groups and organisations, raising questions about epistemological agency in C&V sector, how and what groups exist inside or outside the discourse and policy process and as a consequence outside or inside the ability to be part of the implementing of strategy with access to resources. The chapter also outlined the nature of boundaries between the sectors, the veridiction of truth in suicide prevention, considering how knowledge/truth is determined what is/is

not knowledge and as a consequence how practice is informed and resourced, raising issues about power in the policy process, a subject discussed elsewhere in this study.

Chapter 2: <u>Methodology, Document Analysis and Literature Search</u>

Introduction

This chapter outlines the methodological approach used to meet the objectives of the study and answer the research questions. It also provides a rationale for the chosen methods, outlining the introduction to literature and document search, analysis and review. The sampling framework, recruitment approaches and ethical considerations are discussed, with the chosen approach to analysis described and justified.

The key research questions for the literature review are: Is there quality evidence examining the research question, namely the impact of relationships between the community, voluntary and statutory sectors on the process of developing suicide prevention policy in Ireland. Central to which is an assessment of the quality of available evidence and research on suicide prevention sectors and relationships therein, the structures, policy making and the policy making process.

The literature review was comprehensively explored to support the study objectives and inform research questions. The approach carried out a review of key textbooks on the topic of suicide, definitions and nomenclature, suicidality and suicide prevention, national and international policy developments and suicide prevention strategies, annual reports from National Office of Suicide Prevention (NOSP).

. The significant body of literature that exists in the field of suicide prevention prompted the author to focus on carrying out a review of existing systematic reviews, manual searches, using key search terms and examination of organisational publications and meta-analysis papers. Whilst not completing a systematic review, steps associated with systematic review methodology were employed. This included, the use of explicit search strategies, exclusion and inclusion search criteria, a clear assessment of quality and extraction of pertinent themes and findings using manual methods and NVivo as a formal data extraction tool.

The literature search had a particular focus on accessing general texts, quality studies and examined primary suicidology texts, policy analysis literature and annual reports and policy documents, thus focussing on a range of reading, as considered within particular criteria. In addition, by combining a study of policy documents, annual

reports and qualitative research studies, analysis was necessary to ensure a review with accurate results of literature on the chosen research subject. The literature search examined existing reviews of suicide prevention theories, national and international policies, annual report of key stakeholder organisations and primary texts and books. The language restriction was for publications in the English language and the date restriction was applied was 1995.

A number of key search terms were determined and used control terms such as 'suicide' and/or 'suicide prevention' and /or "suicide prevention policy" keywords including 'suicide prevention' or 'suicide' and 'prevention' and "suicide Prevention Ireland". In addition the search included terms "voluntary sector and suicide prevention and/or Ireland. As required the search terms were amended and modified for particular databases and this literature review acknowledges that search results for some of the terms yielded limited results and recall. Using the search methods and U search through Ulster University, a number of electronic databases were used, including the following:

- Cinahl
- Cochrane Library
- Sage Journals
- ProQuest
- Scopus
- SSRN

The literature also examined hand searched reference lists of selected key texts, policy documents, annual reports and reviews located by the electronic searches. The results were checked against a series of updated reference lists and the WHO Preventing suicide: A global imperative report (WHO, 2014) and the WHO Website Self harm and suicide list of references to ensure significant key texts were not missed. The resulting materials and abstracts were screened and every full-text article retrieved was reviewed to ensure that decisions around inclusion were made on a consistent basis.

Literature review included reviews and analysis of suicide prevention policy, reviews and studies that had definition/nomenclature of suicide; texts and/or reviews that included suicide prevention policy development and key texts about public policy development in Ireland. Themes included participation and consultation, power and politics in policy development also informed literature searching

International and National Policy documents including those from England, Australia, New Zealand, Northern Ireland, Scotland and USA; relevant articles and annual reports from NOSP and Voluntary Sector (IAS), irrespective of publication date were examined. In addition single studies on suicide prevention relating to policy development and policy process and the voluntary sector were examined in support of the key research question.

A number of key search terms were determined and used control terms such as 'suicide' and/or 'suicide prevention' and /or "suicide prevention policy" keywords including 'suicide prevention' or 'suicide' and 'prevention'. As required the search terms were amended and modified for particular databases. The aim of the search strategy was for high precision and recall and the study examined reference lists of systematic reviews and hand searched references for reviews located by the electronic searches.

Aim, Objectives and Research Question

Aim of the Study

The aim of the study is to examine the extent to which relationships between the community, voluntary and statutory sectors impact the process of developing suicide prevention policy in Ireland.

Objectives of the study

- Identify the context of the study by examining relevant literature, documents and research on suicide in Ireland and evidence based suicide prevention practices.
- Chronicle the characteristics of policy process in Ireland (1998-2015), examining structures, systems and engagement mechanisms.
- Situate and consider influence on Irish suicide prevention strategy from an international context, examining a sample of policies. (U.S, England, N.I., Scotland, New Zealand and Australia
- Consider the impact of power in cross-sectoral relationships on the process of developing Connecting for Life (2015-2020) suicide prevention strategy in Ireland

Research Questions

This thesis is titled: Collaborative Working in Suicide Prevention: An Exploration of the Relationships between the Community, Voluntary and Statutory Sectors on the Process of Developing Suicide Prevention Policy in Ireland. Kumar (2014) describes the focus of research in social sciences as people, problems, programmes and phenomena, and this study is based upon a combination of this list. In developing the study, the principal research question was developed as follows: Do relationships between the community, voluntary and statutory sectors impact on the process of developing suicide prevention policy in Ireland. The question is a complex one, as the population (sectors) are diverse and cross-sectoral relationships are dynamic and difficult to define. Furthermore, the impact of relationships on policy processes is difficult to articulate as this involves capturing the nature of consultation and cross-sectoral engagement at various stages of policy development and implementation.

The study attends to elements of the policy making processes, the structures, systems and power dynamics and the impact upon the relationships in suicide prevention policy decision-making. The study question will be evaluated by focusing on one aspect of the policy process, agenda setting, and asking *who decides, who decides* in the early phase of policy making. This questions the role of representatives, stakeholders or policy actors in policy development and the participatory processes involved. The thesis considers the importance of relationships with government, its departments and agencies, factors that influence dynamics between statutory and C&V sectors, and the economic climate in which third sector organisations are competing for funding and survival during economic downturn and resulting austerity measures.

The research question can be broken down into more specific sub-questions, which help to better clarify the issues involved:

1. How do we articulate the structures, characteristics and definitions of the statutory and C&V sectors as policy sub-systems?
2. What is the impact of relationships within and across sectors on the suicide prevention policy process?
3. What is meant by engagement in policy process, and how are consultation, participation and representation defined?

To effectively address the questions, a research design would be required that would identify themes in policy issues, assess relationships and test the efficiency of processes. These are dynamic and subjective concepts involving complexity that is best managed

using a qualitative research design. The research strategy and specific methods will be discussed in depth further in this chapter

This study is an examination of policy process using a qualitative approach. Data was collected using document analysis, semi-structured interviews analysed thematically and NVivo data analysis software was used in the study. The aim was to examine cross–sectoral relationships, participation, consultation and engagement between the statutory and C&V sectors and the extent to which the relationships do or do not, impact the process and development of suicide prevention strategy in Ireland. The exploratory hypothesis in the study was that relationships between the community, voluntary (C&V) and statutory sector impact upon the process of developing suicide prevention strategy in Ireland. To meet the complex research objectives, it was essential to have a research design which would capture and identify patterns of policy process, encapsulate and concisely assess the nature of processes in suicide prevention policy making. The study was concerned with nuanced and complex concepts and has a particular interest in the relationships and dynamics of policy making. To capture this, a qualitative research design was employed.

This study employed an ethnographic approach to data collection which sought to articulate the subjective experiences of respondents, in this case those from statutory and C&V sectors who participated in the suicide prevention policy process. Hammersley and Atkinson (2007) argue that features of ethnographic research include a focus on people and their accounts, usually a single case or setting, and can include a range of data sources. The thematic analysis therefore involved assessing the meaning and the perceptions of respondents.

Objectives were developed to organise the study and support the collection of data in testing the above hypothesis. Firstly, a comprehensive overview of relevant primary and secondary literature, documents, reports and research studies was conducted to critically reflect on established and current theories, methods of prevention and understanding of suicide in Ireland and globally. Secondly, there was a review of policy process theory and the key characteristics and phases in policy making. The social context and timeline of the development of suicide prevention strategy in Ireland is discussed from 1998-2015. Thirdly, International polies were considered, including supranational guidance and strategies across a number of countries (U.S, England, Scotland, N.I., New Zealand and Australia), to situate the study in a wider international

context of suicide prevention. The countries selected were either neighbouring jurisdictions (N.I., England and Scotland) or International countries (U.S.A., New Zealand and Australia) whose strategies have informed and influenced Irish policy and a sample of English speaking, high to middle income countries, with comparable cultures and democratic systems. In addition, the influence of the guidelines of the United Nations (1996) and the World Health Organisation (2014) on suicide prevention policy process were considered. This also allows for the examination of patterns and themes, influences and differences in the process of making policy and development of strategies. Fourthly, interviews were conducted with key participants from C&V and statutory sectors aimed at articulating their subjective experiences of the Irish suicide prevention policy making process from 1998-2015.

| 1. Documents-Suicide Ireland | 2. Theory -Policy Process -Ireland | 3. International Policy - Ireland | 4. Interviews - Policy Process Connecting for Life |

Methodological Approach

The research has been designed to collect and analyse data using a critical and activist research perspective. It is reflective of both the authors' ontological and epistemological perspective, one which acknowledges being moved toward a critical paradigm, a critical theory or conviction that research is conducted for "the emancipation of individuals and groups in an egalitarian society" (Cohen, Manion and Morrison, 2007. p. 26). Kurt Lewin (1951) focused social research on the transformation of inequitable social arrangements and in a similar way activist research is that which troubles and speaks back against, often taken for granted assumptions. As an activist with direct involvement in suicide prevention and policy actor at community level my 'methodological attitude' is also one of "emergent subjectivity" (Gallacher and Gallagher, 2008), that which acknowledges a position of "methodological immaturity, admits to vulnerability and fallibility" but aims to engage with participants in a flexible manner, with humility and respect at all points of the study and data collection process. Reflection on method choice must consider the expression and influence of the researcher and have awareness and acknowledgement of the human as not an expert. Gallacher and Gallagher describe this as 'emergent becoming' recreating subjectivity

through action and ensuring humility informs the social researcher's approaches to gaining access to others' social experiences (2008, p. 511).

Critical Reflection

The study is concerned with suicide prevention in Ireland and as such it is, as Denscombe (2001, p. 58) states, "driven by the need to solve practical and real problems". The methodology considers Kumar's (1999, p 2) view that research should critically examine "ways of thinking"; and various aspects of practice and in doing so provide the opportunity to develop new theories to enhance processes involved in the development of suicide prevention policy in Ireland. Methodological design involved consideration of which best afforded the possibility of capturing, as stated by Reason and Bradbury (cited in Punch 2005, p. 160) findings which "bring together reflection on theory and practice, in the pursuit of practical solutions to issues of pressing concern to people". Additionally, the author considered a methodology which would, as outlined by Greenwood and Levin (cited in Blaxter, Hughes and Tight 2001, p. 67); produce tangible and desired results for the people involved; producing insights both for the researcher and the participants. Reflection on method asserted that a qualitative approach would enhance the study and the rationale for this view is presented in this section. The use of case study and qualitative methods to collect the data provided the opportunity to explore issues in more depth with the participants in their own words. Furthermore, the approach would be interactive and humanistic, enabling the author to accumulate understanding and knowledge from the participants in their own setting. Quantitative research methods are considered as deductive (Bryman, 2004); they assume social reality as objective and thus apply scientific models in measurement and collection of data (p. 19). Qualitative methods, on the other hand, are inductive and interested in subjective experiences. Such methods are aimed at generating data based on accounts of respondent reality, one in which social reality is considered as ever changing and is not fixed. Since the study is concerned with complex phenomenon, namely policy process and cross-sectoral relationships therein, the measurement and generation of data would be based upon accounts of the experience by participants and thus a qualitative approach was determined as most appropriate.

Activist Research

Activist research is often carried out in settings, located 'outside of university and academic institutions' (Choudry, 2013, p. 128) and this study is influenced by

researcher experience in a number of settings. Concepts associated with research activism inform the research in addition to researcher experience as a clinical therapist, community and youth practitioner, academic and founder of a community based suicide prevention organisation. The aim is to conduct a study which is 'theoretically driven and intended to be put to use' (Hale, 2001: p. 210). The philosophical and epistemological foundation to the study is addressed in chapter one, acknowledging a philosophical lens in the thesis that situates at a boundary between a style of work affiliated to post-structuralism, an influence of Foucault and the imbrication with social constructionism approach. There is therefore an interest in challenging the taken for granted way of developing policy in Ireland and offering 'active political commitment to resolving a problem and rigorous scholarly research on that topic' (Hale, 2001). In addition, the commitment is as a researcher to be, as outlined by Fine and Vanderslice (1992), "the facilitation and documentation of structural and social change processes" (1992, p. 18).

Researcher Position and Managing Impartiality in Research

Impartiality required rigour in attending to objectivity, bias and detachment in conducting the study. These ethical themes are a primary consideration in research and particularly in practice based studies of such sensitive subject matter such as suicide. Protection of interviewees and data management are fundamental ethical considerations. However, as stated in the previous paragraph, the study was informed by a research activist perspective. This included studies previously undertaken (2013) and experience as a C&V practitioner in suicide prevention. The validity of data, reliability and success of the study depended upon rigorous attention to detailed ethical considerations. This necessitated mindful regard, reflection and reflexivity on researcher position, resulting in a number of practical and practice implications. Most significantly, I resigned as chair of a C&V organisation, this afforded objectivity through detaching from day-to-day organisational practice. Academic and clinical supervision was reviewed, the latter a requirement of professional therapeutic bodies. Both types of supervision were regular and ongoing for the duration of the study, with clinical supervision (1.5 – 2 hrs monthly) facilitated by an accredited supervisor, experienced in mental health and suicide prevention practice in Ireland. As an accredited psychotherapist with BACP (British Association of Counselling and Psychotherapy and IACP (Irish Association of

Counselling and Psychotherapy) I ensured that the study adhered to the ethical and good practice guidelines of both professional bodies in addition to the ethical requirements and regulations of the of Ulster University. Ethical considerations also include awareness of sampling issues to ensure representation including gender, disability, LGBT and ethnicity and in this study geographic, urban and rural issues that may emerge regarding consultation. As an accredited and practicing clinical therapist I am experienced in assessing service user need and endeavoured to ensure respondent well-being throughout. I ensured knowledge and referral procedures to a number of agencies in the community to be explored should the need have arisen.

Punch (2005, p. 160) proposes that research aims to design inquiry, to build upon knowledge, to use the service of action to solve a particular problem and activist research is that which troubles and speaks back against, often taken for granted assumptions. Hence the purpose is to direct action to solve a realistic problem or solve a realistic question. Such research "seeks to bring together action and reflection; theory and practice, in participation with others, in the pursuit of a practical solutions to issues of pressing concern to people". Greenwood and Levin (cited in Blaxter et al., 2001, p. 67) consider that research is holistic; it produces tangible and desired results for the people involved; producing insights both for the researcher and the participants. Reason and Bradbury (cited in Punch, 2005, p. 160).Linking with Kumar's (1999, p. 2) view that action research is a way of thinking; whereby you critically examine various aspects of your practice and in doing so provide the opportunity to develop and test new theories to enhance a profession. Having considered accounts of activist research; it is evident that elements of this approach are a consideration within the study, offering a framework for articulating the purpose of the study, which is seeking an answer to a practical and important question: to what extent do cross–sectoral relationships impact the process of making suicide prevention strategy in Ireland?

Methods of Data Collection

The primary focus of the study is policy process and methodological design aimed to generate knowledge about the key elements of the decision making and agenda setting phase, the actors, organisations and individuals from the statutory, community and voluntary (C&V) sector involved in policy development. As stated, a qualitative methodological framework was used which included case study strategy and the rationale for this being outlined later in this chapter.

Desk Research: Literature and Document Analysis

In order to situate the study of suicide prevention policy process in a wider context, primary and secondary sources of data were examined. As stated above desk research used a range of search engines to generate the most up to date and relevant sources, in addition to manual searches of primary literature and documents. Internet sources also provided information including organisation websites, government department websites, which yielded statistics and annual reports. Secondary sources included government and departmental reports, research texts, non-governmental, organisational and statutory documents. In addition, to a thematic analysis of national policy documents, international strategies/policies were considered, to ascertain if an influence on Irish policy process. Using NVivo to organise, a detailed consideration of policy content was conducted, identifying themes and repetitions, similarities and differences across policy documents. This consideration of primary and secondary sources involved careful reflection, conducted to ensure consistency between examination of the documentary sources and the transcripts of interviews by participants in the study. Thematic analysis was conducted informed by constructionist theory and perspective informed by the aim of the study, research questions and literature. Document analysis included a review of data on rates and the reporting of suicide in Ireland using official statistics. This assisted in outlining the setting for the study, articulating the complexity of patterns, structures, characteristics and resourcing of the statutory and C&V suicide prevention sector.

Primary literature, reports, government documents and secondary data (Friel and Gallagher, 2013), were critically reviewed. As well as informing the context, document analysis informed the development of research questions. The retrospective and contemporary policy making process, with a particular emphasis on the participation and inclusion of the C&V sector was considered.   Methods also involved a review of key policy documents, including the Report of the National Task Force (1998) Reach Out Strategy (2005) Connecting for Life strategy (2015). The history and development of strategy in Ireland was examined and situated in an international policy context with an examination of how Irish strategy is informed and shaped by developments in other countries, by the UN and WHO, this being addressed elsewhere in the study.

Using manual analysis and NVivo organising software, emerging themes from primary and secondary texts were articulated for references to engagement, participation and

consultation. The study evaluated engagement practices and engagement theory in the development of suicide prevention strategy in Ireland and situated this against other examples from international studies. The secondary source documents included

- Arensman et al, (2013) examination of suicide awareness training among police officers in three European regions.
- Scottish Government engagement paper on the prevention of suicide and self-harm (Gov.scot, 2013),
- Scottish Equality and Human Rights Commission: Good Practice in Community Engagement from an Equality Perspective, (Scvo.org.uk, 2009)
- Harris et al (2013) study of evaluating the implementation of an early intervention in suicide prevention in four European countries.
- Scottish National Standards for Community Engagement (scdc.org.uk, 2015)
- Irish National Office for Suicide Prevention Report (2015) of the Engagement Advisory Group.

The purpose of the document analysis was to examine participation, engagement methods and cross-sectoral consultation in policy process. In addition, literature review considered factors that impact policymaking and implementation in Ireland. Document analysis was inclusive of the period from 1998 when the National Task Force produced its recommendations, to 2005 when Reach Out, the first national policy was launched and finally, 2015 with the succession planning and subsequent launch of Connecting for Life (2015 – 2020).

Methodology also examined the process and practice of suicide prevention policy development across a number of countries as stated earlier and considered how strategy in Ireland was influenced and impacted by developments across a global policy making context. The selection of countries for consideration was informed by those regions that are near neighbours (N.I, Scotland and England) and a sample of those with a well-developed suicide prevention policy in the English-speaking world (New Zealand, U.S and Australia) where evidence of influence, interaction and impact on Irish policy development exists in literature as discussed elsewhere in this study. The purpose was to examine the evidence that informed primary approaches and principle components of such policies. This included a consideration of factors which influenced the setting of strategy goals or objectives. In particular, evidence of engagement and cross-sectoral consultation in policy development and the process therein was considered, thus

situating the policy process in Ireland within an international context. The study of policy documents from Ireland, England, Scotland, Northern Ireland, New Zealand, United States of America (USA) and Australia is presented in further chapters of this study.

Research Questions and Topic Guide

Using key themes identified through the literature review and the information required to effectively address the aims of the study, a topic guide for semi-structured interviews (see Appendix 7.) was drawn up. The questions focus on participant experience of suicide prevention policy making in ROI - from the 1998 Task Force to the review of the Reach Out Policy (2005 -2014) and development of Connecting for Life in 2015. Participant views about how policy is formulated included exploring *who, where, how and what* groups are involved. In addition, the study was interested in:

- Participants' Involvement in policy making, whether this is at local, regional or national level.
- Decision making and consultation strategies in the policy process
- Level of participant involvement
- who, where, how and what organisational representatives were involved, how this happened, i.e. invitation or nomination
- perceptions about inclusion and exclusion criteria in policy decision making
- consultation and how it was undertaken, frequency and at which stages in the process, (agenda setting, planning, draft policy stage, policy completed/opened for input)

.Of particular interest is the nature of the relationship between the statutory and voluntary sectors and participation of the latter C&V sector in policy making. The study questions were designed to ascertain respondents' perceptions of the policy development process and engagement models between sectors, with discussion about participant subjective experience of, information provision, information flow and cross-sectoral communication methods. Participants were asked their view of the impact of relationships between the statutory and voluntary sectors in the policy development process and finally the key challenges and problems in implementing the Connecting for Life (2015-2020) strategy in Ireland.

Ethical Implications and Data Collection

The approach determined appropriate to generate data that answered the research questions was a qualitative methodology. This involved using interview methods aimed at capturing the subjective perceptions of a sample of respondents. A primary consideration was the safety and well-being of participants and the assurance of confidentiality in the management of interview, data collection and management, within the required safety parameters. This is discussed further in the interview outline below however; the ethical considerations are elaborated to ensure clarity in methodological considerations. This research deals with human subjects, ethical approval was sought and granted from the Ulster University Ethics Committee. As there were no vulnerable groups or individuals represented in the sample, the primary ethical considerations included informed consent, protection of data, and the safety of researcher and participants. Governance and ethics in social science research stipulate that informed consent consists of that which is given by a participant who has been made aware of the identity of the researcher, the purpose and scope of the research, the terms and conditions, and the sponsoring body (Bryman, 2004). Anonymity was discussed with interviewees and all data collected, the success of the study undertaking depended on the participation and willingness of respondents and thus they were assured that information was treated confidentially, kept safely and anonymity was protected. The study was examining policy process and respondents were drawn from a range of organisational settings. It was also important to consider an additional factor, namely the theme of suicide prevention; it is an emotive topic and had the potential for impact on respondents. Interviewees were assured that should participation place them at risk or cause stress and distress, participation would cease and appropriate advocacy methods would be used to signpost to the relevant supports. Access to the subjects was negotiated by contact by email and telephone where it was clearly explained the purpose and range of the study, management of data collected, limitations of data use and confidentiality. An information sheet (Appendix 8) was given and a consent form (Appendix 9) received in writing with assurance that organisation procedures were adhered to at all times. As stated above, this study adhered to the ethical and good practice as specified by Ulster University. Interviews were carried out in organisational and public locations as determined to meet the needs of respondents.

Case study

Defined by Bromley (1990), case study is a "systematic inquiry into an event or a set of related events which aims to describe and explain the phenomenon of interest" (p. 302). In this study there is a retrospective, a current and prospective focus, all of which are relevant to understanding the process in developing suicide prevention strategy. Walt and Gilson's framework investigating actors, processes and contexts were employed to inform a better understanding of the factors influencing the stakeholder interaction and policy process (Walt and Gilson, 1994 and Kingdon, 1995). Stakeholder analysis framework informs the understanding of power and networking relationships between stakeholders and sectors and there is consideration of elements including the political will of key actors involved in the suicide prevention policy process in Ireland (Majchrzak, 1984; Brugha and Varvasovszky 2000).

A qualitative research strategy using case study method has been determined upon for this topic, the rationale for the approach and data collection method is based on the nature of the subject area and aimed to establish a design which would adequately address research questions and elicit subjective responses that allowed identification of key policy process themes and patterns. To address the questions and allow for articulation of the complex subject matter a qualitative design was considered most suitable. The choice of the research paradigm is influenced by and reflects a social constructivist approach, methods of data collection that incorporate understanding of social context, interpretive, critical and narrative accounts of sample experience in the area under study, namely suicide prevention policy process.

Interviews

Semi-structured interviews with key informant participants were conducted in various locations in the Republic of Ireland and research questions were informed by the literature, document analysis and key thematic areas for analysis of policy process. Participants were selected through purposive and snowball sampling based on the aforementioned analysis of documents and literature. Interviews were recorded where permission was given and extensive notes were taken where permission was not awarded for recording. All notes were verified with the participants and interviews transcribed and analysed. In addition to interviews with key informants and document analysis, participation at suicide prevention action plan meetings, consultations and events provided opportunities for notes and observations. A personal researcher

reflective diary was written and checked for personal bias in conducting interviews and thematic analysis.

Recruitment and Sample Size

Methodological considerations included how many interviews would sufficiently generate data to answer the research question. Flick (2011) identifies two dimensions for consideration in sampling, namely those inside and outside the study. The inside study dimension is the question, which is seeking answers from the experiences of individuals. In this study the sample is drawn from individuals and representatives of statutory, community and voluntary sectors. A variable for consideration is how close participants are/are not to suicide prevention policy making in Ireland, hence membership of national task force or advisory group is an important consideration. An additional variable and methodological consideration was interviewee experience of consultative and engagement processes at local, regional or national level. The aim was to ensure representative sampling across a range of sectors, government departments, political parties, academic institutions, individuals affected by suicide and C&V at local and national level.

The outside determinants for defining the number of interviews were accessibility to and participation of interviewees, resources for the research, including travel, time constraints impacting the study, including transcription and analysis of findings generated through interview. An additional dimension would be snowballing effect and possible signposting by interviewees to additional sources of information. It was essential that there would be sufficient interviews across the range of actors within the policy process, to ensure quality and rich data that informs the research question.

For the reasons outlined above participants were selected through purposive and snowball sampling based on analysis of documents, existing databases and literature. (N=16) subjects were drawn from the aforementioned national planning and oversight Group, the advisory groups including research, practice and particularly policy advisory groups.

Sampling included those drawn from the Statutory Sector, relevant departments and HSE, Political Parties and a number of advisory group members involved in developing the current Connecting for Life strategy. Participants were also drawn from the Voluntary and Community Sector at national, regional and local level, and finally it was considered essential to interview representatives of those bereaved through suicide from

a number of locations across the country. This afforded the study a range of participants drawn from the suicide prevention sector across Ireland, the aim being to gather responses of a cross section of groups with an interest in the subject area. Sampling aimed to mitigate against the power differential that may exist between the statutory and voluntary sector, due primarily to funding management. Purposive sampling methods were used to secure subject organisations and individual views on the policy making process and this variable is significant in the sampling process.

The review of suicide prevention policy and development of Connecting for Life (2015 – 2020) was coordinated by the National Office of Suicide Prevention in Ireland and the process managed by a Planning Oversight Group with overall responsibility for development of the strategy. In addition, a number of advisory groups were established in specific areas: research, policy, communications and media, practice and engagement with tasks delegated and assigned under each theme outlined above.

Table 2.1 Participants

Participant	Position/Role	Statutory Voluntary Community	Category/ Type	Participation Policy Making/Process
Participant 1	Political Party Representative	Dáil Eireann	Research and lobby, involved in C&V, policy making	Yes National Previous Current
Participant 2	Director	Academic Research	Research Voluntary, Policy expert	Yes National Previous Current
Participant 3	Director and Researcher	Academic Research	Research Voluntary, Policy expert	Yes National Previous Current
Participant 4	Statutory Sector Regional Staff	Officer HSE	Capacity building, suicide prevention, statutory sector	Yes Local National
Participant 5	Community Development Worker	Consultant	Consultation, community development/ engagement, policy review	Yes Current Local and national

Participant	Position/Role	Statutory Voluntary Community	Category/ Type	Participation Policy Making/Process
Participant 6	Political Party Representative	Dáil Eireann	Constituency representative, suicide prevention /mental health activist	No – Current
Participant 7	Political Party Representative	Dáil Eireann	Constituency representative, /mental health portfolio	No Current
Participant 8	Director	Voluntary Sector	Policy advisor, advocacy work, research, policy making.	Yes Current Previous
Participant 9	Chair/Director	Community Sector	Service Delivery Advocacy, suicide prevention	Yes Local
Participant 10	Activist/suicide prevention	Community Sector	Advocacy, lobbying	Yes Current Local
Participant 11	Director CEO	Voluntary Sector	Umbrella Organisation National Service Delivery, advocacy, lobbying	Yes Current National
Participant 12	Activist suicide prevention	Community Sector	Service delivery, lobbying, advocacy	No
Participant 13	Director	Statutory Sector	Policy Development, implementation, funding	Yes Current and Previous National and local
Participant 14	CEO/Director	Regional Voluntary Sector	NGO, Regional service Delivery and Community Development, Multiple areas of activity	Yes Current Local
Participant 15	Clinical Director	Voluntary Sector	Service Delivery, lobbying, advocacy	Yes Current National
Participant 16	Elected Representative	Statutory Sector Council	Service delivery, community development, suicide prevention	No

Thematic Analysis and Presentation

Following transcription, data analysis utilised and was informed by structures and processes derived from Nvivo and thematic analysis. The purpose was to ensure methods that allow for extraction of concepts and developing themes including repetition of topics, emerging categories, similarities and differences in participants' responses to the questions. Each participant was allocated an I.D. number and position and organisation was coded to ensure confidentiality and thus participants could not be identified to ensure internal and external participants are identified. Coding was informed through immersion in data, from the literature informing a coding frame and through NVivo. Thematic analysis involved listening to interviews, reading transcripts and notes and familiarising myself with the data, making summaries of each interview and emerging themes a number of times. Regularities in the data were detailed and this offered an opportunity to categorise, compare and extract themes, based on sentences, comments, phrases and key words or concepts discussed by interviewees. Ryan and Burnard, cited in Green and Thorogood (2014) describe a number of strategies to extract themes, including, repetition of topics, "in vivo" categories used by respondents to describe the world, metaphors and analogies, similarities and differences. (2014: p. 211). This study approached thematic analysis informed by common strategies as described. The topic guide for consideration included identifying internal stakeholders, those within the organization promoting or implementing policy process or external stakeholders. In addition participant's knowledge regarding the research questions and reflections upon the policy process. Themes of interest also included participants' position regarding support, opposition, or neutrality in considering questions about relationship across sectors impacting policy process. The aim was to inform an understanding of alliances across sectors, across organisations, influence, power and characteristics, degrees of collaboration and competition in policy process. Data was analysed based on participants' position on the research question, knowledge, position and support of topic under review, interest in the policy process. Data analysis utilised NVivo methods of organising data with detailed thematic analysis. This was used to extract concepts, themes including repetition of topics, emerging categories, similarities and differences in participants' responses to the questions.

NVivo and Data Analysis

Qualitative research has endeavoured to improve the generalisability, validity and replicability of findings derived from case studies and ethnographic research examining subjective in vivo experience of subjects. To improve the reliability and reproducibility of qualitative analysis, software packages have been developed. While they do not *do* the analysis, they offer a set of tools for the management and organisation of data. The NVivo tool was considered a useful and essential aspect of analysis in the study, offering a framework for highlighting and validating emerging themes. Used alongside thematic analysis I determined that the methods would offer depth to the analysis of data and emerging themes.

As a Gestalt psychotherapist I am informed by fundamental principles based on field theory (Lewin, 1951), existentialism and contacting process, with Gestalt determined as the whole being greater than the sum of its parts. It is a discipline that attends to the subjective process to determine the emerging themes and therefore I considered thematic analysis as a useful theoretical step by step approach and guide to data analysis. Thematic analysis, as described above, describes in-depth attention and consideration of participant subjective experiences and process, leading to the development of understanding as a whole (gestalt), this being greater than the sum of its parts and therefore the concepts and coding methods was useful in data analysis in this study.

Interviews were transcribed, with notes written from two interviews where recording was not permitted or possible. Having been transcribed and saved as soft copies all of the transcripts were printed to hard copy for examination and reading purposes. The recorded interviews were played on a number of occasions, with notes taken of particular topics, themes and responses during interview. Data analysis involved immersing into and thematically reading and re-reading the transcripts on a number of occasions to extract and capture the subjective perceptions of respondents to the questions asked during the interviews. Following a critical reflection, a reading and re-reading of transcripts, the data was coded, nodes created, the data organised and populated, corrected and evaluated to allow for interpretation of emerging themes, recurring concepts and distinctions and differences across the material.

The interview topic guide is available in the appendices to the study. Having identified the emerging topics manually, NVivo was employed as a method of organising the data

and extracting themes, in addition to using thematic and elements of Interpretive Phenomenological analysis. The purpose of using a number of methods was to ensure as thorough a consideration of the data as possible; reflexivity being of paramount importance ensuring objectivity in the analysis of data. As the author is an activist researcher in the subject area of suicide prevention it is therefore essential to ensure data analysis using a number of methods that support increased impartiality. There is, in addition, a degree of heuristic inquiry to this qualitative method, allowing for reflection on the complexities and layers of themes emerging in the transcripts of respondent's subjective experience of the interview.

Interviews were carried out with 16 participants, generating transcripts (N=14) as two of the meetings involved 2 interviewees. Fourteen transcripts were uploaded to NVivo 11 in "Sources Internal" an interview folder titled "Interview" was created and participants were numbered 1 to 14. In addition, four sub folders designating the sector that the participant belonged to were created:

- Statutory Sector
- Community and Voluntary Sector
- Political Sector
- Research Sector

Each of the interviews was assigned a node which contained the entire transcript of the interview under the "Folder Participants in Node" view and at this point the open coding exercise began. Firstly, as stated above all of the hard copy transcripts were read and re-read for immersion purposes, each was annotated on the left margin with words, phrases, themes or ideas as the document was analysed on a line by line basis, frequently re-reading for context. Having considered the content of the transcripts, data analysis proceeded using manual NVivo coding rather than automatic as variations emerged in the participant responses depending on the sector that they were a part of and their knowledge and insight on the questions and themes of the study. It was evident that respondents described a range of experiences and knowledge across a number of themes and the semi structured interview format allowed opportunity for interviewees to expand on their subjective perceptions in one or more areas at the expense of topics that were not in their breadth of experience or knowledge.

An open coding container node was created and the first transcript was then re-read from the NVivo soft copy, with responses from the participants manually coded to

nodes based on this particular reading, with reference to the hard copy annotations from the previous thematic examination and analysis. The process was then repeated for each of the remaining transcripts using the same methodology. Having completed the process a second pass/reading was completed from 1 to 14 to capture responses and also code to the newly created Nodes from later transcripts, this completing the initial Open Coding.

Table 2.2 Open Coding: Example 1

Accreditation	3	4
Advocacy	7	17
Bureaucracy	2	5
Capacity	9	29
Connections	13	55
Cross sectoral	14	203
Decriminalisation	5	16
Engagement	13	159
Evidence Base	11	27
Funding	12	72
Gaps	10	42
Governance	8	11
Guidelines	3	7

Phase 2 of NVivo analysis involved each of the coded entries being created into to a Node folder of the same name, responses were re-ordered, re-labelled, distilled and merged into Nodes which were renamed to more accurately reflect coded content to allow a more in-depth understanding of the subject matter and emerging themes. An example for the theme of "Consultation" is outlined below and indicates the greater depth afforded when content is distilled and thematically considered as follows:

Table 2.3 Consultation

Consultation on strategy Aspirational	3	3
Consultation on strategy Negative	5	27
Consultation on strategy Neutral	4	13
Consultation on strategy Positive	8	49

Phase 3 analysis involved a further re-ordering of coding, themes were re-ordered, re-labelled, distilled and merged into Nodes as labelled and outlined in the following themes:

Table 2.4 Coded items

Phase 3 Analysis

Name	Sources	References
Consultation	10	88
Cross sectoral Collaboration	14	187
Decision Points	10	41
Engagement	13	140
Funding	12	70
Implementation	13	86
Policy informed by evidence	13	45
Policy Making Involvement	13	64
Voluntary collaboration with Statutory	13	70

The final phase 4 analysis involved a moving of the already coded responses into container Nodes which mapped into themes findings that emerged during the course of the interview analysis. There were a number of emerging findings that offer significant relationship to the general scope of the subject matter and research questions in this study, however; a number of additional themes have emerged which will be discussed and which could possibly form the basis for further research in the future.

Table 2.5 Phase 4 Analysis

Phase 4 Analysis		
Name	**Sources**	**References**
Further distilling and re-labelling to selected themes	0	0
C & V Sector role in Policy Process	11	42
Cross Sectoral Relationships	11	55
How is policy arrived at	9	37
Implementation structures	8	16
Influences on what policy contains	10	33
Political process	8	22
Power hierarchy	10	30
Who Decides who decides	5	12
Who decides who to fund	10	24
Who decides who to invite	8	17

As each of the phase analyses were completed, memos were also produced to capture important themes and insights provided by the respondents' answers to questions and further comments made by them during the course of the interviews. These have also helped to inform the findings, conclusions and recommendations which are discussed in later chapters.

Determining Methodology - Qualitative and Quantitative Approaches

In order to explicate the rationale for the methodology, other considerations were examined.   As the two primary types of research qualitative and quantitative approaches, should not be viewed as polar opposites or dichotomies: instead representing a continuum (Newman and Benz, 1998), with studies tending to be more qualitative than quantitative or vice versa. Mixed methods research is toward the middle of such a continuum incorporating elements of both approaches. Quantitative and qualitative research strategies are widely used in social research (Punch, 2005, p. 2) and a review of research methodology provided the knowledge required to establish a rationale for which method best suited the study.

Quantitative Research

Quantitative research has a specific focus and deals with information collected in measurement or numerical format. This permits larger samples to be investigated, allowing the conclusion of improved reliability thereby supporting inferences to be made to wider population (Silverman, 2005). Whilst this is an advantage, a disadvantage can be the assumption that facts are true and the same for all people all the time. "Large volumes of quantitative data can be analysed relatively quickly, provided adequate preparation and planning has occurred in advance. Once the procedures are up and running researchers can interrogate their results relatively quickly" (Denscombe, 1998, p. 205). Quantitative research is considered more objective and scientific and objective, as the numerical format can be presented in forms such as graphs and tables (Denscombe, 1998). Creswell (2003, p. 18) points out that quantitative research collects data on predetermined instruments that yield statistical data, the researcher determines the structure, can be uninvolved with the participants and more focused with applying measurement procedures to the social world. The function of quantitative research is to measure phenomena in order to transform it into numerical data that can be analysed using statistical techniques and whilst these techniques are reliable, they are dependent on the input of numerical data. A research hypothesis is established with a predetermined research design in quantitative studies (Denscombe, 2007). Although this permits precision, control and replicability which contribute to the validity and reliability of the method, it fails to take into consideration people's unique ability to interpret their experiences and construct their own meanings (Creswell, 2003).

Kerlinger's definition of a theory as "a set of interrelated constructs, definitions and propositions that presents systematic view of phenomena by specifying relations among variables, with the purpose of explaining natural phenomena" (Kerlinger, 1979, p. 64) is still valid and quantitative research has established some historical precedent for testing and subsequently viewing a theory as a scientific prediction or explanation. A theory may appear in a research study as a discussion, rationale or argument and it helps to explain or predict phenomena that occur in the world. Labovitz and Hagedorn add to this definition the idea of a theoretical rationale defined as "specifying how and why the variables and relational statements are interrelated" (Labovitz and Hagedorn, 1971, p. 17).

The breadth of coverage of theory is considered by Newman (cited in Getzen 2000) who described three levels; Micro – Level, Meso – Level and Macro – Level. Micro Level theories provide explanations limited to small slices of time, space or numbers of people and as such is applicable to this study, which aims to explain how people experience, or are excluded from, the process of deciding suicide prevention policy. Meso Level theories link the micro and macro levels, are theories of organisations, social movement, or communities and in this case can be considered in developing an understanding of policy analysis, policy process, and theory of power, advocacy coalitions and actors in organisations and the impact on suicide prevention policy process in Ireland. Macro Level theories explain larger aggregates, such as social institutions, cultural systems and whole societies and this is a consideration in this study which considers the wider context in which suicide prevention strategy is made in Ireland, Europe and internationally.

Bryman's (2004, pp. 286-287) list of common contrasting features of quantitative and qualitative research argue the use of a questionnaire as quantitative as the research is distinct and uninvolved with the participants. Denscombe (1998, pp. 220-222) proposes an inclusive critique of the advantages and disadvantages associated with quantitative analysis. On examination of the advantages and disadvantages the author was of the opinion that a quantitative approach was not applicable to the study as it was the participants' subjective experience of policymaking process that is the area of interest and in addition quantitative methods would not permit the collection of data that elaborated on process, which is a complex, concept and is determined as an individual and idiosyncratic account of a particular topic, in this case the suicide prevention policy process.

Qualitative research

Bell (2010, p. 5), states that a qualitative perspective relates to the understanding of an "individual's perceptions of the world", with Punch's (2005, p. 5) view that a qualitative approach is empirical research about the world, where data is not in the form of numbers, but may include words, pictures and visual aids. Matthews and Ross (2010, p. 145) propose that qualitative approaches offer the opportunity to explore issues in more depth with the participants in their own words. Consequently, qualitative data is concerned with the understanding of the social world, by examining the participants' view, is focused towards discovering meaning of questions that are not

easily quantifiable. "Qualitative implies a direct concern with experience as it is lived or felt or undergone and the aim is to understand experience as nearly as possible as participants feel it or live it" (Sherman and Webb, 1988, p. 22). Bell states a "doubt whether social facts exist and question whether a scientific approach can be used when dealing with human beings" (Bell, 2005, p. 7). Qualitative research uses multiple tools that help to look for the understanding rather than statistical perceptions of the world, using people, things, and events in their natural surroundings to assemble their knowledge. Punch (1998, p. 139) refers to qualitative research 'as not a single entity, but an umbrella term which encompasses enormous variety'.

The features of an ethnographic approach, according to Hammersley and Atkinson (2007), include a focus on people and their accounts; the study will be on a single case or setting; there will be a range of data sources and the analysis will involve interpretation of meaning. On the premise of the views put forward, the author believed that a qualitative approach is essential to the study. The case study, use of semi-structured interviews to augment existing data generated through literature and desk based examination of documents provides the opportunity to explore issues in more depth with the participants in their own words. Furthermore, the approach taken has and remains interactive and humanistic, enabling the author to accumulate understanding and knowledge from the participants in a natural setting.

Mixed Method, Eclecticism and Paradigms

The 'dichotomy between qualitative and quantitative traditions' has been debated during the past number of years (Teddlie and Tashakkori, 2009, p. 4); with the former having historically been associated with an interpretivist paradigm and quantitative methods considered realist. Over recent years' research has increasingly examined complex issues with a mixing of qualitative and quantitative data (Creswell and Plano Clark, 2007, p. xv). Teddlie and Tashakkori (2009) argue studies have always existed that used mixed methods and until the 'paradigm wars' of the late twentieth century combining methods was unproblematic and indeed unremarkable. Teddlie and Tashakkori (2009) defined six existing social research positions regarding the relationship between paradigm and method (ibid, p. 96). Some argue that paradigms are incompatible and thus mixing methods is impossible, with alternative views considering that a single paradigm ought to steer mixed method study. This study is predicated upon what Teddlie and Tashakkori (2009) call a dialectic stance, which is that 'all paradigms are

valuable, but only partial world views. To think dialectically means to examine the tensions which emerge from the juxtaposition of these multiple diverse perspectives' (ibid, p. 96).

Gorard and Taylor (2004) encourage eclecticism about methodology, arguing that deductive and inductive, qualitative and quantitative debates are part of wider considerations including direct and indirect methods of gathering data. They suggest alternate descriptors for research strategy, including 'active' and 'passive' or 'descriptive' and 'explanatory' (ibid, p. 5). In other words the qualitative/quantitative divide is not an exclusive way to view research practice. "Once on the road to conduct research, everything is potentially informative and the researcher becomes a 'Hoover' of data, as far as possible. The research starts with draft research questions, and continues with an attempt to answer them by whatever means it takes. It is difficult to imagine why anyone would do anything very different" (Gorard and Taylor, 2004, p. 5). In addition, they assert that 'words can be counted, and numbers can be descriptive' (ibid, p. 6), thus data can be collected in a number of ways, methods and from varying sources.

