School-Based Suicide Risk Assessment Using eHealth: A Scoping Review

CIHR Knowledge Synthesis Final Report

November 2020

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Suggested Citation: Exner-Cortens, D., Baker, E., Conde, C. F., Gray, S., Rivera, R. R., Van Bavel, M., Vezina, E., Ambrose, A., Schwartz, K., & Arnold, P. (2020). School-based suicide risk assessment using eHealth: A scoping review. *CIHR Knowledge Synthesis Final Report.* https://www.hopelab.ca

Acknowledgements: We would like to thank Diane Lorenzetti, MLS, PhD from the University of Calgary and Robert Olson, Karin Lavoie and Mara Grunau from the Centre for Suicide Prevention for their support developing our search protocol, and to Robert Olson for his multiple reviews of this document. Thanks also to Emily Matejko for her invaluable support on this project. We are also deeply grateful to our expert reviewers for their time and feedback: Ryley Hatchard, Deb Nunziata, Chris Pawluk, Lori Roe and Mike Velthius Kroeze. This work was supported by a Knowledge Synthesis: COVID-19 in Mental Health & Substance Use Operating Grant from the Canadian Institutes of Health Research.

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1. Background

Suicide is a leading cause of death for Canadian youth (Children First Canada, 2020; Navaneelan, 2019). Beyond prematurely ending the life of a young person, suicide has wide-reaching negative impacts on friends, family and the larger community (Robinson et al., 2013). Suicide also has substantial economic costs (Bennett et al., 2015): for example, in 2010, the Government of Canada estimated that suicide resulted in $2.96 billion in direct (e.g., health care) and indirect (e.g., lost productivity) costs (Government of Canada, 2020).

In the context of COVID-19, suicide risk for some youth may be elevated due to social isolation and associated mental health impacts of the pandemic (Liang et al., 2020; Xie et al., 2020). In addition, due to ongoing school closures/online learning, many youth may not have in-person contact with the school personnel who play a critical role in identifying risk for suicide and supporting youth to seek help. Instead, school staff may find themselves identifying students at risk when they connect with youth virtually/remotely, and may be uncertain about how to best support the student when they are not face-to-face. Thus, this **knowledge synthesis explores promising practices for conducting school-based suicide risk assessment with youth via eHealth in the context of COVID-19.**

1.1 Suicide Prevention and the Role of Schools

Because of their frequent access to most youth in Canada, schools are a key suicide prevention and intervention site. In the non-COVID context, school personnel are in regular contact with most students, and thus have multiple opportunities to intervene (De Silva et al., 2013; Freedenthal & Breslin, 2010; Gould et al., 2009; Steele & Doey 2007). Further, since many youth at risk for suicide are reluctant to ask for help (Reis & Cornell, 2008), school personnel play an important role in actively screening and referring at-risk youth to appropriate community-based services (e.g., mental health clinics, emergency departments). However, while school personnel play a critical role in providing targeted intervention (i.e., initial response, risk assessment), training on how to assess for risk effectively, and the use of standardized school policy that guides referrals to community-based interventions, is not available in most schools (Hatton et al., 2017; Nadeem et al., 2011; Reinke, Stormont, Herman, Puri, & Goel, 2011; Ross, Kolves, & De Leo, 2017; Whitney, Renner, Pate, & Jacobs, 2011). For

example, in 2013, the Alberta Centre for Injury Control and Research completed an environmental scan with 45 school divisions across the province regarding their school-based suicide prevention practices (Alberta Centre for Injury Control & Research [ACICR], 2013). In this scan, they found that school-based suicide prevention practices (including risk assessment) were lacking, and that practices that were implemented tended to be one-off approaches that relied on a single individual to respond to all student concerns related to suicide. For students identified as at-risk, standardized referral pathways to community-based supports were also uncommon. A lack of standardized protocols for suicide risk assessment leads to both false positives (i.e., over-response to disclosures that do not indicate an immediate crisis) and false negatives (i.e., under-response for students in need of immediate attention) (ACICR, 2013). Both of these outcomes are detrimental for all stakeholders (Granello, 2010), including youth, families, the health care system, and schools

1.2 A School-Based Suicidal Ideation Response Protocol

In response to these findings, and the noted lack of training/support for school personnel on appropriate, evidence-based suicide risk assessment, a group of school mental health stakeholders in Alberta convened a multi-sector working group in 2017 (led by Alberta Health Services, Addiction and Mental Health – Calgary Zone). The group's goal was to create a standardized suicide risk assessment protocol for schools across the province. Together, the multi-sectoral team (representing health, education, community providers and academia) developed a multi-component protocol and related training, called the *School-Based Suicidal Ideation Response Protocol* (the *SI Protocol*). *The SI Protocol* is grounded in best practice recommendations from the National Association of School Psychologists (Thomas, 2014) and the Substance Abuse and Mental Health Services Administration (SAMHSA, 2012), and has standardized response patterns for school teachers/support staff, school point people, school mental health professionals, and school administrators. The response pattern for each target group contains a step-by-step process for responding to a distressed student, with activities that are appropriate to the person's role and training. Implementation of the *SI Protocol* is supported by a free, online training co-developed by the team. The protocol was launched in August 2019, and has been implemented in over 100 schools in four Alberta school divisions to date. Pilot internal evaluation data indicate the protocol is very promising for preparing school

staff and mental health professionals to intervene with students at risk for suicide. Initial data also indicate that use of the *SI Protocol* has reduced the number of students sent to emergency departments inappropriately (specificity), and has increased admission rates for students who are sent to the emergency department (sensitivity).

1.2.1 School-Based Suicide Risk Assessment in the Context of COVID-19.

Given nationwide school closures that occurred due to COVID-19 in March 2020 (and are ongoing in a number of areas), schools across Canada may need to provide school-based mental health services – including suicide risk assessment – through eHealth (eHealth refers to the use of information and communication technologies in healthcare. In this paper, this includes virtual and/or remote technologies, such as telephone, text, Zoom, Google Meet, etc.). In our own context, partner school divisions in Alberta have shared that they are still implementing the *SI Protocol* virtually/remotely, but do not know optimal practices for e-delivery (e.g., building rapport and safety in an online environment, maintaining connections with vulnerable youth), leading to concerns about safety and effectiveness for students expressing suicide risk in these challenging times. Given the increased mental health distress some youth may experience during and following situations causing widespread loss/turmoil (Becker-Blease, Turner, & Finkelhor, 2010; Goldmann & Galea, 2014; Overstreet, Salloum, Burch, & West, 2011) – including COVID-19 (Liang et al., 2020; Xie et al., 2020) – virtual/remote use of suicide risk assessment protocols is likely to be an ongoing need, and thus guidance on e-delivery is critically needed, in Alberta and beyond. To fill this evidence gap, this report explores promising practices for conducting school-based suicide risk assessment with youth via eHealth**.**

1.3 Knowledge Synthesis Research Question and Objective

This rapid knowledge synthesis aims to address the following research question: *What are promising practices for providing school-based suicide risk assessment to youth using eHealth?* The overall purpose of our knowledge synthesis is to summarize current evidence on key recommendations for virtual/remote implementation of suicide risk assessment, including needs, strengths and gaps, and to apply these recommendations to the school context. To address this question and objective, we used a systematic scoping review methodology (Anderson, Allen, Peckham, & Goodwin, 2008; Arksey & O'Malley, 2005; Levac, Colquhoun, & O'Brien, 2010; Peters et al., 2015), following the PRISMA Extension for Scoping Reviews

(PRISMA-ScR) checklist (Tricco et al., 2018). We chose this methodology as it is appropriate for rigorously but rapidly understanding key concepts in areas not previously the focus of systematic study, where the goal is to summarize and mobilize existing research to knowledge users and decision makers. To gather the most up-to-date information, we include both peer-reviewed and grey literature in our review. We included grey literature because we felt that substantial information on virtual/remote risk assessment would likely be available via professional associations and health/school authorities, and – because of its closer connection to these issues in practice – it is often better suited to rapidly respond to emerging concerns.

2. Methods

2.1 Peer-Reviewed Literature

2.1.1 Search strategy.

The search protocol for this project was co-developed by the research team, and reviewed by a medical research librarian and the Centre for Suicide Prevention before searches were conducted. To locate relevant peer-reviewed literature for this scoping review, we searched six databases (PsycINFO, Medline, EMBASE, CINAHL, ERIC and Education Research Complete) on May 28th, 2020. Searches were all conducted by the first author. Search terms were *(youth OR adolescen* OR teen* OR child*)* **AND** *(risk OR suicid* OR safety OR self-harm OR self-injury OR "self-injur* behavio*")* **AND** *(assessment* OR screen*)* **AND** *(eHealth OR telepsychology OR telehealth* OR remote* OR virtual OR web-based OR online OR mobile health OR mHealth OR telemedic* OR e-Health OR apps OR computer-based OR digital technolog* OR e-resources OR e-support* OR internet OR iphone* OR smartphone* OR teleconsult* OR tele-consult* OR tele-health* OR tele-medic* OR telemonitor* OR tele-monitor* OR telepsychiatr* OR tele-psychiatr* OR teletherap* OR tele-therap* OR tele-psychology OR virtual care OR website*)*. We searched the first three search strings (the adolescent terms, the risk terms and the assessment terms) as individual subject headings and as title/abstract search strings in each database. We searched the final search string (the technology terms) as a title search string only, to increase the relevancy of returns.

2.1.2 Inclusion criteria.

Searches were restricted to peer-reviewed articles published in English in the prior 20 years (i.e., 2000-2020). We made this restriction as we hypothesized that most eHealth articles would be relatively recent (in addition, a special issue on eHealth ethics

was published in 2000 (Eysenbach, 2000), and a Google Scholar search of the term "eHealth" indicated that the first full-text articles on this topic primarily began to appear after the year 2000). To be broadly inclusive, searches were not restricted by geographic region or methodology. To be included, articles needed to provide information relevant to completing suicide risk assessments with youth in an eHealth (i.e., virtual and/or remote) environment. Articles were excluded if they did not make relevant recommendations; if risk assessments were not completed virtually/remotely within the study; if the study did not focus on risk assessment; if the full text wasn't available; or the study was a duplicate (Figure 1).

2.1.3 Review procedures. Screening of located articles was completed using Covidence by a team of five research assistants from the University of Calgary (three doctoral students in school and applied child psychology (SG, MVB, CFC); one master of social work graduate (RRR); and one undergraduate psychology honours student (EV)). Research assistants reviewed the title and abstract of each of the 2,114 potential articles in pairs (Figure 1). Each member of the pair independently reviewed each article. If the pair did not agree on an inclusion decision, they met to come to consensus. After screening, 107 articles remained for full-text review (Figure 1). Given the expedited nature of this search, all full-text articles were reviewed by the first author. Following full-text review, 95 articles were excluded because they did not meet inclusion criteria (Figure 1), leaving a final sample of 12 articles that provided recommendations relevant to the objective of this review (Table 1). However, no articles were found that directly focused on promising practices for conducting suicide risk assessment (in schools or otherwise) with youth using eHealth (Figure 1).

2.1.4 Data abstraction. Data from the 12 included articles were abstracted using a standardized data charting template created for this study, based on the recommendations of Tricco et al. (2018) and Levac et al. (2010). The standardized data charting template collected information on the study's source of funding; design; sample (size, age, demographics); setting/location; data analyses; and relevant recommendations for eHealth suicide risk assessment with youth. Abstractions were completed in pairs by the team of research assistants. Each member of the pair independently reviewed their assigned articles, and the pair then met to come to consensus on the final abstraction. Abstractions were all then

reviewed by the first and second authors. We did not assess data quality, as this is outside the parameters of scoping reviews (Tricco et al., 2018).

2.2 Grey Literature

To supplement our search, we also included key websites (i.e., professional websites focused on school mental health, suicide prevention and/or youth mental health). Websites for inclusion were identified by the research team and the Centre for Suicide Prevention. These websites were not restricted by geography (i.e., could be outside the Canadian context). Between May 28th and June 19th, 2020, we reviewed 17 websites for information relevant to eHealth suicide risk assessment with youth:

- https://www.apa.org/advocacy/suicide-prevention/
- https://www.canada.ca/en/public-health/services/publications/healthy-living/suicide-prevention-framework.html
- https://www.csmh.uwo.ca
- https://www.cymh.ca/en/index.aspx
- https://www.integration.samhsa.gov/clinical-practice/suicide-prevention
- https://www.mentalhealthcommission.ca/English/what-we-do/suicide-prevention
- https://mhttcnetwork.org
- http://www.schoolmentalhealth.org
- https://smho-smso.ca
- http://www.sprc.org
- https://www.suicideinfo.ca
- https://suicideprevention.ca
- https://suicidepreventionhub.org.au
- https://suicidepreventionresearch.ca
- http://teenmentalhealth.org/
- http://www.togethertolive.ca/prevention-tools-and-resources
- https://zerosuicide.edc.org

Each website was reviewed by one research assistant, and relevant documents/information were saved to a shared folder. A pair of research assistants (which did not include the research assistant that originally pulled documents from the website) then abstracted the information from these saved documents using the same procedure as for peer-reviewed articles (see 2.1.4). The standardized data charting template for websites included the title of the relevant page on the website and a summary of relevant recommendations. Information from relevant websites was then reviewed and summarized by the first and second authors.

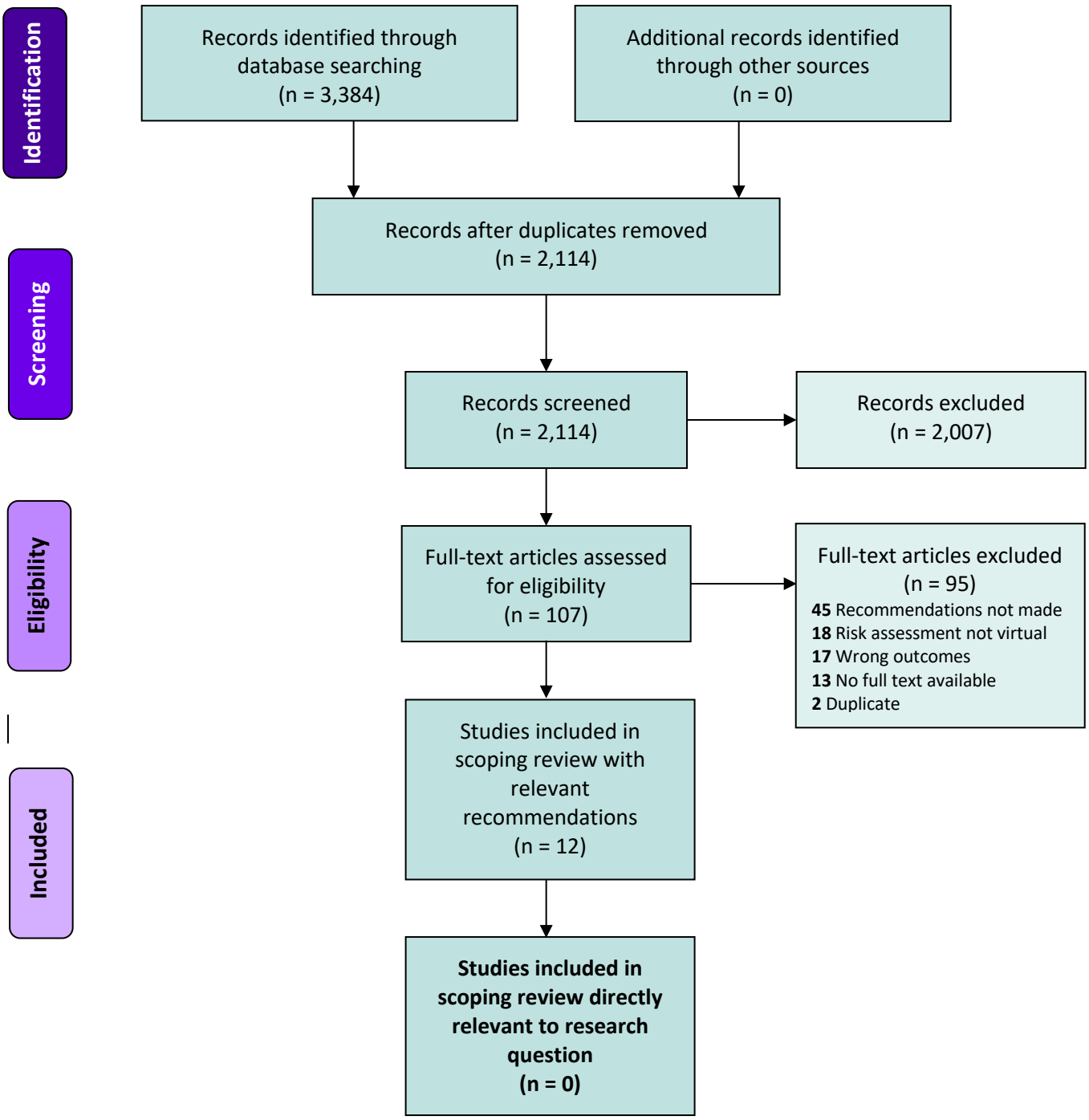

Figure 1. PRISMA diagram (Moher, Liberati, Tetzlaff, Altman & PRISMA Group, 2009; Tricco et al., 2018)

2.3 Priority Populations

To additionally supplement our search and specifically focus on groups of youth at disproportionate risk of suicide, relevant dissertations and websites were reviewed to identify recommendations for conducting eHealth risk assessments with priority populations. These populations include male youth; Indigenous youth; newcomer, immigrant and refugee youth; LGBTQ2SIA+ (lesbian, gay, bisexual, transgender, queer, two-spirit, intersex, asexual) youth; and youth with (dis)abilities (Government of Alberta, 2019). During our search, we also found information specific to rural youth, and so also include that information in **Appendix C** and Section 3.3.

2.3.1 Dissertation review.

Relevant dissertations were located by searching ProQuest Theses and Dissertations on July 13th, 2020. Searches were conducted by a doctoral-level research assistant (CFC). The search was focused on male youth; Indigenous youth; newcomer, immigrant and refugee youth; LGBTQ2SIA+ youth; and youth with (dis)abilities. Search terms were identified using database subject headings, and included ("adolescent and young adult men" OR “adolescent male") OR ("Native Americans" OR "Native children & youth" OR "Indigenous peoples" OR "First Nations" OR Indigenous OR "Indigenous youth") OR ("immigrant students" OR immigrants OR immigrant) OR ("immigrants & refugees" OR refugee) OR ("transgender persons" OR "LGBTQ studies" OR bisexuality OR homosexuality OR queer OR lesbian OR pansexual OR nonbinary) OR ("disabled children" OR "disabled students" OR "disabled people" OR "youth with disabilities") AND (suicides OR “suicide attempts” OR suicid*) AND (teenagers OR youth OR teen* OR adolescen*) AND ("risk assessment" OR Assessment OR screen*) AND (telehealth OR eHealth OR telepsychology or eMental health). All strings were searched so that subject headings and keywords could be found anywhere in the document to maximize the number of returns.

2.3.1.1 Inclusion criteria for dissertations.

Searches were restricted to dissertations published in English in the prior 20 years (i.e., 2000 to 2020). As with peer-reviewed articles, searches were not restricted by geographic region or methodology.

2.3.1.2 Dissertation review procedures.

Screening of located dissertations was completed by a doctoral-level research assistant (CFC). The research assistant reviewed the title and abstracts of 618 potential dissertations. After screening, 608 dissertations were excluded because they

did not meet inclusion criteria (see 2.1.2). A final sample of ten dissertations remained for full-text review. Although no dissertations were found that focused on suicide risk assessment with specific youth populations using eHealth, five of these ten dissertations had general recommendations that we felt could be helpful for eHealth suicide risk assessment with youth. As such, data from these five dissertations were extracted by the research assistant using the same procedures as for peer-reviewed articles (see 2.1.4).

2.3.2 Distress centre review. To better understand suicide risk assessment practices for priority populations, a review of local and national Distress Centre websites was completed by two research assistants (MVB, EV). The search included Distress Centre websites from Canada, Australia, the United States and England. These countries were selected due to similarities to Canada in demographics, as well as policies and practices for suicide prevention. The aim of the search was to identify Distress Centre websites that contained relevant information on suicide prevention and/or suicide risk assessments with priority populations. The priority populations considered were male youth; Indigenous youth; newcomer, immigrant and refugee youth; LGBTQ2SIA+ youth; and youth with (dis)abilities. Distress Centre websites directed to the general population, but that also contained specific information on priority populations, were included. A Google search of this grey literature source was conducted between July 7th and July 23rd using the terms ("Distress Centre" AND Canada OR Australia OR "United States" OR England). This general search was followed by a specific search where the following terms were added ((men OR immigrant OR newcomer OR refugee OR LGBTQ+ OR disability) AND (youth OR adolescents)). Websites were included if they discussed the process of conducting suicide risk assessments and if the information was relevant to priority population youth.

Between July 7th and July 23rd, 2020, the two research assistants screened 25 websites (16 from Canada; 6 from Australia; 2 from the United States; and 1 from England) and found four that contained relevant resources. LBGT Youthline is a Canadian Distress Centre with recommendations on working with LGBTQ2SIA+ youth. QLife (another resource specific to LGBTQ2SIA+ individuals) in Australia also contained information relevant to the aim of this search. Third, CAMS-Care in the United States contained three relevant resources on suicide

risk assessment with priority populations. Finally, the National Suicide Prevention Lifeline in the United States also offered a relevant recommendation for caregivers of Indigenous youth.

