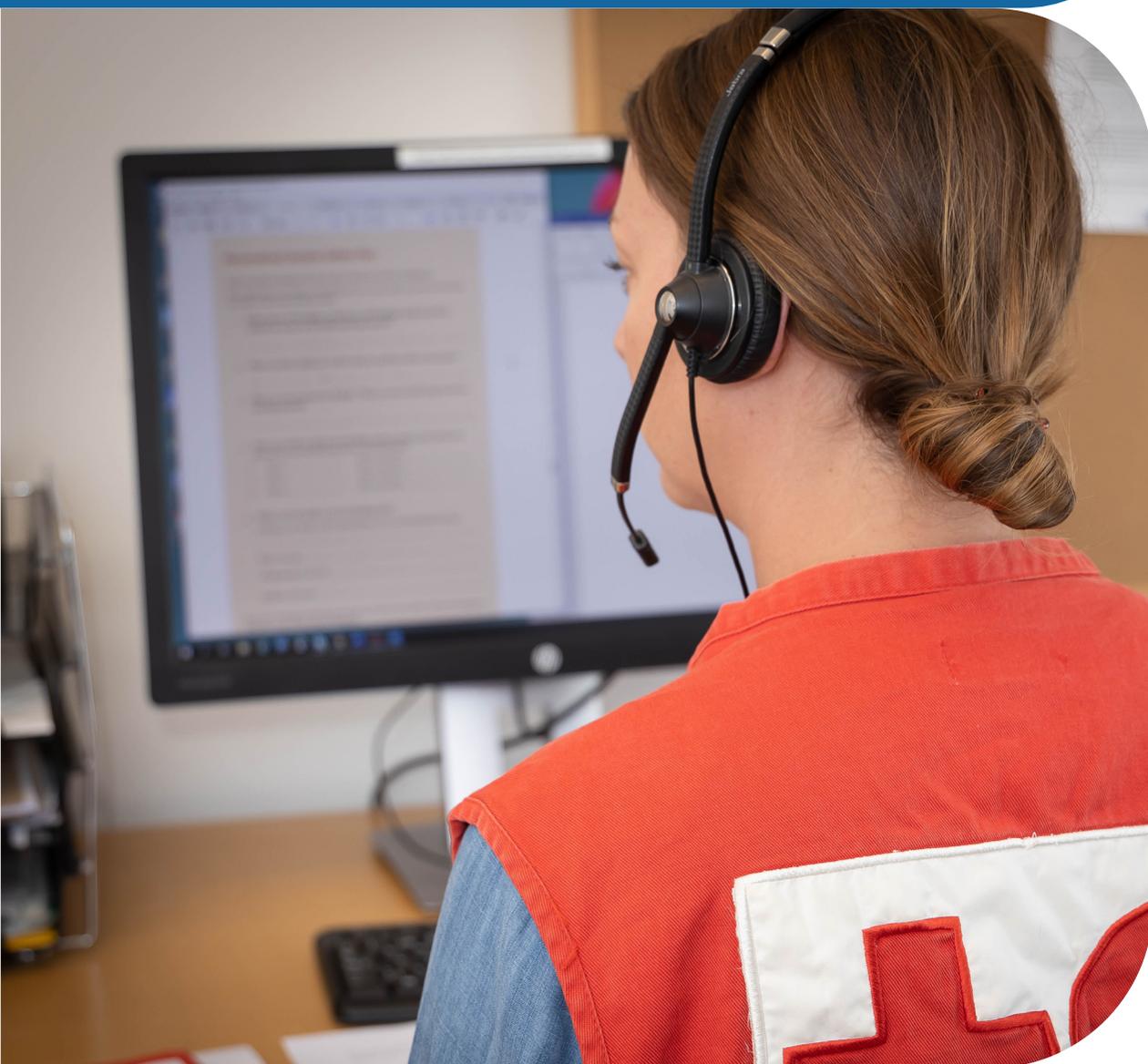


Suicide prevention during COVID-19



May 2020

Psychosocial Centre



International Federation
of Red Cross and Red Crescent Societies

Suicide prevention during COVID-19

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Introduction

Approximately 800,000 people die by suicide each year, with 75% of these deaths occurring in low- and middle-income countries (LMIC)¹. For each person that dies by suicide, an additional twenty people within the population are estimated to have attempted suicide.² Evidence on the association between COVID-19 and suicide behaviour is limited. While COVID-19 may be associated with a decrease in suicide behaviour in some contexts, it may increase in others. The long-term impact of the financial crisis because of COVID-19 response measures is also of concern to the global community, as economic downturns and associated rises in unemployment are followed by increases in suicide.³ One model projects that suicides associated with COVID-19 related job loss could increase by up to 9,570 per year.⁴ In addition, frontline workers need support more than ever, given the levels of stress and increased risk of suicides in healthcare workers related to COVID-19.

A recent exercise to map the Movement's involvement in mental health and psychosocial support (MHPSS) activities (see Mapping of Mental Health and Psychosocial Support Activities within the International Red Cross and Red Crescent Movement, December 2019) found that twenty-one National Societies were implementing suicide and self-harm prevention programmes. Since the onset of COVID-19, National Societies have been tasked with a variety of new programmes, including operating national hotlines and helplines, providing psychological counselling and supportive services (in person and via phone or internet), running hospitals, quarantine sites, emergency medical services and ambulance services.

The challenges associated with COVID-19 make it essential that National Societies are well prepared in their suicide and harm prevention response both during and after the pandemic. While there may be an increase in those who are at risk during this time, there is much that can be done to try to prevent an increase in the number of people who attempt to take their life by suicide.

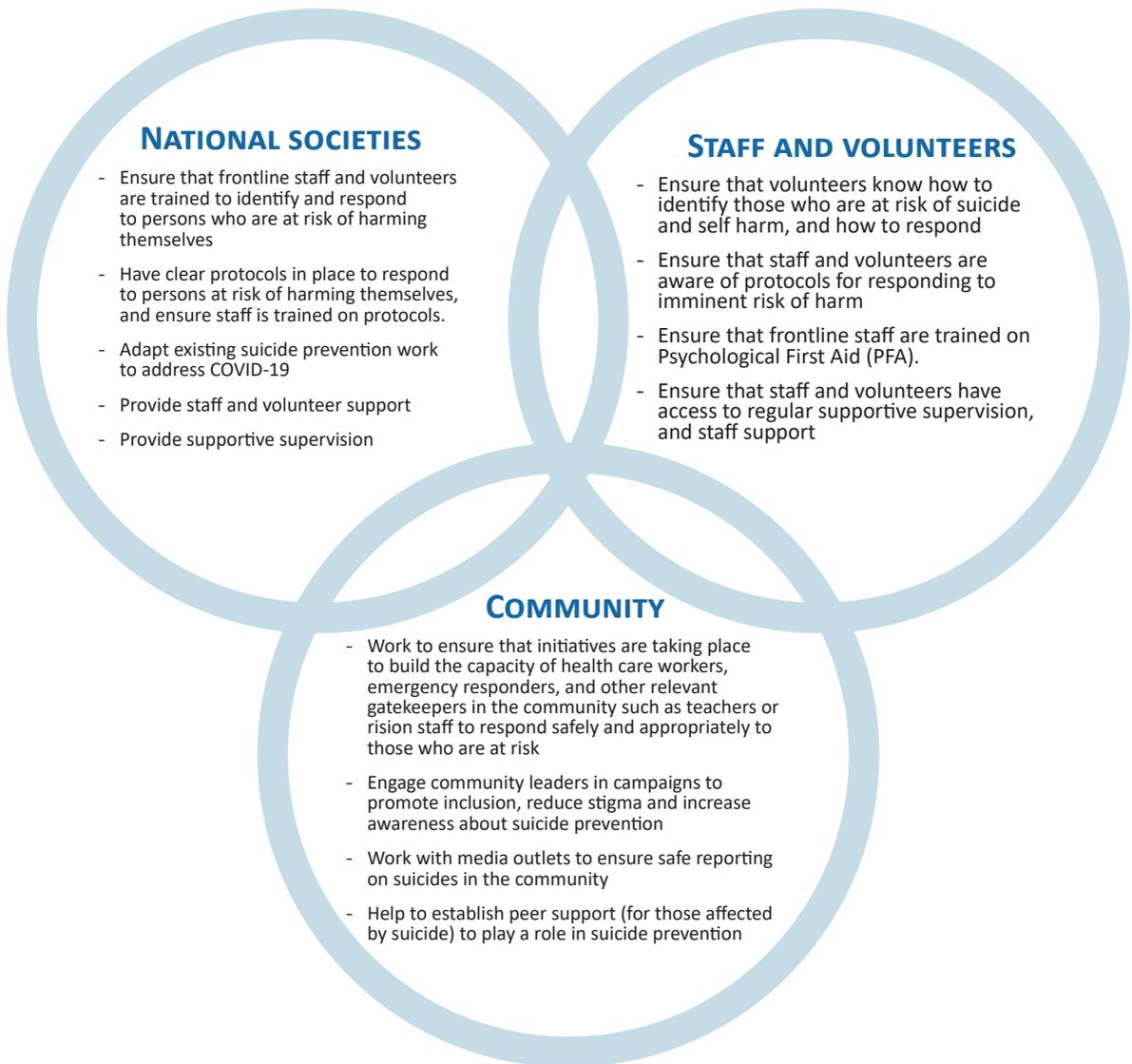
About this guidance

This guidance provides materials on suicide and harm prevention, tailored to the needs of National Societies. It offers resources relevant to those who may be implementing suicide prevention initiatives for the first time and to those who may be adapting existing activities around suicide and harm prevention to the specific challenges of COVID-19.

The guidance provides information across a broad range of considerations for responding to self-harm and suicide, and to engage in suicide prevention initiatives. While it is not intended to be a training package, there are several practical components within the document that can be used and adapted for training purposes. Certain activities should only be implemented by volunteers who have been trained to deliver MHPSS or are specialized in some way. These activities are clearly indicated in the guidance.

This guidance was developed in several stages, drawing on a desk review of suicide prevention materials including identified promising practices, followed by a peer review process. It was reviewed by staff within IFRC, suicide and harm prevention experts, and MHPSS specialists from other international humanitarian organisations, and by academics from institutions across the world.

Please contact the IFRC Psychosocial Centre with any feedback on this guidance.



The mental health impact of COVID-19

COVID-19 emerged in December 2019, and by March 2020, the virus had spread worldwide, causing serious threats to physical and mental health. The unprecedented scale of measures taken to contain the spread of the disease such as physical distancing, self-isolation and quarantine has affected people's daily lives, routines and livelihoods. In addition, COVID-19 itself and the stressors of the pandemic have triggered and exacerbated a wide range of mental health problems, and there is emerging evidence of self-harm and suicides related to COVID-19 around the world.⁵ The longer-term impacts of the pandemic on people's livelihoods are also expected to potentially last for years, further compounding the effects.

Information is beginning to emerge about the impact on mental health of COVID-19, but evidence from previous outbreaks and epidemics offers some guidance on the effects of the current pandemic. Research from the Ebola response, for example, tells us that a significant number of individuals impacted by Ebola experience symptoms of anxiety and depression.⁶ Details of the impact of SARS on mental health also indicate that affected persons such as patients and healthcare workers experience psychological stress and PTSD,⁷ alcohol use or dependency problems,⁸ as well as increased suicide rates among older adults.⁹ Groups such as survivors, family members and health workers are more likely to present symptoms of PTSD, obsessive-compulsive disorder, psychological distress, complicated grief, sleep disorder, suicidal ideation, substance abuse and social anxiety.¹⁰

Current and previous experiences indicate that the mental health impacts of epidemics and distressing events can have immediate and long-term impacts.¹¹ Incidence of loneliness, depression, harmful alcohol and substance use, domestic violence, self-harm and suicide may rise following the COVID-19 pandemic.¹² The landscape of the COVID-19 pandemic is rapidly changing and so will the groups at risk of developing mental health problems.