Bell (2005, p. 117) Asserted methods of data collection must be critically assessed to ensure they are valid and reliable, with reliability being the degree to which the methods are used; and may produce similar results no matter when and how often they are tested. Validity informs the researcher if the tool used describes what it was supposed to. Sapsford and Jupp (cited in Bell 2005, p. 117) consider validity as 'the design of research to provide credible conclusions; whether the evidence which the research offers can bear the weight of the interpretation that is put on it'. Having considered the views that no single paradigm is dominant in collecting data, this research uses a qualitative method to consider the exploratory hypothesis and answer the research questions proposed.

Conclusion

The methodological approach and the rationale for the same was presented in this chapter, which addressed data collection methods considered most appropriate for attending to the research questions and capturing the experiences of participants. A method was required to enable an initial description of the participant experience, further the aim of the study and yield sufficient data whilst also taking into account factors such as access to interviewees, resources and time constrictions in carrying out the study. A qualitative approach and case study method was considered appropriate for

this type of critical research. It would maximise resources and enable consideration of the themes together with the need to maintain awareness of researcher subjectivity. In addition, this section articulates the author's heuristic and activist experience in suicide prevention and the ethical considerations required for the study, recognising finally that it is the same sectoral experience which prompted the themes and research questions in the first place.

Chapter 3: Suicide Prevention Policy in Ireland: Retrospective and Contemporary Process.

Introduction to Chapter

Much has changed in the study of public policy since the first efforts to address suicide rates in Ireland brought the subject out of the darkness of criminalisation and taboo. Whilst this is the case, much of the focus in policy studies attends to content, implementation and the achievement of outcomes. This study asserts that understanding the processes carried out by government and suicide prevention policymakers is also an essential activity informing the explicit and implicit dynamics embedded in policy making in Ireland. Examining the process involved in developing policy and the relationships within and across sectors dealing with the issue of suicide policy is an essential foundation to understanding policy planning, content, implementation and outcomes.

Suicide prevention "process" is central, not simply a backdrop to this study. As such, this chapter offers a retrospective analysis on suicide prevention policy from 1998 - 2015 articulating how policy was developed and assessing the influences and factors on policy formation in Ireland. It considers the changing social structures, the social policy process in the country and how partnership developed in social and particularly public policy. The impact of policy making process is a feature that has not received sufficient attention in Ireland. This was noted at the launch of the Irish Journal of Public Policy in 2009 by Garrett FitzGerald , former Taoiseach, who stated that "in Ireland we have been curiously deficient in terms of outlets for discussion of public policy'' (McMahon, 2009). The chapter documents the historic and contemporary journey of suicide prevention strategy in Ireland, critically reviewing the context prior to the first private members Suicide Bill (1991) aimed at decriminalising suicide. Although proposed in the Dáil by Dan Neville in 1991, it was 1993 before the act of suicide was decriminalised in Ireland.

This chapter examines the characteristics of policy process in Ireland and pathway to developing strategy, offering a retrospective and contemporary consideration aimed at understanding stages and process in suicide prevention in the nation. Themes about partnership, cross sector collaboration, engagement and the relationship between sectors are considered in the examination of the evolution of the nation's efforts to address the

rate of suicide discussed. The decision network that informs membership of committees is considered. The chapter reflects on who/what groups decide strategy, from the most recent Connecting for Life (2015), the Reach Out Strategy (2004) and the National Task Force (1996). Evidence has been gathered through the review of primary and secondary sources, key texts on policy process, reports and policy documents to identify themes that are of relevance to the research question.

Ireland, Social Structure and Change

The 60's witnessed economic growth and this turnaround yielded economic resources for basic reform and social services improvements (Considine, 2009). This was also a period of immense social change, which was instrumental in highlighting both social policy progress and inequalities, with subsequent differences in how governments responded. The social, economic, cultural and political structure of Ireland has been transformed since the 1970's, with substantial effect on Irish society (Considine, 2009). The 1970's was a period of radicalism nationally and internationally, with protest and developments in trade union and community movements against a backdrop in Northern Ireland of civil rights campaigns and conflict. There were mobilised efforts for social change as witnessed by the growth in the women's movement, efforts to address poverty and evidence of capacity for social change generated at community level. This challenged the status quo and the conservative and traditional values that had historically influenced and informed social policy in Ireland (ROI). There were some reforms aimed at economic development and increasing employment, and efforts to redress inequalities faced by women; however, improvements in health and particularly mental health policy remained limited with progress substantially slow at the time.

The seventies witnessed substantial change in Ireland. As a society it was slowly becoming more modern and as a consequence there was a broadening of citizens' cultural awareness. Through such changes, and exposure to national and international mass media information, the result in Ireland was challenges to traditional thinking and changing people's views. News articles emerged addressing previously hidden issues including the impact of alcoholism, deprivation and the experiences of unmarried mothers in Ireland. It is noteworthy that the state, recently (RTE News: 9 O'clock, 2017) acknowledged the experiences of many women and children, subjected to abuse at state sponsored and religious institutions, with the Taoiseach, Enda Kenny, reiterating the 2013 apology to those traumatised and affected by treatment of pregnancy outside

wedlock (Irish Times, 2013). Ireland has moved from being a socially conservative nation to a more secular and liberal country although significant influence is still wielded by the Catholic Church in some areas of the public sphere e.g. Education and social care

Through increased access to global media, an atmosphere of social change on an international scale, and a more general social liberalisation in Europe, there has been an evolution in public policy in line with these changes. Political participation is now embedded in policy making (Newman, cited in Waterhouse Bradley, 2012), with C&V sector inclusion in policy systems (Almond and Verba, cited in Waterhouse-Bradley, 2012). These recent events are occurring some forty years later when evidence of unmarked burial sites at Tuam and other sites were uncovered and this demonstrates the significant changes that have occurred in Irish societal attitudes and values.

In addition to the international developments in policy, changes in mass media and the growth of television had a major social impact in Ireland. This resulted in the "spread of a questioning mentality and a receptivity to change" (Lee, 1979) with the Catholic Church being subjected to questioning in a major shift toward critical thinking unheard of traditionally in Ireland. The church was a key actor in social policy planning and implementation, an influenced by of the second Vatican Council (1962-65). The aim was modernisation and social change with the church critical of Government for not doing enough to improve social conditions. The latter years of the 70's decade witnessed a decline in religious vocations with consequential reduction in religious presence in schools, hospitals and other areas of social services.

Social Change 1980's to 1990's

The wider economic and social situation is important in understanding the context for the development of suicide prevention policy in the country. The 80's witnessed the implementation of cutbacks, impacting the most vulnerable (Considine, 2009 p. 67). Health Boards reduced availability of services, mass emigration occurred, housing grants were abolished and the national experience was one of hardship. The result was a coalescence of factors generating a new resolve to tackle inequality and create social reform. The Social Partners negotiated with government for a Programme of National Recovery(PNR) which identified the difficult task facing policy makers in addressing economic and social issues, such as emigration, national borrowing, youth unemployment (highest in EU in 1985) and the absence of national growth. The

stagnation impacted developments in addressing issues, including mental health and the prevention of suicide and in spite of slight economic improvement from 1988, not felt by the general population, Ireland's economic recovery only began in the 90's and 2000's with an opportunity for social policy, such as suicide prevention, to be addressed. The 1980-1990 period witnessed a period of economic and social stagnation in Ireland. At this time the Catholic Church had immense influence, with the intrinsic relationship between church, and state, having a strong impact on the social, educational and life experience of its citizens.

Policy developments in mental health had been slow, but substantive change in mental health policy occurred in the 1980's against a background of economic recession, mass emigration and cutbacks to social services (O'Connor, 2009). Unemployment resulting from economic downturn exacerbated poverty and exposed shortcomings in social services and welfare identifying at risk groups including those with mental health issues and in long term institutional care. The Psychiatric Services: *Planning for the Future* (1984) outlined a framework for mental health policy advocating community based care in a move away from institutionalisation, with the rationale based on integration rather than segregation in mental health care. Implementation of community based care proved problematic, a consequence of economic recession, demographic pressure and a heavy state burden in areas of health and welfare.

Social Change in Ireland 1990's–2000's

Ireland became significantly more plural and secular during the 80's and 90's, it opened up more to influences from media. Music Television (MTV) was launched in 1984, introducing international music and soap operas to the nation. In 1986, the BBC programme EastEnders with its portrayal of Angie Watt's suicide attempt, received immense media coverage and the exposure of the secret of suicide ideation in a national and popular soap opera was significant. The divorce referendum was passed in 1995, Ireland elected a female president, Mary Robinson, (1990) and the nation witnessed accounts of abuse through media programmes about Industrial School abuses, incest cases and the abuse of children in state care. Against this backdrop the neglect in health services was highlighted by multiple media outlets both print and broadcast media and as economic prosperity occurred in the 90's resources allowed for investment in social services and improvements in health and education infrastructure. As these resources became available it enabled the funding of The National Task Force on Suicide which

was formed in 1995, with the aim to examine suicide in Ireland and how the nation might address the problem. The recommendations and report of this Task Force were published in 1998.

During this time frame, Ireland witnessed the changing influence of religion in Irish society from highly religious to low rate of practice and a challenge to belief systems (Fahey, 1998), (Keenan, 2013). The relationship between lessening religious values and reduced church influence in institutions had an inevitable impact on social change as it occurred in Ireland during the period from 1980 – 2005 when Reach Out, the first suicide prevention policy was published. Allegations and investigations into clerical and institutional abuse changed the relationship, power and trust between the Catholic Church and its citizens conclusively (Keenan, 2013). Established in 2004 under the Commissions of Investigation Act the Commission of Investigation into Dublin Archdiocese (Department of Justice and Equality, 2009) concluded that the central concern in responding to cases of child sexual abuse, at least until the mid-nineties was the preservation of assets, concealment and avoidance of scandal, the defence of the reputation of the Church with considerations, including the welfare of children and justice for victims, secondary to these priorities. The social changes and their consideration inform the backdrop against which the development of policy takes place and this is considered throughout this chapter when the journey toward a policy to address suicide in Ireland is articulated.

The media, and in particular broadcast media, as one of the key institutions in the state play a powerful role in shaping community and national identities and values and attitudes. They are an important vehicle of social change and it is important to cite the role of the media in influencing views and in its portrayal of suicide and mental health as Ireland moved toward decriminalising the act of suicide and creating a prevention policy for the nation (Connolly, J. cited in Foster-Ryan and Monahan, 2001). In addition, as international broadcast media became more available and the internet developed in Ireland, the messages from outside the country shaped values, identity, morals and beliefs thus creating a shift toward a less insular nation and media message.

Ireland, through the economic growth influenced by European Union membership, became more European and global in perspective and outlook, less insular and more multicultural in identity. Economic growth throughout the nineties led to social, political and policy change and the recent past has witnessed the country moving from

being primarily an agricultural to an industrial and economically more technologically advanced nation.

Ireland and EU

Entry to the EEC, The European Economic Community, the forerunner of the modern EU (1973), opened the nation to outside influence and the development of the women's and trade union movement resulted in the emergence of a number of community and voluntary agencies. There was a change from the traditional view of social service provision as benevolence, toward a self-help and community care philosophy which also exposed major gaps in provision. This was the beginning of a burgeoning community and voluntary sector, a shift toward empowerment, activism and participation (Donoghue, 1998).

Considine (2009) argues that this period witnessed social action across many issues including women's groups, tenant and housing provision, with activism in poorer, rural and urban communities. Curtin and Varley (cited in Considine 2009, p. 53) describe this emerging theme as "oppositional community action" involving criticism of the state founded on structural analysis which concluded that the state role was one of reinforcing and sustaining patterns of disadvantage rather than alleviating it. The EEC had established an anti-poverty programme in Ireland which resulted in an increase in community engagement and empowerment. This strengthened and consolidated the C&V sector as social policy actors in Ireland. European legislation and funding remained a cornerstone of social development and change in policy process in Ireland. . Funding provision and structures can require certain sets of conditions be met, such as the impact of conflict, risk or deprivation. Hence, there emerges a competitive C&V industry in which communities and organisations are pitching for funding against each other. The result can be sustained division, disadvantage and patterns of competition between groups.

The emergence of a C&V sector initiated a change to social policy process establishing an enlarged and disparate range of actors involved in policy planning and implementation. Thus was established the cross-sectoral infrastructure and it is suicide prevention cross-sectoral policy process which is the subject of this study.   Further social policy progress occurred with the establishment of the National Economic and Social Council (NESC) in 1973. Now referred to as the Social Partners, specific terms of reference and interests were considered as areas for attention and modernisation.

This emerging structure for social partnership comprised representatives of employers, trade unions and farming at that time. The C&V pillar was later added in 1996. In a structure that remains today, the NESC examined previously overlooked themes and enabled a movement of knowledge and evidence toward decision makers in government. The NESC (1975) stated its rejection of a narrow definition of social policy concepts in guiding process and policy decisions and argued the importance of recognising distributional, effects and implications of policies developed in Ireland.

Partnership in Policy Making in Ireland

In the sixties Lemass, Sweetman and Whittaker led a change to the opening of the economy, growth in business and parallel change in the civil service. Aimed at economic development the plan contributed to tripartism in public policy making with representative of trade unions and business appointed to many state and public bodies, this being the dominant approach in the seventies in developing national wage agreements and understandings (O'Donnell and Thomas, 1998). As stated above the National Economic and Social Council (NESC) established in 1973 and comprising the Social Partners, advises the Taoiseach on strategic policy issues and from 1986 to 2006 produced strategy reports that formed the basis for negotiating the social partnership agreements. The history of social partnership in Ireland originates in the forties when Sean Lemass, politician and eventual Taoiseach, proposed methods, along corporatist lines, of restructuring collective bargaining and industrial relations. Aimed toward economic growth, Lemass had limited success in a context that offered inadequate political support and where industrial relations were voluntarist in tradition. O'Donnell (1999) and Hardiman (1992), among others, consider the merits of the present day connection between these historical developments and the development of the social partnership approach to public policy making in the 1986 -1990 period.

Social partnership approach is at the foundation of policy making processes in Ireland and comprise of five 'pillars': business and employers, trades unions, farmers, environmental NGO's and the 'Community and Voluntary Pillar' which comprises 17 community and voluntary organisations. This study is interested in the composition of, engagement with and decision making between the state agencies (NOSP and DOH) and C&V organisations in deciding suicide prevention policy in Ireland. It was through such an approach, involving employers, farmers, civil servants and trade unions in 1986 that the National Economic and Social Council (NESC) carried out analysis of social

policy issues and published The Strategy for development (1986) aimed at national recovery and an escape from spiralling debt and stagnation in the country. This led to new programmes negotiated from 1986-1996, using a social partnership approach. The Programme for National Recovery (PNR) has been involved in a range of economic and social policies, such as tax reform and health. Significant achievements have been made in Irish public policy making as a result of the development and influence of the partnership approach. In many cases the internal policymaking processes between the executive and their public servants and partners are not investigated (Hardiman, 2006) and this study aims to shine of a light on the interactions and process in suicide prevention policy review, consultation and engagement in the hope that it will offer an additional aspect for consideration in future processes.

The Community and Voluntary (C&V) Sector

This study of cross-sectoral relations in suicide prevention policy process is informed by an examination of the C&V sector as a subsystem and particularly its role in addressing the policy topic under consideration. It is therefore pertinent to consider the origins of C&V sector, its purpose and functions in Ireland. Between 2005, when the Reach Out Strategy was launched and 2015, the scale of development and activity within the suicide prevention C&V sector changed how suicide is responded to in Ireland. A more detailed discussion occurs in chapter one, with a portrait of the suicide prevention C&V sector, where the findings of research conducted by the author, "Quality Systems and Accreditation Standards for Voluntary Suicide Prevention Organisations in Ireland" (Friel and Gallagher, 2013) is presented. The findings indicate a C&V suicide prevention sector in Ireland that is relatively immature, suicide having been decriminalised in Ireland 25 years ago in 1993. The sample of organisations reveal that the majority were formed after decriminalisation (Friel and Gallagher, 2013) and the C&V sector consists of a range of small local, larger regional and national organisations involved in suicide prevention, intervention and postvention activities.

The power of the state and political process in decriminalising suicide in 1993 is noteworthy. The action of decriminalisation opened up discussions and gave voice to the topic of suicide that was previously suppressed, shrouded in secrecy, stigma and taboo. Decriminalisation transformed the status of the subject, thus politically

introducing it to the public sphere, creating legislation, policy and service developments.

The emergence of C&V sector historically is discussed in this chapter of this study, but was influenced by many factors, including global developments and in N.I. civil rights in the 1970's and 1980's. The development of a distinct form of C&V in Ireland in the 1980's can also be linked to the impact of unemployment, fiscal and economic crises (Larragy, 2014) which led to cutbacks, charges on healthcare and marginalisation across sections of Irish society. The result was a growth in organisations with a focus on broad rather than specific issues and this resulted in the emergence of a community and voluntary sector as stated by Larragy (2014) "of new associations anxious to engage with the state" (2014: p. 72). This led the creation of the Community Voluntary Pillar in Irish social partnership.

Many of the suicide prevention organisations across Ireland formed in reaction to actual or perceived lack of adequate services and responses to suicide by the state sector and the C&V represents the resulting diverse range of organisations working across a variety of locations, target groups, purposes and themes. In such a disparate subsection it is inevitable that sub-groups or constituencies exist. Subgroups will comprise dissimilar, possibly incompatible and contradictory, concerns and inclinations, which may have a direct influence on the strategies and preferences of that group and as a consequence influence on policy process. It might also follow, that the scale and impact of suicide in Ireland might act to moderate the diverse opinions within and between negotiating constituencies and sectors in suicide prevention policy making. Cross sectoral relationships and dynamics between stakeholders have the potential to significantly impact the level of influence of C&V on policy process. In addition, consultation processes are a relatively new concept in Irish suicide policy process and it is therefore important to note that power imbalances, political factors and issues within the consultation process itself can affect the development and subsequent implementation of policy.

Defining the C&V in Suicide Prevention Policy

It is useful to consider what we mean in discussing the Community and voluntary sector, there have been multiple definitions offered for the C&V or third sector, with some arguing that definition varies depending on purpose and meaning. Almond and Verba (1963), cited in Waterhouse-Bradley (2012) suggest that citizen participation in

political process is enhanced by the community and voluntary sector.   For others, definition of such a sector is a contested field, as both the existence and definition of a third sector are subject to debate (Alcock, 2010). It is useful to consider definition of the C&V sector as it pertains to this research, as this affords an opportunity to identify and describe the sector and its role in suicide policy process.

Definition, discussion and debate results in disagreement due to different perspectives, those of academics, policy makers and indeed organisations and practitioners themselves. More broadly, as Alcock (2010. p. 5) argues, "in international debate there are distinct cultural and political legacies arising in different national settings", a useful distinction to consider when comparing Irish strategy with international evidence and policy. In a study of definition   Halfpenny and Reid cited in Alcock (2010) concluded that no clear definition for the third sector exists and in a diverse sector effort to impose homogeneity was problematic, with definition being pragmatic and related to purpose.

Levitt (cited in Alcock, 2010) a US economist described the third sector as 'an enormous residuum' (2010, p. 7), located outside public and private sectors and Deakin, cited in Alcock (2010) states, "There is no single "authentic" voluntary sector for which a simple master plan can be drawn up" (2010, p. 7). In a similar consideration, Salamon and Anheier, (cited in Waterhouse-Bradley, 2012) consider the third sector as a grouping of private organisations offering a wide range of services, including advocacy and information. Classifications within the sector can range from cultural and social, educational and health and social services (Salamon and Anheier, 1997).   Whilst the sector might lack consistency in definition, literature distinguishes it from the statutory sector using a range of terms, including non-profit, non-governmental and non-statutory sector. The organisations carry out a range of civic and social functions ranging from interest based, thematic, civic and social, Boris and Mosher-Williams (cited in Waterhouse-Bradley 2012 p. 120), aimed at promoting and protecting the interests and rights of specific groups (Salamon and Anheier, cited in Waterhouse-Bradley, 2012). For Larragy (2014) in an examination of the C&V pillar in Irish social partnership, the introduction of C&V organisation into social partnership raises themes about the place and legitimacy of such associations in liberal democratic systems. Larragy argues the locus of legitimacy as unstable as it is the result of "asymmetric distribution of resources and power in a system of production that is prone to cyclical instability and crisis" (2014, p. 32-33). In spite of this and the lack of power and resources, organisations that are representative of sections of society can be effective, acting as

catalysts for change and whilst this "effectiveness is not a given, it should not be dismissed" according to Larragy (2014, p. 33). Indeed, it is also the case that some small organisations can experience windows of opportunity in policy process through changes and shifts in context. Whilst the smaller groups may not have bargaining power or status arising from being involved in social partnership, they are effective as experts, with policy ideas and roots in communities (Larragy, 2014).

The history of the burgeoning C&V sector and civic engagement in Ireland has been discussed elsewhere in this study, however to develop understanding, it is pertinent to examine the function and role of the C&V and the elements and factors that affect the sector's place and influence in policymaking. It is therefore useful to examine the effectiveness of the C&V sector as a representative subsystem in policy process.

The mediating role of the third sector was explored in Almond and Verba's analysis of engagement by civic groups with political structure and processes in *The Civic Culture*, cited in Waterhouse Bradley (2012) which considered a sample of 1,000 participants from G.B. Italy, Germany, Mexico and U.S.A. The study centred on the national political culture, defined as "the political system as it is internalised by the cognitions, feelings and evaluations of its populations" (p. 123). The knowledge of the political system is considered as cognitive orientation, with the affective orientation assessed as the meaning or feelings towards the political system and the evaluation of the societal political system includes the opinions and judgment of the systems by the populations (p. 124).

According to Almond and Verba (cited in Waterhouse-Bradley 2012) the political culture comprises of three categories of "political objects" (p. 124), firstly, roles or structures; secondly, incumbents of roles, and finally, policies, decisions or enforcement of decisions. In characterising political culture, Almond and Verba developed a "matrix" of three classifications: parochial, subject, and participant (Ibid. p. 124). In parochial political cultures, no formal relationship structure exists between the state and its citizen, who has limited or no knowledge of political objects. In subject political culture, citizens have awareness of political objects, although they do not consider themselves active participants in the system, being recipients of state policies in a top-down flow of power. In participative political culture citizens have, not just awareness of actors and political systems, but are also active participants in an interactive civic process. Described by Almond and Verba, civic culture "is a participant political culture in which the political culture and political structure are congruent" (Ibid. p. 125).

C&V and Access to Political Culture

The C&V is credited with creating aspects of the participative political and civic culture as described above. The collective involvement through voluntary groupings creates greater possibility for successful access to government and as stated by Almond and Verba are 'the prime means by which the function of mediating between the individual and the state is performed' (cited in Waterhouse-Bradley, 2012: p. 125). It would appear that affiliation, membership and inclusion of C&V provides enhanced levels of confidence for individual, improving access to policy making and increasing the bargaining power and capacity to effect change. Such an outcome would be beneficial for individuals, communities and stakeholders with the desire to impact change to suicide prevention policies and services in Ireland.

The Role of the C&V sector

As with the defining the sector itself, varied understandings exist of the role of the C&V third sector, with service provision; support, lobbying, advocacy and community building, among a range of considerations by Kendall cited in Waterhouse-Bradley (2012). It is important to note that service delivery would be the most significant factor cited as purpose by the suicide prevention C&V sector in Ireland, particularly as many groups and organisations formed in direct response to the impact of suicide at community, regional or national level. In addition, as stated above, organisations were developed due to experiences arising from service gaps, or perception of a lack of service by the state agencies. It is therefore not surprising that Casey (Ibid, 2012) found that the majority of C&V voluntary groups did not consider influencing policy as part of their role, with service delivery as their main objective and function.

The role of community groups has been perceived as one of motivating and engaging inactive people and encouraging awareness of their political responsibility, (Shaw and Martin cited in Waterhouse-Bradley 2012). Similarly, Boris and Mosher-Williams (ibid) portray the voluntary sector as an essential link in feedback between population and the state. This emphasises the importance of representativeness in political decision making. There is an impact of policy when C&V groups are not involved and monitors or critics of the process and its decisions. This is an important reminder of the role of the sector and a consideration when examining suicide prevention policy process.

It is worth remembering that the suicide prevention policy and strategy making is relatively young as a process in Ireland. Decriminalisation occurred in 1993 and the first strategy Reach Out (2005-2014) was developed as a top-down approach with limited levels of consultation and participation by the C&V sectors. This is related to the developments of the social partnership approaches to policy making and the role of the C&V therein, which was very much in the early stages of development. The development of consultation, engagement and participation across statutory and C&V sectors occurred between the Reach Out strategy and Connecting for Life (2015-2020) and the relationships between sector in developing national suicide prevention strategy is the focus of this study. In a study of social partnership in Ireland, Adshead (2011) argues that when social partnership agreements are first being made there is less trust, habits and fewer norms, with interactions and negotiations being informed by strategies based on partner's perceptions of their power and shifts in power as negotiations proceed. Given that the review of existing suicide prevention strategy and developing the succession, Connecting for Life (2015-2020), this recent opportunity was the first time such level of consultation and engagement between the state and C&V occurred in developing national suicide prevention actions in Ireland.

Policy Process and Policy Making in Ireland

This study is a descriptive and prescriptive analysis of the suicide prevention policy making process in the Republic of Ireland. The descriptive examines how suicide prevention policy was historically developed and the prescriptive considered how policy making could or ought to be made. The policy process is not linear; stages overlap and it can be untidy with C. J. Friedrich summing up this phenomenon by stating that 'Public policy is being formed as it is being executed, and it is likewise executed as it is being formed' (Friedrich, cited in Hill, 2014. p.158)

It is important to assert that this study is focussed on process rather than impact and this chapter examines how policy is formulated and determined in Ireland. This is valuable to our understanding of the factors impacting upon suicide prevention policy process. Theories of policy process have been addressed in the study, and it is recognised as a complex and often muddled study of a range of complicated and disparate factors. As stated in the previous chapter, historically a number of frameworks were developed to capture the nature of policy development (Hogwood and Gunn, 1981). Articulating the

determinants for policy making in the political systems and the factors influencing policy implementation (Sabatier, 2014) is a complex task which resulted in the development of methods aimed at examining the process. This included Hofferbert's (1974) Funnel of Causality in policy process and the later Advocacy Coalition framework (ACF). .

Systems and Policy Process

Systems theory considers political process as a series of behaviours, rather than a set of institutions. The application of systems theory to policy process recognises the interdependent systems and subsystems and how they relate to each other. One of the most important of these is the political system, where citizens' direct needs and demands toward a process of political endeavour that leads to policy decisions. There are three important aspects of the political system that must be considered when assessing how the system of government responds to demand for change. Firstly, it is important to address the efficiency with which the political system responds to demand, this being a factor when one is considering how government responds to suicide. The source of the demand is also an important factor to be addressed, is it from within the political system itself or from the society it governs? The momentum created when there is an outcry about suicide and mental health can mobilise a political response.

Finally, it is important to acknowledge how the political system is concerned with the resources to meet the demand, a noted theme in developing the Connecting for Life strategy in 2015. Limitations to resources will have a direct impact on the policy making system and how it responds to societal demands for change. Resource limitation often means demands cannot be met and those that do become issues for political resolution directed back toward citizens and society as decisions or policy outputs. Decisions about resources impact not just the strategy content, but the distribution of resources linked to implementing actions and objectives contained in the national plan. The complexity of the policy context was concisely illustrated by outgoing Taoiseach Enda Kenny in May 2017 when he said, "People at the edges are looking to their politicians for a far greater degree of certainty and when politicians look for something that is deliverable, what the people want is deliverance." Kenny further stated, "You can find plenty of people to talk about delivery in perfectly packaged soundbites but often times, without humility, because nobody has all the answers". The resourcing of suicide prevention strategy, the efficiency of responding and how

government responds to demands for change are important considerations in this study. There are those who argue (Lee, 1989; Barrington, 1987 and Earley, 1999) that resource limitations result in obstacles and obstruction to policy development in Ireland, thus the content of strategy and its design may be constrained by resource limitations.

The history of social policy in Ireland is discussed in this chapter. The rationale for doing so is to offer improved understanding of the framework and context in which suicide prevention strategy develops in Ireland. By situating suicide prevention policy in a discussion of structures and system, it clarifies the conclusion that progress toward decriminalisation (1993) and development of policy was a somewhat inefficient, slow and difficult process. It is a useful endeavour to consider the factors that influence, inhibit and encourage and indeed gate keep developments.

Gatekeeping in the Policy Process in Ireland

At varying stages in the policy process gatekeeping occurs to regulate the flow of demands on the political system. The policy process is one of stages or channels and gatekeeping may, in some ways, be a necessity that avoids a collapse of support for the political system. The process of gatekeeping creates pathways, stages through which the issue/demand must pass and it is the decision makers, the coalition of individuals, groups and institutions that will determine if the issue/demand will be gate kept out or proceed to the next stage in the policy making process. Gatekeepers possess position, authority, and expertise to influence and determine the progress of demands within the system. Any of the actors involved in efforts to influence the creation of policy or modify existing policy are gatekeepers to the process in suicide prevention. This includes community and voluntary sector groups and organisations, trade unions, individual TDs and party spokespersons representing the interests of constituents. In addition, the media, academics and civil servants and statutory sector organisations who act as advisers to government on the subject of suicide and its prevention are also gatekeepers to the suicide process. Characteristics, such as power in policy making process are examined further in this study and are evident in the gatekeeping process. These factors influence which demands are translated into political action and can determine the outcome of policy; gatekeepers operate in the system itself and also have an impact on the progression of the issue/demand towards output (policy).

The policy process comprises a set of governmental and stated structures and systems and these can regulate the gatekeepers, bearing in mind that they do not operate in a

void. The actions or inaction in the development of strategy are restricted by cultural mechanisms that also regulate the policy process. This involves social norms and values that are an intrinsic influence. What this means in practice, is that demands for change, that may have that been opposed and prevented, can eventually be developed and implemented following a situational or contextual change in social values, or sustained lobbying, advocacy and public movements.

Suicide prevention is one such example where there was evidence of a shift in understanding, reduced stigma, changing values and norms. In addition, there was a shift in religious belief, less fear of the punitive labelling that suicide was sinful. (McAuliffe cited in Foster-Ryan and Monahan, 2001). Cultural change in Ireland prompted new ideas, the identification of an emerging change in attitude in the treatment of mental health and suicide prevention in Ireland. The result was a momentum that created the conditions for political will to respond to change and thus develop a national strategy in Ireland.

Policy Making in Ireland – Map

Political process is a series of behaviours on the part of actors rather than a set of institutions. The actors or individuals form part of a process and in Ireland government departments; the Oireachtas, civil service and Seannad form the primary institutions of social policy making. Oireachtas Policy Brief (2017) identifies a 'map' of policy-making in Ireland identifying clusters of bodies in policy making:

The Oireachtas is only one – albeit the most important – body in the political process in Ireland. But how exactly does it fit in, especially from the perspective of voluntary and community organisations?

The 'map' of policy-making in Ireland comprises several main clusters of bodies, each with an important role:

- The government, which at its core is the 15 ministers of the cabinet and below them 15 Ministers of State, or 'junior ministers';
- Government departments, each of which has a minister responsible, staffed by civil servants;
- State agencies, which number about 600, which include development bodies, regulatory agencies, commercial bodies, service providers (e.g. HSE) and advisory groups, staffed by public servants;

- The social partners, who comprise of five 'pillars': business and employers, trades unions, farmers, environmental ngos and the 'Community and Voluntary Pillar' which comprises 17 community and voluntary organisations;

- The political parties, numbering nine (with two alliances), which generate policies for their parties and have a mobilizing role at elections;

- Think tanks, like Tasc and the Economic and Social Research Institute. Private consultancies may also be commissioned to provide policy research and advice for government;

- The European Union, which has an important role in determining, with Ireland's participation, policies in key areas such as trade, development, agriculture, the environment and equal opportunities;

- The media, which provide the channels whereby policy issues are debated and discussed, or not.

In the case of suicide prevention policy the responsibility lies with the Minister for Health, Department of Health (DOH) and National Office for Suicide prevention (NOSP). NOSP is considered a state agency, as described above, one of the approximate 600 in Ireland (2017) including development bodies, regulatory agencies, commercial bodies and service providers (e.g. HSE), and advisory groups usually staffed by public servants. This study is interested in the composition of, engagement with and decision making between the state agencies (NOSP and DOH) and C&V organisations in deciding suicide prevention policy in Ireland.

The Dáil, as the Irish parliament currently (2017) comprises 9 political parties, with two alliances (which are two collections of independent members formed into technical groups i.e. Independents 4 Change and Rural Independents Group). These groups generate policies for their party, mobilized from election manifesto and through their gatekeeping of the mandate from the electorate and constituents they represent. In reviewing the Reach Out Policy (2005-2014) and devising Connecting for Life (2015-2020) contributions were made by academic and research groups, including National Suicide Research Foundation (NSRF), Health Research Board (HRB) and Policy Planning groups, in addition to the commissioning of consultants tasked with oversight and chairing of the National Task Force. Ireland has been a member of the European

Union since 1973 and as consequence, many of the developments in national policy, in key areas including trade, economic development, agriculture, the environment, equal opportunities, peace and conflict and rural development have been determined by the EU The media, worldwide web and social media played a significant role in transforming the awareness of the nation by addressing previously hidden issues and widening the national perspective from insular and conservative, to more global and better informed. There has thus been increased awareness and shaped perspective across many topics, providing the range of channels whereby policy issues are debated and discussed or not, an important issue in managing the reporting of suicide, promotion of positive mental health and reduction of risk.

Policy Making Process in Ireland

Mc Mahon (2009) states that in Ireland, for a variety of reasons, including secrecy inherent in decision-making, there has been little emphasis placed upon the processes underlying the evolution of a policy in a particular field or on those who often craft policy (p. 219).

Historically, policy making activity was managed and directed through the statutory sector and social partners, the content and finished product being a primary focus of attention with little emphasis on the process therein. This is evident in examining the historical policy documents in suicide prevention, the National Task Force (1996-1998) and the Reach Out Strategy (2005-2014). They are examples of their time and place in policy making and it is evident that the primary purpose is the content, recommendation and objectives, with limited references to engagement and/or consultation in policy making.

The social partnership approach to policy making in Ireland can also inhibit progress and development making in policy. Historically policy making occurred in a closed sphere (McMahon, 2009) and as a result there was limited openness in releasing documents or records of the process and decision making. This limited access to how the system made policy and how power was exercised in the decision making processes. The Irish governmental system's high level of secrecy historically had the effect of preventing adequate oversight of government policy (O'Connor, 2009 and O'Malley, 2010). Given that this study is interested in the relationship, engagement and consultation in policy process, transparency in the decision making is an important feature.

Birrell (2010) cites the absence of party political consensus, limited policy-making capacity and the low level of conceptual analysis as barriers to evidence-based policy-making in a Northern Ireland context. These themes are relevant in considering the policy process in Republic of Ireland in this study, namely if the "whole of government" approach stated in Connecting for Life suicide prevention policy, refers to a whole of Oireachtas approach, including party political consensus.

Key decisions are made by government cabinet and approved by the Oireachtas; often this is complicated when the government of the time is a coalition of parties with varying demand about the policy decision in question. Oireachtas Brief (2017) indicates that many key decisions are made by the weekly cabinet meeting, then adjusted (but rarely overturned) by the Oireachtas. A memorandum to the government by the minister and his/her department advising a specific policy/strategy precedes the cabinet meeting. The principle of collective responsibility (Oireachtas Brief, 2017.) requires that all members of government agree and can support the proposed decision. Government is advised by officials and dedicated advisors, informed by consultants and strategists in policy making in Ireland. Cabinet, government and the Oireachtas also receive decisions and proposals that have emerged through government departments, arising from the agenda of the specific department at that time (Oireachtas Brief, 2017). In the case of suicide prevention, strategy is taken to government through the Department of Health (DOH) Brief (2017). The business of each department develops a momentum for reform and public policy, with the agendas competing for time and attention in the houses of the Oireachtas.

This principle of collective responsibility and whole of government approach is rhetoric indicative of cohesive policy planning within government and its departments, and is now the prevailing theme in the national strategy Connecting for Life (2015). However, this study is interested in examining the perception and experience of participants in the policy making process in suicide prevention, in order to ascertain if 'whole of government' means whole of the Dáil and Seannad and how collaborative and joined up the approach is in practice. It raises interesting themes in considering how and who monitors and evaluates the level of cooperation between the official bodies that are responsible for developing strategy and for delivering the actions contained in suicide prevention strategy.

The provision of professional advice is not confined to central government as many organisations, both governmental and C&V lobby to create momentum around particular topics. In the case of suicide prevention, the recent Connecting for Life (2015-2020) draft strategy was subject to two reviews by a cross-departmental Senior Official Group. This was chaired by the Department of an Taoiseach before being presented to the Cabinet Committee on Social Policy and Public Service Reform for approval and launch.

Connecting for Life documents reference the engagement and consultation process undertaken in reviewing the Reach Out Strategy and developing its successor. Engagement is defined, in the new strategy, as aimed to "ensure all voices and parties who wished to be part of the process could do so, by making a submission" (p. 3). Recruitment processes for those involved in the range of sub committees are not discussed or outlined, but an engagement advisory group was established by NOSP and included statutory and C&V organisations, with service users and an external consultant as chair. Engagement referred to HSE (2015) "Tell Us What You Think" study and input from Dáil na nOg (Dcya.gov.ie, 2013) Irelands youth parliament, report on mental health

Evidence in Policy Making in Ireland

Policy making consists of a range of engagement and planning mechanisms to inform each stage of the process. Evidence based policy planning is a significant priority and this features prominently in policy content, strategic plans and objectives. The review of the Reach Out Policy gathered evidence from a range of sources, including international studies and systematic reviews. One such example included *Suicide Prevention: An Evidence Review* (2015) by the Health Research Board (Dillon et al). Systematic reviews across a number of methods, citing a range of key texts and authors and examining a range of interventions acknowledge the difficulty in measuring what works in suicide prevention. Death by suicide is, thankfully, a relatively rare act, and studies tend to rely on large scale random control trials (RCT). As such, gathering data can be problematic and affect the validity of data, sampling and outcomes. The development of a robust and holistic national suicide prevention plan must determine an evidence base for consideration and inclusion in policy. It must be remembered that social sciences and suicidology as disciplines increasingly consider a range of measurements for the effectiveness of local, regional and national policies and practice. The focus on

studies completed using a quantitative methodology, RCT can contribute greatly to the body of evidence supporting policy development, and delivery and the data collected is important in supporting the national plan; however, it is also only part of the comprehensive body of knowledge, which informs suicidology and the study and management of the phenomenon.

According to the Health Review Board (2015), evidence is inconclusive in systematically reviewing what works in suicide prevention (Dillon et al, 2015). This author asserts that this may not mean the interventions are ineffective, rather that the evidence, as quantified within the parameters of the research criteria and methodology have yielded particular outcomes. The challenge to examining and completing research on suicide prevention interventions and suicidal behaviour must also consider the context in which the actions to prevent are located as there are many other factors to reflect upon in developing a national prevention strategy. It is therefore limiting to only consider a body of research which measures one intervention using RCT.

 The assessment of outcomes must also recognise the development of qualitative methodologies, which allow for the capture of unique narrative and human experience. Whilst the replication of said research is noted, there is increasing evidence that relationship and belonging help reduce risk, concepts which are difficult to measure using RCT and some methodologies. As stated, death by suicide is a rare event and "studies to determine if an intervention significantly reduces the numbers of completed suicides requires very large sample sizes" (Dillon et al, 2015), thus mixed methods and qualitative methodologies, can inform the body of knowledge and support the development of actions. Community audit, consultations and process led studies aimed at improving a sense of belonging and increasing community resilience can contribute toward supporting recovery and reducing risk. Whilst recognising the limitations of findings based in a particular context, with a specific population to other populations in a different context, the evidence informed methodologies contributing to policy making must acknowledge the importance of small scale studies examining relational approaches in suicide prevention and intervention.

The C&V suicide prevention sector consists of many small, local, regional, large and national organisations. With such variety in the range of groups, there are different standards of governance, some organisations have highly structured large voluntary groups and some small local community groups are run entirely by volunteers with

minimal structure and procedures. The result is a diverse C&V sector with inconsistent nomenclature, varying definitions about practice and mistrust and misunderstanding about standards between C&V and statutory suicide prevention sectors in Ireland (Friel and Gallagher 2013).

Organisations use different terminologies, they classify and measure risk using differing tools, the articulation of practice and measurement of outcomes can vary greatly across the sectors (Friel and Gallagher, 2013). This is a feature that results in great variation in the management of data collated across suicide prevention nationally. There is no national collation of the data across the C&V sector and no standardised risk assessment tools used across therapeutic organisations. There is no national database of C&V suicide prevention organisations, or data about the range of activities carried out by voluntary groups across in Ireland (Friel and Gallagher 2013).

The levels of unregistered and undocumented social support provided by C&V contribute to social capital and emotional well-being, however this is not quantified, and it is social support activity with varying definitions and meaning attached to it. There is evidence of a lack of consistency across studies in what constitutes 'treatment as usual' (Dillon et al, 2015) and this is important in that no national baseline exists for the assessment of risk, for the accreditation of programmes and for the delivery of services

High quality rigorous research using adequately powered RCTs is a prerequisite to the identification of the impact of suicide prevention and interventions practices. However, developing a community led, holistic set of actions requires qualitative, small-scale respondent led narrative and community based research to inform a developing process, not a fixed set of actions, ongoing review and consultation deliver evidence and yield useful data for policy planning.

Suicide Prevention - The Report of the National Task Force on Suicide (1996-1998) to Reach Out Policy (2005-2014) and Connecting for Life (2015-2020)

Suicide was decriminalised in 1993 after a lengthy campaign led by then senator and now retired TD Dan Neville, supported by psychiatrists Michael Kelleher and John Connolly along with individuals and groups from within the government, statutory and C&V organisations. The passing of the Criminal Law (Suicide) Act (Irishstatutebook.ie, 1993), facilitated efforts to research suicide openly, develop strategies for suicide

prevention and lobby for policy. The key milestones are outlined below and there will be an examination of the National Task Force (1998), Reach Out Policy (2005) and Connecting for life (2015) with particular focus on aspects of policy process across key policy texts. The timeline of suicide developments is articulated as follows:

1995: National Suicide Research Foundation (NSRF) established aimed at investigating the extent of suicidal behaviour/possible causes.

1995 (November): Minister for Health, Michael Noonan, establishes National Task Force with terms of references that included: to define numerically and qualitatively, the nature of the suicide, attempted suicide and parasuicide problem in Ireland; the associated costs involved and to identify the various authorities with jurisdiction and make recommendations on how service providers can most cost effectively address the problems of attempted suicide and parasuicide, to formulate, following consultation with all interested parties, a National Suicide Prevention/Reduction Strategy.

1996: Irish Association of Suicidology (IAS) established - its aim the promotion of public/professional awareness of suicide prevention.

1998: Final Report of the Task Force (86 recommendations)

1998: National Suicide Review Group (NSRG) was appointed by the Chief Executive Officers of the Health Boards.

1998: Health Boards appoint Resource Officers for Suicide Prevention, supported by Regional Steering Committees.

2000: National Parasuicide Registry was implemented by the NSRF.

2001: Suicide in Ireland: a national study 2 was published providing in-depth information on 2 years of suicide data in Ireland.

2001: Health (Miscellaneous Provisions) Act 2001 was passed, requiring the Minister for Health and Children to report annually on the activities of Health Boards in the area of suicide prevention.

2001: Medicinal Products (Controls of Paracetamol) Regulations

2005: Reach Out, the National Strategy for Action on Suicide Prevention, was launched by the Minister for Health and Children, Mary Harney TD.

2005: The Joint Oireachtas sub-Committee on High Level of Suicide in Irish Society was set up to investigate the phenomenon of suicide and to report on the matter.

2006: Seventh Report: The High Level of Suicide in Irish Society. The Joint Committee on Health and Children was established in November 2002.

2007: National Office for Suicide Prevention commissions a study through the HSE to inform a national mental health awareness campaign.

