



Risk Assessment and Crisis Intervention for Youth in a Time of Telehealth

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Abstract

For the last decade, there has been growing concern regarding the rising rates of youth engagement in self-injury and suicide. The worldwide outbreak of the coronavirus disease 2019 (COVID-19) has elevated these concerns due to increased risk factors pertaining to social, family, economic, and health stressors, in addition to changes to typical routines and support systems. Unfortunately, there are many barriers to at-risk youth being able to access evidence-based mental health services including cost, lack of trained providers, transportation issues, and physical distancing due to the pandemic. Providing school-based prevention and intervention programs that promote social, emotional, and behavioral well-being helps to address many of these barriers. This article highlights important considerations to providing these services in a school-based telehealth modality. Symptom clusters that put youth at risk of harm to self are described. Best practice therapeutic modalities that can be disseminated in a school-based telehealth modality, such as cognitive behavior therapy, dialectical behavior therapy, and mindfulness-based approaches, are reviewed. Although there is growing empirical literature for these school-based prevention and intervention approaches, additional research is needed to determine how to best support at-risk youth remotely.

Keywords Risk assessment · Telehealth · Self-directed violence · Suicide · Youth · School-based intervention

Depression, anxiety, and suicide rates have been on the rise for youth in the United States (U.S.) over the past decade (Younger 2017), demonstrating the need for effective prevention and intervention models to meet the mental health needs of children. In survey research with high school students conducted by Stephenson et al. (2020) in 2019, 18.8% of respondents were found to seriously have considered suicide, with 15.7% of students having made a suicide plan, 8.9% having attempted suicide, and 2.5% having an attempt that required medical attention. The prevalence of attempts was higher among females (24.1%) than males (13.3%). When considering race and ethnicity, White females (24.3%), Black females (23.7%), and Hispanic females (22.7%) were more likely than White males (13.8%), Black males (10.7%), and Hispanic males (11.4%) to

seriously consider attempting suicide. These numbers are higher than the previous survey results conducted just 2 years prior (Kann et al. 2016). LGBTQ youth have also been found to be at significantly higher risk for depression and suicidality (23.4%), with even higher risk for youth who identify as transgender and/or nonbinary (Green et al. 2020; Johns et al. 2020; Stephenson et al. 2020). Currently, suicide is the 2nd leading cause of death among youth ages 10–19 years old (Centers for Disease Control and Prevention [CDC] 2020c). Prevalence rates for students who have engaged in nonsuicidal self-injury (NSSI), defined as deliberate, self-inflicted harm to one's body without suicidal intent (e.g., self-mutilation, cutting; Zetterqvist 2015), are even higher than rates for suicide attempts, with 12–37% of students in secondary schools having reportedly engaged in self-harm behaviors (Whitlock 2010).

In a 2020 CDC national survey studying suicidal ideation, mental health, and substance use during the pandemic of adults, there was a high percentage among 18–24-year-old respondents who reported thoughts of suicide in the past 30 days (25.5%). Minoritized groups (Hispanic [18.6%], Black [15.1%], and essential workers [21.7%]) also presented a higher risk. Approximately 40.9% of participants reported

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having one or more adverse mental or behavioral health symptoms (e.g., anxiety and depression [30.9%]), and trauma- or stress-related disorder (26.3%) that was linked to COVID-19. The effects of COVID-19 have been shown to disproportionately impact at-risk individuals with pre-existing conditions, essential workers, and minoritized youth. In comparison to 2018, suicidal ideation cases have doubled (Czeisler et al. 2020).

While youth have demonstrated the lowest mortality rate due to COVID-19 (CDC 2020b), many are reportedly experiencing a deterioration in their mental health since the onset of the pandemic (Hawke et al. 2020), consistent with trends from previous outbreaks of infectious disease (e.g., SARS; Brooks et al. 2020). Across the U.S. and globally, schools have closed in order to help prevent the spread of the virus (CDC 2020a). Evidence suggests that the emotional effects of the current pandemic may serve to escalate mental health risk for youth through factors such as increased social isolation, family conflict, and economic and health concerns, as well as changes in typical routines and support systems (National Association of School Psychologists [NASP] 2020a; Stanley et al. 2020). Existing literature has shown a strong positive relationship between social isolation and suicidality in youth (Goosby et al. 2013; Calati et al. 2018). For all of these reasons, it is imperative that counselors and school psychologists be able to remotely assess for risk of harm to self and know best practices for telehealth intervention for at-risk children and adolescents (NASP 2020a; Stanley 2020). While school mental health professionals and educators do not have the same access to their students during this time, school-based care still serves to be the most accessible source of support for at-risk youth, therefore making it critical that students are able to access services virtually (Green et al. 2020).

Access to mental health services is inhibited by several obstacles. Students are often hindered from acquiring support due to financial insecurity, absence of insurance coverage, lack of transportation, and difficulty navigating the stigma associated with mental health (Pradhan et al. 2019). As a result, one in five youth with a mental health disorder will receive little to no treatment (Younger 2017). This issue is compounded by a scarcity of trained mental health professionals who specialize in working with children and adolescents. Concerns regarding access to evidence-based mental health services for youth have compelled researchers to critically evaluate barriers, particularly for underserved populations. Provision of mental health services via telehealth has been identified as one possible solution to improve access to care (Burke et al. 2008; Ijadi-Maghsoodi et al. 2018). As school and community service providers increasingly utilize alternative forms of mental health service delivery (e.g., telehealth) during the pandemic, it is important to be informed of best practices.

