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PLANNING FOR PREVENTION AND RISK MITIGATION OF SUICIDE IN REFUGEE SETTINGS

A Toolkit for Multisectoral Action

Field-test version 2023

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UNHCR partner NGO, the Transcultural Psychosocial Organisation, holds a counselling session with a group of South Sudanese refugee women with suicidal thoughts in Uganda's Bidibidi settlement. © UNHCR/Rocco Nuri

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Acronyms

CBP	Community-Based Protection
CSCAG	Community Stakeholders Consultation and Advisory Group
GBV	Gender-based violence
HIS	Health Information System
IDP	Internally Displaced Persons
IEC	Information, Education and Communication
IMS	Information Management System
iRHIS	Integrated Refugee Health Information System
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex, and queer and other diverse identities
MHPSS	Mental Health and Psychosocial Support
NGO	Non-governmental Organization
PFA	Psychological First Aid
SOP	Standard Operating Procedure
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

ABOUT THIS DOCUMENT

This document was developed in response to requests from UNHCR personnel in various countries who have over time sought guidance on how to best respond to suicidal behaviour among refugees and asylum seekers and what their operations could do to prevent and mitigate suicidal behaviour.

This toolkit is made with the following users in mind:

- Technical personnel working in mental health and psychosocial support (MHPSS).
- Personnel in public health, protection (including community-based protection, child protection and gender-based violence), education, operational and field coordination, and other sectors as applicable.
- Managers and those responsible for resource allocation such as programme officers and heads of units.
- Relevant personnel of partner organizations.

The toolkit aims to support UNHCR personnel and partners in:

- Obtaining a global overview of actions they can undertake and adapt to their context.
- Facilitating the development of a structured multisectoral action plan for suicide prevention and risk mitigation for populations of concern.

BOX 1:

Using this document in settings of internal displacement

This document has been developed based on the experiences with refugees and is intended to be used by UNHCR and partners working in refugee operations. This toolkit will likely also be useful for UNHCR and partners working with internally displaced people (IDPs) and can support the implementation the Building Blocks for IDP Protection.

It could be particularly useful for actors working on the implementation of the building block for Community-based interventions & Social Services. It complements the IASC Guidance Note on Addressing Suicide in Humanitarian Settings (IASC 2022). We solicit feedback from users in IDP settings so that a next iteration of this toolkit can be further tailored to the needs in IDP settings.

The toolkit contains links to relevant resources for more in-depth reading and has deliberately been kept concise to include only information and resources that could be used within settings of displacement. For a broader overview we advise the readers to consult other documents such as:

- Guidance Note on 'addressing suicide and self-harm in humanitarian settings' by the IASC. Reference group for Mental Health and Psychosocial Support in Emergencies.
- Materials on the website of the World Health Organization.

Table 1: Definitions of key terms

Key Terms	Definitions
Suicide	Act of intentionally terminating one's own life.
Suicide attempt	Active attempt to terminate one's own life which does not result in death. This includes acts that are not actually lethal if the person doing the act thought it could be lethal.
Suicidal behaviour	A range of actions that could cause a person to die. This includes suicidal ideation, planning suicide, suicide attempts and death by suicide. Preparatory acts such as the purchasing/acquisition and assembling of means to die by suicide are usually also considered suicidal behaviour.
Suicidal ideation	Thoughts about the possibility of ending one's life. These include contemplation, wishes, and preoccupations with death and suicide. Ideations may vary in intensity and duration from transient thoughts to being fully preoccupied with wanting to die. *Passive* ideations are thoughts about wanting to be dead. *Active* ideations are thoughts about the actions to kill oneself.[1]
Suicide intervention	Direct efforts to stop an individual from attempting to die by suicide.
Suicide postvention	Activities following a death by suicide that reduce risk of recurrence or copying the act by other community members and/or that promote recovery and healing among those affected.
Suicide prevention	Activities targeted at groups or populations to reduce risk factors for suicide and increase factors that promote resilience.
Suicide risk mitigation	Activities to identify, assess, intervene, and respond with the intention to reduce exposure of individuals and communities to suicide risks and reduce related adverse effects.
Suicide contagion	Process by which exposure to suicide or suicidal behaviour of persons in families, peer group or communities, or through reports in social media or press, triggers suicidal behaviour in others ('imitative suicidal behaviour').
Suicide cluster	An unusually high number of people with suicidal behaviour occurring closer together in time and/or space than would be expected by chance.

[1] People usually do not suddenly develop suicidal ideations, but develop these over a longer period, often starting with transient suicidal thoughts or the wish to escape from a situation that is perceived as painful or difficult. This can gradually evolve into more consistent thoughts about death and suicide and to concrete plans or an actual attempt. Suicidal thoughts are not a matter of 'present' or 'absent' but they go and come with varying levels of intensity. Most people with suicidal thoughts do not develop a concrete intention to end their life. Suicidal thoughts can be very frightening, especially when they appear uncontrollable.

Key Terms	Definitions
Self-harm/self-injury	Intentional self-injurious behaviour that has a non-fatal outcome. Such behaviour includes cutting, scratching, hitting, burning the tissue on one's own body and self-poisoning. Some persons experience suicidal ideations while they harm themselves, but others do not. Sometimes, a person can perceive self-harm as self-soothing, for example when it is done to relieve tension that arises from inner turmoil.
Gatekeepers	Individuals in a community (such as teachers, community-leaders or religious leaders) who have face-to-face contact with many other community members as part of their usual routine and who may be trained to identify, assist, and refer persons at risk of suicide.

BOX 2:

Language to avoid

Do not use the phrase '*committing suicide*' as it suggests a criminal element to the act which may increase stigma and discourage people from seeking help. Avoid descriptive language such as 'successful', 'failed' and 'completed' as it implies positive and negative connotations. Instead, use neutral terms such as 'attempted suicide' or 'died by suicide'.

In the English language, the term '*para-suicide*' is sometimes used to indicate nonfatal, self-injurious behaviour with a clear intent to cause bodily harm or death. Because the term is difficult to translate in some languages, we do not recommend its use.

INTRODUCTION

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Suicide among refugees and asylum seekers

Over the last years, UNHCR operations are increasingly confronted with worrisome levels of suicidal behaviour among the people we serve. We do not know whether this represents a real increase in such behaviour or an increase in reporting but, regardless, UNHCR and partners need to develop plans to prevent and mitigate suicide risk, to respond effectively to people expressing suicidal behaviour, and to take appropriate actions to reduce the effects on others when people die by suicide.

Most evidence around suicide among refugees and asylum seekers is collected in high-income countries, with little data from low and middle-income countries where most refugees live. Refugees and other displaced populations have increased risk factors for suicide, which can be related to prior life experiences, their physical and mental health state, the stressors of daily life in displacement and the loss of hope for the future. Of particular concern are refugee children and adolescents who were exposed to violence or who live in extremely difficult circumstances: Exposure to violence and child neglect or abuse increases the risk for suicide later in life. Forced displacement can also aggravate risks for gender-based violence including early and forced marriage, which can be risk factors for suicidal behaviour in girls and women. Long stays under adverse conditions in closed camps for refugees and asylum seekers greatly increases the risks for mental health conditions including self-harm and suicide.

People who have been through lengthy and uncertain asylum processes often describe that they felt humiliated and dehumanized, which can lead to helplessness and hopelessness and increase suicide risk.

Suicide as a growing concern

Suicide is a serious public health issue in many populations and in many settings. Globally more than 700,000 people die by suicide every year. In fact, suicide is one of the leading causes of death in the world, and every year more people die due to suicide than to malaria, HIV/AIDS, breast cancer or war/homicide. In 2019, more than one in every 100 deaths (1.3%) resulted from suicide. For every suicide, there are many more who attempt suicide. The relevance of suicide as a global problem is explicitly recognized in the Sustainable Development Goals with an indicator on suicide mortality rate (SDG Indicator 3.4.2) to which all national governments must report.

Suicide and suicidal behaviour

In 2018, UNHCR commissioned a systematic review on suicide prevention that found there are limited evidence-based interventions that have been tested in humanitarian settings and that suicide and suicidal behaviour can only be tackled through long-term multisectoral approaches combining community-based interventions with focused interventions for people at risk. Many factors influence a person's risk for suicidal behaviour, including factors:

- within a person's mind and body,
- within their social environment such as relationships, households, and families, and
- within their community and in the society at large, including in their current context and in countries of origin.

Such factors can be related to experiences in the past, to current life circumstances and to people's perceptions of and outlook for the future.

Risk and protective factors

To understand someone's risk for suicidal behaviour, it is important to consider various aspects of the person's life. This includes not only factors that increase suicide risk but also positive elements in the person's life situation that may be protective.

1. **Protective factors** are characteristics that make it less likely that individuals will consider, attempt, or die by suicide.
2. **Risk factors** are characteristics that make it more likely that an individual will consider, attempt, or die by suicide.
3. **Warning signs** are indicators of imminent suicidal behaviour.

It is important to understand that suicidal behaviour is often an attempt to end overwhelming pain or distress, and usually occurs when a person feels helpless and hopeless and cannot see another way to stop the suffering. With the current lack of research, we cannot adequately predict who in the refugee population will attempt to end their life, but we can do many things to decrease the chances that a person will resort to suicidal behaviour, and to identify and support individuals who are at imminent risk.

Within each context, the identification of the most important risk and protective factors can help determine the nature and type of interventions required. Risk factors can exist at various levels, including the individual, social, or contextual level and at multiple interaction points. Where risk factors are present, it needs to be assumed that there is a greater likelihood of suicidal behaviours. Some important risk and protective factors for refugees and asylum seekers are listed below in **Table 2**.

Table 2: Protective and Risk Factors for Suicide in Refugees and Asylum Seekers

Protective factors	Risk factors
• Restricted access to means of suicide (such as pesticides and other lethal methods) • Skills for problem-solving and conflict resolution • Skills for emotional regulation and distress tolerance • Strong connections to individuals, family, community, and social institutions • Religious or spiritual beliefs • Economic opportunity and stability • Pro-active help-seeking behaviour • Access to quality mental health care and psychosocial support	• Previous suicide attempt(s) (this is the strongest risk factor for suicide) • Mental health conditions (particularly severe depression, anxiety and psychosis) • Family history of suicide • Knowing someone who has died by suicide. In asylum centres, migration detention centres and crowded refugee camps the exposure to peer suicidal behaviour can increase the risk of suicidal behaviour in others • Feelings of hopelessness (which can be fuelled by a sense of feeling 'trapped' by one's circumstances including a lack of durable solutions, rendering people feeling powerless and unable to plan for their future) • Social isolation, not experiencing support by family and/or community • Lack of social integration in the host country • Experiences of recent loss (or accumulation of multiple losses) such as death of a loved one, having applications for refugee status or resettlement being rejected • Fear of being deported or refouled (sent back involuntarily to the country of origin) • Separation from family • Long-term confinement • Job or financial loss (economic constraints) • Conditions related to alcohol, drugs, or other substances • Chronic pain or illness • Trauma or abuse • Forced marriage and other harmful traditional practices • Being rejected, excluded, discriminated and/or marginalized by family and/or community (e.g. LGBTIQ+ persons and/or racial, ethnic or religious minorities)

Risk factors do not cause or predict a suicide, rather they are characteristics that make it more likely that an individual will consider, attempt or die by suicide. However, warning signs for suicide are indicators that a person may be in acute danger and may urgently need help. Sometimes, suicide warning signs are clear and obvious, but they might also be difficult to recognize. Also, some people who attempt suicide may not show any warning signs at all. Behaviour listed in Table 3 may be warning signs that someone is thinking about or planning suicide.

Table 3: Warning Signs for Suicide

Warning Signs
• Often talking about death, dying or suicide • Making comments about being hopeless, helpless, or worthless • Expressing strong feelings of guilt or shame, or belief of being a burden to others (e.g., saying "others will be better off without me") • Expressions of having no reason for living and having no sense of purpose in life; saying things like "It would be better if I wasn't here," or expressions of detachment with projects and activities a person used to be involved in • Using drugs and/or alcohol more often than usual • Withdrawal from friends, family and community • Engaging in reckless behaviour or more risky activities, seemingly without thinking • Dramatic mood changes • Talking about 'feeling trapped' or seeing no solutions for current difficulties • Giving away possessions and/or arranging end-of-life personal business

Elements of a prevention and risk mitigation action plan

Given the multifactorial nature of suicidal behaviour, the actions to prevent suicide and mitigate suicide risks should be multisectoral. Planning for suicide prevention and risk mitigation should not be seen as the exclusive realm of professionals in mental health and psychosocial support. In UNHCR operations, plans for suicide prevention and risk mitigation shall be developed jointly by people involved in various sectors and become operationally linked to other programmes (e.g., such as community empowerment, public health, gender-based violence and education).

A prevention and risk mitigation action plan, implemented by UNHCR and partners, should consist of practical steps that, when implemented together, have the best prospect to prevent and mitigate suicidal behaviour. Generally, an action plan combines interventions on a *group level* that can decrease the chances that people will resort to suicidal behaviour ('*public health approaches*') with interventions on an *individual level*, to support persons who have shown signs of suicidal behaviour or have high risk for imminent suicidal behaviour ('*clinical approaches*').

When developing a suicide prevention and risk mitigation action plan,[2] it is important to include actions that improve direct responses to a person in crisis and include preventative approaches to reduce the overall risk. The following three pillars are to be taken in consideration when designing an action plan:

1. **Prevention:** ***Actions that decrease the chance that suicide attempts will happen:***
    - Strengthening protective factors for individuals at risk within their social environment, thereby creating safety nets
    - Reducing risk factors in individuals, families and communities

[2] In this document, we will use the term 'action plan' to refer to a suicide prevention and risk mitigation action plan.

2. **Intervention/Crisis Intervention:** ***Responding with appropriate interventions to people who are in crisis or display suicidal behaviour. This can include:***

   - Direct support to the person who is at imminent risk for suicide or who has attempted suicide
   - Ongoing and consistent follow-up of the person after the imminent risk is managed
   - Indirect support, through others, to keep the person safe

3. **Postvention:** ***Appropriate and helpful actions after a death by suicide with the aim to reduce the negative impact and elevated risk for others, for example by:***

   - Supporting the bereaved (family, friends, peers) to cope with the loss
   - Supporting professionals who were involved in the suicide response to cope with their own feelings and stress

   Related actions:

   - Reducing the risk of imitative suicidal behaviour in the affected community
   - Formulating lessons to be learned by the response team about what can be done better in the future

Links with national systems and services

UNHCR actively promotes and facilitates the integration of refugees into national services. This is also true for suicide prevention. It is therefore of paramount importance to:

- Know the prevailing policies and strategies
- Promote inclusion of refugees into existing services
- Work in collaboration with local and national actors to strengthen services

Given the dearth of nation-wide actions for suicide prevention and risk mitigation in many countries, UNHCR can have a catalysing role by advocating for such actions and contributing available resources and expertise to ensure a coordinated approach.

The great suffering and distress that comes with each suicide and the disruptive effects a suicide has on the refugee community and humanitarian workers, form strong imperatives for UNHCR to act, both in supporting national governmental initiatives and initiating concrete local action in the settings where refugees live.

Links with communities

In line with UNHCR's focus on working with affected communities, it is essential for the development and implementation of a suicide prevention and risk mitigation plan to work closely with communities and involve them in all stages of the programme.

Structure

This document describes the essential actions that UNHCR and partners should take when making a plan for suicide prevention and risk mitigation among refugees and other people we serve. The document has two parts:

Part One:

Part one describes the steps in a **process** to develop a functional suicide prevention and risk mitigation plan in a refugee setting:

1. Create a multisectoral taskforce for suicide prevention and risk mitigation
2. Collect information to better understand the problem within the context
3. Analyse and synthesise available information
4. Prioritize and select interventions and activities to be included in a multisectoral suicide prevention and risk mitigation action plan
5. Ensure buy-in of all involved partners
6. Develop a monitoring system for the action plan

Part Two:

Part two contains a **menu of 16 interventions and activities** to be considered when making a multisectoral suicide prevention and risk mitigation action plan:

1. Implement activities to foster the involvement of communities in suicide prevention and risk mitigation
2. Awareness raising through community wide outreach
3. Promote healthy coping skills for dealing with situations of distress
4. Facilitate activities to increase community cohesion and mutual support
5. Restricting access to means of suicide
6. Promote accessible mental health care
7. Train community gatekeepers to identify and respond to warning signs of suicide
8. Advocate for access to livelihoods and socio-economic inclusion for refugees
9. Train personnel on helplines and switchboards to respond to calls of people in distress
10. Train first responders in safety planning
11. Train MHPSS and health personnel in the assessment and management of suicidal behaviour
12. Develop a clear pathway for who does what when a person is suicidal
13. Provide support to people affected by suicide
14. Promote well-being of personnel and volunteers
15. Develop a crisis communication plan
16. Conduct an operational debrief/post-incident review

PART 1

Six steps to develop an action plan for suicide prevention and risk mitigation in refugee settings

1: CREATE A MULTISECTORAL TASKFORCE FOR SUICIDE PREVENTION AND RISK MITIGATION

Suicide prevention and risk mitigation is not only a matter for specialists in mental health and psychosocial support (MHPSS) but must be integrated across all relevant sectors and stakeholders. The best way to do this is by establishing a multisectoral taskforce for suicide prevention.