2013: Media Guidelines on Reporting Suicide launched by Irish Association of Suicidology (IAS) and Samaritans

2015: Connecting For Life: Suicide Prevention Strategy

Figure 3.1 Public Policy Timeline

28th Dáil 1997 Election

Fianna Fail (FF) + Progressive Democrat (PD) Minority

29th Dáil 2002 Election

Fianna Fail (FF) and Progressive Democrat (PD)

30th Dáil 2007 Election

Fianna Fail (FF) Green (G) and Progressive Democrat (PD)

31st Dáil 2011 Election

Fine Gael (FG) – Labour (Lab)

32nd Dáil 2016 Election

Fine Gael (FG) – Independent (minority)

1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016

National task force on suicide appointed and National Suicide Research Foundation (NSRF)

Health (Miscellaneous Provisions) Act requiring the Minister to report annually on the activities of Health Boards in the area of suicide prevention. Also, Medicinal Products (Controls of Paracetamol) Regulations

Connecting for Life (2015) Launched. Successor to **Reach Out**

National Suicide Review Group (NSRG) was appointed by the CEO's of the Health Boards

Reach Out, the National Strategy for Action on Suicide Prevention was launched

1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016

Suicide decriminalised in Ireland

Irish Association of Suicidology (IAS) was established

National Parasuicide Registry was implemented by the NSRF.

Suicide in Ireland: a national study 2 was published

Final Report of the Task Force was published making 86 recommendations.

Also, Health Boards appoint Resource Officers for Suicide Prevention, supported by Regional Steering Committees

Toward and Outcomes of the National Task Force (1998)

The background to the establishment of the National Task Force on Suicide reveals there had been a reluctance to even discuss the issue and this made the compilation of accurate data on the frequency and pattern of suicide more difficult. The numbers of reported suicides and attempted suicides in Ireland had increased over the previous twenty years and investigation and detailed research into the causes of suicide had not been developed or progressed slowly and in an ad-hoc manner at national and international level. The World Health Organisation, in its Targets for Health for All, had recommended action to reverse the rising trend in suicide by the year 2000 and the European Commission had also established a committee of national experts to formulate a programme of community action on injury prevention. It was against the background of this programme, in the context of the framework for action in the field of public health, that the focus on addressing the topic of suicide in Ireland was addressed. The Health Strategy, Shaping a Healthier Future, had documented concerns, expressed by health care professional and members of the community, about the increase in the rate of suicide, especially among young people in Ireland. The new programme and strategy for mental health services, Planning for the Future, policy had recommended a shift in the delivery of services from an institutional to a community-based setting. With these developments, the aim to ensure appropriate help for those considered at risk and a desire to ensure the availability of reliable information on the occurrence of suicidal behaviour, the Minister for Health, Mr Michael Noonan TD, established the National Task Force on Suicide. The Task Force was appointed by the Minister for Health, in November 1995, with Terms of Reference that included:

- Numerically defining and qualitatively assessing the nature of the suicide problem in Ireland.
- Defining and quantifying the problems of attempted suicide and parasuicide in Ireland including the associated costs involved.
- To make recommendations on how service providers can most cost effectively address the problems of attempted suicide and parasuicide, identifying the various authorities with jurisdiction in suicide prevention strategies and their respective responsibilities.
- Consulting and formulating a National Suicide Prevention/Reduction Strategy.

It is interesting to note the difficulties in assessing the rate of suicide and attempted suicide in Ireland in 1996 when the interim report was compiled. At a time when stigma and shame prevailed about suicide and attempted suicide, deaths that were not caused by natural and external events resulted in a coroner's inquest. The returned verdict resulted in a Death Certificate which was sent to the Registrar of Deaths, the deceased's relatives and the Central Statistics Office. The local Gardai completed a confidential statistical (Form 104) for submission to the CSO, containing the medical evidence, information on how the relevant injuries were sustained and whether the death was considered accidental, suicidal, homicidal or undetermined. The CSO relied heavily on the completion of Form 104 in coding the cause of death, and in turn, determining the number of suicides in Ireland. Given the particular religious and legal issues faced by those at risk of suicide was/is surrounded by denial, shock and traumatic impact for families and communities across Ireland. CSO recording of suicide and compilation of Form 104 could be subject to inaccuracies as a difficult and subjective activity for those compiling the evidence, thus impacting the recording of deaths in Ireland.

This chapter examined the National Task Force (1998), the Reach Out strategy (2005-2014) and Connecting for Life (2015-2020) strategies to consider how decisions are made about membership of policy making process and to articulate the representation from statutory and C&V sectors. There is no specific discussion about decision making processes, although references indicate that individuals and organisational membership is determined due to knowledge or statutory responsibility for service delivery in the area of suicide prevention or treatment.   It is noteworthy that the national Task Force (1998) and Reach Out Strategy (2005) were, as one respondent in this study stated, "of their time" when fewer C&V organisations existed and policy making was dominated by government and its departments. The tables below indicate the composition of strategy and policy groups and this is relevant to this study as it reveals the role of the sectors as it has changed over the years as strategies developed.

Table 3.1a Composition of National Task Force on Suicide

National Task Force Composition	DOH	Health Board	CSO	Garda	Legal/coroner	G.P.	C&V
1996 - 1998	2	6	2	1	1	1	1 (Samaritans)

Reach Out Policy (2005–2014)	National Suicide Review Group	National Suicide Research Foundation	Irish Association Of Suicidology	HSE Public Health	Irish College of Psychiatry Depts. of Psychiatry NEPS/ Psychology	Prison Service	Irish College of G.P's	Garda Coroner Legal	HSE Suicide Prevention Resource Officers (Org of regional events)	Dept. of Health and Children	C&V: Samaritans Mental health Ireland. Irish Advocacy Group.
Oversight Group	1	2	1	1							
Steering Group	1	1		1	2	1	2	1	10	2	3
Reference Group	1				3					1	

Table 3.1b Cross-sectoral representation and Composition of Reach Out Planning Committee (2005)

Policy Process and Reach Out (2005-2014)

One significant development in the Reach Out policy was the degree of international consultation and reference to a more global suicidology sector, with connections having been established by the burgeoning statutory and C&V sector during the '90's. Those with a research and practice interest in suicide prevention established European and international links allowing for collaboration and informing study, research and practice.   The establishment of the National Suicide Research Foundation (NSRF) (1995) and the contribution to an understanding of suicide by organisations such as the Irish Association of Suicidology (1996) and academic and C&V research has served to inform understanding and knowledge, based on national and international evidence and good practice. A reference group was established to assist the development of Reach Out drawing on expertise from across a range of academic and specialist national and international research including:

Canterbury Suicide Prevention Project, Christchurch, New Zealand

Australian Institute for Suicide Research and Prevention, University of Adelaide, Australia

Department of Social Medicine, University of Bristol, England

Centre for Suicide Research, Oxford University, England

WHO Collaborating Centre for Research and Training for Mental Health, England

Department of Clinical Psychology, Free University of Amsterdam, the Netherlands

Department of Mental Health, Queen's University Belfast, Northern Ireland

Mental Health Commission, Ireland

Research Unit in Health, Behaviour and Change, University of Edinburgh, Scotland

National Research and Development Centre for Welfare and Health, Finland

Setting Actions

In reviewing the Reach Out (2005-2014) policy there was a change to the language used by those in the decision network, a term used by Hill (1994) to describe the grouping or architects of the ensuing strategy. The review resulted in the development of "setting

actions" and devising strategy over a five-year period, the language was substantially different from Reach Out, which was a policy with ten-year term. The distinction between setting actions rather than specific policy decisions allows success to be determined by outcomes achieved by a range of actors in the decision network (Hill, 1994). This study has at its foundation an interest in how the range of actors involved in the decision network was determined and by whom. Who/what organisations get(s) around the table and how does it happen is an often overlooked element of the policy making process. I am interested in how decisions are made about inclusion and exclusion to the process of creating succession to the Reach Out suicide prevention policy and the study considers the role of the range of actors involved, including lower level actors (Hill) also termed "*street level bureaucrats*" (Lipsky, 1980) and the impact and involvement of those at community level in suicide prevention policy succession planning in Ireland.

Connecting for Life: Ireland's National Strategy to Reduce Suicide (2015-2020)

In the foreword of the Connecting for Life Strategy (2015-2020) Taoiseach Enda Kenny states that suicide is a "whole of society" issue and the government would be taking a "whole of government approach", this study notes a distinction between the latter comment and a whole of Oireachtas approach to suicide prevention. Birrel (2016) in an examination of policy making in a Northern Ireland context, noted that barriers to evidence-based policy-making can be further investigated as the absence of party political consensus, limited policy-making capacity and the low level of conceptual analysis in policy narratives. The role of the political parties in suicide prevention policy process will be discussed in Chapter 4.

The engagement and consultative process employed in Connecting for Life witnessed a considerable progression from the time when Reach Out Policy (2005-2014) was developed, evident in the word "Connecting" as the title for the five-year strategy. A number of factors including the aforementioned marked difference in the social context, reduced influence from the Catholic Church, increased awareness and knowledge of national and international evidence on suicide and demands from a widening C&V sector supported substantial efforts to improve the consultation and engagement process in the establishment of strategy or set of actions. The language contained in the strategy document describes the involvement of all stakeholders, connected services and the establishment of strong connections as the foundation to the five-year strategy.

The responsibility for the development and implementation of suicide prevention strategy resides with National Office for Suicide Prevention (NOSP) an office of the Department of Health (DOH). In the development of Connecting for Life, the Minister for Health and the Department of an Taoiseach were involved. The policy process also consisted of the following committees, engagement activities and decision making groups:

- Strategy Planning Oversight Group
- 5 Expert Advisory Groups
- Research, Evidence & Outcomes- HRB (Health Research Board) Systematic Review
- Engagement Process - (272) submissions
- Government Department Engagement – Discussion and Engagement (Number of Departments)
- Non-statutory Partner Engagement
- Priority Issues filtration

This study considers processes in making suicide prevention policy in Ireland, the decision networks, how membership of policy committees is made, who is making decisions about participation and consultation and what contribution does the C&V sector make to policy making process. Simply put, the author is examining "*who decides who decides?*" and in particular interviewee perception and experience about engagement and consultation in Reach Out (2005 -2014) and the development of the 2015 Connecting for Life: Suicide Prevention Strategy. It is noteworthy that of the 21 membership on the Strategy Planning Oversight Group, documents indicate that 14 are either drawn from HSE, NOSP or DOH and the remaining members are representatives from statutory agencies, consultancy groups, General practice, psychiatry, research and academia. The decision making process involved in establishing policy process and protocols is important and also how such alliances and decision networks become established. It is evident that there is expertise, knowledge and experience across the range of committees and in addition there is possibility of networks, alliances and actor coalitions informing the membership of important decision networks.

Conclusion and informing research questions

In examining the cross-sectoral relationships this study asserts that improved understanding of the processes carried out by government and suicide prevention policymakers is an essential activity as it informs the explicit and implicit dynamics embedded in policy making

in Ireland. Articulating the process and relationships within and across sectors, is an essential foundation to understanding policy planning, content, implementation and outcomes. Suicide prevention "process" is central, not simply a backdrop to this study and this chapter examined the context and social changes and structures that occurred in Ireland, and how this shaped the development of the social partnership approach to policy and particularly public strategy in the country.   The suicide prevention policy timeline from 1998 -2015 was considered against the backdrop of the political changes and role of the government and whole of the Oireachtas, questioning what level of party political consensus and involvement occurs at government and department levels.

Articulating how policy was developed and assessing the influences and factors on policy formation in Ireland also included documenting the historic and contemporary journey of suicide prevention strategy in Ireland from before 1991 when the first private members "Suicide Bill 1991" aimed at decriminalising suicide, was proposed in the Dáil by Dan Neville TD The study of process is complex, described as dense content by one respondent and the aim of this chapter was to improve the understanding of the characteristics of policy process in Ireland and pathway to the development of the first strategy; a retrospective and contemporary consideration aimed at understanding stages and process in suicide prevention in the nation.

Chapter 4: Policy Process Theory in Suicide Prevention

Introduction

> *"Reducing suicide rates requires a collective, concerted effort from all groups in society: health, social services, other professionals, communities and community leaders, voluntary and statutory agencies and organisations, parents, friends, neighbours and Individuals."*

President Mary McAleese, (World Congress of Suicide Prevention, 2007)

The impact of the combined thought of national policy makers or those with a political agenda on suicide prevention policy is examined in this chapter. To better understand the full nature and context of the policy process in ROI, relevant literature will be used to examine the context and relationships involved in the development of suicide prevention policy in Ireland. In his introduction to The Theories of the Policy Process, Weible (2014) argues the essential need for theory in the study of complex policy process. The complexity Weible refers to is due to a range of factors implicitly and explicitly linked to policy process. Included in the list are the interactions among diverse and disparate groups and individuals, pursuing political and policy influence. Additional factors include the context of policy process including geographic, economic, local, national and indeed European and global elements (ibid).

This chapter aims toward a careful and meticulous approach in analysing policy process, theory applied with transparency in the data collection methods and rigour in data analysis. The definition and theory of policy process theory is considered in the chapter and a reflective consideration and comparison of the most up to date and applied range of approaches that enable the scope of the study question. The chapter discusses the application of policy process theory to suicide prevention policy development in Ireland. Emergent themes in policy analysis include: politics and power and the impact in policy decisions; and participation and engagement theory, these are discussed with models and examples of engagement practice in developing suicide prevention strategy.

Policy process is focussed on the interactions, the dynamic in policy making, and although an important factor the process receives limited attention in policy planning and development. Thinking about policy process enables the planning to avoid the cognitive limitations that cause, as Weible states: "being restrained by cognitive presuppositions that cause people to recognise some aspects of the process and ignore others" (2014, p. 3). The knowledge and application of policy process theory allows planning to mitigate against presupposition, it supports vigilance against theory tenacity and confirmation bias (Loehle, 1987). In other words, an understanding of policy process improves awareness and challenges the taken for granted ways of making policy. It can highlight any tendency toward maintaining the status quo in policy making and offers a theoretical basis for the examination of power and relationship in policy design and implementation.

Sabatier (1999) argues that public policy making involves conceptualising a problem, seeking a solution, formulation, implementation, evaluation and revision. Policy making is an engagement between the state and its citizens; it is the political response to calls for change. Policy making is an exercise between actors in development and design, with ranging outcomes and degrees of success. In this instance it is the product of engagement and relationship between statutory and C&V sectors and the power dynamics which govern the interaction in conceptualising and formulating suicide prevention policy. The impact of engagement on participation and decisions is the subject of this study. As Considine states, "The policies of governments and the counter-policies of agitators and special interest groups each offer to make tomorrow different from today" (2005, p. 4).

Policy process reflects the relationships between all of the actors involved including the tensions, conflicts and compromises which emerge. It is a reflection of the society in which the policy is being developed. An examination of policy making requires consideration of the nature of institutions, the political landscape and the cultural and social norms. It also must consider some of the indirect themes, including power dynamics and the perceptions of those included in and indeed those excluded from the policy process – the 'insiders' and 'outsiders'.

Sensitive or controversial policy issues can be an excellent means by which to examine the intricacies of the policy process, as the relationships and public attitudes related to these issues are more pronounced than in most policy areas. This was especially true in Ireland, in the period post 2008, when austerity and economic crisis caused widespread financial and

social hardship (Fraser et al., 2013). The ramifications of this are still being felt, particularly in the public sphere, in which government has a responsibility for services, and in the C&V sector which has experienced widespread reduction in funding and services.

Against this changing economic and social landscape is the examination of policy development, its practice and influence in the social context in Ireland and in this study the focus is the subject area of suicide prevention. Connecting for Life (2015-2020) was launched in June 2015 into a social context in which in Ireland had undergone major social and economic changes from 2008. The consequences of economic downturn are considered in the examination of policy context. Some argue that positive outcomes occur as a result of social and economic changes, with Alain Touraine in *Can We Live Together?* (2000) stating: "What is emerging from the ruins of modern day societies and their institutions is, on the one hand global networks of production, consumption and communication and, on the other hand, a return to community" (2000, p. 3).

The relationship between the statutory and C&V sector in developing suicide prevention strategy will be discussed further in the review of literature. The research question is founded on a hypothesis that cross-sectoral relationships impact decisions about planning and content of suicide prevention strategy in Ireland and the study asks "*who decides who decides*" suicide prevention policy in Ireland. The focus is a particular point in policy making process, namely the preparatory early stage and the dynamic of relations, political influence and engagement between the statutory and C&V sector that is of interest. The review of literature contributes to an articulation and understanding of policy process, approaches to policy analysis and formulation, the stages in the policy process and impact of politics and power in policy development. Literature and its review contributes to clarity in developing research questions and enables the establishment of a structure against which research findings can be considered and reviewed.

Defining Policy Process

Public policy encompasses the priorities, actions and indeed non-actions, of a government or comparable authority. It includes laws and statutes, regulations and decisions and government programmes. Public policies can range from those that are procedural, dealing with technical and specific guidelines, to more substantive, complex and detailed strategies that articulate government actions on a particular topic. Government actions in response to suicide and how this is developed are considered in this study, namely how relationships are established

and how decisions are made in what is a substantive public strategy. Weible (2014) defines policy process research as involving and examining the interactions between public policy "and its' surrounding actors, events and contexts as well as the policy or policies outcomes" (Weible 2014, p. 5). Suicide prevention policy process is complex, involving varied and disparate elements interacting and influencing at different times. It includes stakeholders, 'policy entrepreneurs', a term used by Kingdon (1984, pp. 21; 104) to describe actors who use their knowledge of the process to further their own policy ends. It also involves governmental actors, target and interest groups, C&V agencies at different levels, researchers, media and those affected by suicide all involved in some or many aspects of the process. This study seeks to examine the complex interaction of key elements through the example of suicide prevention policy in Ireland. Policy is a course of action adopted and pursued by a government and considered as "any course of action adopted as advantageous or expedient" (Hill, 1997, p. 6)

Policy process is complex and defining the concept is a more complicated affair than first thought, as Cunningham, a civil servant, noted (1963) "policy is rather like an elephant - you recognise it when you see it but cannot easily define it" (Cunningham, cited in Hill, 1997, p. 6). It can also be considered as "essentially a stance which, once articulated, contributes to the context within which a succession of future decisions will be made" (Friend et al., 1974, p. 40). Developed further by Heclo (1972) policy is "a course of action or inaction, rather than specific decisions or actions, thus defining possible decisions not to act as a policy direction" (Heclo, 1972, p. 85). Sabatier (2014) also includes non-action and action by government or equivalent authority in decisions on public statute.

The complexity in defining the concept is further elaborated by Jenkins who states policy as a set of interrelated "decisions concerning the set of goals and the means of achieving them within a specified situation" (1978, p. 15). Smith (1976) recognised the need for attention to inaction and resistance to change in policy making and his definition considers interrelating forces, a need to attend to those resisting change and are difficult to articulate because they may not be represented in the policy making process. Defining policy recognises that it is not a concrete phenomenon; it may involve groups of decisions and may often continue to evolve from the beginning stage to the implementation stage. Policy is a web of decisions - a decision network. It is varied and complex. It could be a set of actions, or may be simply an orientation and can involve a series of decisions and phases, responding to multiple factors.

For the purpose of the study, policy is considered as a "course of general plan or action to be adopted" (Hill, 1997). Policy analysis aims at achieving resolution by examining the simpler elements. Policy process analysis therefore considered in this study as concerned with examining the simpler elements that occur in developing a plan or set of actions, in this case aimed at preventing suicide in Ireland. Policy analysis approaches assist in explaining the interaction between institutions, groups and stakeholders in the process, although Shipman (1959) argued that the partition between administration, politics and policy was artificial and needed greater understanding of the integration arguing "the first and most urgent need is for a theory of the governmental process" (1959, p. 7). Shipman displayed insight into the dynamics of policy process and how the interrelated institutions of legislators, politics and administrators combine into an intricate process for clarifying and satisfying societal values.

Policy Process and Analysis

Theory in policy process is defined by Weible (2014) as a "range of approaches that can specify the scope of inquiry, lay out assumptions, provide a shared vocabulary among members of a research team and clearly define and relate concepts in the form of principles and testable hypothesis and propositions" (Weible 2014, pp. 3–4). There have been recent advancements in applying theory to studies of policy process which has led to improved understanding of the subject area (Smith, 2007). Historically policy analysis has had limited application in policy studies, which instead focused primarily on descriptive accounts of policy outputs and outcomes. Outputs refer to the measurable products or actions in the implementation of policy, whereas outcomes refer to the effect of such policy and practice, as a result of implementation for particular target groups and individuals (Smith, 2007). Whilst a focus on these elements can be useful, it fails to examine disputes over *why* and *how* policy is designed, implemented and justified (Smith, 2007), capturing instead only the final product and related impact.

The 'how?' of policy making is the focus in this chapter. Early phases in policy making will be considered, as well as an attempt to understand the relationships between actors involved. This study will use the terms policy and strategy, with the latter defined as policy with actions. The aim is to articulate the power dynamics, cross-sectoral relationships, and the political context in policy formation.

Institutional process is central to the study of policy process and understanding the relationships, dynamics and rules underpinning the design of strategy. By examining the

policy development process, we are highlighting, in many ways, the structures of the society in which policy is being shaped. More specifically the act of policy development, review and re-design highlights how structures can hold society together and can also push societies apart. The importance of creating an inclusive, collaborative set of future actions when designing suicide prevention policy cannot be underestimated. Decisions about content and implementation have a direct impact on the availability of services and thus potentially save lives.

Hill (1997) recognised complexity in the study of policy design and believed it cannot be considered only from a scientific perspective. It is the complication of process that is of interest. The challenge is to articulate this, complication of process, in suicide prevention policy making in Ireland. I am inclined to agree with Hill, in asserting that the examination of policy design from a purely scientific viewpoint fails to recognise the intricacy of policy processes. There are features that are of particular interest to me: firstly, it is the analysis *of* suicide prevention strategy and how it is made; secondly, a deeper understanding of the process in making suicide prevention strategy will assist those driven to improving the process *for* review of Connecting for Life, the current national plan. In addition, the *means* by which the national strategy is developed, the mechanisms and factors that determine stakeholder participation are also important considerations. In order to explicate these complex, intricate and subtle themes associated with the research question, I will consider theories of participation, power, politics, engagement and consultation in policy process.

Historical and Contemporary Policy Process Theory

In order to capture and articulate the nature of policy development a number of frameworks developed (Hogwood and Gunn, 1981) that have been evolving and changing from inception. This study is aimed at capturing relationships in policy process, whilst acknowledging that determining the range of complex factors that influence the development of policy is a complex task. As such this study required consideration of theoretical frameworks that afforded an appropriate understanding of the aim, which is to examine if cross-sectoral relationships impact policy process. Examples of theoretical frameworks included Hofferbert's (1974) Funnel of Causality in policy process and the later Advocacy Coalition framework (ACF) and Punctuated Equilibrium Theory (PET), (Baumgartner, Jones, and Mortensen, 2014). Hofferbert's Funnel of Causality articulated policy process as a filtering of factors, each conditioning the next, such as social, environmental and political factors that

all influence policy design. The model was limited by its failure to define and critique factors and output sizes. Hofferbert's model did, however contribute to the development of the Advocacy Coalition Framework (ACF) which was described by Sabatier as an approach aimed at understanding and articulating regulatory policymaking.

Agenda Setting

Themes discussed above are considered through the study of cross-sectoral relationships in policy making. It is a particular phase in policy process that is of interest in this study. This is the network of decisions at the agenda setting stage. It is at this point that the political and policy agenda is set in policy making. Decisions by policy actors and elites determine the level of policy change that will occur and indeed whether limited change will take place in the policy process, content and context. Questions about agenda setting in the policy process include, articulating extent of engagement between sectors, the level of consultation and collaboration in policy planning. Furthermore, it is pertinent to consider which organisations and individual policy actors participate in policy process and how or who determines participation and contribution. The question of the roles of key actors is considered in the context of suicide prevention primary sectors and includes, political parties, government and its departments including, NOSP, HSE and DOH and the C&V organisations that do or do not contribute to the policy process.

The difficulties for new ideas to break through the established policy system was articulated by Schattschneider (1960) and Cobb and Elder (1971). The system and structures in policymaking can be conservative, favouring the status quo and resistant to adjustment and change. In a study of U.S. policy Baumgartner and Jones (1993), articulated three significant themes. Firstly, policymaking has periods of stasis, leaps, issues emerge and recede in profile, and this is particularly significant in the study of suicide, where trends affect the profile of the subject. The political institutions exacerbate the trend to punctuated equilibrium and the party-political structure in Ireland is an important consideration in the process. Finally, policy image has a role in expanding a policy issue, in this case suicide, beyond the control of specialists, special interest groups that occupy policy monopolies.

Policy process is marked by periods of stability or stasis and change in policy making is usually incremental and often slow (Baumgartner, Jones and Mortensen, 2014). Occasionally events occur that prompt a departure from the status quo and, shift away from familiar ways

of making policy i.e. long periods of stability interrupted by instances of radical change-punctuations. In suicide prevention, for example, increasing death rates and raised profile of particular cases, or clusters of suicides will act as leverage for action. Public policy making involves separated institutions combining to create a dynamic between the policy subsystems (suicide sectors) and macro-political (Dáil/Government). It is within this dynamic that there is a block to impetus for change, or indeed sometimes mobilising for change when the interests of the system are entrenched. In the study of American policy process, Baumgartner and Jones (1993) found that political institutions were designed to resist change, thus making mobilization a necessary feature in any effort to overcome established interests. Suicide prevention policy making in Ireland is a complex, interactive practice, with differentiated subsystems and macro-politics interacting in a long term agenda with ebb and flow and periods of stasis interrupted by punctuation. The study of this complex subject area, and early stage policy process, is concerned with power in and between subsystems, communities of experts, and the degree of engagement, consultation, collaboration, autonomy in process and the interface between those making the policy, the macro political system (Dáil) and its constituents (public/service users).

For Kingdon, agenda in policy making is conceived as any list or series of problems that government and those close to the policy area are paying attention to and agenda setting narrows the list to those that will be the focus of attention. This is the point of focus for this study, the agenda setting, but even more specifically who sets agenda; who decides who gets around the table in making policy? Agenda is not subject to incremental change as they are subject to many contextual and political forces, including top down and bottom up punctuations and sudden changes. Drawing on the work of Cohen, March and Olsen (1972) "organised anarchies" model (p. 41), Kingdon (1995) describes three streams to agenda setting, namely problem, proposals and politics. Government and those with responsibility in government departments focus of a specific problem, they propose and refine policy proposals and political events, like changes to the mood, awareness in the public, changes in administration or government and actions by interest groups or lobbying are all moving at their own dynamic. The streams are all independent of each other and he states "*proposals are generated whether or not they are solving a problem, problems are recognised whether or not there is a solution and political events move along at their own dynamics" (page 41).* Baumgartner, Jones and Mortensen (2014) describe the difficulties that new ideas and disfavoured groups experience at the agenda setting phase in the established systems of

policy making. National policy making systems are considered conservative in nature, often favouring the status quo. There can be resistance to change, apart from moderate, minor adjustments, thus conflict or major effort is necessary to extract major changes to policy making processes. The present study considers the historic development of suicide prevention policy in Ireland, particularly policy process in Connecting for Life (2015-2020) the focus on agenda setting, early phase and decision making about *who decides policy*. Agenda setting, as a phase or window (Kingdon, 1995) in policy making consists of decisions being made as a process unfolds, considered by Cohen, March and Olsen (1972) as a collection of ideas rather than a coherent structure.

Advocacy Coalition Framework

This study considers suicide prevention policy process in Ireland and is informed by Advocacy Coalition Framework as a theoretical foundation. The history of Advocacy Coalition Framework (ACF) centred on the 1981-1982 experience of Sabatier at the University of Bielefield in the German Federal Republic and was conceptualised by his discussions with policy scholars and exposure to existing theories. Sabatier developed the ACF as a method of considering aspects of top-down and bottom-up approaches to policy change and approaches to implementation. As a framework it was also aimed at addressing shortcomings in existing policy research at the time including the need for alternative policy process theory. Sabatier and Jenkins developed the concepts, categories and assumptions of ACF and these have evolved and changed as the framework was established and implemented. Jenkins –Smith, Nohrstedt, Weible and Sabatier (cited in Sabatier and Weible 2014: p. 188) state that ACF is informed by the work of Ostrom (2005), Lakatos (1970) and Easton (1953) and is best considered as a framework for considering a number of overlapping focuses which are considered below.

ACF provides a platform to describe and explain phenomena and offer a vocabulary across different policy areas. Distilled into three conceptual areas, these include how coalitions form in policy process, the cohesiveness and the differences between them, secondly how learning occurs within coalitions, is it from within or from competing coalitions and finally how policy change occurs. It defines both stable (environmental factors) and political (actors in coalition) factors in policy process. The ACF approach is useful in the context of this

study, as it allows relatively stable factors to be considered alongside the dynamic political and social environments. The author is inclined to the term decision process (Sabatier and Jenkins-Smith, 1993) in considering the topic of this study and I define this as the "manner, practice and progression of a course of action" in this case how relationships between the statutory and C&V sectors in suicide prevention policy process impact decisions about developing and implementing suicide prevention strategy in Ireland. ACF contains a number of basic concepts and assumptions; these are discussed below as they inform this study.

Figure 4.1 Advocacy Coalition Theory and Policy Process
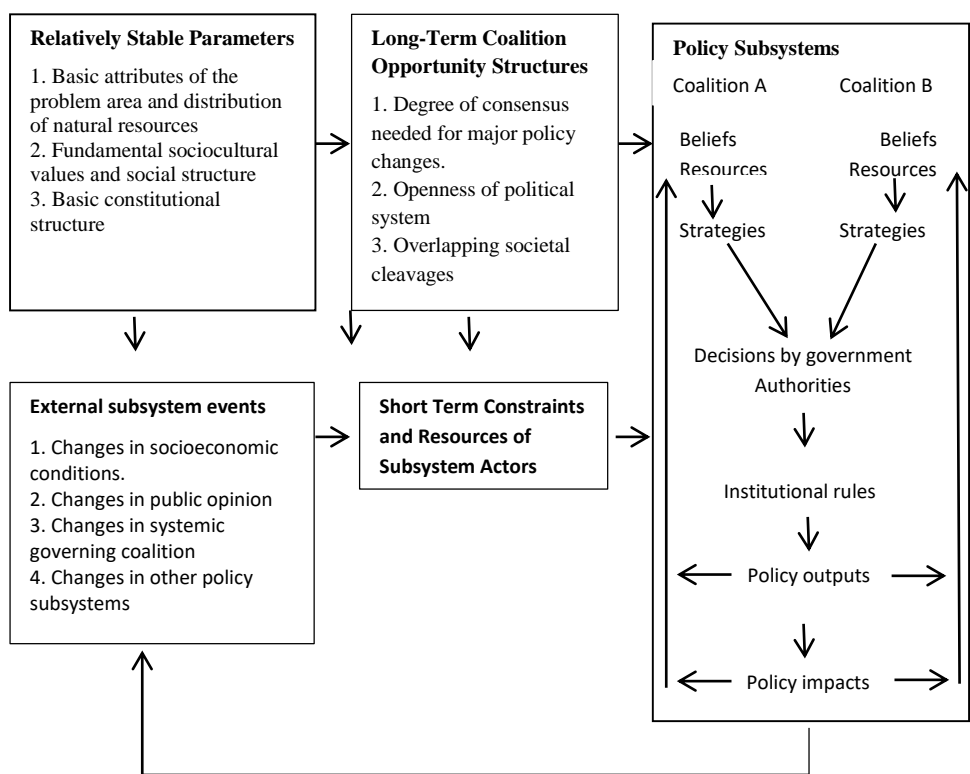
A Flow Diagram for the Advocacy Coalition Framework

Source: Adapted from Sabatier, P.A., & Weible, C.M. (2007). The advocacy coalition framework: Innovations and clarifications. In P.A. Sabatier (Ed.), *Theories of the Policy Process* (2nd Ed., pp.189-222). Boulder, CO: Westview Press

Concepts and Assumptions: ACF and Policy Process Subsystems

The policy subsystem is the unit of analysis for understanding overall policy process. The subsystem is defined by the topic, in this case suicide prevention, the actors (statutory and C&V) involved and how they are influencing the subject, in this instance how cross sectoral relationships impact suicide prevention policy process. There are a number of elements and properties within the subsystem that support interpretation, firstly, there are a myriad and immeasurable number of elements that interact to result in outputs and outcomes in a given policy topic. Thus a subsystem consists of physical and institutional characteristics and the characters and belief systems of actors from a variety of public and private organizations who are actively concerned with a policy problem or issue.

This study is articulating the characteristics and physical institutions of the statutory and C&V suicide prevention sector and also using interview data to articulate the subjective experiences of policy actors who seek to impact and influence policy in that domain. In most policy subsystems there will be numerous laws and policy initiatives at any given point in time and this study is aimed at shining a light on a complex set of characteristics that comprise the suicide prevention policy process in Ireland. It is the policy subsystem that delineates the integrated and not integrated actors in the policy topic, a theme of interest to this study of suicide prevention policy making process. In addition, to determining inclusion and exclusion in decision making, it is useful to examine how such decisions occur and thus power is a feature to be considered in the subsystem. Cross sectoral relationships in the suicide prevention policy subsystem is the topic under consideration and imbrication, overlap and collaboration is an important feature, thus the structural statutory and C&V agencies and the interaction with other subsystems are a theme of interest to this study.

Actors, involvement and influence

ACF considers actors as including anyone regularly endeavouring to place influence on the business of the subsystem and influenced by Heclo (1972) considers both top-down and bottom-up policy influence. In the context of this study, policy actors consist of anyone aiming to influence policy making process from across the statutory and public system the C&V and any other stakeholders in the suicide prevention subsystem including the range of government departments, academics, media, constituents and those impacted by suicide.

Bounded Rationality, Belief Systems and ACF

The ACF describes a structure of belief systems, characterised as hierarchical and include "deep core ontological and normative beliefs that are extraordinarily difficult to change" (Jenkins-Smith, Nohrstedt, Weible and Sabatier, cited in Sabatier and Weible 2014: p. 185). The ACF approach specifically identifies beliefs as the causal driver for political behaviour and suggests a hierarchy within the belief systems of all policy actors Adshead (2011). Sabatier's 1987 concept of the individual is interesting to consider in this study which examines the coalitions and cross sectoral relationships in suicide policy. Sabatier developed a modified theme of methodological individualism with the assumption that *change in the world is primarily driven by people and not by organisations* (cited in Sabatier and Weible: 2014. P. 190). In using the term coalition, he refers to individuals comprising the coalitions and thus references in ACF to *coalition beliefs*, *coalition learning* and *coalition behaviour* refers to the individuals that comprise the coalition, thus coalitions do not learn but the actors within do. ACF recognises that individuals are shaped by context, institutions and intensity of conflict from other actors and opponents. For ACF, individuals are considered as boundedly rational, thus motivated by goals and limited in cognitive abilities to process information and experience. In ACF it is considered that the individual, developing simplified belief systems can be prone to bias. Belief systems include deep core beliefs or normative values and ontological positions and postulation, these deep core beliefs are not policy specific. Policy core beliefs are determined, bound and shaped by the topic of the policy subsystem and impact the orientation, values and priorities within the policy topic. This study has discussed bounded rationality in considering policy process, specifically as defined by Punctuated Equilibrium Theory (PET) above. This impacts policy process by individuals being limited in responding to difference, change and new concepts presented by alternative actors and coalitions in policy subsystems.

This study examines cross-sectoral relationships and the impact they do/do not have on suicide prevention policy process. Sampling is discussed in the methodology chapter and as purposive sampling, involved policy actors drawn from statutory, C&V and across a range of the suicide policy subsystem organisations. As individuals, they are representative of organisations and as stated above are responsible and active in changing/influencing policy suicide prevention policy process. It is noteworthy, as the quote above describes that policy process is primarily "driven by people and not by organisations" they might represent during

interview for this study (cited in Sabatier and Weible: 2014. p. 190). In gathering data, it is therefore important to note that coalitions in suicide prevention policy subsystem comprise individuals, referencing deep core and policy beliefs. It is therefore important to remember that the influence in policy process may reflect refer to the individual actor behaviours, thus coalitions do not influence/change/learn but the actors within as they actually comprise the coalition.

Advocacy Coalitions and affiliation in ACF

Advocacy coalitions comprise and are defined by actors that "share core beliefs who coordinate their actions in a nontrivial manner to influence a policy subsystem" Jenkins-Smith, Nohrstedt, Sabatier and Weible (2014). Thus ACF can inform this study by offering a framework against which the cross-sectoral relationships and their impact policy process can be considered. In addition, ACF helps articulate the beliefs within coalitions in suicide prevention policy, the impact of resources as leverage in policy decision making and how positions are taken in policy making.

Politics and Policy in Ireland

The relationship between policy and politics is an essential factor in any consideration of policy process and development. The Irish constitution, heavily influenced by Catholicism, enshrined the preservation of life and the Catechism in 1994 asserted that as "stewards, not owners, of the life God has entrusted to us; it is not ours to dispose of" (Bowers, 1994, p. 51). Irish politics was traditionally influenced by a political culture that was highly conservative and where there existed a strong religious patronage that impacted on political will for social change. This resulted in a narrow interpretation of the democratic process, the parameters for policy development. This impacted on the understanding of mental health issues and the treatment of suicide in the political system.

A consistent feature of the state's approach to social policy has been its willingness to share institutional responsibility for the welfare of its citizens with private, that is, non-state organisations. Under British rule, the Irish state developed an approach to social policy that involved a willingness to share or franchise out institutional responsibility for the care and welfare of citizens. Commencing in the nineteenth century, an example is the welfare of its Irish Catholic citizens which was passed to the Catholic Church (Inglis, 1998). The Irish Free

State sanctioned and endorsed the domination of the church in moral and welfare matters, and this only diminished in the latter part of the 20th century. The Catholic Church still retains a role as a non-state provider in education, health and social services.

The state has increased its authority and power over policy making and implementation and since 1987 developed a social partnership approach in policy making (Powell, 1992; Considine and Dukelow, 2009). The history and context of social policy is discussed in subsequent chapters of this study, the social partnership approach is considered, with some considering that it is a legitimised new institutional model that is disconnected from opposition and potential dissent (Allen, 2000; Kirby et al., 2002; Meade, 2005)

Immense social and economic changes have occurred in recent years and, until recently; Ireland had been hailed, by advocates of neoliberalism, as an example of successful deregulation. The nation experienced severe economic downturn, caused by the banking crisis and since 2008, austerity and economic crisis has had a profound impact on all aspects of life for citizens.

It is argued that there is a deepening and extending of the influence of neoliberalism in Irish society (Fraser et al., 2013) and thus in this contracting economic and political landscape there has been a social impact due to a direct withdrawal of services. The banking crisis and abuse scandals in the church and state agencies have resulted in public trust deteriorating significantly in public bodies. This is an environmental factor that shaped the policy context and has an effect on the public trust in organisations tasked with mental health and community care. In this case the state public body responsible for developing and implementing suicide prevention strategy in Ireland is the Department of Health (DOH) and its office the National Office for Suicide Prevention (NOSP). The history and development of suicide prevention policy in Ireland is considered in previous chapters, with detailed discussion of the social context in which suicide prevention is framed.

The role of government, its departments and public bodies is considered central to policy making as are the motivations of the primary political parties and coalition relationships. Policy is driven by the key political actors alongside statutory public sector agencies responsible for crucial aspects of review, design and implementation. A crucial feature of policy development is therefore decision and non-decision, action and non-action or action and the impact of the same at various stages or phases in the process. Policy analysis literature (Heclo, 1972 and Smith, 2007) have argued that decision and non-decision includes

political activity aimed at resisting challenge to existing values, resisting change, and maintenance of the status quo. Any analysis of suicide prevention policy process must reflect on the political dynamic in the policy process. It is a consideration in this study that there may be a resistance to changing the taken for granted way of deciding policy and this will impact suicide prevention strategy review and change.

The role of government and cross-party collaboration in developing suicide prevention strategy from 1998 – 2015 is considered and the table below lists the cabinets of the Irish Dáil during the period of the study. This is important as it highlights the party political composition of the Oireachtas. As can be seen policy development was taking place in a Dáil comprising of a range of coalition and minority governments, this being a factor that would shape the course of legislative changes through the political process.

Table 4.1 Composition of Government and Coalition (1997 – 2016)

Dáil No.	Election Year	Government comprised of:
28th Dáil	1997 Election	Fianna Fail (FF) and Progressive Democrat (PD)Minority
29th Dáil	2002 Election	Fianna Fail (FF) and Progressive Democrat (PD)
30th Dáil	2007 Election	Fianna Fail (FF) Green (G) and Progressive Democrat (PD)
		FF-Green- Independent (From Nov 2009)
		FF (minority) from January 2011
31st Dáil	2011 Election	Fine Gael (FG) – Labour (Lab)
32nd Dáil	2016 Election	Fine Gael (FG) – Independent (minority)

It is worth noting that all of the main coalition partners in each of the above governments would be considered as centre right in their ideological leanings.

There is a history to the suicide prevention policy in Ireland that is interwoven with the changing political landscape.   The first bill aimed at decriminalising suicide had been tabled in the Dáil in 1991 and it was two years later in 1993 before the bill processed successfully through the houses of the Oireachtas. The report of the National Task Force on Suicide was commissioned in 1996 and published in 1998, with the National Task Force asked by the then

minster for Health to examine the issue of suicide in Ireland and recommend a way forward in addressing the problem.

The final National Task Force report contained a foreword by the Fianna Fail Minister for Health, Brian Cowen and this party (Fianna Fail) remained the main political party in the Dáil from (2002-2011). It was seven years after the report from the National Task Force that Fianna Fail as the government in power developed and launched the Reach Out Suicide Prevention Strategy (2005-2014).

As can be seen there were minority and coalition governments formed throughout the period and this would impact on the policy making process and progress of legislation through various stages in the Dáil. When considering suicide and its impact on families and communities, it might be naive to consider that it would prompt cross party collaboration and not be subject to the party-political division in the Oireachtas. The extent of political influence on decisions about suicide prevention strategy and the implementation by agencies and the institutions of government are discussed in later chapters and forms part of the findings in the study. In addition, the extent of cross party collaboration and communication in developing and implementing suicide prevention actions in Ireland is an essential feature for examination and is also considered in further chapters.

In Ireland the National Office for Suicide Prevention acts as the overseer of strategy review and development on behalf of the government and this is similar to the co-manager (Gilmour and Halley, 1994) principle which has been used to describe the direct intervention of government in the details of policy decision and implementation.

Agenda Setting and Suicide Prevention Policy Process

The link between agenda setting and policy responsiveness to public opinion in suicide prevention in ROI has received little scholarly attention. One area of interest is the ebb and flow of policy topics, in this case suicide prevention, on the political agenda. There are many competing policy agendas and it can be tragic deaths as a result of suicide that prompts change and which raises suicide as a policy topic further up the political agenda. Does the effect of change in party political agenda depend upon the policy preferences expressed by the public, or vice versa? Since we know that government can't attend effectively to all possible and pertinent social issues and problems, how does the policy-making structure pay more attention to some policy topics rather than others?

This chapter has discussed the suicide prevention policy time line and in particular the policy process associated with three substantive government initiatives, the National Task Force (1998), Reach Out Policy (2005-2014) and Connecting for Life (2015-2020). Chapter 1 examines suicide statistics and the sectors in Ireland and chapter 3 the historical and contemporary social context of suicide. Themes such as agenda setting have been considered as the study question *"who decides who decides?"* suicide prevention policy and how the issue elevates up or down the political and subsequently policy making agenda. No straightforward explanation has been confirmed, however, this study would consider that the expansion of suicide prevention in agenda setting results from:

- A multifaceted mix of new ideas and research from the international suicidology sector,
- A level of conflict and competition between existing policy subsystems consisting of the statutory suicide prevention sector, (NOSP, HSE suicide prevention officers and a range of Government departments)
- A community and voluntary sector that includes local, regional and national organisations competing for decreasing resources and offering a range of services as discussed in Chapter 1.

 In addition, changes to policy making can arise from re-defined policy images and the interest arising from high profile political and celebrity policy actors or policy entrepreneurs. The range of actors involved in suicide prevention has increased substantially, the previous chapter having discussed the number of C&V organisations involved in suicide prevention. There is inevitably a network coalition and actor groups, with multiple events that occur to create changes in public demand, expectations and feelings about the need for action in reducing suicide. Unfortunately, tragedy for individuals, families and communities can create punctuation or change with suicide raised up the political agenda.

