IASC Inter-Agency Standing Committee

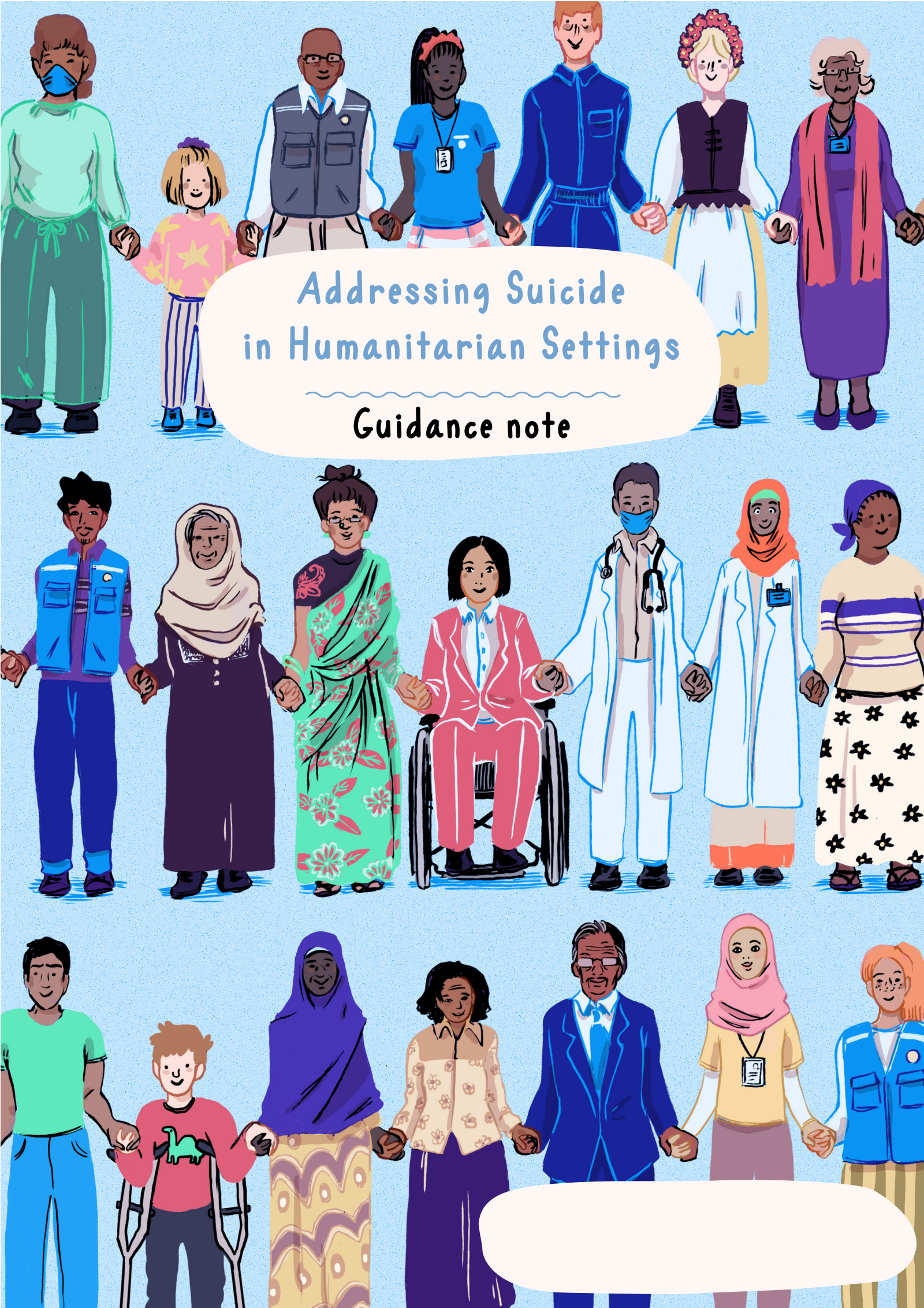
Guidance

ADDRESSING SUICIDE IN HUMANITARIAN SETTINGS

Authoring body

December 2022

Endorsed by IASC OPAG



Addressing Suicide in Humanitarian Settings

Guidance note

Suggested citation:

Inter-Agency Standing Committee (IASC). Guidance Note: Addressing Suicide in Humanitarian Settings. IASC, Geneva, 2022.

Translations:

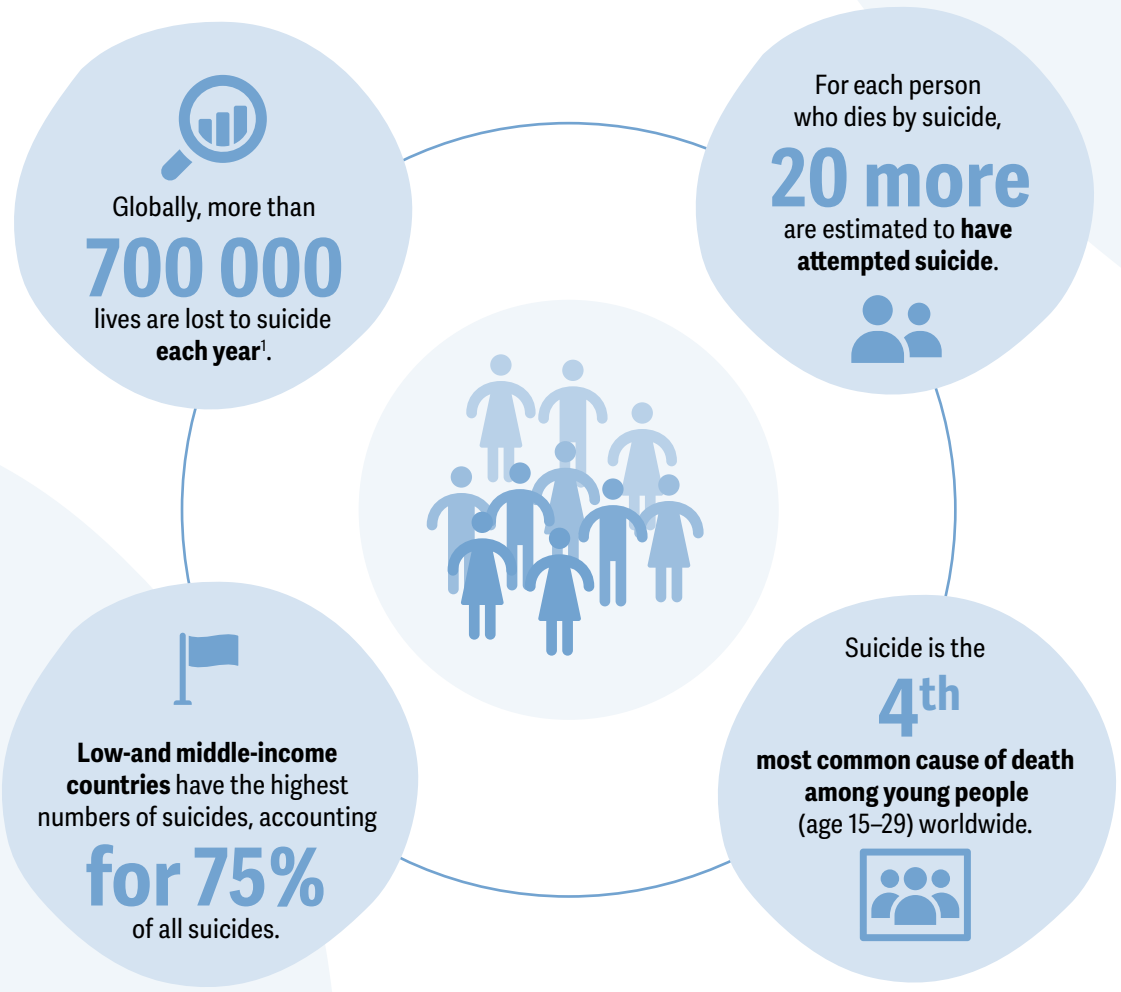
All completed translations will be posted on the IASC MHPSS RG website. Please contact the IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings (mhpss.refgroup@gmail.com) for coordination of translations.

If you create a translation or an adaptation of this work, kindly note that:

- You are not allowed to add your logo (or that of a funding agency) to the product.
- In case of adaptation (i.e. changes in the text or images), the use of the IASC logo is not permitted. In any use, there should be no suggestion that IASC endorses any specific organization, product or service.

- You should license your translation or adaptation under the same or equivalent Creative Commons licence. CC BY-NC-SA 4.0 or 3.0 is suggested. This is the list of compatible licences: https://creativecommons.org/share-your-work/licensing-considerations/compatible-licenses.
- You should add the following disclaimer in the language of the translation: "This translation/adaptation was not created by the Inter-Agency Standing Committee (IASC). The IASC is not responsible for the content or accuracy of this translation. The original English edition 'Inter-Agency Standing Committee (IASC). Guidance Note: Addressing Suicide in Humanitarian Settings', Licence: CC BY-NC-SA 3.0 IGO, shall be the binding and authentic edition.

Introduction:
Addressing suicide in humanitarian settings



Humanitarian emergencies tend to take place most often in low-and middle-income countries (LMICs), which may be less equipped to prevent and respond to suicide, given they have more limited human resources and budget allocations for mental health services and adequate reporting systems, and limited mental health awareness at the community level.

In addition, populations affected by humanitarian emergencies may experience contextual stressors that can increase the risk for suicide, such as economic difficulties, loss of resources, violence and abuse, and social isolation. Concurrently, access to family support and appropriate mental health care may be limited, and stigma around mental health is pervasive.

There is also a strong need for more data and research on suicide risk in these settings, as well as effective suicide prevention and postvention for emergency-impacted populations in LMICs[2].

1. World Health Organization (2021). LIVE LIFE: An implementation guide for suicide prevention in countries.
2. Ibid

Risk and protective factors

In a crisis-affected population, some individuals may think of ending their lives. Much can be done to reduce the chances that a person will resort to self-harm or suicide and to identify persons who are at risk.

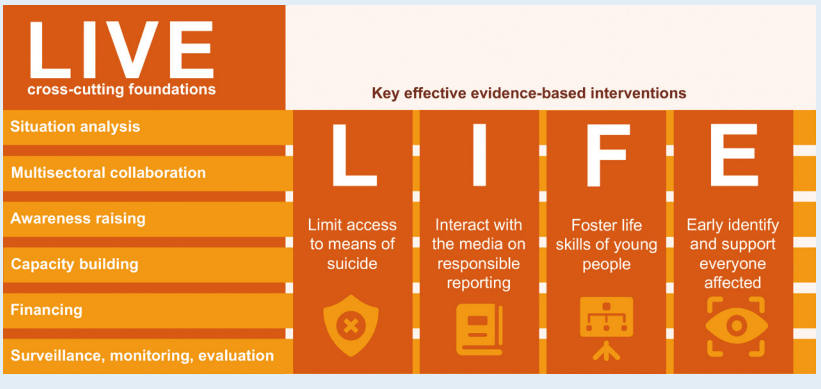
Risk and protective factors can exist at various levels, including the individual, relationship, community and society levels.

Factors that affect suicide risk[3]

Health Systems	Barriers to accessing healthcare (persons affected by humanitarian crises not being able to access care due to barriers such as high costs, transport, mistrust towards service providers, stigma of seeking help).
Society	Access to means; inappropriate media reporting; stigma associated with health-seeking behavior.
Community	Disaster, war and conflict; stressors of acculturation and dislocation; discrimination; violence (including gender-based violence – GBV), traumatic events and abuse.
Relationships	Sense of isolation and lack of social support; relationship conflict, discord or loss, GBV (including intimate partner violence – IPV).
Individual	Previous suicide attempts; mental disorders; harmful use of alcohol and other substances; job or financial loss; hopelessness; chronic pain; adverse childhood experiences; disability; family history of suicide; genetic and biological factors.

Every single loss of life is a tragedy, and suicide prevention efforts are critical to save lives. The United Nations Sustainable Development Goals (SDGs) and **WHO's Comprehensive Mental Health Action Plan 2013–2030**[4] include a **target** to reduce the global suicide mortality rate by one third by 2030. As indicated in the latest WHO Mental Health Atlas (2020), the progress made by the end of 2019 was a 10% reduction in the rate of suicide since 2013.[5]

World Health Organization (WHO) 2021 LIVE LIFE components[6]



Global guidance has been developed by WHO to assist governments with the development of comprehensive national suicide prevention strategies[7], engaging communities in suicide prevention[8], establishing and maintaining surveillance systems of self-harm[9] and establishing a public health model for suicide prevention. In 2021, WHO launched LIVE LIFE, an implementation guide for suicide prevention[10] at the country level. This guidance note has been developed to be consistent with LIVE LIFE, with specific adaptions and considerations for humanitarian settings.