KEY TERMS

Self-harm is when someone hurts themselves on purpose, for example, by cutting or burning their skin and flesh, or poisoning. It should be noted that not all self-harm is a suicidal behaviour, so it is important to explore what the self-harming actions mean with the person affected. The most important distinction between self-harm and suicidal behaviour is intent to take one's life.

Suicide is when someone intentionally takes their own life.

Suicidal ideation is when someone is thinking about taking their own life.

Suicidal behaviours are actions that a person might take to attempt to take their own life.

Suicide attempt is when someone actively attempts to take their own life.

Language used to refer to suicide and self-harm should be carefully considered. Phrases like 'commit suicide' should be avoided, as it suggests a criminal or immoral element to the act, which may increase stigma¹³ and discourage people from seeking help. Language such as 'attempted suicide', 'took their own life', and 'died by suicide' have been found to be most accepted among those affected by suicide.¹⁴

Special considerations for preventing suicide during COVID-19

Disruptions to daily routines have been a defining feature of COVID-19. With much of the world in situations of physical distancing, quarantine, and lockdown, the global community has had to rethink the way in which to work, connect, support one another, and keep emotional connections. This emergency has also highlighted the strong role of local responses. Neighbours and community members may be able to support one another, and volunteers living within affected communities can often be mobilised. However, the COVID-19 pandemic has raised considerable challenges for the response which warrant special consideration. These include limitations on service delivery, increased reliance on remote support and disruptions in the continuation of mental health services. Special considerations will vary depending on the context.

Impacts on mental health care

Continuity of mental health care is and will continue to be a challenge of the COVID-19 pandemic. Healthcare and social systems across the world in different ways depending on the stage and spread of the virus. Resources prioritised for infection, prevention and control of COVID-19 will likely impact access to mental health care. In many low-middle-income countries across the world, where the prevalence of suicide is highest, there is already a pre-existing shortage of mental health professionals and facilities for those in need of specialised mental health services. This will no doubt be exacerbated by the crisis.¹⁵ Similarly, access to psychological care and psychosocial supports might be interrupted, especially when access to alternative remote care (such as by phone or internet) is not available. This could have potentially detrimental impacts, including risk of increased suicidality.

In addition to disruptions in accessing specialised mental health care, the pandemic may impact the medical supply chain. This may in some cases lead to supply disruptions and shortages of psychotropic medicines (medication used to treat mental illness) resulting in the interruption of treatment for those with psychiatric diagnoses that require medication for the management of mental health conditions. This is particularly concerning in situations where individuals are not able to access professional mental health guidance on how to safely stop taking their medications. COVID-19 response plans should therefore include careful consideration of how to continue working with those who need mental health support and how to respond to those who might be at risk of self-harm and suicide.

Increased reliance on remote support

The availability and accessibility of technological resources will no doubt impact the provision of mental health and psychosocial services during the COVID-19 response. In situations of strict lockdown and quarantine measures, remote support may be the only option. Creative solutions such as tele-mental health and psychosocial support (tele-MHPSS) interventions conducted over the phone and adapting interventions for use on virtual platforms will allow for some continuity of care. This is, however, hugely

challenging in contexts where there is no access to phones, e-mail, virtual platforms or a reliable internet connection. To date, there is guidance on how to adapt PFA and supportive supervision, psychological interventions, SGBV case management and other activities remotely are produced within and outside the Movement. See the Further resources section for more information.

It is essential to provide safe and secure means for volunteers to continue to provide MHPSS services and to receive supportive supervision, whether being done remotely or in person. If support is taking place in person, this must be done in such a way that volunteers are not placed at unnecessary risk. This means ensuring that there is access to personal protective equipment (PPE) and the means to safely maintain physically distances. Each context will have different levels of access to technology and communication platforms, and sensitive information should be protected. If volunteers are expected to use a specific platform, they should be trained in preparation. It should not be assumed that they have the knowledge and skills to do so. Training prior to use, testing, and guidance on data management are crucial for successful and safe use.

Stigma

Stigma against self-harm and suicide is common. It occurs at the community level, where people may be stigmatised if they have attempted or lost someone to suicide or someone within their family or wider network has attempted suicide. It happens at a systemic level, for example, in countries where suicide and self-harm are illegal. It also surfaces in relationships within friends and family. Stigma and social taboos may prevent someone from reaching out to access supportive services, forming a barrier for individuals to feel safe in speaking to others about their distress. It can also hinder systems from strengthening policy efforts, because as a result of stigma the incidence of deaths due to suicide may not be accurately recorded. Efforts to increase awareness about suicide and self-harm are therefore a key element of suicide prevention. Faith leaders and other key stakeholders may play an active part in communities in reducing stigma associated with suicide behaviour.

The media are important actors in terms of disseminating information about self-harm and suicide. It is very 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 sensationalise or normalise 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.

In addition to stigma against self-harm and suicide, other groups may face xenophobia, stigma, and hate speech as a result of COVID-19, such as those of Asian and European descent, refugees and migrants, and health care workers and their children. Stigma against people who have contracted COVID-19 or who have been quarantined or isolated may increase the risk of suicidality among this population.¹⁶ Supporting community reintegration efforts and checking in on these individuals when appropriate can help to decrease risk. Every effort should be made to counter the stigmatisation of these and other groups.

STIGMA AGAINST HEALTH CARE WORKERS

Claudia, a nurse, was walking home from the hospital after her shift with her two colleagues. A small group of masked people were shouting at them, blaming them for spreading COVID-19. Suddenly Claudia felt something hitting the side of her head, and she and her colleagues were beaten and yelled at. The police finally came, and the masked people ran away.

A few days later, once Claudia had recovered from her physical injuries, she began to think about what the people had said. Was it her fault that people were getting sick and dying? She had done her best to protect herself and others at work, but personal protective equipment supplies were low, so it was not always possible to put on fresh gear. What if she had spread the virus? What if someone had died because of her?

In the next few days, Claudia felt too afraid to go into work and she called in sick. She was afraid she might spread the virus and she was really frightened she might be attacked again. Claudia stopped eating and washing. She became obsessed with the idea that she had somehow killed someone. She began to think of taking her own life and started to put her affairs in order.

One of her colleagues who had also been attacked called Claudia to check in on how she was doing. He had rung several times before, but she had not answered, as she did not want to talk to anyone. This time Claudia decided to pick up because she was now scared for her own well-being. She told her colleague what was going on, and he suggested that she contact her supervisor to ask for a referral to talk to the staff psychologist at the hospital where they worked.

Claudia was unsure if this would help or not, but she promised her colleague that she would make the call. He asked her to call him back after she had called to make an appointment and she agreed.

Preparing frontline workers to respond to suicide and prevent harm

It is vital in response to COVID-19 to prepare frontline workers in suicide and harm prevention and this should be included in all programming. Shifting suicide prevention interventions to remote platforms and mapping safe remote referral pathways will be necessary during the pandemic in many contexts. Even if already trained on suicide prevention, it is advisable to hold refresher trainings focusing on specific measures related to COVID-19.

Volunteers need to know how to identify those who may be at risk and how to respond if someone expresses the intention to harm themselves or has indeed harmed themselves. Providing support to those who at risk of harming themselves can cause responders to feel worried. They may also of course often feel distressed by these situations. Having good training and access to ongoing supportive supervision enables volunteers to be better prepared to identify risk and respond appropriately and be supported themselves in the process.

Preparedness checklist

SUICIDE PREVENTION PREPAREDNESS CHECKLIST

Contextualise suicide prevention efforts

Ongoing efforts to contextualise suicide prevention activities include:

- Facilitating focus group discussions with members of the community to gain deeper understanding of perceptions around suicide
- Making time during supervision to understand if there are biases or misconceptions among volunteers related to suicide and self-harm
- Compiling statistics on national suicide rates, where available
- Identifying whether certain profiles or groups of people within the community are more at risk
- Staying informed of legal issues regarding suicidal behaviours, including criminalisation and mandated reporting
- Gathering related IFRC and National Society policies and guidelines to ensure there is clear protocols for various situations that may arise, including ‘worst case’ scenarios
- Ensuring that definitions of risk and response are accurate and comply with official sources
- Ensuring that suicide prevention data are included in monitoring and evaluation processes

Map available resources

It is essential to map available resources for suicide prevention and response within the community as early as possible. Engage community members and leaders, as well as existing coordination mechanisms such as sector specific clusters and technical working groups, to find out what is available and to establish the safety of those referral sources. It is illegal to attempt suicide in some countries, so alternatives to contacting the police must be identified. In other contexts, health care providers may not be adequately trained to work with those facing suicidality and may need additional support and training to safely provide assistance. A rapid assessment of inpatient psychiatric services should be conducted early on to avoid referring to centres with serious quality or rights concerns.

Examples of resources to map include:

- Primary health care services
- Mental health care services
- Social services
- Accessible services for persons with disabilities

- Child protection, SGBV and case management services
- Community-based health and social care workers
- First line responders and emergency workers such as police, ambulance services, and emergency medical teams
- Faith leaders and non-secular community leaders
- Traditional and local healers
- Crisis lines, including specific crisis helplines
- Peer support networks

In contexts where available resources are limited or do not exist, advocating for resource allocation towards suicide prevention and awareness-raising may be a crucial component of the response.

Ensure safe and functioning referral pathways

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, virtually if necessary, with local and national officials, crisis coordinators, technical working groups (MHPSS, education, protection, health) and agreeing ways of working, including standard operating procedures.

Referral pathways should include the following:

- Basic needs: food, shelter, cash assistance
- Health care
- Social and social welfare services
- Protection services
- Emergency services

Depending on the current operating context, it may be necessary to ensure that these referral pathways are available remotely, and that there are back up plans for safe, in-person supports in case of emergency. Special considerations should be made to find services that are accessible to those with disabilities.

Where there are no available external referral options, map internal resources and ensure they are maximised to respond. Where possible, allocate resources towards improving suicide prevention efforts in the community in order to strengthen the system.

Train staff and volunteers to respond

Staff and volunteers should be trained to identify and respond to those who may have suicidal or self-harm thoughts or behaviours.

All frontline workers should be trained in [Psychological First Aid](#) and [Remote Psychological First Aid](#).

They should know how to identify someone who is at risk and know how to respond. It is imperative that staff and volunteers who encounter someone who is at risk have clear guidance on what to do, including the following:

- Never leave a person alone if they have expressed that they are at risk. If you are on the phone or working remotely with the person, try to get emergency backup numbers for people in their lives who they trust and feel safe with, if at all possible, as well as information on their current location. If the person is at home, invite someone from the household to support the person, if it is safe to do so.
- Have the individual remove anything that could be used to harm themselves. Ask carers to help with this, if possible.
- If you are meeting someone in person and you think they may be at risk of harm, make the space as safe and secure as possible. This may mean finding a quiet, calm place to speak, removing anything dangerous, or perhaps moving away from a room on an upper level of a building or from one with the windows open. Ensure that both the volunteer and the individual at risk are safe and protected from infection by using PPE.
- Use stabilisation, calming techniques and basic helping skills to help keep the individual calm and to reduce distress.
- Always contact your supervisor when responding to someone at risk.
- Have updated information about safe and available resources and referrals at hand.