The Reach Out Strategy (2005-2014) was developed using an international evidence base, from academic and practice innovations, from across national and international expertise. Suicidology has developed improved knowledge of "what works" in preventing suicide and such developments, challenge the taken for granted traditional policy making process.

Topics become defined for, and by, the attention of politicians, government and policy makers, the discourse differs about the subject, giving an ebb and flow in the public agenda.

Policy process becomes embedded, can become set in certain ways. Processes get reinforced and this can lead to resistance and difficulty for anything but modest change, with substantive changes occurring only when there is a substantive questioning about policy or how it's made.

A feature of policy process theories, such as ACT and Punctuated Equilibrium Theory (PET) include the nature of political institutions and bounded rationality in decision making, discussed previously in this chapter. Humans are subject to cognitive limitations in decision making (Wildavsky, 1964) and policy is the result of individual and group decisions limited by bounded rationality. The concept recognises that attention span of government as limited (Simon, 1985; Baumgartner, Jones and Mortensen, 2014). The parallel process, where multiple issues compete in the government agenda, impacts decision making structures. It is through the mechanisms of policy subsystems, communities of experts, government departments (Department of Health) policy entrepreneurs and C&V organisations that suicide is kept on the political agenda.

The activities of the aforementioned subsystems, groups and individuals enable the political system to handle multiple issues at the same time. The agenda setting phase is crucial in determining strategy content, engagement methods and consultation. Decisions at this stage in policy making also determine policy stasis, the degree of incrementalism, change and policy punctuations, important themes in policy review and change.

Process Defined

The term process is considered central to movement and change (O'Leary and Knopek, 1992) and takes place at a boundary, in this instance the boundary between individuals, sectors and actors involved in policy making. The concept of process is difficult to describe. It is complex, fluid and dense. In some ways it can be viewed as a contacting process or point of unity (Zeichner, 2010 and Bhabha, 1994); a connection or merger which can tolerate difference between individuals and which is reachable through consultation, engagement and interaction in policy process. Capturing, measuring and articulating the subtle, changing nature of process is difficult and this author acknowledges a grappling with theory that might assist in capturing and articulating the factors, elements, what or who determines the political agenda and how actors get around the table in suicide policy making in Ireland.

Theorists, (Schattschneider, 1960; Cobb and Elder, 1983; Kingdon, 1984; Baumgartner and Jones, 1993; Baumgartner et al., 2008 and Baumgartner, Jones and Mortensen, 2014) have studied how agenda setting occurs in policy making, although there have been fewer systematic studies of how change in the political agenda influences policy decisions. The questions about how, who and why suicide policy process occurs in the way it does are important to this study. Improving knowledge about cross-sectoral relationships, engagement and collaboration can improve understanding of the impact of a range of factors on suicide policy development. Resources, content, implementation and policy management also impact the perception about whether the process is, or is not, responsive to feedback and public opinion. These views are generally represented by smaller local community groups in the C&V suicide prevention sector.

Themes in the study include, engagement, collaboration and consultation across sectors and when this occurs organisations can be considered as creating a third space, (David Cracknell, 2009; Zeichner,2010 and Bhabha, 1994) that space between professionals that creates a shared language and new thinking, practice and discourse. A third space is the point at which practitioners meet, can think and develop, individually and collectively. It is at this space where the process of change can be nurtured. By drawing on but not constrained and dominated by, the influence of current practice; opportunity is created to support new ideas, change, and the requirements of policy and indeed, initiate solutions to problems.

The nineties witnessed the growth of research exploring organisational responses in an ever changing environment. (Senge, 2006; Squirrell, 2012) and in the context of austerity and funding competition, the C&V sector requires responsiveness and proactivity.

Cross-sectoral policy process and multi-disciplinary policy sub-systems must develop a shared language, a collaboration of knowledge in policy making. Inevitably the policy process is determined by the political context, institutional structures and the availability (or restriction) of resources. The nature and impact of funder and funded relationship also impacts the policy process, if the statutory public body can be the funder of C&V activities in suicide prevention.

The activities of C&V sector are increasingly characterised by measurable outcomes, time limited projects, clear project cut offs and deliverables (Ord, 2012). This creates a strong focus on outcomes; neglects process and can have a negative impact on the quality of contact for C&V organisations and consequently programmes and service users (Harland and

Morgan, 2006). It is essential to have a clear policy making process that is proactive and adaptable, has vision and ethos that ensures the fundamental principles of client centeredness, meaningful consultation and transparent engagement are not compromised. The question about how and why collaboration, engagement and consultation across sectors is relevant in policy making is important, but all the more important if it can be shown that the phenomenon actually has a systematic effect on public policies content and as a consequence implementation

Power and Policy Process

Policy process is better understood when consideration is given to power dynamics involved; both in policy making and in the wider society. To examine power, one must consider relationships across sectors and the nature of participation by the C&Vs in public policy process. By examining a stage in the policy making process, the aim is to capture the impact of the relationship between statutory and C&V sectors in the suicide prevention policy process and at the core is a foundation in critical theory, a desire to influence and shape the activity of governments, the practice of state and outcome for members of society.

The catalyst to suicide prevention activity at community level is often profound loss and a desire for reducing death rates. Against, what can be an emotionally charged backdrop, it is important to examine the complex concept of power, another key component in the policy process. In suicide prevention, there can be reluctance to consider power; with a preference for terms such as influence. The word 'power' can generate reactivity with its association to control, authority, rule, domination and possible sense of powerlessness at the other end of a continuum. It is my opinion that in the context of suicide and its prevention powerlessness evokes a strong reaction. It touches that human incapacity to prevent the unthinkable, even a hopelessness and despair when death by suicide has occurred. Therefore, particular consideration to cross-sectoral relationships and the associated power dynamics is integral to any consideration of policy process.

Defining Power

Power is everywhere, according to Michel Foucault, who greatly influenced the analysis and understanding of the concept. It is embedded in discourse and knowledge and what he calls *'regimes of truth'* (Foucault and Rabinow, 1991.); Power is what makes us, according to Foucault, who transformed the view from that of power actors who use it coercively. In this

regard Foucault differs from other traditional concepts of power. As Gaventa (2003, p. 1) argues, Foucault was radical in departing from traditional concepts of power toward the idea that power is more diffuse rather than concentrated, embedded, embodied and acted rather than possessed by actors. It is subtler and more discursive and as Gaventa states power "constitutes agents rather than being employed by them" (2003, p. 1).

In his analysis, Foucault challenges the concept of power being used by actors or coalition groupings using acts of coercion. Instead, he sees power as a dispersed phenomenon. He states power is and 'comes from everywhere' thus it is neither an agent nor agency (Foucault, 1998, p. 63). Power is instead 'metapower' or 'regime of truth' where the concept is pervasive and in constant negotiation in society. The phrase 'power and knowledge' was used by Foucault to indicate how power is constructed by what is accepted as truth, knowledge or science.

It is, as stated by Foucault (in Rabinow 1991), the types of discourse which society accepts, the politics of truth and the regime that functions to create a 'truth' produced through forms of constraint that induce the regular effects of power. It makes power function as if true, creating the methods, occasions and means which sanction it and in addition, the accepted discourse accords value to the status of the power actors who are given responsibility with saying what counts as true (1991). Thus, in the case of suicide prevention policy development, it is the accepted format and process, the methods and regime of truth, accepted as such a truth, pervasive and within the systems that embeds the power and status of the actors with responsibility and control of how policy development takes place and the process therein.

The generalised politic or considered regime of truth is the result of science and discourse and is reinforced through institutions responsible for education and media. It can also change as the political landscape changes. In Ireland, the political state, with a strong reliance on the statutory institutions and systems has a subtle set of rules, 'the rules according to which the true and false are separated and specific effects of power are attached to the true'… a battle about 'the status of truth and the economic and political role it plays' (Foucault, in Rabinow ed. 1991 p. 74). Power can be perceived and defined as a boundary, one which can inspire action and as noted by Hayward (1998) people have the capacity to know and shape these boundaries. Indeed, Foucault recognised power as productive, essential and a positive force in society rather than only negative, coercive or repressive (Gaventa 2003, p. 2): "We must

cease once and for all to describe the effects of power in negative terms: it 'excludes', it 'represses', it 'censors', it 'abstracts', it 'masks', it 'conceals'. In fact, power produces; it produces reality; it produces domains of objects and rituals of truth" (Foucault, 1991, p. 194).

Engagement Theory, Models and Practice

Understanding power allows for improved understanding of the nature of participation by government, statutory organisations, C&V groups and interested parties in policy process. Page (1985) offers an analysis of democracy and is implications for the engagement and participation of citizens in policy decision and implementation. The "Institutional" view is of democratic *control* where representative institutions participate in policy making. This model focuses on the mechanisms that link politicians with the institutions, in this case the ruling government parties, or coalition and the statutory institutions (NOSP, DOH) in policy making. The engagement and participation of citizens is therefore by a bureaucracy, managed by statutory organisations and the officials therein. There can be a power elite and thus the participatory and democratic process of citizen engagement can be undermined by control over policy formation and implementation (Hill and Hupe, 2014). Rowe and Frewer define three categories of public engagement, public communication, where information is set out to the public by decision makers, public consultation whereby information is conveyed from the public to decision makers and finally public participation, a process which is reciprocal and where information flows up and down between public and decision makers (Rowe and Frewer, 2005, p. 255). Themes that are of interest to this study include the degree of collaboration and consultation between community and voluntary and cross-sectoral engagement in decisions about suicide prevention policy formation and review. Using manual methods and NVivo organising software primary and secondary texts were examined thematically for references to *Engagement*, *participation*, *statutory sector and C&V consultation* and the study evaluated engagement practices and engagement theory in the development of suicide prevention strategy in Ireland. Secondary source documents were examined, as discussed in page 50 of this thesis.

There is evidence of an improved recognition for public participation in policy process due to a range of factors, not least changes in policy making patterns in Ireland, the changes and growth in C&V suicide prevention sector, the reliance of government on a partnership approach for the delivery of suicide prevention actions or objectives by funding national, regional and local C&V groups and this is discussed in further in chapter 1. The literature

and document analysis indicates a shift toward consultation and engagement from 1998 when the National Task Force produced its report, through 2005 when Reach Out, the first national policy was launched to 2014 with the succession planning and subsequent launch of Connecting for Life 2015 – 2020.

Participation in Policy Process

Bishop and Davis (cited in Waterhouse- Bradley, 2012) state that participation is defined as "the expectation that citizens have a voice in policy choice" (p. 91). As described above, defining and understanding policy development involves the consideration of a number of factors. Policy networks may involve groups of decisions, a web of interacting decisions made by a complex decision network involved in the action of developing policy. The emerging policy may comprise a set of decisions occurring as a series of decisions rather than one simple action. The policy may change and be adjusted over time with major directional adjustments, actions and non-actions, reviews following implementation, evaluation and policy succession planning, it is therefore a dynamic rather than static concept with shifting patterns.

Additional characteristics that impact on the policy environment are the range of stakeholders and interest groups that can shape and have significant influence on policy process and pertinent events surrounding suicide in Ireland, public concern and media influence. This depends upon the knowledge of, accessibility to and influence on policy processes and stake in the suicide prevention issue. It is important to recognise the characteristics outlined may be typical in many health policy situations, but not all characteristics or themes will be pertinent in a given point in time in the analysis of policy process.

It is recognised that policy processes changed in the past number of years with initial policy developments being top down, state led by the public or government sector and politicians, bureaucrats and interest groups (Hogwood and Gunn, 1984; Grindle and Thomas, 1991). A change to the policy making process highlighted involvement of, and increasing importance of, an increasing range of policy actors in the policy process (Buse et al., 2005), including private sector, for-profit and not-for-profit or third sector national, regional and local organisations. This has resulted in change to the policy environment, influence on and shaping policy development of partnership between private, public and third sector. Policy analysis must therefore consider the context including such forces as global changes, civil society and boundaries outside the state (Keck and Sikkink, 1998).

The suicide prevention sector is now global, reflecting less geographical boundaries with increased exchanges in ideas, in communication and research. The Irish policy environment is influenced by more complex European, cross-border, inter-organisational, cross-discipline academic and varied relationships, with policy development influenced by global and European decisions. The developing web and technology facilitates access to international information, communication and networking, both between governments, or statutory sector and stakeholders with a vested interest in the subject area.

Whilst the statutory sector, government and its departmental, hierarchical and bureaucratic institutions are central to policy process, it is essential that the context of policy analysis is considered, and reflects the diverse range of open-ended, more ad hoc arrangements which can affect policy making. Hajer and Wagenaar (2003, p. 8) argue that policy analysis must be deliberative, less top-down, consider an expanse of networks and take account and interpret individual's stories, understanding, values and beliefs. Policy analysis recognises subtle changes and experiences in the process and Hajer and Wagenaar describe 'new spaces of politics' with 'concrete challenges to the practices of policymaking and politics coming from below'. The public expectation and demand that suicide rates in Ireland be addressed has created a challenge to policy process and a new space for growth in community and voluntary groups with subsequent desire for voices to be heard and to be involved in the policy process.

Conclusion: Informing research Questions

This chapter examined policy process theory and how this can be considered in the understanding of Irish suicide prevention policy development, both historically and at present. The chapter reflects on the tensions, relationships dynamic of government and the range of C&V actors involved. It articulates the concept of power as a dynamic part of the process, influencing the context, both a positive and negative yet human and subtle aspect of the process and a reflection of the society in which the policy is being developed. As stated, an examination of policy making involves consideration of the dynamics of institutions, the political landscape, the cultural and social processes and subtle themes including the experiences and perceptions of those included in and indeed those excluded from the policy process. Policy process was considered as it is applied to suicide prevention policy succession planning and development in Ireland. Consultation and participation themes were considered

to gain an understanding of change and progress in engagement in developing suicide prevention strategy.

The literature offers some challenging questions that were considered, with challenge defined by the author as an invitation to be curious about emerging themes and concepts in the study. Such questions were refined as themes for interviews with respondents. It is useful to consider how decisions and certain topics get on the political agenda for policy making and indeed how the agenda setting in suicide prevention policy in Ireland informed.

Emerging themes and concepts in the literature review were refined as themes and topics in the interviews with respondents. This included:

- Agenda setting in suicide prevention policy making
- What influences decision making in policy process
- What are the factors that determine the priority for suicide prevention policy development in Ireland?
- Who/What groups are the primary stakeholders in policy process
- Power and its understanding in policy process and participant views about where power resides in suicide prevention policy making.

The chapter has considered how decisions and certain topics get on the political agenda for policy making, particularly the agenda for developing a suicide prevention policy in Ireland. A conclusion must be that the early phases of policy making may not be sufficiently informed or considerate of dynamic and process. The factors that determine the political priority for suicide prevention policy making have been discussed. The research question has been considered using ACF which offers a framework for the articulation of what is a complex set of factors, the subtle and ever changing policy process. Finally, it is essential to consider the research question against a theoretical base, one which offers a language and framework for the articulation of what is a complex set of factors, the subtle and ever changing policy process.

Chapter 5: Suicide Prevention Policy in Ireland and the International Evidence

Introduction

The development of a global suicide prevention sector has changed the policy environment, influencing and shaping policy development across many countries, including Ireland. Policy analysis must therefore consider the wider context that shapes strategy in this country, including such forces as global changes and the international influences from outside the state (Keck and Sikkink, 1998). The suicide prevention sector is now global reflecting less geographical boundaries than in the past. Sovereign policy development is being increasingly influenced by global and European decisions. This reflects the increased exchanges in knowledge and ideas being shared across Europe and indeed the wider world. These exchanges include communications, academic research and literature. This environment is further influenced by more cross-border, inter-organisational, cross-discipline and varied relationships. Moreover, the development of the internet and digital technology facilitates access to international information, communication and networking, both between governments, or statutory sector and stakeholders with a vested interest in the subject area which has influenced policy development.

Whilst the statutory sector, government and its departmental, hierarchical and bureaucratic institutions have an important role, the policy analysis context must consider a diverse and range of open-ended, more ad hoc arrangements which can affect policymaking. As Hajer and Wagenaar (2003, p. 8) describe 'new spaces of politics' with 'concrete challenges to the practices of policymaking and politics coming from below' now play a role. They argue that policy analysis must be deliberative, less top-down, consider an expanse of networks, and take account, and interpret, individual's stories, understanding, values and beliefs as the policy analysis recognises subtle changes and experiences in the process.

This chapter examines the process and practice of suicide prevention policy development across a number of countries and considers how strategy in Ireland is influenced and impacted by developments across a global policymaking context. The selection of countries for consideration was informed by those regions that are near neighbours (N.I., Scotland and England) and a sample of those with a well-developed suicide prevention policy in the English-speaking world (New Zealand, U.S and Australia) where evidence of influence,

interaction and impact on Irish policy development exists in literature as discussed in Chapter 3.

The chapter examines also the evidence that informs primary approaches and principle components of such policies, factors influencing the setting of strategy goals or objectives. In particular, evidence of engagement and cross-sectoral consultation in policy development and the process therein is discussed.

Primary Approaches in Suicide Prevention

National policy approaches to suicide prevention developed during the past 20-30 years, strongly influenced and informed by psychological and sociological theory and applied concepts. Central to such development has been alignment of psychiatry, mental health services and the medical model approach to care. The Institute of Medicine ((IOM), 1994 cited in Platt, 2012) established a unifying framework for the categorization of prevention into universal, selective and indicated populations and over the years, has been widely adopted in the prevention of suicide.

The model developed in 1994 considered for the first time the importance of a universal strategy targeting general population or sub-groups in the delivery of general health services. As a consequence of this approach, programmes were intended to result in a reduction in suicide risk through improved knowledge about protective factors and how to help those at risk; improving provision and access to support and attention. The model includes education and awareness campaigns and programmes, reducing access to means of suicide and also includes programmes aimed at targeted groups where there is evidence of increased probability of suicidal risk and behaviour. Examples include screening programmes and increased accessibility to crisis services for those indicating early signs of risk behaviours.

Whilst there has been increased information and understanding of risk and protective factors that may lead to suicidal behaviour (Farrington, 1995; Brendtro and Larson, 2006) difficulties remain about the general nature of data from gathered evidence of risk in suicide prevention. Prediction and thus prevention of suicidal behaviour is difficult and has limited success or accuracy in forecasting patterns and trends. This is due to the generally low 'base rate' of suicide in the population, the existence of some risk indicators across some considerable numbers of people, with the existence of a "false positive" as the majority of people will not be involved in suicidal behaviours (Platt, 2012).

A number of primary studies in Suicidology acknowledge the difficulties in efforts to demonstrate the effectiveness of prevention and intervention strategies using random control trials (RCT). These difficulties arise due to the requirement of a gold standard or 3-star methodology, sample size, replicability and sufficient information to enable deduction, or satisfactorily identify themes and evidence for generalisation. As Pokorny states (1983, p. 141) "We do not possess any item of information or any combination of items that permits us to identify to a useful degree the particular persons who will commit suicide"

The development of international policymaking in suicide prevention was accelerated in the 1980s by the World Health Organisation (WHO) and subsequently in 1996 when the United Nations published guidelines stressing the importance of countries developing their own national suicide prevention strategies using a clear conceptual framework (United Nations 1996). New Zealand was one of the first countries to develop a comprehensive national suicide prevention strategy, with their current policy and Health Ministry retaining close links to the World Health Organization (WHO). In addition, the International Association for Suicide Prevention (IASP) formed in 1996 created an international platform for knowledge exchange and facilitated collaboration between UN member nations in monitoring international developments in suicide prevention research, policy and practice.

Among those countries which produced a strategy after 1996, there is considerable convergence as these tend to make reference to the UN guidelines as an important source document. The 1996 UN guidelines emphasise a mix of public health (universal, population based) and health care/high risk group approaches incorporating universal, selective and indicated strategies. The recommendation by the UN was for the incorporation of a number of activities and approaches into the national strategies (UN 1996, p. 2) including:

- Adoption of culturally appropriate protocols for public reporting of suicidal events;

- The promotion increased access to comprehensive services for those at risk of, or affected by, suicidal behaviour;

- The provision of supportive and rehabilitative services to people affected by suicidal behaviour;

- The reduction of availability, accessibility and attractiveness of the means for suicidal behaviour; and

- The establishment of institutions/agencies to promote and coordinate research, training and service delivery with respect to suicidal behaviour

(United Nations, 1996)

The guidelines of The United Nations (1996) and WHO (2014) influenced the growth of national policymaking and by 2016; twenty-seven countries had National policies with the numbers continuing to grow. In addition, international suicide prevention policy development is informed greatly by a global network of increased collaboration through the establishment of IASP, networks of academic and national research institutes and publications by experts from across a now global Suicidology community of experts.

As a result of the network and increased international collaborative efforts, there developed internal and external knowledge transfer with policy planning, flocking and copying with subsequent sharing of policy content, objectives, implementation and practice. This chapter, therefore, discusses the results of NVivo and thematic analysis of each national suicide prevention policy or strategy. They were reviewed to develop an understanding of the development for each country around key topics or themes including C&V and cross-sectoral participation, engagement and consultation models and the participation of C&V in the policy process.

Suicide prevention across a number of international jurisdictions has progressed from devising policy to drawing up a strategy. The distinction is somewhat complex, as policy informs strategy. However, for the purposes of this study, the terms are used interchangeably and the term strategy is considered as a comprehensive plan, devised to accomplish actions and goals while policy is a set of guiding principles that lead toward a strategy. In the review of the 'Reach Out' strategy a decision was made to draw up a set of actions in the following one (which became 'Connecting for Life') that are specified, concrete and measurable outcomes to address suicide in Ireland.

Examination and review of the English, Scottish, N.I., U.S. Australia and New Zealand policies identified links in national policy process and policy content between the Irish policy and those of our neighbours. Whilst recognising the distinctiveness of Irish contextual factors, the retrospective and contemporary policy development, this chapter situates Irish policy process and the identifying analytic categories of this study (C&V, Consultation,

engagement, participation) in relation to other national policies thus deepening the understanding of policy context, policymaking and content in Ireland.

It is evident that many national policy and suicide prevention strategies are informed and formulated from the aforementioned UN and WHO recommendations, from the systematic reviews and studies, perspectives and theories linked to national and international fora and networks. The importance and centrality of IASP is noted for its role in creating an international cohesiveness to the exchange of knowledge and practice and this must be acknowledged.

National strategies are developed with often similar design and objectives, informed by the evidence, research and expertise across other nations. This knowledge exchange is essential, useful and necessary. However, the author is mindful about what constitutes the "taken for granted" in knowledge discourse and evidence consideration informing national and international discussion and against which policies are developed. The qualitative narrative, community engagement and small scale study, reflecting the nature of lived experiences of those affected by suicide, can be overlooked in deliberating what constitutes evidence that informs policymaking processes. This study argues the validity of qualitative methodology as an opportunity to use case study and narrative as a valid method of informing the direction of future strategy and actions in Ireland.

The International Evidence and Policymaking

The development of more robust evidence to support suicide prevention strategies and programmes is, as stated by Beautrais (2005) one of the central challenges for the 21st century. In a number of nations, including Norway and Finland, a range of methods and models exist where there is a direct connection between the institutions responsible for policymaking, academics, researchers and practitioners in suicidology. The latter groups being in a position: to instigate policy change (de Chenu, 2013); initiate problem definition, the construction of policy and its review and subsequently practice and provision for service users. Research findings (de Chenu, 2013) in a comparative study of policy process in the English and Norwegian models highlighted how separation of national governmental power enables access for policy interest actors and coalitions thus influencing policymaking, the problem definitions and policy design. This can be identified as a factor in Irish policymaking where the definition of the issue (suicide) occurs in a context where there is separation of institutions in policymaking, namely departments (DOH) and NOSP and

political process, NSRF, academic and other experts and C&V organisations influencing the policy process.

The chapter considers themes in the national policies, highlighting those relevant to the study question namely '*who is deciding policy?*' and policy process between statutory and C&V sectors. This form of public policy analysis in the realm of suicide prevention policy process falls under the tradition of Wildavsky's concept of 'Speaking Truth to Power' (1979). The study is concerned with the early stage in the process, the problem definition phase in policymaking. This is the point at which a policy problem is portrayed and can be identified as causal arguments regarding the severity of the issue/problem and the portrayal of problem populations (Rochefort and Cobb, 1994; Stone, 2002) and as a result, how policy is subsequently to be developed. A number of relevant themes across the sample of international strategies/policies are presented in this chapter.

What Works – International Studies

The use of general population based suicide prevention strategies is supported by some suicidologists (Paris, 2006; Yip, 2005) advocating effectiveness in reducing suicide rates. Others argue that prevention needs to be directed at targeting high risk groups (Cavanagh et al., 2003; Beautrais, 2005) "The major focus of suicide prevention efforts should be directed at minimising rates of psychiatric disorders and addressing the risk factors and life pathways that lead to these disorders" (Beautrais, 2005 p. 53).

National universal prevention strategies tend to have a number of themes in common, namely education and public awareness strategies aimed toward improving services for those seeking help when experiencing mental health issues (Ireland, U.S. Scotland, and England). However, in contrast, the emerging evidence is limited in studies of the effect of education programmes on rates of suicide (Platt, 2012). An overarching theme in the strategies reviewed is the importance of population-based approaches, which according to the US Strategy are based on 'Healthy and Empowered Individuals, Families, and Communities', the aim being creating environments that support and promote health and wellbeing and reduce suicide risk by addressing risk and protective factors (Pillinger, 2014).

Means restricting is a theme developed in a number of national strategies due to the demonstrable link between restricting access to means and reduction in rate. This has included access to commonly used geographic locations, when access can be restricted.

Studies in Russia and Iceland have shown that limited access to alcohol has reduced rates of suicide. Yet despite evidence of these successes, this approach has not been widely implemented or informed policymaking in other nations. A contextual factor of note is that Russia in particular has had a large alcohol abuse history related to suicide rates, this being less common to other jurisdictions.

Media: Prevention and Policy

The Irish Association of Suicidology and The Samaritans first developed media guidelines about reporting suicides in Ireland in 2000 (updated in 2010, 2016) and further work has been carried out to assess the impact of accountable and regulated reporting on suicide rates. In countries including Austria there has been some discernible links between reduced deaths by certain means, for example deaths on railways and regulated reporting and sensitivity in media reports (Krysinska and De Leo, 2008). Less capacity for regulation exists across social media and there is work to be done to establish protocols with the primary social media network providers regarding guidelines, responsibility and good practice.

Pillenger (2014) in a review of international suicide prevention policy also cites the promotion of safe reporting and portrayal of suicidal behaviour by the media, aimed at safe and responsible reporting that helps reduce stigma. Others argue for the monitoring of media coverage of suicide and regulation of the subject sensitively in the media (Pillenger, 2014) (Connolly, cited in Samaritans, 2017), a goal to encourage dialogue that includes responsible use of social media and new technologies, this being embedded as an action in Scottish strategy. Also in the New Zealand strategy, responsible media reporting is a separate, stand-alone goal.

Targeted approaches

Targeted approaches in national policies are common and directed at high-risk groups. In Ireland this includes rural isolated older men, those with previous indicators of risk, history of self-injury and particular "at risk" groupings such as the Travelling community and LGBT young people. There is limited evidence that succinctly captures the impact of the interventions. Some small-scale studies exist across organisations, but the findings cannot be generalised. Relational based programmes that engage the elderly, use listening ear or youth work interventions, in addition to Counselling in Primary Care (CIPC) Services (2016) and Jigsaw Ireland (2015) have evidence supporting positive outcomes in screening risk with

young people (15-25 years). Using CORE Outcome Measurement data, or other measurements, can offer indication of improvement in well-being, client perception of problems and functioning, with associated reduction in risk scoring. Overall, however at national level in Ireland, evidence is limited about any effect of clinical practice, programmes and interventions on national suicide rates.

Jenkins and Singh (2000) in a review of Scottish strategy notes that target setting can be an essential means of encouraging achievements. Targets can influence the activities of government, public services and professional education and training bodies. Targets can also impact on the performance across statutory and C&V and private sectors which can contribute to the success of suicide prevention objectives or actions. Targets also make explicit the framework, the responsibilities and requirements within all sectors. Ireland's strategy, for example, contains wide-ranging recommendations and actions recently supplemented by an implementation plan but no targets developed into specific timescale for implementation.

Access to Mental Health Services

A number of national strategies have objectives linked to improved access to mental health services. This includes Scotland, Ireland (Reach Out 2005-2014; Connecting for Life 2015-2020), the England, Northern Ireland, Australia, USA and New Zealand. These objectives aim to reduce suicide through a more direct access to at risk and crisis services for those vulnerable and presenting with suicide ideation. Ireland recently launched its SCAN Pilot programme associated with local GP services yet the data is not yet available and this is a signposting service to other therapeutic interventions.

Recent austerity has witnessed a cut in funding to psychological services in Ireland. Staff shortages in the HSE, CAMH and adolescent MHS have resulted in lengthy waiting times for those requiring psychiatric assessment and access to mental health services. An associated reduction in funding to the C&V sector, as stated in chapter 1 has resulted in those objectives across the sector being unable to be met.

Psychopharmacological interventions

Studies have examined a number of particular prevention strategies, testing psychopharmacological interventions with those at risk of self-harm and mental health issues, with varied indicators of success. Most noticeable has been effectiveness with treatment of

bi-polar diagnoses. One of the ongoing debates in mental health services has been about the role of anti-depressants in suicide prevention, the possible effects of medication in contributing to suicide rates among vulnerable people and the correlation between levels of prescription and suicide rates. In addition, it is argued that pharmaceutical interventions cannot be recommended with a caveat about effectiveness (Leitner et al., 2008).

G.P. and Front Line Education

Mann et al. (2005) in a systematic review of effective interventions found some promising evidence from, and recommended further study of general practitioner education in recognising and treating depression and increasing restricted access to lethal methods (du Roscoät and Beck; Mann et al., cited in Dillon et al., Suicide Prevention Review, 2015). The review noted evidence of success through school and community-based education and awareness campaigns and the role of community based mentors and gatekeepers (Isaac et al, in Dillon et al., 2015). Improved screening and treatment of higher risk psychiatric patients and improved media guidelines were also noted as effective in reduction of rates (Bohanna and Wang, cited in Dillon et al., 2015) although other reviews consider the evidence for the impact of media guidelines as inconclusive with Mann (2005) having considered international evidence (Mann et al., 2005 and Teuton, Platt and Atkinson in Dillon et al., 2015) and WHO, (2014).

Therapies

Cognitive (CBT) and Dialectical (DBT) Behavioural Therapies have noted some success as have relational based listening services in community locations. Leitner et al. (2008) noted the absence of evidence regarding provision for reduction in suicidal behaviour or ideation in asylum seekers, lesbian, gay, bisexual or transgender people, the recently bereaved; socio-economically deprived, unemployed; homeless or survivors of sexual abuse. Systematic reviews (Dillon et al., 2015) of therapeutic supports would indicate that intensive therapeutic care with outreach support has a degree of success in reducing suicide ideation (du Roscoät and Beck; Scott and Guo, cited in Dillon et al., 2015), Given the aforementioned austerity and funding issues facing mental health and suicide prevention in Ireland it is noteworthy that Connecting for Life (2015-2020) was launched as a whole government approach and depends on a multi-agency commitment across a range of government departments to meet the established objectives. It will be important to review evidence of the success of this stated implementation strategy as respondents to this study indicated that implementation across the

range of agencies and cross department appeared slow with limited clarity of cross department, cross government cohesiveness and joined up thinking in meeting the stated objectives .

Best Practice Approaches

Thematic examination of Irish and international policies reveals a number of key elements in policy development. Firstly, while mental ill-health is a key risk theme, it is essential to also identify other multiple risk factors such as socio-economic, cultural factors and the social impact of economic downturn, addressed in chapter one. This study is addressing the theme of cross-sectoral relationships and the role of the C&V in suicide prevention policy making process. The policies studied cite the importance of inter-agency participation and engagement between stakeholders, e.g. government departments, local authorities, education, non-statutory and C&V, service users and the social partners (Irish policy) (Arensman et al., 2013). Connecting for Life (2015) notes the necessary involvement of stakeholders from key delivery organisations as essential to implementation strategy. It is also noteworthy that the Irish government and NOSP in particular have listed key delivery partners in the implementation strategy, the rationale for choosing such partners being an important theme in understanding the policy process. The list of stakeholders and partners includes, health service providers, An Garda Síochána, prisons, non-statutory and community organisations, sports (GAA) and religious organisations with the experiences of service users stated as paramount in the engagement process (Mann, J.J et al, 2005, Jama 294 pp. 2064-74)

Community Involvement in Policy Making and Implementation

The Commonwealth of Australia states the essential requirement of an active community involvement in the implementation of strategy. It is stated that the aim is an approach that encourages community-wide ownership of suicide prevention. This is also a stated aim in Connecting for Life (2015), although the Australia model encouraged activities to facilitate community sector participation in the planning, development and implementation of strategic activities (Commonwealth of Australia 2008).

Interviewees from Australia discussed consultation methods that include proportional representation measures and quotas to ensure community engagement is representative and across sectors; such measures are not utilised as consultation methods in Irish policymaking. The evidence from New Zealand indicates greater success when communities develop

county/shire/community-wide suicide prevention plans. They appear most effective when the approach is planned, is based on safe suicide prevention interventions, when leadership is identified, has a clear and shared vision and is co-ordinated. Greater success appears to occur when existing community structures and specialist services and initiatives are used with a planned approach to readiness and community capacity building.

Suicide prevention policy in England, in a similar way to the rest of the strategies examined, begins with the view that "no one organisation" can deal with all the complex factors that cause suicide. The policy states, as a vital requirement to success, a commitment across government departments, Education, Justice, Health, the Home Office, Department of Transport Work and Pensions and other sections of Government. It is also explicitly cited that successful implementation requires the support of the voluntary (C&V), statutory sectors, academic organisations, businesses, industry, journalists and other media. The policy states the involvement of communities and individuals, affected by suicide, as fundamental to policy success. Objective (No.20) notes the need for those working in health and care, education and the voluntary sector to be aware of the high rate of emotional and mental distress, substance misuse, suicidal behaviour or ideation increased risks of self-harm amongst certain target groups (e.g. LGBT). In recognising the profound effect of suicide on the local communities it is considered essential within the policy that support for families bereaved or affected by suicide; effective local responses to the aftermath of a suicide; and information and awareness support for families, friends and colleagues who are concerned about someone who may be at risk of suicide are basic elements.

The Cross-sectoral in Policy Making

Suicide prevention policy in the U.S. argues that "everyone" has a role in prevention, not just healthcare and issue specific community groups, this being enshrined in Connecting for Life, the 2015 Irish policy which describes a 'whole of community' response as part of its ethos. Outlined in U.S policy as strategic direction 1 (Healthy and Empowered Individuals, Families, and Communities) the policy's goal is to "integrate and coordinate suicide prevention activities across multiple sectors and settings". U.S. policy is defined as inclusive of a broad range of organisations involved in suicide prevention. Implementation involves the establishment of collaborative suicide prevention programmes at state/territorial, tribal, and local community levels that also involves public-private partnerships aimed at advancing suicide prevention. Training for community and clinical service providers on the prevention

of suicide and related behaviours was prioritised and the policy included the dissemination, implementation and evaluation of guidelines for communities responding to suicide clusters. The U.S. policy stated its support for those tasked and involved in implementation through education, training, and consultation. However, there is limited evidence to date of evaluating the evidence of rolling out sustainable and successful cross-sectoral collaboration and C&V involvement in either US or other policies examined for this study.

The Cross-sectoral and Collaborative in Northern Ireland:

In Northern Ireland, Protect Life, a new strategic framework for public health was developed in 2012, replacing the Investing for Health Strategy and stating an "overarching policy" aim to reduce health inequality and the improvement of public health. In 2012, the strategy was allocated £3.2 million funding per annum to support community implementation of "Protect Life" and this figure increased to £7 million in the Protect Life 2 review in 2016. Central to the new strategy framework was a stated focus on disadvantaged neighbourhoods and population groups, with an emphasis on community involvement in both the design and delivery of programmes based on local need. Addressing the wider social and environmental factors influencing suicide rates was central to the stated strategy framework. In setting the strategic direction, community involvement was articulated as essential in design and delivery of programmes based on local need. This resulted in support for local communities, through cross-sectoral partnerships, to develop and deliver suicide prevention initiatives and services such as bereavement support, counselling, awareness and intervention training, awareness raising, and complementary therapies. Despite the draft strategy in 2016, the launch of Protect Life 2 requires ministerial signature and executive sign off which is delayed at the time of writing as a result of the dissolved local assembly at Stormont.

Suicide clustering was addressed, due to the higher prevalence of death in particular locations in N.I., the strategy recognised, as addressed in some literature, that one death can activate suicide attempts, increasing risk, amongst those with a connection to the deceased. Identifying such risks is recognised in the N.I. strategy as necessitating the development of co-ordinated, community emergency response plans, involving a wide range of organizations including local community groups and primary care, local clergy, youth services, schools, social services, mental health services, PSNI, and the local councils. Whilst the stated aim was the implementation of community response plans in all areas in N.I. from 2012, the C&V sector across N.I. has been affected by austerity and funding constraints, which can increase

the competitiveness between organisation and thus impact capacity for a collaborative engagement in developing response plans, programmes and prevention. Indeed, the consultation for Protect Life 2 recognised the weakness in monitoring and evaluating the outgoing Protect Life and the N.I. Department of Health committed to strengthening this element considerably in the incoming strategy with an outcomes based approach, published reviews and independent monitoring by RQIA (Regulation and Quality Improvement Authority).

The N.I strategy was informed by the Republic of Ireland's National Suicide Research Foundation (NSRF) review of the evidence base for suicide prevention, citing the primacy of suicide awareness and positive mental health training for community "gatekeepers" and those working with survivors of abuse. Protect Life was also informed by a community feedback process with stated key findings and recommendations including encouraging closer co-operation within community and voluntary sectors (C&V), particularly in sharing information and best practice. The feedback process also recommended developing sector standards for community-led services and carrying out a cross-sectoral review of delivery structures, the improvement of service interfaces and handovers between providers. The evidence from the feedback process is clearly articulating themes that are of interest to this study, namely the level of collaboration, participation and consultation across sectors and indeed with sectors in the development, implementation and improvement of suicide prevention in the wider society. Northern Ireland has faced a particular threat to the successful achievement of outcomes in the Protect Life strategy caused by the dissolved Northern Ireland assembly that began in January 2017 and the associated impasse within the devolved local parliament at Stormont. The subsequent impact on funding and local services has been immense. In addition, there are wider economic and austerity factors that are affecting funding to statutory and C&V sectors and a lack of longer-term recurrent funding impedes community providers.

The review for the draft Protect Life 2 involved a consultation, launched on 9/9/2016 consisting of 800 emails and letters distributed to a range of C&V, political, independent stakeholders, with consultation events and working group meetings held across a number of locations, coordinated by the VSB Foundation, a body promoting volunteering throughout Northern Ireland. The format and method of selection was not specified, the assumption being that existing databases of suicide prevention, intervention and postvention groups was used. In addition, some organisations arranged their own responses and as a result, a total of 104 submissions were received. There were additional consultation meetings between the

Ministerial Coordination Group on Suicide Prevention, the Suicide Strategy Implementation Body, the All Party Group on Suicide Prevention and the Bamford Protect Life and Emotional Health and Wellbeing Group. How/who decides the membership of the aforementioned committees is a theme that is of interest to further study. The consultation responses articulated that suicide prevention should be a responsibility for all Executive Departments at Stormont, not just Health. This objective is similar to the Irish and Scottish policies and how successful this cross-departmental process is will be an important indication of how much investment has improved in the implementing and reviewing of Protect Life 2. Responses to the consultation process emphasised the importance of measurement for evaluation of implementation and recommended the setting of target dates and timeframes, with a reduction in actual numbers of actions in the new strategy. It was also felt that the target for reduction in death be agreed in line with WHO at 10%. Interestingly, the Protect Life 2 draft focuses on Crisis Intervention and Postvention, a decision made at ministerial level to launch a separate Mental Health Promotion action plan to run concurrently and address prevention, early intervention and targeted practices. All of the above are subject, as Departmental response states to "available funding" with timeframes requiring additional scoping. It will be interesting to evaluate how a separation of activities within the strategy has the potential to either make a significant contribution to suicide prevention actions being implemented more successfully or if the risk exists of a fractured and disparate implementation that is hard to evaluate and are reliant on other Executive strategies tackling the range of factors impacting suicide rates, including unemployment, low educational attainment, mental health and drug or alcohol abuse.

The outgoing strategy and draft Protect Life 2 emphasise the need for increased uptake of suicide prevention and mental health awareness training This is being addressed in the new Mental Health plan and includes suicide awareness and mental health awareness for a range of health and social care professionals, and community "gatekeepers". These "gatekeepers" include teachers, youth workers, clergy, trade union officials, taxi drivers, hairdressers, community workers, sports coaches, etc. Evidence based training programmes such as Applied Suicide Intervention Skills Training (ASIST) and Mental Health First Aid Training (MHFA) and Safe Talk will be delivered. The Departmental response to the consultation states the new strategy will be *"in effective partnership/collaboration with public and private sector organisations, academia, professional bodies and voluntary and community agencies" (Department of Health N.I., 2016)* with the consultation process underpinning this as a required principle in any new strategy.

Local responses and Cross-sectoral Collaboration

The most recent England, Irish and N.I. strategies articulate the importance of local response, responsibility, planning and delivery. Actions 37, 38, 39 of the English strategy state the development of evidence based local approaches, linked to and based on national actions. There will be local responsibility, through local agencies to adapt and prioritise the aims, planning and work to prevent suicides will be carried out locally. The national plans include developing evidence based local approaches, grounded on national actions to support these local approaches. This is stated as an integral aspect of Connecting for Life (2015-2020) with goal 2 as stated to support local communities' capacity to prevent and respond to suicidal behaviour. To date (29/12/2017) 16 local area action plans are in the process, or have been developed across Ireland. This study is concerned with collaboration in national policymaking, interviews have also been carried out with local suicide prevention organisations as the level of collaboration at local, regional and indeed national strategy review and planning is an important aspect of this study.

The Cross-sectoral Collaboration in: Connecting for life (2015-2020)

Connecting for Life, Ireland's strategy launched in 2015, states that the planning process involved the engagement of a broad range of statutory, non-statutory and community stakeholders who were involved in identifying, agreeing and setting goals and strategic priorities and objectives. The method by which the task force, various sub committees, local and national planning committees were constituted is not captured or described but it is evident that experts from across a range of known groupings were invited to participate, this being underpinned by established alliances across DOH, HSE and NOSP. There is evidence that the level of engagement in the planning process has improved and appears more inclusive. This is in some ways a recognition by DOH and government that, due to social change from the time of the 'Reach Out' strategy, there has developed a strong advocacy and mobilised C&V sector aimed at securing opportunity for engagement in the strategy and in the development process of *Connecting for Life*. There is a perception that there appears to be a gatekeeping in the policy process strategy. This was discussed by one respondent to this study, who articulated a perception that final draft strategy partially reflects the results of the engagement and consultation process. Other factors, e.g. resources can take priority, changing the outcome of the consultative process. Evidence and knowledge gained from experts, international best practices, resources, funding and decisions based on the input of

other sub-committees is given primary consideration in the writing of strategy across most countries, with evidence informed prevention a priority.

Engagement and Suicide Prevention Strategies

Chapter 3 of this study examines power and how it informs the understanding of engagement and participation in policy process. In a discussion of democracy, engagement and citizen participation in policy making, Page (1985) describes a number of key features. The Institutional view of democratic control, involves representative institutions participating in policymaking. According to Page, this is the mechanisms that link politicians with the institutions. In this study, it is a representative system that links government, political parties and the statutory institutions (NOSP, DOH) in policymaking.

The engagement and participation of citizens is therefore by a bureaucracy, managed by statutory organisations and the officials therein. This results in a power elite in policy process. Thus the participatory and democratic process of citizen engagement has the potential to be undermined by issues of control over policy formation and implementation (Hill and Hupe, 2014). Potential barriers to implementation of Connecting for Life (2015-2020) are described by NOSP (HSE.ie/Eng/Services…, 2018) as including, lack of support at all levels of government, cultural and political barriers and potential opposition from vested interests. Further potential barriers include poor levels of cross-agency co-operation and lack of ownership for actions in the suicide prevention strategy. In addition, organisational barriers can include resistance to changing practices in organisations and thus mind-set and organisational cultures are important features to be reviewed and evaluated throughout the time-span of the strategy.