This article explores the special considerations practitioners need to employ when working with youth deemed at risk for harm to self in a telehealth environment. Ongoing risk assessment, including specific safety protocols and guidelines, recognition of factors and symptoms that are associated with increased risk, parent and caregiver involvement, and evidence-based therapeutic practices for working with at-risk youth through school-based telehealth are overviewed. This article focuses on children in the middle and high school years, as research shows these groups are most at risk for harm to self in the pediatric population (Kann et al. 2014).

A Brief Introduction to Telehealth

The term “telehealth,” also widely referred to as “telemental health,” “teletherapy,” “telepsychology,” and “telepsychiatry” (Jobes et al. 2020; NASP 2017), is an intentionally broad term for the virtual delivery of mental health services by a mental healthcare professional. Services are provided through a range of telecommunication technologies including real-time online video conferencing services, telephones, and mobile communication devices (Jobes 2020). Telehealth affords a number of advantages to traditional face-to-face service delivery including immediate access to care irrespective of location (e.g., rural, lack of transportation), increased ability to incorporate caregivers and other professionals, and improved ability to provide comprehensive services, including increased access to specialized care services (Durland et al. 2014; Pradhan et al. 2019).

Despite its many potential benefits, telehealth has not been fully embraced due to policy barriers, concerns of privacy, inadequate training, licensing issues, and concerns of effectiveness of services. School-based telehealth experiences additional obstacles. Limited research exists on implementing telehealth services through school-based providers; however, many have adopted principles of care used by community providers in order to develop specialized school-based mental health services (Sanchez et al. 2019). Coverage for telehealth services varies by state and Medicaid plans may not recognize a school-based health center (SBHC) as a covered health care provider (American Telemedicine Association [ATA] 2013). However, due to COVID-19, Congress and the Centers for Medicare and Medicaid Services (CMS) introduced waivers to allow for the reimbursement of telehealth services for the duration of the public health emergency period (CMS 2020). Therefore, school psychologists are increasingly utilizing third-party services to provide telehealth. In general, school providers are expected to follow Health Insurance Portability and Accountability Act (HIPAA) guidelines in addition to Family Education Rights and Privacy Act (FERPA) guidelines (NASP 2017), though many regulations have been loosened since the pandemic. It is important to check with current

state regulations in the region wherein services are being provided for the most up-to-date guidelines.

The Evidence Base for Using Telehealth with At-Risk Youth

The robust research base on adult telehealth has shown that there are no differences in mental health outcomes when an evidence-based therapy is delivered through telehealth compared to in-person delivery (Gilmore and Ward-Ciesielski 2019). There is also evidence in the literature that a strong therapeutic alliance between clinician and client can be developed over telehealth (Myers et al. 2017). When reviewing the literature specific to child and adolescent telehealth, several notable randomized controlled trials (RCTs) comparing in-person services to telehealth psychotherapy treatment with various treatment modalities have been conducted, including cognitive behavioral therapy (CBT) for depression (Nelson et al. 2006), obsessive-compulsive disorder (OCD; Comer et al. 2014), and behavioral treatment of tics (Himle et al. 2012), all of which reported comparable treatment effectiveness for the telehealth mode when compared to in-person delivery. The effectiveness of telehealth and family interventions/parent-management training has also been documented (Glueckauf et al. 2002; Reese 2012; Tse et al. 2015; Xie et al. 2013). Additionally, there is strong evidence that risk assessment and intervention can be conducted safely and effectively through telehealth means (Myers et al. 2017).

Children and adolescents may particularly benefit from telehealth methods of care due to young people's technology literacy and access, as well as general caregiver acceptance of virtual service delivery noted in the literature (Myers et al. 2017; Sanchez 2019). According to Pew Research Center (2018), approximately 95% of youth ages 13 to 17 have access to smartphones. The general familiarity with smartphones and videoconferencing apps such as Face Time™ may prove to enhance young people's comfort with and willingness to engage in mental health services (Myers et al. 2017). In fact, in studies looking at clinicians' perceptions of school-based telehealth, many providers noted that students appeared comfortable communicating through video conferencing and often disclosed more information than they typically would during in-person sessions (Cunningham et al. 2013). In a systematic review of school-based telehealth, Sanchez et al. (2019) found that of the 7 studies reviewed that measured parent satisfaction, all reported positive perception. Parents reported high ratings of perception of safety and quality of telehealth services, economic savings, and increased trust in school personnel. The existing evidence base and the technology literacy of today's youth can help school-based clinicians feel more confident in their ability to deliver mental health services through telehealth, while also offering the opportunity to increase

family-school collaboration (Poletti et al. 2020; Sanchez 2019).

Though telehealth has been supported as a means for delivering mental health services to youth, some providers may feel that those at risk for suicide should be excluded from this form of treatment. This, however, is not the case. According to the American Psychological Association (APA) Guidelines for Telepsychology and the ATA Practice Guidelines for Telemental Health with Children and Adolescents, active suicidality is not considered a contraindication for the use of telehealth services across the age spectrum (APA 2013; Myers et al. 2017). While high-risk populations have largely been excluded from RCTs comparing telehealth with in-person treatment, the literature does provide evidence that emergency situations can be effectively managed through telehealth (Hetrick et al. 2017; McGinn et al. 2019). Specific challenges, safety recommendations, and protocols will be described in the next section.