Training for all those involved directly in suicide prevention should include the following:

- Policies and procedures relevant to harm prevention, including emergency protocols
- Background on relevant contextual factors
- Psychological First Aid
- Remote Psychological First Aid during COVID-19
- Psychoeducation on definitions of suicide, risk and protective factors, warning signs, stigma, coping, de-escalation and stress management
- Protocol for working with children
- Gender inclusive suicide prevention approaches
- Basic helping, problem solving and communication skills
- Key questions to ask and how to ask them
- How to identify risk
- Increasing social supports
- Safety planning
- Making safe referrals
- Follow up
- Engaging with supervision in response
- Self-care

Training should use role play to build the confidence of those responding to people who are at risk of harm. Links to training materials and additional information on training topics can be found in the Further resources section.

Promote staff and volunteer well-being

An important component of staff and volunteer well-being is ensuring that safe and quality suicide prevention measures are in place prior to any incident. Staff and volunteers who feel confident and comfortable in how to manage a crisis situation will feel less stress and anxiety. Due to the difficult nature of responding to those who are at risk, it is important to include the following in all suicide prevention activities:

- Continuous access to supervision facilitated by appropriately qualified staff
- Regular check ins and post-session follow up
- Access to peer support
- Referral options for additional support

Suicide prevention for staff and volunteers

Preparedness ensures the safety and well-being of staff and volunteers working with those at risk of suicide or self-harm. It is therefore vital to develop clear, detailed plans indicating how staff and volunteers should respond to high-risk situations, as this will go a long way in helping to prevent unnecessary stress and anxiety for staff and volunteers.

Volunteer should be trained in basic helping and communication skills; in how to identify those who are at risk; in what to do if an emergency occurs; and in how to link affected persons to supports and resources. Volunteers should always have access to someone who has been trained to assess risk, offer psychosocial support, and do safety planning.

Staff and volunteer care

COVID-19 inevitably impacts everyone in some way, both staff and volunteers. They may, for example, have family members or loved ones who have been sick or have died. They may have felt afraid and anxious or may have experienced financial losses as a result of the pandemic. They may have children who are at home because of school closures, adding additional responsibilities and strain on family life. However, many will gain a positive sense of purpose through their work. A study on suicide prevention for local volunteers and relief workers in disaster-affected areas found that meaningful engagement in disaster relief efforts had a positive impact on mental health.

Care is needed, as overwork and interference with personal life may be harmful and associated with suicidal ideation. Discretion is needed in managing a local workforce, particularly with long work hours making it difficult to maintain a healthy work-life

balance. Providing information on supportive practices such as resources about stress and coping during COVID-19, and ensuring that staff and volunteers have appropriate working hours, regular supportive supervision and access to medical and mental health services for themselves are all essential strategies in maintaining well-being.

Supervision

Supportive supervision for volunteers is important for safe and successful MHPSS interventions in general. However, it is absolutely essential for staff and volunteers working with those who are at risk.¹⁷

Many staff and volunteers will feel anxious or nervous about working with those who may wish to harm themselves. Even though they may feel they understand how to deal with the situation having been trained to respond, they are still likely to feel apprehensive and benefit from additional support.

Key functions of supervision in suicide prevention:

- **Harm reduction**

Having a supervisor available for consultation while staff and volunteers are working with those who are at risk is an instrumental component of reducing the risk of causing harm. Supervisors, whether on site or remotely, can be available to join sessions with those at risk with their permission, or be available for phone consultation in real time. This ensures that the supervisee is equipped with tools and resources needed to determine the safest and best course of action for the individual at risk.

The supervision process itself also reduces the risk of helpers causing harm to those they are supporting. It provides a space for supervisors to observe those they are supervising in role play and to engage them in discussion. This may indicate areas that need further development.

- **Continuous skill development**

During supervision sessions, as a group or individually, it is possible to build the confidence and comfort level of supervisees in completing interventions such as risk assessment and safety planning and build their capacity to identify risk through the use of role plays. It is also helpful to work with volunteers to role play how to follow up with individuals who may have attempted suicide and survived. This will offer the opportunity to build upon the skills learned in training and troubleshoot with supervisees things that may be unclear or that need more support.

- **Support**

Supervision allows space for staff and volunteers to receive emotional support from their peers and their supervisor. They are exposed to increased stress during COVID-19 in the challenging, if fulfilling, role of providing support to their communities. Supervisors may find that during these times, it will be necessary to spend additional time on staff care and well-being activities. However, it is important that supervision does not take the place of mental health services, so referral pathways should be identified for those who may need additional support.

Key considerations for supervisors:

- All supervisees should be aware of the protocol for what to do when working with someone who is suicidal or who is self-harming. Training before an incident happens is absolutely vital.
- Work with management to agree how supervisors should be reached in the event that staff and volunteers encounter someone who is at risk.
- If a supervisee is working with someone who is at risk, it is important to reach out to them to provide support. Do not wait for them to make the first contact. They will need space to debrief and process feelings around the encounter.
- Volunteers who work with persons who self-harm or are suicidal may experience feelings of guilt, loss, fear, and anxiety. Supportive supervision can help them to overcome those feelings, but more specialised support may be needed. Supervisors should advocate for supportive human resource practices that allow for time off if needed.

Essential helping and communication skills

Volunteers may find themselves in a situation where they encounter someone who is expressing that they wish to harm themselves. This is not an uncommon response when someone has experienced distressing events, financial crisis, feelings of hopelessness, guilt, and grief. It is extremely important in these circumstances that the volunteer stays calm and does not pass any judgement about the disclosure. They should seek to normalise the person's feelings and thoughts of distress (but not the intent to self-harm) and continue to use basic helping skills to engage them and connect them to the support that they need. They should seek to develop trust such that they are able to understand how best to help.

Communicate clear limits to confidentiality:

It is important that the person who is at risk understands that if the helper believes they are in imminent risk of harming themselves, staff and volunteers will need to break confidentiality to help keep them safe. Agreeing with the individual on safe and supportive people in their lives that might be able to take part in suicide prevention efforts is ideal, as well as obtaining emergency contact information of those who can provide support in case of emergency. It is also recommended to inform the person that staff and volunteers receive ongoing supervision in which their case might be discussed, and that in a situation where the individual is at risk, the supervisor may be called into the session to provide support. Not making an individual aware of the limits of confidentiality goes against legal, ethical, and professional codes of conduct in many contexts and will negatively impact trust and the relationship between the helper and individual.

Having clear scripts for staff and volunteers to follow to discuss limits to confidentiality with individuals who are seeking services supports these limits. It is vital that protocols governing confidentiality take account of the specific laws and guidelines relating to social and protection services in each context. Special considerations should be made for anyone under 18.

Respect service users:

Staff and volunteers should genuinely want to help individuals, regardless of their background. They should ensure that they never discriminate against any individual seeking services, or pass judgement on their beliefs, even when they are different from their own. Even challenging service users should be treated respectfully and with an unconditional positive regard.

Exploring the beliefs of staff and volunteers and identifying where there may be misinformation around suicide should be done to reduce stigma among staff and volunteers. Supportive supervision can play a key role in exploring areas in which staff and volunteers might have biases or difficulties working with particular groups of people.

Basic helping skills:

Staff and volunteers should be empathetic, communicate concern, and use active listening skills such as reflecting and paraphrasing. They must be comfortable using open-ended questions, validation, and have non-verbal communication skills, such as open body language and appropriate eye contact. It should be noted that validation in this context does not mean validating suicidal or self-harming behaviours and thoughts, rather validating the difficult life circumstances that are causing distress. Being able to genuinely communicate empathy builds trust and makes it safe to disclose details around suicidality. Basic helping skills usually state that helpers should avoid giving direct advice. However, for suicide prevention, advice is given to keep a person safe.

Verbal communication:

Communication should always convey non-judgement, patience, and empathy. This is particularly important during the COVID-19 response when many interventions are taking place remotely. Helpers should speak slowly and clearly, demonstrating that they are focused on the affected person. They should ensure that their tone of voice is calm and empathetic. Even when they may be struggling to manage difficult reactions and emotions, helpers should do their best to communicate in a caring and calm way.

Ability to manage reactions:

Working with people who are at risk is challenging, even for the most experienced helpers. Being able to use calming and self-regulation techniques during a crisis situation is crucial when working with those who are suicidal. Managing emotions such as shock, surprise, anger, frustration, anxiety, and impatience is vital in creating a safe and supportive environment for the individual seeking support. Supervision is an important place where staff and volunteers can explore some of the emotions that might come up for them when working with those who are at risk and provide opportunity for them to learn coping and self-regulation strategies.

CASE STUDY: ESSENTIAL HELPING AND COMMUNICATIONS SKILLS

Heba volunteers at her local branch. She works on a hotline for people calling in about COVID-19 supports. So many people in her community needed emotional support that she decided to help out. She took a one-year psychology course at the university and she has had training on PFA and lay counselling, and a recent training on how to respond to callers who are at risk.

One evening a young woman called the hotline. She was very upset, and she said that she was thinking about harming herself. Heba first paraphrased what the woman had told her, *'I understand that you are feeling very overwhelmed right now because you and your husband have both lost your jobs and you don't know how you are going to feed your children. You said that you are feeling so overwhelmed that you are thinking about maybe taking your own life.'*

Heba allowed the woman to continue to talk. The woman said she was scared to tell Heba because in her culture, suicide was not allowed, and many people will think less of you and your family. Heba listened with empathy and told the caller that she understood her concerns, and that she was not there to judge. Heba told the woman that it is ok to be feeling the way that she was feeling. She told the woman that she was glad that she had reached out, and that she was there to try to help.

The woman continued to talk, confirming that she was thinking of taking her own life. Heba continued to listen. She made 'mm-hmm' sounds so that the woman knew that she was still engaged. Heba was starting to feel very nervous because this was the first time that a caller had ever said that they were suicidal. She took a few deep breaths like she was taught in her training so that she could stay calm, and she sent a message to her supervisor informing him that she had a suicidal caller. She made sure that she did this in a way so that the caller would not think that she was not listening to her.

When she could, Heba told the woman, *"Thank you very much for sharing with me how you are feeling." I can hear that you are feeling very afraid of what will happen to you and your family in the future, and that you are wondering if maybe it would be better if you were no longer here. I wonder if it would be ok if I asked you a few questions so that I can understand how best to support you? Before I do though, I want to let you know that because you are thinking of suicide, I cannot guarantee that everything you tell me will stay confidential. This is because the most important thing for me is your safety. This means that if I am concerned you are in immediate risk of hurting yourself, it may be necessary for me to call the emergency services. I would also like to include my supervisor in this conversation, if that is ok with you. He is very good at providing support during situations like this, so I think that he could also be a big help. Would it be ok if I called him onto the line?'*

After getting the woman's consent to continue, Heba, whose supervisor had confirmed that he had received her message and would be available to help, then called her supervisor onto the line. Heba's supervisor introduced himself and let Heba and the caller know that he would let them continue to speak but would be there just in case any additional support was needed. Heba continued her conversation and did a risk assessment with the woman. When it was determined that the caller was not at immediate risk, Heba and the woman completed a safety plan together. The woman agreed to share the plan with her husband who would help her to ensure their apartment was safe. Heba then gave the woman information on other support, including a psychologist who offers remote sessions and a caseworker who assists families with financial difficulties.

