WHAT IS KNOWN ABOUT THE DESIGN, GOVERNANCE, DELIVERY, AND EFFECTS OF NATIONAL MENTAL HEALTH AND SUICIDE PREVENTION STRATEGIES?

A RAPID REVIEW SYNTHESIS

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Supporting Transformation through Research, Evidence, and Action in Mental Health (STREAM) at the Waypoint Centre for Mental Health Care

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STREAM Lab

The Supporting Transformation through Research, Evidence, and Action in Mental Health (STREAM) Lab is dedicated to providing timely and comprehensive evidence reviews to support provincial partners in improving mental health and addictions care across Ontario. STREAM Lab products deliver actionable health system insights that can inform planning and decision-making processes.

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Table of Contents

Key points

Mental health concerns and suicide have profound impacts at a population level. Many countries have national mental health and/or suicide prevention strategies (NMHSPs) to address these complex concerns. This rapid evidence synthesis addresses the question: what is known about the design, governance, delivery, and effects of NMHSPSs?

We conducted a structured review of the academic literature, identified examples of NMHSPSs that have been implemented and evaluated globally, and interviewed experts in the field on this topic. We identified 25 academic papers, one grey literature report, and 9 examples of NMHSPSs, and spoke to experts from 6 different countries. Our findings are summarized below.

Findings in academic literature and strategy documents	**Key recommendations from evaluations and key informants**
Design	
There are a fairly consistent set of elements across NMHSPSs, including elements relating to promotion and prevention. Common inputs include engagement of people with lived/living experience/expertise (PWLE), members of the public, Indigenous leaders and leaders of other equity-denied communities, policymakers, and health and social service providers; research evidence; international guidance; and learning from past policies and other jurisdictions. The existence of multiple, overlapping strategies and policies can create fatigue and confusion.	Considerations for the design process include: • ongoing engagement of PWLE and members of the public, beginning early in the design process • recruiting and supporting PWLE as leaders • facilitating Indigenous self-determination at a system level and through community engagement • uniting multiple concurrent strategies through common underpinning principles and/or a single overarching framework
Governance	
Whole-of-government approaches are needed to tackle the determinants of mental health and suicide. Whole-of-government approaches can be complemented by leadership and advisory structures such as lived experience panels.	Whole-of-government approaches should: • involve senior staff from all relevant departments and ministries • ensure all involved departments and ministries have accountabilities, and not merely commitments • include feedback loops and structures for ongoing collaboration
Delivery	
While local flexibility and autonomy can support tailored approaches, it can also introduce confusion over objectives and accountabilities.	The following considerations can support a balance between a unified approach and local flexibility: • Providing clear roles and accountabilities • Providing supporting resources at each level of implementation

	• Creating locally-tailored implementation plans • Identifying outcomes that are relevant and achievable at a local level, while also linking to intended outcomes of the system plan
Evaluation	
Evaluation of NMHSPSs is complex. Population health outcomes are rarely evaluated, and strategy elements may be evaluated in isolation rather than the strategy as a whole.	Evaluations should be: • built into NMHSPSs from the start • based on program logic and realistic timelines • conducted transparently and independently • supported by necessary resources, data collection, and development of linked data sets
Equity considerations	
Equity concerns and social determinants of health are frequently referenced in NMHSPSs. However, the actions taken on these issues—and the effects of these actions—are not always documented.	Equity and social determinants must be embedded in actions across the full life cycle of NMHSPSs by: • beginning with a situation analysis that includes data on inequities • engaging disproportionately-affected communities • committing to a whole-of-government approach to enable actions on social determinants of health, and monitoring and evaluating these actions

What does this mean for decision-makers in Canada?

Decision-makers in Canada can consider engagement, multi-level contexts, and evaluability at all stages in the life cycle of a NMHSPS.

Cross-cutting theme	Implications for decision-makers in Canada
Engagement	• Recruit, mentor, train, and support diverse lived experience leaders for the strategy, in collaboration with existing lived experience leaders and organizations • Uphold Indigenous self-determination by embedding Indigenous leadership at a national level as well as meaningful community engagement • Seek ongoing, active, and accountable involvement of senior leaders across government departments and ministries
Multi-level contexts	• Identify actions and outcomes at federal, provincial, and regional/municipal levels • Consider the delivery systems, implementation supports, and data collection capacities available at these different levels • Consider interdependencies across levels and across concurrent strategies (including strategies at various levels e.g., provincial mental health plans, as well as strategies of various branches of government) • Embed accountabilities, including accountability to communities
Evaluability	• Use program logic to define actions, accountabilities, indicators, and timelines • Plan for evaluation that will capture equity effects, including experiences and outcomes for equity-denied populations

Introduction

Mental health concerns and suicide have a profound impact at a population level. Over 5 million Canadians experienced symptoms of anxiety, depression, or substance use disorder in 2022 (Statistics Canada, 2023), and approximately 4,500 Canadians die by suicide each year (Statistics Canada, 2023). Determinants of mental ill-health concerns and suicidality span the life course and range from individual-level factors to broader social structures (Allen et al., 2014). Meanwhile positive mental health and wellbeing have been recognized as essential resources for daily living, and for success at school and work (OECD, 2023). A coordinated, multi-level response is required to address population mental health concerns and suicide, and to support positive mental health (OECD, 2023; Patel et al., 2023; Sinyor et al., 2024).

In many countries around the world, national strategies have been developed to confront this challenge. By 2020, 75% of World Health Organization Member States had a mental health plan or policy (World Health Organization, 2021). Meanwhile, over 40 countries have a national suicide prevention strategy (Sinyor et al., 2024). In Canada, multiple strategies relating to mental health and/or suicide prevention have been developed at a federal level. These include: *Working Together to Prevent Suicide: The Federal Framework for Suicide Prevention* (Public Health Agency of Canada, 2016); *National Aboriginal Youth Suicide Prevention Strategy (NAYSPS) Program Framework* (Health Canada, 2013); and *Changing Directions, Changing Lives* (Mental Health Commission of Canada, 2012); among others.

Given the widespread development of national mental health and/or suicide prevention strategies (NMHSPSs), it is important to understand their effects—and how strategies may be designed and implemented to optimize outcomes. This rapid evidence synthesis addresses the question: what is known about the design, governance, delivery, and effects of NMHSPSs?

This rapid synthesis

We collaborated with decision-maker partners to refine our research question and approach. We subsequently included four evidence sources in this review:

1. **Structured search of academic literature**: We searched two academic databases (MedLine and Health Systems Evidence), using terms to capture mental health and/or suicide prevention, and national-level strategies or plans. We applied consistent inclusion and exclusion criteria to the results in order to identify relevant articles. A detailed description of the structured search process can be found in **Appendix 1**.
2. **Targeted searching**: We identified a relevant recent systematic review identified through hand searching, and reviewed its reference list for additional articles. We also included academic and grey literature suggested by key informants.
3. **Jurisdictional scan**: We used internet searches to identify NMHSPSs launched in the past 10 years in OECD countries, then searched for evaluations or other grey or academic literature for each. We selected examples with the richest evaluative findings for inclusion in this report.
4. **Key informant interviews**: We identified international experts in consultation with decision-maker partners, as well as through our literature review. We presented key informants with a high-level summary of our findings, and followed a semi-structured interview guide to address gaps in the literature or elicit examples from practice. This guide is located in **Appendix 2**.

What is known about the design, governance, delivery, and effects of NMHSPSs?

Information from the structured and targeted searches and jurisdictional scan was extracted using an organizing framework (see Appendix 1). When items in the organizing framework are not reported, this is due to lack of data in the reviewed documents.

Finally, two citizen reviewers provided feedback on a draft of this report, drawing on their lived experience. We incorporated their feedback into our interpretation and presentation of findings.

What we found

We located 19 relevant academic articles on NMHSPSs through our structured search. These articles include five policy analyses (based primarily on document review), six descriptions of policy initiatives, four commentaries, two unstructured literature reviews, one quantitative study of effects, and one qualitative case study of policy development. Through citation chaining and key informant recommendations, we added a further six academic articles (including one systematic review, two policy analyses, one quantitative observational study, and two commentaries) and one grey literature report. Data extracted from these 26 documents can be found in **Appendix 3.**

We included nine NMHSPSs, and a total of 19 associated evaluations or other supporting documents, in our jurisdictional scan. A summary of these strategies and findings from relevant evaluations or reports are included in **Appendix 5.**

Finally, we interviewed six key informants. These included researchers and officials in governmental and non-governmental organizations who had deep knowledge of, and involvement in, NMHSPSs. None were in roles of community or lived experience leadership. Key informants were based in Europe, the United Kingdom, Australia, and Canada. The interview guide is located in **Appendix 2.**

Below we present findings about the design, governance, delivery, and evaluation of NMHSPSs.

Design of NMHSPSs

Content of NMHSPSs

Across the academic and grey literature, NMHSPSs each include a fairly consistent set of elements. Below we discuss mental health strategies' content relating to mental health promotion and mental ill-health prevention; other elements of mental health strategies; elements of suicide prevention strategies; and key underpinning values across NMHSPSs.

Mental health promotion and mental ill-health prevention are not consistently distinguished from each other within the strategy documents that we reviewed, nor are distinct levels of prevention (eg. primary, secondary) articulated in most strategies. Promotion and prevention activities described in mental health strategies often encompass both universal and targeted interventions, including action on social determinants of health. Definitions of social determinants varied in terms of richness, as well as specific determinants and affected populations referenced. For example:

- In Canada, *Changing Directions, Changing Lives* describes social determinants as "the conditions that people face in their lives shape whether they feel safe, secure, and supported at home and in their communities" (Mental Health Commission of Canada,

2012). The strategy includes six priority areas, each with supporting actions. Three of these priority areas have direct relevance to promotion and prevention:
    - "Promotion and prevention" is itself identified as a strategic direction. Actions included in this priority area include awareness-raising, as well as interventions targeting groups across the lifespan including children, youth, and seniors in settings such as schools, workplaces, and homes.
    - "Disparities and diversity" is a separate strategic direction. Related actions include addressing inequities in risk factors for mental ill-health by strengthening social determinants such as housing, and by supporting community organizations. This priority area also includes health care-focused actions such as increasing access to culturally-relevant care.
    - A third strategic direction focuses on First Nations, Inuit, and Métis communities. This direction addresses community capacities to promote wellness, alongside the need for access to a continuum of culturally-safe care. Intergenerational effects of colonization are pointed out as an important determinant of Indigenous wellness (Mental Health Commission of Canada, 2012).
- In New Zealand, *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing* is centred on a holistic concept of wellbeing that encompasses interconnections across the life course, within communities, and between people and their environment.Determinants of wellbeing cut across these domains, with social exclusion as a common element in factors such as "colonisation, racism and discrimination, monoculturalism, social isolation, poverty, trauma, adverse childhood experiences, disabilities, stigma associated with mental health challenges or the potential legal consequences of some substance use" (New Zealand Ministry of Health, 2021). The strategy proposes a greater focus on promotion and prevention, in order to "re-balance" the historical focus on health care services. It includes five core focus areas, two of which are identified as falling within promotion and prevention:
    - The first focus area addresses "social, cultural, economic, and environmental foundations for mental wellbeing," ie. a focus on social determinants of mental health. Examples of activities within this priority area include housing initiatives and family violence prevention.
    - The second focus area aims to enable communities, families, and individuals to support wellbeing. This focus area includes activities such as educational campaigns, supports for caregivers, multi-sectoral engagement, and community development.
    - A third focus area, community-led approaches, spans both promotion/prevention and health care (New Zealand Ministry of Health, 2021).
- Ireland published a national plan focused specifically on mental health promotion in December 2024 (An Roinn Sláinte, 2024). This was not included in our jurisdictional scan as it has yet to be evaluated. However, a key informant shared a report that informed the plan's development (Barry et al., 2023). This report defines social determinants as "a web of biological, psychological, social, economic, cultural, environmental and political factors" that span the life course (Barry et al., 2023). It distinguishes between prevention and mental health promotion, where the latter is described as focusing on positive mental health, whole populations, multi-sectoral action, and social determinants. The report identifies priority areas for mental health promotion including: perinatal and parenting programs, and social determinants in early life; targeted and universal mental wellbeing programming for children and youth; community empowerment; workplace mental health promotion; "upstream actions to

reduce structural inequities"; and a "mental health in all policies" approach (Barry et al., 2023).

Beyond prevention and promotion, mental health strategies typically refer to a full continuum of care including community-based and specialized services, Additional common elements of strategies include workforce enhancements (such as health workforce strengthening, as well as expanded mental health knowledge among social service providers, educators, and others); leadership and governance; and enhancements to the knowledge base through data and lived expertise. For example:

- *Changing Directions, Changing Lives* identified the following priorities in addition to those described above: a focus on access to services, including peer support, housing and employment services, and community-based and acute care; leadership and governance, including a whole-of-government approach, leadership of people with lived/living experience/expertise (PWLE), and infrastructure for data collection; and recovery and rights-based approaches (Mental Health Commission of Canada, 2012).

- *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing* identifies a need for expanded primary care supports and strengthened specialized services. It also addresses workforce development, technology, policy, use of information including data and lived experience, and leadership including strengthening Crown-Maori partnerships and cross-government coordination (New Zealand Ministry of Health, 2021).

National suicide prevention strategies also include a common set of elements. A 2019 paper identifies the following elements of suicide prevention strategies: 1) reduced access to means of suicide; 2) responsible media reporting; 3) access to health and social care; 4) training and education; 5) psychotherapy; 6) follow up after suicide attempts; 7) crisis intervention; 8) postvention (e.g., support for individuals bereaved by suicide); 9) awareness; 10) stigma reduction; 11) surveillance and monitoring; and 12) coordination and governance (Platt et al., 2019). It is important to note that literature in this area is evolving, including through the articulation of a life promotion approach grounded in Indigenous knowledge and strengths (White & Mushquash, 2016). The strategies included in our jurisdictional scan mostly reflect Platt and colleagues' 2019 paper, for example:

- Northern Ireland's *Protect Life 2* strategy included all of the above elements, and includes additional focus on outreach to individuals not connected to services, engaging colleges and universities, and fostering "safer custody" practices in prisons (Department of Health, 2019).
- In Scotland, *Every Life Matters* includes nine of the 12 elements described by Platt and colleagues. It does not address the following elements: means of suicide; psychotherapy; and media reporting (with the exception of brief reference to an existing guidance document on the latter) (The Scottish Government, 2018).