The 25 websites screened in this part of the search were:

a) General Distress Lines

- CAMS-Care - https://cams-care.com/resources/educational-content/a-guide-to-contextualizing-the-reality-of-systemic-racism-and-black-suicidology/
- Canadian Mental Health Association Edmonton Distress Line - https://edmonton.cmha.ca/programs-services/distress-line/
- Crisis Centre: Youth in BC - https://youthinbc.com
- Crisis Services Canada - https://www.crisisservicescanada.ca/en/
- Distress Centre Calgary - https://www.distresscentre.com
- Distress Centres of Greater Toronto - https://www.spectrahelpline.org
- Distress Centre Ottawa and Region - https://www.dcottawa.on.ca/24-7-distress-line/
- FraserHealth - https://www.fraserhealth.ca/health-topics-a-to-z/mental-health-and-substance-use/conditions-and-symptoms/suicide-and-suicidal-thoughts#.Xw9f8C85Q1g
- Kids Help Phone - https://kidshelpphone.ca
- Mind for Better Mental Health - https://www.mind.org.uk/information-support/guides-to-support-and-services/crisis-services/helplines-listening-services/
- National Suicide Prevention Lifeline - https://suicidepreventionlifeline.org/help-yourself/native-americans/
- On the Line - https://ontheline.org.au/counselling-services/
- Suicide Call Back Service - https://www.suicidecallbackservice.org.au

b) Distress Lines Specific to LGBTQ2SIA+ Individuals

- Goodhead.ca - https://goodhead.ca/en/about/#what
- Intersect: Identity, Spirituality, Wellbeing - http://www.lgbtiqintersect.org.au
- LBGT Youthline - https://www.youthline.ca/get-support/ways-we-support/
- LGBTQ Prideline Durham Helpline -https://distresscentredurham.com/gethelp/lgbtprideline/
- Mental Health Commission -Sexual Minorities and Suicide - https://www.mentalhealthcommission.ca/sites/default/files/2019-05/Sexual%20minorities%20and%20suicide%20fact%20sheet.pdf
- Q Life - https://qlife.org.au/resources/qguides
- The Trevor Project - https://www.lifevoice.ca/crisis-supports/LGBTQ-crisis-supports
- Trans Lifeline - https://www.translifeline.org/in-the-media

c) Distress Lines Specific to Men

- On the line: MensLineAustralia - https://ontheline.org.au/mental-health-helplines/mens-mental-and-social-health/

d) Distress Lines Specific to Indigenous Populations

- Crisis Centre: First Nations Health Authority - https://crisiscentre.bc.ca/fnha/
- Indian Residential School Crisis Line - https://sk.211.ca/service/21339693_23395989/indian_residential_school_crisis_line
- Kamatsiaqtut Nunavut Helpline - http://nunavuthelpline.ca

2.3.3 Indigenous departments and related websites. Indigenous-focused government departments and other Indigenous-specific websites were searched to locate additional

information on suicide risk assessment with Indigenous peoples. Indigenous departments are (typically colonial) government offices responsible for policies related to Indigenous peoples. Indigenous departments often operate at the federal level.

Indigenous departments and other Indigenous-specific websites in Canada, the United States, and Australia were reviewed by two research assistants (MVB, EV). These three countries were selected for review as their Indigenous populations share a common history of resisting and surviving colonization. A Google search of grey literature was conducted between July 7th and July 24th, 2020. Specifically, a Google search was conducted for the search terms: ("Indigenous Department" OR "Aboriginal Department" OR "American Indian Department") AND (Canada OR "United States" OR Australia). To capture any missing websites, a general search was then conducted using the terms ("suicide prevention" OR "suicide risk assessment") AND ("Indigenous Department" OR "Aboriginal Department" OR"American Indian Department"). Twenty-seven websites were identified and screened for relevant information (12 from Canada; 8 from Australia; 7 from the United States). Websites were included if they discussed virtual/remote risk assessments with Indigenous populations or culturally appropriate suicide prevention efforts with Indigenous populations. Of these twenty-seven websites, nine contained relevant information on suicide prevention and/or risk assessments with Indigenous peoples. The 27 websites screened in this part of the search were:

- Alberta Native News - https://www.albertanativenews.com
- Assembly of First Nations - https://www.afn.ca
- Association on American Indian Affairs - https://www.indian-affairs.org
- Australian Government - https://www.indigenous.gov.au
- Centre for Suicide Prevention - https://www.suicideinfo.ca/resource/indigenous-suicide-prevention/
- Egale - https://egale.ca/wp-content/uploads/2012/12/LGBTQ-YSPS-Conference-Paper.pdf
- Health.vic - https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/suicide-prevention-in-mental-health-services/suicide-risk-and-Aboriginal-people
- Indian Health Services - https://www.ihs.gov/suicideprevention/riskfactors/
- Indigenous Affairs Office – https://www.toronto.ca/city-government/accessibility-human-rights/indigenous-affairs-office/
- Indigenous and Northern Affairs Canada - https://www.canada.ca/en/indigenous-northern-affairs.html
- Indigenous Services Canada - https://www.canada.ca/en/indigenous-northern-affairs.html
- Ministry of Indigenous Affairs - https://www.ontario.ca/page/ministry-indigenous-affairs
- Ministry of Indigenous Relations and Reconciliation - https://www2.gov.bc.ca/gov/content/governments/organizational-structure/ministries-organizations/ministries/indigenous-relations-reconciliation
- National Congress of American Indians - http://www.ncai.org
- National Indigenous Australians Agency - https://www.niaa.gov.au

- Native American Rights Fund - https://www.narf.org
- Principles of Practice in Mental Health Assessment with Aboriginal Australians - https://www.telethonkids.org.au/globalassets/media/documents/aboriginal-health/working-together-second-edition/wt-part-4-chapt-16-final.pdf
- Statistics Canada - https://www150.statcan.gc.ca/n1/pub/99-011-x/99-011-x2019001-eng.htm
- The Aboriginal Healing Foundation - http://www.ahf.ca/downloads/suicide.pdf
- The Australian Indigenous Psychologists Association – www.indigenouspsychology.com.au
- The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention - https://www.cbpatsisp.com.au/our-research/screening-assessment-tools/
- The Medical Journal of Australia - https://www.mja.com.au/journal/2019/210/6/telehealth-game-changer-closing-gap-remote-aboriginal-communities
- Thunderbird Partnership Foundation - https://thunderbirdpf.org/nnapf-document-library/
- Tribal Court Clearing House- http://www.tribal-institute.org/index.htm
- U.S. Department of the Interior – https://www.doi.gov/tribes
- U.S. Department of the Interior Indian Affairs - https://www.bia.gov/bia
- Victorian Transcultural Mental Health website - http://www.vtmh-culturalassessmentformulation.online/interview#/cfi/

While searching for websites that were relevant to Indigenous populations, two United States websites related to farming and rural communities were found along with a webinar, which we felt might be relevant to the broader goals of this review. Thus, these three sources were also included, in order to provide specific information for conducting assessments with rural youth.

- Depression, Alcohol and Farm Stress: Addressing Co-occurring Disorders in Rural America - https://mhttcnetwork.org/sites/default/files/2020-04/depression-alchohol-and-farm-stress_0.pdf
- Mental Health Technology Transfer Center Network - https://mhttcnetwork.org/centers/mountain-plains-mhttc/event/providing-mental-health-telehealth-services-farming-and-rural
- National Association for Rural Health - https://www.narmh.org/

2.3.4 Additional searches for priority populations: National, provincial, and state suicide prevention plans/documents.

Finally, a grey literature search was conducted using Google to better understand national, provincial, state and/or county approaches to suicide prevention. This search was conducted by four research assistants (RRR, SG, EV & MVB) between July 6th and July 31st, 2020. This search was focused on exploring suicide prevention policies for male youth; Indigenous youth; newcomer, immigrant and refugee youth; LGBTQ2SIA+ youth; and youth with (dis)abilities within Canada, Australia, the United States, and the United Kingdom. Each country was first searched nationwide followed by individual provinces/states/counties. The search terms were “male youth”OR “Indigenous youth” OR “immigrant youth”OR “newcomer youth” OR “refugee youth” OR “LGBTQ+ youth” OR “youth with disabilities” AND “suicide prevention,” combined with a location. For example, to search Google for suicide prevention plans for male youth in Canada, the search terms were (“male youth” AND “suicide

prevention" AND "Canada"). Following this specific population search, a general search was also conducted (e.g., "suicide prevention" AND Canada) to ensure no documents were missed due to differing vocabulary (e.g., Aboriginal vs. Indigenous). A total of 735 documents were screened for inclusion to determine if they pertained to suicide prevention efforts with a priority population and/or discussed virtual/remote methods of suicide risk assessment/prevention. Screening of documents was completed by five research assistants (CFC, EV, MVB, RRR & SG). Documents were analyzed for recommendations on eHealth suicide risk assessment with priority populations. The number of articles scanned and included are provided within the description of findings for each country (see **Appendix C**).

3. Findings

3.1 Peer-Reviewed Literature

3.1.1 Description of included articles.

We did not find any articles that directly addressed our research question (i.e., promising practices for conducting suicide risk assessment with youth via eHealth in school-based settings). However, we did locate 12 articles which – while not directly focused on our question – did provide recommendations we thought were relevant and could inform future research and practice on school-based suicide risk assessment with youth via eHealth (Table 1). Included articles used samples from the United States (n=5), Australia (n=3), the United Kingdom (n=2), and Indonesia (n=1) (Table 1). All articles were published between 2008 and 2020, with the majority (83.3%) published since 2015 (Figure 2). The most common study design was quantitative (Figure 3). For non-review articles, most samples were comprised of youth ages 12-25 (Table 1). We also included one qualitative article whose sample was comprised of eMental health professionals (Navarro, Sheffield, Edirippulige, & Bambling, 2020), and one article that described risk assessment outcomes for an eMental health clinic for adults, as the recommendations were highly relevant to our study (Nielssen et al., 2015). The sample size in included articles ranged from 9 to 9061 (Table 1).

While youth, in general, experience elevated risk of suicide (Miller & Prinstein, 2019), youth at disproportionate risk are those that experience marginalization due to certain aspect(s) of their identity (e.g., Indigenous youth; newcomer and refugee youth; immigrant youth; LGBTQ2SIA+ youth; and youth with (dis)abilities; Cha et al., 2018; Goldston et al., 2008; Government of Alberta, 2019). Due to stereotypical gender role norms that discourage help-seeking, male youth are also at heightened risk (Government of Alberta, 2019). Thus, in summarizing included studies, we specifically explored if they included consideration of ethnocultural group, gender, and/or LGBTQ2SIA+ identity (Table 1). Of relevant studies (i.e., non-review articles, n=9), we found that 88.9% (n=8) reported on participant (cis)gender, 55.6% (n=5) reported on participant ethnocultural group, and 11.1% (n=1) reported on LGBTQ2SIA+ identity (by stating there were 0 transgender individuals in their sample; Radovic et al., 2018). Where (cis)gender and ethnocultural group were reported, samples were primarily female-identified (range, 55.6%-81.0%; median = 68.9%) and White (range, 67.0%-98.5%; median =

72.9%). Thus, relevant recommendations (see Section 3.1.2) should be interpreted with caution, as they primarily pertain to White, female-identified and likely heterosexual youth.

Table 1. Summary of Relevant Peer-Reviewed Articles (n=12)

Authors & year	Study design	Study location	Sample size	Sample age, range or mean (SD)	% white	% female	% LGBTQ2SIA+	Brief study description
Anderson et al., 2017	Review of lessons learned	Australia	-	12-18	-	-	-	Shares lessons learned in the development and evaluation of a fully automated internet-based cognitive behavioral therapy (iCBT) program for youth experiencing symptoms of OCD
Arjadi et al., 2018	Quantitative	Indonesia	313	24.5[a]	-	81.0[a]	-	Presents a randomized controlled trial of the Guided Act and Feel Indonesia (GAF-ID) program, an online behavioural activation intervention which includes lay support
Fairchild et al., 2020	Quantitative	United States	87	5-17	98.5	66.0	-	Evaluates the outcomes of children and youth who received telemental health services within a rural emergency department
Goodday et al., 2020	Review of lessons learned	United Kingdom	-	-	-	-	-	Reports on experiences using the True Colours remote mood monitoring system across a large number of users and settings
Haas et al., 2008	Mixed methods	United States	1162	Under-graduate students	-	71.8	-	Evaluates an interactive, Web-based approach to encourage youth at risk of suicide to seek help
King et al., 2015	Quantitative	United States	76	22.9 (5.0)	71.1[a]	59.2[a]	-	Evaluates the effectiveness of an online intervention (*e*Bridge) for college students at risk of suicide
Navarro et al., 2020	Qualitative	Australia	9	27-67; mean (SD) age 42.6 (14.3)	-	55.6[a]	-	Explores how eMental health professionals view youths' reasons for accessing text-based online counseling, and moderators of service delivery effectiveness
Nelson et al., 2011	Literature review	-	-	-	-	-	-	Reviews the telepsychology literature (using video to deliver evaluation and/or treatment); Presents telepsychology guidance for current practice environments
Nielssen et al., 2015	Quantitative	Australia	9061	18+	-	-	-	Reviews procedures used to manage risk and case summaries for adults who were urgently referred for crisis intervention while using a remote screening assessment/therapy clinic (MindSpot)

Radovic et al., 2018	Mixed methods	United States	96	14-26	67.0	75.0	0 trans-gender individuals	Evaluates the feasibility, acceptability and utility of a social media website (SOVA) designed to improve mental health literacy and decrease negative health beliefs about depression/anxiety, among youth with a history of depressive or anxiety symptoms
Sayal et al., 2019	Mixed methods	United Kingdom	22	16-30	95.5[a]	77.3[a]	-	Reviews the feasibility of a randomized controlled trial of a remotely delivered problem-solving cognitive behavior therapy for youth with repeat self-harm and depression (e-DASH)
Thomas et al., 2018	Quantitative	United States	494	1-19 (mean age 13.2[a])	72.9[a]	60.1[a]	-	Evaluates a telepsychiatry program at a geographically dispersed pediatric emergency department

[a]Hand calculated from information in the article

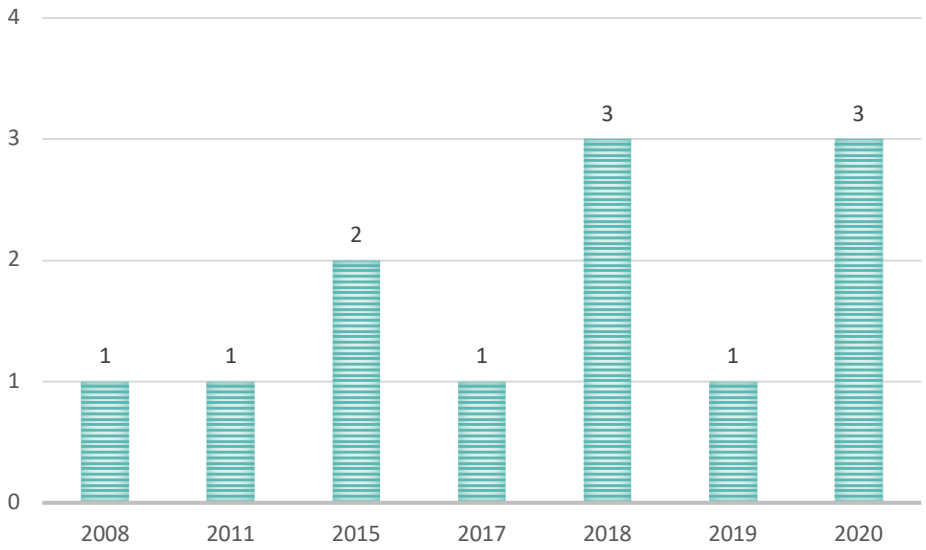

Figure 2. Number of included peer-reviewed articles, by study year

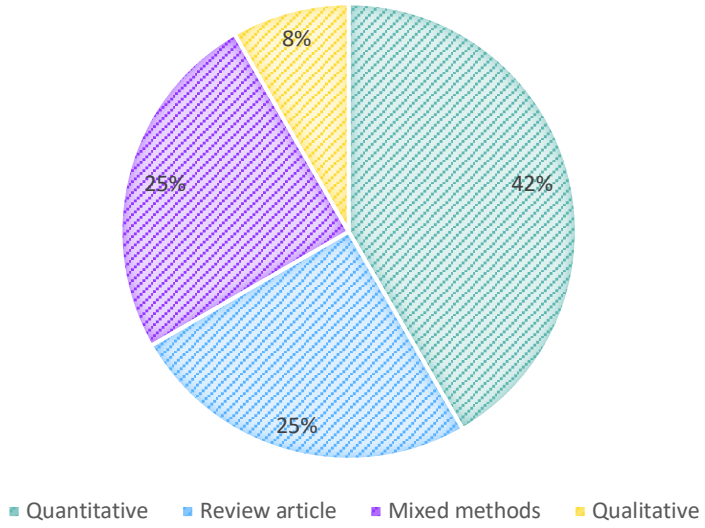

Figure 3. Study design of included peer-reviewed articles

3.1.2 Relevant recommendations. To organize relevant recommendations extracted using the standardized data charting template, the first author inductively applied codes to recommendations using Dedoose (an online mixed-methods data analysis software). Codes were then reviewed and revised by the second author. From this coding, five categories of relevant recommendations emerged: 1) accessibility; 2) consent procedures; 3) session logistics; 4) safety planning; and 5) internet privacy (Table 2). Several studies also specifically noted strengths and barriers of using virtual/remote methods for mental health service delivery, which were relevant to the objective of our review (Table 3).

3.1.2.1 Accessibility. Two articles discussed recommendations relevant to accessibility of eMental health services generally, which also seemed potentially relevant for using eHealth for youth suicide risk assessment within school settings (Arjadi et al., 2018; Navarro et al., 2020). Both articles were original studies. One original study from Indonesia was conducted with youth whose mean age was 24.5 (Arjadi et al., 2018), and the other from Australia was a qualitative study with service providers (Navarro et al., 2020). The samples were primarily female (median=68.3%). In their article, Arjadi et al. (2018) point out that there are important contextual factors around accessibility to consider when working in the eHealth environment, for example ensuring that service delivery is accessible for individuals living in poverty, in rural areas and/or with restricted internet access (Table 2).

3.1.2.2 Consent procedures. Two articles discussed recommendations relevant to consent procedures in the eHealth environment (Nelson, Bui, & Velasquez, 2011; Sayal et al., 2019). One of these articles was an original study from the United Kingdom conducted with individuals ranging in age from 16-30 (95.5% white, 77.3% female; Sayal et al., 2019), and the other was a review article (Nelson et al., 2011). Recommendations included ensuring that the provider had the name and contact information for the primary caregiver (and, given the potential need to contact someone quickly, service providers may wish to have the names/contact information for several supportive adults prior to starting the session, in case an urgent suicide risk emerges; Table 2). It is also important that the youth/caregiver knows who they should contact in case of crisis, especially when the school-based provider is not available, and that the consent form describes the risks and benefits of eMental health (Table 2).

3.1.2.3 Session logistics. Five articles discussed recommendations relevant to virtual/remote session logistics (Arjadi et al., 2018; Haas et al., 2008; Nelson et al., 2011; Nielssen et al., 2015; Radovic et al., 2018). Four of these articles were original studies from the United States, Indonesia and Australia (Arjadi et al., 2018; Haas et al., 2008; Nielssen et al., 2015; Radovic et al., 2018), and one was a review article (Nelson et al., 2011). Where information was reported, the original studies were conducted primarily with older, predominately female youth and/or adults, and, for the articles conducted in the United States and Australia, samples were primarily White. From their experience working with over 9000 adults in an eMental health setting in Australia, Nielssen et al. (2015) concluded that (for adults), online suicide risk assessments should follow the same basic steps as in-person risk assessments, including specific protocols and procedures. However, given the nuances in the eHealth environment (e.g., non-verbal clues; how to communicate the safety plan to youth and caregivers), service providers should receive specific training on how to conduct suicide risk assessments via eHealth (Table 2). Providers should also have a back-up plan in case the youth is in crisis and internet and/or technology issues occur, and go over this plan at the beginning of the session (Table 2). Finally, it is important that providers understand relevant professional requirements for providing eMental health services to youth at risk for suicide.

3.1.2.4 Safety planning. Nine articles discussed recommendations relevant to eHealth safety planning (Anderson, Rees, & Finlay-Jones, 2017; Arjadi et al., 2018; Fairchild et al., 2020; Goodday et al., 2020; King et al., 2015; Nelson et al., 2011; Nielssen et al., 2015; Sayal et al., 2019; Thomas et al., 2018). Six of these articles were original studies from Australia, the United Kingdom, the United States and Indonesia (Arjadi et al., 2018; Fairchild et al., 2020; King et al., 2015; Nielssen et al., 2015; Sayal et al., 2019; Thomas et al., 2018), and three were review articles (Anderson et al., 2017; Goodday et al., 2020; Nelson et al., 2011). Where information was reported, the original studies were conducted primarily with older, predominately female youth and/or adults, and, for the articles conducted in the United States, the United Kingdom and Australia, samples were primarily White (median=84.2%). A relevant recommendation emerging from this work is the potential use of screening data and personalized feedback to remotely monitor risk and increase youth engagement, respectively (Table 2). Specifically, since

service providers are not interacting with students daily at school, these screening data may help providers monitor for risk in the remote environment. Related to this, Nelson et al. (2011) suggest that more check-ins may be required when using an online format as compared to the in-person environment, especially for youth who are more isolated (e.g., rural youth). Finally, it is important to provide clear guidelines to caregivers on how to manage risk and seek appropriate help (Table 2).

3.1.2.5 Internet privacy. Four articles discussed recommendations relevant to internet privacy when providing mental health services virtually/remotely (Arjadi et al., 2018; Haas et al., 2008; Nelson et al., 2011; Thomas et al., 2018). Three of these articles were original studies from the United States and Indonesia (Arjadi et al., 2018; Haas et al., 2008; Thomas et al., 2018), and one was a review article that discussed internet privacy issues (Nelson et al., 2011). Where information was reported, original study samples were primarily comprised of older, predominately female youth, and samples from the United States were predominately white. Recommendations included using an encrypted email to send session invitations, and to ensure the virtual/remote session hosting platform is compliant with relevant health privacy laws (Table 2). Storage of youth information (e.g., email addresses, cell phone numbers) is also an important privacy consideration (Table 2). Reviewing the telepsychology literature, Nelson et al. (2011) also recommend asking youth who else is in the room, and whether they are comfortable having those people there/whether those people's presence complies with health privacy laws (who is in the room should also be considered on the service provider side, to ensure that the assessment is conducted privately and confidentially).