3. Adapted from: World Health Organization (2014). Preventing suicide: A global imperative.

4. World Health Organization (2021). Comprehensive Mental Health Action Plan 2013–2030.

5. World Health Organization (2021). Mental Health Atlas 2020.

6. World Health Organization (2021). LIVE LIFE: An implementation guide for suicide prevention in countries.

7. World Health Organization (2018). National suicide prevention strategies: Progress, examples, and indicators.

8. World Health Organization (2019). Suicide prevention: Toolkit for engaging communities.

9. World Health Organization (2016). Practice Manual for establishing and maintaining surveillance systems for suicide attempts and self-harm.

10. World Health Organization (2012). Public health action for the prevention of suicide.

How to read this guidance note

This guidance note aims to support programme implementers, coordinators and others in humanitarian settings and brings together a wide range of approaches, tools, reference documents and case examples. The graph below can be used to navigate content and select the most relevant sections to read:

Examples from the field

Iraq p.10

occupied Palestinian territory p.10

Turkey/Syria border p.11

South Sudan p.21

Jordan p.21

Ukraine p.21

Bangladesh p.25

Iraq p.32

Bangladesh p.33

Uganda p.38

India p.38

Egypt p.38

General key resources and guidance

LIVE LIFE World Health Organization (2021). LIVE LIFE: An implementation guide for suicide prevention in countries.

United Nations High Commissioner for Refugees (2022). Draft: Preventing suicide and mitigating suicide risks in refugee settings: A multisectoral toolkit for UNHCR operations.

The Mental Health and Psychosocial Support Minimum Services Package.

World Health Organization (n.d.). Suicide prevention resources.

World Health Organization (n.d.). E-learning: Engaging communities in preventing suicide.

World Health Organization (n.d.). E-learning: Preventing self-harm/suicide. Empowering primary health care providers.

IFRC Reference Centre for Psychosocial Support (2021). Suicide Prevention.

IFRC Reference Centre for Psychosocial Support (2021). Suicide prevention during COVID-19.

WHO (2021). WHO World Mental Health Day 2021. Key messages on suicide.

World Health Organization (2019). mhGAP Intervention Guide - Version 2.0: for mental, neurological and substance use disorders in non-specialized health settings. Provides guidance for non-specialized health workers in the assessment and management of suicide and self-harm

IASC IASC (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings

1.
Inter-agency coordination and assessment

1.1. Coordination and collaboration across multiple sectors and stakeholders

Why?

Suicide is a complex issue and prevention efforts in humanitarian contexts require **coordination and collaboration among multiple sectors and stakeholders** to be effective. Exchange of experience and expertise among persons working in multiple sectors and working effectively with what is already available[11] (identifying existing community-based response mechanisms and practices, integration of suicide prevention into other programmes such as mental health services as part of general health care, responses to GBV, case management, safe spaces and child protection (CP) programmes and initiatives to support persons with disabilities) ensure that initiatives are comprehensive, well integrated and more likely to achieve their intended goals[12].

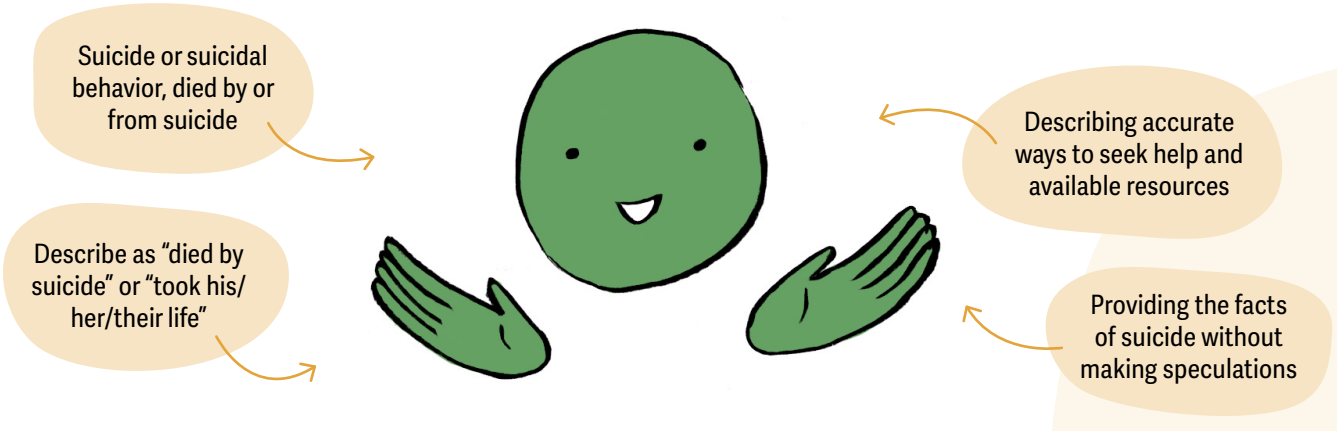
How?

Coordination and collaboration are **key parts of all suicide prevention activities. Identify existing task forces or coordination groups** and decide to:

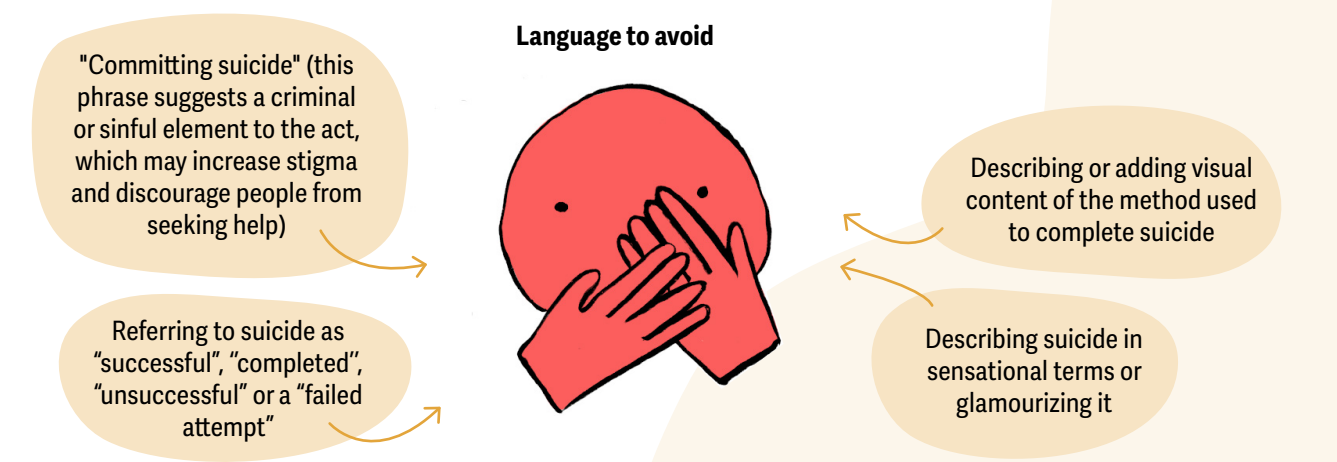
- Join and coordinate with an existing group that has a focus on suicide prevention,
- Support inclusion of a suicide prevention focus in an existing group (MHPSS Technical Working Groups or a government led task force on mental health),
- Lead or support the initiation of a new group that focuses on suicide prevention.

When communicating about suicide and suicide prevention, ensure correct word choices

Language to use



Language to avoid



11. World Health Organization (2021). LIVE LIFE: An implementation guide for suicide prevention in countries.

12. Kolves K, Fitzgerald C, Nordentoft M, Wood, SJ, Erlangsen, A. (2021). Assessment of suicidal behaviors among individuals with autism spectrum disorder in Denmark. JAMA Network Open. 4(1):e2033565.

What should stakeholders consider ?

Multisectoral approaches include more than one sector such as health, education, social welfare, protection, agriculture, religious affairs, law and defense. In humanitarian settings, this could include ministries overseeing support to refugees, migrants and Internally Displaced Persons (IDPs) or disaster management personnel, and it should include relevant coordination groups or clusters such as Health, Protection, Education, Shelter, Livelihoods and others.

Multi-stakeholder approaches include collaborating with community stakeholders, non-governmental organizations (NGOs) and people from affected communities, including those with lived experience of mental health conditions. It is helpful to elicit feedback from persons whom the **community has designated as leaders and experts**, rather than only those appointed as leaders by and for humanitarian response structures. Where there is mental health stigma, these "insider" partners can be engaged in awareness-raising discussions to provide information and dispel myths about suicide.

Youth and those working directly with young people, including school counsellors, nurses, local health and protection actors, sports clubs and youth associations, should be included in the design and review of interventions, awareness-raising campaigns and response structures. Parents and caregivers should also be engaged. Youth can play a vital role in engaging their peers, and can be integrated into activities as spokespeople, advisers, trainers and peer mentors.

A **stakeholder mapping exercise** (creating a table showing the different stakeholder roles, expertise/resources and networks) may help clarify the motivations, skills and possibilities of potential community stakeholders.

Mental Health and Psychosocial Support Technical Working Groups (MHPSS TWGs)[13]

MHPSS TWGs, which work across sectors, should be engaged in contexts where they are available and can provide support. MHPSS TWGs can:

- Support **stakeholder engagement** (linking with government and with specific humanitarian clusters or Areas of Responsibility (AoRs), ensuring that the needs of groups such as those affected by GBV and persons with disabilities are addressed);
- Host a topically **focused task force or sub-working group** dedicated to suicide prevention to lead and coordinate activities and provides an opportunity for dedicated attention, capacity building and coordination;
- **Map available services and support** for suicide prevention and response and share resulting mapping report outlining needs and gaps and develop service **directories;**
- Where **gaps** have been identified in the assessment/situation analysis, make plans to advocate for and coordinate provision of adequate services for intervention (including crisis management) and follow-up;
- Map relevant service providers and ensure that suicide prevention and response actions, are part of the development of **referral plans and flowcharts**. Referral pathways should be clearly structured and ensure **confidentiality** in the referral process;
- Disseminate and elevate **advocacy messages** and support the uptake of awareness campaigns by actors in different sectors who participate or collaborate with the MHPSS TWG; along with **hosting events** related to relevant campaigns;
- Support **surveillance and Monitoring and Evaluation** and help identify agencies with stable capacity to host data collected from surveillance activities;
- Host and/ or coordinate discussion and **capacity building** forums such as orientations, trainings or workshops with support from the dedicated sub-working group and implementing partners;
- Support conducting an operational **debrief after acts of suicide or self-harm** involving relevant stakeholders to better understand contributing factors, compile lessons learned and advocate for needed changes and suicide prevention efforts;
- Ensure **postvention** support for family members, friends and community members who are affected by acts of suicide or self-harm.

13. *The Mental Health and Psychosocial Support Minimum Services Package.*

Examples from the field

In Iraq, following 40 years of stressors associated with war, sanctions and civil conflict, the rising suicide rate has become a public health crisis[14]. The national MHPSS TWG formed a subcommittee in July 2019 to coordinate different suicide prevention efforts. The subcommittee is chaired by a local organization, Azhee, supported by the International Organization for Migration – Iraq (IOM Iraq). **Azhee organized the first national suicide prevention conference in September 2019** and, as a result of the working groups of this conference, IOM provided support to government actors in developing the first draft of a National Suicide Prevention Strategy that is currently in the process of review and endorsement by the Iraqi government[15].

In the occupied Palestinian territory, the population is faced with the psychological impacts of the ongoing humanitarian crisis alongside the stigma associated with suicide. The National Committee for Suicide Prevention was established in 2018 and is composed of representatives from the Ministry of Health (MoH), the Ministry of Education (MoE) and Higher Education, the Ministry of Awqaf (Religious Affairs), the Public Prosecution Office, the Family Protection Unit of the Police, the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), WHO and international and national NGOs. The Committee determined that a comprehensive multisectoral suicide prevention strategy was critically needed, and a National Suicide Prevention Strategy for 2021–2026 was developed. **Strategic objectives include effective monitoring of suicide rates to improve identification of at-risk individuals, including children and youth, and trends in suicidal behaviour, improving the accuracy of case registrations and death registrations** at hospitals, training public and health-care professionals and gatekeepers such as religious leaders in the detection of signs of suicidal ideation and risk factors, and addressing potential stigma around suicide in health-care and educational facilities. The National Strategy also identifies the need for collaborative effort by a range of individuals and organizations and their potential contributions, such as the police, schools, family members, media, religious leaders and staff working in health facilities[16].