What should a taskforce for suicide prevention in a refugee setting do?

The main aim is:

- To achieve a more effective suicide prevention and response plan in a specific setting or population of refugees, asylum seekers and people we serve, including through establishing leadership and fostering ongoing multisectoral engagement and partnerships with agreed-upon roles and responsibilities.

A context-specific **Terms of Reference** (see **Box 3** for a sample version) should provide the scope of work and describe specific tasks with concrete deliverables that are developed in consultation with key stakeholders including affected populations.

- Sharing knowledge and experience related to suicide prevention and risk mitigation
- Developing and conducting assessments to understand context-specific aspects of suicide and self-harm in the target population
- Routinely collecting data or developing/enhancing surveillance systems
  - Functional system for routine reporting of death by suicide or suicide attempts. Where possible this should be integrated into existing systems such as UNHCR's Integrated Refugee Health Information System (iRHIS) or governmental health information systems
- Mapping existing services and support
- Identifying needs and gaps in suicide prevention, intervention and postvention service provision
- Developing and implementing a context-specific suicide prevention and risk mitigation action plan
- Strengthening the capacity of humanitarian staff and community members to implement the action plan
- Monitoring and evaluation

Who should be part of the taskforce?

It is important to have a diverse membership from relevant sectors, but it is equally important to not make the taskforce too large, because that can render meetings and processes lengthy and inefficient. The taskforce should be multidisciplinary and include different areas of expertise through representatives of UNHCR and partners (Government and NGOs) from relevant sectors and intersectoral areas.

- **Public health**
- **Protection (including child protection, community-based protection and GBV)**
- **MHPSS**
- **Education**
- **Operations or field coordination**
- **Others as applicable to the context**

Active involvement of communities and their leadership is essential. This can be done in different ways:

1. including representatives of the refugee community and surrounding host population within the taskforce
2. creating community advisory groups that can inform and validate decisions and plans (See the section on 'Implement activities to foster the involvement of communities in suicide prevention and risk mitigation' on **page 48** for more details
3. identifying community engagement groups (women's groups, sports clubs, volunteer groups, religious groups and leaders, etc.) to assist in awareness raising and implementation of activities. Affected community groups should also be included in training initiatives

Where should the taskforce be situated within the humanitarian structures?

There is not one single way to situate a suicide prevention task force and the precise situation is to be decided in each context.

In some country operations, the taskforce can be a thematic subgroup of the MHPSS Technical Working Group. Whatever the setup:

- The Taskforce should be linked to relevant sectors such as protection and health, and to the Technical Working Group for MHPSS
- MHPSS specialists in UNHCR and partner agencies should take a leading role in establishing and co-chairing such a taskforce, but the taskforce must include others as well

It is important to embed the work of the Refugee Suicide Prevention and Risk Mitigation Taskforce within existing structures in the country, such as provincial or national bodies for suicide prevention and response and to share findings and experiences with them.

BOX 3:

Sample terms of reference for a multisectoral taskforce for suicide prevention and risk mitigation

Context:

[Add a few lines here why the task force is needed, e.g., to respond to a certain need that was identified.]
...
...
...

Purpose

This multisectoral taskforce aims to achieve a more effective suicide prevention and risk mitigation for ... ... [mention population] in ... ... [mention the geographical setting] through establishing leadership and fostering ongoing multisectoral engagement and partnerships with agreed-upon roles and responsibilities.

Activities

1. Carry out assessments (and analyse the results) around suicidal behaviour and its drivers in the target population and setting
2. Review and improve suicide data collection and surveillance systems
3. Facilitate the integration of suicide prevention and risk mitigation within the work of various sectors by reporting into the other sectoral coordination meetings (e.g., by making the work of the Taskforce a standing agenda item in these meetings)
4. Review challenges and gaps in resources and tools for addressing suicide
   - *Jointly reviewing and contextualizing suicide prevention and response tools and protocols*
5. Prepare a workplan on suicide prevention and risk mitigation with specified actions, lead actors, required resources and a timeline
6. Liaise within decision-makers about allocation of funds for priority suicide prevention and risk mitigation activities, ideally within budget lines of existing sectoral plans
7. Support implementation of the workplan by:
   - *Joint capacity building activities around suicide prevention and risk mitigation for a range of actors within communities, national actors, NGO partners and UN agencies*
   - *Establishing functional referral pathways*
8. Support communication and community engagement around suicide prevention
9. Report periodically (every X month) on achievements, challenges and recommendations.

Membership

The membership of the taskforce shall reflect the different sectors (health, protection, MHPSS specialists). Membership is open to actors from ... ... [add sectors and locations]. The taskforce is co-chaired by two persons from different sectors or organisations.

Lifetime of the group

This is a task-oriented group that is meant to be time-limited and not to replace existing sectoral and intersectoral coordination mechanisms. A review of the group's activities is to be done after x months.

Reporting

The group will report its findings to and seek approval for its recommendations from .... (list here for example: Senior Management, MHPSS Technical Working Group, Protection Working Group, Health Working Group).

2: COLLECT INFORMATION TO BETTER UNDERSTAND THE PROBLEM WITHIN THE CONTEXT

This section is harmonized with the section on Assessment in the IASC Guidance Note 'Addressing Suicide in Humanitarian Settings' (2022). An updated version will be included in the forthcoming revision of the WHO/UNHCR Toolkit for humanitarian settings: Assessing mental health and psychosocial needs and resources.

A rapid situational analysis/assessment focusses on gathering essential information that is required to plan next steps. It does not have to be exhaustive and can usually be completed within a few weeks. It must consider age, gender and diversity of the population.

Situational analyses or rapid assessments usually focus on:

- understanding the country context (e.g., legal frameworks and corresponding reporting requirements, national plans)
- understanding the perceptions, experiences and attitudes of the affected population related to suicide
- documenting the capacities and resources within the communities of interest, and the existing services for health, mental health & psychosocial support, and protection
- collecting community and staff perceptions of gaps and opportunities in current programming

A situational analysis usually consists of multiple methods (that can be done by different persons and organisations) using various tools to obtain data from a variety of sources and to explore the issue from diverse angles.

Before starting a new assessment, determine if there are other assessments with information on suicide and self-harm and utilise this existing information prior to collecting new information.

Methods, tools and questions listed here can be used for a situational analysis/assessment specific to suicide prevention or can be part of a broader and more general MHPSS assessment.

Personnel and volunteers collecting MHPSS data from affected populations need to know how to follow ethical principles and safety recommendations, use effective basic interviewing skills and enact basic psychosocial support skills (including referral and psychological first aid (PFA)).

Coordination is needed with relevant stakeholders and groups (e.g., MHPSS TWGs, specific taskforces or working groups) to ensure collaboration in coherent and efficient suicide prevention activities. Upon completion, assessment results should be documented, collated, reviewed, validated, and shared with all relevant stakeholders, including with the involved communities.

Table 4: Elements that can be included in a situational analysis/rapid assessment on suicide.

Assessment questions	Methods to gather information	Key considerations
Policy and Legal Frameworks and National Strategies		
• What is the legal framework in the country around suicide and mandatory reporting? • Is there a dedicated national plan or strategy for suicide prevention? • Is suicide prevention mentioned in other existing relevant plans such as for mental health, alcohol, or non-communicable diseases? • Are populations affected by humanitarian emergencies included in these plans?	• Discussions and key informant interviews (e.g., with government, UN agencies, MHPSS TWGs). • Literature search and review of national plans or strategies. • See WHO links to national strategies and WHO MindBank.	• What is the legal status of suicidal behaviour and what are the legal consequences for individuals and/or families (e.g., 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 (e.g., of persons expressing acute suicidal intent)? • Is there existing legislation or policy relevant to suicide prevention (e.g., 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?** • If there is no governmental policy: Who has the official mandate to address suicide and self-harm? Who are key stakeholders? Who could support pushing the topic forward on a national agenda? • Which ongoing national suicide prevention activities can be used, adapted or extended to emergency-affected populations?

Assessment questions	Methods to gather information	Key considerations
Available Data and Information about Trends		
What data and other information is available on suicide and self-harm such as: • Number of deaths by suicide • Number or extent of self-harm (fatal and non-fatal) • Methods of suicide and suicide attempts • Demographic details of the individuals (e.g., sex, age, geographical area) • Suspected causes or precipitating factors of suicide • Support and interventions received (e.g., in health care or settings) • Quality or frequency of reporting in the media Are certain profiles or groups of people within the community more at risk (such as a specific gender, age group, ethnic group or people in specific geographical locations)?	• Desk review and analysis of available data sources, such as health information systems, mortality registers, protection monitoring systems (ProGresV4, GBV Information Management System (IMS), and Child Protection Systems. • Discussions and key informant interviews with community members and service providers (e.g., mental health service providers, general health providers trained in mental health, social care and protection service providers).	• How and by whom is suicide ascertained? (Ascertainment of suicide is the process of deciding whether a death is caused by suicide. In some settings this must be done by coroners, medical professionals or others tasked to do this). • Consider how ascertainment may affect the reporting of suicide, the quality of data available and potential under-reporting (e.g., related to stigma, legal framework). • How and by whom are suicide and self-harm registered and reported? • By which variables are the data disaggregated? • Calculate rates (deaths or cases per 100,000) in addition to counting absolute numbers to identify subpopulations disproportionately impacted. Obtain data according to: • a) context (e.g. national, regions, districts, inpatient services, detention facilities, refugee camps, etc.). • b) population groups (e.g., whole population and disaggregated by sex, age groups, ethnic groups, religious groups, refugee status, urban, rural, socioeconomic status). • Review multiyear data to identify trends
• What are the most commonly used methods for suicide? • Are affected populations located close to potential hot spots? • How readily available or accessible are the most common methods of suicide to affected populations?	• Key informant interviews and focus group discussions. • Review of data from existing Information Management Systems or reports from MHPSS Data Management Systems.	• Are there key 'hotspots' (e.g., rivers railways, bridges or high-rise buildings, associated with previous suicides)?

Assessment questions	Methods to gather information	Key considerations
Community Perceptions		
• What are community perceptions towards suicide and suicide prevention, including religious views? • What are ways of coping with suicidal behaviour and where and how do they seek help? • What are barriers and facilitators to receiving care for persons (including sub-populations) with suicidal thoughts and/or relevant mental health conditions (e.g., depression)? • What are the perceptions of national/ host community personnel around suicide? • What barriers (e.g., knowledge, attitudes) may arise preparing and implementing activities for suicide prevention? What could be solutions to address such barriers?	• Desk review (including literature from social scientists e.g. anthropologists). • Key informant interviews and focus group discussions with community members and service providers.	• Ask about knowledge, attitudes and stigma. • Ask about community care responses. Consider carefully how to invite participants: • General community members. • Purposely selected participants such as community gatekeepers, health and social care staff, educational personnel, police, spiritual leaders, people representing at-risk groups, media representatives, survivors of suicidal behaviour and family members of people who died of suicide. Ensure that diversity is accounted for as people may have different experiences and views: • Different ethnic groups. • Displaced population and host communities. • Vulnerable populations. Consider ways to build on existing resources and ways of coping.

Assessment questions	Methods to gather information	Key considerations
Available Resources and Supports		
• 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). • What services and supports (formal and non-formal) are available and accessible to people who are at risk for suicide or to persons bereaved by suicide (e.g., 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)? • What are the barriers faced by the health workforce and related occupations in providing early identification, assessment, management and follow-u p, and in reporting self-harm? • What are the current capacities and gaps in knowledge and skills (e.g., among health care, social care, education, judiciary, service-user groups) in responding to suicide risk? • Are health care providers, police and others responding to suicide emergencies trained to manage the effects of popular means of suicide (e.g., pesticide ingestion)? • Are there current capacity building initiatives for early identification, assessment, management and follow-up, including for local, regional, educational, health and security workers? • Are there any existing groups or associations for service users and/ or people with lived experience and what support do they provide?	• Service directories. • MHPSS 4Ws mapping. • MHPSS Minimum Service Package Gap Analysis. • Discussions with MHPSS TWGs and other coordination group discussions. • Discussions with relevant workers (e.g., health, protection, education, security/police), health, social welfare and education ministries.	• Identify existing (public and private) services (e.g., 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, identify any issues of accessibility (including among certain groups). • Where are 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? (See multi-sectoral collaboration section). • Which actors are already implementing or have designed training materials, which can be built upon?

Methods and tools to be used in a situational analysis or rapid assessment

Key informant interviews

Key informant interviews provide information on critical aspects of community life and meaningful indications about access, risks, priorities, vulnerabilities, and capacities at the community level. This method is especially useful as a way to gain more in-depth information after preliminary information has been obtained and may provide a safer space for some to share reflections they do not want to share in a group. For key informant interviews, it is recommended to interview at least 10-15 people to obtain a sufficiently diverse sample. It may be necessary to interview more than 15 people whenever additional interviews are likely to lead to relevant, new information.

A common mistake in key informant interviews is to ask too many questions that are not subsequently analysed, reported, or otherwise used. Language and vocabulary used should be adapted in consultation with the affected community to reduce stigma and avoid ostracizing participants.[3]

Focus group discussion with community members[4]

Focus group discussions are a good way to identify community opinions and views held by different sub-groups. The group is not expected to produce a consensus, as the assessors are looking for all points of view on a topic.

Surveys

Doing surveys well requires careful planning and sufficient resources and expertise to collect, store and analyse the data. In the practice of humanitarian work such requirements are hard to meet, and in general we do not recommend surveys as a routine tool. Surveys often put unnecessary burden on the community as well as take valuable time and effort away from other, more constructive activities for personnel.

A survey is usually not needed to plan interventions for suicide prevention and risk mitigation. There are other ways that are more cost effective to get similar data (literature search, global or national estimates, qualitative data). It is possible to ask about suicidality in indirect ways (not inviting people to express their own private experiences but asking if the issue occurs in their community) in qualitative assessments that are planned such as an annual Participatory Assessments. The multisectoral taskforce for suicide prevention and risk mitigation can support increased identification and more coordinated response by encouraging agencies who regularly engage in needs assessments to include age and gender-sensitive and culturally relevant questions around suicidal behaviours in their routinely planned assessment activities. Data may also be obtained through mental health questionnaires, used in general surveys, such as the Patient Health Questionnaire-9, which contain a question on suicidal thoughts.

See also WHO UNHCR 2012 Assessment Toolkit, Section 3.3. Collecting qualitative and quantitative data.

[3] Adapted from IASC Reference Group (2012). MHPSS Assessment Guide page 5-6.
[4] Adapted from WHO (2018) Preventing Suicide: A Community Engagement Toolkit (pp 37 - 38).

BOX 4:

Practical and ethical considerations for doing focus group discussions and key informant interviews

- Explain the purpose of the discussion/interview (e.g., concern about the topic of people taking their life and how to prevent this).
- Obtain informed consent prior to conducting the session (see template in **Box 5** below).
- Ensure the anonymity and confidentiality of the collected data. If an interpreter or notetaker is present, UNHCR must seek written agreement that the personal data will be kept confidential. The following are a few key considerations per the 2018 Guidance on the Protection of Personal Data of Persons of Concern to UNHCR:
  - Anonymization: *The point and characteristic of anonymization is that a set of personal data has been irreversibly modified in such a way that the data subject is no longer identifiable.*
  - Confidentiality: *The duty of confidentiality extends to all communications with persons of concern, and all data provided by them or obtained on their behalf by personnel and partners in the course of UNHCR's activities.*
- Interview people in a safe place that is convenient to them and adapted to their needs.
- Choose participants strategically, to meet your information needs.
- Take measures to ensure that participants do not get into trouble by participating in interviews (for example, by being stigmatized or rejected by other members the community).
- Have a plan about what to do if a participant becomes very distressed during the interview. Make sure you have an arrangement on how to deal with such a situation (for example, arrange ahead of time with a partner who can provide PFA or other crisis support).