Rowe and Frewer (cited in Waterhouse – Bradley, 2012) define three categories of public engagement: Public communication, where information is set out to the public by decision makers; Public consultation whereby information is conveyed from the public to decision makers; and public participation, a reciprocal process with information flowing up and down between public and decision makers (p. 90).

To further explicate the research themes, manual and NVivo methods were used to examine primary and secondary texts for references to *Engagement*, *participation*, *statutory sector and C&V consultation*. The review evaluated references to the search terms across a sample of national suicide prevention strategies. This included Ireland, England, N.I., Scotland, New-

Zealand, Australia and United States. In addition, a number of secondary source documents were reviewed using NVivo and manual methods. Presented below, the review elaborated references to the themes outlined above.

Table 5.1 NVivo and Emerging Themes in Policy Documents

Name	Sources	References
Collaboration	8	209
Community and Voluntary sector	4	38
Consultation	8	108
Cross Sectoral relationships	2	14
Engagement	8	660
Implementation	10	412
Leadership	4	20
Participation	9	349
Resources and funding	10	129

Engagement and approaches to consultation emerge as a priority area in the review of documents. As indicated in the above table, collaborative approaches, involving participation of stakeholders is a feature in the development of strategies, although the documents reviewed provided limited accounts of the mechanisms or models utilised to ensure participation and engagement processes. It is evident that there is greatly improved acknowledgement of the importance of stakeholder participation in public policy processes. This is developing across policymaking in Ireland, representing a transformation in policy process patterns in Ireland. Specific to this study, is the growth and development in C&V suicide prevention sector, creating advocates, policy entrepreneurs, experts and coalitions that are central to the policymaking activity. As stated previously, the recent strategy, Connecting for Life, witnessed the development of strategic partnership approaches between NOSP, HSE, DOH and a number of key C&V partners. Commissioning was aligned to key actions and outcomes in the national strategy. Such a model creates a new set of coalitions and groups of actors in the policy subsystem. It creates a new relationship between statutory and C&V organisations and is an important development within the Irish suicide prevention landscape.

The Connecting for Life (CfL) implementation plan (2017-2020) acknowledges complexity in that there is "no one definitive theory or single framework commonly accepted on how health strategy should be implemented" (HSE.ie, 2018: p. 7). Any successful strategy, such as suicide prevention, is reliant on a systematic and structured approach, recognising

implementation as a process, not a fixed or one-off event. The CfL Implementation emphasises co-ordination in the delivery of key actions across government departments and agencies, with recognition that implementation process from policy to practice can be at least a three-year cycle.

Key factors to success, as discussed elsewhere in this study, include the need for government, departmental and state agency leadership - a critical driver in implementing strategy. Furthermore, this study has stated the importance of evaluation as a continuous cycle, considered essential to monitor implementation of the strategy. Evaluation offers evidence in determining review and future planning. As stated by NOSP (HSE.ie, 2018: p. 8) "monitoring and evaluation are essential to determine whether desired indicators are being met and outcomes are being achieved".

A Cross Divisional Implementation Group has been established to progress a HSE cross-divisional Connecting for Life implementation plan. It is accountable for the specific actions, timelines and resources allocated to the plan. In addition, under Action 2.1.1 local implementation structures have been developed to support implementation of local suicide prevention action plans. Membership and support for each local structure comprises of senior and middle management from service delivery agencies including statutory and NGO, HSE senior and middle management from key service delivery agencies, service user representatives, family/carer representatives and families bereaved through suicide. Local implementation groups are chaired by senior HSE management. The implementation strategy states that by 2018, 17 local action plans will be in place around the country. Local plans offer an opportunity, generating specific, geographic and thematic evidence toward evaluation and review of current strategy. The success of local plans is important as they are crucial links between national strategy and its effective implementation nationwide.

Continued stakeholder engagement is described as essential to the implementation of the Connecting for Life strategy and the implementation plan (2018) considers collaborative work and building an infrastructure of support from national through to local level as an integral feature of the strategy. This, it is stated "is best achieved when individuals, families, health and community organisations, workplaces, government departments and communities" (2018: p. 8) work collaboratively to do so.

The National Office for Suicide Prevention (NOSP) is part of the HSE's Mental Health Division. It is funded centrally as part of the HSE's annual service planning process, with an

annual budget of €11.75 million. NOSP holds two distinct functions in Connecting for Life. It is the lead agency in 16 actions and support partner in 21 actions in the strategy. As a driver of implementation, NOSP's role is to monitor, coordinate, support and inform the implementation of the national strategy.

A number of working or special advisory groups have been established, linked to particular cross-sectoral actions contained in the national strategy (2018: p. 12). They include:

• Cross-Sectoral Group on Suicide Prevention Interagency Operational Protocols

• HSE Communications Working Group

• Research and Evaluation Advisory Group

• Education and Learning Working Group

• National Suicide Bereavement Service Working Group

• HSE Connecting for Life Health Professionals Working Group

The focus of this study is cross-sectoral relationships and impact on policy process. The particular focus was agenda setting in policy making, or *deciding to decide.* In particular, the research aimed at understanding decision making in determining composition and membership, inclusion and exclusion, power and the role of policy actors and coalitions in the process. The formulation of early phases in policy making is a most important step in the process. The findings in this study suggest that agenda setting, engagement and consultation processes are the foundation upon which the development of suicide prevention strategy is built. Conversely, any deficiencies or lack of clarity may adversely impact the development, implementation and ultimately success of strategy.

The literature and document analysis indicates a shift toward consultation and engagement from 1998 when the National Task Force produced its report, to 2005 when 'Reach Out', the first national policy was launched and then to 2014 with the succession planning and subsequent launch of 'Connecting for Life 2015 – 2020'. As stated previously in the chapter, questions remain about how the engagement and consultation process influences the content of the reviewed strategy, the rhetoric sometimes differing from the actual inclusion of the results of the cross-sectoral engagement process involving the C&V sector and those who lobby during policy review.

Changing the Landscape: Partnership Approaches

Connecting for Life states in Goal 2.1 an aim to "improve the continuation of community level responses to suicide through planned, multi-agency approaches" thus (2.2): "ensuring that information, guidance and suicide prevention are provided for community-based organisations e.g. family resource centres, sporting organisations" *(*Connecting for Life 2015 xiv*).* It is noteworthy that family resource centres, sporting organisations, national organisations e.g. Pieta House and a particular range of C&V organisations are specified as partners in the delivery and implementation of the national and local plans. Chapter 1 discusses the structure of the sectors in Ireland and it is noted that there are as many as 350 small C&V organisations and as yet no national standards (Friel and Gallagher, 2013). It appears that an alliance or collaboration of a specified affiliated coalition of statutory and voluntary groups has been confirmed as the new establishment, a partnership approach between the DOH, NOSP specific government departments and approved organisations. This appears to be the new structure by which (2.3) to "ensure the provision and delivery of training and education programmes on suicide prevention to community-based organisations" (2015 xiv). It is important for the future of suicide prevention in Ireland to establish how decisions are made regarding engagement, partnership and the subsequent delivery of services. Funding is a competitive process and the establishment of alliances has the potential risk of creating an exclusive funding mechanism which excludes those outside the established consortium. This has the potential to undermine smaller groups of C&V service providers who are more unlikely to have the governance required to seek State or private commissions. Connecting for Life strategy states its aim seeks to create a "joined up thinking across government departments, between individuals, communities, service providers and people with lived experience" (2015, p. 10). Evaluating the implementation of Connecting for Life will indicate how successful this joined up approach has been, a respondent in this study stated that implementation was "at best, ad-hoc" and consideration must thus be given to the level of cross-departmental collaboration as well as cross-sectoral collaboration in any review of achievement and evaluation of success of this strategy..

Evaluation and Review in International Policy

A stand out feature of US policy and strategy is how it is informed and continually assessed, evaluated and reviewed regarding achievements, success and failures and how to improve. There appears to be a 'continuous improvement' approach rather than starting with a blank

canvas for each strategy. The U.S established a National Action Alliance for Suicide Prevention (NAASP), a public-private partnership group which is aimed at a new approach to encourage multi sectoral collaboration involving American citizens in the fight to prevent suicide. As stated by the U.S. Surgeon General, who is also a member, this multi-sectoral nature "has great promise to really move us forward in this effort" (National Strategy for Suicide Prevention 2012, p. 3). The NAASP comprises a multi-sectoral approach defined as all Federal, State and local statutory bodies, business, military and veteran groups, sports and ethnic minority groups. The alliance also consists of individual task forces set up to look at particular at-risk groups and is populated by other leaders of statutory and community organisations, with the Action Alliance mission to champion suicide prevention as a national priority and advance the national strategy. Its additional role is catalysing efforts to implement the objectives of U.S. strategy and cultivating the required resources to sustain progress with review and evaluation as an ongoing feature.

In addition, the U.S appears to follow UN recommendations with a high level of money and resources committed to suicide prevention strategy. Investment in research is high and there is a willingness to see what works in other jurisdictions. As with the Irish context, it is useful to consider the method by which decisions about membership of Action Alliance in the U.S. are made and the level of consultation and engagement that takes place and the evaluation and review of the same. As stated, there are differentiating features in the approaches and mechanisms for implementation, some strategies not quite getting further than the stating of objectives to discuss implementation. A fewer number of strategies address implementation offering detailed plans for action. This includes the U.S. and Scotland where an identified budget and designated coordination team was specified to support development and evaluation. There is evidence of some improvement to the implementation of action in Connecting for Life, although progress is slow, perceived as "ad-hoc" as stated by one respondent to this study. It will be important to assess progress regularly as the strategy is now in its third year (2018) and will be due for review shortly (2020). The review of international strategies is presented in the following table, which captures the approaches as defined in the literature relating to each national document.

Table 5.2: Implementation approaches in national suicide prevention strategies

Country	Surveillance	Research	Programme development	Evaluation: programmes of action	Evaluation: strategy	Resources identified (exec/ technical/ financial)
Australia	+	+	+	+	+	+
England	+	+	+	+	-	+
Ireland	+	+	+	+	-	-
Scotland	+	+	+	+	+	+
Northern Ireland	+	+	+	+	+	-
New Zealand	+	+	+	+	-	+
USA	+	+	+	+	+	+

Key:

+ indicates that the strategy adopts this approach

- indicates that the strategy does not adopt this approach

Table adapted and updated from Suicide Prevention Strategy – (2013-2016)

The RASCI model is utilised to articulate how policy implementation is defined in Ireland's Connecting for Life, this data being determined by the assigned responsibility designated through the partnership approach within government departments. As can be seen, certain specified government departments and the C&V sector are designated as **Support** namely as specified partners involved in implementation of certain activities. The **Responsible** and **Accountable** or **Approval** is primarily that of government, departments and NOSP/HSE. This table below is presented as a way of articulating the model of policy implementation.

- **R** – **Responsible** - Who is responsible for carrying out the entrusted task?
- **A** – **Accountable -** (also Approver) - Who is responsible for the whole task and who is responsible for what has been done?
- **S** – **Support** - Who provides support during the implementation of the activity / process / service?
- **C** – **Consulted** - Who can provide valuable advice or consultation for the task?
- **I** – **Informed** - Who should be informed about the task progress or the decisions in the task?

Table 5.3 RASCI Example

	Final Policy	Policy submission	Writing policy	Research
Government	A			
Government Depts. E.g. Health	R	R		
HSE	I	I		C
NOSP	R	R	R	A
CMHS	C			S
Coroner				S
G.P's				S
A&E				S
Gardaí				S
Community and Voluntary				S

Conclusion

Chapter 5 sets Irish suicide prevention strategy into an international context by examining, comparing and contrasting content, evidence, implementation, the engagement models and particularly cross-sectoral collaboration in Irish, English, Scottish, Northern Ireland, New Zealand, U.S. and Australian suicide prevention strategies. The purpose of this examination is to ascertain how strategy, especially recently developed actions in Connecting for Life (2015-2020), are informed and influenced by practice in neighbouring jurisdictions and countries with well-established policy.

The international strategies and policies are informed by, based upon and draw heavily upon an international evidence base. Evidence from a number of studies (Platt, 2012; Paris, 2006, and Yip, 2005) indicate that universal strategies are more effective in reducing overall rates of suicide; others suggesting the evidence from strategies focusing on reducing mental ill health are priority for suicide prevention (Cavanagh et al., 2003; Beautrais et al., 2005). In a Scottish study, Leitner et al., (2008) suggest the most promising models of service provision is specialist service provision through dedicated centres and teams and in a recent review of national strategies there appears to be mixed, and in some cases inconclusive, findings about the impact of what works and effectiveness in suicide prevention policies and strategies (Pillenger, 2014).

Although each of the individual national strategies examined have had their own task forces, special focus groups and commissioned additional research to help in the creation of their frameworks or strategies going forward, each has taken a large part of their direction from the UN report of 1996 and subsequent recommendations from the WHO Ireland with Connecting for Life seems to have followed this pattern along with the England strategy.

There is great emphasis on the need for a co-ordinated multi-sectoral approach with a 'Whole of Government' approach across the majority of strategies examined, this being a more explicitly stated development across government in each country. This is significant in Connecting for Life (2015-2020) as it marks a departure from Reach Out Policy (2005-2014) which saw implementation of policy being undertaken by the DOH, HSE and NOSP working in isolation and without specified responsibilities being dispersed across the whole of Government. Most of those policies/strategies examined have very senior Government or

business leaders as approach sponsors and likewise most are drawing on the full power of their respective Departments or Ministries or secretariats. This study is concerned with evidence of how decisions regarding involvement and membership of task force, special focus groups and deciding policy are made and there is little evidence in the examined strategies about the process used to determine membership of groups involved in devising strategy across the international suicide prevention context. It appears that experts, government ministries, academics and researchers are invited to participate and a network exists that is national and international involving large statutory and C&V organisations.

Most of the national policies are derived from UN guidelines and all seem to agree that their strategies need to address prevention goals and/or objectives on three different levels:

- o Universal or population based
- o Selective interventions
- o Indicated interventions: these are more targeted interventions that focus on specific individuals and groups that have a high risk of suicide

Evidence of policy copying exists and Flocking which indicates that, of the studied strategies, which occurred at varied pace and at different times, most have come from a starting point of not having anything in place to a strategy aimed at an end (ad infinitum) point that works in the goal of reducing death by suicide in the jurisdiction in question. Most of those national strategies examined appear to be aiming to achieve this by broadly similar but not identical means. An analogy would be birds flocking to the same destination but choosing different, although similar, routes to get there. In other words, there may be more than one "correct strategy" and also that what works for one jurisdiction may not necessarily work in another.

Each nation must consider specific elements and evidence that determine the necessary conditions for policymaking in specific context and in Ireland this includes a number of factors. Firstly, the national strategy has determined its targets and destination based on international guidelines and it is essential that there must be clarity and consideration to what actually is the destination, e.g.→ Zero. Strategy making in varying nations must take account of political and societal will of acceptable losses and how the determination of resources and funding occur or recur after this point is reached.

Chapter 1 discusses the data and trends in suicide and the range of factors that impact on rates in Ireland. There are specific factors across each nation that mean rates and causes of suicide

are varied. There can be cycles of higher incidences, as specified in chapter one, during specific periods and within particular groups. Factors noted as impacting rates of suicide include those such as austerity, economic downturn and recession, depression, conflict, catastrophe, disaster, bullying. Factors also include: lack of belonging – isolation, terrorism, lack of opportunity, social inclusion and exclusion, deprivation, epidemic and pandemic, ethnicity, and as stated previously in this chapter national variations in alcohol or drug use/misuse and access to means, e.g. firearms. An additional national consideration is frequency and method of evaluation of progress within the strategy, e.g. 3, 5, 10, 20-year cycles and where within this cycle. Also for consideration is whether evaluation is throughout and continuous or is periodic.

This chapter has examined strategies to determine areas of similarity across the range of national policies/strategies considered. One consistent emerging theme is the significance of belonging, connections to community, family and support. Common themes include, enhancing access to services and improving skills of those at risk and restricting access to the means of suicide.

As discussed, suicide prevention strategies tend toward an emphasis on population based and targeted approaches that are evidence based and include the following:

- GP education and training for front line and first responders.

- Strategy and objectives aimed at restriction of access to means

- Media and social media guidelines for reporting on suicide;

- Education and awareness on drug/alcohol in specific target groups, for example, young people

- Improved access for specific groups at risk of mental ill-health, exclusion and inequality

The international strategies emphasise the need for development of a multi-sector and coordinated strategy for suicide prevention. Such an approach means that it draws together a range of suicide prevention methods and interventions that target risk factors at a number of different levels. This is an important consideration for NOSP and the HSE in driving robust cross-governmental and multi-sectoral, partnership approaches in suicide prevention strategy. This involves driving policy coherence and coordination in suicide prevention by including promising international evidence. This study is interested in how the 'whole of government'

approach will be achieved, noting that at the time of writing it is now 2018 and three years into Connecting for Life strategy (2015-2020) and there appears to be, as stated by one respondent to this study an "ad-hoc" approach to implementation.

The principal role in suicide prevention in Ireland remains with Department of Health / HSE and states that Connecting for Life would be coordinated and implemented through plans across different health services divisions. The strategy outlines specific roles and actions government departments, including social inclusion, Accident and Emergency services, mental health services and public health/health promotion. There is stated actions aimed at linking and joined up approaches between GPs and primary care teams and community mental health teams, increasing support services for people on discharge from care and in the community, and linked to community/NGO service providers etc.).

In reviewing Irish strategy against a number of international policies, it is evident that for improved suicide prevention outcomes, there needs to be active involvement across a wide range of partners. These need to be drawn from across local, regional and national areas, and this must allow for the integration of suicide prevention into the aims, vision and mission of a wide range of organisations and programmes.

This chapter acknowledges that the review was somewhat limited as the study had as its focus what is contained in published national strategy documents. There was access to some documents from sub-committees to the Connecting for Life strategy, but policy process reports and committee meeting minutes were not available due to access restrictions that prohibited the accessibility of international documents and resources associated with each national policy review process. In spite of the limitations to the data analysis in this chapter, there is an important outcome in conducting this review of international and neighbouring countries suicide prevention strategies, namely it situates the process conducted in reviewing Reach Out Strategy in 2014 and the development and publication of Connecting for Life in 2015. Despite the necessary qualifications attached to what can be read into strategy documents, several points emerge. The strategies reviewed draw heavily on and are informed by a common set of international guidelines and a growing body of research on risk and causes for suicide and thus the strategies tend to have many similarities in terms of broad goals and priorities but there are also striking divergences in terms of definition and pathways.

It is essential to recognise the international influences that shape not just Irish policy, but those of other nations. It is also noteworthy that international evidence about what works finds its way into the content of said policies and the development of this knowledge exchange is essential. The limitations therein are also noted and as De Leo and Evans noted that it is difficult to establish sufficient evidence to indicate that national suicide prevention strategies have a positive impact on rate of death by suicide (2004). It is therefore incumbent on all involved to ensure that the evidence base, knowledge and research toward a better understanding of how strategy can be translated into more effective interventions, actions and reduced rates of death, remains an important national and international priority. This includes ensuring that there is an effective, efficient and clearly defined policy review process, which is the focus of this study.

Chapter 6: Toward an Understanding of Policy Process

Introduction

The following two chapters present the findings of the systematic research process, involving interview method with key respondents to the policy process. The collection of data was informed by desk research and document analysis as discussed in the methodology chapter. The research questions and topic guide (see appendix 7), that formed the basis for interview was also determined by the literature review and analysis of national and international research studies and policy documents. This chapter provides the reader with a discussion of the findings and will draw upon the earlier theoretical discussion and context to 'bring to life' the factors in relation to policy process. The aim of the overall research is to determine the extent to which relationships between the community, voluntary (C&V) and statutory sectors influence the process of developing suicide prevention policy and this is specifically investigated in this chapter with regard to original data collected as part of this study.

The aim of the questions was to ascertain interviewee knowledge and experience of suicide prevention policy. The timeframe under investigation was from the establishment of the National Task Force (1998) to the development of the Reach Out Strategy (2005) and the current Irish strategy, Connecting for Life (2015). The focus was to capture interviewee experience and perceptions of the policy process, the cross-sectoral relationship, the management of policy making and their experience of engagement, consultation and participation of the C&V sector in particular.

Chapter 2-5 discussed the theoretical, contextual and historical timeline and background to suicide prevention strategy in Ireland. The chapters described the systems, structures and procedures in the policy making process. The political structures were elaborated upon, in order to contextualise the history and development of the C&V suicide prevention sector in the country. The emerging international evidence base and influences on Irish policy, from a global perspective, have been reviewed through the examination of relevant policy and strategy documents, primary and secondary literature and data from international strategies and systematic reviews.

Findings and Policy Process Theory

A number of conclusions are articulated from emerging themes in this study and it must be said that determining the wide ranging factors that influence the development of policy is a complex task. This study required a theoretical framework that afforded an appropriate understanding of the aim, to examine if cross-sectoral relationships impact policy process. The research is interdisciplinary, drawing from across social sciences and influenced as one would expect, by the author background and experience. Although this is not a social policy thesis, the contribution of policy process theory and the Advocacy Coalition Framework (ACF) was helpful in articulating the complex areas of study. ACF allowed a conceptualization of the suicide prevention policy sub-system, which highlighted the structures, systems and policy relations more clearly (Adshead, 2006).

The AC framework articulates the impact of the individual; the decision network comprises representatives, individuals as experts and policy actors. It is useful to articulate this structure in public policy making. The concept of the policy subsystem can be more clearly identified using ACF concepts. The theoretical foundation of ACF articulates aspects of top-down and bottom-up approaches to policy change and the findings in this study suggest an historic top-down approach to suicide prevention policy making, articulated by document analysis and interviewees involved in the National Task Force (1996-1998) and Reach Out (2005-2014). This study argues applying ACF approach to the study of policy process contributes to a more precise conceptualization of policy making in suicide prevention. It must be acknowledged that the statutory sector remains a primary policy actor, the NOSP agency is the key driver in the implementation of strategy on behalf of the government. The structure as it currently exists must be acknowledged as the most appropriate. The precarious nature of the C&V landscape inhibits any major redistribution of primary responsibilities between sectors in developing, implementing and reviewing strategy.

This articulation of the characteristics and structures in the suicide prevention subsystem also articulated experiences of policy actors. In doing so, there emerges a complex set of characteristics that comprise the suicide prevention policy process. Decisions in the subsystem delineate the integrated, excluded actors in the policy topic. In addition, findings reveal the experiences of such decisions, as described by interviewees. The impact of power in the policy subsystem is the topic, the consensus emerging that fundamentally, power is retained by government and its state agencies with moderate changes in policy making taken

under consideration and whilst cross-sectoral collaboration is an important feature, the need for changes in mind-set in some government departments and agencies is a perception of some interviewees.

Findings reveal a range of policy, with an ebb and flow to the level of influence in the process. There is a greater level of influence by the statutory and its agencies including the range of government departments, with varying levels of policy influence and impact emerging for policy experts, academics, designated strategic partners, other C&V agents and constituents and those impacted by suicide.

As discussed previously, "deep core ontological and normative beliefs that are extraordinarily difficult to change" (Jenkins-Smith, Nohrstedt, Weible and Sabatier in Sabatier and Weible, 2014. p. 185). Findings suggest a hierarchy in the belief systems of the policy actors (Adshead, 2011) and this is linked to degrees of influence, as described above.

The assumption by Sabatier that *change in the world is primarily driven by people and not by organisations* (cited in Sabatier and Weible, 2014. p. 190) means that policy is shaped by individuals. Additionally, policymaking is shaped by context, institutions and intensity of conflict from other actors and opponents. Belief systems include deep core beliefs or normative values and ontological positions and policy core beliefs are determined, bound and shaped by the topic of the policy subsystem and impact the orientation, values and priorities within the policy topic. It is noteworthy, as the quote above describes that policy process is primarily "driven by people and not by organisations" they might represent during interview for this study (cited in Sabatier and Weible: 2014. p. 190). Advocacy coalitions comprise and are defined by actors that "share core beliefs who coordinate their actions in a nontrivial manner to influence a policy subsystem" Jenkins-Smith, Nohrstedt, Sabatier and Weible (2014) and the findings of this study reveals the existence of coalitions in policy making, both within and across sectors. The characteristics and complexity of the suicide prevention policy subsystem inevitably impacts on the cross-sectoral relationships and on the policy making process.

Emerging Themes - Document Analysis

Key policy documents were examined to inform research questions and to consider policy developments. Documents included the Report of the National Task Force (1998) Reach Out

Strategy (2005) Connecting for Life strategy (2015). This allowed a retrospective examination of strategy development in Ireland and influences on policy from international policy context. Irish strategy is informed and shaped by developments in other countries, by the UN and WHO, and the influence and evidence is an important consideration in the study.

Using manual analysis and NVivo organising software, emerging themes from primary and secondary texts were articulated for references to engagement, participation, consultation and the study evaluated engagement practices and engagement theory in the development of suicide prevention strategy in Ireland and other examples from international studies. A number of secondary source documents were included in the evaluation, including ,Arensman et al, (2013) ,Scottish Government engagement paper (Gov.scot, 2013), ,Scottish Equality and Human Rights Commission, (Scvo.org.uk, 2009),Harris et al (2013), report (2015) of the Engagement Advisory Group, with the full list discussed in page 49 of this study.

The importance of engaging community facilitators and gatekeepers is concluded by Arensman et al (2013) in one reference arguing that they are important components of suicide prevention strategies. Engagement is cited as key in the development of strategy, with 660 references to the concept (8 sources). The NOSP report from the Engagement Advisory Group (48 references) outlined the engagement and consultation process designed for the review of Reach Out (2005-2014) and development of Irelands current strategy Connecting for Life (2015-2020).

The defined aim of the engagement process for the Connecting for Life Strategy (2015-2020) was to "ensure all voices and parties who wished to be part of the process could do so, by making a submission" (page 3). It stated its purpose to ensure open, broad and genuine process that engaged stakeholders, statutory organisations and members of the public. Consultation involved a call for submissions in 2014 through national media and stakeholder organisations. The result was 118 submissions from organisations, a total of 272 submissions in total and findings from 3 focus groups. Themes for inclusion in the national strategy were refined from the data and this task was carried out by 55 people from the HSE, Department of Health and stakeholder organisations creating objectives and outcomes from 14 identified "work streams" (page 12). NOSP senior executives and Department of Health (DOH) officials engaged with 10 departments of government with a role in policy and delivery of services in the area of mental health. The Engagement Advisory Group stated that it secured

the agreement, commitment and sign up of each of the departments and agencies to implement assigned actions in the Connecting for Life strategy.

The purpose of the document analysis was to examine engagement methods and cross-sectoral consultation in public policy and there is evidence of an improved recognition for public participation in policy process. This may be due to a range of factors, not least changes in policy making patterns in Ireland and increased demand for inclusion by stakeholders, including the C&V suicide prevention sector. The development of strategic partnership approaches in the implementation of suicide prevention strategy and the impact on funding for national, regional and local C&V was considered in the examination of literature and interview data, as discussed in this chapter. The literature and document analysis reflected the historical development of consultation and engagement methods in suicide prevention strategy making in Ireland. The period of study indicates consistently improved consultative processes from 1998 when the National Task Force produced its report, to 2005 when Reach Out, the first national policy was launched and finally, to 2015 with the succession planning and subsequent launch of Connecting for Life (2015 – 2020).

Introduction to interviews

With the aim of addressing and answering the study questions data was collected through (N=16) interviews with stakeholders from the statutory sector (3), C&V sector (8), political representatives (3) and research/academic sector (2) to the policy process. The interview data was organised and analysed, as discussed in the introduction to this chapter, using NVivo, thematic and interpretive analysis. Findings, responses and emerging themes arising from the semi-structured interviews will be presented and discussed in this and following chapters.

This chapter will draw on a series of the *retrospective* accounts of interview experience about the historic developments from the National Task Force (1998) to the Reach Out Strategy (2005) and process therein. It will then present findings from respondent experience in Connecting for Life, the current national strategy. The chapter will outline the complexity and differing meanings associated with the term "collaboration" highlighting the evidence of multiple layers to the policy process as articulated by respondents during the interviews I conducted. The responses included a distinction between cross-sectoral collaboration and views about efficacy in the level of collaboration within specific sectors, particularly in the statutory agencies and departments, discussed as an ongoing concern by a number of

interviewees. Emerging themes arising from interviews will be discussed, including: perceptions of power in policy process; parity of esteem between sectors; standards and governance issues in the C&V and how this influences cross-sectoral collaboration.

 "*Who decides who decides?*" suicide prevention policy in Ireland was a question, a strapline in this study, interested in considering who gets around the table and what policy actors, agents or groups influenced decisions about involvement and inclusion or exclusion to the process. This chapter articulates respondent perceptions of influence and decision making in the policy process. In particular, it focuses on interviewee's experiences of policy process directly related to the **contemporary** strategy Connecting for Life (2015-2020). Findings reveal a number of important themes for participants, including funding and resources and the decision-making procedures and practice associated with the allocation of resources linked to the Connecting for Life strategy. The implementation of strategy was not directly included as a variable in determining the exploratory question of this study. It has become an emerging theme and the perceptions of respondents are discussed in this chapter as a number of pertinent views and ongoing concerns regarding challenges in the implementation of Connecting for Life (2015-2020) were expressed. It is possible that the nature of the research study questions, aimed at exploring perceptions of the policy making process and the relationship across sectors, prompted respondents to consider their views and experiences of how the current national strategy is being implemented.

The Development of Policy

A number of interviews were conducted as part of this study with academics and researchers, political representatives and representatives from statutory agencies In addition, interviews were conducted with a purposive sample of respondents from national, regional and local voluntary and statutory organisations. A number of interviewees were involved in the early efforts to decriminalise suicide in Ireland and lobby for a strategy and government response to suicide.

Before the establishment of the National Task Force (1996) there had been limited development or discussion about suicide prevention strategy in Ireland. Indeed, suicide had only recently been decriminalised in the State in 1993 and the bills met with resistance in the houses of the Oireachtas This resistance was shown both overtly and also by a lack of interest in engaging on the subject by TDs (*Teachtaí Dála* - members of Dáil Éireann, the lower house of the Oireachtas; it is the equivalent of terms such as "Member of Parliament" (MP) or

"Member of Congress" used in other countries) and Senators. This, in the views of the participants, was partly because of the stigma of suicide and the fact that historically it was considered to be a taboo subject.

The UN guidelines published in 1996 appeared to act as a catalyst for the beginning of a change in the narrative from a public policy perspective. Previous chapters discussed the transformation in the social context in Ireland in the 1990's which created the conditions for the creation of awareness that a policy/strategy was required to address suicide rates in Ireland. The nation began to change from a highly religious to a more secular society; there was a developing multi-cultural perspective and a broadening of perspectives and views due to external influences including the development of the internet and social media. Running in parallel with this was the pressure being exerted within the Oireachtas by some of the original forces behind the decriminalisation bill i.e. Senator Dan Neville and Dr. Michael Kelleher and it was as a result of their lobbying that a task force was set up to study the factors associated with suicide and suicide prevention at the time. Respondents discussed their experiences with varying consultations, formal and informal information gathering and sharing with various government departments in efforts to mobilise government toward action in addressing suicide rates.

Decriminalisation and the National Task Force (1998)

As stated above the proposal for the establishment of a National Task Force was developed by Dr. Michael Kelleher and Senator Dan Neville who had led in efforts to decriminalise suicide in Ireland and continued to promote the topic of suicide into the domain of the political sphere. The establishment of the Task Force was undertaken by the Department of Health (DOH) with representatives from a range of state agencies and government departments. The C&V sector was very limited in size and as a result, the Task Force was largely composed of actors from the statutory sector and having been established in 1996 it published its recommendations in 1998. In one interview with a representative from the political sector, it was noted that there was resistance to the process of the Task Force. He states: "I know that during the course of the construction of the reports, drawing up the report, members of the Department on the task force often tried to frustrate it, delay it" (Political Representative Participant (Interviewee 1).

The resistance and factors that impede policy making or change are often not articulated or documented as this comment illustrates. Such elements often appear difficult to describe and

can remain with policy actors as a feeling or perception and difficult experience long after the strategy, or in this case the Task Force document has been produced. Policy making is a web of decisions and the attention to inaction and resistance in policy making is an important aspect for consideration (Smith, 1975).

The interviews included discussions about the perceived issues facing those making efforts to address the lack of government response to suicide in Ireland. Interviewees reflected on the formal engagement, particularly within the political and statutory domains and the mechanisms utilised to place the bill before the Dáil. Efforts towards the decriminalisation of suicide had taken two years, from the first time the bill had been brought before the Dáil in 1991. There was a perception that some of the political efforts were aimed at inhibiting the progress of the bill through the stages of government. It was this politicisation which was commented on by a number of respondents. For example, one participant noted that "once the task force was introduced, it was now political, in that a minister would decide to implement it" (Interviewee 1). Matched with this politicisation of the issue was also a resistance to particular policy strategies because departments felt they were already doing the work. For example, one research participant who works in the field of academia said "Back along at the Task Force, there was a very strong feeling in the department of health (DOH) that the Task Force recommendations were enough at the time, that there actually wasn't need for a strategy. So there actually was resistance too" (Interviewee 3).

The perspective of those interviewed from the political and statutory sectors revealed experiences of resistance in those early years. There is a recognition that the highly religious context, influence of the church and relationship between church and state at that time contributed toward some of the difficulties in the political sphere and reluctance of some politicians to declare support. The interviews revealed an interesting snapshot of the processes towards the development of the Decriminalisation of Suicide Bill in 1993 and the lobbying for the establishment of the Task Force some three years later in 1996. It is interesting to note the particular context and political climate and process at that time, if as stated above, the Departments felt it unnecessary to pursue the development of strategy, having received the recommendations of the National Task Force in 1998.

From that time efforts continued to implement the recommendations of the National Task Force, with a number of significant developments. This included the appointment of the

National Suicide Research Group (1998) and the same year witnessed the appointment of Suicide prevention officers by the Health Boards. In 2000 the National Parasuicide Register was implemented by the NSRF. The Health Act 2001 included a requirement of accountability by the Minister for Health and Children to report on activities related to suicide prevention.

Reach Out Strategy (2005-2014)

Chapter 3 describe how Ireland was a nation undergoing rapid social and economic changes in the years prior to the development of the Reach Out Strategy (2005-2014). The momentum toward Reach Out strategy resulted from heightened public awareness and outcry about suicide, increased media attention, reducing stigma correlating with increased lobbying by a burgeoning community and voluntary sector involved in activism and lobbying for change. The international influences on strategy development were also evident as the Irish suicidology sector formed knowledge exchanges and began to generate research on a global and international platform, this being one of the priority areas for the Irish Association of Suicidology (IAS) (1996) and National Suicide Research Foundation (NSRF) both of which were formed in the 1996 -1998 period.

The need for a National strategy was well established and mechanisms created to develop what became the Reach Out strategy. In examining the document there is little articulated about cross-sectoral relationships in policy development. Although there was a developing C&V sector it was immature, with limited influence. Policy making mechanisms at that time were top-down in approach, this did not result in any significant contribution to policy process by the C&V sector. As with the National Task Force in 1998, there was a confirmed acknowledgement of the need for a strategy and the mechanisms were established to develop what became Reach Out Strategy. However, it appears that although there were increased numbers of C&V sector organisations, policy making mechanisms did not automatically result in C&V influence and significant contribution to policy process.

A number of interviewees had particularly strong feelings about the engagement and consultation process of the Reach Out Strategy. The social partnership approach to policy making had been established in Ireland in the 1980's, it included the C&V Pillar from the mid 1990's, and this is one of the reasons why policy making was determined to be the

responsibility of government and statutory sector, in this case the Department of Health and National Office for Suicide Prevention (NOSP)

It is evident that the membership of the committee responsible for developing the Reach Out Strategy was largely derived by representations of public sector agencies. The perception amongst respondents was that the state held responsibility and policy making which was top down in approach. Membership and sub-committee composition in policy making is discussed in more detail in the next chapter which describes interviewee perceptions of planning in the policy process. One explanation for the composition of the planning groups is offered by a representative from the statutory sector (Interviewee 13) who discusses the C&V sector as a somewhat smaller sector at that time. Discussions with interviewees suggest that there was less consideration about the need for consultation between statutory and C&V sector, with higher level of representation by official bodies in policy/strategy development. Interviewees reveal a less developed, unorganised C&V sector and one respondent from the statutory sector (Interviewee 13), said: "I'm not sure who you collaborated with. Right?" This interviewee described the improvements and developments in policy design and planning from 2005 to 2015 when the new strategy was launched. Commenting on the previous plan, he says; "Even the style of Reach Out was written in a format that was fairly broad based. There were no outcomes, no indicators of impact written into it. And it was very much in the style of the day. But it was quite an ambitious document of its time" (Ibid).

Whilst it appears that consultation processes and cross-sectoral collaboration were recognised as important features in the design of strategy, these themes were given higher priority in the most recent review. When Reach Out was being written, it is also acknowledged by two interviewees that stigma about mental health was an obstacle to the development of cross-sectoral and cross-departmental commitments to the strategy. One interviewee who is an academic and researcher, describes the stigma as,

> A huge stumbling block to progress with consultations, and also to get buy-in. Because in those days, people didn't even talk about cross-sectoral collaboration, but looking at some of the key stakeholders… Now in addition to health, one of the key stakeholders was education. But one couldn't communicate with education because they moved everything that had to do with mental health directly through the back door to health. So in other words, mental health was fully stigmatised. (Interviewee 2)

The Reach Out Strategy was written with influences from a number of national and international sources and, as stated, was dominated by the statutory agencies and departments, with one respondent from the statutory sector (Interviewee 13) describing Reach Out as a "brave effort to develop a national policy, largely in a vacuum." At this time there was a limited, but developing international knowledge exchange and organisations such as NSRF and IASP were developing academic and networks at a national and international level. This afforded, as described by the same interviewee, "some evidence and people were bringing data and information to bear, in terms of how the world was looking at suicide prevention and I think that helped inform. Reach Out was a fabulous document of its time."

As outlined above, interviewees feel that the document was a significant achievement in its day. Respondents raised the point that the stigma associated with suicide and mental health issues exacerbated the difficulties experienced for those lobbying for a national strategy. It is evident that early efforts in championing the development toward strategy arose as a result of the efforts of a limited number of practitioners, researchers, bereaved families and academics, supported by a small C&V. Interviews, therefore, revealed an emerging theme about the degree of collaboration in policy process, an emerging theme that will be addressed further in the following sections.

Consultation, participation or Tokenism in Policy Process

Cross-sectoral collaboration and the impact on suicide prevention policy process is a primary focus in this study and it became evident that this was a much more complex theme than first considered as the study commenced. One respondent described the complexity of the policy process as "dense" and this study has examined a complicated, obscure, somewhat difficult, and at times impenetrable, policy structure and process.

An emerging issue, identified by interviewees mostly from the C&V sector, is a perception of tokenism in the management of consultative policy processes by the statutory sector. Arnstein's *Ladder of Citizen Participation* (as cited in Lane 2005) outlines three types or degrees of citizen power, non-participation and degrees of tokenism (p. 284) and considers citizen control and delegation of power as optimum is cultivating participation in the policy process. Consultation, according to Arnstein (as cited in Lane, 2005), is determined as tokenism, in that it allows an elite to feel they have encouraged participation without surrendering or giving up any final decision making authority or power. The consultative

process can therefore be considered as legitimising the taken for granted and usual way of making policy as 'there is a critical difference between going through the empty ritual of participation and having the real power needed to affect the outcomes of the process' (Lane, 2005, p. 284)

The perception of a tokenistic consultation approach to the policy process was expressed by a number of interviewees involved in planning both the Reach Out (2005-2014) and Connecting for Life strategy (2015-2020). The perception of tokenism in the policy planning process was less evident for respondents with higher levels of participation in the development of the strategy, hence a correlation with degrees of inclusion/exclusion to the process. The decision making linked to inclusion/exclusion in Connecting for Life are addressed in the following chapter. Consultation has been the dominant method of engaging with stakeholders and public on draft strategies for many years and Arnstein (1969, cited in Lane 2005) and others (Pateman, 1970, and Dennis, 1972, both cited in Lane 2005) consider this as tokenistic as it allows minimal power to the participants in the exercise.

A differing perspective is offered by Painter (1992, cited in Lane 2005) who contends that the model offered by Arnstein (1969) blur the concepts of 'power' with 'powers' (cited in Lane, 2005, p. 286). Painter discusses the need to differentiate actual power and the potential power to exert influence by participants in the policy process. This concept was illustrated by one research participant who contributes to the voluntary sector but noted the distinctions in the power dynamics in the policy development process. She noted that meetings tended to be dominated by official representatives. This respondent stated "it seemed to me that predominantly those involved are those who are paid to be there. So the voluntary sector if you like, the voluntary side are very under-represented. I would imagine that in most meetings, I'm the only one there who's there as a volunteer, rather than because of my paid work." (Volunteer, Interviewee 9)

This also raises an interesting note in this study, namely that the HSE and NOSP as the statutory agencies that ultimately have formal decision-making powers; they also have the definitive responsibility for strategy and its success. Thus there is seemingly inevitability that this impacts the consultative process and relationships therein.

Improving Participation Processes

The research study has revealed significant positive developments in the consultative process within the suicide prevention sectors in the years 1998-2015, the timeframe which was the focus of the study. It appears that there are no standardised procedures for policy consultation and a formalised mechanism may benefit in future from a review of national strategy which would include process, engagement and consultation. In spite of the perceptions of tokenism as outlined above, it is widely accepted by respondents to this study, triangulated by evidence from the literature analysis, that there have been improvements and a demonstrated willingness across all sectors to improve the participation processes. Consultation is fundamental to good governance in devising strategy. It is an essential element that ensures strategy is demand driven and encourages effective implementation. This was noted as an important factor by numerous respondents such as a participant from the statutory sector (Interviewee 13) who said that "we emerged with the bones or the indicators for the seven strategic goals that are in Connecting for Life. And I won't say it was easy after that, but the hard work was done, in that we had sign-off from a very wide range of statutory, community and NGO partners around what we needed to do".

Respondents also noted operational challenges in the consultative process which can slow down the policy planning and formulation process. Given that Connecting for Life required national and CHO (Community Healthcare Organisations in HSE) area or county based consultations, it is evident that variations in the efficacy of the consultative activity are present. Some respondents reflected on how they felt heavily involved, whilst others were unaware that consultation had been taking place in their region. For one C&V respondent (Interviewee 11) the consultation experience was a positive one, in which she felt the process facilitated "relationships with the rest of the team, which was fantastic to realise that there was just these amazing people working, for example in NOSP."

There is an opportunity to determine set planning and consultation procedures in future suicide prevention strategy review in Ireland. The development of a number of key measures when reviewing Connecting for Life (2015-2020) will provide leverage in the planning process and consolidate and embed the positive steps already underway by NOSP/HSE and strategic partners during the past number of years. One of those interviewed, from the statutory sector, who was involved in the development of strategy describes the need for cohesion in the process (Interviewee 13) and for a systematic approach in "developing

evidence, looking at policy, listening to people, collaboration, and getting agreement." It is acknowledged by this interviewee that the policy process involves "people with very diverging views" and he believed that acknowledging such diversity, combined with an evidence based approach, contributed to improvement in planning the recent Connecting for Life strategy.

Parity of Esteem

Parity of esteem is an important feature linked to consultation mechanisms in Northern Ireland policy making. This is a feature of the contested political space in N.I. and has its history in areas of conflict transformation including the Good Friday Agreement in (1998) which recommended 'a government based on the principle that each community has an equal voice in making and executing the laws or a veto on their execution, and equally shares administrative authority' and that 'Parity of esteem between the two communities should not only be an ideal. It ought to be given legal approval, promoted and protected, in various ways which could be considered.' (Lee, 2017: p. 3)

The importance of the concept of parity of esteem cannot be underestimated in policy making and it was raised by a number of interviewees. As a concept it has a subjective, personal and professional impact and resonance for those who feel less valued or heard in the policy making process. It links to self and self-esteem, which is a crucial ingredient of personal and social identity. A positive sense of self-esteem, along with a sense of self-efficacy (a sense of personal competence) and self-consistency (a sense of personal coherence), contributes to improved sense of meaning in the social world linked to membership of a particular group or social category.