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Table 2. Relevant recommendations for eHealth suicide risk assessment with youth from peer-reviewed articles, by theme

Theme	Relevant Recommendations
Accessibility	• Ensure sessions are accessible for youth with restricted internet access (e.g., youth living in poverty, rural/remote youth; Arjadi et al., 2018) • Consider providing youth with session transcripts to help them remember information and strategies to use in daily life, if aligned with privacy requirements (Navarro et al., 2020)

Consent procedures	• Consent for service form should include the name and contact information for multiple adult contacts, in case one is not available (Sayal et al., 2019)[a]
	  ○ Consent should detail who the youth/caregiver should contact in case of crisis, especially when school-based eMental health services are not available (Nelson et al., 2011)
	  ○ Consent for service form should also describe risks and benefits of eMental health (Nelson et al., 2011)
	  ○ Service providers should maintain communication with caregivers to ensure continuity of care (Nelson et al., 2011)

Session logistics	• Ask youth participants to provide contact information for themselves and one supportive adult at the beginning of each session in case you are disconnected and need to get support to them (Radovic et al., 2018) • Service providers require training and clinical supervision to provide suicide assessment via eHealth (Nielssen et al., 2015) • Have a back-up plan in case there are internet or technology issues *before* the session starts, and ensure the youth understands this plan (Nelson et al., 2011) • If immediate risk is identified through standard assessment, refer youth to crisis mental health services (Arjadi et al., 2018; Nielssen et al., 2015) • Understand relevant professional requirements for providing eMental health services to youth at risk for suicide within the school setting (Haas et al., 2008)

Safety planning	• Online risk assessments follow same basic steps as in-person risk assessments (e.g., completing a safety plan; having information for in-person resources and emergency services ready before session, in case needed; Nielssen et al., 2015)[a]
	  ○ Like in-person assessments, specific suicide risk assessment protocols and procedures outlining steps and reporting requirements should be provided to all service providers (Nielssen et al., 2015; Sayal et al., 2019)
	  ○ Core professional principles and ethics remain critical in the eHealth environment (Nelson et al., 2011)
	• If risk is not immediate, develop a safety plan – send the safety plan to the youth and their caregiver, and include contact information for 24 hour resources (Nielssen et al., 2015; Fairchild et al., 2020)
	  ○ If possible, continually monitor risk via weekly online assessments; if risk increases, contact the caregiver and the youth (Nielssen et al., 2015)

	• Consider using ongoing screening data, and having youth provide data on an agreed upon schedule (e.g., daily, at agreed upon times, through weekly online assessments), to remotely monitor risk (Arjadi et al., 2018; Goodday et al., 2020; Nielssen et al., 2015)
	  ○ Providing youth with ongoing, personalized feedback on suicide risk indicators and then giving them the option to receive online counselling can have a positive impact on engagement in professional mental health treatment (Anderson et al., 2017; King et al., 2015)
	  ○ More check-ins may be required than when youth are in school, depending on the level of isolation of the youth (Nelson et al., 2011)
	• Inform caregivers if suicide risk issues arise, and provide clear guidelines to caregivers on how to manage risk and seek appropriate help (Anderson et al., 2017)[a]
	  ○ Notify caregivers of the risk, recommended next steps, and a list of appropriate crisis services and support agencies (Anderson et al., 2017)
	  ○ Consider having a caregiver sit with the youth when conducting risk assessment, if safe and age-appropriate (Fairchild et al., 2020; Thomas et al., 2018)

Internet privacy	• Send virtual session invitations via a secure and encrypted email (Thomas et al., 2018) • Give each youth a unique, non-identifying username and password (Arjadi et al., 2018; Haas et al., 2008) • Store youth information (e.g., email addresses) in an encrypted computer system (Haas et al., 2008) and use encrypted point-to-point technologies when videoconferencing (Nelson et al., 2011) • Ensure virtual session hosting platform is compliant with relevant health privacy law in your area (e.g., HIPAA) (Thomas et al., 2018) ○ Determine who is in the room on both sides (other than the youth and service provider), and ensure that the people in the rooms meet privacy law requirements (Nelson et al., 2011)

[a]One of our expert reviewers noted that the consent procedures described by these articles are not as applicable for the school context (particularly around the need for caregiver involvement and youth safety planning). In the typical school setting, providers are able to conduct a suicide risk assessment without caregiver consent because there are adults in the school who will monitor the youth for safety throughout the process (i.e., once a disclosure has been made, youth are never left alone). At the end of the risk assessment process, the school provider then contacts the youth's caregiver so that the caregiver can continue supervision as part of the safety plan. However, in the eHealth environment, school providers generally need to notify the caregiver *before* beginning the risk assessment process, in order to ensure the youth's immediate safety (i.e., caregiver notification is done during the initial assessment in the eHealth environment, and not during the safety planning process). If it is not safe to contact the caregiver, and the need is urgent, the police and/or Children's Services may need to be called to bring the youth to a setting for the assessment where there is supervision. Given these differences in the school environment, the literature for consent for eHealth does not completely align with school-based risk assessment, as the school-based setting is less straightforward than a typical eMental health setting with adults. Research that is specific to conducting eHealth suicide risk assessment with youth in the school environment is critically needed.

3.1.2.6 Strengths and barriers. Nine articles discussed specific strengths of eMental health care for youth that were also deemed relevant to the objective of our study, and nine articles discussed barriers or gaps (Table 3). Strengths of virtual/remote mental health service delivery include increasing youth choice for intervention setting and engaging students that may be hard to reach using traditional face-to-face methods, including rural and remote youth. However, specific barriers also exist, including potential issues with poor internet connectivity/access; financial costs for youth and families to obtain necessary equipment (e.g., computer with a camera); and additional training required for service providers (Table 3).

Table 3. Strengths and gaps of eMental health care from the peer-reviewed literature, as relevant to virtual/remote suicide risk assessment with youth

Strengths	Barriers/Gaps
• Having eMental health options available can increase participant choice for intervention (Goodday et al., 2020; King et al., 2015; Sayal et al., 2019) ○ eMental health can facilitate communication across family members and systems of care (e.g., teachers, case managers) when creating an intervention plan (Nelson et al., 2011) • May be able to reach students who don't seek help using traditional face-to-face formats (Haas et al., 2008; Navarro et al., 2020) or who have had a previous negative in-person experience (Navarro et al., 2020) • May be especially beneficial to reach rural and remote youth (Arjadi et al., 2018; Fairchild et al., 2020; Navarro et al., 2020; Thomas et al., 2018) • eMental health options are considered to be cost effective for both youth and providers (Arjadi et al., 2018; Nelson et al., 2011; Thomas et al., 2018)	• Poor internet connectivity/access can create access issues (Arjadi et al., 2018; Navarro et al., 2020; Sayal et al., 2019) • Financial costs for youth to access needed equipment (e.g., computer with camera) (Arjadi et al., 2018; Fairchild et al., 2020) • Additional training for staff may be required (King et al., 2015; Nelson et al., 2011) • If service is provided over the telephone, difficult to assess non-verbal cues (Navarro et al., 2020) • Effect of eMental health services on youth/provider relationship unknown (Thomas et al., 2018) • Potential data security concerns, that may be heightened by youth's living situation (e.g., lack of privacy; living with violence in the home) (Goodday et al., 2020; Haas et al., 2008; Sayal et al., 2019)

3.2 Grey Literature[a]

Overall, there was much more specific and detailed information in the grey literature (i.e., documents from relevant websites) on using eMental health with youth, both generally and to conduct suicide risk assessments. In total, from the 17 websites, we extracted relevant recommendations from 23 documents. These sources were located through the American Psychological Association; Mental Health Commission of Canada; Mental Health Technology Transfer Center Networks; National Center for School Mental Health; National Association of School Psychologists; Ontario Centre of Excellence for Child & Youth Mental Health; School Mental Health Ontario; Suicide Prevention Resource Center; Together To Live; and ZEROSuicide Institute websites. Resources highlighted that during COVID-19, it is especially important to assess youth at risk of suicide on an ongoing and regular basis, given the stressful changes many youth are experiencing (ZERO Suicide Institute, n.d.c).

The first and second author reviewed the 23 relevant documents using the standardized data charting process, and summarized key content (**Appendix B**). The first author then created themes from these summaries, which were reviewed for accuracy by the second author. Specific recommendations from the grey literature fell into six primary categories: 1) building rapport/establishing a therapeutic space; 2) helping youth prepare for virtual/remote sessions; 3) school mental health professional boundaries; 4) consent procedures; 5) session logistics; and 6) safety planning. These themes substantially overlap with and expand on themes found in the peer-reviewed literature (**Appendix A**). However, more specific detail was provided in the grey literature than peer-reviewed literature. A summary of recommendations within each category is provided below. Full information on relevant grey literature sources is provided in **Appendix B.**

In addition to the number of specific recommendations, a second key difference between the grey and peer-reviewed literature was the former's focus on issues of equity and access, and how technology can reinforce inequalities (Hatcher, 2014). A number of resources

[a] Grey literature is "a field in library and information science that deals with the production, distribution, and access to multiple document types produced on all levels of government, academics, business, and organization in electronic and print formats not controlled by commercial publishing, i.e., where publishing is not the primary activity of the producing body." Definition from http://www.greylit.org/about.

specifically detailed that it is imperative for providers to consider youth's ability to use different virtual/remote technologies, and ensure that care is accessible (e.g., considering internet connection, data or phone minutes restrictions). For example, in a webinar from the Mental Health Technology Transfer Network, presenters highlighted that each youth should be evaluated based on their individual, communal and national culture (e.g., how different cultures demonstrate pain/distress; Evans, 2020). This webinar also highlighted that certain accents may become difficult to understand over technology, and it is key that providers recognize when someone may have difficulties understanding them/when they may have difficulties understanding someone else (Evans, 2020). In terms of language diversity, efforts should be made to provide services in the language in which the youth is most comfortable (Evans, 2020).

Another document discussed how remote methods may be especially valuable for LGBTQ2SIA+ youth in rural settings (Stapel, n.d.). Gender is also important to consider, as youth who identify as female may be more likely to use online services (Ontario Centre of Excellence for Child & Youth Mental Health [CYMH] & Children's Mental Health Ontario [CMH], n.d.). Efforts should also be made to increase accessibility for any resources provided (e.g., closed captions, sign language, photos, etc.; Evans, 2020). Overall, it is critical for school mental health professionals to explore "intersections of culture, sociodemographics, geography, and technology" when providing eMental health services – including suicide risk assessment – with youth (Hilty et al., 2013, p. 452).

Table 4. Relevant recommendations for virtual/remote suicide risk assessment with youth from grey literature, by theme

Theme	Relevant Recommendations

Building rapport/ establishing a therapeutic space	• Make sure youth can see and hear you clearly (Ontario CYMH & School Mental Health Ontario [SMH], 2020; Reinert, 2020; Van Dyk et al., 2020) , and that your screen is big enough to see the youth's face (CYMH & SMH, 2020)
	  ○ Both auditory and visual information are key to providing good virtual care (CYMH & SMH, 2020), so it is ideal to have both sources of information if possible given the youth context
	  ○ It can be harder to pick-up on non-verbal cues in the virtual environment, so pay special attention to facial cues (CYMH & SMH, 2020). Also pay attention to youth's tone of voice, use of negative language and atypical speech patterns (Mental Health Technology Transfer Centre Network [MHTTC Network], n.d.).
	• Stay on screen the entire time and maintain eye contact (American Psychological Association [APA], 2020b; Cox, 2020). Make sure youth can clearly see your face throughout the session (Reinert, 2020; Van Dyk et al., 2020).
	• Discuss how to increase youth privacy (e.g., picking a time of day for the session that is quieter in the house, having a code word if someone is nearby, using chat if they can't speak privately, wearing headphones, password-protected sessions) (Cox, 2020; CYMH & SMH, 2020; National Association of School Psychologists [NASP], 2020a; Reinert, 2020; ZERO Suicide Institute, n.d.b)
	• Choose a mode of technology for sessions that meets youth needs/preferences (APA, 2020b; Cox, 2020; NASP, 2020a; NASP, 2020b; ZERO Suicide Institute, n.d.b)
	  ○ Equity and access issues are critical to consider (American School Counselor Association [ASCA], n.d.; CYMH & SMH, 2020). This can include using the phone/texting when internet is not an option (CYMH & SMH, 2020), and checking with youth how many phone minutes they have to talk (MHTTC Network, n.d.).
	• Set-up your room to promote youth comfort (e.g., remove personal items, minimize distractions, use a headset so your voice is clear, ensure you are well-lit, set-up your computer so you can maintain good eye contact) (Alvord, Baker & Associates, LLC, n.d.; APA, 2020b; CYMH & SMH, 2020; Van Dyk et al., 2020). Let youth know they can be informal and use a background or emojis if that makes them more comfortable (Van Dyk et al., 2020).
	• Discuss what virtual/remote sessions will look like (e.g., security concerns, whether the session will be recorded) (Alvord, Baker & Associates, LLC, n.d; Van Dyk et al., 2020). Reassure youth at start of the session that you are in a private space. (Cox, 2020; CYMH & SMH, 2020; Reinert, 2020). Let the youth see your whole office (CYMH & SMH, 2020; Van Dyk et al., 2020).
	• Keep youth engaged (e.g., use screen sharing, play a game together, have youth share a photo, show them things in your environment like art or toys) (CYMH & SMH, 2020; Lowenstein, n.d.; Van Dyk et al., 2020)
	  • Give the youth space to speak, since this can be more difficult in the remote environment (Van Dyk et al., 2020). Let youth know they can interrupt you at any time if they need to tell you something (CYMH & SMH, 2020).
	• Convey warmth and enthusiasm through your facial expressions and tone (Lowenstein, n.d.; Reinert, 2020)

	• Ask youth what they need from your virtual relationship, and how you can make them feel safe and secure (CYMH & SMH, 2020)
Helping youth prepare for virtual/remote sessions	• Help youth find a quiet, private place for your sessions where they will have minimal distractions (American Psychiatric Association, 2020; MHTTC Network, n.d.). Involve caregivers to make sure the space is private for the duration of your session (Cox, 2020). • Encourage youth to test out technology before using (ZERO Suicide Institute, n.d.a) • Remind youth to make sure their phone (or other device, such as a laptop) is fully charged before the session (Cox, 2020; MHTTC Network, n.d) • Suggest turning off smart devices to increase privacy (e.g., Alexa, Google Home) (Cox, 2020) • Encourage youth to write down what they want to talk about before session, and to bring a paper and pen to the session to take notes (American Psychiatric Association, 2020; MHTTC Network, n.d.)
School mental health professional boundaries	• Make sure youth and caregivers know when you are and aren't available, and who to contact when you are not available (ASCA, n.d.; CYMH & SMH, 2020; NASP, 2020a; NASP, 2020b; Reinert, 2020; Suicide Prevention Resource Centre [SPRC], 2020) ○ Arrange coverage periods if possible, and let youth know when you will be away (SPRC, 2020) • Connect with youth and caregivers using institutional (not personal) devices (ASCA, n.d.) • Have a clear schedule for when you meet with youth (Reinert, 2020)

Consent procedures	• Obtain caregiver consent/youth assent to conduct session remotely (Abrams, 2020; Alvord, Baker & Associates, LLC, n.d.; APA, 2020a; CYMH & SMH, 2020; NASP, 2020a)
	  ○ Consent topics include telling the youth you will not record the session without permission; whether you will use a webcam during the session (if relevant); using a secure internet connection; having a back-up plan (what to do if there are technology issues); having the name and contact information for at least one emergency contact; and knowing the closest emergency room to where the youth is (APA, 2020a)
	• The consent form can also detail (NASP, 2020a):
	  ○ A description of the eMental health service
	  ○ Any required technical considerations
	  ○ What you can and can't do (i.e., eMental health limits)
	  ○ Expectations of service provider, youth and caregiver
	  ○ Emergency contacts and multiple communication options
	  ○ What will happen if the youth is determined to be in immediate safety risk and/or what will happen if caregivers cannot provide supervision
	  ○ Consent for youth to participate in eMental health

Session logistics	• Make sure you are competent with whatever virtual/remote platform you plan to use and in providing risk assessment virtually/remotely (Abrams, 2020; Alvord, Baker & Associates, LLC, n.d; CYMH & SMH, 2020) Service providers need training and supervision (ZERO Suicide Institute, n.d.c). Have a plan for receiving remote supervision as needed (NASP, 2020a).
	  ○ Check your technology right before the session (e.g., for software updates) (Alvord, Baker & Associates, LLC, n.d)
	  ○ Ensure technology meets relevant privacy requirements (ZERO Suicide Institute, n.d.a). Understand relevant local laws and regulations around providing eMental health services (Telligen Health Information Technology Regional Extension Centre & Great Plains Telehealth Resource & Assistance Centre, 2014).
	  ○ Plan a practice session with youth, if possible, to make sure you are both comfortable (ZERO Suicide Institute, n.d.a)
	• Make sure you can access your school division's suicide risk assessment protocol electronically (NASP, 2020a)
	  ○ Completing a full suicide risk assessment virtually may be difficult, and so it is okay for service providers to focus on the most critical information needed to assess risk (SPRC, 2020)
	• Verify the youth's identity at the start of the session (if can't see them/haven't met them before) (Alvord, Baker & Associates, LLC, n.d.)
	• Confirm consent/assent (Alvord, Baker & Associates, LLC, n.d.)
	• Review privacy (Alvord, Baker & Associates, LLC, n.d.; CYMH & SMH, 2020)
	  ○ Check if the youth is safe to talk (Perlman et al., 2011). Be prepared for next steps if they say no.
	  ○ Take steps to mitigate any potential privacy issues (ASCA, n.d.). For example, having the youth play white noise from an app (SPRC, 2020). Discuss what to do if privacy is interrupted, like if a sibling walks in (e.g., use of code word, hitting mute, switching to chat) (Reinert, 2020; ZERO Suicide Institute, n.d.b).
	• Review safety precautions (Alvord, Baker & Associates, LLC, n.d.)
	  ○ Confirm the youth's physical location at start of the session (Alvord, Baker & Associates, LLC, n.d.; APA, 2020b; MHTTC Network, n.d.; NASP, 2020a; SPRC, 2020; Telligen Health Information Technology Regional Extension Centre & Great Plains Telehealth Resource & Assistance Centre, 2014; ZERO Suicide Institute, n.d.b)
	  ○ Have a back-up plan for what you will do if technology difficulties occur. Know how you can reach youth if you get disconnected (Alvord, Baker & Associates, LLC, n.d.; APA, 2020b; CYMH & SMH, 2020; MHTTC Network, n.d.; NASP, 2020a; ZERO Suicide Institute, n.d.a) and let them know how they can reach you (Alvord, Baker & Associates, LLC, n.d).
	  ○ Have a list of urgent and non-urgent nearby resources ready (Alvord, Baker & Associates, LLC, n.d). Know the 24/7 emergency services in your area and who you can/need to contact if the youth is at risk of suicide (NASP, 2020).
	  ○ Make sure you have up-to-date and accurate emergency contact information (that works) for at least one primary caregiver, and ensure this person is available in case they are needed (Alvord, Baker & Associates, LLC, n.d; APA, 2020a; Cox, 2020; MHTTC Network, n.d.; NASP, 2020a; SPRC, 2020; ZERO Suicide Institute, n.d.a; ZERO Suicide Institute, n.d.b). Can consider having information for one contact inside the house and one outside (Cox, 2020).

	• Monitor how youth is feeling (e.g., through messaging) throughout the session and slow things down if needed (Nassar, Costello, & Wolf-Prussan, 2020) • Have a plan for how you will stay connected to the youth if you need to contact emergency services (especially if you are connecting with them by phone) (SPRC, 2020; ZERO Suicide Institute, n.d.b). Stay connected with youth while you call 911 and until emergency services arrive (CYMH & SMH, 2020; MHTTC Network, n.d.). Maintain constant verbal (and if possible visual) contact until resources arrive (NASP, 2020). • Documentation is key – make sure to document when assessment started and ended, what platform you used/any technological difficulties, specific topics covered, and any other issues that occurred (CYMH & SMH, 2020; NASP, 2020a; ZERO Suicide Institute, n.d.a; ZERO Suicide Institute, n.d.b) • Close the session by asking what can be improved and making a plan for your next meeting (Cox, 2020; Zero Suicide Institute, n.d.b). If youth miss the session, check in with them to see what is going on and how you can adjust to make it easier/more comfortable for them to attend (CYMH & SMH, 2020).

Safety planning	• Overall, safety planning is the same as in person (Telligen Health Information Technology Regional Extension Centre & Great Plains Telehealth Resource & Assistance Centre, 2014). Work together to build a safety plan (e.g., by sharing screen) (ZERO Suicide Institute, n.d.a), and find a way to get the plan to them (e.g., email). (SPRC, 2020; ZERO Suicide Institute, n.d.a; ZERO Suicide Institute, n.d.b; ZERO Suicide Institute, n.d.c)
	  ○ Ask about increased access to lethal means (e.g., medication, firearms) (SPRC, 2020)
	  ○ Ask about additional COVID-19 related risk factors (e.g., social isolation, family financial stress) (SPRC, 2020)
	• Consider using virtual safety planning tools, like the My3 app (NASP, 2020a)
	• Check-ins may need to happen more often (SPRC, 2020; ZERO Suicide Institute, n.d.c). Consider using a short screener during check-ins to remotely monitor risk (NIMH, 2020; SPRC, 2020). Youth could also use an app to rate their mood/suicidal ideation daily, so they know when they might need urgent care (Kaslow, 2014). Can also use check-ins to review and update safety plans (Van Dyk et al., 2020).
	• Figure out a way for the youth to get a copy of their safety plan (e.g., text it to them, have them take a screenshot) (SPRC, 2020; ZERO Suicide Institute, n.d.a; ZERO Suicide Institute, n.d.b; ZERO Suicide Institute, n.d.c)
	  ○ Let the primary caregiver know you have developed a safety plan (CYMH & SMH, 2020; NASP, 2020a)
	  ○ Develop a plan with caregivers on how they can access support for themselves (ASCA, n.d.)
	• Identify coping strategies on the safety plan that can be done during COVID-19 (e.g., virtual activities, virtual connection with friends) (SPRC, 2020)
	• Encourage the youth to keep a daily schedule and make plans for each day (SPRC, 2020)

3.3 Priority Populations

The original set of grey literature websites we reviewed (see Section 3.2) provided more information about conducting eHealth suicide risk assessments with youth from priority populations than the relevant peer-reviewed literature (see Section 3.1). However, as understanding the specific needs of youth from these groups is important to effective risk assessment, we supplemented our original grey literature search of key websites with a number of additional searches specifically focused on priority populations (i.e., male youth; Indigenous youth; newcomer, immigrant and refugee youth; LGBTQ2SIA+ youth, and youth with (dis)abilities; Government of Alberta, 2019). See **Appendix C** for more information and a full summary of these resources. A full list of specific recommendations from these documents is provided in Table 5.

