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Piloting of a suicide first aid gatekeeper training (online) for children and young people in conflict affected areas in Syria

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ABSTRACT

Suicide among internally displaced people remains an under-researched public health issue especially in conflict affected countries. Given the limited and sometimes inaccessible mental health services, there is a need for scalable evidence-based suicide prevention programmes that could be delivered by trained and supervised non-specialists. The Suicide First Aid Guidelines approach aims to support humanitarian workers who deal directly with children and families with the appropriate knowledge and skills to identify and support those at risk of suicide until they can access further specialized support services or until the crisis passes.

This paper presents the findings of an online pilot training of 56 humanitarian workers from different sectors (e.g. Child Protection, Nutrition and Mental Health and Psychosocial Support) in conflict affected areas in Syria. The quantitative and qualitative evaluations were based on pre- and post-training questionnaires and revision journals completed between training sessions. Suggestions and examples provided in the journals and during the trainings were incorporated into the succeeding trainings. This was to contextualize and modify the gatekeeper training to fit the Syrian context and provide adaptations for future research and suicide prevention guidelines. Overall, the evaluation indicated that the pilot training raised awareness and improved participants' knowledge on how to assist a suicidal person, including warning signs. It also contributed to a positive change in attitude or beliefs towards suicide. Although the pilot training was considered adequate for the Syrian context some improvements were suggested.

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Introduction

Suicide is a preventable public health issue with over 800,000 global mortalities every year (Ingabire & Richters, 2020). Youth suicide is the leading cause of death among children under 15 years old and is the second cause of death among young people aged 15–29 years (Biswas et al., 2020). An estimated 10–20% of adolescents worldwide will experience mental health problems, especially those living in low resource settings (Biswas et al., 2020).

The majority (86%) of the world's most vulnerable population[1], half of which are children and young people, live in Low-and-Middle-Income countries (LMICs) (UNHCR, 2021). Of the 86%, 65% are forced migrants[2] who are internally displaced people (IDPs) (Morina et al., 2018). An estimated 79% of the global burden of suicide occurs in LMICs (Ingabire & Richters, 2020). In LMICs, vulnerable groups like IDP children and young people are at an increased risk of suicidal behaviours due to socio-cultural and environmental factors (Sundvall et al., 2018; Vijayakumar et al., 2021). Yet, despite its substantial significance, suicidal behaviours among IDPs remain an under-researched public health issue, especially in conflict affected countries like Syria (Haroz et al. 2020; Jaroudy and Colucci, In Press).

Syria hosts the world's largest forcibly displaced population with an estimated 6.6 million refugees and 6.7 million IDPs (UNHCR, 2021). Nearly half of the IDPs are children, accounting for 18% of all injured Syrians (van Berlaer et al., 2017). The conflict in Syria has had a devastating impact on the mental health and psychosocial wellbeing of IDPs including children

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(Hassan et al., 2016). Conflict-related violence encompasses frequent exposure to traumatic events, multiple losses, breakdown of social networks, daily stressors of displacement, inadequate living conditions, lack of basic needs, abuse, early childhood marriage, and other forms of exploitation (Hassan et al., 2016; Silove et al., 2017). Moreover, Nelson et al. (2020) found that chronic exposure to adversity impacts children's mental wellbeing by increasing their risk of cognitive, emotional and behavioural difficulties later in life, which may lead to suicidality.

According to the 2019 WHO report on global suicide, the estimated age-standardized suicide rates of all ages in Syria was 2.4 per 100,000 people compared to 0.4 per 100,000 people in 2014 (WHO, 2014, 2019). Like in many other LMICs, suicidal behaviours in Syria are often under-reported due to social stigma, religious and cultural taboos, as well as legal ramifications making suicide and associated behaviours a crime under Syrian law (Hassan et al., 2015; Jordans et al., 2018). This may mean that mental health specialists, when available, are required to report suicidal attempts under national law[3], which may prevent people from seeking specialized support and disclosing any suicidal behaviours (Hassan et al., 2015). Additionally, obtaining accurate data on suicidal behaviours in Syria may be challenging due to the lack of a registration system to record suicides (World Health Organization (WHO), 2014, 2019).

