Indian Academy of Pediatrics Consensus Guidelines on Prevention and Management of Suicidal Behavior in Adolescents

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Justification: Suicide is an important cause of adolescent mortality and morbidity in India. As pediatricians are often the first point of contact for adolescents and their families in the healthcare system, they need guidelines to screen, assess, manage and prevent adolescent suicidal behavior to ensure survival, health and mental well-being of this vulnerable population. **Objectives**: To formulate guidelines to aid pediatricians for prevention and management of adolescent suicidal behavior. **Process**: Indian Academy of Pediatrics, in association with Adolescent Health Academy, formed a multidisciplinary committee of subject experts in June, 2019 to formulate guidelines for adolescent suicide prevention and management. After a review of current scientific literature and preparation of draft guidelines, a national consultative meeting was organized on 16 August, 2019 for detailed discussions and deliberations. This was followed by refining of draft guidelines, and discussions over e-mail where suggestions were incorporated and the final document was approved. **Guidelines**: Pediatricians should screen for mental distress, mental disorders and suicidal and para-suicidal (non-suicidal self-injury) behavior during adolescent health visits. Those with suicidal behavior should be referred to a psychiatrist after providing emergency healthcare, risk assessment, immediate counselling and formulation of a safety plan. Pediatricians should partner with the community and policymakers for primary and secondary prevention of adolescent suicide.

Keywords: *Care cascade, Counseling, Emergency management, Risk assessment, Safety plan.*

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Adolescents form 18% of India's population, and suicide is the third leading cause of adolescent mortality [1]. Only 1% of the pediatric population with mental disorders seeks treatment, due to the scarcity of mental health services and the social stigma [2]. Currently, there is an approximate 75% shortage of mental health professionals in the country [3]. Hence there is a need to stepped care approach to pediatric mental healthcare with active involve-ment of non-specialists. As pediatricians share a long stan-ding rapport with families, parents often seek their advice for management of adolescent mental health issues. Majority of the adolescent suicides are impulsive and timely intervention can save young lives. Hence there is a need to formulate practical guidelines for pediatricians for management and prevention of adolescent suicidal behavior.

Existing Adolescent Mental Health Status

The National Mental Health survey (2015-2016), reported a 7.3% prevalence of mental disorder in adolescents, higher in urban metro regions with similar distribution between males and females. The most common disorders were anxiety and depression [4]. Half of the mental illnesses begin by the age of 14 years [5]. In 2021, UNICEF reported a two times increase in prevalence of adolescent mental disorders due to pandemic related stressors [6].

The risk of suicides among adolescents in India is 1.3% [7]. Among high school students, the prevalence of suicide ideation is 6.0-21.7% and of suicide attempts is 0.39-8%. [8]. In adolescents with mental disorders, the estimated risk of suicide is 47-74% [9]. In 2020, one adolescent committed suicide approximately every hour with more girls than boys [10] The actual figures may be higher as in most cases there is inaccurate reporting [10,11]. Hanging, poisoning, drowning and self-immolation were the main modes of committing suicide. Family problems (35%), break-up in romantic relationships (12%), physical and mental illness (12%)

and failure in examinations (10%) were the main causes of suicide in adolescents [10].

Suicide risk identification is a window of opportunity for a pediatrician to contribute to suicide prevention. It is estimated that of all youth presenting with a suicide attempt, 25% have a reattempt and 5-10% commit suicide subsequently. A substantial proportion of youth have had medical visits in the year preceding completed suicide [12]. Adolescents with suicidal ideation might not reveal about their thoughts unless asked. Extreme hopelessness and absence of belongingness with easy access to means may trigger a suicidal attempt [13]. Asking about suicide does not increase the risk for the same. There is evidence to suggest that brief behavioral health interventions with follow-up care have a positive impact on outcomes [14,15]. There is currently inadequate evidence for efficacy of specific suicide prevention interventions [16-18]. A combination of strategies is known to work the best in prevention (**Web Table I**). WHO has recently released guidelines for framing country-specific suicide prevention programs and strategies for promoting positive mental health in adolescents [19,20].