Symptom Clusters for Youth At-Risk for Harm

Predicting risk can be challenging, particularly when doing so via telehealth, and providers should be sure to thoroughly assess how the frequency, intensity, and/or duration of risky behavior contribute to the potential for harm (Rae et al. 2009). Certain symptom clusters and warning signs can also alert providers to the possibility of risk for harm. Clinicians should consider the added benefit of supplementing the clinical interview with administration of evidence-based measures to the client and/or guardian (Carlisle 2013). The following are symptom clusters, along with specific diagnoses, that have been linked to increased risk of self-harm.

Harm to Self Risk Factors

Harm to self for the purposes of this article will include both NSSI and suicidal ideation and attempts. Both those experiencing suicidality and those engaging in NSSI are generally driven by a desire to manage or eliminate overwhelming and seemingly intolerable stress and/or psychological pain. The important distinction made between NSSI and suicidality is *intention*. Those experiencing suicidal thoughts or engaging in suicidal behaviors have a desire to end their lives, whereas those engaging in NSSI do not intend to die but, rather, are trying to relieve emotional pain and lower psychological distress (Gollust et al. 2008; Whitlock et al. 2015). In fact, some youth engaging in NSSI may be attempting to avoid suicidal behaviors (Paul et al. 2015). Although there is a clear distinction between suicidal behaviors and NSSI, there is high co-occurrence between the two (Zetterqvist 2015). Longitudinal research has found that adolescents engaging in NSSI are at significantly higher risk of future suicide attempts (Cox et al.

2012; Wilkinson et al. 2011) and a substantial number of youth who attempt suicide also engage in NSSI (Asarnow et al. 2011). Risk factors for engaging in NSSI include feeling isolated, having few effective mechanisms to cope with emotional stress, feeling worthless, and having a history of trauma, abuse, or chronic stress (Whitlock et al. 2015). Due to the increase in social isolation brought on by COVID-19, it will be increasingly important for school-based mental health professionals to openly address suicidality and NSSI with their students at the onset of treatment (Stanley 2020).

Suicide in youth is a significant health problem in the United States (Glenn and Nock; 2014; Younger 2017). Additionally, some youth who attempt suicide will not die from it but may still suffer significant injuries that could impair their quality of life (Miller 2012). Therefore, it is essential that professionals who work with youth be well-versed in factors that increase suicide risk, in order to more accurately identify and intervene with these students. In a study by Taliaferro and Muehlenkamp (2014), specific risk factors were identified that distinguished between youth who attempted suicide and those who did not. Risk factors that were common for both males and females included running away from home, engaging in self-injury, having a sexual abuse history, experiencing depressive symptoms or other mental health difficulties, and feeling hopeless. Among females, additional factors included experiencing dating violence victimization, having a physical abuse history, perceiving oneself as overweight or engaging in maladaptive dieting behaviors, and experiencing stress or anxiety. Among males, the factor that best differentiated those at risk was engaging in self-injury, followed by feeling hopeless (Taliaferro and Muehlenkamp 2014). Also, it is important to note that although females have higher rates of suicide attempts, males die at a rate approximately five times that of females (Miller and Eckert 2009). This finding can be accounted for by the fact that males tend to use more lethal means (e.g., firearms) in their attempts (Miller 2012).

Situational risk factors must also be considered, including those unique to the current COVID-19 pandemic. Youth who have had exposure to others who have engaged in self-harm are significantly (up to eight times) more likely to subsequently report their own risk of self-harm (McMahon et al. 2013). Other situational factors that may lead to an impulsive suicide attempt include being bullied, having a disciplinary action either at home or school, going through a relational breakup, or experiencing an academic failure (Soole et al. 2015). COVID-19-related stressors such as social isolation, family conflict, and lack of typical routines and support networks (NASP 2020a) also increase risk. Additionally, having a mental health disorder diagnosis, namely depression or other mood disorders, anxiety, and substance use disorders, such as alcohol or drug abuse (Whitlock et al. 2015), is associated with increased risk, along with attention-deficit/hyperactivity

disorder (ADHD) and disruptive behavior disorders (Miller 2012; Soole et al. 2015). LGBTQ youth with high levels of parental rejection are six times more likely to experience depression and eight times more likely to report a suicide attempt (Green et al. 2020; Ryan et al. 2009), making current isolation from their peer groups particularly concerning. Most youth who die by suicide often have multiple risk factors, including several comorbid mental health disorders (Mazza 2006).

Considerations in Telehealth Risk Assessment

Harm to Self Risk Assessment

Before engaging in any form of treatment, a provider should first assess and evaluate suicidal ideation through an interview and a suicide screener (Luxton et al. 2014; Stanley 2020). It is essential to evaluate risk factors in relation to the current pandemic (i.e., increased social isolation, increased feelings of anxiety and depression) and identify access to lethal means (i.e., medications, weapons). Luxton et al. (2010) suggest frequently monitoring suicidal symptoms during treatment through depression screeners such as the Beck Depression Inventory (BDI) or Children's Depression Inventory (CDI). These screeners can also be used as a pre and post intervention rating scale (Carlisle 2013). Godleski et al. (2012) note that video telehealth can offer visual cues about the patient's emotional state and can reduce the need for hospitalization with appropriate risk assessment and intervention, so whenever possible, risk assessments conducted virtually should incorporate both audio and video. NASP provides a plethora of accessible resources for conducting virtual suicide risk assessment for school-based professionals such as *Conducting School Suicide Intervention in a time of Distance Learning: An Intervention Checklist* (NASP 2020b). It is recommended that a virtual risk assessment include the following: (1) identifying the location and contact information of primary caregivers; (2) initiating contact with caregivers and obtaining consent, if not already obtained; (3) documenting the reason for referral (e.g., risk factors, warning signs); (4) identifying the location and contact information of the student at risk; (5) conducting the student suicide risk assessment interview using tools such as the *Columbia-Suicide Severity Rating Scale* (C-SSRS; Posner et al. 2008; Viguera et al. 2015) to assess suicidal thoughts, current plans, history of suicidal ideation and attempts, treatment history, risk assessment data, risk factors, and protective factors; (6) conducting a primary caregiver interview; (7) determining risk level (e.g., low, moderate, high risk), identifying appropriate interventions, and developing a safety plan; (8) creating a primary caregiver action plan; (9) collaborating with relevant stakeholders (parents, student, other professionals as necessary); and (10) re-entry planning