Before ending the call, Heba asked the woman if it would be ok if she called her the next day to check in on her, and the woman agreed. After the call, Heba and her supervisor discussed the call and next steps together.

CREATING AND ENGAGING IN SUPPORT NETWORKS

During COVID-19, strengthening social supports is more important than ever. Leading theories of suicide emphasise the key role that social connections play in suicide prevention. Therefore, from a suicide prevention perspective, it is concerning that the most critical public health strategy for the COVID-19 crisis is coined as social distancing rather than physical distancing. In addition to using technology to reach out and be in touch with others, COVID-19 presents a unique opportunity to find creative solutions to keep individuals connected to their formal and informal support networks.

Within each culture and community, and for everyone, social supports can mean very different things. When working with those at risk, it is important to create space to talk about what support looks like to them. Explore if the individual feels an increased sense of loneliness and isolation because of the COVID-19 pandemic and the associated guidance on distancing and self-isolation. Understanding what support looked like prior to COVID-19 compared to their present circumstances may help the individual to feel understood and supported. Being an empathetic listener is key to understanding and helping them to create a personalised plan for engaging socially. In this way, staff and volunteers can encourage individuals to connect with others and identify different support mechanisms.

Psychoeducation:

- It is helpful to discuss why social supports are good for the well-being of human beings. When facing adversity, people tend to cope better when they are connected to social supports. Help the individual know that it is normal to sometimes not have the energy or motivation to connect with others, especially when they are feeling down. They may have already mentioned people who are in their life that can be considered social supports. Social supports will mean different things to different people. It can be calling a trusted friend and talking about a problem or joining an online knitting group. There is no correct way to engage in social supports so long as it is safe and found to be helpful.
- Sometimes, it can be difficult to engage in social supports. Some people may feel anxious about reaching out to others or they may not have the energy. It is ok to take small steps to begin to slowly (re)incorporate or strengthen social supports.
- For those who are at risk, it can be very helpful to engage a family member or trusted friend in safety planning and managing risk. Asking if there is anyone who they are comfortable bringing in to the conversation can be very helpful.

Sample questions to explore social supports:

- *Can you think of a time when you were supported?*
- *How did it feel to have that support? Are those people/that group still around? Are there ways for you to connect with them?*
- *Are there any types of supports you have found to be helpful in the past that maybe were not people? This could be activities or places you went to that helped you to feel calm and connected.*
- *What might stop you from reaching out to supportive people or things? How might you overcome these barriers?*

Identification of those who are at risk

A person may be at risk of suicide due to a combination of genetic, psychological, social, and cultural risk factors, together with experiences of trauma and loss. While the link between suicide and mental disorders in particular, depression and alcohol use disorders is well established in high-income countries, many suicides happen impulsively in moments of crisis. This may happen when a person is unable to deal with life stresses, such as financial problems, relationship break-up or chronic pain and illness. In addition, experiencing conflict, disaster, violence, abuse i.e. stressful life events, or loss and a sense of isolation are strongly associated with suicidal behaviour.¹⁸ Other contributory factors include availability of alcohol and drug abuse, access to psychiatric treatment, attitudes to suicide, help-seeking behaviour, physical illness, availability of means e.g. firearms, pesticide, and marital status.¹⁹

To understand someone’s risk for self-harm and suicide, it is important to take account of as many aspects of the person as possible, including the warning signs that may be evident of risk of harm; the risk factors operating for that individual; and the protective factors that provide positive elements in the person’s life. This can be accomplished by staying calm and seeking to build a relationship with the individual in the response.



Protective factors are characteristics and factors that make an individual less likely to consider or attempt suicide. They vary between individuals and cultures. It is important for helpers to identify together with the individuals they are supporting the protective factors which contribute to keeping them safe.

Risk factors are characteristics and factors that can increase the likelihood that someone might attempt suicide. They also vary between individuals and cultures and contexts. As part of preparedness efforts, it is therefore important to discuss with community members what risk factors might be relevant in the specific context, and if a local or national evaluation of risk factors has been conducted to understand which groups might be more vulnerable.

Warning signs are immediate actions or behaviours that put people at immediate risk of self-harm or suicide.

On an individual level, a previous history of suicide attempts is the greatest risk factor for self-harm or suicide.

Risk factors	Protective factors
<ul style="list-style-type: none"> • Previous suicide attempts • Having a family history of suicide • Being exposed to or influenced by others who have died by suicide • Psychiatric conditions • History of abuse and neglect • Lack of social support and increasing isolation • High levels of shame, humiliation • Hopelessness • Job and financial losses • Relational or social losses • Access to lethal means such as pesticides, knife, guns, poison, or fire • Major physical illnesses, especially with chronic pain • Impulsivity • Alcohol and/or substance abuse • Chronic stress • Moral injury • Stigma associated with help seeking • Barriers to access health care • Exposure to suicidal behaviours, including in the media • Local clusters of suicide in a community • Being a member of the LGTBQI community • Belonging to an ethnic minority 	<ul style="list-style-type: none"> • Social supports leading to a sense of belonging • Sense of responsibility towards family • Having a variety of coping skills • Possessing problem-solving skills • Having conflict resolution skills • Religious faith or cultural beliefs that discourage suicide • Activities that give a sense of meaning to life • Positive self-image • Help seeking behaviour • Access to good quality mental and physical health care, including substance use support • Support from ongoing psychosocial support • Employment • Balanced physical health

Risk factors for youth	Protective factors for youth
<ul style="list-style-type: none"> • Previous suicide attempts • Family history of suicide • Local clusters of suicide in a community • Access to lethal means such as pesticides, knife, guns, poison, fire • Psychiatric condition • History of abuse • Survivor of incest • Bullying • Witnessing or experiencing violence, including sexual and emotional abuse • Loss • Feelings of shame, hopelessness, humiliation 	<ul style="list-style-type: none"> • Supportive caregiver • Family supports • Peer supports and sense of connectedness • Positive adult relationships (example with educators) • Positive self-image • Access to good quality mental and physical health care, including substance use support • Support from ongoing psychosocial care • Coping and problem-solving skills • Involved in activities that bring a sense of meaning and belonging

Risk factors

Risk factors may be present at the individual, community or societal level. Risk factors indicate that a person is more vulnerable to suicide and self-harm, but do not necessarily mean that the person is in immediate danger of self-harm.

By far the strongest risk factor for suicide is a previous suicide attempt. It is estimated that around 20% of suicides across the globe are due to pesticide self-poisoning, most of which occur in rural agricultural areas in low- and middle-income countries.²⁰ Other common methods of suicide are hanging and firearms.

The majority of suicides and suicide attempts occur in low- and middle-income countries, where treatment options might be limited. Men are more likely to die by suicide than women worldwide. Suicide rates are also high amongst vulnerable groups who experience discrimination, such as refugees and migrants; indigenous peoples; lesbian, gay, bisexual, transgender, questioning (or queer), intersex (LGBTQI) persons; and prisoners.²¹ After resettlement to high-income countries, refugee populations show higher prevalence of suicidal behaviours compared to non-refugee populations.²² Other at-risk populations include immigrants, young pregnant women, and military personnel.

Protective factors

Protective factors, like risk factors, may also be present at many levels: individual, relationship, community and societal. Protective factors can give people hope, add meaning to their lives, and give them a reason to live. For example, within communities being part of faith-based groups and having cultural ties may be important sources of support. At the societal level, having access to mental health service that are safe and can provide supportive care can serve as a protective factor.

Each individual has a unique combination of protective factors operating in their life. It is vital that volunteers explore which protective factors are important in the lives of the individuals they are supporting. Sometimes, what may be a protective factor to one

person may actually be a risk factor for another, such as family. Taking time to do this will enable helpers to better understand how to support those individuals. This then helps to determine how to decrease their risk of self-harm or suicide, and explore how best to intervene. The process of identifying protective factors with an individual may also be helpful in reducing their feelings of helplessness and hopelessness.

GENDER AND SUICIDE

While females attempt suicide more frequently than males, loss of life from suicide is around three times higher in males. This could be because males are less likely to seek help and often are not socialised to talk about their emotions. Men typically use more lethal means. It is vital to raise awareness about this and target outreach activities to men within communities and develop gender-sensitive activities in the suicide prevention efforts.

Warning signs

In adults

There are certain warning signs that may indicate that a person is thinking about or planning suicide. These include:

- Lack of concern about personal welfare
- Disengagement from work, other activities and people
- Putting personal matters in order, such as giving away personal effects, getting financial affairs in order
- Calling or visiting people to say goodbye
- Interest in themes of death and violence
- Increased impulsivity or saying things such as “Everyone would be better off without me” or “It would be better if I were dead”
- Strong feelings of hopelessness
- A sudden change from being very depressed to being calm and happy

In youth:²³

There are certain warning signs that may indicate that a young person is thinking about or planning suicide. These include:

- Changes in sleeping and eating habits
- Loss of interest in activities that they previously enjoyed such as sport or art
- Isolating themselves or withdrawing from family and friends
- Headaches, stomach aches, and other physical symptoms that cannot otherwise be explained by a medical condition
- Refusing to go to school or beginning to do poorly in school
- Talking about death often, asking questions about death
- Researching or looking up ways to die
- Drawing pictures or writing stories, plays or doing other artwork about death or suicide.

- Saying things like “I wish I was dead”, or “It would be better if I wasn’t here”
- Hopelessness
- Giving away their favourite things
- Changes in their behaviour such as going from being quiet to being aggressive

Many of these warning signs can be difficult to differentiate from changes caused by COVID-19, particularly during periods of lockdown. However, it is important for helpers to keep them in mind in relation to the individuals they are supporting, within the ongoing context.