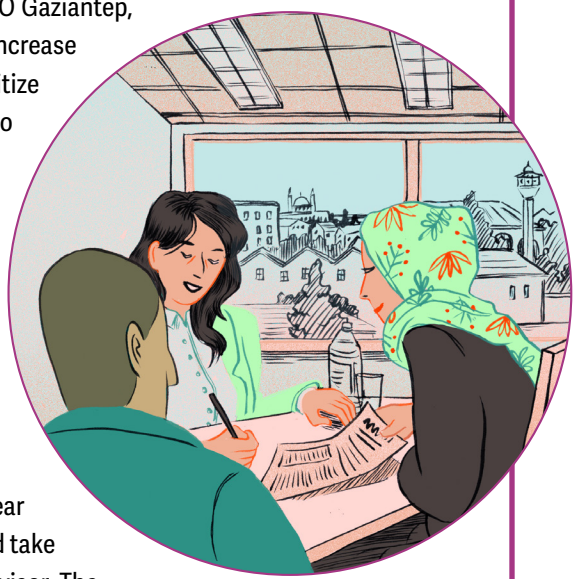
14. World Health Organization. An increasing number of suicide cases in Iraq worries public health experts amid COVID-19 pandemic

15. Marzouk HA (2021). International organization for migration Iraq mental and psychosocial support programme suicide prevention activities. Intervention. 19(2):255-260.

16. Jabr S, Helbich M (2021). The Process of Evolving a National Plan in Suicide Prevention in a Context of Political Violence. Intervention 19:208-14.

Examples from the field

On the Turkey/Syria border, collaborative efforts were undertaken by WHO Gaziantep, through the MHPSS TWG, to conduct a situational analysis, which indicated an increase in reports of suicide in northwest Syria. The TWG established a task force to prioritize prevention and response efforts, including a capacity-building workshop to ensure that psychosocial, health-care and protection workers received training and supervision to respond effectively. WHO developed and disseminated training and supervision on suicide prevention and response to additional MHPSS specialists. The training of trainers workshop was led by the MHPSS Collaborative and WHO for 21 Arabic-speaking MHPSS specialists. **Trainers and trainees jointly developed a suicide response plan tailored to the context, based on data and expert feedback.** This plan includes standard operating procedures (SOPs), consent for services and information usage, suicide and self-harm assessment questions to determine risk level, a decision tree to inform what actions are taken and a sample safety plan. A table was developed with clear risk levels, referrals and actions based on the level of risk that care workers should take into account to respond effectively, and information on when to contact a supervisor. The response plan was integrated into training for frontline workers and was used as a framework to be incorporated into existing MHPSS services, including a mapping of services for referrals.



Key resources and guidance: coordination and collaboration across multiple sectors and stakeholders

World Health Organization (2021). LIVE LIFE: An implementation guide for suicide prevention in countries. Part A: LIVE LIFE Core Pillar: Multisectoral collaboration.

The Mental Health and Psychosocial Support Minimum Services Package. MSP Activities 1.1 Coordinate MHPSS within and across sectors; 2.1 Design, plan and coordinate MHPSS programmes.

1.2. Assessment of the context, needs and resources to guide programming

Why?

A rapid assessment or situational analysis can provide key background about suicide and suicide prevention for a country, a region or an affected community, and is essential to inform the **planning of context-specific** suicide prevention activities, ensure their **effectiveness** and provide interventions where there is **most need** in humanitarian settings.

How?

Determine if there are **existing situational analyses or other assessments** which are focused on or include information on suicide and self-harm (by government or humanitarian actors). Aim to use existing information as much as possible before collecting new information.

Situational analyses or rapid assessments in humanitarian settings usually focus on:

- Understanding the **country context** (legal frameworks, national plans)
- Understanding the **perceptions, experiences and attitudes** of the target population related to suicide
- **Documenting capacities and resources** within the communities of interest, and the existing services for health, mental health and protection/social care
- **Collecting views** on gaps and opportunities in current programming

Conducting accurate and effective surveys requires careful planning and sufficient resources and expertise to collect, store and analyse the data. In humanitarian contexts, such requirements are hard to meet, and in general it is not recommended that surveys are used as a routine tool for collecting sensitive information about suicidal thoughts and behaviours.

- Methods, tools and questions listed here can be used for a **situational analysis/assessment specific to suicide prevention or can also be part of a broader and more general MHPSS assessment**.
- A rapid situational analysis/assessment focuses on gathering essential information that is required to plan next steps. It is recommended that it is completed **within a few weeks**.
- Staff and volunteers collecting MHPSS data from affected populations need to know how to follow ethical principles and safety recommendations and use effective basic interviewing skills, and must have **basic psychosocial support skills** (including referral for additional services).
- **Coordination** is needed with relevant **stakeholders** and groups (MHPSS TWGs, specific task forces; see also section 1.1) to ensure collaboration in coherent and efficient suicide prevention activities.
- All **reports should be made available** through the MHPSS TWG and other relevant groups to avoid duplication and to inform the humanitarian response.

Policy and legal frameworks, national strategies and plans

Assessment questions

What is the **legal framework** in the country around suicide and mandatory reporting?

Is there a dedicated **national strategy** (including allocated budget) **for suicide prevention?**

Is suicide prevention mentioned in other existing **relevant plans** such as plans for mental health, alcohol and substance use or noncommunicable diseases?

Are **populations affected by the humanitarian emergency** included in these plans?

Methods and tools to gather information

Discussions and key informant interviews (with government, United Nations agencies, MHPSS TWGs)

Literature search and review of national plans and strategies; see also WHO links to national strategies[17] and WHO MiNDbank[18].

Key considerations

- What is the **legal status** of suicide and suicide attempts and what are the legal consequences for individuals (judicial sentences)?
- Where relevant, what is the scope for **decriminalization** of suicide, suicide attempts and other acts of self-harm?
- What are national laws concerning **mandatory reporting and psychiatric hospitalization** (of persons expressing an intention to die)?
- Is there existing **legislation or policy relevant to suicide prevention** (mental health services, reducing harmful use of drugs and alcohol, employment, universal health coverage/insurance, social welfare services)?
- Which suicide prevention activities are **included and prioritized in national strategies and plans?**
- Which ongoing national suicide prevention activities can be used, adapted or extended to **emergency-affected populations?**
- Ensure that services are **accessible for all groups,** including **migrants** who are often more vulnerable due to language, exclusion from the national health system, or other barriers.

17. World Health Organization (2018). National suicide prevention strategies: Progress, examples, and indicators.
18. World Health Organization (n.d.). WHO MiNDbank: More inclusiveness needed in disability and development.

Available data in the humanitarian setting

Assessment questions

What data and other information are available on suicide and self-harm?

Are certain profiles or groups of people within the humanitarian setting more **at risk** (such as a specific gender, age group, ethnic group or people in specific geographical locations)?

- Number of **deaths** by suicide
- Number or extent of incidents of **self-harm**
- **Methods** of suicide and suicide attempts (self- immolation)
- **Demographic details** of the individuals (sex, age, geographical area)
- Suspected **risk factors** or **precipitating** factors of suicide (including specific stressors)
- Support and **interventions** received (in health care or other settings)
- Quality or frequency of **reporting in the media.**

Methods and tools to gather information

Desktop review and analysis of available data sources (health information systems, mortality registers, protection monitoring systems such as proGres V4, cumulative data from the GBV Information Management System (GBVIMS), child protection systems).

Discussions and key informant interviews with community members and service providers (mental health service providers, general health providers trained in mental health, general health care staff working in emergency rooms, social care and protection service providers, including GBV and CP specialists).

Key considerations

- How and by whom is **suicide ascertained**? Consider how ascertainment may affect the reporting of suicide and the quality of data available, and potential under-reporting (related to stigma, legal framework).
- How and by whom are suicide and self-harm **registered and reported?** Is there an informal tracking system in countries where suicide is criminalized?
- By which variables are the data **disaggregated?**
- **Obtain data according to:**

  a) context (national, regions, districts, inpatient services, outpatient services, emergency room department, detention facilities, refugee camps, etc.);

  b) population groups (whole population and disaggregated by gender, age groups, ethnic groups, religious groups, migrant status, urban, rural, socioeconomic status; persons with mental health conditions and persons with disabilities).
- **Calculate rates** (deaths or cases per 100 000) in addition to numbers to identify subpopulations disproportionately impacted.
- Review multiyear data to **identify trends.**

Information about trends in the humanitarian setting

Assessment questions

How readily **available or accessible** are the most common means of suicide?

What are the most **commonly used means of suicide?**

Are affected populations **located close** to potential hot spots?

Methods and tools to gather information

Key informant interviews and focus group discussions.

Review of data (IMS and operational MHPSS data management systems).

Key considerations

- Are there **specific sites** (rivers, railways, bridges or high-rise buildings) associated with previous suicides?
- Are **affected populations** located close to such specific sites?

Community perceptions

Assessment questions

What are **community perceptions** around suicide and suicide prevention among affected populations and service providers (knowledge, stigma, cultural and religious attitudes)?

What are ways of **coping and help-seeking** and what are **barriers** to receiving care for persons with suicidal thoughts and/or relevant mental health conditions (depression)?

Methods and tools to gather information

Desktop review (including literature from social scientists and anthropologists).

Discussions with service providers serving affected populations.

Key informant interviews and focus group discussions with community members and service providers (these can be general community members or purposely selected groups such as gatekeepers, health and social care staff, educational personnel, police, spiritual leaders; traditional healers; people representing at-risk groups; media representatives, survivors of suicidal behaviour and family members of people who died of suicide).

Key considerations

- Consider what **barriers** (knowledge, attitudes, language) may be faced when preparing to implement activities, and prepare **solutions** to address the barriers.
- Consider ways to build on **existing resources** and ways of coping.

Available resources and supports

Assessment questions

What is the status of planned or ongoing **implementation** of effective suicide prevention **interventions** or **pillars** by government or humanitarian actors? (see WHO (2021). LIVE LIFE)

Are health-care providers **trained** to manage **medical emergencies** related to suicide (acute pesticide intoxication)?

Are there **current capacity-building initiatives** for early identification, assessment, management and follow-up, including for local, regional, educational, health and security workers?

What **relevant services and supports** (formal and non-formal) are available and accessible to people who are at risk of suicide or to persons bereaved by suicide (specialized mental health services, general providers trained in assessment and management of suicide, any relevant health, social care or other community workers trained in basic psychosocial support and referral)?

Are there any existing **groups or associations for service users and/or people with lived experience,** and what support do they provide?

What are the **barriers faced by the health workforce and related occupations** in providing early identification, assessment, management and follow-up and in reporting self-harm?

Are health-care providers and police and others responding to suicide emergencies **trained to reduce imminent risk of suicide** (reduce access to means of suicide)?

What are the current **capacities and gaps in knowledge and skills** (among health care, social care, education, judiciary, service-user groups) in responding to suicide risk?

Are the available **services and materials accessible and inclusive** for all groups within the population affected by the humanitarian crisis (information to access services is available in relevant languages and in different formats such as easy-to-read, and audio)?

Are there any previous **awareness campaigns** at national or regional levels organized, and what was the **impact** of these campaigns?

Methods and tools to gather information

Service directories

MHPSS 4Ws (**Who** is doing **What**, **Where** and **When**) mapping

MHPSS MSP Gap Analysis

Discussions with **MHPSS TWGs** and other **coordination** group discussions.

Discussions with **relevant workers** (health, protection, education, security/police, health, social welfare, and education ministries).

Discussions with different **community representatives** (young people, men, survivors of GBV, persons with disabilities)

Key considerations

- Identify **existing (public and private) services** (in the health sector, the community and other relevant sectors, helplines or adult and child protection services) and consider the availability, uptake and quality of existing services and how they can be strengthened.
- Determine the **gaps in available services** and identify any issues of accessibility (including among certain groups).
- Ensure that services and materials are available in **relevant languages** to make them accessible to migrants and refugees who do not speak the local language(s).
- Where are there opportunities for **capacity-building?** Include pre-service and occupational training along with ongoing professional development.
- Where can **linking** and **referral** between services/community workers be strengthened?
- Which **stakeholders** are already implementing suicide prevention activities or providing services and can be **engaged** (also section 1.1.)?
- Which actors are already implementing or have **designed training materials** that can be built upon?

Key resources and guidance: assessing the context, needs and resources to guide programming

World Health Organization (2021). LIVE LIFE: An implementation guide for suicide prevention in countries. Part A: LIVE LIFE Core Pillar: Situation analysis.

World Health Organization (2014). Preventing suicide: A global imperative. Box 8. Conducting a situation analysis: SWOT example (p. 68).

The Mental Health and Psychosocial Support Minimum Services Package. MSP Activities 1.2 Assess MHPSS needs and resources to guide programming; 2.1 Design, plan and coordinate MHPSS programmes.

IASC (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Action sheet 2.1.

United Nations High Commissioner For Refugees (2022). Draft: Preventing suicide and mitigating suicide risks in refugee settings: A multisectoral toolkit for UNHCR operations. This resource includes a detailed list of suggested tools and templates for situational analyses/rapid assessments.

Illustrative examples of situational analyses focusing on or including suicide prevention

Abbas MJ, Alhemiary N, Razaq EA, Naosh S, Appleby L (2018). The Iraqi national study of suicide: Report on suicide data in Iraq in 2015 and 2016. J Affect Disord. 15(229):56-62.

International Medical Corps (2017). Puerto Rico suicide prevention case study.

De Lara M. (2019). WHO Gaziantep situational analysis conducted in Northwest Syria (online survey data).