NMHSPSs also frequently reference key underpinning values, such as:

- Equity (e.g., Department of Health, 2019; Mental Health Commission of Canada, 2012; New Zealand Ministry of Health, 2021)
- Indigenous self-determination (e.g., Gayaa Dhuwi (Proud Spirit) Australia, 2025; New Zealand Ministry of Health, 2021)

- Holistic wellbeing (e.g., Gayaa Dhuwi (Proud Spirit) Australia, 2025; New Zealand Ministry of Health, 2021)
- Human rights (e.g., Mental Health Commission of Canada, 2012; New Zealand Ministry of Health, 2021)
- Evidence-based and/or data-driven approaches (e.g., Department of Health, 2019; Mental Health Commission of Canada, 2012; The Scottish Government, 2018)
- Person-centredness (e.g., Department of Health, 2019) and person and whānau-centredness (where whānau is a Māori concept referring to extended, intergenerational family groups; New Zealand Ministry of Health, 2021)

Inputs into NMHSPSs

Key informants stated that it is essential for NMHSPSs to be based on multiple sources of evidence and knowledge. Common inputs reported in academic and grey literature include engagement of PWLE, members of the public, Indigenous leaders, policymakers, and health and social service providers. Other sources of evidence include research evidence, international guidance, and learning from past policies and other jurisdictions. Below, we highlight considerations for some of these domains.

Inputs	Findings
Engaging PWLE, members of equity-denied communities, and members of the public	***Examples*** • The development of *Changing Directions, Changing Lives* used an iterative approach, involving in-person and online deliberative dialogues, storytelling, and focused advisory committees. Online approaches engaged members of the public broadly, more than half of whom identified as living with mental illness. Advisory committees included people with specific lived experiences, such as Indigenous identities, legal system involvement, or family caregiving (Mulvale et al., 2014). • In Scotland, a lived experience advisory group provided ongoing input into the national suicide prevention strategy. This group included people with experience of suicide attempts or suicidal thoughts; family caregiviers; and people bereaved by suicide (Scottish Action for Mental Health, n.d.) ***Recommendations from evaluations and key informants*** • Begin early in the process and continue through design, delivery, and evaluation (Scottish Action for Mental Health, n.d.; Te Hiringa Mahara – Mental Health and Wellbeing Commission, 2024). • Include structured recruitment and training processes (Scottish Action for Mental Health, n.d.). A key informant spoke to the importance of recruiting and mentoring PWLE in leadership roles. • Tailor engagement structures to fit the purpose and timelines. A key informant noted that heterogeneous advisory groups can generate rich discussion, while those focused on a single issue may reach consensus faster.
Engaging Indigenous leaders and communities	***Examples*** • *The Aboriginal and Torres Strait Islander Suicide Prevention Strategy* stemmed from an Australian government-commissioned project led by researchers at the School of Indigenous Studies at the University of Western Australia. These researchers conducted an extensive review

	of the evidence base on Indigenous-led suicide prevention, which included consultations held in Indigenous communities (Dudgeon et al., 2016). The strategy itself is co-led by the Australian Government Department of Health and Aged Care, and Gayaa Dhuwi (Proud Spirit) Australia, a community-controlled association representing Indigenous mental health organizations (Gayaa Dhuwi (Proud Spirit) Australia, 2025). ***Recommendations from evaluations and key informants*** • Plan for sustainability of Indigenous leadership structures. For instance *Kia Manawanui Aotearoa* had Māori self-determination as a core principle, but the creation and dissolution of a statutory Māori health authority posed a barrier to genuine partnerships at a system level (Te Hiringa Mahara – Mental Health and Wellbeing Commission, 2024).
Engaging policymakers	***Examples*** • A Provincial/Territorial Reference Group provided input into *Changing Directions, Changing Lives* (Mulvale et al., 2014). • According to a key informant, officials from 24 departments in Sweden's national government were tasked with reviewing their portfolios' mental health-related activities to inform the development of a strategy. ***Recommendations from key informants*** • Several key informants suggested engaging senior government officials in the design process. • One key informant suggested considering both political and administrative engagement. They noted that Ontario's 2012 mental health strategy was guided by an all-party committee, promoting stability despite political changes (see also Bullock & Abelson, 2019).
Research evidence	***Examples*** • *Talk to Me 2*, a suicide prevention strategy in Wales, drew primarily on epidemiological data, and also referenced clinical research and child death reviews (Moore, 2022). • A Senate report on the *Canadian Federal Framework for Suicide Prevention* criticized the framework for lacking a strong evidence base, but acknowledged some expert witnesses noted evidence is limited (Senate Standing Committee on Social Affairs, Science, and Technology, 2023). ***Recommendations from evaluations and key informants*** • One key informant suggested building linkages between government and academia, which may enable governmental officials to request tailored evidence products from researchers.

Multiple, overlapping strategies

The design of NHMSPSs may occur in a context where related strategies or policies either already exist or are in development. Two Australian evaluations noted that overlap across strategies and other policy initiatives can create confusion or overwhelm during implementation (King et al., 2022; Knight et al., 2024). Where multiple strategies exist, key informants suggested that there should be common underpinning principles and ideally a single overarching framework to which all related strategies refer.

What is known about the design, governance, delivery, and effects of NMHSPSs?

Governance of NMHSPSs

Whole-of-government approaches

Reference to "whole-of-government" and multi-sectoral approaches are common across the academic literature on NMHSPSs (e.g., Bassilios et al., 2024; Mulvale et al., 2014; Pirkis et al., 2024; Quinlan et al., 2021), and were present in almost every strategy included in our jurisdictional scan. "Whole-of-government" approaches refer to the engagement of multiple ministries and departments in a coordinated approach, to support multi-sectoral engagement and address social determinants of health (Barry et al., 2023; Bassilios et al., 2024; Pirkis et al., 2024). These approaches therefore relate to the mental health promotion and mental ill-health prevention aspects of NMHSPSs as described above. The report developed to inform Ireland's *National Mental Health Promotion Plan* reviewed literature, international policies, and expert opinion on whole-of-government approach to mental health promotion. The authors identify:

- activities such as building a shared understanding; mapping policies and political environments to identify opportunities and challenges; co-designing an outcome framework with multi-sectoral representatives; identifying priority actions; and assigning and coordinating roles
- structures such as an intersectoral monitoring and oversight committee, designated mental health champions from a range of sectors, and "collaborative structures at and between all levels (local, regional, national)"
- enablers such as strong leadership and senior-level commitment, alignment with global contexts (e.g., sustainable development goals), and networks for shared learning (Barry et al., 2023).

Key informants further suggested several strategies to operationalize a whole-of-government approach:

- Involve all relevant departments and ministries, reflecting the full range of determinants and factors influencing mental health and suicidality
- Ensure all involved departments and ministries have accountabilities, and not merely commitments, under the strategy
- Consider leadership from outside of the health sector (e.g., an official in the prime minister's office or a specially-appointed minister) to underscore a genuinely multi-sectoral approach and demonstrate high-level commitment (see also Pirkis et al., 2024)
    - This approach can also support accountability, since a health department cannot necessarily hold other departments or ministries accountable for actions under a NMHSPS
- Involve senior-level staff from each department or ministry
- Develop feedback loops and structures for ongoing collaboration among different ministries and departments, for instance through regular working group meetings or reporting expectations
- Identify and monitor meaningful, cross-cutting outcomes

A key informant stated that Ireland's 2015 suicide prevention strategy, *Connecting for Life,* was supported by a strong whole-of-government approach. A cross-sectoral implementation and steering committee comprised senior civil servants from multiple departments, each of whom were responsible for specific actions. This committee met every three months, and was intended to provide a venue not only for decision-making, but also peer accountability. This approach was contrasted with instances where departmental staff were consulted on a strategy,

but staff turnover and a lack of structures for ongoing engagement hampered continuity and follow-through.

Whole-of-government approaches are often complemented by a core leadership group and expert advisory structures (Barry et al., 2023). For instance, a National Implementation Advisory Group was responsible for coordination, monitoring, and evaluation of *The Aboriginal and Torres Strait Islander Suicide Prevention Strategy* in Australia (Gayaa Dhuwi (Proud Spirit) Australia, 2025). In and the National Suicide Prevention Leadership Group (NSPLG) was established to oversee implementation of *Every Life Matters* in Scotland, which included an academic panel and a lived experience panel (Platt et al., 2021). Quinlan and colleagues (2021) further argue that delegation of leadership must be accompanied by resources, authority, and accountability to act.

Policy levers

The academic and grey literature describes a number of policy levers associated with NMHSPS. These include, but are not limited to:

- Legislation, such as Mental Health Acts or anti-discrimination laws (Coles et al., 2016; Grace et al., 2015; New Zealand Ministry of Health, 2021; Sharkey, 2017)
- Delegation of authority to local governments, nongovernmental organizations, or commissions (Coles et al., 2016; Grace et al., 2015; Lock et al., 2023; New Zealand Ministry of Health, 2021)
- Development of standards, such as service standards or minimum data sets (Coles et al., 2016; Grace et al., 2015; Sharkey, 2017)
- Use of outcome-based or targeted funding (Grace et al., 2015)

The choice of lever is context-dependent. For instance, a paper on *Changing Directions, Changing Lives* argues that engagement was especially essential as the Mental Health Commission of Canada did not have legislative authority or funding for implementation (Mulvale et al., 2014). Past policies also create context for future policymaking. In Australia, new mental health plans are released on a regular basis. While legislative changes took precedence early on, plans subsequently prioritized standards and then regulations to reflect this updated legislative context (Grace et al., 2015).

Delivery of NMHSPSs

Implementation at local levels

Many NMHSPSs seek to enable local autonomy or flexibility. For instance, in Wales, the national government was responsible for oversight of a mental health strategy, while implementation was intended to be locally-driven (Welsh Government, 2015). In Australia's *National Suicide Prevention Trial*, sites were required to select a target population and a multi-component evidence-based approach, but had broad leeway to tailor their approach (Australian Government Department of Health and Aged Care, 2023). Local implementation may reflect existing structures and regulations at a local level, as well as variation in the perspectives of interest-holders involved (Fjellfeldt, 2020). It can also allow adaptation to local needs: an evaluation of the *National Suicide Prevention Trial* noted, "what was well received and effective at individual Sites was very much context dependent" (Currier et al., 2020). However, flexibility comes with risks such as a lack of shared purpose or understanding (Coles et al., 2016; Fjellfeldt, 2020) and confusion over local accountabilities (Lock et al., 2023; Public Health Agency and Department of Health, 2024).

One key informant commented that NMHSPSs "cascade" across levels. They stated that in the implementation process, policies at one level become contextual factors for the next level down. Key informants made several suggestions for effectively channeling that cascade (some of which are echoed in evaluations and commentaries, cited below where applicable):

- Activities must be delegated to the appropriate level; for example, some means restriction activities may be highly local, while changes to health services may span localities
- There need to be a clear accountabilities at each level, accompanied by supporting resources including funding (Lock et al., 2023; Public Health Agency and Department of Health, 2024)
    - Stability of funding is important, as local authorities may be reluctant to pursue programming or changes that cannot be sustained in the long-term (Currier et al., 2020)
- Implementation plans need to be tailored to the structures and resources available at a local level (Lock et al., 2023; Public Health Agency and Department of Health, 2024)
- Outcomes must be identified that are relevant and achievable at a local level
    - Suicide is a rare event, and changes in suicide rate take time to observe; this is amplified in areas with small populations, underscoring the importance of intermediate or process measures (Pirkis et al., 2024)

Effects of NMHSPSs

NMHSPSs are challenging to evaluate: they involve complex interventions, and multi-causal outcomes (Platt et al., 2019). Current evaluative practices may not fully address this complexity. For instance, a systematic review of evaluations of national mental health policies found that evaluations often address single components rather than entire strategies (Aliev et al., 2023). Meanwhile Grace and colleagues (2017) note that evaluations of Australia's successive mental health plans have increasingly focused on narrow, tangible indicators rather than broad objectives. Timelines pose a further evaluative challenge. For instance, some successes were found to unfold over the course of multiple Australian mental health plans. The authors suggest this may be due to the cumulative impact of multi-component, sequential approaches, as well as time for trial and error (Grace et al., 2017). One commentary notes that NMHSPSs may take time to have an effect, and calls for 10-year commitments within NMHSPSs to enable measurable change (Pirkis et al., 2024). Another paper notes that suicide is rare, and rates fluctuate over time for many reasons; the authors state that evaluation of suicide prevention strategies should consider intermediate outcomes linked to specific strategy components (Platt et al., 2019).

Given this complexity, it is perhaps unsurprising that the systematic review cited above found few evaluations of health outcomes achieved through NMHSPSs (Aliev et al., 2023). Similarly, studies and evaluations included in this evidence synthesis focus nearly exclusively on implementation processes. However, we identified three sources that consider effects of NMHSPSs on suicide rates, with mixed findings. The *European Alliance Against Depression* approach to suicide prevention was implemented in 16 German regions. An analysis found the decrease in suicide rates did not differ significantly from non-intervention regions, which the authors note contrasts with findings from earlier studies (Köhler et al., 2021). A comparison between four countries with suicide prevention plans and four without concludes that that national suicide prevention programs were associated with a significant decline in suicide rates among males aged 25-65 (Lewitzka et al., 2019). Schlichthorst and colleagues (2023) attempted to identify elements of national suicide prevention strategies that are associated with reduced suicide rates. They found that no elements were significantly, independently associated

with changed suicide rates. They note that prior studies have found an effect for strategies as a whole, and state, “It is possible that whole strategies, which are intrinsically complex and multilevel, make a difference, unlike individual-specific components” (Schlichthorst et al., 2023).