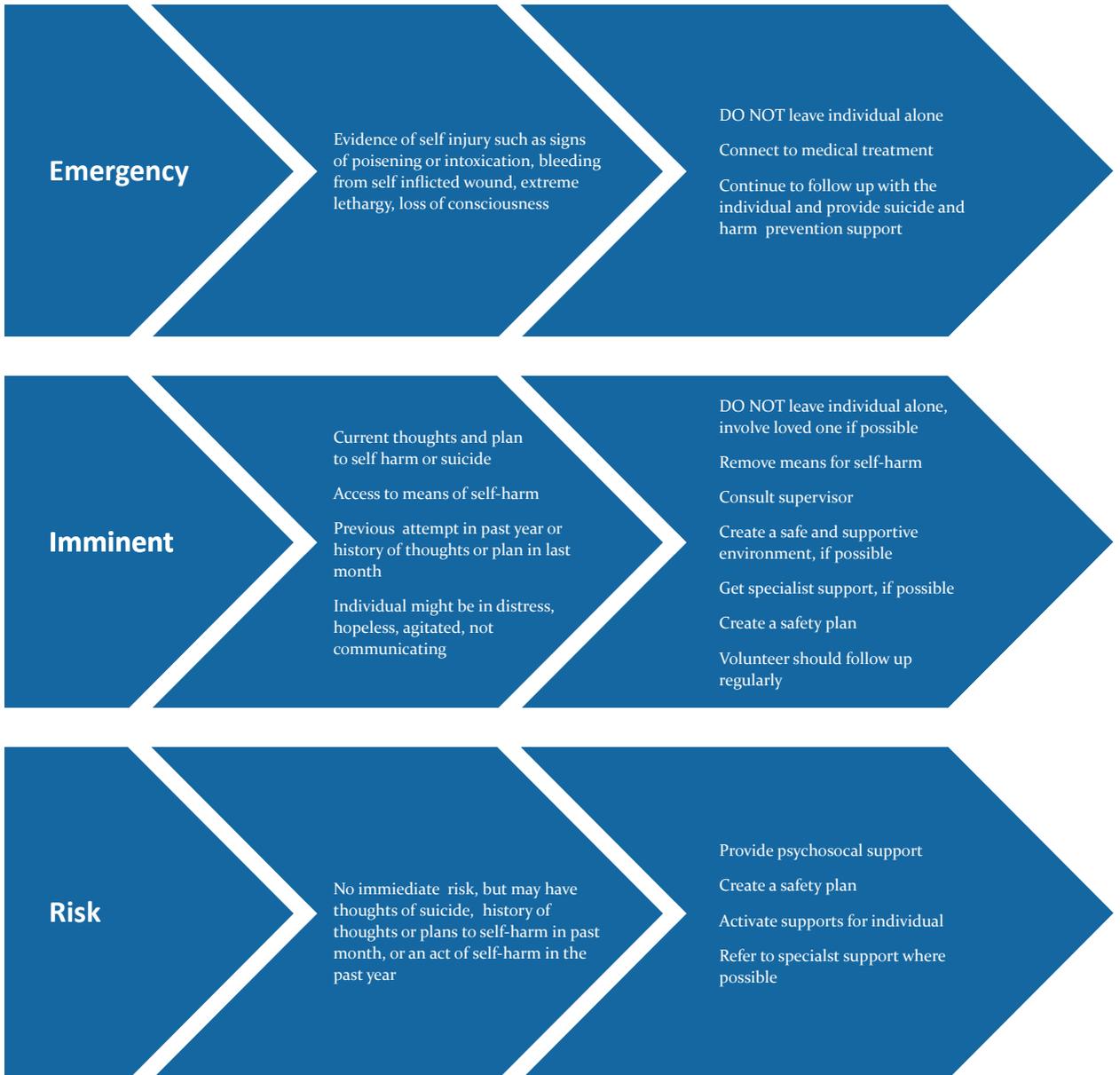
Identifying warning signs for self-harm or suicide in young persons can be challenging too. For example, aspects of ‘normal’ developmental behaviour in young people include being dramatic or impulsive and it can be complicated to see if these behaviours indicate a heightened level of risk of self-harm or suicide. Helpers must always explore how those they are supporting are feeling and seek to understand the extent of their sense of hopelessness. If suicidal feelings are expressed in any way, even if temporarily, they should always be taken seriously, as they may be acted on impulsively.

COMMON PRESENTATIONS OF THOSE WHO ARE SUICIDAL OR SELF-HARMING

Individuals may present themselves in very different ways when they are in despair and at risk of self-harm or suicide. One person may never mention their intent to harm themselves and may appear calm, despite how they are feeling inside. Another person may be shouting about wanting to kill themselves. There are a variety of ways that individuals may present themselves including:

- visibly distressed
- apathetic
- calm
- depressed
- anxious
- affected by alcohol or drug use
- erratic
- angry

Responding to those who are at risk



Imminent risk and emergency situations

Staff and volunteers may be faced with a situation in which an individual is in need of emergency support. Signs of an emergency situation include individuals who may have physical signs of poisoning or intoxication, bleeding from self-inflicted wounds, and extreme lethargy. It is essential to contact emergency services to medically stabilise the individual in order to keep them safe. However, the availability of appropriate resources to respond may vary from context to context. In some situations, it may not be possible to

refer individuals to services that are safe and appropriate to the need. Circumstances may have been made even worse by the demands on medical services because of COVID-19, leading to increased difficulties in accessing mental health services. National Societies should have a plan in place when referral of those at imminent risk is not possible. This should include guidance for staff and volunteers, outlining a protocol for emergency situations.

Staff and volunteers will be under great strain when responding to imminent risk. Supervisors and managers should do everything they can to provide supportive supervision, promoting positive mental health and coping strategies to manage stress. They should be ready to explore options for other support with staff or volunteers, if needed.

IN EMERGENCY AND IMMINENT RISK SITUATIONS:

- DO NOT leave the individual alone
- Call emergency services if medical attention is needed
- Remove any means of self-harm
- Bring the individual to a safe, supportive environment, if possible
- Include trusted supports of the individual (such as a friend or family member) if possible
- Consult with and involve the supervisor or a MHPSS specialist as soon as possible during the situation

Responding to suicide and self-harm: for trained responders

! Self-harm and suicide prevention strategies such as doing a thorough risk assessment and safety planning should only be done by those who have had specific training on these topics and have access to supervision for their work. Individuals with this level of training should always be accessible in MHPSS programming. Responders must always have a supervisor available if they are volunteering on suicide prevention specific initiatives.

Completing a risk assessment

If someone discloses that they are thinking of harming themselves, or it is observed that the person is expressing thoughts or ideas that lead to concerns for their safety, it is important to complete a risk assessment. Doing so will help identify the next steps. As indicated above, it is crucial that this is only done by someone who has been trained in conducting a risk assessment.

Assessing risk is an essential step to help ensure that the individual is safe and provided with resources for support. The process of risk assessment includes taking careful account of how the person is presenting themselves, as well as how they verbally respond to questions. Creating a warm and trusting environment is fundamental to establishing an open and honest dialogue, where the helper can see and listen to the person and respond

without judgment and with empathy.

The process should therefore not be a ‘yes’ or ‘no’ exercise to determine if someone is at risk. Many people who die by suicide may actually appear to be ‘low risk.’²⁴ Taking account of body language, tone of voice, feelings expressed are vital in speaking with someone who might be at risk. Changes in body language (depending on cultural norms in different contexts) that may indicate distress include lack of eye contact, excessive fidgeting and nervousness, body posture. Determining protective factors is also key for understanding risk.

A sample script for assessing risk is included below. It is extremely important to adapt all the questions to the specific context or culture and age of the person being assessed. It should be noted, however, that by directly asking someone if they are thinking of self-harm or suicide will not be ‘putting the idea into their head,’ or put them at risk. Often, the person disclosing the information can feel relief by talking about their thoughts.

Supervisors and managers may want to work with volunteers and staff to explore different ways of managing their stress if they are working with a suicidal person. Some of these techniques might include breathing exercises and grounding activities.

- ! A person must always be medically stabilised before beginning a risk assessment. For example, if someone has harmed themselves or has a serious medical condition, medical attention is a priority.

SAMPLE RISK ASSESSMENT SCRIPT

Sample sentences and probing questions for volunteers are shown in italics.

Begin by reviewing with the affected person how confidentiality is observed and explain how there are limits in relation to persons at risk of self-harm or suicide. This should always be done at the start of any helping relationship. When assessing risk of self-harm and suicide, it is important to review these limits. Failure to do so can negatively impact relationship between the volunteer and the affected person.

Then begin the risk assessment by saying:

It sounds as though you have been going through a difficult time. I am concerned about you. I'm wondering if I could ask you a few questions to help me understand how best to support you. Often when people are feeling like you are (insert what person has disclosed to you: hopeless, sad, angry), they might think about hurting themselves. These questions will help me to better understand what you are going through.

Sample questions (choose the questions that are most appropriate to the situation):

- *Have you had thoughts of killing yourself?*
- *Do you think about dying or sometimes wish that you were dead?*
- *I have heard you say things such as “It would be better if I were gone”. I am wondering if you sometimes think about hurting yourself? Or have you ever thought about it in the past?*
- *Have you ever tried to harm yourself in the past?*
- *Have you ever felt like you were no longer in control?*

SAMPLE RISK ASSESSMENT SCRIPT CONTINUED

If the person says ‘no’ and the person does not appear to be at risk, discontinue the assessment. If the person says ‘no’, but they have expressed feelings of hopelessness, being alone, isolated and have few supports, continue with the assessment. It is important for staff and volunteers to trust their intuition.

If the person says ‘yes’, or if the responses do not match observations of the person, as described above, continue with the assessment.

If ‘yes’, ask:

- *It is common for people who are in situations like yours. (Use concrete examples if they have already mentioned some – they may have said they feel hopeless, for example). Can you tell me more about these thoughts or feelings?*
- *Can you tell me more about what happened in the past? What happened when you felt like you were no longer in control?*
- *What did you do in that situation? What stopped you in the past?*

Gently ask additional questions to understand if the individual has a plan to take their own life. Stay calm, do not pass judgement, and assure the person that it is ok to be feeling the way that they are feeling. Remember that by asking these questions, the person is not made more likely to harm themselves. If possible, map or discuss protective factors and possible supports when exploring what has prevented them from taking action in the past.

Ask:

- Can you tell me about how you would hurt yourself, or take your own life?
- What would you use? Do you have access to that now, or a way of getting it?
- When would you do it?
- Where would you do it?

If someone reports they have thoughts about harming themselves or ending their life by suicide, but has not thought specifically how they would do so, the volunteer should work with the individual to create a safety plan. This includes exploring protective factors and connecting the individual to their supports.

If the individual expresses that they have the intention to harm themselves, a plan, a means, and/or have attempted suicide in the past, helpers should liaise directly with their supervisors and refer to a mental health professional or emergency services if needed. Keeping in mind, different contexts will have different laws, protocols, and resources to manage suicidal and high-risk individuals. It is important to be aware of these laws and guidelines and that volunteers and staff are trained on how to respond in their specific context.

Persons considered to be in danger of harming themselves or of suicidal behaviours are not be left alone at any point. If providing support remotely, stay on the line with

SAMPLE RISK ASSESSMENT SCRIPT CONTINUED

the individual and see if there is someone else in the household that can be brought into the conversation.

Helpers must contact their supervisors for additional guidance and to confirm a plan of action. If working remotely, it is very helpful to have a second means of communicating so that the individual can stay on one line and contact to the supervisor goes through another platform.

A safety plan should be completed, depending on level of risk, and most importantly, with follow up with the person.

Say:

I really appreciate you being open and honest with me. I can imagine that it is not always easy to talk about these things. It is very important that you do not harm yourself, and that you are safe. Would it be ok if we came up with a plan together to help keep you from harming yourself?

I think that it would also be helpful if I contacted my supervisor in order to get additional support. They are trained to help in situations where people are feeling that they might hurt themselves. Would it be ok if I asked them to join our talk?

Is there anyone in your house we could ask to join us? Or maybe a friend or someone you trust that we could have with us today?

After completing the necessary steps to ensure the individuals safety, follow up with the individual within 24 hours.

Say:

I will follow up with you tomorrow to see how you are feeling and to check in on how our plan is going.

Safety planning

Personalised safety plans have been shown to help reduce suicidal thoughts and actions, including with displaced populations.²⁵ The purpose of a safety plan is to identify warning signs and coping strategies for when a person is thinking about suicide. Together with the helper, the person in question identifies coping strategies, social supports, ways of making their environment safe and resources for who to reach out to in case of crisis or emergency. The helper can also work with the person and their caregiver or trusted support person, if available and appropriate, to identify ways of limiting access to the means of harm such as pesticides, firearms and pills.

A sample safety plan is shown below. Safety plans should be personalised and adapted to fit the context. Helpers 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. They should also have blank copies of the safety planning form in case individuals wish to update their plan, as needed.

Who benefits from making a safety plan? Safety planning is appropriate for individuals who are not at imminent risk of harming themselves, but NOT for anyone who needs an immediate referral or emergency action to be taken. It is also appropriate for individuals who may have a history of suicidal behaviour or current or recent thoughts of suicide. It is also relevant for persons who were previously at imminent risk but may be back to seek support.