2.
Essential components of all programmes

2.1 Awareness-raising and advocacy

Why?

Awareness-raising to prevent suicide in humanitarian settings is vital for drawing attention to suicide as a serious and preventable public health issue and reaching both humanitarian actors and affected populations.

Advocacy can contribute to more efficient multisectoral collaboration, resource allocation and policy development to enhance suicide prevention measures and influence different decision- and policy-makers and other stakeholders.

How?

Consider involving multiple **stakeholders** such as media, ministries of health, humanitarian coordination mechanisms (including MHPSS TWGs, the Health cluster, CP and GBV AoRs), people with lived experience, representatives of the target audience (young people, men, survivors of GBV, persons with disabilities, migrants) or NGOs and community influencers (religious or community leaders, traditional healers, youth peer support networks) or mental health champions (relevant celebrities with lived experience).

The two notable annual dates for suicide prevention are:

World Suicide Prevention Day (WSPD) *was established in 2003 by the International Association for Suicide Prevention (IASP) in conjunction with the World Health Organization (WHO). The 10th of September each year focuses attention on the issue, reduces stigma and raises awareness among organizations, government, and the public, giving a singular message that suicide can be prevented.*

Awareness-raising and development of key messages should engage key stakeholders (see section 1.1), build on results from the assessment/situational analysis (common misconceptions, available resources: see section 1.2) and can cover topics such as:

- Suicide and its associated **risk and protective factors**
- **Warning signs** and **early identification** of suicidal behaviours (including age and gender differences and population sub-groups)
- Supporting **at-risk groups**
- Common **misconceptions**
- **Positive ways to cope** with psychological distress and suicidal thoughts
- **How to help** and support people with suicidal thoughts or behaviours
- Postvention support including tips on **supporting** bereaved families.

Ensure that messages are **always kept positive and hopeful.**

It is critical that **information is included on where and how to access help** (information on available local MHPSS hotline numbers, MHPSS centres or local mental health services, and child protection helplines[19]).

19. World Health Organization (2018). Preventing suicide: A community engagement toolkit.

Ensure that messaging is appropriate and that it addresses myths and misconceptions and uses language that is not sensational or inflammatory. Test messages first with target groups and persons with lived experience (see section 1.1) and closely monitor and evaluate how messages are perceived and further adapt messages based on feedback.

Adapt the methods and messages to ensure that they are relevant and accessible to the target population in the humanitarian context and consider:

- Different **age groups** (older adults may prefer different communication methods from adolescents) and **gender**;
- **Sociodemographic** and **language** composition of a community (messaging in predominant languages; images and messages are representative of the community i.e. race, sexuality, migrant status, religion, etc.);
- **Literacy** of the population (use verbal or visual i.e. image-based messaging);
- Multiple ways to **reach target populations** depending on the context (social media, radio broadcasts, community events and discussions, flyers and billboards);
- **Accessibility and inclusivity** for all groups in the community, including **children and persons with disabilities and survivors of GBV** (e.g., consider communication barriers and ensure information and materials are available in accessible formats, easy-to-read and in relevant languages).

Integrate awareness-raising and key messages with available services and supports that at-risk groups may be accessing, such as:

- Health services
- Community-led MHPSS activities
- Group activities for the mental health and psychosocial well-being of children and adolescents
- Formal and informal education and learning spaces
- Protection services, including safe spaces for women and girls
- Registration or verification points, distribution sites and service delivery points.

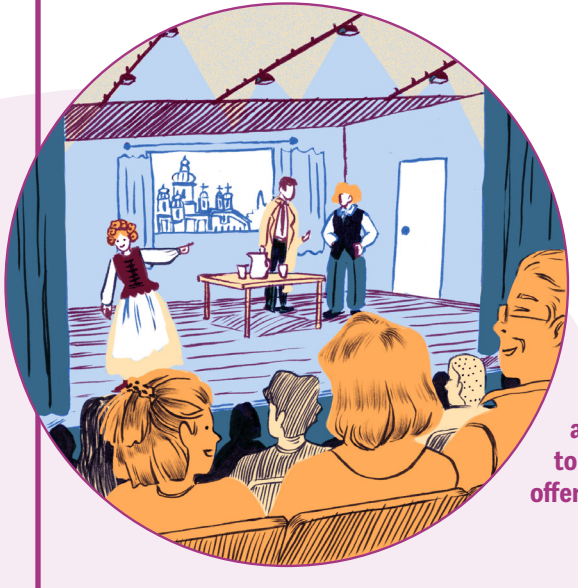
Advocacy is used to influence change:

- More **funding** to be allocated to suicide prevention measures, including donor funding;
- Suicide prevention to be integrated into **plans for schools, workplaces and health systems;**
- **Policies** (including decriminalizing suicide), resources and support for vulnerable groups;
- **Specific suicide prevention actions** (see section 3.1 on reducing access to means and section 3.2 on responsible communication and media coverage);
- Actions that help to ensure that the **humanitarian response** aims to minimize distress and promotes mental health, well-being and support for affected populations.

Examples from the field

In South Sudan, five years on after the civil war and with the nation experiencing a severe food shortage crisis, **IOM supported a programme where musical and drama performances were aired through local radio stations.** These aimed to promote suicide prevention measures and build the community's awareness of simple gestures or actions, such as reaching out and inquiring if a person is doing alright, supporting others in voicing their worries and offering a listening ear. Key messages on suicide prevention were designed by IOM and disseminated to educate and sensitize community members on suicide prevention, as well as on reducing stigma towards those who have attempted suicide and their families[20].

In Jordan, which has been a longstanding host of refugees over the decades, there are currently around 1.3 million Syrian refugees (with 672 000 formally registered), 80% of whom are living below the poverty line. In addition, 15% of Jordanians are living below poverty line, and the country is also hosting two million Palestinian refugees. GIZ (Deutsche Gesellschaft für Internationale Zusammenarbeit), UNHCR, the Dutch Embassy and International Medical Corps (IMC) Jordan have partnered **on a project to facilitate workshops and exhibitions that enable people with prior lived experience of suicidal behaviours to use art as a form of expression,** to work together and to present their work at exhibitions to increase awareness of suicide and to give a voice and form of expression to those with lived experience of suicidal thoughts and behaviours[21].



In Ukraine, in a context of ongoing war, IMC organized an awareness-raising campaign on self-harm and suicide prevention among adolescents and youth. The MHPSS team trained community outreach workers, who provided awareness-raising sessions on self-harm and suicide prevention at the community level. Information leaflets focused on explaining how to recognize if a person might have intentions of suicide, how to communicate in a proper way and how to help them find MHPSS support, and included phone numbers for national crisis hotlines. In addition, **an amateur youth theatre group from a village in the area close to the contact line provided theatre performances to adolescents and youth in different locations to educate people on how to offer messages of hope to those who might need support.**

20. International Organization for Migration – South Sudan (2020). Mental Health and Psychosocial Support Quarter 3 report.
21. Francis A (2015). Jordan's refugee crisis. Carnegie Endowment for International Peace.

Facilitate activities to increase community cohesion and mutual support

Risk factors for suicide which are common in humanitarian settings include insufficient social support and social connectedness. Persons living in such settings may become overwhelmed by feelings of hopelessness and despair, and they may lose a sense of "agency" and develop a profound attitude of dependency and lethargy. This can fuel many social problems, including suicidality. Key elements of suicide prevention are the promotion of community well-being and the creation of community-based networks that can foster protective and supportive environments and a feeling of social connectedness.

Potential activities that foster social support, and where key messages and awareness-raising can be integrated, must be co-designed with communities and can include:

- The establishment of safe community spaces and community centres, which can serve as places of hope, positivity and social connectedness;
- Support for community-based initiatives that strengthen solidarity and social cohesion;
- Facilitation of cultural and recreational activities that people are familiar with, particularly those that bring community segments of different generations together.

Ensure that all such activities are age- and gender-appropriate to ensure safe community spaces for children and adolescents.

mhpssmsp.org/en

MHPSS MSP Activities:

3.3 Disseminate key messages to promote mental health and psychosocial well-being;

3.4 Support community-led MHPSS activities;

3.5 Provide early childhood development (ECD) activities;

3.6 Provide group activities for children's mental health and psychosocial well-being;

3.7 Support caregivers to promote the mental health and psychosocial well-being of children;

3.9 Provide MHPSS through safe spaces for women and girls.

Caution: ensure that you can meet demand for services and support

By improving mental health awareness, there will likely be an **increase in demands for services** and support. This means that, alongside efforts on awareness-raising, staff should be prepared to meet the increase in demand or be able to **refer to appropriate services and support.**

Key resources and guidance: awareness-raising and advocacy

LIVE LIFE World Health Organization (2021). LIVE LIFE: An implementation guide for suicide prevention in countries.

The Mental Health and Psychosocial Support Minimum Services Package. MSP Activities 3.1 Orient humanitarian actors and community members on MHPSS and advocate for MHPSS considerations and actions; 3.3 Disseminate key messages to promote mental health and psychosocial well-being.

WHO (2021). WHO World Mental Health Day 2021. Key messages on suicide.

World Health Organization (2019). World suicide prevention day 2019 – 40 seconds of action.

World Health Organization (2014). Preventing suicide: A global imperative.

World Health Organization (n.d). Preventing suicide: Information for journalists and others writing about suicide. International Association for Suicide Prevention.

World Health Organization (n.d). Suicide Prevention.

Youth engagement and youth-led advocacy: United Nations Children's Fund (2020). Adolescent Mental Health Matters.

United Nations Children's Fund United Kingdom (2019). Youth Advocacy Toolkit.

Example of an awareness-raising video: International Association for Suicide Prevention (2022). World Suicide Prevention Day: Creating Hope Through Action.

IASC (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Action sheets 8.1, 8.2.

2.2. Surveillance, monitoring and evaluation

Why?

Monitoring & Evaluation efforts assess whether prevention and response activities have the desired outcomes. Evaluation over the long term using a variety of indicators is needed to determine if the observed changes are related to prevention activities (enhanced knowledge, attitudes and practices of health/mental health staff, increased number of people using supportive services) and can help optimize programming.

How?

A comprehensive list of indicators designed for emergency settings is available in the WHO LIVE LIFE implementation guide[22] and the IASC Monitoring and Evaluation Framework for MHPSS[23].

Use relevant data responsibly

Data collected should be used primarily to inform the development of programme activities and to highlight any negative impacts of contextual stressors on community well-being, or to advocate for expanding prevention and response resources. Necessity, risk and ethical implications should be carefully considered prior to approving the use of collected data for external communications, including governmental or donor reporting. Any potential uses for data should be included in the informed consent materials, which should be available in written and/or verbal form in the language of the affected population as appropriate.

Lessons learned through monitoring and evaluation of programmes should be shared (through MHPSS TWGs, with national actors) to help inform other suicide prevention efforts.

Risks and safety of data collection

The design of surveillance systems must consider the utility and necessity of all data collected, as well as **inherent risk** to the entire affected community, in particular those who may experience adversity as a result of data collection (GBV survivors, older persons, children and youth). Additionally, the **legal context of suicide** in the country should be considered so that collected data are de-identified/ anonymized and not traceable, in order to prevent criminalization of survivors. Only data necessary for targeted public health interventions, as agreed upon by the affected community, should be gathered.

Conduct ongoing risk analyses to assess data collection methods, storage methods and data use. The impacts of contextual changes and challenges should also be reviewed.

Prioritize making these data available to the community from whom they are collected. This can be done through community presentations, radio broadcasts or other means preferred by the community itself.

When choosing a platform for data hosting and maintenance, ensure that the hosting entity is relatively stable, confidential and well-established in that context. A record of ethical data management practice is even more important than technical capacity. **Verify the hosting agency's willingness to continue ongoing, meaningful partnership with the affected community.**

22. World Health Organization (2021). LIVE LIFE: An implementation guide for suicide prevention in countries.

23. IASC (2021). IASC Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings: With means of verification (Version 2.0).