In 2019-2020, guidance for medical officers to manage suicidal behavior and mental disorders in children and adolescents and a manual for caretakers of shelter homes to manage non-suicidal self-injury (NSSI) in female adolescents in Indian settings were published by National Institute of Mental Health and Neurosciences (NIMHANS) [21,22]. Recently, suicide has been decriminalized under the National Mental Health Care Act 2017. The Government of India is currently considering framing a national comprehensive suicide prevention strategy [23].

OBJECTIVES

To empower pediatricians with guidelines to screen and manage adolescent suicidal behavior in clinical practice, and to outline practical strategies for preventing suicides.

PROCESS

The process of forming these guidelines started on 1 June, 2019 with the formation of a national committee of multidisciplinary subject experts in collaboration with Adolescent Health Academy. The experts were selected on the basis of their professional competence and commitment. They are well known in their respective fields with a specialty post graduate and/or doctorate degree with over two decades of professional and research experience. Five sub groups of experts including adolescent health specialists, psychiatrists and pediatricians were formed to evaluate scientific evidence regarding existing status of adolescent mental health, risk and protective factors for suicide, clinical assessment, prevention and emergency management. Each sub-committee reviewed the existing published literature using the following indexing bodies/ databases, but not limited to, Medline, Pubmed Central, Citation index, Sciences Citation index, Expanded Embase, Scopus, Directory of Open access journals (DoAJ). The types of articles that were reviewed included meta-analysis, systematic reviews, original papers, case series, case reports, guidelines from WHO and paediatric professional bodies, international and national statistics in the public domain. Some search words and terms included were: suicide, adolescents, guidelines on suicide prevention and management, non suicidal self-injury, self-harm, suicides in India, suicidal attempt, counselling, etc. After multiple rounds of discussions, the sub-committees prepared draft guidelines pertaining to their respective topics. The draft guidelines were presented and discussed in depth at the National Consultative Meet conducted at Bangalore on 16 August, 2019. During the pandemic, due to the inability of organizing physical meetings, further discussions were continued via digital media. The final document was prepared after consensus through a series of online and email discussions and partial Delphi method. Updates based on revised literature review (up to January, 2022) and suggestions of the team members were incorporated in the guidelines document.

GUIDELINES

Pediatricians should assess all adolescents presenting to a healthcare facility for suicidal behavior and perform a brief risk assessment. If suicidal behavior or risk is detected, pediatrician should refer to a child psychiatrist/ psychiatrist after providing emergency care and counselling. Pediatricians should advocate for adolescent suicide prevention measures.

Risk and Protective Factors

All adolescents should be screened for risk and protective factors **(Table I)**. Existence of multiple risk factors increases the risk of suicidal behavior and protective factors decrease the risk [24-28]. Suicide occurs due to a dynamic interaction between numerous biopsychosocial factors. Ninety percent of suicidal attempts among adolescents are impulsive [8]. Adolescents have a high emotional reactivity due to differential maturation of the parts of the brain in this phase of life which makes them prone to impulsive behavior, especially in emotionally charged situations and conditions of extreme distress [25]. A major life stressor like a break up of an intimate relationship, academic failure, adverse influences of digital and social media and availability of lethal means of committing suicide can trigger suicide [25]. Adolescents with academic difficulties and learning problems have a 3-times higher risk of suicide compared to those who do not have these issues [26].