Similar to the peer-reviewed (see Section 3.1) and general grey (see Section 3.2) literature, most of the information in the documents located in this targeted search was not specific to school-based suicide risk assessment with youth via eHealth, but nonetheless provided relevant information that could be applied to virtual/remote risk assessment with priority populations. For example, across all priority populations, it was noted that it is important to use a holistic lens and to identify unique risk factors that could be impacting youth. This analysis should include both specific barriers, as well as what is important for creating a safe space for this population (e.g., asking about pronouns). Another overarching theme from these documents was the recommendation to partner with local communities (e.g., a local friendship centre) to understand locally relevant risk and protective factors that could be impacting individual youth. Related to this, it is important to recognize that, while we refer to them as priority populations, these groups are heterogenous and thus recommendations are likely not relevant in all contexts. Overall, then, it is important for school-based providers to recognize the heterogeneity within priority population groups, and, when planning to support these populations, to gather information from the local community/ies that will be served in order to understand their specific needs, strengths, risk/protective factors, and barriers to service provision in context. Thus, for risk assessment with local priority populations,

much of the work needs to be done *prior* to the process of engaging in school-based suicide risk assessment via eHealth.

3.3.1 Recommendations for male youth.

Recommendations for male youth fell into six categories: a) designing targeted approaches and understanding the unique needs of male youth (BACP, n.d.; Poole, 2016; Tucker, 2020), b) understanding stigma and other barriers that could compromise willingness of male youth to engage in eMental health support (Chadwick, Owens, & Morrissey, 2019; East Lancashire Hospitals NHS Trust, 2020; HM Government, 2019; Lancashire County Council Suicide Prevention Strategy, n.d.), c) creating online resources that are accessible and inviting (Gale, n.d.; Mokkenstorm et al., 2013), d) using male-friendly language (e.g., action based, goal-oriented; HM Government, 2019; The Australian Men's Health Forum, n.d.; Wilkins & Kemple, n.d.), and e) taking a problem solving-approach (Australian Government Department of Health and Ageing, 2008; Kõlves, Kumpala, & De Leo, 2013; The Australian Men's Health Forum, n.d.). Though some resources discussed emphasizing strength and bravery (HM Government, 2019; Wilkins & Kemple, n.d.), from a gendered perspective, this is not recommended, as these approaches can inadvertently reinforce health-harming gender norms (Flood, 2019).

3.3.2 Recommendations for Indigenous youth.

For Indigenous youth, it is important to consider the historical and current oppression faced by these youth in any risk assessment process (whether in-person or virtual) (Kaufman and Associates Inc. & Montana Department of Health and Human Services [MDHHS], 2017). In particular, service providers are encouraged to recognize the continued discrimination Indigenous peoples face when accessing mental health services, and incorporate this consideration into risk assessment and safety planning. Further, Indigenous youth may be (rightly) fearful of being removed from their home or punished for having suicidal thoughts or behaviours (Kaufman and Associates Inc. & MDHHS, 2017); thus, it is very important that providers are up front about the limits of confidentiality, so that youth and caregivers are fully informed.

Consistent with grey literature recommendations for the general population of youth (see Section 3.2), it is important to build rapport and create a safe space for Indigenous youth when conducting risk assessments via eHealth. However, for some Indigenous youth, a safe

space may also involve understanding cultural needs (i.e., emphasizing community and personal relationships; Victoria State Government, n.d.), conducting the assessment at a relaxed pace (Victoria State Government, n.d.), and referring youth to an Indigenous mental health professional for follow-up care, if available and desired by the youth and their family. Referrals to an Indigenous provider may be especially important when language barriers exist, so that youth can seek help in the language in which they are most comfortable (Dudgeon et al., 2018).

However, prior to engaging in culturally-focused work, it is critical that the provider explores how the youth interprets their Indigenous heritage. Specifically, due to the ongoing experience of colonization Indigenous youth face, they may have internalized stigma about their Indigenous identity, and thus emphasizing specific cultural needs or expectations may cause a negative reaction. In addition, youth and families may not want to work with an Indigenous counsellor or be referred to Indigenous services, as they are concerned about issues of confidentiality given the interconnected nature of their community. Thus, a choice should always be given as to service delivery options for Indigenous youth and their families.

When assessing risk and building a safety plan, holistic assessments that incorporate physical, mental, emotional *and* spiritual well-being were recommended when working with Indigenous youth (Kirmayer et al., 2007); however, this should again only be used after the provider explores how the youth interprets their Indigenous heritage, in order to honour the youth's voice and choice. In addition, including spiritual well-being is something that can be considered for all youth, and not only Indigenous youth.

Similar to recommendations for male youth, using youth-friendly language can also benefit the assessment process (Multi-Agency Alcohol and Substance Abuse Prevention Collaboration, 2015). It is also important to identify unique risk factors (including structural risk factors, e.g., discrimination) that could be impacting the individual (Trzesinski, 2015). Collaborating with local Indigenous communities was highlighted by several resources as an important way to determine unique needs and what culturally-relevant services are in place (Kirmayer et al., 2007), as well as understanding each community's views on suicide (Committee

on Indian Affairs, 2009; Committee on Indian Affairs, 2010; Kaufman and Associates Inc. & MDHHS, 2017; SAMHSA, n.d.; SPRC, n.d.b; Warren, Murkowski, Grijalva, & Cole, 2013).

3.3.3 Recommendations for newcomer, immigrant and refugee youth.

Similar to Indigenous groups, newcomer, immigrant, and refugee youth may also benefit from creating multilingual and culturally sensitive spaces for eHealth suicide risk assessment (Administration for Children and Families, 2015; Cambridgeshire County Council, 2019; Chadwick et al., 2019). Partnerships with different community organizations can support the identification of other internal and environmental factors that can create distress (Administration for Children and Families, 2015; Cambridgeshire County Council, 2019; HM Government, 2012). For Syrian refugees and immigrants in particular, one document highlighted that some youth may benefit from addressing specific concerns about Canadian mental health services (Yachouh, 2018).

3.3.4 Recommendations for LGBTQ2SIA+ youth.

A variety of resources with recommendations for working with LGBTQ2SIA+ youth underscored the importance of incorporating youths' narratives (Q Life, 2020), and recognizing the stigma experienced by sexual minorities (Salway, 2017). Similar to other groups, it is important to create a safe space to engage with youth. Practitioners should use gender-inclusive language and ask youth for their pronouns as part of building rapport and showing respect (NAMI, n.d.). Creating safe spaces and emphasizing staff training can also reduce LGBTQ2SIA+ youths' experiences with discrimination during suicide risk assessment (Abrar, 2019; Franks et al., 2010; SAMHSA, n.d.; Tasmanian Government, 2013). Specific to transgender youth, it is important to provide trans-friendly services (Welsh Government, 2019). For example, providers can list their pronouns alongside their screen name to show that they are comfortable talking about gender identity issues.

3.3.5 Recommendations for youth with (dis)abilities.

Fewer recommendations were found for youth with (dis)abilities. Youth with (dis)abilities might require support to manage and access technology (Hadley, 2018). Further, some youth might need adaptations to talk about suicide (e.g., text-to-speech technology) (Sussex Partnership NHS Foundation Trust, n.d.).

3.3.6 Recommendations for rural youth.

Fewer recommendations were found for rural youth. In rural communities, it is important to consider unique stressors (e.g., isolation,

increased access to lethal means) (Hazell et al., 2017; Welsh Government, 2015). In addition, several resources noted that technology has been helpful in preventing suicide in rural areas (Mental Health Commission of New South Wales, 2014; Robinson, Bailey, Browne, Cox, & Hooper, 2016; Roinn Sláinte & O'Poustie, 2019; The National Centre of Excellence in Youth Mental Health, 2016).

Table 5. Relevant recommendations for virtual/remote suicide risk assessment with youth from priority populations

Priority Population	Specific Recommendations

Male youth	• Male youth may require targeted approaches to better understand needs and prevent suicide attempts (BACP, n.d.; Poole, 2016; Tucker, 2020)
	  ○ Aim to strengthen social relationships and improve recognition of mental health issues (Welsh Government, 2015)
	  ○ Ask opinions on current services offered, rather than what services they want, in order to assess gaps in services (Chadwick et al., 2019; Suffolk User Forum, 2016)
	• It is important to consider barriers that influence willingness to engage with eHealth supports among male youth (Chadwick et al., 2019; East Lancashire Hospitals NHS Trust, 2020; HM Government, 2019; Lancashire County Council Suicide Prevention Strategy, n.d.)
	  ○ Create school campaigns to target stigma around male youth seeking help (BBC News, 2019; Caerphilly County Borough Council, 2019; Cardiff and Vale, n.d.; HM Government, 2017)
	  ○ Highlight positive masculine norms, such as courage and leadership (Kelly, 2019) (as noted in Section 3.3.1, this recommendation should be used <u>with caution</u>)
	  ○ Create opportunities for male youth to practice/observe help-seeking conversations with strangers (Chadwick et al., 2019)
	• Create online resources/risk assessments that are inviting and accessible (Gale, n.d.; Mokkenstorm et al., 2013)
	  ○ Make online resources/risk assessments interactive (Wilkins & Kemple, n.d.)
	  ○ Online resources/risk assessments should be private and confidential (Isle of Wight Council, n.d.; Oxford Health NHS Foundation Trust, n.d.; Wilkins & Kemple, n.d.)
	  ○ Encourage use of online resources/risk assessments wherever possible for male youth and those in contact with male youth, as this may be a more user-friendly format for these youth (CYMH & CMH, n.d.)
	• Use male friendly language (e.g., action based, focus on goals) (HM Government, 2012; The Australian Men's Health Forum, n.d.; Wilkins & Kemple, n.d.)
	• Emphasize a problem-solving focus (Australian Government Department of Health and Ageing, 2008; Kõlves et al., 2013; Poole, 2016; The Australian Men's Health Forum, n.d.)

Indigenous youth	*NOTE: Indigenous communities are diverse and these recommendations <u>may or may not apply</u> to specific groups/individuals. It is important for school-based providers to engage with local Indigenous communities to understand the local context, as well as unique risk and protective factors within that context. It is also important for provider's to explore the youth's own connection to their Indigenous identity and heritage.* • Consider historical and current oppression and discrimination faced by Indigenous youth in Canada (Kaufman & Associates Inc. & MDHHS, 2017) ○ Recognize the continued discrimination many Indigenous youth face in mental health settings

	○ Recognize that youth may be fearful of being removed from their home or punished for suicidal ideation or behaviours (Kaufman & Associates Inc & MDHHS, 2017) • Rapport building: Create a safe process for youth (The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, n.d.) ○ Assess at a relaxed pace and emphasize the role of community and personal relationships in safety planning (Victoria State Government, n.d.) ○ Focus the conversation by understanding cultural needs, if this fits the youth: Some individuals might prefer to talk about protective factors rather than suicide directly. Others might wish to include a family member or Indigenous health worker. ○ If further intervention is necessary, refer the individual to an Indigenous mental health professional/agency if available and if this is what they and their family want • Incorporate different languages ○ Address language barriers so all can seek help (Dudgeon et al., 2018) • Holistic assessment ○ Integrate a holistic framework into risk assessment that considers individual, family, community, and societal factors (Adams et al., n.d.; The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, n.d.). Consider the physical, mental, emotional, *and* spiritual aspects of well-being, if this fits the youth (Kirmayer et al., 2007). Consider the balance across different aspects of well-being (ACT Health, n.d.; Dudgeon et al., 2016; NMHS, 2017; NSW Government, Western NSW, & Far West Local Health Districts, 2020). ○ Understand views on suicide among local Indigenous communities so that these views are respected during the assessment ○ Follow DSM-5 guidelines for working with culturally diverse peoples (Adams et al., n.d.) ○ Assessments can benefit from youth-friendly language rooted in holistic health (e.g., the medicine wheel), if this fits the youth (Multi-Agency Alcohol and Substance Abuse Prevention Collaboration, 2015) • Unique risk and protective factors ○ Common risk factors include discrimination, isolation on reserve, and suicide clusters (Indian Health Services, n.d.) ○ Consider whether structural risk factors (e.g., victimization, discrimination) played a role in triggering suicidal ideation/behaviors (Trzesinski, 2015) ○ Consider intersecting identities (e.g., for a two-spirit Indigenous youth) in the assessment of risk and protective factors • Community-wide collaboration ○ Determine current culturally-relevant services that are in place, and identify the distinctive needs of youth from each local Indigenous community (Kirmayer et al., 2007)

	○ Connect and partner with local communities to explore their understanding of suicide and the impact of traditional knowledge on these views (Committee on Indian Affairs, 2009; Committee on Indian Affairs, 2010; Kaufman & Associates Incorporated & MDHHS, 2017; SAMHSA, n.d.; SPRC, n.d.b; Warren et al., 2013)
Newcomer, immigrant and refugee youth	*NOTE: Newcomer, immigrant and refugee youth are a heterogenous group from different parts of the world. Thus, these recommendations may or may not apply to certain populations. It is important for school-based providers to engage with local newcomer, immigrant and refugee communities to understand the local context, as well as unique risk and protective factors within that context. It is also important for provider's to explore the youth's own racial, ethnic and cultural identity.* • Provide suicide prevention services, including suicide risk assessment, that are culturally sensitive and available in different languages (Administration for Children & Families, 2015; Cambridgeshire County Council, 2019; Chadwick et al., 2019) ○ Consider suicide risk assessment screening tools that are culturally relevant for refugees (Sari, 2018) ○ Collaborate with organizations that have contact with refugees to improve appropriate identification of medical, social, and educational factors that should be included in the risk assessment (Chadwick et al., 2019; "East Sussex Suicide Prevention Plan", n.d.) ○ Tailor risk assessment to the needs of the refugee community by considering the variety of factors that could be impacting the individual (e.g., language barriers, PTSD) (Administration for Children & Families, 2015; Cambridgeshire County Council, 2019; HM Government, 2012) • Incorporate family-based mental health support (Yachouh, 2018), if this fits the youth • For some Syrian refugees, involving the individual's family could support service provision (Yachouh, 2018). Address individual concerns about mental health services. Some Syrian refugees might feel embarrassed or might perceive mental health support as exclusive to 'crazy people' (Yachouh, 2018).
LGBTQSIA+ youth	• Provide support that is culturally responsive (New York State Suicide Prevention Task Force, 2019; SPRC, 2008) ○ Suicide risk assessment can incorporate the LGBTQ2SIA+ youth's narrative and experiences with discrimination to inform care (Q Life, 2020) ○ Recognize the stigma that can precede distress in sexual minorities (Salway, 2017) ○ Consider the youth's intersecting identities when assessing risk for suicide (e.g., two-spirit Indigenous youth) ○ Consider individual differences, cultural diversity, and sexual preferences when adapting risk assessment forms (Victoria State Government, 2016) • Create a safe space ○ Ask youth the pronouns they use (NAMI, n.d.) – avoid assumptions regarding youth's sexual orientation or gender (SPRC, n.d.c) ○ Use gender-inclusive language (NAMI, n.d.) ○ Display an inclusive approach (e.g., having pride flags in your background) (NAMI, n.d.)

	○ Provide specialized training and raise awareness about specialized supports in the local community for LGBTQ2SIA+ youth (Abrar, 2019; Franks et al., 2010; SAMHSA, n.d.) ○ Train all school-based service providers to reduce experiences of discrimination and prejudice for LGBTQ2SIA+ youth (Tasmanian Government, 2013) • Consider risk factors specific to this population to appropriately address their needs (O'Hara, 2013) ○ Communicate directly with the local LGBTQ2SIA+ community to understand unique risks and protective factors in their social context (Christensen et al., 2013; Dudgeon et al., 2018; Robinson et al., 2016; Silburn et al., 2013) ○ Include LGBTQ2SIA+ youth input to strengthen assessment/safety planning strategies that target their specific needs (Kõlves et al., 2013; Mental Health Commission of New South Wales, 2014; Skerrett et al., 2013) • Trans youth ○ Provide trans-friendly services by including trans and non-binary options on records and promote the use of different titles such as 'Mx' (Welsh Government, 2019), or make the gender identity field one that the youth fills in themselves
Youth with (dis)abilities	*NOTE: Youth with(dis)abilities was a population not widely addressed within the literature. More research with this diverse population is needed to fully understand specific needs during eHealth suicide risk assessment.* • Adaptions need to be created for how to talk about suicide with youth with (dis)abilities (Sussex Partnership NHS Foundation Trust, n.d.)
Rural youth	• Incorporate unique stressors (i.e. isolation, increased lethal means) into suicide risk assessment services for youth living in rural and remote areas (Hazell et al., 2017; Welsh Government, 2015) ○ Encourage professionals completing risk assessments to ask and be aware of the local rural communities' unique risk factors (Welsh Government, 2015) • Consider the use of eMental Health services in providing suicide risk assessment, even post-pandemic. Technology has been a helpful tool for suicide prevention in rural areas (Government of Western Australia Mental Health Commission, 2019; Health and Sport Committee, n.d.; Primary Health Tasmania, 2018; Silburn et al., 2013; Suicide Prevention Australia, 2020) ○ Telehealth can address some of the challenges in mental health service delivery in rural communities by enhancing privacy, reducing costs, providing care that is culturally competent, and increasing access to services (Centre for Suicide Prevention, 2013)

4. Summary

While the amount of peer-reviewed and grey literature specifically focused on conducting school-based suicide risk assessments with youth via eHealth was very limited, we nonetheless located six common recommendations across the multiple sources reviewed for this knowledge synthesis (**Appendix A**).

1. *Youth engagement (accessibility, building rapport, establishing a therapeutic space and helping youth prepare for virtual/remote sessions)*
2. *School mental health professional boundaries*
3. *Consent procedures*
4. *Session logistics*
5. *Safety planning*
6. *Internet privacy*

Through our targeted search on information relevant to priority populations, we also describe a number of specific considerations for most of these six general recommendations (**Appendix A**). We hope these general recommendations and specific considerations are helpful to school-based providers as they continue to conduct suicide risk assessments with youth via eHealth during the COVID-19 pandemic and beyond. However, as these recommendations are generally from research conducted outside of the school setting, they should be applied with caution (e.g., recommendations around consent procedures). *Research that is specific to conducting eHealth suicide risk assessment with youth in the school environment is critically needed.*

In our comprehensive search of the peer-reviewed literature, we located no peer-reviewed articles that specifically described recommendations for conducting suicide risk assessments (school-based or otherwise) with youth via eHealth. Thus, this represents a major gap in the literature. Research is needed that specifically addresses school-based vs. community suicide risk assessment services that are delivered via eHealth, due to the different requirements in these settings (e.g., around confidentiality, liability). Of the 12 peer-reviewed articles that did provide some relevant information, they were also primarily focused on White, female, presumably heterosexual youth. As such, new research in this area should specifically concentrate on expanding diversity of youth participants.

While we located very limited peer-reviewed literature, we did locate a number of grey literature documents that gave specific recommendations in our search of key websites, and many of these recommendations overlapped and expanded upon the limited information available in the peer-reviewed literature (**Appendix A**). Thus, while more research needs to be conducted on best practices for conducting suicide risk assessment with youth via eHealth in the school setting, as school mental health professionals and decision makers are in need of immediate guidance in the face of COVID-19, we feel the relevant recommendations detailed by peer-reviewed and grey literature sources represent a set of six promising practices for current implementation. In our more targeted grey literature search (specifically focused on priority populations), we also found a number of specific additions to these six general best practices (**Appendix A**). While there are ways that school-based providers can make virtual/online suicide risk assessment a better fit for these youth in the moment, a key take-away from this targeted search is that much of the work to adapt suicide risk assessment protocols needs to be done *before* the risk assessment takes place, by working with local communities.

The lack of peer-reviewed research located in this review reflects the state of the e-suicide prevention literature more broadly. Specifically, in their systematic review of mobile/web-based suicide prevention literature published between 2000 and 2015, Perry and colleagues (2016) found only one study that met inclusion criteria (youth aged 12-25; included suicidality as a primary outcome; any study design; published in English in a peer-reviewed journal). Thus, our review further illuminates this critical gap in the literature. Given the increased access that e-suicide interventions (including risk assessment) offer youth in the context of COVID-19 – and post-COVID-19 for rural, remote and hard-to-reach youth – it is critical that future research addresses this gap. Recommendations from grey literature sources provide rich information on which to base this work.

In the context of COVID-19, new research is also emerging rapidly, including on the topic of suicide prevention. For example, a very recent article by Szlyk, Berk, Peralta, and Miranda (2020; published after we conducted our peer-reviewed literature search at the end of May 2020) explores the implications of COVID-19 for adolescent suicide prevention. In this article,

Szlyk and colleagues (2020) recommend several evidence-based strategies to address mental health needs and decrease the risk of suicide among adolescents during the COVID-19 pandemic. First, restrict access to potential means of suicide (firearms, medication, knives). Second, for adolescents with a history of suicide attempts, ideation, or self-harm, consider limiting their time spent alone. Third, collaboratively monitoring social media use and setting healthy limits around internet usage. They also suggest having frequent check-ins with the adolescent, and creating a safe space where they can have open discussions about their feelings. Fourth and finally, Szlyk and colleagues recommend taking any discussion of self-harm or suicide seriously; for school-based providers, this means continuing to conduct risk assessments remotely, and contacting emergency services when indicated per the assessment. These four recommendations align with many of the recommendations we note in **Appendix A.**

While we did locate a number of studies that examined eMental health interventions generally for youth, almost none of them described their risk assessment procedures for participants experiencing suicidal ideation, and thus these articles were excluded from this review. As such, we recommend that future eMental health intervention research be explicit about describing procedures for how they assessed and managed youth suicide risk virtually/remotely. Finally, the limited peer-reviewed research that did provide relevant recommendations for our review was primarily conducted with older, female-identified, White, presumably heterosexual youth. Given that groups at disproportionate risk for suicide include male-identified youth; Indigenous youth; immigrant, newcomer and refugee youth; LGBTQ2SIA+ youth; and youth with (dis)abilities (Centre for Suicide Prevention, 2020; Government of Alberta, 2019), this represents a further gap in the literature. In addition to including diverse youth, it is also critical that future research on this topic centers youth voice and experience (Radovic et al., 2018), and explicitly considers intersections of power and privilege (Canadian Council for Refugees, n.d.).