Greenberg (cited in DuToit, 2004) makes a useful distinction that "self-esteem is the feeling that one is an object of primary value in a meaningful universe. Individuals sustain self-esteem by maintaining faith in a culturally derived conception of reality (the cultural worldview) and living up to the standards of value that are prescribed by that worldview"

A compromised parity of esteem refers to the negative experience of self and to self-esteem that occurs as a result of inter-group relationships which result in the emergence of an in-group and an out-group. This transpires in a social identity that favours the in-group and even some useful and relevant out-groups but disfavours those considered out-groups where contribution is perceived insignificant and not equal.

Tajfel and Turner state that the comparison is rewarding to the extent that the in-group may have perceptions of themselves as distinctive and definitively dissimilar from the out-groups, because "the aim of differentiation is to maintain or achieve superiority over an out-group on some dimensions" (Tajfel and Turner, 1979, p. 41). Being distinctive is one thing, but lack of parity of esteem implies one group as better as or worse than the other. The consequence in suicide prevention policy process is a perception of voices not being heard, contribution being of lesser value and invitation to the table being declined. One experience articulated by a respondent from the statutory sector illustrated this clearly citing the tag line used in the Connecting for Life strategy, "Everyone has a responsibility. You know we use that tagline; suicide is everyone's business" (Interviewee 5). She further describes how the new strategy is founded on the basis that everyone needs to be involved. Her views about parity of esteem between the sectors is succinctly described in the following comment,

> I know it's a well-used term, but I hadn't heard it much before, this parity of esteem between the statutory and the community and voluntary and I don't think it's there. I don't think the statutory… It's almost like, I think the statutory, we all know this, they're propped up by the community, and they don't give them parity of esteem. They just think, well you'll do it anyway, and you'll do it anyway because you're not doing it for money. You're doing it because you believe in it. So that skews the relationship (Interviewee 5).

For one participant from the C&V research sector there could be an opportunity for the sectors to learn from each other:

> We don't have closed minds. But it's amazing how many statutory bodies and voluntary organisations have a very clear closed mind on their aspect of it. I mean they are both equally valid. They're both equal. But you have the same problem in voluntary organisations as you do in the statutory ones (Interviewee 8).

While another C&V participant was of the view that certain status or role was held in higher esteem than others in the policy process. Giving the example below to illustrate her point; "In the health system, the doctor is still the king, and the doctor will be listened to above everybody else. So you don't have parity of esteem around the table, amongst the charitable, voluntary and NGO sector, you don't have parity of esteem either." (Interviewee 11)

Parity of esteem and the experience of the minority, smaller groups in policy process are not peculiar to the area of suicide prevention strategy review but also in many other areas of policy making too. In a study of the Council of Europe's management of minority language rights Mc Dermott (2016) describes the need for partnerships in the arena of language policy between vested actors such as NGOs, academic researchers and those working with immigrants, providing platforms to highlight the 'gaps' in current provision at European level. Mc Dermott argues that "state policy-makers, representatives of organisations like Council of Europe (CoE) and academics from a variety of disciplines require interrelated and collaborative debate on the feasibility of implementing a more accommodating coverage for the millions of speakers of immigrant languages in Europe" (2016, p. 21). It is through such exchanges that McDermott believes the "hierarchical system might be effectively challenged to present a more inclusive interpretation of human rights that better reflects Europe's contemporary demography". Although this is an examination of a different policy area there is a similar theme in that this highlights how issues around parity of esteem in how policy change might be managed, not just nationally but across a European context. It also articulates the importance of collaborative approaches to policy review that challenge to hierarchical and 'usual' way of making policy to offer a more transparent and inclusive policy process. As one respondent from the C&V sector stated: "We spent a huge amount of time and effort in building relationships. Because those relationships were built, the value of what we had to say was heard, and then we were invited to the table". (Interviewee 11)

Politics and Policy Process

The interviews for this study reveal that the political sector is a significant actor in the policy process, the review of Connecting for Life was led by the office of Enda Kenny, *an Taoiseach (*Prime minister) and this is discussed in detail below. The minority government at the time of writing, headed by the Fine Gael Taoiseach Leo Varadker, relies on Fianna Fail, led by Michael Martin, for a supply and confidence arrangement to keep the government functioning. Because of this arrangement the current government have tended to take on board various amendments proposed by Fianna Fail to legislation at the bill stage. As such, this arrangement has slightly diluted the traditionally dominant role of the government parties in the actual legislation process. This was illustrated by a comment from a representative from the political sector, "In the current administration, there's probably better access for the opposition spokesperson for Fianna Fáil with the government, because of the confidence arrangement that's facilitating the government being in power" (Interviewee 6). The

traditional party political manner in which legislation is managed in the Dáil was discussed by a member from an opposition party whose impression was, "I met the minister (Health) once. Otherwise no interaction with officials if you like. Probably historically in here [Leinster House], it probably doesn't work that way you know". (Interviewee 7)

At this point it should be noted that all bills going through the Dáil have to go through a reading in the Seanad where they are debated. The Seanad has the power to send bills back to the Dáil with proposed amendments but this is not actually binding on the Dáil. All legislation needs to be signed off by the President before it actually becomes law and this office has the power to send bills back unsigned, particularly if he/she thinks they could be unconstitutional, this however is relatively rare.

Lane (2005) notes a change to the making of policy, particularly relating to the role of government in the process. Of note is the developing centrality of participation as a characteristic of policy making and implementation. Lane argues that in policy process "government has been replaced by governance" (2005, P. 283). This is elaborated by Van Driesche & Lane, (cited in Lane 2005)   who argue that:

> The world has become too complex and our leaders too fallible for anything approaching a universal good even to exist, let alone be reliably located. The new political culture no longer places much faith in solutions imposed from above, increasingly relying instead on a network of decision-making relationships that link government and civil society across many scales (2005, p. 283).

There has been a significant change in how government and civil society engage in a changing culture and context in which national strategy in created. Whilst this new complex political landscape has generated a rhetoric regarding participation, consultation and communication in policy making, the reality as perceived by actors engaging in developing strategy may be somewhat different.

Collaboration: Tiers in Policy Making Context

During the interviews conducted as part of this study the theme of cross-sectoral collaboration emerged as expected, with the interviewees, depending on which sector they

belonged to, expressing a range of observations, both positive and negative about the consultation process in the development of the current strategy Connecting for Life.

For the majority of interviewees, the review of the Reach Out Strategy (2005-2014) and development of Connecting for Life (2015-2020) was the first opportunity to influence or participate in the development of suicide prevention strategy. This was due to the passage of time, from 2005 -2014, and it is evident that knowledge and methods in policy process had developed in the intervening years. The review process commenced in 2014 and interviewee responses for this study reflected how varying perceptions were about transparency and inclusivity in the consultative process associated with Connecting for Life. One interviewee from the C&V sector, felt her contribution as a representative of the community sector was valued,

> …people realised that we all have a hand to play in this, and that it's a whole community approach, which is not always a natural place for statutory agencies to be in. So I think that that was helpful and that was useful. And obviously relationships are built being around that table as well (Interviewee 11).

Collaboration was discussed in different ways as some mentioned their experience during the consultative phase while others spoke about it as a topic of concern in the implementation of the Connecting for Life strategy which is now at the mid-way point (2018). It also became evident that as interviewees were describing varying themes around consultation, it emerged as a much more complex, opaque and complicated and layered theme in the policy process. What became evident is that the collaboration involves relationships between various actors in the political, statutory, research and academic sectors. The C&V is also in relationship between other national, regional and local organisations as well as its engagement across sectors with the aforementioned departments and agencies from the statutory settings. Those involved in policy process aimed at the prevention of suicide comprise a complexity of sectors which is not straightforward, as there are many types of relationship. In order to explicate emerging themes, the assessment of interview data was formulated more explicitly into a list of primary tiers in policy process (suicide prevention). These have been identified and are presented and discussed, using material emerging from interview data below.

Tier 1. Government leadership to Government Departments

Tier 2. Government Departments to Statutory Agencies

Tier 3. Statutory Agencies and their Offices to National C&V Organisations

Tier 4. Statutory Agencies and their Offices to Local C&V Organisations

Tier 5. Statutory Agencies to other Statutory Agencies

Tier 6. National, Regional and local C&V to each other

Tier 1. Government Leadership to Government Departments

The relationship between the Government leadership to the various Government Departments and the intergovernmental departments to each other is not always as straightforward as one might think as politics can have an influence on the relationships. Some of the interview respondents expressed a perception of a lack of collegiality between these actors who were not necessarily working together voluntarily when it came to their involvement with developing the Connecting for Life strategy. One interviewee, closely linked to the policy process, felt there was strong political leadership, perceived as direct and forthcoming and explicitly expressing the Taoiseach's and cabinet's expectations of government departments. He described one cabinet meeting where, "the Taoiseach turned round and said, 'are you satisfied that all the government departments are on the page? I want everybody on the page" (Interviewee 13). The importance of strong political leadership at governmental level is further elaborated by the same interviewee, who is from the statutory sector and explained the process as follows,

> [An Taoiseach] said "if there's departments missing, you have a week to come back. These people are after telling you, presenting the evidence about what's needed. Go and do it". And it was political… There was a significant volume of activity with some government departments, one or two in particular and then it emerged. So in terms of clinching the deal, the political ownership was really very important. (Interviewee 13)

The interviews reveal that a mandate from government and the office of An Taoiseach supported and encouraged the consultative and planning process, resulting in the emergence of commitment from a range of departments.   The process was explained by a statutory sector interviewee, who said,

> …they went round the houses then, and said here's what's after emerging. Will you sign up to do? And if you won't sign up, take it out. So that brought it down to ten government departments, 22 agencies of state, including all the divisions of the HSE,

> and the NGO sector. And the rule of thumb was very simple. If you're not going to do
> it, take it out of it. (Interviewee 13)

The political will and backing for the Connecting for Life strategy was reflected upon by respondents during interview. It appears the new strategy was well supported by the Taoiseach and government. However, it also emerged that an opportunity for a whole of the Oireachtas approach was missed, according to a number of interviewees. This referred to the lack of inclusion and participation of representatives from opposition parties and independent TDs and senators. In this way the progress of the strategy became party political rather than involving all sides of the political landscape. One member of the Dáil described their perception of political policy process, using the following example,

> I suppose an example is that the minister set up the taskforce on youth mental health
> that was to bring in all sections of society to come up with a plan. There was an
> opportune moment to bring in maybe the Fianna Fáil and the Sinn Féin
> spokespersons. But it's so purely a governmental response. (Interviewee 7)

Tier 2. Government Departments to Statutory Agencies

The relationships between the departments and statutory agencies tend to be hierarchal in nature as in a lot of cases the statutory agencies are really subsidiaries of government departments. An example in the field of suicide prevention is the National Office for Suicide Prevention (NOSP) which is an office of the Health Service Executive (HSE), which in turn is an agency of the Department of Health. In this case it is really top down relationship as the department is the purse holder and also has the ability to make changes to the other two in the same way as employer can. One respondent who is from a statutory sector background described her perception of the departments in the policy process as complex due to the lack of cross-departmental communication, she states, "These are all the heads of Justice, Education, the whole lot and you know the relationships… They've no relationships themselves because it's all about their department" (Interviewee 14). It is evident from the data there is a complexity, sensitivity and negotiation required in the development of strategy in an environment and context where there is limited cross-departmental collaboration. One interviewee from a national C&V organisation said, "These people (departments) aren't even working together. Absolutely, they don't even communicate" (Interviewee 11). There was an element of surprise for another interviewee; again she had been involved in the national strategy as a C&V representative, who reflected on departmental collaboration, saying:

"Right. So you link closely with your mental health counterparts? No you don't, because you don't know who they are!" (Interviewee 12).

It became clear from the interview data that there was a perception of the government departments as bureaucratic, with limited cross-departmental communication. The structure in government departments appeared to some interviewees as somewhat rigid and slow to change. The government departments have been perceived, by some participants, as operating autonomously and separated from each other, giving the impression that they are resistant to a collaborative approach. This may or may not be true but one interviewee from the C&V sector, who has lengthy experience in suicide prevention, said, "That's why you need really to have all the input into things and the departments involved. But you have to be careful when you involve all the departments that they don't just brutalise the thing into a kind of narrow little pigeonholes as it were, and become bureaucratic" (Interviewee 8).

Tier 3. Statutory Agencies and their Offices to National C&V Organisations

When it comes to the relationships between the statutory agencies and C&V sector there is an interesting dynamic associated with resource allocation. Connecting for Life witnessed the establishment of strategic partnership agreements between the HSE and NOSP and some number of C&V agencies to deliver on the outcomes and actions in the strategy. Although HSE/NOSP do not have ownership of the National, regional or local C&V organisations, it is somewhat inevitable that there is a large degree of influence on those organisations that are funded heavily through NOSP/HSE. This is succinctly captured below by one interviewee from the statutory sector who was involved in decision making, developing and managing resources associated with the Connecting for Life strategy, "Everybody wanted to be a lead agent, including the NGOs. The Connecting for Life would have been 2000 pages long. Let's say he who pays the piper plays the tune. And it's their responsibilities, and it is the state's responsibility to deliver this." (Interviewee 13)

There is evidence from some of the C&V groups that they felt their views were not considered during policy decision making, this creating, at times, a strained relationship between statutory agencies and the C&V at national and, particularly, at local level as one respondent from the C&V sector articulated, "It's like your voice is listened to in certain times, and at other times it's ignored. Not that you demand to be heard on every issue, but once a decision has been made that implementation of certain policy is going to be rolled out,

it seems that that is just going to happen regardless of any other opinion on the matter"
(Interviewee 9).

An additional view was expressed by a respondent, from the political sector, about standards, governance and structures in the C&V sector. It was noted that statutory agencies and official bodies have reservations about standards, accreditation and governance, an issue that has been outstanding for some years in the management of national suicide prevention efforts. The development of draft national standards was undertaken and written by the author to this study in 2013 and these are discussed further in this chapter and in chapter one. The respondent was from the political sector, active in the area of suicide prevention expressed a view regarding legislation for the regulation of charities. Some of the main provisions of the Charities Act (2009), which was written to regulate charity organisations, have been slow to commence. The final regulations, offering authority and enforcement were being launched in September 2016 .Progress has been slow, the perspective of the interviewee that this was due to, "probably resources, or the lack of them is preventing that happening. And until that happens, I think departments and ministers and the HSE will be less likely to embrace organisations, no matter how good they might be on the ground, and listening to what they have to say" (Interviewee 6). It is important to consider the connection and emerging link between standards in the C&V (governance, accreditation) and parity of esteem and consultation in policy process.

Tier 4. Statutory Agencies and their Offices to Local C&V Organisations

A further theme emerging from interviews was that for those C&V not funded by statutory agencies, there is limited influence on their activities. This sometimes also having the consequence that the standards, professionalism and governance is perceived to be of a lower standard. For one representative of the C&V sector the experience of suspicion in her engagements with some statutory agencies was a source of frustration. She noted, (Interviewee 9) "My overall opinion is that, or my sense is that, the statutory bodies tend to view the voluntary sector, particularly the voluntary sector with suspicion. That somehow if you're operating without funding or without payment, that somehow the service is of less value or of lesser quality or a lower standard"
Interviews also revealed a perception of mistrust in the statutory sector engagement with C&V, due to standards as mentioned above, a theme discussed further in this chapter. An

additional factor is power and parity of esteem and a degree of frustration was expressed in the observations of one respondent from the statutory sector,

> [The volunteer] is never going to get paid for that piece. But that doesn't mean because she's not paid that her contribution is any less valuable. And actually it's probably more valuable, because she's doing it because she believes in it. And actually that balance between the two is hugely important. Massively important. So you have someone who is there because he's been in the job 30 years and he's been told to go there, and then you've got someone there because she wants to be there, because she believes in everything she's doing, and who's treated like crap. That's what's wrong. (Interviewee 5)

Tier 5. Statutory Agencies to other Statutory Agencies

When looking at the statutory to statutory on a local level, what is termed CHO areas, there seems to be more co-operations, the result of historical relationships built up over time. The networking and engagement across statutory agencies comprises many different subjects other than suicide prevention. For example, the people in the local councils would have a lot of experience in dealing with the development partnerships, and this reveals a distinction between the collaborative practice at local and national department level. A volunteer from C&V sector said, "It's very easy for them (statutory agencies) to have a coffee together or work something out, have a quick meeting. Whereas the other groups tend to be more spread out around the whole area… So it's much more of an effort to bring those together. There's existing relationship, and I think there's a lot of respect between statutory organisations".

There can be a range of factors that affect collaboration and one of these is geography and regional variations in practice. Some regions appear to collaborate more effectively across sectors, and within sector than others. This can be due to a number of factors including geographic in local/county or CHO planning in particular. For one interviewee, who works in the statutory sector, her perception was that local policy process may offer a more collaborative opportunity, "I think that there's a willingness to engage and a willingness to work together, and I think it's probably the nature of the CHO local area that has made us work together more" (Interviewee 14). In another case a respondent, again from a government agency, felt the same describing the local experience, "We have better relationships in general here I think, and more history of collaboration" (Interviewee 4). In contrast, the view of an interviewee from the voluntary sector, who is CEO of a national

organisation, expressed a view that collaboration and consultation across sectors can be difficult, "The other thing around all of this is the time that's wasted within the statutory agencies around politics and process, and who's leading, and power. That's a whole different thing. But it impacts." (Interviewee 12)

Tier 6. Relationship between National, Regional and Local C&V to each other

Policy process must take account of the dynamic within the community and voluntary sector. The impact of the relationship between national, regional and local community and voluntary organisations emerged as a theme during interview. This is caused by the limited resources available to groups, a situation exacerbated by austerity and economic downturn from 2008 in Ireland. Although cross-sectoral relationships in policy process was the primary focus, it was acknowledged by a number of participants that relationships within the C&V sector can be competitive, negatively affecting collaboration in policy process and subsequent implementation of suicide prevention strategy. One C&V interviewee questioned the relationships in policy process from a community and voluntary organisational perspective, stating that for some groups the motivation was, "What's in it for me? Why would I sit round this table? What's it going to do for me?" Her perception was that, "some community and voluntary organisations, need to be seen to be doing things. So they're there, but they contribute nothing" and she also alluded to parity of esteem within the C&V sector, stating, "It also comes back to that whole nonsense of bureaucracy, where people aren't actually adding any value whatsoever, but it's retaining their own funding. It's fundamentally a hierarchy within the community and voluntary sector." (Interviewee 11)

As noted above, parity of esteem issues exists within the community and voluntary sector and this is cited by one respondent, from a national voluntary suicide prevention organisation, who noted the competition and watchfulness between C&V organisations in the policy process, "From my experience, and just being around it was, firstly within ourselves, all the voluntary and community, we were all watching each other, because we've all been set up to compete with each other. And that in itself is unhealthy, because it sort of gives us a disadvantage." (Interviewee 11)

Influence by C&V on Statutory Sector

When it comes to the relationships between national, local and regional C&V groups, the HSE and the NOSP do not have the same degree of influence on the voluntary organisations

which are not funded by them. They do indeed have a large degree of influence on the activities of those commissioned to deliver actions in the strategy. As we have already discussed, the decision about who decides policy, and gets invited, is largely in the hands of the statutory sector. This is also the sector with responsibility for the successful rollout and implementation of the national strategy.

Unless the C&V organisations have aligned their practice to the national strategy and bought into the visions presented, they are less likely to play a role in the policy making process or its implementation. It is also evident that the statutory sector, although tasked with the responsibility, are unable deliver everything themselves so they need buy-in from these sectors to alleviate any gaps in service; especially in the whole of society approach as defined by Connecting for Life. One respondent, from the statutory sector, gave their opinion that although the work that the C&V sector had done in the past was taken for granted, the HSE was waking up to the fact that the C&V sector were needed to effectively implement the strategy going forward:

> I think that they (HSE Statutory) actually see that now. Where they were taking it for granted perhaps in the past, because the community and voluntary sector was quite strong and it was delivering. But because they've been squeezed, and resources have been squeezed for them, they're not able to take up that mantle anymore. And I think now is the only time that, I think they definitely recognise that need for the community and voluntary sector. (Interviewee 14)

The impact of resources on cross-sectoral relationships is an important emerging theme for the suicide prevention C&V sector. This is the result of a high level of reliance on public sector funding, with the effect that the funder/funded relationship between C&V and government and state agencies, changes the power balance. A consequence for the C&V sector can be risks to its independence and in a study of voluntary sector in N.I. Ketola and Hughes (2016) describe threats as three types as in the table below:

Table 6.1 Independence of Community and Voluntary Sector

INDEPENDENCE OF PURPOSE	This refers to the ability of organisations to stay true to their mission and values.
INDEPENDENCE OF VOICE	This concerns the extent to which organisations are able to exercise a critical voice, protest, campaign and negotiate without fear of negative consequences or retribution.
INDEPENDENCE OF ACTION	This concerns the ability of organisations to design and deliver effective activities and services, take risks and innovate and respond to beneficiaries' needs creatively.

(Baring Foundation cited in Ketola and Hughes, 2016)

Cooper (2017) suggests the need for a mutual recognition of common purpose between the statutory and C&V sectors in Ireland, to do so would increase respect and facilitate a collaborative or partnership relationship. At the present time the sense of common purpose is, according to Cooper "increasingly obscured by the adversarial and contractual relationships inherent in current commissioning, procuring and tendering approaches. These approaches have resulted in a purchaser/provider split that has undermined the sense of common purpose that informed traditional partnership approaches between the two sectors" (Cooper, cited in Slocock, 2017. p. 74).

Slocock (2017) in an examination of the independence of the voluntary sector in the U.K. considers the smaller organisations to be most vulnerable in the commissioning and competition for resources. The findings in this study suggest a similar experience of risk for the smaller organisations in the community and voluntary sector in Ireland.

Perceptions of Power –Relationships and Hierarchy

Articulating perceptions of hierarchy and power in the policy process requires clear understanding of the policy pathway in Ireland which was discussed earlier. There emerged through interviews with several respondents, a naming of power and hierarchy related themes and in order to map these, it is relevant to again recognise the C&V, statutory, local, national and governmental aspects to this.

The government position is largely transparent. It is very much a top-down approach. The most elevated position at the top of the hierarchical tree is held by the leader of the government of the day i.e. An Taoiseach and his/her Cabinet which includes ministers and junior ministers of the various departments e.g. Department of Health, Education, and Justice etc. These are the actors in positions who have the power to decide on government policies or strategies in any given field. As one respondent from the academic sector stated, "It's a top down, you know and I think it's even becoming more so. I think with the Connecting for Life, Enda Kenny took control of that, well his department seemed to take control of that, and they were jumping to their agenda as far as I could see." (Interviewee 2)

The strapline of the campaign in Connecting for Life was that of a 'Whole of Government' approach and it appears that this did not translate into an inclusive 'whole of Oireachtas' management of strategy review. There was limited evidence in discussion with a political representative of a cross-party, involving the opposition, consultation in developing the new national suicide prevention strategy. Indeed, one respondent, from the political sector expressed the view that an opportunity to be more collegiate was missed because of party politics, "I suppose an example is that the minister set up the taskforce on youth mental health that was to bring in all sections of society to come up with a plan. There was an opportune moment to bring in maybe the Fianna Fáil and the Sinn Féin spokespersons. But it's so purely a governmental response." (Interviewee 7)

The party-political in policy making has been addressed in this chapter; however it is mentioned here to illustrate the hierarchical nature of policy making and the perceptions of power in the process. A further illustration of this is captured by a respondent from the political sector who offers a succinct description of the mechanisms within the Oireachtas. This is an important emerging theme in the study, namely the degree of communication between government and its departments on the subject of policy change and review in, this instance, suicide prevention. Cross-department communication and collaboration, one would consider essential to the achievement of the 'whole of government' approach to suicide prevention and successful implementation of the national strategy. However, according to the following interviewee, who is from a political party and contributed to Connecting for Life (2015), there are impediments to the 'whole of Government' approach:

I've always felt that the government departments are like pigeonholes, and there's no door between one and the other. So they don't operate seamlessly. There's no, well

maybe there is, but you would think there isn't any cross-departmental team at assistant secretary or higher level that can, at a weekly meeting, remove stupid bureaucratic administrative obstacles from achieving progress on a particular issue (Interviewee 6).

The government backbench TDs and Senators can wield influence on the cabinet and are responsible for the creation of many bills which finally find their way into law. Of lesser influence, in usual times, are the TDs and senators of parties not in power. These groups can be represented on various Dáil committees and sub-committees where there is an opportunity for contribution on various topics of concern. The reason for the mention of 'usual times' above, is that, as noted earlier, the current minority government (2018) headed by the Fine Gael Taoiseach, Leo Varadker, relies on Fianna Fail, led by Michael Martin, for a supply and confidence arrangement to keep the government functioning. Because of this arrangement the current government have tended to take on board various amendments proposed by Fianna Fail (but not by other parties who are not part of the supply and confidence arrangement) to legislation at the bill stage. This arrangement has slightly diluted the traditionally dominant role of the government parties in the actual legislation process. An opposition political party respondent expressed the following view, "The state's default position is you're wrong, they're right. And that's a problem. Because the house always wins. And even if you're right and they are wrong, the path to success is to find a way to give them the credit for the change" (Interviewee 6).

Respondents expressed the perception that a hierarchy of power exists in suicide policy process. This power is wielded by the statutory bodies and their agencies and offices. Power is usually delegated from the government departments and in the context of suicide prevention the statutory bodies consist of the Department of Health (DOH) and Health Service Executive (HSE) and National Office for Suicide Prevention (NOSP).

The National Office for Suicide Prevention (NOSP) is tasked with the brief to manage the development and implementation of the national strategy. They are the organisation with statutory responsibility for the roll-out of the initiatives contained within the Connecting for Life strategy. One person who works in the statutory sector described the principal decisions in policy process as follows, "NOSP was doing the work, and would have said that they were being asked to do it by department of health (DOH). But I think a lot of it was coming from themselves as well. You know they would have had definite ideas within NOSP of how this was going to go." (Interviewee 5)

The office (NOSP) has established a number of strategic partners aimed at delivering key aspects of the strategy. There has tended to be influence and cooperation with large national organisations in the policy process and close connection between NOSP and academic/research groups such as NSRF and advocacy groups such as the IAS also exist in this space. Changes to the funding context have been shaped also by issues linked to governance matters arising from audits into the activities of publicly funded organisations, including Console, a national suicide bereavement organisation that faced investigation over its accounts and governance (2016).

The national strategy, Connecting for Life, has been developed with an implementation plan and structure included with the Cabinet sub-committee on social policy and a cross-departmental steering group, chaired by the Department of Health. The successful management of implementation and perceptions about the course and manner of how this is administered is discussed in the next chapter. It does feature here in descriptions of power in the process. As one statutory sector respondent stated,

> I think it was encouraging that people were committed to coming round the table to work together around it. But I still think it's held by the HSE, very much led by them. I still think that people see that that is where it's housed. Connecting for Life is a whole of government, a whole of society approach. That's very clear. But how that actually translates remains to be seen. And how much different will it be? (Interviewee 5)

The findings reveal the necessity for a redistribution of power (Arnstein, 1969, cited in Lane, 2005, p. 284) in the policy process. From such a perspective, unless there is a genuine prospect of affecting outcomes in policy making, participation is generally concerned with 'therapy' and 'manipulation' of participants (Ibid 1969, cited in Lane 2005, p. 284). (Amy, 1987, cited in Lane, 2005, p. 284) also considered power as the fundamental variable and the distribution of power determines the fairness of a given process because it creates imbalances in the relationships between actors in the policy making process. (Arnstein, 1969, cited in Lane, 2005, p. 285) conceived of power in public participation in the policy and planning processes as a ladder or a spectrum, ranging from 'non-participation' through to 'degrees of citizen power as described by Painter' (Painter, 1992, cited in Lane 2005). It is worth noting there are a number of features emerging to the understanding of perceptions of power.

Firstly, there are the formal powers that exist, in this case with the statutory sector (NOSP/DOH), that is a significant feature and dimension of consultation and participation. Secondly, it is clear that any understanding of power requires an assessment of implementation, actions and outcomes in the strategy, rather than simply reflecting on an analysis of comparative power dynamics proceeding to the implementation and delivery of national strategy.

Standards and the Suicide Prevention Sectors

A number of significant themes emerged during the course of the interviews as respondents discussed their subjective experiences of the policy process. National standards of accreditation for the C&V suicide prevention sector was an issue raised by a number of those interviewed and the reflections are discussed below. Although not part of the original scope of this thesis this is an important emergent consideration as it revealed the views of those interviewed for possible further research and examination. It is also noteworthy that the author to this study had previously completed research entitled Quality Systems and Accreditation Standards for Voluntary Suicide Prevention Organisations in Ireland (Friel and Gallagher, 2013). This information may have been known to the respondents and thus introduced a variable influencing discussion about standards and accreditation. It is also the case, as the comments reveal below, that standards of governance and practice are a feature of interest, if not concern, for some within the suicide prevention sectors and therefore it is an area they would want to elaborate on regardless of the presence of the author to this study.

The issue raised about standards is interlinked with the previously discussed parity of esteem because if voluntary organisations, particularly smaller ones, are not perceived to be operating to high standards of governance and procedures, which can be verified, there is a feeling that somehow they are not operating to a level that would be sufficient to expect parity of esteem from their statutory and large national organisation counterparts. An absence of accreditation in the suicide prevention field exacerbates this as the voluntary organisations which in fact do operate to high standards are often seen to be grouped together with others which do not operate to this level although well-meaning but lacking expertise. The fact that there are large numbers of organisations often duplicating services in some areas is also seen as less than ideal in the views of some of the interview participants. Interestingly, the complexity of setting standards is further complicated as agencies within the statutory sector may also work to varying degrees of governance, accreditation and standards of good practice

as highlighted by an interviewee from a statutory agency who states, "There's two or three fundamental issues. How do the set of standards which have a large, fairly significant focus on the NGO sector, how can we talk about those if we're not working off the same standard in the statutory sector?" There is no doubt that governance and standards in C&V organisations is, as described by one academic, "a huge gap" particularly as there are numerous small organisations, "with the best intentions, but where safety, governance and quality is debatable" (Interviewee 2). It was clearly felt by one interviewee from the statutory sector that NOSP, "have specific responsibility for the development of standards for the sector." For another interviewee from the statutory sector, there is a conflict for those managing resources and implementing strategy. This is due to uncertainty about standards in C&V and she states, "There is no experience of the standards of those organisations. So therefore there's that kind of difficulty around, Connecting for Life can't support every organisation, so therefore how do you then, at national level, make a decision about X, Y, Z organisation that must be demonstrating that they're meeting X, Y, Z standard?" (Interviewee 5)

There is evidence above that the respondents value the importance of implementing standards of governance across the C&V suicide prevention sector in Ireland. The evidence suggests that by doing so there would be greater definition and distinction between organisations. It is the perception of some respondents that there would be clarity in the relationship between the C&V and statutory sector and particularly in the funder/funded engagement. The contribution of the C&V sector is difficult to quantify in the absence of clear standards of governance, data collection, cross-sectoral communication and measurement of risk. It is also evident that various respondents perceive a direct correlation between the absence of sector standards and parity of esteem between C&V and statutory sector in suicide prevention policy making process in Ireland.

Conclusion

The findings in this chapter reveal many positive changes and improvements in the suicide prevention policy process, from 1993 when the decriminalisation bill successfully passed through the houses of the Oireachtas, to the launch of the Connecting for Life suicide prevention strategy in 2015. The cross-sectoral relationships in policy process, as the focus of this study, have benefited from significant improvements and achievements in establishing a

collaborative, partnership and effective response to suicide in Ireland. There has been a systemic change to the policy making process, reflective of a number of factors.

The C&V suicide prevention sector comprises a strong third sector, made up of a disparate range of groups working across prevention, intervention and postvention. They work across education to therapeutic practice and in a variety of geographic locations. There are those organisations in already established strategic partnerships with government (DOH/NOSP) to deliver parts of the national strategy. There are also many smaller C&V, non-funded organisations, also delivering significant aspects of the actions associated with Connecting for Life. Some of these are deliberately aligned to actions/outcomes in the strategy or not aligned but responding to local and arising need.

Consultation has improved significantly, there is much to consider that would improve the planning and effectiveness of the consultative process; however, this study acknowledges the major developments and evidence of proactive approaches to cross-sectoral collaboration led by NOSP and associated actors in developing the Connecting for Life strategy.

What emerged during the interviews is that there are many layers to the dense and complex suicide prevention policy process; there are constantly changing sets of relationships, involving a varied set of policy actors, experts and stakeholders. Regarding emerging themes, consultation was a significant issue where it became evident that different groups mean different things when using the term and the 6 tiers to the collaborative policy process were discussed above.

The experiences of respondents in the policy process appears to have been mixed with ranging perceptions described as positive in developing Connecting for Life, to those articulating exclusion and tokenism in the consultative experience. There is evidence that the sectors would benefit from standardised mechanisms in policy planning, clarifying purpose, time-frame and type of consultation to be undertaken. The chapter concludes by examining additional themes including standards in suicide prevention organisations, perceptions of power and parity of esteem as expressed by a number of interviewees.

Chapter 7: Influence and Policy Process

Introduction to Chapter

This chapter focuses on decision-making, participation and influences in policy process and the perceived impact on inclusion or exclusion to the process. It articulates further results of the interviews, presenting and discussing respondent replies and emerging themes in the policy process. The previous chapter discussed findings from participant accounts of retrospective policy development linked to the National Task Force (1998) and Reach Out Strategy (2005) presenting a number of emerging themes. This chapter differs in that it commences with a consideration of developments and progress that have been made in the policy process. The focus of the chapter was on the interviewee experiences of the *contemporary* strategy Connecting for Life (2015-2020), the findings revealing a number of important topics, including funding and the decision making process associated with the allocation of resources and the delivery of the strategy. Implementation of the strategy was not directly included as a variable in determining the exploratory question of this study. It has, however, become an emerging theme due to the fact that respondents often brought this issue to the fore during interviews without being prompted. This became an important emergent finding and is discussed in this chapter by drawing on the pertinent views and ongoing matters raised regarding the implementation of Connecting for Life (2015-2020).

Progress and Development in the Policy Process

The literature, document analysis and the retrospective examination of previous strategies reveals that there has been substantive progress and development in the suicide prevention strategy making process in Ireland from 1993 when suicide was decriminalised. The social changes and current context of suicide prevention is discussed elsewhere in this study. However, as noted, the focus in this chapter is to critically review the indicated improvements and changes to the policy planning, consultative and cross-sectoral processes from the time of the National Task Force (1998) to 2015 when Connecting for Life was launched.

The data emerging from the interviews has revealed evidence of significant changes in cross-sectoral relationships, with evidence of improved collaboration and development of a strategic partnership approach to planning and implementing strategy that involves the statutory suicide prevention sector, other government departments and specified NGO and

C&V groups. This is described by one respondent from the statutory sector who explained that government policy makers:

> [The official bodies]…used a systematic approach around developing the evidence, looking at policy, listening to people, collaboration, and getting agreement and all of that. It was a very active process. There were people with very diverging views. So what they learned was, when you present evidence well, and things are well researched, people get it. And it's easier to move people when you say 'well that really isn't right', or 'there's no evidence that that works', etc. etc. So that was a particularly successful process. (Interviewee 13)

A significant development was the method used to review the learning from the Reach Out strategy (2005-2014) and develop the Connecting for Life. This involved utilising consultative procedures and evidence methods that had yielded successful outcomes in other jurisdictions, such as Scotland. One respondent, when referring to the architects of the new policy, stated, "So they [architects of new strategy] set up a number of working groups, one that looked at policy, one that looked at practice, one that looked at engaging with the community and taking advice and listening to people, one that looked at clinical practice I think, one was about communications. There were five working groups." (Interviewee 13)

There are challenges that must be identified and addressed in efforts to ensure that policy process is inclusive. The need exists to pay close attention to the complexity and dynamics in the early stages of policy making and, as the previous chapter discussed, there exists multiple layers in the statutory sector and similarly within the C&V sector. This raises issues about the in-sector and cross-sector dynamic, how this is taken into account or informs a monitoring of the decision-making process at the early and indeed all subsequent stages in policy process. Lasswell describes the categories that constitute activities in the policy decision process, identifying these as intelligence, recommendation, prescription, invocation, application, appraisal and termination (1956, p. 93). These decision processes were subsequently adapted into a policy cycle and developed by, among others, Jones (1970) and Brewer (1974) who defined categories in the policy cycle as initiation, estimation, selection, implementation, evaluation and termination (1974, p. 120).

It is clear that improvements have occurred in the consultative and participatory procedures in Irish suicide prevention policy process. This requires additional focus aimed at understanding and taking cognisance of the complex network of decisions in each stage of the cycle. The previous chapter has described the multiple layers in the decision process. This includes the range of government agencies and departments involved in suicide prevention policy process, and the multiple diverse C&V organisations included, excluded and making submissions to the decision process.

It is therefore useful to consider developing a specified planning and consultation process. To do so may help to alleviate perceptions that consultation is not inclusive and wide ranging. In addition, the protocol and procedures, the responsibility and authority for leading the planning process must be clearly articulated, taking account of the complexity already outlined.

Scepticism about the level of investment to meet the demands of the new strategy was discussed, with one respondent from the academic sector expressing the belief that the National Office of Suicide Prevention (NOSP) has not been resourced sufficiently to manage the complexity of developing and implementing the new strategy, "it is their brief", "They are the organisation with statutory responsibility for the roll out of the initiatives contained within the Connecting for Life" (Interviewee 4).

The National Office for Suicide Prevention (NOSP) is the agency responsible for the implementation of Connecting for Life, with the strategy just past the midway stage of its lifespan (2018). The office has undergone significant changes throughout the years, with one respondent from the voluntary sector organisation acknowledging: "that organisation has changed hugely and we've seen these changes and we've worked with them over the years, and we've had to adjust as well too, you know. But it is very much, it's a top down, you know. And I think it's even becoming more so" (Interviewee 3). NOSP is an office of the HSE, which in turn is an agency of the DOH. As with many government departments, the Department of Health (DOH) is a bureaucratic, structured, procedural official body. Policy planning approaches in government departments are perceived as slow, with a reluctance to change from the usual, traditional methods. Hence the perception is of a top-down, less inclusive approach.

Influences on Policy content

During interviews, it became apparent that respondents were clearly articulating their knowledge and understanding of the content in the Connecting for Life strategy and outlined their perceptions of the various processes and consultations that informed the development of the evidence. This was much more pronounced than their articulations of the preceding policy (Reach Out, 2005) which would suggest that the consultative process had improved, as discussed above. This thesis has noted the Connecting for Life Strategy on a number of occasions. However, it is now an appropriate point at which to provide much more specific detail on the consultative process of this policy as this was identified as a key point by many respondents.

In early 2014, Kathleen Lynch TD and then Minister for Primary care, Social Care and Mental Health commissioned the review of Reach Out strategy and development of a new national plan to reduce suicide in Ireland. The period the strategy would cover was 2015-2020. A number of advisory groups were established in the areas of, research, policy, practice, engagement and communications/media. Included in the membership of the advisory groups were government departments, policy makers, community leaders, clinicians, researchers, non-statutory partners and those affected by suicide, with the process of membership having been considered elsewhere in this study. The findings and recommendations from these groups were integrated into the evidence for and formulation of the Connecting for Life strategy. A national strategy was to be launched in 2015 and in addition, using the Connecting for Life national plan as a template, local area plans were written in each CHO area of the HSE. Additional evidence and data influenced what was to be contained within the Connecting for Life strategy, and included:

- An examination of key learning points from Reach Out

- 272 written submissions arising from the public consultation, of which 120 were personal accounts from people directly affected by depression and those who had lost people close to them by suicide

- Research on risk and protective factors for suicide

- Central Statistics Office material

• National Registry of Deliberate Self-Harm research reports, including National Registry of Deliberate Self-Harm Report (2013)

• Policy Paper on Suicide Prevention – A review of national and international policy approaches to suicide prevention, commissioned by HSE NOSP (Pillenger, 2014)

• Review of the evidence base for interventions for suicide prevention by the Health Research Board (HRB) Suicide Prevention: An evidence review, commissioned by HSE/NOSP

• International evidence about key elements in effective suicide prevention strategies

• Evidence on social media and social marketing strategies, language and stigma reduction and media reporting issues and interventions

• The WHO 2014 Report Preventing suicide: A global imperative

• Review of training linked to Reach Out, commissioned by HSE NOSP.

Source: Connecting for Life (2015)

As stated earlier, once it was decided to review the Reach Out strategy, a framework was put in place by the National Office for Suicide Prevention (NOSP), with the stated effort to be as inclusive as possible. The process was informed by practice standards and international evidence. This included the 1996 UN guidelines; WHO (2014); and research, review and academic expertise, including HRB Review(by Dillon et al, 2015); NSRF; Pillenger, (2014); Ella Arensman and Steve Platt whose perspective on international best practice formed part of the evidence base. As an academic from Edinburgh University and a policy expert, Steve Platt offered knowledge and expertise of the planning and architecture of the Scottish strategy. This informed the view, in Connecting for Life, that for a national strategy to be a success it needed to be a whole of society approach. (See appendices 1 – 6 for a list of Government Departments and agencies; and members of the steering and advisory working groups).

It would appear that NOSP, having considered the Scottish guidelines, introduced a similar methodology for collaboration and consultations with the various sectors, agencies and public. One respondent from the academic sector stated, "With this one they decided to go a very different way with it. They involved lots and lots of different organisations and people.

A huge consultation process went into it as well too. And it is very much focused now" (Interviewee 3). The respondents' found this approach to be inclusive of a greater number and range of people, this aligning with best practice in policy planning.

The Connecting for Life document outlines participation as being encouraged through an open submission process and according to the strategy, 62% of all adults in Ireland were reached with the media advertisements. The strategy document reports the receipt of contributions by 272 individuals or groups including service users and their families; professional bodies and community interests and organisations, these being examined and distilled as the process developed. One interviewee from the statutory sector described the robust nature of the consultation process:

> We had of course, a whole lot of comments. Everything was transcribed from the public consultation meetings; we had the other stuff from either the survey monkey or from the postcards. So what we did was, we looked through it all, and that took a good long time. Once we had all the comments together, we then met with, the members of the working group, got together and looked at a system to manage and to collate and distil them. (Interviewee 4)

Articulating the perceptions of a cross-sectoral sample of participants to national and local policy process is central to this study, which considers if the rhetoric translated into reality in the consultative experience of participants.

The interviews reveal that participants' opinions varied about the level of influence the various sectors actually had. One C&V respondent, quoting their experience of a number of consultative meetings, was finally brought on board an advisory committee and stated that "At that point we did begin to feed in, and we had a small degree of influence in changing a few of those things. Or at least on paper, changing a few of those things. In my experience as it's gone on in the last year and a half, I think the community/voluntary sector has very little say" (Interviewee 9).

However, it also appears that for some respondents, the consultative process offered somewhat limited improvements in the cross-sectoral relationships and participative process, as stated below.

> In a more negative situation, we've seen where policy has been implemented even despite concerns raised. And that has then been implemented and rolled out in a way that does not reflect or respond to any of the concerns that we raised. So, therefore, it's like your voice is listened to in certain times, and at other times it's ignored. It's not that you demand to be heard on every issue, but I think once a decision has been made that implementation of certain policy is going to be rolled out, it seems that that is just going to happen regardless of any other opinion on the matter. (Interviewee 9)

The responses to interviews also appeared to vary between sectors. For example, comments from the academic sector tended to be positive such as interviewee 3 who noted "So with this one [Connecting for Life] they [the architects of the strategy] decided to go a very different way with it. They involved lots and lots of different organisations and people. A huge consultation process went into it as well too. And it is very much focused now." This positive perception is also evident from the statutory where one interviewee stated, "It seemed to be, we'll say, a bit more democratic perhaps than the previous one, so I think it was more inclusive" (Interviewee 8).