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BOX 5:

How to do focus groups on suicide and suicide prevention

A focus group is facilitated by:

- A skilled moderator (who has done focus group discussions before) who facilitates an open and safe discussion.
- An interpreter from the concerned community to support as co-facilitator (when necessary).
- A separate note taker if feasible and agreeable to participants (in some settings, people may be reluctant to speak when there is obvious note taker).

The group should start with a general introduction including explaining the purpose of the discussion, setting ground rules (e.g., listening to each other, responding to others respectfully and with sensitivity, respecting confidentiality) and obtaining informed consent as appropriate.

Three types of questions can help guide the conversation regarding suicide prevention and response:

1. Engagement questions: introduce participants to and make them comfortable with the topic of discussion. For example:
   - What do the participants know about suicide?
   - What do they know about suicide prevention?
   - Are there any suicide prevention activities in place?
2. Exploration questions: get to the core of the discussion. For example:
   - What are the available services if someone was to have suicidal thoughts?
   - What are the gaps in services and infrastructure at present?
   - What are the barriers to suicide prevention in the operation?
   - What are cultural and contextual factors influencing help-seeking behaviour and provision of services?
   - How does the community respond to a person who talks about/attempts suicide?
   - How does the community help a person who talks about/attempts suicide?
   - What is the reaction of the community or relatives when a person has died by suicide or has attempted suicide?
   - What is the participants' perception of the effectiveness of suicide prevention activities in reducing suicide?
3. Exit question: check to see if anything was missed in the discussion. For example:
   - Would anyone like to add anything?
   - Are there any further questions?

The language to be included in questions should be developed in partnership with community members. It is important to use terms that are clear to the participants and not stigmatizing. Sometimes to use descriptive terms for suicide such as 'ending one's life' may be needed.

It is important to select the participants of a focus group in such a way that it allows for open and free exchange of opinions. The selection therefore requires an understanding of the socio-cultural context of the participants and should align with UNHCR's 2018 Policy on Age, Gender and Diversity Accountability. It is advised to organize separate focus group discussions for groups that would otherwise not be able to speak their mind freely. In many cases, this implies separate groups for women and for men, for adolescents and youth and for older people, and sometimes separate discussions for groups who are marginalized and whose voice may get lost in mixed groups (e.g., people from ethnic minorities, religious minorities, etc.). See an example here.

As a rule of thumb, hold at least two focus group discussions with people that have the same profile. The number of focus group discussions depends on the diversity in the community and to what extent new focus groups provide new information. If new groups do not provide new information the point of 'data saturation' has been reached and it is usually not helpful to do more groups.

For focus group discussions, a group size of 6 to 8 is recommended. It is important that groups are not too large because this may prevent a free exchange of ideas. Focus groups are structured around a set of carefully predetermined questions, usually no more than 10, but the discussion is free flowing.

Usually, a focus group discussion takes around 1-1.5 hours.

BOX 6:

Informed consent template (focus group discussion)

Date (dd/mm/yyyy):	_____/_____/_____	*Camp ID:*	
Interviewer:		*Notetakers:*	
Translator:		*Languages:*	

FOCUS GROUP DISCUSSION DETAILS:

Group Name/description: _____ **Total Male:** _____ **Total Women:** _____

Number of participants:		*Age range:*	
Start time:		*End time:*	

Before the group begins, conduct the introduction and informed consent process.

Welcome introduction and consent

Read: *Good morning/afternoon.*

My name is _____. I would like to introduce you to our co-facilitator, interpreter (if applicable), and note taker(s) _____.

You are invited here today, as you are members of the community. We are collecting data on behalf of (include all names of implementing partners and the United Nations High Commissioner for Refugees).

We are here to gain information to understand your community better. Specifically, we are interested in learning more about a difficult topic, namely thoughts and behaviour that people may have about ending their life ('suicide').

We understand that some of the subjects are difficult to talk about, but we are hoping that you will help us better understand these issues in your community so we might be able to help preventing this from happen in the future. We want the discussion to be relaxed, so you don't need to wait for us to call on you. We encourage you to respond directly to any comments made by others in the group; however, we ask that you are respectful of what others are saying. Our notetaker(s) will be writing during our discussion, so we do not forget or miss any comments. We will keep all your identities and remarks private. We want you to speak freely, openly, and honestly. Remember, there are no right or wrong answers as everyone has different experiences. Your participation is voluntary, meaning you are free to choose not to answer questions, and you may decide to leave the discussion at any time.

There will not be any negative consequences if you decide not to participate, nor will you receive any individual benefit for your participation. However, we would appreciate your participation in this discussion since the results may help in the future. We estimate that this discussion will take between one hour and one hour and a half.

After the discussion, we will analyse the data from both this group and other group discussions and we will share the results with you in the following ways: ....

Does anyone have questions or concerns?

I am quickly going to go around the group and ask you whether you agree to participate. Please answer yes or no.

NOTE: If any individual declines participation, allow them to leave the group before proceeding:

Consent-All Yes ☐
Number of Refusals: _____ Number Consenting: ____

A couple of things to cover before we get into our discussion:

To make sure our discussion proceeds in a good way we want to discuss the group rules with you: *(e.g., logistics, transport, cell phones)*

1. ...
2. ...
3. ...

Source: Based on field examples from the MHPSS TWG in Kakuma/Kalobeyei (Kenya)

Assessment Tool 1:

Obtaining information about community perceptions, suicide risks and trends

Method:
(Individual or group) key informant interviews or focus group discussions with community members.

Human resources needed:
One person (interviews) or two persons (focus group discussions), interpreter (if applicable), and a notetaker.

Component	Example questions
1. Relevant contextual information about community beliefs, at risk groups and methods	
Culture-specific beliefs and perceptions (e.g., knowledge, attitudes, stigma)	• What is your community's attitude related to suicide and actions taken to prevent suicide? • When someone in the community dies from suicide, how does the community respond? • What are potential barriers that may be faced when engaging with the community around the topic of suicide and suicide prevention?
Perceived causes and contributing factors	• What do you consider to be the main drivers of suicidal thinking and behaviour? • What do you and other people in your community believe are major factors contributing to suicide and self-harm in your community? • Are these drivers and factors believed to be the same for males and females and younger and older people?
At-risk groups	• We do not want to know the names of or to discuss specific individuals, but in general, are there groups of people in your community who are more at risk for suicide or self-harm (such as a specific gender, age group, ethnic group or people in specific geographical locations)? - Who else? ...and who else? • Why do you think do these groups face higher risk? (e.g., stressors, contributing factors).
Suicide methods/means	• If a person tries to end their life, how do they do that? Where does it usually occur (e.g., are there key locations such as railways, bridges or high-rise buildings, associated with previous suicides)?

Component	Example questions
2. Ways of help-seeking and existing sources of support	
Coping mechanisms & community sources of support and resources	• When individuals are feeling very distressed or hopeless and may be experiencing thoughts about suicide are they likely to seek help (e.g., from family, community members, service providers)? Why or why not? Are there any barriers to seeking or receiving support? • How do people around a person who is suicidal usually react? What do they say and do? • What does the community do to support the person? • Where can someone experiencing suicidal thoughts seek help? • What services or support are available for families and friends bereaved by suicide? (formal and informal) • Where do people who are bereaved seek help? • Are there any additional services or support that you think should be available to persons affected by suicide? If yes, which?
Suicide prevention activities	• What are community members doing right now to prevent suicide? Is this approach working? Why or why not? • Does the community work to reduce access to means for persons at risk of suicide? • Is there anything else that could be done in your community to prevent suicide?

Assessment Tool 2:

Mapping of available resources and support

Method:
Desk review, key informant interviews with persons knowledgeable about available services (e.g., government staff, coordinators).

Human resources needed:
One person and one interpreter (if applicable).

An important part of planning and developing services in your operation is first to understand what services are currently available in terms of general health, mental health and social services. It is important to assess which service providers have been trained to provide care for people experiencing suicidal behaviours to understand gaps in capacity and variations in quality which may influence help seeking from those providers. Service mapping is best done by taking a broad approach since there may be many sectors and providers involved in services that can benefit people in need of care. It is also important to capture all of this activity, so that you can share information and pathways for referral in your community. Additionally, the mapping of current service provision will help you to identify where the gaps are and to plan strategically for developing further services.

BOX 7:

Strategies for conducting service mapping

- Make use of existing information such as 4Ws mapping and service directories.
- Generate a list of all health and non-health services that may benefit people with mental health conditions – including general health services, mental health services, and protection services including community-based protection support. Write down the names and contact details of people who represent these services and can respond to requests for services, consultation and support.
- Ask others in the community to help you fill in information if you are unsure about what services exist in a specific sector.
- Once you have generated a list of all relevant services, ask questions (in person, via telephone, or using mail or email questionnaires) to individual providers who represent these services – including what kinds of care and services they provide, types of providers offering these services, average fees for services, and how to refer people to these services.
- Categorize these services according to type (health versus non-health service), location (health centre versus school) and age group targeted (children, adolescents, adults, older adults).
- Consider a graphic way to organize such information to make it easy to use at the community level.
- Regularly update the mapping.

Type of service	Location of services	Who these services are for and what is provided?	Contact person

Type of service	Location of services	Who these services are for and what is provided?	Contact person

Type of service	Location of services	Who these services are for and what is provided?	Contact person

Assessment Tool 3:

Current practices and capacities in suicide prevention and risk mitigation

Method:
(Individual or group) key informant interviews with formal and informal service providers (e.g., workers in health care, social care, education, judiciary, service-user groups).

Human resources needed:
One person (facilitator) and one interpreter (if applicable).

Once you have mapped services and supports, you may want to focus more in depth on specific service providers and supports for potential joint activities, capacity building and strengthening referral networks.

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BOX 8:

Format for key informant interview with service providers

Setting (e.g., general health facility): .....

Location: .....

Type of service provider: .....

Date (dd/mm/yy): .....

Interviewer: .....

	Example questions
PREVIOUS TRAINING	• *Have you received any previous training as part of your formal education or during your work (e.g., in-service training, continued education) on how to identify and respond to persons who express suicidal thoughts or intent? Or on how to ask about suicidal thoughts if someone is expressing distress and hopelessness?* - If yes, please describe what was included in the training (e.g., what types of interventions).
KNOWLEDGE, ATTITUDE AND PRACTICE	• *Do you come across people who have suicidal thoughts or have attempted suicide?* • *What do you currently do when you come across someone who expresses suicidal thoughts or intent? (e.g., listen for any points on further assessment and questions, provision of basic support, monitoring and follow up)?* • *Do you feel comfortable asking a person about suicidality? What could be risks? (some providers have the erroneous belief that asking about suicide will invoke suicidal behaviour)?* • *Is there anyone you can turn to for support when you have a patient with suicidal though or behaviour (e.g., a supervisor or another provider with more expertise)? If yes, who?* • *Do you offer referral or link someone to services? If yes, which service/provider do you refer to? And what is the process for referral (e.g., a verbal recommendation to the person, a formal referral form)?*
INFORMATION SYSTEM	• *Do you collect any data related to suicide (e.g., suicidal ideation as part of HIS categories, number of suicides or suicide attempts)? How and to whom is this data reported and how is it used?*
PERCEIVED CAPACITY NEEDS	• *Do you feel that you are well equipped with the needed knowledge and skills when responding to someone with suicidal thoughts or intent? Are there any areas where you feel that you would like more knowledge and skills?*
EXAMPLE	• *Can you think of an example (without giving names or specific information) about someone you came across during your work who expressed suicidal thoughts or intent? What happened? Did they receive any additional support? Do you know how they are doing now?*

BOX 9:

Organizing a planning workshop

The next steps are to:

1. Analyse all collected information and identify contributing factors and potential ways to modify these factors (Described in detail under Step 3) .
2. Identify gaps in service provision.
3. Formulate and prioritize potential actions (Described in detail under Step 4) .
4. Formulate a time-bound and resource-appropriate action plan with assigned roles/responsibilities (Described in detail under Step 4).

These steps can be combined in one or more *planning workshops* with the members of the taskforce, in order to select the actions that are likely to have the largest impact and can be implemented given the available human and financial resources.

The location and format of the planning workshop should take into consideration any mobility restrictions and other barriers that may exist which would prohibit community members from participating. Adjustments should be made to allow for full participation of community representatives in the planning workshop.

It is important to take sufficient time for such a workshop. As a rule of thumb, we estimate that at least a one-day workshop (or two half-day workshops) should be allocated as these discussions cannot be done properly in a brief meeting of one or two hours.

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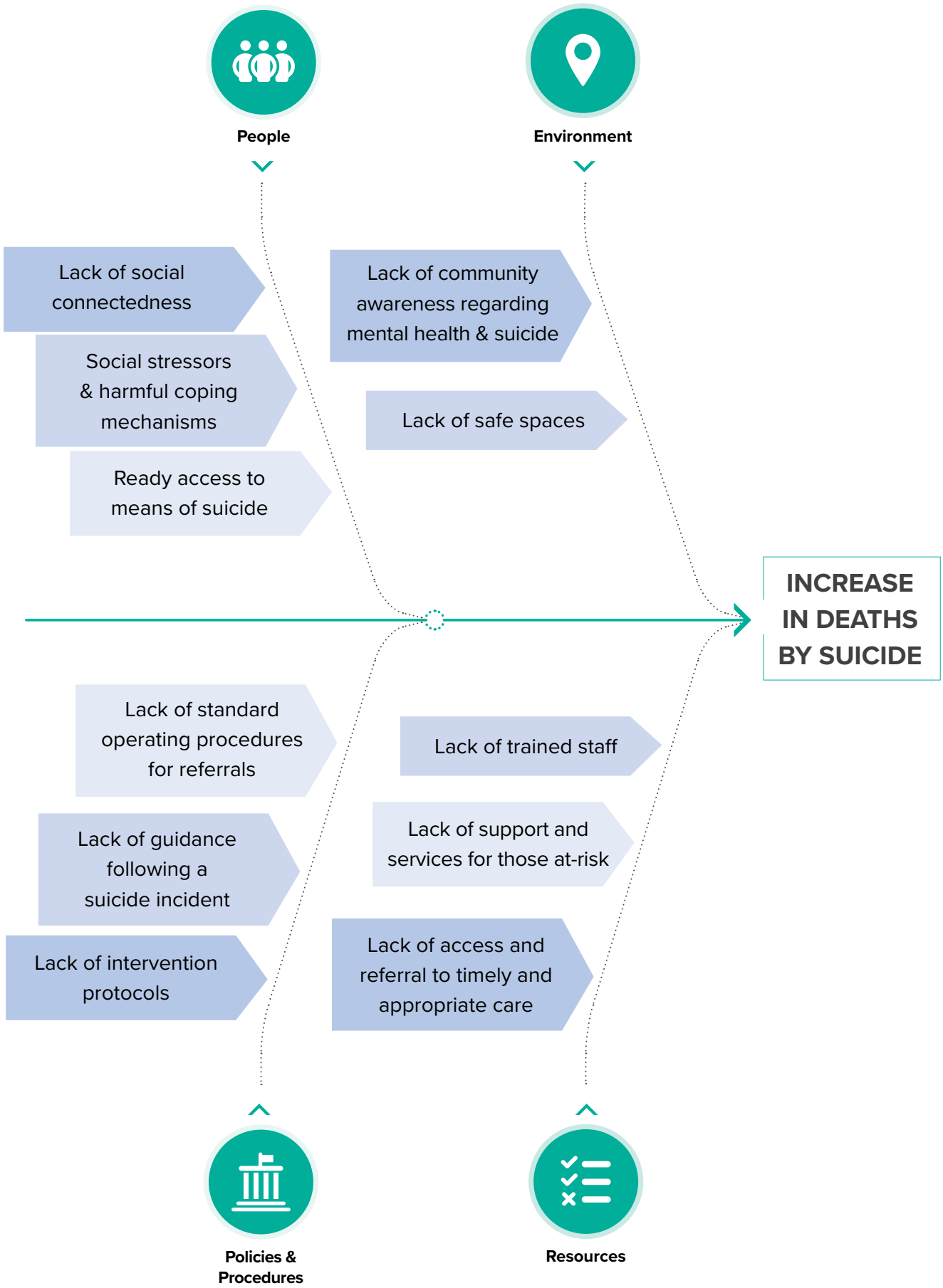
3: ANALYSE AND SYNTHESISE AVAILABLE INFORMATION

All collected information from Step 2 needs to be brought together (synthesized) and presented with the goal of identifying factors that contribute to suicidal behaviour in a specific context and defining potential ways ('change ideas') to modify these factors. This involves generating a list of potential contributing factors. We propose the following two tools to do this concisely.