Research with adults suggests that suicide risk assessment can be done successfully via eHealth. Reviewing the case records of over 9000 people who accessed the MindSpot Clinic in Australia (an eMental health service), Nielssen et al. (2015) report that approximately one in four reported thinking about or intending to die by suicide. These clients all received telephone

follow-up, where standard risk assessment planning was conducted. Of the over 2300 clients who were contacted by telephone, only 51 (0.6% of the full sample) were referred to urgent crisis care. They conclude that "the procedures for identifying and managing those [urgent] patients were satisfactory, and in every case, either emergency services or local mental health services were able to take over the patient's care. [This study] shows that the uncertainty associated with taking responsibility for the remote treatment of patients who disclose active suicidal plans is not a major impediment to providing direct access online treatment for severe forms of anxiety and depression" (Nielssen et al., 2015, p. 6). However, these findings need to be replicated with youth in school-based settings.

4.1 Limitations and Future Directions

There are several limitations to our review. First, it primarily relies on grey literature, which is generally not independently reviewed. Thus, recommendations should be applied with caution. Second, while we considered any virtual and/or remote approach to fall within our definition of eHealth, most of the recommendations we found were for mediums that included a voice component. As text-based interactions are a different context that likely require a different skill set, the recommendations from our review may not apply to text-based approaches. Finally, as noted above, almost none of the literature we reviewed (peer-reviewed or grey) was specific to the school setting, and thus recommendations should be applied with caution.

There are also three specific limitations to note for our priority population search. First, while we found grey literature specific to rural youth, we did not include rural youth as a search term. Second, the search terms used for youth with (dis)abilities in ProQuest (dissertations and thesis search) were limited by the search terms by subject available in that database. This is a limitation as most of these terms did not use person-first language, and may have missed other key search words as a result. Finally, the grey literature we located on refugees did not specifically focus on unaccompanied refugee youth, who are a "small but clinically significant population" (Majumder, O'Reilly, Karim, & Vostanis, 2014).

Beyond the future research noted above, an important future direction is to apply the findings from this review to the *SI Protocol*. The group that developed this protocol – and who

were instrumental in supporting this research – will now work on creating a supplementary *SI Protocol Guide for eHealth Assessment*, in collaboration with the University of Calgary research team. This guide will reflect the recommendations outlined in **Appendix A**.

4.2 Conclusion

From this systematic scoping review, we conclude that promising practices for conducting suicide risk assessment with youth via eHealth in school settings represents a critical research gap. Future research with diverse youth is required to address this gap. However, for knowledge users and decision makers searching for immediate guidance, a number of specific recommendations exist on reputable school mental health/suicide prevention websites, and we feel these recommendations represent the most promising practices for suicide risk assessment with youth via eHealth in school settings until additional research is available.

5. References

**reference indicates the peer-reviewed article/grey literature source provides relevant recommendations*

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6. Appendix A. Six Promising Practices – Comparison of Relevant Recommendations from Peer-Reviewed and Grey Literature

Promising Practice	Relevant Recommendations: Peer-Reviewed Literature	Relevant Recommendations: Grey Literature	Relevant Recommendations: Priority Populations

Youth engagement: Accessibility, building rapport, establishing a therapeutic space and helping youth prepare for virtual/ remote sessions	• Ensure sessions are accessible for youth with restricted internet access (e.g., youth living in poverty, rural/remote youth; Arjadi et al., 2018)
	• Consider providing youth with session transcripts to help them remember information and strategies to use in daily life, if aligned with privacy requirements (Navarro et al., 2020)
		• Make sure youth can see and hear you clearly (CYMH & School Mental Health Ontario [SMH], 2020; Reinert, 2020; Van Dyk et al., 2020) , and that your screen is big enough to see the youth's face (CYMH & SMH, 2020)
		  ○ Both auditory and visual information are key to providing good virtual care (CYMH & SMH, 2020), so it is ideal to have both sources of information if possible given the youth context
		  ○ It can be harder to pick-up on non-verbal cues in the virtual environment, so pay special attention to facial cues (CYMH & SMH, 2020). Also pay attention to youth's tone of voice, use of negative language and atypical speech patterns (Mental Health Technology Transfer Centre Network [MHTTC Network], n.d.).
		• Stay on screen the entire time and maintain eye contact (American Psychological Association [APA], 2020b; Cox, 2020). Make sure youth can clearly see your face throughout the session (Reinert, 2020; Van Dyk et al., 2020).
		• Discuss how to increase youth privacy (e.g., picking a time of day for the session that is quieter in the house, having a code word if someone is nearby, using chat if they can't speak privately, wearing headphones, password-protected sessions) (Cox, 2020; CYMH & SMH, 2020; National Association of School Psychologists [NASP], 2020a; Reinert, 2020; ZERO Suicide Institute, n.d.b)
		• Choose a mode of technology for sessions that meets youth needs/preferences (APA, 2020b; Cox, 2020; NASP, 2020a; NASP, 2020b; ZERO Suicide Institute, n.d.b)
		  ○ Equity and access issues are critical to consider (American School Counselor Association [ASCA], n.d.; CYMH & SMH, 2020). This can include using the phone/texting when internet is not an option (CYMH & SMH, 2020), and checking with youth how many phone minutes they have to talk (MHTTC Network, n.d.).
		• Set-up your room to promote youth comfort (e.g., remove personal items, minimize distractions, use a headset so your voice is clear, ensure you are well-lit, set-up your computer so you can maintain good
			Male youth
			• Male youth may require targeted approaches to better understand needs and prevent suicide attempts (BACP, n.d.; Poole, 2016; Tucker, 2020)
			  ○ Aim to strengthen social relationships and improve recognition of mental health issues (Welsh Government, 2015)
			  ○ Ask opinions on current services offered, rather than what services they want, in order to assess gaps in services (Chadwick et al., 2019; Suffolk User Forum, 2016)
			• It is important to consider barriers that influence willingness to engage with eHealth supports among male youth (Chadwick et al., 2019; East Lancashire Hospitals NHS Trust, 2020; HM Government, 2019; Lancashire County Council Suicide Prevention Strategy, n.d.)
			• Create opportunities for male youth to practice/observe help-seeking conversations with strangers (Chadwick et al., 2019)

		eye contact) (Alvord, Baker & Associates, LLC, n.d.; APA, 2020b; CYMH & SMH, 2020; Van Dyk et al., 2020). Let youth know they can be informal and use a background or emojis if that makes them more comfortable (Van Dyk et al., 2020).
		• Discuss what virtual/remote sessions will look like (e.g., security concerns, whether the session will be recorded) (Alvord, Baker & Associates, LLC, n.d; Van Dyk et al., 2020). Reassure youth at start of the session that you are in a private space. (Cox, 2020; CYMH & SMH, 2020; Reinert, 2020). Let the youth see your whole office (CYMH & SMH, 2020; Van Dyk et al., 2020).
		• Keep youth engaged (e.g., use screen sharing, play a game together, have youth share a photo, show them things in your environment like art or toys) (CYMH & SMH, 2020; Lowenstein, n.d.; Van Dyk et al., 2020)
		• Give the youth space to speak, since this can be more difficult in the remote environment (Van Dyk et al., 2020). Let youth know they can interrupt you at any time if they need to tell you something (CYMH & SMH, 2020).
		• Convey warmth and enthusiasm through your facial expressions and tone (Lowenstein, n.d.; Reinert, 2020)
		• Ask youth what they need from your virtual relationship, and how you can make them feel safe and secure (CYMH & SMH, 2020)
		• Help youth find a quiet, private place for your sessions where they will have minimal distractions (American Psychiatric Association, 2020; MHTTC Network, n.d.). Involve caregivers to make sure the space is private for the duration of your session (Cox, 2020).
		• Encourage youth to test out technology before using (ZERO Suicide Institute, n.d.a)
		• Remind youth to make sure their phone (or other device, such as a laptop) is fully charged before the session (Cox, 2020; MHTTC Network, n.d)
		• Suggest turning off smart devices to increase privacy (e.g., Alexa, Google Home) (Cox, 2020)
		• Encourage youth to write down what they want to talk about before session, and to bring a paper and pen to the session to take notes (American Psychiatric Association, 2020; MHTTC Network, n.d.)
			Indigenous youth
			• Rapport building: Create a safe process for youth (The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, n.d.)
			  ○ Assess at a relaxed pace and emphasize the role of community and personal relationships in safety planning (Victoria State Government, n.d.)
			  ○ Focus the conversation by understanding cultural needs, <u>if this fits the youth</u>: Some individuals might prefer to talk about protective factors rather than suicide directly. Others might wish to include a family member or Indigenous health worker.
			  ○ If further intervention is necessary, refer the individual to an Indigenous mental health professional/agency if available <u>and if this is what they and their family want</u>
			• Connect and partner with local communities to explore their understanding of suicide and the impact of traditional knowledge on these views (Committee on Indian Affairs, 2009; Committee on Indian Affairs, 2010; Kaufman & Associates Incorporated &

			MDHHS, 2017; SAMHSA, n.d.; SPRC, n.d.b; Warren et al., 2013)
			
			LGBTQ2SIA+ youth
			• Create a safe space
			  ○ Ask youth the pronouns they use (NAMI, n.d.) – avoid assumptions regarding youth's sexual orientation or gender (SPRC, n.d.c)
			  ○ Use gender-inclusive language (NAMI, n.d.)
			  ○ Display an inclusive approach (e.g., having pride flags in your background) (NAMI, n.d.)
			  ○ Provide specialized training and raise awareness about specialized supports in the local community for LGBTQ2SIA+ youth (Abrar, 2019; Franks et al., 2010; SAMHSA, n.d.)
			  ○ Train all school-based service providers to reduce experiences of discrimination and prejudice for LGBTQ2SIA+ youth (Tasmanian Government, 2013)

School mental health professional boundaries	• No specific recommendations provided	• Make sure youth and caregivers know when you are and aren't available, and who to contact when you are not available (ASCA, n.d.; CYMH & SMH, 2020; NASP, 2020a; NASP, 2020b; Reinert, 2020; Suicide Prevention Resource Centre [SPRC], 2020) ○ Arrange coverage periods if possible, and let youth know when you will be away (SPRC, 2020)	• No specific recommendations provided

		• Connect with youth and caregivers using institutional (not personal) devices (ASCA, n.d.) • Have a clear schedule for when you meet with youth (Reinert, 2020)	

Consent procedures	• Consent for service form should include the name and contact information for multiple adult contacts, in case one is not available (Sayal et al., 2019)[a]
	  ○ Consent should detail who the youth/caregiver should contact in case of crisis, especially when school-based eMental health services are not available (Nelson et al., 2011)
	  ○ Consent for service form should also describe risks and benefits of eMental health (Nelson et al., 2011)
	  ○ Service providers should maintain communication with caregivers to ensure continuity of care (Nelson et al., 2011)
		• Obtain caregiver consent/youth assent to conduct session remotely (Abrams, 2020; Alvord, Baker & Associates, LLC, n.d.; APA, 2020a; CYMH & SMH, 2020; NASP, 2020a)
		  ○ Consent topics include telling the youth you will not record the session without permission; whether you will use a webcam during the session (if relevant); using a secure internet connection; having a back-up plan (what to do if there are technology issues); having the name and contact information for at least one emergency contact; and knowing the closest emergency room to where the youth is (APA, 2020a)
		• The consent form can also detail (NASP, 2020a):
		  ○ A description of the eMental health service
		  ○ Any required technical considerations
		  ○ What you can and can't do (i.e., eMental health limits)
		  ○ Expectations of service provider, youth and caregiver
		  ○ Emergency contacts and multiple communication options
		  ○ What will happen if the youth is determined to be in immediate safety risk and/or what will happen if caregivers cannot provide supervision
		  ○ Consent for youth to participate in eMental health
			Indigenous youth
			• Consider historical and current oppression and discrimination faced by Indigenous youth in Canada (Kaufman & Associates Inc. & MDHHS, 2017)
			  ○ Recognize the continued discrimination many Indigenous youth face in mental health settings
			  ○ Recognize that youth may be fearful of being removed from their home or punished for suicidal ideation or behaviours (Kaufman & Associates Inc & MDHHS, 2017)
			• Incorporate different languages
			  ○ Address language barriers so all can seek help (Dudgeon et al., 2018)
			
			Newcomer, immigrant and refugee youth
			• Provide suicide prevention services, including suicide risk assessment, that are culturally sensitive and available in different languages (Administration for Children & Families, 2015; Cambridgeshire County Council, 2019; Chadwick et al., 2019)

			LGBTQ2SIA+ youth • Trans youth ○ Provide trans-friendly services by including trans and non-binary options on records and promote the use of different titles such as 'Mx' (Welsh Government, 2019), or make the gender identity field one that the youth fills in themselves

Session logistics	• Ask youth participants to provide contact information for themselves and one supportive adult at the beginning of each session in case you are disconnected and need to get support to them (Radovic et al., 2018)
	• Service providers require training and clinical supervision to provide suicide assessment via eHealth (Nielssen et al., 2015)
	• Have a back-up plan in case there are internet or technology issues *before* the session starts, and ensure the youth understands this plan (Nelson et al., 2011)
	• If immediate risk is identified through standard assessment, refer youth to crisis mental health services (Arjadi et al., 2018; Nielssen et al., 2015)
	• Understand relevant professional requirements for providing eMental health services to youth at risk for
		• Make sure you are competent with whatever virtual/remote platform you plan to use and in providing risk assessment virtually/remotely (Abrams, 2020; Alvord, Baker & Associates, LLC, n.d; CYMH & SMH, 2020) Service providers need training and supervision (ZERO Suicide Institute, n.d.c). Have a plan for receiving remote supervision as needed (NASP, 2020a).
		  ○ Check your technology right before the session (e.g., for software updates) (Alvord, Baker & Associates, LLC, n.d)
		  ○ Ensure technology meets relevant privacy requirements (ZERO Suicide Institute, n.d.a). Understand relevant local laws and regulations around providing eMental health services (Telligen Health Information Technology Regional Extension Centre & Great Plains Telehealth Resource & Assistance Centre, 2014).
		  ○ Plan a practice session with youth, if possible, to make sure you are both comfortable (ZERO Suicide Institute, n.d.a)
		• Make sure you can access your school division's suicide risk assessment protocol electronically (NASP, 2020a)
		  ○ Completing a full suicide risk assessment virtually may be difficult, and so it is okay for service providers to focus on the most critical information needed to assess risk (SPRC, 2020)
		• Verify the youth's identity at the start of the session (if can't see them/haven't met them before) (Alvord, Baker & Associates, LLC, n.d.)
		• Confirm consent/assent (Alvord, Baker & Associates, LLC, n.d.)
		• Review privacy (Alvord, Baker & Associates, LLC, n.d.; CYMH & SMH, 2020)
		  ○ Check if the youth is safe to talk (Perlman et al., 2011). Be prepared for next steps if they say no.
			Indigenous youth
			• Community-wide collaboration
			  ○ Determine current culturally-relevant services that are in place, and identify the distinctive needs of youth from each local Indigenous community (Kirmayer et al., 2007)
			
			LGBTQ2SIA+ youth
			• Provide support that is culturally responsive (New York State Suicide Prevention Task Force, 2019; SPRC, 2008)
			  ○ Suicide risk assessment can incorporate the LGBTQ2SIA+ youth's narrative and experiences with discrimination to inform care (Q Life, 2020)
			
			Youth with (dis)abilities
			• Adaptions need to be created for how to talk about suicide with

	suicide within the school setting (Haas et al., 2008)	○ Take steps to mitigate any potential privacy issues (ASCA, n.d.). For example, having the youth play white noise from an app (SPRC, 2020). Discuss what to do if privacy is interrupted, like if a sibling walks in (e.g., use of code word, hitting mute, switching to chat) (Reinert, 2020; ZERO Suicide Institute, n.d.b). • Review safety precautions (Alvord, Baker & Associates, LLC, n.d.) ○ Confirm the youth's physical location at start of the session (Alvord, Baker & Associates, LLC, n.d.; APA, 2020b; MHTTC Network, n.d.; NASP, 2020a; SPRC, 2020; Telligen Health Information Technology Regional Extension Centre & Great Plains Telehealth Resource & Assistance Centre, 2014; ZERO Suicide Institute, n.d.b) ○ Have a back-up plan for what you will do if technology difficulties occur. Know how you can reach youth if you get disconnected (Alvord, Baker & Associates, LLC, n.d.; APA, 2020b; CYMH & SMH, 2020; MHTTC Network, n.d.; NASP, 2020a; ZERO Suicide Institute, n.d.a) and let them know how they can reach you (Alvord, Baker & Associates, LLC, n.d). ○ Have a list of urgent and non-urgent nearby resources ready (Alvord, Baker & Associates, LLC, n.d). Know the 24/7 emergency services in your area and who you can/need to contact if the youth is at risk of suicide (NASP, 2020). ○ Make sure you have up-to-date and accurate emergency contact information (that works) for at least one primary caregiver, and ensure this person is available in case they are needed (Alvord, Baker & Associates, LLC, n.d; APA, 2020a; Cox, 2020; MHTTC Network, n.d.; NASP, 2020a; SPRC, 2020; ZERO Suicide Institute, n.d.a; ZERO Suicide Institute, n.d.b). Can consider having information for one contact inside the house and one outside (Cox, 2020). • Monitor how youth is feeling (e.g., through messaging) throughout the session and slow things down if needed (Nassar, Costello, & Wolf-Prussan, 2020) • Have a plan for how you will stay connected to the youth if you need to contact emergency services (especially if you are connecting with them by phone) (SPRC, 2020; ZERO Suicide Institute, n.d.b). Stay connected with youth while you call 911 and until emergency services arrive (CYMH & SMH, 2020; MHTTC Network, n.d.). Maintain constant verbal (and if possible visual) contact until resources arrive (NASP, 2020). • Documentation is key – make sure to document when assessment started and ended, what platform you used/any technological	youth with (dis)abilities (Sussex Partnership NHS Foundation Trust, n.d.)

		difficulties, specific topics covered, and any other issues that occurred (CYMH & SMH, 2020; NASP, 2020a; ZERO Suicide Institute, n.d.a; ZERO Suicide Institute, n.d.b) • Close the session by asking what can be improved and making a plan for your next meeting (Cox, 2020; Zero Suicide Institute, n.d.b). If youth miss the session, check in with them to see what is going on and how you can adjust to make it easier/more comfortable for them to attend (CYMH & SMH, 2020).	

Safety planning	• Online risk assessments follow same basic steps as in-person risk assessments (e.g., completing a safety plan; having information for in-person resources and emergency services ready before session, in case needed; Nielssen et al., 2015)[a]
	  ○ Like in-person assessments, specific suicide risk assessment protocols and procedures outlining steps and reporting requirements should be provided to all service providers (Nielssen et al., 2015; Sayal et al., 2019)
	  ○ Core professional principles and ethics remain critical in the eHealth environment (Nelson et al., 2011)
	• If risk is not immediate, develop a safety plan – send the safety plan to the youth and their caregiver, and include contact information for 24 hour resources
		• Overall, safety planning is the same as in person (Telligen Health Information Technology Regional Extension Centre & Great Plains Telehealth Resource & Assistance Centre, 2014). Work together to build a safety plan (e.g., by sharing screen) (ZERO Suicide Institute, n.d.a), and find a way to get the plan to them (e.g., email). (SPRC, 2020; ZERO Suicide Institute, n.d.a; ZERO Suicide Institute, n.d.b; ZERO Suicide Institute, n.d.c)
		  ○ Ask about increased access to lethal means (e.g., medication, firearms) (SPRC, 2020)
		  ○ Ask about additional COVID-19 related risk factors (e.g., social isolation, family financial stress) (SPRC, 2020)
		• Consider using virtual safety planning tools, like the My3 app (NASP, 2020a)
		• Check-ins may need to happen more often (SPRC, 2020; ZERO Suicide Institute, n.d.c). Consider using a short screener during check-ins to remotely monitor risk (NIMH, 2020; SPRC, 2020). Youth could also use an app to rate their mood/suicidal ideation daily, so they know when they might need urgent care (Kaslow, 2014). Can also use check-ins to review and update safety plans (Van Dyk et al., 2020).
		• Figure out a way for the youth to get a copy of their safety plan (e.g., text it to them, have them take a screenshot) (SPRC, 2020; ZERO Suicide Institute, n.d.a; ZERO Suicide Institute, n.d.b; ZERO Suicide Institute, n.d.c)
		  ○ Let the primary caregiver know you have developed a safety plan (CYMH & SMH, 2020; NASP, 2020a)
		  ○ Develop a plan with caregivers on how they can access support for themselves (ASCA, n.d.)
		• Identify coping strategies on the safety plan that can be done during COVID-19 (e.g., virtual activities, virtual connection with friends) (SPRC, 2020)
		• Encourage the youth to keep a daily schedule and make plans for each day (SPRC, 2020)
			Male youth
			• Use male friendly language (e.g., action based, focus on goals) (HM Government, 2012; The Australian Men's Health Forum, n.d.; Wilkins & Kemple, n.d.)
			• Emphasize a problem-solving focus (Australian Government Department of Health and Ageing, 2008; Kõlves et al., 2013; Poole, 2016; The Australian Men's Health Forum, n.d.)
			