Reflecting on this complexity, key informants suggested that evaluations should be:

- built in to NMHSPSs from the start
- multi-component and based on program logic, with one key informant suggesting realist methods
- reflective of the time required to achieve full implementation, as well as the expected time needed to achieve specific desired changes
- conducted transparently and independently
- supported by data collection and development of data sets that are linked across services and sectors and over time to enable detailed evaluation, including outcomes outside of health and mental health services (such as those pertaining to social policies and social determinants of health)

Equity considerations in NMHSPSs

Equity concerns, and related concepts including social determinants of health are frequently referenced in NMHSPSs (including in relation to promotion and prevention, as described above). However, it is not always clear how social determinants and social inequities are addressed within strategy implementation. For instance the evaluation of Australia’s *National Suicide Prevention Trial* found that Aboriginal and Torres Strait Islander services were challenged by social determinants of suicidality that were beyond their scope to address (Currier et al., 2020); it is not clear in the evaluation whether other organizations were responsible for intervening more directly in this domain. Data availability can also pose a challenge for tracking progress on equity-related concerns. Actions targeting “upstream” social determinants of health may not be reported or measured (Bassilios et al., 2024). The evaluation of Australia’s *National Suicide Prevention Trial* mentioned above reported efforts to target population groups including LGBTQ+ persons and younger adults, but only anecdotal evidence was available to understand effects on help-seeking and other indicators (Currier et al., 2020).

Equity and related values must be embedded in actions across the full life cycle of NMHSPSs. Key informants suggested that this could be accomplished through:

- Beginning with a situation analysis that includes data on mental health and suicide inequities
- Meaningfully engaging disproportionately-affected communities in design, governance, implementation, and evaluation of NMHSPSs
- Committing to a whole-of-government approach that can enable actions on social determinants of health (which the health system is often unable to influence directly), and monitoring and evaluating actions taken outside of the health system

Limitations

This report has several important limitations. It was conducted by a team affiliated with a mental health hospital, with experience in health systems-focused evidence synthesis. Public health is not our typical area of focus, which may influence our interpretations of findings. To facilitate a rapid approach, we applied narrow inclusion and exclusion criteria to our structured search. For instance we excluded articles focusing on plans at a subnational level (e.g., provincial or state plans), as well as articles focused solely on implementing a single component of a NMHSPS or implementation in a specific local area. In our search for grey literature, we included NMHSPSs

from the past 10 years that had been evaluated; however, the most recent NMHSPSs likely have yet to be evaluated. Finally, we spoke with a limited subset of experts in the field. No key informants for this review held a lived experience role, and/or a role focused on Indigenous mental health or suicide prevention. Our snowball approach to identifying key informants may also introduce bias, as key informants may be more likely to suggest additional interviewees with whom they share a viewpoint. These are important gaps that should be considered when assessing the report's findings.

Our report is also limited by methodological and conceptual weaknesses across the literature that we reviewed. Many included articles were solely descriptive in nature. Evaluations also varied in depth and quality. As noted above, very little literature explores the outcomes of NMHSPSs, including distal outcomes such as population health or suicide as well as more proximal outcomes that may be meaningfully influenced in the shorter term. As such, little is known about outcomes achieved at a population level as a whole, or for specific equity-denied groups. There was limited distinction between mental health promotion and mental ill-health prevention within some NMHSPSs that we reviewed. While social determinants of health were broadly referenced, there is scope for more clearly linking social determinants to both promotion and prevention through description of specific activities, mechanisms of action, and anticipated effects. Social determinants are also described with varying degrees of richness across the included literature. A broad array of social and structural factors are associated with mental health and suicide risk, such as racism and discrimination on the basis of sexual and gender diversity (Huggard et al., 2023; Na et al., 2025). Included documents did not always encompass this full spectrum of potential factors in their description of social determinants. The broad scope of social determinants has important implications for the fulsome operationalization of a whole-of-government approach: for instance, a review on suicide prevention policy in the American context notes the impacts of policies relating to LGBTQ+ rights (Purtle et al., 2025). Finally, the included literature offers limited concrete guidance on engagement with PWLE. Additional bodies of literature highlight practical considerations such as including the importance of clear expectations, fair compensation, opportunities to debrief, collaborative working relationships, and genuine commitment from decision-makers to seek out and act on feedback from PWLE (Faulkner et al., 2015; The National Mental Health Commission, 2017; The Provincial System Support Program, 2019).

Implications for decision-makers in Canada

A number of findings cut across the design, delivery, governance, and evaluation of NMHSPSs. These findings have implications for decision-makers in Canada, as described below.

Engagement

- Recruit, mentor, train, and support diverse lived experience leaders
    - Diversity should encompass a range of intersecting identities and lived experience, with particular focus on leaders from communities most affected by mental ill-health and suicide
    - Decision-makers can benefit from the deep expertise of current Canadian lived experience leaders, and lived experience organizations operating at federal, provincial, and local levels
    - Lived experience leaders and organizations can support the recruitment, training, and mentorship of individuals newer to leadership roles

- Uphold Indigenous self-determination by ensuring Indigenous leadership at a national level as well as community engagement
- Seek ongoing, active, and accountable involvement of senior leaders across government departments and ministries
    - A strong shared vision and mechanisms for peer accountability may support engagement

Multi-level contexts

- Identify actions and outcomes at federal, provincial, and municipal levels
- Consider the delivery systems, implementation supports, and data collection capacities available at these different levels
- Consider interdependencies across levels and across concurrent strategies (including policies and strategies at various levels e.g., provincial mental health plans)
- Embed accountabilities across levels, and create mechanisms for accountability to communities
-

Evaluability

- Use program logic to define actions, accountabilities, indicators, and timelines
    - This should include concrete, measurable, and accountable actions on social determinants of health in addition to health care
- Ensure evaluation will capture equity effects, including experiences and outcomes for equity-denied populations

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What is known about the design, governance, delivery, and effects of NMHSPSs?

Appendices

Appendix 1: Search strategy

A structured rapid review of the literature was undertaken to collect studies related to national mental health and suicide prevention strategies.

Structured search strategy and study selection

We conducted the following two searches:

- MedLine: ((“mental health” or wellbeing or well-being or wellness or suicide or “life promotion”) adj3 (strategy or framework or plan or roadmap)).ti,ab and (design* or develop* or govern* or implement*).ti,ab and (national or federal).ti,ab
- Health Systems Evidence: ("mental health" OR wellbeing OR well-being OR wellness OR suicide OR “life promotion”) AND (design OR develop* OR govern* OR implement*) AND (strategy OR framework OR plan OR roadmap) AND (federal OR national)

We applied the following inclusion and exclusion criteria:

Inclusion criteria	Exclusion criteria
• paper addresses strategies, frameworks, or other overarching guidance for mental health promotion or intervention • strategy is at a national/federal level • strategy is in a high-income country • paper is available in English • paper was published in the past 10 years	• strategy is at a subnational level • strategy is in a low- or middle-income country

Search results were imported into Covidence, where duplicates were removed. Title and abstracts were independently screened by two research team members. Conflicts were resolved through discussion. The full text of all studies included after title and abstract screening were then independently reviewed by two research team members, and conflicts were again resolved through discussion.

Retrieval of additional articles

We identified a recent systematic review on mental health policies and plans that was not retrieved through our systematic search. We included this review and screened its reference list for additional articles meeting our inclusion criteria. We further retrieved sources identified by key informants during interviews.

Data extraction

A single team member completed data extraction for each article. We extracted:

- study characteristics, including title, authors, jurisdiction, objectives, and methods
- content relating to the design, governance, delivery, and evaluation of national mental health and/or suicide prevention strategies
- major study limitations or other notes

What is known about the design, governance, delivery, and effects of NMHSPSs?

Appendix 2: Key informant interviews

Decision-maker partners identified several potential key informant interviews. We further used a snowball approach by asking key informants for further recommendations of experts to whom we could reach out. Key informants were provided with a brief overview of the literature. A semi-structured interview guide was then used to facilitate interviews. Interviews were conducted over Zoom and detailed notes were taken throughout.

Overview and interview guide provided to key informants

Summary of findings to date

We conducted a rapid, structured review of literature on national-level mental health and suicide prevention strategies. We identified 15 relevant studies. Our preliminary findings are summarized below:

Design of mental health and suicide prevention strategies

- Lived experience, international guidance, and research-based evidence are common inputs
- Mental health strategies include a fairly consistent set of elements (including stigma reduction and awareness raising, health promotion, and service and workforce development) and underpinning principles (including social determinants of health, whole-of-government approaches, and recovery)

Governance of mental health and suicide prevention strategies

- Whole-of-government approaches are often mentioned, but rich description is lacking
- A range of policy levers are used (eg. legislation, regulation), in varying combinations

Delivery of mental health and suicide prevention strategies

- The literature describes iterative approaches to strategy development and implementation
- Many frameworks seek to enable local autonomy or flexibility, and this can create challenges in terms of a shared understanding
- Some authors note that process evaluations do not always reflect underpinning principles, eg. upstream approaches are often prioritized but not often reported or measured

Effects of mental health and suicide prevention strategies

- Some studies note the inherent complexity of evaluating mental health and suicide prevention strategies
- The literature does not describe effects of mental health strategies for population health
- One review attempts to identify effects of suicide prevention strategy components and finds no individual component is associated with changed outcomes

We are in the midst of reviewing grey literature on national mental health and suicide prevention strategies internationally. We are also speaking with experts in the field, such as yourself, to help us understand and address some of the gaps in the literature.

What is known about the design, governance, delivery, and effects of NMHSPSs?

Questions for key informants

Design of mental health and suicide prevention strategies

1. The design of mental health and suicide prevention strategies is often based on research and evaluation evidence, international guidance (e.g., from the WHO), and the engagement of people with lived experience.
    - What structures and capacities must be in place for governments to leverage these inputs?

2. Countries may have multiple mental health-related strategies (e.g., strategies for suicide prevention, mental health promotion, and mental health of specific populations).
    - How can these strategies align and complement each other to avoid duplication of efforts or gaps?

3. How can equity be addressed in the design of national mental health and suicide prevention strategies? Do you have any examples of how equity has been addressed in existing strategies?

Governance of mental health and suicide prevention strategies

4. The literature on national mental health and suicide prevention strategies calls for whole-of-government approaches.
    - In your experience, what does a whole-of-government approach look like in practice?
    - What supports, strategies, or structures facilitate this approach effectively?

Delivery of mental health and suicide prevention strategies

5. There is often tension between establishing an overarching national strategy and ensuring strategies are adaptable to the needs, cultures, and strengths of local communities.
    - What strategies or structures can help balance the need for a unified national strategy while being responsive to local considerations?
    - What strategies or structures are necessary to translate broad national strategies into effective, actionable interventions at the local level?
6. Mental health and suicide prevention strategies often acknowledge the importance of social determinants of health. However, researchers have argued these strategies have led to limited concrete action on social determinants.
    - How can implementation of mental health or suicide prevention strategies address the social determinants of health?

Effects of mental health and suicide prevention strategies

7. Measuring the success of national strategies is inherently complex.
    - What are appropriate ways to monitor and evaluate the impact of such strategies?
    - What types of data, indicators, or evaluation frameworks have been particularly useful in your experience?

What is known about the design, governance, delivery, and effects of NMHSPSs?

Appendix 3: Data extraction

Data extraction categories

We extracted content relating to the categories below:

- Design of national mental health strategies
  - Development of the framework
    - Engagement of people with lived experience, communities, and members of the public
    - Engagement of health and social-care providers
    - Engagement of other interest groups
    - Inter-ministerial, whole-of-government, and inter-sectoral approaches
    - Use of research evidence
    - Guiding principles
    - Alignment with national policy context
    - Other
  - Elements of the framework
    - Promotion of mental wellbeing and prevention of mental ill-health
    - Suicide prevention/life promotion
    - Crisis and distress services, including helplines
    - Mental health care
    - Population mental health surveillance and measurement
    - Other
- Delivery of national mental health strategies
  - Implementation strategies, barriers, and facilitators
    - Strategies, barriers and facilitators for decision-makers and intermediaries
    - Strategies, barriers and facilitators for service provider organizations
    - Strategies, barriers and facilitators for care providers and recipients
    - Other
  - Process measures
    - Strategy reach
    - Strategy adoption
    - Fidelity
    - Program/service access
    - Intersectoral partnership and integration
    - Maintenance over time
    - Other
- Governance of national mental health strategies
  - Inter-ministerial and inter-sectoral approaches
  - Centralization and delegation of authority, including use of intermediary organizations
  - Engagement of people with lived experience, communities, and members of the public
  - Engagement of health and social care providers
  - Other
- Effects of national mental health strategies
  - Population health outcomes
  - Equity outcomes
  - Cost and service utilization outcomes
  - Service user and community member experiences
  - Care provider experiences
  - Service user and community member knowledge, beliefs, and attitudes
  - Provider knowledge, beliefs, and attitudes
  - Other

What is known about the design, governance, delivery, and effects of NMHSPSs?