Supporting surveillance systems

The **lack of sufficient knowledge about suicide in humanitarian contexts** is in part due to poor data surveillance and registration systems for suicide and self-harm. The information gathered by surveillance and monitoring activities **informs public health strategies and targeted interventions for programme design and implementation.**

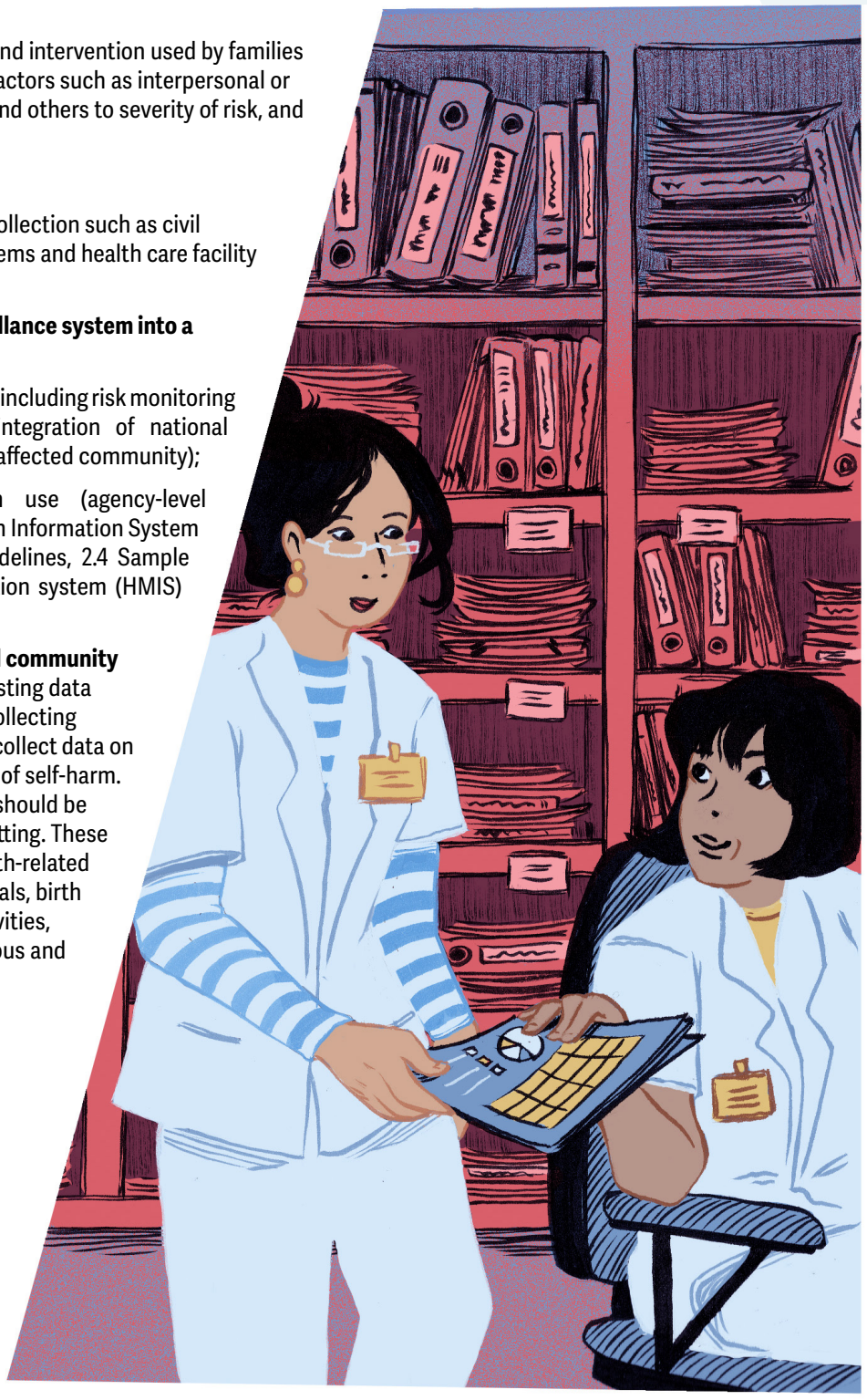
- **Surveillance** can provide insight into the scope and severity of suicidal behaviours and the key factors driving them, and can further illuminate the impacts of contextual stressors on suicidality.
  Surveillance remains **effective and appropriate as the context evolves** and that the affected community and key stakeholders remain comfortable and accepting of data collection and storage practices.

Surveillance: what to record

- Data on the **number of suicides** and **self-harm** (disaggregated at a minimum by gender, age and method).
- **Action taken** (referral to MHPSS services and intervention used by families or community members, identified causal factors such as interpersonal or contextual stressors, awareness of family and others to severity of risk, and point of initial service contact).

Surveillance: sources of information

- Review **existing systems** for routine data collection such as civil registration and vital statistics (CRVS) systems and health care facility and police records.
- Consider **modelling or integrating a surveillance system into a functional existing system:**
  - national suicide prevention strategies, including risk monitoring and surveillance (preferred when integration of national strategy does not increase risk to the affected community);
  - local data collection systems in use (agency-level programming, GBVIMS, UNHCR Health Information System – Mortality Register and Sphere Guidelines, 2.4 Sample routine health management information system (HMIS) surveillance reporting form[24].
- Partner with a **variety of humanitarian and community actors** likely to have unique insight into existing data collection systems, risks associated with collecting sensitive data in the context and where to collect data on suicide deaths, suicide attempts and cases of self-harm. This will vary with culture and context and should be independently assessed in each specific setting. These partners may include actors in mental health-related roles and others (those responsible for burials, birth and death records, certain community activities, etc.). Community actors may include religious and community leaders, midwives and others.
- **Sensitize** staff on the use of surveillance, considering possible hesitation or societal stigma related to reporting and registering suicides and self-harm.



24. Sphere (2018). The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response.

Examples from the field

Developing an Information Management System in Bangladesh

In Cox's Bazar, Bangladesh, Rohingya Muslims who fled Myanmar have lived in refugee camps since 2017[25]. A Humanitarian Suicide Risk Information Management System (HSR-IMS), was developed by the Inter-Sector Suicide Prevention Subgroup, Rohingya Refugee Response. It was informed by global guidelines for mortality and morbidity registers and modelled after the GBVIMS structure[26]. **The HSR-IMS collects data on ideation, suicide attempts and deaths from suicide, utilizing the existing KoBo ToolBox data collection software[27].** Data collection is streamlined through signatory agencies who agree to regular, responsible data collection. The information collected triangulates data on suicidal behaviour to reveal more about the scope, severity and prevalence of suicidal behaviours of that community. The HSR-IMS will be piloted through the Inter-Sector Suicide Prevention Subgroup of the MHPSS Working Group, with inputs from signatory agencies.

Key Resources and guidance: monitoring and evaluation

LIVE LIFE

World Health Organization (2021). LIVE LIFE: An implementation guide for suicide prevention in countries.

The Mental Health and Psychosocial Support Minimum Services Package. MSP Activity 2.2 Develop and implement a monitoring and evaluation (M&E) system.

World Health Organization (2018). Preventing suicide: a community engagement toolkit. Chapters 1–3, 5–6, pp. 1–30, 35–43.

IASC

IASC (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Action sheet 2.2

25. Action Against Hunger (2021). Rohingya crisis: Challenges in Cox's Bazar continue.

26. GBVIMS (2021). Gender-Based Violence Information Management System. Intake and Consent Forms.

27. KoBo Toolbox. Simple, robust and powerful tools for data collection.

Key resources and guidance: surveillance

LIVE LIFE World Health Organization (2021). LIVE LIFE: An implementation guide for suicide prevention in countries.

World Health Organization (2021). Preventing suicide: a resource for suicide case registration.

World Health Organization (2014). Preventing suicide: A resource for non-fatal suicidal behaviour case registration, pp. 6–21.

World Health Organization (2016). Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm. Chapters 2–5, pp. 13–56.

World Health Organization (2018). Preventing suicide: a community engagement toolkit. Chapters 1–3, 5–6, pp. 1–30, 35–43.

Illustrative examples of surveillance, monitoring or evaluation

Cwik MF, Barlow A, Goklish N et al. (2014). Community-based surveillance and case management for suicide prevention: An American Indian tribally initiated system. American Journal of Public Health. 104(SUPPL. 3):18-23.

Fleischmann A, Bertolote JM, Wasserman D et al. (2008). Effectiveness of brief intervention and contact for suicide attempters: A randomized controlled trial in five countries. Bull World Health Organization. 86(9):703-709.

Haroz EE, Decker E, Lee C (2018). Evidence for suicide prevention and response programs with refugees: A systematic review and recommendations.

Vijayakumar L, Pathare S, Jain N et al. (2020). Implementation of a comprehensive surveillance system for recording suicides and attempted suicides in rural India. BMJ Open. 2020;10(11):1-9.

2.3. Staff and volunteer care and well-being

Why?

The well-being of staff and volunteers is particularly important in humanitarian crisis settings, as it affects their ability to function in their role and to support affected populations. A suicide incident among staff or affected populations often generates strong emotional reactions, and initial support is critical.

Staff and volunteers providing services and support in **highly stressful and challenging conditions** (acute emergency response, care provision during infectious disease outbreaks) can also be at higher risk of suicide. Consider the importance of providing appropriate staff care and support.

How?

An important component of staff and volunteer well-being is ensuring that safe and quality suicide prevention measures are in place **prior to any incident.**

This includes providing a **safe environment** where staff are encouraged to access **confidential** MHPSS services, providing access to **resources and tools** on healthy coping and well-being, ensuring adequate supportive **working conditions,** conducting regular supervision and **check-ins** and encouraging a **network** or support group of peers. It also includes **reducing access to means** in workplaces (to medications or poison, installing barriers on roofs, also see section 3.1).

Key resources and guidance: staff and volunteer care and well-being

The Mental Health and Psychosocial Support Minimum Services Package.
MSP Activity 2.3 Care for staff and volunteers providing MHPSS.

IASC (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Action sheet 4.4.

2.4. Staff and volunteer competencies

Why?

Suicide is a complex and sensitive topic, and those working on suicide prevention and response may have particular cultural and contextual beliefs that affect their perspectives on suicide. In addition, staff may be under increased levels of psychological stress when supporting individuals that need urgent support. Therefore, it is important that staff are supported to competently support at-risk individuals.

How?

Before implementation of a programme, ensure that staff and volunteers are oriented and trained.

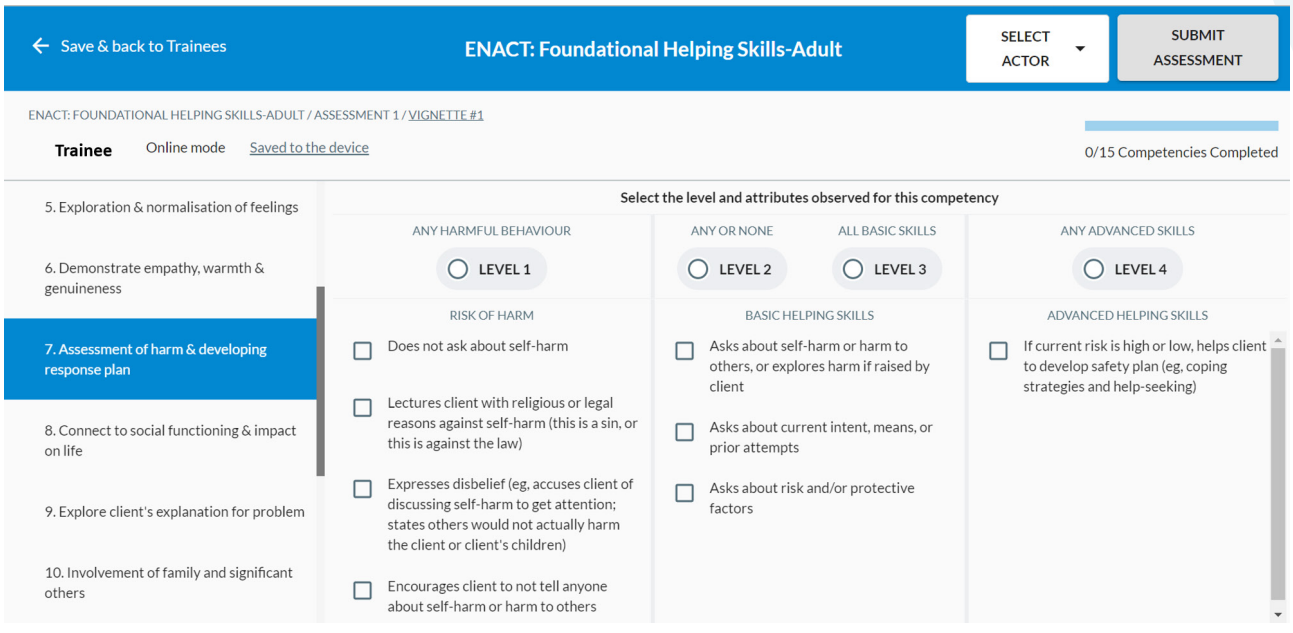
Staff and volunteers should be supported on:

- **Appropriate language** to use (see section 1 on language considerations);
- Protecting **confidentiality**, limits to confidentiality and safety (see section 1.1 on situational analysis);
- **Assessing for risk** of self-harm or suicide, including warning signs related to imminent risks, inclusive of individual-level risk factors, relationship factors, community risk factors and societal-level and health risk factors, as well as youth-specific risk factors (see example from ENACT below);
- Assessing for protective factors that may reduce imminent or short-term risks for self-harm and suicide;
- How to provide **basic support** for persons affected by suicidal thoughts or persons bereaved by suicide (see section 3.4), including empathy, being non-judgmental, making validating statements, using basic psychosocial skills and implementing the principles of non-discrimination and inclusion, children's participation and the best interests of the child, enhancing people's safety, dignity and rights and avoiding exposing them to further harm, ensuring people's access to impartial assistance according to need and without discrimination, and strengthening children's resilience in humanitarian action;
- What **services and supports are available** and **how to refer to mental health services** (contact information of providers, referral pathways and harmonized, collaborative procedures and safe access) and to other needed services and supports (financial support, protection services);
- Referral pathways should be agreed upon and communicated with **MHPSS TWGs** and other relevant coordination groups (education, CP and GBV AoRs) and be part of **mapping** (the 4Ws) and **service directories** (see also section 1.1).