(NASP 2020a). Lastly, a provider must also have knowledge of triaging to facilitate a student's access to appropriate emergency services (Carlisle 2013). Evidence-based measures such as C-SSRS are widely used as useful methods of screening and have been proven to be sensitive to detecting risk. In a study by Viguera et al. (2015), 19 out of 20 participants screened at risk on both the C-SSRS and a comparative tool, indicating high concurrent validity and sensitivity to respondent suicidal ideation. In conjunction with interview information, a positive screening can alert clinicians of indication of risk for suicide (Viguera et al. 2015).

Acute Safety Planning

The first step in safety planning is to determine if the youth is physically safe. If the provider is not face to face with the youth, at the outset of the call/video session, it is good practice for the provider to confirm the physical location of the client, determine if there is an adult present in the home, and make a plan for what to do if the call is disconnected. Obviously, if the risk is considered high, the youth may need immediate professional help via inpatient psychiatric care or going to the local emergency room. It is preferred if the family can transport the youth themselves, as contacting 911 or sending police to a suicidal individual's home may cause further harm to the mental well-being of a client, especially people of color, and can result in a traumatic experience (National Academies of Sciences, Engineering, and Medicine 2018). If possible, it is best to stay on the line with the client until emergency services arrive and to communicate clearly with the arriving team the situation so as to best support the youth and their family.

Once it has been determined that the at-risk youth is not imminently at physical risk for harm, providers should collaborate with the youth in developing a safety plan. In contrast to safety contracting, which has no empirical evidence supporting its efficacy and is focused on what *not to do* (Garvey et al. 2009), safety planning is collaborative in nature and focuses on what the youth *will do*. Stanley and Brown (2012) have highlighted safety planning as a promising intervention when working with at-risk youth and have outlined five basic components of a safety plan, including the following: (1) recognizing warning signs of an impending crisis (e.g., thoughts of harm); (2) employing internal coping strategies (e.g., self-soothing activities; Whiteside 2020); (3) utilizing socializing strategies as a means of distraction and support (e.g., listing important social supports); (4) contacting family members to help resolve the crisis (e.g., knowing who to call and times of the day that each support could be available); and (5) reducing access to lethal means (e.g., removing firearms from the home). It is recommended that youth identify key adults who can play a part in the safety plan and to coach these identified individuals on how to best support youth in crisis. Specific considerations for safety planning in

remote settings include encouraging youth to remember that physical distancing does not have to equate to social isolation. School mental health professionals and teachers are encouraged to hold virtual office hours and extracurricular school sports and clubs should continue to hold meetings virtually when possible to decrease youth's feelings of disconnection from others.

Risk and Safety Recommendations for Conducting Telehealth Risk Assessment

Predicting risk of youth via telehealth assessment can be challenging and wrought with concerns including technological barriers, lack of quality of communication due to Internet connectivity issues, and patient privacy (Luxton et al. 2010). Specific concerns reported by mental health providers also include challenges with access or training around virtual risk assessment tools, and lack of control over the environment, as well as difficulties with triaging and collaboration (Gilmore and Ward-Ciesielski 2019).

In conjunction with school or district-wide protocols, individual school-based providers should be familiar with their state telehealth practice laws and professional organization guidelines (e.g., NASP) as they apply to school-based telehealth care delivery (ATA 2013; NASP 2017; NASP 2020a). NASP also recommends that school-based providers consult with their state department of education and state psychology boards, as well as continually monitor updates from the U.S. Department of Education, and state (SEAs) and local educational agencies (LEAs; NASP 2020c). Before meeting with clients via telehealth, the mental health professional must establish a standard operating procedure (SOP) for emergency situations, evaluate client-specific resources and information, and establish clear roles for the care team members (Kramer et al. 2013). Most schools may have existing protocols for individual crisis intervention; however, these protocols must be reviewed and updated to reflect the current modality of service (i.e., virtual delivery), including the addition of specific guidelines for how to document and report such intervention. All protocols must be made electronically accessible to all school staff in direct contact with students (e.g., teachers) in order to facilitate communication between at-risk youth and school-employed mental health professionals. Protocols must clearly state exactly what actions should be taken if a student is suspected of having suicidal thoughts, plan, and/or intent. Students should also be given instructions on what to do if they have concerns about their safety and/or the safety of another student (NASP 2020a). An additional concern is that most current safety protocols only focus on acute risk assessment and hospitalization, as opposed to crafting reintegration plans for return to home and school (Gilmore and Ward-Ciesielski 2019). Whenever possible, it is recommended that

protocols include guidelines for treatment monitoring and in-person or virtual school re-entry planning (NASP 2020a).

As mentioned previously, when conducting a risk assessment via telehealth, school-based providers should first confirm the location of the client and discuss with the client what to do in the case of a technical malfunction (e.g., call on phone instead). While verbal consent from the legal primary caregiver is recommended, because risk assessment is considered a crisis intervention, it is not required (NASP 2020a). Similar to in-person counseling, after the first session, informed written consent is required. School districts must be sure to update existing consent forms to reflect information related to telehealth, including risks and benefits (ATA 2017; NASP 2017), and ways of electronically delivering such forms.