Data extraction from structured search

Study information	Design, delivery, governance, and effects of strategy	Notes
Author: Basilios et al. **Date:** 2024 **Title:** Government funded suicide prevention in Australia – an environmental scan **Jurisdiction:** Australia **Methods:** document review **Objective:** "This article summarises findings from an environmental scan of government-led suicide prevention in Australia, conducted as an input for the development of the new Strategy"	**Design of strategy** • ***Engagement of people with lived experience, health and social care providers, and other stakeholders:*** The National Suicide Prevention Adviser's Final Advice reflected views of people with lived experience of suicidality, service provider organizations, Indigenous suicide prevention leaders; • ***Inter-ministerial, whole-of-government, and inter-sectoral approaches:*** "In 2021, the Federal Government announced the establishment of the National Suicide Prevention Office (NSPO) tasked with working across governments, portfolios, and sectors to drive the development of a nationally consistent and integrated approach to suicide prevention." At the time, multiple federal and state initiatives addressed suicide prevention. The National Mental Health and Suicide Prevention Agreement provided "a key mechanism for formalising a joint Federal-state/territory approach including Federally funded PHNs and Medicare Benefits Schedule (MBS) services and state/territory government funded Local Hospital Networks (LHNs); as well as an explicit commitment to a whole-of-government approach." • ***Use of research evidence:*** the NSPO's strategy is based on "a public health, whole-of government approach to suicide prevention developed by Pirkis and colleagues" as well as the National Suicide Prevention Adviser's Final Advice and other inputs. • ***Key principles:*** "The Final Advice is founded on 'whole of system, whole of life' principles, aiming to provide early intervention anywhere it could be needed in the service delivery system. This tenet is reliant on a whole-of-government approach to suicide prevention" • ***Elements:*** At the time of this article's development, the framework to guide strategy development included focus areas ("Strengthening protective factors and wellbeing • Mitigating the impact of known drivers of distress • Empowering earlier intervention • Providing accessible, comprehensive, and compassionate care • Supporting long-term wellbeing") and enablers ("Governance and collaboration across governments and portfolios • Embedding lived experience decision-making and leadership • Data and evaluation • Workforce and community capability") **Delivery of national strategy** • ***Process measures, other:*** Current policies/initiatives do not fully align with the framework for strategy development. In particular interventions tend to be focused on risk factors rather than population-level wellbeing and protective factors; no current services and strategies address social determinants of distress; mechanisms for integration are weak; and there is limited detail regarding the operationalization of a whole-of-government approach.	

	However, most policy documents and a third of regional plans address involvement of people with lived experience. Broadly, evaluation is inconsistent and data is limited.	
Author: Borg et al. **Year:** 2022 **Title:** Developing the 2020-2030 mental health strategy for Malta: Addressing the needs of a small island state undergoing rapid socioeconomic transition **Jurisdiction:** Malta **Methods:** case description **Objectives:** "This paper seeks to analyse the policy development process, outline the content of the strategy, set out the challenges to be overcome and highlight the key lessons learnt which can be helpful to other countries facing similar challenges."	**Design of strategy** • ***Alignment with policy context:*** Malta is undergoing social change including increased migration, increased workforce participation of women (and therefore lower availability of informal caregiving), and increased cost of living. These changes introduced growing demand for mental health services, including culturally-sensitive services. A new Mental Health Act was introduced, which included the creation of the Office of the Commissioner for Mental Health in 2012. Factors affecting agenda-setting around mental health included advocacy from the commissioner and from NGOs, a performance review of the country's mental health hospital, increased public awareness and media attention to mental health, a national health system review, and priorities in two international documents (Malta-WHO Regional Office for Europe Country Cooperation Strategy 2016-2021 and the WHO-Malta Biennial Collaborative Agreement 2018-2019). • ***Engagement of other interest groups:*** The strategy was developed by a working group with technical support from the WHO, and in consultation with "[v]arious Ministries, entities, organisations, unions, professionals, patients and carers." • ***Use of research evidence:*** "The content of the Mental Health Strategy for Malta 2020-2030 [12] was informed by a thorough needs assessment, a literature review including strategies from other European countries and key WHO documents. The underlying framework is in alignment with the European Mental Health Action Plan 2013-2020 [32]." • ***Guiding principles:*** "The strategy upholds the values of dignity, autonomy, human rights, accessibility and equity... The concept of resilience [33] has been put as a central tenet guiding the development of the strategy." • ***Elements of strategy:*** The strategy includes: mental health promotion, including addressing determinants of mental health; a new mental health services framework that focuses on a shift to community-based services and integrating mental health care into general health settings; rehabilitation and social assistance for patients, families, and caregivers including significant others; workforce strengthening; performance measurement; and deployment of electronic health records. The strategy is guided by the following approaches: 1) life course approach; 2) prevention focus; 3) "protection from stigma and discrimination"; 4) evidence-based; 5) "governance and delivery driven by reliable information"; 6) person-centred care; 7) inter-sectoral; 8) prioritizing community-based services; 9) integration of physical and mental health care; 10) inter-jurisdictional learning with local adaptation; 11) flexible implementation; 12) sustainable, stepwise implementation; 13) adequate funding and value for money. **Delivery of strategy**	

	• ***Strategies, barriers and facilitators for decision-makers and intermediaries:*** Reducing hospital beds requires the concurrent development of comprehensive community services. Workforce capacity-building and rolling out electronic records have also been identified as a challenge, along with addressing COVID-related effects on population mental health. • ***Strategies, barriers and facilitators for service provider organizations:*** Intersectoral collaboration is identified as a challenge. • ***Strategies, barriers and facilitators for care providers and recipients:*** The reallocation of service providers to community-based services requires a shift in skills and attitudes.	
Author: Coles et. al **Year:** 2016 **Title:** Getting It Right for Every Child: A National Policy Framework to Promote Children's Well-being in Scotland, United Kingdom **Jurisdiction:** Scotland, UK **Methods:** policy analysis **Objectives:** "This article explores the origins and emergence of GIRFEC and presents a critical analysis of its incremental design, development, and implementation"	**Design of strategy** • ***Alignment with policy context:*** Getting It Right For Every Child (GIRFEC) emerges out of a trajectory towards integrated, rights-based approach to child policy in Scotland, which in turn responds in part to the 1989 UN Declaration on the Rights of the Child. Specific elements of GIRFEC echo earlier policy approaches, eg. a "named individual" to coordinate services was first referenced in an earlier strategy. GIRFEC also makes use of existing structures put in place through efforts to integrate child services, such as the Individual Assessment Framework. • ***Use of research evidence:*** Tools and models of care under the strategy are informed by child development theory, as well as experiences with similar assessment frameworks in England. • ***Elements of strategy:*** GIRFEC is based on 8 domains of wellbeing: "all children should be safe, healthy, active, nurtured, achieving, respected, responsible, and included." It encompasses two major elements: "(1) the roles of Named Person and Lead Professional and (2) the National Practice model (comprising 3 assessment tools and a single child's plan, used by practitioners for assessment, planning, and action)." All children should have a Named Person who can act as a gatekeeper to services, while a Lead Professional coordinates services across multiple agencies for children with complex needs. ○ It is further described as included 10 components: 1) focus on improved outcomes & shared understanding of wellbeing; 2) common approach to consent and information-sharing; 3) involvement of children and families in assessment, care planning, & intervention; 4) coordinated approach to identifying issues and goals based on common indicators; 5) streamlining processes; 6) integration and coordination across agencies; 7) Named Person and Lead Professional; 8) increased skills of workforce within universal services to identify and intervene early; 9) "A confident and competent workforce across all services for children, young people, and their families"; 10) ability to share information digitally.	GIRFEC does not address mental health per se, but rather addresses childen's wellbeing broadly at a population level.

	Delivery of strategy
	• ***Strategies, barriers and facilitators for decision-makers and intermediaries.***
	  ○ A staged and iterative approach to implementation was adopted. The policy was developed, followed by an implementation plan. It was then piloted in the Highlander region (as this region already had "a multiagency working model) from 2006-2009. National guidance was produced that integrated learnings from the pilot, and rolled out in 2008.
	  ○ Barriers included opposition to the "Named Person" approach, which was challenged in court. This approach was perceived as intrusive and indicative of undue state surveillance of families, given that it applies to all families and not only those perceived to be at risk. Privacy concerns were raised around information-sharing duties; these were brought to the UK Information Commissioner's Office. Concerns were also raised around services' capacity to implement a Named Person approach, and impingement on professional roles and autonomy.
	  ○ A further barrier is a lack of shared understanding of GIRFEC concepts, which may in part reflect a Scottish policy context that prioritizes local autonomy and discretion.
	  ○ The transition to a universal approach requires a shift from traditional, problem-oriented services. The authors also note, "there is a danger that inclusive policies that do not specifically highlight and prioritize the complex needs of particular groups may unintentionally exclude them."
	• ***Process measures, fidelity:*** a 2009 evaluation of the pilot project found "every child and young person in the Pathfinder area had a 'named person' in health or education to act as a single point of contact to access services and to help support his or her well-being."
	• ***Process measures, other:*** the child protection sector does not appear to have been fully integrated as it continues to have a number of standalone processes, policies, and assessment frameworks.
	
	Governance of strategy
	• ***Centralization and delegation of authority:*** "Scotland's 32 local authority administrations are charged with implementation… Acknowledging the diversity in different parts of the country, the GIRFEC framework does allow some local flexibility to fit in with existing local structure." In 2013, 5 years into national implementation, national legislation was introduced to support consistent implementation by embedding GIRFEC into a national approach to children's service delivery.	

Author: Desborough et al. **Date:** 2022	**Design of strategy** • ***Engagement of other interest groups:*** "Australia's National Mental Health and Wellbeing Pandemic Response Plan was	

Title: Rapid deployment of support for a mental health crisis: 10 priorities framing Australia's COVID-19 pandemic response. **Jurisdiction:** Australia **Methods:** Descriptive overview **Objective:** Summarize Australia's national mental health policy response to COVID-19	developed by the National Mental Health Commission (NHMC) in collaboration with the states and territories, represented by New South Wales and Victorian Governments, and mental health sector leaders with lived, clinical, and research experience." • ***Elements of strategy:*** The Plan includes 10 priorities: 1) adapting current services to meet "intermediate mental health and wellbeing needs"; 2) implementing new community-based models of care for emerging needs; 3) coordination and integration; 4) addressing complex needs through outreach and home- and community-based services, and decreasing use of inpatient services; 5) addressing risk factors for mental ill-health and suicide; 6) providing targeted responses for vulnerable populations; 7) engaging in informative and clear communication; 8) coordinated suicide prevention; 9) supporting the workforce, including lived experience, professional, and community mental health workers; 10) coordinating across Australia's federated health system. **Delivery of strategy** • A number of concrete actions were taken under the priorities above: ○ 1) *meeting intermediate needs:* a COVID-19 mental health support website was created to provide information and link to services ○ 2) *implementing new community-based models of care*: non-governmental organization Beyond Blue was funded to create resources and provide 24-hour phone-based counselling ○ 4) *addressing complex needs*: peer support services were expanded, and existing psychosocial services were extended ○ 5) *addressing risk factors:* funding was established for rapid research into mental health effects of COVID-19 ○ 6) *providing targeted responses for vulnerable populations:* an online and phone visitor program was expanded to support older adults, and substance use services were funded to scale up ○ 7*) communication:* a national social media campaign was conducted to promote social connection ○ 9) *supporting the workforce:* additional training was provided for counsellors in existing services ○ 10) *coordinating across Australia's federated health system*: a mental health pandemic response taskforce was established to support the implementation of 15 new mental health clinics; National Safety and Quality Digital Mental Health Standards were released to support uptake of digital mental health services; and new primary care billing codes were introduced for virtual mental health care • ***Process measures – intersectoral partnership:*** "Early reported indicated that expanded levels of service and technical integration between primary, community, and	

	tertiary mental healthcare, and access to e-health, were key to organizing an effective response in Australia." **Effects of strategy** • Data is not available to measure outcomes	
Author: Grace et al. **Year:** 2015 **Title:** An analysis of policy levers used to implement mental health reform in Australia 1992-2012 **Jurisdiction:** Australia **Methods:** policy analysis **Objective:** "This study explored how five policy levers (organisation, regulation, community education, finance and payment) were used by the Australian Federal Government to implement mental health reforms"	**Design of strategy** • ***Elements of strategy*:** Australia's first mental health plan focused on deinstitutionalization. The second plan shifted in focus from SMI to common mental disorders, primary care, and promotion and prevention. The third plan focused on integration of care. The fourth focused on workforce issues, reporting and accreditation, and targeted interventions for specific groups. **Delivery of strategy** • ***Implementation strategies for decision-makers and intermediaries:*** Mental health funding was separated from other healthcare funding. Targeted funding was provided for priority populations and programmatic areas. A National Minimum Dataset was created and rolled out. • ***Implementation strategies for care providers and recipients:*** Mental health training was included in tertiary education and professional development for providers. An e-mental health portal and phone-based services were developed to support service navigation. • ***Other:*** Anti-stigma media campaigns targeted the general public. **Governance of strategy** • ***Centralization and delegation of authority:*** over time, governance of plans shifted towards increased use of payment incentives and outcomes-based funding, as well as increased use of standards and regulations (and decreased use of legislation). o Review of anti-discrimination legislation was conducted to support anti-stigma efforts. o First, service standards were updated; subsequently, regulatory changes focused on accountability for these standards. o Regulation was also used to create joint service protocols across sectors and to reduce cross-border "anomalies" to facilitate patient transfers. o Implementation responsibilities were gradually shifted onto non-governmental organizations. o A centralized, independent evaluation committee reports to the federal government. • ***Engagement of people with lived experience:*** "A National Mental Health Consumer Body was established to embed consumer and carer experience within policymaking, program development and implementation."	
Author: Grace et al. ***Year:*** 2017 ***Title:*** An analysis of policy success	**Effects of mental health strategies** • The authors argue that policy evaluation is complex: "attributions of 'success' and 'failure' go beyond outcome and process indicators and can refer to a range of different kinds of achievements or failures." They consider 8 evaluative	

and failure in formal evaluations of Australia's national mental health strategy (1992–2012)
Jurisdiction: Australia
Methods: policy analysis - documentary review
Objective: "The present article draws on theoretical insights from political science to analyse the relative successes and failures of these levers, as portrayed in formal government evaluations of the NMHS"
	indicators (see Table 1): original objectives, target group impact, results (ie. outcomes), significance, source of opposition/support, jurisdictional comparisons, balance sheet, level of innovation, normative stance. Evidence of success/failure is identified for each.
	• Over time, Australian mental health strategies have been evaluated as increasingly successful
	  ○ Authors argue: "The apparent increases in success [over time/subsequent plans] could be indicative of policy learning in relation to setting and appraising objectives to maximise the chance of success, either practically or rhetorically."
	  ○ Evaluations have also increasingly focused on tangible objectives
	  ○ "Proposals involving a single level of government, and those involving relatively straightforward changes to legislation, budget allocations or the organisation of existing services, were achieved in the course of a single Plan. Conversely, proposals requiring cooperation across jurisdictions or service sectors were less likely to meet their objectives or have the intended target group impact, and were thus reported as unequivocal failures. In some cases, more ambitious objectives did appear to be achieved cumulatively over the course of the NMHS…. Cumulative successes were commonly associated with a change in approach and/or the application of a different policy lever (e.g. payment), suggesting that complex health reforms may require some degree of trial and error and/or the coordination of different initiatives over time."	