One way of supporting staff to develop the above-mentioned skills is to **train and assess competencies** in foundational helping skills as outlined in the Ensuring Quality in Psychological Support (EQUIP) Platform.

Staff and volunteers should also be able to reach someone with higher-level expertise for **regular support**, questions and advice (a supervisor, a mental health professional).

EQUIP: Ensuring Quality in Psychological Support



Screenshot of EQUIP-ENACT Competency Assessment tool, competency #7: Assessment and management of risk for suicide and self-harm

Key resources and guidance: staff and volunteer competencies

LIVE LIFE

World Health Organization (2021). LIVE LIFE: An implementation guide for suicide prevention in countries.

The Mental Health and Psychosocial Support Minimum Services Package. MSP Activity 2.4 Support MHPSS competencies of staff and volunteers.

EQUIP: Ensuring Quality in Psychological Support

The Ensuring Quality in Psychological Support (EQUIP) Platform includes an interactive tool to assess competencies in suicide and self-harm assessment as well as safety planning. On the EQUIP Platform, ENACT Competency #7 can be used to identify potentially harmful behaviours as well as basic and advanced helping skills related to suicide risk reduction competencies. In addition, ENACT Competency #3 can be used to evaluate respecting confidentiality as well as discussing when confidentiality may need to be broken in the context of suicide risk reduction. In the ENACT-Remote sections, the confidentiality and suicide assessment and support competencies are tailored for delivering remote psychosocial services (voice or video communication).

EQUIP Foundational Helping Skills (FHS) Training Manual, Module #8, contains training materials on suicide risk reduction competencies, including assessment of suicide and other risks of harm and development of safety planning. Module #3 includes training on confidentiality, including when and how to discuss when confidentiality cannot be assured in the context of emergency suicide risk reduction.

EQUIP Remote includes a course on "Remotely Assessing and Supporting People with Suicidal Behaviours". This includes: Module 1: Preparing to assess suicidal behaviours remotely; Module 2: Assessment of suicidal behaviours remotely; Module 3: Responding to suicidal behaviours and addressing barriers to providing remote support.

IFRC Reference Centre for Psychosocial Support (2021). Suicide Prevention.

IASC

IASC (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Action Sheet 4.1-4.4.

3.
Key effective suicide prevention and intervention programme activities

3.1. Reducing access to means of suicide

Why?

Reduction of access to means of suicide is one of the **most significant and universal, evidence-based and effective ways** of preventing suicide. Restricting access to means has been found to reduce suicide related to those means, as well as reducing overall suicide rates in some countries (as there may be less lethal alternatives). Suicidal ideation and behaviour can be impulsive, and the majority of people who engage in suicidal behaviour are ambivalent about wanting to live or die – another reason why making lethal means less accessible is key.

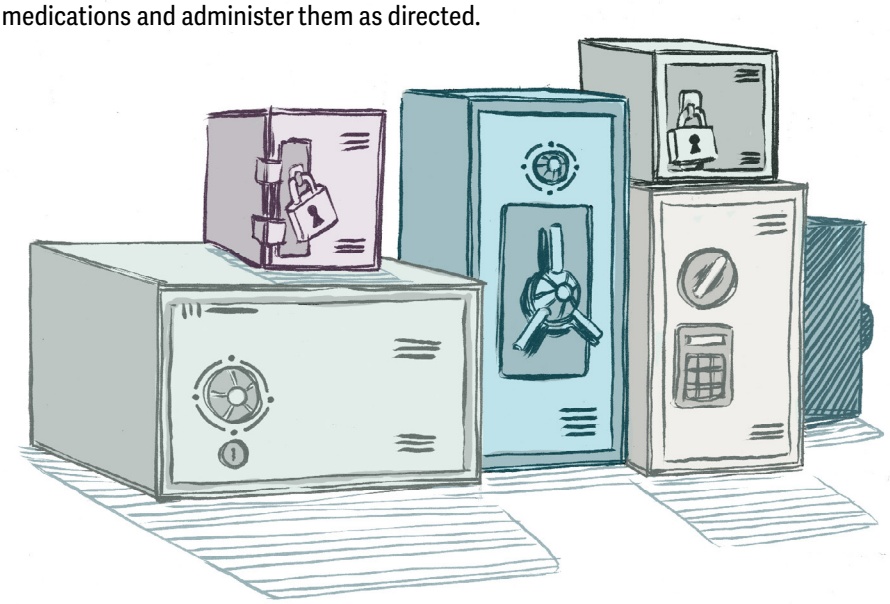
How?

Methods of suicide and attempts vary by humanitarian setting and reflect what is accessible. Generally, common suicide methods are hanging, firearms and self-poisoning with pesticides[28].

Effective **restriction of means** in humanitarian settings should focus on methods that:

- Cause the most deaths and/or are the most lethal means
- Are the most commonly used (see section 1.2 on situational analysis).

- **Identify and involve key humanitarian and community actors/stakeholders for collaborative consultation on feasible community actions to restrict or reduce access to the most lethal and common means of suicide.**
- **Restrict access to the means used in the humanitarian setting, such as:**
  - restricting community access to firearms[29]
  - restricting access to highly hazardous pesticides
  - installing barriers at potential jump sites
  - modifying ligature points in institutional settings or detention facilities
  - restricting the prescription of high-toxicity medicines
  - removing lethal items in the households of at-risk individuals (knives, razors, kerosene, pesticides, ropes).
- **Restrict availability of the means used in the humanitarian setting, for example by:**
  - limiting the quantity of individual sales for toxic medications and other poisonous substances such as pesticides[30]
  - limiting the quantity of psychotropic medications issued to at-risk individuals, and/or appointing another individual to oversee medications and administer them as directed.



28. World Health Organization (2021). LIVE LIFE: An implementation guide for suicide prevention in countries.

29. Lubin G, Werbeloff N, Halperin D, Shmushkevitch M, Weiser M, Knobler HY (2010). Decrease in suicide rates after a change of policy reducing access to firearms in adolescents: a naturalistic epidemiological study. Suicide Life Threat Behavior. 40(5):421-424.

30. Knipe DW, Chang SS, Dawson A et al. (2017). Suicide prevention through means restriction: Impact of the 2008–2011 pesticide restrictions on suicide in Sri Lanka. PLoS One. 12(3):0172893.

Examples from the field

In Iraq, the Ministry of Health's Mental Health Office initiated a national study of suicide (2015–2016) in collaboration with international researchers. **The Ministry of the Interior tasked police personnel to complete forms in relation to individual deaths in their jurisdictions which had been ruled as suicide and to follow up with families where data were missing.** The results were used to identify the population and subpopulation suicide rates (age and gender), common methods used and the profile of medical, mental health, suicide and precipitating factors related to deaths by suicide; at-risk groups were also identified. Lessons learned informed planning for a national register of suicide. The study indicated the need to implement means restriction for firearms and kerosene (related to self-immolation) in future suicide prevention efforts.

Key resources

LIVE LIFE World Health Organization (2021). LIVE LIFE: An implementation guide for suicide prevention in countries. Part B: Key Effective Interventions for Suicide Prevention: Limit access to the means of suicide, pp. 58–63.

The Mental Health and Psychosocial Support Minimum Services Package. MSP Activity 2 3.1 Orient humanitarian actors and community members on MHPSS and advocate for MHPSS considerations and actions.

World Health Organization (2012). Public health action for the prevention of suicide: A framework.

3.2. Ensuring responsible communication and media coverage

Why?

Media outlets play a key role in influencing public opinion and can support the prevention of suicide, but they can also contribute to increasing risks of suicide.

Repeated, glamourized coverage of high-profile cases which include detailed descriptions of the methods of suicide have been shown to **increase the risk of suicidal behaviour**[31]. Fictional portrayals of suicide that do not accurately represent reality are similarly problematic.

How?

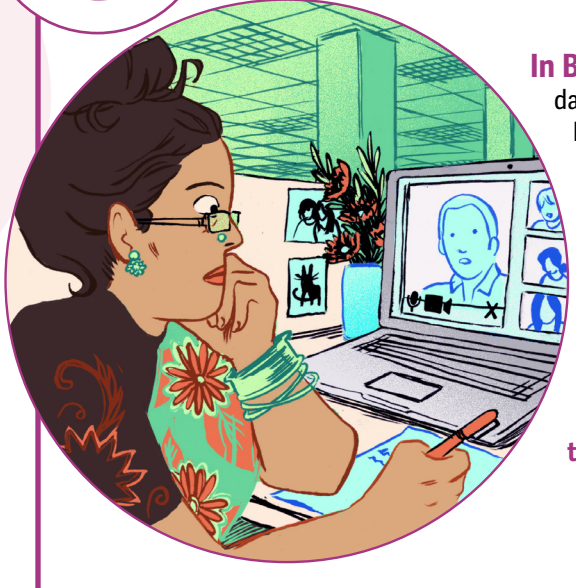
Media outlets can **reach large numbers of people** simultaneously and can reach specific groups of people depending on the outlet (media channels or radio broadcasts accessed by affected communities).

Media can **bolster suicide prevention** efforts by conveying key messages and messages of hope, by raising awareness (see section 2.1) and by covering the topic sensitively and accurately.

To cover the topic of suicide with sensitivity and relevance, the following actions are recommended:

- **Identify key stakeholders and key actors** within the humanitarian setting, within media and within government for collaboration and engagement (see section 1.1), including national, regional or local media organizations and regulators and social media companies.
- Determine the **area of media focus** such as journalism, entertainment or social media and **jointly develop key messages** with media outlets.
- Engage with media proactively, not just as a response to sensational or unsafe reporting.
- Consider **strategically important times for reporting:** for example, training could be part of new employee induction, or media events could be planned for specific days (see section 2.1).
- Conversations around **sensational reporting** of suicide should not be punitive or judgmental; rather they should be collaborative and based around shared responsibility for ethical and responsible reporting and the positive impact that responsible reporting can have in suicide prevention.

Examples from the field



In Bangladesh, the Inter-Sector Subgroup on Suicide Prevention hosted a half-day virtual training on "Suicide Reporting and Prevention for Journalists and Media Professionals". With guidance from a national suicide prevention expert, it was determined that, nationally, reporting practices on suicide rarely adhered to WHO best practice guidelines. **Training content was developed in partnership with Subgroup members, with a goal of contextualizing and disseminating these guidelines nationwide.** Training invitations were disseminated through professional and academic networks of Bangladeshi media professionals, including those engaged in the Rohingya humanitarian response. This initiative facilitated connections between national media professionals, academic psychiatrists and the humanitarian response in Cox's Bazar and **encouraged follow-up and advocacy by journalists within their own networks, including in professional training programmes.**

31. World Health Organization (2017). Preventing suicide: A resource for media professionals.

Develop strategies that will be used to increase responsible reporting

- Building **good relationships with media stakeholders**, such as through actively involving them in awareness-raising activities, can help to create a more welcoming relationship in preparation for training or policy development.
- Agree upon the use and adaptation of existing resources or develop new **policies and guidelines on responsible reporting.**
- If guidance, policies and training exist, ensure that they are **up-to-date** and contain latest evidence-informed best practice.
- Develop **a press information kit** that provides resources for media or contact details for suicide prevention experts for media professionals to use when covering a story on suicide.
- For **social media**, consider highlighting referral pathways, information on how to access mental health services and other resources which are specific to the population in the humanitarian setting.
- Agree on **accountability mechanisms** to monitor and manage problematic reporting.
- Develop systems to recognize and **highlight good practice,** or to nominate media outlets for existing awards on excellence.

- Develop and collaborate on **training for media professionals, media students, NGO media units** and other key stakeholders on the implementation of the WHO resource booklet for media professionals[32]. Remember that those in the media might be impacted by stories of suicide or may be personally affected.
- **Monitor and evaluate all activities** (see section 2.2). Indicators might include changes in sensationalized media reports or number of examples of responsible reporting. Plan for the dissemination of key outcomes to encourage wider uptake of initiatives or to serve as lessons learned for other professionals. Tools for evaluating media reporting of suicide can help to monitor adherence to safe reporting guidelines within a given media sector or media outlet[33].

Key resources and guidance: ensuring responsible communication and media coverage

LIVE LIFE World Health Organization (2021). LIVE LIFE: An implementation guide for suicide prevention in countries.