Telehealth Interventions for At-Risk Youth

Given the serious nature of NSSI and suicidality, it is imperative that effective interventions be provided for youth at risk. School mental health professionals, including school psychologists, are among the qualified professionals who can and should offer evidence-based therapeutic services to students in need of mental health or behavioral intervention (NASP 2015). Numerous psychological interventions have been developed and empirically evaluated to address youth at risk for harm to self. Those psychological interventions that have shown the greatest impact in reducing risk of harm to self are based in a behavioral and cognitive behavioral framework, and are included in the list of evidence-based services school mental health providers, such as school psychologists, are qualified to deliver (NASP 2015; Robinson et al. 2011). Additionally, “third wave” behavioral and cognitive therapies, such as mindfulness-based interventions and dialectical behavior therapy, have also been given increasing attention and appear promising in helping this population (Liehr and Diaz 2010; Miller et al. 2006). Furthermore, the most efficacious interventions were typically found to include a significant family or parent training component (Glenn et al. 2019). It is important to note that, to date, there has been limited published research specifically examining the effectiveness of the delivery of evidence-based psychotherapies for actively suicidal individuals via telehealth and fewer directly addressing the needs of at-risk youth (Gilmore and Ward Ciesielski 2019; Jobes et al. 2020). Further research must be conducted in this area due to the increasingly high need for therapies to be delivered remotely.

Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) is a time-limited, problem-focused therapy that emphasizes exploring the relationship between a person’s thoughts, feelings, and behaviors.

Clients are taught specific skills, such as behavioral activation and cognitive restructuring, to change unhelpful thinking and behavior patterns. While CBT is a well-established treatment for adolescent depression (David-Ferdon and Kaslow 2008), only a few studies have evaluated its effects when treating harm to self with this population. A meta-analysis evaluating all randomized controlled trials (RCTs) of psychological interventions for adolescents presenting with NSSI, suicidal ideation, and suicide attempts found that CBT interventions are supported (Robinson et al. 2011). One particularly noteworthy study included in this meta-analysis was conducted by Slee et al. (2008), which compared a CBT group with treatment as usual. Findings included clinically significant reductions in suicidal ideation, including a medium effect size (0.53) for reductions in NSSI and a large effect size (0.82–1.24) for all other variables, including reductions in suicidal cognitions and depressive symptoms, when assessed at 9 months post-treatment. Alavi et al. (2013) conducted an open labeled clinical trial using CBT with a group of 30 depressed adolescents who had a recent (i.e., within the last three months) suicide attempt and found a significant reduction ($P < 0.001$) in suicidal ideation and hopelessness in the treatment group compared to the waitlist control group.

More recently, the Collaborative Assessment and Management of Suicidality program (CAMS; Jobes 2006), originally created for adults and heavily drawing from the theory of CBT, is developing a program for adolescents and children, the CAMS-4Teens and CAMS-4Kids. Two preliminary papers discussing adaptations for use of CAMS with suicidal youth have been published and further research is currently underway in several school districts in North Carolina as well as in other settings such as the juvenile justice system, clinics, and children’s hospitals. Thus far, the results are encouraging and have found the CAMS-4Teens to be an effective intervention that can be readily integrated into a Multi-Tiered Systems of Support (MTSS; Jobes et al. 2019). The baseline assessment component of CAMS, known as the Suicide Status Form (SSF), currently has well-established psychometric validity and reliability for adults (Jobes et al. 2019) and has been used in a study of 1100 youth (ages 8–18 years old) where it was found to be an effective assessment and treatment development tool (Romanowicz et al. 2013). Currently, the SSF is undergoing a stringent psychometric study for its use with suicidal adolescents. Preliminary data suggests psychometric validity and reliability for this instrument in differentiating suicidal risk in adolescents. Taken together, CBT has been shown to have modest, albeit mixed, effects on improving NSSI and suicidal behaviors.

Though telehealth-based CBT has been found to be as effective as in-person CBT for the treatment of adolescent depression and anxiety (Bashshur et al. 2016; Nelson et al. 2006), research on telehealth and Internet-based CBT

interventions where the primary outcome is reduction in suicide risk is still emerging. Recently, the CAMS has been adapted for use with patients in home settings due to the COVID-19 pandemic (Jobes et al. 2020). While RCTs have not been completed, pilot studies are currently being conducted and have found preliminary results suggesting that the telehealth implementation of CAMS reduces the need for hospitalization and, in turn, increases patient engagement in treatment (Jobes et al. 2020). Additionally, a systematic review and meta-analysis of Internet-based CBT was conducted with the aim to determine whether CBT interventions specifically designed for individuals with high-suicide risk could lead to reductions in suicidal ideation (Büscher et al. 2020). The review included six randomized controlled trials (RCTs), all of which reported significant reduction in suicidal ideation for Internet-based CBT participants compared to control participants (effect size averaged across all studies = -0.29 ; 95% CI = -0.40 to -0.19 ; $P < 0.001$). Two studies in the meta-analysis evaluated high-risk school-age students, one of which investigated the implementation of a school-based Internet CBT intervention for youth at risk for suicide and NSSI (Hetrick et al. 2017). In the Hetrick et al. (2017) study, participants in the control group were given school counseling support, while the intervention group was given both the online CBT intervention and counseling. Improvements in suicidal ideation, frequency of suicide attempts, depression, hopelessness, anxiety, and problem-solving ability were seen in both study groups, with a larger but not statistically significant difference ($P = 0.593$) for the CBT telehealth group. Additionally, participants from the intervention group were found to have an increased use of cognitive and behavioral skills when compared to the control group. Results also evidenced that Internet-based CBT had the capacity to be more accessible and less stigmatizing than traditional in-person methods (Hetrick et al. 2017). Considering the high prevalence of suicide for this age group, as well as the level of comfort youth have with technology, more researchers and practitioners may feel confident with using telehealth as an intervention for those at-risk for suicide.