The fishbone diagram

The fishbone diagram illustrated below, is a visual tool that may be used to logically organize and present the multiple causes that might contribute to an event, phenomenon or problem (e.g., suicide or suicidal behaviour) and how these causes influence each other. Using a flipchart or whiteboard, the problem is placed at the right end of a large arrow and the facilitator then writes the main categories (4 or 5) of causes on branches that lead off from the arrow. All possible causes in each category are then listed at relevant branches, with the understanding that not all of these causes will ultimately be deemed worthy of further attention. **Figure 1** below shows a hypothetical example of a fishbone diagram noting contributing factors for an increase in deaths by suicide observed within an operation. This can help the workforce to identify efficient points of intervention to successfully promote change.

Figure 1: Example of a cause and effect diagram



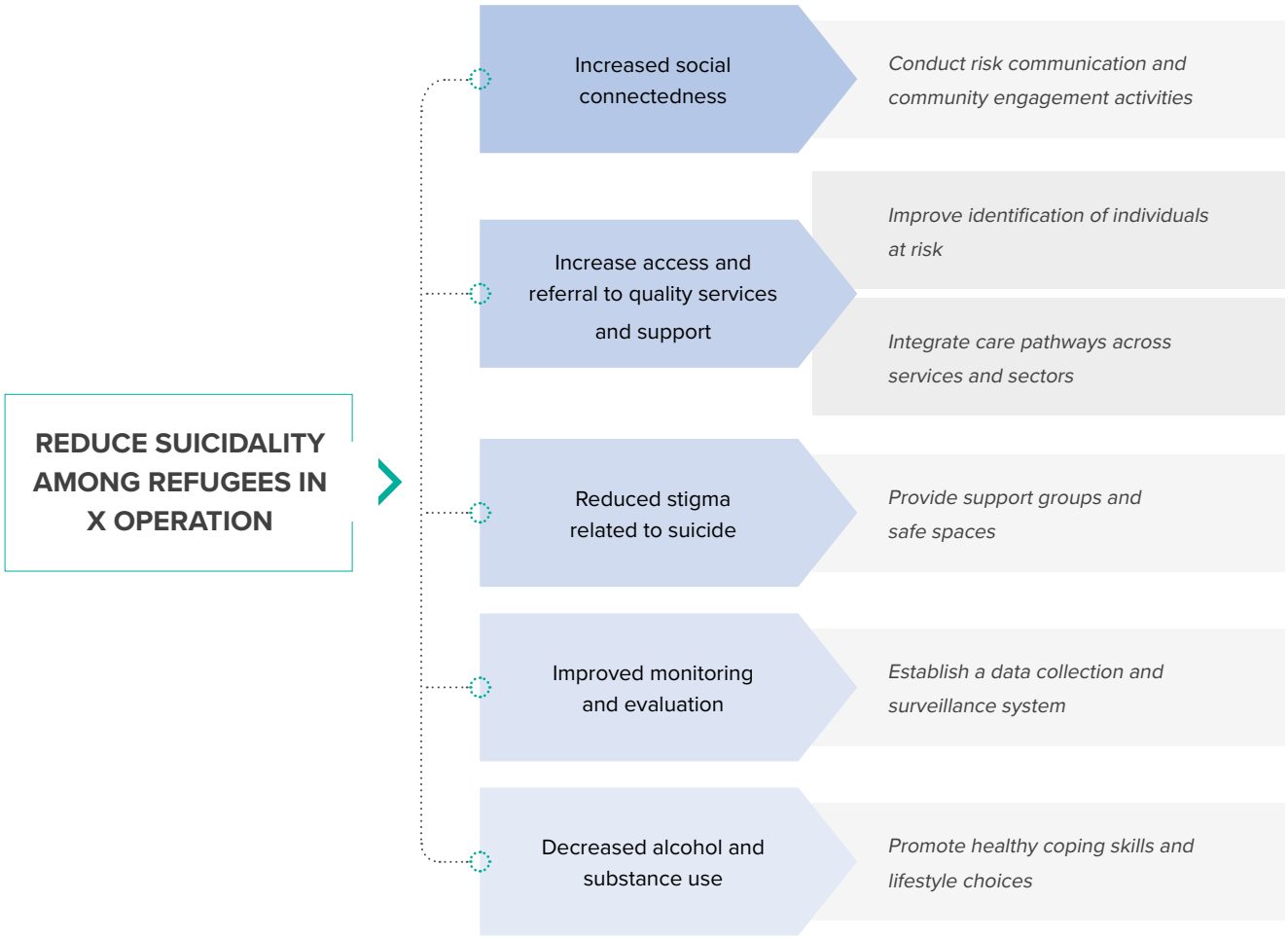
The driver of change diagram

While a *cause-and-effect diagram* assists the intersectoral taskforce to formulate what is causing an effect (i.e., what leads to suicidal behaviour (see **Figure 2**) in refugees in this context), *a driver of change diagram* can serve as a visual display of what "drives change" (i.e., what can contribute to change in suicidal intent or behaviour? (see **Figure 3**)). The contributing factors to suicide risks vary in different contexts, but the following example may be helpful.

Example Template for making a 'driver of change diagram':

List the causes/contributing factors you will be working to address	Change ideas
1. Lack of understanding of suicide and mental health within the community	• Reduce stigma by increasing risk communication and community dialogue on suicide and mental health. • Work with religious leaders to reduce stigmatization.
2. Lack of access and referral to timely and appropriate care	• Map existing care resources available for referral pathways. • Train first responders (e.g., community police, community health workers and primary health care workers) to assess, manage and follow up suicidal behaviours sensitively and therapeutically. • Train community leaders and other gatekeepers to be effective resources for community members at risk. • Promote crisis support services and help-seeking behaviour.
3. Ready access to the means of suicide (e.g., pesticides, kerosene, rope)	• Community interventions for safer access to pesticides. • Discuss ways that family members can monitor access to kerosene, rope, pesticides etc., for individuals identified as at risk.
4. Social stressors and harmful coping skills	• Provide life skills training that includes problem-solving coaching and psychoeducation on replacing unhealthy coping skills. • Integrate those at risk (or who have attempted) into the design of prevention programmes.
5. Lack of support and services for persons who are vulnerable to or bereaved by suicide	• Set up support for bereaved families and those with lived experience of self-harm. • Identify risk and protective factors. • Target prevention programmes at vulnerable groups. • Create a referral directory, link all local services and programmes, and map pathways.
6. Normalisation of violence	• Support the (re-) learning of peaceful skills, practices, behaviour and reflexes.
7. Lack of viable economic opportunities	• Increase access to meaningful and reliable livelihood options for groups at high risk for suicidal behaviour. • Promote integration of MHPSS into livelihoods interventions.

Figure 2: Example of driver of change diagram



4: PRIORITIZE AND SELECT INTERVENTIONS TO BE INCLUDED IN A MULTISECTORAL SUICIDE PREVENTION AND RISK MITIGATION ACTION PLAN

Given the strained resources (e.g., shortage of personnel, funding) in most refugee settings, it is important to carefully prioritize the proposed activities. A simple ranking could be agreed upon by the taskforce.

Please see an example of a prioritization matrix in **Table 5,** which asks participants to rate activities along various dimensions:

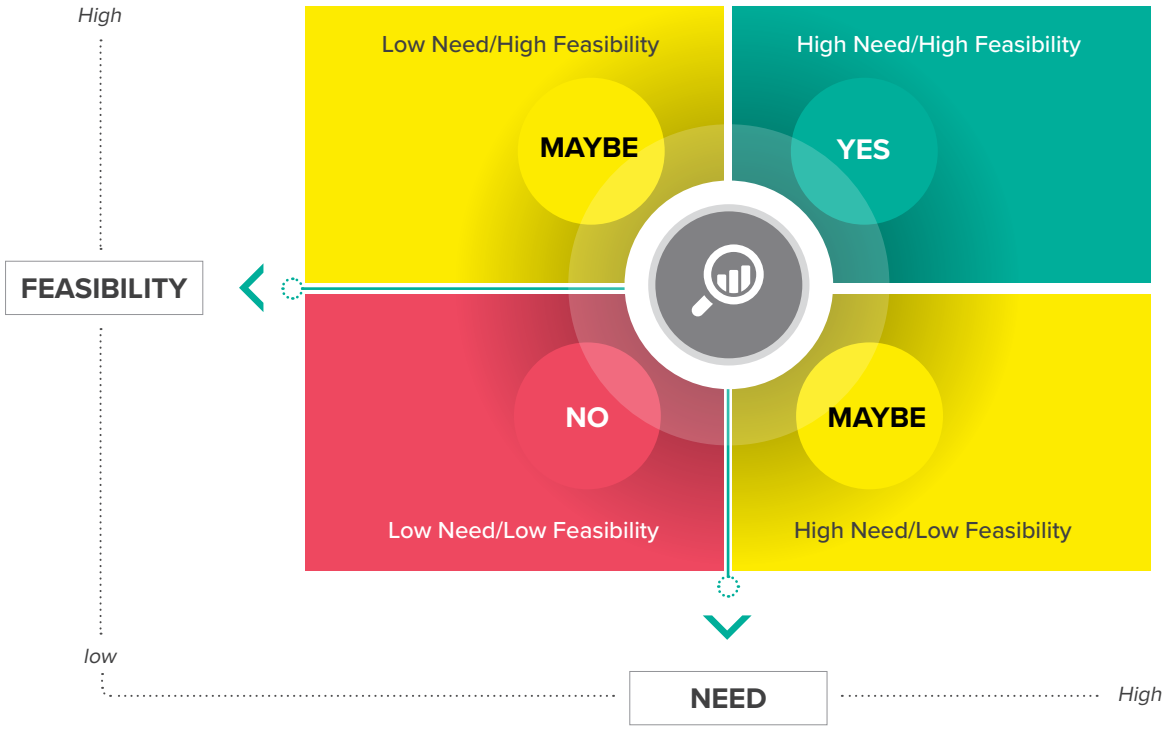
1. Perceived need by the community: what do the community members (e.g., in the Community Stakeholder Consultation and Advisory Group, see **Tool 1:** Implement activities to foster the involvement of communities in suicide prevention and risk mitigation on **page 48**) see as the most important actions? This can also be informed by the results of the assessments with communities.
2. Perceived need by the humanitarian community and actors in the national system: What do these professionals see as the most important actions?
3. Evidence of effectiveness: Is there experience with using this tool in similar settings, what was the effect? What is known from research?
4. Feasibility: Includes human and financial resources and timeframe.

Table 5: Format for prioritization

Activity	Perceived need by community	Perceived need by humanitarian organisations	Evidence of effectiveness	Feasibility: *(human and financial resources, timeframe)*	Overall priority *(list in order from 1 (highest) to x (lowest)*

Emphasis should be placed on the 'perceived need' and 'feasibility' when prioritizing activities as follows:

Figure 3: Example of perceived need and feasibility diagram



In general, it is advisable to select **at least one** intervention in each of the following categories:

1. **Prevention:** Activities with the intended outcome that people will not develop suicidal behaviour and will know where to seek help. Such activities are usually on a population level (targeting a community or a subgroup within the community, including people with known elevated risks for suicide, such as adolescents, people with depression, etc.).
2. **Intervention:** Activities to assist individuals who have developed suicidal thoughts or behaviour with the aim to help them maintain safety through the period of increased risk.
3. **Postvention:** Activities after a death by suicide, with aims to 1) support people who were impacted by the suicide or had contact with the person who died by suicide; 2) mitigate the risks of rumour and increased community tensions and 3) reduce the risk of copycat suicidal behaviour 4) learn what could be done better.

Formulate a time-bound and resource-appropriate action plan

Following the prioritization of the key actions, the taskforce can begin to draft an action plan. This plan should provide a clear division of work and should assign responsibilities according to the resources and expertise available. It is important to consider the resources needed, their availability, and the cost.

Keep the following questions in mind while formulating the action plan:

- Who should be involved in the planning, implementation, evaluation and advocacy of the actions?
- What human resources are available? Do they have sufficient capacity (time, knowledge, etc.) to take on these additional activities and if not, what is needed to create that capacity?
- Which activities could be directed or facilitated by community members (how should they be trained and supervised)?
- How much funding is needed for implementation?
- Is there a need for a communal physical space (e.g., a community centre, a public space)?
- Is there a need for confidential space for therapeutic intervention and some postvention activities?
- Can any resources be utilized for free?
- Is there a government programme that can be accessed?
- Which organizations and sectors should be involved?
- What is the timeline for the activities? Is there an ideal time to implement the activities?

Action plan template

Priority ranking *(high to low)*	**Activity** *(What activities will be needed to reach the goal?)*	**Desired outcome** *(What will each activity lead to?)*	**Resources needed** *(Space/ Equipment/ Material/ Funds/HR)*	**Responsible** *(Person or organization)*	**Start date**	**End date**	**Notes** *(Other sectors to engage)*
Goal 1: [FILL IN GOAL HERE]							
.....							
.....							
.....							
Goal 2:							
.....							
.....							
.....							
Goal 3:							
.....							
.....							
.....							
Goal 4:							
.....							
.....							
.....							

5: ENSURE BUY-IN OF ALL PARTNERS INVOLVED

Before rolling out the actions that were prioritized in Step 4, it is important to ensure that key partners in humanitarian action have a good understanding of the issues, endorse the action plan and know their role in the planned activities.

This can be done by organizing meetings with stakeholders such as the senior management of UNHCR and other UN agencies, MHPSS Technical Working Group members, nongovernmental partners, governments and representatives of displaced and host communities. In such meetings the findings of the situational analysis can be presented, followed by a description of the proposed actions, and discussion about what is planned, feedback and suggestions from the stakeholders about the plan and practical ideas for how each can contribute to this plan.

The goals of such meetings are to foster a good understanding and 'buy-in' of key decision makers, and to adapt the plans where needed based on their feedback.

6: DEVELOP A MONITORING SYSTEM FOR THE SUICIDE PREVENTION AND RISK MITIGATION PLAN

Once an action plan has been created and actions are being implemented, it is important to check progress against the action plan and timeline, adjust for changes in a timely manner, change focus, adapt the action plan as necessary, and document obstacles and lessons learned.

While a lot of effort goes into implementing the activities, evaluation should ideally be integrated into the suicide prevention and risk mitigation plan throughout the development stages. It is important to find out what actually works, whether it helps people or hinders them, who it is most suitable and useful for, and if it can be adapted for use by other communities.

Monitoring is important to operational efforts for the following reasons:

- Continuous monitoring allows the taskforce to gauge how the action plan is progressing and if any adjustments and changes are required along the way.
- Lessons learned help to inform other suicide prevention efforts in the same operation or in others.
- Surveillance systems document quantitative change in overall trends in the number of suicides and suicide attempts.

Establish systems for data collection, surveillance and reporting

The lack of knowledge about suicide in humanitarian contexts is in part due to poor data surveillance and reporting systems for suicide and suicidal behaviour. Functional systems for surveillance and reporting of suicide help quantify the size of the problem, provide insights in demographics such as age and sex, and methods used of persons who die by and attempt suicide, and provide information on trends of suicide over time. This information is fundamental to the development of targeted suicide prevention and risk mitigation plans and to identify trends in suicidal behaviours.

Collection and collation of accurate data on suicide and suicide attempts has been a major challenge in most countries. With some simple steps that are consistently used the quality and completeness of information can be significantly improved.

Key considerations when establishing a case reporting system for suicide mortality:

- Consistent criteria and clear operational definitions for suicide and related behaviour (see the definitions in the integrated Refugee Health Information System (iRHIS) or similar systems from the Ministry of Health which are often based on the WHO system for International Classification of Diseases (ICD), distinguishing deaths due to suicide from other causes of mortality.
- Accurate death certification practices.[5]
- Collection of case information using a standardized reporting form.
- Ensure data protection.
- Anonymizing of information: Consider using a unique case identification number – this ensures that the register will not contain other identifying information about the person. It may require a separately kept file that links the case identification number to personal data such as birth data and address. If the reporting system is only used for trend analysis a unique case identification number will not be necessary. If the reporting system is also being used as a case management tool a case identification number and/or event number may be necessary.
- Explore the feasaiblity of alignment of data recording with official mortality registration systems and or existing case management systems such as RAIS and ProGres V4 as used by UNHCR in various operations.

The completion of this form should trigger a suicide/suicide attempt debrief/post-incident review. For further information on how to conduct an operational debrief/post-incident review, see **page 84**.

[5] Death certification is meant to document the immediate cause of death, which can be an event, clinical condition, or a disease process.

Example reporting form for suicide and suicide attempts

*Name and title of the person who completed the form: .....

*Contact (email/phone) of person who compiled the report: .....