How should safety planning be done? Safety planning should be done collaboratively between the helper and the individual who is at risk together with a supportive caregiver or trusted person that the individual chooses to include. To be effective, the safety plan must be meaningful to the individual. If the individual is under 18 years of age, a parent or caregiver should be involved in the safety planning unless there is risk that could come from their involvement. The caregiver or trusted person should not provide information and responses on behalf of the individual at risk, as the strategies chosen to help keep them safe must be meaningful to the individual. Caregivers and trusted supports can help explore options with the individual, but the individual who is at risk should feel that they have control over their choices.

Explain the purpose of the safety plan. The process of safety planning should be as conversational as possible, to allow the individual to explore past experiences to gain insight into their triggers and ways of coping. Be patient, empathetic, encouraging, and use basic helping skills to promote open communication. Invite the individual to read the prompt questions and give time for them to write down their responses, if at all possible. If not, helpers may assist in recording the individual's responses.

During COVID-19, safety planning may be done in person if circumstances allow or if not, it can be done remotely. It should take between 30 to 40 minutes to complete.

Personalised sample safety plan

To be completed together by the staff or volunteer and the individual.

This safety plan is to help you think about how to stay safe and what to do when you feel at risk of harming yourself.

- 1. What types of thoughts, situations and feelings make me feel suicidal or make me feel like hurting myself?**

- 2. What activities help me to feel calm or positive when I am upset?**

a. _____ b. _____ c. _____

- 3. What are my reasons for living? / What or who would stop me from hurting myself?**

- 4. Who can I talk to when I am feeling upset? (name more than one person in case the first person is not available)**

1) Name: _____ Phone number: _____

2) Name: _____ Phone number: _____

3) Name: _____ Phone number: _____

- 5. What can I do when I am not feeling safe?**

Change I can make in the environment (ex. removing lethal means):

Place I can go: _____

Professional I can call: _____

Hotline I can call: _____

If you are in danger of hurting yourself or fear for your safety, call your emergency response or go to the nearest hospital:

Emergency number: _____

Closest hospital (address and phone number): _____

Psychoeducation for family and friends of those at risk

Psychoeducation can be provided on the following topics to support friends and relatives of someone at risk of ending their life by suicide:

- Help to create a safe environment in the home of a loved one by e.g. removing lethal means, encouraging safe and supportive activities, keeping a close eye on their loved one.
- Discuss with loved ones that they are not responsible for the actions of others.
- Teach them about common warning signs of suicide and self-harm and what to do if they are concerned.
- Inform them that it is essential that they maintain their own boundaries and encourage their loved one to seek support.
- If a loved one is at imminent risk of suicide, they should call emergency services if this is possible in the current context.

Staff and volunteers should apply skills learned in Psychological First Aid training, particularly in 'linking' family members of those at risk to supports and services. It is important to have a list of services available for this support. If there are no services available in the community, it may be important to consider establishing support groups. For more information about support groups, survivor and community engagement, please see the Further resources section of this document.

Support for friends and relatives of those who are at risk or have died by suicide

Having a loved one who is suicidal or at a high risk of suicide has a significant impact on their 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.

Key considerations in providing support to friends and relatives include:

- Use active listening skills to ensure that they feel supported and heard.
- Acknowledge their feelings and that they reached out for help.
- Ensure that they are validated in knowing that there is no one right way to grieve, and everyone will respond differently.
- Explore what existing supports they have in their life.
- Refer them to support groups.
- Encourage them to engage in their own counselling or support sessions.
- Strengthen their social supports.

Be mindful that being a family member of a loved one who has died from suicide may increase someone's risk to self-harm and suicide. Also, be aware that many people in this situation may feel responsible for the safety of their loved ones, or that they have not or are not doing enough. Volunteers can play an important role in offering psychosocial support for friends and relatives during this time. Supporting bereaved family members with their grief and feelings will be an integral part to their healing.

Engaging the community when suicide occurs is important to prevent further suicides. This includes contacting the local media to ensure that family and friends are not

unnecessarily interviewed at the time of loss. It is very important that any reporting that is done is not sensationalised, as this can increase the distress of those who have been bereaved. Working with schools and other institutions is also vital in helping those affected to understand and process the loss and to know where to find additional support. This can play a key role in recovery and suicide prevention.

Additional resources on supporting friends and family members can be found in the Further resources section of this document.

SUPPORT GROUPS

Support groups for those who have been directly impacted by suicide have been found to have positive recovery outcomes. Groups like this help support members and also have an important advocacy role within the community. Establish peer run groups for members of the community who may be impacted. Peer support networks made up of survivors and those who are bereaved can play an important role in suicide prevention efforts with communities.

CASE STUDY: SUPPORTING FAMILIES

John is living in a camp. He came to the camp five years ago with his mother and his little sister. Life there is difficult. Everyone lives very close together and finding work outside of the camp is very hard. John's mother is getting older and is slowing down. She was recently diagnosed with lung cancer, and her treatment has been very hard on her. She still misses John's father, who died in the war, and has been struggling with depression ever since.

His little sister is going through a difficult time because she is to be married, but she does not want to marry the man she is engaged to. John was working in a shop, but then COVID-19 came and the city that the camp is in has gone into lockdown. The shop he was working in had to let him go. John was the only person in the family who was working, and now they are not sure how they are going to pay for his mother's medical care and for the things they need. His little sister began to look for work and found a position at a hospital as a nursing assistant. John is worried about her taking the job because it would put her at risk of getting COVID-19. He is also worried about his mother getting sick because she is vulnerable to infection because of the cancer. He feels very worried and has started to consider other ways of earning money that are not very safe, including working at the local mine where many people recently died. It hasn't officially opened again, but a group is paying to have it cleared, against the government's wishes.

His mother has become more depressed. She no longer gets out of bed and she has stopped bathing. She is upset with John for talking with the people at the mine and is worried about her daughter working at the hospital. She says that she is a burden on the family, and if it were not for her medical expenses, then John and his sister could live off the rations given at the camp. She talks about life being better for John and his sister if she were not there. John has tried to tell her that everything is going to be ok, but she seems to have lost all hope. John recently found a bottle of poison that she had hidden away near her bed. He started to feel very afraid for her life and didn't know what to do. He didn't know who to talk to about it, especially since it was not easy at all to talk to other people about suicide.

He asked one of the Red Crescent volunteers about it who told him to call a volunteer helpline to see if they had any ideas. He called and spoke to a woman who listened and was very kind. She said that it is ok to feel scared and to not know how to manage the situation, and that it was very good that he reached out. She talked to him about how to help make sure that the house was safe, and to remove the poison and anything else that his mother could use to hurt herself. She gave him the number of a counsellor that his mother could speak to and a number he could call himself so that he could get more support for himself. She also told him what he could do if he was afraid that his mother was going to try to kill herself, and what the warning signs were.

John went back home and told his mother and sister all about the conversation he had had with the woman on the helpline. He did what he could to make the house safer. His mother reluctantly agreed to call the number John gave her but only if he promised to not go work in the mines!

Annex

Impact on specific groups

Particular groups of people are likely to be at increased risk of negative mental health consequences during and after COVID-19. These groups include those experiencing financial and protection concerns, older persons, healthcare workers, children and youth, those who are quarantined, and persons with mental health and substance use conditions. At this time, because of the restrictions imposed because of the virus, it is probable that individuals at risk of self-harm and attempt suicide will have reduced levels of support. For those who are most vulnerable, this may place them at greater risk if they are cut off from their regular support networks. A mapping of those who might be more at risk of suicide or self-harm behaviours during COVID-19 should be carried out.

The IASC Interim Briefing Note on Addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak provides additional information and considerations, including interventions for older adults, people with disabilities, children, adults in isolation and quarantine.

Those with financial concerns

Economic downturns and associated rises in unemployment are followed by increases in suicide.²⁶ The extent of the economic impact during and after the pandemic is yet to be seen. Unprecedented job loss and unemployment rates are being seen across the globe. Half of the global workforce is working in the informal sector, almost 1.6 billion persons, and they are of particular concern. As job losses continue, many are at immediate risk of losing their livelihoods, having no income to secure their futures or provide basic necessities such as food for themselves and their families. Understanding how COVID-19 has impacted individual livelihoods will assist volunteers when determining risk. Connecting individuals to livelihood opportunities can play a key role in suicide prevention during this crisis.

Persons with protection concerns

Protection concerns have come to the forefront of the COVID-19 pandemic as one of the indirect consequences of measures put in place to stop the spread of the virus. Individuals who have experienced abuse and exploitation have an increased risk of suicidality.

Increased stress can potentially lead to an increase of violence within households, which can detrimentally impact the mental and physical well-being of families. Children are at risk of an increase in child abuse, neglect, and exposure to interpersonal violence in the household.²⁷ They might not be able to access the supportive services that were previously available to them in schools or within the community because of closures. In addition, there might be barriers to being able to report or respond to reports of abuse in households.

Domestic and intimate partner violence has increased because of lockdown measures. Disruptions of services and inability to leave the home means that those affected are less likely to be able to get away from perpetrators and less likely to seek help. The impact of this has been found to increase sleep problems, anxiety, and thoughts of suicide.²⁸ SGBV

survivors may face stigma because violence has been perpetrated against them which may also increase their vulnerability to self-harm and suicide. Due to pre-existing gender inequalities and harmful norms, most societies tend to blame the victim/survivor, and the social rejection often results in further emotional damage including shame, self-hate, and depression.

Individuals may also be at increased risk of sexual exploitation, trafficking or child labour due to reduced incomes in their household, increases in early or forced marriages, and adolescent pregnancies.²⁹

Additional protection concerns may arise within different settings, and it is essential to be aware of these risks. Further information and guidance on key protection considerations during COVID-19 can be found in IFRC's How to Consider Protection, Gender and Inclusion in the Response to COVID-19.

Older persons

The highest number of suicide attempts globally of any age group occurs in older persons above the age of 70. Isolation among older persons is in itself a serious public health concern, having a negative impact on mental well-being. However, during COVID-19, this group may be even more prone to isolation. This arises in relation to the general recommendation to limit contact to reduce their exposure to the virus and in relation to restrictions on visiting care homes. Self-isolation among older persons also puts them at a great risk of depression and anxiety.³⁰ Loneliness and isolation have also been strongly associated with increased substance use, all-cause mortality and depression.³¹

Feelings of isolation are no doubt exacerbated during the COVID-19 crisis, as much physical social interaction has been curtailed. Many now rely on communication via technology platforms, particularly in high-income countries. Older adults tend to be less familiar with these platforms than other members of society, a disadvantage that can be compounded by lower literacy rates in general among older adults, particularly in low-income countries.

However, many older adults may play a key role in designing and implementing psychosocial support activities for others among them other older adults. Volunteers have the benefit of being a part of communities they work with and can provide support to older adults by helping with errands, arranging for members of the community to sing or play music to help keep them connected and supported.

It is important to consider the barriers facing older adults if they wish to seek help if they are having thoughts of suicide. Raising awareness within the community about suicide prevention among older adults is a crucial step in identifying those who may be at risk. Strategies such as establishing regular times to check in with those who are at risk and promoting other ways of preventing isolation are important in keeping this group as safe as possible. Faith leaders can be of great importance too in responding to experiences of loss and grief and in offering social support and spiritual guidance.

More information about messaging and interventions to increase connection with older adults can be found in the Further resources section of this document.