Table I Risk and Protective Factors for Adolescent Suicide

Risk factors	*Protective factors*
Individual	
Female sex	Positive coping skills
School drop out	Emotional self- regulation skills
Previous history of suicidal attempt	High self esteem
Death wish/ suicidal notes/ online posts	Conflict resolution skills
Non suicidal self- injury	Involvement in hobbies and activities
Child abuse/ trafficking	Employment
Bullying, cyberbullying	Religious belief
Marginalized youth	Good social skills
Mental and physical illness	Help seeking behavior
Failed intimate relationship	
Substance use disorder	
Children in conflict with law and in need of care and protection	
Gender minority youth: LGBQTIA	
School and Peers	
Failure in exam	Academic achievement
Learning problems	Positive peer relationships
Violent peers	Strong school connectedness
Lack of school counselling services and social support	Life skill education, suicide and bullying prevention programs
Family	
Family dysfunction and violence	Family stability
Child abuse and neglect	Authoritative parenting
Economic crisis, environmental disasters	Strong family connectedness
Family h/o suicide, mental disorder, alcohol use disorder	Positive discipline
Community	
Access to means of suicide	Access to adolescent friendly and mental health services
Unsafe media portrayal of suicide	Responsible media reporting
	Comprehensive national policy for suicide prevention

Prepared with material from references 23-28. LGBQTIA - Lesbian, gay, bisexual, queer, transgender, intersex, asexual.

Adolescents living in difficult circumstances e.g., in childcare institutions, street children, exposed to adverse childhood experiences, sexually abused, in poverty, areas of armed conflict, natural disasters, with severe substance use disorder and emotional dysregulation are prone to parasuicidal behavior or non-suicidal self-injury (NSSI) [21]. NSSI behavior is defined as deliberate destruction or alteration of body tissue without suicidal intent. Self-cutting is the most common NSSI [21]. Research indicates that adolescents indulge in NSSI to alleviate feelings of anger, sadness, to distract themselves from problems, to secure attention and as a form of self-punishment. NSSI is a risk factor for suicide [22].

Factors which protect against suicidality are family support, peer and school connectedness, physical and mental well-being, life skills (e.g., problem solving and coping skills) and availability of adolescent healthcare resources. [13].

Risk Assessment

All adolescents should be screened for suicidal behavior including suicidal ideation, thoughts, attempts and NSSI during clinical encounters and annual health visits using the HEEADSSS psychosocial interviewing framework, in privacy and after explaining the limits of confidentiality [29,30]. Questions should be short, non-judgmental and in developmentally appropriate language. Collateral information should be obtained from parents, peers, school teachers and counselors. Disclosure of suicidality entails sharing this information with a trustworthy caregiver that the adolescent chooses, to discuss further management plan to ensure his/her safety. Pediatricians should maintain medical records regarding documentation of assessment of suicidal behavior and management plan.

Those with suicidal ideation and NSSI should be asked about intent and plan **(Table II)**. Adolescents with suicidal thoughts can be classified into three risk groups [31]:

- *Low risk*-thoughts of death only; no plan or behavior.
- *Moderate risk* -suicidal ideation, with limited suicidal intent and no clear plan.
- *High risk*- suicide plan with preparatory behavior

When adolescents do not reveal suicidal behavior, there is a possibility of detecting suicidal risk using 'IS PATH WARM' mnemonic developed by the American Association of Suicidology, which can be used to identify warning signs of suicide [32,33] **(Box I)**. Those with suicidal thoughts and plan of self-harm in the past one month or with a past history of self-harm in the past one year, currently presenting with extreme agitation, violent episodes, distress and lack of communication are also considered as high risk, even though they may not express suicidal thoughts, intent or plan [34].

All adolescents with suicidal thoughts should undergo detailed history taking and examination to rule out medical, neurodevelopmental and mental disorders. Assessment of emotional and behavioral issues should be conducted. Risk and protective factors for suicide should be assessed.

Additional screening tools: Screening tools may complement but not replace thorough clinical assessment and can be self-administered. Ask Suicide Screening Questionnaire (ASQ) is a 4-item measure that has good sensitivity in identifying youth at risk for suicide [33]. Other screening tools include Columbia Suicide Severity Rating Scale, Beck Depression Inventory and Patient Health Questionnaire- 9 **(Web Table II)**.