The Mental Health and Psychosocial Support Minimum Services Package. MSP Activity 3.1 Orient humanitarian actors and community members on MHPSS and advocate for MHPSS considerations and actions.

World Health Organization (2019). Preventing Suicide: A resource for filmmakers and others working on stage and screen.

Everymind (2020). Mindframe for media professionals.

World Health Organization (2017). Preventing suicide: A resource for media professionals.

Suicide Prevention Resource Center (2013). Responding to a cry for help: Best practices for online technologies.

Reporting on Suicide (n.d.). Best Practice and Recommendations for Reporting on Suicide.

Republic of Lebanon, Ministry for Public Health (2019). Practical guide for media professionals on the coverage of mental health and substance use.

32. World Health Organization (2017). Preventing suicide: A resource for medical professionals.
33. Sorenson CC et al. (2022). The Tool for Evaluating Media Portrayals of Suicide (TEMPOS): Development and Application of a Novel Rating Scale to Reduce Suicide Contagion. International Journal of Environmental Research and Public Health, 19(5), 2994.

3.3. Capacity-building of frontline workers and gatekeepers

Why? In order to identify risks of suicide, and refer to appropriate services, it is vital that frontline workers in various sectors (health, education and social care workers), as well as community gatekeepers, are trained to safely **identify** individuals at risk of suicide, provide or mobilize **support** for them, and provide **referral** and follow up[34].

How? Prospective frontline workers and gatekeepers may be **selected strategically** in the humanitarian setting, such as those working in **high-risk geographical areas** or those able to deliver capacity-building in rural or hard-to-reach areas.

Frontline workers and gatekeepers can include:

- **Health workers** (such as emergency medical workers, general physicians, nurses, community health workers or social workers), especially those working in units likely to come into contact with at-risk individuals such as those dealing with substance use disorders, chronic pain or chronic diseases;
- **Workers from other sectors and other community gatekeepers** such as emergency service workers (police, firefighters, ambulance or crisis line personnel); education sector staff (teachers); those providing child protection and GBV protection services; those delivering basic needs/livelihoods;
- **Community gatekeepers** (persons likely to come into contact with at-risk individuals) or persons with influence in a community (community leaders, leaders including older youth, public transport workers, hairdressers, taxi drivers, religious leaders).

Training should include:

- Understanding cultural and traditional **attitudes** that influence the identification of and care for people at **risk** as well as risk and **protective** factors;
- An awareness of **groups that may be especially at risk,** depending on the specific humanitarian context and role of the worker (sexual and gender minority person refugee and asylum seekers, survivors of GBV, current or former military personnel, pregnant adolescents);
- Ensuring information and services are **accessible and inclusive** for different groups of the affected population;
- An awareness of the **common presentations** of self-harm/suicide in order to identify at-risk individuals;
- Basic skills of **assessment and management** of risk, including in crises (how to ask about self-harm; recognizing self-inflicted injuries or self-poisoning);
- Basic **psychological support** (applying principles of Psychosocial First Aid, providing psychoeducation about suicide; mobilizing family and community sources of social support; supporting persons bereaved by suicide);
- **Referral** to mental health care (non-specialists who have been trained in suicide prevention and in delivering appropriate interventions using WHO mhGAP-HIG (see section 3.5) or other needed services), including referral pathways and relevant referral forms and procedures (consent, sharing of information); continued **follow-up**;

Capacity-building should be **ongoing and sustainable**. Models which promote sustainability are the training-of-trainers model, the provision of continued support and supervision, and planning of refresher training.

34. Vijayakumar L, Mohanraj R, Kumar S, Jeyaseelan V, Sriram S, Shanmugam M (2017). CASP – An intervention by community volunteers to reduce suicidal behaviour among refugees. The International Journal of Social Psychiatry, 63(7), 589–597.

Reducing risk among asylum seekers and refugees

Factors contributing to **risk of suicide among asylum seekers and refugees** include mental health conditions (comorbid depression or PTSD, alcohol abuse), having newly arrived in a host country (the first six months), perceived threat of rejection of the asylum application and being rejected for asylum after a long waiting time[35]. Persons in detention can also be at increased risk of suicide and suicidal ideation[36].

It is critical to **build the capacity of staff working with asylum seekers and refugees** and ensure the provision of support and interventions, especially across different stages (at the time of arrival, during waiting time and at the time of an asylum decision, time of relocation or repatriation).

Protective factors should be promoted, which include early education on the language and culture of the host country; early provision of economic and educational activities; ensuring communication and connections to social support networks; and engaging communities and media efforts to create a welcoming and supportive environment for asylum seekers and refugees.

Addressing the needs of survivors of gender-based violence (GBV)

GBV survivors (including IPV survivors) experience an **increased risk of suicidal ideation or death** by suicide. Some estimates indicate that a third of females who die by suicide have experienced IPV[37]. IPV survivors are at particular risk of death by suicide, and this risk has been shown to increase for survivors who have experienced patterns of **coercive and controlling behaviour and high-risk IPV** (non-fatal strangulation, use of weapons[38]). These risks are heightened when a separation occurs, as is also the case for intimate partner homicide[39].

It is important that **gatekeepers are trained in responding supportively and in a survivor-centred manner to GBV survivors** who are expressing suicidal thoughts or intent and referral to GBV specialized actors. It is crucial that those assisting and supporting GBV survivors are trained in identification, basic support and referral (those working as part of GBV case management services, persons working in safe spaces for women and girls, health-care workers who are trained in clinical management of rape).

Relevant resources on responding to suicide ideation within the context of GBV response:

Gender-based Violence Information Management System (GBVIMS) Steering Committee (2017). Interagency Gender-Based Violence Case Management Guidelines. Responding to suicide risks in a survivor centered manner and safety planning. See pages 70-74 for suicide risk assessment, Annex Part VI for Suicide Safety.

How to support survivors of gender-based violence when a GBV actor is not available in your area – Pocket Guide.

GBV AoR (2020). Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming.

GBV AoR, UNFPA (2021). COVID-19 Guidance on Remote Gender-Based Violence Services Focusing on Phone-based Case Management and Hotlines. See Section IV: Remote services guidance for engaging with suicidal clients on a GBV hotline call.

35. Wasserman D (2017). Suicide risk in refugees and asylum seekers. European Psychiatry, 41(S1), S35–S36.

36. Gargiulo A, Tessitore F, Le Grottaglie F, Margherita G (2021). Self-harming behaviours of asylum seekers and refugees in Europe: A systematic review. Int J Psychol. 56(2):189-98.

37. Walby S. (2004). The Cost of Domestic Violence. London: Women and Equality Unit (DTI).

38. Aitken R and Munro V (2018). Domestic abuse and suicide: exploring the links with Refuge's client base and work force. London; University of Warwick, School of Law: Refuge.

39. Vulnerability Knowledge and Practice Programme (VKPP) (2021). Domestic Homicides and Suspected Victim Suicides During the Covid-19 Pandemic 2020–2021.

Establishing a crisis helpline

Crisis helplines can help to alleviate the distress that a person may be experiencing and can reduce the intensity of such feelings to enable problem-solving and practical actions to be considered in response to personal problems. The confidential services offered by crisis helplines may help to overcome the barrier of stigma surrounding suicide and mental health problems that could prevent a person from seeking help.

Crisis helplines can:

- Provide 24-hour access to staff trained in suicide assessment and intervention;
- Thoroughly assess for risk of suicide, provide support, offer referrals, develop a safety plan and dispatch emergency intervention, if necessary;
- Connect directly with local mobile crisis teams;
- Avert unnecessary visits to emergency departments;
- Intervene when a caller is not willing or able to ensure his or her own safety.

Additional considerations:

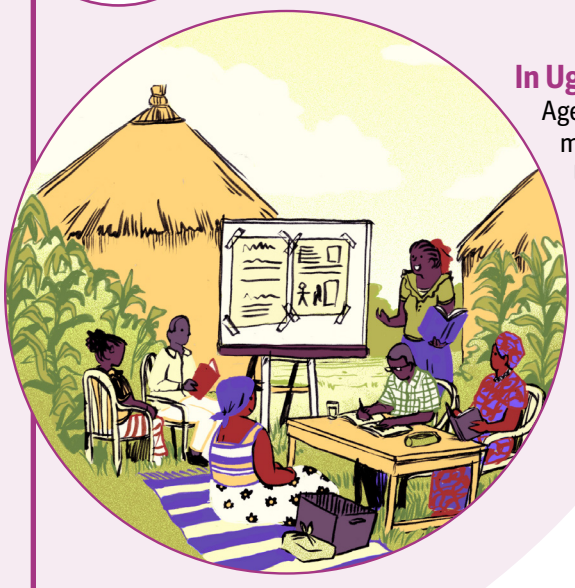
- Consider building capacity in suicide prevention in other crisis hotline staff such as GBV and child protection hotlines.
- Crisis helplines in humanitarian settings seldom include staff trained on suicide assessment and intervention specifically for young people. Child and adolescent-focused training for helpline staff must be prioritized, and strong linkages established with community-based MHPSS services.
- Ensure contextual considerations such as access to phones (which may be limited for women or young people), possible restrictions in telecommunication networks.

Relevant resources

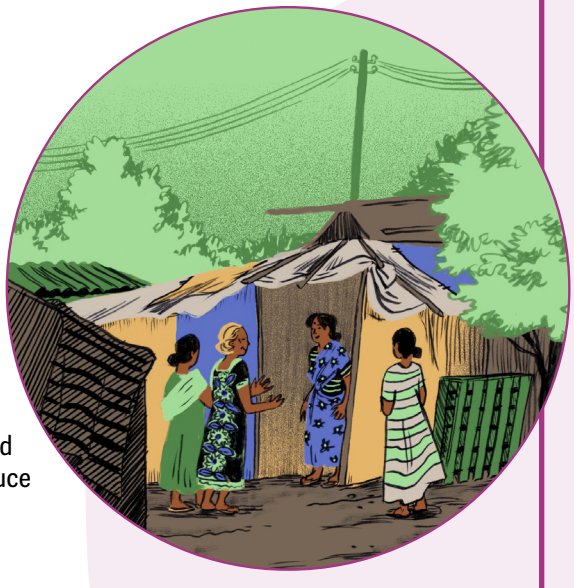
National Suicide Prevention Lifeline (2021). Follow-Up Care. A resource for establishing a crisis line and Helpline Checklist.

GBV AoR and UNFPA (2021). COVID-19 Guidance on Remote GBV Services Focusing on Phone-based Case Management and Hotlines. See Section IV: How to Engage with a Suicidal Client.

Examples from the field



In Uganda, where 40% of South Sudanese refugees are living, UNHCR, the UN Refugee Agency, found that the number of suicides and suicide attempts among refugees had more than doubled in 2019 compared with the previous year[40]. With support from UNHCR, local NGO Transcultural Psychosocial Organization (TPO) Uganda ran a suicide prevention programme that reached 9,000 refugees and local Ugandans in and around Bidibidi Refugee Settlement in 2019. Among other support strategies, it offered counselling on how to manage negative thoughts, reach out for help and engage in social activities. **Programmes to minimize stigma around mental health and to train health-care providers and community-based counsellors were also conducted[41].**



A study was conducted in 2017 among **Sri Lankans living in South Indian** refugee camps to assess the feasibility of an intervention that utilizes community self-help and social support to reduce suicidal behaviour. The intervention required regular contact and use of safety planning cards (CASP). Community volunteers took part in a 20-hour training programme to administer assessments and to implement the intervention among refugees. **These volunteers visited individuals identified as being at high risk,** provided emotional support and collaborated with them to create safety planning cards that listed warning signs and coping strategies, along with available support. The results of the study showed that the intervention could be delivered easily and that it could be used to reduce suicidal behaviour among refugees[42].

In Egypt, organizations supporting refugees and asylum seekers were concerned about high numbers of suicide attempts and deaths. Cultural attitudes can lead families and communities to hide those at risk. After a suicide, it was often acknowledged that this person had been showing signs of depression or despair and had even made other attempts. Communities discussed this and agreed that greater awareness could help prevention efforts. **The Psycho-Social Services and Training Institute in Cairo (PSTIC – a programme of Terre des hommes) trained refugee psychosocial workers were trained to organize awareness workshops in local languages at community sites.** The workshops included data on suicide; conversations on the reasons for despair and loss; and facilitated discussions with questions to help participants gain a better understanding of cultural attitudes (e.g., What are your community's attitudes towards people who die by suicide; How does this influence a person who has suicidal thoughts and needs help? How do these attitudes influence families and communities when helping someone who is has suicidal thoughts?). **Trainees were taught about the importance of prevention and taking warning signs seriously. They learned to "GO – ASK – LISTEN – CARE – ENCOURAGE – REFER – FOLLOW UP":** GO to the person at risk immediately and ensure their safety; ASK questions to determine risk; LISTEN to what is said; CARE about the person and engage the social support system; ENCOURAGE the person to let them and others help; REFER to professionals for added help, and FOLLOW UP!