Health care workers

Health care workers, the vast majority of them being female, are at higher risk of developing mental health problems during this time, and a number of suicides have been reported across the globe. A study surveying health care personnel in China found high levels of mental health symptoms among frontline health care workers caring directly for COVID-19 patients.³²

As mentioned in the introduction, indications from other public health emergencies tentatively suggest that the mental health of health care workers may deteriorate after the response. It is important to prepare for this possibility and have supports in place for health care workers as a preventative measure, such as offering regular psychosocial sessions to staff and volunteers.

FACTORS CONTRIBUTING TO PSYCHOLOGICAL DISTRESS AMONG HEALTH CARE WORKERS INCLUDE:³³

- Emotional strain and physical exhaustion when caring for growing numbers of acutely ill patients of all ages who have the potential to deteriorate rapidly
- Caring for co-workers who may become critically ill
- Grief and guilt when co-workers die from COVID-19
- Shortages of personal protective equipment (PPE) that intensify fears of coronavirus exposure at work leading to serious illness
- Concerns about infecting family members with coronavirus from workplace exposures, especially family members who are older, immunocompromised, or chronically ill
- Shortages of ventilators and other crucial medical equipment in COVID-19 hot spots that are rapidly becoming overwhelmed by critically ill patients
- Faced with ethical dilemma of who will receive care in the light of equipment shortages
- Anxiety about assuming new or unfamiliar clinical roles and expanded workloads in caring for patients with COVID-19
- Limited access to mental health services for managing depression, anxiety, and psychological distress
- Less likely to seek support when they need it
- Fear of infecting their patients in intensive care units, care homes, during home visits, and other health care facilities
- Long working hours with little time off between shifts
- Reports of health care workers being evicted by their landlords or harassed by their neighbours due to the fear of getting the virus. Where schools have reopened, children of health care workers have been harassed and bullied for bringing the virus at school.³⁴

Children and youth³⁵

Not much is known about the impact of pandemics on suicidal behaviour among youth. At present, suicide is the second leading cause of death for adolescents 15-19 years of age, which is a particular concern for this population. What is known is that youth considered to be particularly at risk of COVID-19 negatively impacting their mental health are those with pre-existing mental illness. For example, children and young people under the age of 25 who had a previously identified mental illness were surveyed in the UK. 83% said that the pandemic made it worse and 24% said that they were not able to access mental health support.³⁶ Additional evidence identified quarantine as a predictor of post-traumatic stress among children.³⁷

Children's mental health and psychosocial well-being is impacted by COVID-19. They experience anxiety, fear, depression, grief, anger, uncertainty, grief and loss.³⁸ Like adults, they too are exposed to constant media reporting and information about the pandemic that provokes fear and confusion. They are indeed perhaps more vulnerable to these feelings if they do not have a supportive caregiver to help them make sense of the events around them. Children and adolescents exposed to high levels of stress and anxiety among the adults in their lives can be negatively affected themselves too. In terms of suicide, children whose parents have died by suicide are at higher risk themselves³⁹. It is therefore very important to consider family and social factors as well as individual factors into account in responding to the needs of children and adolescents during and after the pandemic.

The impacts of COVID-19 and disruptions on daily life will no doubt have a negative impact on the psychological well-being for some children. With schools being closed in many countries, children and adolescents are cut off from normal routines, peer supports, and for some, access to meals, health care, and psychosocial supports provided in school. Education and exams have been interrupted or cancelled for some, and others might be facing uncertainties about their educational future. Youth may feel stress because of the disruptions to their learning, which may be increased in areas where technology is not available for remote learning. Some children may also be stigmatised in their school communities because they are thought to be transmitters of the virus.

Some children and adolescents may be in households where there is domestic abuse and other protection concerns, and without being able to go to school, there is no escape. Some may not be adequately cared for or may be exposed to difficult living situations. Children around the world are at risk of becoming separated from caregivers or unaccompanied because of the pandemic, of being exposed to domestic violence, forced labour, required to drop out of school to support their families, GBV, and sexual exploitation.

Children across the world will have loved ones who become ill or who may die during the pandemic. It is essential that they have an adult in their life who can help them to make sense of the information and situations that are occurring around them, to help mitigate some of the negative impacts this can have on their mental wellbeing. Children may not have the opportunity to be with their loved ones in hospital or at funerals as a result of restrictions, which can complicate the grieving process.

Suicide and harm prevention programming should be tailored to young people. This includes ensuring that volunteer response is implemented safely, taking account of the protection needs of children and youth. It is important to implement outreach activities and support services specifically for young people featuring information about COVID-19 in suitable formats.

SPECIAL CONSIDERATIONS AND KEY MESSAGES FOR WORKING WITH THOSE UNDER 18:⁴⁰

- Including parents and caregivers in conversation about harm and suicidality is an important element to ensure that children have the support they need. In some cases, a child may not have a safe caregiver in their life. Work with teachers and other members of the community to identify risks and warning signs of self-harm and suicidality and how to respond appropriately.
- Have clear protocols in place for when including a safe adult in the conversation occurs, ensure all are trained on IFRC Child Protection Policy and distribute scripts for volunteer and staff to explain confidentiality and its limits to children and their caregivers.
- There is psychological benefit to talking to children about illnesses that are life-threatening in a sensitive way.⁴¹ Talking with them about COVID-19 to gain insight into their understanding of the situation is important. Story books such as [My Hero is You](#) can help explain what is going on. Children need information about what is happening around them to be told in an honest and sensitive way. When they do not have all the information, they will try to make sense of the situation on their own, which can increase feelings of anxiety or guilt that the child might feel. Working with caregivers in the child's life to relate important information is a key role that staff, and volunteers can play to minimise distress.
- How distress and suicidality is expressed varies across different age groups and developmental stages, so it is important to train staff and volunteers to be aware of these differences and be sure not to over or under simplify information shared and conversations around self-harm and suicidality.
- Be aware that youth may be at increased risk of being stigmatised for spreading COVID-19, it is important to be aware of these possibilities and to talk with youth about what is going on.

Persons in quarantine

Quarantine is the separation and restriction of movement of people who have potentially been exposed to a contagious disease to see if they become unwell and to reduce the risk of them infecting others. It may have a long-lasting impact on mental health. A large body of evidence indicates quarantine is a predictor of post-traumatic stress among hospital staff and children.⁴² A recent systematic review summarised evidence on the psychological impact of quarantine. The authors found that persons undergoing quarantine report substantial psychological distress: emotional disturbance, depression, stress, low mood, irritability, insomnia, posttraumatic stress symptoms, anger and emotional exhaustion.⁴³ Three years after the SARS outbreak, alcohol abuse or dependency symptoms were associated with having been quarantined (among health care workers).⁴⁴ These impacts of quarantine can contribute to the level of risk for self-harm or suicide for individuals.

Identified stressors of quarantine include:

- The duration of the quarantine
- Fearing the infection
- Fear for safety and protection, particularly for those at risk of sexual violence, in quarantine centres
- Frustration or boredom
- Inadequate supplies of items such as food, toiletries, menstrual hygiene products, personal protective equipment (PPE)
- Inadequate information on the spread of COVID-19 in the locality
- Impact on finances because of job loss, financial market loss
- Stigma

Special care should be taken to ensure that those who are in quarantine are contacted regularly to check in on their well-being; that they have access to support; and that they receive timely and accurate information about COVID-19.

Persons with mental health and substance use conditions

Individuals with severe mental illness, alcohol and substance use are at a high risk of contracting COVID-19 and face a severe course of the illness. This is because they tend to have pre-existing chronic health conditions and it can be difficult for them to follow the official guidelines for hygiene, protection against infection, and physical distancing. There have been reports of the virus spreading in psychiatric hospitals causing death, with patients suffering increased isolation because of the resulting discontinuation of support activities, which has potentially had negative impacts on their mental health. Smaller social networks for those with mental health conditions may limit opportunities to obtain support from friends and family members, should individuals with serious mental illness become ill.⁴⁵ Those who might have common mental health disorders may no longer be able to access their psychosocial supports because of disruptions in service delivery if remote supports are not well established. In addition, for those feeling distressed or suicidal, they may put off seeking help because of concerns of catching the virus.

COVID-19 may severely disrupt accessibility of mental health care including access to psychotropic medication (medication to treat mental health disorders) in both high- and low-income countries. This disruption could potentially contribute to an increase in suicidal and self-harming behaviours, and for those people living with substance use conditions, discontinuation can be life threatening.

Further resources

Resource platforms

[IFRC PS Centre Resource Centre](#) has a number of resources translated into numerous languages

[The MHPSS Network](#) has numerous resources and communities of practice

[GBV Resource Centre](#) has tools and resources on GBV specific to COVID-19

COVID-19 MHPSS specific resources

[IASC Interim Briefing Note](#) Addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak

[IASC Basic Psychosocial Skills: A Guide for COVID-19 Responders](#)

[#HealthAtHome](#) campaign by WHO with information on how to stay connected and other psychosocial messages

[Mhpss.net COVID-19 Toolkit](#)

Suicide prevention resources

[WHO Preventing suicide: a global imperative](#)

[WHO Preventing suicide: how to establish a crisis line](#)

[WHO Preventing Suicide: A Community Engagement Toolkit](#) on how communities regardless of their resources can implement suicide prevention initiatives

[WHO National suicide prevention strategies: progress, examples, indicators](#)

[WHO Public Health Action for the Prevention of Suicide: A Framework](#) for information of how to establish and suicide prevention strategy at national-level.

[WHO Preventing Suicide: A Community Engagement Toolkit](#) on how communities regardless of their resources can implement suicide prevention initiatives

[WHO LIVE LIFE](#) presents a diagram (at the end of the PDF) to help guide the development of suicide prevention strategies

[WHO Preventing suicide: a resource for media professionals](#)

[General guidelines for suicide prevention](#) developed by an EU consortium of European regions

For responders

[WHO Messages on suicide for professionals](#) (e.g., physicians, prison workers, managers, counsellors, media, frontline workers, etc.) and [leaflets](#) with pictures

[WHO Instructions on how to start a crisis line](#), including information of basic helping

skills, types of training and supervision

[IASP - Crisis centres and helplines around the world](#)

Australian Red Cross initiative of [daily telephone call to older persons](#)

[WHO mhGAP Intervention Guide](#) (mhGAP-IG)

[WHO mhGAP Intervention Guide: training manuals](#)

[WHO mhGAP Intervention Guide: App](#)

[WHO and UNHCR mhGAP Humanitarian Intervention Guide](#) (mhGAP-HIG)

[A Guide to Psychological First Aid for Red Cross and Red Crescent Societies](#)

[IFRC PS Centre Lay Counselling: A Trainer's Manual](#)

[WHO messages for people with thoughts of suicide](#)

[Psychoeducation messages for persons with thoughts of suicide](#) (mhGAP, page 138).

[Ensuring Quality of Psychosocial Support - EQUIP remote](#)

Support for family and friends

[WHO Instruction on how to start a survivors' group](#)

[WHO messaging for family and friends](#)

[Help is at Hand: Support after someone may have died by suicide](#)

[Suicide support and information for bereaved family members](#)

[Alliance for Hope: for suicide loss survivors](#)

Support for older persons

[HelpAge: COVID-19 Guidance and Advice for Older People](#)

[IASC Interim Briefing Note](#) Intervention 1 Helping older persons cope with the stress

[Guidance on working with Older People](#)

Support for children

[Child Helpline International](#)

[Technical Note: Protection of Children during the Coronavirus Pandemic \(v.1\)](#) Alliance for Child Protection in Humanitarian Action.