*Reporting Source	☐ Facility	☐ 24h grave monitoring	☐ Key informants	
	☐ Home visit	☐ Community surveillance	☐ Other (please specify):	
***Case identification number**				
*Sex	☐ Female	☐ Male	☐ Unknown	
***Age (in years)**				
*Status	☐ Refugee	☐ Asylum Seeker	☐ IDP	☐ National
***Date of incident (dd/mm/yyyy)**				
*Type of incident	☐ Suicide (suspected)	☐ Suicide (confirmed)	☐ Suicide attempt (with intent to die)	
*Place of incident	☐ Health Facility	☐ Camp	☐ Other (please specify):	☐ Unknown
***Method Used**				
Risk factors and/or possible trigger	☐ Alcohol/ substance use	☐ Access to means (firearms, pesticides, etc.)	☐ Family history (of suicide, attempts, or psychiatric disorders requiring hospitalization)	☐ Current/ past mental disorders (please specify)
	☐ Prior suicidal behaviour (history of prior suicide attempts or self-injurious behaviour)	☐ Change in MHPSS treatment (discharge from psychiatric hospital, provider or treatment change)	☐ Social isolation/ lack of social support	☐ Recent loss of relationship/death of close other
	☐ Financial loss/debts	☐ Family dispute/ social conflict	☐ Sexual or gender-based violence	☐ Rejection of refugee status or resettlement request
	☐ New or deteriorated medical illness	☐ Other (please specify)	☐ No known risk factors or possible triggers	☐ Unknown
Did the person communicate suicidal ideation or threats prior to death?	☐ No	☐ Yes (please specify)	☐ Unknown	
Was a suicide note found on scene?	☐ No	☐ Yes	☐ Unknown	

PART 2

A menu of potential interventions activities for suicide prevention and risk mitigation

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*The second part of this toolkit consist of a series of activities that can be considered by the taskforce. It is unlikely that all interventions can be implemented in one setting, but it is important to choose a set of activities that jointly cover the whole spectrum from prevention and crisis intervention to postvention (see **Table 6**).*

Table 6: Table of potential activities

+ = activity is relevant for this goal ++ = activity is highly relevant for this goal

Potential activities	Prevention	Crisis intervention	Postvention
1. Implement activities to foster the involvement of communities in suicide prevention and risk mitigation	++	+	+
2. Raise awareness through mass campaigns	+		
3. Promote healthy coping skills for dealing with situations of distress	++	+	+
4. Facilitate activities to increase community cohesion and mutual support	++		
5. Restrict access to means of suicide	+		
6. Promote accessible mental health care	++	+	+
7. Train community gatekeepers to identify and respond to warning signs of suicide		++	
8. Advocate for access to livelihoods and socio-economic inclusion for refugees	+		
9. Train personnel on helplines and switchboards to respond to calls of people in distress		++	
10. Train first responders in Safety Planning		++	
11. Train professionals (MHPSS and health) in the assessment and management of suicidal behaviour		++	
12. Develop a clear pathway for who does what when a person is suicidal		+	
13. Provide support to people affected by suicide			+
14. Promote well-being of personnel and volunteers	+	+	++
15. Develop a crisis communication plan for use after suicide incidents			+
16. Conduct an operational debrief after suicide incidents			+

1: IMPLEMENT ACTIVITIES TO FOSTER THE INVOLVEMENT OF COMMUNITIES IN SUICIDE PREVENTION AND RISK MITIGATION

Working with communities is important to create awareness, address risk factors for suicide, promote early identification of people at risk, reduce stigma, promote help-seeking behaviour, and foster more effective support towards people who have attempted suicide and bereaved family members.

Genuine engagement of community members in activities for suicide prevention and risk mitigation is not just an 'activity to tick the box' but requires a long-term process in which community members have an active role in shaping activities. In order to do that, it is essential to create a system to engage closely with communities. Engagement with community leadership is essential: starting with informal consultations with ''allies'' (for example, those leaders potentially aligned with objectives) and then those for whom the topic of suicidality may be more sensitive.

Community stakeholder consultation and advisory group

It is important to work with a range of representatives from the concerned communities - which can be refugees, asylum seekers, internally displaced people and members of the surrounding host community - and involve them in the action planning. One way to do this is by forming a *Community Stakeholder Consultation and Advisory Group*. Such groups should consist of around 10-15 members with different areas of expertise and representing different perspectives within the community.

When creating such a group, look for people who:

- Could relieve barriers in the community related to suicide prevention and risk mitigation programming and could help mobilizing resources in their community.
- Could be involved for longer periods in implementing and maintaining the activities.
- Have participated in past suicide prevention and risk mitigation.
- Have a strong motivation to be involved, for example because suicide has affected their own life, family or work. It is important to include people with lived experience when developing suicide prevention initiatives.

Think for example of:

- Community leaders from refugee and surrounding host populations.
- Individuals with lived experience (those who have attempted suicide and those who have lost a loved one to suicide).
- Community workers such as community health workers, para-counsellors, community outreach volunteers.
- Representatives from community groups for women, adolescents, youth, older persons or people with disabilities.

- Spiritual and religious leaders, traditional healers, community elders (including those from minority groups).
- Teachers and youth workers.
- Healthcare workers.
- Police officers, security guards, fire fighters.

A stakeholder mapping exercise (see **Table 7**) may help in obtaining a clearer picture by identifying the motivation, skills, and possibilities of potential community stakeholders.

Table 7: Grid for a mapping exercise for community stakeholders in suicide prevention and risk mitigation

Stakeholder	Motivation/ reasons to engage	Role in community	Network in community and relationship to target groups	Resources, skills, expertise, and weaknesses	Contact details
.....					
.....					
.....					

Facilitating a meaningful dialogue on suicide prevention and risk mitigation in the community

Suicidality is a topic that is often hard to discuss and within communities the topic may be shunned or talked about in sensational and pejorative terms. Attitude change in communities often starts with providing a safe social space where community members can engage in meaningful conversations about mental health and suicidality. This may help to reduce stigma and to encourage help-seeking behaviour. There are many ways to foster such meaningful dialogues. Here are some examples:

- Facilitate workshops with small groups of community members in one location to allow for more reflection with lower stakes. These “coffee corner discussions” or “teatime discussions” can also be used to galvanize housing clusters or blocks to set up their own mechanisms for mitigating suicide risk and identifying and referring those at risk. Plan a one- or two-hour interactive workshop which can be delivered in schools, community centres, places of worship, libraries, women’s centres, child and youth-friendly spaces, mother-baby spaces, or workplaces.
- Utilizing places where people gather (and are ‘waiting’) to do brief sessions to raise awareness and discuss some of their concerns (e.g., community health workers, outreach workers, women’s groups, youth groups, registration or verification points, distribution sites, and service delivery points).
  - Ensure that volunteers and personnel in these contact points are familiar with Psychological First Aid, basic psychosocial helping skills, identification of signs of distress and MHPSS referral pathways.
- Organize a community forum or “town hall meeting” where anyone interested in the community can gather. Give a short talk or have guest speakers give short talks and then facilitate discussion.
  - Consider inviting people affected by suicide to share their experiences if they feel comfortable.

- Use interactive/creative methods to enable people to share their views and experiences, for example through:

  - Organizing a play by a theatre group followed by a discussion with the audience.
  - Showing a movie on the topic in a community centre or school, followed by a discussion.
  - Include it as a topic in community-based psychosocial work such as 'narrative theatre', or arts-based projects such as Artolution.
  - Schools: Considering that the risk for suicide increases in younger populations, events such as the Why You Matter campaign can be impactful.

- Set up meetings with law enforcement actors (police officers) and camp managers about ways to respond to suicidal behaviour and prevent lethality while encouraging help seeking, particularly in countries where suicide is criminalized. Talk in respectful ways of national laws and local customs whilst seeking space within these laws and customs to help people who have suicidal thoughts or behaviour. Emphasize that judgmental attitudes toward suicide make it harder for people to open up about suicidal feelings and seek help. Mention that law enforcement officers can contribute to a climate in which people in emotional distress can seek help.
- Consider discussion meetings with religious leaders (see box 10).
- Organize group discussions on social media for example in groups by and for refugees. This requires good preparation, excellent moderation skills and a plan to respond to people who get distressed, agitated or disruptive.

BOX 10:

Engagement of religious leaders in suicide prevention

Religion is an important source of support for many people. Religious leaders can have an important influence on attitudes towards suicide prevention and risk mitigation. Many religions have strong interdictions against suicide which may complicate discussion on the topic. Some argue that religious interdictions install meaning and hope for the suicidal person and as such diminish the likelihood that people will engage in suicidal behaviour. However, negative attitudes toward suicide can also make it difficult to open up about feeling suicidal, this can create a sense of 'entrapment' or 'being boxed in' among people who have suicidal thoughts and increase their despair and loneliness. It may prevent people from seeking support and finding professional help. Given their moral authority in many communities, is it therefore important to explore how religious authorities can be allies in suicide prevention and risk mitigation.

Best is to start with small informal exchanges with some trusted religious leaders who are known to be open to dialogue with mental health professionals before widening the discussion. It can be helpful to organize the discussion in various stages:

1. Sketching 'the problem' (that suicidality among refugees is a serious problem and that we seek ways to reduce its occurrence),
2. exploring what the religion says about suicide and how religious leaders respond to issues related to suicide,
3. presenting some findings from suicide prevention programming,
4. discussing ways in which religious leaders could be involved in suicide prevention and risk mitigation programmes.

2: AWARENESS RAISING THROUGH COMMUNITY WIDE OUTREACH

In addition to the more small-scale methods for direct community engagement with communities as described above, it is also possible to set up larger campaigns with the aim to reach high numbers of people. Such mass campaigns need to be well prepared and thoroughly informed by knowledge on the community dynamics and context.

Examples are:

- **Radio:** Collaborate with local radio stations to plan short spot messages about mental health and/or suicidality. A trained mental health professional can also engage in open discussions on suicide through live programmes that can receive calls from (anonymous) listeners.
- **Social media:** Utilize existing UNHCR country operation social media platforms such as Facebook or WhatsApp groups to raise awareness and disseminate information. This may include sensitization sessions conducted by refugee-led groups via Facebook Live.
- **Flyers or factsheets:** Develop a one-page flyer or factsheet containing information about suicide and self-harm to be distributed at UNHCR registration and reception centres, health centres, schools, places of worship, or other community spaces.
- **Community events or forums:** Organize a community forum or "town hall meeting" where anyone interested in the community can gather or commemorate World Suicide Prevention Day (10 September) or World Mental Health Day (10 October) with a candlelight march, sporting event, poetry readings or other engaging event.

In preparing community wide outreach, consider the following:

- Compose messages that are tailored to the community context, are age, gender, and diversity sensitive, reflecting key audience questions, perceptions, beliefs, and practices.
- Make information available in relevant languages and formats, avoid specialized medical or psychiatric terms, include positive and hopeful messages.
- Provide concrete suggestions on how people can help themselves or others.
- Promote effective help-seeking behaviour by explaining what people can do and where people can go to seek help including available MHPSS services (providing telephone numbers, addresses of places where people can go to).
- Check for examples from other contexts, including from non-humanitarian settings and adapt the materials in consultation with affected communities (and pilot before rolling them out).

- See for following examples:
  - R U OK? *(Australia)*
  - 113 *(Netherlands)*
  - Stop Suicide *(Switzerland)*
  - Embrace *(Lebanon)*
  - Befrienders *(Kenya)*

- Include examples from people with lived experience (people who survived a suicide attempt or family members of people who died by suicide) to create awareness and enlighten others on how to overcome certain life challenges.
- Mainstream relevant messages into communication material of other sectors such as shelter, WASH, protection, education, as relevant.
- Include individuals with lived experience in the planning and co-design of awareness-raising activities.
- Establish or use existing community feedback mechanisms to ensure that community beliefs, concerns, and suggestions are heard.
- Ensure that mass campaigns do not absorb too large a part of the scarce human and financial resources to the expense of direct community support and intervention.

See Working with media: World Health Organization (undated). Preventing Suicide: Information for journalists and others writing about suicide.

3: PROMOTE HEALTHY COPING SKILLS FOR DEALING WITH SITUATIONS OF DISTRESS

Subjective personal well-being and effective positive coping strategies protect against suicide. Healthy lifestyles that promote mental and physical well-being include physical activity, a nutritious diet, consideration of the impact of alcohol and drugs on health, adequate sleep, social connectedness, and effective stress management.

A major challenge is that refugees may have limited options to make healthy lifestyle choices because of the context in which they live, and some may become lethargic or hopeless. It is important therefore that interventions to promote life skills are developed in close consultation with refugees to prevent that these strategies are perceived as a 'band aid' that is being imposed upon them.

Life skills training should ideally be offered to children (including adolescents) as a part of health promotion or child protection activities. Such training can also be useful to those coping with life changes or difficult situations. Areas to consider include:

- **Decision-making**
- **Creative thinking and critical thinking**
- **Communication and interpersonal skills**
- **Self-awareness, identifying help and empathy**
- **Assertiveness**
- **Self-compassion**
- **Emotional regulation**
- **Problem-solving**

This toolkit does not go into detail about how to conduct life skills training. For more information, see the tools and resources referenced in the WHO 2019 mhGAP Community Toolkit.

BOX 11:

How can you promote healthy coping skills and lifestyle choices?

- Practice healthy coping and lifestyle choices and model this for others, particularly in the workplace.
- Raise awareness informally with your friends, family, and colleagues.
- Public awareness campaigns.
- Programmes can be designed to promote behaviour (and culture) change in operational settings such as health facilities, schools, workplaces, libraries, places of worship, women's centres, youth centres, or other community centres. Such programmes can focus on health choices in general or may be specific to one activity (such as doing more exercise or reducing alcohol consumption).

Fostering socio-emotional life skills in displaced adolescents and youth

Adolescence is a period of rapid development during which individuals experience profound physical, social and psychological changes. Refugee adolescents and youth often face the impact of multiple negative experiences, such as experiences of violence in their country of origin or during flight, and stressors in their current life. Many face issues of poverty, lack of opportunities for education or employment, limited perspectives for durable solutions, high levels of interpersonal stress and conflict in families and communities, and gender inequality. Such experiences can have a long-lasting influence into adult life. Moreover, adolescence is also a period in which many mental health conditions may start. Therefore, strengthening socio-emotional skills associated with positive mental health is so important for young peoples' development into mentally healthy adults.

WHO's Helping Adolescents Thrive Toolkit provides evidence-informed recommendations on psychosocial interventions to promote mental health, prevent mental health conditions, and reduce self-harm and suicide among adolescents. The guidelines are designed to be delivered across various platforms such as schools, health or social care, the community, and digital media.

You may also want to check out WHO Consolidated Guideline on Self-Care Interventions for Health: Sexual and Reproductive Health and Rights which includes essential strategies for creating and maintaining an enabling environment for self-care.

4: FACILITATE ACTIVITIES TO INCREASE COMMUNITY COHESION AND MUTUAL SUPPORT

High levels of suicidality may be an indicator of insufficient social support and social connectedness within communities. Life in settings of displacement can be hard and people may get overwhelmed by feelings of uncertainty, hopelessness and despair.

Refugees may lose a sense of 'agency' and develop a profound attitude of dependency and lethargy. This can fuel many social problems of which suicidality is one. Social connectedness is an important protective factor against developing mental health issues and suicidality.

A key element of UNHCR's protection response is to facilitate refugees to regain a sense of control and purpose and feel connected with others around them. This is at the heart of *community-based protection approaches* to bolster the capacity among community members to foster psychosocial wellbeing for themselves and others.

Supporting community initiatives that strengthen mutual solidarity and care and that support a sense of 'agency' and social cohesion among refugees are important to improve wellbeing and mental health. A key element of suicide prevention is therefore the promotion of community wellbeing and creating community-based networks that can foster protective environments, even if such initiatives do not explicitly focus on suicide prevention.

Examples of activities that may foster social connectedness and mutual support are:

- Safe community spaces and community centres, which can serve as places of hope, positivity, and social connectedness, as well as learning.
- Community-based initiatives that strengthen solidarity and social cohesion such as:
  - Community groups that come together based on a common interest and implement activities to support their communities.
  - Community clean-up and greening activities.
- Sport for Protection programmes for young people can contribute to improved psychosocial well-being, social inclusion and social cohesion. (see upcoming UNHCR Sport Strategy 2022).
- Cultural and recreational activities that people are familiar with, particularly those that bring community segments of different generations together.
- Volunteer networks, ensuring the participation of women, youth, older people, and persons with disabilities.
- Small scale funds for projects that are co-designed and co-led by community members to address protection problems while fostering social cohesion.
- Livelihoods programmes.
- Programmes to foster peaceful relations between host and displaced populations.

Such activities provide opportunities for refugees to become more involved in their community and to connect with others, which may result in enhanced overall mental, social and physical wellbeing, thereby reducing risk of suicide. Such activities also make it easier for community members to talk to others about personal issues and seek help when needed.