Author: Happell et al. **Date:** 2015 **Title:** Applying the world health organization mental health action plan to evaluate policy on addressing co-occurrence of physical and mental illness in Australia **Jurisdiction:** Australia **Methods:** document review **Objective:** " ...to document Australian policies on the physical health of people with mental illess and evaluate the	**Design of strategy** • ***Elements of strategy:*** The Fourth National Mental Health Plan (FNMHP) includes two priority areas relevant to physical health: 1) prevention and early intervention (Priority Area 2); and 2) service access, coordination and continuity of care (priority Area 3). **Delivery of strategy** • ***Process measures, other:*** Evaluation of the Plan in relation to the WHO Action Plan shows important gaps in the approach to physical health of people with mental illness. There is some attention to integrated care (eg. through Medicare co-payments), but beyond that there is limited relevant strategic direction at a national level. Physical health screening guidelines are available, but processes are not in place to ensure these guidelines are met. There are limited pathways for consumers to influence mental health policy, including policies relating to physical health of people with mental illness.	

capacity of policy to support health needs."		
Author: Iskander & Crosby **Date:** 2021 **Title:** Implementing the national suicide prevention strategy: Time for action to flatten the curve. **Jurisdiction:** USA **Methods:** Commentary **Objective:** To review trends in the epidemiology of suicide and suicidal behaviour to provide an overview of the recently released Surgeon General's Call to Action to fully implement the National Strategy.	**Design of strategy** • ***Engagement of people with lived experience:*** The Call to Action to Implement the National Strategy for Suicide Prevention (CTA) was developed by a group of stakeholders including people affected by suicide. • ***Elements of strategy:*** The CTA includes multiple action steps: o "[L]aunching an encompassing public health response to suicide" that engages people with lived experience, builds knowledge about risks, and communicates key messages broadly o Addressing "upstream factors" o Addressing safety of lethal means, including but not limited to firearms o Collecting complete, timely, and high-quality data about suicide deaths and suicidal thoughts and behaviours o Adopting evidence-based care for people at risk of suicide o Enhance crisis care **Delivery of strategy** • ***Process measures, other:*** The authors state that evaluation should be ongoing and based on implementation science. They propose the following criteria would indicate full implementation has been achieved: o Intersectoral engagement and uptake o Availability of complete, timely data o Implementation of multi-disciplinary public health suicide prevention interventions o Use of communication through traditional and social media to decrease stigma without promoting suicide contagion ***Effects of strategy*** • The authors also state that reduced suicides "and related outcomes" would be an indicator of full implementation	
Author: Mulvale et al. **Year:** 2014 **Title:** Engaging civil society through deliberative dialogue to create the first Mental Health Strategy for Canada: Changing Directions, Changing Lives **Jurisdiction:** Canada	**Design of strategy** • ***Engagement of people with lived experience, communities, and members of the public:*** The strategy was developed using a deliberative approach to engagement: "We define deliberative approaches to be those that aim to foster particular kinds of structured conversation that feature informed and reasoned discussion, attentive listening to understand the values underlying different views, weighing of reasons for and against a proposed action or policy (deliberation) and a desire to build towards common understanding and action." These approaches included in-person and online methods, encompassing of dialogues and creative approaches such as storytelling. The approach was iterative. The first stage, framework development, engaged over 450 in-person participants and "over 1700 members of	

Methods: case study **Objective:** "In this case study, we review the essential role that engagement of civil society played in the creation of the Strategy"	the public and 300 stakeholders" online. The second stage, strategy development, involved consultation with 125 members of advisory committees representing specific areas of focus eg. youth, family caregivers, or mental health and the law. Given MHCC's position, it was essential for participants to understand what could and could not be done through deliberative methods (i.e., the "priority was on listening, understanding the values of each group, and demonstrating the capacity to be responsive to the concerns of each constituency" but they could not execute the recommendations). Engagement was perceived as critical to build legitimacy and buy-in, since the MHCC "could not count on having the 'carrot' of investment dollars to incent uptake of the Strategy, nor did it have the 'stick' of legislative authority." • ***Inter-ministerial, whole-of-government, and inter-sectoral approaches:*** "To build support across levels of government, the MHCC also created a Provincial/Territorial Reference Group and sought regular feedback from federal government departments, and national indigenous organizations."	
Author: Quinlan et al. **Date:** 2020 **Title:** Supporting a public health approach to suicide prevention: Recommendations for state infrastructure. **Methods:** Commentary **Objective:** recommend a framework for organizing an emerging evidence base on the infrastructure and systems that are needed to support an effective, sustainable, public health approach to suicide	**Delivery of strategy** • ***Strategies, barriers and facilitators for decision-makers and intermediaries:*** The authors describe six proposed components of state infrastructure to support suicide prevention, all of which require adequate funding, supportive partnerships, data systems, and skill building: o Designating a lead organization or division, and ensuring it has resources, authority, and accountability to act o "Maintain a dedicated leadership position, as well as core staff positions" and cross-agency partnerships within government o Support state-level public-private partnerships o Collect and analyze data at state and local levels o "Create a multi-faceted life-span approach to suicide prevention across the state and allocate sufficient resources to fully implement and evaluate it" o Build capacity for state and local efforts **Effects of strategy** • Authors argue for the development of a literature base "that can draw a direct line from increased infrastructure supports to improved delivery of evidence-supported interventions to reduce suicide mortality," including use of complex evaluation methods to address "relative contribution of various infrastructure elements," economic evaluation/demonstration of value through funding models, and "valid, reliable measures of the state of infrastructure elements."	Does not describe a specific strategy.
Author: Schlichthorst et al **Year:** 2022 **Title:** Evaluating the Effectiveness	**Design of strategy** • ***Elements of strategy:*** The authors refer to Platt and colleagues (2019) identification of typical elements of a national suicide prevention strategy: means restrictions; responsible media reporting; access to health and social	

of Components of National Suicide Prevention Strategies **Jurisdiction:** 29 countries (including 15 high-income countries) Methods: narrative review and interrupted time series analysis **Objective:** "To describe components included in national suicide prevention strategies and analyze the potential contribution of individual components to reduce suicide rates."	care; training and education; psychotherapy; follow up after suicide attempts; crisis intervention; postvention; awareness; stigma reduction; surveillance and monitoring; coordination and governance. ○ "The number of components adopted by countries ranged from 4 to 11." ○ Training and education was included in over 95% of strategies, and 93% included surveillance. ○ 20% included psychotherapy, and 38% included crisis intervention. **Effects of mental health strategies** • The study found that no elements were significantly associated with changed suicide rates. The authors note that prior studies have found an effect for strategies as a whole, and state, "It is possible that whole strategies, which are intrinsically complex and multilevel, make a difference, unlike individual-specific components." They also note that they considered the existence of a national strategy but not its degree of implementation.	
Author: Sharkey, T. **Year:** 2017 **Title:** Mental health strategy and impact evaluation in Qatar **Jurisdiction:** Qatar **Methods:** none - description **Objective:** "This article discusses the development of the National Mental Health Strategy for Qatar, Changing Minds, Changing Lives, 2013–18, its implementation, and the findings from an independent impact evaluation carried out in 2015."	**Design of strategy** • ***Engagement of other stakeholders:*** developed with technical input from World Health Organization. • ***Elements of strategy*****:** The strategy includes 10 priorities: 1) raise awareness and reduce stigma; 2) make information resources available; 3) "ensure most people can access their treatment in primary care and community settings"; 4) develop specialist services; 5) provide individualized and evidence-based care; 6) workforce development; 7) "provide a coordinated multi- sectoral approach to mental health policy development and planning"; 8) "enact mental health law"; 9) report on a minimum data set; 10) "ensure mental health research evidence translates into improvements in clinical practice and patient outcomes". **Delivery of strategy** • ***Implementation strategies for decision-makers and intermediaries:*** Implementation involved an implementation framework, investment plan, business cases, technical committee, subject matter experts, and implementation teams. "One major challenge has been capacity-building in the face of a shortage of mental health professionals, limited local expertise and slow local recruitment processes." • ***Process measures, other:*** The strategy was found to align with most elements of the WHO recommendations for national mental health policies. New legislation and policies were developed including a "draft action plan for the prevention of psychiatric disorder and mental health promotion," a school mental health plan, a draft law to "safeguard the human rights of people with a mental illness,"	

	a minimum data set and research agenda. New services were also created including a community service hub.	
Author: Surdey et al. **Year:** 2024 **Title:** Developing Irelands first National Student Mental Health and Suicide Prevention Framework for Higher Education **Jurisdiction:** Ireland **Methods:** Descriptive **Objective:** To describe "the development of Ireland's first National Student Mental Health and Suicide Prevention Framework for Higher Education"	**Design of strategy** • ***Alignment with policy context:*** The National Student Mental Health and Suicide Prevention Framework was developed by the Higher Education Authority to fulfill its obligations under Ireland's broader suicide prevention framework. • ***Use of evidence:*** The framework was informed by a scoping review. • ***Engagement of people with lived experience:*** Two consultation events were held with students. • ***Engagement of health and social care providers:*** A consultation event was held with "groups in the education and health sectors" and "institutional leaders, researchers, practitioners, academics, and international experts." • ***Elements of the strategy:*** The framework includes 9 themes ("lead, collaborate, educate, engage, identify, support, respond, transition, and improve") which are intended to be viewed as interconnected. **Delivery of strategy** • ***Strategies, barriers and facilitators for decision-makers and intermediaries:*** Implementation should be student-centred, and conducted in collaboration with students and staff. • ***Strategies, barriers and facilitators for service provider organizations:*** Institutions need to foster a culture of "diversity, inclusivity, and compassion," and to offer mental health supports for students, including protocols for crisis response and supports aimed at vulnerable groups. Institutions should partner with Ireland's free 24-hour crisis text line. There are reporting requirements for implementation progress.	
Author: Rosenberg et al. **Year:** 2023 **Title:** Mental health reform in Australia – unfinished business **Jurisdiction:** Australia Methods: Descriptive **Objective:** To describe the reform of Australia's National Mental Health Strategy, including, "progress of reform, outlining some strengths, weaknesses and	**Design of strategy** • ***Alignment with policy context:*** "Australia's National Mental Health Strategy was developed partly in response to issues emerging from a national inquiry by the Human Rights and Equal Opportunity Commission, which found egregious examples of poor treatment and care in mental health services." **Effects of strategy** • "No evaluation of the [five] national plans has occurred since 2008." While data collection occurs, this is not always linked to processes of quality improvement. Population-level effects have not been observed.	

prospective challenges."		
Author: Rochford et al. **Year:** 2023 **Title:** The public health approach to suicide prevention in Ireland **Jurisdiction:** Ireland **Methods:** Descriptive **Objective:** "This article provides an overview of the public health approach to suicide in Ireland" and "detail on the current suicide prevention strategy in Ireland, Connecting for Life, which is a whole-of-government, systemic, multicomponent national strategy"	**Design of strategy** • ***Alignment with policy context:*** Connecting for Life 2015-2020 builds on the first national suicide prevention strategy in Ireland called Reach Out (2005). • ***Elements of strategy:*** CfL has seven goals: "1. To improve the nation's understanding of, and attitudes to, suicidal behaviour, mental health and wellbeing.; 2. To support local communities capacity to prevent and respond to suicidal behaviour.; 3. To target approaches to reduce suicidal behaviour and improve mental health among priority groups.; 4. To enhance accessibility, consistency and care pathways of services for people vulnerable to suicidal behaviour.; 5. To ensure safe and high quality services for people vulnerable to suicide.; 6. To reduce and restrict access to means of suicidal behaviour.; 7. To improve surveillance, evaluation and high quality research relating to suicidal behaviour." **Delivery of strategy** • ***Strategies, barriers and facilitators for decision-makers and intermediaries.*** 23 NGOs are funded to partner with government on implementation. Implementation is intended to be "bottom up" and locally driven. Sixteen local action plans were developed, driven by local steering groups. • ***Progress measures, other:*** A review found some actions had been taken on all seven strategic goals, in particular: "stigma reduction, self-harm, public health communications, media monitoring, the development of local Connecting for Life plans, early intervention services, the coronial process for suicide death registrations, General Practitioner (GP) prescribing behaviours (regarding benzodiazepines), amongst other strategic areas." Areas with limited progress included "co-ordinated delivery of suicide prevention training, strategic planning around priority or vulnerable groups, restricting access to means of suicide in public places and evaluating the cost-effectiveness of the strategy."	
Author: Alimi et al. **Year:** 2021 **Title:** Improving child mental health policy in Canada **Jurisdiction:** Canada **Methods:** commentary **Objective:** not stated	**Delivery of strategy** • ***Process measures, other:*** The authors conclude that Evergreen, Canada's first framework for children's mental health, has been ineffective as "Taken together, although Evergreen, Canada's first official national mental health framework "only four provinces met the WHO guidelines for child mental health policies, which shows that Evergreen has not been effective."	Basis for author's conclusions is unclear; link between strategy and provincial policymaking is not described.
Author: Arensman et al. **Year:** 2020 **Title:** Suicide and Suicide Prevention From a Global Perspective	**Design of strategy** • ***Alignment with policy context:*** The WHO report *Preventing Suicide: A Global Imperative* was published in 2014, following on the 2013 publication Global Mental Health Action Plan, 2013–2020. The report is intended to have broad relevance to countries with different degrees of prior suicide prevention activity (eg. with or without an existing national approach).	