Nonetheless, over the past few years, the number of Syrians who died by suicide has significantly increased across the country (Middle East Monitor, 2020; Save the Children, 2021; Taylor, 2017). This concerning phenomenon has been highlighted by multiple press releases and news reports as well as through non-peer reviewed reports from non-governmental organizations (NGOs), (Aoun & Myers, 2017; McDonald, 2017; Save the Children, 2021). Save the Children (2021) reported a sharp rise in suicidal behaviours in Northwest Syria due to the deteriorating economic situation and hard living conditions. In addition, adult key informants reported that children and young people are increasingly turning to whatever is available to cope with stress, including resorting to self-harm or suicidal attempts (Anning, 2019; Aoun & Myers, 2017; McDonald, 2017). Furthermore, a study on refugees and displaced persons in Syria documented that vulnerability coupled with increased anxiety, depression, fear and hopelessness led to an increase in suicidal attempts (Quosh et al., 2013). This is consistent with a study carried out in a similar context with Palestinian middle school children living in the Gaza Strip, West Bank and United Nations Relief and Works Agency refugee camps where adolescents reported having higher rates of suicidal behaviours (Itani et al., 2017).

Although Mental Health and Psychosocial Support (MHPSS) services have received increased attention in Syria (WHO, 2021), Syria has only 4 psychiatrists serving a population of 4 million people, leaving 75% of Syrians with mental health conditions with no access to treatment (WHO, 2020). Given the limited and sometimes inaccessible mental health services, there is a need for scalable evidence-based suicide prevention programmes such as gatekeepers trainings that can be delivered by trained and supervised non-specialists (Cohen & Yaeger, 2021; Persaud et al., 2019).

Suicide could be avoidable with timely and effective preventative measures (Haroz et al., 2020). Suicide prevention gatekeeper training has been identified by several studies as a community-based approach that promotes mental health and raises awareness on suicide (WHO, 2012; Patel et al. 2016). Gatekeeper training aims to equip lay workers (e.g. in this project humanitarian workers, mainly Syrian nationals, without mental health backgrounds) with the knowledge and skills to identify and assist persons at risk of suicide (Bertolote & Fleischmann, 2005; Persaud et al., 2019; World Health Organization (WHO), 2012). Gatekeepers, i.e. individuals who are frequently in contact with affected members of the community, are trained to recognize associated risk and protective factors for suicide, warning signs and how to respond effectively (Bertolote & Fleischmann, 2005; World Health Organization (WHO), 2012). This training also addresses common misconceptions that can play a crucial role in prevention (e.g. 'if you talk to someone about suicide, you will put the idea into their mind'), one of many barriers in suicide prevention (Arensman et al., 2020; Bertolote & Fleischmann, 2005; Colucci et al., 2017).

Following the recommendations from another gatekeeper training in a LMIC, Guyana (Persaud et al., 2019), Save the Children Syria Response Office, undertook the gatekeeper training in suicide prevention across Syria in 2020. SC commissioned the first author as a private consultant to develop and hold gatekeepers training on suicide prevention in the Syrian context. The training was based on the Suicide First Aid Guidelines approach (Colucci et al., 2018), aimed to support humanitarian workers who deal directly with children and families with the appropriate knowledge and skills to identify and support those at risk of suicide until they are able to access further specialized support services (when/if available) or until the crisis passes (Colucci et al., 2018; Jaroudy &

Colucci, In Press). This is relevant since the majority of young people experiencing suicidal thoughts or at increased risk of suicide do not seek professional help, instead they rely on the support of their social networks (Arensman et al., 2020; Michelmore & Hindley, 2012). The training also tried to address the related stigma among the community and the service providers (Arensman et al., 2020).