Criteria for Referral

All suicidal ideation and attempts and NSSI should be taken seriously, and require referral to a mental health specialist. Emergency mental health referral is needed if there is immediate threat to life, and for patients assessed as moderate to high risk and with severe mental distress. Urgent mental health referral within 48 to 72 hours is needed for patients with low risk.

Emergency Management of Adolescent Suicidal Behavior

The potential emergency situations encountered in clinical settings are:

Box I Warning Signs of Suicide (IS PATH WARM)

I	Ideation (Talking or writing or posting online about death, threatening to hurt or kill self, giving away prized possessions)
S	Substance use
P	Purposelessness (Having no reason to live)
A	Anxiety
T	Trapped
H	Hopelessness
W	Withdrawal
A	Anger(uncontrolled)
R	Recklessness
M	Mood changes

Prepared with material from references 31,32.

Presentation with life threatening health effects: As in poisoning, near drowning and hypoxic ischemic encephalopathy following hanging. This situation needs to be handled with triaging, resuscitation, stabilizing and appropriate referral following brief interventional counselling focusing on the physical health needs of the adolescent and assurance of support to the family. The pediatrician inter-ventions should continue through the recovery period to complete the protocol suggestions.

After an event: Parents and adolescent seeking intervention following an attempted suicide or self-harm attempt.

Adolescents categorized as high risk for suicide: Adolescents with warning signs of suicide, past history of suicide attempt, severe mental disorders, substance use disorder, multiple risk factors and refusal to follow the safety plan are considered to be high risk even if they present with only suicide ideation without a plan

A protocol is suggested to provide a minimum care systematic strategy with the intention of effective suicide prevention at first contact and an outline of follow up care. (**Fig.1** and **Box II**). After medical clearance, the cascade of care suggests therapeutic assessment and interventions

Table II Screening Questions for Suicidal Behavior

Ideation (frequency, intensity)	*Intent*	*Plan*
There are times when situations are unbearable and hopeless, young people think of hurting or killing themselves to end it all. Have you ever thought of hurting /killing yourself? How often do these thoughts happen? How long do they last? What do you do when you have them? What coping strategies do you use? What are the triggering events for these thoughts?	Have you ever thought of acting on your thoughts? How likely do you think that you will act on your thoughts?	Do you have a plan? If so, how would you intend to do it and where? Which means would you use? Do you have a time line in mind?

Prepared with material available in references 30-33.

covering counseling of the adolescent with focus on inculcating 'hope', safety plan, protective support, lethal means counseling and handling substance use [35,36]. This is followed by a plan for inpatient or outpatient care. National 24×7 toll-free mental health helpline numbers should be shared with the patient and the parents. Subsequent interventions include motivational counselling, addressing treatment barriers, using caring contacts and multidisciplinary collaborative care with psychiatrists, psychologists, psychiatric social worker, educators and counsellors [12].

Pediatricians should consider any suicide risk as an emergency akin to a coronary ischemic event. They should ensure the following steps, ensuring complete medical documentation [36]:

i) Stabilize physical health, ensure emergency wound care and completion of age appropriate tetanus immunization schedule and rule out medical problems with acute psychiatric symptoms with altered sensorium like brain tumors, seizures, hypothyroidism, hyperthyroidism, hyperammonia, Wilson disease, hypocalcaemia, drug overdose and substance abuse [37].

ii) Evaluate mental health status and assess the degree of mental distress, the extent of functioning in the form of ability for self- care, sleep, appetite, educational grades and interpersonal problems like bullying and abuse [30]. Questionnaires like patient health questionnaire-2 and 9 (PHQ 2 and 9), Becks depression inventory, screening for childhood anxiety related emotional disorders (SCARED) and screening to brief intervention tool (S2BI) can be used for screening for depression, anxiety and substance use disorder respectively [38-41]. The final diagnosis of mental disorders is made using the Diagnostic and statistical manual -5 (DSM-5) criteria.