Jurisdiction: international **Methods:** unstructured literature review **Objective:** "In this introductory chapter, we provide the background and rationale for the compilation of overviews of national suicide prevention strategies from all geographic regions globally."	• ***Engagement of other interest-holders:*** The report was prepared by members of the International Association for Suicide Prevention (IASP), from multiple regions around the world. The IASP Special Interest Group "is tasked with developing guidance for establishing, implementing, and evaluating community-level suicide prevention activities in countries where a national strategy is not currently feasible." **Delivery of strategy** • ***Process measures:*** The strategy has attracted broad international interest: "the WHO report has been translated into all six United Nations (UN) languages, and regional launches have been held in Mexico (with representatives from Spanish-speaking countries), in Cairo (with representatives from the WHO Eastern Mediterranean Region), and in Tokyo (with representatives from the WHO Western Pacific Region)."	
Author: Ben Abdelaziz et al. **Date:** 2023 **Title:** Creating 'wellbeing societies': moving from rhetoric to action **Jurisdiction:** international **Methods:** commentary **Objective:** "In this paper we describe the background and context for these initiatives [Geneva Charter for Wellbeing and the WHO Wellbeing Framework], the concept of wellbeing societies and how the WHO is advancing this global agenda."	**Design of strategy** • ***Alignment with policy context:*** The WHO Global Wellbeing Framework was developed following endorsement of the Geneva Charter for Wellbeing and the Sustainable Development Goals. • ***Elements of strategy*****:** The framework includes 6 strategic directions: "1) nurturing planet Earth and its ecosystems; 2) designing social protection and welfare systems based on equity, inclusion and solidarity; 3) designing and supporting implementation for equitable economies that serve human development; 4) promoting equitable universal health coverage through primary health care, health promotion and preventive services; 5) promoting equitable digital systems that serve as public utilities, contribute to social cohesion and are free of commercial interest; and 6) measuring and monitoring wellbeing." It is intended to be operationalized through a whole-of-government approach.	
Author: Tomaszewski et al. **Date:** 2024 **Title:** Eighty Years of National Mental Health Policy: Exploring the Inclusion of a Human Rights Approach	**Design of strategy** • ***Guiding principles:*** 21st century mental health policies in US have focused on "parity" or equivalence of mental and physical health in the context of insurance coverage. Policies have also been framed around human rights. Authors suggest this rhetoric is not always reflected in contents of legislation, which tends not to address social determinants of mental health inequities.	Extraction only addressed recent (2000s onwards) policies.

What is known about the design, governance, delivery, and effects of NMHSPSs?

Jurisdiction: United States **Methods:** unstructured literature review **Objective:** "the article presents an analysis of 80 years of United States mental health policy, explores the framing of mental health as a continuum, highlights efforts to achieve mental healthequity, and proposes pathways to creating mental health equity."		
Articles excluded due to focus on a single element within a plan, or local implementation		
• A commentary on the establishment of forensic services under Qatar's mental health strategy • A qualitative study of the implementation of suicide prevention training under Scotland's suicide prevention strategy • A study comparing mental health service activity and capacity in Australia, Tasmania to estimates produced by the National Mental Health Service Planning Framework (NMHSPF) • A critical analysis of crisis care policy under the 1999 UK National Service Framework for Mental Health • Implementation evaluation of guideline-based suicide prevention policies in Dutch mental health services, under the Dutch National Suicide Prevention Strategy • Survey of local authorities in Japan to explore how a national fund supported implementation of the 2007 'General Principles of Suicide Prevention Policy' • Evaluation of the effects of suicide prevention training on knowledge, attitudes, and behaviours under "Suicide Prevention Austria" strategy • A critical analysis of Canadian suicide surveillance policy and its implications for Indigenous communities • A document review exploring Australian mental health monitoring and reporting in relation to mental health reforms • Effectiveness and implementation study of a Zero Suicide model for healthcare settings, endorsed in the US National Strategy for Suicide Prevention and implemented in New York State • Qualitative study of Lisbon-based managers' views on psychosocial care under the Portuguese National Mental Health Plan • Description of indicator development for a national surveillance system in Germany • Description of concepts relevant to mental health systems modelling, to inform service planning under Australia's Fifth National Mental Health Plan		

Data extraction from citation chaining and key informant files

Study information	Design, delivery, governance, and effects of strategy	Notes

What is known about the design, governance, delivery, and effects of NMHSPSs?

Author: Aliev et al. **Date:** 2023 **Title:** Methods and tools to assess implementation of mental health policies and plans: A systematic review **Jurisdiction:** multiple (32/43 were high-income countries) **Methods:** systematic review **Objective:** "We aimed to map and analyse methods and tools used to assess the extent, process and impact of implementing MHPPs [mental health policies and plans]"	**Delivery of strategies** • ***Other:*** 14 studies assessed the existence or extent of implementation (using indicators such as activities completed, or perceptions). 27 studies assessed implementation processes, most often focusing on barriers and facilitators. **Effects of strategies** • ***Other:*** The authors categorize 27 studies as assessing impact, with indicators such as number of referrals made and development of new services; quality of care; incidence and prevalence of mental health concerns and/or suicidality; quality of life; and costs. They note methodological weaknesses across the literature including limited reporting on methods and tools used. "Assessments of entire MHPPs, as opposed to only certain parts of them, are rare." https://www.cambridge.org/core/journals/global-mental-health/article/methods-and-tools-to-assess-implementation-of-mental-health-policies-and-plans-a-systematic-review/0361A5F59F5C0BDF7F64D6FA1B7B5D93	The authors categorize some studies as assessing impact which may be better described as assessing process indicators.
Author: Fjellfeldt **Date:** 2019 **Title: One new policy:** A variety of applications—The implementation processes of a new mental health policy in Sweden **Jurisdiction:** Sweden **Methods:** qualitative case study **Objective: "**This study aimed to explore the implementation process regarding regional and local responses to national policy"	**Strategy design** • ***Strategy elements:*** Sweden introduced a new policy integrating a broader, public health-informed definition of mental health (compared to a previous focus on severe or complex mental illness) **Governance of strategy** • ***Centralization and delegation of authority:*** each of Sweden's 21 counties was responsible for developing an action plan under the new policy, and were provided funding to do so based on number of inhabitants **Delivery of strategy** • ***Implementation strategies, barriers and facilitators for decision-makers and intermediaries:*** there was wide variation in interpretation and implementation of the policy, reflecting local priorities (eg. priority populations), existing structures and regulations (and different approaches to working within these structures or creating distinct projects), and the interest-holders involved in implementation. Year-to-year funding posed a barrier to recruitment and planning. "Small-scale projects offered opportunities for learning processes and modifications before implementation on a larger scale," but no structured plans were in place for policy learning. There was some disagreement about the concepts underpinning the new policy, with critiques that it individualized the social problems that underpin mental health inequities.	

	https://onlinelibrary.wiley.com/doi/10.1111/spol.12572	
Author: Lewitzka et al. **Date:** 2019 **Title:** Are national suicide prevention programs effective? A comparison of 4 verum and 4 control countries over 30 years **Jurisdiction:** 8 high-income countries **Methods:** interrupted time series **Objective:** "The aim of the present study was to analyze the effectiveness of national suicide prevention programs taking a statistical approach"	**Effects of strategies** • ***Population health outcomes:*** This study compared Finland, Norway, Sweden, and Australia (verum; implemented national suicide prevention programs in the 1990s) with Canada, Austria, Switzerland and Denmark (control; no national suicide prevention programs during the same time period). The authors conclude that national suicide prevention programs were associated with a significant decline in suicide rates among males aged 25-65, and a smaller effect for females >45 years, beginning two years after implementation. In control countries, a decline was only seen for males and females over 65 years of age. https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-019-2147-y#Sec10	
Author: Pirkis et al. **Date:** 2024 **Title:** Preventing suicide: a public health approach to a global problem **Jurisdiction:** n/a **Methods:** commentary **Objective:** puts forward a public health model of suicide prevention and argues for whole-of-government and whole-of-society responses	**Design of strategies** • The authors present a public health model of suicide prevention that highlights social determinants of health including macroeconomic, public, and social policies, health systems, and sociocultural factors. Their model also includes commercial determinants including firearm and alcohol industries. They argue for greater emphasis on universal interventions targeting these determinants and argue this "will require a policy reset involving genuine whole-of-government commitment." They suggest: prime ministers or specially appointed ministers should "sign off" on suicide prevention policies; broad engagement should be undertaken, constituting a whole-of-society approach; policies should entail a long-term commitment, eg. 10 years. They also state that access to data is essential to understand the problem and evaluate responses. Evaluation should use rigorous methods, including implementation science alongside outcomes, and can focus on distal outcomes eg. suicidal thoughts instead of suicide per se when warranted by program logic. https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(24)00149-X/fulltext#fig2	This is one in a series of six papers; the remaining papers tackle more focused elements of the proposed approach. The full series can be found here.
Author: Platt et al. **Date:** 2019 **Title:** National Suicide Prevention Strategies – Progress and Challenges **Jurisdiction:** n/a	**Design of strategies** • ***Alignment with policy context.*** In settings with prior suicide prevention activities, strategy development should begin with a situation analysis mapping current activities and gaps to inform consolidation and delegation. Countries with a more comprehensive	

Methods: commentary **Objective:** describes the current state of national suicide prevention strategies internationally	response should focus on evaluation and improvement. • ***Elements of strategy.*** Means restriction; media reporting; health and social care; education and training; psychotherapy; follow up care; crisis intervention; postvention; awareness; stigma reduction; surveillance, monitoring, and evaluation; and coordination and oversight. "The evidence base supporting the incorporation of these components in a national suicide prevention strategy is reasonably extensive but uneven in terms of quality, scope, and consistency." • ***Other.*** The authors define national suicide prevention strategies (NSPSs) as "a systematic way of developing a comprehensive and integrated national response to suicidal behavior and a structural framework to support effective suicide prevention action and evaluation." They argue that NSPSs are needed to indicate commitment; provide a framework and leadership; identify partners, responsibilities, and resource needs; provide an evaluation framework; and shape advocacy and research. **Effects of strategies** • "While there is an evidence base relating to the effectiveness of discrete components (interventions) of national suicide prevention strategies (see above), research evidence on the effectiveness and cost-effectiveness of national suicide prevention strategies, considered as a whole, is extremely limited." Implementation evaluations exist but outcome evaluations at a national level do not. Monitoring suicide trends in the absence of an evaluation framework is insufficient. Evaluation challenges include: the rare nature of suicide; unreliable incidence data; difficulty defining when a plan has reached full implementation, and linking extent of implementation to outcomes; confounding and regression to the mean; and complexity of interventions. https://econtent.hogrefe.com/doi/full/10.1027/0227-5910/a000587?rfr_dat=cr_pub++0pubmed&url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org ce	
Author: Bullock & Abelson **Date:** 2019 **Title:** A Fresh Approach to Reform? A Policy Analysis of the Development and Implementation of Ontario's Mental Health and Addictions Strategy	**Design of strategy** • ***Engagement of people with lived experience, communities, and members of the public:*** service users and members of the public were widely consulted through the Minister's Advisory Group and all-party committee described below. • ***Engagement of other interest groups:*** A Minister's Advisory Group comprised of "researchers, service providers, professional associations, consumer groups, the Mental Health Commission of Canada, social development organizations and immigrant	At a provincial, rather than a national, level

Jurisdiction: Ontario (Canada) **Methods:** policy analysis **Objective:**" We analyzed the formulation and implementation of [Open Minds, Healthy Minds] to address the question: What are the prospects for transformative change in Ontario's current approach to mental health and addictions?"	services" identified key priorities for the strategy. This group engaged in consultation and commissioned working papers. It produced a framework for the strategy and held a summit with over 1000 invitees included service users and other experts. It then developed final recommendations for the strategy. • ***Inter-ministerial, whole-of-government, and inter-sectoral approaches:*** an all-party Select Committee on Mental Health and Addictions held public hearings and accepted written submissions. The multipartisan nature of this committee "improved the likelihood that the resulting strategy would be acceptable to and supported by each of the parties in the event of a change in political leadership at the provincial level." An inter-ministerial group of 14 assistant deputy ministers was tasked with coordinating policy initiatives and including mental health as a standing item on inter-ministerial meeting agendas. **Governance of strategy** • ***Inter-ministerial and inter-sectoral approaches:*** each initiative under the strategy had an identified program lead. In the first three years of the strategy, four ministries had direct accountability for one or more initiatives. Various inter-ministerial working groups and committees regularly discussed the strategy. • ***Centralization and delegation of authority, including use of intermediary organizations:*** initiatives were delegated to a range of organizations. "For example, the initiative 'Provide Nurses in Schools to Support Mental Health Services' was delegated for implementation to the Registered Nurses Association of Ontario. Similarly, in education, the Hamilton Wentworth District School Board was designated lead for 'Implement School Mental Health ASSIST Program and Mental Health Literacy Provincially.'" • ***Other:*** A 20-member Mental Health and Addictions Leadership Advisory Council was convened to provide advice. https://pmc.ncbi.nlm.nih.gov/articles/PMC7008686/	
Author: Barry et al. **Date:** 2023 **Title:** Development of the National Mental Health Promotion Plan: Report prepared for the Department of Health, Ireland **Jurisdiction:** Ireland/multiple **Methods:** policy analysis,	**Design of strategy** • ***Use of research evidence:*** this report draws on research evidence to inform Ireland's National Mental Health Promotion Plan • ***Guiding principles:*** the Well-being Framework for Ireland was developed by the Government of Ireland in 2022. It is intended to integrate health promotion, social and structural determinants of health, and whole-of-government and whole-of-society approaches, and is suggested as "an important frame of reference for orienting Ireland's National Mental Health Promotion Plan"	Extraction is a very high-level summary. Full report includes a wealth of detail; Chapter 2 (on governance) may of particular interest.

unstructured literature review on policy models, scoping review on implementing whole-of-government approaches, roundtable discussions **Objective:** the full report describes conceptual underpinnings of Ireland's mental health plan, international policy models and implementation considerations, and draft priority areas for policy	• ***Other:*** the report reviews policy documents from Northern Ireland, Scotland, Wales, England, Finland and New Zealand to support inter-jurisdictional policy learning. **Governance of strategy** • ***Centralization and delegation of authority:*** National-level, intersectoral oversight and monitoring should be complemented by advisory groups, a core team of experts, mental health champions, an independent board, and "collaborative structures at and between all levels (local, regional, national)." Important processes include building a shared understanding based on evidence and key concepts eg. health promotion, and mapping policies and political environments to identify opportunities and challenges. • ***Inter-ministerial, whole-of-government, and inter-sectoral approaches:*** Priority actions should be identified, with clear local and national roles assigned and coordinated. An outcome framework should be developed that includes social determinants and service user experiences, and is co-designed across sectors. Mental health indicators should be embedded in sectoral plans, and mental health policy objectives should be monitored and evaluated. "Communities are well placed to mobilize an integrated response that appropriately addresses social and structural inequities within the local ecosystem," while national commitment and resources can support consistency across local activities. **Delivery of strategy** • ***Strategies, barriers and facilitators for decision-makers and intermediaries:*** Enablers include strong local and national leadership, senior-level commitment, sustained investment and capacity development planning, alignment with global contexts eg. sustainable development goals, networks for shared learning, close ties to research, and civil society participation.	