Methodology

SFAG training description

The Suicide First Aid Guidelines (SFAG) for people from migrant and refugee backgrounds that formed the basis for this training was developed through a structured consultative process (supported by the Delphi-consensus method), and involved two panels of international experts (professionally and/or by lived experience) on suicide among people from migrant and refugee backgrounds, but unfortunately it was not possible at that time to include any panel member from Syria as not available (Colucci et al., 2018).

Training objectives

This training aimed to build local capacity for suicide prevention based on the SFAG through a gatekeepers' approach. The participants were expected to exhibit the following by the end of the training:

- Increased awareness of suicide including its magnitude as a public health problem and the impact of culture on suicide in Syria;
- Improved skills in identifying the warning signs of suicide;
- Enhanced skills on how to communicate with persons-at-risk and motivate them to seek help, while keeping the person safe.

The training included Arabic-translated guidelines, infographics and training videos where warning signs and first aid actions were identified and discussed in-depth (see https://movie-ment.org/suicide-first-aid-guidelines). Gatekeepers' training programs might also contribute towards changing attitudes towards suicide and breaking the widespread stigma surrounding people considering taking their lives.

Participants and procedure

Due to Covid-19 challenges, the training was conducted online, which limited critical aspects such as role-play and face-to-face engagement. The training was offered to a total of 56 humanitarian workers in Syria (from SC and several Syrian local NGOs) from different sectors (e.g. Child Protection, Nutrition and MHPSS) across its North-East and North-West Syria operations (Table 1).

Table 1. Number and gender of participants in North East and North West of Syria.

Group	Total	Gender
North-East Syria-A	14	F = 6 M = 8
North-East Syria-B	14	F = 4 M = 10
North-West Syria	28	F = 14 M = 14

Participants took part in 2–3 training sessions of 4–5 hours each, followed by revision/supervision sessions after 2–3 months from the initial training. The participants who received the 2-day training have taken part in 3 follow-up revision/sessions whereas only one was offered to those in the 3-days training group. The training was conducted in English with Arabic translation.

The training, included:

- Suicide and cultural diversity: suicide prevention in IDP populations
- Suicide First Aid Guidelines
- Warning signs and risk/protective factors
- Approaching and talking with someone who is suicidal
- Assessing how urgent the situation is
- Keeping the person safe
- Seeking professional and/or other help

Participants took part in quiz, group/chat discussions and videoed case vignette activities aimed to facilitate reflections and develop skills around identification of warning signs and first aid actions, which apply to children and adolescents in the participants' working contexts.

Participants were given interim activities to do between training sessions and between the training and revision/supervision sessions. These consisted of reviewing the guidelines and reflecting on how they might apply in Syria. Participants were asked to complete a reflective journal before the revision sessions and note their confidence level in their suicide gatekeeper role.

Participants were informed that the comments and (unidentifiable) examples provided would be noted and incorporated in a revised version of the training that would be provided to succeeding groups. This was to contextualize and adapt the gatekeeper training to fit the Syrian context and provide adaptations for future research and guidelines.

Table 2. The mean pre and post-test results on warning signs (# indicates lower scores).