Protection and violence prevention

[IFRC Strategy of Violence Prevention](#) (including suicide and self-harm) with some examples of Red Cross Red Crescent work

[The Alliance for Child Protection in Humanitarian Action: Technical Note: Protection of Children during the Coronavirus Pandemic v.1](#)

[IFRC's How to Consider Protection, Gender and Inclusion in the Response to COVID-19](#)

[IFRC Guidance on GBV Case Management in the Face of COVID-19 Outbreak](#)

[UNICEF Not Just on hotlines and mobile phones: GBV service provision during COVID-19 pandemic](#)

Staff and volunteer care

[IFRC PS Centre Brief Guidance Note on Caring for Volunteers during Covid-19](#)

[IFRC PS Centre Mental Health and Psychosocial Support for Staff, Volunteers and Communities in an Outbreak of Novel Coronavirus](#)

[IFRC PS Centre Guidelines for Caring for Staff and Volunteers in Crises](#)

[IFRC PS Centre Caring for Volunteers Toolkit](#)

[Key actions on caring for volunteers in COVID-19: mental health and psychosocial considerations](#)

[Volunteering with the Red Cross Red Crescent in crisis situations – disasters and pandemics](#)

[Volunteering in response to COVID-19: spontaneous volunteers](#)

[IASC Responder Training for Basic Psychosocial Care](#)

[IASC Interim Briefing Note Intervention 5 health workers and their leads](#)

[WHO stress management](#)

[WHO Doing what matters in times of stress](#)

Supervision

[IFRC PS Centre Supportive Supervision During COVID-19](#)

Endnotes

- 1 Knipe D, Williams AJ, Hannam-Swain S, Upton S, Brown K, Bandara P, & Kapur N. (2019). Psychiatric morbidity and suicidal behaviour in low- and middle-income countries: A systematic review and meta-analysis. *PLOS Medicine*, 16(10), e1002905. doi:10.1371/journal.pmed.1002905
- 2 WHO, Suicide prevention. https://www.who.int/health-topics/suicide#tab=tab_1Date accessed: March 24, 2020
- 3 Chang, Shu-Sen, David Stuckler, Paul Yip, and David Gunnell. "Impact of 2008 Global Economic Crisis on Suicide: Time Trend Study in 54 Countries." *BMJ: British Medical Journal* 347 (2013): f5239. <https://doi.org/10.1136/bmj.f5239>. <http://www.bmj.com/content/347/bmj.f5239.abstract>.
- 4 Kawohl, W. & Nordt, C. (2020). COVID-19, unemployment, and suicide. *The Lancet Psychiatry*, 7(5), 389-390. [https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366\(20\)30141-3/fulltext](https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(20)30141-3/fulltext)
- 5 COVID-19-Related Suicides in Bangladesh Due to Lockdown and Economic Factors: Case Study Evidence from Media Reports. *International Journal of Mental Health and Addiction*. DOI link: <https://doi.org/10.1007/S11469-020-00307-Y>
The Guardian, New York ER doctor who treated coronavirus patients dies by suicide. 28 April 2020. Available at <https://www.theguardian.com/us-news/2020/apr/28/dr-lorna-breen-new-york-er-coronavirus>
- 6 Cénat JM, Mukunzi JN, Noorishad P-G, Rousseau C, Derivois D, Bukaka J. (2020). A systematic review of mental health programs among populations affected by the Ebola virus disease. *Journal of Psychosomatic Research*, 131, 109966. doi:<https://doi.org/10.1016/j.jpsychores.2020.109966>
- 7 Lee AM, Wong JG, McAlonan GM, et al. (2007) Stress and psychological distress among SARS survivors 1 year after the outbreak. *Can J Psychiatry*. 52(4): 233-240. doi:10.1177/070674370705200405
- 8 Brooks SK, Webster RK, Smith LE, Woodland L, Wessely S, Greenberg N, Rubin GJ. (2020). The psychological impact of quarantine and how to reduce it: rapid review of the evidence. *The Lancet*, 395(10227), 912-920. doi:10.1016/S0140-6736(20)30460-8
- 9 Yip PS, Cheung YT, Chau PH, Law YW. (2010) The impact of epidemic outbreak: the case of severe acute respiratory syndrome (SARS) and suicide among older adults in Hong Kong. *Crisis*. 31(2): 86-92. doi:10.1027/0227-5910/a000015
- 10 Same as above
- 11 Galea S, Merchant RM, Lurie N. The Mental Health Consequences of COVID-19 and Physical Distancing: The Need for Prevention and Early Intervention. *JAMA Intern Med*. Published online April 10, 2020. doi:10.1001/jamainternmed.2020.1562
- 12 Same as above
- 13 Nielsen, E., Padmanathan, P., & Knipe, D. (2016). Commit* to change? A call to end the publication of the phrase 'commit* suicide'. *Wellcome open research*, 1, 21. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5341764/>
- 14 Padmanathan P, Biddle L, Hall K, Scowcroft E, Nielsen E, Knipe D. (2019) Language use and suicide: An online cross-sectional survey. *PLoS ONE* 14(6): e0217473. <https://doi.org/10.1371/journal.pone.0217473> Retrieved from: <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0217473>
- 15 WHO, COVID-19 and the Need for Action on Mental Health. Available at https://www.un.org/sites/un2.un.org/files/un_policy_brief-covid_and_mental_health_final.pdf
- 16 Gunnell, D., Appleby, L., Arensman, E., Hawton, K., John, A., Kapur, N., . . . Yip, P. S. F. (2020). Suicide risk and prevention during the COVID-19 pandemic. *The Lancet Psychiatry*. doi:[https://doi.org/10.1016/S2215-0366\(20\)30171-1](https://doi.org/10.1016/S2215-0366(20)30171-1)
- 17 For more information on how to adapt supportive supervision to COVID-19, please see IFRC PS Centre Supportive Supervision during COVID-19

- 18 World Health Organization. (2019). Fact sheets: Suicide. Retrieved from <https://www.who.int/news-room/fact-sheets/detail/suicide>
- 19 Mann JJ, Apter A, Bertolote J, Beautrais A, Currier D, Haas A, . . . Hendin H. (2005). Suicide prevention strategies: a systematic review. *Jama*, 294(16), 2064-2074. doi:10.1001/jama.294.16.2064
- 20 World Health Organization. (2019). Fact sheets: Suicide. Retrieved from <https://www.who.int/news-room/fact-sheets/detail/suicide>
- 21 Same as above
- 22 Haroz E, Decker E, Lee C, Bolton P, Spiegel P, Ventevogel P. (2020). Evidence for suicide prevention strategies with populations in displacement: a systematic review. *Intervention*, 18(1), p 37-44.
- 23 For further information on the warning signs commonly displayed by children and youths, see <https://www.psychom.net/children-and-suicide>
- 24 Large, MM, Ryan CJ, Carter G, Kapur N. (2017) Can we usefully stratify patients according to suicide risk? *BMJ*, 359: j4627
- 25 Haroz E, Decker E, Lee C, Bolton P, Spiegel P, Ventevogel P. (2020). Evidence for suicide prevention strategies with populations in displacement: a systematic review. *Intervention*
- 26 Chang, Shu-Sen, Stuckler, D. Yip, P Gunnell, D. (2013) "Impact of 2008 Global Economic Crisis on Suicide: Time Trend Study in 54 Countries." *British Medical Journal* 347: f5239. <https://doi.org/10.1136/bmj.f5239>. <http://www.bmj.com/content/347/bmj.f5239.abstract>.
- 27 Alliance for Child Protection in Humanitarian Action. Technical Note: Protection of Children during the Coronavirus Pandemic (v.1) https://alliancecpha.org/en/system/tdf/library/attachments/the_alliance_covid_19_brief_version_1.pdf?file=1&type=node&id=37184
- 28 Pertek, S. et al.(2020) 'Forced migration, SGBV and COVID-19 - Understanding the impact of COVID-19 on forced migrant survivors of SGBV'. University of Birmingham. Available at: <https://www.birmingham.ac.uk/news/latest/2020/05/migrant-sexual-violence-survivors-face-global-covid-19-threat.aspx>
- 29 IASC, Identifying & Mitigating Gender-based Violence Risks within the COVID-19 Response (6 April 2020)
- 30 Armitage R, Nellums LB. (2020). COVID-19 and the consequences of isolating the elderly. *The Lancet. Public health*, S2468-2667(2420)30061-X. doi:10.1016/S2468-2667(20)30061-X
- 31 Leigh-Hunt N, Bagguley D, Bash K, Turner V, Turnbull S, Valtorta N, Caan W. (2017). An overview of systematic reviews on the public health consequences of social isolation and loneliness. *Public Health*, 152, 157-171. doi:<https://doi.org/10.1016/j.puhe.2017.07.035>
- 32 Lai J, Ma S, Wang Y, Cai Z, Hu J, Wei N, . . . Hu S. (2020). Factors Associated With Mental Health Outcomes Among Healthcare workers Exposed to Coronavirus Disease 2019. *JAMA Network Open*, 3(3), e203976-e203976. doi:10.1001/jamanetworkopen.2020.3976. Ayanian JZ. (2020). Mental Health Needs of Healthcare workers Providing Frontline COVID-19 Care. *JAMA Health Forum*.
- 33 Informed by Ayanian, J.Z. (2020). Mental Health Needs of Healthcare workers Providing Frontline COVID-19 Care. *JAMA Health Forum*.
- 34 Yaker, R. (2020) Securing the safety and wellbeing of women frontline healthcare workers in the COVID-19 response https://gbvguidelines.org/wp/wp-content/uploads/2020/04/202003-securing-safety-and-wellbeing-of-women-frontline-healthcare-workers-covid-19_final_version.pdf
- 35 The terms 'youth' and 'young people' in the IFRC cover people in the age range of 5 to 30 years. This includes children (5 to 11 years old), youths (12 to 17years old), and young adults (18 to 30 years old).
- 36 Lee, J. "Mental Health Effects of School Closures During Covid-19," *The Lancet. Child & Youth*
- 37 Brooks SK, Webster RK, Smith LE, Woodland L, Wessely S, Greenberg N, Rubin GJ. (2020). The psychological impact of quarantine and how to reduce it: rapid review of the evidence. *The Lancet*, 395(10227), 912-920. doi:10.1016/S0140-6736(20)30460-8.
- 38 Alliance for Child Protection in Humanitarian Action. Technical Note: Protection of Children during

the Coronavirus Pandemic (v.1) https://alliancecpha.org/en/system/tdf/library/attachments/the_alliance_covid_19_brief_version_1.pdf?file=1&type=node&id=37184

- 39 John Hopkins Medicine. (2010) Children who lose a parent to suicide more likely to die the same way https://www.hopkinsmedicine.org/news/media/releases/children_who_lose_a_parent_to_suicide_more_likely_to_die_the_same_way
- 40 For more information about communication with children about COVID-19, see Dalton, Rapa, and Stein, "Protecting the psychological health of children through effective communication about COVID-19."
- 41 Stein A, Dalton L, Rapa E, et al. Communication with children and youths about the diagnosis of their own life-threatening condition. *Lancet* 2019; 393: 1150–63
- 42 Brooks SK, Webster RK, Smith LE, Woodland L, Wessely S, Greenberg N, Rubin GJ. (2020). The psychological impact of quarantine and how to reduce it: rapid review of the evidence. *The Lancet*, 395(10227), 912-920. doi:10.1016/S0140-6736(20)30460-8.
- 43 Same as above
- 44 Same as above
- 45 Druss BG. (2020). Addressing the COVID-19 Pandemic in Populations With Serious Mental Illness. *JAMA Psychiatry*. doi:10.1001/jamapsychiatry.2020.0894

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