If such activities exist, they are ideal entry points for more focused activities for suicide prevention such as described in **Action 7.**

5: RESTRICTING ACCESS TO MEANS OF SUICIDE

Restricting access to the means of suicide has been shown to be effective in preventing suicide. Direct access or proximity to means (including pesticides, firearms, ropes, kerosene, heights, railway tracks, poisons, medications, sources of carbon monoxide such as car exhausts or charcoal, and other hypoxic and poisonous gases) increases the risk of suicide.

The availability of and preference for specific means of suicide also depends on geographical and cultural contexts. It is important to gather information about means during assessment and community consultations. The Task Force may consider options for engaging with companies, distributors and retailers to reduce the access to means (e.g., reducing the quantity of medication or pesticide able to be purchased in a certain period).

Pesticides are among the most significant means of suicide, accounting for a substantial proportion of all suicides worldwide. Pesticides are of particular concern in rural areas of low- and middle-income countries. It is important to engage the community in reducing people's access to pesticides in contexts where suicides are impulsive, and to provide community education, awareness campaigns and training of retailers and pesticide users. For further information, see WHO and FAO's Guidance Preventing suicide: A resource for pesticide registrars and regulators.

One modifiable risk factor for suicide, especially relevant for young people at risk, is alcohol and drug use. Exposure to conflict, disaster, abuse/neglect, or other potentially traumatic events; physical injury or mental health problems; new difficult environments (e.g., refugee camps); boredom and marginalization; and loss of resources (e.g., social and/or financial) and key aspects of identity can precipitate the use of substances as a coping mechanism and amplify pre-existing risk factors and vulnerabilities. They can also increase the risk for suicide. Communities can support alcohol- and drug-free environments (e.g., during special events such as youth sports events) and support policies to restrict and limit the sale of alcohol.

BOX 12:

How to elicit from the individual their own thoughts about their substance use

1. Reasons for the person's substance use. (Ask: "Have you ever thought about why you use [substance]?")
2. What the person perceives as the benefits of substance use. (Ask: "What does [substance] do for you? Does it cause you any problems?")
3. What the person perceives as the actual and potential harms from the substance use. (Ask: "Has [substance] use caused you any harm? Can you see it causing harm in the future?")
4. What is most important to the person. (Ask: "What is most important to you in your life?" "Does [substance] impact this negatively?")

6: PROMOTE ACCESSIBLE MENTAL HEALTH CARE

A well-functioning mental health care system for people with mental health conditions such as depression, anxiety, posttraumatic stress disorder and severe mental disorders is important to ensure that people in need do not stay without care and develop serious symptoms.

UNHCR has guidance that describes how we can support an acceptable level of mental health services in refugee settings. For further information, see Annex 2 (MHPSS Technical Sheet, pp 42-49). See UNHCR's 2021-2025 Global Public Health Strategy and the MHPSS Minimum Services Package.

Key activities include:

1. **Integration of mental health into primary health care**
   Depending on the capacities of the public mental health system, organize a cooperative plan with the public system to integrate mental health care into primary health care.

   - Training and supervising primary health care staff to identify and manage priority mental health issues. Trainings usually take 3-5 days and need to be followed by supportive supervision and refresher trainings.

     - WHO/UNHCR (2015): mhGAP Humanitarian Intervention Guide.
     - WHO/UNHCR (2022): Training Manual mhGAP Humanitarian Intervention Guide.

   - Support a routine supply of essential medication for mental disorders to health centres.
   - Arrange for a mental health professional to manage people with complex conditions and provide clinical supervision to the general health workers. Depending on the context this can be a psychiatrist, psychiatric clinical officer, psychiatric nurse or clinical psychologist.

2. **Integration of MHPSS into community health work**
   The community health workers are a bridge between communities and the health facilities. Mental health needs to be a part of their training curriculum and they should be regularly supervised on mental health issues. In some operations more specialized community MHPSS volunteers are trained to do more focused work. Community volunteers can be trained in Psychological First Aid, communication techniques for persons in distress, identification of signs of distress and MHPSS referral pathways. They can share tips and techniques on stress management with the community through volunteers, community centre activities, refugee websites/social media, or refer community members to self-help applications.

3. **Introduce scalable psychological interventions**
   Mild and moderate mental health conditions can be effectively addressed through brief scalable psychological interventions (5-8 sessions) that can be delivered by non-specialized workers after a brief training and with supportive clinical supervision by a mental health professional. There are several such methods.

The choice is dependent on the population needs what the programme wants to achieve, costs, availability of trained personnel and intervention versions that are contextually and linguistically adapted. Widely used methods are:

- Group Interpersonal Therapy for Depression (IPT). This method is developed for people with depression including those with suicidal behaviour.
- Problem Management Plus (PM+), which is widely used, and can be helpful, but uses suicidality as an exclusion criterion for entering the programme.

A general training in basic clinical skills can also make a great difference in perceived support among care-seeking of at-risk beneficiaries. For example, the EQUIP (Ensuring Quality in Psychosocial Support) Platform makes freely available competency assessment tools and e-learning courses to support governments, training institutions, and non-governmental organizations to train and supervise the workforce to deliver effective psychological support to adults and children.

Establish MHPSS-referral pathways highlighting available multi-layered MHPSS services. Special attention and training must be dedicated to ensure that referral pathways are functioning and sensitive to the community needs to avoid further stigmatization or refugees being caught in a 'referral loop' while trying to access care. See also the Inter-Agency Referral Form.

7: TRAIN COMMUNITY GATEKEEPERS TO IDENTIFY AND RESPOND TO WARNING SIGNS OF SUICIDE

It is important to identify people who are suicidal and respond adequately to their needs. Many people who are suicidal are not under care by a mental health professional, and therefore, early identification and response by community members and others is important.

Gatekeepers are individuals in a community who have person-to-person contact, formal or informal, with large numbers of community members as part of their usual routine and who are trusted by them. They can be people with a formalized role in the community such as community leaders, volunteers and personnel in community centres, schools, and health facilities, but can also include those who have frequent informal contact with people who are at higher risk for suicide. Examples are hairdressers, barbers, community midwives, members of informal religious groups, leaders of informal youth groups, and shopkeepers.

Gatekeepers can have an important role in suicide prevention if they are able to recognize when someone is in distress or at risk of suicide and can intervene to get them connected to resources. Training of gatekeepers should be competency-focused and tailored to the specific participants and settings.

A workshop for gatekeepers could consist of the following elements:

1. Understanding basic facts about suicide including risk and protective factors (see **Table 2** on page 11).
2. Recognizing warning signs for imminent suicide (see **Table 3** on page 12).
3. Learning how to talk with someone who may be suicidal:

   It is important that participants in a gatekeeper training develop confidence to ask about issues related to suicide in a way that is culturally appropriate. This usually includes:

   - **Approaching the person in an appropriate way, choosing a private place to talk with the person, and allowing enough time to talk about their concerns.**
   - **Asking questions in an open, non-judgmental way about how someone is doing and ask clarifying questions:**

     - "How are you feeling?"
     - "How do you see the future?"

   - **Asking for clarifications:**

     - "Can you tell me more about that?"
     - "What do you mean with xxx?"

- **Continue asking concrete questions about suicidality when needed:**

  - "Do you ever think: 'I wish I were dead'?"
  - "Do you ever think: 'I don't want to live like this'?"
  - "Do you ever think about suicide?"
  - "Do you have plans how to do it?"
  - "Did you make preparations for it?"

- **Responding with compassion and hope when engaging with suicidal persons:**

  - "Thank you for sharing this"
  - "It must be really tough for you"
  - NB: also discuss responses that are not helpful, such as: "You don't really want to die, do you?", "You're not going to do crazy things, are you?" "Just stop thinking about such bad things", "A good Muslim/Christian/Buddhist would never end their life."

4. Jointly seek steps for **further support** such as:

   - Identifying potential support persons in the social environment.
   - Calling an MHPSS help line or switchboard.
   - Contacting a professional MHPSS worker.
   - Discuss with the person how they can stay safe for now. If a person has acute risk for suicidal behaviour, the aim is to get a commitment from the person to accept help and to make concrete arrangements to get that help (where, how and what, and whether the person needs support to accompany them through the referral process).

     - If necessary, activate psychological support from family and friends (to accompany the person).

5. Keeping boundaries: A gatekeeper is not a professional MHPSS worker, and it is important that they do not raise unrealistic expectations about what they can do or try on their own to solve the problems of the suicidal person. It is important that a gatekeeper can discuss their own feelings and responses with someone.

Curricula for gatekeeper training in refugee contexts have been developed in various countries. The following materials can be excellent sources of information when developing a gatekeeper training. These are made in high income countries and need to be contextually adapted.

- Colucci, E. et al (2016). Suicide First Aid Guidelines for People from Immigrant and Refugee Backgrounds. Melbourne.
- Procter, N. et al. (2021). An evaluation of suicide prevention education for people working with refugees and asylum seekers: Improvements in competence, attitudes, and confidence. Crisis: The Journal of Crisis Intervention and Suicide Prevention.

BOX 13:

Warning signs

- Often talking about death, dying or suicide.
- Making comments about being hopeless, helpless, or worthless.
- Expressing strong feelings of guilt or shame, or belief of being a burden to others (e.g., saying "others will be better off without me").
- Expressions of having no reason for living and having no sense of purpose in life; saying things like "It would be better if I wasn't here," or expressions of detachment with projects and activities a person used to be involved in.
- Increased use of alcohol and/or drugs.
- Withdrawal from friends, family and community.
- Reckless behaviour or more risky activities, seemingly without thinking.
- Dramatic mood changes.
- Talking about 'feeling trapped' or seeing no solutions for current difficulties.
- Giving away possessions.

Where feasible, gatekeepers should be trained in Psychological First Aid, Remote Psychological First Aid and, if possible, other scalable psychological interventions such as Problem Management Plus (PM+) or Interpersonal Counselling for Depression (a 3-session variant of Interpersonal Therapy).

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8: ADVOCATE FOR ACCESS TO LIVELIHOODS AND SOCIO-ECONOMIC INCLUSION FOR REFUGEES

In many settings where UNHCR operates, major drivers of despair among refugees and other forcibly displaced people are the limited options for employment and livelihoods. Issues such as legal barriers to accessing the labour market in the host country, scant possibilities for higher education, and reduction of food rations or cash-based assistance may fuel a sense of frustration and hopelessness, which can be correlated with increased prevalence of suicidal behaviour.

UNHCR works closely with national governments donor agencies, UN agencies and other partners to realise decent opportunities for livelihoods and socio-economic inclusion. Advocacy around such topics needs coordination and leadership from UNHCR country teams. The Taskforce can provide important input for external advocacy.

Actions that can be considered by the suicide prevention and mitigation taskforce:

- Document the prevalence of suicidal behaviour and the longitudinal patterns.
- Describe possible associations between contextual changes with patterns of suicidal behaviour but refrain from positing causal relations.
- Discuss the findings with the senior management of the UNHCR.
- Explore options to use findings from the assessment in reports, proposals and media reports.
- Make people involved in MHPSS case management aware of the options for referral to existing activities (i.e., not special programmes for people with mental health conditions) for livelihoods and socio-economic inclusion.
- Make people involved in activities for livelihoods and socio-economic inclusion aware of the MHPSS programmes and the importance of livelihoods/socio-economic inclusion in addressing psychosocial distress.

9: TRAIN PERSONNEL ON HELPLINES AND SWITCHBOARDS TO RESPOND TO CALLS OF PEOPLE IN DISTRESS

Helplines focused on people in emotional crisis

Crisis lines usually focus their work on people in the community and offer non-judgmental and confidential emotional support in times of personal crisis when individuals may feel unable to cope with the challenges in their lives, particularly persons at risk of suicide or thinking about suicide. Helpline responders are aware of available services and make referrals as needed.

Most crisis line services are:

- Provided free of charge (or the caller pays only the cost of a local telephone call).
- Staffed by trained volunteers, paid mental health professionals, or paid paraprofessionals.
- Anonymous: a name/personal identification is not necessary to receive the service.
- Confidential (except in emergency situations with grave safety concerns).

Crisis helplines/emergency lines/hotlines can help alleviate the distress a person may be experiencing and can reduce the intensity of such feelings, which enables problem-solving and practical actions to be considered in response to personal problems. Confidential services offered by crisis lines may help overcome the barrier of stigma surrounding suicide and mental health problems that could prevent a person from seeking help. Such lines are very useful but also have limitations in what they can offer due to physical distance and anonymity. Some country-specific helplines are available via Opencounseling.com/suicide-hotlines and Findahelpline.com.

It is unlikely that UNHCR would be able to set up its own suicide prevention helpline, but it may be possible to liaise with existing suicide prevention helplines and assist staff to better respond to persons in need of help and support. If partners consider establishing a crisis helpline refer them to existing resources including WHO's Preventing suicide: A resource for establishing a crisis line and Helpline Checklist.

Strengthening the capacity of non-specialized helplines

Many UNHCR operations have telephone lines "switch boards" ("lignes vertes") that can be called by refugees for questions on a range of issues. Sometimes the responders (who may be working in protection and/or registration) receive calls from people who are in acute distress and could be suicidal. Therefore, it is important to train these non-specialized helpline staff in how they should respond when receiving calls from refugees in distress, including those who are suicidal. Training in suicide prevention and response for staff in general helplines can consist of the following elements:

- Engaging persons at-risk and practicing communication skills:
  - briefly building trust/rapport
  - active and empathic listening
  - staying calm, de-escalating
  - reframing
  - engaging at an emotional rather than factual level (e.g., do not try to argue with facts, but express how difficult it must be for the caller)
  - normalising the person's feelings and thoughts of distress (but not the intent to self-harm).
  - separating distress from desire to die ("people want to end their lives because they want to end their pain. If the pain could be managed, they wouldn't want to die. We have many ways to help you manage your pain.")
  - offers to call back
- Respecting confidentiality and when to break it.
- Identifying warning signs of suicide: This requires that the helpline personnel should be trained to ask actively about suicidality, for example, in the case of possible suicidality, ask specific 'prompt' questions to explore:
  - current suicidal desire ("Are you thinking of hurting or killing yourself?")
  - recent suicidal desire (past two months), ("Have you thought about hurting or killing yourself in the last two months?")
  - past suicide attempts ("Have you ever attempted to end your life?")
- An affirmative answer to any of these three questions should lead to a more in-depth suicide risk assessment .
- Assessing degree of suicide risk (see **Box 14** below): refer to IFRC.
- Taking action to reduce suicide risk (safety plan, engage familial or social support, engage local emergency response team, etc.).
- Referral of callers who are at immediate risk or have attempted suicide and need acute medical care.
- Self-care and supervision:
  - Debriefing and support after a call to help the worker with emotional reactions and difficulties encountered during the call.
  - Provision of feedback to crisis line workers to improve their skills.
  - Assistance with organizational and administrative procedures such as record-keeping and, depending on procedures, follow-up planning or notes for other workers who may receive a call from the same person.
  - Quality control, by ensuring that callers receive appropriate and useful help.

Further reading and guidance

- IFCR (2020). Suicide prevention during COVID-19. IFRC Reference Centre for Psychosocial Support, Copenhagen.
- Draper, J., et al. (2015). Helping callers to the National Suicide Prevention Lifeline who are at imminent risk of suicide: The importance of active engagement, active rescue, and collaboration between crisis and emergency services. Suicide and Life-Threatening Behavior, 45(3), 261-270.

10: TRAIN FIRST RESPONDERS IN SAFETY PLANNING

Safety planning consist of a personalized set of coping strategies and resources for people to support themselves during the onset or worsening of suicide-related distress or suicidal urges.

The content of the safety plan is co-created between the worker and person in distress. It is different for each person and reflects the thinking of the individual about strategies that are 'right' for them and that they can put in place when suicide-related distress starts or becomes worse. It consists of a menu of activities in increasing layers of safety and protection, from very simple and immediate actions that the person can do for themselves, things that may help a person to distract themselves, make their situation safer, reinforce their reasons for living, through to more robust actions involving assistance from others. Safety plans have been proven to be effective in reducing suicidal ideation and behaviour, decreasing hopelessness, reinforcing reasons for living and lowering hospitalizations for suicide attempts.

How to develop a safety plan?