Warning signs	Mean pre-test	Mean post-test
1. Threatening to kill or hurt themselves.	0.84	0.89
2. Engaging in self-injurious behaviour such as cutting, poisoning or hitting their head against the wall.	0.74	1.0
3. Looking for a way to kill themselves (e.g. seeking access to pills or poisons, weapons or other means), including asking information about possible suicide methods (e.g. 'would 100 mg of this kill me?).	0.84	1.0
4. Recurrent physical complaints of pains with no clear physical source	0.26	0.79
5. Talking or writing about death, dying or suicide (including making unexpected jokes about these topics.	0.79	0.95
6. Describing themselves as a burden to others or expressing feelings of guilt or shame (e.g. stating that others will be better off without them).	0.84	0.89
7. Stating that they want to disappear or disappearing.	0.89	0.79#
8. Withdrawing from friends, family or society.	0.84	0.84#
9. Desire or making threats to kill others	0.84	0.47#
10. Having dramatic change in behaviour, mood, appearance.	0.95	1.0
11. Having sudden or dramatic increase in depressed mood.	0.95	1.0
12. Giving away valued possessions and getting affairs in order including asking others to take on responsibility for the care of people or pets.	0.74	0.89
13. Deep regret over the decision to immigrate	0.33	0.89
An important warning sign for suicide is if a person is expressing (in words or actions):		
14. That they feel worthless or that their life is worthless.	0.89	1.0
15. Hopelessness (first aider should be aware of different cultural expressions of hopelessness and negative emotions).	1.0	0.95#
16. The desire or hope that they will die (including praying that God may take their life).	0.68	0.95
17. That suicide is the only solution to their problems.	0.36	0.84
18. A lack of reasons for living, or having no purpose in life.	0.74	0.79
19. A lack of interest in or plans for the future.	0.68	0.74
20. That they are feeling trapped, and that there is no way out	0.74	0.95
21. Strong sense of feeling alone and cut off, even if surrounded by family or friends	0.89	0.89#
22. Fear of being deported, especially if there is risk of torture or death	0.84	0.84#
23. Feeling that death is an honourable solution to their situation	0.74	0.84
24. Distress about intrusive memories of past traumatic events	0.89	0.63#
25. That their lives have been a failure, they would have been better off in their country of origin.	0.68	0.63#
An important warning sign for suicide is if a person:		
26. Is giving up efforts to reunite with their loved ones who live in another country	0.39	0.72
27. Stops life-saving medical treatments/medications	0.84	0.63#
28. Contacts people (e.g. family members and/or people they have not spoken to in a long time) to say goodbye, make amends or ask for forgiveness	0.84	0.68#
29. Is quitting their job or schooling	0.26	0.84
30. The first aider should be aware that warning signs for suicide may be different in different cultures	0.95	1.0

To evaluate the usefulness and adequacy of the training and assess participants knowledge and understanding, they completed a pre-and post-training questionnaire and a journal, which they were informed would be used for SC evaluation/monitoring purposes. The outcomes from both of these pilot sets of data and the key fieldnotes taken by the facilitator during and after the training and revision sessions are reported below. The quantitative analyses were performed by an independent SC staff member.

Findings

Evaluation/monitoring results: pre and post-test

Participants were asked to identify if the item provided was a warning sign for potential suicide among people living in Syria from refugee backgrounds (including IDPs). Warning signs for suicide were defined as the earliest detectable indication of increased risk for suicide in the near future (e.g. within minutes, hours or days). The wrong answer at pre and/or post-test was inputted as 0 and the right answer as 1. The mean scores are reported in Table 2.

At post-test, participants improved their ability to recognize suicide warning signs on 20/30 of the items provided. It is important to note that a large part of the training was aimed to adapt the existing warning signs to the Syrian conflict-affected community. All the items on which participants scored lower at post-test were the items they identified in need of adaptation in order to be applicable in their context. Therefore, the lower scores (indicated with # in the table) suggest that they have applied the knowledge about the inadequacy or partial adequacy of that warning sign in their context and it is, therefore, a positive outcome.

Table 3 reports the mean scores at pre- and post-test on the Attitude towards Youth Suicide Scale (AtYS), which was measured on a 5-point Likert scale (1 Strongly agree, 2 Agree, 3 Undecided, 4 Disagree, 5 Strongly disagree)[4] (Colucci 2014; Colucci & Lester 2020). The post-test scores with an asterisk (*) indicate that for that item a lower score shows a positive

Table 3. The mean pre and post-test results on AtYS.