iii) Identify the protective factors and risk factors with intention to enhance protective factors and reduce risk factors. Classify severity of risk by using a screening tool. The risk for suicide attempt recurrence is assessed by administering a self-report either in person or by writing

iv) Impart psychoeducation, counsel the adolescent and family, activate psychosocial support and impart lethal means counselling. **(Fig. 1)**

v) Create a safety plan. This safety plan is a written and discussed treatment plan with the adolescent and family which outlines all the protection supports and contacts in the event of a future situation of suicidal intent **(Box II)**

vi) Facilitate treatment of identified mental illness

vii) Enhance resilience with a planned strategy of life skills education using training manuals e.g the NIMHANS adolescent life skill series or the life skill educators' modules [42].

viii) Impart positive parenting training sessions that include information about normative adolescent development and the vulnerability to risky behaviour under stress. Parents are counselled to provide a secure, supportive and safe home environment, to use effective communication and positive discipline techniques, to encourage a healthy lifestyle and hobbies and to inculcate life skills in their children

ix) Make a timely referral to a psychiatrist

x) Retain the adolescent in follow-up with proactive efforts and motivation for a minimum period of 6 months up to a maximum of 2 years. Follow up visits are scheduled once a week for 2 months, once a month in the first one year, and twice in the second year [34].

Suicide Prevention

Pediatricians can play an important role in primary and secondary prevention of adolescent suicide.

Primary Prevention Strategies

These strategies target the risk factors to mitigate the suicidal behavior in clinical and community settings and are detailed below [43, 44].

i) *Fostering resilience*: During annual health and medical visits, pediatricians can highlight the adolescent's strengths, encourage self-efficacy, teach effective problem-solving skills, and identify protective factors, such as positive religious and spiritual beliefs and thus promote resilience [45]. Life skill education manuals can be used to facilitate these sessions [42].

ii) *Promoting school, peer and family connectedness*: Pediatricians should screen for family, school and peer connectedness and teach strategies of authoritative parenting, assertive communication and conflict resolution to strengthen these [46,47]. Gender equality and discrimination issues should also be discussed [23]. Partnerships with NGO and medical social workers should be established to enable economic help for deprived families.

iii) *Intervening on parent psychopathology*: Pediatricians should refer parents (of adolescents) with mental disorder to mental health professionals at the earliest [45].

Pediatricians should partner with schools to plan and

Fig. 1 Cascade for emergency care of adolescent suicidal behavior (*Prepared from material available in references 34-37*).

Box II Sample Safety Plan

(To be formulated by the adolescent, pediatrician and caregivers)

a) Warning signs like thoughts, images, persons, situations, events

1. 2. 3.

b) What I can do to distract myself immediately even without involving other people (e.g praying, relaxation, deep breathing, imagery, reverse counting from 100 to 1)

1. 2. 3.

c) Places and people who can help you to distract (e.g grandparents, friends, playground, mall, neighbor, relative, music, painting)

1. 2. 3.

d) People whom I can ask for help.

1. Name: Phone no: 2. Name: Phone no: 3. Name: Phone no:

e) Doctors, clinic, hospital, helpline that I can contact for help.

1. Child helpline Phone no: 1098 2. Name: Phone no: 3. Name: Phone no:

Reminder: I am precious. My life is precious. The one thing that is very important for me and makes my life worth living for is .....

Note: Fill in the points as per your preference and choices. Think about what is practical and will work for you. Keep this safety plan handy for reference on your phone, pasted on your door etc. So that you can remind yourself that you can keep yourself safe at all times.

Signature of adolescent Signature of caretaker/s Signature of pediatrician

Prepared with material from references 30, 35-37.

implement effective school-based interventions [46]. The school-based interventions include adolescent life skill education to promote overall mental well-being and interactive talks with adolescents, parents and teachers about causes and warning signs of suicide and mental disorders like depression and anxiety. Pediatricians can utilise the 'Living Life Positively' manual of National Institute of Health and Family Welfare (NIHFW) to conduct these sessions [47]

Secondary Prevention Strategies

Secondary suicide prevention efforts aim at helping those identified at risk for suicide, screening and treating mental disorders [48,49]. In the outpatient setting, pediatrician can use screening questionnaire for suicidality and other mental health disorders, as previously mentioned. If there are signs of suicidality, the care cascade can be followed. For those with mental disorders, psychotherapy in form of cognitive behavior therapy, dialectical behavior therapy, interpersonal therapy, family therapy and psychcopharmacology under the supervision of a psychiatrist is recommended [25,30,34]. Tele health and mHealth are potential methods to manage mental health issues in areas where there are limited mental health resources or where access to health services is restricted [50,51].