- Safety planning is for individuals who are not at imminent risk of harming themselves.
- A safety plan is co-developed by the person at risk of suicide in collaboration with a professional helper who has been trained in using safety planning. If the person agrees, it can be helpful to involve someone the person trusts in developing the safety plan. In some instances, a family member or friend can be present and provide assistance during co-development.
- If the person at risk is under 18 years of age, a trusted parent or caregiver should be involved in the safety planning unless there are risks related to their involvement.
- The caregiver or trusted person may help explain the purpose of the safety plan but should not provide responses on behalf of the individual at risk, as the strategies chosen to help keep them safe must be driven by and be meaningful to the individual.
- It is important to be patient and encouraging while using basic helping skills to promote trust and open communication.
- Invite the individual to read the prompt questions and give time for them to write down their responses or, in case the person is illiterate, find alternative ways for the person to remember the actions.
- On average, it should take between 30 to 40 minutes to complete a safety plan. The plan should be revised and adapted over time.

Structure of a safety plan

- A typical safety plan includes six components: **(1)** recognizing individual warning signs; **(2)** identifying and employing internal coping strategies; **(3)** using social supports as distractions; **(4)** contacting trusted family or friends for help; **(5)** contacting specific mental health services; **(6)** reducing access to/use of lethal means.
- Staff and volunteers should make sure they have the current contact details for local emergency services and for other resources, which may be needed by individuals completing their safety plans.
- It can be helpful to have a pre-printed form on thick paper (in the language of the person) on which the person can write down their specific strategies.
- A sample safety planning template is shown in **Box 14**. You can adapt this for language and context. Creativity is encouraged to adapt the plan to meet the literacy level and support needs of the person an audio recording, drawing or small coping card kept in a pocket should be considered as possible formats for the safety plan.

Reading more on safety planning:

- To learn more about the concept of safety planning see this brief video.
- To see the structure of a safety plan see page 30 IFRC (2021). Suicide Prevention.
- To get some ideas of what an individual could consider adding in their safety plan see here.

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BOX 14:

Template for a safety planning card

Name: .....

1.	**Recognizing personal warning signs**
	What are thoughts, images, mood, situations, behaviour that indicate that a crisis may be developing?
1.1	
1.2	
1.3	
2.	**Making your situation safer**
	What can you do immediately to improve your safety? Is there a place you can get to easily where you feel safer? What can you do in the longer term to improve your safety? Can you remove (or distance) anything you might use for hurting yourself? If you need regular medication, could you store it somewhere safely or perhaps store a small amount in your house? Is there anyone you trust to look after some of it for you?
2.1	
2.2	
2.3	
3.	**Doing things to lift or calm your mood**
	Write down things you think will help lift your mood or help you feel less distressed or calmer. Add anything you think will be helpful and be specific.
3.1	
3.2	
3.3	
4.	**Doing things to lift or calm your mood**
	Write down things that will help distract you from the thoughts of wanting to hurt or kill yourself.
4.1	
4.2	
4.3	

BOX 14: Template for a safety planning card (Cont.)

4.	**Doing things to lift or calm your mood**
	Write down things that will help distract you from the thoughts of wanting to hurt or kill yourself.
4.1	
4.2	
4.3	
5.	**Using social supports**
	Write names and contact details of people with whom you can connect to feel safer. This can be people to send a message to or get in touch with just for a chat and not necessarily to tell them about your feelings in any detail. Write all contact details and when and how you can contact them.
5.1	
5.2	
5.3	
6.	**Talking about your feelings or thoughts related to self-harm or suicide**
	List who you can talk to about feeling distressed or thinking about self-harm or suicide. Write details on how to contact them (phone numbers/address). Include all ways to contact them, including messaging them and phone numbers such as home, mobile and work.
6.1	
6.2	
6.3	
7.	**Contacting emergency professional support**
	Include all contacts for emergency services and professional support, including ways to message them and phone numbers such as home, mobile and work.
7.1	
7.2	
7.3	

The one thing that is most important to me and worth living for is: Here you can identify reasons for living. It can be something related to your family, future plans - anything you consider most important.

11: TRAIN MHPSS AND HEALTH PERSONNEL IN THE ASSESSMENT AND MANAGEMENT OF SUICIDAL BEHAVIOUR

Personnel working in MHPSS services or in general health services need to be well trained in engaging in conversations with people who are (or may be) suicidal. The training is more comprehensive than training for gatekeepers or helpline staff. The goals are to explore the level of suicidality and to engage with the person to make a proper plan for next steps.

Such training can be part of a 5-day training in mhGAP HIG (see action 6) or be offered as a stand-alone training in the context of suicide prevention activities. A stand-alone training on assessment and management of suicide can be half- to full-day and should minimally consist of:

1. Refresher of assessment of mental health conditions such as depression, psychosis, acute stress, PTSD (in mhGAP see action 6).
2. Training on assessment and management of suicidal behaviour (see page 59-51 of the mhGAP HIG), with a strong focus on experiential learning (through role plays) and strengthening communication techniques (affirmations, asking permission to explore feelings) see **Box 15**.
3. Safety planning (See **Tool 10**) and follow up measures for various levels of suicidal behaviour as skills that can be used in conjunction with mhGAP skills. Safety planning can be implemented by MHPSS personnel and volunteers.

BOX 15:

How can professionals in MHPSS and health assess suicide

1. First, explore the person's negative feelings and then ask if they have any plans or thoughts about self-harm/suicide:

"I can see that you are going through a very difficult time. In your situation many people feel like life is not worth living. Have you ever felt this way before?"

If the answer is YES, continue to explore:

- What are some of the aspects in your life that make it not worth living?
- What are some of the aspects in your life that make it worth living?
- Have you every wished to end your own life?
- Have you ever thought about harming yourself?

If the answer is YES to either of the last two points, ask:

- Have you thought about how you would harm yourself?
- Have you thought about how you would end your life?
- Have you told anyone else about these ideas?

  - If yes: What was their response? If no: Why not?

2. Now employ some direct questioning to really understand how imminent the risk of self-harm/suicide is:

- What thoughts specifically have you been having?
- How long have you been having these thoughts?
- How intense have they been? How frequent? How long have they lasted?
- Have these thoughts increased at all recently?
- What makes these thoughts stronger?
- Do you feel like you want to end your life?
- Do you have a plan for how you would die or kill yourself?
- What is it? Where would you carry this out? When would you carry it out?
- Do you have the means to carry out this plan?
- How easy is it for you to get the gun/ropes/pesticide, etc. (means)...?
- To what means do you already have access? What steps do you need to take to access the means?
- Have you made any attempts already? If yes: When? What happened?

3. After you have asked questions about a person's negative feelings and thoughts/plans of self-harm/suicide, balance this by asking about positive elements in their life and possible protective factors:

- What are some of the aspects of your life that make it worth living?
- What would help you to feel or think more positively, optimistically or hopefully about your future?
- How have you coped before when you were under similar stress?

  - What has helped you in the past?

- Who can you turn to for help? Who will listen to you? Who do you feel supported by?
- What changes in your circumstances will change your mind about killing yourself?
- What would make it less likely that you would try to take your own life?
- If you began to have thoughts of harming or killing yourself, what would you do to cope with these thoughts and stay safe?

Explain to the person that when people feel overwhelmed, they may go through periods of wanting to die, however this is a reaction to escape the pain or stress of what they are experiencing. After the stress or pain is lessened, they usually do not feel that way anymore. Explain that you can see that the person is feeling overwhelmed by their current situation, and you are concerned about them and their safety, and you would like to work with them to take steps to keep them safe.

Supporting a person with imminent risk of suicide or self-harm

A person is at imminent risk for suicide or self-harm if either of the following is present:

- Current thoughts, plans or acts of suicide
- Person who is now extremely agitated, violent, distressed or uncommunicative and has a history of

  - thoughts or plans of self-harm or suicide in the past month and/or
  - acts of self-harm in the past year

BOX 16:

Key actions to support a person with imminent risk of suicide or self-harm include

- Remove (or distance) means of self-harm/suicide.
- Create a secure and supportive environment; if possible, offer a separate, quiet room while waiting for treatment.
- Do not leave the person alone.
- Supervise and assign a named staff or family member to ensure person's safety at all times.
- Attend to mental state and emotional distress.
- Co-create a safety plan (see action 10 above).
- Provide psychoeducation to the person and their carers.
- Offer and activate psychosocial support.
- Offer carers support.
- Consult a mental health specialist, if available.
- Maintain regular contact and follow-up.

Supporting a person who is at risk of suicide or self-harm

For people who do not have an immediate risk for suicide but who have thoughts of suicide, history of thoughts or plans to self-harm in past month, or an act of self-harm in the past year follow these steps:

- Offer and activate psychosocial support.
- Create a safety plan (see **Section 10**).
- Engage family or other support persons for observation and removal of means, if appropriate.
- Consult a mental health specialist, if available.
- Maintain regular contact and follow-up.

Intervention protocols specific to suicide death, suicide attempt, and acute distress help staff to respond in an organized, timely, and compassionate way. Clear and consistent protocols that outline what to do and who to contact will also help minimize uncertainty and fear. Operations should ensure that staff in health facilities receive training on how to respond when an individual is identified as considering suicide or has evidence of a medically serious suicide attempt.

Supporting a person who has done a medically serious suicide attempt

We talk about a medically serious suicide attempt when there is any of the following:

- Evidence of self-injury such as signs of poisoning or intoxication.
- Signs and symptoms that require urgent medical treatment such as bleeding from self-inflicted wound, loss of consciousness, or extreme lethargy.

The sections below are adapted from the section 'Responding to those who are at risk' in IFRC'S document Suicide prevention during COVID-19.

Actions to be taken are described in **Box 17**.

BOX 17:

Actions to take in the case of a medically serious suicide attempt

- For all cases: Place the person in a secure and supportive environment, where possible at a health facility with inpatient services.
- Do not leave the person alone.
- Medically treat injury or poisoning. If there is acute pesticide intoxication, follow management of pesticide intoxication protocol (see WHO Guidance: Clinical Management of Acute Pesticide Intoxication).
- If hospitalization is needed, continue to monitor the person closely to prevent further suicide attempts.
- Care for the person with self-harm (inquire about what the person needs, for example, a blanket, food, water, communication, etc.).
- Offer and activate psychosocial support.
- Offer support to carers.
- Consult a mental health specialist, if available.
- Once the person is discharged, arrange with family or other support systems to ensure the person is not left alone.
- Develop a safety plan with the person (See **Section 10**).
- Maintain regular contact and follow-up.

12: DEVELOP A CLEAR PATHWAY FOR WHO DOES WHAT WHEN A PERSON IS SUICIDAL

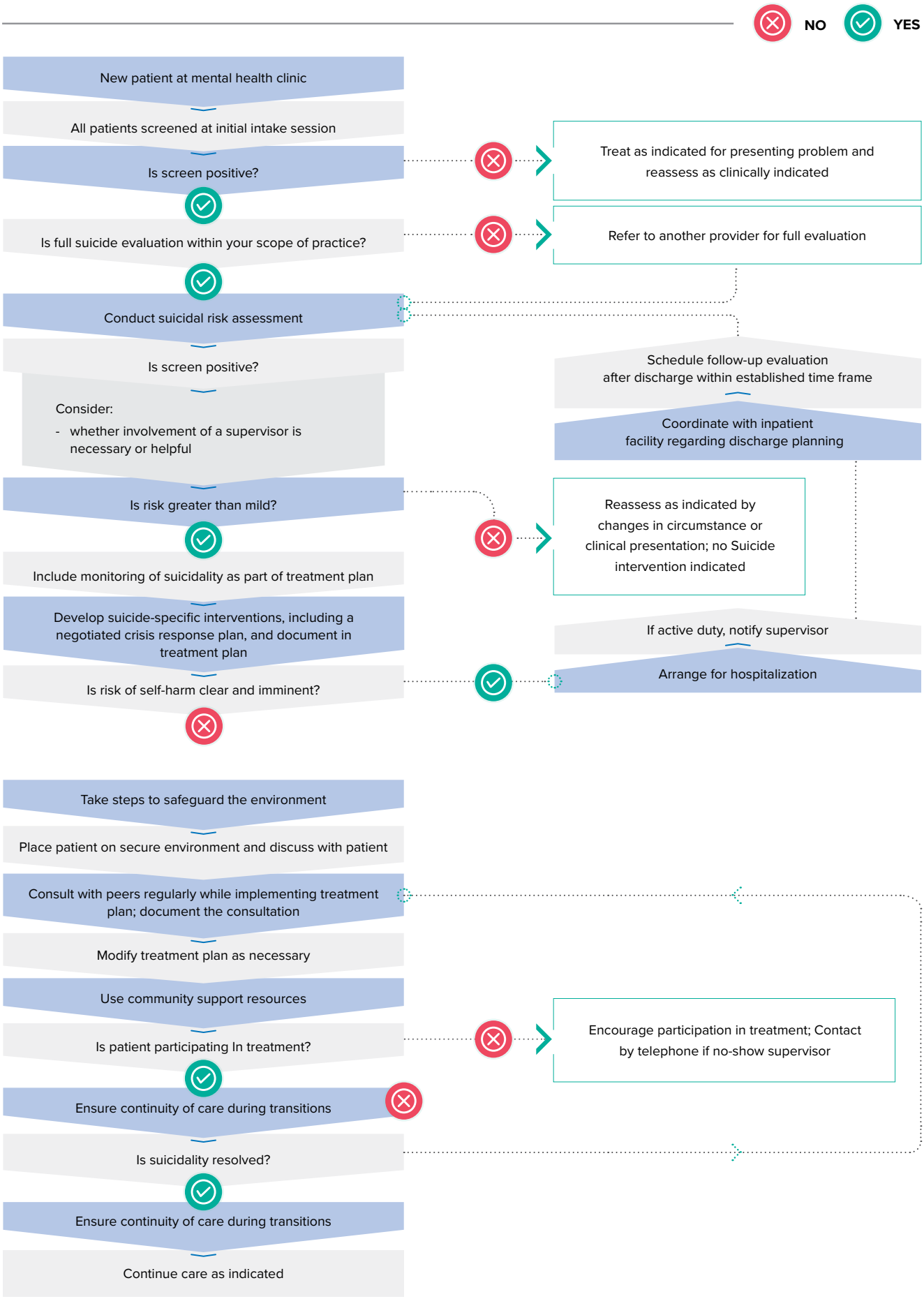
Having a shared understanding of the current response process helps teams identify problems or bottlenecks, focus discussions, and identify resources.

For example, teams can identify steps in the process that do not add value, such as delays; unnecessary work, duplication, or expense; and breakdowns in communication. It is at these points where improved pathways can start. Referral pathways should be clearly structured and efficient and integrate mechanisms to ensure confidentiality in the referral process.

In situations where there are safe and available referral options, response coordinators should test the referral pathways to ensure that they are functioning. This may include meeting with local and national officials, crisis coordinators, technical working groups (MHPSS, education, protection, health) and agreeing on ways of working, including standard operating procedures.

A flowchart, also known as a “process map” is a visual representation of the sequence of steps in a process. Understanding the process as it currently operates is an important step in developing ideas about how to improve it. The use of a flowchart can help to clarify complex processes related to suicide prevention and response, remove unnecessary steps in the referral process, and serve as a basis for designing new processes.

Example flowchart template



13: PROVIDE SUPPORT TO PEOPLE AFFECTED BY SUICIDE

Having a loved one who is suicidal or at high risk of suicide has a significant impact on close friends and relatives. Staff and volunteers may encounter people seeking support because someone they care about is at risk of suicide or has attempted or died by suicide. Families and loved ones who have lost someone will grieve in their own way and in their own time.

It is important to understand that there is no single or right way to grieve or to resolve grief. Death by suicide is usually sudden, often unexpected and may be emotionally or physically disturbing. Family members and friends often are left in shock as they struggle to make sense of what has happened and wonder why it has happened and if they could and should have done things to prevent it. Emotional reactions may be intense and complex, ranging from feelings of guilt, anger, shame, sadness, and fear. People who have been bereaved by suicide may become vulnerable to thoughts of suicide themselves, or experience periods of sustained or situational depression. Many people who have been bereaved by suicide often feel isolated and experience that others may avoid them. This all makes the grieving process complicated and last longer than other types of bereavement.

Providing individual support to people bereaved by suicide

Supporting bereaved family members with their grief is important for their healing. It is important that this is done in a non-intrusive way and is centred around the needs of the bereaved. Such support needs to be coordinated closely with professionals with various sectors (community-based protection, MHPSS, etc.). Sometimes the support can be quite modest (though meaningful for the bereaved): making a phone call or home visit to check in and ask how someone is doing or asking community MHPSS volunteers who live in the same area to get in touch and make themselves available to the bereaved family from time to time. In other cases, the bereaved person needs more support and can benefit from counselling sessions to discuss feelings of anger, guilt, shame, sadness, or other forms of support and care. There is no one right way to grieve. People will respond differently. Grieving is a normal process and many people do not need professional support. However, family members of a loved one who has died from suicide have themselves an increased risk for suicide, so it is important to be watchful.