			Indigenous youth
			• Holistic assessment
			  ○ Integrate a holistic framework into risk assessment that considers individual, family, community, and societal factors (Adams et al., n.d.; The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, n.d.). Consider the physical, mental, emotional, *and* spiritual aspects of well-being, <u>if this fits the youth</u> (Kirmayer et al., 2007).
			  ○ Consider the balance across different aspects of well-being (ACT Health, n.d.; Dudgeon et al., 2016;

	(Nielssen et al., 2015; Fairchild et al., 2020) ○ If possible, continually monitor risk via weekly online assessments; if risk increases, contact the caregiver and the youth (Nielssen et al., 2015) • Consider using ongoing screening data, and having youth provide data on an agreed upon schedule (e.g., daily, at agreed upon times, through weekly online assessments), to remotely monitor risk (Arjadi et al., 2018; Goodday et al., 2020; Nielssen et al., 2015) ○ Providing youth with ongoing, personalized feedback on suicide risk indicators and then giving them the option to receive online counselling can have a positive impact on engagement in professional mental health treatment (Anderson et al., 2017; King et al., 2015) ○ More check-ins may be required than when youth are in school, depending on the level of		NMHS, 2017; NSW Government, Western NSW, & Far West Local Health Districts, 2020). ○ Understand views on suicide among local Indigenous communities so that these views are respected during the assessment ○ Follow DSM-5 guidelines for working with culturally diverse peoples (Adams et al., n.d.) ○ Assessments can benefit from youth-friendly language rooted in holistic health (e.g., the medicine wheel), <u>if this fits the youth</u> (Multi-Agency Alcohol and Substance Abuse Prevention Collaboration, 2015) • Unique risk and protective factors ○ Common risk factors include discrimination, isolation on reserve, and suicide clusters (Indian Health Services, n.d.) ○ Consider whether structural risk factors (e.g., victimization, discrimination) played a role in triggering suicidal ideation/behaviors (Trzesinski, 2015) ○ Consider intersecting identities (e.g., for a two-spirit Indigenous youth) in the assessment of risk and protective factors

	isolation of the youth (Nelson et al., 2011)
	• Inform caregivers if suicide risk issues arise, and provide clear guidelines to caregivers on how to manage risk and seek appropriate help (Anderson et al., 2017)[a]
	  ○ Notify caregivers of the risk, recommended next steps, and a list of appropriate crisis services and support agencies (Anderson et al., 2017)
	  ○ Consider having a caregiver sit with the youth when conducting risk assessment, if safe and age-appropriate (Fairchild et al., 2020; Thomas et al., 2018)
			Newcomer, immigrant and refugee youth
			• Consider suicide risk assessment screening tools that are culturally relevant for refugees (Sari, 2018)
			• Collaborate with organizations that have contact with refugees to improve appropriate identification of medical, social, and educational factors that should be included in the risk assessment (Chadwick et al., 2019; "East Sussex Suicide Prevention Plan", n.d.)
			• Tailor risk assessment to the needs of the refugee community by considering the variety of factors that could be impacting the individual (e.g., language barriers, PTSD) (Administration for Children & Families, 2015; Cambridgeshire County Council, 2019; HM Government, 2012)
			• Incorporate family-based mental health support (Yachouh, 2018) if this fits the youth
			• For some Syrian refugees, involving the individual's family could support service provision (Yachouh, 2018). Address individual concerns about mental health services. Some Syrian refugees might feel embarrassed or might perceive mental health support as exclusive to 'crazy people' (Yachouh, 2018).
			
			LGBTQ2SIA+ youth
			• Recognize the stigma that can precede distress in sexual minorities (Salway, 2017)

			• Consider the youth's intersecting identities when assessing risk for suicide (e.g., two-spirit Indigenous youth)
			  ○ Consider individual differences, cultural diversity, and sexual preferences when adapting risk assessment forms (Victoria State Government, 2016)
			• Consider risk factors specific to this population to appropriately address their needs (O'Hara, 2013)
			  ○ Communicate directly with the local LGBTQ2SIA+ community to understand unique risks and protective factors in their social context (Christensen et al., 2013; Dudgeon et al., 2018; Robinson et al., 2016; Silburn et al., 2013)
			  ◦ Include LGBTQ2SIA+ youth input to strengthen assessment/safety planning strategies that target their specific needs (Kõlves et al., 2013; Mental Health Commission of New South Wales, 2014; Skerrett et al., 2013)
			
			Rural youth
			• Incorporate unique stressors (i.e. isolation, increased lethal means) into suicide risk assessment services for youth living in rural and remote areas (Hazell et al., 2017; Welsh Government, 2015)

			• Encourage professionals completing risk assessments to ask and be aware of the local rural communities' unique risk factors (Welsh Government, 2015)
Internet privacy	• Send virtual session invitations via a secure and encrypted email (Thomas et al., 2018) • Give each youth a unique, non-identifying username and password (Arjadi et al., 2018; Haas et al., 2008) • Store youth information (e.g., email addresses) in an encrypted computer system (Haas et al., 2008) and use encrypted point-to-point technologies when videoconferencing (Nelson et al., 2011) • Ensure virtual session hosting platform is compliant with relevant health privacy law in your area (e.g., HIPAA) (Thomas et al., 2018) ○ Determine who is in the room on both sides (other than the youth and service provider), and ensure that the people in the rooms meet privacy law requirements (Nelson et al., 2011)	• No specific recommendations provided	• No specific recommendations provided

[a]One of our expert reviewers noted that the consent procedures described by these articles are not as applicable for the school context (particularly around the need for caregiver involvement and youth safety planning). In the typical school setting, providers are able to conduct a suicide risk assessment without caregiver consent because there are adults in the school who will monitor the youth for safety throughout the process (i.e., once a disclosure has been made, youth are never left alone). At the end of the risk assessment process, the school provider then contacts the youth's caregiver so that the caregiver can continue supervision as part of the safety plan. However, in the eHealth environment, school providers generally need to notify the caregiver *before* beginning the risk assessment process, in order to ensure the youth's immediate safety (i.e., caregiver notification is done during the initial assessment in the eHealth environment, and not during the safety planning process). If it is not safe to contact the caregiver, and the need is urgent, the police and/or Children's Services may need to be called to bring the youth to a setting for the assessment where there is supervision. Given these differences in the school environment, the literature for consent for eHealth does not completely align with school-based risk assessment, as the school-based setting is less straightforward than a typical eMental health setting with adults. Research that is specific to conducting eHealth suicide risk assessment with youth in the school environment is critically needed

7. Appendix B. Summary of Key Grey Literature (Key Websites) Resources

Alliance for Inclusion & Prevention – Telehealth Guidelines for School Mental Health Professionals: Strategies for Engaging Students and Building Resilience (Reinert, 2020)

This document provides telehealth guidelines for school mental health professionals. While this document is not specific to suicide risk assessment, it may still be useful to school mental health professionals as they prepare to work with youth using eMental health. The document notes that it can be difficult to engage youth via telehealth, especially if the service provider did not have a previous relationship with the youth. In this case, the service provider might want to use an exaggerated amount of enthusiasm to neutralize the negative aspects of being online (e.g., more distractions, poor internet connectivity, harder to communicate non-verbally). Other tips from this document include:

- Make sure youth can hear and see you clearly
- Talk about who is in the room or nearby and make plans with the youth to increase privacy if needed (e.g., planning calls during certain times of day, using a code word if someone is nearby, wearing headphones).
- Create a clear schedule for your sessions and make sure the youth knows who to contact if you're unavailable
- Even though you are generally seated during telehealth, make sure you and the youth get up and move around as a relaxation technique
- Take advantage of screen sharing as a teaching technique (e.g., using a graphic to explain what CBT is)

American Psychiatric Association (APA) – How to Prepare for a Video Appointment with your Mental Health Clinician (American Psychiatric Association, 2020)

This short document provides tips for clients as they prepare to engage in eMental health services. School mental health professionals may wish to share some of these tips with the youth they are working with. While the tips in this sheet are not for youth specifically, many are still highly relevant. Tips include:

- Finding a quiet, private place for your session
- Making sure your technology will work for your session
- Thinking about what you want to talk about during your session
- Bringing a paper and pen to your session to take notes
- Asking questions during the session just like you normally would

American Psychological Association (APA) – Office and Telepsychology Checklist for Telepsychological Services (APA, 2020b)

This webpage has tips and a checklist for preparing to offer eMental health services. While this checklist is not specific to youth or suicide risk assessment, it may still be useful to school mental health professionals as they prepare to work with youth using eMental health. Key areas for consideration include deciding whether the technology being used meets the needs of the youth and privacy requirements; the set-up of the room (e.g., private, quiet location; removing personal items; maintaining good eye contact); doing pre-session planning (e.g., having a back-up plan if technology difficulties occur); and beginning the virtual session (e.g., confirming the youth's location and where/how you can reach them if you get disconnected).

American Psychological Association (APA) – Ethical Guidance for the COVID-19 Era (Abrams, 2020)

This article from the *Monitor on Psychology* presents practical tips for psychologists during COVID-19. While this article is not specific to youth or suicide risk assessment, it may still be useful to school mental health professionals as they prepare to work with youth using eMental health. Topics for consideration include competence (e.g., being competent with online platforms being used to deliver services); informed consent; confidentiality and setting boundaries.

American Psychological Association (APA) – Informed Consent Checklist for Telepsychological Services (APA, 2020a)

This short webpage provides tips for eMental health consent forms. These tips may be useful to school mental health professionals as they engage with youth in the virtual/remote environment. Tips include telling the client you will not record the session without permission; specifying if you will use a webcam during the session (if relevant); using a secure internet connection; having a back-up plan (what to do if there are technology issues); having the name and contact information for at least one emergency contact, and knowing the closest emergency room to where the youth is.

American School Counselor Association (ASCA) – Planning for Virtual/Distance School Counseling During an Emergency Shutdown (ASCA, n.d.)

This two-page document highlights that it is critical for schools to consider equity and access issues when implementing eMental health services during COVID-19 or other emergency shutdowns. Ideally, a team is involved in planning and ongoing discussion about issues as they arise. Specific tips include:

- Ensuring that youth and caregivers know how to reach their school counselor through institutional (not personal) email accounts or phones
- Youth and caregivers know what to do when their school counsellor is not available (for both urgent and non-urgent situations)
- Steps to take to mitigate issues with confidentiality and privacy in the virtual environment, and ensure youth and families understand potential privacy issues
- Preparing youth to participate in mental health services in the virtual/remote environment

COVID-19 Tips: Building Rapport with Youth via Telehealth (Van Dyk et al., 2020)

This preprint provides tips on using telehealth with children and youth. While this document is not specific to suicide risk assessment, it may still be useful to school mental health professionals. Specifically, information is given on setting the scene (e.g., minimizing distractions in view of your camera; encouraging caregivers to minimize distractions where the youth is set up; allowing youth to have an informal setup; giving younger children the option to sit wherever they want or to get up and move around; letting teenagers have sessions without a caregiver present if that makes them more comfortable; allowing freedom in using background features such as being in outer space; making sure the youth can clearly see your face throughout the session), introducing telehealth to youth (e.g., explaining why you are using telehealth; discussing security; letting them know if a session is being recorded; letting them see your whole office; discussing technical difficulties; letting them ask questions), building rapport (e.g., use exaggerated expressions; use humor if you experience technical difficulties; give them opportunities to speak and/or assert control since it's difficult to interrupt or speak over someone with telehealth) and keeping youth engaged (e.g., use screen sharing; allow them to show you things in their environment such as art or toys; take advantage of features that allow you to play games together).

Creative Interventions for Online Therapy with Children: Techniques to Build Rapport (Lowenstein, n.d.)

This document provides techniques for building rapport with children when using online therapy. While this document is not specific to suicide risk assessment with youth, it may still be useful to school mental health professionals. Practitioners are encouraged to be vigilant about conveying warmth through facial expressions and tone of voice. Also, developmentally-appropriate playfulness is encouraged (e.g., wearing a wacky hat). Various examples of games are given (e.g., having the child show the practitioner something in their room that is important to them; playing rock, paper, scissors, and the winner gets to ask the other person a question).

Mental Health Commission of Canada (MHCC) – Toolkit for e-Mental Health Implementation (McGrath et al., 2018)

This toolkit provides considerations for use of eMental health, and a roadmap for implementing eMental health services. While this toolkit is not specific to youth or suicide risk assessment, it may still be useful to school mental health professionals as they prepare to work with youth using eMental health.

Mental Health Technology and Transfer Center Network (MHTTC), Northeast and Caribbean (HHS Region 2) – Engaging with Clients Over the Telephone and Using Texts (MHTTC Network, n.d.)

This document highlights that using the internet to provide eMental health services (including suicide risk assessment) is not a possibility with all youth. Thus, it is also important that school-based service providers are prepared to use either phone calls or texts to engage. Tips for using the phone include:

- Asking the youth/caregiver how many minutes they have for talk and text, and any other relevant phone access information
- Understanding your school division's requirements for getting consent to provide services over the phone
- Helping youth be ready to engage in the phone session. This includes things like finding a quiet, private location; removing distractions; making sure their phone is charged; and having a pen and paper available to they can take notes.

On the phone, service providers also cannot see body language or non-verbal clues, and so instead they can pay attention to tone of voice, use of negative language and use of atypical speech patterns (for that youth).

If youth have limited phone call minutes, texts are another option. With texts, service providers and youth should still find an agreed upon time to talk, so the conversation is happening in real time. Texts can also be a way to provide support or check-ins in between phone calls.

Just like when using video technologies, if a service provider is worried a youth is at risk, they should:

- Make sure they have the youth's physical location at the start of the session
- Make sure they have emergency contact information for primary caregivers
- Have a contact plan in case the phone call/text is interrupted
- Stay on the phone with the youth until emergency services arrive, if needed

National Association of School Psychologists (NASP) – COVID-19 Resources: Comprehensive School Suicide Prevention in a Time of Distance Learning (NASP, 2020a)

This document discusses suicide prevention, intervention and postvention in the virtual/remote environment. It also provides specific tips for conducting school-based suicide risk assessment with youth via eHealth. NASP has also created an intervention checklist that supports service providers to prepare for and conduct[b] a risk assessment with youth in the eHealth environment. Tips from this document include:

- Recognize that schools are not open 24/7, and so youth at risk need to know who to contact when school-based supports are not available
- Make sure suicide risk assessment protocols are available electronically for service providers
- Adaptations to consider in the virtual environment include how to connect with students virtually, how to secure student safety remotely, how to do secure supervision, and how to contact and consult with primary caregivers
- Have a range of virtual options available to best most youth needs (e.g., telephone, Zoom, Google Hangouts), as is relevant to your division's privacy requirements
- Ensure youth and caregivers understand privacy risks within the virtual service delivery environment, and work with youth to promote their privacy (e.g., use of headphones)
    - For primary caregivers, the consent should include:
        - A description of the eMental health service
        - Any required technical considerations
        - What you can and can't do (i.e., eMental health limits)
        - Expectations of service provider, youth and caregiver
        - Emergency contacts and multiple communication options
        - Consent for youth to participate in eMental health
- Have multiple back-up options ready to go (e.g., if using Zoom, also make sure you have a least one phone number), and know how you can contact primary caregivers

[b] Documents available at https://www.nasponline.org/x55253.xml (prepare) and https://www.nasponline.org/x55254.xml (conduct).

- Know the 24/7 emergency services in your area and who you can/need to contact if the youth are at risk of suicide
- Documentation is key – make sure to document when assessment started and ended, the youth's physical location, and the location of their primary caregiver(s)
    - If possible, ensure that primary caregiver(s) are available and understand the safety plan (e.g., means restriction, or limiting access to lethal methods of suicide)
    - Consider using virtual safety planning tools, like the My3 app
    - If urgent intervention is required, maintain constant verbal (and if possible visual) contact until resources arrive
- Ensure you have immediate access to supervision to support you after intervening

National Association of School Psychologists (NASP) – Considerations for Delivery of School Psychological Telehealth Services (NASP, 2017)

This document provides tips and considerations for offering school psychology services via telehealth. While this checklist is not specific to youth or suicide risk assessment, it may still be useful to school mental health professionals as they prepare to work with youth using eMental health. Topics covered include benefits and drawbacks of telehealth, considerations for certification and licensure, legal and ethical implications and a set of nine key recommendations.

National Association of School Psychologists (NASP) – COVID-19 Resources: Virtual Service Delivery in Response to COVID-19 Disruptions (NASP, 2020b)

This document reviews recommendations for school mental health professionals who need to deliver services virtually in the context of COVID-19. While this checklist is not specific to youth or suicide risk assessment, it may still be useful to school mental health professionals as they prepare to work with youth using eMental health. Things to consider include making sure the service provider has clear limits on when they are and aren't available (and what the youth/caregiver should do when service providers are not available); ensuring confidentiality agreements are updated as needed to include the remote environment; and, ensuring youth have equitable access to virtual/remote services (e.g., youth who do not have a computer or internet).

National Center for School Mental Health – Telemental Health 101 Webinar (Cox, 2020)

This webinar discusses practical tips for conducting telemental health. While this webinar is not specific to suicide risk assessment, it may still be useful to school mental health professionals as they prepare to work with youth using eMental health. Tips are given regarding the physical location (e.g., work with caregivers to make sure it is private, there is adequate lighting, minimal distractions); establishing a therapeutic space (e.g., making sure everyone knows who is on the call on both sides, considering who might be able to hear the sessions, staying on screen the entire time and maintaining eye contact; speaking slowly and clearly; using non-verbal cues); technical considerations (e.g., plug into a network instead of using WiFi; consider the best option for cost and what is user-friendly); preparing for the call (e.g., make sure devices are fully charged; turn off smart devices such as Alexa; use headphones; send resources ahead of time); safety (e.g., having emergency contact information - one inside the home, one outside; developing a safety plan); and ending the session (e.g., ask for feedback about what can be improved; plan for next session).

National Institute of Mental Health (NIMH) – COVID-19: Youth Suicide Risk Screening Pathway (NIMH, 2020)

This one page assessment pathway is designed to support service providers who need to provide suicide risk assessment to youth over the phone. It includes recommendations on screeners that can be used in this setting, and guidance on what to do if the youth is identified as low risk, moderate risk (further evaluation needed) or high risk. In high risk cases where the service provider recommends the youth go to their local emergency department, they should tell the youth to bring a mask. The pathway also recommends avoiding sending the youth to the emergency department if possible, to lower potential COVID-19 transmission risk. Follow-up guidance is also provided.

National Register of Health Service Psychologists – TeleMental Health via Video Conferencing Checklist (Alvord, Baker & Associates, LLC, n.d.)

This document provides a checklist of things to do to prepare for a telemental health session (pre-session and immediately before the session). While this checklist is not specific to youth or suicide risk assessment, it may still be useful to school mental health professionals as they prepare to work with youth using eMental health. Pre-session, service providers should obtain informed consent from the primary caregiver; discuss the risks and benefits of telemental health; verify identity; discuss privacy (e.g., who is in the room, others in the home, whether the session is being recorded); discuss safety (e.g., back-up plan in case of getting disconnected, emergency contact information, a number client can call you at, location of client during session, nearby resources); and review technical issues (e.g., how to use technology). Immediately before the session, service providers should make sure their technology works (e.g., check for software updates, check camera, check audio, adjust settings) and that they are set-up properly (e.g., lighting, background, no distractions). During the session, service providers should check their visual and audio clarity again; reiterate informed consent; verify privacy; and review emergency contact information and location of the client.

National Rural Health Resource Center – Telehealth Start-Up and Resource Guide (THITREC & GPTRAC, 2014)

A comprehensive document that explains what telehealth is, why it is important, practice guidelines, and various educational resources. Service providers should think of telehealth the same way they would in-person intervention (e.g., maintain standards). It is also important to make sure there is technical support in place to ensure security and privacy, and that service providers are up to date with regulations and laws regarding telehealth, as they can change frequently.

Ontario Centre of Excellence for Child & Youth Mental Health/School Mental Health Ontario – Virtual Care 101 Webinar: Questions & Answers (CYMH & SMH, 2020)

This webinar discussed providing virtual mental health care delivery with children and youth in school and community settings. While this document is not specific to suicide risk assessment, it may still be useful to school mental health professionals. It defines virtual care as "the use of digital tools to communicate and provide mental health services to clients in real time through video messaging, texting, apps or phone" (p. 4). Topics covered include how to set-up virtual care sessions; ethics, privacy and legal issues in the virtual care environment; client engagement; clinical considerations; and comfort building/troubleshooting technical issues. Specific tips/recommendations include:

- Make sure you have the right equipment, and a screen big enough to see the client's face. Also make sure you are at the center of your screen and looking at the camera.
- Practice using the technology before the session
- Make sure the platform you are using meets your division's privacy standards
- Obtain consent to provide services through a virtual/remote platform
- Use a good quality headset and mic, so your voice is clear and even, and make sure you are well-lit and easy to see
- Make sure youth feel comfortable by showing them that you are in a quiet, secure, private space (e.g., use the camera to show them your space). Reassure them you are alone in the private space. Revisit informed consent and confidentiality at the start of each session.
- Provide youth and families with an orientation letter, so they know what to expect
- Check-in with youth who miss their session to find out what is going on and how you can adjust to make it easier/more comfortable for youth to attend
- Talk to the youth about how to increase privacy and confidentiality, especially if the computer is in a shared space (e.g., headphones; asking others to stay out of room during session; using chat function). Remind the youth about the strategies you are using to maintain privacy/confidentiality at the start of each session.
- Set boundaries around when you are and aren't available
- Document what platform you used to conduct the session, any technology difficulties; start/stop time of session; session attendees; specific topics covered in the session; and any process issues that might have arisen

- Have a back-up plan in case technology issues happen
- Ask youth what they need from your virtual relationship, and how you can make them feel safe and secure
- Have an idea about strategies you can do remotely to engage youth (e.g., sharing a photo, a favorite song)
- If it is safe to do so, involve both youth and their primary caregiver in building a safety plan
- If youth is in immediate danger, keep connected with them while you call 911
- If youth experience dysregulation, ask if there is someone in the home who can help them to regulate their emotions
- It can be harder to pick-up on non-verbal cues in the virtual environment, so pay special attention to facial cues
- Let youth know they can interrupt you at any time if they need to tell you something
- Recognize that using the internet for virtual care is not an option for all families. Phone consultations may be the best option in these cases.