Strategies for Advocacy

IAP should update and revive the Mission Kishore Uday program launched in 2019 on adolescent suicide prevention and intervention [52,53]. IAP should organize nationwide workshops with comprehensive gatekeeper training of pediatricians, parents, teachers and adole-scents to disseminate these guidelines

Widespread community level advocacy activities for adolescent suicide prevention and intervention should be planned by IAP, in collaboration with school management and personnel, volunteers of NGOs, community leaders and health workers, religious leaders and adolescents themselves.

Prevention can be universal, selective and indicated [54]. Universal strategy is for entire population and includes suicide awareness programs, education programs for media on suicide reporting practices, and school based crisis response plans and teams. Selective strategies target risk groups (e.g. grade 10 and 12 students) and includes screening programs, gatekeeper training for teachers/ parents, school personnel, peers and enhance-ment of accessible crisis services and referral. Indicated strategies focus on high risk individuals with early warning signs of suicide. Skill-building programs for school/college students and parent support training programs that aim at reducing risk factors, increasing protective factors and imparting life skills.

IAP should advocate for framing a comprehensive national policy for adolescent suicide prevention. This policy should be included in the national adolescent health strategy, Rashtriya Kishore Swasthya Karyakaram on priority basis [23,55]. A national registry should be

Box III Summary: IAP Consensus Guidelines for Adolescent Suicide Prevention and Intervention

1. Suicide screening: All adolescents should be evaluated for suicide risk by pediatricians as a part of routine healthcare visit or annual medical checkup. The two basic questions to be asked as part of universal HEEADSSS screening are: *i*) Sometimes when things get difficult, many young people think of death and even hurting/killing themselves. Have you had any such thoughts? If yes, *ii*) Have you actually tried hurting/killing yourself anytime? Additional screening tools may be utilized to assess severity, immediacy of risk and to calibrate further medical interventions.
2. Assessment: All adolescents should be assessed for mental wellness, strengths and disorders through HEEADSSS screening and appropriate screening tools on an annual basis. This is in addition to and independent of suicide risk assessments.
3. Referral criteria: All adolescents with suicidal behavior should be referred to the psychiatrist. Adolescents with high risk for suicide, psychosis and moderate/severe depression and substance use should be referred on an emergency basis.
4. Emergency care and management: The care cascade algorithm should be used to manage an adolescent with suicide risk. The pediatrician should provide first responder services that enables the adolescent and the family to foster hope. They should offer help, counter the feelings of hopelessness, helplessness, worthlessness, shame and guilt and prepare a safety plan.
5. Collaborative management: The group recommends that the pediatrician coordinates the care with the psychiatrist, counselor, social worker, educator and a psychologist for physical and mental well-being, resilience building and safety monitoring for a minimum period of 6 months.
6. Prevention: All pediatricians should familiarize themselves with life skills training programs that can be implemented on individual and community settings.
7. Advocacy: As gatekeepers for child and adolescent health, pediatricians should disseminate the guidelines to healthcare professionals, community, government and non-government agencies.

maintained for collection of accurate statistics regarding adolescent mental disorders and suicidal behavior to evaluation various preventive measures [56]. Media reporting guidelines should be implemented and regulated to avoid suicide contagion (copycat suicide). The availability of child helpline 1098 and the existing mental health services including telecounseling services should be disseminated and periodically highlighted through various media channels. Educational and examination reforms to decrease academic stress on the students should be considered. At a national level, there should be a strategy to reducing the access to means of suicide e.g., regulation of sale of organophosphorus pesticides and prescription medicines.