Key considerations in providing support to friends and relatives include:

- Use active listening skills to ensure that the bereaved feels supported and heard.
- Validate feelings expressed.
- Acknowledge courage to reach out for help.
- Explore existing care arrangements, support and resources.
- Encourage them to use their social support system.
- Consider offering them to participate in a support group (See below).
- Determine whether additional risk assessment is needed (and refer when necessary).

Read more: Survivors of Bereavement by Suicide (2019). Support after a Suicide.

Engaging the community

It is helpful to contact community gatekeepers such as community leaders, religious and cultural leaders and teachers to help guide the way that the suicide is spoken about publicly in the community and to galvanize support for the bereaved and prevent gossip or social ostracization. Community supports are important for the bereaved to help understand and process the loss. Take actions to prevent that reporting about the suicide is sensationalized, as this can increase the distress of those who have been bereaved.

Group work with people who are affected by suicide

Bringing people together who share a similar life issue or problem can have powerful effects such as feeling understood and validated, learning from the experiences of others and a sense of belonging. For these reasons, group work can be considered as part of the activities around suicide prevention and risk mitigation. But setting up such groups also brings risks that need to be considered. We distinguish between two types of groups (see **Table 8**).

Self-help groups

These groups are self-governing (not led by professionals) and composed of individuals sharing the same or similar concerns or issues who meet on a regular basis to provide emotional support and advice to each other. They usually develop organically and are rather open in format (not following a curriculum).

- Self-help groups of people who are bereaved by suicide can provide an important opportunity to be with other people who have been through the same experience (counteracting stigma), to gain strength and understanding from others within the group and to provide the same to others. The group may also take on an educational role in their community, providing facts relating to suicide and where to get help. While such groups are largely self-led, some form of external support or guidance is often helpful such as technical advice, information for members about where to go for additional support. See: World Health Organization. (2018). Preventing suicide: a community engagement toolkit.

- **Self-help groups of people who have attempted suicide** may spontaneously develop in communities that are heavily affected by suicide. However, the atmosphere in a group of suicide survivors can shift dramatically from being hopeful to very negative, especially if a member becomes acutely suicidal or has a new suicide attempt. We advise to not set up such self-led groups but instead consider a professionally operated support group (see below).

Professionally operated support groups

Such groups are facilitated by MHPSS professionals, who usually do not share the problem of the members. The facilitator organizes the invitations, arranges the venue and facilitates discussions. They are usually time-limited and may follow a structured curriculum.

- **Support groups for people who have attempted suicide** can provide a safe, non-judgmental space for people to talk about the reasons and feelings that led them to attempt suicide and the impact that their attempt had on their lives. UNHCR and partners in some settings have good experience with such groups. For example, in response to very high rates of suicide attempts in one refugee settlement in Uganda, the UNHCR partner set up an eight-week support group that was facilitated by an MHPSS professional. The group provided an opportunity for its participants to connect with peers who shared similar experiences and included an emphasis on tools and skills (e.g., coping skills through safety planning) that could help members stay safe from a future suicide attempt. Support groups might be perceived as imposed if done too early after the incident.Such groups should only be considered if there are well trained and experienced facilitators who are comfortable with leading such groups and able to handle complex dynamics and strong emotions in the group.

  A well-articulated resource that might be useful in developing the curriculum for such a group is:

  - Didi Hirsch Mental Health Services (2021). Survivors of Suicide attempts: Manual for support groups. Los Angeles, DDMHS.

- **Support groups for bereaved family members can be very helpful.** They can be facilitated by an MHPSS professional or trained and supervised volunteer. Such groups can provide a safe place for people who are bereaved by suicide to share their experiences, learn coping and healing skills and find support from others.

Table 8: Overview of group support for people affected by suicide

	For people who have attempted suicide	For family and friend bereaved by suicide
Self-help group *(self-led or by community volunteer)*	Not advised	Yes *(if additional support is available)*
Support groups facilitated by MHPSS professional	Can be considered if led by experienced professional	Yes

14: PROMOTE WELL-BEING OF PERSONNEL AND VOLUNTEERS

A suicide incident often generates strong emotional reactions in first responders and the persons who were involved in providing support. Initial support is critical and the support and response to colleagues who have experienced a critical incident may influence the duration and severity of their emotional reaction.

An important component of personnel and volunteer well-being is ensuring that good suicide prevention protocols are in place. Personnel and volunteers who feel confident and comfortable in how to manage a crisis will feel less stress and anxiety. Due to the challenges of responding to people who are suicidal, it is important for managers and colleagues to promote the well-being of personnel and volunteers by ensuring the following actions to build trust and a healthy work environment:

Provide information to personnel and volunteers about staff care options within the organisation

For UNHCR personnel:

Informing personnel about the UNHCR Staff Health and Wellbeing Team and the trained mental health professionals available. The UNHCR Wellbeing Platform also includes a variety of self-assessments to help personnel and volunteers better understand their psychological well-being. Personnel and volunteers should also be aware of the UNHCR Psychosocial Wellbeing Hotline (+41227397388), available 24/7 for those in urgent need of support. This hotline will connect personnel and volunteers to a staff counsellor on duty for guidance.

UNHCR has teamed up with the Rome Institute, an external mental health service provider, to be able to give more psychological support to colleagues who may require it. An appointment can be requested with one of their clinical psychologists, psychological counsellors, and psychotherapists by sending an email (a request will be answered within 24 hours). The first two sessions are provided for free, and the services are available in English, French and Spanish.

For personnel of partner organisations:

- Check with your organisation what resources are available to support personnel.
- The Mental Health and Psychosocial Support Minimum Service Package includes a section on staff support with recommended resources.
- Utilize information from organizations that support staff care for humanitarian workers such as the Headington Institute or the Antares Foundation.

Distributing tools and promoting events to help personnel and volunteers manage their mental well-being

The following resources are recommended:

- Well-being for managers:
  - Why is mental health and wellbeing important?
  - Improve you own mental health
- Burnout and heavy workload:
  - Dealing with a heavy workload
  - How to deal with burnout
- Mental health wellbeing:
  - Grief and how to cope with it
  - Coping with traumatic events
  - How to feel less anxious
  - How to get better sleep
  - Substance use
  - Thinking styles and resilience
- Fitness and workout resources:
  - Recommended fitness apps
  - Simple ways to stay fit
  - Progressive muscle relaxation
  - Fitness classes
  - Morning yoga series

Conducting regular check-ins and post-session follow up

Connecting with your team and creating opportunities for team-building activities are important to staff wellbeing and overall team health. Allowing a few minutes each week to check in with each other (especially vulnerable colleagues) helps build rapport amongst team members and helps establish open communication as a team norm. The following ways to follow-up can be used:

- **Make a phone call**
- **Send a short text message**
- **Connect over email**
- **Write a letter**
- **Visit at home**
- **Schedule a dedicated meeting/time at the office**

It can also be helpful to organize a regular case consultation for personnel responding to suicidal behaviours (this not only supports wellbeing but helps increase confidence and strengthens quality of intervention).

Encouraging a network or support group of peers

For UNHCR personnel:

The Peer Advisors Network (PAN) is a global network of UNHCR personnel who volunteer their time to support colleagues in need. The network is supported by the offices of Psychosocial Wellbeing, Ethics and Ombudsman, and is largely focused on colleagues who work in the field. All Peer Advisors are trained to give low intensity psychosocial support, provide guidance on dispute resolution and conflict, and act as ethical influencers throughout UNHCR. They respond to a range of issues pertaining to the needs of the individual, including conflicts and grievances in the workplace, wellbeing and psychological concerns, and critical incidents.

For personnel of partner organisations:

See the resources in the Mental Health and Psychosocial Support Minimum Service Package.

15: DEVELOP A CRISIS COMMUNICATION PLAN

Suicide and suicide attempts generate strong emotions in all those involved. Sometimes rumours and false information can spread rapidly and give rise to more distress and sometimes even to additional suicide attempts.

A crisis communication plan is critical to ensure that rumours and misinformation related to suicide can be mitigated and addressed. Steps for crisis communication include:

- Establishing a coordination structure (with clear roles and responsibilities)
- Developing a communication tree
- Creating and using a mechanism to monitor what is going on in the community
- Identification of spokespersons
- Training

It is important to work with media outlets and social media to ensure responsible reporting of suicide and to develop awareness campaigns for the community. Ways of doing this include:

- Ensuring that reporters are sensitive when interviewing friends and family of the individual
- Supporting the media not to sensationalize or normalize suicide
- Not providing details about suicides, including means used, site and location, photographs or video
- Providing information to the media about where people may seek help, how to cope with stressors, and how to avoid spreading myths or increasing stigma

Media and online coverage of suicide should be informed by using best practices. Some suicide deaths may be newsworthy. However, the way media covers suicide can influence behaviour negatively by contributing to contagion[6] or positively by encouraging help-seeking. It is important to develop Standard Operating Procedures to address suicide events; work closely with the media; build trust among the public; and communicate with the affected population.

[6] Suicide Contagion occurs when one or more suicides are reported in a way that contributes to another suicide.

Instead of this	Do This
Big or sensationalistic headlines, or prominent placement	Inform the audience without sensationalizing the suicide and minimize prominence
Including photos/videos of the location or method of death, grieving family, friends, memorials, or funerals	Use school/work or family photo; include crisis helpline logo and information on where to seek help
Describing recent suicides as an “epidemic,” “skyrocketing,” or other alarmist terms	Carefully investigate the most recent CDC or other public health data and use non-sensational words like “rise” or “higher”
Describing a suicide as inexplicable or “without warning”	Most, but not all, people who die by suicide exhibit warning signs (but people around them are not trained to recognized them).
“John Doe left a suicide note saying…”	“A note from the deceased was found and is being reviewed by the medical examiner”
Investigating and reporting on suicide similar to reporting on crimes	Report on suicide as a public health issue
Quoting/interviewing police or first responders about the causes of suicide	Seek advice from suicide prevention experts
Referring to suicide as “successful,” “unsuccessful” or a “failed attempt”	Describe as “died by suicide”

Suggested Resources: Reporting on Suicide - SAVE

16: CONDUCT AN OPERATIONAL DEBRIEF/POST-INCIDENT REVIEW

A suicide death that occurs within a refugee camp or settlement is an event that often has considerable impact on all who are involved in the incident and its aftermath. Each incident, as sad as it is, also provides opportunities to learn about what has happened and what can be done to reduce the chance that it will happen again.

An operational debrief (also referred to as a post-incident review) encourages open, supportive and constructive discussion and is an essential part of reviewing and improving suicide response and risk mitigation efforts. It should (ideally) be conducted immediately after a death by suicide or a suicide attempt. The purpose of the operational debrief is to improve the quality of suicide response protocols and mental health programming to prevent future mortality and to identify actions to prevent future shortcomings in access to quality essential mental health and psychosocial support services. The purpose of the operational debrief is to identify any significant risk factor and circumstance data in suspected or known cases of suicide, as well as general mortality information to be used in prevention efforts, not to determine possible negligence or accountability.

After analysing all relevant information, individuals involved need to agree on key lessons learned from the process and commit to actions that will improve suicide prevention and risk mitigation efforts. It is important to consider lessons and actions related to both the community and to the health system. Try to formulate your actions in a **SMART** way, with deliverables that are specific, can be measured, are acceptable in the context, are realistic and time specific.

BOX 18:

Example operational debrief form

Date of debrief (dd/mm/yy): . . . . . .

Name and title of person conducting the debrief: . . . . . .

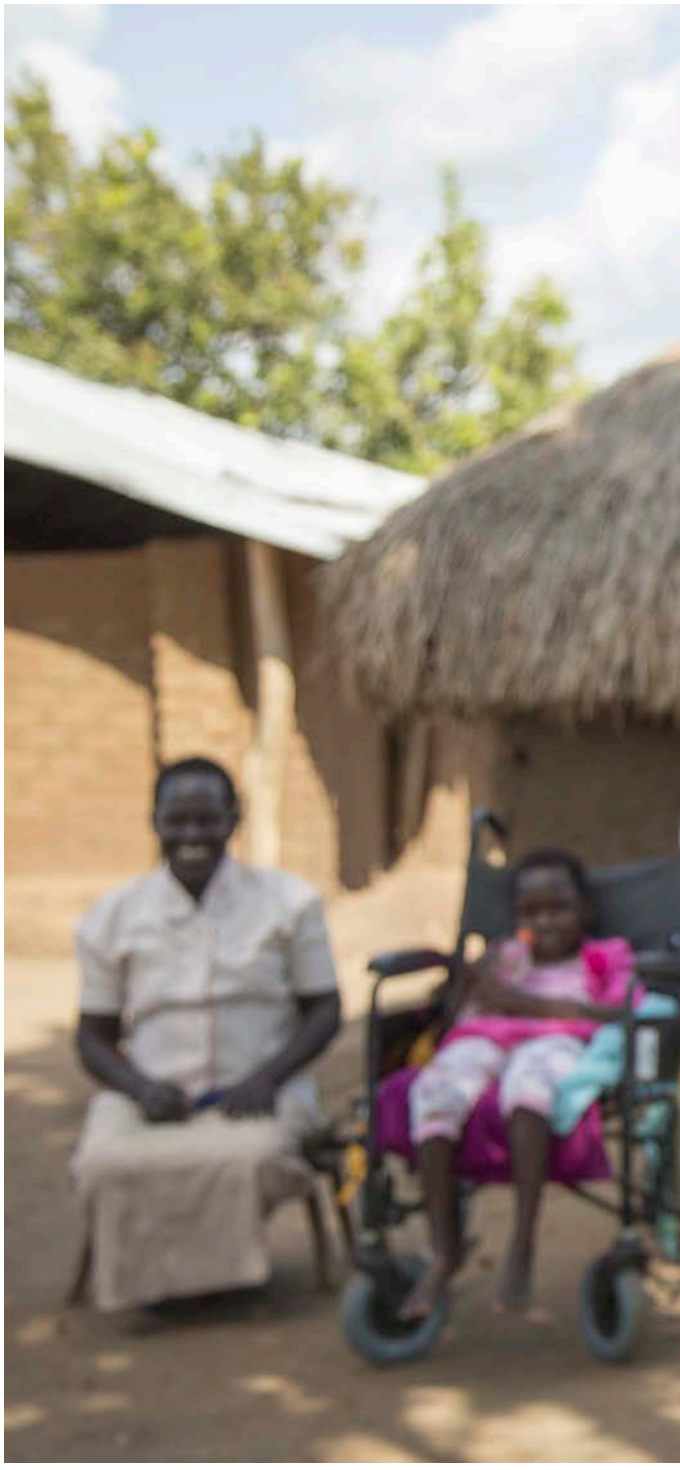
Contact information (email/phone): . . . . . .

Name of personnel and other persons participating in the debrief	☐ *UNHCR personnel Name(s):*	☐ *Implementing partner personnel Name(s):*
	☐ *Family members Name(s):*	☐ *Health/MHPSS staff involved Name(s):*
	☐ *Community members Name(s):*	☐ *Referral hospital staff Name(s):*
	☐ *Community health workers Name(s):*	☐ *Other(s) Name(s):*

Debrief Details	Prompts	Capture feedback below:
FACTS • *Review the details of what happened (who, what, when, and where)* • *Ensure a clear timeline of events and full details of the people involved*	• *Use open ended questions* • *Avoid blaming, accusations or to offer corrective suggestions*	
REFLECTIONS *An opportunity to explore and reflect on why the incident occurred and what could be done differently* • *Possible risk factors and/or triggering events* • *If prevention interventions were attempted:* *- What worked well?* *- What did NOT work well?* • *Discuss lessons learned*	• *Allow the participants to express how they are feeling* • *Identify good practices and areas for improvement (regarding response efforts)* • *Remind staff to reach out if additional support is needed (and refer accordingly)*	

BOX 18: Example operational debrief form (Cont.)

Debrief Details	Prompts	Capture feedback below:
AGREED ACTIONS • *Turn the reflections into practical actions* • *Set realistic expectations for what can be done, and within what timeframe*	• *Consider whether there may be actions relevant to the operation's suicide response and mitigation plan* • *Assign responsible person(s) or organization(s) to follow-up on agreed actions*	
FEEDBACK LOOP • *Ensure all relevant stakeholders keep each other updated on relevant feedback, especially on agreed actions*	• *Consider limits of confidentiality and think about what can be shared (e.g., how and where the incident has been reported)*	



UNHCR
The UN Refugee Agency

PLANNING FOR PREVENTION AND RISK MITIGATION OF SUICIDE IN REFUGEE SETTINGS

A Toolkit for Multisectoral Action

Field-test version 2023