Suicide Prevention Resource Center (SPRC) – Treating Suicidal Patients During COVID-19: Best Practices and Telehealth (SPRC, 2020)

This webinar (moderated by Julie Goldstein Grumet and hosted by Dr. Barbara Stanley)[c] discussed best practices for working with suicidal clients during COVID-19. These include:

- Obtaining the youth's physical location at the start of the session in case you need to contact emergency services
- Obtaining emergency contact information for at least one person at the start of the session (and making sure this contact information works)
- Developing a back-up plan in case of technology failure
- Making sure the youth has privacy as much as possible (e.g., somewhere where siblings won't interrupt). Could suggest putting a towel under their door or playing white noise from an app to increase privacy.
- Having a plan for how you will stay on the phone with the youth while arranging emergency services if needed
    - Use videoconferencing if possible for the session, so you have your phone available to contact emergency services if needed
- Asking about increased access to lethal means (e.g., medication)
- Asking about additional COVID-19 related risk factors (e.g., social isolation, family financial stress)
- Checking in with the youth more often than you normally would when they are at elevated risk. During brief check-ins, consider doing a brief suicide screen (i.e., screen for suicide regularly). Make sure the youth knows when you will contact them next.
- Ensuring the youth and their caregiver know who to contact (e.g., crisis hotline) when the service provider is not available
- Working with the caregiver to monitor the youth's safety (if appropriate and safe for the youth). Developing a plan for how to bring the caregiver into the conversation.
- When developing a safety plan, communicate that this is particularly important to do during COVID-19 because hospitals have limited capacity
- Figure out a way for the youth to get a copy of their safety plan (e.g., text it to them, have them take a screenshot)
    - Let the primary caregiver know you have developed a safety plan, and involve them if possible
- Identify coping strategies on the safety plan that can be done during COVID-19 (e.g., virtual activities, virtual connection with friends)
- Encourage the youth to keep a daily schedule and make plans for each day

[c] We found three different offerings of similar webinar content as it pertained to suicide risk assessment via eHealth. In addition to the webinar "Treating Suicidal Patients During COVID-19: Best Practices and Telehealth" (SPRC, 2020), this content was also offered as part of the Mental Health Technology Transfer Center (MHTTC) Network's Clinical Innovations in Telehealth Learning Series, "Clinical Innovations in Telehealth: Telehealth and Suicide Care" (Goldstein & Stanley 2020) and as part of the School-Based Health Alliance/National Center for School Mental Health's webinar on "Suicide Prevention, Intervention & Postvention During COVID-19: What School-Based Staff Need to Know" (Goldstein, Stanley, Myers & Duckless, 2020).

- For service providers, arrange coverage periods if possible, and let youth know when you will be away

Finally, doing a full suicide risk assessment virtually may be difficult, and so it is okay for service providers to focus on the most critical information needed to assess risk.

ZEROSuicide Institute – Telehealth and Suicide Care During the COVID-19 Pandemic (ZERO Suicide Institute, n.d.a)

This document provides information on how practitioners can adapt to using telehealth to provide safe and effective suicide care. While this document is not specific to youth, it may still be useful to school mental health professionals. Practitioners can use Zoom or Skype for Business, as these are HIPAA compliant options. Before the session, practice using the online platform so you are familiar and comfortable with it – this will help you to communicate clearly during the actual session. Have the youth practice beforehand as well (e.g., playing with chat feature, doing a 5-minute practice session) so they are comfortable. If possible, schedule a 5-minute practice session with the youth to make sure they and you are both comfortable. Have a backup plan in case there are technical issues (e.g., having a phone number to call and connect with the client). Discuss ways to make sure the youth feels a sense of security (e.g., muting the conversation if someone walks in during the call, wearing headphones so others can't hear, getting their choice on whether or not you record the session). Gather emergency contact information in case the client needs to be transported to emergency care, work together to develop a safety plan (e.g., by sharing your screen and having them contribute), and then email the plan to the patient and their parent/guardian. Service providers should continue to keep detailed records for each client.

ZEROSuicide Institute – Telehealth Tips: Managing Suicidal Clients During the COVID-19 Pandemic (ZERO Suicide Institute, n.d.b)

This document provides tips on evaluating and treating suicidal individuals through telehealth. While this document is not specific to youth, it may still be useful to school mental health professionals. Before initiating contact, practitioners should develop a plan for how to stay on the phone with the youth in case they need to contact emergency services. Once on the phone, practitioners should request the youth's location (in case they need to contact emergency services) and emergency contact information. Ask the youth's permission (as is developmentally appropriate) to talk with individuals in the home who can help monitor and provide support for the youth in-person. Develop a safety plan with the youth and provide a copy to them. Take the youth's preferences into account (e.g., some prefer texts while others like phone calls). Schedule the next phone call while you are ending the current one to ensure follow-ups. Keep documentation of all interactions.

ZEROSuicide Institute – Zero Suicide Implementation During COVID-19 Response (ZERO Suicide Institute, n.d.c)

This document discusses the challenges of preventing suicide during COVID-19 and things practitioners should consider during the pandemic. While this document is not specific to youth, it may still be useful to school mental health professionals. Recommendations include increasing phone check-ins given the stressful changes youth are experiencing with COVID-19 and using that time to review and update safety plans and making sure youth have easy access to their updated safety plans (e.g., pictures of the plan, texting). It is also recommended that service providers receive training and supervision in telehealth.

8. Appendix C. Summary of Priority Population Resources

8.1 Dissertations

The ten dissertations identified for extraction were not directly related to our research question (i.e., eHealth suicide risk assessment practices for priority youth populations). However, five of these documents had general recommendations that we felt could inform school-based eHealth suicide risk assessment with priority populations, and so we summarize these here.

Included dissertations used samples from the United States (*n* = 2) and Canada (*n* = 3). All dissertations were completed between 2011 and 2018, with the majority submitted in 2018 (60%). The most common study design was qualitative (60%). One study used a multimethod research design (Salway, 2017) and another used mixed methods (Mah, 2011). The majority of the documents were doctoral dissertations (80%). Only one document was a master's thesis (Yachouh, 2018).

The emphasis of the included documents was on recommendations that could support virtual/remote suicide risk assessment with specific populations (i.e., male youth; Indigenous youth; newcomer, immigrant and refugee youth; LGBTQ2SIA+ youth; and youth with (dis)abilities). The dissertations that were selected had relevant recommendations for online environments which are summarized below (e.g., considerations for students with physical (dis)abilities). The majority of the studies obtained information by interviewing mental health providers (60%). For example, one study reviewed practitioners' (i.e., counselors, psychologists, and speech language pathologists) experiences in telepractice (Hadley, 2018). Six of the eleven practitioners used telepractice in schools with youth ages 12 to 18 years (Hadley, 2018). Other studies focused on exploring telehealth providers' experiences in First Nations communities (Mah, 2011) and recommendations for clinicians to provide counseling in virtual settings (Murphy, 2018). Finally, one dissertation analyzed Canadian data on gay and bisexual sexual minority men (Salway, 2017) and another interviewed Syrian refugees and immigrants (Yachouh, 2018). In these documents, participants' ages ranged from 18 to 65 years old. Thus, recommendations should be interpreted with caution, as most studies (*n* = 3) focused on adult priority populations (though some were obtained from studies with clinicians who work in virtual environments with youth in schools). Relevant recommendations obtained from the five documents can be grouped into three main themes: 1) school-based recommendations for clinicians, 2) recommendations for sexual minority populations, and 3) recommendations for Syrian refugee and immigrant populations.

8.1.1 School-based recommendations for clinicians.

Three dissertations provided information for clinicians working with youth in online environments. For clinicians working with youth with (dis)abilities, it was highlighted that youth with severe physical limitations might need support to manage and have access to technology to receive support online (no specific examples of what this support might look like were given, however; Hadley, 2018). A relevant recommendation for Indigenous populations was to provide services in the communities' language to ensure comprehension (Mah, 2011). Since youth can be hesitant to share information in virtual

settings, exploring different communication formats is also recommended (e.g., texting, using emojis; Murphy, 2018).

8.1.2 Recommendations for sexual minority populations.

One dissertation provided information relevant to working with gay men, bisexual men, and other male sexual minorities (Salway, 2017). The age range of the studies in this dissertation included men between the ages of 18 and 59. Although specific recommendations on working with gay youth were not provided, the document notes that clinic-based supports for sexual minorities could benefit from acknowledging the societal stigma that impacts sexual minorities (Salway, 2017). Recognizing stigma is important when working with sexual minorities because it can precede distress (Salway, 2017).

8.1.3 Recommendations for Syrian refugee, newcomer and immigrant populations.

A thesis that included a sample of Syrian refugees and immigrants in Canada described the importance of trust when discussing mental health concerns with individuals who have moved to Canada (Yachouh, 2018). Specifically, some of the people interviewed expressed concerns over engaging in mental health support with a professional due to uncomfortable feelings and thoughts (e.g., feeling embarrassed, perceiving supports as only for 'crazy people'; Yachouh, 2018). Some individuals preferred to approach family members or friends for mental health support rather than mental health professionals (Yachouh, 2018). Participants in this project also described engaging in religious activities to support their mental health (Yachouh, 2018). The study included young adults in their sample (ages 22 to 63), but information was drawn from a primarily adult sample (Yachouh, 2018). Based on their data, they concluded that families are an important source of support for this population (Yachouh, 2018).

8.2 Distress Centres

Overall, we found little information on the reviewed Distress Centre websites on how to conduct suicide risk assessments with youth who are members of priority populations via eHealth. In total, we pulled relevant recommendations from four websites: LBGT Youthline (Canada), CAMS-Care (United States), National Suicide Prevention Lifeline (United States), and QLife (Australia). From these four websites, we noted three overall recommendations.

8.2.1 Recommendations for who conducts the risk assessment.

LGBT Youthline and CAMS-Care both suggested that there should be diverse representation among those providing eMental health services (LGBT Youthline, n.d.; Tucker, 2020). For example, given the history of and continued oppression Black people face, Black mental health providers may be more helpful as they can better understand the lived experiences of their client (LGBT Youthline, n.d.). Diverse service providers may also include those who are transgender, Indigenous, or people of colour (Tucker, 2020). The second recommendation from these sites was to assess the unique risk factors of the priority population. For example, why and how people die by suicide can vary by gender. As such, assessing suicidal risk factors by gender may lead to a better understanding of the reason and prevent a future suicide attempt (National Suicide Prevention Lifeline, n.d.). The National Suicide Prevention Lifeline also shared that Indigenous youth's unique risk factors, including intergenerational trauma and community-wide distress, should be explored during risk assessments (National Suicide Prevention Lifeline, n.d.). The National Suicide Prevention Lifeline also noted that

safety plans should incorporate unique protective factors such as connection to culture and spirit (National Suicide Prevention Lifeline, n.d.).

8.2.2 Recommendations for addressing cultural identity.

Jarvis (2020) shared that clinicians should acknowledge cultural identity as it helps build trust and rapport. Acknowledging culture can mean showing interest or seeking to understand the client's inner workings. For example, one could use phrases like, "Hmm... now that's a term I'm not familiar with, can you explain it to me?" or "Ah, I didn't know that. I'm glad to learn something new about your culture" (Educational Content page) (Jarvis, 2020). Acknowledging culture may help a client better understand their own situation, and can lead to a conversation on how cultural identity can be incorporated into a suicide safety plan (Jarvis, 2020).

8.2.3 Recommendations for working with LGBTQ2SIA+ youth.

QLife offers a series of general and specific resources and fact sheets for working with LGBTQ2SIA+ youth (QLife, 2020). Specific to suicide prevention with this population, risk assessments should be made in the context of one's life history (e.g., mental health history, risk-taking history; QLife, 2020). QLife also suggests that clinicians explore LGBTQ2SIA+ youth's common narrative of battling discrimination and then validate that this information will inform effective care strategies (QLife, 2020).

8.3 Indigenous Departments and Related Websites

While many websites reviewed did not directly discuss suicide risk assessment with Indigenous populations, there was transferable information that we felt could inform school-based practice. Themes from the nine included websites were: building rapport, providing holistic assessments, considering local languages, unique risk and protective factors, and the need for community collaboration.

8.3.1 Building rapport.

Building rapport is important for creating a safe and comfortable process for all youth (The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, n.d.). When working with Indigenous peoples, however, this is especially important given the history (and continuation) of unfair and discriminatory treatment by mental health professionals. Suggestions for building rapport include conducting the assessment at a relaxed pace and emphasising the value of personal and community relationships (Victoria State Government, n.d.). During the process, there may be hesitation or resistance as some Indigenous people prefer not to speak about suicide directly; thus, it is recommended to instead focus the conversation on protective factors. Further, some may prefer to have a family member or an Indigenous health worker present. However, these general recommendations should be taken with caution, as Indigenous communities are very diverse. Clinicians are thus encouraged to have open conversations about the process to ensure tailored care. If follow-up treatment is required, it is best practice to recommend an Indigenous mental health professional if available (and the individual wants this). If preferred, allow the individual to involve their family or an Elder in treatment planning.

8.3.2 Language.

The Baffin crisis telephone line in Kamatsiaqtut, Nunavut was developed by community members and is run by community volunteers who predominantly speak Inuktitut (Kirmayer et al., 2007). While this type of service is not available in all settings, it is nonetheless important to integrate cultural and linguistic

knowledge into the risk assessment so the process aligns with youth's beliefs and values. Helpful services include those available in the language the client is most comfortable with. People are often connected to their emotions and thoughts through language, yet few mental health providers or interpreters try to learn local Indigenous languages (Kirmayer et al., 2007).

8.3.3 Holistic assessments. Supporting Indigenous clients includes providing services that are culturally appropriate and embedded in a holistic framework. A holistic framework is systemic in that it takes into consideration individual, family, community, and societal factors (Adams et al., n.d.; The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, n.d.). A holistic assessment also considers the four dimensions of well-being: physical, mental, emotional, and spiritual (Kirmayer et al., 2007). Distress and sadness are thought to occur when one of these four components is out of balance, akin to how a car would drive if one tire was flat (Kirmayer et al., 2007). Further, assessments should respect Indigenous views on suicide. For example, some Indigenous peoples view suicide as a sickness of the spirit (Kirmayer et al., 2007).

To further provide a culturally appropriate assessment, it is important to engage the client as a partner using the Diagnostic and Statistical Manual of Mental Disorders (DSM)-5 guidelines for working with culturally diverse people (Adams et al., n.d.). These guidelines include asking about cultural identity, cultural explanations of the illness, cultural factors associated with psychosocial and environmental functioning, and cultural elements of the relationship between the client and the practitioner. A standardized process for asking questions about culture can be found in the Cultural Formulation Interview (CFI) (Victorian Transcultural Mental Health, 2018). This is a 16-item comprehensive, standardised method for conducting general mental health interviews that could be adapted to relevant procedures, such as the safety planning process. In this interview, culture and identity are openly discussed to consider their role in the crisis (e.g., "Are there any aspects of your background or identity that are causing other concerns or difficulties for you?"; note: these recommendations speak to mental health assessments more broadly and are not specific to suicide risk assessments).

8.3.4 Unique risk and protective factors. Risk factors that increase Indigenous peoples' risk of suicide include experiences of discrimination, isolation on reserves, and local epidemics of suicide (also known as 'suicide clusters'; Indian Health Services, n.d.). Experiences of discrimination and victimization are more prevalent among Indigenous people due to historical and ongoing oppression (Dyck, 2012b). When assessing, structural risk factors (e.g., discrimination) will be important to be aware of as they may have played a role in triggering the event. It is also important to consider youth's intersecting identities (e.g., if they are a two-spirit Indigenous youth) when conducting risk assessments. Finally, to balance the assessment of risk factors, it is also important to amplify protective factors. While these factors are understudied, some protective factors for Indigenous youth include social support, connection to land, cultural connectedness, spirituality, and ancestry (Kelly, Dudgeon, Gee, & Glaskin, n.d.).

8.3.5 Community-wide collaboration. If a school/school division is seeking to collaborate with a local reserve and anticipates providing remote telehealth services, there are some important considerations (Trzesinski, 2015).

First, the school/school division should determine the relevance of eHealth services for the Indigenous community by surveying the community to better understand service preferences, current availability, infrastructure, and anticipated barriers (e.g., internet service availability/reliability). This needs assessment process was completed by Trzesinski (2015), who learned that their services should operate from a strengths-based approach, provide information on cultural models of health, use proper symbols and terminology, and include plain-language resources. Adapting or creating mental health services for Indigenous populations will require systematic rethinking and attentiveness to the distinctive features of Indigenous communities such as the lack of mental health services and Indigenous mental health professionals, and cultural and linguistic diversity (Kirmayer et al., 2007).

8.4 Recommendations for Rural and Farming Communities

During the search for Indigenous departments/websites, three websites containing information on rural and farming communities were found that we felt were relevant to the current search. The table below overviews the barriers that may prevent rural youth from seeking support using traditional mental health services and why telehealth can be a viable solution to address those barriers (Robert, Baker, & Gillaspy, 2020). More details on recommendations for working with rural populations are described in Section 8.5.

Barriers to Traditional Mental Health Services in Rural Communities (Roberts et al., 2020)	Solutions using Telehealth (Roberts et al., 2020)
Lack of anonymity and stigma as those in rural communities are more likely to fear negative labelling from others	Telehealth enhances privacy by reducing the public nature of therapy which can increase comfort for those in rural communities
Therapist shortage	Telehealth increases access to services by allowing clients to access providers from anywhere
Lack of culturally competent care	Telehealth increases access to providers who can offer culturally competent care
Un-affordability of care	Telehealth may offer lower-cost services
Transportation and distance (services may be far away)	Telehealth can be accessed anywhere

8.5 National, Provincial, State and County Suicide Prevention Plans and Documents

We found few specific recommendations among these plans/documents regarding assessing suicide risk via eHealth with youth priority populations. The relevant recommendations we did find are summarized by country.

8.5.1 National and provincial plans/documents in Canada.

After reviewing the 93 located Canadian documents and websites, 17 were identified as having information relevant to suicide prevention in specific populations. However, only one resource provided specific recommendations for supporting vulnerable youth online (Mishna, 2020). In this video, the recommendations were framed in the context of violence prevention and apply to therapy, but underscore the safety concerns for youth who have experienced violence prior to the COVID-19 pandemic (Mishna, 2020). Because of the pandemic, many youth have been disconnected from safer spaces and services that keep them away from harmful situations and/or self-harm (Mishna, 2020). To provide support online, it is thus recommended that service providers adopt an empathetic, trauma-informed stance so that they can understand the youth's context and create a safer space for them (Mishna, 2020). Privacy concerns and

connectivity issues were also noted as barriers to online service provision in this document (Mishna, 2020). Other recommendations to support privacy included suggesting or teaching safe internet usage (e.g., incognito mode) (Mishna, 2020). However, these activities may not be applicable for youth at immediate risk. For example, if a youth is in crisis and wants to take their life, teaching them how to use incognito mode would not be appropriate. For youth who have experienced trauma, it is recommended to focus on building trustworthiness because they might not trust others (Mishna, 2020). To this end, when using technology, the therapist needs to summarize the limits to confidentiality (Mishna, 2020). At the beginning of the session, the therapist can remind the youth that the session will not be recorded or posted online (Mishna, 2020). This reminder can help youth feel more comfortable sharing their thoughts, especially if they have experienced trauma (Mishna, 2020).

Most of the located resources focused on Indigenous populations. The main themes identified for Indigenous populations were a) involving community members (Centre for Suicide Prevention, 2013; First Nations Health Authority, 2020), b) respecting and recognizing community values and connections (McCue et al., 2019), and c) the benefits of increasing community awareness (Health Canada, 2013; Kral, 2017) and making crisis hotlines available (Kirmayer, Boothroyd, Laliberté, & Laronde Simpson, 1999; Kirmayer, Fraser, Fauras, & Whitley, 2009; Suicide Prevention Advisory Group, 2002). In terms of involving the community, researchers who developed a suicide prevention toolkit for Indigenous youth recommend that engaging community members who understand the local cultural and social context is important (Centre for Suicide Prevention, 2013). Thus, including Elders and Band Councils is encouraged for suicide prevention programs (Aboriginal Healing Foundation, 2007; First Nations Health Authority, 2020). Another recommendation is to ensure that prevention strategies are respectful of the youth's culture and language (Bazinet, Hébert, & Plante, 2014). Mental health services need to be culturally appropriate for the population they serve (Government of Nunavut, 2010). Some researchers suggest that incorporating identity, resilience, and culture could support suicide prevention efforts (Northern Human Services Partnership, n.d.). Further, suicide prevention efforts can be supported by raising awareness of risk factors in the community (Health Canada, 2013). Of note, several documents highlighted the importance of crisis hotlines to support suicide prevention efforts in First Nations (Kirmayer et al., 1999; Suicide Prevention Advisory Group, 2002), Inuit (Kirmayer et al., 1999; Kral, 2017), and Indigenous communities in general (Kirmayer et al., 2009).

For the general population, and consistent with other information provided in this review, stigma can make individuals feel disempowered (Wilson & Gauvin, 2012). For LGBTQ2SIA+ youth, a summary of the LGBTQ2SIA+ Youth Suicide Prevention Summit from 2012 suggests that sexual minority youth might hesitate to access services due to fear of discrimination from service providers (Dyck, 2012a).

8.5.2 National and provincial plans/documents in the United Kingdom

8.5.2.1 Northern Ireland. This search yielded 22 resources to review at the national level. After reviewing documents from this region, we found that one document was relevant to LGBTQ2SIA+ populations and one document was relevant to rural communities as well as to the general population. However, there were no recommendations specific to eHealth suicide risk assessments; instead, recommendations were generally broad.

Relevant recommendations include the need for suicide and self-harm strategies to incorporate specific needs and risk factors of the LGBTQ2SIA+ population in order for services to properly address the needs of this community (O'Hara, 2013). Recommendations for the general population include continued, as well as increased use of, eHealth suicide interventions as anonymity can provide a safer space for this work (Roinn Sláinte & O'Poustie, 2019). Ongoing efforts to promote equity and rural mental health through the use of eMental health services were also endorsed (Roinn Sláinte & O'Poustie, 2019).

8.5.2.2 Scotland. This search yielded 21 resources at the national level, and one county-level resource (Glasgow). Of these resources, two were specifically for men. Overall, there were no specific recommendations for eHealth suicide risk assessment, with many alluding to general policies needed to address health inequalities such as increased suicide prevention training, early interventions, and awareness campaigns. However, Scottish work on suicide prevention plans led to several recommendations for men and boys. These documents identified that males have unique needs and a 'a one size fits all' approach cannot be used (BACP, n.d.). Resources and crisis lines should design marketing that is both developmentally appropriate and geared towards gendered needs. For example, adolescent boys are at a stage where they are beginning to internalize masculine norms of emotional detachment and lack of vulnerability. These norms can act as a barrier in seeking help. Thus, Scotland's 113Online suicide prevention website was designed to be more inviting and accessible for males (Mokkenstorm et al., 2013). Some may instead prefer mental health apps as these can be used privately and are anonymous. To increase use of apps, it is important to make sure they are barrier free (e.g., cost free; BACP, n.d.).