40. United Nations High Commissioner for Refugees (2020). Suicides on the rise among South Sudanese refugees in Uganda.

41. Ibid.

42. Vijayakumar L, Mohanraj R, Kumar S, Jeyaseelan V, Sriram S, Shanmugam M (2017). CASP – An intervention by community volunteers to reduce suicidal behaviour among refugees. The International Journal of Social Psychiatry, 63(7), 589–597.

Key resources and guidance: capacity-building of frontline workers and gatekeepers

World Health Organization (2021). LIVE LIFE: An implementation guide for suicide prevention in countries. Part A: LIVE LIFE Core Pillars: Capacity-building and Part B: Early identify, assess, manage and follow up anyone who is affected by suicidal behaviours.

The Mental Health and Psychosocial Support Minimum Services Package. MSP Activities 3.2 Orient frontline workers and community leaders in basic psychosocial support skills; 3.13 Provide MHPSS through protection case management services.

Pan American Health Organization. Preventing self-harm/suicide: Empowering primary health care providers.

Pan American Health Organization (n.d.). Engaging communities in preventing suicide.

IFRC Reference Centre for Psychosocial Support (2022). Heartbeat of Humanity: Suicide Prevention in The Red Cross Red Crescent Movement (Podcast).

IASC (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Action sheet 4.1-4.1.

Illustrative examples of capacity-building for suicide prevention:

Haroz EE, Decker E, Lee C (2018). Evidence for suicide prevention and response programs with refugees: A systematic review and recommendations. Geneva: United Nations High Commissioner for Refugees.

Haroz EE, Decker E, Lee C, Bolton P, Spiegel, B, Ventevogel P (2020). Evidence for suicide prevention strategies with populations in displacement: a systematic review. Intervention, 8(1):37-44.

Vijayakumar L, Mohanraj, R, Kumar S, Jeyaseelan V, Sriram S, Shanmugam M. (2017). CASP – An intervention by community volunteers to reduce suicidal behaviour among refugees. International Journal of Social Psychiatry. 63(7):589-597.

3.4. Providing mental health care as part of general health services

Why?

In humanitarian settings, there is usually **a vast treatment gap for mental health,** given the increased needs and the shortage of qualified mental health service providers. **Mental health conditions** such as depression and alcohol and drug use are often more prevalent in humanitarian settings and can contribute to the risk of suicide. A well-functioning **mental health care system,** including adequate training of staff, can contribute to suicide prevention[43].

How?

Integrate the provision of **mental health care into general health care services** by training and supervising providers in the assessment, management and follow-up of priority mental health conditions, including suicide (see WHO/UNHCR mhGAP-HIG or WHO mhGAP 2.0).

Consider developing **detailed intervention protocols** and training health and MHPSS staff on their use[44].

Following contact with health services after a suicide attempt, people can feel isolated and are at substantially increased risk of further suicide attempts. Prompt and **systematic follow-up** care is essential and has been shown to reduce suicide risk.

Postvention support should be available for people who have attempted suicide, and for those who have been bereaved by suicide[45].

Addressing substance use conditions[46]

Especially among **young people**, the **use of substances** as a coping mechanism can be precipitated by exposure to conflict, disaster, abuse/neglect, physical injury or mental health problems; new and difficult environments (refugee camps); boredom and marginalization; and loss of resources (social and/or financial); and this can amplify pre-existing risk factors and vulnerabilities and increase the risk of suicide. Harmful use of drugs and alcohol can be addressed at the **general health care** level (see also mhGAP-HIG) and **community-level activities** can support alcohol- and drug-free environments (during special events such as youth sports events) and introduce policies to limit the sale of alcohol.

Key resources and guidance: providing mental health care as part of general health services

LIVE LIFE

World Health Organization (2021). LIVE LIFE: An implementation guide for suicide prevention in countries. Part B: LIVE LIFE Key Effective Interventions: Early identify, assess, manage and follow up anyone who is affected by suicidal behaviours.

The Mental Health and Psychosocial Support Minimum Services Package. MSP Activities 3.10 Provide mental health care as part of general health services; 3.11 Provide MHPSS as part of clinical care for survivors of sexual violence and intimate partner violence; 3.12 Initiate or strengthen the provision of psychological interventions.

World Health Organization. mhGAP application for non-specialized health workers in the assessment and management of self-harm/suicide.

World Health Organization (2019). Self-harm/suicide module of the WHO mhGAP Intervention Guide and associated training materials: mhGAP training manuals.

IASC

IASC (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Action sheet 6.1-6.5.

43. Fleischmann A, Bertolote JM, Wasserman D, De Leo D, Bolhari J, Botega NJ, De Silva D, Phillips M, Vijayakumar L, Värnik A, Schlebusch L, Thanh HTT. (2008). Effectiveness of brief intervention and contact for suicide attempters: A randomized controlled trial in five countries. Bulletin of the World Health Organization, 86(9), 703–709.

44. International Federation of Red Cross and Red Crescent Societies (2021). Suicide prevention during COVID-19.

45. Vijayakumar L (2016). Suicide among refugees – A mockery of humanity (Editorial). Crisis: The Journal of Crisis Intervention and Suicide Prevention, 37(1), 1–4.

46. Kane JC, Greene MC (2018). Addressing alcohol and substance use disorders among refugees: A desk review of intervention approaches. Geneva: United Nations High Commissioner for Refugees.

3.5. Building life skills among young people

Why?

Young people are a uniquely vulnerable group to the risk of death by suicide. Globally, suicide is the **fourth leading cause of death among 15–19-year-olds**[47]. Adolescence (10–19 years of age) is a critical period for the acquisition of **socio-emotional skills** which are the foundation for later mental health. Adolescence also marks a period of risk for the **onset of mental health conditions,** with half of all cases occurring by age 14. Additionally, adolescents in humanitarian settings can be at further risk for mental health conditions due to the adverse conditions that can disrupt their cognitive, emotional, social and physical development.

How?

Education settings are a main point of contact for young people. In humanitarian settings, many young people may be out of school and may not have access to appropriate learning spaces, and are often among the most vulnerable. It is important that programmes reach target groups through **implementation of socio-emotional life skills training in schools,** informal learning spaces, recreational spaces, vocational programmes, life skills programmes or youth clubs[48]. Also consider integration with group activities for children's mental health and psychosocial well-being (see MSP Activity 3.6[49]), activities at youth centres or relevant accessible programmes adapted for digital use.

Peer support mechanisms among children and youth are important to consider in these settings, particularly given that children and adolescents often have the agency and capacity to develop skills to support their friends. It is important to ensure that they can do so safely with close adult supervision and attention to child safeguarding[50].

- Identify **existing initiatives** for building life skills of young people at national or regional levels and existing manuals and materials that have already been used and adapted for target populations.
- **Assess training needs and capacities** of staff working in selected settings (through consultations with teachers and other education personnel and with education authorities such as officials of the education ministry).
- **Recognize possible risk factors** and ways to support specific groups of young people (e.g., youth/adolescents with disabilities).

Remind teachers or caregivers that talking about suicide with young people will not increase suicide risk but will allow young people to feel more comfortable to approach them for support when needed.

Select an evidence-based intervention for young people (see also Resources section below).

Adapt the programme for the target population and context, including age-appropriate considerations (whether it addresses existing myths about suicide, whether it addresses context-specific factors which hinder the management of suicidal behaviours).

- **Involving education staff** and other targeted workers in **adapting the training** to the local context can enhance motivation and the effectiveness of the training (informed by culture and context, involving adolescents in discussions and feedback to inform design and use of language).
- **Engage young people** in adaptations, design and giving early feedback about the programme (on students' attitudes to mental health, how to identify risk factors for suicide, how they communicate warning signs, common help-seeking behaviours, how best to engage their peers).

Ensure that schools have a plan of action in place to support students and adequate links to mental health services to which they can refer students at risk. Establish clear referral pathways for persons at risk of suicide and for caregivers, including to child and adolescent mental health services where they exist and to other needed services and supports (health, social protection and child protection services).

Rather than focusing explicitly on suicide, it is recommended that programmes employ **a positive mental health approach**[51]. Effective suicide prevention in schools will aim to improve mental health awareness and reduce stigma, and will strengthen protective factors such as problem-solving skills, decision-making, critical thinking, stress management, emotional regulation, self-esteem, self-awareness, identifying help and empathy and healthy interpersonal relationships[52].

Sustainability

Identify **opportunities for longer-term capacity-building,** such as including socio-emotional life skills in educational curricula and in pre-service or continued training (professional development for teachers).

Implementation of evidence-based socio-emotional life skills programmes in schools includes:

- Activities to **increase mental health** awareness among young people;
- **Gatekeeper training for education staff** on how to create a supportive school environment, how to recognize risk factors and warning signs of suicidal behaviour, how to provide support to distressed young people and how to collaboratively refer to additional support;
- Facilitating a **safe school environment** (anti-bullying programmes, initiatives to increase social connection, staff training on creating a supportive environment);
- Creating and strengthening **links to external support services** (mental health care), and providing this information to students;
- Establishing **specific support for students at risk,** such as those who have previously attempted suicide, have been bereaved by suicide or are from groups at risk of suicide (because of sexual orientation or gender minority);
- Providing a **clear policy and protocols for staff** when suicide risk is identified (including ensuring anonymity of students and who should and should not be informed of a student's details); for communication of an attempt or suicide among staff or students; and for supporting a student to return to school following a suicide attempt;
- **Involving parents** to increase their awareness of mental health and risk factors;
- Educating on **healthy use of the Internet and social media** (safe Internet use; use of social media to build healthy social support; and recognizing and responding to unhealthy online activity such as bullying);
- Developing **initiatives to address other risk factors** for young people (parental violence, family trauma, substance use).

47. World Health Organization (2021). LIVE LIFE: An implementation guide for suicide prevention in countries.

48. The 2012 version of the Child Protection Minimum Standards in Humanitarian Action (CPMS) included "Standard 17: Child friendly spaces". In the 2019 edition, this was replaced by the broader "Standard 15: Group activities for child well-being". Structured group activities for child well-being (sometimes known as "guided" or "manualized" programmes) involve a series of facilitated sessions, planned according to a curriculum with explicit MHPSS goals.

49. The Mental Health and Psychosocial Support Minimum Services Package. MSP Activity 3.6 Provide group activities for children's mental health and psychosocial well-being.

50. United Nations Children's Fund (2021). I Support my Friends: A Four-Part Resource Kit for Children and Adolescents to Support a Friend in Distress.

51. A positive mental health approach involves a focus on fostering students' strengths and abilities and helping them to develop new skills to improve overall mental well-being rather than focusing specifically on suicide.

52. World Health Organization (2014). Preventing suicide: A global imperative.

Key resource: WHO and UNICEF: Helping Adolescents Thrive (HAT)

WHO and UNICEF jointly developed Helping Adolescents Thrive guidelines, which provide evidence-informed recommendations on psychosocial interventions to promote mental health, prevent mental health conditions and reduce self-harm and other risk behaviours among adolescents. The guidelines are designed to be delivered across various platforms such as schools, health or social care, the community or digital media. The guidelines include a package of interventions – the HAT toolkit – which was developed to support the operationalization of the guidelines. The toolkit describes programmes that show evidence of promoting mental health in adolescents or reducing risk factors for mental disorders, substance use and self-harm. The toolkit focuses on: 1. improving laws and policies; 2. improving environments within schools, communities and online to promote and protect adolescent mental health; 3. supporting carers; and 4. improving adolescents' psychological skills.

Key resources and guidance: building life skills among young people

LIVE LIFE World Health Organization (2021). LIVE LIFE: An implementation guide for suicide prevention in countries. Part B: LIVE LIFE Key Effective Interventions: Foster socio-emotional life skills in adolescents.

The Mental Health and Psychosocial Support Minimum Services Package. MSP Activities 3.6 Provide group activities for children's mental health and psychosocial well-being; 3.8 Support education personnel to promote the mental health and psychosocial well-being of children; 3.12 Initiate or strengthen the provision of psychological interventions.

World Health Organization (2021). Guidelines on promotive and preventive interventions for adolescents: Helping Adolescents Thrive.

World Health Organization (2000). Preventing suicide: A resource for teachers and other school staff.

Hope Squad (2021). What is Hope Squad?

Suicide Prevention Resource Center (2002). Enhance Life Skills and Resilience.

American Foundation for Suicide Prevention and Suicide Prevention Resource Centre (2011). After a Suicide: A Toolkit for Schools.

Karolinska Institutet (2021). SEYLE: Saving and Empowering Young Lives in Europe.

Papyrus (2018). Building Suicide-Safer Schools and Colleges: A guide for teachers and staff.

Save the Children (2017). PFA II: Dealing With Traumatic Responses in Children.

Substance Abuse and Mental Health Services Administration (2012). Preventing Suicide: A Toolkit for High Schools.

Sources of Strength (n.d.).

IASC IASC (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Action sheet 7.1.