The influences on content in the new strategy were broad based, taking into account views from the aforementioned groups and individuals from the various sectors that fed into the advisory groups. It appears that efforts were made during the consultation process to be inclusive; however, the evidence in this study suggests that positive or negative perceptions of the consultative process correlated with levels of involvement in the development of the strategy itself. Those from the statutory and academic sectors appeared to express a more positive perception than respondents from C&V sector. It is evident that not all voices can be considered and, from a pragmatic perspective, some may express the feeling that their views are not listened to or acted upon if particular parts of the strategy or its action points are not aligned with their vision of how things should be approached.

This does not suggest that perhaps some good inputs were missed but rather that, as with all endeavours, there will always be room for improvement in later follow up strategies. This was articulated by interviewee 2, from an academic sector, who stated "my conclusion was that the policy advisor should have been present at the meetings of the research advisory group, and should maybe have had a listening ear with the clinical group, the communication group. Because with all respect, I felt it was too theoretical, and there was not a very strong focus on priorities that were immediately clear from some of the groups for Ireland"

One respondent from the research sector, invited onto a national committee, described the need for sequencing and strategic planning in policy making. For the author, this necessitates that suicide strategy be developed with clear planning and advocacy protocols and procedures. In considering advocacy planning, Davidoff (1965) discussed the concept as aspirational with equal accommodation and representation for everyone within the planning processes. As an aspirational process it must be acknowledged that planning and consultation will never achieve perfection, it cannot be exhaustive and fool-proof. The findings from interviews indicate that improvement in planning/consultation methods would improve levels of participation. As a result of the findings, I am also of the perspective that policy process is a perpetual cycle of making policy, implementing policy and reviewing policy. It is also evident that as strategy is being implemented, it is being reviewed. Having a continuous review cycle is a most useful way to ensure ongoing engagement with stakeholders from all sectors. The policy process cycle is illustrated below:

Figure 7.1 The Cycle of Policy Process
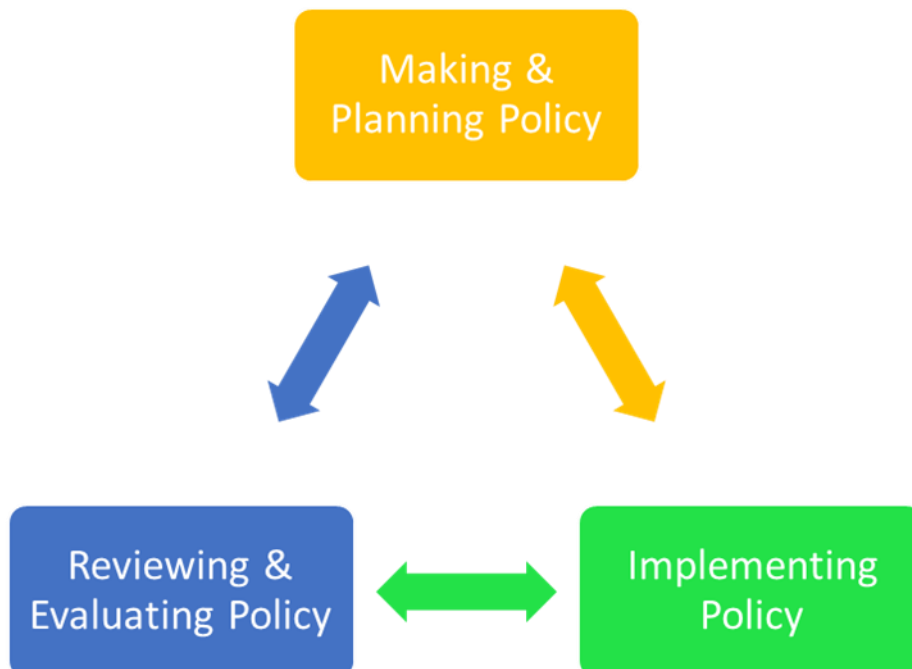
As stated above, planning, consultation and participation in policy process is not exhaustive, it is aspirational, but policymakers can endeavour to continually improve the process. This will go some way to address the perception that suicide prevention planning is "top-down" with limited reference to the experiences of those most affected in the community. As stated by a respondent from the statutory sector, "The evidence seemed to say that what you need is a multi-layered strategy at national level, coupled with local implementation plans, and they need to be locally based, with local ownership and all the rest. So you have the national policy, you've regional and local". (Interviewee 4). In order to address perceived or real gaps in the suicide prevention strategy planning, a few central tenets in models of planning can be considered. Firstly, there is a high level of inequality in the bargaining power between different groups, secondly, there is not equality of access to the political process and finally there are sizeable groups and individuals that are not organised and as a consequence unrepresented by interest groups (Mazzioti, 1982).

Who decides who decides? Policy in Ireland

Decision making in early stages of policy planning is an area of interest in this study, thus the question '*who decides who decides?'* policy emerged as an aspect of the research. The study is interested in who makes decisions about who will formulate strategy, who gets around the table and how this happens nationally specifically here in relation to the Connecting for Life plans. This aspect of suicide strategy development is interconnected with discussions about cross-sectoral relationships, parity of esteem, methods of consultation and power, these themes having been discussed in the previous chapter. Healey (1992) describes how increasingly public participation became a fundamental objective, rather than a marginal planning technique in public policy.

Findings indicate that the architects of Connecting for Life aimed to ensure high levels of participation in policy development. The consultative process is not exhaustive and may be limited by additional factors, including time and resources. It is important to state that some respondents to this study, reflecting on their experience, considered the consultative process: a marginalising and tokenistic experience, rather than a meaningful attention to levels of participation. This reflects the subjectivity and perceptions of some interviewees and emerged as a result of their level of participation

The range of interviews yielded a number of interesting results regarding degrees of involvement, inclusion and feelings of exclusion in the policy making process. A number of participants, mostly from the smaller C&V organisations, describe very limited knowledge of the suicide strategy consultation and review process. In contrast those from C&V that were involved in the review, with membership of sub-committees or participation in the consultation process felt informed. This finding appears to confirm that C&V organisations, regardless of size, are more likely to have influence if their activities align with actions in national strategy and they are therefore known to those making decisions and managing policy review and development.

The methodological approach was designed to ascertain respondents' views about who decides strategy and a number of those interviewed expressed the view that 'they', the hierarchy, establishment or statutory sector, basically decided who should decide strategy. One participant from the community and voluntary sector stated "The establishments decide and they bring in who they are gonna fund and who should be sitting at that table"

(Interviewee 12). The level of subjectivity in the decision process was further highlighted by a further respondent who stated:

> My guess would be that it's people sitting round the table and saying who should we have here… As opposed to thinking about right, this is our end game, therefore… Do you know what I mean? And so it's relying almost on that expertise, rather than saying right this is our goal, so we must have organisations A to Z, and community groups A to Z around the table. And I would say it's quite subjective. Because I think in some of the discussions, it came down to personality; therefore, I'd say it's quite subjective (Interviewee 5).

It appears therefore that invitations to the consultation on the Connecting for Life strategy were issued to those considered as knowledge experts or representative of a particular discipline, target group or sector. C&V inclusion appears to have been based on, knowledge expertise, relational factors and being well-known. In addition, certain C&V organisations were invited as representative of a wider geographic or sub-group, an example being development partnership organisations that are considered as representing all C&V in a geographic area.

It is evident that decisions about who gets involved are made by NOSP after being advised by official bodies and knowledge experts. The development of strategy is carried out by those invited to participate in the planning process. The output of the working groups and sub-committees was subsequently written into the Connecting for Life strategy. One respondent from the statutory sector commented on the influence of certain official bodies: "It was a collaborative process in terms of writing the thing. But the way it pulled together, there was about 150 people involved and the feedback from the five working groups was all there and they (NOSP) said this needs to distil down into themes" (Interviewee 13).

The Statutory sector, on the other hand, had a very clear view of whom it was that was actually deciding who decides. This was most apparent in a number of comments regarding the Government Cabinet meeting when Connecting for Life was being discussed. The then Taoiseach, Enda Kenny, as leader of the Government, insisted that all government

departments and agencies sign up to what was being presented to them at that time. The Office of the Taoiseach was tasked to check the progress with each government department. This was in keeping with the whole of Government approach which had been recommended by the international organisations including the World Health Organisation (WHO) and the United Nations (UN) and embedded in strategies in neighbouring jurisdictions, such as Scotland. The experience of one participant, who attended a cabinet discussion about suicide prevention strategy, from the statutory sector, succinctly describes the influence and approach of the then Taoiseach in the policy process, stating:

> The Taoiseach chaired it. And it was interesting. And the Taoiseach turned round and he said: These people are after telling you. Presenting you with the evidence about what's needed. Go and do it. And it was a political... There was a significant volume of activity with some government departments, one or two in particular. The Taoiseach's department rang and said are you happy with what they've given? And they went back, and it emerged. So in terms of clinching the deal, the political ownership was really very important (Interviewee 13).

This example demonstrates that on this occasion there was clear evidence of a top down approach being employed by the office of the Taoiseach to ensure departmental buy-in and commitment to the process. In order to examine the slightly deeper and more complex question of who is actually deciding strategy content and implementation, the study considered responses from a wide range of participants across sectors. It is evident from the findings, that the statutory sector and particularly the Department of Health and its agencies, the H.S.E. and the NOSP were the bodies involved in reviewing the previous strategy and then deciding who/what agencies, knowledge experts and government departments decided the new strategy. In doing this there was considerable input from the academic and research sector, particularly the National Suicide Research Foundation (NSRF), who are national and international knowledge experts in the area of suicidology. The development of strategy was also informed by HRB systematic review of evidence and contributions from national and international academic research.

The importance of research and evidence based approaches to the development of national strategy is clear. It is essential to ensure high standard of national and international academic, practice based research and expertise is considered in the review and formulation of strategy. The NSRF and other academic experts were important as advisors to the policy process. There is thus a compelling argument that national strategy for suicide prevention in Ireland is now more greatly informed by a national and international evidence base. Therefore, there is influence on the policy process by the research and academic sector, including the NSRF in deciding the direction, contents and actions associated with strategy. As a result, this also informs what/who gets involved in strategy formation. This of course possibly over simplifies how decisions are made about inclusion in policy making. It would appear however, that the expert advice supported the planning and setting of priorities. The planning resulted in the commitment from a range of government departments to implement actions in the strategy.

Participation and Policy Process

'Who decides who to invite?' can also be broken down further, this being dependent on to what aspect of the policy process participants were being invited to:

- o Local consultations
- o National consultations
- o Population level e.g. the submissions
- o Working groups Local
- o Steering groups Local
- o Working Groups National
- o Steering groups National
- o Cabinet sub-committee

A number of working groups, with sub-committees were established at national level to examine various strands. The nominated chairs of the groups were advised through Department of Health and appointed by the Minister of Health with NOSP inviting and adding nominees to the various working groups. So although the Government minister appointed the chairs, the decision network was influenced through NOSP. It can therefore be argued that Government decides who to empower in the HSE and NOSP and those bodies decide who gets the strong voices on the important working and steering committees. The

appointment of working groups was outlined by an interviewee from the statutory sector who, in response to the question, "How did you decide membership of the oversight group and the five sub-groups?" described the following process, "Well senior advisors went into the department DOH) and said, well who would be helpful?. The advisor had the chairs of the five working groups whom they picked and they were able" (Interviewee 13).

Another observation from interview data is that there were different tones to the dialogue relating to the different sectors involved. In an examination of the interviewee transcripts it was noted how C&V respondents tended to use phrases such as *'I guess'* whereas in the statutory sector "We decided ourselves", was often noted in relation to the decision process and designing strategy. This contrasted with the research sector who advised "*let's have them on board now"*. In conclusion, it is the view of this thesis that it is the HSE and its NOSP office, empowered by Government and advised by the academic and research sector, who actually decides the formation of Suicide prevention strategy in Ireland. This was corroborated by one participant from the research sector who stated: "And then they said one thing to resolve this is, we should already have gotten one or two representatives of the [particular sector] on board here as early as possible, but let's have them on board now" (Interviewee 2).

Thus the advisory tone is evident in the reflection of the respondent describing a contribution to the decision process. There was clarity in the perspective of a respondent (interviewee 13) from the statutory sector who outlined the decision process as follows:

> Well we decided ourselves. In our own discussions and the discussions with the department of health, we decided A, that there was need for a new strategy, and it needed to be written a bit differently and developed a bit differently than Reach Out. We decided on a collaborative approach". (Interviewee 13)

The description above clarifies how decisions were made about the establishment of the working groups as stated by a statutory sector participant,

So we set up a number of working groups. One that looked at policy. One that looked at practice. One that looked at engaging with the community and taking advice and listening to people. One that looked at clinical practice. One was about communications. There were five working groups. (Interviewee 13)

As stated previously there is evidence that policy process has developed with measures actively implemented to improve the participative and consultative methods of engagement between the statutory and C&V sector. One participant responding to my question about who decides strategy said:

Well I don't really know about that. I mean NOSP was the main leader, I think. The original had run its course. Of course, we were coming into this at a time when money was very short, second round. So NOSP really were the leaders, and they chose who was to be involved. Very selectively. But it seemed to be, we'll say, a bit more democratic perhaps than the previous one, so I think was more inclusive (Interviewee 8)

This comment is significant in articulating the perception that certain individuals, organisations, government departments, policy experts and academics were targeted for inclusion, based on a decision process as articulated above. If this is the case then there are advantages and disadvantages to the policy process. One advantage is the inclusion of those considered knowledgeable, experienced and valuable to policy making. The targeting process is expedient, saves time and resources, thus allowing for pragmatic and decisive recruitment to the policy process. A primary disadvantage is the possible development of elite policy networks, coalitions of policy experts and entrepreneurs, with the potential to exclude alternative views or dissenting voices.

Decision Making and Policy Making

For the purposes of this discussion this study refers to strategy, as policy with action points, and in this case strategy is arrived at on a number of levels:

- Local

- National
- Government.

The strategy from a Government perspective is informed by the recommendations received from the offices and agencies that they have tasked with this matter. In the case of suicide prevention Connecting for Life, the strategy was tasked to the NOSP who directed the planning of the working groups and steering committee. The Department of Health had overall control prior to presentation to Government and cabinet level where it was strongly endorsed by the then Taoiseach who insisted on a whole of government buy-in to all of the recommendations. The strategy was formulated by the office of the NOSP following the consultative process whereby open submissions were received from any interested parties, the work of the working groups both at a national and local level was compiled and the views of the various sectors who were represented were considered. The contribution of the academic and research sector has been discussed previously and the evidence impacted and offered an authoritative base to the discussions at the working groups. This sector provided the empirical evidence of what works in other jurisdictions, as informed by the WHO guidelines and as one participant from an academic setting describes, "We wanted to follow the just published WHO guidelines, because we said there's an opportunity now." (Interviewee 2)

The Community and Voluntary sector also had input into the policy process, but it would appear that this was less than their statutory counterparts and probably not as much as the respondents would have liked. The study acknowledges that it is impossible to have all groups considered and their input taken on board. Representative processes were used, the disadvantages of this process being discussed in this chapter. This was particularly reflected by one C&V representative, who described the consultative process as follows:

> My experience of that process was, as somebody who's facilitated discussions and strategy before, it felt to me that it wasn't sufficiently targeted, because it involved people who were on the very ground level who had experienced suicide, or family members experiencing suicide, right the way through to those of us who are involved actively on the ground regularly frequently in the suicide prevention. (Interviewee 9)

There are difficulties with the use of representative groups, due to possible conflicts of interest if the same organisations may be in competition for resources. The model utilised was discussed further by a statutory sector respondent who said:

> If they were coming from the community and voluntary system, they were clearly there representing a number of groups, not just themselves. So for instance when we had somebody from youth organisations sitting around, the deal was that that person had to link out with all the youth organisations. Because you couldn't have everybody sitting around. So we went to the community health fora, which is a network of community and voluntary organisations at local level. So we've had representation from them. (Interviewee 4)

It therefore appears that representatives from the C&V must clearly define their role, in order to avoid claims of a conflict of interest. They need to decide if they are representative of an organisation or advocacy planners. Such a role is essentially a facilitator designated as responsible to either catalyse the participation of underrepresented stakeholders and inarticulate actors. In this instance such advocacy clearly assumes the role of directly representing the interests of others not invited to the table.

Parity of esteem between the C&V sector and statutory agencies has been discussed in the previous chapter, which also discussed parity within the third sector, between larger national/regional and smaller organisations. This is a prevalent issue, regularly reported through anecdotal and informal evidence discussed by C&V groups in the suicide prevention sectors over the years. Interviews with respondents from the local/smaller C&V organisations reveal a perception of lack of parity with the other sectors as evidenced from the response of respondents. For example, one participant stated:

> When you've got the people who are in control of the policy formation who hold a particular view, and come from an establishment type of approach, and a very established establishment approach, then it's very difficult to get information to that

table. Because it's almost like poo-pooed because you're not the expert. And people's individual expertise is not recognised. Expertise in themselves is not recognised as valid when you have professionals (Interviewee 11).

The comment above underlines the perception of a number of respondents about the validity of evidence based on the experience of the C&V sector in policy formation and raises other key themes in the study; namely what influences policy content and what constitutes valid evidence in strategy planning.

As stated previously, there are indications that improvements have been made to the process of making strategy. Numerous participants reflected on the improved use of evidence, the influences from a global network of research and increased participation by C&V and other groups of knowledge experts. This was discussed by one interviewee from the academic sector who concluded, "When I look at the recommendations and learnings from the point of view of WHO, a very important key point, and I think that was done a lot better with Connecting for Life than with Reach Out is, getting your key stakeholders as soon as possible, but together with one or two experts in policy development" (Interviewee 2)

 The cross-sectoral relationships, consultative processes and collaborative approaches to suicide strategy formation were juxtaposed to the global strategic planning by the World Health Organisation (WHO) by one respondent with knowledge of international policy planning. She described feeling "genuinely very positive" (Interviewee 2) about the efforts of WHO, how the organisation strategically, under the leadership of Shekhar Saxena, mobilised all health ministries of WHO member states towards committing themselves to the global mental health action plan. This is cited as a positive example of networking aimed at attaining a reduction in global suicide rates by 10% by the year 2020. The reason for the success of this WHO strategy is the respect with which the organisation is held. The interviewee stated his/her surprise in the change of direction in policy development which she felt was driven by the international clout of the WHO. She stated that: "Nobody would have expected what happened (the commitment) and that's obviously because you have a very great respect for WHO. Surprisingly all health ministers of all countries signed that document."
The example outlined above highlights the importance of clarity and networking, ensuring

that resources and planning are committed to the negotiation stage in attaining collaboration and sign up of all departments and essential stakeholders. This is discussed by one academic who stated that, "…the sequencing of policy and the connectedness between policies is obviously very key, so you need policy, but you need strategic planning. And obviously what is also key, you need the enforcement" (Interviewee 2).

An important feature in the formation of suicide prevention strategy is the planning for sufficient resources to ensure the realisation and implementation by those organisations and departments who signed up and were tasked with the administration and delivery of specific actions. This is an important recommendation for future reviews, to advocate for the creation of an authority with powers to ensure that strategy is ratified and endorsed across Ireland. One interviewee, for instance, acknowledged that, "the evidence seemed to say that what you need is a multi-layered strategy at national level, coupled with local implementation plans, and they need to be locally based, with local ownership and all the rest. So you have the national policy, you've regional and local" (Interviewee 4).

The need for some level of monitoring and enforcement was discussed by two respondents, and a greater number (5) acknowledged uncertainty about implementation and meeting outcomes/strategic actions in the strategy. For instance, one respondent from the statutory sector wondered if the implementation was not being monitored and enforced - "Yes I mean Connecting for Life is a whole of government, a whole of society approach. That's very clear. But how that actually translates remains to be seen?" (Interviewee 5).

This was significant because the strategy is predicated on strategic actions being implemented by other government departments, official bodies and C&V strategic partners. There appears to be a gap in the implementation plan, namely about how to enforce or hold other statutory sector departments and agencies to account for the commitments they signed up to at the launch of Connecting for Life.

Participants' Considerations on Who decides who to fund? Resources and Relationships

The issue of funding was not a focus of the study but it was addressed in earlier chapters discussing the context of suicide prevention in Ireland. Resources and funding, however, clearly emerged as a theme of concern for a number of participants in the study. Resourcing

suicide prevention projects in Ireland must consider funding for various parts of the sector or sub-sectors, including:

- o Local Community and Voluntary sub-sector
- o Regional and National Community and Voluntary groups.
- o Research Sector
- o HSE and its offices and agencies

Each of the above are funded from a variety of sources to implement their plans and activities accordingly. This study has already referred to the relationship between resources, power and competition. In this context, the statutory sector is perceived as purse holder and thus in a position of power. Organisations within the C&V sector describe competing against each other for positions and relationships with funders in order to strategically strengthen the position of their own organisation. As one participant in the statutory sector succinctly stated, "He who pays the piper plays the tune" (Interview 13).

Larragy (2014) offers an examination of the community and voluntary pillar in Irish social partnership structures and discusses the role and complexity of the social partnership approach in negotiation across a range of social policy contexts. Whilst acknowledging the effectiveness and success of the social partnership approaches, Larragy refers to scepticism concerning the representativeness of national groups and their mandate to represent and speak for those interest groups and communities not at the table. O'Cinnéide, cited in Larragy, describes the "danger of unaccountable and self-serving groups overriding democratically accountable institutions" (2014, p 11). Moreover, this is considered by Larragy as a distraction for such community and voluntary organisations who are discouraged from criticising government policy and strategy given the strategic positioning required to ensure funding. An additional factor is that some of the representative C&V organisations at national and local level may be compromised if they are competing for funding against those very groups they are representing at the negotiation and consultative table. In some instances, groups successful in attaining funding under Connecting for Life may then be required to work with those groups who did not receive financial support under the same funding stream.

The smaller, generally more local community and voluntary organisations and groups are funded through a range of sources, including:

- o Local fundraising activities including events and donations.

- o Grants from local councils and development partnerships
- o Grants from local HSE offices
- o Grants from national HSE offices including NOSP
- o Other charitable, EU and philanthropic awarding bodies

Not all organisations are funded by all these methods. Some may have access to all five strands of funding above but many, particularly the smaller ones, have only access to one or two of them. Fundraising is a time-consuming business and many local smaller groups lack the personnel and resources to prioritise this task.

The larger C&V national organisations, with staff and more advanced structures can afford a dedicated fund-raising department and thus the competitive nature of resources can be difficult for all concerned. This is particularly so during times of austerity, which can adversely affect the C&V sector directly. In this regard, in examining the responses from the interview participants, various factors emerge regarding resources. This includes being known to funders, having a proven track record, meeting certain conditions and also having a relationship or profile across the sector. This was explained by a respondent who stated "Because who funds who? You know so the HSE would potentially give the C and V, and they choose who they are going to fund. And who knows what those choices are made on" (Interviewee 5).

An additional theme emerged for a number of participants about the role of public pressure or lobbying and its link to the allocation of resources. One respondent from the academic sector described resource and funding allocation, during the tenure of the 'Reach Out' strategy (2005-2014), as follows: "I would think it seemed to be whoever shouted loudest got the funding at the time. Whoever was the best at lobbying. Whoever you know had connections. Yeah. It certainly seemed like that, you know" (Interviewee 3).

Reviewing suicide prevention strategy, during times of austerity, can have an impact on the policy process, necessitating a creative and pragmatic decision process by NOSP as managers of the process. The decisions affect funding for the implementation and delivery of, in this instance, the suicide prevention strategy. For one respondent, this was a significant issue affecting implementation. She stated *"So there was no additional funding. There's no funding attached to Connecting for Life. There's no pot of funding that comes with it, except what the partners around the table can commit from their own funds that I am aware of. There definitely isn't. There's been no call for funding around it"* (Interviewee 14). As a

consequence, the competitive dynamic regarding resources can become problematic affecting the relationships within and across C&V and statutory agencies. Some C&V organisations receive grant funding from national HSE offices including NOSP and, unlike the smaller C&V's, they often have the resource capacity to actually prepare the funding applications. This was discussed by one respondent from the statutory sector who describes the process as follows:

> NOSP did this at the back end of last year (2016), developed their own template, and have been funding most of the NGOs in the suicide prevention space… NOSP traditionally has funded national organisations or organisations of a national reach, or innovative programs that have potential to be scaled up, nailed their colours and if they want to fund local services locally out in the HSE, that's their business (Interviewee 13).

The HSE and its agencies and offices including NOSP are state funded via the Department of Health's budget for Mental Health which comes from the overall National budget. This sometimes can be reduced or re-allocated in times of scarcity of funds, as one representative from the political sector (Interviewee 6) stated: "Then you have this debacle of 30 million additional funding per year for a number of years to go into the mental health areas specifically. But yet when there was a financial calamity in the HSE broadly, that was the first account to be raided." This reflects some of perceptions that mental health is considered the Cinderella of the health sector, receiving less funding than other areas of the health budget, a theme addressed elsewhere in this study.

The theme of resourcing and funding suicide prevention has been contentious for many years, with some expressing the view that mental health services are the poor relation in health services priority and suicide prevention a lower priority again. It was interesting to note the range of views about resourcing decisions, which varied depending on the sector from which interviewees were drawn.

Respondents from the political sphere expressed clear views about funding decisions with one commenting:

I doubt there's a sufficient one [funding procedures], because of the resources that are available to them. I mean the National Office for Suicide Prevention is located from an infrastructure perspective within the bowels of the HSE. It's subservient to their overall budgetary constraints. And when there are additional moneys made available, it's probably gone up 4 or 5 million over the last number of years; it's still down on the pitiful 12, 15 million at most. Whereas my view on it is, if you want to start solving this, I think it was 80 or 90 million is where I felt it needed to be. (Interviewee 6)

Another political sector respondent described their experience of constituency lobbying and advocacy, stating:

The only thing I can do is, if an organisation came to me and they weren't getting the funding they thought they needed, I can only do two things. One is ask parliamentary questions and write in to the minister to try and put pressure on that way. And the second, really your strongest thing you can do is probably bring them into the AV room here, and try and create a bit of hu-ha around it. Basically you're needing publicity to put pressure on to the minister. It's external pressure. There's no internal avenues. (Interviewee 7)

The comments above reflect the view, expressed across the suicide prevention sectors in Ireland, that the funding structures appear nebulous, vague and unformulated. It appears that through proximity to HSE/NOSP, national or high profile organisations are able to leverage funding, but for some the structures and transparency of the funding protocols appear unclear, leading to a perception, possibly a false assumption, that decision making is selective, subjective and somewhat ad-hoc in awarding resources. Indeed another political representative described this as follows:

The only thing I find is, because the HSE relies on voluntary organisations so much, it becomes very ad hoc. Like just taking it back to my own area, in [location], there are two, and a third one starting up, good organisations that you can just talk to. But you could have another area where there mightn't be any. So the services become very ad hoc

that way. And the HSE doesn't seem to be saying well, there are services in [location], we'll support them. There's none in [location], so we'll try and get them set up. Instead it's kind of, the organisations go to the HSE looking for money, and the HSE kind of give you the money based on requests. So it's kind of demand led instead of need led, and that's, I think, a major problem now with the HSE at the moment (Interviewee 6).

The experience of tolerance of the C&V sector is elaborated as follows:

My feeling, and it's personal, is that the voluntary organisations have been tolerated. I don't think there is a willingness or a desire to engage with the voluntary sectors. You know they're doing good work. Let them off. We'll give them a bit of funding. That's been my feeling. Yeah. I don't know how universal that will be."(Interviewee 3)

Participants' views on Changes to Funding and Resource Allocation

Thus far, I have focused on the suicide prevention context across Ireland from 1998 – 2015 and identified the impact of austerity and the economic downturn on delivery and funding across the sector. The landscape is changing in Ireland, with the increasing national profile of larger groups and services, such as Pieta House and Headstrong/Jigsaw. There is, thus, a changing profile for local/smaller C&V organisations who may struggle for funding

There appears to be a shift change occurring in how the statutory sector is managing the funding of suicide prevention and thus the implementation of the Connecting for Life strategy.
The management and governance structures are being reconfigured within the government departments and this will be an important theme in observing how suicide prevention and strategy are resourced in Ireland in the future. As stated by one respondent: "The role of NOSP in Connecting for Life has been very clearly defined. And the operational side of it, or any of the delivery systems, they are moving away from that. And that responsibility will move next year or the year after, back into the mental health division and to the operational services" (Interviewee, 13).

From the statutory sector perspective, it is evident that there needs to be knowledge of, and confidence in those C&V groups they are willing to fund. This is not surprising, given the high number of C&V organisations in Ireland. One respondent from the statutory sector, with knowledge of decision making in resourcing strategy describes an example as follows, "The funder gets stuff from some parts of the country, with one in today you know, where all the politicians are jumping up and down about why is this crowd not out and not getting money. The funder has no idea who they are and are not giving them money if they know nothing about them" (Interviewee 13).

Those interviewed from the statutory sector also described changes to the funding protocols from 2016. At this time the NOSP developed templates for the funding of the NGOs in the suicide prevention sector with whom they had partnership agreements. The organisations linked their strategic goals to the actions and objectives of Connecting for Life, articulating the projected delivery and preparing bids for funding accordingly. This suggests that the allocation of resources was targeted by the statutory agencies to those organisations considered most appropriate to meet specific needs and actions associated with the new strategy.

The organisations were already known and involved in strategy planning, resulting in a perception by others that resource allocation can involve subjective decisions and a somewhat closed market. One participant from the statutory sector noted that this was a perception that they would like to change. "I'd like to turn that around completely next year and say, here are three things we'd like you to deliver on, and with some kind of quality assurance behind that. One of the actions is that programs in mental health promotion will be delivered right out in the community and specific groups" (Interviewee 4).

This is further discussed below by the same respondent who described surprise that organisations will remain connected to the activities in suicide prevention despite funding restrictions. This was summarised by a respondent from the statutory sector as follows, "I'm amazed sometimes at the organisations that stay in good contact, even though you're saying to them you've no funding". The resilience of those organisations that continue to offer voluntary activities, in spite of funding restrictions is evident. Funding procedures appear unclear and not transparent, for some respondents from the C&V sector. The funding environment has changed due to austerity and the distribution of resources is being tightly

managed and clearly aligned to meeting objectives/actions contained in the Connecting for Life strategy.

This can have an impact on reshaping the suicide prevention context as the competitive process and decisions made by NOSP/HSE favour national or larger groups, thus excluding the smaller more local community organisations. This was articulated by one interviewee, who said:

> The problem, of course, as well as the local organisations, is the fact that the bigger, huge national organisations have moved in to give local services. I think that's a pity in many ways you know. And how you weigh the two together and get the best and most efficient way of doing things, it's quite difficult. It's very sad, the fact that there's still so little money in all of it. Not that money is everything you know? (Interviewee 8)

The findings reveal that for smaller C&V organisations a great deal of time is spent cultivating cross-sectoral relationships in the hope of a positive result, either being consulted and heard in the policy process or being considered for funding as part of the implementation strategy. One respondent, commenting on the heavy and emotional labour associated with this said:

"We spent a huge amount of time and effort in building relationships. Because those relationships were built, the value of what we had to say was heard, and then we were invited to the table." This particular organisation described their contribution as "very limited" initially, with their expertise increasingly recognised as the series of consultations progressed. Invitations to the table increased and as a result this particular community organisation was invited to represent C&V on one of the national committees, the constitution of which they found "a little surprising (Interviewee 11).

The surprise noted by a number of respondents from the Community and Voluntary sector was due to the presence and participation in developing Connecting for Life by some representatives with limited involvement in suicide prevention activities in their usual service provisions. This was succinctly captured by another respondent who said:

…Rather than particularly focused on the area of suicide prevention. So while there's certain levels of expertise and certain groups that definitely needed to be at the table, there are others you are sort of wondering why they were at the table? Because you sort of think, well actually, what is their specific regular daily contribution to this area? It would seem that rather it was the norm to invite them, rather than necessarily they are actually rolling out on the ground service or on the ground policy or whatever around this area. (Interviewee 11)

This comment reflects the views of some regarding inclusion, exclusion, participation and consultation in policy process.

Implementation of Connecting for Life was not initially a central theme for this study, the aim being to examine cross-sectoral relationship and process in developing suicide prevention strategy. However, during the research process itself it became apparent that the application of Connecting for Life was a significant case at hand and thus an important point of reflection. The author of this study, as a Gestalt psychotherapist and teacher of mindfulness, has researched the process of change in therapeutic situations and work with high risk young people and families (Friel and Sweeney: 2017). The study of process aims to capture and articulate how relationship, rapport and interaction can create conditions for positive change. It is this curiosity that led to this current study of cross-sectoral relations and how they impact the policy making process.

It was to be expected that participants would discuss the implementation of the Connecting for Life strategy which was launched in 2015. However, the questions asked during interview (see appendix 7) prompted reflection about who participated in developing the strategy, how they were invited and by whom. This inevitably resulted in those being interviewed considering how the strategy was resourced, who made decisions about the roll out of plans and actions and how responsibility was allocated to certain groups and government departments. Implementation was therefore raised as a theme during interview and this is discussed below.

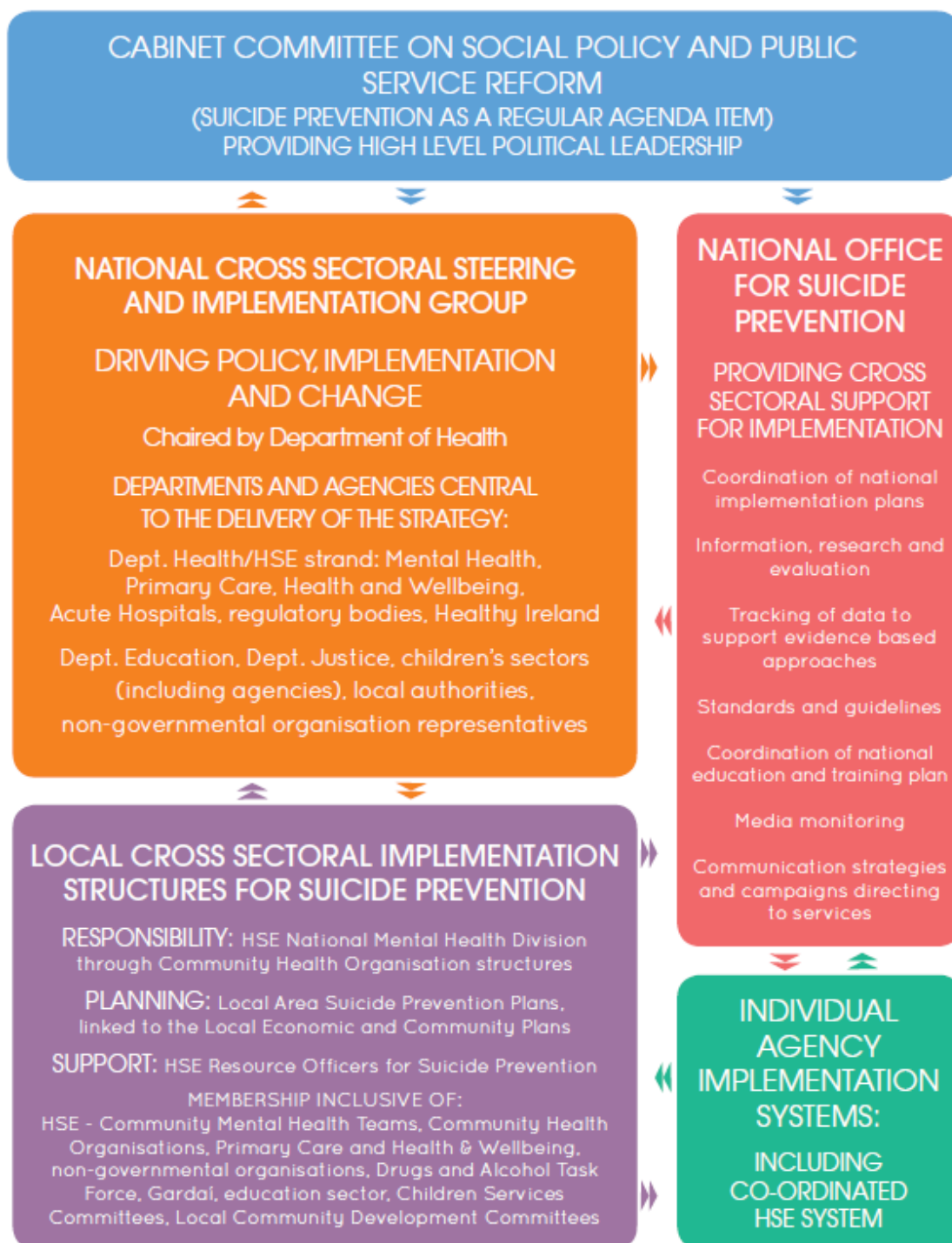## Implementation and Connecting for Life (2015-2020)

Implementation structures have been outlined in the Connecting for Life strategy and these are illustrated below. As a national plan it is described as a whole of government approach, indeed a whole of society strategy. To ensure that the goals and actions are delivered, strategy requires accountability, level of authoritative enforcement, co-operation and communication between all of the relevant stakeholders, strategic partners and statutory agencies. An implementation plan therefore needs to be part of the process, ensuring clarity of responsibility in achieving the objectives within each goal. The key structures identified by the strategy according to the actual Connecting for Life document are:

• Cabinet Committee on Social Policy and Public Service Reform – Suicide prevention as a regular agenda item

• National Cross-Sectoral Steering and Implementation Group – with representation from the health sector, government departments, agencies and NGOs

• The National Office for Suicide Prevention (NOSP) will provide cross-sectoral support for implementation

• Local Cross-Sectoral Implementation Structures – to produce local area plans and community-level response reflecting national actions

• Individual Agency Implementation Systems – Including a co-ordinated HSE system.

(Source: Connecting For Life 2015)

The document also states that the Cabinet Committee on Social Policy & Public Service Reform will monitor overall progress on implementation. For those from the statutory sector, implementation processes are clearly defined. As one participant stated "It's the national policy anyway. Like in terms of implementation, Connecting for Life has implementation structures included in it. And at the top of the tree is the Cabinet sub-committee on social policy. There is a cross-departmental steering group, chaired by the Department of Health that has met a number of times" (Interviewee 13). The schematic structures for Connecting for Life are designed in the strategy document and are illustrated below (source Connecting for Life; 2015 p. 55).

Figure 7.2 Schematic structure for Connecting for Life

The Connecting for Life strategy describes detailed implementation plans, as articulated by the authors of the document. It is important to state that interviews for this study commenced in October 2016 and concluded in August 2017 and therefore the intervening ten-month implementation period may have influenced the reflections and experiences of participants. Changes in personnel in NOSP and at the head of government (Fine Gael) are additional

factors to be considered in the discharge and realisation of the strategy, with the retirement of the then Taoiseach Enda Kenny in March 2017 and restructuring and changes in the National Office for Suicide Prevention. The strategy reflects the view that it is a whole of government approach and it is noteworthy to consider the impact of a change at different points in the implementation structures and subsequent effect on how the discharge of strategy is managed and enforced.

The role of the National Office for Suicide prevention NOSP changed somewhat because of the new strategy. Its brief is to monitor, evaluate and to report on progress. One statutory sector interviewee concludes that this role "is slow in happening" (Interviewee 13). By late 2017 NOSP completed more of a quantitative rather than qualitative assessment of the completed progress on actions by "asking all the government departments what have you done? Here are your actions, what's your progress? And NOSP were able to say that there's action on 96% of the actions" (Ibid.). The same interviewee concluded "You know, that people are up and doing what they said they would. And in some cases it's really good. From the perspective of the statutory sector and NOSP in particular, there appears to be confidence that the commitments made by government departments will be followed through" (Ibid.).

A number of respondents from C&V and state agencies articulated a degree of uncertainty and lack of clarity about implementation. In one example a respondent stated that implementation remains an issue, highlighting that "they (NOSP) certainly have made the connections and got the commitments" (Interviewee 5). For this interviewee they wondered if the commitments might or might not translate into policy. This participant also remained sceptical asking "Are they going to deliver on their actions? For example, the Department of Education and Skills have made a commitment to make sure that all the schools implement the wellbeing primary school and post-primary school guidelines. So the Department of Education have said that's going to happen. Will it?" (Ibid.)

This raised the question about enforcement, accountability and review as part of the implementation plan. The concern expressed by one person from the statutory sector includes the possibility that certain commitments will not be met, stating "you can have a commitment and they'll say they'll do it, but it seems to be okay not to do things" (Interviewee 5).

A number of respondents discussed the difference between the rhetoric and reality in the practice of implementation, from questions about how it was being managed, where the assigned leadership and responsibility lies and perceived gaps in accountability and enforcement. Some from the C&V, who were involved in developing national and local plans, were surprised when Connecting for Life was published, to discover that the majority of actions and programmes contained in the strategy were being rolled out by other statutory agencies and government departments. One, for example, stated. "I was talking to somebody and we were chatting, they said they had ten programmes to lead out. And I'm going where's the voluntary and community? And with that, I only realised, (in the last month really) that actually 80% of this has been delivered in-house [*statutory sector*]. I was like wow!! So I'm still quite shocked" (Interviewee 11).

As stated above the responsibility for implementing Connecting for Life lies in the statutory sector and a small number of interviewees expressed the view that commitments made by some government departments were the result of obligation, requiring them to identify as being co-partners in some of the delivery of actions contained in Connecting for Life. The view expressed by one person was "that it was more political, rather than a willingness or an ability to deliver" (Interviewee 14). For this respondent, implementation is being "knitted as it is going along, it's not something that's very strategic. We have this strategy, but how we're going to do it hasn't quite been worked out yet" (Interviewee 11). This interviewee also believes there is a gap between the implementation plan as stated in the strategy and the emerging practice, "So you've got the Connecting for Life, You've the beautiful book, and you've all the different boxes. So what I learned is they're winging it. They are winging it, you know. They've got this and they're winging it" (Interviewee 11).

It is the view of one participant from the academic sector that "implementation is where a lot of things fall down" (Interviewee 4). Thus there is a need to ensure the necessary resources and planning for delivery of strategy. He/she noted that "For every piece of work, a lot of thought has to go into it. How is it going to be implemented? What is the support needed to make sure implementation happens at an optimum level? And that attention to detail is not there" (Interviewee 4)

In summary, whilst there is an implementation plan there appears to be differences between respondents and a degree of scepticism from some of the interview respondents about how successful that actual implementation is and will be. It is the view of some participants that

implementation has not been well thought out. There is limited evidence of accountability by the departments and state agencies tasked with certain actions. Enforcement by NOSP is clearer and straightforward when they are funding, mostly national C&V organisations to deliver certain aspects of the Connecting for Life strategy. Resources are directly linked to certain actions and outcomes, thus there is a more transparent and accountable process involved.

Conclusion

The two ends of the continuum in the policy process are captured in the findings of this chapter. Firstly the planning phase and secondly implementation. It is evident that both stages require a considered and well-structured set of protocols or procedures to ensure success at the initiation and application or implementation stage of the policy process. Indeed, they have in common the need for clarity in planning, consultation and participation. The communicative approach to planning identified by Healey (1992) assumes the importance of public participation. This is also implied in the communicative model which demands argument, discourse and dialogue (Hillier, 1993; Healey, 1996) alongside widening the scope and range of actors whose views are considered as legitimate in planning (Hillier, 1995). In this study, the discussion includes planning decisions regarding who gets to the table, how resources are decided, who/what influences strategy content/actions and how implementation is to be managed and enforced.

It is evident that there have been substantive improvements to the policy process, those involved in the review of Reach Out and development of Connecting for Life have made strident efforts to improve levels of participation. The planning and development of suicide prevention strategy has learned much from WHO, UN and neighbouring jurisdictions, notably Scotland.

Gaps and areas for attention have been identified by respondents and these have been discussed above. Priority themes include establishing planning procedures and protocols, particularly ensuring transparency around cross-sectoral participation, concerned negotiation, bargaining and debate (Dryzek, 1990; Giddens, 1994) in the consultation process. This is aimed at addressing the perceived tokenism and placation, as described by some interviewees. This chapter asserts that there is potential to improve upon the progress already made in Ireland's national efforts to address suicide by considering the very processes

through which strategies are made. This includes paying attention to, firstly the process involved in decisions about who gets to decide strategy; and secondly, to create a plan, with resources and authority, to implement and continuously review the national suicide prevention strategy for Ireland.