Attitude towards Youth Suicide (AtYS) Scale	Mean pre-test	Mean post-test
1. It is always possible to help a young person with suicidal thought	4.66	4.33*
2. Suicide can never be justified	2.26	2.79
3. Suicide is among the worst thing to do to one's family	1.63	1.95
4. Once a young person has decided to suicide, no one can stop him/her	4.0	4.74
5. People do have the right to suicide	3.89	4.63*
6. Youth who make suicidal threats seldom kill themselves	3.05	3.74
7. Suicide is a subject that one should not talk about	4.55	4.83
8. Almost everyone has at one time or another thought about killing him/herself	3.37	2.26*
9. Suicide occurs without warning signs	3.68	4.68
10. If someone wants to commit suicide, it is their business and we should not interfere	4.47	4.84
11. Youth who talk about suicide do not commit suicide	3.84	4.21
12. Youth suicide can be prevented	1.53	1.47*
13. I would feel ashamed if a member of my family committed suicide	3.0	3.61
14. Potentially, every one of us can be a suicide victim	2.37	2.0*
15. In general, suicide is an act not to be forgiven	2.58	3.74
16. Youth do have the right to suicide	4.31	4.53*

the (*) post-test scores indicates that for that item a lower score shows a positive change in attitude or beliefs towards suicide.

change in attitude or beliefs towards suicide whereas for the other items, this change is shown by a higher score at post-test.

In summary, although change in attitudes towards suicide was a potential additional benefit of the training and changes in attitudes generally happen over time, participants' AtYS showed improvement on all items (except for two, i.e. items 5 and 16) at the end of the last training day. Of particular note is that while participants expressed more disagreement post-training with the item 'Suicide can never be justified', they also indicated a much stronger disagreement post-training with 'In general, suicide is an act not to be forgiven'. The participants and facilitator had several discussions about the widespread view of suicide as a sin and part of the training tried to create a more empathic and understanding response towards people experiencing suicidal feelings/behaviour, which might be reflected by this change.

Revision journals

In the questionnaires completed before revision, participants indicated that they felt generally confident in all key aspects of their gatekeeping role as shown in Table 4.

Participants were then asked to indicate how useful they found the SFAG and the online-training received, using a 5-points Likert scale (1 = not at all and 5 = very much). The average score for this question was 4.28, indicating that most participants found the training and resources highly useful.

Given that the focus of this pilot training was also to check its relevance for the Syrian and humanitarian contexts, another question asked how relevant/applicable participants found the SFAG and the online training they received to their context. The average was 3.78, which indicates that, overall, the training and materials were considered relevant/adequate but further adaptations are required.

Two open-ended questions in the required interim journals written by the participants explored which part of the training participants found most and least useful and/or relevant. The most frequent responses about what was most useful and relevant were:

- Differentiation between warning signs and risk factors of suicide
- Identification of warning signs including variations in different settings
- How to deal with someone who is suicidal
- How to talk with someone who is suicidal (including what to say and what not to say)
- Rapport between the helper and the suicidal person
- Realize common misconceptions about suicide
- Identify contextual factors interconnected with suicide (e.g. education, religion)
- Identify the most vulnerable people (to suicidal behaviour)
- Guidance on referrals and how to ask for help.

In regards to what was less useful or relevant, the most frequent answers were:

- Professional skills (e.g. how to provide further professional support, how professionals respond to someone who is suicidal)
- How to report suicidal cases
- Research data from other countries (e.g. India)
- Some warning signs need to be adapted according to the Syrian context.

Some participants indicated they would have liked more practical sessions (e.g. role-plays), as initially had been planned for the face-to-face training.

Table 4. Scores of participants on the level of confidence in their ability to perform as gatekeepers.

Level of confidence in your ability to perform each of the following actions:	Notconfident	Somewhat confident	Confident	Very Confident
I can recognise key suicide warning signs	2	8	23	12
When faced/dealing with a person with suicidal ideation, I feel confident to talk about it with them	2	14	16	14
I can tell how urgent the situation is and how to keep the person safe	2	13	21	11
I can support a person who is thinking about suicide to seek help	2	6	19	18
I can provide immediate emotional support to a person who is thinking about suicide	2	6	20	17
I know what to do when faced with someone at imminent risk of life	2	14	18	11

Participants also noted their preference for a face-to-face training to allow for better engagement in the group activities/case scenarios and avoiding poor internet connection issues.