8.5.2.3 Wales. This search yielded 19 relevant documents for review (9 national level; 10 county level). Of these documents, 7 had information relevant to suicide risk assessment for priority populations.

Youth at-risk of suicide are best supported when the helper is able to identify and encourage discussion on thoughts of suicide, understand reasons for suicide as well as reasons for living, can develop a safety plan, can recognize potential barriers to seeking help, and can offer community resources for follow-up care (Flintshire Government, n.d.). Thus, several resources discussed reasons for suicide and barriers to seeking care among priority populations

For example, boys are generally less likely to seek emotional support and tend to die by suicide at a higher rate than girls. In general, there is a need to strengthen boy's social relationships and improve their recognition of mental health issues (Welsh Government, 2015). With this knowledge, Wales has initiated several campaigns and redesigned websites with the hope of encouraging more males to seek support. The campaigns *Talk to Me,* #IPledge2Talk, and *Big Boys Do Cry* were developed to encourage men to seek support and let them know that help is available for them 24/7 (BBC News, 2019; Caerphilly County Borough Council, 2019; Cardiff and Vale, n.d.). While these recommendations are not relevant to the process of conducting a risk assessment, schools are encouraged to consider factors influencing boy's willingness to use eHealth supports.

The mental health needs of those living in rural communities were noted as these communities tend to experience higher levels of isolation (Welsh Government, 2015). Local suicide prevention plans need to take this

unique risk factor into account. Those living in rural communities may also have increased access to lethal means such as firearms (Welsh Government, 2015). As such, individuals completing risk assessments are encouraged to be aware of and ask about this.

Related to transgender youth, risk factors that may trigger suicidal thoughts and behaviors were discussed in a report by the Welsh government. Suicidal ideation for transgender youth can be brought on by long wait times to access health clinics, delays in gender reassignment treatment, discrimination, and marginalization (Welsh Government, 2019). To support transgender youth and reduce any further feelings of marginalization, include an 'other' or 'nonbinary' option on all records, use the gender neutral title, 'Mx', and respect people's pronouns (Welsh Government, 2019). Schools are encouraged to acknowledge the specific needs of transgender people to ensure services are transgender friendly.

8.5.2.4 England. This search yielded 176 documents for review. Although no documents referenced virtual/remote suicide risk assessment specifically, a total of nine documents referenced online or remote eHealth. However, some additional documents on general suicide risk assessment were relevant to eHealth and thus also included. This led to a total of 37 documents included. Priority populations addressed in these documents were male youth, LGBTQ2SIA+ youth, and refugee youth. Generally, England's regional and county suicide prevention documents highlighted the need to work in collaboration with multiple groups and/or agencies (Chadwick, 2019; Health Education England, 2018; SAMHSA, n.d.) and improve and/or increase specialized training of individuals working with specific at-risk or vulnerable populations (Derbyshire Healthcare, 2016; Health Education England, 2018; Suffolk User Forum, 2016). Additionally, risk assessment practices were encouraged to be adapted to become culturally sensitive (Health Education England, 2018; PSPP, n.d.; SAMHSA, n.d.) and focus on determining needs, rather than attempting to make predictions ("Birmingham Suicide Prevention Strategy", n.d.; Health Education England, 2018). Changing risk assessment practices to become holistic (such as integrating strengths-based assessment and looking at a person as a whole and part of a community) and meaningful (such as working collaboratively with the individual to determine their personal experiences, wishes, goals, etc.) was encouraged in order to increase participation of individuals at risk, as well as to determine the specific vulnerable populations in a given area that require targeted supports (Health Education England, 2018; Mackley, 2019; PSPP, n.d.; Public Health England, 2016). The government of England also highlighted the importance of tailoring approaches to suicide prevention and risk assessment to meet the specific needs of vulnerable populations (Department of Health, 2012; Gale, n.d. ; HM Government, 2019). Part of tailoring approaches involves making those approaches accessible to the targeted population (Department of Health, 2012; Health Education England, 2018; HM Government, 2012). For example, DVDs and audio/pictorial resources can help overcome language barriers (Department of Health, 2012) and adaptions need to be created for how to talk about suicide with those with (dis)abilities (e.g., Autism Spectrum Disorder; Sussex Partnership NHS Foundation Trust, n.d.).

There were several recommendations for suicide prevention with young men found within England's national and county specific documents. Beginning with a focus on telehealth, any online resources/supports

which target young men were created as interactive online resources (Wilkins & Kemple, n.d.). Many men were found to prefer using computers to interact with medical professionals and they preferred online resources that were more engaging and interactive, as compared to women (Wilkins & Kemple, n.d.). Furthermore, The Isle of Wight's suicide prevention plan (2018-2021) encouraged the use of online resources wherever appropriate for men in crisis, as well as those in contact with men in crisis (Isle of Wight Council, n.d.). Online resources should allow for the provision of a range of services to reach young men who may not be comfortable seeking in-person help (Isle of Wight Council, n.d.; Oxford Health NHS Foundation Trust, n.d.; Wilkins & Kemple, n.d.). England and its counties tailored many different crisis hotlines and online resources to meet the needs of men in crisis (Department of Health, n.d.; Gale, n.d.; Wilkins & Kemple, n.d.). These male-specific resources included CALMzone, which provides specialized crisis hotlines and resources, and Trust, which provides online training and app development for individual assessment (Gale, n.d.).

Initiatives addressing suicide in men targeted the stigma surrounding mental health and help-seeking for this group. Two progress reports for the nationwide, cross-government suicide prevention strategy and Lancashire's suicide prevention policy and board meeting highlighted efforts to reduce this stigma through campaigns that encouraged awareness and help-seeking for mental health in men (Chadwick et al., 2019; East Lancashire Hospitals NHS Trust, 2020; HM Government, 2019; "Lancashire County Council Suicide Prevention Strategy", n.d.). Such campaigns included "CALM" (Campaign Against Living Miserably), "It's Okay to Talk", "Just Talk", and "It Takes Balls to Talk," which targeted male stereotypes and offered supports and skills training (e.g., coping skills) (Department of Health, n.d.; Health and Wellbeing: Mental Health, 2017; Hertfordshire County Council, 2018; HM Government, 2017). Through these campaigns, a progress report on nationwide prevention policies found that young men responded well to the opportunity to practice and/or observe help-seeking conversations with someone they did not know well and marketing strategies that were subtle/easily concealed (e.g., credit card sized information) (Chadwick et al., 2019). The above information helps to inform risk assessment practices with male youth as it highlights that, due to stigma, male youth are less likely to reach out for support and risk assessments must take special consideration of the support network available to these youth and the likelihood of them reaching out for help when they need it. Furthermore, it highlights the potential for online risk assessment, which can be done subtly and can be easily hidden, both of which were outlined as preferential for this population. Other strategies for tailoring suicide risk assessment and prevention to men included using male-friendly language (e.g., action-based, emphasis on goals), emphasizing strength, and emphasizing problem-solving (HM Government, 2019; Wilkins & Kemple, n.d.). Furthermore, in order to gain a better understanding of what resources men want and what gaps exist, asking questions about male's opinions of current services, rather than asking what services men want, was effective (Chadwick et al., 2019; Suffolk User Forum, 2016;).

The LGBTQ2SIA+ community and refugees were the other priority populations specifically addressed within England's national and county suicide prevention documents. With regards to the LGBTQ2SIA+ community, Franks and colleagues (2010) reviewed current offline/online practices for addressing suicide distress in this

population, and noted that there were no evidence-based online suicide prevention and risk assessment methods for this group. Current online-based supports for the LGBTQ2SIA+ community in England focused on general mental health supports and networking (The Mental Health Centre of Greater Manchester, n.d.; Wilkins & Kemple, n.d.). Such online/remote initiatives included "The Trevor Project", "Peer Listening Line", "It Gets Better", and a "LGBTQ Hotline" (The Mental Health Centre of Greater Manchester, n.d.). Given the gaps noted, Franks and colleagues (2010) emphasized how more research is needed in order to create evidence-based suicide resources specific to the LGBTQ2SIA+ population. In general, suicide prevention efforts for the LGBTQ2SIA+ community were noted as needing to use inclusive language, creating a safe environment that welcomes differences, increasing marketing and positive images of the LGBTQ2SIA+ community, respecting individual experiences, and allowing for individual autonomy through developing collaborative relationships and allowing the individual choice wherever possible (Chadwick et al., 2019; Department of Health, n.d.; Public Health England, 2016; Wilkins & Kemple, n.d.). When working with the LGBTQ2SIA+ community, a number of resources highlighted using community-based approaches and working in partnerships with other organizations ("East Sussex Suicide Prevention Plan", n.d.; Franks et al., 2010; HM Government, 2012; Public Health England, 2016). Raising awareness and training professionals regarding specialized supports for the LGBTQ2SIA+ community was also noted as important to successfully tailoring suicide prevention approaches (Guerra, 2015; Hartley, 2014; Sussex Partnership NHS Foundation Trust, n.d.). The above considerations are important to recognize when developing online suicide risk assessments targeting this population.

With regards to the refugee community, national and county documents from England highlighted the need to increase awareness and work collaboratively with organizations that have contact with refugees in order to identify who requires risk assessment (e.g., social services, medical professionals, schools) (Chadwick et al., 2019; "East Sussex Suicide Prevention Plan", n.d). Suicide risk assessment should be tailored to the refugee community through addressing specific compounding factors (e.g., language, PTSD) (Cambridgeshire County Council, 2019; HM Government, 2019). Lastly, marketing and service provision of suicide prevention strategies needs to be culturally sensitive and available in different languages (Cambridgeshire County Council, 2019; Chadwick et al., 2019).

8.5.3 National and state plans/documents in the United States.

In total, 316 resources from the United States were scanned, with 30 containing relevant information. Relevant recommendations for specific populations include Black youth, Indigenous youth, LGBTQ2SIA+ youth, refugee youth, and Hispanic youth. Of note, most of the recommendations focused on suicide prevention efforts in different communities rather than assessing the risk of suicide in online environments. However, the recommendations described below were included in our review because they seemed relevant to online environments.

8.5.3.1 Recommendations for Black youth.

Recommendations for working with Black youth generally referred to a need for screening tools that captured culture-specific expressions of mental health as well as the unique risk and protective factors for Black youth (Coleman, n.d.). For example, one resource suggested that Black

youth, particularly males, may be more likely to report somatic symptoms or changes in behavior as opposed to feelings of depression and hopelessness (Coleman, n.d.). It is also necessary to consider current events and their impact on populations. With respect to Black communities, the disproportionate impact of COVID-19 and police violence may expose them to trauma while increasing distrust in institutions (SPRC, 2020).

Culturally competent mental health care is needed to ensure the experiences of Black youth are understood and properly interpreted. Some evidence suggests that while suicidal thoughts and plans among Black adolescents have decreased, attempts have increased (Coleman, n.d.). Factors contributing to this statistic need to be better explored to determine if youth are attempting suicide without prior planning, or if they are not comfortable disclosing their thoughts and feelings. Further exploration is also needed to inform assessments and recommendations for follow-up care.

Black youth may feel uncomfortable accessing care or disclosing symptoms due to various barriers, including: mental health care provider bias, underrepresentation of multicultural providers, and inappropriate treatment referrals or recommendations (Kaufman & Associates Inc. & MDHHS, 2017; SPRC, n.d.a). Culturally competent mental health care is necessary as evidenced by Black Americans receiving higher rates of inaccurate diagnoses and ineffective mental health treatment when compared to White Americans (Kaufman & Associates Inc. & MDHHS, 2017). Culturally competent mental health care may include being aware of cultural and spiritual beliefs, as Black youth may prefer to rely on faith-based supports (Coleman, n.d.).

8.5.3.2 Recommendations for Indigenous youth. When working with Indigenous groups, an important consideration is that fear and stigma around mental health may be prevalent, due to historical and continued oppression and discrimination (Kaufman & Associates Inc. & MDHHS, 2017). Youth may fear being removed from their home or being punished for having suicidal thoughts or behaviours (Kaufman & Associates Inc. & MDHHS, 2017). When engaging in prevention efforts, it is important to connect with the community (The National Child Traumatic Stress Network, 2012) in order to establish collaboration between researchers, service providers, and the community (Kaufman & Associates Inc. & MDHHS, 2017). This way, prevention efforts can be informed by the community's understanding of suicide and how traditional knowledge impacts these views (Committee on Indian Affairs, 2009; Committee on Indian Affairs, 2010; Kaufman & Associates Inc. & MDHHS, 2017; SAMHSA, n.d.; SPRC, n.d.b; Warren et al., 2013). Further, asking for input from Elders and council members can be informative (State of Rhode Island Department of Health, n.d.; The National Child Traumatic Stress Network, 2012). In the state of Montana, for example, the Montana Native Youth Suicide Reduction Strategic Plan suggests that telehealth networks and systems in the community and schools can support suicide prevention efforts (Kaufman & Associates Inc. & MDHHS, 2017). Further, connecting to local Indigenous governments helps assess community strengths and areas of need (i.e., protective factors, access to services; North Carolina Injury and Violence Prevention Branch et al., 2015). Assessments with Indigenous youth may also benefit from being strengths-based, presented in youth-friendly language and rooted in traditional concepts of holistic health (e.g., the medicine wheel) (Multi-Agency Alcohol and Substance Abuse Prevention Collaboration, 2015). For example, the Applied Suicide Intervention Skills

Training (ASIST) has been adapted to fit the needs of Indigenous communities (Committee on Indian Affairs, 2010; The National Child Traumatic Stress Network, 2012). The Maine Youth Suicide Prevention Program is also modifying its gatekeeper training program to better identify and support Indigenous students at-risk of suicide (SAMHSA, n.d.). Hotlines or support lines were highlighted as relevant for Indigenous groups to promptly connect individuals in crisis with culturally-relevant assistance (North Carolina Injury and Violence Prevention Branch et al., 2015).

8.5.3.3 Recommendations for LGBTQ2SIA+ youth. A culturally responsive approach is important when working with LGBTQ2SIA+ youth (New York State Suicide Prevention task Force, 2019; SPRC, n.d.c). For transgender youth, school service providers need to be educated on specific risks that impact this subgroup (e.g., harassment, discrimination) (Breux & Samet, n.d.; SPRC, n.d.c.). School service providers should also seek to create a safe space by assuming youth may be any sexual orientation or gender (SPRC, n.d.c). Finally, school service providers can help youth feel more comfortable by asking for the youth's pronouns, using gender-inclusive language, and implementing non-discriminatory policies (National Alliance on Mental Illness, n.d.).

8.5.3.4 Recommendations for Latinx youth. In the Latinx community in New York, stigma towards mental illness is still common (Carlucci & Rivera, n.d.). Reducing stigma through a culturally responsive approach was mentioned as an important consideration in prevention efforts, which includes hotlines (Carlucci & Rivera, n.d.; New York State Suicide Prevention Task Force, 2019).

8.5.3.5 Recommendations for refugee youth. It is important to note that suicide risk assessment screening tools may not be culturally relevant for specific populations (e.g., refugees; Sari, 2018). If supporting refugee youth, consider that English may be a second language and thus they may have difficulty communicating their thoughts and feelings during a risk assessment (Administration for Children and Families, 2015).

8.5.3.6 General recommendations. Suicide prevention programs need to be sensitive to cultural differences, can benefit from being trauma-informed, and should be able to reach a wide range of populations (Maryland Department of Health, 2018). In Oregon, enhancing crisis services and screening for suicide in vulnerable populations was described as a strategy that could benefit these populations (e.g., Indigenous youth, White males, depressed youth; Breux & Samet, n.d.). States like Virginia recommend increasing access to mental health services through hotlines with access to different languages and using different technologies to reach more people (Suicide Prevention Interagency Advisory Group, 2016).

8.5.4 National and state plans/documents in Australia. In this search, we found 88 resources; 44 of these were relevant to suicide prevention with priority populations. Relevant documents included information about the LGBTQ2SIA+ community, Aboriginal and Torres Strait Islander (Indigenous) communities, the male population, rural and remote communities and the general youth population. Overall, a key recommendation to prevent suicide among priority populations was to seek input from the populations themselves. By communicating directly with the priority populations, mental health providers can gain a better understanding of their unique risk and protective factors and the social conditions that influence these (Christensen et al., 2013; Dudgeon et al., 2018;

Robinson et al., 2016; Silburn et al., 2013). In addition, priority populations should be included in the design of suicide prevention services (Dudgeon et al., 2016; Government of Western Australia Mental Health Commission, 2015; Kõlves et al., 2013; Mental Health Commission of New South Wales, 2018; Queensland Mental Health Commission [QMHC], 2019; Victoria State Government, 2016).

8.5.4.1 Recommendations for Indigenous peoples. Indigenous populations require mental health professionals to understand their history, culture and relevant community factors as these impact health and wellness (Dudgeon et al., 2018; Lifeline, 2019). Suicide prevention should also seek to address language barriers so all can seek help (Dudgeon et al., 2018). Another important consideration is cultural understandings of mental health. Aboriginal people tend to take a holistic view of mental health (i.e., mental, physical, social, and spiritual health) where all aspects of well-being need to be in balance (ACT Health, n.d.; Dudgeon et al., 2016; National Mental Health Strategy, 2017; NSW Government et al., 2020). Those conducting risk assessments should help Indigenous youth identify what is out of balance so intervention can seek to restore balance (PHN Australian Government Initiative, n.d.).

Individual, family and community factors should also be considered to ensure appropriate risk assessments are conducted (Dudgeon et al., 2014). To better understand Indigenous conceptualizations of mental health, school-based providers should consider partnering with the community and co-designing culturally relevant supports (Australian Government Department of Health and Ageing, 2013; De Leo et al., 2011; Dudgeon et al., 2016; Kirmayer et al., 2009; Mental Health Commission of New South Wales, 2014; National Aboriginal Community Controlled Health Organization, 2019; National Mental Health Strategy, 2017; Suicide Prevention Australia, 2020; Thirrili/National Indigenous Critical Response Service, 2019). Evidence suggests that when Indigenous youth provide input on risk assessment tools, there is stronger construct validity, reliability and appropriateness (De Leo et al., 2011; University of Western Australia, n.d.). Culturally appropriate and competent support is highly valued in Aboriginal and Torres Strait Islander communities (Australian Government Department of Health, 2016; Australian Government Department of Health and Ageing, 2013; Dudgeon et al., 2016; Government of Western Australia, 2019; Government of Western Australia Department of Health, 2009; Government of Western Australia Mental Health Commission, 2019; Government of Western Australia Mental Health Commission, 2020; Mental Health Commission of New South Wales, 2018; Menzies School of Health Research, n.d.; National Aboriginal Community Controlled Health Organization, 2019; National LGBTI Health Alliance, 2016; National Mental Health Strategy, 2017; NSW Government et al., 2020; Public Health Association Australia, 2018; Ridani et al., 2016; Silburn et al., 2013; Suicide Prevention Australia, 2020).

8.5.4.2 Recommendations for LGBTQ2SIA+ communities. Culturally and socially appropriate suicide prevention strategies are also important for other priority populations, including LGBTQ2SIA+ communities and rural and remote communities (QMHC, 2019; Suicide Prevention Australia, 2010; Thirrili/National Indigenous Critical Response Service, 2019; University of Western Australia, n.d.; Victoria State Government, 2016). The input of LGBTQ2SIA+ individuals can strengthen preventive actions by better targeting specific needs or circumstances

(Kõlves et al., 2013; Mental Health Commission of New South Wales, 2014; Skerrett et al., 2012). Consider adapting risk assessment forms to ensure they are LGBTQ2SIA+ friendly by taking into consideration individual differences, cultural diversity and individual preferences (Victoria State Government, 2016). Also, it is important to provide training to frontline staff to reduce ongoing experiences of discrimination and prejudice (Tasmanian Government, 2013).

8.5.4.3 Recommendations for men. Stigma is often associated with men's mental health, making it difficult for men to seek help and discuss topics like suicide. Men may feel empowered to discuss mental health if suicide prevention services emphasize suicide as being a preventable health issue and provide services that focus on problem-solving skills (Australian Government Department of Health and Ageing, 2009; Kõlves et al., 2013; Poole, 2016). Suicide prevention programs should develop strategies to encourage men to reach out, and should consider adapting their general services to address the differences in suicide by gender (Poole, 2016). Male-friendly services, especially for men living in rural areas, should encourage them to seek help and counter isolation (Australian Government Department of Health and Ageing, 2009; The Australian Men's Health Forum, n.d.) . Male-friendly services can target men directly through male-friendly language, be strengths-based, and placed in locations where men typically go (The Australian Men's Health Forum, n.d). While many stereotypical masculine norms have negative impacts on men's mental health, there are positive traits like courage and leadership which can be encouraged to strengthen mental health (Kelly, 2019).

8.5.4.4 Recommendations for rural populations. It is important to incorporate the unique stressors of individuals living in rural and remote areas (e.g., sense of isolation; Hazell et al., 2017). Technology is extremely helpful for suicide prevention in rural and remote areas (Mental Health Commission of New South Wales, 2014; National LGBTI Health Alliance, 2016; Robinson et al., 2016; The National Centre of Excellence in Youth Mental Health, 2016).

8.5.4.5 Recommendations for the general youth population. Evidence suggests that using technology for youth suicide prevention is advantageous as youth feel empowered online, unashamed, confident and are more likely to talk about sensitive issues (Mental Health Commission of New South Wales, 2014; Suicide Prevention Australia, 2010; The National Centre of Excellence in Youth Mental Health, 2016). eMental health could thus be very helpful in terms of appropriately identifying, supporting, and referring people to services, especially youth (Mental Health Commission of New South Wales, 2014). Involving youth, especially Indigenous and LGBTQ2SIA+ youth, in suicide prevention services is recommended to improve the acceptability, appropriateness and efficacy of these services for young people (Suicide Prevention Australia, 2010; The National Centre of Excellence in Youth Mental Health, 2016). In general, a community-based approach including person-centred care is ideal, especially with priority communities in order for their unique needs to be considered (Government of Western Australia Department of Health, 2009; National LGBTI Health Alliance, 2016; Primary Health Tasmania, 2018; Suicide Prevention Australia, 2020; Tasmanian Government, 2013; Victoria State Government, 2016).