Mindfulness

Mindfulness is a way of attending to the present moment in a non-judgmental and reflective fashion and has been found to be useful in the treatment of internalizing and externalizing problems in youth (Liehr and Diaz 2010; Zelazo and Lyons 2012). There are many techniques and practices associated with mindfulness, including meditation, deep breathing, acceptance of thoughts or circumstances, and yoga. In a review of several dozen studies on the use of mindfulness-based interventions with children, Harnett and Dawe (2012) concluded that the use of mindfulness can be an important addition to the repertoire of existing therapies with youth.

Mindfulness techniques have been found to reduce some of the symptoms and risk factors that are associated with youth suicidal behaviors, such as reducing depressive symptoms (Liehr and Diaz 2010; Raes et al. 2014), increasing emotional regulation (Metz et al. 2013), and decreasing stress (Barnes et al. 2004). It is thought that by increasing one's mindfulness of psychological processes, one can reduce the desire to engage in experiential avoidance of pain, a key function of both NSSI and suicidal behaviors. Therefore, the person is equipped with a means of coping with the pain (use of mindfulness) instead of engaging in self-harm (Hayes et al. 2006). Additionally, self-compassion, stress reduction, and living in the moment can all be fostered when using mindfulness with those at risk of self-harm (Luoma and Villatte 2012), thereby creating resiliency for the individual.

Mindfulness practice increasingly is being applied through modes that are more cost-effective and accessible, such as online programs and mobile phone applications (Cavanagh et al. 2013). The online Mindfulness-Based Stress Reduction (MBSR) program and Mindfulness-Based Cognitive Therapy (MBCT) have been proven to significantly reduce stress and anxiety for youth (Ma et al. 2018). Self-directed interventions paired with online group sessions and discussions provide an added factor of social support that can help to increase the effects of enhancing mood and decreasing stress. Meta-analyses of the effectiveness of online approaches are still emerging, yet the few that have been conducted have evidenced overall positive results (Ma et al. 2018). In addition to online programs, mobile phone applications (e.g., Mindfulness Daily, The Mindfulness App, Headspace, Calm) have been shown to be effective supplements to interventions (Lucas-Thompson et al. 2019). Consistent with this, mindfulness combined with the delivery of structured or unstructured intervention through text messages (ecological momentary intervention (EMI); ecological momentary assessment (EMA)), followed with frequent evaluation, encourages and empowers youth to use acquired mindfulness tools in alternate settings. School-based professionals can create scheduled times for delivering the intervention while also addressing concerns of translating learned skills and applying them within the context of the home environment. A study by Lindsay et al. (2018) was the first to show that brief smartphone-based mindfulness training can impact objective biological stress outcomes, including blood pressure (treatment vs. control: $\chi^2(1) = 10.16$, $p = 0.001$, $d = 0.72$) and cortisol levels (treatment vs. control: $F(1,140) = 4.79$, $p = 0.030$, $d = 0.47$). Lucas-Thompson et al. (2019) found improvement in well-being of youth at risk for NSSI and suicidal ideation using mindfulness and EMIs. Though research in this area is emerging, the use of these kinds of apps appears to be promising for use with the adolescent population (Nock et al. 2009).

Dialectical Behavior Therapy (DBT)

Dialectical behavior therapy (DBT) is a well-established empirically supported treatment for adults with borderline personality disorder (BPD), with a recent meta-analysis demonstrating that DBT was superior to treatment as usual (TAU) in reducing suicidal behaviors and NSSI in adolescents (Ougrin et al. 2015). Using a dialectical framework, individuals are taught to balance and synthesize opposing ideas, most notably, acceptance and change. This is achieved through the use of CBT techniques, in conjunction with acceptance and mindfulness-based strategies. More specifically, treatment utilizes dialectical strategies, acceptance-oriented validation strategies, and change-oriented problem-solving strategies. Skills training is an integral component of treatment and focuses on four core modules: mindfulness, emotion regulation, interpersonal effectiveness, and distress tolerance (Linehan 2014).

DBT has been formally adapted for adolescents (DBT-A) presenting for treatment with BPD features such as NSSI, suicidal ideation, suicide attempts, and intense and inappropriate negative emotions (e.g., anger; Miller et al. 2006). This modified DBT intervention has been shown to reduce the length of treatment from 1 year to 16 weeks. Additionally, it simplifies the skills to make them more developmentally appropriate, incorporates family members into treatment, and adds an additional skills module (Walking the Middle Path) that addresses common dialectical dilemmas that occur between adolescents and parents (Rathus and Miller 2014). The evidence supporting the efficacy of DBT-A continues to grow. A narrative review completed by Groves et al. (2012) demonstrated that DBT-A was shown to have strong treatment acceptability and retention, as well as reduced NSSI, suicidality, impulsivity, and depressive symptoms. More recently, an initial meta-analysis of DBT-A was conducted and showed preliminary evidence of the positive impact of DBT for adolescents, including decreased engagement in NSSI (effect size = 0.81, 95% CI = 0.59 to 1.03) and improvement in depressive symptoms (effect size = 0.36, 95% CI = 0.30 to 0.42; Cook and Gorraiz 2016).