Finally, participants were encouraged to provide written additional reflections. The most frequent points raised were to adapt the training, particularly the examples and case scenarios/videos used, to the Syrian context (e.g. stigma, norms and traditions). Participants also recommended role-plays in face-to-face training, and slowing down the Arabic translation. Additionally, participants requested more trainings on suicide covering specific groups including persons suffering with addiction and drug abuse. Further prevention strategies suggested were: a suicide hotline, awareness programs in schools, train/support those who receive the gatekeepers training to become trainers to increase the number of potential helpers within Syria and conducting more research on suicide in Syria.

Training and revision fieldnotes

During and after the training and revision sessions, the facilitator took fieldnotes that could guide the adaptation of the training and related materials.

The SFAG pilot training was overall deemed to be comprehensive and adequate for the Syrian context. Therefore, only a few changes were made to the training materials, including adapting a few of the existing warning signs and first aid actions (noting that their validity/usefulness should be assessed for future research or experts' consultations). Some warning signs seemed to be common among IDPs, therefore potentially not useful to identify people at immediate risk for suicide. Some of the additional warning signs proposed were:

- Expressing deep concerns about financial/economic circumstances
- Becoming angry, short-tempered, nervous, shouting and/or fighting with family members
- Not trusting anyone or becoming totally silent
- Refusing to express feelings and concerns
- Being distracted and/or having difficulty concentrating
- Stops eating or does not eat well
- Apathy, losing energy and motivation or passion about anything in life
- Looking for a 'religious exit' so that it would not be labelled as suicide (e.g. they ask around in what circumstances God can be merciful, for instance, if they are sick or have lost everything) in order to be forgiven.[5]

For most of the participants despite receiving Psychological First Aid training, this was the first opportunity they had to learn about suicide and suicide prevention. Thus, more training needs to be offered around basic suicide prevention concepts (including protective factors), difference between warning signs and risk factors and common myths about suicide, which were widespread among the three groups in this pilot.

The first session of the training clarified to the participants that the training would not make them suicide prevention specialists. However, throughout the sessions, participants expressed a need to develop their knowledge and skills further through a Training-of-Trainers (ToT) model. The intended aim would be to create focal points within Save the Children in order to assist local humanitarian workers to respond better to suicide prevention and support other staff when dealing with people with suicidal behaviours. In fact, some MHPSS staff involved in this training seemed to have several myths about suicide and its prevention. Participants discussed the harmful impact that untrained MHPSS staff might have on suicide prevention, hence highlighting the need to include suicide prevention as part of their training.

One criticism made by participants was that NGOs focused mainly on affected populations residing in camps, hence limiting its MHPSS services including

suicide prevention learnings to the broader community. As a result, participants requested extending services to the affected communities outside the camps and to develop a plan on how to implement their learnings as part of their community-based suicide prevention education/awareness campaigns.

Although specialized suicide prevention help is not available in the camps, it would be useful to work together with SC and their collaborating local organizations to develop a basic referral pathway for children/youth at suicide risk including different kind of potential help-providers (mental health and others) depending on the specific circumstances of the suicidal person. However, participants trained in any suicide gatekeeper trainings in low resource settings (e.g. LMICs and humanitarian/forced migration settings) must be reminded that referring cannot be the only or main aim of the training (as most of the time there are no suicide specialists available to provide adequate professional help) and they must, therefore, be able to provide the first aid support needed to the best of their abilities.