What is known about the design, governance, delivery, and effects of NMHSPSs?

Appendix 4: Reference lists for searches

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Appendix 5: Jurisdictional scan

Strategy and description	Evidence
Jurisdiction: Scotland **Strategy title:** Suicide prevention action plan: Every life matters **Year:** 2018 **Ministry, Department, etc.:** Scottish Government *Design* The development of *Every Life Matters* included in-person and online engagement events, as well as engagement of health, social care, and voluntary sector organizations. It built on a 2017 mental health strategy. It includes 10 specific actions, namely: 1) creation and funding of the National Suicide Prevention Leadership Group; 2) training for health and social care providers; 3) public awareness campaigns; 4) supports for people bereaved by suicide; 5) use of evidence in crisis services; 6) use of digital technology in suicide prevention; 7) prevention targeted at high-risk groups; 8) consideration of children and young people; 9) use of data and improvement methodologies; 10) review of all deaths by suicide. *Governance* The National Suicide Prevention Leadership Group is comprised of representatives from multiple sectors, and people with lived experience. It reports to the government on progress, engages interest-holders to support development of local action plans, and makes recommendations relating to local implementation. A Youth Commission on Mental Health will also make recommendations and co-design awareness campaigns for youth.	In 2021, a survey was conducted to evaluate implementation progress. It was found that "the pace of progress has perhaps been slower than anticipated." COVID-19 created some implementation barriers including limited engagement opportunities; other barriers included a perceived lack of evidence on which to base recommendations, recruitment challenges, and the lack of a "delivery infrastructure." Facilitators included collaboration and support of the NSPLG, government, external partners, and organizations responsible for service delivery. There was widespread engagement of the workforce and general public, development of public-facing outputs like a website, and collaboration with local suicide prevention leads, nonprofit organizations, and other interest-holders. It was noted that "much of the planning and development was undertaken in year two," and that there is additional "lead-in time that may need to be built in...to any future strategy before it will be possible to see substantive change." Authors of the evaluation make several recommendations including the need to tie activities to short-, intermediate- and long-term outcomes, and embed evaluation. (Platt et al., 2021) The National Suicide Prevention Leadership Group (NSPLG) was established to oversee implementation of the strategy. It included an academic panel and a lived experience panel (LEP). An evaluation of the LEP found strengths including access to a diversity of experience; dedication of panel members; support of the coordinator, NSPLG, Academic Advisory Group, and senior management; and well-received recruitment and training processes. Participants felt that the LEP was engaged more collaboratively as time went on. Its work was perceived as increasing awareness of and interest in lived experience involvement. Challenges included emotional complexities involved for both panel members and those engaging with the LEP; lack of awareness of the LEP; a need for greater diversity across a panel of 12-14 people; "the capacity of the LEP"; "slow progress and feedback"; challenges to engagement during the COVID-19 pandemic. Recommendations arising from the evaluation include: attending to panel membership including diversity; co-producing onboarding processes; time limits for panel membership to include new perspectives; creating

	involvement options for unsuccessful applicants; including lived experience in every action, from the start; paying members; creating focused subgroups; having a coordinator role; and develop support structures to expand the scope of lived experience engagement. (Scottish Action for Mental Health, nd).
Jurisdiction: Germany/European Union Strategy **Title:** European Alliance Against Depression (EAAD) **Year:** Established in 2008 **Ministry, Department, etc.:** involves several European Union research institutions but is housed at the non-profit organization, EAAD (based in Germany) *Design* This strategy has its origins in the Nuremberg Alliance against Depression, a community based intervention programme. The European Union provided funding to adapt the intervention for multiple European regions, and pilot and evaluate it. This strategy employs a 4-level approach with overall goal of "improving the care for people with depression and preventing suicidal behaviour": 1. Primary care and mental health care, including training primary care providers in treating depression and assessing suicidal ideation 2. Public awareness campaigns to increase knowledge of depression treatments and reduce stigma 3. Educational workshops and gatekeeper training for community stakeholders 4. Supporting patients, high-risk groups and relatives, including ensuring access to professional crisis care when needed as well as building partnerships and expanding self-help groups and other options *Governance* This approach is currently coordinated by a non-profit research organization, the European Alliance Against Depression, which has 20 national chapters across Europe and 12 affiliates outside of Europe.	A retrospective analysis of regional suicide rates in Germany prior to and during the intervention of EAAD. 16 regions implemented EAAD; while the EAAD approach is manualized, “regional alliances differ greatly in terms of the intensity of the interventions, depending on the resources available and the stakeholders involved” and coordinators were not always able to implement the intervention at the desired intensity due to resource shortages. The authors note that some previous prospective studies found EAAD is effective while another found no effects. In the present study, a trend towards reduction of suicides was found in the intervention regions, but this did not differ from the non-intervention regions. The authors note that this could be explained by methodological weaknesses or by unanticipated effects such as increased recognition of suicide as a cause of death (Kohler et al., 2021). A study considered the impact of the EAAD approach on stigma in the Netherlands, using analysis of population surveys over time. The model was implemented in six regions, although most of those regions were missing at least some of its core elements. Respondents in the intervention regions were more likely to be aware of the national suicide helpline, had less stigma towards depression, and perceived professional support as more valuable. Contrary to the study hypothesis, there was no exposure-response relationship. (van der Burgt et al., 2021) A narrative (non-structured) review reports on lessons learned from the EAAD approach over time. Six “lessons” were identified: 1) Combine the objectives of depression treatment and suicide prevention, due to efficiencies from overlap in affected populations and potential for greater community resonance 2) Act on all four intervention levels at once to leverage synergies, eg. awareness campaigns can support uptake of primary care interventions 3) Balance community-led approached with top-down approaches like national policy

	4) "Work independently of the pharmaceutical industry" to avoid perceived conflicts of interest 5) Start locally with a model project in a single region, then expand to leverage learning and exchange among regions 6) Define regions, timelines, and scope (Hegerl et al., 2021)
Jurisdiction: Canada **Strategy title:** Changing Directions, Changing Lives: The Mental Health Strategy for Canada **Year:** 2012 **Ministry, Department, etc.:** Mental Health Commission of Canada *Design:* The MHCC first developed *Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada* (the Framework), which then informed the strategy itself. The development process involved consultation with people with lived experience, family members, researchers, organizations, and governments. The strategy "aims to help improve the mental health and well-being of all people living in Canada, and to create a mental health system that can truly meet the needs of people living with mental health problems and illnesses and their families." It includes 6 priority areas, each with associated priorities and actions: 1) Promotion and prevention, including reduction in stigma and discrimination 2) Recovery and rights, with priorities including policies and practices, involvement and shared decision-making, and criminal justice 3) Access to services, including peer support, housing and employment services, and community-based and acute care 4) Reducing mental health disparities, responding to needs to diverse communities, and addressing social determinants 5) Working with First Nations, Inuit, and Metis to address unique needs, rights, and culture 6) Leadership and governance, including a whole-of-government approach, leadership of people with lived experience, and infrastructure for data collection	In 2016, the Office of Audit and Evaluation carried out an evaluation of Health Canada, PHAC, and the MHCC's mental health-related activities. This evaluation was based on document review, a survey, and interviews. We only discuss findings related to the MHCC's strategy here. The Strategy had been widely disseminated, and most key informants were aware of it and described it as "accessible and relevant." The MHCC had established over 350 partnerships to advance priorities, although information was not available to determine impacts of this work or fidelity to the Strategy. Financial reporting of the MHCC does not link to specific priority areas, so investments in these areas are unclear. It was also noted that partnership with Indigenous organizations was an area for growth. The Strategy was perceived to be too broad, without clear responsibilities for implementation (including no lead agency), no implementation plan or resources, and no monitoring. Some participants also raised concerns with the separation of mental health and addictions. (Office of Audit and Evaluation, 2016) In 2016, the MHCC published a table summarizing the status of actions taken in response to evaluations of the Mental Health Strategy for Canada. At the time of publishing this table, the MHCC was developing a "performance measurement framework for the organization" which includes "specific measurable indicators" for the advancement of the Strategy, and updating the 2010 Case for Investment. The MHCC set a strategic objective to align all MHCC activities with the Strategy. Stakeholders were engaged in dialogues, surveys, and focus groups to discuss how recommendations from the Strategy are being implemented and how this could be "accelerate[d]." (Mental Health Commission of Canada, 2016)
Jurisdiction: Canada **Strategy title:** The federal framework for suicide prevention **Year:** 2016	A 2022 progress report lists actions taken, including: media campaigns (eg. for farmer's mental health); statistical reporting; supporting knowledge exchange; and defining "best practices

Ministry, Department, etc.: Government of Canada *Design* The Federal Framework for Suicide Prevention responds to the 2012 Federal Suicide Prevention Framework Act. It was informed the WHO report *Preventing Suicide: A Global Imperative* and was intended to complement existing federal and provincial mental health and suicide strategies. The development process included consultation with interest-holders including provincial and federal governmental officials, national Indigenous organizations, and non-governmental organizations, as well as online consultation with members of the public. Objectives of the framework are to: reduce stigma and increase awareness; support connections across people and resources; and support use of evidence including research, lived expertise, and Indigenous ways of knowing. As per legislated requirements under the Act, the Framework addresses 6 domains of action: 1) Guidelines for increasing public awareness 2) Dissemination of information about suicide and suicide prevention 3) Public reporting of suicide statistics 4) Knowledge exchange across regions and sectors 5) Defining best practices for suicide prevention 6) Supporting use of research and evidence-based suicide prevention practices Guiding principles include hope, resiliency, health promotion and public health approaches, use of evidence including research and other types of knowledge, partnerships, and avoidance of duplication. *Governance* The Framework acknowledges that "No one jurisdiction has the sole responsibility for all that is needed to achieve a comprehensive approach to suicide prevention." It establishes a National Collaborative for Suicide Prevention co-chaired by the Mental Health Commission of Canada, Canadian Association for Suicide Prevention, and the Public Health Agency of Canada.	for suicide prevention" and promoting "the use of research and evidence-based practice", including through various specific initiatives (e.g., creation of a National Suicide Prevention Advisor position, a clinician handbook, and mental health process guidelines; supporting a knowledge mobilization and research hubs, community-based approaches, online learning modules; etc.). (Government of Canada, 2022) The Standing Senate Committee on Social Affairs, Science and Technology published an evaluation of the framework in 2023 based on expert testimony from people with lived experience, clinicians, and other experts. Broadly, the report concludes: "Data and witnesses tell the same story: the Federal Framework for Suicide Prevention is not doing enough to prevent suicide in Canada. It is centered around ideas of what feels good instead of seeking out what works." Reported strengths of the framework include its dual emphasis on clinical and public health interventions, the decoupling of suicide and mental health, and the support of knowledge exchange and partnerships. However, it was noted that the framework does not include measurable outcomes. It was also criticized for failing to "prioritize evidence-based interventions for suicide prevention" (although other witnesses noted that the evidence base on suicide prevention is limited). Indigenous witnesses called for a focus on life promotion, cultural connectivity, and early intervention. It was noted that suicide rates have not changed in Canada since the framework's development, with the exception of some changes more attributable to COVID-19 and related social responses including economic supports. Opportunities to strengthen the framework include: limiting means of suicide; education for general practitioners; improved data collection, evaluation, and (timely) dissemination, as well as making use of existing data; supporting further research; use of culturally-relevant data collection approaches; engaging Metis communities; and targeting populations disproportionately affected by suicide. (Standing Senate Committee on Social Affairs, Science and Technology, 2023)
Jurisdiction: Wales **Title:** Talk to Me 2 **Year:** 2015-2022 **Ministry, department etc.:** Health and Social Services *Design*	An evaluation was conducted of Talk to Me 2 (T2M2) in conjunction with Wales' suicide prevention strategy. The evaluation included document review, data analysis, and interviews and focus groups with practitioners, leaders, and service users. T2M2 was widely supported but there were limitations in data collection and