DBT has been implemented by some school districts utilizing an MTSS model (Tiers 1–3) with the program Comprehensive School-Based DBT (CSB-DBT). CSB-DBT contains five core components: (1) weekly individual DBT counseling, (2) roughly 30 weekly skills group sessions, (3) skills coaching by DBT-trained school personnel as needed during school hours, (4) weekly consultation team meetings, and (5) monthly or as-needed family meetings or parent skills reviews. Initial pilot studies suggest promising results including anecdotal reductions in NSSI behaviors and significant reductions in depression, anxiety, and social stress as measured by the Behavioral Assessment System for Children-second edition (BASC-2; Reynolds and Kamphaus 2004);

however, more research must be done (Miller et al. 2020). A social-emotional learning curriculum, DBT Training for Emotional Problem Solving for Adolescents (DBT STEPS-A), has also been developed as a universal prevention program (Tier 1) based on the DBT skills training component (Mazza et al. 2016; Mazza and Dexter-Mazza 2018). In the DBT-STEPS-A manual, several initial studies are described evaluating the positive utility of teaching DBT skills in a school environment. Since the publication of the manual, two pilot studies have been conducted that suggest that adolescents can benefit from participating in school-based DBT programs (Flynn et al. 2018; Mazza and Hanson 2015). Additional research is needed, however, as no randomized controlled trials have been published examining the effects of DBT-A in a traditional school-based setting.

While DBT appears to be a promising therapeutic treatment for youth at risk for harm to self, there are no current studies on the implementation of DBT-A, CSB-DBT, or DBT STEPS-A in a telehealth environment (McGinn et al. 2019). Still, in this unprecedented time, DBT skills training has been adapted to the web-based environment and can be used by school-based mental health providers working with clients remotely. DBT STEPS-A lessons have been made available for free through YouTube by the curriculum developers (Mazza and Dexter-Mazza 2020) and the website NowMattersNow.org offers DBT skills training for actively suicidal adults and adolescents seeking help online (Whitesides et al. 2019). According to Whitesides and colleagues (2019), adults who visited the site for as little as 10 min experienced a reduction in suicidal thoughts. The website features lessons based in DBT skills that can be accessed for free by the public. Research is currently underway with adolescents to determine if the NowMattersNow.org skills resources are equally as effective for this age group (Whitesides et al. 2019).

Parent and Family Work

Incorporating parents, families, and caregivers into a youth's mental health treatment has many advantages including increased treatment engagement, better generalization of skills, and improved ability to address parenting/family factors that may be contributing to the presenting problems (Taylor and Adelman 2001). When families are included in the treatment of youth at risk of harm to self, they are also better able to create a home environment that facilitates improved communication and collaborative problem-solving (Woitaszewski et al. 2012). A major component of fostering this alliance is to provide psychoeducation to parents on their child's presenting problems, the warning signs that their child may be at risk for harm to self, and how to best support their child in the home (Reamer and Siegel 2007). Research supports the idea that youth who have healthy relationships with significant

adults in their lives, including, but not limited to, their primary caregivers, have increased levels of resiliency and decreased depressive symptoms (Hazel et al. 2014). A study by Karcher (2008) of 516 predominately Latino students across 19 schools found that a school-based mentoring program increased self-reported connectedness to others and school and greater self-esteem for youth, and, for elementary-aged boys, higher levels of social skills, empathy, and hopefulness, although effect sizes were small (0.10). Involving parents in intervention has been shown to reduce child internalizing ($d = -0.177$) symptoms, including depressive ($d = -0.156$) and anxiety ($d = -0.273$) symptoms, at a minimum of 6 months after the intervention was delivered (Yap et al. 2016). In general, the involvement of parents and the power of the interpersonal relationship with caring adults must be considered an important contribution to the overall well-being of youth.

As discussed above, the development of DBT-A recognized the importance of incorporating parents into treatment and added an extra module (Walking the Middle Path) to address common dialectical dilemmas that occur between youth and their parents (Rathus and Miller 2014). Empirical support for the inclusion of parents is well-documented in a meta-analysis (Ougrin et al. 2015), which revealed that studies with a strong family component were associated with more significant reductions in NSSI and suicidal behaviors (risk reduction -0.14 [95% CI = -0.27 to -0.02]). Incorporating parents into CBT-based treatment models has also been increasingly emphasized. For example, the SAFETY program is a 12-week cognitive behavioral family-based intervention utilized in emergency service settings that focuses on enhancing protective supports within the youth's social systems. According to Asarnow et al. (2014), 57.1% of youth reported NSSI prior to intervention in comparison to reports of 31.3% of NSSI youth post intervention, with an overall medium intervention effect size (0.38). This program has been shown to significantly reduce suicidal behaviors, hopelessness, parent and youth depression, and improve youth social adjustment (Asarnow et al. 2014). While these preliminary studies have shown great promise in demonstrating the added benefit of including parents and families in the treatment of youth at risk of harm to self, additional research is needed.