Implications and conclusions

In summary, based on the pre- and post-tests outcomes and the feedback, comments and suggestions from the participants in their revision journals and during the training/revision sessions, the following conclusions can be made tentatively:

- The pilot training achieved its goals in raising awareness of warning signs for suicide and increased knowledge on how to support a person with suicidal ideation;
- Some confusion between risk factors and warning signs persists;
- The need for more role-plays and case studies – especially adapted/specific to the Syrian context
- Demand for more training courses on suicide due to its sensitivity and lack of information on the topic, including ToT courses to become suicide gatekeepers' trainers as well as suicide prevention focal points within the organization;
- The need to develop a suicide referral pathway that includes mental health as well as other kind of supports (e.g. for gender-based violence);
- Further research on suicide in Syria should aim to address the evidence-gap and devise more tailored training material and resources (e.g. warning signs and scenarios), the impact and efficacy of which should be explored in depth and with larger samples.

Study limitations

This SFAG pilot study represents a step towards shedding light on the lack of literature and importance of designing context appropriate suicide prevention programmes in Syria. Nonetheless, this study has some limitations. The training was conducted online due to Covid-19 and as such a shorter version of the original training was offered, which restricted the ability for interactive activities such as role-plays. Moreover, a more in-depth training could have offered more opportunities to explore the role of culture, religion and gender as central intervening factors and provided more culturally-relevant explanations, which would have significantly enriched the training and subsequent findings (Colucci & Lester, 2012). This highlights the need for more research addressing cultural influences and suicide in Syria. Furthermore, the quantitative outcome measures rely on self-reported data, which may be subjected to bias and were based on a relatively small number of participants. Additionally, there were no long-term follow-up evaluations to assess knowledge learnt and how it will be applied at 6 months or 1 year. Moreover, a local focal organization or person was not appointed during or after the training to support participants when dealing with suicidal cases. Hence, it is essential for future trainings to attend to all the issues mentioned above as well as to appoint an MHPSS technical focal point of reference or person/s to undertake this role and follow up on all these issues.

Way forward

This paper concludes with a number of recommendations that can be taken forward by the practitioners (including humanitarian organizations) and scholars to further strengthen the prevention and response to suicide in Syria and perhaps other humanitarian settings.

A structured (research-based) revision of the SFAG guidelines is necessary to further contextualize them for Syria. Taking into account the limited specialized support services, the adapted guidelines would benefit from an additional focus on systems strengthening that can be implemented in volatile settings, such as Syria. This could involve training of healthcare professionals and other non-humanitarian service providers, while establishing clear and functional referral pathways between the 'gatekeepers' and more specialized support services.

To further build on this initial pilot online training provided to SC staff, a series of Training-of-Trainers

approaches should be conducted (ideally face-to-face to allow for more interactive sessions and in-depth discussions) to a selected group of staff, particularly those with a focus on MHPSS or Child Protection. This could be complemented by ongoing support and supervision provided by a focal organization with more specialized background on suicide prevention. In the second phase, the adapted 'gatekeepers' approach should be extended to the community-based structures such as Youth Groups or Child Protection Committees and integrated in the existing community-based awareness raising initiatives. Finally, there is a need to complement the MHPSS and Psychological/Mental Health First Aid with Suicide First Aid approaches developed specifically for conflict affected settings, as discussed in the findings of this evaluation.

Notes

1. Vulnerability in humanitarian emergencies is the result of class, gender, age, ethnic, racial, able-bodied, and religious inequalities and hierarchies that prevent the individual from satisfying basic needs, accessing resources, and exercising their rights (Zhukova, 2020).
2. We use this term to refer to refugees, asylum seekers, those who have had the experience of being internally displaced or IDPs (i.e. individuals who have been forced to leave their home but remain within their country's borders), undocumented migrants and other people with a precarious immigration status.
3. National law is applied under government- controlled areas in Syria. Different practices may apply in non-government-controlled areas such as North West and North East of Syria.
4. For more information about the scale including the factor analysis undertaken in India, Australia and Italy readers can refer to Colucci and Lester (2020).
5. Another warning sign proposed which potentially is linked to this was: 'Joins a militant group or threatens to join them with the aim of being killed'.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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