CONCLUSION

Pediatricians should screen adolescents for protective and risk factors of suicide/suicidal behavior, and conduct a mental health evaluation at annual healthcare visits. During these visits, they should discuss strategies with adolescents and parents to enhance protective factors and over all mental well-being. Mental disorders, if detected, should be treated at the earliest. All cases of suicidal behavior should be referred to the psychiatrist after a risk assessment and brief intervention including immediate counseling of adolescents and parents, and formulating a safety plan. Pediatricians should collaborate with mental health professionals for treatment and follow-up **(Box III)**.

Note: Additional material related to this article is available at *www.indianpediatrics.net*

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ANNEXURE

IAP Guidelines Committee on Prevention and Management of Suicidal Behavior in Adolescents

Chairpersons: MKC Nair, Digant Shastri; **Convener**: Preeti M Galagali; **Writing Committee Members**: Amitha Rao Aroor, Chitra Dinakar, Preeti M Galagali, Piyush Gupta, Chandrika Rao, Latha Ravichandran, Dheeraj Shah. **Members:** PV Arya, CP Bansal, Piyali Bhattacharya Sushma Desai, JC Garg, Atul Kanikar, Satish Pandya, Garima Saikia, RN Sharma, JS Tuteja. **Invited experts**: PS Russell (Child and Adolescent Psychiatrist), Poongodi Bala (Psychiatrist). **Rapporteur**: Kritika Agarwal. **Ex-officio**: Remesh Kumar R.

All members attended the National Consultative Meet at Bengaluru on 16 August, 2019 except CP Bansal, JS Tuteja, and Paul Russel.

Web Table I Evidence Based Strategies for Suicide Prevention

Prevention strategies	*Available evidence*
Universal interventions	
Mitigating unemployment, poverty and inequalities	Implemented by Government authorities. Unplanned studies
Restricting access to lethal means of suicide-safer designs of buildings, prisons. stringent firearm rules, limitation to pesticide access. Barriers and safety nets.	Case studies Retrospective observations. Review articles
Public awareness	
School based interventions, cyber bullying, monitoring bullying, Social media watch, Helplines, Accessible Mental health service	Randomized controlled trials
Selective interventions	
Gatekeeper training – Health personnel, teachers, priests, volunteers among parents and students	Uncontrolled studies
Vulnerable population interventions- Deaddiction, Evaluating depression, social isolation,	Randomized controlled trials
Discharge, Contract and follow up for one year minimum,	
Indicated interventions	
Treatment of mental disorders.	Randomized controlled trials

Prepared with material available in references 43-45.

Web Table II Screening Tools for Suicide Risk and Common Mental Disorders

Screening tool	*Web link*
Suicide Screening	
Columbia suicide severity rating scale	https://cssrs.columbia.edu/wp-content/uploads/C-SSRS_Pediatric-SLC_11.14.16.pdf
Becks depression inventory (BDI)	https://www.ismanet.org/doctoryourspirit/pdfs/Beck-Depression-Inventory-BDI.pdf
Patient health questionnaire-9: Modified for teens (PHQ-9)	https://www.aacap.org/App_Themes/AACAP/docs/member_resources/toolbox_for_clinical_practice_and_outcomes/symptoms/GLAD-PC_PHQ-9.pdf
Adolescent Suicide- Screening Questionnaire (ASQ):	https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/asq-tool/asq-screening-tool
Depression screening	
Patient health questionnaire-2 (PHQ-2), PHQ-9 and BDI	https://aidsetc.org/sites/default/files/resources_files/PHQ-2_English.pdf
Anxiety disorder screening	
Screen for child anxiety related emotional disorders (SCARED)	https://www.ohsu.edu/sites/default/files/2019-06/SCARED-form-Parent-and-Child-version.pdf
Substance use disorder screening	
Screening to brief intervention tool	https://www.drugabuse.gov/ast/s2bi/#/