Understanding the role of culture in the family's life of the youth at risk for self-harm is important to support caregiver participation. For some families, cultural barriers, language barriers, and mistrust of systems can play a role in a parent's participation and must be addressed in the telehealth setting (Carlisle 2013; Owings-Fonner 2020). Youth who engage in self-harm typically experience intense levels of pain, and a practitioner's ability to accurately empathize and provide culturally informed care with the at-risk client is essential to building communication, destigmatizing the situation, and giving the client and their family a message of hope

(Newman 2018). In a study conducted by Mancoske et al. (2012), therapists that were perceived by families as being more culturally competent reported improved clinical outcomes in all the areas measured, including access and service outcome. This was true regardless if the cultural background of the family matched the background of the provider. Establishing open communication with families and developing an understanding of what they need is key in supporting students during these times of uncertainty. NASP recommends having readily available school and community resources for families with consideration of what is open and accessible during COVID-19 closures. Information should be distributed to parents through various modalities via phone, email, and mail and having psychoeducational tools and resources available on the school website. It is important to provide services in the preferred language of the child and family. Providers should be flexible and responsive to the family's needs, maintaining check-ins with students, monitoring progress, and involving families in the processes (NASP 2020c).

Apps and Other Virtual Tools

Families and at-risk youth need easily accessible and cost-effective tools at their fingertips, particularly within the context of COVID-19. Young people are increasingly utilizing smartphones and other technologies, reporting a greater sense of privacy and increased likelihood of discussing sensitive topics through their use. A study of adolescents who received crisis intervention found 50% prefer technology-based intervention over traditional approaches (O'Brien et al. 2017). Smartphone use is shown to increase engagement, enhance effectiveness, and provide greater opportunities to deliver evidence-based interventions, including self-monitoring of depressive and anxious symptoms and suicidal thoughts (Luxton et al. 2011). For example, the Crisis Care app provides skill-based content that is based on cognitive behavioral strategies dealing with suicidal feelings for both youth and their families. A pilot study of the Crisis Care web application of 20 caregivers and adolescents with high suicidal risk evidenced the app showed promising results regarding usability, utility, and acceptability. Post-discharge from a crisis care facility adolescents reported decreased feelings of loneliness and isolation as a result of family-focused intervention and app usage. Both caregivers and youth reported similar ratings of the usefulness of the app during a crisis situation (O'Brien et al. 2017). Further research and development is necessary of the content and effectiveness of Crisis Care and other suicide apps in determining apps as an effective supplement and evidence-based family practice for dealing with and managing suicidal ideation.

Providers and parents can also encourage youth to connect with peers through phone and video calling, and virtual activities such as online gaming, virtual exercise classes, and movie watch parties (Green et al. 2020), in order to reduce risk associated with social isolation. Other considerations include free, evidence-based phone applications (apps; e.g., Virtual Hope Box [Bush et al. 2017; Bush et al. 2015], MY3 [Ly et al. 2014], A Friend Asks [The Jason Foundation 2017], ReliefLink [Kaslow 2017; Kaslow 2018]) and electronic worksheets (NASP 2020b; Stanley and Brown 2008) that have been developed to help make safety plans accessible to clients, providers, and caregivers through telehealth (NASP, 2020a). A written copy of this plan can be kept in various places to remind the youth and parents of the steps to follow if the ideation worsens (Stanley and Brown 2012). Alternative applications vary in content and engagement; for example, the MY3 app connects an individual to emergency contacts and allows for the development of an individualized safety plan (adapted from the work of Stanley and Brown (2008)), whereas ReliefLink allows youth to track mood, access mental health resources, and create a safety plan during a time of crisis (Luxton et al. 2015; O'Brien et al. 2017). Suicide prevention apps provide accessibility, confidentiality, and quality interventions for families; however, their use continues to remain uncommon among mental health professionals due to the lack of research of technology-based suicide intervention measures (De la Torre et al. 2017). While all apps listed above have been evaluated for quality (Luxton et al. 2015) and have elements based in suicide prevention research, few have undergone rigorous evaluation in the form of published RCTs (e.g., Virtual Hope Box) and should therefore be used with caution. Tools available to clinicians to review such electronic intervention tools include One Mind Institute's PsyberGuide, a non-profit digital guide offering unbiased reviews of mental health apps written by experts in the field (Lipczynska 2019). Further development of effective suicide prevention apps is necessary considering the accessibility and appeal of technology-based resources for youth.

Conclusion

Currently, there is a scarcity of causal research specifically targeting school-based telehealth for at-risk youth. Meanwhile, youth suicide continues to be a national health crisis, and with the COVID-19 pandemic, students will need the support of school-based mental health providers more than ever. School-based professionals best serve youth through collaboration and consultation with teams and can continue to do so virtually through the use of adapted guidelines, protocols, and interventions. School-based practitioners must consider individual, social, and environmental risk factors when working with and selecting interventions for youth

deemed at risk for harm to self through telehealth. Advances in technology provide a plethora of emerging research in incorporating online and mobile phone interventions. Research thus far has found that when evidence-based interventions are used, there is no significant difference in intervention effectiveness when comparing in-person to telehealth service delivery. Furthermore, the evidence suggests that risk assessment and safety planning conducted through telehealth is both safe and effective. Though some individual interventions, such as CBT, DBT, and mindfulness were identified as current best practice for follow-up care with at-risk youth, outcome research is either scant or mixed in a telehealth modality. Overall, DBT-A does appear to be the most well-supported therapeutic approach for those youth at risk for harm to self to date; however, it is important to note that DBT programs for youth have not yet been formally adapted to telehealth. Family and caregiver involvement significantly improves the quality and outcome of intervention by providing youth and families with coping tools and psychoeducation. Further research is needed in order to identify best practice intervention approaches that should be used when working with at-risk youth in a school-based telehealth model.

Compliance with Ethical Standards

This research is in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. This article does not contain any studies with human participants or animals performed by any of the authors. Therefore, no informed consent was necessary.

Conflict of Interest The authors declare that they have no conflict of interest.

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