Connecting for Life states it is a whole of government approach, to a whole of society problem. The suicide prevention context is a diverse and cross-sectoral gathering of local, regional and national organisations. The sector engages in suicide prevention, intervention and postvention activities across urban and rural geographic locations. Policy is a cycle of making-implementing-reviewing in a continuous way. The diversity within the sectors offers a uniquely varied perspective. Planning policy requires an assurance for procedures including, communication, engagement, consultation and cross-sectoral collaboration that are enshrined in meaningful discourse. Meaningful engagement with stakeholders supports that ultimate aim to organise 'attention to the possibilities for action' (Forester 1989, p. 19) aimed at preventing suicide in Ireland. Given the evidence in this chapter it is clear that a focus on the very process of policy process in this area will only improve future planning for strategies and policies aimed at reducing suicide rates in Ireland.

Chapter 8: Conclusion and Recommendations

Introduction

This chapter offers the conclusions and recommendations of this thesis emerging from document analysis and fieldwork interviews carried out across eight counties in Ireland (ROI). The interviews were conducted with statutory and C&V participants (N=16) about their subjective experience in the policy process. The investigation question was, do relationships between the community, voluntary and statutory sectors impact on the process of developing suicide prevention policy in Ireland? An examination of national and international policy documents articulated influences on suicide prevention strategy from an international context and considered how global suicidology informs the evidence base for strategy. In addition, a desk-based review of relevant literature and research informed the understanding of the structure and systems in which suicide prevention strategy is developed in Ireland.

The findings of the interview data (N=16) was presented and discussed in the previous two chapters, articulating emerging themes from participants' responses to questions. This concluding chapter distils the discussion, to consider if the theory and empirical findings corroborate the research question, namely if relationships between the community, voluntary and statutory sectors impact on the process of developing suicide prevention policy in Ireland. Recommendations arising from the data are presented and areas for future study are outlined in suicide prevention policy development in Ireland. The chapter is presented in the following format:

- Structures and Systems: Impact on policy process
- Engagement processes: Consultation and participation
- The impact of Power on Policy Process
- Recommendations for Future Strategy
- Areas for Future Research
- Contributions to Knowledge

Structures and Systems: Impact on Policy Process

The context of Ireland's suicide prevention policy process was examined in chapters 1-5, outlining the systemic and sectoral structures in which strategy is developed. The critical

review portrayed the dynamic between and articulated the distinctiveness of the statutory and C&V as the primary suicide prevention sectors. The review also revealed the complex characteristics of the suicide prevention context in Ireland. The C&V sector comprises up to 350 (IAS, 2012) suicide prevention, intervention and postvention organisations in Ireland. It is a loosely structured sector, some parts are weakly systemized and unregulated and it is a disparate sector comprising many parts. The analysis also indicated a C&V sector that is eclectic, diverse and responsive, operating against a backdrop of reduced resources and limited capacity, but with high levels of commitment in a competitive and difficult context. Standards and accreditation within the C&V sector was raised as an emerging theme and as an explanation for the perceived mistrust of the credibility of some sections of the community and voluntary sector by the statutory sector.

Statutory Sector

The statutory sector comprises of government, its departments, statutory agencies and their offices as the official bodies representing state activity in policy process. In the case of suicide prevention, the statutory agencies are DOH, HSE and its office NOSP which manage the development and implementation of suicide prevention strategy. The statutory sector is portrayed as tightly structured, highly regulated, stratified and standardised. It includes a number of layers or tiers as discussed in the previous findings chapter. The structures and systems in which the strategy is developed is of fundamental importance to the success of policy planning and implementation and has an impact on the policy making process in a number of ways.

A stated aim of official strategy is a whole of government approach to suicide prevention and therefore the political landscape and role of the political parties and political process also has a profound impact on the planning and successful implementation of strategy. The interaction between the state and stakeholders, in this case the suicide prevention sector, is a significant feature in this study. Interviews revealed that whilst there was a government commitment to the development of Connecting for Life, this did not result in a whole of Oireachtas approach which, given concerns which were raised by many interviewees, would have been preferable. The whole of Oireachtas broadens the perspective on consultation and implementation in suicide prevention beyond party politics and includes all representatives such as constituency spokespersons.

It is evident from the interviews, that the structure and system in which suicide prevention process takes place has a significant effect on the ability of stakeholders to impact policy change. Previous chapters discussed theoretical considerations about how the state manages policy process and how open or closed the political systems may be. Discussed elsewhere in the study, Hajer and Wagenaar (2003) argue that policy process, if it is to be successful, must be more deliberative and less top-down in approach. They outlined the need for an expanse of networks to be considered, with an account of a wider range of stories, values and beliefs. The findings of interviews corroborate theoretical considerations, such as the need to include a range of policy actors in the process (Buse et al., 2005). Moreover, the importance of policy context and political factors and the impact on participation in policy planning is also critical (Keck and Sikkink, 1998).

The literature and interviews reveal the complexity of the policy process and context in which suicide prevention strategy is devised. It is, therefore, important to take account of sectoral structures, systems and dynamics in planning and developing strategy, noting how the distinctiveness of each sector impacts on the policy making process. Whole of government does not necessarily result in a whole of Oireachtas approach to strategy as the current system does not involve consultation across all political representatives in the Dáil. This is a noted gap in consultation, in planning, implementing and reviewing strategy. The topic of suicide is a whole of society concern and as such, political representatives across all parties could be invited to contribute to the strategy to represent all constituent groups, a large number of which may be otherwise unrepresented in the process.

Resources

A new set of structures and systems was established linked to the implementation of Connecting for Life (2015-2020) and the responsibilities for the activities in the strategy. This included involving a range of government departments and securing commitment and buy-in from specific state offices to deliver actions associated with the strategy. A central feature of this new structure was the management of resources.

Access to resources is predicated on strategic partners (C&V) being commissioned to deliver actions on behalf of the statutory sector. It therefore follows that practice by C&V organisations becomes defined and determined by the direction and outcomes in strategy. The combination of the existing structural and systemic factors, associated with the new regime

for delivering strategy has created even greater degrees of competition than already existed for the C&V. The sector has experienced austerity and economic downturn, creating a perfect storm or funnel of factors, increased austerity, reduced funding, increased levels of personal distress and thus higher demand for services. This combination of elements presented challenges and raised themes for interviewees about the impact of the structure and systems on services and organisations' ability to meet demand within the new structures.

Interviewees raised additional concerns arising from the structural and systemic changes, including parity of esteem, not just between C&V and statutory sectors but also within the C&V sector itself where access to limited resources can be impossible for unrepresented groups and those not part of the political negotiation or policy elite.

Cross-sectoral relationships in policy process, as the focus of this study, have witnessed significant changes through the establishment of strategic partnership approaches to delivery of actions and objectives to reduce suicide in Ireland; the success of the approach in the Connecting for Life strategy is yet to be determined.

There has been a systemic change to the policy making process, reflective of a number of factors. As stated, there exists in Ireland a strong third sector, a C&V suicide prevention sector comprising of a number of sections. There are those organisations in already established strategic partnerships with government (DOH/NOSP) to deliver parts of the national strategy. There are also many smaller C&V, non-funded organisations, also delivering significant aspects of the actions associated with Connecting for Life. Some of these smaller organisations are deliberately aligned to actions/outcomes in the strategy or not aligned but responding to local and arising need.

In creating a new system and procedures linked to strategy, the political structures and agents of government (Government Departments and HSE) have the capacity to negatively or positively impact the level of participation in policy process. In theory, these new governance and structural systems create a different and new arrangement to replace the traditional bureaucratic order. Considine however, argues that changes in structure and the creation of new market innovations, with supply contracts, lead to a "fragmentation of services and multiplication of the actors involved in their delivery" (2005, p. 165). The findings revealed that austerity, the new structures and funding protocols have inadvertently led to increased competition amongst C&V groups. The result can be increased reification of

the sector, dominance of larger service providers, with a decrease in collaboration due to increased competition. Funding and resourcing strategy is fundamental to success and budgets should be independent of other departmental resources and ring-fenced for suicide prevention spending only. Strategic partners committed to aspects of the suicide preventions strategy should be resourced for the duration of the strategy's lifespan, subject to monitoring and evaluation for transparency and accountability. There is also an opportunity for a review of how the new structures and systems directly impact funding streams in suicide prevention. It is useful to examine the procedures and protocols associated with the commissioning of C&V groups to deliver actions contained in strategy. This could take account of representativeness and advocacy by elite groups in the C&V sector and the role of gatekeeper organisations, an important feature of policy process linked to resourcing.

Findings reveal that the statutory sector is perceived as bureaucratic and slow to embrace change in policy planning, government departments are experienced as somewhat resistant to changing practice. This is evident in the study of suicide prevention and it is useful to identify and explain this as the concept of resistance. I draw a distinction between reluctance, which is somewhat passive and ambivalent to change and resistance, which is actively working to prevent or stop change (Egan, 2009).

Interviews and the analysis of policy documents from 1998-2015 reveal that there have been substantive improvements in the consultative process associated with the development of suicide prevention strategy. In spite of changes that were implemented to improve participation in policy planning, the outcome of this study indicates a statutory sector with systems and structures that can inhibit policy process improvements. The structures within the state systems appear rigid with bureaucratic regimes that appear slow to engage with new processes or expediency in planning and implementation of policy. Resistance to change is part of the exercise of power, according to Foucault (cited in Kendall and Wickham, 1999). This is addressed below in a greater detailed examination of the impact of power in policy process.

The evidence from the document and interview data indicate limited and slow levels of investment to the actions contained in the Connecting for Life strategy at departmental level within the statutory sector. Because of the economic downturn in 2008, government departments have been subject to budgetary constraints. Departments have specific portfolios and responsibilities, such as Education, or Justice and have many competing agendas and

priority issues. These competing demands are in addition to the actions/outputs associated with suicide prevention strategy. These are structural and systemic factors that can impact on policy making and implementation across the statutory sector and are an important consideration in policy process.

Establishing improved cross-departmental communication strategies, identifying specific achievable targets and timescales are important in such a complex area and against competing agendas and issues. In developing strategy, it is essential to outline a model with clear methods and systems for successful evaluation of achievements, of outcomes/actions associated with strategy and to devise plans accordingly.

The findings also suggest that it would be beneficial to consider developing an authority body or research department to evaluate the implementation of strategy and review delivery of actions and commitments by varying government departments and agencies. The outcomes of strategy could be improved by the introduction of monitoring programmes, with associated powers for ensuring effective implementation and evaluation of current and potential strategy outputs by both the state agencies and strategic partners from C&V sector.

The statutory sector, comprising government structures, departments (DOH), agency (HSE) and offices (NOSP) are responsible and endowed with the authority, powers and governance to manage suicide prevention strategy on behalf of the nation. Whilst it is considered that the statutory sector is the most appropriate to manage policy process, the role requires a partnership approach with multiple stakeholders, including C&V and those impacted by suicide. There is a high level of policy expertise from national research and academic institutions, evidence and guidelines available through international networks, including the World Health Organisation (WHO). Suicide prevention planning process has benefitted from a global knowledge exchange and can continue to be influenced and informed by academic expertise. The research outputs produced by national academic and research institutions, such as NSRF, inform the evidence and are an invaluable resource in reviewing and developing future strategy. The investment in evaluation and continuous review of statutory and C&V practice would improve the evidence base for future strategy. Inclusive approaches that ensure a wide range of stakeholder involvement would increase the participatory process and inform future strategy development.

The context in which strategy is developed is an essential variable, based on the premise of the developmental model of participation (Jones, 1996). This asserts that communities are important to the solution of a problem, in this instance suicide. The findings of this study indicate that local, smaller community-based organisations are vulnerable in the current and proposed structures and systems. This is due to a number of factors, including governance and standards within some smaller organisations, lack of funding and not having resources and capacity to compete with large C&V organisation.

There is, therefore, a threat to the smaller C&V sector and the interview findings reveal that this sub-section of C&V contributes much to local suicide prevention. It is therefore incumbent on the architects of strategy to take account of the narrative and qualitative, small scale and community-based experiences of stakeholders in policy planning, implementation and review. Inclusive policy processes increase the understanding of explicit and implicit dynamics embedded in policy-making in Ireland. This is essential to improve knowledge in planning content, implementation and outcomes in strategy, with improved awareness of the broad influences and factors that shape policy formation.

As stated previously, there have been substantive improvements to the engagement and consultation methods employed in policy process in recent years. The findings reveal that, in spite of positive developments, there are gaps and the policy process requires a precise, clear model for planning and developing suicide prevention strategy. It is also evident that policy planning is a process of continuous modification, amendment and review of the progress already made. Better definition in engagement and consultation methods with stakeholders, alongside ongoing review, will offer a more robust, distinct and well-defined method for effective participation.

The context and social structure in Ireland, in which the study was carried out has been described and previous chapters have examined the development of the social policy systems and structures. David Donnison (1962), from the London School of Economics, stated: "Social services are not an unproductive frill tacked on to the economy as a charitable afterthought, they are an integral and necessary part of our economic and social structure" (cited in Brown, 1983, p. 8). Improving social services provision for suicide prevention in Ireland must recognise that the strategy cannot be studied in a vacuum, but is understood in the context of the political, governmental and social structures in Ireland, a process massively assisted by academic research in the social sciences.

The systemic and structural factors described above can lead to rigidity and a set way of doing things, embedded in predetermined functions that can miss alternative or dissenting voices. Past successes and current strategy informs future development, this being linked to the essential evaluative and review processes in the policy cycle. Lasswell (1956) described "knowledge *of* and knowledge i*n*" policy making, thus review and evaluation is a continuous part of the process. Literature and interviews reveal a range of decision networks as outlined by Lasswell, including intelligence gathering and assessment; recommendations at varying points in the process; prescription about content; actions and objectives in strategy; invocation and implementation decisions; application; appraisal and termination in policy process.

Engagement Processes: Consultation and Participation

Having examined the research question, findings would support the conclusion that relationships between the C&V and statutory sectors do have an impact on the suicide prevention policy process. There have been significant efforts to improve participation in the policy process between statutory, C&V and other stakeholders, a precedent set in the Connecting for Life strategy through the establishment of the engagement mechanisms. The establishment of thematic sub-groups at national and local level was indicative of innovative planning procedures being used for Connecting for Life in 2015. With a specified engagement sub-group as a theme, this created a new pattern and model in suicide prevention policy process mechanisms in Ireland.

Foucault considered power as coming from discourse (1991) and accordingly, talk of participation, results in it becoming the new orthodoxy, the world-view changed as a result of discourse. There has been much discussion about participation in policy process. It is a complex subject, with many meanings and definitions. The concept of participation in suicide prevention ranges from direct and creative work in the community to representative work on committees to fulfil government policy agenda.

The findings indicate that those from C&V who were directly involved, those at the table in policy process, felt improved communication with statutory representatives to the policy process. However, there were identified gaps, namely the unrepresented stakeholders and smaller organisations. Some participants perceived the policy process as limited, not widely communicated to smaller groups. For example, two participants were unaware that

consultations were taking place. This reveals a number of structural and systemic gaps perhaps related to the fact that there is no national database of the C&V suicide prevention sector, consultation mechanisms may be limited and newspaper advertisements may not be seen by those the process wishes to target. In addition, reviewing the methods of communicating the consultative process would benefit through a widening of the range and number of representations across the geographic and practice area.

Findings from literature and policy analysis reveal limited discussion models of consultation utilised in suicide prevention policy process. It is therefore difficult to assess, review or measure the efficacy of the consultation method used in policy planning. Through the introduction of planning models there is an opportunity for evaluation and as a consequence the potential to improve the engagement mechanisms for future strategy development.

The responses of participants in interviews revealed that the practice of consultation has a direct impact on the level of participation by the C&V sector in the development of suicide prevention strategy in Ireland. From 1998, when the National Task Force on Suicide published its report, to 2015 when Connecting for Life was published, there has been improved investment in public participation. Formal consultative processes developed in the intervening years, with a range of consultation methods being outlined and utilised when the current strategy was being developed. Irish policy making was influenced by international interest in public participation processes, with some arguing that the past 25 years has witnessed a growth of a consultation industry in the fields of public services and policy (Brickell, 2000; Beck and Purcell, 2010). Brickell argues that a negative consequence of the move toward consultation was that it has diverted people away from activity in the community (2000).

Moreover, the effectiveness of a participation strategy is determined by the efficacy of the consultation methods used in policy planning. The interview data reveals that despite improvements in the consultative process, the perception remains that engagement is carried out with stakeholders, to gain support for decisions that may already have been made, with some respondents feeling they did not have equal power in decision making.

Participation according to Arnstein (1969) is a process whereby those currently excluded from economic and political process are actively included. It allows for a redistribution of power and ranges from citizen control, with a high degree of citizen power to manipulation

where there is no participation. Arnstein's Ladder of Participation is useful in identifying current and desired levels of participation in policy making.

Table 8.1 Arnstein's Ladder of Participation

Level	Type of Participation	Nature of the Experience
8	Citizen Control	Degrees of Citizen Power
7	Delegated Power	As above
6	Partnership	As above
5	Placation	Degrees of Tokenism
4	Consultation	As above
3	Informing	As above
2	Therapy	Non-participation
1	Manipulation	Non-participation

Wilcox (cited in Beck and Purcell, 2010) developed on Arnstein's Ladder of Participation and refocused it toward practice, he describes three levels of partnership that are a useful consideration to policy process. Deciding together, acting together and supporting independent community initiatives are used as terms to broaden participation as defined by Arnstein above. Successful public participation requires citizens to have equality in the decision-making process. The interviews revealed that a number of respondents felt included and that they influenced decisions. By contrast others felt included but that they did not have influence. A number of respondents felt excluded. What was evident in the interviews was that none of the C&V participants in this study described being equal partners in developing or implementing strategy.

Consultation

The policy process for Connecting for Life (2015) utilised a range of consultative methods, including submissions, focus groups, media campaigns and advertisements. As noted, the outcomes of the consultation reveal varying degrees of participation by C&V in the consultation process. Previous chapters discussed that planning and implementation stages of policy process require well-structured procedures to ensure success in the development of consultation and participatory approaches. Findings in this study aligned with the communicative approach to planning as identified by Healey (1992) which grounded the importance of public participation. The communicative model has a foundation in argument, discourse and dialogue (Hillier 1993; Healey 1996) and emphasises widening the scope and range of actors whose views are considered as legitimate in planning (Hillier 1995).

It is noteworthy that planning and development of suicide prevention strategy has learned much from WHO, UN and neighbouring jurisdictions, notably Scotland. The methods used to consult, gather evidence and formulate strategy are informed by research from statutory, C&V and academic sectors, including IASP, IAS and NSRF. It must be said, that the national suicide prevention strategy has benefitted greatly from the expertise of the academic and research practitioners that contribute to the process and are internationally renowned. This is an aspect of policy process to be valued and resourced in order to further contribute to a future national strategy. Academia in particular brings a knowledge and network of international practice and approaches and thus social policy research is vital in the development of future policy.

Gaps and areas for attention were also identified by respondents and these have been discussed above. Themes included establishing planning procedures and protocols, particularly ensuring transparency around cross-sectoral participation, negotiation, bargaining and debate (Dryzek, 1990; Giddens, 1994) in the consultation process. This is in opposition to the perceived tokenism and placation, as described by some interviewees. It must be concluded that there is potential to improve on the progress already made in Ireland's national efforts to address suicide by paying attention to, firstly, the process involved in decisions about who gets to decide strategy; secondly, to create a plan with resources and authority, to implement and continuously review the national suicide prevention strategy for Ireland. Findings reveal that consultation methods must be transparent, this being important to secure commitment by stakeholders to policy process and involvement in future strategy. In order to improve implementation of strategy, the consultative process must also move

beyond the perception that it is tokenistic, which was an emerging theme for some respondents from the C&V sector. In addition, the improved engagement methods in recent years, whilst noted, require clear, well- planned consultative processes. Policy planning is a process of continuous modification, amendment and review of the progress already made. Better definition in engagement and consultation methods with stakeholders, alongside ongoing review, will offer a more robust, distinct and well-defined method for effective participation. The issue of accreditation and standards for C&V organisation in suicide prevention is an important theme for participants. Some respondents noted that C&V organisations are perceived as unregulated and lacking credible systems and governance. This is a factor that determines the level of participation and inclusion and future strategy development would benefit, if a model of accreditation and registration be implemented across the C&V sector.

Planning requires a set of procedures including, communication, engagement, consultation and cross-sectoral collaboration mechanisms. In addition, the mechanisms must be perceived as transparent, with meaningful discourse, the ultimate aims of which will be to organise 'attention to the possibilities for action' (Forester 1989, p. 19).

Consultation has improved significantly but there is much to consider that would improve the planning and effectiveness of the consultative process. Nonetheless, this study acknowledges the major developments and evidence of proactive approaches to cross-sectoral collaboration led by NOSP and associated actors in developing the Connecting for Life strategy.

What emerged during the interviews is that there are many layers to the dense and complex suicide policy process; it is a constantly changing set of relationships, involving a varied set of policy actors, experts and stakeholders. Regarding emerging themes, consultation was a significant issue where it became evident that different groups mean different things when using the term and the 6 tiers to the collaborative policy process were discussed above. Policy process was considered as it applies to suicide prevention policy succession planning and development in Ireland. Consultation, participation and engagement theory and models were considered to gain an understanding of change and progress in engagement practice in developing suicide prevention strategy.

The experiences of respondents in the policy process appears to have been mixed with ranging perceptions described as positive in developing Connecting for Life, to those

articulating exclusion and tokenism in the consultative experience. There is evidence that the sectors would benefit from standardised mechanisms in policy planning, clarifying purpose, time-frame and type of consultation to be undertaken. Additional themes including perceptions of power and parity of esteem were expressed by a number of interviewees arising from discussions about consultation and participation.

Representation

The previous chapter discussed perceptions of interviewees regarding the role of the C&V as representative in policy process. The chapter referred to the complexity of the C&V sector and potential for conflict of interest if representative C&V organisations are competing for resources against the very groups they are representing in policy process. The chapter referred to Larragy (2014) who articulated the difficulty faced by C&V organisations, who having strategically negotiated a place at the table, may feel unable to criticise government as a consequence of the positioning required to secure funding. Knowledge of policy process and ability to influence are additional factors to be considered in examining C&V representativeness in policy process, those negotiating on behalf of the sector, must be representing the community and stakeholders they represent. As an assigned or assumed role, this was not evident in the interview findings with C&V organisations. The autonomy and independence of representatives of the C&V is an essential element for consideration in future strategy. The capacity for impartial representation and ability to challenge the official bodies in the policy process is an important feature of partnership approaches. This necessitates dedicating resources to the establishment of standards/accreditation and a national database of C&V suicide prevention organisations. Historically the latter role was somewhat developed by the Irish Association of Suicidology (IAS) a role that could be resourced and implemented in the future. It would be useful for future strategy planning to establish and resource an independent and autonomous representative umbrella body that can document, register and advocate for C&V and other stakeholders in the policy process.

Foucault (cited in Kendall and Wickham, 1999) informs the understanding of power and how it is manifested in policy process. Power is subtle, illusive and hard to define and a dynamic part of the process. It influences the context and is both a positive and a negative aspect of the process. As stated, an examination of policy making involves consideration of the dynamics of institutions; the political landscape; the cultural and social processes; the subtle

themes including the experiences and perceptions of those included in and indeed those excluded from the policy process.

The Impact of Power on Policy Process

The experience of power in policy process has been considered throughout the study and is a feature of policy process. Power and resistance to changing how policy is developed and implemented emerged as themes in interviews. The statutory sector are the architects and directors of suicide prevention strategy management in Ireland. This is the sector possessed of power and exerciser of governance in suicide prevention policy process. The perceived resistance to change is a characteristic element of the governance process (Kendall and Wickham, 1999) and it is necessary to articulate the way resistance operates as part of power. The systems and structures in which suicide strategy is developed have been described above and include the systems of governance that are political in government departments, their offices and agencies.

It is essential that resistance and power is understood and considered as a complex feature of policy landscape rather than a simple opposition to it (Kendall and Wickham, 1999). Wickham's (cited in Kendall and Wickham, 1999) view is that governance is always subject to politics, with resistance being a technical component of governance. Foucault stated, "Resistance is part of the fact that power can only make a social machinery run imperfectly or incompletely" (cited in Kendall and Wickham, 1999. p. 51).

Power is derived from knowledge and discourse (Foucault, cited in Kendall and Wickham, 1999) thereby raising questions about epistemological agency and what participants perceived as being inside or outside the discourse in policy process. The interviews revealed that is the ability to influence content, implement actions or have potential access to associated funding streams is connected to and a consequence of exclusion or inclusion.

The structures and systems are perceived as closed to some C&V groups and considered resistant to change or challenge. In a closed system, access for new ideas is difficult and this impacts the veridiction of 'truth' in suicide prevention. In a closed system how knowledge and 'truth' is determined is limited. The worldview becomes narrow about what is, or is not knowledge or evidence and this negatively impacts policy process. There is a high level of inequality in the bargaining power between different groups and there is not equality of

access to the political process, with sizeable groups and individuals not organised and as a consequence unrepresented in the policy process (Mazzioti, 1982). The interviews described power imbalances and raised issues about parity of esteem in the policy process. This referred not simply to parity and power between C&V and statutory sector, but also parity of esteem issues within the C&V sector. Inequality occurs as a result of competition for resources and position and the findings support the view that coalitions of elites emerge that advocate certain policy agendas, in favour of certain groups. There is a perception of insider and outsiders to the policy process and the result is unequal distribution of power in cross-sectoral and within sector consultation. The research study question considered if relationships between the community, voluntary and statutory sectors impact on the process of developing suicide prevention policy in Ireland? The findings reveal that this is the case; however, the answer to the question was much more complex, as the study reveals the development of suicide prevention policy is also impacted by the dynamics, systems and structures within the distinct sectors where power also clearly manifests.

Recommendations for Future Strategy

Suicide prevention in Ireland relies on robust strategy that requires effective planning, implementation and review. The research question asked if relationships between the community, voluntary and statutory sectors impact on the process of developing suicide prevention policy in Ireland. There is no doubt that cross-sectoral relationships do impact the process, but as stated, this is a much more complex area of study than the title question indicated. The review of national and international policies revealed succinct accounts of the development of content in strategy, but limited information about policy process and the dynamics and relationships involved. The interviews revealed subjective perceptions and participant descriptions of experience in policy process.

The limitations to the validity and replicability of data and findings in this qualitative study are recognised. The case study articulated emerging themes that are subtle, subjective and capture the narrative accounts of participants involved in the development of suicide prevention strategy from 1998-2015 in Ireland. In order to capture the subtlety of the process; the dynamics between and within sectors; perceptions of power, parity, inclusion and exclusion; a qualitative approach using interviews was appropriate. It can be perceived that a disadvantage of the study is that some of the themes are difficult to measure, quantify and articulate – which is often the criticism of any such interpretivist approach. An advantage of

qualitative methodology is providing the means by which the study examined subjective perceptions about important themes in suicide prevention strategy development.

A number of recommendations have been identified arising from emerging themes and findings. These are distilled from the narrative accounts and presented below.

- Findings (Chapter 6) reveal the complexity of the two principal sectors (statutory and C&V). Articulation of structures is not straightforward, they are revealed as disparate and distinctive, with unique characteristics that have an impact on cross sectoral relationships. This complexity is described by interviewees, (No. 11) and (No. 6) it is recommended that this is considered as an important feature in policy making. This affords an account of sectoral structures and differences, imperative in planning and development, to be noted. The impact of the distinctiveness of each sector on the context and relationships in policy process is significant.

- The study reveals the need for transparent engagement. This includes with all stakeholders and in cross-sector consultative processes. The imperative is for clearly articulated consultation at all stages in policy making, review and implementation. A theme of significance to a number of interviewees (No. 2) and (No. 13), this is discussed and elaborated in greater detail in Chapter 7.

- An essential emerging theme is the centrality of evaluation as a priority in the implementation of the Connecting for Life strategy. This was raised by a number of respondents (No 8 and No 13) and this study recommends the development of an evaluation strategy as essential to successful policy cycle, discussed in Chapter 7 and illustrated in Figure 7.1. Ongoing evaluation permits review and responsiveness if, for example new evidence emerges or strategic change is necessary.

- An important focus is the monitoring of suicide prevention as a policy topic across government departments. The effectiveness of cross-department collaboration was raised as a theme in the study, discussed further in Chapter 6 of this study.

- It is also recommended that representativeness be considered as a pertinent characteristic that impacts relationships in the policy process. This is discussed in Chapter 7 and highlights features impacting the independence of C&V in policy making. Attending to such emerging themes can mitigate against the potential development of policy elites or conflict of interest in the policy process for representative organisations in the C&V sector.

- The topic of suicide is a whole of society concern and as such, members of the Dail and Senate, independent and cross-party, must be included in policy making. They are representatives of constituents and stakeholders that may otherwise not be heard as part of the process. An important finding, discussed in chapter 6&8 is the distinction between a whole of government and a whole of Oireachtas approach in the policy making process.

- Resources emerged as an important feature of policy making in this study. Decision making and strategic changes to resource distribution and allocation were important themes. Respondents expressed frustration about the stress involved in competing for funding, with resources reduced due to austerity. Additional themes included, confusion about commissioning of services, how strategic partnerships develop and uncertainty regarding future resourcing across sectors. The particular implications for the C&V sector are discussed in Chapters 6&7, including the power imbalances and parity of esteem associated with the funder/funded relationship in policy process.

- The findings in Chapter 4 &5 demonstrate the significance of international and national research, both academic and clinical RCT studies. In addition, suicide prevention policy process can benefit from evidence generated through narrative accounts, practice and evidence gathered using varied approaches and studies. This ensures a broad participatory process involving a wide range of stakeholders in the gathering of valid accounts of what works in suicide prevention.

The recommendations represent a number of the key findings from this study. These have emerged as a result of the desk based and interview data, which articulated the perceptions of respondents. It is important to note that additional themes, beyond the scope of this PhD also emerged as areas for future research and as a final point of consideration are outlined below.

Areas for Further Research

The findings reveal a number of areas for future research that emerged as a result of the interview findings, policy analysis and literature review. Further research would enhance this area of study and elaborate on emerging themes and complement this study. The question in this study was prompted by research completed by the author in 2013, discussed in chapter 1.

Funded by NOSP and commissioned by the IAS, the research developed a draft set of standards and an accreditation model for the C&V suicide prevention sector in Ireland.

The accreditation of the C&V suicide prevention, intervention and postvention sector remains an area that would benefit from further research. This could focus on the development of a national database of accredited C&V organisations. In addition to documenting the expertise within C&V, it would offer a means of establishing a quantified account of data generated by the activities of the C&V sector, much of which, at present, is not documented and therefore strategy is currently developed without accurate evidence of practice by many organisations.

The findings and conclusions recognised the complexity of the systems and structures in which the suicide policy process takes place. Arising from the study I believe it would be useful to develop research in a number of additional areas:

- Developing planning and engagement models and mechanisms in suicide prevention policy process, informed by best practice in an international context.
- Understanding and elaborating on the structural and systemic characteristics in the statutory sector. This includes reviewing the political and governmental structures and evaluating how cross-departmental mechanisms can be altered to improve collaboration and reduce the silos and separateness that exists in policy process.
- Elaborating and exploring the issue of representativeness as addressed by respondents from the C&V sector. This would improve the understanding of the impact on policy planning process by those who speak for the excluded and under-represented in policy process.
- Most importantly, it would be beneficial for continuous research to be conducted on the implementation of Connecting for Life (2015-2020). Ongoing review and evaluation allows the strategy to be live, responsive and emergent, evolving and developing as the context or evidence changes nationally and internationally.

Contribution to knowledge

There are a number of ways in which the study contributes to the knowledge base in the field of suicide prevention and policy process. As an academic I completed previous research at a national level in Ireland in 2013. I have been a research activist in the area of suicide prevention since 2009. Findings from the previous research (2013) and anecdotal reports led

to the development of the research question, which asked if relationships between the community, voluntary and statutory sectors impact on the process of developing suicide prevention policy in Ireland? In attending to the research question, the study has made a number of contributions to inform future policy process.

The study presents data from an under-developed research area namely cross-sectoral relationship and impact on the policy process. The study of the planning phase and early stages in policy making examined the complexity of processes and dynamics, an area not usually addressed in studies of suicide prevention strategy in Ireland.

Finally, findings revealed the importance of ensuring robust engagement models and mechanisms and documented perceptions about tokenism as opposed to partnership in the consultation and participation approach employed in suicide prevention policy process. The findings contribute to improved knowledge about the importance of participatory mechanisms and stakeholder engagement in policy process. The study has developed understanding and knowledge about structures and systems and the impact on policy process in suicide prevention. This contributes to future policy review and planning. By articulating and elaborating on structural and systemic features of the statutory sector there is improved knowledge of cross-departmental mechanisms. This can be evaluated to improve collaboration and reduce the silos and separateness that exists in policy process. Future development of strategy can benefit from the knowledge generated by the review of the political and governmental structures and their contribution/impact on suicide prevention policy process. By elaborating and exploring the impact of representation on policy process, by those who speak for the excluded and under-represented, the study contributes to knowledge of the dynamics of representativeness as an important characteristic in planning. A significant aspect of the research is the revelation that all sectors and stakeholders bring knowledge which is critical in addressing suicide in Ireland. Connecting for Life (2015-2020), the current strategy, requires continuous evaluation, linked to the cycle as illustrated below

Knowledge of policy process is enhanced by the findings of the study, that continuous and ongoing evaluation and review results in a more responsive strategy. Furthermore, policy is complex; it is evolving process and developing as the context or evidence changes nationally and internationally. Improved outcomes for future suicide prevention strategy are possible through transparent engagement, well-defined planning and partnership approaches to at all

stages in the policy cycle. The findings here are a means of capturing perceptions of the importance and impact of cross-sectoral relationships in policy making. The policy process in suicide prevention must be understood if we are to find a solution that reduces the rate, each loss having a devastating and profound effect on families and communities. This thesis aims to be a point of reflection and a contribution to the knowledge of how improved suicide prevention can be achieved by all sectors in Ireland.

Appendices

Appendix 1.

Members of the Strategic Planning Oversight Group	
Kieran Ryan (Chair)	Irish College of General Practitioners
Prof Ella Arensman (Vice Chair of Research Group)	National Suicide Research Foundation
Dr. Tony Bates	Headstrong
Kirsten Connolly (Chair of Communications Group)	HSE Communications
Colm Desmond (Chair of Policy Group)	Department of Health
Fergal Fox	HSE Health and Wellbeing Division
Patricia Gilheaney (Chair of Practice Group)	CEO Mental Health Commission
Cate Hartigan	HSE Health and Wellbeing Division
Hugh Kane (Chair of Engagement Group)	GENIO
Susan Kenny (Strategy Development Lead)	HSE NOSP
Prof. Kevin Malone	Irish College of Psychiatry
Patrick McGowan	HSE Service-Family Member and Carer Engagement
Owen Metcalfe (Chair of Research Group)	Institute Public Health
Stephen Mulvany	HSE Mental Health Division
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Kate O'Flaherty	Department of Health
Gerry Raleigh (Director NOSP)	HSE NOSP
Martin Rogan	HSE Mental Health Division
Dr. Matthew Sadlier	HSE Mental Health Division
Sandra Walsh	Department of Health
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Appendix 2

Policy group members	
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Margaret Grogan	Department of Education and Skills
Jacinta Hastings	Bodywhys
Susan Kenny	HSE NOSP
Anne O'Donnell	Department of Children and Youth Affairs
Ronan Toomey	Department of Health
Sandra Walsh	Department of Health
Rachel Wright	Samaritans

Appendix 3

Practice Group Members	
Patricia Gilheaney (Chair)	Mental Health Commission
Ciaran Austin	Console
Kieran Brady	Pieta House
Margaret Brennan	HSE Quality and Patient Safety in Mental Health Directorate
Catherine Brogan	Samaritans
Dr Justin Brophy	HSE Mental Health Services
Michael Byrne	HSE Psychology
Bernie Carroll	HSE NOSP
Aisling Culhane	Psychiatric Nurses Association
Eithne Cusack	HSE Office of the Nursing and Midwifery Services
Dr Brendan Doody	HSE Mental Health Services
Joseph Duffy	Headstrong
Cathal Kearney	The Family Centre
Susan Kenny	HSE NOSP
Paula Lawlor	Suicide or Survive
Derek McDonnell	South County Dublin Partnership
Fenella Murphy	ReachOut.com
Anne Sheridan	HSE Health and Wellbeing Directorate

Appendix 4

Communications group members	
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Jim Breen	Cycle Against Suicide
Mary Cannon	Irish Association of Suicidology
David Carroll	BeLonG To
Dr John Connolly	Irish Association of Suicidology
Kahlil Coyle	HSE NOSP
Elaine Geraghty	ReachOut.com
Dr Claire Hayes	Aware
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Michelle Merrigan	HSE Communications
Angie O'Brien	HSE
Garreth Phelan	HSE Health and Wellbeing Directorate
Ian Power	SpunOut.ie
Margie Roe	ISPCC
Collette Ryan	Rehab
Enda Saul	HSE Communications
Eileen Williamson	National Suicide Research Foundation
Rachel Wright	Samaritans

Appendix 5

Research group members	
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Susan Kenny	HSE NOSP
Dr Teresa Maguire	Health Research Board
Declan McKeown	HSE
Prof Siobhan O'Neill	Queen's University, Belfast
Dr Noel Richardson	HSE
Dr Paul Surgenor	Pieta House

Appendix 6

Government departments and national agencies that made commitments as part of the strategy:	
• Department of An Taoiseach	• Central Statistics Office
• Department of Agriculture, Food and the Marine	• Department of Children and Youth Affairs
• TUSLA Child and Family Agency	• Department of Communications, Energy and Natural Resources
• Broadcasting Authority of Ireland	• Press Council of Ireland •
• Press Ombudsman Office	• Department of Defence
• Department of Education and Skills	• Higher Education Authority
• National Education Welfare Service	• National Educational Psychological Service
• Department of Environment, Community and Local Government	• Local Authorities
• Department of Health	• HSE Acute Hospitals
• HSE Estates	• HSE Health and Wellbeing
• HSE Mental Health	• HSE Primary Care
• National Office for Suicide Prevention	• Department of Jobs, Enterprise and Innovation
• Health and Safety Authority	• Department of Justice and Equality
• An Garda Síochána	• Coroners' Offices
• Irish Prison Service	• The Probation Service
• Department of Social Protection	• Department of Transport, Tourism and Sport
• Irish Sports Council	

Appendix 7

THEMES AND QUESTIONS

Date of Interview:

Place of Interview:

Identity of Informant:

Name: _____ Organisation: _____

Title: _____Email/Phone: _____

Role and Position: _____ Practice: Research/Policy/Programmes

1. Experience of Suicide Prevention in ROI:
    a. Task Force
    b. Reach Out
    c. Connecting For Life
    d. Other

2. How is Suicide Prevention policy formulated:
    a. Dictated by National Policy planning? What group
    b. Directed by national policy planning (stat) customised CHO area/county
    c. Directed nationally with Local policy based on local needs
    d. other

3. How is *national* suicide prevention policy developed in Ireland?
    a. This includes exploring *who, where, how and what* groups are involved in policy formation.

    b. What is the participants involvement in policy making at local, regional and national level

4. How are decisions made about who formulates suicide prevention policy: Consultation with stakeholders:

    a. Formal structured consultations

    b. Informal but structured consultations

    c. Ad hoc unstructured consultations

    d. What mix of stakeholders

        i. Statutory sector %

        ii. Non- statutory and C&V %

        iii. Non-statutory profit (Business)

        iv. University/research centres

        v. Trade Union/Civil

        vi. Service users

        vii. other

    e. This includes exploring *who, where, how and what* groups are involved in deciding who is involved in policy formation.

    f. If the participant is involved in policy making process, how did this happen, who invited, nominated, proposed their inclusion

    g. When is consultation undertaken and how frequently

        i. Agenda setting

        ii. Planning

        iii. Draft policy stage

        iv. Policy completed/opened for input

5. What is the nature of the relationship between the statutory and voluntary sectors in policy development process?

6. Consultation in policy formation. How decisions are made about consultation and engagement and the extent of consultation and stakeholder engagement in policy processes.

    a. Engagement models, timing, type

    b. Information provision

    c. Information flow

    d. Communication methods

    e. Proportionality

    f. Consultation

    g. Participation

    h. Other view

7. Do the organisational relationships between the statutory and voluntary sectors in the policy development process impact on:

    a. Agenda setting in policy making

    b. Content and objective setting

    c. Implementation

    d. Delivery

    e. Review

    f. Resourcing

8. Was the participant involved in any particular policy formation committee, or subcommittee, e.g. Research, policy review or other?

9. What are the key problems in implementing Suicide prevention Policy

10. What are the key drivers in Suicide Prevention Policy

11. What are the challenges in suicide prevention policy process

12. Is there information that would better support cross-sectoral relations in suicide prevention policy process?

Appendix 8

Ulster University   Faculty of Social Sciences

School of Sociology and Applied Social Studies.

Participant Information Sheet

Study Title

Collaborative Working in Suicide Prevention: An exploration of the impact of relationships between the community, voluntary (C&V) and statutory sectors on the process of developing suicide prevention policy in Ireland (Republic)

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Ask questions if anything you read is not clear or would like more information. Take time to decide whether or not to take part.

What is the purpose of the study?

This study is undertaken by the researcher as part of a PHD study. The aim of the project is to examine the extent to which relationships between Government and the community, voluntary and statutory sectors influence the process of developing suicide prevention policy in Ireland.

Why have I been invited?

You have been invited to participate in this study because you are a member of a statutory and/or voluntary/community sector organisation involved in suicide prevention, intervention and/or postvention activities in Ireland (ROI). Your experience will be invaluable to this study. There are 19 other participants in this study.

Do I have to take part?

Taking part in this research study is entirely voluntary. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form (which you will be given a copy of to keep). If you decide to take part and then change your mind, you can do so without giving a reason.

What will happen to me if I take part?

Participation involves a semi-structured interview (approx. 1 – 1.5 hours' duration) about your understanding and experience of suicide prevention policy making process in Ireland and how policy informs practice. If you agree, the interview will be audio recorded and then transcribed by the researcher.

Will my taking part in the study be kept confidential?

Recordings will be identified only by code, and will not be used or made available for any other purpose other than the research project. These recordings will be destroyed at the end of the study.

All written data will be identified by a code, with personal details kept in a locked file or secured computer with access only by the immediate researcher. A master list identifying participants to the research codes data will be held on a password protected computer accessed only by the researcher and in accordance with the Data Protection Act 1998.

What are the possible disadvantages and risks of taking part?

There are no perceived risks to participants of this study. However, the exploratory nature of the interviews may highlight sensitive issues which may in turn cause upset, therefore the researcher will be mindful and manage the situation appropriately.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for those participating in the project, it will provide an opportunity to reflect on policy making process and emerging themes and the researcher hopes that the information obtained will help to increase the understanding of suicide prevention policy making in Ireland.

What if there is a problem?

If you have a concern about any aspect of this study, you should contact the researcher who will do her best to answer your questions.

What will happen if I don't carry on with the study?

If you withdraw from the study all the information and data collected from you, to date, will be destroyed and your name removed from the study files.

What will happen to the results of the research study?

The results of this study will form part of the researcher's dissertation and will be submitted to Ulster University in March 2018. The project has received ethical approval from the Faculty of Arts Humanities and Social Sciences ethical approval committee, Ulster University.

Contact for further information

Thank you for taking the time to read through the information. If you have any questions or would like further information you can contact the researcher by email or telephone: bn.friel@ulster.ac.uk. Telephone 00442871675765

Appendix 9

Ulster University   Faculty of Social Sciences

School of Applied Social and Policy Sciences

Consent Form

Study Title

Collaborative Working in Suicide Prevention: An exploration of the impact of relationships between the community, voluntary and statutory sectors on the process of developing suicide prevention policy in Ireland (Republic)

- I confirm that I have read and understand the Participant Information Sheet.
- I have had the opportunity to ask questions and had them answered.
- I understand that all personal information will remain confidential and that all efforts will be made to ensure I cannot be identified (except as might be required by law).
- I agree that data gathered in this study may be stored anonymously and securely, and may be used for future research.
- I understand that my participation is voluntary and that i am free to withdraw at any time without giving a reason.
- I agree to take part in this study.
- I have been given a copy of this consent form.

Participant's signature....................................Print...................................

Date....................................

Researcher's signature....................................Print...................................

Date....................................

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