Talk to Me 2 includes the following core elements: 1) Increased awareness and knowledge about suicide, including among the general public, and relevant professionals 2) Crisis response and early interventions supports 3) Support for people bereaved by suicide 4) Support responsible media reporting on suicide 5) Reduce access to means of suicide 6) Support monitoring systems and research *Governance* The Welsh government is responsible for national leadership and oversight of the strategy, while implementation will be locally-driven. All regions in Wales have a multi-agency suicide prevention forum. These regional bodies report to the National Advisory Group. The National Advisory Group reports annually to the Welsh Government. The Welsh government also collaborates with UK government departments as needed.	measurement, and it was considered difficult to isolate its effects from other policies and general social processes. While T2M2 initially lacked clear governance and accountability structures, appointing the national and regional coordinators and the national advisory group (NAG) was generally seen to have increased accountability, although coordinators were seen as tasked with too large of a geographic area. With respect to specific elements: 1) Prevention activity directed at men was said to have been especially beneficial in raising awareness. 2) There was a strong sense among some practitioners and stakeholders that access to help for people in crisis has improved dramatically during the lifetime of the T2M2 strategy. A significant increase in the number of urgent assessment appointments available was noted, although wait times for individuals not in crisis continue to be an issue. 3) Perceptions were mixed around achievements of improved supports for people bereaved by suicide. 4) The NAG supported translation and adoption of responsible media guidelines. 5) Further action needed 6) A suicide surveillance system was launched. Self-harm data is limited. With respect to implementation, T2M2 was said to have resulted in greater cross-governmental collaboration, in turn building awareness in partner sectors. It was advised that detailed local and national action plans could support coordination, and that Public Health Wales should be involved in delivery of the successor strategy. While workforce numbers and skills increased, there was still a perceived shortfall of human resources. “Active offer” of Welsh-language services was not implemented consistently and organizations reported needing more funding to do so consistently. (Lock et al., 2023) Semi-structured interviews and document review were carried out to understand the role of research evidence in suicide prevention strategies in Wales. Epidemiological data on suicide rates and admissions for self-harm were the main type of evidence used, although clinical research and qualitative data (eg. from child death reviews) was also cited in the framework. Lived experience was not referenced. (Moore, 2022)
Jurisdiction: New Zealand **Strategy title:** Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing	A government report on progress identified several actions including creation of: the Mental Health and Wellbeing Commission; a Maori

Year: 2021 **Ministry, department, etc.:** Ministry of Health *Design:* This strategy is one element of an ongoing response to a 2019 inquiry into mental health. It also builds on a short-term strategy put in place to address urgent COVID-related needs and aligns with Whakamaua: Māori Health Action Plan 2020–2025. Kia Manawanui is intended to provide a framework for alignment across multiple levels, rather than an exhaustive prescription for action. Kia Manawanui is oriented around a holistic concept of wellbeing for individuals, families, and environments. Core principles include Māori self-determination, equity, person- and family-centredness, rights, collaboration, and innovation. The strategy identified five areas of focus: 1) "Build the social, cultural, economic, and environmental foundations for mental wellbeing" 2) Enabling communities, families, and individuals to support wellbeing 3) Community-driven approaches 4) Expanded primary mental health care 5) Improvements to specialized services System enablers of these priorities include: 1) Leadership (including strengthening Crown-Maori partnerships and cross-government coordination) 2) policy (including human rights review of legislation, replacing Mental Health Act), investment 3) Information (including data and lived experience) 4) Technology 5) Workforce The strategy addresses three timeframes: 1) short term (2021-2023) focused on mechanisms for collaboration, addressing system gaps and equity 2) medium term (2023-2027) "extend trials of new ways of working developed in the short term," disseminating guidance, and expanding approach to more populations 3) long term (2027–2031) embed and iterate new approach *Governance* Monitoring is delegated to the Mental Wellbeing Commission. Its implementation is concurrent with substantial health reforms in New Zealand; it was anticipated that responsibility for the strategy will eventually be shared across multiple existing and new government agencies and departments.	statutory health entity, Te Aka Whai Ora, that would take primary responsibility for suicide prevention commissioning; cross-agency working groups; lived experience roles within the Ministry of health; regional public service commissioners; and a service framework. Public engagement had been conducted relating to the Mental Health Act, and initial reforms were conducted. It was noted that the Ministry of Health would maintain oversight of wellbeing policy during ongoing government reforms. (Ministry of Health, 2023) The Mental Health and Wellbeing Commission conducted interviews to monitor progress. Interviewees notes that the creation of a national Maori health entity fostered Crown-Maori relations, and the subsequent dissolution of that entity demonstrated ongoing imbalances in those relations. Maori organizations also supported development of Maori lived experience leaders. However, tokenism remains a concern. Engagement of people with lived experience has been uneven. There is a need to engage PWLE in problem definition (not just providing feedback on solutions), to invest in career development, and to create “an independent home outside of government agencies and service delivery organisations" for these roles. A “case study” of a Housing First initiative is presented, which found collaborative, trust-based relationships with government agencies but challenges in navigating an issue (homelessness) for which no government agency had primary responsibility (Te Hiringa Mahara – Mental Health and Wellbeing Commission, 2024).

What is known about the design, governance, delivery, and effects of NMHSPSs?

Jurisdiction: Australia **Strategy title:** Aboriginal and Torres Strait Islander Suicide Prevention Strategy **Year:** 2025-2035 **Ministry, Department, etc.:** Gayaa Dhuwi (Proud Spirit) Australia; Department of Health and Aged Care *Design* ATSISPEP is based on the work of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project. It is organized into three levels of intervention: population-wide, targeted to groups and higher risk, and targeted at individuals who are at higher risk of or have attempted suicide. Core principles of the strategies are described as: "Aboriginal and Torres Strait Islander-led; underpinned by culture; lived experience informed; holistic and integrated systems and services; place-based responses." Enablers include funding; implementation; monitoring, evaluation, and governance. Priorities are: 1) leadership and self-determination; 2) thriving communities; 3) informed and supportive communities; 4) culturally safe, accessible, targeted, and coordinated care; 5) responsive workforce; 6) evidence and data Specific outcomes and initiatives are defined for each priority area. *Governance* Gayaa Dhuwi will convene a National Implementation Advisory Group to support whole-of-system approaches and coordinate with other policy and strategic areas; to monitor and evaluate the strategy; and to centre voices of Aboriginal and Torres Strait Islander peoples.	A survey and scoping review was carried out to evaluate ATSISPEP. Overall, there was widespread awareness of the report, although awareness of associated resources was lower. Primary Health Networks had been successful in partnering with Aboriginal organizations, providing cultural competency training to staff, and incorporating cultural elements into programming. The area with the least progress was evaluation of commissioned services. ATSISPEP was adopted by all seven national suicide prevention trial sites that focus on Aboriginal and Torres Strait Islander populations, and it informed federal and state policies, clinical programs and guidelines and non-governmental organizations' actions. Among Primary Health Networks (PHNs), enablers of uptake included: establishing a dedicated portfolio within the PHN; the strategy's evidence base; promotion at conferences; and associated resources. Barriers of uptake included: lack of funding, large geographic areas, timing issues (ie. report released shortly after commissioning occurred), and a lack of strategic approach within PHNs. PHNs also noted that Aboriginal Community Controlled Health Services should be funded directly, rather than funding flowing through PHNs to commission ACCHSs. Among National Suicide Prevention Trial sites, barriers included: poor visibility of the framework and its associated supports and resources; limited engagement from implementation support; multiple concurrent frameworks to navigate; funding cycles; and the lack of a system-wide approach. (Knight et al., 2024)
Jurisdiction: Australia **Strategy title:** National Suicide Prevention Trial **Year:** 2016/17-2020/21 **Ministry, Department, etc.:** Department of Health and Aged Care *Design* Primary Health Networks (PHNs) in 12 locations participated in a trial led by the University of Melbourne, the Black Dog Institute, and the Department of Health and Aged Care. The trial was designed with flexibility for the sites in order to meet local needs: sites were required to select one focus population group and a multi-	A mixed-methods evaluation was conducted to explore “planning, implementation, impacts, and outcome of the Trial.” Facilitators of developing a system-wide approach included use of a relevant framework, engaging stakeholders beyond the mental health sector, balancing community engagement with top-down approaches, and fostering integration at service and system levels. The time-limited nature of the trial (and associated funding) posed a challenge, as some PHNs were hesitant to commission services they would subsequently withdraw. Stakeholder engagement and co-design is also

component evidence-based approach to be used, and to participate in trial evaluation. Approaches used included: improved primary, emergency and follow up care and use of evidence-based treatments; increasing workforce competencies; early intervention in schools; community engagement and training; reducing access to means; and responsible media reporting. Trial sites received dedicated funding. *Governance* PHN sites have flexibility within the broader trial framework as described above.	time-intensive. Additional challenges included difficulty recruiting staff, especially in rural areas; service gaps including limited availability of aftercare services or pathways for clients exiting services, as well as overall rural service capacity; hospital distrust in non-clinical aftercare services; community trust and readiness for participation; and limited local-level data to inform planning. It was noted that sites varied widely in terms of their approach and that "what was well received and effective at individual Sites was very much context dependent." With respect to service enhancements, trials resulted in the establishment of aftercare services for people following a suicide attempt at four trial sites, and the establishment of co-designed population specific services (LGBTI and Aboriginal and Torres Strait Islander peoples) at two sites. Staff developed increased knowledge of suicide and developed new inter-organizational linkages. Community knowledge also increased. Users within aftercare services reported reduced suicidal ideation and distress as measured on standardized scales, and reported satisfaction with services including in relation to culture and sexual and gender identity. (Comparison to prior services was not included in the evaluation.) The evaluation also explored impacts of services for specific populations: Aboriginal and Torres Strait Islander services increased wellbeing and service collaboration, but were challenged by drivers of suicidality beyond their scope to address; services for men, young people, and LGBTI people increased suicide awareness, but only anecdotal evidence is available for increased help-seeking; a new peer model for veterans was developed and scaled; there was limited evidence for impact on older adults. (Currier et al., 2020) The Department of Health and Aged Care produced a discussion paper based a review of evaluations and other literature. It identified the following key themes: ": "1. Model identification and adaptability to local communities, based on community engagement 2. Sequencing and timing of the multiple components making up systems-based approaches 3. Data collection and evaluation challenges around observing and measuring outcomes 4. Partnerships and relationships as a central enabler, dependent on adequate engagement 5. Workforce capacity and capabilities necessary to deliver trials and retention challenges 6. Time and resourcing with time an important resource to enable effective

	implementation." Particular challenges were noted around governance (including role ambiguity and community involvement), implementing interventions for Aboriginal and Torres Strait Islanders, and "engaging more diverse lived experience voices." Considerations going forward include adopting flexible governance approaches, co-design, and community engagement; incorporating quality improvement, evaluation, and clear outcome measures from the outset; and creating longer-term trials. (Department of Health and Aged Care, 2022) A qualitative study explored PHN staff and community perspectives on implementation of the National Suicide Prevention Trial. Participants identified three facilitators: "'a collaborative PHN', 'an engaged community', and 'a negotiated approach'." Barriers included tensions between PHNs and communities; staff turnover or lack of skill; and fatigue from frequent policy changes and initiatives. Community stakeholders were predominantly satisfied with consultation processes. Some felt the trial "disregarded their knowledge, lived experience, local priorities, and work already done" and felt it may wastefully overlap with existing services, while others appreciated its structured approach. (King et al, 2022)
Jurisdiction: Northern Ireland **Strategy title:** Protect Life 2 **Year:** 2019-2024 **Ministry, Department, etc.:** Department of Health *Design* The strategy includes: population-based approaches to restricting means, encouraging help-seeking, raising awareness, and supporting responsible media reporting; pre-crisis intervention including training for health care staff, improved risk management and screening approaches, outreach to those not connected to services (especially men), substance use services, "safer custody" in prison, and engaging colleges and universities; crisis de-escalation and case management; postvention for people bereaved by suicide; and data collection and reporting. Guiding principles include using approaches that: are evidence-based, collaborative, coordinated, and based on engagement and inter-jurisdictional experiences; are person-centred, reduce inequities, and are targeted to at-risk groups when needed; are sustainably funded; and are informed by broader determinants of mental health.	A survey and interest-holder engagement were carried out to evaluate how well the actions of Protect Life 2 are informed by their listed guiding principles. The survey found that "45% of respondents were of the view that the principles are always or usually informing actions, with a further 29% stating the principles sometimes informed the actions" and "over 80% of respondents were of the view that the effectiveness of progressing objectives were at least somewhat effective." Workshop participants noted a lack of clear accountability to lead each action in the strategy, and "to re-consider use of unmeasurable terms such as 'encourage' and 'promote.'" Recommendations included a more detailed action plan, informing local implementation plans developed by Local Protect Life Implementation Groups; clear accountabilities, objectives, and plans for monitoring, including for inter-dependent actions; public reporting; and a full review and refresh of governance strategies in the initial PL2. (Public Health Agency/Department of Health, 2024) A nongovernmental organization published a response to the decision to extend PL2 to 2027. They critiqued the lack of evidence base for this

Governance PL2 takes a cross-departmental approach to suicide prevention involving multiple departments. The Department of Health provides strategic oversight and liaises with the All Party Group on Suicide Prevention, the Ministerial Co-ordination Group, and the Protect Life 2 Steering Group (which plans and monitors implementation). The Protect Life 2 Steering Group will also be in engagement with the Strategy Subgroups and the Protect Life Implementation Groups/Community of Interest Groups.	decision and called for: a justification of this decision, including data relating to suicide rates; an evaluation using the framework and indicators specified in PL2; consultations with communities on acceptable targets for suicide rate reduction; targeted actions aligned with need; and clarification on the legislative and regulatory frameworks with which PL2 must comply. (New Script for Mental Health, 2024)